How, and to what extent, can the prevalence and severity of mental ill-health be reduced through more effective mental health promotion (equipping the population to maintain good mental health),

Children should be taught good mental health utilising programs similar to those run for physical health. They should be given the tools that will equip them for the future. With the emergence of social media, they also need to learn resilience and anti-bullying strategies.

Identification and prevention (such as interventions targeted at people with a high-risk of mental illness, including to prevent relapse)

Family members, teachers/educators and general practitioners are best placed to identify those in need of early intervention. The gap between identification and treatment is a crucial time. Generally the carer and/or family of those identified are not experts, have no knowledge of the mental health system, and are left trying to wade through pamphlets, websites and asking random people for advice.

If the system allowed for a general practitioner to refer people to a community based case manager, as part of a Mental Health Plan, the gap between identification and treatment would be substantially lessened, resulting in better outcomes for the person, their carer and the community. This system could also be implemented, in a timely manner, for relapses or crisis situations to support the people, their carer and family.

Early intervention (care provided soon after an episode of illness becomes evident).

As previously mentioned, access to a local community based case manager or support coordinator as part of a Mental Health Plan could be implemented immediately after diagnosis, crisis situation and relapse to ensure the person, carer and family were steered towards positive outcomes.

For example, KPMG and Mental Health Australia (2018) found evidence to support greater provision of cognitive behaviour therapy for young people who have a parent with a diagnosed depressive order (prevention)

The community based case coordinator, as part of a Mental Health Plan could assess the whole of family and report back to the general practitioner of the possibility of early intervention for family members. It should also be noted that witnessing mental illness within a household for extended periods can also have a detrimental effect on other family members, especially children. Allocating case management early will lessen the time that these family members will be witnessing the initial, often traumatizing, effects on their own mental wellbeing.

Community-based assertive outreach for individuals experiencing initial onset of psychosis (early intervention).

The community based case coordinator, as part of a Mental Health Plan would likely benefit in initial onset of psychosis.

- *Why have past reform efforts by governments over many years had limited effectiveness in removing the structural weaknesses in healthcare for people with a mental illness? How would you overcome the barriers which governments have faced in implementing effective reforms?*

    Unfortunately, some groups in society seek weaknesses in funding models for their own gain. These groups tend to see the funds as an avenue to 'exploit employees and make money for managers and upper level management' instead of funding employees correctly with little or no profit however giving meaningful service to those in need.

    Taking support coordination/case management away from these groups, making it mandatory for them to be independent or better still, government employed would alleviate the current move towards unethical practice.

- What, if any, structural weaknesses in healthcare are not being targeted by the most recent and foreshadowed reforms by governments? How should they be addressed and what would be the improvements in population mental health, participation and productivity?

    I commend the attempts in the 'step-model' which allows access to support coordination/case management. It will be important to have these support coordinators/case managers independent, but working in a team with health professionals. They should NOT be managed or have any direct association with any current service providers or NDIS registered organisations. Many registered organisations are currently advertising for support coordinators.

    It is unethical for them to be working for and being paid by an organisation that provides support workers, cleaners, etc whilst supporting their clients to have their NDIS goals met. How can a support coordinator provide unbiased support recommendations unless they are independent of a service provider?

    An independent local community based support coordinator or case manager would alleviate the current burden on those with mental illness, their carers and family. They would also alleviate the burden on the cost to government by reducing the burden on general practitioners and psychiatrists.

- *Does the configuration and capabilities of the professional health workforce need to change to improve where and how care is delivered? If so, how should the workforce differ from current arrangements? How would this improve population mental health, participation and productivity?*

  Treatment for mental illness is dependent on money. The more severe the mental illness, the more likely the person has no money. With no money and a severe mental illness, the resulting option for treatment falls to the general practitioner and psychiatrists who bulk bill.

  The general practitioner and psychiatrist, with all their training, expertise and experience, empathy and compassion, becomes the 'go-to' person for everything from therapy to filling in forms and writing letters for government agencies i.e. housing, centrelink, RMS, state debt recovery, legal aid, therapy animal places, advocacy groups etc. etc. This waste of resource is enormous.

  Having a 'middle man', a local community based case manager, would be a more cost effective resource. At approximately ¼ of the price of a general practitioner and even greater for a specialist, these community mental health case managers could drastically reduce this burden on medical professionals, reduce anxiety and stress to the patient and reduce the cost to the community.

- *What can be done to address health workforce shortages in regional and remote areas? In which areas or circumstances would greater use of technology and tele-health services be suitable? What prevents greater remote provision of services to address the shortages?*

  The use of tele-health is a great strategy for those with mental illness in regional and remote areas. A local community based mental health case manager, a person with empathy and compassion who has built a trusting relationship with the person, their carer and family could help facilitate great use of tele-health technology. As the training required for a mental health case manager, can be accessed through online courses such as Diplomas and Cert IV through TAFE, people would not need to leave the local community to obtain the necessary education.

- *What restrictions exist on the scope of practice for different professions, such as GPs, nurses, clinical versus other psychologists, and social workers? Are these restrictions unwarranted and, if so, how could they be addressed and what would be some of the costs and benefits?*
  I do not have an answer to this question

- *What could be done to reduce stress and turnover among mental health workers?*
  Mental heath workers are often compassionate and generally enter the workforce to 'help people'. Unfortunately, the pressure of working everyday with people in distress can be 'contagious'.

Mental health workers need to have realistic case loads and need to be able to build a therapeutic rapport with their case load; not every worker will be able to build a rapport with every patient and this needs to be addressed by management to find the best fit for each patient and be prepared to make changes when necessary.

Perhaps mental health workers could be rotated in an out of the frontline during a year to help alleviate the pressure of their work environment.

- *How could training and continuing professional development be improved for health professionals and peer workers caring for people with a mental illness? What can be done to increase its take up?*
  Continuing professional development should be mandatory. There is constant research in 'best-practice' and new techniques that will enhance their care of the patients. Peer review, perhaps on a monthly basis, would also be a forum to 'vent' which could also be beneficial.

- *What changes should be made to how informal carers are supported (other than financially) to carry out their role? What would be some of the benefits and costs, including in terms of the mental health, participation and productivity of informal carers and the people they care for?*

  Community based case management would greatly improve the wellbeing of informal carers. Having case management support would alleviate the pressure for the informal carer allowing them to gain timely access for their loved one into the requirement treatment. The informal carer would likely have less need to take leave from their employment to wade through the treatment options, they would have more time to train for employment if they had previously had to leave employment due to their caring responsibilities and have better mental health wellbeing.

- *How could non-clinical mental health support services be better coordinated with clinical mental health services?*
  Community based case management would provide a conduit between non-clinical and clinical mental health services. A case manager/support coordinator knowledgeable in the local services available to those with mental illness, their carers and families who also has a therapeutic rapport with the patient, carer and family can only optimize the outcome for all and provide a more cost effective system.

- *Are there significant service gaps for people with psychosocial disability who do not qualify for the NDIS? If so, what are they?*
  There is a significant impact for those with mental illness, their carers and family from the effect of psychosocial disability. Mental illness often results in the inability to 'fight' for basic human rights resulting in lost opportunities for participation and social wellbeing. Access to a case manager/support coordinator through a Mental Health Plan would often enable the carer and family of those with mental illness the knowledge to pursue the services available. Psychosocial disability is generally understood, because it can't be seen it is overlooked and those suffering continue to be housebound.

- *What continuity of support are State and Territory Governments providing (or plan to provide) for people with a psychosocial disability who are ineligible for the NDIS?*
  I don't have an answer to this question.

- *Are the disability support pension, carer payment and carer allowance providing income support to those people with a mental illness, and their carers, who most need support? If not, what changes are needed?*
  The application process for the DSP is reasonable, however waiting often up to a year, to have a claim examined it a disgrace. The mental torture that ensues from making people wait and wait and wait and wait, making them call and call and call to receive an update is also disgraceful. The resulting anguish of this "claim process" is often further deteriorating mental illness.

  The carer payment, whilst not replacing the income the carer has likely lost, or not representative of the otherwise cost to the community, it is better than the alternative of Newstart. I feel that the carer payment should also have avenues similar to the Austudy payment where a carer can build up an larger income bank to allow for instances when the person they care for is at a more 'stable' time, allowing them to keep some avenues for moving into an out of work without losing their ability to return to full time care when necessary.

  The carer allowance, who can say what it is trying to achieve, it certainly would not pay for a support worker to do day welfare checks, take someone for medical appointments, ensure they are getting sufficient nourishment or remembering to take their medication: it is unlikely to pay even the fuel costs for most carers.

- *Is there evidence that mental illness-related income support payments reduce the propensity of some recipients to seek employment?*
  The stringent guidelines and the added burden of the claim process is hindering those with mental illness. The possibility that anybody who is successful in their DSP claim would be capable of any meaningful work is ludicrous. If anybody had been capable of some part-time or casual work before their claim, the stress of claim process itself would likely have quashed any future possibility.

- *How could mental illness-related income support payments better meet the needs of people whose capacity to work fluctuates over time?*
  Some mental illnesses are subject to fluctuating times, however those that have illness such as bipolar disorder are generally unsuccessful in their claim for DSP. As mental illnesses such as these are not curable it would be advantageous to all if they had DSP available when necessary and employment when possible. Those in human services appear to need extra training in mental health. Mental health can not be compared to other illnesses and therefore can not be treated as such.