



Tuesday, January 14, 2020

Dear Commissioners,

**Re: response to Productivity Commission Inquiry into Mental Health Draft Report.**

Please find our response to the **Productivity Commission Inquiry into Mental Health Draft Report**. drummond street would like to address some key considerations in relation to this report, specifically, we would like to draw attention to the social and economic cost benefits of the Commonwealth Early Intervention – Targeted Mental Health Program: Family Mental Health Support Services (FMHSS).

We have included a brief discussion paper to encourage increased attention to this program and type of early intervention investment in the context of the **Productivity Commission's** draft recommendations. This is followed by a brief, additional submission containing our other general recommendations regarding the draft report.

While we acknowledge many draft recommendations examine better ways to include families/or carers in mental health services, we believe a gap exists in non-clinical family service provision that encapsulates the report's draft recommendation principles; and which, respond to whole of family risk and protective factors to wellbeing which influence mental health and resilience. The FMHSS is one investment which has capacities to engage communities in the creation of positive outcomes for families and, yet it is both underfunded with an uncertain future.

FMHSS has been operating for over a decade and was re-orientated in 2011-2012 to support children and their families, early in life and early in onset. It is one of the **few** current investments both nationally or state, which provides mental health early intervention and prevention targeting vulnerable children and young people (0-18yrs) at risk of or affected by mental illness which uses a community-based, whole-of-family approach.

**FMHSS provides significant cost benefits to State and Commonwealth mental health programs and initiatives.** FMHSS has a national footprint, with 121 services operating across Australia (<sup>1</sup>), including regional and remote locations. Currently drummond street is the largest Victorian FMHSS provider with sites in Geelong, Wyndham, Brimbank, Inner Northern Melbourne and Whittlesea. drummond street built these services by applying our learnings from the delivery of the FMHSS demonstration pilot program for Inner-Southern Melbourne between 2006-2015.

---

<sup>1</sup> <https://www.dss.gov.au/our-responsibilities/mental-health/programs-services/family-mental-health-support-services/locating-a-family-mental-health-support-service-fmhss>



Our learnings are situated within a strong evidence base which shows mental health interventions that address early risk factors should:

- factor significant life transitions
- take a family systems perspective on child wellbeing;
- apply a social health determinants framework
- apply a public health model

drummond street believes it is vital to invest in funding models that focus on early intervention, work separately and alongside clinical interventions, deploy an evidence-base known to be effective in working with children and young people, and recognize the context of their family and home environments.

We look forward to the Productivity Commission's final report and I welcome any further queries regarding the content of this submission.

Kind Regards



Karen Field (CEO drummond street services)



## About drummond street

**drummond street** is a 133-year-old, non-denominational, not-for-profit organisation that provides services across the North Western regions of Melbourne and Geelong. These services include a range of specialist child, youth and adult mental health services and targeted programs for LGBTIQ+, First Nations, migrant and refugee communities. drummond street works closely with State and Commonwealth services across mental health promotion, prevention, early intervention, primary (and), specialist mental health, emergency and crisis services. Our sector relationships range from service delivery partnerships, advocacy networks, contracted consortia's and research partnerships, to the provision of training and secondary consultation.

drummond street drives innovation and research into family support interventions. We apply a public health approach and a social health determinants lens which underpins all our programs and services. We use population-based data and identify common life-course risk and protective factors to wellbeing across multiple domains to map community needs and address negative preventable outcomes <sup>(2)</sup>.

drummond street's health and human services sector capacity-building work extends nationwide through our Stepfamilies Australia National Office and our national Centre for Family Research and Evaluation (CFRE) which works closely with a range of university partners. Over the past decade drummond street has been at the forefront of developing innovative responses to marginalised populations with complex trauma histories including child and adult experiences of family violence, institutional child sexual abuse and LGBTIQ communities.

drummond street's additional sub entity, queerspace is the first nationally funded LGBTIQ+ community specialist mental health service and is Victoria's largest provider of LGBTIQ+ specialist mental health services. queerspace provides services for individuals, families, children and young people and works to the principle 'for community/by community'.

---

<sup>2</sup> Program Planning and Evaluation: how to use evidence to support Communities for Children's services drummond street services and Deakin University, 2016, Program and Planning and Evaluation p. 10 cites Toumbourou, J. (2015)



## FMHSS: Considerations for Productivity Commission Inquiry

### A Discussion Paper

#### Discussion Paper Key Recommendations

**Recommendation 1:** That Government provide funding certainty to the FMHSS program.

**Recommendation 2:** That Government explore the current functions and capabilities of FMHSS in the context of the Productivity Commission Inquiry into Mental Health and increase funding to FMHSS so it may fill gaps identified by the Productivity Commission where these relate to the FMHSS's current functions, capabilities and reach.

#### FMHSS model background

From 2006, as part of the National Action Plan on Mental Health 2006-2011, the Commonwealth funded community organisations across Australia to provide early intervention and intensive support to vulnerable children and young people at risk of or affected by mental illness. The Commonwealth Early Intervention – Targeted Mental Health Program: Family Mental Health Support Services (FMHSS) were implemented to provide flexible, responsive, non-clinical mental health support services to meet the needs of children and young people affected by, or at risk of, mental illness, and their families and carers.

In 2011 the Government identified the FMHSS as key to reaching the most severely affected by mental illness; and that the FMHSS program would improve access to the full range of services people needed to stay well and out of hospital through a single point of contact. An additional 40 FMHSS sites were funded to provide integrated prevention and early intervention services to over 30,000 children and young people; and to also help them and their families navigate mental health and other key human services systems. The expansion of FMHSS complimented national coverage of 'headspace' and Early Psychosis Prevention and Intervention Centres (EPPIC) <sup>(3)</sup>.

The FMHSS Activity funds organisations to deliver a model which **includes three levels of support:**

1. **Intensive**, long-term, early intervention support for children, young people and their families which may include: Assessment and identification of needs; practical assistance and home-based support; linking with other relevant services; and, targeted therapeutic groups.
2. **Short-term** immediate assistance for families which may include: Assessment of needs; information or referrals; and, limited direct support.

---

<sup>3</sup> National Mental Health Reform, Statement by the Hon Nicola Roxon MP, Minister for Health and Ageing, the Hon Jenny Macklin MP, Minister for Families, Housing, Community Services and Indigenous Affairs, the Hon Mark Butler MP, Minister for Mental Health and Ageing, 10 May 2011, (p. 24, 3 & 6)

3. **Community outreach, mental health education and community development activities** which may include: organisation of, and participation in, community events; and, general group work in the community (4).

FMHSS service providers must include the following in their program:

- A primary focus on children and young people in a whole-of-family context
- Quickly/early response to achieve best outcomes for children, young people and families/carers
- Flexible use of funding for practical assistance tailored to the needs/ circumstances of each child, young person and family/carers, and;
- Quality partnerships and links with first to know agencies, services, good referral pathways into and out of the service to reach vulnerable children, young people, families and carers who may be disengaged with the mental health or children's service sector (5).

### **Saving Costs Upstream**

The use of a public health framework within the FMHSS model encourages interventions across the spectrum, and as early upstream as is possible with a given individual, family or community, towards children's mental health and wellbeing. The FMHSS model also recognises mental illness in adults often originates in childhood and adolescence. Young people and children experiencing mental illness are at increased risk of attempting or completing suicide (6). Research has shown the first symptoms of mental illness typically precede the full onset of the illness by two to four years (7, 8). Half of all lifetime cases of mental health disorders start by age 14 years and three fourths by age 24 years (9), with onset peaking between 12 and 24 years (10).

### **Family inclusive engagement with children under 12 years**

The potential of flexible funding has been canvassed for some time, with the PHN's flexible funding pool established to support the planning and commissioning of primary prevention through a stepped care model (See: Discussion Paper 13 figure 5 11). The model outlines specifically what needs to be achieved and which services may achieve these objectives. However, it was a striking

---

4 Early Intervention Support for Vulnerable Families with Children and Young People who are Showing Early Signs of, or are at Risk of Developing, Mental Illness – Family Mental Health Support Services (FMHSS) Operational Guidelines, Department of Social Services, p.8

5 Early Intervention Support for Vulnerable Families with Children and Young People who are Showing Early Signs of, or are at Risk of Developing, Mental Illness – Family Mental Health Support Services (FMHSS) Operational Guidelines, Department of Social Services, p. 8

6 Australian Government Response to: Before it's too late: Report on the inquiry into early intervention programs aimed at reducing youth suicide - House of Representatives Standing Committee on Health and Ageing's Inquiry into early intervention programs aimed at reducing youth suicide. June 2013.

7 National Research Council and Institute of Medicine. Preventing mental, emotional, and behavioral disorders among young people: progress and possibilities. Washington, DC:National Academies Press, 2009.

8 Commissioner for Children and Young People Western Australia. Report of the Inquiry into the Mental Health and Wellbeing of Children and Young People in Western Australia. Perth: Commissioner for Children and Young People Western Australia, 2011.

9 Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR & Walters EE (2005). Lifetime prevalence and age of onset distributions of DSM-IV Disorders in the National Comorbidity Survey replication. Archives of General Psychiatry, 62, p 593

10 Kessler, R.C., et al., Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 2005. 62(6): p. 593-602.

11 Australian Government Productivity Commission 2019, The Social and economic benefits of improving Mental Health: Productivity Commission Issues paper



omission that the family setting is absent from the stepped care model especially in relation to child and adolescent mental health. This is frequently the issue also for clinical models.

However, programs such as FMHSS can resource much needed whole-of-family, wrap-around case support and group programs. The FMHSS model can also cover the administration incurred linking people with PHN's allied health stepped care services. The Commonwealth's PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance <sup>(12)</sup> note recommends 'PHN's liaise with relevant local organisations in the context of future regional planning, *including those delivering Family Mental Health Support Services (FMHSS)*'.

The National Mental Health Commission 2018 report identifies 0 – 12yrs as a critical gap which requires local and integrated community action to ensure healthy child development and wellbeing <sup>(13)</sup>. This includes the provision of necessary supports for primary care givers.

Through our experience in service delivery of both TPS and FMHSS services, that FMHSS is in a unique position to work with and wrap services around Child and Adolescent Mental Health offerings within different jurisdictions (Federal and State Mental Health funding), and at a local level.

FMHSS also has strong capacity to value-add and further integrate service systems which could target and respond to earlier risks occurring *prior to adolescence*. FMHSS can create support touch points where service gaps exist in the mental health systems alone (for example children under 12 who are not targeted by Headspace). In addition, FMHSS could support the Productivity Commission draft recommendation goals to achieve Universal Perinatal Mental Illness Screening <sup>(14)</sup> because FMHSS contact with couples and families often occurs prior to the birth of the first and any subsequent children.

drummond street note the importance of addressing the full range of life's challenges do not cease upon the birth of a new child. Regardless of parenting preparation much additional support can be required to deal with a range of social determinants impacting the ability to parent. These challenges will not be met through the intended investment in early childhood and education settings as this task requires collaborative support from a broad range of services which FMHSS functions to bring together. Some PHN's are funding perinatal mental health initiatives which support both parents and child, however they are in trial phases and lack certainty.

From a public health context, the partnership between FMHSS and the range of other Federal and State Mental Health services already provides the combination of expertise and effort required to facilitate a broad 'front door'; and introduce a critical mass of younger children and their families to mental health promotion and literacy efforts, illness prevention and early intervention services. Family-based models also provide a gateway to child and adolescent mental health clinical treatment services when required.

We acknowledge and welcome the draft recommendations by the Productivity Commission that focus on early childhood and school education, however similarly to those recommendations

---

<sup>12</sup> [http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental\\_Tools](http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental_Tools) (see sheet 7) *Child and Youth Mental Health services*

<sup>13</sup> National Mental Health Commission, 2018: *Monitoring mental health and suicide prevention reform: National Report 2018*. Published by: National Mental Health Commission, Sydney

<sup>14</sup> Productivity Commission inquiry into Mental Health Draft report Vol 1, p. 82, Canberra



around perinatal screening - there remains a gap where issues may occur with more than one child and/or considerable other challenges are faced by parents.

Therefore, a strong case can be made for the role of FMHSS in family's lives. It's goals and principles also align with the draft report recommendation Principles which;

- place families at the centre of services,
- recognise prevention of poor mental health outcomes extends beyond the health system and;
- view mental health as a systemic issue requiring in sector and cross portfolio collaboration<sup>(15)</sup>.

Given the overwhelming evidence of risk and protective factors to mental health *residing in the family setting*; and, evidence of the effectiveness of family/parenting interventions to address child/adolescent needs, it is concerning there are limited investments responding to this evidence.

### Funding certainty for FMHSS

Mental health prevention is effective in improving population mental health in the longer term when it assesses **individual risk factors alongside** others such as **family and social factors, school contexts, life events and community and cultural factors**. Services which both *identify risks to mental health* and concurrently *mitigate and respond to the impacts of mental ill health* are required.

The FMHSS remit currently supports mental health through initiatives and activities which target populations at risk of mental ill-health due to inadequate social participation and inclusion – in particular, those at risk of not accessing universal service platforms. It plays a useful role in overcoming barriers to better coordinated health, mental health and non-health services.

The Commonwealth has been historically reluctant to relocate expenditure away from acute/crisis services due to unclear dichotomy between community and hospital-based services including the role of hospitals in the management of community based clinical mental health services<sup>(16)</sup>. However, the primary prevention, early intervention and recovery support role of the FMHSS makes sense and can aid easing burden on clinical services in hospitals and community. drummond street note neither the last two action plans for the implementation of the National Plan for the Protection of Australia's Children included FMHSS despite the public health model of the Framework, nor have key Mental Health Policy Initiatives.

FMHSS regions receive \$480,0000 per annum and the cessation of funding is imminent (June 2020). Certainty and significant funding increases are required to provide these much-needed additional resources to the universal platforms provided by the Commonwealth. drummond street believes the continuation of FMHSS funding would be suited to current National tender processes for Sub-Activities funded under the Community Mental Health Activity of the Disability, Mental Health and Carers Programme.

---

<sup>15</sup> Productivity Commission inquiry into Mental Health Draft report Vol 1, p. 132, Canberra

<sup>16</sup> Australian Government, 2015, Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services, p. 10



We acknowledge future reforms in health could alter the scope of PHN data collection. However, the current capacity and focus of PHNs on clinical care and primary health provision; as well as the variable approaches by PHNs to commissioning and service design shape our preference for the Commonwealth to administer FMHSS services into the future. This would ensure consistency in both FMHSS service provision and the collection of national outcomes data for children and families. We note this would be transferrable to any change of commissioning responsibilities under the Productivity Commission’s recommendation for a ‘rebuild model’ where regional funding pools would be conferred to the responsibility of States and Territories (<sup>17</sup>).

Finally, it is vital to consider the cost of cessation of FMHSS funding, particularly where this program meets the needs of the marginalised cohorts and communities. The cost and additional workload to meet the needs of families with complex needs, (e.g. where more than one parent or child is facing comorbid issues or other risks to wellbeing alongside mental illness) cannot be picked up by one service system regardless of how much additional training the workforce has in mental health.

---

<sup>17</sup>*Productivity Commission inquiry into Mental Health Draft Report Overview Canberra p. 45*



## Part 2

### Response to the Productivity Commission Inquiry Mental Health draft report

#### drummond street's general recommendations

**Recommendation 1:** That Government ensure any evaluation of mental health and suicide prevention programs - and other programs with key reporting requirements on mental health outcomes - include the evaluation of *engagement methods* with vulnerable communities and measure *consumer engagement experience*.

**Recommendation 2:** Government undertake analysis of targeted mental health investments in prevention and early intervention against mental health treatment cost fluctuations to identify any influence these activities have on the expenditure in mental health care.

**Recommendation 3:** That the National Mental Health and Suicide Prevention Agreement incorporate a planning and accountability mechanism to determine the best value for money in non-mental health programs that interface with mental health services; and where specifications for the delivery of these programs and services have reportable outcomes related to mental health.

**Recommendation 4:** The Productivity Commission propose a separate National Whole of Government Mental Health Prevention and Early Intervention Plan to accompany the establishment of targets to specify key mental health and suicide prevention outcomes as per draft Recommendation 22.4.

**Recommendation 5:** That the Productivity Commission propose any standardised regional reporting requirements (as per draft Recommendation 25.6) undertaken by the PHN's - or their replacement agencies - include the integration of baseline data collection (as soon as practicable and determined as part of the process of NMHC stakeholder consultations outlined in recommendation 25.4 ) on outcomes for at risk cohorts identified in the Productivity Commission's draft report (e.g. First Nations, LGBTI, and culturally and linguistically diverse communities).

**Recommendation 6:** That the Productivity Commission provide further clarity around the use of the terms 'early intervention' and 'prevention' in the final report to differentiate between the clinical and public health contexts in which these terms are used.

**Recommendation 7:** That the Productivity Commission suggest mechanisms for further clarity on how short- and long-term goals regarding the Peer Workforce (listed in draft Recommendation 11.4) may be integrated into the implementation and ongoing reviews of the National Mental Health Workforce Strategy.

**Recommendation 8:** That the Productivity Commission recommend further exploration of how to evaluate and measure the benefits of group wellbeing, social connection, and other psycho-social educational type activities against the costs of MBS rebated psychological therapies.



## Response to the draft report recommendations

*Beyond the scope of the considerations we have raised about the future of the FMHSS, drummond street would like to make the following comments regarding the draft Productivity Commission Inquiry into Mental Health draft report:*

### Increased monitoring and reporting in prevention and early intervention is welcome

drummond street support a stronger evaluation culture as per draft Recommendation 22.5 <sup>(18)</sup> through “the evaluation of mental health and suicide prevention programs funded by the Australian, State and Territory Governments, and other programs that have strong links with mental health outcomes, including those in non-health sectors”. drummond street note too, the report’s draft Recommendation 25.4 <sup>(19)</sup> for ‘monitoring and reporting on mental health and suicide prevention, activity and reforms across portfolios’. We believe this analysis should include the evaluation of **engagement** methods with vulnerable communities.

drummond street would also welcome the analysis of targeted mental health investments in *prevention and early intervention* against *mental health treatment* cost fluctuations to identify any influence these activities have on the expenditure in tertiary, acute and primary mental health care.

### COAG terms of reference and prevention

drummond street was pleased to see the draft Recommendation 22.2 that COAG amend the Council terms of reference “to include other COAG Councils in policy discussions and decisions, or ministers responsible for portfolios that do not have a relevant COAG council, where this is necessary to cement cross-portfolio commitment to reforms directed at the social determinants of mental health and suicide prevention” <sup>(20)</sup>.

We see currently the Draft Recommendation’s sixth dot point states that the National Mental Health and Suicide Prevention Agreement should ‘recognise the role of non-health supports in meeting consumer and carer needs, particularly psychosocial supports’. We believe beyond ‘recognition’ the Agreement needs to incorporate a planning and accountability mechanism to determine the best value for money in non-mental health programs that interface with mental health services, **and where specifications for the delivery of these programs and services have reportable outcomes related to mental health.**

Furthermore, drummond street would welcome a **separate National Whole of Government Mental Health Prevention and Early Intervention Plan** to accompany the establishment of targets to specify key mental health and suicide prevention outcomes as per draft Recommendation 22.4 <sup>(21)</sup>. This plan should take a public model of health approach and identify a means to balance investments against social determinants and known risk factors faced by communities.

---

18 Productivity Commission inquiry into Mental Health Draft report Vol 1, p. 102, Canberra

19 Productivity Commission inquiry into Mental Health Draft report Vol 1, p. 110, Canberra

20 Productivity Commission inquiry into Mental Health Draft report Vol 1, p. 100, Canberra

21 Productivity Commission inquiry into Mental Health Draft report Vol 1, p. 101, Canberra



## Standardised regional reporting

We would like to see any standardised regional reporting requirements (as per draft **Recommendation 25.6**) undertaken by the PHN's - or their replacement agencies - <sup>(22)</sup> include baseline data collection on outcomes in for at risk cohorts identified in the Productivity Commission's draft report (such as LGBTI, and culturally and linguistically diverse communities), and that this monitoring and reporting stretch across mental health promotion, prevention, early intervention, primary (and), specialist mental health, emergency and crisis service delivery.

This should occur as soon as practicable and determined as part of the process of NMHC stakeholder consultations outlined in recommendation 25.4 to identify outcomes for at risk cohorts identified in the Productivity Commission's draft report (e.g. First Nations, LGBTI, and culturally and linguistically diverse communities). Only this can begin to build the knowledge we need to identify best service responses to these cohorts.

## Scope and family programs

drummond street welcome the recommendations targeting families and carers but note these mainly focus on clinical mental health settings; and once people are identified as having symptoms of poor mental health or a mental health diagnosis. Despite 'family and home' being identified by the Productivity Commission as a key setting which influences mental health, a deeper exploration on how and when services should provide whole family assessments and respond to these is absent. Missing specifically is exploration on how the integration of wrap around service offerings for families which lie beyond the mental health sector can be beneficial to positive mental health outcomes.

For example, in the case of LGBTIQ youth, risks to a young person's mental health can be mitigated by supporting family members to come to terms with the young person coming out, rather than focusing on the pathology of the young person's anxiety or depression. Assessment of the whole family, and referral of family members to services either together (or separately where support to an individual is determined to aid family resilience and reduce conflict) is vital.

drummond street would like to see more value attributed to the assessment of and response to whole families with complex high-risk factors in the mental health prevention space. It is these family members who often end up presenting at multiple services once they hit crisis point. A client's mental distress may be averted without the need for clinical treatment services.

## A Note on Report Language

drummond street believe further clarity around the use of the terms 'early intervention' and 'prevention' would be helpful. Throughout the draft report these terms are used in relation to clinical interventions as well as in reference to a public model social determinants context interchangeably. Given the activities to intervene early or prevent mental illness in both clinical and public health contexts can be vastly different, and workforce skillsets in these areas unique - we believe it is important to define these terms clearly to aid understandings of how relevant output and evaluation measures might be determined.

---

<sup>22</sup> Productivity Commission inquiry into Mental Health Draft report Vol 1, p. 111, Canberra



### **Forthcoming update on the National Mental Health Workforce Strategy**

drummond street would like to see some further clarity on how both the short- and long-term goals regarding the Peer Workforce (listed in draft Recommendation 11.4) may be integrated into the implementation and ongoing reviews of the National Mental Health Workforce Strategy as outlined in draft Recommendation 11.1 (23).

We would also like the National Mental Health Workforce Strategy and any initiatives around peer workforce to include specific considerations related to the unique skillsets for early intervention and prevention workforces so it might be clear how and where peer workers can contribute to this important work.

### **Social prescription and non-clinical supports for increase wellbeing and connection**

drummond street know through our work with families that clinical (either individual or group therapy) is not always a preference, or it may be avoided due to stigma. However other activities focusing on broad areas of physical wellbeing or social connection can be of great or equal benefit.

In relation to draft Recommendation 5.5, draft finding 5.2 (24) and growing recognition in Australia of 'social prescribing' (25), drummond street encourages further consideration of how to evaluate and measure the benefits of group wellbeing, social connection and psycho educational type activities against the costs of MBS rebated psychological therapies.

Particularly if some of these activities could be subsidised in place of rebated therapies or alongside in conjunction with rebated therapies using pre and post service evaluations. If such activities were determined to be of equal benefit to MBS counselling sessions and less costly the possibility might exist for people to access a higher number of activities for equal cost if this was their preference.

---

23 Productivity Commission inquiry into Mental Health Draft report Vol 1, p. 61, Canberra

24 Productivity Commission inquiry into Mental Health Draft report Vol 1, p. 57, Canberra

25 Productivity Commission inquiry into Mental Health Draft report Vol 1, p. 129, Canberra