



Australian Government
Productivity Commission

Mental Health

Productivity Commission
Inquiry Report
Volume 1

No. 95, 30 June 2020

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ISSN 1447-1329 (print) | 1447-1337 (online)

ISBN 978-1-74037-699-0 (Set)

ISBN 978-1-74037-700-3 (Volume 1)

ISBN 978-1-74037-701-0 (Volume 2)

ISBN 978-1-74037-702-7 (Volume 3)



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An appropriate reference for this publication is:

Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra

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The Productivity Commission

The Productivity Commission is the Australian Government's independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians. Its role, expressed most simply, is to help governments make better policies, in the long term interest of the Australian community.

The Commission's independence is underpinned by an Act of Parliament. Its processes and outputs are open to public scrutiny and are driven by concern for the wellbeing of the community as a whole.

Further information on the Productivity Commission can be obtained from the Commission's website (www.pc.gov.au).



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30 June 2020

The Hon Josh Frydenberg MP
Treasurer
Parliament House
CANBERRA ACT 2600

Dear Treasurer

In accordance with section 11 of the *Productivity Commission Act 1998*, we have pleasure in submitting to you the Commission's final report into *Mental Health*.

Yours sincerely

A stylized, handwritten signature in black ink, consisting of a large 'S' and 'K'.

Stephen King
Presiding Commissioner

A handwritten signature in black ink, appearing to read 'Julie' followed by a stylized surname.

Julie Abramson
Commissioner

A handwritten signature in black ink, appearing to read 'Harvey' followed by a stylized surname.

Harvey Whiteford
Associate Commissioner

Terms of reference

Inquiry into the economic impacts of mental ill-health

I, Josh Frydenberg, Treasurer, pursuant to Parts 2 and 3 of the *Productivity Commission Act 1998*, hereby request that the Productivity Commission (the Commission) undertake an inquiry into the role of improving mental health to support economic participation and enhancing productivity and economic growth.

Background

In 2014-15, four million Australians reported having experienced a common mental disorder.

Mental health is a key driver of economic participation and productivity in Australia, and hence has the potential to impact incomes and living standards and social engagement and connectedness. Improved population mental health could also help to reduce costs to the economy over the long term.

Australian governments devote significant resources to promoting the best possible mental health and wellbeing outcomes. This includes the delivery of acute, recovery and rehabilitation health services, trauma informed care, preventative and early intervention programs, funding non-government organisations and privately delivered services, and providing income support, education, employment, housing and justice. It is important that policy settings are sustainable, efficient and effective in achieving their goals.

Employers, not-for-profit organisations and carers also play key roles in the mental health of Australians. Many businesses are developing initiatives to support and maintain positive mental health outcomes for their employees as well as helping employees with mental ill-health continue to participate in, or return to, work.

Scope

The Commission should consider the role of mental health in supporting economic participation, enhancing productivity and economic growth. It should make recommendations, as necessary, to improve population mental health, so as to realise economic and social participation and productivity benefits over the long term.

Without limiting related matters on which the Commission may report, the Commission should:

- examine the effect of supporting mental health on economic and social participation, productivity and the Australian economy;
- examine how sectors beyond health, including education, employment, social services, housing and justice, can contribute to improving mental health and economic participation and productivity;
- examine the effectiveness of current programs and initiatives across all jurisdictions to improve mental health, suicide prevention and participation, including by governments, employers and professional groups;
- assess whether the current investment in mental health is delivering value for money and the best outcomes for individuals, their families, society and the economy;
- draw on domestic and international policies and experience, where appropriate; and
- develop a framework to measure and report the outcomes of mental health policies and investment on participation, productivity and economic growth over the long term.

The Commission should have regard to recent and current reviews, including the 2014 Review of National Mental Health Programmes and Services undertaken by the National Mental Health Commission and the Commission's reviews into disability services and the National Disability Insurance Scheme.

Process

The Productivity Commission should undertake broad consultation, including with carers and consumers, and by holding hearings in regional Australia, inviting public submissions and releasing a draft report to the public.

The final report should be provided to the Government within 18 months.

The Hon Josh Frydenberg MP
Treasurer]

[Received 23 November 2018]

Disclosure of interests

The *Productivity Commission Act 1998* specifies that where Commissioners have or acquire interests, pecuniary or otherwise, that could conflict with the proper performance of their functions during an inquiry they must disclose the interests.

Professor King has advised the Commission that he is Adjunct Professor at Monash University. He is married to a Psychologist who is in private practice.

Ms Abramson has advised the Commission that she is a Council Member and Chair of the Regulatory Risk Committee of the Photography Studies College, a dual sector higher education provider.

Professor Whiteford has advised the Commission that he is a Fellow of the Royal Australian and New Zealand College of Psychiatrists and has served previously as the Director of Mental Health for the Queensland Government, the Director of Mental Health for the Australian Department of Health and as a National Mental Health Commissioner.

With his appointment at the University of Queensland, Professor Whiteford's research funding has included grants and contracts from the National Health and Medical Research Council and the Australian Department of Health. He has regularly provided clinical and technical advice on mental health service reform to the Australian Department of Health and to State Governments. His research team at the University of Queensland is currently contracted to undertake revisions of the National Mental Health Service Planning Framework on behalf of the Australian, State and Territory Governments.

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- I Benefits and costs of improved mental health**
- J Mental health, labour market outcomes and health-related quality of life**
- K Detailed assumptions about benefits and costs**

Acknowledgments

The Productivity Commission thanks the members of the community, and numerous organisations and government agencies who have provided data and other information for use in the inquiry. A number of service providers shared their time with us, and explained and walked us through the operations of their services, which considerably enhanced our understanding. We would particularly like to thank those people with lived experience who shared their stories with us — in individual meetings, in hearings and through submission and comments to this Inquiry. The insights provided by people who are or have lived with mental ill-health, and their families and carers, have been invaluable. We cannot express our appreciation strongly enough.

The commissioners express their strong and deep appreciation to the Inquiry Assistant Commissioner Rosalyn Bell and the Inquiry team who have undertaken one of the largest inquiries in the Productivity Commission's history. It involved extensive consultations across Australia, the most submissions ever received by the Commission, drafting of the report and preparing the underlying analysis.

Inquiry team and contributors

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Tracey Horsfall	Roger Hassan	

and 14 additional unnamed Commission staff who made significant contributions during the Inquiry.

Abbreviations

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and other drug
ATAPS	Access to Allied Psychological Services
CALD	Culturally and linguistically diverse
CAMHS	Child and Adolescent Mental Health Services
CAT	Crisis assessment and treatment
CBT	Cognitive behavioural therapy
COAG	Council of Australian Governments
COVID-19	Coronavirus Disease 2019
CPI	Consumer Price Index
DoH	Department of Health (Australian Government)
DSP	Disability Support Pension
DSS	Department of Social Services (Australian Government)
ED	Emergency Department
FTE	Full-time equivalent
GP	General Practitioner
GST	Goods and services tax
HILDA	Household, Income and Labour Dynamics in Australia
IPS	Individual Placement and Support
LGBTIQ	Lesbian, gay, bisexual, transgender, intersex and queer
LHN	Local Hospital Network
MBS	Medicare Benefits Schedule
NAPLAN	National Assessment Program – Literacy and Numeracy
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NGO	Non-government organisation
NICE	National Institute for Health and Care Excellence
NMHC	National Mental Health Commission
NMHSPF	National Mental Health Service Planning Framework

NSQHS	National Safety and Quality Health Service
OECD	Organisation for Economic Co-operation and Development
PBS	Pharmaceutical Benefits Scheme
PHN	Primary Health Network
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCA	Regional Commissioning Authority
SEIFA	Socio-Economic Indexes for Areas
WHS	Workplace Health and Safety

OVERVIEW

Key points

Australia's mental health: we would all benefit from an improved mental health system

- Mental ill-health affects all Australians either directly or indirectly. Almost one in five Australians has experienced mental illness in a given year. Many do not receive the treatment and support they need. As a result, too many people experience preventable physical and mental distress, disruptions in education and employment, relationship breakdown, stigma, and loss of life satisfaction and opportunities.
- Reform of the mental health system would produce large benefits. These are mainly improvements in people's quality of life — valued at up to \$18 billion annually. There would be an additional annual benefit of up to \$1.3 billion due to increased economic participation. About 90% of the benefits — about \$17 billion — could be achieved by adopting identified priority reforms, requiring expenditure of up to \$2.4 billion and generating savings of up to \$1.2 billion per year.

To create a person-centred mental health system, Australia needs reforms that ...

Focus on prevention and early help: early in life and early in illness.

- The mental health of children and families should be a priority, starting from help for new parents and continuing through a child's life. Schools should have a clearly defined role in supporting the social and emotional wellbeing of students, with effective pathways to care.
- Prevention and early intervention should continue through tertiary education and employment. Mentally healthy workplaces that focus on psychological safety as much as physical safety, and access to early treatment funded through workers compensation schemes, are part of our reforms.

Provide the right healthcare at the right time for those with mental illness.

- People should have real choices in managing their own mental health and be empowered to choose the treatment and supports that are right for them.
- Technology should play a larger role by improving assessment and referrals, and increasing access to, and the range of, treatments and supports. For people who choose face-to-face treatment and support, these should be affordable and in line with clinical evidence.
- The cycling of people in and out of hospital at great personal cost and cost to taxpayers, should be addressed. Emergency departments – or alternatives – should be adapted to work for those experiencing mental illness, and hospital discharges into homelessness should be avoided.

Make sure effective services support recovery in community.

- Community treatments and supports should be expanded for people who do not require hospital care but do require more care and support than provided by a GP. Seamless care between hospital and community services for people recovering from a suicide attempt should be a priority, as should reducing the life expectancy gap for people with severe mental and physical illness. And the consideration and involvement of families, kinship groups and carers, wherever possible, would be expected of providers to improve outcomes.
- Housing, employment services and services that help a person engage with and integrate back into the community, can be as, or more, important than healthcare in supporting a person's recovery. Clinical and community services should be coordinated to create a system of care that promotes recovery, with care coordinators to help people with complex needs.

Provide seamless care, regardless of the level of government providing the funding or service.

- The 'back office' to our mental healthcare system needs redesigning with local planning to meet local needs. Providers and governments should be held to account through the transparent monitoring, reporting and evaluation of what works, with meaningful input from those with lived experience of mental illness, and their carers.

Priority reforms



Prevention and early help for people

- Support the mental health of new parents
- Make the social and emotional development of school children a national priority
- National stigma reduction strategy
- Follow-up care for people after suicide attempts
- Empower Indigenous communities to prevent suicide



Improve people's experiences with mental healthcare

- Create a person-centred mental health system
 - Evidence-based mental health assessment and referral processes that help people find the services that are best for them
 - Identify, support and include families and carers as part of mental healthcare
- Get people the right services at the right time
 - Expand supported online treatment, group therapies and access to mental healthcare via telehealth
 - Review limits on psychological treatment funded through Medicare and trial variations
 - Alternatives to emergency departments that are designed for people with mental illness
 - Expand community-based mental healthcare, including hospital outpatient clinics and outreach services
- Improve mental healthcare outcomes
 - Address adverse outcomes from prescribing practices of mental health medication
 - Reduce the gap in life expectancy for people with severe mental illness and physical illness
- Care continuity and coordination



Improve people's experiences with services beyond the health system

- Meet demand for community support services that help people with mental illness recover and live well in the community
- Commit to no discharge from care into homelessness
- Increase assistance for police responding to mental illness related incidents
- Legal representation for people facing mental health tribunals



Equip workplaces to be mentally healthy

- Elevate importance of psychological health and safety in workplaces
- No liability clinical treatment for mental health related workers compensation claims
- Expand the individual placement and support program for people with mental illness



Instil incentives and accountability for improved outcomes

- Develop implementation plans for national strategies that integrate healthcare and other services
- Commit to regional planning, decision making and commissioning, with systemic cooperation and creation of new commissioning agencies if outcomes not improved
- Expand the remit and independence of the National Mental Health Commission
- Consumer and carer participation and advocacy in all aspects of the mental health system
- Strengthen evaluation culture, focusing on outcomes that matter to people and reporting at service provider level

A mental health system for our future

Mental ill-health affects all Australians, either directly or through our families, colleagues, friends and loved ones. It does not discriminate. But Australia's mental health system has not kept pace with our needs. This Inquiry report presents a series of recommendations to rectify this situation and set Australia on a path for sustainable, generational reform of its mental health system.

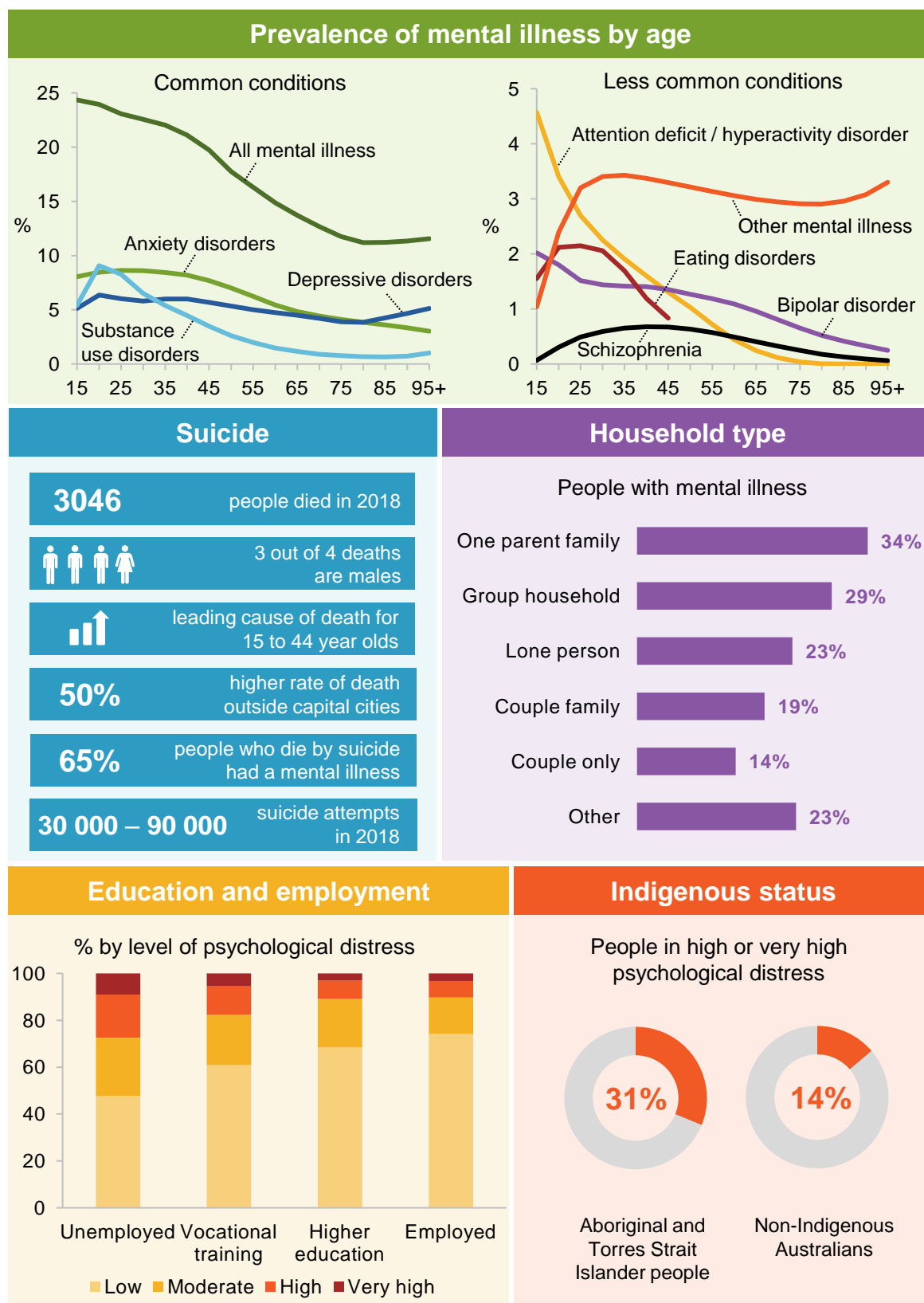
Some Australians are more likely to experience mental health problems, including young Australians, single parent families, the unemployed and Aboriginal and Torres Strait Islander people (figure 1). But anyone can be affected by mental ill-health. It can occur at any stage of life and some Australians will face the debilitating effects of mental illness across their lives. Australia's mental health system needs to support all people who require care, wherever they live in Australia, and whatever their age, cultural background or health condition.

Mental illness covers a wide range of conditions: anxiety disorders, depressive disorders, personality disorders, bipolar disorder, schizophrenia, to name just a few. The effects, severity, treatment and consequences of these conditions vary widely. Some people can have multiple conditions while others may need to access care without a specific diagnosis. And mental illness can go hand-in-hand with physical illness. Australians with severe mental illness on average die 10 to 15 years earlier, usually as a result of physical comorbidities. Australia's mental health system needs to focus on the individual and their life circumstances to address this diversity. It needs to be holistic and person-centred.

Multiple factors can adversely affect mental health including biological, environmental and social factors. Mental ill-health can be founded in trauma and stress, potentially from early childhood. It can originate in social conditions, such as the stress experienced by many Australians during the COVID-19 and 2019-20 bushfire crises. Some of these risks can be mitigated or will dissipate in time; with others, it is about dealing with the resulting stresses early to contain the impact on mental health. Australia's mental health system needs to focus on prevention and early intervention, whether early in life or in the progress of illness. And it needs to be flexible, to ramp up and down as individual and social needs and stresses change.

Mental illness can impact all aspects of our life: relationships, home life, schooling, work, and social interactions. To help people have lives that are meaningful to them and productive, Australia's mental health system needs to offer the right mix of community and clinical supports for people — noting that for some people, clinical treatment will not be part of their solution. Recovering from mental illness is about so much more than clinical care; it means rebuilding relationships, strengthening skills, finding and maintaining secure housing and employment.

Figure 1 **Who is mentally distressed and unwell**



Mental illness is stigmatised. Social views of mental illness have improved but still trail a long way behind our knowledge of how mental illness affects people's lives. This stigma creates barriers to individuals seeking care and can reduce the effectiveness of that care. Australia's mental health system (and the professions charged with assisting people) need to be stigma-free, empowering individuals who seek care.

Australia's current mental health system is not comprehensive and fails to provide the treatment and support that people who need it legitimately expect. The clinical care system has gaps, including, but not limited to, the so-called 'missing middle'. The recommendations in this report aim to fill these gaps. The system of community supports in Australia is ad hoc, with services starting and stopping with little regard to people's needs. Our recommendations aim to establish a comprehensive community support system that operates seamlessly and in balance with the clinical care system, based on consumer and carer input and local requirements.

Australia's mental health system does not focus on prevention and early intervention. Too many people are treated too late. Young Australians at risk and their families cannot easily access support. And those with developing mental health problems can face a bewildering array of unpredictable gateways to care: they know what services they need, but timely access is not possible. Our recommendations aim to refocus the mental health system, recognising the truth in the adage that 'prevention is better than cure'.

Australia's mental health system does not empower those who need it. People with mental illness often have little say in their own treatment and are deprived of the information and other resources that they need to manage and make decisions about their own care. Providers of clinical and community services too often deliver what they think consumers need, sometimes based on ill-informed assumptions about the decision-making capacity of the consumer and sometimes based just on the symptoms presented to them rather than a holistic view of the individual. Our recommendations aim to empower the service users, in partnership with their families and carers, to have real input into the health decisions that affect their lives. In part, this will require community-wide efforts to reduce the stigma that acts as a barrier to informed choice and deliberate steps to prioritise the recovery of people within their communities.

Put simply, Australia's mental health system is not 'person-centred'. It should be.

Reform direction: a person-centred mental health system

What we are aiming at

Our vision is for a person-centred mental health system with the following features.

- Information and supports that help people to live well within their communities, managing their own mental health where possible.

-
- A focus on prevention and early intervention — both early in life and in the development of a condition — to minimise the harm that mental illness can cause.
 - For those who need additional care, services that are accessible, affordable and timely, with their quality, cultural relevance, mode of delivery and effectiveness reflecting the consumer's values and what recovery means for the individual and their relationships with family and kinship groups.
 - Participation of the consumer's family or carer actively sought to add to the value and effectiveness of the clinical or support service.
 - Treatment and support that is seamless for people, regardless of the gateway by which they enter the mental health system. There would be no gaps in care over a person's lifespan or as their condition changes.
 - The outcomes for the consumer would be what matters for every clinical and support provider, and this would underpin the hiring and training of staff and the culture of service settings. The consumer — rather than the provider — would be the focus of service delivery.
 - Measurement and transparent reporting of all service outcomes, as perceived by the people using services, would be used to enhance ongoing improvement in both the effectiveness and efficiency of services, and to facilitate individual choices.

This vision of a person-centred mental health system is consistent with the National Mental Health Commission's *Vision 2030*. The components have been presented to us by the many people who contributed to this Inquiry. But implementing this vision will not be easy. It will take resources and time. Most importantly, it will require a change in culture and the way that Australian society views mental health. The recommendations in this report provide a long-term roadmap for this reform.

What gaps and barriers need to be addressed

The problems with Australia's mental health system extend beyond clinical mental healthcare to the interaction of mental healthcare with the physical healthcare system and with sectors beyond healthcare that are important for a person's recovery. In particular, reform of Australia's mental health system means addressing the key gaps and barriers that lead to poor outcomes for people, including the following.

- A narrow view of people seeking treatment and support — mental health services are often based on an incomplete picture of what people are seeking, failing to look beyond the symptoms being presented to work out what help an individual needs to recover and remain well in the longer term, and how to most effectively deliver that help.
- Under-investment in prevention and early intervention — the result is that too many people live with mental ill-health for too long.

-
- Disproportionate focus on clinical services — overlooking other determinants of, and contributors to, mental health, including the important role played by family, kinship groups and carers, and providers of social support services, in facilitating a person's functional recovery within their community.
 - Difficulties in finding and accessing suitable support — sometimes because the relevant and culturally capable services do not exist in the regions where the people who need them live, the services have a very long wait list or little information about their availability and outcomes, or services needed are not linked together to provide seamless care as people's conditions evolve and circumstances change.
 - Supports that are below best practice — in part due to a lack of measurement and evaluation of what works, and in part due to a culture of superiority that places clinicians and clinical interventions above other service providers, consumers and their families and carers.
 - Stigma and discrimination — in how people view themselves, and how people with mental illness and those who support them are viewed by the community and service providers.
 - Dysfunctional approaches to the funding of services and supports — leading to poor incentives for service providers, and increased costs to both the people seeking support and to taxpayers.
 - A lack of clarity across the tiers of government about roles, responsibilities and funding — leading to persistent wasteful overlaps, yawning gaps in service provision and limited accountability.

The report recommends reforms to address these gaps and barriers. The objective is a person-centred but flexible mental health system: one that can be 'ramped up and down' to meet changing community need, particularly in times of crisis. Reforms are extensive, comprising a mix of large-scale institutional changes, cultural changes and small but important adjustments to existing supports.

That said, this report is bounded. Broader issues of health and social services reform lie beyond the scope of this Inquiry — although some of these issues have been the subject of previous Productivity Commission work (such as the *Reforms to Human Services* and *Shifting the Dial* reports). And we do not and cannot make recommendations that would eliminate mental ill-health. There are a range of risk factors, such as those arising from deeply entrenched social, economic and environmental challenges, which lie beyond the scope of this Inquiry. While our recommendations would deliver a mental health system that is ready for the next major recession, pandemic, climate-change crisis or other shock to our community, we do not purport in this Inquiry to eliminate the risk of these and other social and environmental challenges.

What lack of progress on mental ill-health is costing us

The benefits for Australia of even modest reforms could be extensive. The number of people directly impacted by poor mental health is very large (figure 2). Almost half of all Australian adults have met the diagnostic criteria for a mental illness at some point in their lives, and almost one in five Australians have met the criteria in a given year. These numbers are likely to rise, at least in the short term, given the multiple crises faced by the Australian community in 2020. And while mental ill-health affects people of all ages, about three quarters of adults with mental illness first experience mental ill-health before the age of 25 years.

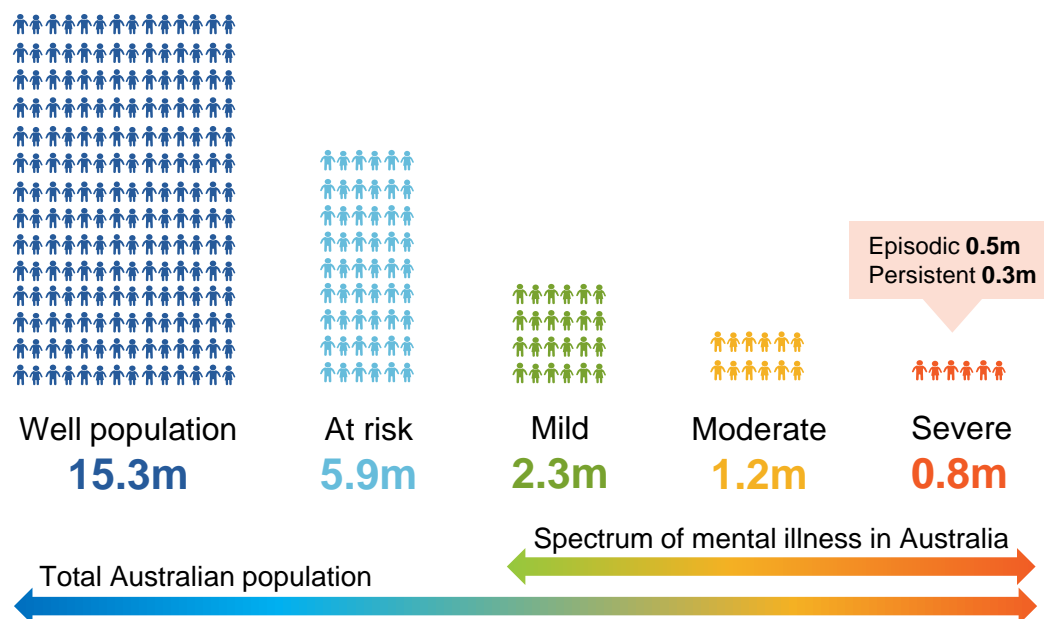
The vast majority of people manage their health themselves (such as through the support of family and friends, the use of online resources, social interactions and positive adjustments to their diet, exercise or sleep). For those who need help, the consequences of them either getting (or not getting) the help that is right for them, and as early as possible, are substantial. Care that enables people with mental ill-health to reach their potential in life, have purpose and meaning, and contribute to the lives of others, benefits both the individual and the wider community: it reduces preventable physical and mental distress; allows more rewarding relationships with family and friends; provides more opportunities for carers; scope for a greater contribution through volunteering and community groups; a more productive workforce; and an associated expansion in national income and improvement in living standards.

It is not necessary to quantify the cost of mental illness and suicide to understand the damage that they impose on the lives of individuals and the community as a whole. But quantifying these costs helps to identify where reform efforts should be focused.

The cost to the Australian economy of mental illness and suicide is estimated (conservatively, given data limitations) to be up to about \$70 billion per year. We currently spend at least \$0.5 billion per year on attempting to lessen the prevalence of mental ill-health and prevent suicide, and \$9.2 billion per year treating people who have nevertheless developed mental illness. These costs have been rising over time, with no clear indication that the mental health of the population has improved. Additional to this is a further (largely avoidable) cost of approximately \$150 billion per year associated with diminished health and reduced life expectancy for those living with mental illness (table 1).

These are large numbers. In total, mental illness, on a conservative basis, is costing Australia about \$200-220 billion per year. To put that in context, this is just over one-tenth of the size of Australia's entire economic production in 2019. The cost is between \$550 million and \$600 million *per day*. Not all of this cost is avoidable, but there is considerable scope for Australia to do better.

Figure 2 **Distribution of mental health among the Australian population**



These costs of mental illness and suicide are not just numbers, they are very personal — borne by those people with lived experience of poor mental health and of caring, and also by their families and friends, governments (through current and future taxpayers), employers, insurers, and the broader community. These costs include:

- the resources used for healthcare and other services and supports, as well as the time and effort spent by family members and friends in caring for and supporting people with mental illness
- the lost opportunities and lower living standards that arise when young people disengage from education and when those with mental illness and their carers have reduced hours of work, cannot work, or are less productive when at work
- the social and emotional costs of pain, suffering, exclusion and in some cases, premature death
- the loss to the community as a whole from not having the unique and valued contribution of a significant group of its people.

Table 1 Estimated costs of mental illness and suicide
2018-19

<i>Cost category</i>	<i>\$ billion per year</i>
Mental healthcare and related services	15.5
Government healthcare expenditure	9.7
diagnosis and treatment (Cth, State and Territory Governments)	9.2
research, strategy, promotion and prevention (Cth Government)	0.5
Related services & supports expenditure (Cth, State and Territory Governments)	4.1
housing, justice, employment services, NDIS	4.1
preschools, schools, tertiary education providers ^a	—
Individual out-of-pocket expenses	0.7
Insurer payments for healthcare	0.9
Informal care provided by family and friends	15.3
Loss of participation and productivity	12.2 – 39.1
Lower participation	12.2 – 22.5
Absenteeism	9.6
Presenteeism	7.0
Cost to economy (excluding the cost of diminished health and wellbeing)	42.9 – 69.8
Cost of disability and premature death (for those living with mental illness or self-inflicted injuries, and/or dying prematurely)	150.8
Mental illness	122.0
Suicide and self-inflicted injuries	28.8
Income support payments for those with mental illness and carers ^b	10.9

^a Government departments were unable to consistently provide separate estimates for mental health related expenditure in preschools, schools and tertiary institutions. ^b Income support payments are not included in the 'total cost to economy' because they are a transfer between different members of the community, rather than a cost to the community as a whole.

How reform should proceed

This Inquiry report presents a long-term reform agenda for a person-centred mental health system that is responsive and flexible. The recommended changes are substantial but would set Australia on a path for sustainable, generational reform of its mental health system.

The Productivity Commission's recommended reforms fall into five broad areas:

1. helping people to maintain their mental health and reduce their need for future clinical intervention, including by tackling early mental health problems and suicide risks
2. improving people's experience of the mental healthcare system to ensure the care received is person-centred, timely, consistent with treatment needs and does not impose undue burden on either the consumer or their carers

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3. improving the experience of people with mental illness and their carers beyond the healthcare system, recognising that there are numerous gateways in the community through which people enter the mental health system and a range of services beyond healthcare — in particular, psychosocial services, housing and justice — that are important for an individual's social and emotional wellbeing and recovery
 4. helping people to remain engaged in education and stable employment; reforms designed to support and enable Australians with mental health problems to reach their potential in life, have purpose and meaning to them, and contribute to the lives of others
 5. reforming the behind-the-scenes arrangements and incentives to ensure services for people in need are as seamless, connected and timely as possible.

Unsurprisingly, many of the reforms recommended in this Inquiry report have been proposed before. Some were not accepted due to inadequate evidence at the time. Others faced barriers to implementation.

This Inquiry addresses both of these issues. We consider evidence that has emerged, and we tackle the implementation barriers.

Reforms to create a person-centred mental health system are not without cost. However, substantial gains can be made by reprioritising and coordinating existing expenditure — in terms of services, location of supports and the timing of interventions. More efficient and effective use of current spending is possible in a number of areas, but there is also scope to change the trajectory of spending in some areas over time. Some reforms, such as those in early intervention and prevention, are investments paid for today that could be expected to reduce expenditure on more costly services in the future.

Nonetheless, we are starting from a position in which there are significant and costly gaps in services, so reforms to establish a flexible and accessible mental health system and reduce the ongoing costs to Australia of mental ill-health would require extra government expenditure. Additional taxpayer funding would require Governments to make choices and identify priorities, not just within the mental health system but across all areas of public expenditure — a dollar spent in mental health represents a dollar not spent on another, potentially equally important, area of need.

An important part of this Inquiry is for the Productivity Commission to provide an implementable roadmap to reform. This includes ranking reforms — what should be done first and, when trade-offs are needed, what reforms are more fundamental. To facilitate this, we have identified priorities in each area of reform based on the following criteria:

- *Potential to improve lives at either the individual or community level* — Some reforms can be expected to significantly improve the quality of life for a small number of people (such as follow-up care after suicide attempts). Other reforms can be expected to improve the quality of life in a small way but for a large portion of the community (such as access to online services). We estimated the extent to which each reform area is likely to lead to improved health-related quality of life.

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- *Benefits to the economy and expenditure required to achieve these* — The economic benefits that have been estimated are the increase in labour force participation for consumers and carers benefiting from each reform area, and the higher wages possible through increased productivity of those people who are working. Additional benefits to the economy that were *not* measured reflect a reduced need by people for costly services in the longer term, including a reduction in people's out-of-pocket costs associated with using services, a reduction in insurer payments for healthcare, and a reduction in informal care provided by family and friends. Estimated expenditure to implement reforms is confined to government outlays.
 - *Ease of implementation* — Reforms that involve the redeployment of existing resources, involve comparatively little disruption to other parts of the community, and require changes by just one government or government agency, were considered easier to implement than reforms requiring the significant redirection of resources from other programs, or the cooperation of multiple agencies.
 - *Sequencing* — Many reforms would need to be implemented in stages with the feasibility of some measures dependent on the success of earlier actions. Some reforms require trials to first generate a sound evidence base on how implementation could be cost-effectively achieved to deliver the desired benefits, before they can be implemented on a national scale. Others may first require negotiation and agreement between multiple governments, or additions to the skilled workforce to deliver relevant services. For example, improving the way the education system supports the wellbeing of students would involve training the relevant workforce and developing evaluation processes for schools.

With many of the prioritised reforms, there should be an understanding that the expected benefits, while potentially substantial and widespread, may not be evident for many years into the future. For example, reforms such as improving the social and emotional wellbeing of young Australians could provide substantial benefits in quality of life and income opportunities, but these benefits would be realised over the longer term. Furthermore, major changes, such as many of those presented in this Inquiry report, require continuous feedback and learning, to make sure that the reforms are working to improve the lives of Australians.

A number of recommended reforms are not priorities but would nevertheless significantly improve mental health outcomes. Implementation of these should be planned, taking into account any necessary underpinning reforms and resources available after priority reforms have been adopted.

How much could reform benefit Australia?

The benefits of key recommended reforms have been estimated in terms of people's additional capacity to work and earn higher wages, and in terms of their improved health-related quality of life. However, some benefits could not be readily quantified, such as the benefits of improvements to system governance, the use of trials to improve the evidence base for later interventions, the benefits of reforms for those people interacting with the justice system, the flow-on benefits for an individual's family of providing secure housing, or the broader community benefits associated with improved mental health.

In this sense, the benefit estimates presented in this report should be viewed as *lower bounds* on what could be achieved. When only some benefits can be measured, there is potential for bias. What gets measured, gets done — even if the real but unquantifiable benefits from other reforms are greater. To avoid this bias, when determining the relative priority of reforms, we supplemented the quantified benefit estimates with evidence received by the Inquiry on the qualitative benefits of reforms (such as improvements in how individuals would be able to live their lives).

The economic benefits of the recommended reforms to Australia's mental health system were estimated to be up to \$1.3 billion per year as a result of the increased economic participation of people with mental ill-health. About 85% of these economic benefits (\$1.1 billion) could be achieved from the identified priority reforms alone. Achieving the benefits associated with the priority reforms would necessitate additional expenditure in the order of \$1.9–\$2.4 billion per year, but is also likely to result in annual savings (primarily reduced government expenditure) of between \$0.9–\$1.2 billion per year.

Not surprisingly, additional benefits to the economy are estimated to be small. This reflects two aspects. First, the analysis does not quantify the longer term social investment benefits of reforms — that improving an individual's mental health early in their life can have life-long benefits for both that individual and those they interact with, while at the same time potentially reducing their lifetime demand for Australia's healthcare services (both physical and mental healthcare). Second, there is no disguising the extent to which some of the recommended reforms are about addressing deep-seated cultural and societal problems — including cultural inequities, stigma, homelessness — that have benefits which cannot be readily quantified.

Indeed, the main benefits of this Inquiry's recommended reforms would be a substantial increase in the quality of life for a large number of Australians. These gains were estimated to be the equivalent of up to \$18 billion per year (an improvement of 84 000 quality-adjusted life years), were the full list of recommended reforms implemented. Ultimately though, the benefits of reform extend to all Australians: those who are currently receiving or require treatment and support for their mental health; their carers, families and colleagues; and those who are well now but may one day seek help for themselves or someone they know. You do not have to be unwell now to benefit from improvements to Australia's mental health system.

While there are substantial reforms within the healthcare system that would offer net benefits to the Australian economy and increase the quality of people's lives, the most significant increases in net benefits and quality of lives are estimated to be possible in sectors beyond health.

Some reform benefits could be achieved relatively quickly by redirecting existing resources and/or achieve a net saving in expenditure. Reforms in these areas that should be considered priorities for action include:

- assess the treatment and support needs and then plan for service provision in every region of Australia, as necessary first steps in improving the availability and distribution of services for people, and reducing current inefficiencies in the way resources are directed

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- add rigour to individual mental health assessment and referral processes to enable people to make informed choices on evidence-based treatment options
 - expand access to telehealth (videoconference or telephone) treatment with psychologists and psychiatrists to enhance accessibility and convenience benefits to consumers and potentially reduce healthcare expenditure
 - provide follow-up support for people after a suicide attempt, with immediate benefits in saving lives, improving quality of lives and reducing ongoing health costs.

Beyond these clearly beneficial reforms that could be implemented relatively quickly, a tradeoff between gains in economic net benefits and improved quality of life for people, would likely be required. For some reforms, benefits may be immediate; for others, there should be an expectation that they would likely take time to implement on a scale that would be fully effective.

A number of the Productivity Commission's priority reforms warrant government attention on the basis of the estimated improvement likely in the quality of life for people (figure 3). These particularly include reforms to:

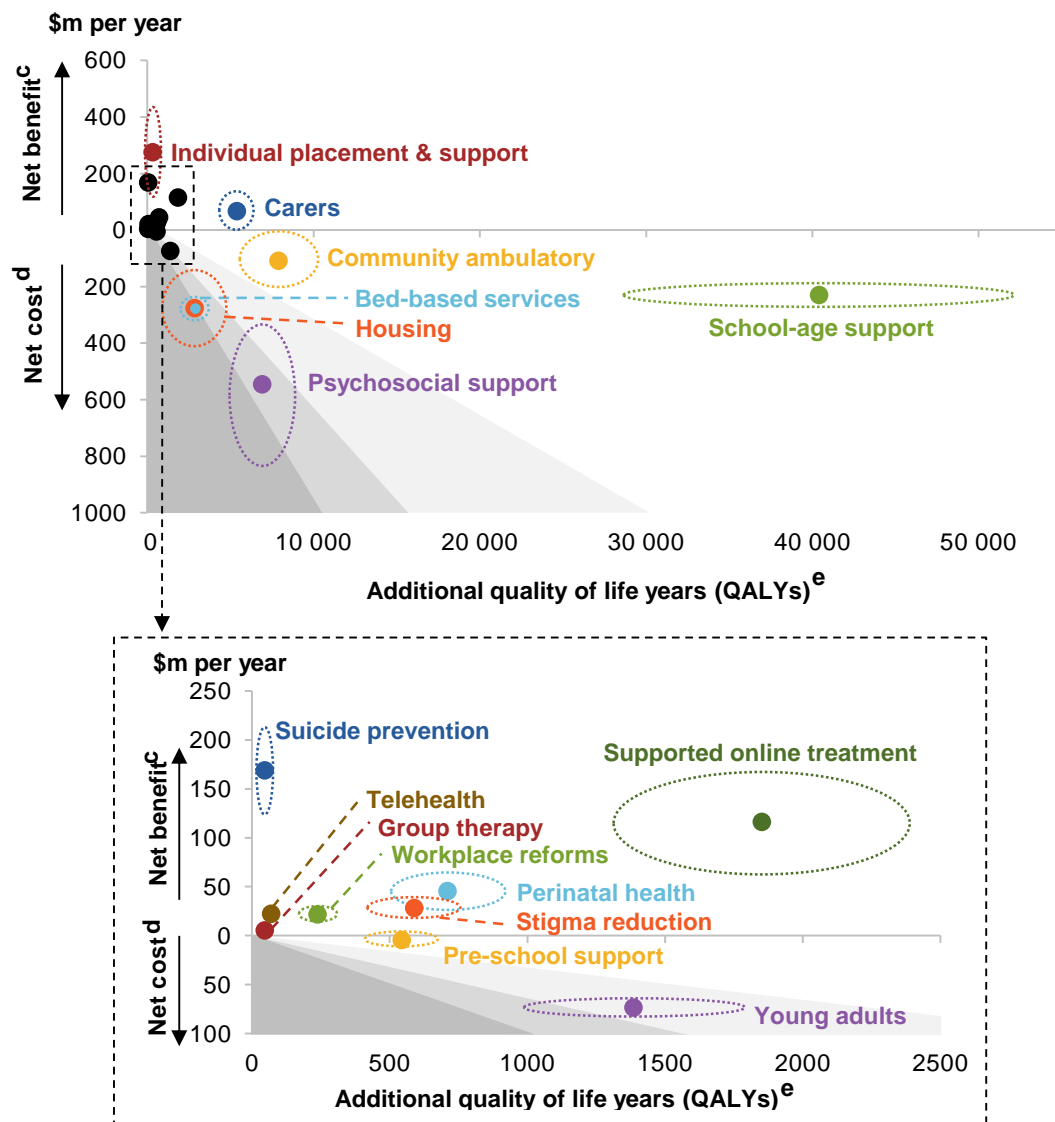
- help schools support the social and emotional wellbeing and mental health of their students
- augment community ambulatory services
- meet gaps in demand for psychosocial supports
- adopt family and carer inclusive practices.

In the case of some interventions — such as those to improve the social and emotional wellbeing of families with young children — it is anticipated that the benefits would initially be evident in family workforce participation and school engagement, but persist for some years beyond the intervention, improving connections with community, outcomes from education and work, and ongoing mental health. Reforms to psychosocial support arrangements are estimated to significantly improve the quality of life for recipients, but come at a net cost to the economy.

Reforms likely to provide significant economic benefits that should be prioritised for prompt implementation include:

- expand individual placement and support for people with mental illness entering the workforce
- require provision of no-liability early treatment for people with mental health related workers compensation claims
- expand supported online treatment
- support new parents in the perinatal period
- instigate a national campaign for stigma reduction

Figure 3 Recommended reform areas^{a,b}



^a Chart shows only those reforms that were able to be quantified. Dotted orbits represent uncertainty in estimates for each reform, showing the range of simulated estimates between the 5th and 95th percentiles for changes in costs and quality-adjusted life years (QALYs). ^b Shaded areas show thresholds of cost effectiveness — darker shading indicates lower cost effectiveness (appendix I). Reforms that sit above zero are cost saving. Reforms that sit below zero and outside the shaded areas cost less than \$33 000 per QALY gained. Reforms that sit in the lightest shaded area cost \$33 000–\$64 000 per QALY gained. Reforms that sit in the medium shaded area cost \$64 000–\$96 000 per QALY gained and are considered marginally cost effective. Reforms that sit in the darkest shaded area cost more than \$96 000 per QALY gained and are considered not cost effective. ^c 'Net benefit' is the estimated cost savings and additional employment income generated by the reform that exceeds the estimated cost of implementing the reform (every dollar spent will generate a benefit of more than one dollar). ^d 'Net cost' means the estimated cost of implementing the reform is larger than the estimated cost savings and additional employment income generated by the reform (every dollar spent will generate a benefit of less than one dollar). ^e QALYs measure the improvement in health experienced by reductions in the duration and severity of illness.

A number of individual reforms, highlighted throughout this report, were considered very likely to provide significant net benefits (and therefore should be considered seriously as reform options), but quantification of individual estimates was not feasible. Legal representation for people detained and receiving mental health treatment involuntarily is one such example. Similarly, we acknowledge that there would be regional variations in the net benefits of some reforms (such as housing support) and differences between States and Territories in the extent to which some recommended reforms have already been implemented (such as in support for police responding to incidents involving people who have mental illness). While we were unable to take such regional variations into account in assessing the net benefits of reforms at a national level, it could be expected that with more detailed knowledge of regional needs and service gaps, the States and Territories would be able to do so.

Some of the relevant reforms would not be easy or quick to implement, requiring negotiation between multiple government agencies and/or an up-skilling of the relevant workforce and changes in deep-seated workplace and community cultures. However, the Productivity Commission considers that these limitations should not deter policy makers from pursuing highly beneficial reforms.

1. Prevention and early help for people



PRIORITY REFORMS

- Support the mental health of new parents
- Make the social and emotional development of school children a national priority
- National stigma reduction strategy
- Follow-up care for people after suicide attempts
- Empower Indigenous communities to prevent suicide

Early intervention — either early in life or early after the detection of risk factors that may lead to mental illness — is important to prevent the onset of illness or curtail a deterioration in mental health. However, up to one million people with mental illness have never accessed mental health services nor seen their GP about their condition. This may not be a significant problem for some people with mild mental illness, which can dissipate as the individual's risk factors subside. But for others, untreated mental illness may percolate throughout their life, reducing the wellbeing and standard of living of the affected individuals and often those around them.

Interventions early in people's conditions are discussed in the context of the key gateway at which they present to the mental health system — be it health, housing, justice, further education, workplaces, or some other community facility. This section focuses on the issues and priority reforms regarding: prevention of mental illness; early identification of risks in, and help for, young children and families; cultural and social barriers to improving wellbeing; and suicide prevention.

Prevention

The aims of prevention are to reduce the incidence of mental illness and the recurrence in those who have previously experienced mental illness. These aims can be achieved by reducing exposure to risk factors, assisting individuals to strengthen resilience and coping skills, and providing supports that mitigate the effects of economic, social or environmental stresses. There is increasing evidence to support the effectiveness of some programs that promote mental wellbeing and prevent mental illness. Such programs can target a whole population, people within a population who are at increased risk, or people showing early signs of mental ill-health. In the latter case, prevention can delay the onset of severe mental illness or help an individual toward a less debilitating outcome.

Early identification of risks and help for families and children

Early identification of risks to children offers the greatest potential for improving health, social and economic outcomes. Supporting the social and emotional wellbeing of young Australians and helping them to thrive is expected to set them up to better cope with future risks to their mental health, and lead to improved long-term academic outcomes (figure 4) and post-school opportunities.

There are many opportunities to support children and their families from a very young age, but priority reforms for governments should be: (i) screening and support for new parents; and (ii) in all schools, the creation of clear dedicated strategies, including leadership and accountability structures, to deliver wellbeing outcomes for their students.

Support the mental health and wellbeing of new parents

The mental health of parents has a strong influence on the wellbeing of infants and young children, including their emotional, social, physical and cognitive development. This suggests a strong case for supporting parents, particularly at times of major life transitions, such as in the perinatal period (pregnancy and the weeks following birth). About one in ten women experience depression during pregnancy, and one in seven women in the year following the birth. One in five women experience anxiety in the perinatal period, and one in ten new fathers or partners experience perinatal depression and/or anxiety.

Governments should, as a **priority reform**, put in place strategies to reach universal screening for mental ill-health of new parents. This may include use of existing maternal and child health services, online screening and outreach services. The frequent interactions of families with healthcare providers in the perinatal period afford a valuable opportunity to improve detection of mental ill-health and offer early intervention — indeed, the potential to improve people's lives from an early age and the relative ease of implementation of this measure contribute to it being a priority reform.

Support social and emotional wellbeing for school age children

Identification of children at risk (either because of their own ill-health or that of a family member) is simply a starting point. Schools need to be effective gateways for students and their families to access help.

All schools should have dedicated clear strategies, including leadership and accountability structures, to deliver wellbeing outcomes for their students, in the context of the student's family life and school environment. As with interventions for new parents, this **priority reform** has strong potential to improve the quality of lives for children from an early age. It is also an important early step in a sequence of recommended reform options for helping schools to support their students' social and emotional wellbeing.

Many schools have wellbeing policies and dedicated staff, and governments have developed numerous frameworks and policies. Schools are already funded to provide social and emotional wellbeing programs. However, they face a confusing and disjointed proliferation of poorly evaluated programs and services, along with a multitude of uncoordinated government interventions. There is no clear policy framework that defines the role that teachers, principals and the education system more broadly are expected to play in supporting mental health and wellbeing, and what outcomes they are expected to achieve.

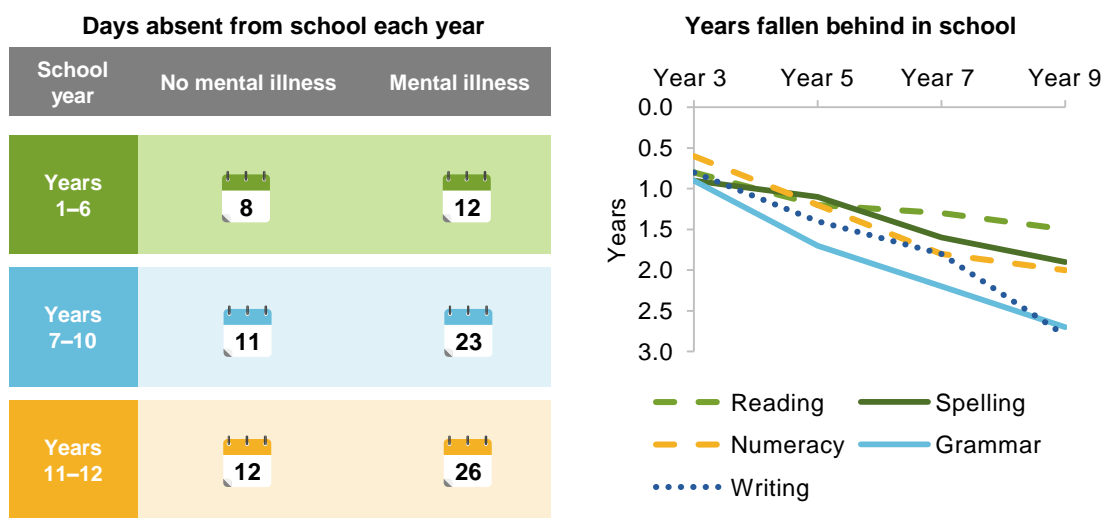
The National School Reform Agreement, which sets out governments' expectations for the education system, funding structures, and reporting requirements, should be updated to include student wellbeing as one of its outcomes. This would place wellbeing on an even footing with academic progress and student engagement as an important goal that schools across all sectors of the education system must work towards, and report on their progress.

Designating student wellbeing as one of the outcomes of the National School Reform Agreement would require all jurisdictions to monitor and evaluate the progress that schools make towards improving wellbeing. This is a complex, multi-faceted goal, and as such would require not only the collection of data, but also extensive evaluation of the policies and processes that schools put in place to support their students. These processes should include clear leadership and accountability structures, such as having a dedicated wellbeing leader or team responsible for whole-of-school strategies, supporting individual students and their families, and building links with services in the local community.

While most teachers are well able to identify behaviour that is atypical, we were advised that many teachers find that their training has generally not equipped them to either identify mental health risks or respond effectively. The initial training of early childhood educators and of teachers should include more explicit instruction in child and adolescent social and emotional development with practical tools to support students. Training on social and emotional development should also form part of teacher professional development requirements and is a necessary step to enable success of the priority reform to support student social and emotional wellbeing.

Nationally consistent wellbeing measurement should be rolled out across all schools, with principals accountable for annual reporting on outcomes and improvement over time. Data collected should contribute to an evidence base for future interventions. It is expected that dedicated additional funding through a flexible funding pool in the order of \$150 million per year nationally would be needed to deliver these improvements in wellbeing programs delivered for Australia’s school children.

Figure 4 **Children with mental illness fall behind in school**



Other reform options to improve mental health from early in life

Beyond these priority reforms, there are a number of other reform options in Australia’s education and health systems that the Productivity Commission considers would offer significant benefits for the mental health of young people.

Up to one in five children starting school have high levels of emotional problems, which are likely to get worse as they get older and make it harder for them to learn. Early identification of emerging emotional problems in the preschool years offers an opportunity to help children start school ready to learn, and avoids an escalation of issues that families must cope with in years to come. The expansion of the existing optional physical development checks of Australia’s 1.25 million 0 to 3 year olds in community health services to incorporate social and emotional wellbeing aspects of development would enable necessary assistance to be made available to both the child and parents/carers.

Some children face a much higher risk of mental ill-health from a very young age. Children who are exposed to trauma (that either affects them directly or their family), those who are affected by entrenched disadvantage in their communities and children in the out-of-home care system face substantial risks to their mental health — but at the same time, they are also far less likely to have access to care and support, compared with other children in the population. Children affected by mental illness fall behind in their educational achievement (figure 4); they are more likely to disengage from school and may face substantial barriers to go back to school, and later on, enter the workforce or go on to higher education.

Timely access for students with mental illness (and indeed, all students) to educational adjustments in schools would be a relatively low-cost way to improve engagement with education, and in turn, improve a child's future outcomes. In addition to supports within their school, children should be linked into mental health treatment and support services in the local community (provided the complementary reforms are acted on to fill gaps in child and adolescent mental health services in communities). Continued engagement in education of those children with mental illness would require a partnership between schools and local mental health services. In addition, Departments of Education should put in place clear policies for outreach services to proactively engage with students and families referred to them, once a student's attendance declines below a determined level, and monitor their implementation.

Cultural and societal barriers to improving mental health and wellbeing

Some cultural and societal influences, such as stigma toward mental illness, exacerbate the cost of mental ill-health. They contribute to a reluctance for people to seek help (particularly in some cultural groups and in smaller communities where it is difficult to receive care without others becoming aware of this), alter the types of help people seek and the symptoms they experience, delay diagnosis, compromise adherence to treatment, and reduce the availability of social supports to both the consumer and their family and carer.

Most people with mental illness report experiencing stigma, although the degree, nature and experience of stigma and consequent discrimination varies with the type of mental illness, and with the person's age, gender and culture. People with mental ill-health can also experience self-stigma. For example, in the workplace, an individual with mental ill-health may feel that they are 'letting down their colleagues'. Reducing stigma (both self-stigma and that of the community) about mental illness can relieve some of this pressure by making it more acceptable for people to seek help.

Address stigma, cultural and social barriers

Effective stigma reduction requires an ongoing commitment over a long time period in order to ensure that reductions in stigma persist. As a **priority reform** to address stigma toward mental illness, the National Mental Health Commission (NMHC) should develop and drive the implementation of a renewed national long-term stigma reduction strategy that: targets stigma reduction messages for different audiences (such as health

professionals); focuses on the experiences of people with those mental illnesses that are poorly understood by the community; addresses different aspects of stigma including perceptions of danger and unpredictability; and identifies and draws on a small number of national ambassadors for mental health.

Additional reform options to address cultural and social barriers

Given the cultural diversity within Australia, the training of all clinicians should include measures that instil an understanding of how people's cultural background affects the way they describe their mental health and their compliance with treatment options. This, and more, should be done for the mental healthcare of Aboriginal and Torres Strait Islander people. Best practices should be evaluated for partnerships between mainstream mental health services and traditional healers — who protect and heal the physical, emotional and social wellbeing of individuals and communities — to support Aboriginal and Torres Strait Islander people with mental illness and facilitate their recovery in their community.

Suicide prevention

The facts on suicide in Australia are stark. Just over 3000 people are lost to suicide each year in Australia, an average of more than 8 people per day. It has been the leading cause of premature death in Australia's young adults, accounting for around one-third of deaths among people aged 15-24. Suicide rates of Aboriginal and Torres Strait Islander people are more than double that of other Australians, with young males and those in regional communities particularly at risk. And there has been no significant and sustained reduction in the death rate from suicide over the past decade, despite ongoing efforts to make suicide prevention more effective. For every death by suicide, hospital records show there are as many as 30 attempts of suicide. However, ambulance data suggests this could be much higher, as not everyone who intentionally self-harms is admitted to hospital. The debilitating effects of non-fatal suicidal behaviour on the subsequent quality of life for those who experience long term harm, and their families, can be substantial.

Only a very small proportion of those with mental illness self-harm or have suicidal thoughts; two thirds of people who die by suicide had a reported mental illness. However, 15-25% of people who attempt suicide will re-attempt, with the risk being significantly higher during the first three months following discharge from hospital after an attempt. Half of those discharged from hospital after a suicide attempt do not attend follow-up treatment and the responsibility of services and accountability for follow-up is unclear and inconsistent.

Follow-up care for people who attempt suicide

Adequate aftercare could reduce the number of people who are in hospital emergency departments, having attempted suicide, by about 20%, and all suicide deaths by 1%. This is equivalent to preventing 35 people per year from dying by suicide, and a further 6100 people

per year from attempting suicide that results in some level of incapacity for them. It is estimated that effective aftercare could conservatively provide a long-term return on investment of \$2.37 to \$6.90 for every dollar spent, depending on the extent of aftercare provided and the income earned by people whose suicide or suicide attempt was prevented. As a return on investment, this exceeds (and in some cases, far exceeds) the return from investing in a range of high priority projects currently identified by Infrastructure Australia, some of which are estimated to deliver a return of less than \$2 for every dollar spent.

A program to provide access to timely, effective aftercare for every person who presents to a hospital, GP or community mental health service following a suicide attempt or in suicide distress should be provided, as a **priority** intervention by governments. Aftercare should include support prior to discharge or leaving the service, as well as immediate and sustained follow-up support. The priority of this reform reflects its significant potential to save and improve lives. But we have assessed that the reform is also likely to reduce medical, administrative and other costs of suicide attempts that would exceed the cost of providing aftercare, and it could be incorporated into existing care with relative ease.

For Aboriginal and Torres Strait Islander people, suicide attempt aftercare and other suicide prevention activity should, as a **priority**, have Indigenous-controlled organisations as the preferred providers, to increase the likelihood that program provision is sensitive to the experiences, culture and specific social issues faced within particular communities. Stronger connection of individuals with their culture and control over services have reduced suicide risk and improved social and emotional wellbeing in some communities.

Additional reform options to support suicide prevention

A range of suicide prevention trials are underway in different parts of Australia, and due to be evaluated over the next few years. A key aspect of these trials is that they reflect the needs of local communities in a coordinated approach to preventing suicide. The features of these programs that are evaluated as effective should be determined and published, to enable other localities across Australia to similarly adopt effective suicide prevention measures.

Beyond the short term, the linkage of data on agreed risk factors for suicidal behaviour could be useful in preventing some suicides. While privacy needs to be respected, as does an individual's control over their data, this should not be used as an excuse to limit the sharing of data that would preserve someone's life.

2. Improve people's experiences with mental healthcare



PRIORITY REFORMS

- Create a person-centred mental health system
 - Evidence-based mental health assessment and referral processes that help people find the services that are best for them
 - Identify, support and include families and carers as part of mental healthcare
- Get people the right services at the right time
 - Expand supported online treatment, group therapies and access to mental healthcare via telehealth
 - Review limits on psychological treatment funded through Medicare and trial variations
 - Alternatives to emergency departments that are designed for people with mental illness
 - Expand community-based mental healthcare, including hospital outpatient clinics and outreach services
- Improve mental healthcare outcomes
 - Address adverse outcomes from prescribing practices of mental health medication
 - Reduce the gap in life expectancy for people with severe mental illness and physical illness
- Care continuity and coordination

Implementing person-centred care consistently across the mental health system would be a significant cultural shift. This shift would require structural changes to aspects of the mental health system, workforce training, a more holistic approach to families and carers and an increased focus on monitoring and improving outcomes for people.

In developing recommended reforms to improve mental health, the Productivity Commission has recognised that the right care for an individual can involve a mix of healthcare services, but also supports from sectors beyond the health system (figure 5). There are a host of non-healthcare measures and supports that can be just as (or more) important as healthcare in facilitating a person's mental wellbeing and recovery — including, for example, psychosocial support services, housing services and supports in workplaces.

In reforming the mental health system to be person-centred, we are primarily interested in ensuring people are able to access services and supports in ways that are right for them, when they need them and at prices they can afford. Just as the intensity of clinical care should change with an individual's clinical needs (as in a stepped care model), so too should the intensity of other services adapt as an individual's needs vary.

This section focuses on the issues and priority reforms in healthcare: making entry into care person-centred; getting people the services that are right for them; improving outcomes for people; and enabling care continuity and coordination.

Figure 5 **A care mix that adapts to people's needs**

		Community support needs		
		Complex	Moderate	Low
Mental healthcare needs	Complex care Inpatient services; larger care team	Specialised psychosocial supports* (e.g. daily task support, care coordination, Individual Placement and Support, and Housing First)	Psychosocial supports* by dedicated government programs (e.g. Disability Employment Services and supported housing)	
	High intensity care Psychiatric care; single care plan and care team			
	Moderate intensity care GP and MBS-rebated psychological treatment	– <i>within scope of this inquiry</i>	– <i>within scope of this inquiry</i>	
	Low intensity care Clinician-supported online treatment; group therapy	Higher intensity community supports from mainstream government services (e.g. public housing)	Moderate intensity community supports from mainstream government services (e.g. jobactive)	Low intensity community supports from mainstream government services (e.g. Centrelink)
	Self-management (Of symptoms) self help information and resources			
	Preventative care (No symptoms) e.g. through education and employment	– <i>outside scope of this inquiry</i>	– <i>outside scope of this inquiry</i>	– <i>outside scope of this inquiry</i>

* Psychosocial support addresses a person's emotional, social, mental and spiritual needs. Supports include a range of services to help people manage daily activities, rebuild and maintain connections, build social skills and participate in education and employment.

Make entry into the health system person-centred

When people recognise they are becoming mentally unwell, there are three main *health* gateways through which they typically seek help — online resources, community health services (such as GPs) and hospital emergency departments. Some important features of gateways into healthcare are that they should be readily accessible to people as and when they need help, be affordable, culturally capable, and connect to services that individuals value. Priority reforms for Governments to make entry into the health system person-centred are: (i) improved mental health assessment and referral processes; and (ii) provision of alternatives to hospital emergency departments for people experiencing a mental health crisis, particularly outside standard hours.

Resources for people who can help themselves

The first port of call for many Australians are online resources. The recent bushfire disaster in many communities and the COVID-19 pandemic have seen sharp spikes in people seeking online information about managing stress and anxiety. Many Australians experiencing psychological stress or mild mental illness are able to manage their mental health without formal clinical intervention and without significant impact on their relationships or engagement in activities. What is needed to allow this is access to relevant information and the capacity to act on that information (such as by adjusting sleep patterns or diet, exercising, or learning stress management techniques).

There is much information already freely available. But directing people to information that is evidence-based and effective would be improved through: an expansion of online portals to include more information on e-health; telehealth and group therapy services, and mental health pathways in local communities; as well as information on how specific aspects of mental ill-health can impact people's functionality and ability to participate in education, work and the community.

Improve the gateways into healthcare for people

For people who prefer face-to-face assistance, the most common gateway used to access mental healthcare is via a community mainstream health service — a GP clinic, Aboriginal Medical Service, or a primary health network (PHN)-commissioned service (such as a headspace centre).

As an entry point to healthcare, people rightly expect clinicians to either have the professional competency and cultural capability to assess and treat them, or be able to refer them to someone who can.

Yet there can be significant delays in getting a GP appointment in some (urban and regional) areas, attending appointments can be very expensive and time consuming (sitting in waiting rooms), and not everyone experiences their GP as a useful, accessible or culturally capable person with whom to discuss their mental health. The way most GPs are subsidised creates a financial incentive for them to limit their discussion time with each person, and not all GPs are competent in relating to the variety of cultural backgrounds of people who may need their help. Furthermore, while many GPs do an excellent job, some lack knowledge and skills in mental health, and rely too readily on medication as a treatment option. More competency is required in: identifying risks, diagnosing conditions, assessing and recognising the physical health consequences of prescribed treatments, and connecting people with other services (including online mental health services, allied health services and non-clinical services such as counsellors).

Create a new person-centred pathway to care

Providing people with information on potential mental healthcare options so that when they reach a clinician they are an informed consumer, is a key part of creating a person-centred mental healthcare system. To provide people with more information on care options that might be suitable to their needs, empower them to seek and directly access help that is most suitable to their circumstances — and assist GPs in referring people to supports that are suitable — the Productivity Commission recommends establishment of a ‘national digital mental health platform’. As a **priority reform**, creation of the platform should occur as soon as possible, as it underpins other reforms directed at helping people get services that are right for them.

The principal focus of the platform would be on ensuring that the multiple gateways by which people seek mental healthcare all enable people to access services and supports that are accessible, effective and affordable and match their needs and circumstances.

A core component of the platform would be a tool for a common approach to assessment and referral, consistent with the Department of Health’s guidance on Initial Assessment and Referral. This tool should be accessible at no charge to both individuals and clinicians (regardless of whether they are in urban or regional parts of Australia), would enable clinician-supported assessments and online treatment, and make clinician-endorsed recommendations for referral to culturally relevant online or face-to-face psychological and psychosocial services within the individual’s local region. The assessment and referral tool would replace mental health treatment plans as a requirement for accessing MBS-rebated psychological therapy, and offer clear and structured guidance to referring clinicians and consumers on the types of services likely to best meet the individual’s needs and preferences.

The platform would also include some low-cost, accessible and evidence-based low-intensity digital services (discussed further below) and provide an entry point to other clinical treatment and non-clinical support services, delivered digitally or face-to-face.

Giving substance to these components, the platform would, in time, connect to a new online navigation portal in each region that would detail specific services that are of relevance to particular mental health needs. These regional navigation portals should be accessible to clinicians and other providers in the health system, and to those who facilitate entry of consumers to the mental health system via non-health pathways — such as schools, aged care facilities, Indigenous service providers and correctional facilities. The portals should act as centralised online and phone gateways, be able to identify services available and directly book consumers into a service. The HealthPathways portal model, which is already used by most PHNs, could be used as the basis for navigation portals.

GPs would remain a primary gateway to mental healthcare for people who have ready access to them locally and/or have physical as well as mental health concerns. While many people are likely to receive a prescription for medication if consulting a GP about a mental health problem, one in five people receive a referral, usually to a psychologist, or less commonly, to a psychiatrist. With mainstream community health services (including GPs) linked to the

new national digital mental health platform, people would be assured they are receiving an assessment that is rigorous and treatment recommendations that are evidence-based and match their needs.

Many of the components required to establish such a digital platform already exist — the next step would be making them easily accessible to all consumers and health services and promote community recognition of the platform as a gateway into mental health treatment and support services.

Provide pricing information to help people choose services

In addition to provision of information on services available, greater transparency in pricing information would help people choose between care options, where choices exist. While treatment effectiveness should be a key consideration in service choice, the reality is that for many people, any out-of-pocket cost (such as that incurred for a GP consultation, outpatient consultations with a psychiatrist, or a MBS-rebated psychological therapy session) can reduce their compliance with a recommended course of treatment.

The Australian Government should include on the Medical Costs Finder website the fees and areas of specialty of all individual psychiatrists, paediatricians and allied health providers for MBS-rebated therapy.

Improve the ED experience and provide alternatives

People experiencing a severe episode of mental illness often (re)enter mental healthcare via a hospital emergency department (ED). The rate of mental health presentations at EDs has risen by about 70% over the past 15 years, in part due to the lack of community-based alternatives to ED, particularly in the evenings and on weekends.

Compared to people with other health conditions presenting at an ED, people with mental illness are:

- nearly twice as likely to arrive by ambulance
- ten times more likely to arrive by police or correctional services vehicles
- twice as likely to be in ED for more than 8 hours
- overrepresented among those kept waiting in ED for an inpatient bed
- even more overrepresented among those delayed in leaving ED due to an inpatient bed not being available.

While reforms are underway at some hospitals, the typical ED experience too commonly exacerbates the distress of those with mental illness, frustrates and diverts emergency clinicians, paramedics and police, and is an entry point that is very expensive for the community. One option to reduce ED presentations is to have mental health workers

accompany police when they attend a person experiencing an acute episode of mental illness (discussed below).

Complementing this, State and Territory Governments should, as a **priority reform**, aim to provide more and better alternatives to EDs for people with mental health problems. This may include providing separate spaces in or near EDs for people with mental illness, or otherwise creating a more de-escalating environment, such as peer- and clinician-led after-hours services and mobile crisis services. The ‘Safe Haven’ spaces created in Melbourne and planned in Queensland provide an effective model for this. The provision of alternatives to EDs are estimated to be cost-saving and could substantially improve the mental health outcomes for people benefiting from them. When EDs are built or renovated, the design should take account of the needs of people with mental health problems.

The right services for people at the right time

Consistent with a person-centred approach, we want a mental healthcare system that allows people to choose and access care options that are right for them, given their needs and circumstances. This means that there needs to be a range of different ways that services are delivered, to be accessible as and when people need them, that are not just clinically effective and culturally relevant, but impose minimum burden on the individual seeking care. People are more likely to choose, persist with, and benefit from, treatment that matches their needs.

Priority reforms to help people get the services that are right for their needs are: (i) provision of supported online treatment; (ii) a review of the effectiveness and targeting of MBS-rebated psychological therapy, with a trial of additional sessions; (iii) enabling access to MBS-rebated psychological therapy and psychiatry via telehealth regardless of where people live; (iv) expanding community mental healthcare.

Bridge the care gaps

There are significant gaps in Australia’s mental healthcare system and people typically discover these gaps when they are in most need of care. Up to one million people with mental illness are estimated to be receiving no clinical care. Some are able to self-manage their health or are accessing non-clinical supports; but some need clinical help and have encountered gaps in the options available to them.

While people encounter barriers to most forms of mental healthcare, we identified two key gaps in care that are particularly detrimental to mental health outcomes for a large number of Australians — a gap in low intensity services, and a gap known as the ‘missing middle’.

The *low intensity gap* is a large gap in the utilisation of low cost, low risk, and easy to access services. Two groups of people encounter a low intensity gap — an estimated 500 000 people who would benefit from low intensity care but are not accessing any care; and up to 2 million people who are being treated with medication and/or individual therapy that are more costly

for them than what is necessary and who could have their treatment needs equally well met through services that offer a lower treatment burden (in terms of time, financial cost, and treatment adverse side-effects).

That many people are not accessing services that are right for them is evidenced by treatment drop-out rates. For example, close to half of those people accessing MBS-rebated psychological therapy use three or fewer sessions (rarely enough to enable recovery, in those for whom psychological therapy is the most appropriate intervention), while about half of those people who commence the NewAccess low-intensity therapy program complete the full course of six sessions.

The Productivity Commission has concluded that the low intensity gap exists primarily because of under-provision of low cost, low risk and easy to access services, and because of a lack of information — for referring clinicians and for consumers — about the existence of such services and their clinical and cost effectiveness.

The *missing middle gap* is a service gap encountered by several hundred thousand people who have symptoms that are too complex to be adequately treated by a GP and the limited MBS-rebated individual sessions with psychologists. But their condition also does not reach the threshold for access to State or Territory funded specialised mental health services. Alternative services, such as private psychiatrists or private hospitals, may be inaccessible due to long waiting lists or very high out-of-pocket costs.

The Productivity Commission has assessed that the missing middle gap primarily reflects a lack of community mental health services, but this gap is larger for some groups of people and in some parts of Australia.

For example, some groups in the community — such as Aboriginal and Torres Strait Islander people — face additional barriers to care because of a lack of culturally capable services and discrimination. And people in some rural, regional and remote communities can face further barriers associated with lack of availability or continuity in the trained workforce.

Recommended reforms address these healthcare gaps by increasing the range and accessibility of relevant services for people to choose from, including by ensuring there is an appropriately skilled workforce available to deliver the services that people choose and sufficient capacity in community and hospital facilities to cater for people's needs.

Expand supported online treatment as a flexible option for people

Supported online mental health treatment expands consumer choice of flexible treatment options and helps fill the low intensity gap in healthcare, complementing other treatments people may choose, and improving the person-centred focus of the mental health system.

For many people, supported online treatment provides a convenient, effective, low cost way for them to manage their mental ill-health. It allows people to undertake treatment at a place and time that is suitable and convenient for them — for example, in their own home, at a local

health service, or at a psychosocial support hub or clubhouse. One online service reported that almost half of the people using its site accessed it outside of normal business hours, and that access occurred all days of the week.

Supported online treatment has been available as a trial or for routine care for more than two decades. It is now well established that clinician supported online treatment is as effective as face-to-face treatment for some conditions. In particular, supported online treatment is an effective intervention for people with high prevalence mental illness (such as anxiety and depression). There is also some evidence that supported online treatment may be effective in complementing specialist mental health treatment for severe and less prevalent conditions, such as schizophrenia, bipolar disorder and bulimia nervosa. Online treatment carries the added benefit of fidelity of the treatment (it avoids individual providers administering their own personal versions of the intervention), could be made culturally appropriate, and can be cost effective to provide to a large number of people.

About 20 000 people per year access online mental health information and services, with about 4000 of these receiving online treatment supported by a clinician. As a starting point to more widespread use of supported online mental health treatment options, the Australian Government should, as a **priority reform**, expand the capacity of online treatment services. The initial beneficiaries of greater access to supported online treatment would be those people who have faced so many barriers to accessing treatment, that they have gone without help. A gradual expansion would recognise that it may take time for both individuals and clinicians to increase their knowledge of this means of accessing treatment and that expanding capacity within the sector should be undertaken in ways that preserve the quality of treatment for people and include only services with a strong evidence base.

The recommended expansion of supported online treatment forms part of the broader vision of the national digital mental health platform that is offering a person-centred pathway to assessment and treatment, supporting both individuals and health professionals to make decisions about the right treatment options. It is estimated to be a cost-effective reform for both consumers and taxpayers and should be implemented regardless of government and service provider progress on the new platform.

Enable psychological therapy to meet the needs of people who would benefit most

Approximately 1.3 million people currently receive MBS-rebated sessions of face-to-face psychological therapy (individual or group) each year. The 'Better Access' program provides psychological therapy services at a significantly lower per-session rate than comparable services funded through means other than the MBS. However, face-to-face psychological therapy (and the workforce who deliver it) should be focused on helping some of those people who are encountering the missing middle gap in the mental health system.

The recommended introduction of more rigorous and consistent assessment and referral processes to access mental health treatment needs (discussed above), combined with a recommended replacement of the current mental health treatment plans (which show no evidence of having improved either GP referral practices or mental health outcomes for

people) with a structured mental health assessment and referral tool, should help people get the treatment they need. In particular, these measures would have the dual effect of ensuring that people with low intensity treatment needs are not directed into higher intensity treatment options that come at a higher cost to them, and that people with moderate to high intensity treatment needs (who stand to gain the most from face-to-face psychological therapy) are able to access these services when needed.

The Productivity Commission estimates that up to 10% of those accessing individual therapy would benefit from an increase in the number of subsidised sessions (predominantly those people with moderate to high intensity treatment needs). A trial on the number of MBS-rebated psychological therapy sessions should be undertaken to assess the merits of increasing the current number of rebated sessions.

The Better Access program should, as a matter of **priority**, be rigorously evaluated to ensure that it is delivering cost-effective benefits for those who need it.

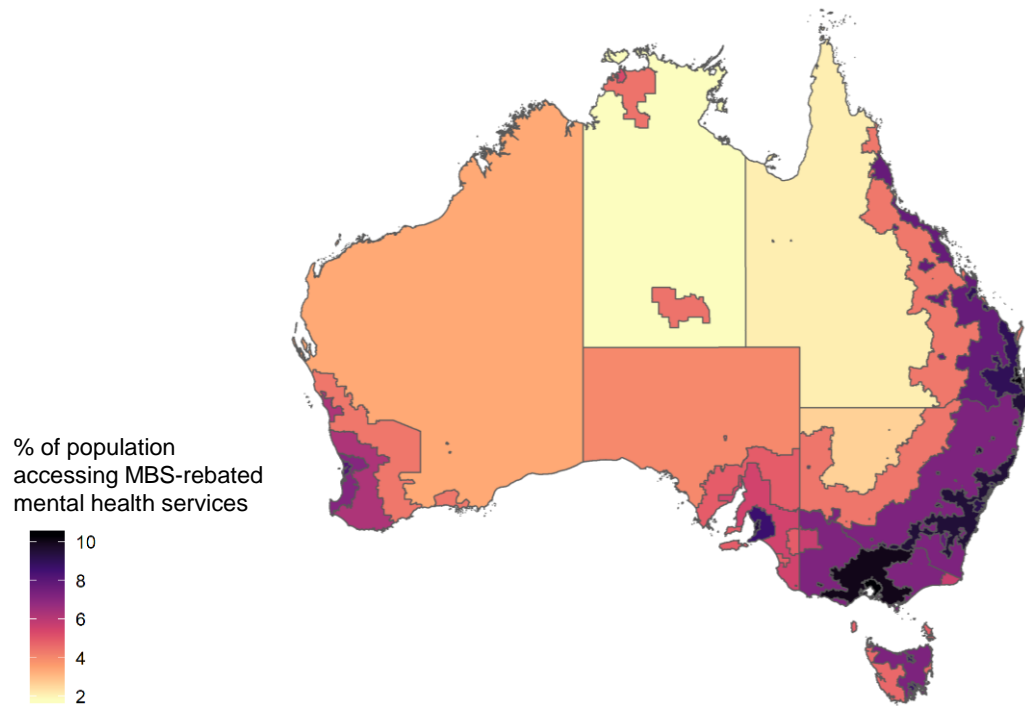
Enable ongoing access to telehealth

Ironically, access can be an issue with the Better Access program. Use of the program, and other MBS-rebated mental health services, is disproportionately by people in Australia's large urban centres (figure 6). This reflects the location of most psychologists and psychiatrists. Group sessions and sessions via telehealth are significantly underutilised.

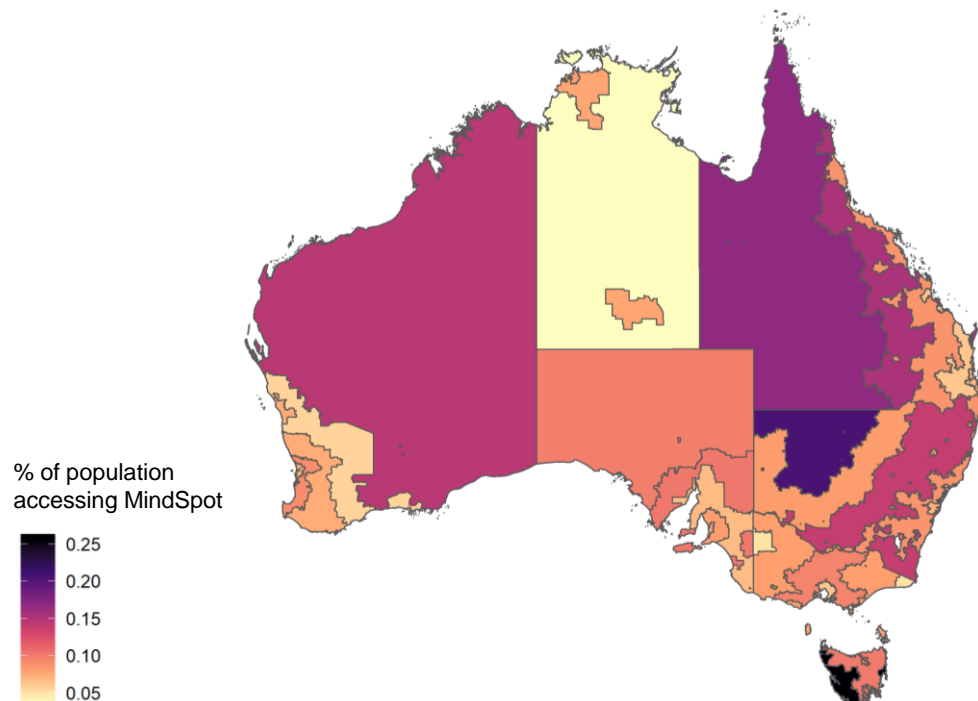
For people who have difficulty accessing psychological therapy (for example, because they live in a part of Australia where there are no psychologists or for reasons related to their mental illness, transport access, or family scheduling), access to psychological therapy by videoconference should be widened as a **priority reform**. Some mental illnesses (such as anxiety) can, at times, include symptoms that prevent an individual leaving their home to attend face-to-face therapy. Regardless of whether an individual resides in an area designated as a 'telehealth area', if they have been assessed as benefiting from psychological therapy, then they should be able to access MBS rebates for psychological therapy via videoconference. In large part, this would involve a continuation of the universal video-psychological therapy approaches adopted during the COVID-19 crisis.

Figure 6 **Regional access to low and moderate intensity care services**

Use of MBS-rebated mental health services is lower in regional areas



Users of supported online treatment are geographically widespread



A workforce competent in mental healthcare to fill the gaps

Empowering people to access the mental health treatments that are right for them means ensuring there is a competent workforce able to deliver the treatments needed, and that embraces evidence-based clinical interventions and a person-centred focus.

Improve the competency of mainstream health services in mental healthcare

Even with a recommended ramping up in the use of clinically-supported mental health assessment, referral and treatment options, GPs would likely remain a dominant provider of mental healthcare services. All GPs need to be competent in treating people with mental illness. In any given year, at least 5 million Australians see their GP for assistance with their mental health, including treatment of a mental illness. Of these people, 6 in 10 are prescribed medication by the GP; 3 in 10 receive some counselling, education or advice. Only 2 in 10 receive a referral to a psychologist or a psychiatrist; about 400 000 people see private psychiatrists and 1.3 million people see psychologists.

Despite their central role in providing primary mental healthcare services and prescribing medications, most GPs receive minimal training in mental healthcare when qualifying as a GP (although some subsequently gain specialist mental health skills). Aspects of existing GP mental health training and professional development that should be re-oriented include: more rigorous approaches to assessing mental health (including consideration of cultural influences, relationships and trauma); inclusion of carers and family in diagnosis and treatment discussions; attitudes to peer workers; buy-in to a person-centred ethos; and adherence to evidence-based clinical practices (including the clinical appropriateness of GP's prescribing practices for mental health medication, management of medication side effects and de-prescribing).

Mental healthcare specialists

Most people who access care from a mental healthcare specialist do so for a limited time until their recovery reaches a point where less intensive care is sufficient. For a small proportion of the community, mental health specialists are an ongoing and regular part of their mental health treatment and support network. Lack of specialists in some parts of Australia and long wait lists are issues for many people needing care. Trust — that the specialist will regard the individual, their concerns and preferences as important — and finding (and retaining) a specialist with whom the individual feels some rapport, can be additional major challenges that many people never surpass.

Among those providers who work specifically in mental health in Australia, there is considerable disparity in workforce numbers between urban and regional areas, and between the public and private sectors, and an inefficient use of skilled professionals (such as mental health nurses) in administrative roles that could likely be undertaken by non-clinical staff. There are also notable gaps in the availability of some specialists in a number of parts of Australia.

Access to psychiatric care is particularly constrained, with high costs and long wait times in some areas. The number of psychiatrists for Australia's population is at the low end of rates in developed countries. The profound difficulty of children and adolescents, people in aged care and people in rural, regional and remote areas in accessing psychiatrists, should particularly be addressed. Governments should collectively develop a national plan to increase the number of practising psychiatrists, including an increase in the availability of supervision for trainees, with a focus on sub-specialties and localities where there are substantial shortfalls.

Mental health nurses are a critical part of the current mental health workforce, being the largest clinical occupational group dedicated to mental health, and one of the most geographically dispersed and cost-effective sources of expertise for combined management of mental and physical health, and care coordination. The number of mental health nurses practicing in Australia — in GP clinics, community health services, and aged care facilities — should be significantly increased to support the recommended expansion in community mental health services and inpatient bed-based services. Recommended measures to promote this are focused on training, because Australia is unlikely to be able to continue to rely on recruiting mental health nurses from overseas. The development of a three year direct entry (undergraduate) degree in mental health nursing, similar to options available in midwifery in Australia and for nurse training in the United Kingdom, is recommended.

Peer workers — people employed on the basis of their lived experience of mental illness — are well placed to support people with mental illness during their recovery. Indeed, evidence to the Inquiry made it clear that this type of assistance was highly valued by people with mental illness. The nature of the experience and training required to allow peer workers to be most effective and the circumstances in which they can best be included, is the subject of ongoing work in the sector. A barrier to more widespread use of peer workers is the acceptance of their role by clinicians. A program to build support among clinicians for the role and value of peer workers should be developed and implemented in collaboration with the relevant professional bodies.

Beyond these general measures to strengthen the mental health workforce, we consider that technology is a primary means to overcome those gaps in access to mental healthcare in rural, regional and remote parts of Australia that are a result of workforce shortfalls. This includes technology to enhance consumer access and technology to augment training and supervision opportunities for remote clinicians. Ultimately, attracting more workers into these areas requires either mandating their presence (such as through internships) or increasing their reimbursement. Governments have tried both options with uncertain success. The Productivity Commission considers the continuation of these measures — along with increased use of telehealth, a new online assessment and referral platform, online psychiatric assistance for GPs, clinician-supported online treatment, and devolution of service provision for Aboriginal and Torres Strait Islander people to Aboriginal Community Controlled Health Services — as the most effective ways to get culturally capable mental health services and supports to people in rural, regional and remote Australia.

Higher intensity care options for those who need them

People experiencing severe episodes of mental illness require higher intensity, often multi-disciplinary care, from specialist services such as those delivered through MBS-rebated or government salaried psychiatrists and community-based clinical services.

For many people, community mental healthcare services are a first step to receive more intensive care as an alternative to being admitted to a hospital psychiatric unit, or after discharge from a psychiatric unit. These services comprise non-acute residential care within the community and ambulatory care (including hospital outpatient services and day programs, and outreach services into people's homes or aged care facilities). Ramping up such care options within the community — so that people can live in the community, instead of being in an acute hospital bed for extended periods — eases pressures on hospitals, is an important part of filling the gap in mental healthcare for people and supports a recovery model of care as discussed below.

As a **priority reform**, an expansion in community ambulatory services across Australia is needed to meet the needs of — in particular — children, adolescents and older people with mental illness. While this expansion would require more community mental healthcare workers in some regions, the Productivity Commission has assessed that, with increases in time spent on consumer-related activities, there could be scope to provide some additional community ambulatory services within current levels of resourcing.

In addition to community ambulatory services, there are only about 3400 non-acute mental health beds in the public system — an estimated half the number likely to be required. Gaps in non-acute services in communities lead to avoidable hospital admissions. Increasing the number of non-acute beds would therefore improve the path of care for individuals in need. Individuals who are best treated in the community would face fewer delays in discharge from hospitals, and as acute inpatient beds in hospitals become available, this would reduce waiting times in EDs. Increasing the number of non-acute mental health beds to meet population needs, would come at an initial net cost to Governments but is expected to reduce the costs of healthcare over time (through lower use of acute inpatient beds) and improve mental health outcomes for people (particularly where these beds are in the community). Accordingly, each State and Territory Government should provide sufficient residential care within their communities to accommodate demand from those with mental illness, as an alternative to admitting people into, and/or retaining them within, hospital acute care.

Not all hospitalisations are avoidable; inpatient beds will be needed by some people experiencing severe episodes of mental illness. Areas of high population growth may need to increase their number of acute inpatient beds in order to meet demand, even after filling gaps in non-acute services. Lack of mental health inpatient beds for children and adolescents seems to be a particular shortfall in some States and Territories. All States and Territories should provide child and adolescent mental health beds that are separate to adults and configure mental health wards to allow gender segregation. Where it is not possible to provide these beds in public hospitals, State and Territory Governments should contract with

private facilities, or if suitable given the individual's condition and their home environment, provide care as hospital-in-the-home or day programs.

Improve mental healthcare outcomes for people

The extent to which mental healthcare is delivering improved outcomes for people is determined by those who experience the care, not by those who provide it. Quality outcomes encompass not just the effectiveness of treatment received but aspects such as the way treatment is delivered to an individual, the extent to which treatment addresses the longer term recovery needs of the individual within their community, the adverse consequences that treatment may impose on an individual, and treatment of comorbid conditions. Consumers, families and carers who participated in the Inquiry made it apparent that there are significant shortfalls in the quality of outcomes delivered by Australia's mental health system.

Priority reforms to improve mental healthcare outcomes are: (i) adoption of family and carer inclusive practices; (ii) rigor and clarity in medication prescribing practices; and (iii) commitment to reducing the life expectancy gap for people with severe mental illness and comorbid conditions.

Focus on personal and relational recovery

Recovery-oriented mental health services — embracing the concept of the personal recovery of an individual within their family, carer, community and cultural context, rather than a narrow focus on clinical recovery — has been endorsed by Australian health ministers. But it is not yet evident in the care received by people. The wellbeing of people with mental illness and their families and carers are interdependent; mental illness can affect the quality of relationships, which contributes to social isolation and impedes recovery.

Families can hold a lifetime of information on family members who have mental illness, which clinicians typically ignore in forming a diagnosis and care plan for people. This hampers clinician's own capacity to effectively help the individual in their recovery. Clinicians who see themselves as an 'advocate' for their patient, but deal with only the 'symptoms' that the individual reveals to them, and/or are dismissive of the concerns of the individual's family and carers, are not supporting the personal recovery of the individual.

The mental health system also ignores the effects that a person's mental illness (and the attitude of clinicians) has on carers and family — to the system's detriment. An effective carer is one who feels informed and secure — a distressed or exhausted carer is not well-placed to support a person's recovery.

Information on the outcomes of mental health service provision should be collected from people at the time that services are delivered, and publicly reported to assist in moving healthcare provision toward a person-centred delivery approach. As a **priority reform**, the Australian Government should extend MBS-rebates for psychologists and other allied

mental health professionals to include consultations with carers and family members. This has the potential to substantially improve mental health outcomes for both the consumer and their consulted carer and family members.

Reduce the adverse consequences of mental health treatment

We heard distressing evidence in the Inquiry about the side effects that some people experience with some mental health medication, including dramatic weight gain, disabling lethargy and increased suicidality. (Reducing the adverse consequences faced by people who face involuntary detention and treatment due to mental illness are discussed later below.) Australians are the equal third most frequent users of anti-depressants among OECD countries; yet for many mental health conditions, psychological therapy is at least as effective as medication, except without the adverse side-effects.

Person-centred care means not only that people would be provided with the relevant information about any medications they are prescribed, but that they would be provided with this information prior to deciding whether medication or some other form of treatment is right for them. As a **priority reform**, clinicians offering mental health medication as treatment should be required to inform the consumer of the side effects prior to prescribing and offer alternative non-pharmaceutical treatment options.

The clinical benefits of many mental health medications (particularly for conditions that are not severe) and the long term physical and mental health outcomes for people who use them, are disputed, with severe side-effects in some population subgroups and substantial over-prescribing for others. More research focused in these areas, and uptake of its resulting lessons among treating clinicians, could generate significant improvements in mental healthcare treatment outcomes.

Target the life expectancy gap for people who have both mental and physical illnesses

Physical ailments are more common when a person has mental illness and can contribute to early death. The link goes both directions, with mental illness (and often the medication taken for it) contributing to physical poor health, and physical illness contributing to mental illness. Compared to people without mental illness, those with mental illness are significantly more likely to have respiratory disease, type 2 diabetes, cardiovascular disease, some types of cancers, chronic pain, osteoporosis, and are more likely to be overweight or obese.

One Australian study estimated that physical illnesses cause almost 80% of the gap in average life expectancy between people with a severe mental illness and the general population, compared with 14% of the gap being due to suicide. As a **priority reform** that could substantially increase the quality of life for people with mental illness, Governments should commit to an explicit target to reduce the gap in life expectancy between people with severe mental illness and the general population, with an implementation plan to reach the target and annual monitoring.

As part of addressing the gap in life expectancy, Governments should also implement all initiatives in the widely supported Equally Well Consensus Statement developed by the National Mental Health Commission. This includes requiring all mental health services to screen for physical health conditions that people with mental illness are at higher risk of, and either provide or refer people to other services for early intervention and/or treatment of these conditions.

Substance use comorbidity is common for individuals with some types of mental illness, and a large proportion of people who present for substance use treatment display symptoms of mental illness. However, people with substance use comorbidities often do not receive adequate care for both conditions. Governments should ensure that mental health and drug and alcohol services address both mental health and substance use needs, by directly providing services, or referring the person to other services where appropriate.

Eliminate stigma in the way care is delivered

The stigma that people with mental illness can experience in the community extends into healthcare and can significantly affect people's recovery. While most people with mental illness report being treated positively by health professionals, a significant minority (about one in ten) consider they have experienced discrimination from a health professional. This can manifest as disrespectful or condescending behaviour from the health professional, treating people with mental illness dismissively, or disbelieving or judging them. Such action by health professionals discourages people from seeking help when they need it, alters the type of help they seek and the symptoms they describe, increases levels of psychological distress, lessens adherence to treatment regimes, and exacerbates mental illness. It can also contribute to diagnostic overshadowing — with the health professional neglecting people's physical health once they have been diagnosed with mental illness.

While there is a lack of quality evidence about effective stigma reduction interventions, there is potential to improve outcomes for people through well-designed interventions targeting the interactions between health professionals and people with mental illness. Accordingly, the training and professional development of health students and practising health professionals (both within and outside mental health) should include interaction with people with a mental illness outside of a clinical environment (such as the Recovery Camp model for alternate clinical placements for students).

Care continuity and coordination

Care plans

Some Australians with episodic or persistent severe mental illness have complex needs arising from their illness. In particular, their mental illness can be accompanied by: physical health conditions that require other clinical services; impaired psychosocial functioning due to the severity of the mental illness; and extreme social adversity. People with complex needs typically

require care from a team of clinical and/or non-clinical service providers. A single care plan should be introduced for these people to help coordinate treatment.

The coverage of the plan would vary from person to person according to their needs at particular points in time, but could include a plan to address aspects such as mental healthcare, physical healthcare, cultural and spiritual needs, psychosocial support needs, housing needs, community inclusion needs, the role of their carer or kinship group, and reintegration into education or the workforce. The effective development and operation of the care plan would necessitate: a sharing of patient information between professions that is not currently evident (even within the health sector); someone to have responsibility for plan development, follow-through and updating the plan; and financial arrangements that incentivise this to occur. An effective care plan would be based around the individual, their treatment needs and their preferences. Many people with complex needs already have at least one care plan. So for many, this reform option would be about ensuring consistency and coordination between these.

Care coordination

Improving outcomes for people with complex needs requires that they have access to the services needed (both clinical care and broader psychosocial and community supports), when they are needed, with effective information flows and coordination between clinicians and other services. People with severe mental health illness and the most complex needs (approximately 354 000 people) should, as a **priority reform**, have both a single care plan developed with and for them and a care coordinator provided to oversee the implementation of the plan. While 64 000 of these people are expected to receive services through the National Disability Insurance Scheme (NDIS), the remaining 290 000 people should also be provided with care coordination. The Productivity Commission estimates that only 75 000 people from this group are receiving psychosocial supports from other Australian, State or Territory Government-funded programs, and the number with adequate care coordination is unknown. Persisting gaps in support services can lead to a deterioration in mental health and, potentially, unnecessary hospitalisation.

Care coordinators would work directly with the consumers, their families and carers, clinicians (or clinical coordinator) and providers from other sectors, to establish the types of services needed and provide access to those services. The level of support would be adjusted according to need — for people with the most complex needs, the care coordinator should bring together a care team, comprising the various services the individual requires, and put in place a detailed plan for their support. For those admitted to hospital, care coordinators would be linked in with the hospital discharge planning, to provide continuity of care.

There are already some government funded programs offering care coordination services to people with a mental illness. However, the coordination of care is often ad hoc, relies on personal contacts of individuals rather than established networks, is delivered by care coordinators of variable competency, and is provided under short-term funding arrangements that encourage premature closure of cases and relapse in mental illness. And while not all

consumers who would benefit from a care coordinator have access to one, some people have multiple care coordinators with overlapping responsibilities.

Efficient and effective care coordination would replace many of these services and would partly be based on existing funding. Furthermore, expenditure for care coordination could be expected to lead to cost savings elsewhere in the health system, as demonstrated by past programs, where care coordination led to reductions in hospital admissions.

Evaluations of other smaller-scale models have suggested that care coordinators should be recruited from outside of the existing mental health workforce, hold vocational qualifications, and be defined more by their ability to relate to their clients than by other skills. Our recommended reforms would not require a clinical background for care coordinators.

3. Improve people's experience with services beyond the health system



PRIORITY REFORMS

- Meet demand for community support services that help people with mental illness recover and live well in the community
- Commit to no discharge from care into homelessness
- Increase assistance for police responding to mental illness related incidents
- Legal representation for people facing mental health tribunals

There are a range of services beyond the health sector that support people (often those with severe mental illness) to live meaningful and productive lives within the community, including psychosocial supports and housing services. The justice system also plays an important role in the lives of some people with mental illness — for those who interact with police as first responders in a crisis, those who commit offences or are victims of crime, and those who confront legal issues associated with their mental health treatment. These services often are not delivered in ways that account for the nature of mental illnesses, impeding recovery or contributing to a relapse in illness.

This section focuses on the issues and priority reforms in: psychosocial supports for people with mental illness; housing services; and interactions with the justice system. Services related to further education and employment are discussed separately below.

For people needing psychosocial supports

Recovery from mental illness necessarily involves recovery not just of the individual alone, but recovery within their family and community context. For all people with mental illness, social inclusion — the capacity to live contributing lives and participate as fully as possible in the community — is a necessary, but too often neglected, part of a recovery plan.

Psychosocial supports are a key facilitator of recovery, can help alleviate some risks of illness relapse and support people as they develop skills to self-manage the effects of variations in their mental health. Services typically provided under this label include respite services, building social skills and relationships in a culturally supportive way, assistance with transport, tenancy or household management and finances, and coordination and support in complying with clinical treatment needs.

Approximately 690 000 people with a mental illness are estimated to be likely to benefit from access to psychosocial support services, were they available to them (about 290 000 of these people have a severe and persistent mental illness). But there is a massive gap in Australia's provision of psychosocial supports. Only about 34 000 people with a primary psychosocial disability receive psychosocial supports under the NDIS (just over 50% of those expected to be eligible once the scheme completes its roll out); and about 75 000 people receive psychosocial support directly from other Australian, State and Territory Government-funded programs.

The gap is a result of a 'perfect storm' of problems within the sector, including: a large but unknown number of small-scale, poorly defined and measured services; little transparency around who is delivering what supports to which people and what outcomes they achieve; confusing and inconsistent eligibility criteria for some supports with delays in application approval; very short funding cycles with funding provision that is unrelated to the number of people receiving support; a lack of job security and consequent difficulty retaining high quality staff; and a loss of funding and staff to NDIS funded services.

Psychosocial supports to meet regional demand

The recommendations of this Inquiry aim to rectify these issues and create a coherent system of regional funding for psychosocial supports designed in partnership with, and that work for, people with mental ill-health. As a **priority**, the Productivity Commission recommends that regional demand for psychosocial supports for people with mental illness be estimated, with a view to expanding services to meet any shortfall. The priority afforded to this reform reflects the potential for access to psychosocial supports to improve the quality of life for a larger group of people with mental illness.

Of course, many other people who do not have mental illness would also gain from improved supports. But our recommendations here relate to those people whose psychosocial support needs arise from their mental illness. Some people with a need for psychosocial supports arising from a mental illness may not have had their mental illness formally diagnosed. Where this is the case the person should be assisted by the support service to obtain a timely assessment to verify that it is mental illness that underpins their need and that they are receiving the full range of treatment and care required. Without this, people with mental illness may miss out on the psychosocial supports they need.

Additional reforms for people receiving psychosocial supports

To enhance the continuity of care for people, Governments should extend the funding cycle length for all psychosocial support programs from what is typically a one-year contract term to a minimum five-year term and develop a transparent plan for ongoing future support provided to people with mental illness in need of psychosocial supports. For those people who are eligible for the NDIS, the psychosocial disability action plan should be fully rolled out across all NDIS sites by the end of 2020, incorporating lessons learned from the Independent Assessment Pilot into the NDIS access and planning processes.

For people needing housing services

Suitable housing — that is secure, affordable, of reasonable quality and of enduring tenure — is a particularly important factor in preventing mental ill-health and a first step in promoting long-term recovery for people experiencing mental illness. Some 16% of people with mental illness live in unsuitable accommodation (homelessness, overcrowding, at risk of eviction or of substandard quality).

Discharge people to stable accommodation

One quarter of all people admitted to acute mental health services are homeless prior to admission and most are discharged back into homelessness. While it is not always obvious that a person in hospital is otherwise homeless, there can be pressure to discharge people to free-up costly hospital beds for others needing care and a lack of suitable accommodation for discharged people to go to. Not only is an individual's recovery challenged by unstable accommodation, but follow-up care after discharge is more difficult (which, in turn, can lead to a cycling of people back through hospital EDs). These same problems of discharge into homelessness are also evident for people with mental illness leaving correctional facilities.

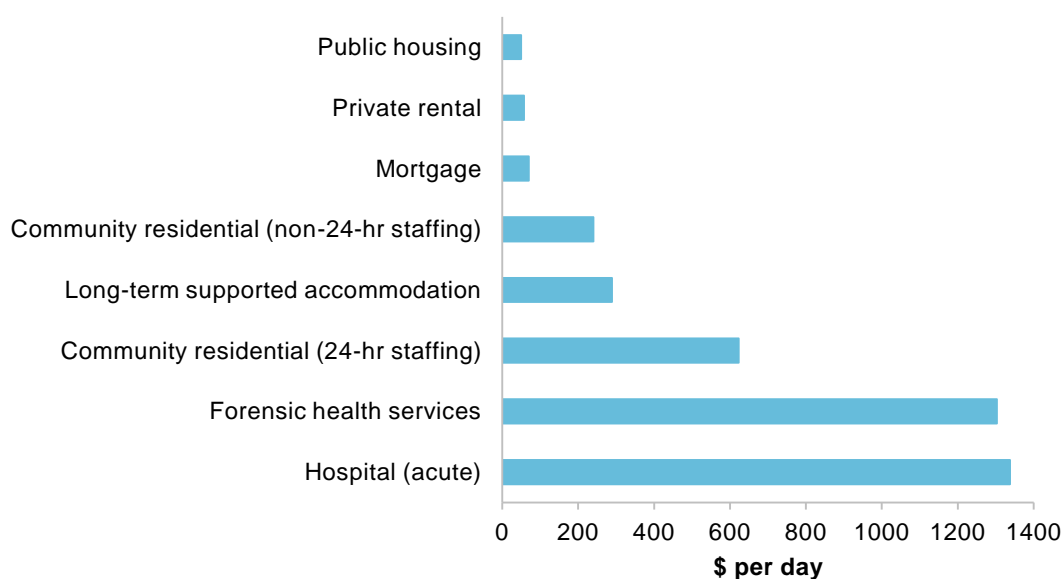
There are some notable examples of hospitals with programs to avoid discharging patients into homelessness (such as the Royal Perth Hospital Homeless Team). Key elements of program success include: staff who are trained to identify at risk patients; care coordinators who make thorough discharge assessments well ahead of discharge and provide timely and assertive follow up; and ready access to transitional housing that meets the long term recovery needs of people.

As a **priority reform**, each Government should commit to, monitor and report on, a nationally consistent policy of not discharging people with mental illness from hospitals, correctional facilities and institutional care into a situation of homelessness. This reform offers potential for significant improvements in quality of life for people who would otherwise be homeless, and is likely to be cost effective in the longer term (evaluation of housing support worker programs, for example, found they provided benefits estimated at about \$9 for every \$1 invested).

Additional reforms for people with mental illness and housing needs

The costs of not adequately addressing the accommodation needs of people with mental illness is evident not just in poorer mental health outcomes but through increased expenditure in the health sector. Surveys suggest that about 30% of admitted patients (about 2000 people) in psychiatric wards could be discharged if appropriate housing and community services were available. For each individual retained in an acute hospital bed, who could be treated (at least as well) in a non-acute bed-based service, the health system is overspending (figure 7).

Figure 7 Average daily ongoing cost of accommodation per person



For those people with severe mental illness that necessitates low to moderate intensity care on a regular basis, supported housing places (integrated housing and mental health supports) in the community provide long-term housing stability, scope to actively interact with the community and provide life satisfaction. There are currently 4 600 supported housing places across Australia. But an estimated 9 000 to 12 500 additional places are required to accommodate individuals with severe mental illness who are at significant risk of housing instability. Evaluations of supported housing programs suggest improved housing and mental health outcomes for participants, with the costs of running a program offset to some extent by a reduction in the use of other relatively high cost services, such as hospitals. Each State and Territory Government, with support from the Australian Government, should address the shortfall in supported housing places in their jurisdiction for people with severe and persistent mental illness.

There are 15 000 to 19 000 people with mental illness in need of stable longer-term housing solutions. To reduce homelessness among people with mental illness, each State and

Territory Government, with support from the Australian Government, should work towards meeting the unmet demand for homelessness services. Small scale measures to address long-term housing needs of people with mental illness (in Australia and overseas) have seen significant associated reductions in use of health, justice and community services.

Some of these additional homelessness services for people with severe mental illness who are persistently homeless, should follow a Housing First approach — rapid access to long-term housing and mental health supports that is not conditional on participants becoming housing ready or engaging with support services. Several trials of Housing First programs in Australia and around the world have been effective at housing thousands of people with severe mental illness, with participants reporting improved quality of life, and reduced health service usage. In some cases, trials show a small net cost or a potential net benefit. Some Housing First programs should be tailored to particularly vulnerable population sub-groups with mental illness, including young people and Aboriginal and Torres Strait Islander people.

For people interacting with the justice system

The mental health system and the justice system are intertwined: the police (as first responders) are an important gateway for many people into mental healthcare; correctional facilities are a setting in which some people first come to need and receive mental healthcare; and people with mental illness are more likely than others in the community to be victims of crime and be in need of advocacy services to resolve legal problems (noting that acute mental illness is one of the few remaining conditions that allows involuntary confinement and treatment of an individual in Australia).

Support police and people with mental illness in their interactions

Responding to mental health related incidents occupies an increasing proportion of police time. Mental health related incidents have been reported as accounting for about 10% of police time in New South Wales, and as having increased by nearly 90% in Victoria in recent years. The interactions between police and people experiencing acute mental illness appears to vary considerably and at its worst, can be extremely traumatising to both the individual and the police involved.

Timely availability of crisis support services can prevent or reduce ED presentations and be an alternative diversion point for police and other crisis first responders. For example, in Queensland, mental health clinicians are co-located in the police communications centre, supported by an on-call forensic psychiatrist; mental health staff accompany police and provide on-site clinical interventions; and police, health and ambulance services partner to identify issues, discuss complex cases and develop preventative interventions, alternative referral pathways and review procedures.

To support both individuals with mental illness when interacting with responding police as well as the police workers, a systematic approach that incorporates mental health expertise at multiple stages of police interaction should be implemented as a **priority reform**. This includes potentially embedding mental health professionals in emergency communication centres and as part of co-response teams (with police and paramedics) attending to incidents. The priority of this reform reflects the potential for improving outcomes for a large number of people experiencing acute episodes of mental illness, their families and carers, and the police workers they interact with.

Additional reforms for mental healthcare at all stages of the justice system

Among those who formally enter the justice system, people with mental illness are overrepresented at every stage. Among police detainees, about 43% of men and 55% of women were reported to have a previously diagnosed mental disorder; while about 40% of prison entrants have been told they have a mental health disorder (including substance use disorder) at some stage in their life — double the rate among the general population. Rates of mental illness are even higher for particular demographic groups within correctional facilities, such as women and Aboriginal and Torres Strait Islander people. While the majority of prisoners with mental illness spend relatively short periods of time in custody before returning to the community, inadequate healthcare in correctional facilities and poor transition support services are likely to raise the burden on the community healthcare system and increase recidivism.

An early intervention approach should be taken to address the over-representation of people with mental illness across all stages of the criminal justice system. In particular, people with mental illness who are at high risk of interaction with the justice system should be identified and provided with mental health support that facilitates their inclusion in the local community and reduces their risks of offending. Some States and Territories have programs in this area already, and they should be endorsed more broadly. For example, NSW's multi-agency Youth on Track program for young people aged 10-17 years who are at medium to high risk of offending, offers support in physical and mental health, education and employment, to attempt to reduce contact with the criminal justice system.

Comprehensive mental health screening and assessment of all individuals (sentenced or awaiting sentencing) should be undertaken on admission to correctional facilities, and on an ongoing basis where mental illness is identified. Those who have an ongoing mental illness should, prior to release, be connected with a relevant community-based service (and care information shared with consent with this service) to enable individuals with mental illness to receive continuity of care post-release. In the case of Aboriginal and Torres Strait Islander people, services within correctional facilities and post-release care should be culturally capable. More generally, the Australian Commission on Safety and Quality in Health Care should review how the national safety and quality standards that apply in the health sector can be implemented in correctional facilities.

For the benefit of those people with mental illness who have further contact with the justice system (as either offenders or victims of crime), State and Territory Governments should

continue to develop and implement Disability Justice Strategies to ensure the rights of people with mental illness are protected in their interactions with the justice system.

Advocacy for people facing mental health tribunals

Legal representation is an important protection for those people who face involuntary detention and treatment due to mental illness. Such people are among the most vulnerable in our community. For example, people who are represented when appearing at a mental health tribunal have been found to receive a longer hearing, shorter periods of compulsory treatment orders, and have a substantially lower likelihood of being subject to electro-convulsive treatment. However, State and Territory legal assistance providers have reported that they have inadequate resources to represent all but a small proportion of clients appearing before mental health tribunals.

While there are many legitimate claims on legal aid budgets, we consider that representation when facing involuntary detention and treatment due to mental illness is a **priority**. To meet this need, governments should provide a grant to legal assistance providers specifically for assisting with mental illness-related legal issues. This could be modelled on the approach taken under the NDIS, whereby legal aid commissions apply to the relevant government department for grants to provide legal assistance in cases outside of the ordinary legal aid guidelines, with consideration of the applicant's capacity to self-represent or obtain other legal assistance. We were unable to quantify the benefits of this reform, but we consider its implementation to be a priority for ensuring basic human rights for people who face involuntary detention and treatment.

4. Increase people's participation in further education and work



PRIORITY REFORMS

- Elevate importance of psychological health and safety in workplaces
- No liability clinical treatment for mental health related workers compensation claims
- Expand the individual placement and support program for people with mental illness

This section focuses on the issues and priority reforms for: participation of young adults in higher education and/or work; mentally healthy workplaces; and income support and employment services. The mental health of the workforce in the future will reflect the mental health of those age groups who are yet to enter the workforce. Therefore, successful interventions to address mental ill-health in younger people — who tend to experience poorer mental health than other age groups — can also improve the mental health of the workforce and the broader population, in the future.

Economic participation of the young adult population

The years of 16 to 24 are an important transition point in a person's life regardless of their mental health. Many are studying, but some are also (or alternatively) working — usually on a non-permanent basis in industries such as retail, tourism and the food services sector that are particularly vulnerable to external economic shocks and sharp changes in the need for employees.

Of all age groups, young adults have the highest rates of mental illness — 26% of 16-24 year olds have an anxiety, mood or substance use disorder — and report relatively high rates of psychological distress.

For tertiary students with mental ill-health

Mental illness in tertiary students — more so than physical health problems — is associated with poorer engagement in education, lower average grades, and higher drop-out rates. Psychological distress has been found to be particularly high among international undergraduate students, and under-reporting (associated with differing cultural views of mental illness) is a significant problem.

The level and types of mental health support offered to students varies substantially between tertiary education providers. At a minimum, tertiary institutions should have a student mental health and wellbeing strategy as a requirement for their registration.

Online services for student mental health should be expanded to meet student needs and include the collection of de-identified data on student mental health to enable ongoing improvements in the effectiveness and relevance of mental health supports. Institutions should arrange for their international students to have private healthcare insurance that includes adequate coverage for any required mental health treatment.

For young adults who are disengaged

About 12% of Australia's 15 to 24 years olds seeking help for mental health problems were not engaged in employment, education or training.

For those young adults with mental illness who are disengaged from both education and work, the Individual Placement and Support (IPS) program (involving a rapid job search, followed by on-the-job training and ongoing support from case workers) may be effective in helping them re-engage with either education or work. The program has been found very effective overseas for adults with severe and complex mental illness. Preliminary outcomes of the Australian trial of IPS for youth with less severe mental illness suggest that a youth focused IPS would need to take account of how the employment support needs of young people differ from those of adults, in particular their education and training needs, and their limited employment history and experience.

Equip workplaces to be mentally healthy

There are particularly strong links between employment and mental health. Being employed can improve mental health and mentally healthy work places are important to maintain the good mental health of those who work there. There are a number of avenues through which employment can improve mental health:

- working can give people a sense of identity, and provide regular interaction and shared experiences with people outside of an individual's immediate family
- the collective effort and purpose of work can provide a sense of personal achievement
- structured routines associated with work help give direction to the day and promote the need for prioritisation and planning
- increased employment of people with mental illness can reduce the stigma of mental illness throughout the workforce.

The lost opportunities and missed chances experienced by those with mental illness to work productively and fruitfully creates economic costs for the individual (in terms of lost income) and the community (in terms of lost output or reduced productivity). These costs are particularly high because the effects of mental illness fall mainly on people during their working lives, as opposed to the burden of most other diseases, which commonly affect older people.

About 2.8 million working Australians have mental illness, requiring time off work to maintain their wellbeing; a further 440 000 working Australians are carers of someone with mental illness. People with mental ill-health took an average of 10 to 12 days per year off work due to psychological distress. Estimates for the cost of workplace absenteeism due to mental ill-health were up to \$10 billion per year. Mental ill-health can lead to presenteeism, affecting a person's ability to function effectively while at work. On average, people with mental ill-health reported that they reduced the amount of work they did on 14 to 18 days per year because of their psychological distress — costing up to \$7 billion per year. As with physical ill-health, the costs of mental ill-health can go beyond just the immediate loss in activity of the person concerned, but also extend to impacts on the productivity of their work colleagues.

There is a growing focus on the role businesses can play in maintaining the mental health and wellbeing of their workforce — particularly the potential high returns to employers in terms of lower absenteeism, increased productivity and reduced compensation claims from investing in strategies and programs to create mentally healthy workplaces. While businesses already have some obligations to ensure the (physical and mental) wellbeing of their staff, we recommend ways to strengthen these and provide additional clarity on what is expected. For the most part, businesses want to have a mentally healthy workplace, they just need to know what evidence-based measures they should take to achieve this.

Explicitly include mental health in workplace health and safety

Psychological hazards in the workplace receive less attention than physical hazards, as they are often harder to define and investigate. However, such hazards, including workplace bullying, are increasingly identified as significant contributors to psychological injuries. For an employer, meeting their duty of care to ensure psychological health and safety in a workplace that is also the employee's home — as was increasingly the case during the COVID-19 pandemic — may present particular difficulties and challenges.

Workplace mental health and productivity would be improved by making psychological health and safety as important as physical health and safety in practice. The same risk management approach that applies to physical health and safety (an approach familiar to employers and employees) should be applied, as a **priority**, to psychological health and safety. This reform would not only improve the mental health of workplaces, but is estimated to generate savings (as reduced presenteeism and absenteeism) in excess of the cost of implementing the reform.

Workers compensation schemes to fund clinical treatment

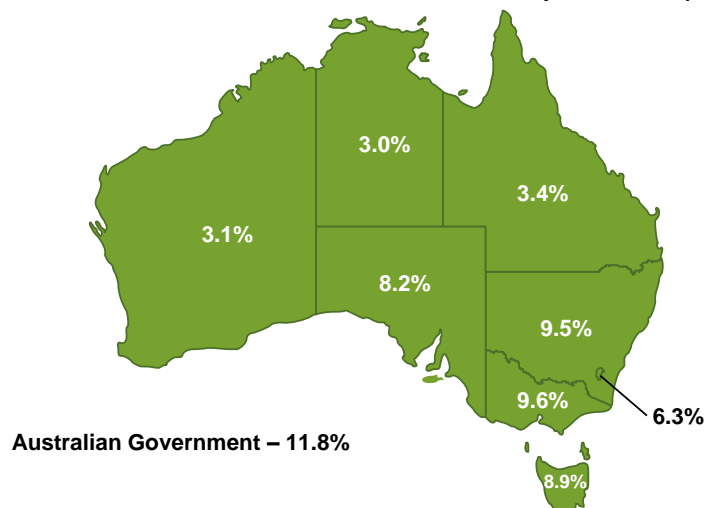
While only about 6% of all workers compensation claims in Australia are for work related mental health conditions, the cost of these claims is typically about 2.5 times the cost of other workers compensation claims, involve 2.5 times more time off work (the median time off work for mental health related workers compensation claims is 16 weeks, compared with 6 weeks for other claims), and are much less likely to be accepted.

In some workers compensation schemes, there can be delays in providing treatment while liability is being determined, which in turn delays recovery and return to work. Over recent years, occupations with the most work-related mental health claims have been police, fire fighters and defence force members (9% of all serious claims), school teachers (8%), followed by health and welfare support workers (6%) (figure 8).

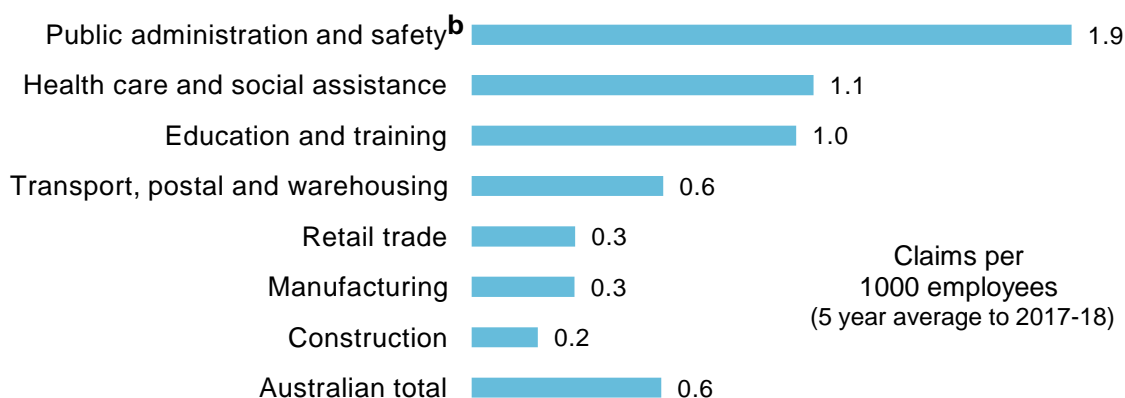
To get people back to healthy lives, including working productively, as quickly as possible, early identification and treatment of mental illness should be encouraged by amending, as a **priority**, workers compensation schemes to fund clinical treatment (including any required rehabilitation) for all mental health related workers compensation claims. This should be provided regardless of liability, until the injured worker returns to work or up to a period of six months following lodgement of the claim. Similar provisions should be required of companies who are self-insurers. There would be no compensation under this provision for loss of income.

Figure 8 **Mental stress related workers compensation claims^a**

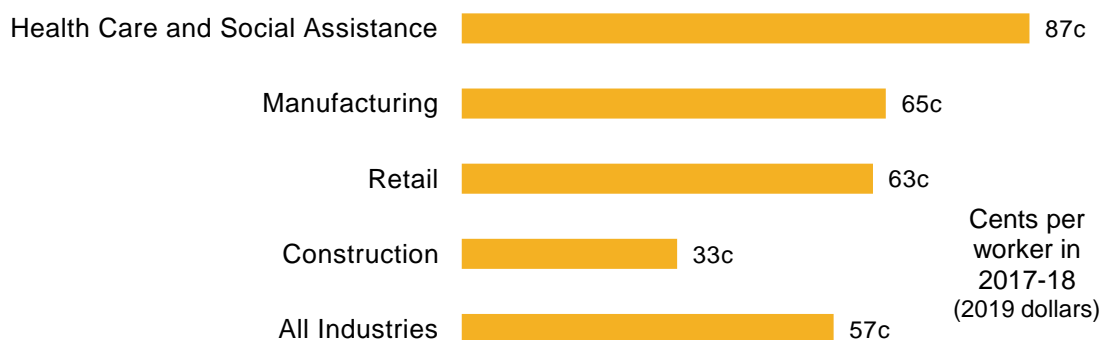
Mental stress claims as a share of all serious accepted claims (2017-18)



Incidence of serious accepted mental stress claims by selected industry



Increase in costs per employee of providing clinical treatment for 6 months



^a Serious claims are those that resulted in at least a week's absence from work. ^b Public administration and safety includes police services, investigation and security, fire protection and other emergency services, correctional and detention services, regulatory services, border control and other public order and safety services.

We estimated that this provision would cost in the order of 0.6% of the total annual premium revenue received by insurers. At the enterprise level (were insurers to pass on the cost of this), the provision would translate to a very small annual additional cost per worker. Given the very small additional costs involved, coupled with the significant benefits achievable through early intervention and early return to work, funding treatment through workers compensation schemes would be an effective approach to improving outcomes for mental health related workers compensation claims. This reform would not only get people experiencing mental illness the help they need earlier, but it is estimated to increase the value of economic production for those businesses that offer such support to their employees.

Additional reforms to motivate improved workplace mental health

Complementing these priority reforms, workplace health and safety agencies should develop and implement codes of practices to assist employers, particularly small employers, to better manage psychological risks in the workplace. They should also monitor (potentially through industry associations) and build a better evidence base on employer-initiated interventions and advise employers of interventions that would likely be effective in protecting and improving the mental health of their employees. This will bring clarity for employers, in what is currently a highly complex web of legal requirements and expectations, and help them and their employees gain the benefits of reduced absenteeism and presenteeism in their workplace.

For employers who implement workplace initiatives and programs that have been considered by the relevant Workplace Health and Safety authority to be highly likely to reduce the risks of workplace related psychological injury and mental illness for that specific workplace, workers compensation schemes should provide for more flexibility in premiums.

For people with mental illness who are searching for work

Although most people with mental illness indicate that they want to work, some find it nearly impossible to either secure a job or retain it while experiencing mental illness.

As a **priority reform** for people with mental illness, Individual Placement and Support (IPS) programs, like those mentioned above for young adults, should be rolled out on a staged basis for all job seekers with mental illness, allowing for the incorporation of lessons learned at each stage, across Australia. Approximately 40 000 people with mental illness are estimated to potentially benefit from participation in IPS. The expenditure to implement IPS is estimated to be lower than the substantial healthcare cost savings, a reduction in costs associated with Disability Employment Services, and some additional employment income.

We identified additional reforms that should also be considered for people with mental illness who participate in Australia's current employment support services — jobactive, Disability Employment Services and the Community Development Program. These services tend to place participants with mental illness (including those with complex needs) into programs that offer limited assistance with job searching and penalise participants when they

fail to complete mutual obligation requirements, where required. The assessment tools for these services should be reviewed, with consideration given to adding a mental health diagnostic instrument to the job seeker classification instrument and supplementing the employment services assessment with a personal and social performance measure.

The Australian Government should also ensure that employment service providers are meeting their obligations to provide personalised job plans that are useful to the individual, targeted at job seekers with complex needs. This should include extending the period of time that participants have to consider and propose changes to their job plan and greater flexibility in the application of the targeted compliance framework for those participants experiencing mental illness.

For those people with mental illness in need of income support

Australia's income support system would ideally enable people with episodic mental illness to flexibly transition on and off income support as their functional capacity to earn income changes with their health. Similarly, those who care for someone with mental illness should have access to income support that is flexible to their circumstances. The episodic nature of many mental illnesses can mean that study or work that is on a part-time rather than full-time basis not only remains possible but is essential to a person's recovery and continued social inclusion.

Approximately 191 000 people with a mental illness receive income support through the JobSeeker Payment or Youth Allowance. A further 259 000 people receive the Disability Support Pension (DSP) because of a psychological or psychiatric disability — this is about one third of all DSP recipients, although one estimate suggests that over half of all DSP recipients have a mental illness. And 76 000 Australians receive Carer Payment to support someone who has a psychological or psychiatric disability, while a number of other carers of people with mental illness receive the Age Pension, JobSeeker Payment or Youth Allowance.

While DSP recipients with psychological or psychiatric disabilities may work while continuing to receive a benefit, very few do so. Many recipients have a limited capacity to work, but for those who do, the weekly hour limit above which the DSP is not payable should be increased from 30 hours to 38 hours, to reduce any disincentive to engage in employment.

To better meet the needs of carers whose care recipient has a mental illness, the Australian Government should amend eligibility criteria for the Carer Payment and Carer Allowance to reflect that: the nature of care provided for someone with mental illness is not necessarily as 'constant' as that for a physical illness, can vary substantially from day to day, and is less likely to relate to the care recipient's 'bodily functions'. To provide more flexibility for the carer in undertaking their own economic and social activity, the restriction on hours that the carer can work should be evaluated over a month rather than each week, and the restrictions on study and volunteer activity should be removed.

Use of insurance to enable ongoing economic and social participation

Given the large number of people who experience mental illness, the negative impact that mental illness has on capacity to earn an income, and the extent to which insurance is used to offset personal financial risk, it is not surprising that the insurance sector is particularly relied on by some people with mental illness. Access to insurance — including life insurance, income protection insurance, temporary or permanent disability insurance, private health insurance and travel insurance — that covers mental illness has been raised as a concern during the Inquiry. One survey found that of those who identified as a mental health consumer and had applied recently for income protection insurance, only 8% had received the product without exclusions or additional premiums.

Insurer practices pertaining to mental health — such as blanket exclusions, the extent to which differences between different types of mental illness are taken into account in assessing risk, information provided to applicants and claimants, and insurer access to clinical records — should be independently reviewed.

5. Instil incentives and accountability for improved outcomes



PRIORITY REFORMS

- Develop implementation plans for national strategies that integrate healthcare and other services
- Commit to regional planning, decision making and commissioning, with systemic cooperation and creation of new commissioning agencies if outcomes not improved
- Expand the remit and independence of the National Mental Health Commission
- Consumer and carer participation and advocacy in all aspects of the mental health system
- Strengthen evaluation culture, focusing on outcomes that matter to people and reporting at service provider level

To reform Australia's mental health system we need to reform the way our governments manage that system.

A range of the reforms canvassed in this report, including a new national digital mental health platform for rigorous assessment and referral, and the integration and coordination of support services to provide seamless care for people, necessitate institutional change within and between each tier of Australia's governments. A whole-of-government approach, whereby different tiers of government work together to improve the mental health system, would be required, with the Australian and the State and Territory Governments held jointly accountable for the outcomes of the mental health system for people (figure 9).

This section focuses on the priority reforms to: deliver integrated care for Australians with mental illness; motivate the funding and commissioning of services that are needed locally by people; and inject accountability to deliver improved outcomes for people. We were

unable to quantitatively assess the net benefits of reforms in these areas, but consider many of these to be important underpinnings of a more flexible and integrated mental health system for Australia's future. In some cases, reforms could be expected to significantly improve the efficacy of expenditure in the mental health system.

Arrangements to lock in integrated care

As the above discussion makes clear, creating a person-centred mental health system requires coordinated reform beyond health. It requires the health system to work together with community and Indigenous services, social security, public housing, education, justice and employment relations.

A number of the recommended reforms detail ways to enhance service integration on the ground. But the only way to make these arrangements endure beyond current players and government interests is to reform the underpinning governance and funding arrangements that create incentives and accountability.

The Productivity Commission recommends, as a **priority reform**, a whole-of-government commitment to a new national mental health strategy. This strategy should comprehensively integrate the roles played by health and non-health sectors, identifying (in collaboration with consumer, carer and cultural diversity representatives) necessary action by not just health agencies, but also by relevant non-health agencies in the Commonwealth and the States and Territories. Additional to this commitment, the Australian Government should, as a **priority reform**, expedite the development of an implementation plan for the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023*.

An important step in the implementation of such a strategy would be the creation of an interjurisdictional special purpose mental health council (SPMHC). The SPMHC would comprise Australian, State and Territory Government health (or mental health) ministers plus ministers of selected social policy portfolios on 18 month rotations. The SPMHC would report annually to Governments on progress against the National Mental Health Strategy and prioritised actions, in integrating mental healthcare between health and non-health agencies.

Reforms to funding and commissioning

Current funding arrangements in the mental health system contribute to persistent gaps in care (including the missing middle described above), inefficient use of taxpayer funds, and poor consumer outcomes. For example, in healthcare, funding arrangements mean that local hospital networks have few incentives to minimise hospitalisations and avoid repeated presentations to EDs. Beyond the healthcare system, funding for other services such as psychosocial supports is fragmented and based on short contract cycles, which make it harder to deliver quality services on a continuous basis to people. Similarly, mental health

interventions delivered in schools and other types of community services are funded through a very wide range of programs, leading to duplication, inefficiency and unnecessary red tape.

To deliver improved outcomes for people involves both addressing the current gaps in care and investing in prevention and early intervention to reduce the future costs and generate long term economy-wide benefits.

In working toward a person-centred mental health system, Governments should reform how they fund and commission mental health services. Reforms aim to improve outcomes for people by:

- creating effective incentives for both intra-government and inter-government coordination and cooperation with clear responsibility and accountability for consumer outcomes
- regional decision making, founded on comprehensive regional level planning of needs and services to eliminate gaps in care.

Cooperative regional planning and service funding to address care gaps

In the Inquiry draft report, we presented two options for how to reform mental health funding and commissioning arrangements. The first — the ‘Renovate Model’ — was largely a continuation of the current approach, with some changes that would give more flexibility to PHNs. The second — the ‘Rebuild Model’ (the Productivity Commission’s stated preferred approach) — was to have most mental health funding held in regional funding pools controlled by each State and Territory Government and administered by Regional Commissioning Authorities (RCAs). The RCAs were intended to overcome unnecessary and inefficient care discontinuities, duplication and gaps that would otherwise persist at the interface between Australian Government and State and Territory Government responsibilities.

Feedback on these options was mixed and we concluded that no single approach was likely to work in all States and Territories, given the diversity of positions they are starting from. Instead, we recognise that each State and Territory would need to assess for itself the trade-offs it needs to make to set it on a path to achieving the goals for improved funding and service commissioning.

In this final report, the Productivity Commission recommends a flexible approach that would allow each jurisdiction — States, Territories and the Commonwealth — to determine as a **priority reform**, if, and how, planning and service delivery at a regional level can occur cooperatively with current PHN–LHN groupings. If this can occur, then it should be tried and tested. If such cooperation is not possible, or if it is tried and proves unsuccessful in driving improved consumer outcomes, then the Productivity Commission considers that the creation of RCAs (under the State or Territory Government), with no involvement by PHNs in mental health commissioning, offers the best chance for getting people the services that they need at a regional level.

Some States or Territories, particularly those where existing PHN-LHN relationships are poor, may seek to create RCAs immediately, recognising that this is their best path to improve mental health and psychosocial support service commissioning. Other States or Territories with strongly cooperative PHN-LHN groupings may prefer to retain existing institutional structures that are working for consumers. However, the option of establishing RCAs to administer pooled mental health funding from both tiers of government and to commission mental health and psychosocial support services should remain available to any State or Territory at any stage. In order to incentivise cooperation and reform, all Governments should commit to the creation of RCAs in the event that PHN-LHN cooperation does not achieve sufficiently improved outcomes within an agreed time period.

Separate (and additional) to the decision about retaining existing PHN-LHN groupings or creating RCAs, considerable reform is necessary by all Governments to deliver improved outcomes.

From the *Australian Government*:




- Guidance on evidence-based practices, public transparency on aspects such as PHN activities, funding, compliance with assessment and referral requirements and with developing and implementing regional plans cooperatively with LHNs, are essential for accountability and ongoing improvement in outcomes, and for credibility on a commitment to improving mental health outcomes.
- Also necessary would be reforms to the way services are commissioned through PHNs. All currently funded services should be required to publicly demonstrate to their region's PHN how they contribute to filling service gaps identified in the relevant joint regional plan. Ongoing funding for these services would then be a decision for the PHN, subject to ministerial approval. In the case of mental health services for Aboriginal and Torres Strait Islander people, Aboriginal Community Controlled Health Services should be identified as preferred providers.

From *State and Territory Governments*:

- Extending activity-based funding to community ambulatory mental health services would both increase their efficiency (by motivating a higher proportion of time to be spent on consumer-related activities) and reduce incentives of local hospital networks to prioritise hospital-based care.
- Increased transparency on funding to, and outcomes delivered by, non-government organisations (NGOs) and other providers of mental health services would also promote improved outcomes for people and represent a necessary first step to delivering integrated services for people.
- For those States or Territories that establish RCAs, the above recommended funding and commissioning reforms for PHNs should similarly be applied to RCAs.

These arrangements should be underpinned by a new intergovernmental agreement. The *National Mental Health and Suicide Prevention Agreement* would clarify the roles and responsibilities of the Australian Government and State and Territory Governments and establish funding commitments by both levels of government.

Figure 9 Reforms to governance of the mental health system

 Strategy
<p>Aim: Commit to a more strategic and cross-portfolio approach to mental health that prioritises prevention, early intervention and recovery.</p> <p>Action: Develop a new whole-of-government <i>National Mental Health and Suicide Prevention Strategy</i> that aligns the collective efforts of health and non-health sectors.</p> <p>Establish a <i>Special Purpose Mental Health Council</i> comprised of health or mental health ministers plus ministers of selected social policy portfolios to facilitate mental health reforms across health and non-health portfolios.</p> <p>Expedite the development of an implementation plan for the national strategy for improving the social and emotional wellbeing and mental health of Aboriginal and Torres Strait Islander people.</p>
 Funding and commissioning of services
<p>Aim: Promote efficient use of funds underpinned by clear government responsibilities and regional decision-making.</p> <p>Action: Bolster cooperative arrangements between PHNs and LHNs through rigorous joint regional planning and stronger oversight.</p> <p>If PHN–LHN cooperation fails to improve outcomes, State and Territory Governments to establish <i>Regional Commissioning Authorities</i> on a State/Territory-specific basis to pool mental health funds from both levels of government and undertake all commissioning.</p>
 Monitoring, reporting and evaluation
<p>Aim: Develop a self-learning mental health system by improving the evidence base for policy and program development, strengthening accountability for implementation and building a strong evaluation culture.</p> <p>Action: Give the <i>National Mental Health Commission</i> statutory authority to:</p> <ul style="list-style-type: none"> – monitor and report on progress towards achieving system-wide outcomes across health and non-health portfolios – monitor and report on PHN–LHN cooperation or development of Regional Commissioning Authorities – lead transparent evaluation of significant mental health and suicide prevention programs funded by governments, including non-health related programs. <p>Task the <i>Australian Institute of Health and Welfare</i> to lead development of mental health services data and gap analyses at a State, Territory and national level.</p>

Monitoring, evaluation and reporting for improved outcomes

Improved monitoring, reporting and evaluation are needed to drive the shift to a person-centred, outcomes-focused mental health system that is flexible to Australia's mental health needs. Key aspects of this are instilling accountability for outcomes and an expectation of continuous improvement in service and program delivery for people.

Require accountability for outcome improvements

National leadership, guidance and coordination of the mental health system needs to be strengthened and a culture of transparent evaluation created. Central to this, the National Mental Health Commission (NMHC) should, as a **priority reform**, be afforded statutory authority status as an *interjurisdictional* body. The NMHC would be tasked with:

- leading the development of the new national mental health strategy and the next national mental health action plan
- monitoring and reporting on progress with joint regional planning and the implementation of plans through cooperative regional commissioning
- reporting independently on whole-of-government implementation and performance of mental health reforms, including system performance and efficacy, and the **priority reforms** of benchmarking mental health outcomes against agreed targets, and consumer and carer involvement and advocacy
- creating an evaluation culture in which evaluations and a culture of learning and improvement would be embedded into program design and regular reporting, including before interventions are funded and scaled up, during implementation and when their intended impacts are realised
- undertake transparent evaluation of prioritised mental health and suicide prevention programs that are funded by the Australian, State and Territory Governments, and other programs that have strong links with mental health outcomes, including those in non-health sectors.

Rigorous evaluations of programs and policies in the mental health system are very important — and very rare. Evaluation should be embedded into program design, not only to ensure that public funds are spent efficiently (for example, by requiring estimates of program cost-effectiveness in funding applications for programs) but also to ensure that programs contribute positively to mental health and wellbeing, and that any lessons learned can be included in future delivery of these and subsequent programs. All Australian Governments should work toward shifting evaluations from a monitoring of program outcomes to measuring the attributable impact of programs.

Underpinning these functions would be an increased focus on use of data to inform decision making of governments (on the efficient use of taxpayer funds), clinicians and other service providers (on the effectiveness and appropriateness of intervention and referral options), and consumers (on the choice of service providers and treatment options). Vast amounts of data

are collected throughout the mental health system, but the system as a whole is data rich and information poor: there is limited use of data to either improve people's choices, experiences and outcomes, or inform improvements in service delivery and effectiveness. For example, data on specialised mental health services collected by State and Territory Governments, data on services commissioned by PHNs, and data in the National Outcomes and Casemix Collection are all underutilised.

Governments should, as a **priority reform**, require monitoring and reporting at the service provider level and services should expect to report outcomes of their activities in exchange for the substantial taxpayer funding and subsidies they receive. Such reporting should include the performance of MBS-rebated mental health services and government subsidised NGO-provided services (such as psychosocial support providers). This would encourage improvements in service quality, transparency and accountability, and inform consumer choice. Long time frames and the interaction of multiple services to improve outcomes complicate reporting on service outcomes, but there is agreement on some basic indicators, to which outcome measures recommended in this report should be added. The Australian Institute of Health and Welfare should be resourced to bring together and publish the additional mental health system data, as a **priority** — including regional level data to be used by regional commissioning bodies for the analysis of gaps between each region's needs and the services delivered — and to undertake such gap analyses at State, Territory and national levels.

Additional reforms to support continuous improvement in the mental health system

Supporting the priority reforms are other data collection and use measures that should be implemented by all Governments and service providers, and research gaps that should be addressed, to support continuous improvement in the mental health system.

There remain considerable gaps in data from some service providers (including PHN-commissioned services and NGO-provided services) and in outcomes of programs, as determined by the people who use them. While reporting information back to governments might seem secondary to providing services to people in need, programs evidenced by data are more likely to be viewed credibly by consumers, referring clinicians, and funders, and have greater scope to improve over time.

Research to fill crucial gaps in the evidence base of what interventions are effective and under what circumstances, is needed to inform best practice treatment that enhances people's wellbeing and ongoing life within their family, kinship groups and community, in both the short and long term. Collaborative centres for research are one approach that has potential to drive research improvements. However, in the first instance, an expansion in research in a coordinated way should be supported by the establishment of a national clinical trials network in mental health and suicide prevention.

RECOMMENDATIONS

For ease of cross-referencing, the number of each recommendation is aligned with the relevant chapter that provides the supporting detail for the recommendation. There are no recommendations associated with chapters 1, 2 or 3.

RECOMMENDATION 4 — CREATE A PERSON-CENTRED MENTAL HEALTH SYSTEM

Governments should create a mental health system that places people at its centre.

The needs, preferences and aspirations of the people who use the system, as well as their families and carers, should shape all parts of a person-centred system — from the work of the individual clinician to the policies proposed by decision makers — to create recovery-oriented services and supports.

A person-centred mental health system would enable people to access the combination of healthcare and community services that will best help them to recover from mental illness and to achieve the outcomes that matter to them. People should be empowered to choose the services most suitable for them, and these services should be evidence-based and responsive to their cultural, social and clinical preferences.

Creating such a system is a long-term goal that would require a number of reforms over many years. There are, however, actions that governments should take now to begin improving people's lives.

As a priority, governments should:

- work towards filling gaps and addressing barriers in the services available to people who need support due to mental ill-health, and their families and carers (Recommendations 5, 7, 8, 9, 11, 12, 13, 18)
- remove barriers to collaboration within and between different parts of the mental health system, by actively encouraging information sharing and coordination between health service providers (Recommendations 10, 14); by creating systems and processes that bring together the range of treatments and supports that people may choose (Recommendations 10, 12, 15); and by reforming funding, to incentivise better cooperation and collaboration across mental health services (Recommendation 23)
- improve coordination and integration between health and other services to better promote recovery (Recommendations 5, 7, 15, 17, 20, 21, 22)
- improve the efficacy of supports delivered through schools and workplaces, to promote better mental health and early intervention (Recommendations 5, 7)
- establish an evaluation and monitoring system that focuses on outcomes, and ensures that mental health services are effective in supporting recovery (Recommendation 24).

RECOMMENDATION 5 — FOCUS ON CHILDREN'S WELLBEING ACROSS THE EDUCATION AND HEALTH SYSTEMS

Governments are investing significant efforts in children's wellbeing — but can achieve much more with an outcomes-focused approach that measures success, and enables improvements in leadership, training and resourcing.

As a priority:

- The mental health of parents affects the social and emotional wellbeing of their children. Governments should take coordinated action to achieve universal screening for mental illness for all new parents. (Action 5.1)
- Governments should update the National School Reform Agreement to include student wellbeing as an outcome for the education system. This would include clear, measurable wellbeing targets. All parts of the education system would be expected to work towards achieving these targets. (Action 5.3)
 - To implement this, Governments should develop guidelines for initial teacher education and professional development programs, to incorporate social and emotional development and mental health. State and Territory teacher regulatory authorities should use the guidelines to accredit providers. (Actions 5.3, 5.4)
 - All schools should be required to report on their progress against wellbeing outcomes, as set out in an updated National School Reform Agreement. Schools would be able to apply for special purpose grants to strengthen their wellbeing policies. (Action 5.6)

Additional reforms within the education system that should be considered:

- Special purpose grants should be established to enhance the ability of early childhood education and care services to support the social and emotional development of children. Grants should be allocated based on need, to fund professional development for staff, and to enable services to access advice from mental health professionals. (Action 5.2)
- Governments should develop national guidelines for the accreditation of social and emotional learning programs delivered in schools. (Action 5.5)
- The upcoming evaluation of the Disability Standards for Education should review the effectiveness of disability funding structures for children with social-emotional disability. State and Territory Governments should review outreach programs for children who have disengaged from their schooling due to mental illness. (Action 5.8)

Additional reforms within the health system that should be considered:

- State and Territory Governments should expand routine health checks in early childhood to include social and emotional wellbeing. (Action 5.2)
- State and Territory Governments should collect data on children's mental health and use of mental health services, and use this data for ongoing improvement of both mental health services and school mental health programs. (Action 5.7)

RECOMMENDATION 6 — SUPPORT THE MENTAL HEALTH OF TERTIARY STUDENTS

The accountability of tertiary education providers should be strengthened with expanded mental health support to their students, including international students.

Reforms that should be considered:

- Tertiary education institutions should continue to expand online mental health services to meet student needs. These services should incorporate de-identified data collection on the mental health of students to enable ongoing improvements in the effectiveness and relevance of mental health support services. (Action 6.1)
- Tertiary education institutions (or their representatives) should make arrangements with insurers providing Overseas Student Health Cover to their international students to ensure there is adequate coverage for any required mental health treatment (including the scheduled fees for treatment and potentially some portion of the student's out-of-pocket expenses). They should also ensure their counselling services are able to meet the language and cultural diversity needs of their international students. (Action 6.2)
- The Australian Government should require all tertiary education institutions to have a student mental health and wellbeing strategy that includes, but is not limited to, staff training. This strategy would be a requirement for registration and would be assessed by the Tertiary Education Quality and Standards Agency or Australian Skills Quality Authority as part of the registration process. (Action 6.3)
- The Australian Government should develop or commission guidance for non-university higher education providers and Vocational Education and Training providers on how they can best meet students' mental health needs. (Action 6.4)
- The Tertiary Education Quality and Standards Agency and the Australian Skills Quality Authority should monitor and collect evidence from interventions initiated by tertiary education providers to improve mental wellbeing and mental health of students and staff. They should then disseminate information on best practice interventions to tertiary education providers. (Action 6.3)

RECOMMENDATION 7 — EQUIP WORKPLACES TO BE MENTALLY HEALTHY

There are benefits to workers, employers and the wider community from improvements to workplace mental health that lower employee absenteeism, increase productivity and reduce mental health related compensation claims.

As a priority:

- Australian, State and Territory Governments should amend Workplace Health and Safety arrangements in their jurisdiction to make psychological health and safety as important in the workplace as physical health and safety. (Action 7.1)
- Workers compensation schemes should be amended to provide and fund clinical treatment and rehabilitation for all mental health related workers compensation claims for up to a period of 6 months, irrespective of liability. (Action 7.4)

Additional reforms that should be considered:

- Workplace Health and Safety authorities should develop codes of practice to assist employers, particularly small businesses, meet their duty of care in identifying, eliminating and managing risks to psychological health in the workplace. (Action 7.2)
- Workers compensation schemes should be permitted to provide more flexibility in premiums for employers who implement workplace initiatives and programs that are considered highly likely to reduce the risks of workplace related psychological injury and mental illness for that specific workplace. (Action 7.3)
- Employee assistance program providers and their industry bodies, along with employers and employee representatives, should develop minimum standards for employee assistance programs and for the evaluation of these programs. (Action 7.5)
- Workplace Health and Safety agencies should monitor and collect evidence from employer-initiated interventions to create mentally healthy workplaces and improve and protect the mental health of their employees and advise employers of effective interventions that would be appropriate for their workplace. (Action 7.6)

RECOMMENDATION 8 — SUPPORT THE SOCIAL INCLUSION OF PEOPLE LIVING WITH MENTAL ILLNESS

People with mental illness are particularly likely to experience social exclusion. There are a number of actions that would improve the ability of people with mental illness to participate socially and experience inclusion.

As a priority:

- The National Mental Health Commission should develop and drive a National Stigma Reduction Strategy designed to reduce stigma towards people with mental illness. (Action 8.1)

Additional reforms that should be considered:

- Best practices for partnerships between traditional healers and mainstream mental health services for Aboriginal and Torres Strait Islander people should be evaluated. (Action 8.3)
- To better support people to live fulfilling lives, changes should be made to improve how the insurance sector interacts with people with mental illness. (Action 8.2)
 - The Financial Services Council should update insurance sector training requirements to ensure an improved understanding of mental illness across the sector.
 - Insurance industry Codes of Practice and industry standards that relate to the provision of services to people with mental illness should be evaluated by the Australian Securities and Investments Commission to ensure that the insurance industry has removed blanket exclusions, differentiates between different types of mental illness and has implemented standardised definitions of mental illness.
 - The Australian Law Reform Commission should review whether protocols for insurer access to clinical records have led to better targeted requests for clinical information and whether they sufficiently protect people with clinical histories that include seeking psychological treatment or counselling.

RECOMMENDATION 9 — TAKE ACTION TO PREVENT SUICIDE

Suicide and attempted suicide create enormous social, emotional and economic impacts on individuals, families and the broader Australian community.

As a priority:

- The Australian, State and Territory Governments should offer effective aftercare to anyone who presents to a hospital, GP or community mental health service following a suicide attempt. Effective aftercare should include culturally capable support before people are discharged or leave a service, and proactive follow-up support within the first day, week and three months of discharge. (Action 9.1)
- Indigenous communities should be empowered to prevent suicide. (Action 9.2)
 - The Australian, State and Territory health ministers should initiate and implement a renewed Indigenous-led National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and Implementation Plan to guide suicide prevention in Indigenous communities.
 - Commissioning bodies should ensure that Indigenous organisations are the preferred providers of suicide prevention activities for Aboriginal and Torres Strait Islander people.

Additional reforms that should be considered:

- Structural changes can be made by governments to improve the delivery of interventions to prevent suicide across Australia (Action 9.3), including:
 - extending the National Suicide Prevention Implementation Strategy to include strategic direction for non-health government portfolios that affect suicide prevention activities
 - identifying responsibilities for suicide prevention across different levels of governments and portfolios in order to create a whole-of-government approach to suicide prevention
 - having the National Mental Health Commission assess the evaluations of current suicide prevention with the aim of implementing successful approaches across Australia.

RECOMMENDATION 10 — INCREASE INFORMED ACCESS TO MENTAL HEALTHCARE SERVICES

Gateways to mental healthcare should be accessible, affordable, and empower people to make informed choices between a range of service and provider options that are evidence-based and clinically recommended for the individual, given their condition and circumstances.

As a priority:

- The Australian Government should fund the development and ongoing provision of a national digital mental health platform, to be co-designed with consumers and clinicians. (Action 10.4) The platform should provide:
 - a tool for free person-centred assessment and referral, to be used by GPs and by individuals to access mental health clinician-supported online assessment and referral
 - ... it should provide clearer guidance on evidence-based interventions and services that would and would not be recommended to meet an individual's needs, given their current circumstances
 - ... it should replace the Mental Health Treatment Plan as a requirement for accessing MBS-rebated Psychological Therapy Services and Focused Psychological Strategies.
 - digital low-intensity services that are low-cost, accessible and evidence-based; initially this should include supported online treatment (Action 11.1) and short-course, structured therapy delivered by videoconference or phone
 - provide a gateway to other clinical treatment and non-clinical support services, delivered digitally or face-to-face, and in time, connect to the recommended navigation portals. (Action 15.2)
- The Australian Government should require that all mental health prescriptions include a prominent statement saying that clinicians have discussed possible side effects and evidence-based alternatives to medication, prior to prescribing. (Action 10.2)

Additional reforms that should be considered:

- The Australian Government should introduce a Medicare item for GPs and paediatricians to get advice from a psychiatrist about a patient under their care. (Action 10.3)
- All referrals to specialist mental health clinicians should include a statement advising people that they can choose their provider, with referring clinicians to support people in choosing. To help consumers choose, the Australian Government Department of Health should include more information about mental health clinicians on the Medical Costs Finder website. (Action 10.1)
- The Australian Government should commission a review into off-label prescribing of mental health and other medications in Australia. (Action 10.2)

RECOMMENDATION 11 — EXPAND SUPPORTED ONLINE TREATMENT

For many people, supported online treatment can provide a convenient, clinically effective, low-cost way for them to manage their mental illness. It should be an option that is available to people as a choice, while recognising that some people will prefer other treatment options or a combination of options.

As a priority, the Australian Government should:

- increase funding to expand supported online treatment for people with mental illness (Action 11.1)
- instigate information campaigns for consumers and health professionals to increase the awareness of supported online treatment as an effective and convenient treatment option. (Action 11.1)

Additional reforms that should be considered:

- To facilitate ongoing service improvement, the Australian Government should commission an evaluation of the performance of online treatment services. (Action 11.1)

RECOMMENDATION 12 — ADDRESS THE HEALTHCARE GAPS: COMMUNITY MENTAL HEALTHCARE

People with mental illness often cannot access the services that are right for them — because the services are not available, they do not know about them, or their location or cost mean they cannot access them. In addition, some services are not as effective for consumers as they should be.

As a priority:

- The Australian Government should commission a rigorous evaluation of MBS-rebated psychological therapy, including trials to test whether consumers would benefit from more sessions in a year, and to test the value to consumers of feedback-informed practice. (Action 12.3)
- The shortfall in community ambulatory services (including the shortfalls both in resources, and in how much time staff are spending on consumer-related activities) should be estimated and published at a State, Territory and regional level. Over time, State and Territory Governments, with support from the Australian Government should increase funding for community ambulatory services to the level required to meet population needs. (Action 12.4)
- State and Territory Governments should investigate and address the reasons for disparity between the amount of time clinical staff are spending on consumer-related activities and what is considered optimal. (Actions 12.4)
- The Australian Government should improve access to low-intensity mental health treatments through:
 - supported online treatment and short-course, structured therapy by telephone or videoconference across Australia, under a prominent and trusted brand, using the national digital mental health platform (Action 10.4)
 - making changes to Medicare to encourage the provision of more group therapy. (Action 12.1)
- The Australian Government should make permanent the changes to expand access to psychological therapy and psychiatric treatment by videoconference and telephone introduced during the COVID-19 crisis. (Action 12.2)

RECOMMENDATION 13 — IMPROVE THE EXPERIENCE OF MENTAL HEALTHCARE FOR PEOPLE IN CRISIS

Hospitals and crisis response services play a vital role in the continuum of care for people with severe and persistent mental illness. It is critical that these services are able to support the recovery of the person in a safe environment which meets their needs.

As a priority:

- To minimise unnecessary presentations to hospital emergency departments, State and Territory Governments should provide alternatives for people with mental illness, including peer- and clinician- led after hours services and mobile crisis services. (Action 13.1)

Additional reforms that should be considered:

- The shortfalls in mental health bed-based services should be estimated at a State, Territory and regional level. Over time, State and Territory Governments, with support from the Australian Government, increase funding to provide mental health bed-based services to meet population demand. (Action 13.3)
- In considering the safety of children, adolescents, and women within inpatient services, State and Territory Governments should work to ensure that hospitals have the capacity to provide mental health beds for children and adolescents that are separate from adult mental health wards, and configure adult wards to allow gender segregation. (Action 13.2)
- To improve the experience of people with mental illness who present at an emergency department:
 - public and private hospitals should take steps to ensure the emergency department environment does not escalate the severity of mental illness, such as through provision of separate spaces for people with mental illness
 - over time, governments should design emergency departments to take into account the needs of people with mental illness. (Action 13.1)
- Best practice approaches to the interactions of paramedics with people with mental illness — including providing paramedics with access to mental health resources when undertaking clinical assessments in the field — should be adopted by Governments in order to improve outcomes for both people with mental illness and paramedics. (Action 13.1)

RECOMMENDATION 14 — IMPROVE OUTCOMES FOR PEOPLE WITH COMORBIDITIES

Many people with mental illness and comorbid physical health problems or substance use disorders do not receive integrated care, leading to poor outcomes, including premature death. Action is needed to improve the care provided to people with comorbidities.

As a priority:

- The Australian, State and Territory Governments should agree to an explicit target to reduce the gap in life expectancy between people with severe mental illness and the general population, and develop a clear implementation plan with annual reporting against the agreed target. (Action 14.1)

Additional reforms that should be considered:

- All Governments should implement all the actions in the Equally Well Consensus Statement, including releasing clear statements covering how they intend to implement the initiatives, including time frames and outcomes against which progress can be measured. (Action 14.1)
- State and Territory Governments should integrate the commissioning and provision of mental illness and substance use disorder services at a regional level. (Action 14.2)
- Mental health services should be required to ensure treatment is provided for both mental illness and substance use disorder for people with both conditions. (Action 14.2)
- Mental health and alcohol and other drug services should jointly develop and implement operational guidelines covering screening, referral pathways, and training, guidelines and other education resources for mental health and alcohol and other drugs workers. (Action 14.2)
- The National Mental Health Commission should report annually on Australian, State and Territory Governments' progress in implementing the Equally Well Consensus Statement. (Action 14.1)

RECOMMENDATION 15 — LINK CONSUMERS WITH THE SERVICES THEY NEED

The overly complex and disjointed nature of the mental health system hampers consumers' ability to access the services they require. Reforms are needed to make the system easier to navigate and improve consumers' access to services.

As a priority:

- Governments and regional commissioning bodies should assess the number of people who require care coordination services and ensure that care coordination programs are available to match local needs. (Action 15.4)

Additional reforms that should be considered:

- The Australian Government should continue to develop and improve Head to Health and use it to inform the recommended national digital mental health platform. (Action 15.1)
- The Australian, State and Territory Governments should ensure that government funded real time consumer assistance services (provided by voice or text) are receiving sufficient funding to meet consumer demand, and require these services to implement warm referral processes, including a verbal handover. (Action 15.1)
- Regional commissioning bodies should develop and maintain online navigation portals that include detailed clinical and non-clinical referral pathways, which can be accessed by clinical and non-clinical service providers (Action 15.2). In time, these portals should be linked in with the national digital mental health platform (Actions 10.4, 15.2).
- Governments support the development of single care plans for consumers with moderate to severe mental illness who are receiving services from multiple providers. (Action 15.3)

RECOMMENDATION 16 — INCREASE THE EFFICACY OF AUSTRALIA'S MENTAL HEALTH WORKFORCE

The efficiency and effectiveness of Australia's mental health workforce can be improved by placing greater emphasis on the recovery needs of mental health consumers and considering new ways of delivering health services.

Reforms in workforce planning that should be considered:

- The Australian Government aligns the skills, costs, cultural capability, availability and location of mental health practitioners with the needs of consumers through the forthcoming National Mental Health Workforce Strategy. Workforce planning should factor in the potential for substitution between occupations and consider new ways of meeting consumer needs. (Action 16.1)
- The Australian Government in collaboration with stakeholders, should develop a new curriculum standard for a three-year direct-entry undergraduate degree in mental health nursing. In addition, a discrete unit on mental health should be included in all nurse training courses. (Action 16.4)
- Australian, State and Territory Governments develop a national plan to increase the number of psychiatrists in clinical practice — particularly those practising outside major cities and in sub-specialities with significant shortages. (Action 16.2)

Reforms to established workforce practices and sector perceptions that should be considered:

- The Australian Government should act to improve practitioners' training on medications and non-pharmacological interventions. (Action 16.3)
- The Australian Government should strengthen the peer workforce by providing once-off, seed funding to create a professional association for peer workers, and in collaboration with State and Territory Governments, develop a program to educate health professionals about the role and value of peer workers in improving outcomes. (Action 16.5)
- The Australian, State and Territory Governments, in collaboration with professional bodies, should incorporate mental health stigma reduction programs into the initial training and continuing professional development requirements of all health professionals. (Action 16.6)
- The Australian, State and Territory Governments, in collaboration with specialist medical colleges, should take further steps to reduce the negative perception of, and to promote, mental health as a career option. (Action 16.7)

RECOMMENDATION 17 — IMPROVE THE AVAILABILITY OF PSYCHOSOCIAL SUPPORTS

The delivery of psychosocial supports — including a range of services to help people manage daily activities, rebuild and maintain social connections, build social skills and participate in education and employment — has been hampered by inefficient funding arrangements and service gaps. This is affecting the recovery of people with mental illness and their families, who can benefit substantially from improved access to psychosocial supports.

As a priority:

- Governments should ensure that all people who have psychosocial needs arising from mental illness receive adequate psychosocial support. To achieve this:
 - The shortfall in the provision of psychosocial supports outside the National Disability Insurance Scheme (NDIS) should be estimated at a regional and State and Territory level. (Action 17.3)
 - Over time, State and Territory Governments, with support from the Australian Government, should increase the quantum of funding allocated to psychosocial supports to meet the estimated shortfall. (Action 17.3)

Additional reforms that should be considered:

- As contracts come up for renewal, commissioning agencies should extend the length of the funding cycle for psychosocial supports from a one-year term to a minimum of five years. Commissioning agencies should ensure that the outcome for each subsequent funding cycle is known by providers at least six months prior to the end of the previous cycle. (Action 17.1)
- State and Territory Governments and the National Disability Insurance Agency should streamline access to psychosocial supports both for people eligible for supports through the NDIS and for people who choose not to apply for the NDIS or are not eligible. (Action 17.2)
- State and Territory Governments should continue working with the National Disability Insurance Agency to clarify the interface between the mainstream mental health system and the NDIS. (Action 17.3)

RECOMMENDATION 18 — SUPPORT FOR FAMILIES AND CARERS

Governments assist families and carers by funding support services and income support payments. There is scope to improve access to these supports and to improve how families and carers are included by mental health services.

As a priority:

- All mental health services should be required to consider family and carer needs, and their role in contributing to the recovery of individuals with mental illness. (Action 18.1)
 - State and Territory Governments should be collecting and reporting on the Carer Experience Survey to encourage carer-inclusive practice.
 - The Australian Government should amend the Medicare Benefits Schedule to provide rebates for family and carer consultations.
 - State and Territory Governments should ensure the workforce capacity exists in each region to implement family- and carer-inclusive practices within their mental healthcare services.

Additional reforms that should be considered:

- The recommended National Mental Health and Suicide Prevention Agreement (Action 23.3) should state that State and Territory Governments will be responsible for planning and funding carer support services related to the mental health caring role and family support services for families affected by mental illness. (Action 18.2)
- The Australian Government Department of Social Services should evaluate the outcomes achieved for mental health carers from its carer support program. (Action 18.2)
- The Australian Government should amend the eligibility criteria for the Carer Payment and Carer Allowance to reduce barriers to access for mental health carers. (Action 18.3)

RECOMMENDATION 19 — TAILOR INCOME AND EMPLOYMENT SUPPORTS

Employment can be important for maintaining good mental health for people. There is considerable scope to reduce barriers to employment faced by people with mental illness and increase their workforce participation.

As a priority:

- All governments should act to extend the Individual Placement and Support (IPS) model of employment support beyond its current limited application through a staged rollout to community ambulatory mental healthcare services. (Action 19.4)
 - The rollout should be staged to allow Governments to thoroughly test and review how to tailor the IPS program in a cost effective manner to particular demographic groups and for people with different types of mental illness.
 - The program should initially be open to all non-employed working age consumers of community ambulatory mental healthcare services who express a desire to participate. Participation in the program should be considered to fulfil any mutual obligation requirements for income support recipients.
 - At each stage of the rollout, data should be shared between IPS sites, with a mechanism put in place to share lessons and best practice between programs on what works for particular targeted groups of participants. If the net benefits of the program apparent on a small scale to date are not replicated as the program is scaled up, its design (and if necessary, its desirability) should be re-appraised.

Additional reforms that should be considered:

- Processes for streaming of participants into employment support programs via improved employment support assessment tools should be tailored to people with mental illness by relevant governments. (Action 19.1)
- The Department of Education, Skills and Employment should ensure that the New Employment Services program includes design features that explicitly consider the needs of participants with mental illness as it is developed and later rolled out as a national program. (Action 19.2)
- For job seekers with complex needs, employment support providers should be required to assist with personalised Job Plans that go beyond meeting compliance obligations. (Action 19.3)
- Over time, the Australian Government should improve the work incentives for Disability Support Pension recipients and recipients should be well informed of their entitlement to work for a period without losing access to the Disability Support Pension by Services Australia. (Action 19.5)

RECOMMENDATION 20 — SUPPORTIVE HOUSING AND HOMELESSNESS SERVICES

Housing and homelessness services help prevent people with mental illness from experiencing housing issues and support people with mental illness to find and maintain housing in the community. But their current capacity falls well short of need.

As a priority:

- State and Territory Governments should, with support from the Australian Government, commit to a nationally consistent policy of no exits into homelessness for people with mental illness who are discharged from institutional care, including hospitals and correctional facilities. (Action 20.2)
 - People with mental illness who exit hospitals, correctional facilities or institutional care should receive a comprehensive mental health discharge plan and have ready access to transitional housing.

Additional reforms that should be considered:

- State and Territory Governments should provide mental health training and resources to social housing workers, and work with the relevant bodies, including the real estate institutes, to assist them in organising training and resources on mental health for private sector real estate agents. (Action 20.1)
- State and Territory Governments should review housing policies to better consider the needs of people with mental illness. This should include information sharing between housing authorities, acute mental healthcare facilities and correctional facilities. (Action 20.1)
- Tenants with mental illness who live in the private housing market should be provided the same ready access to tenancy support services as those in social housing. (Action 20.1)
- The effects of forthcoming reforms to residential tenancy legislation, including ‘no grounds’ evictions, should be assessed by State and Territory Governments to better understand the implications for people with mental illness. (Action 20.1)
- With support from the Australian Government, State and Territory Governments should address the shortfall in the number of supported housing places and the gap in homelessness services for people with severe mental illness. (Action 20.3)
- The National Disability Insurance Agency should continue to amend its Specialist Disability Accommodation strategy and policies to encourage development of long-term supported accommodation for National Disability Insurance Scheme recipients with severe and persistent mental illness. (Action 20.3)
- As part of the next negotiation of the National Housing and Homelessness Agreement, there would be benefit from governments increasing the quantum of funding for housing and homelessness services, including for the expanded provision of services for people with mental illness. (Action 20.3)

RECOMMENDATION 21 — IMPROVE MENTAL HEALTH OUTCOMES FOR PEOPLE IN THE JUSTICE SYSTEM

People with mental illness are over-represented throughout the justice system, including in correctional facilities and as victims of crime. There is considerable scope for improved mental healthcare for people in all parts of the justice system, and improved access to justice for people with mental illness and legal needs.

As a priority:

- State and Territory Governments should implement a systematic approach for responding to mental health related incidents to support all parties involved. Mental health professionals should be embedded in police communication centres and police, mental health professionals and/or ambulance services should be able to co-respond to mental health related incidents. (Action 21.2)
- State and Territory Governments should ensure that people appearing before mental health tribunals, and other tribunals hearing matters arising from mental health legislation, have a right to access legal representation. To facilitate this, State and Territory Governments should adequately resource legal assistance services for this purpose. (Action 21.8)

Additional reforms for people in the justice system that should be considered:

- An early intervention approach should be introduced to identify people with mental illness at high risk of contact with the criminal justice system, and provide supports to reduce the risks of them offending. (Action 21.1)
- State and Territory Governments should work to ensure that people with mental illness who would benefit from mental health court diversion programs, are able to access them. (Action 21.3)
- The Australian Commission on Safety and Quality in Health Care should review the National Safety and Quality Service Standards to determine how they can be implemented in correctional settings. (Action 21.4)
- State and Territory Governments should ensure that people with mental illness in correctional facilities have access to timely and culturally capable mental healthcare. (Actions 21.4, 21.6)
- The forensic mental health component of the National Mental Health Service Planning Framework should be completed and used by governments to inform planning and funding. (Action 21.5)

Additional reforms to improve access to justice that should be considered:

- State and Territory Governments should develop disability justice strategies and work towards integrating legal and health services (including through health justice partnerships) so that people with mental illness are better supported to resolve legal matters and participate in the justice system. (Action 21.7)
- Supported decision making by and for people with mental illness should be promoted through improved access to individual non-legal advocacy services (Action 21.9) and mental health advance directives. (Action 21.10)
- Governments should ensure that treatment orders in mental health legislation are mutually recognised between States and Territories. (Action 21.11)

RECOMMENDATION 22 — BEST PRACTICE GOVERNANCE TO GUIDE A WHOLE-OF-GOVERNMENT APPROACH

Governments should, in collaboration with consumers and carers, commit to a more strategic and cross-portfolio approach to mental health that promotes genuine accountability and that prioritises prevention, early intervention and recovery.

As a priority:

- The Australian, State and Territory Governments should develop a new whole-of-government National Mental Health Strategy that aligns the collective efforts of health and non-health sectors. (Action 22.1)
- The Australian Government should expedite the development of an implementation plan for the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023. (Action 22.2)
- The Australian, State and Territory Governments should establish a clear, ongoing role for consumers and carers in all aspects of mental health system planning, design, monitoring and evaluation. (Action 22.4)
- The National Mental Health Commission should have statutory authority. It should lead the evaluation of government-funded mental health and suicide prevention programs, and other government-funded programs that have strong links with mental health outcomes, including those in non-health sectors. (Action 22.7)

Additional reforms that should be considered:

- The Australian, State and Territory Governments should establish a Special Purpose Mental Health Council to facilitate mental health reforms across health and non-health portfolios. (Action 22.3)
- The Australian Government should fund separate representative peak bodies to represent the views, at the national level, of people with mental illness, and of families and carers. (Action 22.4)
- A national, independent review of Australia's system for handling consumer complaints that relate to the use of mental healthcare services and supports should be instigated. (Action 22.5)
- Where a body does not exist, State and Territory Governments should each establish a body (such as a mental health commission) that is responsible for strengthening government capability to pursue continuous policy and program improvement and fostering genuine accountability for mental health reform. (Action 22.6)

RECOMMENDATION 23 — FUNDING ARRANGEMENTS TO SUPPORT EFFICIENT AND EQUITABLE SERVICE PROVISION

Mental health planning and funding arrangements should be reformed to remove existing distortions, clarify government responsibilities and support regional decision making.

As a priority:

- Governments should strengthen cooperation between Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) by requiring comprehensive joint regional planning and formalised consumer and carer involvement.
 - The National Mental Health Commission should independently monitor and report on compliance by PHNs and LHNs against their commitments. (Action 23.1)
- The Australian Government should support State and Territory Governments that choose to establish regional commissioning authorities (RCAs) to administer mental health funding as an alternative to PHN-LHN groupings. (Action 23.4)

Additional reforms to clarify government roles that should be considered:

- State and Territory Governments should take on sole responsibility for psychosocial supports outside of the National Disability Insurance Scheme. (Action 23.2)
- All Governments should develop a National Mental Health and Suicide Prevention Agreement to clarify responsibilities and the new role of the National Mental Health Commission. It should also specify additional mental health and psychosocial support funding contributions by each level of government. (Action 23.3)

Additional reforms to funding arrangements that should be considered:

- The Australian Government Department of Health should reform the way that it allocates funding to PHNs (or RCAs) to support greater regional equity and remove incentives to engage in cost shifting. (Action 23.5)
- The Australian Government Department of Health should:
 - provide guidance on the evidence base that underpins different types of interventions and require PHNs (and RCAs) to demonstrate that they have commissioned evidence-based services that meet their catchment's needs
 - permit regional commissioning bodies to redirect to alternative services funding hypothecated to particular providers, if these providers are shown to not be meeting the service needs identified in regional plans
 - position Aboriginal Community Controlled Health Services as the preferred providers of services to Aboriginal and Torres Strait Islander people. (Action 23.6)
- The Independent Hospital Pricing Authority should review the Australian Mental Health Care Classification and develop an interim (simplified) model to allow State and Territory Governments to use activity-based funding for community ambulatory mental healthcare. (Action 23.7)
- The Australian Government Department of Health should establish a Mental Health Innovation Fund to trial new system organisation and payment models. (Action 23.8)
- The Australian Government should review the regulations that prevent private health insurers from funding community-based mental healthcare activities, and permit life insurers to fund mental health treatments for their insurance clients on a discretionary basis. (Actions 23.9, 23.10)

RECOMMENDATION 24 — DRIVE CONTINUOUS IMPROVEMENT AND PROMOTE ACCOUNTABILITY

A robust information and evidence base is needed to improve programs, policies, and outcomes for people with mental illness and carers. This requires that governments support data collection and use, transparent monitoring and reporting, program evaluations and practical research.

As a priority:

- The Australian, State and Territory Governments should agree on a set of targets and timeframes that specify key mental health and suicide prevention outcomes.
 - These targets should be co-designed with consumers and carers and include both quantitative and qualitative evidence and data.
 - Aboriginal and Torres Strait Islander people and the National Federation Reform Council Indigenous Affairs Taskforce should be included in discussions about any targets that may affect Aboriginal and Torres Strait Islander people (Action 24.4).
- The Australian, State and Territory Governments should require monitoring and reporting at the service provider level that is focused on consumer and carer outcomes (Action 24.5).
- The Australian Institute of Health and Welfare should publish data on mental health services at a national, State and Territory, and regional level that is aligned with the National Mental Health Service Planning Framework (NMHSPF); and gap analyses against NMHSPF benchmarks. Each regional commissioning body should report a regional-level gap analysis in their joint regional plan (Action 24.8).

Additional actions that should be considered:

- The Australian Government should fund regular national surveys of mental health and wellbeing (Action 24.2) and the establishment of a national clinical trials network in mental health and suicide prevention (Action 24.12).
- The National Mental Health Commission should include outcomes, activities and reforms from all relevant health and non-health portfolios in its national monitoring and reporting (Action 24.10).
- The Australian, State and Territory Governments should:
 - develop a strategy to improve the usability of data collections (Action 24.1) and ensure prioritised data and information gaps are addressed, including data on non-government organisations that provide mental health services (Action 24.3).
 - develop standardised and outcome-focused reporting requirements for service providers and report all data relating to the performance of services at a regional level (Actions 24.6, 24.7).
 - enhance and make all parts of the NMHSPF publicly available (Action 24.9).
 - require funding applications for mental health programs to include an assessment of their expected cost-effectiveness and require all new programs to have been trialled as pilots, before they can be scaled up (Action 24.11).