Submission to the Productivity Commission Inquiry into the Social and Economic Benefits of Improving Mental Health

National Mental Health Commission
April 2019

The National Mental Health Commission (the Commission), established in 2012, has a national remit to provide insight, advice and evidence in ways to continuously improve Australia's mental health and suicide prevention system and act as a catalyst for change to achieve system improvements. The Commission also has a mandate to work across all areas that impact on mental health, including education, housing, employment, human services and social support. There are three main strands to the Commission's work: monitoring and reporting on Australia's mental health and suicide prevention systems; providing independent advice to government and the community; and acting as a catalyst for change.

The focus of this inquiry aligns with the Commission's Contributing Life Framework, which acknowledges the social determinants of good mental health, and the ambition that individuals can lead 'contributing lives'. The framework recognises that a fulfilling life requires more than just access to health care services. It means that people with experience of mental illness can expect the same rights, opportunities, physical and mental health outcomes as the wider community.

This submission aims to respond to the issues raised in the Productivity Commission's (PC) Issues Paper – *The Social and Economic Benefits of Improving Mental Health*, providing feedback on the PC's assessment approach and highlighting key areas where improvements can be made. The key areas are broken down into the broad themes of 'social determinants', 'mental health system performance', and 'measurement and reporting'.

Assessment approach

Given the alignment to the Contributing Life Framework, the Commission broadly supports the assessment approach outlined in the Issues Paper. However, there are two key elements the Commission considers are largely missing from the approach – the specific needs of Aboriginal and Torres Strait Islander peoples; and the exclusion of financial support payments in calculating the cost of mental illness to the community.

The Commission believes that the PC should consider the needs of Aboriginal and Torres Strait Islander peoples explicitly in this inquiry despite the terms of reference and Issues Paper's relative silence on this issue. In 2018, the Commission engaged the Lowitja Institute to conduct research for the purpose of identifying areas for action that support good mental health among Aboriginal and Torres Strait Islander people on their own terms. The research report found that Australia's mainstream mental health system does not meet the needs of Aboriginal and Torres Strait Islander peoples, and that the system does not sufficiently support responses to underlying causes of mental illness in this population. (1)

The Lowitja Institute report reiterates some of the earlier solutions to reforming the system identified in the Commission's *Contributing lives, thriving communities. Report of the National Review of Mental Health Programmes and Services* (2014

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Review), and provides additional approaches to enable a culturally safe system. This includes a systematic approach to build the cultural competence of the workforce, acknowledging and responding to systemic racism in the health system, and ensuring ongoing monitoring and transparent evaluation of all policies and programs. Each of these elements must be addressed as part of a coherent approach to improve the mental health and social and emotional wellbeing of Indigenous Australians and consequently their opportunities for social and economic participation.

A key area for review is the failure to consistently and effectively implement the plethora of policies at both state and national level focussed on improving mental health and social and emotional wellbeing for Aboriginal and Torres Strait Islander peoples. Often, systematic implementation cannot be achieved because the policy was not costed or funded. For example the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023* - an extensive analysis of mental health needs - is described as "critical part of ongoing reform" and is designed to complement the *Fifth National Mental Health and Suicide Prevention Plan(2)* yet it has no costed or accountable implementation plan.(3)

This criticism is echoed in the 2013 Productivity Commission report *Better Indigenous policies: The Role of Evaluation, Roundtable Proceedings* which noted that evaluations and monitoring should not be seen as separate to policy but rather built into program design from the outset.(4) This approach requires adequate resourcing, which includes access to data at the commencement and conclusion of programs, to properly assess the link between policy action and outcomes. The final report from the Lowitja Institute also highlighted the need for all Aboriginal and Torres Strait Islander mental health and wellbeing programs and outcomes to be evaluated per their own publication '*An Evaluation Framework to Improve Aboriginal and Torres Strait Islander Health'.(*5)

The Indigenous Policy Evaluation Commissioner is responsible for developing an evaluation strategy for policies and programs affecting Aboriginal and Torres Strait Islander Australians, to be reported against by all Australian Government agencies. The evaluation strategy provides an opportunity to build the evidence base on what is working, especially in relation to the community controlled sector. The National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) has also developed a tool to assist in understanding the interconnectedness of policy documents at state and national level.

The Commission will continue to highlight the specific needs of for Aboriginal and Torres Strait Islander peoples throughout this submission.

Recommendation 1:
It is recommended that the PC address the needs of Aboriginal and Torres Strait Islander peoples explicitly in this inquiry.

The Commission is also of the view that the rationale for exclusion of financial support payments in the overall calculations of costs of mental ill-health to the community (Figure 4, issues paper) is logically inconsistent with the inclusion of healthcare costs. The assertion that payments are 'transfers between different

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members of the community' is equally applicable to Medicare benefits which are paid directly to individuals having been sourced from other members of the community via the Medicare Levy and Medicare Levy surcharge, levied through the Australian Taxation System.

The Commission has previously sought to quantify expenditure on mental illness, taking a broad view, incorporating costs and expenditures beyond those traditionally used to define the 'mental health sector'. This perspective recognises the nature of the investment required to achieve good mental health across the life course and that the impact of reforms and system change in one domain can have both positive and negative effects in other domains.(6) For the purposes of the 2014 Review, the Commission included carer payment, carer allowance and the Disability Support Pension (DSP) as indirect expenditure.

According to Dr Stephen King, Productivity Commissioner, mental ill health is costing Australia billions of dollars, noting income support is "the fastest growing area for people with mental illness".(7) In 2000-01, there were a total of 625,000 individuals receiving the DSP, with 136,000, or 22% of these receiving the DSP for a 'psychological or psychiatric' condition. In 2016-17, there were a total of 760,000 people receiving the DSP, and 252,000 of these were for a 'psychological or psychiatric' condition (33%). Of the total growth in DSP recipient rates in this period, 86% can be contributed to those receiving the DSP for a 'psychological or psychiatric' condition.(8) In terms of expenditure, total DSP expenditure in 2016-17 was $16.3 billion; of which $5.3 billion was spent on those with a 'psychological or psychiatric' condition - a significant cost to the Australian community, particularly when considering carer payments on top of DSP, estimated to be $1.1 billion 2015. (9). The PC's Issues Paper also identifies the significant expenditure on income support payments in Figure 9 (pg 33), so it is unclear why it is proposed that these costs are not to be considered as part of this review in Figure 4 (pg 8).

While acknowledging that lack of routine reporting on carer payments/allowances by disability type is a key barrier to contemporary assessment of cost and effectiveness, the Commission strongly recommends that this inquiry includes financial support payments in its assessment approach and uses its Final Report to recommend improvements in the transparency of reporting on financial support payments in relation to mental health.

Finally, the Commission recommends the inclusion of costs relating to mental health related payment by insurers, in the context of recent data released by the Financial Services Council, indicating that mental health conditions rank third in the top 10 causes of all claims across life insurance categories, with over 100,000 claims made in 2017-18.(10) Previous work by Nous/Medibank, estimated costs of $106m in mental health related payments by injury compensation insurers (workers compensation and compulsory third party insurers).(11)

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Recommendation 2:
It is recommended that the PC include financial support payments in its assessment of costs of mental illness to the community and consider improvements in the transparency of reporting on financial support payments in relation to mental health. The PC should also consider including workers compensation payments and cost of insurance to individuals and employers in its assessment.

The Social Determinants of Health Outcomes

Some of the most powerful root causes of inequalities in mental health are the social conditions in which people are born, grow, work, live and age, as well as the systems that shape the conditions of daily life.(12) People living with mental illness are also more likely to experience a range of adverse social, economic and health outcomes, including experiencing homelessness, being unemployed, being incarcerated and dying prematurely. This reciprocal relationship between mental illness and other social, economic and health factors means that many investments and policy reforms that have the potential to improve the mental health of Australians may come from outside the health sector and vice versa.

In outlining their social determinants approach to improving mental health, the World Health Organisation (WHO) proposes that the reduction of mental health inequalities will be achieved most effectively through the prioritisation of mental health equity in all policies across all sectors, and that policies from non-health portfolios should explicitly state their likely contribution to mental health.(13)

Echoing this point, the New Zealand Government Inquiry into Mental Health and Addiction(14) notes that "*if we wish to make significant inroads into improving mental health and addiction outcomes, we need to address the wider social determinants that influence not just mental health, but overall wellbeing. These social determinants also underlie and perpetuate inequitable outcomes for many Māori and other groups in New Zealand society. We need to invest in broader prevention and promotion initiatives. Increasing evidence supports the efficacy of universal and selective preventive interventions to promote mental wellbeing and prevent mental health challenges throughout development" - (pg 144).* To successfully take this approach, the inquiry recommends a central agency is established to take a strategic approach to investment across multiple outcome areas.

The effects of social determinants on health cannot, and should not, be addressed by mental health interventions alone. Whilst mental health interventions to improve mental health and suicide prevention are critical, they are not sufficient to counter the significant influence of social determinants. This section will discuss a number of social determinants and where opportunities exist to improve health outcomes.

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Recommendation 3:
Mental health must be seen as a whole-of-government priority if the social determinants of mental health are to be adequately addressed. The Commission believes that a more coordinated approach is needed across government in relation to both policy and investment in mental health. The Commission recommends the PC investigate options for increased strategic oversight and coordination of mental health policy and investment across Federal government and State and Territory governments, going beyond the traditional focus on health. It is further recommended that the function of monitoring and reporting of the outcomes of this increased strategic oversight is undertaken independently from the oversight role.

Mitigating social disadvantage
Supporting population mental health and wellbeing, and intervening early when individuals are at risk reduces distress, disadvantage and disability over the lifetime. It is also known that policies focussed on early intervention and prevention have positive downstream impacts, particularly for the most disadvantaged in our society. It also reduces the likelihood of contact with more costly supports and services including the child protection and justice systems, acute hospital based care, and social support payments.

The majority of mental illness has its onset in childhood and adolescence, and the first 1000 days of a person's life have been highlighted as a critical period for neurodevelopment. While social determinants influence the likelihood of mental illness developing across the life course, they are particularly critical during this first 1000 days, where a number of vital skills and abilities develop. Relieving poverty (particularly in the first 1000 days) has been shown to increase birth weight and other outcomes of health, reducing the likelihood of negative outcomes later in life.(15) It is noteworthy that Aboriginal and Torres Strait Islander children experience poverty at significantly higher rates than their non-Aboriginal counterparts and have some of the poorest health and developmental outcomes in Australia. Further, the rate of demand for costly downstream services continues to grow, particularly for Indigenous communities.

In 2017 Aboriginal and Torres Strait Islander prisoners accounted for just over a quarter (27%) of the total Australian prison population despite representing approximately 2% of the Australian population aged over 18 years. (16) Aboriginal and Torres Strait Islander children are now 10.1 times more likely to be removed from their families than non-Indigenous children, a rate that is projected to triple in the next twenty years if urgent action is not taken.(17) Fewer than half of Aboriginal and Torres Strait Islander children are placed with Aboriginal and Torres Strait Islander carers, following a steep decline over the last 10 years. This places Aboriginal and Torres Strait Islander children who are removed from their families at serious risk of being permanently disconnected from their families, communities and cultures, leading to poorer health outcomes.

Some strategies to address the overrepresentation of Aboriginal and Torres Strait Islander children in the child protection and juvenile justice system include:

- Increased investment in solutions, such as culturally safe preventative and early intervention measures

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- Facilitation of greater access for Aboriginal and Torres Strait Islander children and their families to early years services to ensure the best possible start in life
- Respecting the importance of Aboriginal and Torres Strait Islander decision-making in child protection.

These strategies are reflected in the goal of the Australian 'First 1000 days' model, which aims to work with Aboriginal and Torres Strait Islander Elders, researchers, community members, front-line workers and policy makers to provide a culturally informed intervention to address the needs of Aboriginal and Torres Strait Islander families.[18] Guided by the First 1000 Days Australia Council, this model takes a multigenerational view of family, and reflects the evolution of the 'First 1000 Days' movement from an initial focus on delivery of improved nutrition from birth to age two, to a more holistic view of the importance of the early environment. The expansion of this model is welcome, recognising as it does, the interlinking factors encompassing complex family situations with heightened risk of neglect, underemployment and entrenched cycles of poverty or welfare dependency, which improved nutrition alone cannot correct.

Education and employment

There are clear links that demonstrate people's experience of mental health will impact on their participation in education and employment. An individual's participation at the various levels of education directly impact on their employment options. The average level of education and the rate of employment are lower for those with high levels of psychological distress than for the general population.(19) This is of particular significance for young people; of those young people who are not in employment, education or training 31.3% have high or very high levels of psychological distress, compared to 16.5% of other young people.(20) The Commission's 2014 Review noted this link and discussed how a system that responds to whole of life needs can help to increase the participation of all youth in education, employment and training thereby increasing their capacity for life choices.

Part of the challenge in moving to a system that responds to whole of life needs by addressing mental health in education and employment seeking contexts, is that services in this area are fragmented. Mental health supports for students are delivered both through their educational institution, and through community services, with referral linkages between the two sometimes poor, (21) and support for employment and support for mental health are rarely connected.(19) As well as a need to connect the different elements of support, there are also improvements that can be made within some elements. For example, accessing support services in schools can increase the likelihood of students with poor mental health participating in education and training thereby providing more options in relation to employment.(22) The available supports vary between states and schools, and include services such as learning and support teams and Positive Learning Centres. The *Investing in Youth* report by the OECD also cites the importance of social support for young people at-risk of being out of employment, education or training for prolonged periods, and recommends the reinstatement and evaluation of programs such as Youth Connections, which ended in 2014.(20)

The Commission supports the integration of existing Commonwealth-funded education mental health programs under Mental Health in Education grant for the National Initiative – 'Be You', through to June 2021. This one single, national initiative

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delivered through early learning services, primary and secondary schools will integrate five existing programs: KidsMatter Early Childhood, KidsMatter Primary, MindMatters, Response Ability and headspace School Support. Beyond Blue is now funded to deliver the 'Be You' initiative building on the success and learnings from the evidence base and ten years of experience of these programs aimed at promoting social and emotional health and wellbeing for children and young people in the education space. It will be important to evaluate this initiative to ensure its effectiveness on better outcomes for children and young people.

In terms of the higher education sectors, there are substantial gaps in the data available on mental health and mental health support, particularly in the vocational education and training (VET) sector – a key transitional time in young people's life. We do know that counselling services are available at all universities,(21) but not all VET institutions.(23) Unlike the school setting, there is no information on mental health promotion activities and no national initiative for the VET sector.(19) The mental health support systems in universities, and particularly in VET institutions, needs to be strengthened with more counsellors and a national mental health promotion initiative.

Poor mental health also has an effect on employment, both in securing and retaining work. In 2014-15, 60.7% of those who reported having a mental illness were employed, compared with 78.3% of the general population. (24) There is a significant gap in services that bring together mental health and employment support. Those programs that do, for example the Partners in Recovery and Personal Helpers and Mentors programs, tend to be focussed on those with severe mental illnesses.(19) In addition, these services are currently being phased out with clients transitioning into the National Disability Insurance Scheme (NDIS) where eligible. While the NDIS is currently examining strategies for improving employment rates for participants under the scheme, it is unclear what mental health and employment support services will replace these programs.

Further work is required to better integrate support services for people with mental health issues in educational and employment support settings. Better linkages between employment services, community mental health services and education-institute-based mental health services will reduce gaps and aid those with poor mental health during critical transition stages. In addition, school supports need to be strengthened with evidence based promotion and prevention programs made available in all schools. Similar strengthening of supports available in higher education is also required, but this will need to be underpinned by better data on the supports available, especially in the VET sector.

Workplace mental health

A mentally healthy workplace is not just good for people, it is also very good for business. There is currently a large cost associated with poor mental health in the workplace, and initiatives to improve the mental health of employees can result in significant aggregate gains.

The Commission's Economics of Mental Health project has so far examined two workplace based interventions for prevention and promotion of mental health. The first intervention modelled was a face to face cognitive behavioural therapy intervention offered to all employees. Evidence underpinning the model indicated that up to one year after the intervention was delivered to employees, the risk of

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developing depression was reduced by 9% compared to no intervention.(25) The second intervention was an electronic Stress Management Intervention (eSMI) such as the Australian developed and funded MoodGym which is offered as a targeted intervention for employees at risk of developing mental illness, specifically depression.(26)

The results demonstrated that while both interventions are successful at preventing cases of depression in the target population, only the e-health interventions were cost-effective (return on investment $1.05). Nevertheless there may be good reasons for organisations to invest in both forms of intervention, including as part of a wider commitment to employee health and wellbeing, and employer duty of care to promote a mentally healthy workplace, over and above employee productivity gains alone. There are also likely to be benefits to participants' wider social network including colleagues, friends, family and carers which are not included in the results of the modelling. These benefits could include a decrease on care provided by carers or reduced workplace presenteeism.

Given that a number of e-health programs are already available in Australia, scaling up the rollout of such programs would require awareness raising amongst employers and employees of their availability. The Commission cautions that only programs which have been evaluated for clinical effectiveness should be promoted in this way.

The Commission established the Mentally Healthy Workplace Alliance (the Alliance) in 2013 with partners from business, community and government including: the Australian Chamber of Commerce and Industry, Australian Industry Group, Australian Psychological Society, Beyond Blue, the Black Dog Institute, Business Council of Australia, Comcare, Council of Small Business Australia, Mental Health Australia, Safe Work Australia, SANE, SuperFriend, Australian Council of Trade Unions and the University of New South Wales.

The Alliance is a national approach to encourage Australian workplaces to become mentally healthy for the benefit of the whole community and businesses, big and small. The Alliance aims to make sure all people in the workplace, including those who experience mental health difficulties, their families and those who support them, are supported. This includes minimising harm, promoting protective factors and having positive cultures that are conducive to mental wellbeing. It also recognises that a mentally healthy workplace is not just good for people, it is also very good for business.

The work of the Alliance will be enhanced with the recent announcement of $11.5 million over four years to support the National Mental Health Workplace Initiative in collaboration with the Alliance to provide employers, industries, small businesses and sole traders with the support needed to create a mentally healthy workplace.

Since its inception the Alliance has commissioned a series of products examining the costs and factors associated with a mentally healthy workplace. A 2014 PwC report estimated that Australian businesses were losing $10.9 billion annually as a result of neglecting to address mental health in the workplace, whereas businesses that take action experience a return of $2.30 for every $1 invested in initiatives that foster better mental health in the workplace. (27)

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A 2014 literature review identified six key success factors for creating a mentally health workplace and suggests a five-step process for embedding them. (28)

The six key success factors are:

- smarter work design, including creating flexibility
- building better work cultures, including engaging staff in mental health promotion
- building resilience, including the provision of mentoring and coaching
- early intervention, including facilitating staff to seek help early
- supporting recovery, including flexible leave arrangements
- increasing awareness, including incorporating mental health education in staff induction processes.

The five-step process for embedding the success factors involves establishing commitment and leadership support, undertaking a situational analysis on the workplace, developing a strategy, reviewing the strategy to see if it's effective, and then adjusting the strategy if it is not.

Workplaces across all industries are realising the significant interplay between work and mental health, and increasingly recognising their responsibilities to support their staff and provide inclusive, supportive workplace environments. Workers in some industries face higher risks of mental health conditions as an intrinsic feature of their line of work. For example, first responders such as police and emergency services workers can face repeated exposure to traumatic experiences, which is associated with impacts on mental health.(29) The impacts are illustrated by workplace compensation claims being 10 times higher in the first responder cohort than the general population, and that the median claim payment for first responders is nearly double that of the general population. (30) For first responders, workplaces that provide higher levels of support and inclusiveness, regular discussions about workplace experiences, and effective management of the emotional demands on staff, may help to lower rates of probable PTSD and psychological distress. (31) However, more accurate information is required to accurately gauge the prevalence of mental health conditions in first responders, and subsequent response to such interventions.

Recommendation 4:
Workplaces provide opportune environments for implementation of early intervention and prevention initiatives in mental health. It is recommended that the PC encourage industry groups to promote the uptake of interventions with a good evidence base, appropriate for the workplace conditions of employees. This could be supported by the National Mental Health Workplace Initiative, recently announced in the Federal Budget.

Housing and homelessness

In 2017, the Commission funded the Australian Housing and Urban Research Institute (AHURI) to conduct an in-depth piece of research on housing, homelessness and mental health. This work, as well as drawing on insights from previous consultations and investigative panels, involved an extensive review of the published evidence. The resulting report on this research (the AHURI report)(32) sets

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out 19 policy options to improve support for people with mental illness and their housing needs.

The prevention of homelessness should be a key policy aim. The AHURI report identifies that even a brief period of homelessness may have detrimental effects on a person's mental health, and reduced mental health may persist for some time even after the person finds new housing. Prevention strategies operate at the structural level and include tenancy sustainment programs, building the capacity of the housing sector to recognise and effectively respond to the early warning signs of a mental health crisis, and implementing "no discharge into homelessness" policies in all hospitals.

Another example of an early intervention program is the Community of Schools and Services (COSS) model,(33) which uses a local community of action approach to prevent and reduce youth homelessness and boost school retention rates, in turn reducing the costs to the health and justice systems caused by youth homelessness. The project has seen a 40% reduction in youth homelessness, a 20% reduction in the number of early school leavers, and a 50% reduction in disengagement levels for at-risk young people. The model has been rigorously evaluated and is considered reproducible in other locations.

In addition, an independent analysis of outcomes for an early intervention program (HomeBase) run by Jewish House in Sydney, found that after three months of extended support, 81% of clients were in stable accommodation, rising to 93% after six months of ongoing support.(34) HomeBase provides post-crisis homelessness intervention and prevention by supporting people transitioning from crisis accommodation so that they don't return to homelessness. The independent analysis also found that for an investment of $620,000, the total annual offset of potential costs to the community was $8.6 million.(34)

Integration between housing, homelessness and mental health services is key to achieving better outcomes. The AHURI report identifies that a lack of policy integration, pooled funding, and cross-sector accountability mechanisms between the housing, homelessness and mental health sectors impedes the development of integrated solutions. Changing these factors requires collaborative leadership across all levels of governments and across sectors. The UK's joint commissioning model (35)for housing and healthcare could be considered as a new model for Australia, particularly as a way of harnessing pooled funding.

Social housing stock is another key policy element to improving housing stability for people with mental illness. The AHURI report identifies that there is a lack of affordable, safe and appropriate housing for people with mental illness, and that this is an impediment to scaling up integrated initiatives found to be successful at the local level. The lack of housing stock creates inflexibility in the market, compounded by social housing allocation system requirements restricting choice for those on a waiting list.(36) Having few properties makes it harder for housing providers to offer appropriate housing. This is especially true if the stock does not reflect the needs of the majority of those who need social housing. AHURI recommends coordination with the private rental sector to facilitate access to an immediate and greater supply of established homes.

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Other areas of the housing system that could be addressed to improve mental health outcomes include working with real estate agents to provide education and reduce stigma. There are currently no protections against prejudice in real estate agencies offering rental agreements. As the rental market becomes more competitive, stigma against those experiencing mental illness may become a factor in them finding rental properties. In line with best practice recruitment principles, rental housing applications could avoid asking discriminating questions, such as age and marital status. State based residential tenancy authorities could provide direction around the information to be requested in a tenancy application.

Internationally, the "housing first" model has been used to great effect. This model provides immediate access to housing, with no readiness conditions, on the basis that housing is fundamental to recovery. The AHURI report identifies that while there are "housing first" programs in Australia, most don't practice all of the key principles found in the overseas models. The model could be considered for further implementation in Australia.

Recommendation 5:
It is recommended that the PC draw on the work undertaken by the Commission and AHURI for guidance on improvements to housing and mental health.

Justice sector

In 2013 the Commission dedicated a chapter of its national Report Card to articulating the importance of the justice system in analysis of Australia's mental health systems and services. This identified an urgent need for research and analysis to provide a nationally consistent picture of the different approaches to the mental health needs of justice-involved people. While there is growing epidemiological evidence regarding the mental health and patterns of health service utilisation by justice-involved populations, there remains an absence of nationally consistent frameworks and reporting systems. To this end, the Commission has recently commissioned work which will serve as a benchmark including audit of government strategies, policies and plans and report on gaps relevant to the mental health of justice-involved people.

There has been considerable research demonstrating the critical role of the justice system for achieving public mental health objectives, and the very high prevalence of mental disorder among justice-involved populations, including among those who come into contact with the police, courts, prisons, and the youth justice system. Prisons and youth detention centres are therefore critical sites for reducing health inequalities. The WHO Trencin Statement on Prisons and Mental Health(37) asserts that promoting mental health and wellbeing should be central to a prison's healthcare policy, and that effective leadership and adequate resources are essential to achieving this.

In 2014, the Northern Territory Government commissioned an independent review of the youth justice system, specifically into youth detention following a series of incidents which had resulted in the closure of the Don Dale Youth Detention Centre. Subsequently, a Royal Commission into the Detention and Protection of Children in the Northern Territory was established in 2016. The reviews found that there were inadequate health assessment processes on admission to youth detention; the

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healthcare needs of young people experiencing mental health issues were not adequately met; and that there was a lack of consistency in managing behaviours initiated by a history of trauma, symptoms of foetal alcohol syndrome, ADHD, and other mental health issues in detainees. In addition, youth justice officers were required to identify at-risk behaviours in detainees with minimal or no mental health training. A number of recommendations were made to address the mental health failures identified in the reviews.(38)

As highlighted in the Northern Territory Royal Commission and multiple other reports, the picture for young Aboriginal and Torres Strait Islander peoples is particularly concerning. On an average day Indigenous young people are 15 times more likely to be under juvenile justice supervision than non-Indigenous young people. This over-representation was even higher for those in detention—Indigenous young people were 24 times as likely to be detained as non-Indigenous young people.(16) Indigenous young people also tend to enter their first period of juvenile justice supervision at a younger age than non-Indigenous young people.(16)

Despite the comprehensive report of the royal commission into Aboriginal deaths in custody more than 25 years ago, the majority of these recommendations have not been implemented and the proportion of Aboriginal and Torres Strait Islander prisoners has doubled. These data point to failures in the justice system for Aboriginal and Torres Strait Islander people, with the resulting mass incarceration impacting on mental health and social and emotional wellbeing at an individual, collective and community level.

The report by the Australian Law Reform Commission *Pathways to Justice – An Inquiry into the Incarceration rate of Aboriginal and Torres Strait Islander Peoples* (2017)(39) examines the disproportionately high costs of incarceration in this population, estimating total justice system costs of Aboriginal and Torres Strait Islander incarceration at $3.9 billion in 2016. Further, when considered more broadly to include other economic costs, the total estimate rises to $7.9 billion, and this does not account for broader social costs to the community, particularly when incarcerations are concentrated within a particular community.

The Commission supports the justice reinvestment approach as it redirects government funding away from the criminal justice system into local communities to address the causes of crime, mitigating the effects of individuals being caught up in the criminal justice system. Justice reinvestment was initially developed in the United States as a means of curbing spending on corrections and reinvesting savings from this reduced spending in strategies that can decrease crime and strengthen neighbourhoods.(40) The approach includes diversion away from prison into alternatives such as programs to improve mental health and reduce the use of alcohol and other drugs, programs to support young people and families, programs focussed on sport or other activities, and programs that enhance access to quality education and employment. A Senate Inquiry in 2013 also recommended that Australia implement a justice reinvestment approach to criminal justice in Australia.(40)

The Commission supports the key elements documented in the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) final report as to what works in Indigenous community-led suicide prevention. Based on the disproportionate number of Aboriginal and Torres Strait Islander people in the justice

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and child protection systems and the high rates of suicide, the Commission strongly supports the ATSISPEP recommendation for a justice reinvestment approach to redirect government funding away from the criminal justice system into local Aboriginal and Torres Strait Islander communities to a develop community-led upstream diversionary activity for Indigenous young people. (41)

Recommendation 6:
It is recommended that the PC supports the implementation of a justice reinvestment approach to criminal justice, initially for Aboriginal and Torres Strait Islander communities, and pending the evaluation of this initiative that the approach is more broadly rolled out.

Mental health promotion

There are a number of specific mental health promotion and prevention interventions that have been found to be effective in promoting good mental health and reducing the risk of developing a mental illness. Economic evaluation is a useful tool that assists decision makers to prioritise promotion and prevention interventions for mental health, whilst also determining whether such interventions represent good value for money. Therefore, to extend what is already known about the economic case of mental health, in 2017, the Commission commissioned a literature review and scoping study from Deakin University, examining mental health promotion and prevention initiatives in the Australian context.(42) The Commission requested that the researchers focus on evidence based interventions for special interest populations including Aboriginal and Torres Strait Islander communities, and CALD communities.

Most of the existing research targeted children, adolescents and youth and was conducted in school settings, followed by universities and workplaces. Depression and anxiety were the most common disorders that were targeted by preventive interventions. The majority of mental health promotion interventions focused on a broad range of outcomes of mental health and wellbeing but interventions targeting specific risk factors such as bullying, violence, resilience and stress were also commonly evaluated. The most frequently evaluated interventions were psychological interventions, followed by educational, e-health and physical interventions. A combination of interventions was also found in the mental health promotion evidence base.

The following broad conclusions were drawn from the scoping study:

- Psychological interventions were found to be the most effective across age groups in both general and ‘at-risk’ populations.
- Educational interventions are an effective option (for example, in reducing loneliness or social isolation in older adults).
- Physical interventions were more effective in increasing positive mental health and wellbeing rather than preventing a specific mental health issue (with the exception of post-natal depression).
- There is limited Australian evidence of cost effectiveness of interventions with the majority of evidence coming from the United Kingdom and the United States.
- Local assessment of cost-effectiveness is required for workplace settings, and e-health.

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- Further research is required to establish effectiveness and cost effectiveness of interventions tailored for Aboriginal and Torres Strait Islander peoples. Such work needs to be led by Aboriginal and Torres Strait Islander people.

There were a number of interventions that are promising for mental health promotion and prevention but lack economic evidence. These interventions are good candidates for potential future economic modelling. Some examples include:

- Educational intervention for prevention of anxiety disorders across the age spectrum.
- Parenting interventions for the prevention of mental disorders (generally) in infants, children, adolescents and youth.
- Physical interventions for mental health and wellbeing promotion.

In regards to 'special interest' populations, the review identified only a small number of studies evaluating interventions tailored to Indigenous people and communities which made it difficult to conclude which mental health prevention and promotion interventions are likely to be effective with these populations.

Recommendation 7:
Prevention and early intervention approaches are among the most promising mechanisms for reducing the economic impacts of mental illness later in life but more work is needed to bolster the evidence base. It is recommended that the PC supports further development of the evidence base for prevention and early intervention approaches.

Mental health system performance

Suicide Prevention
Suicide is a significant public health problem in Australia and internationally. In 2017, 3,128 people died by suicide in Australia, making suicide the 13th leading cause of death. (43) The number of people who are hospitalised due to intentional self-harm is more than 20 times the number of people who die by suicide and a previous attempt is the most reliable predictor of a subsequent death by suicide. (44-46)

Aboriginal and Torres Strait Islander rates of suicide are also higher than the rest of the population, with Indigenous Australians 2.1 times more likely than non-Indigenous Australians to have died as a result of suicide in 2016.(43) Suicide is profound for anyone impacted and it is the compounding impact of multiple suicides that is of profound concern for some Aboriginal and Torres Strait Islander communities. Twenty percent of Aboriginal and Torres Strait Islander peoples reported living in rural areas in 2016(47) and these remote areas are seeing increasing numbers of deaths by suicide, particularly among young people.

Young males are of particular concern with reports indicating that young men aged 15-24 are up to 1.8 times more likely to die by suicide than their metropolitan counterparts. (48) There is also an increased risk of youth suicide occurring in clusters in remote areas, an incidence that is not reflected in adult suicide clusters.(49) The impact of suicide extends beyond individual families to entire communities. A recent research study *The Ripple Effect* by Suicide Prevention Australia and the University of New England identified that 89% of respondents knew someone who had attempted suicide, 85% knew someone who had died by suicide,

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and 80% of people had been exposed to both suicide attempt and death.(50) For rural and remote communities, where population size is lower than metropolitan areas, the impact of a suicide is even more pronounced.(51)

Not everyone who attempts suicide seeks healthcare, but a significant minority do and this provides a significant opportunity for intervention.(52) Furthermore, whether a person's experience of accessing a health service following a suicide attempt was positive or negative can influence future help-seeking behaviour. (52)Therefore, it is important to ensure that people who are at risk of suicide are getting a consistent, evidence-based minimum standard of care when they present to health services.

In the United States, to ensure that all people at risk of suicide receive the minimum evidence-based standard of care when presenting to healthcare settings, the American National Action Alliance for Suicide Prevention published the 'Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe'. (53) The recommendations offer practical, evidence-based actions that primary care, inpatient and outpatient behavioural health care, and emergency department settings can take to provide better care for patients at risk for suicide.

In Australia, the National Safety and Quality Health Service (NSQHS) Standards were established to protect the public from harm and to improve the quality of health service provision. These NSQHS Standards have provided a nationally consistent statement about the standard of care consumers can expect from their health service organisations. They also provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met. (54)

The NSQHS Standards include the requirement for health service organisations to have "systems to support collaboration with patients, carers and families to:

- Identify when a patient is at risk of self-harm
- Identify when a patient is at risk of suicide
- Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed".(54)

Similarly, the Australian National Standards for Mental Health Services were created to assist in the development and implementation of appropriate practices in mental health services. The current iteration of the Standards for Mental Health Services requires mental health services to "assess and minimise the risk of deliberate self-harm and suicide within all mental health service settings".(55)

While both standards include broad guidance about how to meet the mandated standards, this guidance is not sufficiently detailed to ensure Australians at risk of suicide receive a consistent evidence-based minimum standard of care across services. This lack of detailed guidance likely contributes to the wide variation in consumer and carer experiences reported to the Commission, which range from receiving excellent care and support through to experiences so poor the consumers were reluctant to seek care for their suicidality in future.

Under the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan), governments have committed to developing a mental health supplement to the NSQHS Standards that will align with the Standards for Mental Health Services and guide implementation of the NSQHS Standards for all mental health services in

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public and private hospitals and community services provided by local health networks. (56) The intention is to ensure a single set of standards for these services, however, it is unclear to what extent the supplement will comment on the care required by people at risk of suicide.

The development of the mental health supplement to the NSQHS Standards constitutes a valuable opportunity to build a national regulatory framework that ensures a consistent minimum standard of care is achieved for all Australians at risk of suicide. The American 'Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe' may be a useful guide for what this could look like.

Improvements to the way suicidal crises are managed by health services are also required. Each year, more than a quarter of a million Australians present to emergency departments seeking help for acute mental and behavioural conditions, including people experiencing a suicidal crisis. Yet, for many of these people, the evidence suggests that emergency departments are not adequately resourced or positioned to be a timely and accessible entry point to the mental health system. In some cases, people leave the emergency department before receiving the care they need. For others long stays in emergency departments are associated with suboptimal treatment like restraint, seclusion and lengthy periods of sedation. (57)

In order to ensure that people experiencing mental health or suicidal crisis get the high quality care and support they need, we must:

- provide alternatives to emergency departments for people experiencing mental health or suicidal crisis who do not require medical intervention, AND
- implement strategies to improve the management of mental health and suicidal crisis within emergency departments.

A number of alternative models have been proposed or trialled.

In the USA, Turning Point run a mental health crisis service called The Living Room. Free of charge to guests and accessible on a walk-in basis, The Living Room provides a comfortable, home-like environment that acts as an alternative to hospital emergency rooms for adults experiencing psychiatric crises.(58) Guests were deflected from EDs on 213 visits within their first year of operation, representing a savings of approximately USD$550,000 to the relevant state government. On 84% (n=192) of the occurrences in which guests were deflected from EDs, they alleviated their crises sufficiently to decide to leave The Living Room and return to the community.(58)

In the UK, the Maytree Suicide Respite Centre bridges the gap in services between the medical support of the National Health Service and the helplines and drop-in centres of the voluntary sector, by providing four nights of respite for suicidal people. Within this limited time Maytree aims to provide opportunities through talking, reflecting, and relaxing for reducing the intense feelings that lead to suicidal behaviour.(59) An evaluation of the first three years of Maytree's operation showed that guests report both short term relief and longer term benefits.(59)

Community crisis respite centres such as The Living Room and the Maytree Centre represent an important alternative to EDs by remedying many criticisms of traditional EDs made by individuals in crisis. Outcomes from The Living Room's first year of

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operation suggest that community crisis respite centres are cost-effective, effective in helping many individuals alleviate crises, and have the potential to decrease the use of EDs for mental health crisis.(58)

The Life Promotion Clinic, located in Queensland, provides specialised outpatient care and support dedicated to people experiencing suicidality. The Life Promotion Clinic was established in 2004 in response to community demand for comprehensive treatment for suicidal people that was not being provided in alternative settings.(60) The Life Promotion Clinic provides an alternative to medical-based care, and does not require a referral from a health service. If expanded to operate outside business hours and scaled nation-wide, the Life Promotion Clinic would provide a viable alternative to emergency departments for people experiencing mental health or suicidal crisis.

In their submission to the Australian Parliamentary Inquiry "Suicide in Australia" in 2010, the Australian Institute for Suicide Research and Prevention proposed trialling a full residential care facility where clinical specialists and support workers care for people who have made a suicide attempt.(61) The proposed facility would provide an alternative to hospital-based care and would also offer non-medical accommodation to people who are suicidal, and provide a comprehensive range of support services. This model has not yet been trialled.

Positive evaluations of international programs such as The Living Room and Maytree Suicide Respite Centre lend weight to the potential value of non-medical alternatives to emergency departments for people experiencing mental health or suicidal crisis in Australia.

Recommendation 8:
It is recommended that consideration be given to trialling and evaluating models providing alternatives to EDs in the Australian context.

In recognition of the negative impact that substandard emergency department practices can have on consumers, carers and clinicians, a range of initiatives to improve emergency department care for people experiencing mental health and suicidal crisis have been trialled. This reflects increasing acknowledgement among mental healthcare professionals that improvements need to be made to range of available crisis intervention services.(58)

The Victorian government is currently establishing six new emergency department crisis hubs – specially designed 24-hour short-stay units in emergency departments, to treat people during times of mental health and drug and alcohol crisis.(62) The Commission recommends that performance of these crisis hubs should be monitored to ensure learnings can be applied more broadly.

In February 2018, Joondalup Health Campus in WA opened a new Mental Health Observation Area (MHOA). The MHOA is an extension of the emergency department which has been purposefully modelled to improve the clinical environment for people presenting with mental distress. The MHOA is a custom built unit comprising six patient bays, four bedrooms with sliding doors, a patient lounge, waiting area and secure outdoor courtyard. It is hoped that the MHOA will function to reduce

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readmissions and waiting times for the 6 per cent of people presenting each year with a diagnosis relating to mental health.(63)

St Vincent's Hospital Melbourne has piloted two projects involving peer support in mental health that aim to improve a mental health patient's pathway to admission and discharge. The pilot employed five peer support workers whose roles include liaising with the nursing staff in the emergency department to ensure that patients' non-clinical needs are addressed at the point of admission to the ward and upon discharge. Given the high risk of relapse in the first four weeks after discharge, the peer workers also continue to provide short term support in this period. (64)

Researchers at the University of Melbourne are also currently working on a project that will identify the optimal role for peer workers in emergency departments. It will co-produce an innovative service model drawing on research evidence in mental health and the built environment, stakeholder perspectives, and expertise from lived experience. This model will complement current innovations in peer roles and emergency settings.(65)

As part of their Suicide Prevention in Health Services Initiative, the Queensland Government continues to implement training for hospital emergency department staff and other frontline acute mental health care staff in recognising, responding to and providing care to people presenting to Hospital and Health Services with suicide risk. (66) Published evaluation of this initiative suggests that the training was effective at improving staff confidence in working with suicidal people, but the evaluation did not analyse if this has translated into improved outcomes for consumers. (67)

Overall, these initiatives constitute welcome attempts to improve services, but will be limited in their impact if they remain confined to their local areas and are not systematically evaluated for their impact on consumer care and outcomes.

Recommendation 9:
It is recommended that further evaluation of strategies to improve the management of mental health and suicidal crises within emergency departments is needed.

Psychosocial support and social inclusion
Social participation and social engagement cannot be mandated by governments. Focus instead needs to be on increasing the public architecture which promotes opportunities for social inclusion in local communities and society at large. The bio-psycho-social model of mental illness encourages practitioners to look beyond traditional views of dysfunction triggered by physical causes and instead examine the social circumstances that affect patient health and wellbeing. It has been estimated that 20% of people consult a general practitioner for what is primarily a social problem, yet until recently, capacity for GPs to address such problems has been limited. (68)

Social prescribing is a model of care that takes a holistic approach to an individual's health and wellbeing.(69) It has been used extensively in the UK (and evaluated) and a standard model has been developed as a result of evaluation and partnerships with stakeholders. Social prescribing is a way of linking patients in primary care with sources of support within the community and has been widely promoted and adopted

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as an approach to reducing use of primary health care services. (70) It provides GPs with non-medical referral options, and can be an important tool to self-management of mental health. (71)

Social prescribing relies on link workers in the local community identifying appropriate and accessible services, groups or activities for the patient. This approach is particularly relevant when a patient has complex and interdependent conditions including chronic disease, mental illness, isolation and other social issues. Social prescribing can involve a range of activities typically provided by voluntary and community sector organisations including sports, arts, cooking, and participant led group learning such as University of the Third Age (U3A).(72)

Reviews of early pilot programs have examined the social and economic impact of social prescribing, with preliminary evidence that social prescribing can lead to a range of positive health and wellbeing outcomes. However, much of the evidence is qualitative in nature and relies on self-reported outcomes.(72) Where economic assessment has been completed i.e. analysis of the impact of social prescribing on healthcare demand and cost implications, the broad conclusions are that social prescribing has a protective effect on service demand but only where patients fully engage with the interventions offered. (68)

In Australia, social prescribing has had some uptake at the regional level, with Primary Health Networks in Sydney and Melbourne promoting it as an option for clinicians and their clients. (73, 74) A recent study by local researchers ran a small group intervention with 46 participants who experienced low social connectedness. By introducing patients to activities traditionally associated with the social prescribing model, GP attendance rates were reduced in the three months after the referral. (75)

Recommendation 10:
It is recommended that social prescribing and other social inclusion initiatives be promoted within the community sector and primary care settings in the context of a larger scale evaluation of their effectiveness in increasing social inclusion and reducing use of primary health services.

Impact of the NDIS on availability of psychosocial supports
A range of psychosocial support options are also available under the NDIS for those deemed eligible. However, the Commission is concerned about the psychosocial support options for those who are found ineligible to access the scheme, or who choose not to test their eligibility or drop out of the process. It is currently unclear what support services will be available for this group, particularly when both Commonwealth and state/territory funding for mental health services is being redirected to the NDIS.(76)

The Commission supports the COAG commitment to ensuring that all existing clients of Commonwealth funded mental health services who do not meet the NDIS eligibility, will be provided continuity of support, consistent with their current arrangements. It is understood that the Commonwealth Government is now working to ensure that continuity of service arrangements are in place by 1 July 2019. The Commission also supports the announcement of the National Psychosocial Support measure to assist people with psychosocial disability who are not eligible for the NDIS, and not currently in any existing Commonwealth Government program.

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The Commission also welcomes the recent announcement (77) to provide funding to the Primary Health Networks to provide an additional 12 months support for clients transitioning from Commonwealth funded mental health programs to the NDIS.

While these announcements recognise the need for psychosocial support options for those who are found ineligible to access the scheme, there is uncertainty about how these services will be accessed and what the nature of these services will be. The Commission recognises that the Government is seeking to facilitate a smooth transition to the new arrangements. However, there is currently a lack of clarity around how these support services will be implemented. The Commission is concerned about the potential impact of the transition process on individuals with a psychosocial disability, given the complex needs of this group.

There is a risk that if people don't have access to appropriate psychosocial supports this could lead to an increased need to access acute services which have wider implications for the broader health system.

Similar concerns have been echoed in multiple other reports and forums, with some stakeholders highlighting the potential impact on more costly downstream services. In a hearing held on 15 February 2018, the Joint Standing Committee on the NDIS heard that the sector is concerned about the transition of services to the NDIS, with one stakeholder stating that "*the rolling over of Commonwealth funding to the NDIS and the resulting decrease in community-based services will lead to more episodes of crisis for individuals with a mental health condition and an increase in complex presentations to emergency departments and hospitals*". (78) Further commentary confirmed that inadequate supports in plans and poor coordination between the health system and disability supports have led to increased hospitalisation of people with mental illness.(78) The most recent and final hearing of the Joint Standing Committee on the NDIS on 26 February 2019 also highlighted the mental health sector's continuing concerns around the lack of clarity for continuity of support funding, the role of Primary Health Networks (PHNs) and what will happen after 30 June when current psychosocial support programs cease. (79)

Recommendation 11:
It is recommended that governments ensure that people with psychosocial disability have access to appropriate and timely psychosocial support services regardless of whether they are in the NDIS.

Comorbid physical and mental health issues

People with serious mental illness typically live between 14 and 23 years less than the general population. The gap seems to be widening rather than narrowing over the past three decades. Around 80% of this excess mortality can be attributed to the much higher rates of physical illnesses, such as cardiovascular and respiratory diseases, diabetes and cancer experienced by this population.(80) Four out of every five people living with a mental illness have a co-existing physical illness. On average people living with severe mental illness experience one and a half times the risk of cardiometabolic diseases including obesity, type 2 diabetes, and cardiovascular disease.(81)

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Access to physical health care services may be less than optimal within mental health facilities. Service users often report that their physical health is neglected once they are diagnosed with a mental illness, referred to as diagnostic overshadowing.(82) To help address this inequity, the World Health Organization has released, for the first time, evidence-based guidelines on management of physical conditions in adults with severe mental disorders. (83) The new Guidelines include recommendations for treating people with severe mental health disorders who have cardiovascular disease, diabetes, HIV/AIDS, tuberculosis and hepatitis B and C, and those with tobacco dependence, or who engage in harmful use of alcohol or other substances and/or who are overweight. Recommendations relate to lifestyle changes such as a healthier diet, increased physical activity and tobacco cessation, psychosocial support and medicines, taking into account possible interactions between different medicines prescribed for mental and physical health conditions.

Despite the presence of physical health treatment guidelines for the management of co-existing physical and mental health conditions, the implementation of these guidelines is limited by service fragmentation, a lack of role clarity, a lack of whole person focus, and poor consultation with consumers. Collaboration between different streams of health services is often limited by different treatment approaches, and health services tend to focus on the treatment of single conditions. To improve the physical health of people living with mental illness, integrated and team based care models need further development and evaluation to better understand the factors which lead to successful implementation, including service culture, defining scopes of practice and funding streams.

In Australia, the Equally Well Consensus Statement (Equally Well) has been developed by the Commission following extensive consultation with key stakeholders across the mental health sector. Equally Well was launched with strong support across the sector including all state and territory governments with over fifty organisations (including all state mental health commissions, PHNs, professional colleges, carer and consumer organisations, peak bodies and non-government organisations). By pledging to the principles of the Equally Well organisations will collectively bridge the life expectancy gap between people living with mental illness and the general population. Equally Well outlines six essential elements for prioritising the physical health of people living with mental illness at all levels of the health system: national, state/territory and regional across the spectrum of health – from promotion and prevention to treatment, for people of all ages across our whole society.

Equally Well is based on the premise that mental health and wellbeing is a basic human right often denied to many in our community. The model is based on the collective impact approach develop by Te Pou under the New Zealand Equally Well banner. People living with mental illness have poorer physical health, yet they receive less and lower quality health care than the rest of the population – and die younger. Implementation of Equally Well has the potential to see significant improvement at the primary health/acute care interface. It aims to reduce variation in care as well as address the often siloed-approach to treatment and care, and improve service effectiveness, efficiency and health outcomes for people living with mental illness and their families and carers.

The commitment of all jurisdictions to implement Equally Well is embedded in the Fifth National Mental Health and Suicide Prevention Plan that identifies improving the

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physical health of people living with mental illness and reducing early mortality as a priority area. PHNs and Local Hospital Districts are jointly working on regional planning and coordination activities to address this priority area. The Commission has a formal role under the Fifth Plan to monitor and report on progress towards implementation the Equally Well across jurisdictions.

Workforce

There is a diversity of professions which contribute to the overall mental health workforce in Australia, and workforce trends are changing over time. In some cases, trends such as the ageing workforce have serious implications for the sustainability of the workforce. In 2016, about 3 in 5 mental health nurses (58.8%) were aged 45 and above, and a third (32.7%) were aged 55 and older.(84) Other clinical specialities including psychiatry and psychology show similar patterns, with over half of psychologists aged 45 and over, and more than one quarter aged 55 and over in 2016. This increased to more than 70% for psychiatrists aged 45 and over, and more than 40% aged 55 and over. (84)

Research into retention issues in the mental health workforce, which is of major concern in rural and remote Australia, has identified common factors including professional and personal isolation with limited access to professional development and training.(85) From the perspective of health services, rural recruitment is most challenging in the context of global, state and national shortages of suitable workers and competition with metropolitan and larger regional centres. Supply of workforce has also been influenced by the move away from hospital based training to tertiary training and is especially acute in specialist areas including social work and Child and Adolescent Mental Health Services.(85)

Further, as the workforce evolves, and new requirements including skill mix and varied scope of practice are placed upon mental health practitioners, there is a need to ensure that high quality training and education are available. This includes knowledge of and capacity to deliver trauma-informed care. Trauma-informed care requires consideration of a person's environment beyond the immediate service being provided, and that their symptoms or presentation may reflect an adaptation to trauma, rather than a specific pathology.(86) Trauma-informed care also reflects an understanding of the widespread impact of trauma, potential paths for recovery, and actively seeks to prevent re-traumatisation. Trauma-informed approaches to care have also been described as a strength-based framework, which contrasts with traditional settings and systems (86) including the move towards employment of staff with lived experiences such as peer workers in acute and community health services.

Consumer peer workers apply their personal lived experience of mental illness and recovery in supporting consumers. Carer peer workers apply their experience from caring and supporting family or friends living with mental illness in supporting other carers and family members. Peer workers are an integral part of ensuring the voices of consumers and carers are central to the work of the mental health system. Benefits of the peer workforce include supporting the staffing mix of broader clinical and community services, and improving awareness of recovery-oriented and trauma-informed service delivery. The employment of peer workers in services leads to more positive outcomes and experience of service for consumers, carers, family and friends.(6)

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The challenges faced by the peer workforce include stigma and discrimination, lack of resources to meet demand, lack of peer supervision and professional development opportunities, and inappropriate and complex award structures and remuneration. There is also a lack of accurate data to monitor and evaluate the growth and effectiveness of the workforce, and unlike other professions peer workers have no professional peak representative organisation. The peer workforce requires support from governments to ensure a safe working environment free from stigma and discrimination, with adequate support structures, to guarantee the workforce grows and retention rates improve.(6)

Alongside the peer workforce, the Aboriginal mental health workforce, and rural and remote workforce are developing as important elements within the overall mental health workforce and are likely to grow in scope and significance. Current support structures for these workforces are inadequate and a focus on increasing access to appropriate supervision (such as peer supervision for peer workers), career progression and workplaces free from discrimination is required.

Under the Fifth Plan, the Commission is leading the development of Peer Workforce Development Guidelines by 2021. This project will support the peer workforce through the development of formalised guidance for governments, employers and the peer workforce about support structures that are required to sustain and grow the workforce. Although local and regional peer workforce frameworks exist, the development of national guidelines will ensure consistency across Australia. National guidelines will also be a step towards professionalisation of the peer workforce.

A mental health system that is culturally responsive and safe is crucial for Aboriginal and Torres Strait Islander communities. A component of a system that provides culturally appropriate care is ensuring Aboriginal and Torres Strait Islander staff are embedded in the health system and that Aboriginal community controlled health organisations are provided the support to continue being the largest employer of Aboriginal and Torres Strait Islander staff. The Fifth Plan prioritises the promotion and growth of the Indigenous workforce including doctors, nurses and allied health professionals.

There is also a need to improve the cultural competence of the non-Indigenous health workforce. The Lowitja report identified:

- the need to recognise the experience of racism both on a personal level but also that institutional racism means Aboriginal and Torres Strait Islander people are not always accessing the health care they need(87)
- evidence of correlation between racism and high or very high levels of psychological distress(88)
- Aboriginal and Torres Strait Islander people's cultural safety – or lack of – as a key barrier to better mental health and wellbeing
- mainstream services are not seen to recognise the importance of strong culture and identity, and what that means for the mental health and wellbeing needs of Aboriginal and Torres Strait Islander people
- a system(s) approach is needed to build the knowledge and skills of the workforce to implement cultural competence and safety.

While the prevalence of mental illness in rural and remote areas is similar to metropolitan areas, people living in rural and remote areas face greater challenges in

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accessing appropriate support services, driven by maldistribution of the mental health workforce, skewed towards urban areas.

The Royal Flying Doctor Service (RFDS) is an innovative service model developed to address the challenge of providing health care over large geographic distances with limited alternative transport options. The RFDS is increasingly being used for mental health related issues, with 24,396 mental health consultations undertaken in 2016-17, an increase of 72% on the previous year.(89)

GPs are also a consistent source of mental health care for people in rural and remote areas living with mental illness. The Commission has previously recommended the expansion of the eligibility criteria for participants in the Commonwealth's Specialist Training Program to include GPs, on the basis that in rural and regional areas, GPs are often the only source of continuing care.(90) The expanded eligibility criteria should focus on training opportunities for mental health and wellbeing promotion, evidence-based interventions for early intervention and management of mild, moderate and severe mental illness within a general practice setting.

Digital technology can also be useful for remote service provision and as an adjunct to the workforce in rural and remote areas, including as a method of providing distance education and training, and e-supervision to health professionals. However, these should not be a substitution for face-to-face care.

One of the biggest issues in relation to the mental health workforce across professional streams and geographical areas is high staff turnover. There are a well-known range of contributing factors including stress and burnout, an ageing workforce, excessive workloads, insecure tenure, limited career paths, and reduced time for training, mentoring and supervision.(91) Mental health professionals operating in rural and remote areas, and those operating in private practice, may also experience isolation.

These issues can be mitigated through a range of workplace initiatives, including innovative supervision and support opportunities, particularly for workforces who are isolated; increased opportunities for training and professional development; addressing staff shortages to alleviate excessive workloads wherever possible; and implementation of mentally healthy workplace initiatives (discussed on page 8-9).

Supports for Aboriginal and Torres Strait Islander mental health professionals should also be a priority. The Lowitja Institute highlights that Aboriginal and Torres Strait Islander health professionals often experience a lack of professional and employer support, and recommends that this be addressed to strengthen the wellbeing of the mental health workforce and prevent burnout.(1)

Recommendation 12:
The Commission supports the development of a National Mental Health Workforce Strategy, announced in the 2018-19 Mid-Year Economic and Fiscal Outlook, to provide options to attract, train and retain mental health workers to support the provision of mental health services across Australia.

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Funding, commissioning and service planning

The fundamental approach to funding mental health services from Commonwealth and State agencies requires considerable review. As the PC's Issues Paper identifies, along with providing payments to the states to provide public hospital services and subsidising primary health services and pharmaceuticals, the Commonwealth directly funds a wide variety of national programs across several portfolios. The Commonwealth's key areas of funding are through primary care (via the Medicare Benefits Schedule) and through PHNs, while States focus on providing public hospital services and funding the community managed or non-government sector. The service landscape between these service options is disjointed, leading to significant gaps in services and barriers to navigating the system for consumers.

The Commission's 2014 review clearly articulated the fact that the mental health system in Australia has fundamental structural shortcomings. In effect, the way the mental health and suicide prevention system is designed and funded means that meaningful help is often not available until a person has deteriorated to crisis point.

The current system gives primacy to the traditional model of health care which promotes ever subspecialised clinical treatment modalities that neglect to acknowledge the broader social, human and economic factors at play. Such siloing is also at work within the approach taken by the PC issues paper, and echoes the challenge of a providing a coherent, comprehensive response to the growing rates of self-harm, suicidal intentions and mental illness in the Australian community.

At the political level, Australia is hampered by short election cycles which fail to promote long term strategic planning and funding commitments, enmeshed in conflict between Commonwealth and state actors about fiscal and policy responsibilities, with minimal coordination between the two.

There are also structural barriers around portfolio-based funding and decision making by governments, which dis-incentivise spending in one portfolio when the economic return over time will accrue in a different portfolio area (and budget), or indeed a different jurisdiction altogether.

The recent New Zealand Report of the Government Inquiry into Mental Health and Addiction(14) acknowledges that they 'have the system they designed', and chose to focus on analysing the underlying reasons why the system has not changed over the past two decades. The New Zealand Report findings are in many ways applicable to the Australian context. Some key learnings include:

- The issues being tackled cannot be addressed by the health system alone. Tackling the social and economic determinants of mental health and wellbeing starts with a co-ordinated integrated approach across both health and social services.
- A focus on population wellbeing is essential while also delivering practical help in the community when people need it. This cannot be achieved while funding continues to be primarily short term, ad-hoc and fragmented.
- A complete dismantling or restructuring of the health system is neither feasible nor desirable and would inevitably lead to widespread disruption of service delivery and delay progress in making genuine reform. The objective must be

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greater integration of services with mental health and addiction services retaining strong links to the wider health and disability system.

- Removing roadblocks to accessing good care means addressing issues of affordability of GP led care, and ensuring that foundations are in place for the 'missing middle' - those who are a step up from management in primary care but not acute enough for inpatient admission.

As outlined below, addressing these key points requires realigned (and increased) funding, an 'invest to save' approach to system funding, more effective commissioning arrangements, and service planning that more closely matches needs in the community.

Investment misalignment

While the government of the day adopted some of the Commission's recommendations for system reform from the 2014 Review,(92) nationally there remains vast unmet need, with resources concentrated in high cost acute care service delivery with insufficient resourcing for prevention and early intervention. Of total Commonwealth spending, 87.5% is absorbed by demand-driven programs including income support and acute care. The strong expenditure growth in such programs is an indicator of system failure – supporting people once they are ill or impaired - rather than investing in programs and policies that 'future proof' people's ability to live productive, contributing lives. As the UK's New Economics Foundation sees it, "*providing services in the same way, while demand increases and resources dwindle, is not a sustainable option*".(93)

Importantly, the Commission does not support a zero-sum reallocation of downstream funding but does support additional growth in funding to community based prevention and early intervention services. In the context of no new budget allocation, the 2014 Review recommended a *reallocation* of acute hospital funding and income support payments into more community-based care. In order to achieve this while maintaining a seamless provision of service delivery to meet current need, this requires, initially, a greater investment in community based prevention and early intervention approaches, which – over time – would should see a shift in demand towards lower cost activities with less reliance on high cost activity and interventions (hospital based care; welfare support). In this way, there will be a gradual strengthening in prevention, early intervention, self-care and participation (education, employment, social inclusion) and reduction in acute demand.

The invest to save model (94) supports this approach and recognises the need to intervene early, investing upfront to avoid significantly higher costs in the future, but not at the cost of existing acute services. Without upfront investments, which have known positive economic returns, downstream mental health costs will continue to grow, including avoidable emergency department presentations and demand for hospital beds, homelessness support, drug and alcohol treatment and income support. Some of the upfront investments recommended by Mental Health Australia and KPMG in the 2018 Investing to Save report include: adopting a Housing First model, assertive outreach post suicide attempt, and workplace mental health interventions. The report suggests that uptake of these recommendations would generate between $8.2 billion and $12.7 billion from an investment of under $4.4 billion.

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The Australian Medical Association (AMA) believes that mental health and psychiatric care is "grossly underfunded" compared to physical health, particularly in light of the burden of disease associated with poor mental health.(95) The AMA has also called for Commonwealth and state/territory governments to work cooperatively to change the current patchwork of overlapping services, recommending that a balance between funding acute public hospital care, primary care, and community-managed mental health is required, and weighted on the basis of need, demand and disease burden.(95)

Recommendation 13:
It is recommended that the PC consider not just the investment in mental health, but how the funding arrangements are structured, both within and between the different levels of Government, to ensure the best outcomes for consumers.

Effective upstream interventions that prevent or ameliorate mental illness and support recovery would realise later savings to a range of other areas of expenditure, and also increase tax revenues. This includes reducing costs incurred through the income support system, which the Commission's 2014 Review identified as comprising around 60% of the Commonwealth's mental health expenditure. Tax revenues would be increased to the extent that effective early interventions allowed people who would have otherwise been incapable of work to pursue and engage in employment, thereby contributing more to tax revenues (direct and indirect) than would otherwise be the case.

However, such savings cannot be realised purely through changes in investment. For example, the DSP's tightly targeted eligibility criteria – which require proof of an ongoing incapacity to work – are not aligned with the often episodic and variable nature of mental illness. A 2015 review of the welfare system(96) found that income support payments need to better differentiate between permanent and temporary incapacity, and take account of modern advances that help support the work capacity of people with mental health conditions. The review also acknowledged the importance of integrated services across employment, mental health and other sectors, to better support people with mental health conditions to move off welfare and maintain stronger connections with the workforce.

Integrated, sustained and comprehensive reforms need to be implemented in parallel in order to realise the savings – and make improvements in people's lives and the wider community's wellbeing – that might be possible through an investment approach. In relation to income support, a better understanding and more flexible response is needed to address the needs of people with mental illness in the employment and the welfare system. One avenue for this could be through mental illness as a specific focus under the Try, Test and Learn Fund(97) overseen by the Department of Social Services.

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Recommendation 14:
It is recommended that the PC develop a proposed methodology for better estimating the downstream economic and fiscal benefits of effective and early policy interventions and investment in the welfare system that address needs and circumstances of people with mental illness and their carers (including a flexible response to the episodic nature of mental illness) and the role of integrated supports and services in helping them pursue education and work.

The Medicare Benefits Scheme (MBS)
As identified in the PC's Issues Paper, the Medicare Benefits Scheme (MBS) is a core structural component of Australia's universal health system, and represents around 10% of total Commonwealth Government funding for mental health. As a universal access system, the MBS provides an important structural lever for funding (and thereby incentivising) best practice approaches in the treatment of mental health conditions. The MBS has also been structured to provide Australians with access to health services that are evidence based, and to serve as a mechanism to encourage population wide health promotion and early intervention.

The primary access point for mental health services through the MBS is the Better Access scheme. Better Access is predominantly demand-driven (albeit with some limits through caps on the number of rebateable sessions available per calendar year and through GPs as gatekeepers to eligibility).The rapid uptake of the Better Access scheme and increased demand since its inception, reflects previously unmet (or unrealised) need for mental health services and supports. Better Access has also played an important role in de-stigmatising help-seeking and providing easy access (financially, socially, practically) to mental health services. Therefore, the flow on effects seen in increased expenditure on mental health related MBS items can be interpreted positively as a reflection of community response to an important and necessary reform.

Limitations and criticism of Better Access to date have included the geographic mal distribution of service providers – with data showing a tendency for providers to cluster in areas of relative socio-economic advantage – and affordability for those who cannot afford 'gap' payments over and above the standard MBS rebate. There are also critiques that Better Access does not tailor service level to need (i.e. many people access fewer than four sessions, while for others with more severe presentations a limit of 10 sessions per calendar year is not sufficient).

The MBS Review Taskforce is currently considering how MBS-subsidised services can be better aligned with contemporary clinical evidence and practice to improve health outcomes. The Commission made a series of recommendations to the MBS Review Taskforce in relation to mental health items, including enabling additional psychological sessions under the Better Access scheme for people with severe or complex high, and low prevalence disorders; removal of required face-to-face sessions under telemedicine guidelines for rural and remote patients; and the inclusion of mental health nurses under the scheme.

The Mental Health Reference Group (MHRG) appointed by the taskforce released its report in February 2019. The report includes a proposal (Recommendation 1) to make Better Access available to people 'at risk' of developing a mental health

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condition. This proposal would support early access to quality services and supports to prevent a person's experience escalating into a diagnosable mental illness. The Commission therefore supports the proposal in principle, but notes that the MBS is just one component of the mental health system, and careful consideration should be given to other potential avenues for supporting early intervention.

The MHRG also proposes a three-tiered approach for Better Access (Recommendation 3), which would see up to 10, 20 or 40 sessions available per year, depending on a professional assessment of need. Again, the Commission supports this in principle, as it would introduce a more comprehensive stepped care approach into the program, and provide an administratively efficient lever for funding additional sessions for those who need them, such as people with severe or complex high and low prevalence disorders. However, more work will be needed to clearly define the gateway criteria for accessing higher levels of sessions and explore relevant administrative and implementation details.

The Commission also supports the MHRG's proposal (Recommendation 9) to build outcomes measurement into mental health related MBS items. In the context of information required of other recipients of public funding (including jurisdictions, PHNs and community managed organisations) it is appropriate that more information is available around MBS client groups and the outcomes being achieved through MBS-subsidised services. This data can then inform assessments of effectiveness and value for money. Although this recommendation is pitched by the MHRG as a longer term action, the Commission would encourage this work be considered for inclusion in the 3rd edition of Mental Health Information Development Priorities (discussed further in this submission below).

The MHRGs subsequent recommendations to the Taskforce are currently still open to consultation and consideration by Government.

Commissioning services

Beyond the larger reforms and structural elements of the mental health system (i.e. primary care, hospitals, NDIS, income support), PHNs have a significant role in identifying gaps and commissioning services to meet need in their local areas.

The PC issues paper raises questions around efficient approaches/value for money in clinical commissioning. In relation to PHNs it may be too early in commissioning cycle to assess value for money overall. However, there is some acknowledgement that the way services are commissioned can either help or hinder the delivery of services for those with mental health issues. A report by Rooftop Social, in collaboration with ANZSOG for Mental Health Australia, found that mental health commissioning and contracting arrangements were hampered by siloed decision making, short-term contracts and insecurity, and inconsistent reporting and data requirements. (98)

The report noted reform trends towards an outcomes focus in commissioning, but cautioned against basing payments solely on the basis of achieving outcomes in areas as complex as mental health. The report also highlighted the need for improvements to commissioning and contracting arrangements, including in light of the findings of the Harper Competition Review and the PC's 2010 report on the Contribution of the Not-for-Profit Sector. The report also recommended exploring

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options for promoting cross-portfolio approaches to mental health services, for example through the use of pooled funding. (98)

Data to inform needs-based provision of services
To inform commissioning of services, it is important to ascertain the correct level of service to meet population needs, and to do so using formal analysis of robust data. Needs based service/workforce planning is essential to establish the resourcing required at local and population level, but Segal and colleagues argue that this has not been consistently applied across all populations, challenging existing estimates for child and adolescent mental health as being five times less than is actually needed.(99) While their sample is restricted to South Australian infants, children and adolescents, globally this matches what has long been known about unmet mental health needs of children and young people in Australia. (100)

The implementation plan of the Fifth Plan recommends that key national data be made available, 'to inform regional level understanding of service gaps, duplication and areas of highest need'. Conducting a gap analysis across local geographic regions requires: (1) region-specific data on the current provision of mental health services; and (2) region-specific data on the optimal distribution of mental health services required to address mental health needs.

The National Mental Health Service Planning Framework – Planning Support Tool (NMHSPF-PST) was developed to produce data on the optimal distribution of mental health services across regions of Australia. In particular, the NMHSPF-PST enables users to estimate mental health needs, the expected level of demand for mental health care and the optimal levels and mix of mental health services required to address needs/demand within the population. However, external scrutiny of regional service planning is limited, as the NMHSPF-PST is not publicly accessible.

The NMHSPF-PST is currently being used by PHNs to plan new mental health services and improve the design of existing mental health services within their catchments. The Commonwealth Government has provided funding to PHNs to produce regional service maps that describe the current provision of mental health services within their respective catchments. It is important for PHNs to produce regional service maps that align with the outputs of the NMHSPF-PST if they are to be used as part of a gap analysis to identify any deficiencies or duplications in the current provision of mental health services (when compared to the optimal levels and mix of mental health services).

The NMHSPF Project Team at The University of Queensland (UQ) (which is contracted by the Department of Health to maintain the NMHSPF) has received consistent feedback from PHNs on the difficulties they face in developing regional service maps for their respective catchments. For example, PHNs have frequently reported that obtaining access to mental health services data for the purposes of regional service mapping is often challenging and/or costly. Furthermore, those PHNs that have obtained the requisite mental health services data have reported problems in aligning data to the outputs of the NMHSPF-PST due to variations in how mental health services data are conceptualised across different states and territories. The absence of a standardised methodology by which to map mental health services data at the regional level has led some PHNs to contract external sources to assist in the mapping of current service provision within their catchments.

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It is yet to be seen whether the data produced by the resulting regional service maps within each PHN will align with the NMHSPF-PST such that they can be used in a subsequent gap analysis. It is also known that the NMHSPF-PST does not include data on the service needs of the forensic mental health population, nor consumers with co-morbidity due to use of alcohol and other drugs.

The Commission has recently sought to address the first of these issues by contracting a team of researchers from UQ to: (1) develop a standardised methodology by which to transform existing mental health services data into regional mappings that align with the outputs of the NMHSPF-PST; and (2) produce a regional service map of current mental health services provided across defined geographic areas throughout Australia. The Regional Services Mapping Team at UQ will aim to complement the work plan of AIHW by assisting them in developing the methodology required to align existing mental health services data to the outputs of the NMHSPF-PST.

The research outputs produced by UQ will aim to ensure that all PHNs have access to a standardised methodology by which to generate regional service maps that align with the outputs of the NMHSPF-PST. In addition, it is hoped that the resulting regional service maps can be used by all service providers to inform any prospective gap analysis that will be performed to improve the provision of mental health services within their catchments.

The Commission is also currently developing *Vision 2030*, using the NMHSPF to inform the development of a long-term national vision for mental health, providing direction for current and future governments to guide investment at the Commonwealth and State levels.

Recommendation 15:
It is recommended that greater access to information on the mental health needs and service availability within regional communities is required for all services and system planners.

Measuring and reporting on the outcomes of mental health policies

Data limitations
In its monitoring and reporting role, the Commission draws on data, indicators and frameworks, as well as qualitative accounts, to inform an assessment of whether progress is being achieved in the implementation of mental health reforms and the impact of any changes on individuals and the community.

At present, the Commission's role in monitoring and reporting on mental health reform is somewhat limited due to the fact that mental health activity (and expenditure) is spread across multiple government agencies and the private sector (including individual co-payments), and data on inputs, outputs and outcomes is not always readily available. For example the NDIS is a major reform that directly impacts people with psychosocial disability. Currently, available data sits outside the health portfolio, limiting the ability for the Commission as well as other agencies to influence the data that is reported publicly.

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In addition, current, routinely reported data on mental health-related expenditure focuses primarily on services or programs provided by Commonwealth and state and territory government health portfolios. In order to obtain a more accurate view of expenditure for Australians who experience mental illness, it would be desirable to report expenditure beyond the health portfolio such as in housing, justice, and education. There is precedent for this, as seen in relation to expenditure on services for Indigenous Australians, reported through the PC's Indigenous Expenditure Report. (101)

Limitations in the availability of information to inform service investment and planning also extend to the research sector. As noted by the Commission in its 2014 Review and also more recently recognised by all governments in the Fifth Plan, there is "a major disconnection between the research sector and the mental health services and supports sector, no clear pathway for the translation of research into practice, and no national mechanism for prioritisation and oversight of mental health research to ensure it is aligned with identified need and policy priorities".(102) There is also a need for independent evaluation of existing government investment in mental health.

The 2017-18 Budget commitment of $50 million for research and evaluation in Indigenous affairs (103) illustrates the importance of a robust evidentiary framework in complex policy areas. The Commission would welcome a similar level of commitment to ensure programs and policies designed to support mental health and wellbeing are effective and delivery good value for money.

These and other issues will be examined in detail by the Commission as it progresses with its task under Action 28 of the Fifth Plan *to "develop a research strategy to drive better treatment outcomes across the mental health sector*".

Recommendation 16:
It is recommended that governments work towards coordinated reporting of all mental health activity, to improve monitoring and reporting of the investment in mental health at all levels of government and in all sectors.

Recommendation 17:
It is recommended that the Commission's position within government is reviewed with a mind to strengthening the Commission's independence and the ability to monitor and report across all relevant portfolios.

More can be done to improve the collection and value of mental health data, including longitudinal data. Understanding and improving the quality of health care systems requires the ability to monitor the same individuals over time, as they experience healthcare events, receive treatments, and experience improvements or deteriorations in their health. It also requires an understanding of the distribution of health and health outcomes across different groups in the population and understanding variations in service availability, care quality and health outcomes.

Existing datasets provide a strong foundation, but further data development and data linkage is necessary to fill key knowledge gaps and facilitate comprehensive monitoring and reporting of the effectiveness of Australia's mental health and suicide prevention systems.

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Data development is needed to overcome known data gaps including the limitations of administrative datasets which typically cover only a single component of a care system, and therefore are unable to provide a complete picture of system performance on their own. Linkage of administrative data can facilitate a long-term, holistic approach to outcome measurement, allowing governments to track improvements in non-health outcomes for mental health consumers, such as reduced homelessness and greater social participation, and the accompanying economic savings that accrue outside the health portfolio.

Globally, there is also a lack of data on:

- Suicide prevention expenditure, workforce training and development and program and service activity at the national and jurisdictional levels.
- Expenditure on mental health-related emergency department presentations or admitted patient care provided in hospitals without a specialised psychiatric unit or ward.
- General practice consultations since the Bettering Evaluation of Care (BEACH) data collection ceased.

Work is currently underway to develop and release the 3rd National Mental Health Information Priorities (NMHIP) through the AHMAC committee structures. This document is a commitment under the Fifth Plan that will articulate a long term strategy for mental health information development over the period 2019 to 2029. The strategy outlined in the NMHIP aims to use information to support the reform of the mental health system, service development and better integration of mental health and related services. The focus of the NMHIP is on public sector mental health services, community managed organisations, private hospitals and PHNs. While this will be an important development in improving the data available for mental health reform, the NMHIP is limited in scope to improving data in the health domain only.

Since June 2015, the Commonwealth's Multi-Agency Data Integration Project (MADIP) has been testing the feasibility and value of combining important national datasets. MADIP shows how combining existing public data can be used to:

- provide insight into the effectiveness of government policies, programs, and services to ensure they are delivering value to the Australian public.
- inform better targeting of services, such as health and early childhood services, to people and communities who need them.
- enable people and businesses to make more informed decisions.

MADIP includes the Mental Health Services Data Integration project, initiated on behalf of the Commission, which brings together for the first time the breadth of Census data with administrative information on people accessing subsidised mental health-related MBS services and Pharmaceutical Benefits Scheme (PBS) prescription medication. One important insight from the data was that when accessing mental health services, people with less education, the unemployed, and those living in rural areas are more likely to be prescribed drugs, while people with more education, living in metropolitan areas were more likely to be prescribed talking-based therapies. This data enables government to better understand inconsistencies in mental health service provision, and create (or amend) policies to address it.

The Mental Health Services Data Integration project is ongoing and is currently being expanded to include Death Registries Data. While this is a significant improvement

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on the existing data, the MADIP dataset is still unable to analyse a consumer's full journey through mental health, health and social support services. This limits Australia's ability to ensure mental health consumers are getting equitable access across the full range of services that can support them to lead a contributing life.

To overcome this limitation, we must test the feasibility of expanding the MADIP dataset to include the mental health-related National Minimum Data Sets, and administrative data from relevant non-health datasets such as disability services and homelessness services, where people with mental illness are known to be over-represented.

While government and non-government researchers can apply for access to MADIP data, access is granted on a project-by project basis. Such an access system prohibits government agencies from using MADIP data for routine, ongoing analysis of the effectiveness of mental health-related government policies, programs, and services, making it difficult to ensure they are delivering value to the Australian public.

Recommendation 18:
It is recommended that the scope for MADIP is increased to enable analysis across mental health, health and social support services, and access requirements are reviewed.

Monitoring and reporting
The Fifth Plan was endorsed by the COAG Health Council (CHC) in August 2017. The Fifth Plan builds upon the foundations of previous reform efforts and establishes a national approach for collaborative government effort over the period of 2017 – 2022, and is the first such plan to commit all governments to work together to achieve integration in planning and service delivery at a regional level.

Underpinned by eight priority areas, the Fifth Plan is aligned with the current aims and policy directions of the National Mental Health Policy. Governance arrangements for the Fifth Plan were designed to assist the CHC to deliver on improved outcomes. These arrangements provide the appropriate authority to implement actions and include mechanisms to receive appropriate advice from consumers and carers.

Under Action V of the Fifth Plan *Implementation plan*, the Commission has been tasked with monitoring and reporting on the implementation of the Fifth Plan and delivering annual progress reports to the CHC. The Commission delivered its first progress report to CHC in October 2018, and is currently finalising a survey to determine the progressive impact of the Fifth Plan on the experiences of consumers and carers.

Given the infancy of the Fifth Plan, it is difficult to provide detailed commentary on its effectiveness. However, the Commission is encouraged by progress currently being made against the actions of the *Implementation plan*, and by the commitment and sustained effort by all stakeholders to improve mental health, and increase suicide prevention in Australia.

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The Commission will use its initial progress report as a baseline, to map activities in future years, providing the community with a sense of how actions are progressing against the plan. As the Fifth Plan approaches the later stages of its life and reforms begin to lead to change that will be visible for consumers and carers and the sector more broadly, the Commission will report on these changes to ensure that there is genuine improvement for people living with a mental illness in Australia.

To determine the efficacy of the Fifth Plan, the Commonwealth Government will commission an independent evaluation of the Fifth Plan (as per Action VI). The Commonwealth contracted provider will be required to consult with a number of AHMAC committees that contribute to the implementation of the Fifth Plan, as well as with the Commission and other key stakeholders on the development of the evaluation plan. Evaluation of the plan will commence during 2022 - the final year of the Fifth Plan.

Concluding remarks

There can be no health without mental health, and good mental health and wellbeing depend on the design, financing and implementation of high quality, evidence based programs and policies across all portfolios. Beyond health and social services, the downstream impacts of poor investment or no investment can be felt in the domains of housing, employment, education and the justice system. Just as, when early intervention and prevention is delivered in the right place at the right time, the benefits may be returned both within the sector and later in time, in reduced spending on health and social services.

In addressing the key issues raised in the PC issues paper, the Commission has highlighted crucial areas where large gains may be made for relatively small investment. This includes improvements to data capture and reporting, the implementation of a justice reinvestment approach to criminal justice, improvements to the management of people going through a suicidal crisis, and the introduction of policies and interventions to promote mentally healthy workplaces. On the more complex end of the scale, the Commission has recommended a whole-of-government approach to mental health to improve strategic oversight and coordination of mental health policy and investment, going beyond the traditional focus on health. Further to this, current siloed and disjointed funding arrangements need to be reviewed to overcome the barriers they create, and to ensure improved outcomes for consumers.

The Commission supports the intent of this inquiry and looks forward to working with the PC throughout the process to ensure the inquiry results in positive change so that all Australians can lead contributing lives. The Commission is well placed to assist the PC throughout the inquiry and would welcome an ongoing role in supporting the delivery of this important work.

List of Recommendations

Recommendation 1:
It is recommended that the PC address the needs of Aboriginal and Torres Strait Islander peoples explicitly in this inquiry.

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Recommendation 2:
It is recommended that the PC include financial support payments in its assessment of costs of mental illness to the community and consider improvements in the transparency of reporting on financial support payments in relation to mental health. The PC should also consider including workers compensation payments and cost of insurance to individuals and employers in its assessment.

Recommendation 3:
Mental health must be seen as a whole-of-government priority if the social determinants of mental health are to be adequately addressed. The Commission believes that a more coordinated approach is needed across government in relation to both policy and investment in mental health. The Commission recommends the PC investigate options for increased strategic oversight and coordination of mental health policy and investment across Federal government and State and Territory governments, going beyond the traditional focus on health. It is further recommended that the function of monitoring and reporting of the outcomes of this increased strategic oversight is undertaken independently from the oversight role.

Recommendation 4:
Workplaces provide opportune environments for implementation of early intervention and prevention initiatives in mental health. It is recommended that the PC encourage industry groups to promote the uptake of interventions with a good evidence base, appropriate for the workplace conditions of employees. This could be supported by the National Mental Health Workplace Initiative, recently announced in the Federal Budget.

Recommendation 5:
It is recommended that the PC draw on the work undertaken by the Commission and AHURI for guidance on improvements to housing and mental health.

Recommendation 6:
It is recommended that the PC supports the implementation of a justice reinvestment approach to criminal justice, initially for Aboriginal and Torres Strait Islander communities, and pending the evaluation of this initiative that the approach is more broadly rolled out.

Recommendation 7:
Prevention and early intervention approaches are among the most promising mechanisms for reducing the economic impacts of mental illness later in life but more work is needed to bolster the evidence base. It is recommended that the PC supports further development of the evidence base for prevention and early intervention approaches.

Recommendation 8:
It is recommended that consideration be given to trialling and evaluating models providing alternatives to EDs in the Australian context.

Recommendation 9:
It is recommended that further evaluation of strategies to improve the management of mental health and suicidal crises within emergency departments is needed.

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Recommendation 10:
It is recommended that social prescribing and other social inclusion initiatives be promoted within the community sector and primary care settings in the context of a larger scale evaluation of their effectiveness in increasing social inclusion and reducing use of primary health services.

Recommendation 11:
It is recommended that governments ensure that people with psychosocial disability have access to appropriate and timely psychosocial support services regardless of whether they are in the NDIS.

Recommendation 12:
The Commission supports the development of a National Mental Health Workforce Strategy, announced in the 2018-19 Mid-Year Economic and Fiscal Outlook, to provide options to attract, train and retain mental health workers to support the provision of mental health services across Australia.

Recommendation 13:
It is recommended that the PC consider not just the investment in mental health, but how the funding arrangements are structured, both within and between the different levels of Government, to ensure the best outcomes for consumers.

Recommendation 14:
It is recommended that the PC develop a proposed methodology for better estimating the downstream economic and fiscal benefits of effective and early policy interventions and investment in the welfare system that address needs and circumstances of people with mental illness and their carers (including a flexible response to the episodic nature of mental illness) and the role of integrated supports and services in helping them pursue education and work.

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It is recommended that greater access to information on the mental health needs and service availability within regional communities is required for all services and system planners.

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It is recommended that governments work towards coordinated reporting of all mental health activity, to improve monitoring and reporting of the investment in mental health at all levels of government and in all sectors.

Recommendation 17:
It is recommended that the Commission's position within government is reviewed with a mind to strengthening the Commission's independence and the ability to monitor and report across all relevant portfolios.

Recommendation 18:
It is recommended that the scope for MADIP is increased to enable analysis across mental health, health and social support services, and access requirements are reviewed.

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