Australian Government
National Mental Health Commission

SENATE SELECT COMMITTEE ON HEALTH

Wednesday 26 August 2015

Thank you for the invitation to appear before this Select Committee today and for this opportunity to provide an opening statement about the National Review of Mental Health Programmes and Services which the Commission provided to the Government last December.

Our intent is that I will make the bulk of the opening statement and then ask Commissioners Crowe and Hickie, as well as Mr Butt, to briefly comment on any further issues we wish to bring to the Committee's attention prior to going to questions.

The vision for our review is highlighted in the title – Contributing Lives, Thriving Communities. Our review is based on the Contributing Life Framework – a whole-of-person, whole-of-life approach to mental health and wellbeing. It recognises that if we enable people to live contributing lives – to have relationships, stable housing, and to maximise participation in education, employment and the community more broadly – we will help build economically and socially thriving communities, and a more productive Australia.

It is particularly timely to be conducting this hearing today given that the National Reform Summit also is being held today. The Commission has provided a number of delegates attending the Summit with a submission about mental health reform, not so much because we expect it to be a key topic for discussion today but rather because we are urging the Summit to recognise mental health

and suicide prevention as key economic reform priorities which can lead to significant productivity improvements and growth opportunities for Australia.

A copy of that submission has been provided to the Committee secretariat.

(NOTE: At this point the committee may move a motion to table the submission)

As Chair of the Commission and an economist, I want to emphasise that mental health is a significant problem for our economy – as significant as, often more significant than, tax or microeconomic reform. Many people do not get the support they need, and governments get poor returns on substantial investment. The economic or GDP gains from better mental health would dwarf most of the gains – often modest ones – being talked about in current economic reform debates.

This is starting to be recognised internationally and we have included examples of this in our submission so I will not repeat them here. However I will use one example, from the world's leading economic commentator, the *Financial Times*' Martin Wolf, who has concluded mental ill health is the developed world's most pressing health problem. He said:

> "Given the economic costs to society, including those caused by unemployment, disability, poor performance at work and imprisonment, the costs of treatment would pay for themselves."

The OECD estimates the average overall cost of mental health to developed countries is about four per cent of GDP. In Australia, this would equate to more

than $60 billion or about $4,000 a year for each person who lodges a tax return or more than $10,000 per family. The costs include the direct costs of treatment; the indirect costs e.g. disability support pensions, imprisonment, accommodation and so on; the costs of lost output and income and finally costs to carers and families, not to mention that their workforce participation is held back by caring demands.

If we can improve the mental health system by 25 per cent, we can deliver a 1 per cent improvement in GDP. That would be a huge contribution. To put it another way for every 10 per cent gain in mental health, GDP would rise by 0.4 per cent.

Mental health is unique among major health challenges in that there is much scope for addressing the three Ps of economic growth – reducing the impact of mental illness on a large population; improving participation; and improving productivity at work.

POPULATION

The population affected is huge, with as many as 20 per cent of the adult population affected by mental ill-health in any given year. In fact, one in two Australian adults will experience mental ill-health at some point – this is 7.3 million Australians (aged 16-85). And the issue is greatest for our young Australians, those who should be participating in the education system and embarking on their working lives. One in four 18-24 year olds experience a mental ill-health problem every year.

To reinforce the point about the size of the problem, I note that mental illnesses

are the leading causes of the non-fatal disease burden in Australia – they account for about a quarter of the total burden. Mental illness also accounts for about 13 per cent of our total burden of disease (including deaths).

PARTICIPATION

Labour force participation is the second major variable in economic growth. The higher the number of people working, the higher the rate of economic growth. Mental illness is responsible for a very significant loss of potential labour supply and output.

Today 37.5 per cent of people affected by mental ill-health are either unemployed or not in the labour force. This compares to 22.3 per cent of people without mental health conditions. And our performance is low by the standards of the leading OECD countries.

The World Economic Forum estimates the cost of lost output and income as being about 1.75 per cent of GDP.

This is not good enough and there is a clear productivity cost. Many people with mental illness want to work but find it difficult to find a job, also impacting on families, carers and other support people. We need to provide better support for people living with mental illness to get into the workforce and stay in it, not only for the benefit of individuals, their families and support people but also for the benefit of the whole population.

PRODUCTIVITY

The third variable is productivity. Mental ill-health generates considerable absenteeism and presenteeism (on the job productivity loss). Those with mental health difficulties are both more likely to take time off from work and to accomplish less than they would like to when they are on the job.

Mental health conditions result in around 12 million days of reduced productivity for Australian businesses each year.[1] And given one in six people in employment experience a mental health issue each year, even small businesses are likely to employ people with a mental illness, which requires proper support.

Mental health and wellbeing is recognised as a serious workplace matter. That's why at the Commission we have formed a collaboration with a very interested business sector, the mental health sector and government through the Mentally Healthy Workplace Alliance.

THE COSTS

Our Review identified that the direct costs of Commonwealth expenditure alone on mental health and suicide prevention programmes are about $10 billion a year (2012-13).

This gives rise to another set of important economic questions: the allocation of spending – is that expenditure effective and efficient?

- Are scarce resources being used cost-effectively to achieve identified objectives?
- Are decisions on what programmes and services the Commonwealth invests in resulting in maximising net benefits to the community?

[1] PwC PricewaterhouseCoopers Australia, Creating a mentally healthy workplace: Return on investment analysis, 2014. Available from www.headsup.org.au

From the limited evidence available, the Commission's view is that much of the funding from the Commonwealth is neither effective nor efficient.

An indicator of this is that a very large amount of spending occurs in downstream programmes engaged in income support and crisis responses, as well as in other benefits and activity-related payments – $8.4 billion or 87.5 per cent of Commonwealth funds is spent in five major programmes:

- Disability Support Pension
- Carers Payments
- Payments to the States and Territories for hospitals
- Mental health related Medicare Benefits Schedule payments (including Better Access)
- Pharmaceutical Benefits Scheme payments

Much of this is payment for failure to treat the problems early and cost effectively.

The Commission therefore has made recommendations about how this heavy expenditure could be reduced with a greater emphasis and investment in prevention, early detection, a focus on recovery from mental ill-health and the prevention of suicide.

THE REVIEW

Our Review – Contributing Lives, Thriving Communities – highlighted that mental health is not just an issue for governments. It touches every industry, every workplace, the vast majority of families and is everyone's responsibility.

We heard from many people with lived experience, their families and supporters, and people who work in the sector.

We found many examples of wonderful innovation and that effective strategies do exist for keeping people and families on track to participate and contribute to the social and economic life of the community.

Fundamentally, the approach we recommend calls for the system to be realigned from a focus on service providers, to a focus on people, where those with lived experience, their families and support people are engaged and involved at all levels —"nothing about us without us".

Central to this are person-centred design principles, where through an integrated stepped care model, services are designed, funded and delivered to match the needs of individuals and particular population groups. This involves a participative and inclusive approach, focused on achieving better outcomes for individuals, their families and communities – not on the role of providers and what activity they produce, though they are indispensable and valuable players.

Importantly, the right approach requires a holistic focus on people, taking into account all of their needs – their mental health and fitness, social and emotional wellbeing, physical health, and other determinants such as culture and a sense of belonging.

We need to shift the focus from downstream to upstream services – from income support and crisis responses, to early intervention, prevention and support for recovery-based community services, stable housing and participation in employment, education and training.

Our Review shows that we have a once-in-a-generation opportunity to create a system that will support the mental health and wellbeing of millions of individuals to enable them to live contributing lives and participate in thriving communities. What's more, the Review shows this is achievable and sets out a blueprint on how we can get there.

STEPPED CARE FRAMEWOK

Key to this is a stepped care framework as outlined in the Review.

This means that there is a range of options that vary in intensity according to an individual's level of need or functional impairment.

People's needs vary dramatically across the spectrum of mental illness. Of the 3.7 million estimated to have mental ill-health problems in any given year, the majority, or 3 million, have a mild to moderate condition, such as anxiety or depression.

Another 625,000 have a persistent complex and chronic illness such as schizophrenia or severe depression. And 65,000 people have severe illness and suffer from a psychosocial disability.

Stepped care services would range from no-cost and low-cost options for people with the most common mental health issues, through to support and wrap-around services for people with severe and persistent mental illness. It includes a greater range of services being available according to need and functional impairment – for example:

- a graduated range of services from self-help and prevention

- a strengthened primary health care approach
- non-clinical psychosocial support within the community, and
- a variety of options between specialised community mental health services and acute hospitalisation – for example, step-up/step-down services where, for example, people can leave costly hospitals and go to less restrictive accommodation with adequate levels of care
- more generally, we need to build community capacity and rely less on new hospital beds – in both the public and private sector.

The overarching aim is to enable all to participate as much as possible within their families and communities, and to lead contributing lives.

Easy to access service delivery models such as e-mental health have an important role to play in assisting people and those who care for them. This would in turn enable more cost effective use of the time and skills of clinical and other professionals.

A fundamental element of a stepped care approach is prioritising the delivery of care through general practice and the primary health sector.

NEW SYSTEM ARCHITECTURE

Our report recommends new system architecture, with a focus on the needs of particular population groups.

In particular, it recommends a stronger focus on the early years and a healthy start to life, to build resilience in children and families, reduce childhood trauma

which can have an intergenerational impact, and protect those who are vulnerable.

We also recommend that agreement be reached on the respective roles of the Commonwealth on the one hand, and the States and Territories on the other. Our view is that the Commonwealth should focus on national leadership and programmes, and that their other key role should be in enabling a much better coordinated, joined up system at a regional and local level.

The current system is too fragmented and with too many siloed services, meaning that the more functionally impaired you are the harder it becomes to navigate the system.

PRIMARY AND MENTAL HEALTH NETWORKS

Right now, organisations are rolling out across the country that could spearhead this change to a more regional, localised approach.

For example, July 1 saw the formation of 31 Primary Health Networks covering the entire country. These provide the ideal architecture to better target mental health resources to meet population needs on a region by region basis.

We propose renaming these as Primary and Mental Health Networks and providing them with bundled funding for planning and purchasing mental health programmes, services and integrated care pathways for mental health that are tailored to individual needs and different communities.

We envisage these Primary and Mental Health Networks will engage with local services, with people with lived experience and with their families and support people to identify local priorities and local responses.

We see it as vital that mental health and wellbeing is identified as intrinsic to primary health care – Australia cannot take a person centred, holistic approach to better outcomes for individuals and communities unless we deal with both the physical and mental health of populations and people's overall wellbeing.

Some of the most disturbing findings of our review related to the physical health of people with a mental illness and in particular the failure of the system to recognise the physical clinical deterioration of people with a mental illness. Few people probably realise that people with psychosis die on average earlier than the general population with the causes being the side-effects of antipsychotic medications, high, increasing rates of smoking and the fact that many people with a mental illness do not get good treatment of their physical illness.

SUICIDE

A good example of what we mean in relation to a regional or local approach is in the area of prevention of suicides and suicide attempts.

In our country seven people die every day from suicide, approximately double the road toll. But while the number of deaths on our roads has diminished substantially, there has been no major reduction in the suicide rate over the past decade.

In particular, death from suicide among Aboriginal and Torres Strait Islander peoples is twice that of non-Indigenous Australians.

There are excellent examples of suicide prevention, treatment, follow-up and postvention in Australia.

However too often services are not joined up, too fragmented, lack sufficient focus and operate from too small a resource base to achieve a meaningful impact.

A new approach is needed and there is some evidence about a range of strategies that work.

Suicide is not just about mental health and nor is it about any one sector. What we need are locally organised and properly coordinated or joined up responses to this major problem.

So we have proposed that the Commonwealth use its resources as incentives to drive the development of community partnerships which co-create solutions at a local level for suicide prevention. These partnerships should encourage buy-in (including financial or in-kind contributions) from local communities, including health services, schools, NGOs, businesses, local government, media, community organisations and clubs, and in particular from families and communities, to all play a part in developing local solutions which provide comprehensive strategies based on local knowledge.

REGIONAL CHANGES

A regional approach provides the opportunity to improve service equity for rural and remote communities through place-based models of care.

We know that the further away you get from major cities the harder it is to access mental health specific services.

Our view is that changing this will require national leadership combined with local responses.

We need to acknowledge diverse regions have different needs and to plan appropriately, and that there is significant regional variation in need, and in access to services and regional equity. A one-size-fits-all approach cannot be applied across metropolitan, regional, rural and remote Australia.

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

Finally, over a considerable period of time, we have seen news coverage that has further amplified areas of crisis in indigenous mental health, social and emotional wellbeing and suicide. In 2011–12, 30 per cent of Aboriginal and Torres Strait Islander adults had high or very high levels of psychological distress. That's almost three times the rate for other Australians.

In 2012/13, the annual suicide rate for Australians generally was 10.3 deaths for every 100,000 population – for Aboriginal and Torres Strait Islander peoples it was 21.4 deaths per 100,000.

This must change. Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing must become a national priority.

There is a strong Aboriginal and Torres Strait Islander presence which flows throughout our review recommendations, with many of the system changes we recommend expected to have a positive impact on Aboriginal and Torres Strait

Islander mental health and social and emotional wellbeing. However, there are two specific recommendations which I want to draw to your attention:

Recommendation 5: Make Aboriginal and Torres Strait Islander mental health a national priority and agree an additional CoAG Closing the Gap target for mental health:

- Establish a new and dedicated National Aboriginal and Torres Strait Islander mental health plan
- Implement the National Strategic Framework for ATSI Peoples' Mental Health and Social and Emotional Wellbeing 2014–2019, the National Aboriginal and Torres Strait Islander Health Plan 2013–2023, National ATSI Suicide Prevention Strategy 2013 and National ATSI Peoples' Drug Strategy

What that Closing the Gap target should be needs to be worked out with the Indigenous community – it may be there need to be two, one on social and emotional wellbeing and the other on suicide prevention.

Recommendation 18: Establish mental health and social and emotional wellbeing teams in Indigenous Primary Health Care Organisations, linked to Aboriginal and Torres Strait Islander specialist mental health services.

- Ensure through contractual performance requirements that general population mental health services are accountable for better Aboriginal and Torres Strait Islander mental health outcomes.

- Train and employ the Aboriginal and Torres Strait Islander workforce needed to close the mental health gap.

CONCLUSION

Traditionally, mental health has been seen as an area of significant common ground between political parties. There also is significant stakeholder agreement on the imperative for reform – probably greater than is realised in the political debate. This creates the environment for widespread agreement on the reform agenda.

Unfortunately mental health has never been given the priority it merits in terms of whole of government/all levels of government/whole of systems approaches.

What we now need is to ensure that mental health reform is recognised as vital to this country – to individuals, families, communities and also to our nation's future prosperity.

In this context, I want to quote from the response of the Mental Illness Fellowship of Australia to the Review report:

> "It's not perfect. We could argue with some of the detail. But our own experiences with mental illness and the mental health services tell us that it seems to be about right on all the big issues. Most importantly, it gives us all a framework that we can get started on as the first part of a ten year plan. Let's argue the detail **after** we get started on implementation."

I would now ask my colleagues whether they wish to briefly add anything prior to going to questions.