Mental Health Australia

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2019-20 pre–Budget submission

December 2018

Mentally healthy people,
Mentally healthy communities

Aim: Expand and reorient mental health services to meet need

Largely due to our legacy health financing arrangements, Australia's mental health system is predominantly shaped around a biomedical model. General practice is experiencing unprecedented presentations for mental health conditions. Psychological conditions represent 60 per cent of the reason for patient visits, and are considered by general practitioners as the health issue causing most concern for the future[i]. 4,045,916 people use medications for their mental health condition[ii], many of whom would benefit from adjunctive therapy. The mental health system has few options for general practitioners to refer people to for complementary community based mental health services.

In 2016-17, 276,954 people presented at overstretched public hospital emergency departments seeking care for mental health related conditions. Only 38 per cent of those people were admitted to hospital or referred to another hospital for admission[iii], indicating the needs of around 62 per cent (166,172) of people presenting to public hospital emergency departments were not met. A world class mental health system would provide the clinical and social care and support that people need, when they need it[iv]. Expanding existing community based mental health services to meet the needs of people with mental health conditions will aid their recovery and support their economic participation and social inclusion.

The Australian Government has announced a Productivity Commission Inquiry into the role of improving mental health to support economic participation and enhancing productivity and economic growth. While the Inquiry will take place over 18 months, it is essential that evidence-based action is not delayed while we await the Commission's findings. There have been many inquiries and reviews over recent years and we know many of the solutions already. The Commission's work will make a valuable contribution, but in the meantime we must act where the evidence for action is clear. We already have strong evidence showing investment to expand mental health services to meet need will deliver economic returns to government and the economy, and achieve positive health and social outcomes for people experiencing mental health issues.

The return on investments outlined in this *pre-Budget submission* have been modelled by KPMG, and are described in detail in *Investing to Save: The economic benefits for Australia of investment in mental health reform*.

Strategic Direction: Expand community based supports

Provide community-based assertive outreach to people who have attempted suicide

ACTION

Fund a range of targeted community mental health supports to reduce the risk of subsequent suicide following discharge from hospital or other care. Follow up should occur through multiple channels (in person, by phone), and should not be dependent on the nature of any other service the person is receiving or has received, or how that service is funded (Commonwealth or State).

THE NEED

In 2017, 3,128 lives were lost to suicide.[v] The biggest risk factor for suicide is a prior suicide attempt. Assertive outreach approaches to integrated suicide prevention can prevent 21 per cent of suicide deaths and 30 per cent of suicide attempts.[vi] Every individual who has attempted suicide and sought hospital treatment for a related injury should be followed up.

All governments have made the following commitment to Australians: "Services will actively follow up with you if you are at a higher risk of suicide, including after a suicide attempt."[vii]

RETURN ON INVESTMENT

$1.30 for every $1 invested

Expand community-based psychosocial support programs

ACTION

Increase the range and availability of services through psychosocial support programs for people who are not eligible for the NDIS.

THE NEED

Around 768,000 Australians have a severe mental health disorder.[viii] Governments have identified that approximately one third (256,000) of these people have a need for some form of social support, ranging from low intensity or group-based activities delivered through mainstream social services to extensive and individualised disability support.[ix] When fully established, the National Disability Insurance Scheme will meet the social support needs of around 64,000 of this group.[x] Funding for the National Psychosocial Support Program[xi] and the NDIS continuity of support[xii] programs are not sufficient to support the remaining 192,000 people. In particular, additional services will be needed for people who will need a service in the future, and for people who do not have a 'permanent impairment' (and will therefore not be able to access the NDIS).

Expand the paid peer workforce

ACTION

Establish an expert group, including consumers and carers, to develop a strategy to create 1,000 more paid peer workforce positions to grow the disability workforce and increase peer workers in the mental health system.

THE NEED

Emerging evidence indicates peer work achieves positive outcomes for consumers who have received support from peer workers. Peer work provides an opportunity for people with lived experience to be trained as mental health support workers. They provide essential support, such as helping consumers transition out of hospital.

RETURN ON INVESTMENT

$3.50 for every $1 invested

Strategic direction: Expand promotion, prevention and early intervention

Cognitive based therapy and other interventions for children and young people

ACTION

Fund preventive and early interventions targeted at children and young people showing first signs of mental health issues to build up protective factors like resilience and lower psychosocial risks.

THE NEED

The majority of mental health disorders begin before the age of 24. Around 50,000 children and young people are:

- experiencing initial onset of depression or anxiety, or
- are at risk for depression due to having one parent with a depressive disorder.

THE RETURN ON INVESTMENT

$1 for every $1 invested in the short term

$7.90 for every $1 invested in the long term

Increase uptake of e-mental health early intervention services

ACTION

Fund a work to raise awareness and increase the use of e-mental health early intervention services.

THE NEED

Around 25 per cent of the workforce experience mild levels of mental ill health, yet less than 50 per cent of people requiring mental health treatment actually receive it.

e-mental health interventions deliver components of psychological therapies through teleconference/telephone, video conference and/or internet-based apps without a one-to-one relationship with a clinician. All people experiencing, or at risk of, mild to moderate depressive and anxiety disorders could derive some benefit from e-mental health interventions. E-mental health initiatives are also effective as adjunct therapies – ie alongside other interventions.

RETURN ON INVESTMENT

$1.60 for every $1 invested in the long term

Strategic direction: Expand support for mentally healthy workplaces

Work with employers to improve workplace mental health and wellbeing

A range of workplace interventions including enhanced job control, CBT-based resilience training and management mental health training can reduce stress. The return on investment for employers is $1.30 to $4.70 for every $1 invested, depending on the specific nature of the workplace intervention.

THE NEED

Almost a third of the workforce are affected by some degree of mental illness. The marginal impact of mental illness is 4-9 per cent on productivity, 2-5 times on absenteeism.

ACTION

Expand the activities of the Mentally Healthy Workplace Alliance by funding the Alliance's basic operations and investing in developing a national framework, ideally in a cost-shared partnership with states, employee representative bodies and the private sector. This framework will detail specific initiatives to encourage businesses to support and employ workers with lived experience of mental illness, and encourage more mentally healthy workplaces.

Increasing the Alliance's capacity, in line with the proposal submitted by the National Mental Health Commission to the Minister for Health. The Alliance to date has been self-funded by members and its leadership activities have been constrained as a result.

Underlying enabler: Consumer and carer co-design

Permanently embed arrangements for ongoing and active co-design with consumers and carers in all areas of policy and oversight, development of models of care, service and program reform, and evaluation. In both the *Fifth National Mental Health and Suicide Prevention Plan: Implementation Plan*, endorsed by the Australian Government, and the National Disability Insurance Scheme, consumer and carer co-design is identified as a key commitment, and as a critical success factor, however negligible funding has been allocated to achieve it. Properly resourced arrangements are a key enabler to successful expansion of mental health services.

THE NEED

Mental health consumers, carers, service providers and other key stakeholders have the right to participate in, actively contribute to, and influence, the development of government policies and programs that affect their lives and businesses.[xiii] Genuine engagement results in greater consumer and carer empowerment and ownership of mental health programs, effective advocacy and, ultimately, higher return on government investment.[xiv] [xv]

[i] The Royal Australian College of General Practitioners. General Practice: Health of the Nation. East Melbourne, Vic: RACGP, 2017.

[ii] Australian Institute of Health and Welfare. Table PBS.2: Patients dispensed with mental health-related prescriptions, by type of medication prescribed(a) and prescribing medical practitioner, states and territories(b), 2016–17

[iii] Australian Institute of Health and Welfare. Table ED.10: Mental health-related emergency department presentations in public hospitals, by episode end status, states and territories, 2016–17

[iv] United Nations Human Rights Council. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standards of physical and mental health. June 2017. Page 6.

[v] Australian Bureau of Statistics. 3303.0 Causes of Death, Australia 2017. Table 11.1 Intentional self-harm, Number of deaths, 5 year age groups by sex, 2008-2017.

[vi] Black Dog Institute. LifeSpan research. <https://blackdoginstitute.org.au/research/lifespan>, accessed 27 September 2018.

[vii] Council of Australian Governments Health Council. The Fifth National Mental Health and Suicide Prevention Plan. August 2017. Page 25

[viii] Based on a population of 24,770.7 in the December 2017 quarter http://abs.gov.au/AUSSTATS/abs@.nsf/mf/3101.0 and the estimate of 3.1 per cent of the population have a severe disorder in Department of Health. Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services. 2015. Page 25.

[ix] Department of Health. Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services. 2015.

[x] Productivity Commission. NDIS Costs Study Report. October 2017. Page 31.

[xi] Federal Budget 2017-18. Budget Paper No. 2.

[xii] Federal Budget 2018-19. Budget Paper No. 2

[xiii] Adapted from National Consumer and Carer Forum, Consumer and Carer Participation Policy: a framework for the mental health sector. 2004.

[xiv] Slay, J & Stephens, L., Co-production in mental health: A literature review. 2013.

[xv] World Health Organization. User empowerment in mental health – a statement by the WHO Regional Office for Europe. 2010.