Maximising Australia's human potential - A national framework to support government investment in preventive mental health.

A submission to the Productivity Commission's *Five pillars of productivity inquiries*.

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1. Introduction.

Thank you for the opportunity to provide feedback on the Productivity Commission's Interim Report on "Delivering quality care more efficiently" as part of the Five Pillars of Productivity Inquires. This submission relates to section three of the report 'A national framework to support government investment in prevention' and focuses specifically on the prevention of mental health conditions such as depression and anxiety disorders, a field of prevention that is frequently overlooked in discussions about preventive health.

2. Why is a focus on mental health important to productivity?

Any government that's interested in boosting the nation's productivity needs to be interested in mental health. Good mental health is key to a healthy, productive, and prosperous community.

Good mental health is more that just the absence of a mental health condition. It's about feeling good emotionally and functioning well psychologically and socially. It can be measured and quantified using validated instruments such as the Mental Health Continuum Short Form or the Warwick Edinburgh Mental Wellbeing Scale.

High levels of mental wellbeing are associated with numerous benefits including higher student engagement and better learning outcomes, greater workforce participation and higher levels of productivity at work, increased prosocial behaviours and higher civic engagement, and the adoption of healthy lifestyle behaviours leading to better health outcomes and increased life expectancy.

By contrast, mental ill-health is associated with an increased risk of poor school performance and early school leaving, presenteeism and absenteeism at work, unemployment, alcohol and drug use disorders, contact with the criminal justice system, homelessness, poor health, and premature mortality from chronic disease and suicide. Not everyone who experiences a mental health condition will experience these issues, but many people do.

Indeed, mental health and substance use disorders are the second leading cause of disability and premature death in Australia, accounting for almost 15% of the total illness burden. Their cost to the community is enormous. A recent inquiry conducted by the Productivity Commission estimated that mental ill-health and suicide cost Australia between $200 billion and $220 billion per year.

In short, good mental health helps individuals reach their full potential, while mental ill-health is distressing and disruptive, and can hold people back due to its negative impacts across multiple life domains. It's therefore imperative that as a community we find ways to promote good mental health and reduce the prevalence and impacts of mental ill-health.

3. Why is a focus on preventive mental health required?

We often hear that "prevention is better than cure", although in truth both are equally important, and the best results come from adopting a 'two pronged' approach which combines a focus on prevention with a focus on "cure" (or treatment). It's therefore quite concerning that when it comes to mental health, Australia has adopted a decidedly 'one-track' approach.

Since the launch of the first National Mental Health Strategy in 1992, governments around Australia have prioritised two main goals: a) promoting greater awareness of mental health

conditions and encouraging timely help-seeking, and b) increasing the range and availability of mental healthcare supports and services for people experiencing a mental health condition.

As a result, the vast majority of Australia's current mental health expenditure is spent on funding mental illness 'awareness' initiatives and mental healthcare treatments, services and supports for people experiencing significant mental health difficulties. Little, if any, funding is directed to promoting good mental health and preventing mental health conditions from occurring in the first place.

Sadly, this approach has failed to produce dividends. Despite a steady increase in per capita investment in mental healthcare supports and services over the last 30+ years, and a steady rise in the proportion of people with mental health conditions accessing treatment, the prevalence of mental ill-health in Australia is increasing rather than decreasing (particularly among young Australians), and the level of psychosocial disability and premature death linked to these conditions continues to rise. Between 2003 and 2024 there was a 31% increase in the disability adjusted life years (DALYs) linked to mental health and substance use conditions, most of which relates to mental health conditions.

While continued, increased investment in treatment is obviously needed, it is time to accept that this current policy approach *has not and will not* improve the mental health and wellbeing of the Australian community, and it is time to add a focus on mental health promotion and preventive mental health to our national mental health policy mix.

The benefits are self-evident. Promoting good mental health will boost wellbeing and productivity while preventing mental ill-health will avert distress and disability and reduce pressure on downstream mental health and health and human services. This will in turn reduce and/or restrain the costs on the care economy both in the short term, and the long term. Given the very strong link between mental ill-health and suicide, this approach will also save lives.

I therefore support the Productivity Commission's recommendation that the Australian Government should work with state and territory governments to establish a National Prevention Investment Framework, however, it is my view that this framework *must* also include a focus on preventive mental health and not just be confined to preventive health.

I also support the recommendation that the framework should be implemented by establishing:

1. an independent Prevention Framework Advisory Board that assesses and provides expert advice on requests for prevention funding.
2. a funding mechanism that supports eligible prevention initiatives across Australian, state and territory governments.
3. an intergovernmental agreement between the Australian, state and territory governments that outlines prevention funding arrangements and the roles and responsibilities of relevant parties.

But once again, I believe that it is vital that the proposed Board includes individuals with expertise in mental health, and that the funding mechanisms and intergovernmental agreements include those related to preventive mental health, not just the prevention of physical health conditions.

When it's all said and done, successive governments have been talking the talk about preventive mental health since 1992, but few have been willing to walk the walk. As a result, there is currently no clear national plan/framework/strategy or funding mechanism to guide action in preventive mental health, and it's high time that there was.

4. What should a preventive mental health investment framework include?

It is my view that an evidence based preventive mental health investment framework that supports informed decision making and prioritisation in resource allocation should be informed by an understanding of what prevention means, the epidemiology and nature of mental ill-health and issues of evidence and equity, and it should therefore be framed around the following key principles:

1. First, get the language right!

The first thing that's required is to clarify what we mean by prevention.

The terminology in this field can be confusing because of the different frameworks that have been developed to describe prevention. For example, one framework uses the terms primary, secondary and tertiary prevention to refer to the *different stages* of disease when an intervention can occur.

Primary prevention is about preventing a condition *from occurring in the first place*, secondary prevention is about the early detection and effective management of a condition *that has already developed* to prevent complications or recurrences, while tertiary prevention is about maximising functioning and quality of life and preventing the disability and handicap that may result from having a particular condition. More recently this list has been expanded to include primordial prevention, which focuses on eliminating the underlying root causes, and quaternary prevention, which is about preventing overmedicalisation and iatrogenic complications that may occur when treating a condition.

Another framework focuses *on the population* that a prevention intervention targets. This classification system notes that universal prevention initiatives target everyone regardless of risk, selective prevention targets people at higher-than-average risk of a condition (e.g., because of family history), and indicated prevention targets people at ultra-high risk or those with the early warning signs/subthreshold symptoms of an emerging condition.

It's my view that while the universal, selective, and indicated prevention framework is helpful and should be retained, the primary, secondary and tertiary nomenclature is confusing and should be abandoned in this proposed framework.

The reason is simple. If 'prevention is better than cure', then we need to avoid conflating prevention with 'cure' (i.e., treatment and management). For example, under the primary, secondary and tertiary classification system one could argue that surgery, radiation therapy, and chemotherapy to stop a cancer from getting worse could be called 'prevention', when clearly, that's an example of treatment and cure.

It is my view that *prevention should only refer to preventing a condition from occurring in the first place* (i.e., primordial or primary prevention), rather than to its early detection and optimum treatment and management (i.e., secondary and tertiary prevention). The reason this distinction is important, is that prevention and 'cure' are distinct endeavours that have their own approaches, systems infrastructure, resourcing and workforce requirements.

Preventing a condition from occurring in the first place is primarily the responsibility of health promotion and public health professionals and mental health promotion/preventive mental

health professionals. 'Secondary' and 'tertiary' prevention is ultimately about best practice in treatment, and it is primarily the responsibility of healthcare/mental healthcare professionals like doctors, nurses and allied health professionals.

We already have investment frameworks for treatment; what's lacking is an investment framework for prevention and so the proposed investment framework should only focus on 'primordial' and 'primary' prevention.

2. **Prioritise investment early in life.**
   Most mental health conditions commence early in life. Overall, around 50% of all lifetime disorders commence by age 14 years, and 75% commence by age 24. If we want to prevent mental health conditions from occurring in the first place, we need to act before these conditions typically start. An evidence-based preventive mental health investment framework should therefore ensure that the majority of the funding is allocated to initiatives targeted to 0–24-year-olds.

3. **Focus on equity.**
   When considering the relative merits of different preventive mental health programs or public policies, it is important to give priority to interventions that can help to restack the odds and equalise outcomes across the whole community. While mental ill-health can affect any one from any background, the evidence shows that the prevalence and negative impacts of mental health conditions are not evenly distributed across the community. Mental ill-health follows a social gradient and prevalence rates are higher in more disadvantaged communities than in more advantage communities. Moreover, LGBTIQ communities, refugee and migrant communities, people with a disability, and First Nations people are also at higher-than-average risk of mental ill-health. A fair and evidenced-based prevention investment framework should therefore prioritise initiatives that close the gap in mental ill-health across different communities in Australia.

4. **Invest in programs and social policies that target key risk and protective factors.**
   Our mental health is influenced by a broad range of risk and protective factors. Deciding which factor(s) to target through a preventive mental health intervention can be difficult because most factors exert a similar level of influence on the development of mental ill-health. That said, the evidence shows that certain factors stand out as needing greater attention because of the strength of their association with mental ill-health and/or their prevalence. The most significant of these is child abuse and neglect.

   Child abuse and neglect is tragically very common in Australia. The recent Australian Child Maltreatment Study found that nearly two in three survey participants (62.2%) aged 16 years and over reported at least one incident in their childhood, most commonly exposure to domestic violence (39.6%), physical abuse (32.0%), and emotional abuse (30.9%), while 2 in 5 (39.4%) experienced more than one type of maltreatment, and 1 in 4 (23.3%) experienced 3-5 types.

   The study also found that individuals who had experienced any form of child maltreatment were about three times more likely to experience a mental health condition in their lifetime, compared to individuals who had not experienced child maltreatment.

Drawing on this data, another study estimated that child maltreatment accounts for 21% of all cases of depression in Australia, 24% of anxiety conditions, 27% of alcohol use disorders, 32% of drug use disorders, 39% of self-harm and 41% of suicide attempts. This study noted that more than 1.8 million cases of depressive, anxiety, and substance use disorders, 66,143 years of life lost, and 184,636 DALYs could be prevented if childhood maltreatment was eradicated.

An evidence-based preventive mental health investment framework should therefore ensure that a significant level of funding was targeted to initiatives designed to prevent and/or address the negative impacts of child maltreatment, as well as to initiatives that target other high-impact risk factors such as family violence, bullying, racism, loneliness, and social disadvantage, or that put in place high-impact protective factors such as social and emotional skills in childhood, positive parenting programs, and social connectedness initiatives.

Ultimately, given the plethora of potential target risk and protective factors, preventive mental health investment decisions should ideally be based on objective data about the relative importance/prevalence of particular risk and protective factors, such as odds ratios (ORs), population attributable fractions (PAFs), and other related metrics.

This 'epidemiological' assessment should also consider what other co-benefits might accrue from targeting a particular risk or protective factor given the significant overlap between mental health risk (and protective factors) and those linked to chronic disease, alcohol and drug use disorders, and other issues. At the end of the day, we need to target the risk and protective factors that have the most potent impact on people's mental health, as well as those most likely to have co-benefits in preventing other issues and conditions.

5. **Accept the need for sustained investment.**
   Rome wasn't built in a day and reducing the incidence and negative impacts of mental ill-health across the community through a focus on preventive mental health can't be expected to happen overnight. Changing the overall balance of risk and protective factors at scale takes time, and success in prevention therefore requires governments to re-think their approach to spending, moving away from short-term funding linked to the 3–4-year budget cycles to funding over 5–10-year periods.

   That said, investments in preventive mental health during childhood and youth will reap benefits quickly. Supporting new and expectant parents and ensuring children thrive in the first 2000 days of life will ensure that more and more children start primary school with strong emotional, social and behavioural health foundations. Likewise, preventive mental health initiatives targeted to primary school children (and their parents, carers and educators) will lead to benefits by the time a child starts secondary school, and continued efforts during adolescence and youth will mean more young people enter adulthood experiencing good mental health and avoiding mental ill-health over the course of their life. We won't have to wait long to see the benefits if we start early in life.

6. **Accept the need for a whole of government approach.**
   Success in preventive mental health also requires governments to move away from rigid departmental siloes where prevention becomes the sole responsibility of one department –

like health – when what's needed is a whole-of-government approach where every department and government agency can contribute to the prevention of mental ill-health (or other conditions) by targeting the risk and protective factors it has influence over. If we are serious about prevention, governments need to focus on what's needed to promote the wellbeing of the community, rather than being held hostage to outdated rules and counterproductive machinery of government mechanisms.

The Federal government also needs to consider how it can work with the States and Territories, given that they are often equally responsible for addressing some of the key risk and protective factors, and they manage many of the settings and sectors in which action needs to be taken such as schools, and local communities.

7. **Invest in an integrated systematic approach not just single interventions.**
   The research is clear. While a variety of evidence based preventive mental health interventions exist, there is no one single intervention that can prevent the occurrence of every mental health condition forever, and instead a multimodal approach is required. Preventive mental health interventions need to build on each other and integration and coordination of effort is essential.

   The investment framework should therefore look at ways to fund an integrated approach to prevention that bundles together a suite of interventions that target a particular risk or protective factor, a particular population, or a specific condition, rather than thinking in terms of a magic bullet solution. This is the way we've tried to prevent physical health conditions, and this is the approach we need to use to prevent mental health conditions.

8. **Use the available evidence of effectiveness but remember - the absence of proof is not proof of absence – and linked investment in research and evaluation is vital.**
   It goes without saying that the investment framework should be guided by research evidence about the effectiveness, safety and cost-effectiveness of interventions. We need to fund things 'that work' and so we need to be guided by efficacy and effectiveness trials. However, in using 'evidence' as a criterion to guide decision making, it's important to acknowledge that we do not have a 'level playing field' when it comes to mental health research.

   It is well established that the quantum of funding for mental health research lags behind the funding available for physical health research, and within mental health research, funding for prevention accounts for only 7% of all mental health research worldwide. The evidence base in preventive mental health is therefore less comprehensive than the evidence base for mental healthcare/treatment (and physical health overall) and this needs to be considered when making decisions based on research evidence.

   First and foremost, we therefore need to create a level playing field and invest more in preventive mental health research and evaluation, and in mental health research overall. Second, we also need to 'lower the bar' somewhat when assessing preventive mental health interventions until this additional research investment starts to strengthen the evidence base. That doesn't mean we should fund just any intervention, but we do need to create a little 'wriggle room' when we assess the merit or worth of a particular initiative.

The most sensible approach would be to start investing in preventive mental health initiatives that already have a proven track record in experimental research through multiple RCTs – things like social and emotional/resilience/mental fitness/psychological self-care skills building programs and positive parenting programs – and take these to scale across the population. We should then invest in interventions that hold promise based on the results of one or two RCTs or a robust program evaluation and evaluate them in situ to determine whether they are likely to have benefits or not. In this way, we're not letting perfect be the enemy of good, while at the same time we're working to strengthen the evidence base around preventive mental health interventions.

9. **Consider both short- and long-term cost savings, as well as total savings across all government portfolios.**
   Preventive mental health efforts are unique when it comes to cost savings. First, because most mental health conditions occur early in life, and many have a chronic relapsing-remitting or persistent trajectory, they are often associated with significant direct and indirect costs over years and *even decades*. Prevention efforts, particularly those targeted to children and young people, can therefore reduce costs over decades, and these long-term benefits should be considered when modelling cost savings or other benefits.

   Second, because mental ill-health is linked to a variety of negative outcomes across multiple life domains, the prevention of mental health conditions will save government money across multiple portfolios including health (e.g., mental healthcare, healthcare, alcohol and drug services), justice, homelessness, employment, and social services. When assessing the value of a particular preventive health initiative it is therefore essential *that all these* potential savings are considered. It is unfair, and unreasonable to only focus on savings over the four-year budget cycle, and/or savings just in the health portfolio, when preventive mental health initiatives typically have such broad and long-term benefits in reducing and/or containing government spending.

10. **Links to other areas of prevention.**
    Given the presence of shared risk and protective factors, and the fact that several prevention interventions have multiple co-benefits across different conditions, efforts to prevent mental health conditions should ideally be linked to and integrated with efforts to prevent physical health conditions.

    However, it's also important to note that preventive mental health is a specialist field of endeavour in its own right, and while it overlaps with preventive health, preventing depression, anxiety disorders, eating disorders and other conditions requires a specific and at times unique approach.

    It's therefore important that preventive mental health is not overshadowed by preventive health, and that the mechanisms put forward in the Interim Report relate to mental health as well as physical health conditions. For example:

    - The proposed independent Prevention Framework Advisory Board should include individuals with specific expertise in preventive mental health. An alternative would be to establish a preventive mental health subcommittee that reports to the Board, which could be modelled on the Preventative Mental Health Task Force in the USA.

- Any new funding mechanism that is created to support prevention should also be used to fund preventive mental health initiatives.
- Prevention should be embedded in the next National Mental Health and Suicide Prevention Agreement, and not just within national intergovernmental agreements related to physical health.

In conclusion, I commend the Productivity Commission on its excellent Interim Report, and the approach it is proposing that the Federal Government should take with respect to prevention.

Mental health conditions – and many physical health conditions – are not inevitable, and the onset of many common conditions can be delayed or completely prevented if we focus on tackling the underlying root causes, putting in place key protective factors, and responding as soon as possible when tell-tale early warning signs and symptoms start to develop.

We have the scientific know-how and a moral imperative to prevent conditions where we can, and so there's absolutely no doubt that as a nation we need to spend more on preventing health and mental health conditions from occurring in the first place, and the proposed investment framework, and the preventive advisory board provide a clear path forward.