Mental Health Council of Australia

SUBMISSION TO THE 2014-15 FEDERAL BUDGET

January 2014

Mentally healthy people, mentally healthy communities

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EXECUTIVE SUMMARY

This submission presents a range of ideas for government action to improve the mental health system – a task that all governments recently committed to through COAG's Roadmap for Mental Health Reform. It outlines the need for sustained, coordinated and systemic reform to mental health in Australia, and identifies critical steps that will be needed in the reform process.

The recommendations of this submission have been framed in light of the current economic climate, taking into account the Government's commitment to more efficient and cost-effective public spending.

The MHCA has identified a number of zero-cost initiatives that could be implemented immediately with no impact on the Budget bottom-line, including endorsing the national mental health targets and indicators proposed to COAG in 2013.

The MHCA also makes other recommendations that – while at a cost – will lay solid foundations for effective future reform. These include a number of issues of longstanding importance to the mental health sector, including better engagement of mental health consumers and carers and a national approach to reducing stigma around mental illness. The weight of evidence suggests that even in financially constrained times, these are the kinds of activities that would justify the re-direction of funding from other areas of government spending. Given the current fiscal climate, the MHCA acknowledges that these costs may need to be funded by reprioritising spending from less effective program areas.

As Allan Fels, Chair of the National Mental Health Commission, observed in his recent letter to the Prime Minister, mental health is an 'invest to save' issue. The benefits of better mental health for all Australians, and better systems to support this goal, are far reaching, for individuals, businesses, communities, and the economy as a whole. Good mental health and recovery from mental illness, is fundamental to individual wellbeing, and in turn, will play a critical role in meeting Australia's productivity and participation challenges.

Delivering on the recommendations in this submission will deliver net financial benefits to government in the long term – and more importantly, will make tangible improvements in the lives of people affected by mental illness.

I look forward to discussing these ideas with the Government in the lead-up to the 2014-15 Budget and beyond, and commend this submission to the Government for consideration.

Frank Quinlan
CEO

SUMMARY OF RECOMMENDATIONS

Mental health reform

RECOMMENDATION 1

The Australian Government must **commit to ongoing reform of the mental health system** through integrated, whole-of-government approaches covering all aspects of the lives of people affected by mental illness, and that this reform be guided by meaningful input by consumers, carers and the broader mental health sector.

COST: Nil

NO COST

RECOMMENDATION 2

The Australian Government should **commit to meaningful consumer and carer involvement** in national mental health reform, through:

- ongoing and additional funding for the National Mental Health Consumer and Carer Forum, the National Register, mental health consumer and carer representatives and the national mental health consumer organisation;

  COST: $6 million over 3 years

- funding a scoping study on the establishment of a new national mental health carer organisation;

  COST: $100,000 in 2014-15

- developing and implementing a national mental health and psychosocial support Peer Workforce Development Framework;

  COST: $100,000 in 2014-15

- consumer and carer representation at all levels of planning and decision making, including the Mental Health, Drug and Alcohol Principal Committee; and

  COST: less than $0.1 million per year

- routinely surveying and reporting consumer and carer satisfaction with all aspects of the mental health system (see indicators and targets).

  COST: Nil

LONG STANDING RECOMMENDATION

RECOMMENDATION 3

The **National Mental Health Commission's review** of mental health programs should be informed by a broad terms of reference, be adequately resourced by the Australian Government to enable comprehensive consultation and engagement with consumers, carers and the mental health sector, and include detailed analysis and long-term planning to guide future investment.

COST: Uncosted

FOUNDATIONS FOR REFORM

RECOMMENDATION 4

The Australian Government should endorse, and seek endorsement by state and territory governments, **national mental health targets and indicators** at the next meeting of the Council of Australian Governments.

COST: Nil

NO COST

The National Disability Insurance Scheme

RECOMMENDATION 5

As a matter of urgency, the Australian Government, negotiating with state and territory governments, must **commit to maintaining or increasing existing funding and levels of service for current and future consumers** of mental health services, regardless of whether those consumers (who may also be carers of people with mental illness) are deemed eligible for the NDIS or are currently accessing mental health services.

COST: Uncosted

NO COST

RECOMMENDATION 6

Consistent with the goal of reducing costs to governments and the community over the long term, the Australian Government, along with state and territory governments, should **ensure that adequate early intervention services and supports are available and readily accessible** to all people with mental illness, regardless of whether they are assessed as eligible for an individualised package of support through the NDIS.

COST: Uncosted

LONG STANDING RECOMMENDATION

RECOMMENDATION 7

The Australian Government should, as a matter of urgency, convene a **new, high-level specialist NDIS Psychosocial Disability/Mental Health Expert Advisory Group**, as per the Terms of Reference proposed at Attachment D.2.

COST: Nil (to be undertaken within existing resourcing)

NO COST

RECOMMENDATION 8

The Australian Government should fund the Mental Health Council of Australia to develop, in consultation with stakeholders, a **comprehensive picture of in-scope Commonwealth and State-Territory mental health programs and services** and to compare the target populations for each program/service to the target population for the NDIS.

COST: $250,000 in 2014-15

FOUNDATIONS FOR REFORM

RECOMMENDATION 9

The Australian Government should fund the Mental Health Council of Australia to undertake **capacity building** work among mental health organisations active in both NDIS launch sites and in Partners in Recovery consortia.

COST: $450,000 over 3 years

FOUNDATIONS FOR REFORM

RECOMMENDATION 10

The Australian Government should **address the concerns of the mental health sector** in relation to the design and implementation of the NDIS by:

- providing detailed information to mental health stakeholders on a range of critical issues, with a presumption in favour of **releasing information publicly** wherever possible;
- **involving mental health stakeholders** to a much greater degree in monitoring and evaluating the effectiveness of the NDIS in meeting the needs of people with psychosocial disability; and
- reviewing, in close consultation with mental health stakeholders, whether the current **NDIS pricing** of all relevant psychosocial disability support services accurately reflects the cost of providing those services.

COST: Nil (to be undertaken within existing resourcing)

NO COST

Other systemic opportunities

RECOMMENDATION 11

That, as interim measures ahead of the National Mental Health Commission's review, the Australian Government should support funding for services and programs for people with experience of mental illness that **fill the gaps created by system failures**, including **homelessness** and **employment services**.

COST: Uncosted

LONG STANDING RECOMMENDATION

RECOMMENDATION 12

The Australian Government should negotiate with state and territory governments to **guarantee a proportion of transferred housing stock will be secured for people with mental illness and psychosocial disability** and adequate support provided for those people to maintain their tenancy and access a range of social supports.

COST: Nil

To be negotiated through existing processes under the National Regulatory Framework for Community Housing

NO COST

Productivity and Participation

RECOMMENDATION 13

The Australian Government **should embed mental health in any future reforms, structures and/or agreements to improve Australia's productivity and participation**, including in relation to boosting human capital, welfare and employment services, industrial relations.

COST: Nil

Mental health awareness can be embedded in current policy development processes. For example, include a mental health impacts item in Cabinet document templates, similar to statements regarding the impacts of policy proposals on families, regional areas, and Aboriginal and Torres Strait Islander peoples.

NO COST

RECOMMENDATION 14

Any changes to Australia's **employment and income support systems** should be designed through close engagement with the mental health sector, including mental health consumers and carers, and any review of these systems should consider:

- the **wider costs to government** of removing or reducing financial and social supports for people with mental health issues and related disabilities;
- **perverse incentives** which discourage people on DSP from moving into the labour market on a flexible basis when they are able;
- the appropriateness of specific **service types and client loads** for people with mental health issues of different kinds;
- **barriers to disclosure** of mental illness to government agencies and service providers by participants in these systems, and the consequences of non-disclosure;
- **stigma and discrimination** against people with mental illness by government agencies, service providers and the broader community; and
- the **implications of recent machinery of government changes** that have separated administrative arrangements for Disability Employment Services from Jobs Services Australia.

COST: Nil *(to be undertaken within existing departmental resourcing)*

NO COST

RECOMMENDATION 15

The Australian Government, in consultation with the Mentally Healthy Workplace Alliance, should support the development, promotion and implementation of innovative and collaborative models for **supporting mental health in workplaces**.

COST: *to be determined, in consultation with the Mentally Healthy Workplace Alliance*

LONG STANDING RECOMMENDATION

RECOMMENDATION 16

The Australian Government should adopt **national standards for psychological health and safety in the workplace**, implement any required regulatory supports, and promote the standards for uniform adoption by state, territory and local governments, as well as outside of governments.

COST: Nil

NO COST

Promoting mental health

RECOMMENDATION 17

The Australian Government should fund the Mental Health Council of Australia to develop, implement and evaluate a sustained strategy for coordinated and well-targeted **national campaigns to promote mental health and reduce stigma**, in partnership with the mental health sector (including with consumers and carers).

COST: $10 million per year, for ten years

LONG STANDING RECOMMENDATION

RECOMMENDATION 18

The Australian Government should increase funding for the Mental Health Council of Australia to coordinate and give broader reach for **World Mental Health Day** in Australia, to raise awareness of mental health through nation-wide promotion and activity coordination.

COST: $5 million per year, for four years

LONG STANDING RECOMMENDATION

RECOMMENDATION 19

The Australian Government should fund the Mental Health Council of Australia to work with government, the insurance industry and mental health stakeholders to develop detailed and practical solutions which will ensure that people with mental illness have **fair access to the insurance market** consistent with any insurance risks they may represent.

COST: $0.5 million over 2 years

LONG STANDING RECOMMENDATION

RECOMMENDATION 20

The Australian Government should commission an **independent actuarial study** to evaluate the relevance and quality of data on which the insurance industry relies to assess the risks associated with mental illness, with terms of reference to be developed in close consultation with mental health stakeholders.

COST: Uncosted

FOUNDATIONS FOR REFORM

INTRODUCTION

ABOUT THE MENTAL HEALTH COUNCIL OF AUSTRALIA

The MHCA is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector, committed to achieving better mental health for all Australians. As an independent peak body with no service delivery role, the MHCA seeks to ensure that the needs of people with experience of mental illness and their carers are met to the maximum extent possible.

The MHCA has strong links across the mental health sector and beyond. MHCA members include national organisations representing consumers, carers, special needs groups, clinical service providers, public and private mental health service providers, researchers and state/territory community mental health peak bodies[1]. The MHCA is also the secretariat for the National Mental Health Consumer and Carer Forum, the combined national voice for consumers and carers participating in the development of mental health policy and the mental health sector.

The mental health sector is united on the many challenges facing consumers, carers, service providers and the mental health system generally. The sector is also united on the broad directions that mental health policy must take if we are to see long-term change in the interests of consumers and carers. In this pre-budget submission, the MHCA makes a series of policy and funding recommendations based on these areas of consensus.

Along with the needs of MHCA members, this submission is informed by the MHCA mission – to create the best mental health system in the world, characterised by the following essential elements:

- full and meaningful participation by people with mental illness and the people who care for them;
- priority given to mental health promotion, prevention and early intervention;
- a recovery orientation;
- seamless integration and coordination of policies, services and program; and
- accessibility, effectiveness and efficiency.

INVESTING IN MENTAL HEALTH: THE POLICY RATIONALE

Mental health is important for all Australians, of all ages, in all locations, and in every element of life: at school, at home, in employment, in interpersonal interactions, and in significant life events. Mental ill-health is also important, and will affect most people in the Australian community either directly or indirectly. **In any one year, one in five Australians will experience mental illness,**

[1] More detailed information about the MHCA is at Attachment A to this submission.

representing more than 3 million people, with 45 per cent experiencing mental illness at some point in their lifetime[2].

The impacts of poor mental health are not recognised in a number of areas – in schools, in workplaces, in the delivery of services; in the way people interact; and in gaining a place as a funding and policy priority for governments.

For example, around 3 or 4 per cent of the population has a severe mental illness[3], a prevalence rate that exceeds that of all cancers combined[4]. **Life expectancy of adults with mental illness is between 10 and 32 years lower than average**, depending on the mental illness[5]. This gap is similar to the life expectancy gap between Indigenous and non-Indigenous Australians is currently around 11 years[6].

Relative to these, and other, high profile public health issues, **mental health services and supports, including community acceptance and understanding, fall far short of the required need**. Although mental illness represents around 13 per cent of total burden of disease and injury in Australia and is the leading specific cause of non-fatal burden of disease[7], it is the target for only 7.5 per cent of national government health expenditure[8]. We know that this is not enough: while there is high demand for already under-resourced services, it has been estimated that around **900,000 people each year are missing out on mental health services** that should be available to them[9]. We also know that many people do not disclose their mental illness at all, often due self-stigma or perceived risk of stigma in the community around mental illness, resulting in a large degree of unmet need in the community.

These disparities contribute to the **significant costs associated with mental illness**. Such costs include **poorer individual outcomes** in relation to physical health, housing, education, social and community life and participation in work and employment[10]. The financial costs are also staggering. **Direct health expenditure** in Australia is estimated at over $13.8 billion per year, plus **direct non-health expenditure** of at least $14.8 billion per year[11]. In addition, billions of dollars are lost through **indirect costs such as lost productivity** and provision of informal care, with an

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[2] Australian Bureau of Statistics, National Survey of Mental Health and Wellbeing: Summary of Results, 2007. Cat. no. 4326.0. Canberra, 2008.

[3] ConNetica (2013) Obsessive Hope Disorder. Reflections on 30 years of Mental Health Reform in Australian and Visions for the Future (Summary Report), p34.

[4] ConNetica (2013) Obsessive Hope Disorder. Reflections on 30 years of Mental Health Reform in Australian and Visions for the Future (Summary Report), p34.

[5] National Mental Health Commission, 2012: A Contributing Life, the 2012 National Report Card on Mental Health and Suicide Prevention. Sydney: NMHC, p28.

[6] National Mental Health Commission, 2012: A Contributing Life, the 2012 National Report Card on Mental Health and Suicide Prevention. Sydney: NMHC, p22, 28.

[7] Australian Institute of Health and Welfare (2007) The burden of disease and injury in Australia 2003, AIHW, Canberra.

[8] Department of Health and Ageing (2010) National Mental Health Report 2010: Summary of 15 years of reform in Australia's Mental Health services under the National mental Health strategy 1993-2008. Commonwealth of Australia, Canberra.

[9] National Mental Health Commission, 2012: A Contributing Life, the 2012 National Report Card on Mental Health and Suicide Prevention. Sydney: NMHC, p82.

[10] Around 40 per cent of people with experience of mental illness were living on incomes of less than $20,000 per year (compared with around 15 per cent of the general population): SANE Australia, SANE Research Bulletin 9: Money and Mental Illness, 2009.

[11] Medibank and Nous Group (2013) The Case for Mental Health Reform in Australia: a Review of Expenditure and System Design.

estimated cost of mental illness to Australia's collective wellbeing at $190 billion a year – equivalent to about 12 per cent of the economy's output[12].

A significant proportion of these costs is preventable. Every year, approximately 2,200 people die by suicide[13], tragic events with significant financial and non-financial costs that could be avoided with the right services at the right time. Productivity costs to businesses can be minimised through more mentally healthy workplaces and greater utilisation of flexible work arrangements. The design and delivery of services could be much more efficient, and a **greater focus on mental health promotion, mental illness prevention and early intervention** will lead to major costs savings in the long-term, both within the health system and in other areas such as the justice system, social security and housing and homelessness services.

With such high costs, both socially and economically, the scope for possible savings through mental health system reform and service improvements is large. Importantly, rather than 'fortuitous underspends', these **savings would be the planned and deliberate result of considered action** across a number of fronts.

The **2014-15 Budget is an opportunity** for the new Government to commit to build on recent efforts to build a cohesive and efficient mental health system for all Australians that is sustainable, fiscally responsible and well-targeted.

[12] Herald-Lateral Economics Index of Australia's Wellbeing, 2013.
[13] National Mental Health Commission, 2012: A Contributing Life, the 2012 National Report Card on Mental Health and Suicide Prevention. Sydney: NMHC, p130.

THE STATE OF MENTAL HEALTH REFORM

Mental health stakeholders across government and non-government sectors agree that **mental health reform must proceed with several key priorities** in mind. These priorities have been articulated in many policy contexts, including in the (current) *Fourth National Mental Health Plan*, but are yet to be fully realised in the service delivery context or in decisions about funding allocations.

First, the **aspirations of consumers and carers must be the starting point** for policy development and implementation. Existing and future mental health initiatives must have appropriate mechanisms to ensure that consumers and carers are involved to the maximum extent possible in decisions that affect them. The *National Recovery Framework* sets out in some detail why consumer and carer involvement is paramount and how it can be achieved.

Second, the **community sector services are a cost effective solution and must be the driving force** behind increased access to services and supports. Non-government service providers understand the whole-of-life needs which must be addressed if long-term outcomes are to improve. One of the most critical areas is housing; it is not acceptable to rely on hospitals to provide accommodation for people who should be living in the community. The community sector, properly resourced, can free up clinical services to assist people with the right services at the right time.

This is not to dismiss the critical work that takes place in the clinical sector to address the needs of people who have pressing medical issues. However, a gap appears to be emerging between arrangements for hospital funding and successive mental health policies which have emphasised the importance of community-based services. For example, there is a **risk that the implementation of Activity-Based Funding could perpetuate the hospital-centric nature of the mental health 'system'** by rewarding in-hospital care over other types of care.

Third, **we must invest more in mental health promotion and mental illness prevention and early intervention**. Preventing illness from developing in the first place, and reducing the severity of symptoms where possible, is the best way to improve individual wellbeing, but it is also of **net financial benefit** to governments. While there will always be people in need of acute care, we can still reduce the load on the service system by promoting good mental health, encouraging help-seeking behaviour at a population level, and identifying and intervening in populations at risk.

Fourthly, we must ensure that those who are severely impacted by mental illness, along with their carers, receive the coordinated and effective support that they require. Too often, this is not currently the case, leading to an escalation of costs in other areas of the budget. Ongoing reforms must continue to identify, promote and support evidence-based models of best-practice mental health services. This must include models of service delivery that targeted for different groups of consumers, including age-appropriate settings and services, and that capitalise on technological advances, such as e-mental health and online networks.

There have been some **important steps made in the path to long-term mental health reform** in Australia in recent years:

- Mental health consumers and carers are now more actively involved in decisions about policy, implementation, service delivery and evaluation than at any time in the past. This

involvement has driven many positive changes in the sector so far, although much more needs to be done to achieve ongoing meaningful consumer and carer engagement.

- The *National Recovery Framework*, recently released, is the first attempt to translate the whole-of-life needs of consumers and carers into a service delivery context.

- The *Fourth National Mental Health Plan* described the need for a National Mental Health Service Planning Framework (NMHSPF) so that governments can identify the level of need for both clinical and community services and make investments accordingly. The NMHSFP, due to be released soon, will, for the first time, make clear the substantial gap between the level of need in the community and what is funded in each jurisdiction.

- The establishment of the National Mental Health Commission has led to the first two National Report Cards on Mental Health and Suicide Prevention, the findings and recommendations of which are broadly endorsed by the mental health sector.

- COAG's *Roadmap for National Mental Health Reform*, in which governments committed to mental health reform as an ongoing national priority. COAG agreed to develop indicators and targets to guide future work.

- A very broad range of mental health and related stakeholders have come to a consensus on a framework for targets and indicators to drive long-term mental health reform. It is now up to governments to endorse – and resource – this framework.

1.1 A WHOLE-OF-GOVERNMENT AND WHOLE-OF-LIFE APPROACH

An effective mental health policy framework – and critically, its implementation – requires efficient and coordinated **whole-of-government activity across all jurisdictions**, encapsulating the full range of social and economic determinants and consequences of mental health and ill health across the lifespan.

While there is much more to be done, the Closing the Gap approach to the complex issue of Indigenous disadvantage illustrates the potential benefits of a nationally agreed, multi-jurisdictional and truly coordinated and integrated whole-of-government approach. Another lesson from Closing the Gap is that overcoming decades of underinvestment and poor policy implementation requires strong and consistent leadership and policy coordination at a national level.

In addition, mental health policy should also reflect a **whole-of-life perspective**. For example, peri-natal care and early childhood supports and services can be critical to mental health for parents and children alike, and have demonstrated benefits for mental health in later years[14]. Mental health is equally important for good health and wellbeing for older Australians, and must be supported with appropriately targeted services[15]. Importantly, a whole-of-life perspective is critical for realising the important flow-on effects of mental illness prevention and early intervention throughout the life-course.

[14] As outlined, for example, in *KidsMatter Literature Review – Component 4: Helping children who are experiencing mental health difficulties*, accessed online at https://www.kidsmatter.edu.au/sites/default/files/public/KMEC-Component4-Literature-Review.pdf

[15] The specific support needs of older adults living with mental illness, and the key areas in need of attention and change, are documented in *Growing older, staying well: Mental health care for older Australians*: A SANE Report, 2013, accessed online at http://www.sane.org/growing-older-staying-well .

A whole-of-life and whole-of-government approach to mental health has been articulated by governments many times in policy documents, but is currently lacking in practice. Consistent with the contributing life framework of mental health, it is imperative that mental health policy be progressed with a holistic, whole-of-life perspective, and implemented through coordinated whole-of-government and multi-jurisdictional efforts.

RECOMMENDATION 1

The Australian Government must **commit to ongoing reform of the mental health system** through integrated, whole-of-government approaches covering all aspects of the lives of people affected by mental illness, and that this reform be guided by meaningful input by consumers, carers and the broader mental health sector.

COST: Nil **NO COST**

1.2 CONSUMERS AND CARERS MUST BE MEANINGFULLY INVOLVED

The best basis for effective mental health services and systems is through meaningful involvement of mental health consumers and carers in the development, implementation, delivery and evaluation of policies and programs. **When designing a new mental health system, the lived experience of consumers and carers must be central**.

Of ongoing concern for the MHCA and its member organisations is the relatively low level of mental health consumer and carer involvement in decisions and policy directions that affect them. Consumer and carer groups and peak bodies require ongoing and additional investment to ensure representative and thoughtful involvement in the reform process.

The Australian and state and territory governments contribute operational and secretariat funding to the National Mental Health Consumer and Carer Forum (the Forum). This limited budget allows the Forum to meet twice a year face to face and twice a year by teleconference. The Australian Government also funds the National Register of Mental Health Consumer and Carer Representatives, a pool of 60 trained consumer and carer representatives available to provide cohesive, constituent-based advice at the national level.

Despite these bodies being the two main sources of trained and supported national level mental health consumer and carer representatives, **limited funding is only secured until end 2014-15**.

While the Australian Government allocated five-year funding in the 2011-12 Budget for the establishment of a new national mental health consumer peak organisation, **there is currently no national body specifically representing and advocating solely for mental health carers**. A scoping study needs to be undertaken on the establishment of a new national mental health carer organisation.

At the state/territory level, some jurisdictions have relatively strong mental health consumer and carer organisations, while others have little or no infrastructure to enable their voice to be heard. Mental health consumer and carer peak organisations should be established and supported in all jurisdictions.

In addition to representative roles, **the peer (consumer and carer) workforce has a significant role to play** in system re-design and reform. Peer workers are employed by mental health services for their expertise developed through lived experience of mental illness as a consumer or a carer. The peer workforce increases understanding, empowerment and engagement of

consumers and carers, promotes consumer and carer perspectives and experiences, reduces stigma and improves service delivery.

Appropriate support and development of the mental health peer workforce would help to manage the workforce demands created by the National Disability Insurance Scheme (NDIS) and meet the needs of people with psychosocial disability, whilst also decreasing demand on the acute sector.

The MHCA supports calls from the National Mental Health Consumer and Carer Forum and the National Mental Health Commission to create a national framework to advance, integrate and support the peer workforce in all mental health and psychosocial disability support and treatment settings.

A more detailed exposition of the costs below is at Attachment B.

RECOMMENDATION 2

The Australian Government should **commit to meaningful consumer and carer involvement** in national mental health reform, through:

- ongoing and additional funding for the National Mental Health Consumer and Carer Forum, the National Register, mental health consumer and carer representatives and the national mental health consumer organisation;

  COST: $6 million over 3 years

- funding a scoping study on the establishment of a new national mental health carer organisation;

  COST: $100,000 in 2014-15

- developing and implementing a national mental health and psychosocial support Peer Workforce Development Framework;

  COST: $100,000 in 2014-15

- consumer and carer representation at all levels of planning and decision making, including the Mental Health, Drug and Alcohol Principal Committee; and

  COST: less than $0.1 million per year

- routinely surveying and reporting consumer and carer satisfaction with all aspects of the mental health system (see indicators and targets)

  COST: Nil

LONG STANDING RECOMMENDATION

A STAGED APPROACH TO SYSTEM REFORM

As with so many perspectives on disadvantage, a comprehensive account of the causes and implications of mental illness requires an understanding of a complex web of interacting social, economic, psychological, biological and environmental factors.

While some of these factors are private matters or may in some cases be inevitable, **there is a clear case for government action in mental health** on several fronts. Quite apart from moral or political concerns, the **public purse bears direct costs** through service provision, as well as indirect costs through the welfare and justice systems and productivity losses. However, governments have typically been ill equipped to respond to such complex challenges, preferring the simplicity of policy and jurisdictional siloes – an approach which has proven to be ineffective and inefficient.

'System reform' has been the catchcry of countless policy documents since the mid-1990s. But, as a result of largely ad hoc approaches over the past 20 years, the term 'mental health system' in Australia is a misnomer. Rather than a single, integrated and comprehensive arrangement, it is a complex maze of separate services, programs and systems, which at some times are overlapping or duplicative, and at others are completely disconnected. Despite constant data collection and reporting over this time, **there is still no clear picture of the mental health system** – what it is, how much it costs, how it interacts with other systems, and most importantly whether it is efficiently and effectively meeting the needs of mental health consumers and carers.

2.1 REVIEWING THE MENTAL HEALTH SYSTEM

With these observations in mind, the MHCA supports the **Coalition's election commitment to resource the National Mental Health Commission (NMHC) to review the effectiveness of mental health programs**. The review is a timely opportunity to learn from the mistakes of the past and to identify the key features of a world-leading mental health system.

To avoid the fragmentation and unpredictability that has characterised previous changes to the mental health system, **it is critical that this commitment be delivered through several carefully managed stages, and is broad in scope** (as per recent MHCA correspondence with the Minister for Health, at Attachment C). In particular, the review process should first address the necessary preconditions to system reform – describing the elements of the system, reviewing data and previous reports, and endorsing nationally agreed mental health targets and indicators.

RECOMMENDATION 3

The **National Mental Health Commission's review** of mental health programs should be informed by a broad terms of reference, be adequately resourced by the Australian Government to enable comprehensive consultation and engagement with consumers, carers and the mental health sector, and include detailed analysis and long-term planning to guide future investment.

COST: Uncosted

FOUNDATIONS FOR REFORM

2.2 TARGETS AND INDICATORS

A critical factor in system redesign efforts is to identify the fundamental purpose for reform through long-term targets. As with the Closing the Gap approach, the identification of specific reform targets and indicators of progress towards those goals form the basis for a coherent framework within which to guide and track reform efforts. Testing progress against what needs to be achieved ensures that governments and all parts of the system remain accountable for investment and helps the community understand and support meaningful goals. Targets and indicators also increase transparency of governments' activities and help to ensure that investments are effectively and efficiently focussed in the right areas. The very presence of well-designed targets and indicators can in of itself drive reform, leading ultimately to improved policy outcomes by maximising the impact of existing investments and guiding new investments where necessary.

For too long, the lack of clearly defined targets and indicators has seen mental health reform lag behind many other significant reform processes.

In September 2013, in response to terms of reference agreed by the Council of Australian Governments (COAG), an Expert Reference Group (ERG) delivered to the Ministerial Working Group on Mental Health Reform a proposed framework for **national, whole-of-life, outcome-based targets and indicators for mental health reform**.

The ERG's deliberations were informed by wide consultation across the mental health sector, including consumers, carers, service providers, non-government organisations and professional groups. The outcomes of these consultations suggest that, should COAG decide to adopt the ERG's framework, it will have the backing of the broader mental health sector and beyond.

In the context of this support, it should be noted that many of the proposed targets and indictors – such as those around stable accommodation, social and economic participation, suicide prevention, and stigma and discrimination – are reflected in the recommendations of this submission.

There is now an **unprecedented opportunity for governments to provide a clear national, long-term direction for mental health reform** with the support of consumers, carers and the non-government sector.

The MHCA has written to the Minister for Health regarding the importance of endorsing the proposed targets and indicators (see Attachment C), and urges this decision be taken no later than in the 2014-15 Budget context.

RECOMMENDATION 4

The Australian Government should endorse, and seek endorsement by state and territory governments, **national mental health targets and indicators** at the next meeting of the Council of Australian Governments.

COST: Nil

NO COST

POTENTIAL SYSTEMIC BARRIERS AND OPPORTUNITIES

It is important that the Australian Government commit to continuing the important work already underway to build an integrated and world-leading mental health system.

However, there are a number of current processes that threaten to undermine the achievements made to date, and upon which **immediate action is required** – namely the National Disability Insurance Scheme and the transfer of housing stock from state and territory governments to the non-government sector.

3.1 NATIONAL DISABILITY INSURANCE SCHEME

The MHCA supports the National Disability Insurance Scheme (NDIS), especially given the bi-partisan commitment to increasing funding to support people with significant ongoing disabilities over the next few years. It is absolutely appropriate that the scheme includes people with a psychosocial disability related to mental illness.

However, the MHCA has strong concerns about the implications of the scheme for mental health consumers, carers and service providers. These concerns relate to the design of the NDIS, the status of existing services, and the likely impact on future mental health programs.

Eligibility

Under the NDIS legislation, in order to qualify for an individualised package of support a person needs to have a 'permanent impairment'. **While permanency may be a meaningful concept for some kinds of disability, in the context of mental illness it is less clear**. Most people with psychosocial disability have needs (and impairments) that fluctuate in severity and in nature over their lifetimes, and it is often difficult or impossible to predict which people will need long-term support and who will exit the 'system'. The MHCA is very concerned about the implications for the **very large numbers of people with a mental illness who will not be eligible for the NDIS** because they are not deemed to have a permanent impairment or because their disabilities are not deemed sufficiently debilitating.

The MHCA doubts that the permanency principle currently embedded in the scheme can be reconciled with these realities. Feedback from the launch sites indicates that these requirements are already causing confusion.

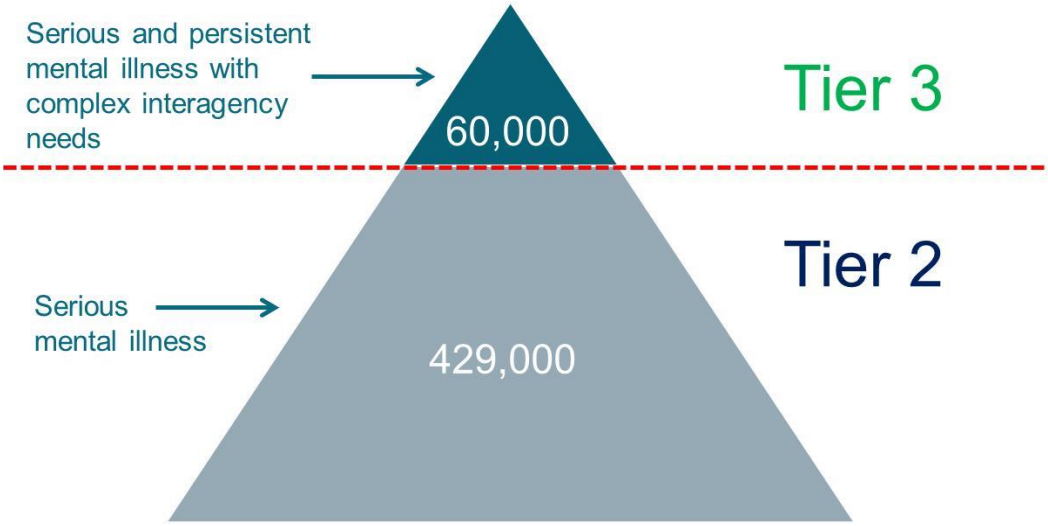
Of the 489,000 people with serious mental illness in Australia, the Productivity Commission estimated that only 60,000 would qualify for an individualised package of support ('Tier 3') because they have a serious and persistent mental illness with complex interagency needs (as shown in Figure 1, below). Among this group, just 6,000 people with psychosocial disability associated with mental illness (that is, only 10 per cent of people with serious and persistent with complex interagency needs) were said to require the most intensive support – a figure that the MHCA believes lacks credibility and vastly underestimates the level of need in the community. In deriving these numbers, the Commission acknowledged major limitations in the available data and the

need for further analysis of the target population. Until the National Mental Health Service Planning Framework is finalised, these still appear to be the only estimates available to the NDIA.

While not all 489,000 people with serious mental illness will require an individualised package of support, many more than 60,000 will have significant disability warranting long-term support. The forthcoming National Mental Health Service Planning Framework, being undertaken by Queensland Health and NSW Health in partnership with the Federal Department of Health, may make clear the gap between the original estimate and the actual level of community need.

If someone with a serious mental illness does not qualify for an individualised package of support (i.e. they are assessed as 'Tier 2' participants), it is not at all clear how the NDIS will benefit them. On the contrary, current indications are that Tier 2 participants will need to rely on existing systems of referral and support, the very systems that are responsible for far too many people falling through the cracks and not getting the assistance they need on their recovery journey. As noted below, many of these existing programs also appear to have uncertain futures as they are absorbed into the NDIS through the current funding arrangements.

Figure 1: Estimated numbers of people with serious mental illness who will be eligible for an individualised package of support



Mental health programs in-scope for the NDIS

Agreements have been reached between the Commonwealth and State/Territory Governments about which existing programs – and what proportions of their funding – are 'in-scope' for the NDIS. **The mental health sector was not consulted before these important decisions were made.**

The NDIA has indicated that at the Commonwealth level, 100 per cent of the Personal Helpers and Mentors program (PHaMS), 70 per cent of Partners in Recovery (PIR), 50 per cent of Mental Health Respite for Carers and 35 per cent of Support for Day to Day Living in the Community are in-scope for the NDIS. Many stakeholders consulted by the MHCA believe that a significantly lower proportion of PHaMS and PIR clients will be eligible for Tier 3 support than is reflected in these numbers.

Another key question relates to what services will be available for people who do not gain access to NDIS support, either because they do not opt in (even though they meet the eligibility criteria) or because their disability is not deemed sufficiently significant or permanent. **While a guarantee of continuity of care is in place (in Commonwealth/State/Territory agreements) for current clients, no such guarantee exists for future clients**, including clients of mental health programs that have a high rate of turnover from year to year.

If replicated nationally, **decisions about in-scope programs are likely to lead to reduced services for large numbers of people with serious mental illness who are ineligible for the NDIS**. Given the high levels of current unmet need and well-established under-investment in mental health in all jurisdictions, the MHCA is deeply concerned that the NDIS could exacerbate rather than ameliorate the problems that people with mental illness have in accessing timely and effective services in the community. The mental health sector and the broader Australian community need assurance that future mental health consumers and carers will not miss out on services, leaving them worse off, as an unintended consequence of a major initiative originally intended to deliver more support.

The possible implications of subsuming in-scope program funding into the NDIS is detailed further in Attachment D.1 to this submission.

Early intervention and psychosocial disability

Many of the mental health programs that are currently in-scope for the NDIS appear to deliver services that the MHCA suggests provide 'early intervention' rather than ongoing or life-long support. While these programs fund services for people with permanent illness/disability, they are usually not life-long solutions. Rather, they are often temporary (and even emergency) interventions to help people manage crisis or overcome negative circumstances that could rapidly escalate.

The fact that a person needs to have a permanent impairment before receiving an early intervention (which will in turn reduce that person's reliance on the service system in the future) is profoundly counterintuitive. Indeed, if early intervention services are reduced from existing levels, we will certainly see **a greater burden on the service system, including additional presentations at emergency departments, increased reliance on crisis accommodation services and a greater risk of people with mental health issues encountering the criminal justice system**. In the context of an insurance scheme which ought to reduce future risks, these arrangements appear misguided.

The MHCA is eager to see the development of a definition of early intervention from the perspective of psychosocial disability. Such a definition can only be developed in close consultation with stakeholders in the mental health sector who have an intimate understanding of the nature of effective non-clinical early intervention services.

A way forward

Addressing these concerns will require a significant and dedicated stream of work, with close and meaningful consultation with all relevant stakeholders.

A critical first step in finding a way forward will be to re-establish stakeholder confidence that governments will ensure that the NDIS will deliver on Australia's commitments under the United National Declaration on the Rights of Persons with a Disability.

The mental health sector, and the broader Australian community, needs **assurance that future mental health consumers and carers will not miss out on services, leaving them worse off**, as an unintended consequence of a major initiative originally intended to deliver more support. This includes an assurance that a range of services will continue to be available for people with psychosocial disability, whether or not they are a participant in the NDIS.

RECOMMENDATION 5

As a matter of urgency, the Australian Government, negotiating with state and territory governments, must **commit to maintaining or increasing existing funding and levels of service for current and future consumers** of mental health services, regardless of whether those consumers (who may also be carers of people with mental illness) are deemed eligible for the NDIS or are currently accessing mental health services.

COST: Uncosted

NO COST

RECOMMENDATION 6

Consistent with the goal of reducing costs to governments and the community over the long term, the Australian Government, along with state and territory governments, should **ensure that adequate early intervention services and supports are available and readily accessible** to all people with mental illness, regardless of whether they are assessed as eligible for an individualised package of support through the NDIS.

COST: Uncosted

LONG STANDING RECOMMENDATION

A formal process needs to be established for developing and providing advice to the NDIA Board about the best approaches to meeting the needs of people with psychosocial disability through the NDIS via a new Expert Advisory Group. Importantly, if its advice is to be meaningful and credible[16], this group must include representation from the non-government mental health sector, as well as consumers and carers.

RECOMMENDATION 7

The Australian Government should, as a matter of urgency, convene a **new, high-level specialist NDIS Psychosocial Disability/Mental Health Expert Advisory Group**, as per the Terms of Reference proposed at Attachment D.2.

COST: Nil (to be undertaken within existing resourcing)

NO COST

Uncertainties about the implications of major mental health programs being in scope for the NDIS are exacerbated by conflicting views on which clients should and do constitute the target population for the NDIS.

[16] The work of the proposed Expert Advisory Group would be distinct from any activity being carried out by the MHCA to build the capacity of the mental health sector to engage with the NDIS. Some (but not all) of that work is currently funded over the 2013/14 financial year by the NDIA; this funding is supporting the MHCA's work to address implementation (rather than policy) issues and to disseminate appropriate information to the right audiences, including mental health NGOs, consumers, carers and workers.

To resolve these tensions, a mapping exercise is needed to match the target groups for in-scope programs at Commonwealth and state/territory levels with those expected to receive support through the NDIS. This exercise would identify areas that will not be addressed through NDIS-funded services, and would provide a much clearer picture of what is likely to eventuate should such programs be subsumed (wholly or in part) by the NDIS in future. Because most of the services in question are delivered through the non-government sector, it is essential that non-government stakeholders (such as Community Mental Health Australia) contribute substantially to this work.

RECOMMENDATION 8

The Australian Government should fund the Mental Health Council of Australia to develop, in consultation with stakeholders, a c**omprehensive picture of in-scope Commonwealth and State-Territory mental health programs and services** and to compare the target populations for each program/service to the target population for the NDIS.

COST: $250,000 in 2014-15

FOUNDATIONS FOR REFORM

In addition, work is needed to develop the capacity of organisations to understand and respond appropriately to the interface between the NDIS and the Partners in Recovery initiative, to ensure that these initiatives are complementary rather than duplicative or competing.

RECOMMENDATION 9

The Australian Government should fund the Mental Health Council of Australia to undertake **capacity building** work among mental health organisations active in both NDIS launch sites and in Partners in Recovery consortia.

COST: $450,000 over 3 years

FOUNDATIONS FOR REFORM

To assist the work of the proposed Expert Advisory Group and to resolve other major uncertainties in the mental health sector, it is critical that the NDIA provide further information on a number of specific issues.

RECOMMENDATION 10

The Australian Government should **address the concerns of the mental health sector** in relation to the design and implementation of the NDIS by:

- providing detailed information to mental health stakeholders on a range of critical issues, with a presumption in favour of **releasing information publicly** wherever possible;
- **involving mental health stakeholders** to a much greater degree in monitoring and evaluating the effectiveness of the NDIS in meeting the needs of people with psychosocial disability; and
- reviewing, in close consultation with mental health stakeholders, whether the current **NDIS pricing** of all relevant psychosocial disability support services accurately reflects the cost of providing those services.

COST: Nil (to be undertaken within existing resourcing)

NO COST

More detail on these recommendations is provided at Attachment D, along with additional commentary on the MHCA's concerns about the NDIS.

3.2 STABLE ACCOMMODATION AND MENTAL HEALTH

Having an affordable, safe and secure place to call home is widely recognised as providing a fundamental basis for good mental health. Evidence from both Australia and overseas indicates that it is significantly more expensive to maintain a person in a state of homelessness than it is to provide them with access to affordable housing and supports to sustain their tenancy[17]. Yet **adequate housing remains a major gap in the provision of community-based care for people with mental illness** who face economic disadvantage[18].

Mental illness in and of itself does not cause homelessness. Generally, homelessness arises from a combination of economic disadvantage, loss of social supports and (often, but not always) mental illness. In 2012, homelessness services supported more than 41,000 people with mental illness. Homelessness services are often places of last resort for people who have 'fallen through the cracks' of other support systems.

In recent years concerted efforts have been made to address gaps in the service delivery system. This has included 'wrap-around' housing and support models with security of tenure for people who have experienced long periods of homelessness and mental illness, and a renewed focus on preventing people exiting mental health settings into homelessness or losing their housing when they are admitted to inpatient care.

It is critical, as well as cost-effective, that these supports are continued as the National Mental Health Commission carries out its review and governments undertake any reform in response to the review's findings. If funding is discontinued – for example, by not extending the *National Partnership Agreements on Homelessness and on Supporting Mental Health Reform* – there is a **very real risk that the significant proportion of people with mental illness who are supported by these initiatives will fall into homelessness**, leading to poorer health and wellbeing outcomes and higher costs for both Commonwealth and State/Territory governments.

RECOMMENDATION 11

That, as interim measures ahead of the National Mental Health Commission's review, the Australian Government should support funding for services and programs for people with experience of mental illness that **fill the gaps created by system failures,** including **homelessness** and **employment services**.

COST: Uncosted

LONG STANDING RECOMMENDATION

[17] Gaetz S, Gulliver T, Scott F (2013) Housing First in Canada. Canadian Homelessness Research Network, Alberta, Canada; Yanos, PT, Barrow SM and Tsemberis S (2004). Community integration in the early phase of housing among homeless persons diagnosed with severe mental illness: Successes and challenges. Community Mental Health Journal, 40(2), 133-150; Zaretzky K, Flateau P, Clear A, Conroy E, Burns L & Spicer B (2013) The cost of homelessness and the net benefit of homelessness programs: a national study. A report for the Australian Housing and Urban Research Institute.

[18] Senate Standing Committee on Community Affairs, Towards recovery: mental health services in Australia. Canberra: Commonwealth of Australia, 2008; National Mental Health Commission, 2012, A Contributing Life, the 2012 National Report Card on Mental Health and Suicide Prevention. Sydney: NMHC.

3.3 TRANSFER OF HOUSING STOCK

Many state and territory governments are currently selling off their stocks of public housing in order to extend the financial viability of the social housing system. This presents **an important opportunity to improve mental health outcomes** through action beyond the traditionally conceived boundaries of the mental health 'system'.

This opportunity stems principally from the fact that many of the transfers are to community housing organisations. Many of these providers have a long history of assisting tenants to connect with support services, including community based mental health services. Such organisations are also adept at using more inclusive models that support tenant participation and decision-making. Further, the transfer of housing stock will enable housing to be offered using income-based rent models that are more affordable for people on fixed and low incomes, which is the case for many people with mental illness[19]. **These attributes make community housing a more attractive tenancy option than the public and private market for many people with mental illness and psychosocial disability.**

It is important that people with mental illness are provided with adequate access to stable accommodation through community housing, and the current stock transfer is an opportunity to expand such housing options. In the context of current high demand, competition for housing is fierce, and it can be difficult for people with mental illness to compete for a position and then maintain their tenancy. With the right support, however, social outcomes for people with mental illness can be improved dramatically. Ideally, such support should be linked to complementary wrap-around services to ensure that tenants can get assistance with a range of issues through one organisation or in the one location.

RECOMMENDATION 12

The Australian Government should negotiate with state and territory governments to **guarantee a proportion of transferred housing stock will be secured for people with mental illness and psychosocial disability** and adequate support provided for those people to maintain their tenancy and access a range of social supports.

COST: Nil
To be negotiated through existing processes under the National Regulatory Framework for Community Housing

NO COST

[19] Around 40 per cent of people with experience of mental illness were living on incomes of less than $20,000 per year (compared with around 15 per cent of the general population): SANE Australia, SANE Research Bulletin 9: Money and Mental Illness, 2009.

PRODUCTIVITY AND PARTICIPATION

In the face of a fiscally challenging environment and an ageing population, the economic imperatives of increasing Australia's productivity and participation are well known.

The levers for doing so, however, have changed over time, with modelling by the Treasury indicating that, unlike the previous decade, growth in living standards will no longer be driven by the terms of trade, but by labour force productivity[20,21].

This means that solving Australia's participation and productivity challenges will need to go beyond economic initiatives – such as international trade, infrastructure and regulatory reform –to also bring a focus to boosting **human capital**.

Acquired through skills, education and training, human capital underpins the innovations and associated participation and productivity improvements that will be needed to make work practices and outputs more flexible and efficient. **What should be clear – but is often overlooked by policy makers and businesses alike – is the critical contribution of mental health to human capital**.

Good mental health supports learning, motivation, decision-making, analytical skills and other attributes commonly valued in the workplaces of today's information age. Perhaps reflecting the changing nature of work, reported rates of mental ill-health are also on the rise in modern workplaces, manifesting as stress or fatigue, for example, as well as diagnosable mental illnesses such as depression. **Supporting good mental health therefore plays a protective and preventative role**, helping people to better manage the stressors of daily life and work towards work-life balance, whether in paid or unpaid workforces[22].

Boosting levels of human capital is also a wise investment, as over time, the benefits accumulate and can become self-sustaining and self-reinforcing. For example, employment brings financial security and stability, and also improves a person's sense of confidence, social connectedness, and physical and mental wellbeing. In turn, these benefits lay the foundation for enduring employment (or other form of participation) and higher productivity, leading to a mutually reinforcing cycle of wellbeing that extends beyond the workplace to family, social networks, culture and community. In this important sense, mental health is an 'invest-to-save' issue – as articulated in the National Mental Health Commission's *2013 National Report Card on Mental Health and Suicide Prevention*[23].

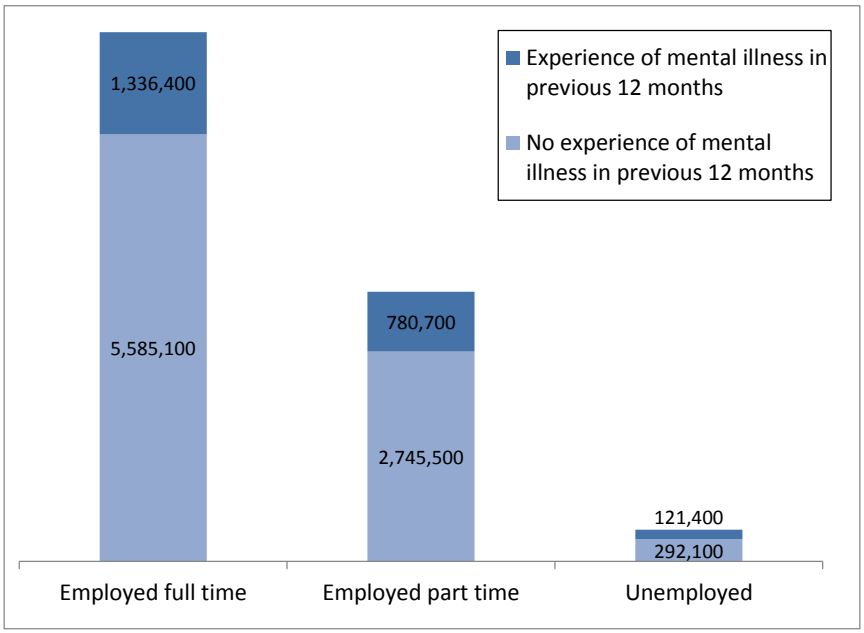
[20] Various data sources including: the Australian Common Ground Alliance Registry Week Surveys, reports on the prevalence of mental illness amongst occupants of boarding houses in the ACT, NSW, SA and Victoria, and Specialist Homelessness Services Data Collection reports from the AIHW.
[21] The Treasury has also noted that productivity growth in the health sector in particular will be essential to managing appropriate service levels in the face of population change, as well as the longer-term fiscal challenge.
[22] There are more than 2.6 million people providing informal and/or unpaid care in Australia, and many more again who are engaged as volunteer workers.
[23] National Mental Health Commission, 2013: A Contributing Life, the 2013 National Report Card on Mental Health and Suicide Prevention. Sydney: NMHC.

Responsibility for human capital development does not clearly reside in any one domain. Rather, it is the responsibility of individuals, families, workplaces and governments, as well as the broader community, to shift attitudes and cultural perspectives on mental health and ill-health. Particular initiatives relating to some of these areas are proposed later in this submission.

Given the high prevalence of mental illness, there are **significant gains to be made** by boosting mental health and wellbeing.

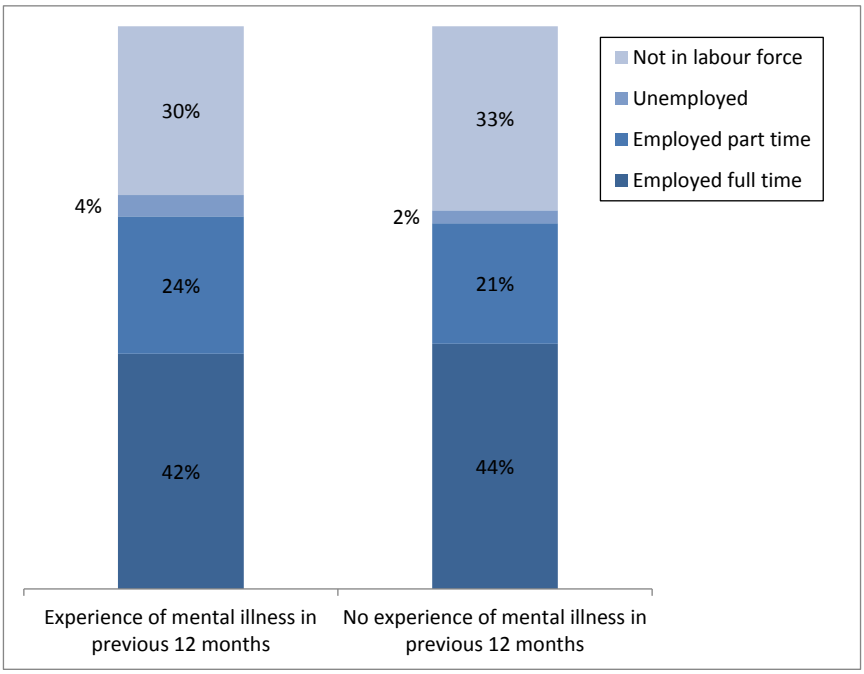
People with mental illness want to be engaged and participating in our communities and in work where possible. The vast majority (around 70 per cent, or approximately 2 million people) of people with mental illness are employed (see Figures 2 and 3, below). There are many benefits – both social and economic – in ensuring these 2 million people maintain their employment and productively participate in the workplace.

Figure 2: Labour force characteristics by recent experience of mental illness, 2007 (numbers of persons)



Source: Australian Bureau of Statistics, National Survey of Mental Health and Wellbeing: Summary of Results, 2007. Cat. no. 4326.0. Canberra, 2008.

Figure 3: Australian labour force and employment participation, proportion of Australian population aged 16-64 years, by experience of mental illness, 2007



Source: Australian Bureau of Statistics, National Survey of Mental Health and Wellbeing: Summary of Results, 2007. Cat. no. 4326.0. Canberra, 2008.

Participation by people with mental illness in voluntary activities is similar to that of the general population. In contrast, rates of labour force participation are lower for people with mental illness than average (see Figure 3, above), suggesting that more needs to be done to address the specific barriers people with mental illness face in relation to paid employment.

- 26.4 per cent of people with mental illness (around 844,000 people) were not in the labour force, compared to 21.6 per cent of people with no mental illness.
- 4.1 per cent of all people with mental illness were unemployed, compared to 2.5 per cent of all people with no mental illness. When only the labour force is considered (i.e. employed plus unemployed), these figures are 5.5 and 3.2 per cent, respectively.

In short, there are large numbers of people who – if provided with the right supports and incentives, including reduced stigma in the workplace – can be assisted to live a contributing life including employment and other types of work when they are ready and able to do so.

Mental health must therefore sit at the heart of any plan to boost Australia's productivity and participation. While this work must progress in partnership with employers large and small, there is a clear role for government in reassessing regulatory settings, providing incentives for fostering mentally healthy workplaces, and removing barriers to getting and keeping a job for people with mental illness. Critically, **national leadership is required** to foster and maintain the mental health and wellbeing of all Australians in order for them to productively engage in the economy.

RECOMMENDATION 13

The Australian Government **should embed mental health in any future reforms, structures and/or agreements to improve Australia's productivity and participation,** including in relation to boosting human capital, welfare and employment services, industrial relations.

COST: Nil

Mental health awareness can be embedded in current policy development processes. For example, include a mental health impacts item in Cabinet document templates, similar to statements regarding the impacts of policy proposals on families, regional areas, and Aboriginal and Torres Strait Islander peoples.

NO COST

To drive productivity, the Australian Government needs to advance mental health specific initiatives in a number of areas:

- for people currently not in the labour force, through a reconsideration of Australia's **welfare and employment services systems**;
- for people in employment, through **workplace supports** and systems and **workforce strategies**, in partnership with employers (including small business); and
- for the **community as a whole**, through awareness-raising and anti-stigma initiatives.

Each of these areas is discussed below.

4.1 INCOME SUPPORT AND EMPLOYMENT SERVICES

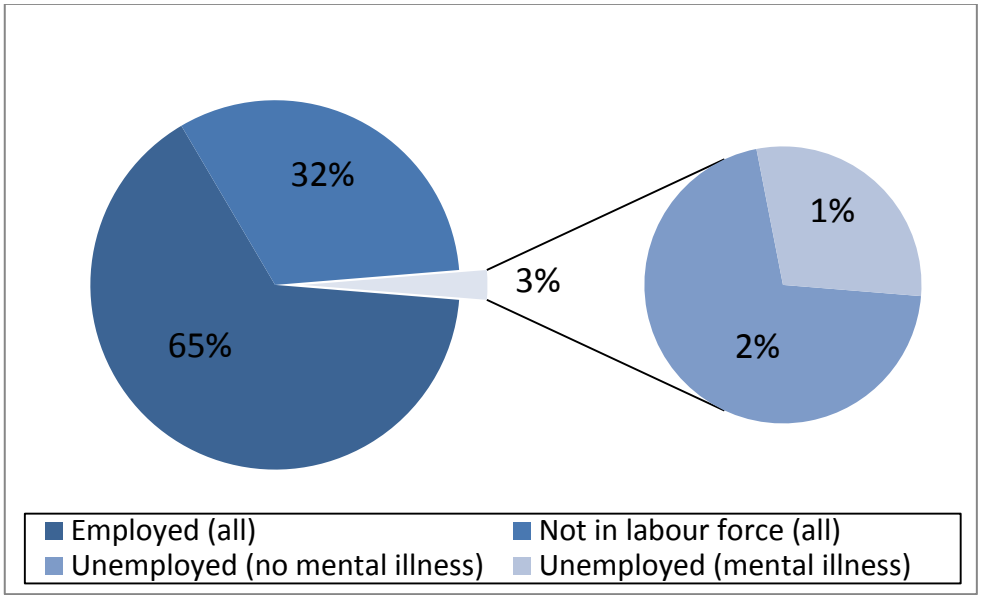
There is a significant opportunity to enhance productivity and participation by improving the operation of Australia's employment and income support systems.

This is suggested by the high numbers of people with mental illness currently receiving employment and income assistance:

- Psychological/psychiatric causes are the leading primary condition for Disability Support Pension (DSP) recipients (around 30 per cent, or 108,000 people), with many more people experiencing mental illness in addition to their primary disability.
- There was a 76 per cent increase in the proportion of DSP recipients with a psychosocial disability between 2000 and 2010. This increased expenditure by $3 billion, with an estimated subsequent productivity loss of $9.7 billion.
- Approximately 30 per cent of unemployed Australians have experienced mental illness in the past 12 months[24] (see Figure 4, below).

[24] Australian Bureau of Statistics, National Survey of Mental Health and Wellbeing: Summary of Results, 2007. Cat. no. 4326.0. Canberra, 2008.

Figure 4: Proportion of working age population who are unemployed, by experience of mental illness, 2007



Source: Australian Bureau of Statistics, National Survey of Mental Health and Wellbeing: Summary of Results, 2007. Cat. no. 4326.0. Canberra, 2008.

A large proportion of people with mental illness want to work and see it as an important part of their recovery. Work can contribute to stress, however it is more beneficial for a person's mental health than unemployment. Employment provides opportunities to regain a routine, achieve a better standard of living and interact with people outside of the mental health system[25,26].

The current design and administration of Australia's income and employment support services and how they interact with related systems (such as health, housing, transport and education) continue to fail the people with mental illness. As a result **Australia is well behind other countries** in addressing this employment issue[27].

Significant barriers to people entering and staying in the workforce include community stigma, a lack of knowledge and understanding of mental illness in most workplaces, a lack of targeted employment supports for people with a mental illness and a lack of data to indicate opportunities for improvement. A more strategic approach to employment participation, that includes addressing these issues, would have a positive impact on participation rates for people with mental illness. Yet stigma and discrimination remain the greatest barrier to the employment participation of people with mental illness[28,29].

[25] SANE Australia, Blueprint: Employment and Psychiatric Disability, SANE Australia, Victoria, 2003.
[26] SANE Australia, Research Bulletin 3: Employment and mental illness,2006, accessed online at http://www.sane.org/images/stories/information/research/0606_info_rb3.pdf
[27] OECD, Sick on the Job: Myths and Realities about Mental Health and Work, figure 2.4: Unemployment Rates for People with a Mental Disorder across Selected OECD countries, 2011, OECD.
[28] National Mental Health Commission. (2012). A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention. Australian Government National Mental Health Commission, Sydney.
[29] Department of Employment, Education and Workplace Relations. (2008). Employer attitudes to employing people with a mental illness. DEEWR, http://foi.deewr.gov.au/documents/employer-attitudes-employing-people-mental-illness .

What is required is a considered and thorough understanding of the incentives and interactions at play in income and employment support systems with respect to these barriers. While there have been many previous undertakings, reviews and reforms, these processes have been flawed due to a lack of consultation with the mental health sector and, most particularly, with consumers and carers. As a result, the true extent of the challenges, and opportunities to address these, remain unacknowledged by the relevant agencies.

In the context of employment services, any future changes should align with the six principles outlined in the recent Jobs Australia report, *Reforming employment assistance: A blueprint for the future*[30], namely:

1. job seekers and employers are front of mind and meaningfully engaged in design, delivery and evaluation;
2. a truly competitive provider market;
3. a diversity of providers to match the diversity of job seekers and communities;
4. a focus on durable outcomes;
5. risk-based quality assurance with less red-tape; and
6. a redefined role for government as a steward, rather than a controller, of the system,.

RECOMMENDATION 14

Any changes to Australia's **employment and income support systems** should be designed through close engagement with the mental health sector, including mental health consumers and carers, and any review of these systems should consider:

- the **wider costs to government** of removing or reducing financial and social supports for people with mental health issues and related disabilities;
- **perverse incentives** which discourage people on DSP from moving into the labour market on a flexible basis when they are able;
- the appropriateness of specific **service types and client loads** for people with mental health issues of different kinds;
- **barriers to disclosure** of mental illness to government agencies and service providers by participants in these systems, and the consequences of non-disclosure;
- **stigma and discrimination** against people with mental illness by government agencies, service providers and the broader community; and
- the **implications of recent machinery of government changes** that have separated administrative arrangements for Disability Employment Services from Jobs Services Australia.

COST: Nil *(to be undertaken within existing departmental resourcing)*

NO COST

[30] September 2013, accessed online at http://ja.com.au/sites/default/files/page_attachment/JAL04%20-%20Blueprint%20for%20a%20better%20system%20FINAL.pdf

4.2 WORKPLACES

Mentally healthy workplaces are critical to increasing productivity and participation, as well as to maintaining mental health across the population.

The vast majority of people with current and past experience of mental illness are employed (see Figure 4, above). The benefits to remaining engaged and productively participating in the workplace, including the mutually reinforcing links between wellbeing and employment, are well known.

Supporting mentally healthy workplaces also makes good business sense, for employers and governments alike. While difficult to definitively estimate, the financial costs of mental illness for business, and for the economy more broadly, are real and significant.

- Psychological distress has been estimated to reduce Australian employee productivity by $5.9 billion per annum[31].
- Access Economics estimates an annual financial cost of $10.6 billion due to youth mental illness alone[32].
- Ernst & Young have calculated mental health related productivity losses of $387,000 per hour across a year amongst young men between 12 and 25 years old, with a total cost to employers of $237 million per year[33].
- KPMG estimates that suicide costs the economy over $1.6 billion per year[34].

Supporting mental health through workplaces can help to reduce these costs by lowering absenteeism and presenteeism (which can lead to lower on-the-job productivity), as well as helping to prevent staff turnover and the associated recruitment and training expenses.

Just as workplaces support people undergoing treatment and recovery in relation to physical illness, supporting mental health in the workplace is important. This is in (at least) two respects.

Firstly, **workplaces are effective settings in which to encourage better awareness and understanding of mental illness** and the value of good mental health. The average Australian will spend approximately one third of their adult lives at work[35]. A stigma-reduction campaign that ignores this will lack full coverage and likely be less effective. There are also important tangible aspects, such as discrimination in employment and the impact of attitudes in the workplace to developing flexible working arrangements. It can – and must – be done.

Secondly, there is a **strong case to be made for mental illness prevention and early intervention in workplaces**. This is particularly relevant for **young people**, for whom mental illness can disrupt the acquisition of skills and experiences required for career development and subsequent financial stability.

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[31] Hilton et al. (2010), cited in in Sax Institute for the Mental Health Commission of NSW (2013) The evidence on the costs and impacts on the economy and productivity due to mental ill health: a rapid review.
[32] Access Economics (2009) The economic impact of youth mental illness and the cost effectiveness of early intervention.
[33] Inspire Foundation and Ernst & Young (2012) Counting the Cost: The Impact of Young Men's Mental Health on the Australian Economy.
[34] KPMG (2013) The economic cost of suicide in Australia. Report for Menslink.
[35] PricewaterhouseCoopers. (2010) Workplace wellness in Australia, Aligning action with aims: Optimising the benefits of workplace wellness.

Importantly, prevention and early intervention in workplaces can be invaluable – and sometimes the only support available – **for the large number of people with mental illness, or who may face a number of mental illness risk factors, but who have no current diagnosis or contact with services**. Coupled with other life events, such as trauma, grief or relationship problems, stressors in the workplace and/or mental illness can quickly lead to a downwards spiral for this group of people. In such cases, workplaces that are well equipped to recognise and provide appropriate support as early as possible can play a critical intervening role in preventing potentially significant personal and financial costs to the employee, the workplace, and the tax payer.

As the OECD has stated, 'the workplace is a key target for mental health policy aimed at improving and sustaining labour market inclusion of those with mental illness'[36]. However, employers and employees might lack the tools to achieve more mentally friendly workplaces.

The Mentally Healthy Workplace Alliance – of which the MHCA is a member – is seeking to address this. A new national approach by business, community and government, the Alliance is developing resources and sharing and promoting best practices around how to encourage Australian workplaces to become mentally healthy. New and tangible supports are required to progress this important initiative.

There are a number of ways through which such supports could be provided. For example, allowing the market to bid on a competitive basis for grant funding to implement innovative workplace approaches. A low cost option might be for the Government to lead by example, and implement trials within government departments, which could both progress the Government's objective of increasing productivity within the public sector, whilst also contributing to the evidence base around best practice workplace mental health supports.

RECOMMENDATION 15

The Australian Government, in consultation with the Mentally Healthy Workplace Alliance, should support the development, promotion and implementation of innovative and collaborative models for **supporting mental health in workplaces**.

COST: *to be determined, in consultation with the Mentally Healthy Workplace Alliance*

LONG STANDING RECOMMENDATION

RECOMMENDATION 16

The Australian Government should adopt **national standards for psychological health and safety in the workplace**, implement any required regulatory supports, and promote the standards for uniform adoption by state, territory and local governments, as well as outside of governments.

COST: Nil

NO COST

[36] OECD (2011) Sick on the Job? Myths and Realities about Mental Health and Work.

4.3 SUPPORTING AND PROMOTING MENTAL HEALTH ACROSS THE COMMUNITY

The sustainability of any type of systemic reform will inevitably rely upon the attitudes that underpin the rationale for change. It is these attitudes that ensure that systemic changes can be continued at minimal effort, by becoming integrated into everyday practice without the need for additional regulation or reporting.

In the case of mental health, the development of positive and supportive attitudes is both the enabling factor for and one of the desired outcomes of successful reform. As well as improving individual outcomes, better community understanding of mental illness can lead to better policy design, more appropriate implementation, higher service quality and fairer assessments of risk and opportunity (for example, in the labour market).

On the flip-side, uninformed and negative attitudes and stigma can present very real barriers to the success of even the best designed programs, undermining the already restricted resources available to the sector.

Addressing stigma and increasing awareness and understanding about mental illness is therefore critical to increasing Australia's productivity and is a crucial building block for the success of future mental health reform.

It should be noted here that mental health promotion also plays a major role in relation to suicide prevention. It is important that this interaction be kept in mind when designing mental health campaigns, in order to ensure the most cost-effective use of investments. However, there are several specific distinctions between these two objectives, including initiatives that are specific to suicide prevention that are important to pursue outside of general mental health promotion.

Unfortunately, stigma around mental illness remains high across the Australian community . The type of improvements required to address this will require cultural change and education. This will take time, but as demonstrated by Australian campaigns such as 'Life Be In It' and 'Slip Slop Slap', is an effective approach to raising awareness of public health issues. This gives rise to an important role for the Australian Government in national leadership on this issue.

The MHCA proposes two specific measures for funding in the 2014-15 Budget: a well-targeted and coordinated national anti-stigma campaign; and expanded support for World Mental Health Day.

4.3.1 A national anti-stigma campaign

Stigma against mental illness is widely prevalent in our communities. It has serious and significant impacts on the lives and experiences of mental health consumers and their carers. Stigma manifests in many ways, in many different settings, including in education, housing, workplaces and mass media, as well as through self-stigma[37]. Stigma is even prevalent amongst those delivering services to people with mental illness, with a MHCA survey finding consumers report similar levels of stigma from health professionals as from the general community[38].

For a long time, the mental health sector has been calling for a nationally coordinated strategy to address stigma and misunderstanding about mental illness in the Australian community.

[37] SANE Australia (2013). *A life without stigma: A SANE Report*.
[38] Mental Health Council of Australia (2011). *Consumer and carer experiences of stigma from mental health and other health professionals*.

The importance of reducing stigma and recommendations for a national anti-stigma strategy has also featured in a long list of government reports (see further detail below), including:

- since 1992, in the first, second, third and fourth National Mental Health Plans[39];
- in three Senate committee reports, in 2006, 2008 and 2010[40]; and
- most recently, in June 2012, in a House of Representatives Standing Committee report[41], which, in the first of its fifteen recommendations, called for the Australian Government to:

  coordinate a comprehensive and multi-faceted national education campaign to target stigma and reduce discrimination against people with a mental illness in Australian schools, workplaces and communities.

Internationally, anti-stigma campaigns are increasingly being recognised and implemented as central to effective national mental health policy approaches, and have been funded by governments since as early as 1997.

- The New Zealand Government has been funding a national anti-stigma program – *Like Minds, Like Mine* – since 1997, and is now funded as a core public health activity.
- Scotland's *see me* anti-stigma campaign has been in place since 2002, and is fully funded by the Scottish Government at around AUD $1 million per year.
- The British *Time to Change* campaign has been in place since 2007, implemented by a combination of academic and mental health organisations.
- The Canadian Government launched its *Opening Minds* campaign in 2009, targeting healthcare providers, youth, workforce and media.
- In the USA, President Obama recently committed his Administration to coordinating national action to reduce stigma and encourage early intervention.

These campaigns are now contributing to a developing body of research around what works in this area, providing a valuable source of evidence, best practice principles and experience upon which an Australian campaign would draw. For example[42]:

- Research by the Institute of Psychiatry and the London School of Economics[43] found that an investment in the Scottish see me campaign of £0.55 per adult person produced a cost-saving of £4.51 pounds per person – an 800 per cent return on investment.

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[39] Agreed by Australian Health Ministers in 1992, 1998, 2003 and 2009.
[40] Senate Select Committee on Mental Health, *A National Approach to mental health – from crisis to community (Final Report)*, 2006; Senate Standing Committee on Community Affairs, *Towards recovery: mental health services in Australia*, 2008; Senate Community Affairs Reference Committee, *The Hidden Toll: Suicide in Australia*, 2010.
[41] House of Representatives Standing Committee on Education and Employment, *Work Wanted: Mental health and workforce participation*, 2012.
[42] Unless otherwise indicated, examples are drawn from SANE Australia (2013). *A Life Without Stigma: A SANE Report*.
[43] McCrone P, Knapp M, Henri M, McDaid D & Barrett B. (2007) *Economics and mental health: cost-effectiveness evidence review and economic implications of stigma*, prepared for Rethink, available online at www.psychminded.co.uk/news/news2007/August07/Rethinkreport.doc

- Analysis of the New Zealand *Like Minds, Like Mine* project found[44]:
    - a cost-benefit ratio for the period 2005-2007 that ranged from 4.1:1 to 13.8:1, depending on the models assumptions and scenarios; and
    - that the total project expenditure of $52 million over 10 years had generated an economic benefit of approximately $720 million.
- The British *Time to Change* evaluation[45] indicates that effective anti-stigma initiatives are targeted to specific groups and settings, and the Canadian experience indicates that targeted campaigns are more effective than broad blanket approaches.
- Educative interventions need to be targeted towards specific influential groups, tailored to local needs, and involve credible and continuous contact.
- More than education alone is needed; successful campaigns also incorporate increased direct contact with people with experience of mental illness, such as through a peer workforce strategy.
- Other countries' campaigns have generally been funded for several years, or on an ongoing basis.

In Australia, while there have been some awareness-raising initiatives and other programs, these have been funded, developed and implemented in an ad hoc fashion, with no sustained, overarching and coordinated national strategy. Despite many government and parliamentary reports recommending nationally consistent messages to promote awareness of mental health issues, Australia still does not have a nationally coordinated anti-stigma strategy.

The 2014-15 Budget is an **opportunity for the Government to distinguish itself from past approaches** and bring Australia into line with the international mental health community by supporting anti-stigma and mental health awareness on a comprehensive and national level.

An Australian strategy to reduce stigma and to promote mental health, delivered as part of a coordinated national approach to mental health, will have a community-wide benefit, enhancing the mental health of people participating in the workforce and increasing the participation rate amongst people currently not in the labour market. Particular targets could include mental health and other health professionals, first responders (such as emergency department workers, police officers and teachers), employers and unions, as well as young people.

Such action would also enable Australia to make an important contribution to developing international understandings of anti-stigma and other mental health initiatives.

[44] Vaithianathan R & Pramm K (2010). *Cost Benefit Analysis of the New Zealand National Mental Health Destigmatisation Programme ("Like-Minds Programme")*. Prepared for Phoenix Research and Ministry of Health. Available online at http://www.likeminds.org.nz/assets/Uploads/like-minds-cost-benefit-analysis.pdf

[45] Henderson C, Corker E, Lewis-Holmes E, Hamilton S, Flach C, Rose D, Williams P, Pinfold V, and Thornicroft G. (2012) England's Time to Change Antistigma Campaign: One Year Outcomes of Service User-Rated Experiences of Discrimination, *Psychiatric Services*, 63(5), 451-7.

RECOMMENDATION 17

The Australian Government should fund the Mental Health Council of Australia to develop, implement and evaluate a sustained strategy for coordinated and well-targeted **national campaigns to promote mental health and reduce stigma**, in partnership with the mental health sector (including with consumers and carers).

COST: $10 million per year, for ten years

LONG STANDING RECOMMENDATION

Additional information on Australian reports, frameworks and policy documents that support and/or recommend initiatives to increase public awareness and understanding of mental illness is provided at Attachment E to this submission.

4.3.2 World Mental Health Day – 10 October

Mental health is increasingly important for the economic and social prosperity of all nations and is recognised across the globe through World Mental Health Day (WMHD) – held on 10 October every year to raise public awareness of mental health issues worldwide.

WMHD provides an opportunity to build public dialogue and to further break down stigma around mental illness. Further, supporting WMHD is a simple and effective signal to the international mental health community that Australia is engaged on this important issue.

WMHD 2013, though successful, was minor in scale compared with other national health campaigns due to limited funding. Additional resources are required to expand the reach and impact of WMHD in 2014 and beyond, including by building upon established collaborative arrangements in the mental health sector and greater exposure and outreach through television advertising.

RECOMMENDATION 18

The Australian Government should increase funding for the Mental Health Council of Australia to coordinate and give broader reach for **World Mental Health Day** in Australia, to raise awareness of mental health through nation-wide promotion and activity coordination.

COST: $5 million per year, for four years

LONG STANDING RECOMMENDATION

Further information on this proposal, including the MHCA's strong track record in delivering the annual WMHD campaign, is provided at Attachment F to this submission.

4.3.3 Insurance discrimination

One of the many areas in which stigma and misunderstanding around mental illness is apparent is in insurance.

Many people with experience of mental illness find it difficult or impossible to access insurance of various kinds, and can be forced to pay increased premiums, have applications and claims rejected, or are excluded from cover all together, regardless of whether the claim is related to mental illness or not.

For people with mental illness, lack of insurance protection can lead to significant financial hardship and worry about the future. Also, the ways insurance companies treat people with mental illness can contribute to feelings of frustration and undermine self-esteem, pride and dignity. This can exacerbate symptoms of mental illness and have unintended consequences in areas such as employment, self-care, and the process of recovery from mental illness.

The stories we have heard from consumers suggest that some insurance policies or practices are **unfair and possibly contrary to anti-discrimination legislation**.

- The Disability Discrimination Act 1992 (Cth) (as well as equivalent state/territory legislation), enables insurers to discriminate against people with mental illness, so long as the discrimination is reasonable having regard to actuarial or statistical data on which it is reasonable to rely and 'other relevant factors'.

- However, due to the proprietary nature of actuarial judgements, it is impossible to determine whether insurers do in fact possess data that would enable a reasonable assessment of risk to be made. We are yet to see evidence that such data exist, and have seen notable evidence to the contrary.

In many cases, the barriers to insurance faced by people with mental illness could be removed through simple steps, such as innovative insurance products and better understanding of the issues around mental illness by insurance underwriters and frontline staff. In other cases, the solutions are not clear, because of the complexity of the risk assessment process. Further, the confidentiality of commercial decisions within the insurance industry means that reasons for decisions are often not disclosed or are communicated very poorly.

Despite ongoing advocacy over the past ten years, there has been **unacceptably slow progress** in improving the insurance outcomes and experiences for people with mental illness.

- To work through several challenges for the regulation of insurance, the Australian Government convened the Insurance Reform Advisory Group (IRAG) in late 2011, with representation from government, industry and other stakeholders.

- A subcommittee of IRAG, the Mental Health and Insurance Working Group (MHIWG), attempted to address the issues outlined above to the mutual satisfaction of industry and mental health stakeholders.

- MHIWG largely failed in this task, with industry representatives displaying little willingness to implement a range of solutions proposed by mental health stakeholders. The MHCA welcomes the Australian Government's recent decision to disband IRAG.

A solution must be found that balances the need to provide fair market access to a huge number of people with the imperative for insurance risk to be assessed and priced appropriately. For such a

solution to be credible, it must have the endorsement of mental health stakeholders, in consultation with consumers and carers, rather than being solely industry-driven. **The MHCA is prepared to take a leadership role** and work with relevant stakeholders to seek a long-term resolution to this critical issue.

RECOMMENDATION 19

The Australian Government should fund the Mental Health Council of Australia to work with government, the insurance industry and mental health stakeholders to develop detailed and practical solutions which will ensure that people with mental illness have **fair access to the insurance market** consistent with any insurance risks they may represent.

COST: $0.5 million over 2 years

LONG STANDING RECOMMENDATION

As a priority, existing anti-discrimination provisions should be enforced. However, to enable this to be done, more light needs to be shed on the legal and actuarial aspects of mental health and insurance.

RECOMMENDATION 20

The Australian Government should commission an **independent actuarial study** to evaluate the relevance and quality of data on which the insurance industry relies to assess the risks associated with mental illness, with terms of reference to be developed in close consultation with mental health stakeholders.

COST: Uncosted

FOUNDATIONS FOR REFORM

Further information on mental health and insurance is provided in a fact sheet published by the MHCA and beyondblue (see Attachment H to this submission)

ATTACHMENT A

Members of the Mental Health Council of Australia

MHCA members include national organisations representing consumers, carers, special needs groups, clinical service providers, public and private mental health service providers, researchers and state/territory community mental health peak bodies. While members participate actively in the MHCA's processes, the views expressed in this submission are not necessarily those of individual member organisations.

FULL MEMBERS

Adults Surviving Child Abuse (ASCA)
Alcohol and other Drugs Council of Australia (ADCA)
Alzheimer's Australia
ANU Centre for Mental Health Research
Australasian Society of Psychiatric Research
Australian Association of Development Disability Medicine
Australian Association of Social Workers
Australian College of Mental Health Nurses
Australian Counselling Association
Australian Infant Child Adolescent and Family Mental Health Association
Australian Medical Association
Australian Psychological Society
Australian Rotary Health
Australian Society of Psychological Medicine
beyondblue
Black Dog Institute
Brain & Mind Research Institute
Carers Australia
Catholic Health Australia
Catholic Social Services Australia
Dietitians Association of Australia
dNet – People Like Us
Grow Australia
headspace
Inspire Foundation
International Association of Infant Massage, Australia Inc
Lifeline Australia
Mental Health Carers ARAFMI Australia
Mental Health Coalition of South Australia
Mental Health Community Coalition of the ACT
Mental Health Coordinating Council
Mental Health Council of Tasmania
Mental Health Foundation Australia
Mental Health Professionals Network
Mental Health Research Institute
Mental Illness Fellowship of Australia Inc
Mind Australia
National Aboriginal Community Controlled Health Organisation
National Anxiety Disorders Organisations Network (NADON)
National Council of Intellectual Disability
National LGBTI Health Alliance
National Rural Health Alliance
NEAMI National
Northern Territory Mental Health Coalition
Occupational Therapy Australia
On the Line
ORYGEN Youth Health Research Centre
Ostara Australia
Pharmaceutical Society of Australia
Post and Antenatal Depression Association (PANDA)
Private Mental Health Consumer Carer Network (Australia)
Psychiatric Disability Services of Victoria (VICSERV)
Psychotherapy and Counselling Federation of Australia (PACFA)
Psychosis Australia Trust
Queensland Alliance
Queensland Centre for Mental Health Research
Ramsay Health Care
Richmond Fellowship of Australia
Royal Australian College of General Practitioners
SANE Australia
Suicide Prevention Australia
The Mental Health Services Conference Inc (TheMHS Conference)
The Pharmacy Guild of Australia

The Royal Australian and New Zealand College of Psychiatrists

WA Association for Mental Health

ASSOCIATE MEMBERS

ACT Mental Health Consumer Network
Anxiety Recovery Centre Victoria
ARAFMI Queensland
ARAFMI WA
Artius Pty Ltd
ASPIRE
blueVoices
Bunbury Pathways '92 Inc
Care Connect
CatholicCare NT
Centacare Catholic Diocese of Ballarat Inc
Centacare Catholic Family Services
Central Coast Family Suppprt Services Inc
CHESS EMPLOYMENT & Support Services (CHESS)
Club Haven
Converge International Ltd
Dulwich Centre Foundation
Eating Disorders Foundation of Victoria Inc
Exercise and Sports Science Australia (ESSA)
Fernhills Clinic
Finding Workable Solutions
Gold Coast Centre Against Sexual Violence
Graceville Centre
Homecare Services Pty Ltd
JobCo Employment Services Inc
Junaya Family Development Services
Karakan Hostels
Lamp Inc
Lives Lived Well
McAuley Community Services for Women
Melaleuca Refugee Centre, Torture and Trauma Survivor Service NT
Mental Health Association NSW
Mental Illness Education ACT
Mental Illness Fellowship of North Queensland Inc
Mental Illness Fellowship of Queensland
Mentally Healthy WA
MLC Community Foundation
Mothers Against Drugs
Newcastle Family Support Services Inc
Norwood Association Inc
NSW Consumer Advisory Group - Mental Health Inc
Open Minds
Peer Support Foundation Ltd
Peninsula Support Services Inc
Post Placement Support Service
Queensland Voice for Mental Health
Reconnexion Inc
Richmond Fellowship of Queensland
Richmond Fellowship of Western Australia
Ruah Community Services
Social Firms Australia
Supported Options in Lifestyle and Access Services Inc
The Australasian Centre for Rural & Remote Mental Health
The Compassionate Friends VIC Inc
Tully Support Centre
UCare Gawler Inc
WISE Employment Ltd
WISHIN Inc
Workability
Youth and Family Service (Logan City) Inc

ATTACHMENT B

Costs of Consumer and Carer involvement in mental health reform

Activity	2014-15 ($ m)	2015-16 ($ m)	2016-17 ($m)
National Mental Health Consumer and Carer Forum, National Register and mental health consumer and carer representatives - meeting costs, including travel and sitting fees - secretariat support - representative development and training - project work	1.0	1.0	1.0
National mental health consumer organisation - annual operating budget, including staff, Board, program/project work, consultations	1.0	1.0	1.0
Scoping study on the establishment of a new national mental health carer organisation - project manager, project work - sitting fees and travel for representatives involved in the project - national consultation, including workshops	0.1	-	-
Developing and implementing a national mental health and psychosocial support Peer Workforce Development Framework - project manager, project work - sitting fees and travel for representatives involved in the project - national consultation - implementation and evaluation - existing Departmental resources and committee structures (nil cost)	0.1	-	-
Consumer and carer representation at all levels of planning and decision making, including the Mental Health, Drug and Alcohol Principal Committee (MHDAPC) - travel and sitting fees for representatives to participate in MHDAPC and standing committee meetings - existing Departmental resources, for participation of consumer and carer representatives in other national meetings	0.05	0.05	0.05
Routinely surveying and reporting consumer and carer satisfaction with all aspects of the system - existing Departmental resources and committee structures	-	-	-

ATTACHMENT C

National Targets and Indicators and Review Terms of Reference

Mental Health Council of Australia
ABN 67 592 218 493

The Hon Peter Dutton MP
Minister for Health
PO Box 6022
House of Representatives
Parliament House
Canberra 2600

Re: **National Targets and Indicators**
Terms of Reference for the proposed Inquiry into Mental Health

Dear Minister

I write in your capacity as Minister for Health and as Co-Chair of the COAG Working Group on Mental Health Reform. I have two requests.

Firstly, I would like to urge the COAG Working Group, and governments nationally, to adopt targets and indicators to drive long-term mental health reform.

In September 2013, in response to terms of reference agreed by COAG, an Expert Reference Group (ERG) delivered a proposed framework for national, whole-of-life, outcome-based targets. The targets are ambitious but achievable and, most importantly, will lead to tangible change. The ERG, chaired by Professor Allan Fels AO and upon which I was a member, provided the framework to the COAG Working Group and also included indicators that would demonstrate short-term progress towards the targets.

Importantly, the ERG's deliberations were informed by wide consultation across the mental health sector, including consumers, carers, service providers, non-government organisations and professional groups.

The Mental Health Council of Australia's extensive consultations this year suggest that, should COAG decide to adopt the ERG's framework, it will have the backing of the broader mental health sector. With this in mind, there is now an unprecedented opportunity for governments to provide clear national direction for mental health reform with the support of consumers, carers and the non-government sector.

I encourage you to embrace this opportunity, and would be pleased to provide any further information you might find useful in your deliberations.

Secondly, I would ask you to consider the Mental Health Council of Australia's proposed Terms of Reference for an Inquiry into Mental Health (attached) as you develop terms of reference for the upcoming inquiry that will be conducted by the National Mental Health Commission.

As you will see from our proposed Terms of Reference, we consider the need for the Commission's inquiry to deliver short-term realisable recommendations for urgent reform along with a longer term plan for lasting reform. We look forward to supporting the Commission's work in advancing this important inquiry. Their track record to date gives us great cause for confidence.

I would be pleased to discuss these issues with you at your convenience.

Yours sincerely

Frank Quinlan
CEO

31 October 2013

Cc: Professor Allan Fels AO
Chair
National Mental Health Commission

Proposed Terms of Reference – National Mental Health Commission

It is proposed that the National Mental Health Commission review the effectiveness of mental health programs in a three-stage process, in line with the Terms of Reference below. In doing so, the National Mental Health Commission will consult extensively with relevant government and non-government stakeholders at federal, state and territory levels, as well as with consumers and carers.

Stage One – Establishing an agreed baseline

The National Mental Health Commission will:

1. Use the targets and indicators that were identified through the recent Expert Reference Group process (and once ratified, the targets and indicators adopted by COAG) as the starting point for analysing current government expenditure on mental health related programs.
2. Work with relevant parties to review current and planned data collection activity relating to the mental health system. This work will identify and prioritise collections most relevant to the inquiry, using data related to the targets and indicators (above) as the starting point for reviewing existing expenditure, including the experience of mental health consumers and carers. The inquiry should consider the full spectrum of mental illness, high and low prevalence, across the full life cycle.
3. Identify the full cost of mental illness in Australia, including, but not limited to, consideration of:
    a. Direct financial costs, such as:
        i. Mental health specific government services (health and non-health);
        ii. Other government services and systems that support people with experience of mental illness and their carers (eg employment services)'
        iii. Mental health in the private sector – including private providers of mental health services and private-sector supports (eg workplaces);
        iv. Insurance and compensation payments; and
        v. Out-of-pocket costs to consumers and carers.
    b. A comparison of the costs of services delivered through hospitals and the community mental health sector, and through clinical and non-clinical services.
    c. Indirect costs (eg productivity losses, the cost of and time lost due to unpaid care, and foregone taxation revenue).
4. Identify the nature and extent of met and unmet need in relation to access to and take-up of services by mental health consumers and carers.
    a. This requires a stocktake of existing services, including the geographic distribution of various services
    b. This also requires a mapping of existing needs, based on demographic distribution, so that distribution of services can be compared to need.
    c. A clear identification of the demand that would be created, and the services that would be required, by improved help seeking behaviour.

Stage Two – identify barriers to service integration and coordination

The National Mental Health Commission will:

5. Examine the interaction between programs and services for mental health consumers and carers and other relevant systems, including in health, housing, education and, participation in work and employment.
6. Identify possible barriers to care for people with mental illness and their carers and families – including financial affordability, geography, cultural appropriateness, complex care pathways, poor physical health, lack of genuine choice, inflexible service models, waiting lists, fear, lack of service availability, discrimination, and access to primary care.

Stage Three – inform public policy debate

The National Mental Health Commission will:

7. Publicly report on the above analyses, and in so doing, publish findings regarding the effectiveness of existing mental health programs. The report will make recommendations for maximising mental health outcomes and improving efficient mental health service delivery, including:
    a. The overall level and targeting of government investment;
    b. Options for matching services to need;
    c. Achieving equitable distribution of and access to services;
    d. Overcoming barriers to care, including any systemic barriers; and
    e. The role and impact of prevention, promotion and early intervention programs.
    f. Implementation at state and national level.

ATTACHMENT D

National Disability Insurance Scheme

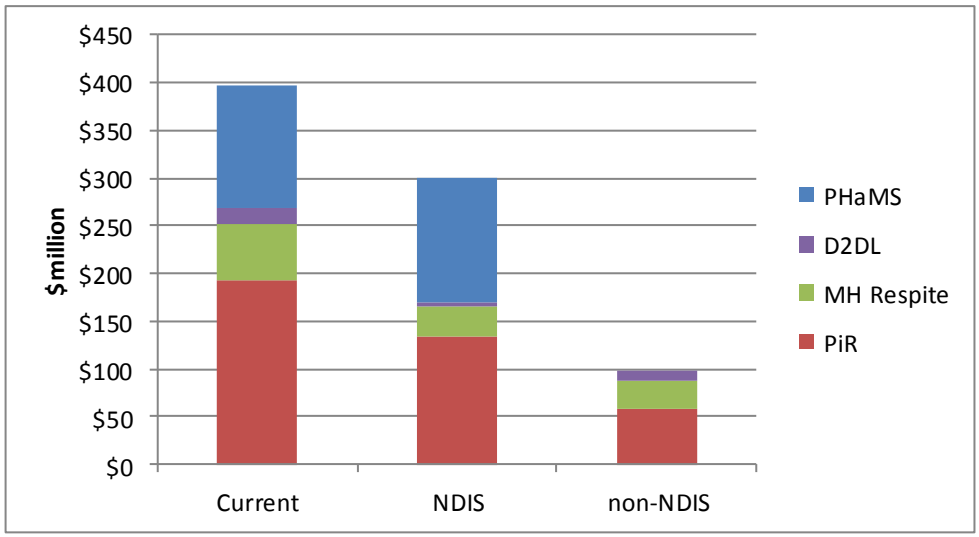
This attachment outlines in detail the concerns of the MHCA in relation to the design, implementation and system implications of the National Disability Insurance Scheme (NDIS).

D.1 IN-SCOPE PROGRAMS, FUNDING AND PARTICIPANTS

The National Disability Insurance Agency (NDIA) has indicated that at the Commonwealth level, 100 per cent of the Personal Helpers and Mentors program (PHaMS), 70 per cent of Partners in Recovery (PIR), 50 per cent of Mental Health Respite for Carers (MH Respite) and 35 per cent of Support for Day to Day Living in the Community (D2DL) are in-scope for the NDIS.

Figure D.1 illustrates that the funding that may remain for the operation of these programs outside the NDIS.

Figure D.1: Mental Health programs in-scope for NDIS – current funding, proposed contribution to NDIS, and funding remaining for non-NDIS psychosocial disability



	Current ($m/yr)	in-scope for NDIS* (%)	in-scope for NDIS* ($m/yr)	Remaining ($m/yr)
PHaMS	129.5	100%	129.5	0.0
PiR	192.4	70%	134.7	57.7
MH Respite	60.2	50%	30.1	30.1
D2DL	15	35%	5.3	9.8
total	**397.1**		**299.5**	**97.6**

* Assumes national application of arrangements in current bilateral agreements

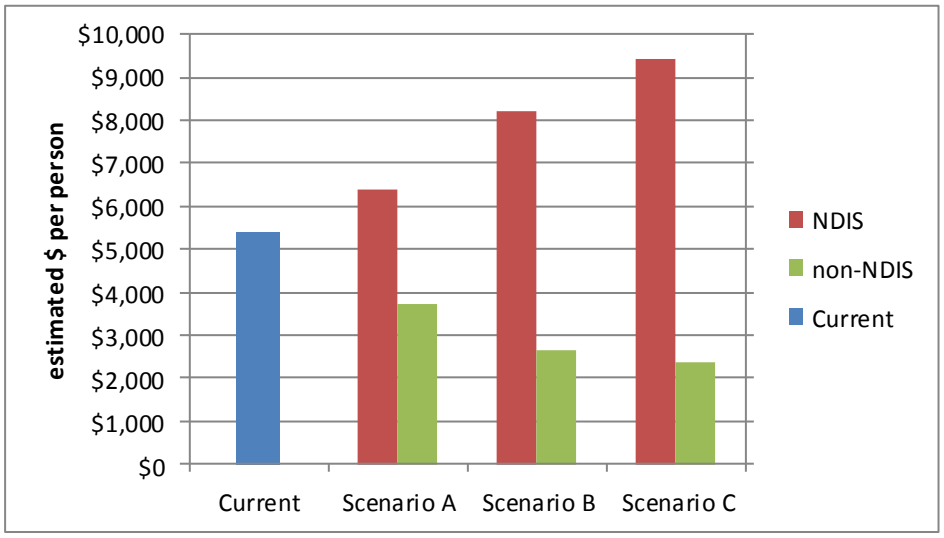
However, it is not at all clear whether similar proportions of people currently accessing these programs will be eligible for the NDIS.

To explore the possible implications of these decisions for the mental health sector, a number of scenarios have been developed based on different assumptions about the overlap between existing programs and the NDIS (see Figure D.2)

Scenario A assumes that the same proportion of participants as funding under each program will be in-scope (i.e. eligible) for NDIS. However, some estimates suggest that a significantly lower proportion of PHaMS clients will be eligible for the NDIS (Scenario B) and similarly for PIR (Scenario C).

While rudimentary and developed in the absence of reliable information[46], these scenarios paint a picture of reduced services for the significant number of people currently receiving treatment for serious mental illness who are likely to be ineligible for the NDIS, either because they do not opt in or because their disability is not deemed sufficiently significant or permanent.

Figure D.2: Possible per person funding for people with psychosocial disability within and outside of the NDIS



[46] At this stage, bi-lateral agreements with participating jurisdictions only detail estimates for the proportion of funding that has been allocated to the NDIS from these programs in the launch-sites. Without having access to the budgets of providers of these programs in the Hunter, Barwon and Tasmanian launch-sites it is difficult for the MHCA to accurately determine whether the figures in the forward estimates to 2015-16 represent an increase in overall funding or support places for eligible participants in the launch-sites.

Scenario assumptions (proportions of current in-scope program clients eligible for the NDIS) and estimated $ per person for psychosocial disability support (NDIS and non-NDIS)

	Current (n)	Scenario A (%)	Scenario A (n)	Scenario B (%)	Scenario B (n)	Scenario C (%)	Scenario C (n)
PHaMS	13,200	100%	13,200	21%	2,772	21%	2,772
PiR	24,000	70%	16,800	70%	16,800	50%	12,000
MH Respite	29,000	50%	14,500	50%	14,500	50%	14,500
D2DL	7,000	35%	2,450	35%	2,450	35%	2,450
NDIS ($pp)	n/a	$6,380		$8,201		$9,442	
non-NDIS ($pp)	$5,425	$3,717		$2,660		$2,352	
% of current $pp		*69%*		*49%*		*43%*	

Such variations will clearly have implications for the *average* funding available to someone with a psychosocial disability/mental illness who qualifies for an individualised package of support under the NDIS. However there is currently no guarantee that funding for these programs will support NDIS participants with mental illness, despite in-scope programs being expressly targeted at this group.

These scenarios also suggest that the resourcing available for non-NDIS participants through in-scope programs could be reduced to between 40 and 70 per cent of current levels of around $5,400 per person per year. Similar outcomes in relation to in-scope state and territory programs are also likely, although the picture is highly variable from state to state.

In addition, these scenarios do not incorporate the high levels of current unmet need, which are likely to further reduce the per person availability of funding. According to the (as yet unpublished) National Mental Health Service Planning Framework, there are around 440,000 Australians who have severe mental illness as their primary condition (with a further 48,500 having serious mental illness as a secondary condition). Only a small proportion of these people would be eligible for the NDIS, leaving a significant number to share in remaining programs and services.

Further, while a guarantee of continuity of care is in place (in Commonwealth/State agreements) for current clients, no such guarantee exists for future clients, including mental health programs that have appropriately high rates of client turnover.

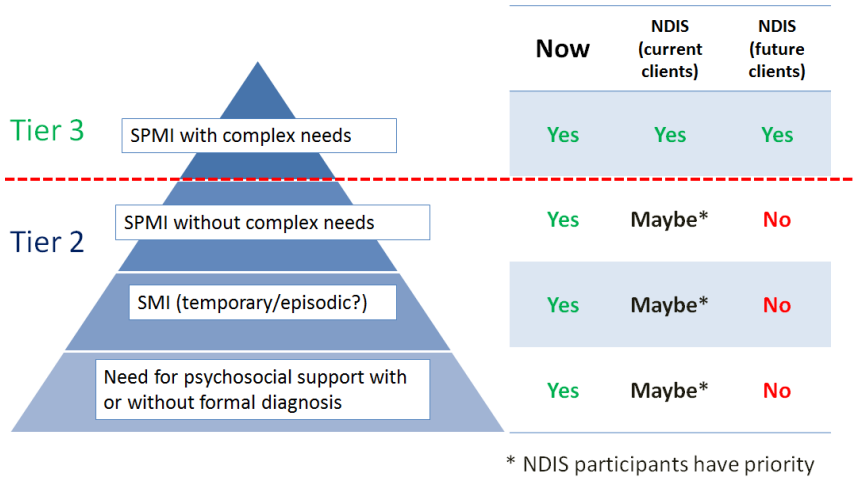
If current arrangements are replicated at the national level, these programs and services will be depleted of resources for clients who are not full NDIS participants. Given the long-run underinvestment in mental health in all jurisdictions, **the NDIS could exacerbate rather than mitigate the problems** that people with mental illness have in accessing timely and effective services in the community.

PERSONAL HELPERS AND MENTORS (PHaMS)

PHaMS currently provides support to participants across a broad range of levels of severity, encompassing severe mental illnesses both with and without complex needs, and people without formal diagnosis.

One hundred per cent of PHaMS funding is in-scope for the NDIS. However, eligibility criteria for PHaMS suggest that not all people who would currently be eligible for PHaMS would be eligible for NDIS support. Subsuming PHaMS into the NDIS in terms of funding and services, and in the absence of any advice to the contrary, will result in a significant number of people without adequate supports.

Figure D.3: Access to PHaMS under the NDIS[47] for people with Severe and Persistent Mental Illness (SPMI), Serious Mental Illness (SMI) and with other psychosocial support needs



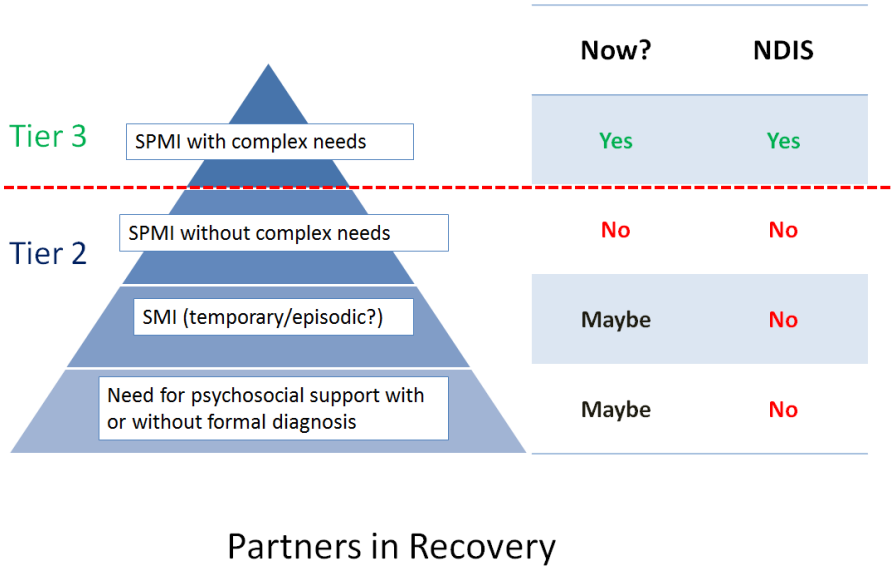
[47] The categories of illness in this figure (serious and persistent mental illness with complex needs, serious and persistent mental illness without complex needs, serious mental illness) are based on categories relied on by experts consulted by the Productivity Commission to developing population estimates for groups which would qualify for the NDIS.

PARTNERS IN RECOVERY

One of the key Commonwealth-funded mental health programs in scope for the NDIS is Partners in Recovery (PIR). This relatively new initiative is targeted at people with serious mental illness whose needs are not currently being met by the service system and who need intensive coordination of support across several areas.

It is difficult at this stage to understand the overlap between the PIR target group and the population of people with psychosocial disability who will be eligible for Tier 3 NDIS funding; the needs of PIR clients may often be crisis-driven or short-term, whereas entry into the NDIS requires that participants have clear long-term support needs. It is also unclear what types of 'in-kind' contributions the PIR program will make to the NDIS, as part of the Commonwealth's commitments in bilateral agreements.

Figure D.4: Access to PIR under the NDIS[48] for people with Severe and Persistent Mental Illness (SPMI), Serious Mental Illness (SMI) and with other psychosocial support needs



[48] The categories of illness in this figure (serious and persistent mental illness with complex needs, serious and persistent mental illness without complex needs, serious mental illness) are based on categories relied on by experts consulted by the Productivity Commission to developing population estimates for groups which would qualify for the NDIS.

D.2: SUGGESTED PROCESS FOR INTEGRATING MENTAL HEALTH INTO THE NDIS

Psychosocial Disability Expert Advisory Group – Proposed terms of reference

Main Role

- Engage with the NDIA to ensure improved outcomes for people living with psychosocial disability related to mental illness.

Specific tasks

- Identify the key differences between the service delivery model being implemented by the NDIA and the services delivered by the broader mental health sector in Australia, including innovative approaches developed in the community mental health sector.
- Review access to, and services available through, the NDIS for people with severe and persistent mental illness.
- Review the interaction between NDIA and current programs and services for people living with mental illness to minimise unintended consequences of the move to the NDIS model.
- Consider developments in the launch sites, the lived experience of people living with severe and persistent mental illness in those locations, as well as feedback from the broader mental health sector.
- Make recommendations relating to:
    - Unintended consequences to the health system and, where possible, other systems as a result of people living with severe and persistent mental illness not receiving assistance through the NDIS, both immediately and in the future.
    - Key reform opportunities building on the core principles of the NDIS and taking into account the needs of people living with severe and persistent mental illness.

Addressing information gaps

The mental health sector is currently operating in an information vacuum in relation to the design and operation of the NDIS. As well as creating uncertainties and tensions, the NDIS may not fully utilise the specialist skills and expertise that reside in the community mental health sector, and that the positive aspects of non-government services for people with mental illness may be eroded as the NDIS evolves.

To address these problems, the NDIA needs to provide detailed information to mental health stakeholders on:

- how assessment is being conducted, including which assessment tools are being used for psychosocial disability, why these tools were chosen, and who is involved in the assessment process;

- de-identified data on the specific reasons why people with mental illness are being assessed as either eligible or ineligible for full participation in the NDIS, including information on how a determination of permanency of impairment is made in practice;

- how participants with psychosocial disability are supported to make decisions about their package of care that are in their best interests, including the roles of carers and service providers/workers who have a pre-existing relationship with those participants; and

- a breakdown of NDIS funds spent on people with psychosocial disability associated with mental illness, matched to the funding commitments made by Commonwealth and state/territory governments in bilateral agreements.

Involving mental health stakeholders in evaluation and policy development

The NDIA needs to involve mental health stakeholders to a much greater degree in monitoring and evaluating the effectiveness of the NDIS in meeting the needs of people with psychosocial disability. This engagement should include, at a minimum:

- an early warning system to identify and act on problems well before the formal evaluation of launch sites is complete;

- timely and mutual communication flows between the NDIA and the sector, including a presumption in favour of releasing any data or other information to mental health stakeholders wherever possible; and

- a robust process to identify the extent and nature of unmet need and the barriers to those needs being addressed.

With substantial concerns about pricing levels for various support clusters published by the NDIA to date, the NDIA should consider, in close consultation with mental health stakeholders, whether the current NDIS pricing incorporates all relevant psychosocial disability support services and accurately reflects the cost of providing those services.

Finally, the NDIA needs to acknowledge the serious difficulties that the mental health sector is experiencing in understanding and (in the launch sites) implementing the NDIS. This could mean, among other things, appointing senior officials within the NDIA to oversee its work to resolve issues specific to the mental health sector.

ATTACHMENT E

Existing reports supporting a national anti-stigma campaign

Previous reports, government frameworks and policy documents that support and/or recommend initiatives to reduce stigma and increase awareness and understanding of mental illness in Australia include:

- in 1992, the **first National Mental Health Plan**, which outlined strategies to further the development of mental health services by, among other initiatives, 'reducing the stigma associated with mental health problems and mental disorders'.
- in 1998, the **Second National Mental Health Plan** planned to continue initiatives to improve community understanding of mental illness and address the stigma and discrimination experienced by people with mental illness.
- in 2003, the **Third National Mental Health Plan** included decreased levels of stigma experienced by people with experience of mental illness as a key outcome.
- in 2006, the **Senate Select Committee on Mental Health** report, A national approach to mental health – from crisis to community, which recommended 'the Australian Government fund and implement a nationwide mass media mental illness stigma reduction and education campaign' and that 'nationwide workplace education and advocacy programs be rolled out to counter workplace stigma'.
- in 2008, the **Senate Standing Committee on Community Affairs** report, Towards recovery: mental health services in Australia, which recommended the Government provide funding for a targeted public awareness program focussed on psychotic illness.
- in 2009, the first Action of the **Fourth National Mental Health Plan** to 'improve community and service understanding and attitudes through a sustained and comprehensive national stigma reduction strategy'.
- in 2010, the **Senate Community Affairs Reference Committee** report, The Hidden Toll: Suicide in Australia, which recommended the Commonwealth fund a national suicide prevention and awareness campaign that linked into other public health and social issues, such as mental health, homelessness, and alcohol and drug use.
- in 2012, **COAG's ten-year Roadmap for National Mental Health Reform** which included the key strategy to 'reduce stigma about mental health issues among service and support providers'.
- in June 2012, the first recommendation of the **House of Representatives Standing Committee on Education and Employment** report, Work Wanted: Mental health and workforce participation, was that the Government coordinate a comprehensive and multi-faceted national education campaign to target stigma and reduce discrimination again people with a mental illness in Australian schools, workplaces and communities.

ATTACHMENT F

World Mental Health Day

Mental health is increasingly important for the economic and social prosperity of all nations and is recognised across the globe through World Mental Health Day (WMHD) – held on 10 October every year to raise public awareness of mental health issues worldwide.

WMHD provides an opportunity to build public dialogue and to further break down stigma around mental illness. Further, supporting WMHD is a simple and effective signal to the international mental health community that Australia is engaged on this important issue.

The WMHD campaign aims to raise public awareness of mental health issues worldwide. As the peak not-for-profit organisation representing the mental health sector in Australia, the MHCA has been managing WMHD activities since 2001.

The 2013 WMHD campaign encouraged people to take personal ownership of their own mental health and wellbeing, with three objectives in mind: encouraging help seeking behaviour; reducing the stigma associated with mental illness; and fostering connectivity throughout communities. The campaign theme, 'mental health begins with me' is a positive message that is relevant for everyone in the community, regardless of their own mental health.

The 2013 WMHD campaign was highly successful with both national and international reach and implications. Key to its success was the integrated use of social networks, leading to over 2,300 'mental health promises' being made online, along with promotion of over 100 events and significant media coverage, including a launch on the Sunrise TV program. Throughout the course of the campaign, 40,000 unique visits were made to the www.1010.org.au website, 162,000 postcards were distributed as well as 20,000 posters and 5,000 wristbands. Displays were also included in 115 shopping centres nationally. However, this activity – though successful – was minor in scale compared with other national health campaigns due to limited funding.

The outcomes and the overwhelmingly positive feedback received so far are just initial indications of the community's appetite for greater awareness and involvement in promoting mental health.

Much more could be done to expand the reach and impact of WMHD in 2014 and beyond, including by building upon established collaborative arrangements within the mental health sector. The MHCA is uniquely placed to progress this work through its extensive connections with consumers, carers and mental health sector organisations. Additional resources are required to enable the MHCA to undertake work to achieve these ambitious goals and elevate the status and influence of WMHD across the country.

This proposal would significantly broaden the reach of the WMHD campaign by providing greater exposure and outreach through television advertising – a medium that has been proven to have a greater impact regarding message delivery.

Television advertising, while effective, is expensive. To begin with, a quality 30 second advertisement costs a lot to create (between $10,000 and $50,000 depending on a range of factors). This doesn't include employing a significant actor to be the face of a campaign, which can increase production costs by upwards of $100,000.Then, the main cost of relaying a campaign message through this important medium is buying airtime. A 30 second commercial on a free to air

network in the morning costs between $1,000 and $3,000 per slot, depending on the network. Prime time advertising, when it has the most impact, can range between $10,000 and $25,000 per 30 second slot. A single 30 second slot during the NRL grand final this year cost $100,000.

With commercial enterprise able to afford these prices, reliance on community service announcements and limited runs can seriously reduce the impact of not for profit messages. Television advertising is a proven way to cut through the noise of product based advertising and proved successful for other public health campaigns (skin cancer, smoking). For this reason, a sustained campaign of television advertising over a four week period, mixing prime time and other times, would be required to have the desired level of cut through with the public.

A sustained four week campaign of this magnitude would cost as much as $4,000,000, just to buy air time. This significant cost represents the main reason for the requested increase in funding.

In addition, online advertising can have a major impact, and allow for the public to click through to information based web platforms. A sustained four week campaign on a site like news.com.au can cost upwards of $500,000 simply to purchase sufficient space to have an impact.

As an invest-to-save issue, this proposal represents value for money compared to other more narrowly focussed campaigns. WMHD targets the factors that underpin stigma, discrimination and low help-seeking behaviour, and targets the whole population regardless of mental illness type.

ATTACHMENT G

Mental Health and Insurance Discrimination

Speak up and take action to reduce discrimination in insurance

In Australia, people with an experience of mental illness may not be able to access insurance in the same way as the rest of the population. A prior history of mental illness can mean that someone is denied insurance cover, asked to pay a higher premium, or has their claim rejected. This is particularly the case in relation to travel insurance, life insurance, total and permanent disability insurance and income protection insurance.

For the past ten years, *beyondblue* and the Mental Health Council of Australia (MHCA) have been working hard to encourage the insurance industry to change their policies and practices to improve access to insurance for people who have experienced mental illness.

Unfortunately, change has been slow to happen, and we need to do more to get a fair deal for people who experience mental illness. *beyondblue* and the MHCA are now building an awareness and advocacy campaign, and **we need your support**.

How insurance companies potentially discriminate against people with mental illness

Generally, under state and federal anti-discrimination legislation, insurance companies can legally discriminate against someone with a disability if their actions are reasonable, having regard to actuarial or statistical data on which it is reasonable to rely. At federal level and in some states if there is no such actuarial or statistical data, insurers can rely on 'other relevant factors', which may be particular to the individual. These factors could include medical opinion, opinions from other professional groups, actuarial opinion and commercial judgment. Some states only permit discrimination if it is reasonable, having regard to actuarial or statistical data.

Unfortunately, *beyondblue* and the MHCA regularly hear stories from people which suggest that insurance companies are not using the right data or considering the full range of relevant factors in dealing with people who disclose an experience with mental illness.

For example:

- A history of one mental illness can mean that people are refused insurance for another, unrelated mental illness. It is hard to imagine someone with a history of (say) stomach problems being excluded from cover associated with a broken leg, yet insurers regularly treat people with mental illness in ways that would be unacceptable for people with physical ailments.
- A person who has a history of depression may be refused increased coverage for an income protection insurance policy, even though they have never taken a day off work because of their mental illness, and have a doctor's opinion stating that their mental illness will not impact on their performance at work.
- Policy wording commonly refers to symptoms of and risk factors for mental illness (e.g. 'stress', 'insomnia') as substitutes for mental illness.
- Insurers have been known to attribute a mental illness to a person in the absence of a diagnosis, such as when someone has seen a counsellor or psychologist.

These kinds of practices demonstrate a basic misunderstanding of mental illness on the part of the insurance industry and we think it is unlikely that there is reliable statistical evidence to support them. However, the commercial nature of actuarial judgments (decisions made by the insurance company about the risks posed by people in different categories) means the data is not accessible, which makes it hard to determine whether insurers are using data upon which it is reasonable for them to rely.

Many people also report that insurers have not considered their personal circumstances when assessing applications and claims. In our experience, this suggests that 'other relevant factors', such as the type of illness, its severity, the individual's treatment or recovery plan and/or effects on income-earning capacity, are often not taken into account in such decisions.

Some of the practices of the insurance industry contradict their stated policies or protocols. While insurers might assert that they do not reject applicants or claimants solely on the basis of having a mental illness, in our opinion the experiences of individual people demonstrate that such discrimination is common.

www.beyondblue.org.au 1300 22 4636

www.mhca.org.au

Some insurance companies allow people with a mental illness to purchase cover if they have been without symptoms or have not sought treatment for a given time period. Unfortunately, this can serve as a disincentive for people to report mental health problems to a health professional or to change their treatment so that they can qualify for insurance. Such practices in fact promote poorer mental health by discouraging early identification and treatment of mental illness.

What can we do about it?

beyondblue and the MHCA believe that much needs to be done to ensure that people with a mental illness can enjoy fair access to the insurance market. For example:

- An independent study on the data that the insurance industry currently holds about the risks associated with mental illness for different kinds of insurance
- Training for insurance workers so they can deal effectively with people who disclose a mental health issue and assess risk appropriately
- A guide to insurance policies for people with a mental illness that are mental health-friendly
- Changing underwriting practices to reflect a more accurate understanding of mental illness
- Removing inaccurate and misguided clauses relating to mental illness in insurance policy documents

While these are all important, **the most important thing in achieving change right now is for as many people as possible to come forward** and tell their stories about ways in which insurance companies may have discriminated against them because of their experience of mental illness.

How can you get involved?

If you have a complaint about an insurance policy or claim, or wish to appeal a decision made by an insurance company, there are several options available:

- Lodge a complaint or appeal with the insurance company's customer complaints section, seeking a review of their decision.
- If contacting the insurance company directly does not lead to a satisfactory resolution of your complaint, you can make a complaint to the relevant industry complaints body. This would most likely be one of the following:
  - Financial Ombudsman Service www.fos.org.au
  - Superannuation Complaints Tribunal www.sct.gov.au
- If you believe you may have been discriminated against because of your experience of mental illness, you can make a complaint of disability discrimination to one of the following:
  - Australian Human Rights Commission, www.humanrights.gov.au
  - Your state or territory based human rights, anti-discrimination, or equal opportunity body.

If you wish to obtain some legal advice about your options, you can contact:

Michelle Cohen
PIAC Senior Solicitor
Public Interest Advocacy Centre (PIAC)
Phone: (02) 8898 6504
Email: mcohen@piac.asn.au

PIAC can provide you with free **legal advice** and, if appropriate, legal representation in relation to your complaint. Legal advice may include advice on the best place to make a complaint for your particular case.

If you would like to tell your story or to stay informed about the campaign, please email your contact details and a brief explanation of your experience regarding discrimination and insurance to **theinsuranceproject@beyondblue.org.au**

Where to find more information about anxiety and depression

beyondblue
www.beyondblue.org.au
Learn more about depression and anxiety, or talk it through with our support service.
1300 22 4636
Email or chat to us online at
www.beyondblue.org.au/getsupport

www.beyondblue.org.au 1300 22 4636 www.mhca.org.au

Mental Health
Council of Australia

Mentally healthy people, mentally healthy communities