PREVENTION UNITED

Joining forces to prevent mental health conditions

Response to the Productivity Commission Mental Health Draft Report

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Foreword

Prevention United welcomes the opportunity to provide feedback on the Productivity Commission Mental Health Draft Report. We would like to start by thanking Professor Stephen King, Ms Julie Abramson, Professor Harvey Whiteford and the Productivity Commission staff on the outstanding work they've already done in this Inquiry.

The Draft Report provides an excellent review of the current state, and the challenges that lie ahead. It highlights the **enormous personal benefits of good mental wellbeing** and the **massive social and economic costs** associated with poor mental health and suicide. It also acknowledges the **major structural changes** that are needed to our mental health system to better tackle this issue.

Prevention United agrees with most of the overarching ideas put forward in the Draft Report and many of its recommendations. However, we believe that some recommendations could be strengthened and there are other ideas for change we believe should be considered. In providing our response, we have elected to focus on how to improve Australia's approach to the primary prevention of mental health conditions **– an area that is significantly under-developed and under-resourced**.

Our starting point is that the primary prevention of common mental health conditions is possible, cost-effective and will save money. Furthermore, while effective treatments for mental health conditions are available, the experience of these conditions is highly distressing and disruptive for affected individuals and their loved ones and preventing these conditions from occurring will **avert this distress**. Critically, preventing mental health conditions will also **avert the many negative personal, social and economic consequences associated with mental ill-health** such as lower educational attainment, reduced labour-force participation, absenteeism and presenteeism, social isolation, poor physical health, psychosocial disability and premature death from suicide or chronic disease.

Continued efforts to improve the effectiveness of medical and psychological treatments and to improve the availability and quality of clinical and psychosocial supports and services for people living with a mental health condition are of course vital. However, it is our view that **we are unlikely to substantially reduce the negative impacts of mental health conditions through improvements in mental healthcare alone**.

Indeed, despite decades of reform and a substantial increase in per capita spending on mental healthcare over the last 25 years, **the prevalence of mental health conditions has not fallen** (and has almost certainly increased among young people) and **the disability and premature death associated with mental health conditions has not declined**.

Prevention and mental healthcare are complementary rather than competing endeavours and if governments are committed to reducing the personal, social and economic impacts of mental health conditions, the best way forward is to make improvements across the **entire continuum of mental health interventions** that spans the promotion of mental wellbeing, the prevention of mental health conditions, early intervention, recovery support and suicide prevention.

One of the simplest places to start in prevention is to **scale-up each of the nine prevention interventions in the National Mental Health Commission's Economic Case for Investing in Mental Health Prevention that have a positive return on investment,** although there are also numerous other steps we believe that the Australian Government should take as outlined in our response.

Response to the Background Information and Draft Findings

While the Draft Report provides a comprehensive review of the current state in mental health there are certain key concepts which are missing from the background information and Draft Findings. In this section we therefore provide some additional information which we believe should be considered when making decisions about the way forward, and which may be useful to include in the Final Report.

Mental health exists along on a continuum.

Neither mental wellbeing nor mental health conditions are simple unitary states. Each of these experiences varies along a continuum. At any given point in time, an individual may be experiencing a level of mental wellbeing ranging from high to low *or* a mental health condition ranging from emerging to mild, moderate or severe. A person's position on this continuum is influenced by a range of past and present, intrinsic and extrinsic factors that combine together in a dynamic fashion. The personal and environmental factors that push people towards mental ill-health are called risk factors and those that pull people towards mental wellbeing are called protective factors. These concepts are presented in Figure 1. **A well-functioning mental health system should keep everyone at the wellbeing end of the continuum** at all times.

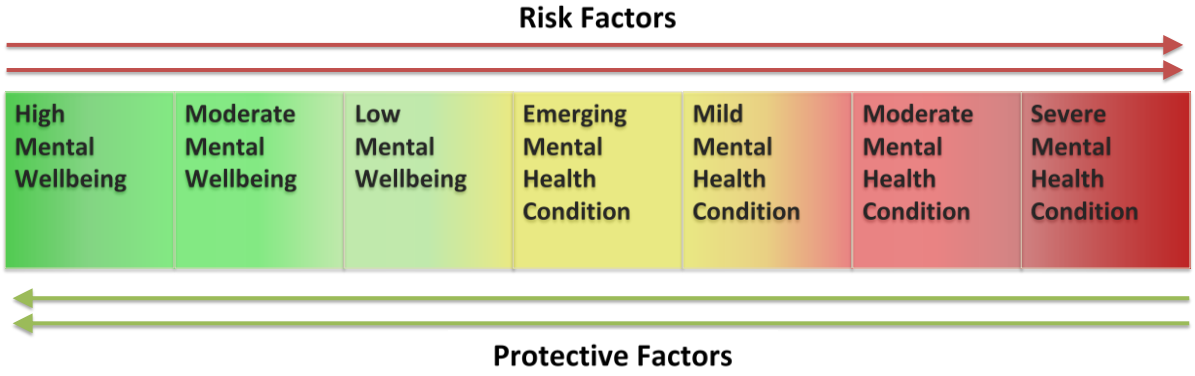

Figure 1: The mental health continuum model.

Mental health interventions also exist along a continuum.

Mental health interventions also exist along a continuum that roughly aligns with the mental health continuum. These interventions can be broadly categorised as the promotion of mental wellbeing, the prevention of mental health conditions, early intervention for threshold conditions, recovery support and suicide prevention. This concept is presented visually in Figure 2. **A robust mental health system should be equally strong across the entire continuum of interventions**.

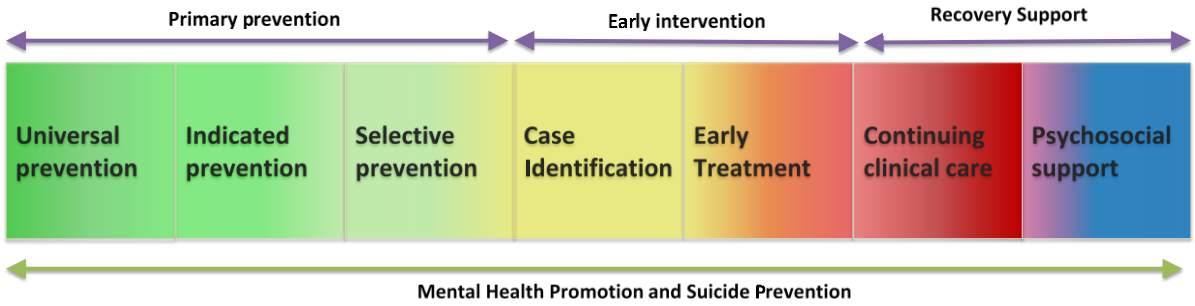

Figure 2: Mental health intervention continuum (adapted from Mrazek & Haggerty, Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research).

Promotion and prevention are different from early intervention.

While often considered together, promotion, prevention and early intervention **are unique endeavours**. Promotion focuses on assisting people to reach the highest possible level of mental wellbeing – sometimes called 'flourishing'. Prevention (aka *primary prevention*) focuses on stopping

the occurrence of a mental health condition, while early intervention focuses on early detection and intensive treatment of a condition that has already developed. While there is some overlap between promotion and prevention, and between prevention and early intervention (particularly when it comes to 'indicated' prevention for subthreshold disorders), **there are also crucial differences between each of these activities**, including what's required to achieve these goals.

Broadly speaking, **the promotion of mental wellbeing and the prevention of mental health conditions require a 'public health approach'**. Such approaches target groups and communities and seek to influence the 'upstream' risk and protective factors that influence our mental health. These activities focus simultaneously on individual behaviour change and on improving the social environments around people using strategies such as public education campaigns; personal skills-building programs; community mobilisation activities; the creation of mentally healthy organisational environments; and mentally healthy public policies. By contrast, **early intervention is a mental healthcare endeavour** that combines medical, psychological and psychosocial interventions delivered through one-to-one interactions with individuals with the aim of treating a condition.

We therefore believe it is better to think of the mental health system as one system with two components – **a public health component and a mental healthcare component**. These components and the types of activities that fall within each realm are shown visually in Figure 3.

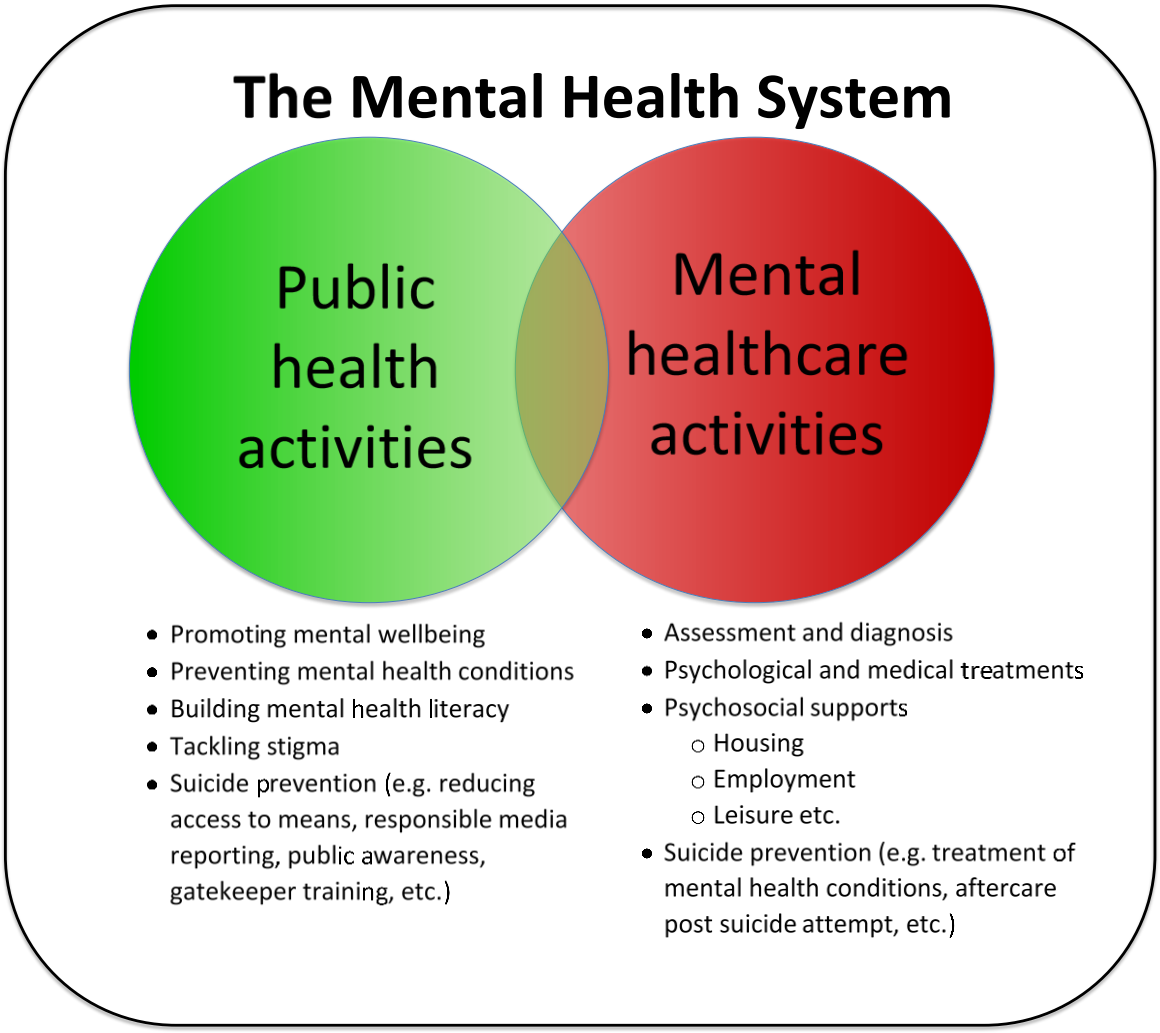

Figure 3: The mental health sector: one system – two components

At present, the bulk of mental health funding flows to the mental healthcare component of the system. Much less flows to the public health component and most of this funding is targeted to improving mental health literacy, stigma reduction and promoting help-seeking. **Very little is dedicated to promotion and primary prevention activities**. As a result, **we have a skewed mental health system** that 'intervenes' only after people become unwell, rather than also trying to keep people well. This needs to change.

Success in prevention requires a 'settings' based, multi-modal approach

Success in **prevention rests on the effective targeting of key risk and protective factors**. Risk and protective factors vary by age and stage and are distributed across a variety of social environments. It therefore makes sense to adopt an approach that focuses on tackling key factors relevant to each developmental stage through settings where the factors operate or can be easily tackled. **The vast majority of prevention activities therefore need to occur in non-mental healthcare settings** such as the home; antenatal and postnatal services; early childhood education and care services, schools, and universities/TAFEs; workplaces; local neighbourhoods; online; and through public policies. It is important to recognise that no single intervention is sufficient, and **success requires a multi-modal approach that features a range of evidence-based programs and policies**.

There are considerable benefits in taking an integrated approach to prevention

There is considerable overlap between risk and protective factors for mental health conditions, substance misuse and chronic diseases. A focus on tackling these shared factors may therefore provide considerable transdiagnostic benefits. **The recently announced National Preventive Health Strategy provides a perfect vehicle for promoting integration in prevention** and should be broadened to include mental health and substance misuse conditions. We simply *must* break down silos.

The structure of the Final Report

In light of this information, we ask the Commissioners to give more attention to the primary prevention of mental health conditions in their Final Report. As part of this, we also ask that the Commissioners consider adopting a different structure for the Final Report than the Draft Report.

We believe that **it would be better to consider prevention separately to early intervention** within a new section devoted to **describing how the Australian Government can bolster the 'public health' component of the mental health system** and strengthen the 'upstream' end of the continuum.

Adopting this revised structure would also allow the Commissioners to discuss other public health activities (aka population mental health activities) that are not well covered in the Draft Report, such as the promotion of mental wellbeing and building mental health literacy, while also allowing the current discussion and recommendations around tackling stigma and the 'public health' focused elements of suicide prevention (e.g. raising community awareness, gatekeeper training, responsible media reporting and reducing access to means), to be included in this new section.

We believe such an approach is highly consistent with the overarching 'systems-thinking' that characterises the Draft Report and would help the Australian Government to **create a mental health system that is equally strong across the entire continuum of public health and mental healthcare interventions**.

Response to the Draft Recommendations

This section outlines our response to the recommendations contained in the Draft Report as well as additional ideas we would like to put forward to the Commissioners for their consideration. **Our feedback is framed by the knowledge that the primary prevention of mental health conditions is possible and several evidence-based, cost-effective and cost-saving solutions already exist**. It is also based on the recognition that very few evidence-based prevention interventions are currently being delivered to the quality and scale needed to make a difference. This must change and we believe a public health informed risk/protective X age/stage X settings matrix model should guide investment in prevention.

Prevention in the perinatal period

Poor parental mental health is a significant risk factor for poor infant and child mental health. We therefore support draft recommendation 17.1 on universal screening for perinatal mental illness with the following comments.

First, while Prevention United supports universal screening, we believe it should be extended to **include screening for substance misuse as well as perinatal mental health conditions**. Both are significant risk factors for poor infant and child mental health. Furthermore, **screening *must* be supported by streamlined access to treatment services for parents who are identified as having a mental health and/or substance misuse condition**. While the various recommendations made in the Draft Report to improve access to mental health services are likely to benefit expectant or new parents as well as others, we believe that **this cohort needs to be given priority status** given that assisting parents living with a mental health/substance use condition will help the parent and their child(ren).

Second, we strongly believe **there needs to be a focus on primary prevention during the perinatal period** and not just on early intervention and recovery support. Evidence based approaches to the primary prevention of perinatal conditions do exist. A recent economic analysis of prevention initiatives undertaken for the National Mental Health Commission found that **exercise programs for the primary prevention of post-natal depression reduced the likelihood of postnatal depression and had a positive return on investment (ROI) at one year ($1.90) and five years ($2.54).** Furthermore, a recent systematic review and meta-analysis found that cognitive behaviour therapy and interpersonal therapy informed one-to-one or group interventions during pregnancy (e.g. Mothers and Babies and Reach Out, Stand Strong, Essentials for New Mothers), can lead to a reduced risk of incident postnatal depression,[1] while the National Mental Health Commission's economic analysis found that **interpersonal psychotherapy to prevent postnatal depression has a ROI of $1.27 in the one year model and $1.63 in the five year model they examined.**

We therefore would like to propose the following revised and additional recommendations:

- Ensure that all expectant parents have access to evidence-based prevention programs during the perinatal period, including exercise programs and CBT- and IPT-informed programs.
- Take coordinated action to achieve universal screening for perinatal mental illness *and* substance misuse disorders.
- Establish specialist community-based perinatal mental health services that provide priority access to parents who are screened as having a mental health and/or substance misuse condition during pregnancy or within the first year of their child's life.

Prevention in the preschool years

The relationship between a child and their caregivers and the quality of the broader family and social environments around them in the first 2000 days of their life can have a profound and enduring influence on a person's mental wellbeing. **Secure attachment and a loving, harmonious, safe and financially secure family environment are crucial for healthy child development** and help to create strong foundations for positive health and mental health outcomes throughout life.

By contrast exposure to adverse childhood experiences (ACEs) such as neglect and abuse; family violence; severe parental mental ill-health, substance abuse or criminal behaviour; and chronic economic disadvantage create high levels of toxic stress that may seriously disrupt development and lead to a wide range of negative physical and mental health outcomes over a person's life. **Preventing ACE exposure** is therefore one of the most critical elements for successful primary prevention and **needs to be a central pillar of mental health policy**. Child maltreatment is particularly harmful. It is the 10th highest contributor to the total burden of injury and disease in Australia and the single biggest contributor to the burden of mental health conditions. **Preventing child maltreatment could lead to a 20-25% reduction in new cases of depression and anxiety conditions**.

To this end we support draft recommendation 17.2 with the following caveats. First, while we strongly support the focus on increasing the capability of early childhood education and care services to promote child social and emotional development, this is not enough, and emphasis also needs to be given to initiatives that focus directly on assisting parents. **Parenting programs are one of the most effective tools that we have available for the prevention of ACEs and the primary prevention of a range of common mental health condition** and we urgently need a systematic approach to the national roll-out of evidence-based parenting programs.

Second, we are cautious about expanding early childhood health checks unless it is clear that these checks are intended to screen for risk factors rather than for mental health conditions. **Screening for risk factors would enable proactive intervention to reduce risk** and, in all probability, would also assist professionals to identify children who need early intervention support. Screening for ACE exposure should be a particular priority. It is important, that child health checks are based on an evidence-based screening tool or assessment protocol; professionals who are undertaking the checks are trained in their use; referral pathways for individuals who screen positive are in place; and there is a service system that can effectively manage these referrals. At present, **not all of these elements are in place and significant time and resources need to be invested to improve the situation**.

We would therefore like to propose the following revised and additional recommendations:

- *All parents, as well as* services for preschool children and their families should have the capacity to support and enhance child social and emotional development.
- Provide universal access to home visiting, Triple P and other evidence-based parenting programs that support parents, promote healthy child development and reduce children's exposure to ACEs.
- Provide increased funding for the primary prevention of child maltreatment and for early intervention for children and young people who have already experienced this trauma.
- Broaden the focus of the proposed National Centre for the Prevention of Child Sexual Abuse to include all forms of child abuse and neglect.
- Ensure that the prevention of Adverse Childhood Experiences features heavily in the proposed National Children's Mental Health and Wellbeing Strategy.
- Develop a National Framework for Prevention and Early Intervention in Adverse Childhood Experiences that links to and draws on The National Framework for Protecting Australia's Children 2009-2020, The National Plan to Reduce Violence against Women and their Children 2010–2022 and initiatives for children of parents with a mental illness or substance use disorder.

Prevention in the primary and secondary school years

Schools are a crucial setting for supporting the mental wellbeing of children and young people and existing efforts to help schools play this role need to be continued and expanded. We therefore support draft recommendations 17.3, 17.4, 17.5 and 17.6 with the following caveats.

First, we believe that **all schools should be required to create a comprehensive Mental Health and Wellbeing Plan that covers the entire mental health intervention continuum**. The Plan should ideally take a whole-of-school approach that embeds student mental wellbeing in all that a school does. The World Health Organization's Health Promoting Schools Framework provides a useful structure for such an approach. This Plan should be reviewed and updated at the beginning or end of each school year to ensure that it stays effective and relevant.

Second, we believe that curriculum-based psychosocial skills-building programs (e.g. SEL) should be a core element of each school's Mental Health and Wellbeing Plan. **Structured evidence-based programs are effective in promoting mental wellbeing and preventing mental health conditions and provide a positive ROI**. We therefore strongly support the recommendation for a national process to accredit and regulate SEL programs, but we believe this recommendation should encompass any type of psychosocial skills-building program, including anti-bullying, resilience and disorder specific prevention programs. **Schools need to be supported and encouraged to *only use* evidence-based psychosocial skills-building programs** while also helping to evaluate new programs.

Third, we agree that schools and teachers need more support to understand child and adolescent social and emotional development. We therefore strongly support the focus on teacher training in social and emotional development, and the proposal to accredit such training courses. Ideally, **this professional development should also focus on supporting teachers on how to effectively implement evidence-based SEL and other psychosocial skills-building programs in the classroom**.

Fourth, we support the view that existing efforts to assist schools through externally managed programs such as Be You **must be complemented by resources provided directly to schools**. We therefore support the idea to employ a student wellbeing leader in each school, however, we **strongly believe this role should *not* include any focus on direct mental healthcare**. Anecdotal evidence from school-based professionals currently occupying similar roles to the proposed wellbeing leaders clearly shows that if such roles include a direct care component their time is very quickly taken up providing support for students with mental health issues leaving very little time to organise, coordinate or implement public health activities such as promotion, prevention, mental health literacy, stigma reduction, and help-seeking. We therefore believe that recommendation 17.6 should be revised so that it's clear that **the school's wellbeing leader's role is a strategic and support role, rather than a direct care role** and existing student mental wellbeing staff, such as school psychologists, should retain responsibility for the latter.

Fifth, we agree that significant improvements are required in the way that we collect and report data on children's social and emotional wellbeing and the ways we use this data to guide decision making. While we support the focus on measuring social and emotional wellbeing outcomes, we also believe that **it is essential to monitor the prevalence of key risk and protective factors that influence mental wellbeing**, so that we can better track the impact of promotion and prevention interventions. This data needs to be collected **at a settings level** so that we can determine whether school and other settings-based interventions are working **and at a population level** so that we can track the aggregate effect of our efforts to promote resilience, reduce risk and improve mental wellbeing.

Last, from a systems perspective, **implementation of School Mental Health and Wellbeing Plans should be a shared responsibility between schools and local child and youth-focused mental**

healthcare services whereby each sector complements the other. Schools are well placed to take lead responsibility for public health type activities that focus on promotion, prevention, mental health literacy, stigma reduction, help-seeking and early detection, and to play a support role in mental healthcare by offering low-intensity mental health services delivered by suitably qualified personnel. Conversely, child and youth-focused mental healthcare services could support schools with their public health activities, while taking lead responsibility with respect to early intervention, recovery support, the clinical elements of suicide prevention and other high-intensity/specialist interventions. This model of shared responsibility and complementary action is shown in Figure 5.

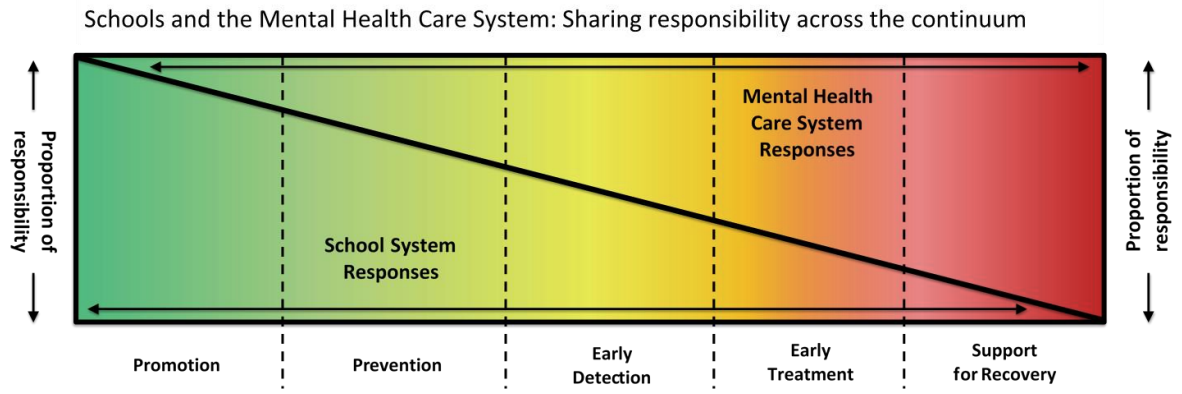

Figure 5. Sharing the load: co-responsibilities of schools and mental healthcare services.

We would therefore like to propose the following revised and additional recommendations:

- Governments should develop a comprehensive set of policy responses to strengthen the ability of schools to deliver *an effective response to promoting mental wellbeing and preventing mental health conditions, including through evidence-based approaches to social and emotional learning and other psychosocial skills-building approaches*.
- All schools should be required to develop a Mental Health and Wellbeing Plan which takes a whole-of-school approach and covers the entire mental health intervention continuum. Schools should be required to publish their Plan on their website.
- All Plans should include the use of one or more *evidence-based* (accredited) curriculum-based skills-building programs that focus on social and emotional learning, building resilience, anti-bullying and/or the prevention of specific mental health and/or substance use conditions. These should be suitable for the age/stage of students, and the characteristics of the school community. Schools should be funded to purchase any licences that are required to use accredited programs, and to enable teaching and student wellbeing staff to attend professional development courses to learn how to effectively implement the school's chosen program/s.
- All schools should employ a dedicated school mental health and wellbeing leader, who will oversee the development, implementation and regular review of a School's Mental Health and Wellbeing Plan, and provide training, supervision and support to teachers and student wellbeing staff to successfully implement all elements of the Plan.
- Primary care and specialist child and youth mental health organisations, should work directly with schools in their local region, to support them to implement their School's Mental Health and Wellbeing Plan, and to promptly assist students who require a level of mental healthcare that is beyond a school's capacity to provide.
- Governments should expand the collection of data on child social and emotional wellbeing *and key risk and protective factors*. It is important to ensure that data is collected, analysed and reported in a way that will also allow schools and other settings to monitor the impacts of their efforts to promote child and adolescent mental wellbeing, as well as to track the aggregated impacts of mental health programs among children and adolescents at a population level.

Prevention in youth

Tertiary education institutions are a key setting for public health and mental healthcare activities that are targeted to young people (and adults). We therefore support draft recommendations 18.1, 18.2 and 18.3 but would like to make the following additional comments.

First, as part of the recommendation that all tertiary education teaching staff undertake training on mental health and wellbeing, we would like to emphasise that this should include information about **the ways in which teaching staff can play a role in promotion and prevention,** rather than being focused solely on their role in assisting students experiencing mental ill-health. Furthermore, as with schools, we believe that training for tertiary education teaching staff should be accredited.

Second, we strongly support the recommendation that **tertiary education institutions should be *mandated* to have a student mental health and wellbeing strategy**. This strategy should take a whole-of-university approach that covers the entire mental health intervention continuum.

Third, as part of their focus on promotion and prevention we believe that tertiary education providers should be required to **offer their students access to SEL, resilience or other psychosocial skills-building programs**. Like schools, we believe that tertiary education providers should be required to only use evidence-based programs or those that are in the process of being rigorously evaluated.

Fourth, we strongly support the recommendation to ensure that university and non-university higher education providers and Vocational Education and Training providers are given guidance on how to meet students' mental health and wellbeing needs. However, we note that relative to school-based approaches, there has been far less research into tertiary education-based approaches to mental health promotion and we therefore believe the government should provide **research funding to strengthen the evidence-base around tertiary student mental health and wellbeing programs**.

Last, it is important to recognise that tertiary education settings are not the only settings that could be utilised for primary prevention initiatives targeting young people. **The online environment is a particularly crucial setting for action**. Online prevention initiatives are currently ad hoc and driven by not-for-profit, commercial and researchers' interests rather than by an overarching national strategic plan. This needs to change, and we believe that the Australian government should develop a national strategy for action and investment in this area to ensure that we maximise the potential of the online environment as a setting for prevention initiatives.

We would therefore like to propose the following revised and additional recommendations:

- The Australian Government should amend the Higher Education Standards Framework 2015 and the Standards for Registered Training Organisations 2015 to *mandate* that all tertiary education institutions have a student mental health and wellbeing strategy.
- Provide targeted funding to support a rapid increase in the evidence-base around what works to promote and protect the mental health and wellbeing of tertiary students.
- Promote the availability of evidence-based psychosocial skills-building programs in all higher education settings to reinforce the social and emotional/resilience skills young people learned at school, and to assist young people who haven't fully developed these skills to acquire them.
- Expand the national accreditation system for psychosocial skills-building programs outlined in draft recommendation 17.3 to enable evidence-based programs for tertiary students to be endorsed by the Australian Government, so that tertiary education settings are in a better position to select suitable resources.
- Develop a National Strategy for Promotion and Prevention Online.

Prevention in adulthood

Workplaces are undoubtedly a key setting for prevention activities targeted to adults because a) they are one of the settings in which adult-onset risk factors for mental health conditions occur and b) they have very high reach. We therefore strongly support Draft Recommendations 19.1, 19.2, 19.3 and 19.5 but would like to make the following comments.

First, we strongly agree that it is essential to improve the focus on psychological safety at work using a mix of stronger legislation, clearer guidance and better regulation and enforcement. **There are still far too many workplaces that are failing to take adequate steps to protect the mental health and wellbeing of their staff**.

Second, the prevention of work-related mental health conditions is complex, and **employers and employees need support to achieve this goal**. A range of for-profit and not-for-profit organisations have taken steps to provide this support and have implemented initiatives to encourage and assist employers to create more mentally healthy workplace environments. Three main support models have emerged including tools for self-directed implementation, local collaboratives, and external consultancy programs. While each has its strengths and limitations, all three approaches are valid, and funding should be provided to expand each of these models. In addition, we also strongly agree that **some form of incentivisation or subsidy is needed to encourage businesses to utilise these supports to help them to create a mentally healthy work environment**.

Third, in keeping with this, we also agree that there needs to be a mechanism by which employers can more easily access evidence-based tools, programs and services to reduce the risk of psychological injury at work. While several research groups across Australia are working on such initiatives (e.g. Black Dog Institute and Everymind), it is not easy for workplaces to find those which have a strong evidence base. We therefore believe Workplace Health and Safety authorities should establish an accreditation system for prevention interventions along the lines discussed in schools and tertiary education and to make these available through a centralised portal that any employer can access.

Last, the **government needs to provide more research funding** for this area as there is still much to learn about how to prevent mental health conditions at work. In late 2017, Work Safe Victoria launched the *Work Well Mental Health Improvement Fund*. This Fund was established to support programs and initiatives that promote mental health and wellbeing and prevent mental injury and illness by changing workplace cultures and practices. While still in its early stages, this initiative is an example of the type of funding support that is required to build the evidence base and create new and better ways to prevent work-related mental health conditions.

We would therefore like to propose the following additional recommendations:

- In addition to codes of practice to assist employers meet their duty of care, Workplace Health and Safety authorities should also work in conjunction with Safe Work Australia to provide *employees* with information about mental health and wellbeing at work that explains their rights and responsibilities.
- Require regulators to work together to develop an accreditation system for workplace psychological injury prevention resources, programs and services and provide employees and employers with access to these through a centralised online portal.
- Continue and expand funding for research into the prevention of workplace psychological injury. Strong consideration should be given to re-funding the Centre of Excellence in the Prevention of Depression and Anxiety (the Prevention Hub) to continue their research on workplace mental wellbeing.

Prevention across all ages: action on social determinants

The nature of the social environments in which people are born, grow, live, work and age, play a major role in the development of mental health conditions. **Access to the social determinants of mental health such as high-quality education, secure employment, financial resources and stable housing all have a significant influence on whether someone will or won't experience mental ill-health**. Ensuring people have equitable access to these resources can therefore contribute to prevention and recovery support.

The Draft Report makes some mention of these issues (e.g. Draft Finding 20.2 and Draft Recommendation 22.2) however they are not given detailed attention. While we agree that it is hard for this Inquiry to examine and make recommendations about every social policy that impacts the mental wellbeing of Australians, at a minimum the Final Report needs to highlight the strong association between social and economic inequality and the higher prevalence of mental health conditions, psychosocial disability and premature death in order to emphasise that **it is not just our mental health system that needs to change, it is our social policies as well**.

This could be achieved in a number of ways, including by **adding a statement about the social determinants of mental health as Draft Finding 1.1,** by emphasising the importance of including positive action on social determinants in the proposed new National Mental Health and Suicide Prevention Agreement and National Mental Health Strategy, and by ensuring that any proposed expansion of the National Mental Health Commission's oversight role includes a mandate to track government action on addressing the social determinants of mental health.

Furthermore, we invite the Commissioners to consider calling for governments to introduce a mechanism that ensures that they **consider the potential mental health impacts of new laws and public policies before they are enacted**. This mechanism could potentially be based on processes used in areas like human rights, gender equality, environmental protection, and heritage listing to ensure that all public policies are reviewed using a 'mental health promotion lens'.

We would therefore like to propose the following additional recommendations:

- The Australian Government should establish a mechanism that can be used to ensure that laws and public policies relating to education, employment, income support, housing and other social determinants of mental health are considered for their potential population mental health impacts before they are introduced.

Governance and funding

There are two major contributors to the current systemic problems in the mental health field. **The first is chronic under-resourcing**. While increasing, current expenditure in mental health is not nearly enough to address the complex nature of this issue and the prevalence of mental ill-health in the community. The second is a **lack of clear targets and a strong, independent oversight body that can monitor progress and hold governments, government departments and commissioning bodies to account**.

While these two issues effect the entire mental health system, they are particularly evident in relation to population mental health activities such as the promotion of mental wellbeing and the prevention of mental health conditions. We therefore strongly agree that major reforms are needed to the funding and governance arrangements that underpin Australia's mental health system and would like to make the following comments.

First, while we do not have a position on the payment, funding and commissioning mechanisms proposed in the Draft Report, we don't believe that they adequately address the issue of **who is responsible for funding promotion, prevention and other public health activities in mental health, and how will these activities be funded** as they are primarily focused on mental healthcare activities. This needs to be addressed in the Final Report.

Second, we believe that the Final Report should provide clear findings and recommendations in relation to the **shortfall between current per capita and total spending in mental health and the level of government funding required to create a more robust mental health system** that includes a strong public health and mental healthcare component. **The Final Report needs to quantify the costs of improvement, and not just the costs of the problem.** Efficiencies alone won't address the problem.

Third, while we strongly support the recommendations around better strategic planning, stronger oversight, and more robust monitoring and evaluation within mental healthcare, we believe that these mechanisms should also apply to promotion, prevention and other public health activities and not just clinical and psychosocial mental healthcare supports and services.

Therefore, in keeping with the above comments **and our original submission**, we call on the Commissioners to recommend that the Australian Government work with State and Territory Governments to **create a National Partnership Agreement on Promotion and Prevention in Mental Health** to enable an increase in capacity, capability and resourcing around promotion and prevention. We also again call on the Commissioners to recommend that as part of this Agreement, **the Australian government establish a national Centre for Promotion and Prevention in Mental Health** that is responsible for:

- Developing a national blueprint for the promotion of mental wellbeing and the prevention of mental health conditions, and an associated monitoring framework.
- Setting, monitoring and reporting against outcomes for promotion and prevention.
- Coordinating multi-sector investment and action to influence key risk and protective factors that impact on mental wellbeing, mental health conditions and other closely related conditions.
- Coordinating capacity building and workforce development.
- Setting out and supporting a national research agenda in promotion and prevention.

This Centre could potentially operate **as a sub-centre within the National Mental Health Commission** or as a standalone body with a leadership and oversight role over all public health related activities in mental health, with a particular emphasis on the promotion of mental wellbeing and the primary prevention of mental health conditions.

Summary and conclusion

Despite nearly three decades of steadily increasing investment and major reform in mental healthcare, the prevalence of mental health conditions has not fallen, the disability burden remains largely unchanged, there have been no sustained reductions in suicide rates, and the life expectancy of people with a mental health condition continues to lag behind the rest of the community. New solutions are required.

We believe that the answer lies in creating a more comprehensive mental health system that includes a stronger focus on the promotion of mental wellbeing and the prevention of mental health conditions as well as greater investment in early intervention, recovery support and suicide prevention. To achieve this, we need to start thinking of the **mental health system as one system with two broad components – a public health component and a mental healthcare component**.

The Productivity Commission Mental Health Draft Report is a strong document that provides an excellent review of the structural changes that are required to strengthen our mental health system and reduce the personal, social and economic impacts of mental ill-health. The document provides many worthwhile recommendations that will help to improve both the public health and the mental healthcare elements of our system; however, we believe it remains skewed to the latter and does not set out a sufficiently coherent vision for how we can also improve our efforts to prevent mental health conditions.

We therefore encourage the Commissioners to place more emphasis on how the Australian Government can enhance the public health component of the mental health system and improve its approach to the primary prevention of mental health conditions. As part of this, we believe that **it would be better to consider prevention separately to early intervention** within a new section devoted to **describing how the Australian Government can bolster the 'public health' component of the mental health system** and strengthen the 'upstream' end of the continuum.

We believe such an approach is highly consistent with the overarching 'systems-thinking' that characterises the Draft Report and would help the Australian Government to create a mental health system that is equally strong across the entire continuum of interventions.

The primary prevention of mental health conditions is possible and several evidence-based, cost-effective and cost-saving solutions already exist. However, very few of these evidence-based prevention interventions are currently being delivered to the quality and scale needed to make a difference. This must change and we believe a public health informed risk/protective X age/stage X settings matrix model should guide action in prevention, as summarised in Appendix 1.

Appendix 1: A matrix model for primary prevention initiatives

AGE/STAGE	MAJOR RISK & PROTECTIVE FACTORS	KEY SETTINGS	PRIMARY PREVENTION PROGRAMS AND POLICIES
Perinatal period	• Poor parental mental health and/or substance misuse	• Antenatal services • Online	• Information resources • Exercise-based programs • CBT & IPT individual and group-based programs (e.g. Mothers and Babies and Reach Out, Stand Strong, Essentials for New Mothers program) • Screening and priority service access for early intervention
First 2000 days	• **Secure attachment** • **Positive parenting** • **Positive family environment** • Adverse childhood experiences (ACEs) especially child maltreatment	• The home • Early Childhood Education and Care Services • Online	• Information resources • Home visiting, Triple P, Exploring Together, and other parenting programs
Primary school age	• **Social & emotional/resilience skills** • **Social connectedness** • **Positive family environment** • **Positive school environment** • ACEs especially child maltreatment • Bullying	• The home • Primary schools • Online • Arts, recreational & sporting clubs	• Information resources • Triple P, Tuning into Kids, Cool Little Kids, Coping Cats, FAST, Strengthening Families and other parenting programs • Skills-building SEL programs (e.g. Friends for Life, the Good Behaviour Game, PATHS) • Anti-bullying programs
Secondary school age	• **Social & emotional/resilience skills** • **Social connectedness** • **Positive family environment** • **Positive school environment** • ACEs • Bullying, homophobia & transphobia	• The home • Secondary schools • Online • Arts, recreational & sporting clubs	• Information resources • Triple P, Tuning into Teens, Resilient Families, Partners in Parenting, and other parenting programs • Skills-building SEL programs (e.g. Friends; the Penn Resiliency Program; the Coping with Stress Course; Blues Program/ Blues Peer Group; CBT Bibliotherapy; and Interpersonal Psychotherapy Adolescents Skills Training) • Anti-bullying programs, including those that focus on homophobia and transphobia

Youth-adulthood	• **Social & emotional/resilience skills** • **Social connectedness** • Social isolation & loneliness • Course workloads & assessment • International study	• TAFEs & universities • Online	• Whole-of-university mental health plan that covers the entire mental health intervention continuum
Adulthood	• **Social connectedness** • **Secure, good-quality jobs** • **Work-life balance** • Workplace psychosocial risk factors	• Workplaces • The home • Online • Local government • Arts, recreational & sporting clubs	• Flexible working conditions, employee participation • Personal resilience programs • Line management training programs
Old age	• Social isolation and loneliness • Chronic illness • Loss of independence	• The home • Residential aged care services • Local government • Arts, recreational & sporting clubs	• Active ageing programs
All ages	• **Healthy lifestyle** • **Social connectedness** • **Social and gender equality** • **Social cohesion** • **Social capital** • Poverty and financial stress • Under- and unemployment • Homelessness • Gender inequality • Family violence • Racism, discrimination & social exclusion	• Public policies	• Employment, income and housing policy initiatives • Anti-family violence initiatives • Anti-discrimination and anti-harassment initiatives • Communities that Care, and other collective impact models (e.g. Planet Youth)

References

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