Australian Government

Productivity Commission

Mental Health

Productivity Commission
Draft Report
Volume 1

October 2019

This is a draft report
prepared for further public
consultation and input.
The Commission will finalise
its report after these processes
have taken place.

Publications enquiries

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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).

Opportunity for further comment

We invite examination of this draft inquiry report and comment on it by **written submission or comment** to the Productivity Commission, preferably in electronic format, by **23 January 2020** and/or by attending a public hearing.

The final report will be prepared after further submissions and comments have been received and public hearings have been held and will be forward to the Australian Government by end May 2020.

Public hearing dates and venues

Location	Date	Venue
Canberra	Friday 15 November 2019	Dialogue 4 National Circuit, Barton
Melbourne	Monday 18 November 2019 Tuesday 19 November 2019	Rattigan Rooms 1-2 L12, 530 Collins Street, Melbourne
Geraldton	Wednesday 20 November 2019	The Geraldton Club 160 Marine Terrace
Perth	Thursday 21 November 2019	Pan Pacific Perth 207 Adelaide Street
Sydney	Monday 25 November 2019 Tuesday 26 November 2019	Wesley Conference Centre 220 Pitt Street
Broken Hill	Thursday 28 November	Broken Hill Civic Centre 31 Chloride Street
Rockhampton	Monday 2 December 2019	Quality Hotel Regent Rockhampton 192 Bolsover Street
Brisbane	Tuesday 3 December 2019	Flex by ISPT (Dialogue) Central Plaza Annex Bldg 345 Queen Street
Launceston	Monday 9 December 2019	Launceston Conference Centre 50 Glen Dhu Street

South Australian and Northern Territory Public Hearings will be held at dates and locations to be advised in early 2020

Commissioners

For the purposes of this inquiry and draft report, in accordance with section 40 of the *Productivity Commission Act 1998* the powers of the Productivity Commission have been exercised by:

Prof. Stephen King   Presiding Commissioner

Ms Julie Abramson   Commissioner

Prof. Harvey Whiteford   Associate Commissioner

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.

Contents

The Commission's report is in two volumes. **This volume 1 contains the overview, recommendations and findings and chapters 1 to 16**. Volume 2 contains chapters 17 to 26, appendices A to E and references. Below is the table of contents for both volumes.

Volume 1

Volume 2

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. The insights of individuals from their use of mental health services and supports, and the stories of their carers and families, continue to be a much appreciated input to the inquiry.

The Commissioners express their appreciation to the inquiry Assistant Commissioner Rosalyn Bell, and the inquiry team who have undertaken extensive consultations across Australia, drafted this report and prepared the underlying analysis.

Abbreviations

ABF	Activity-based funding
ABS	Australian Bureau of Statistics
ADHD	Attention-Deficit Hyperactive Disorder
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and other drugs
CALD	Culturally and Linguistically Diverse
CAT	Crisis assessment and treatment
CBT	Cognitive behaviour therapy
COAG	Council of Australian Governments
CPI	Consumer Price Index
DALY	Disability-adjusted life year
DES	Disability Employment Services
DSP	Disability Support Pension
DSS	Department of Social Services
EAP	Employee assistance program
ECEC	Early childhood education and care
ED	Emergency Department
GDP	Gross Domestic Product
GP	General practitioner
IPS	Individual Placement and Support
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex and Queer
LHN	Local Hospital Network
MBS	Medicare Benefits Schedule
MCS	Mental component summary
MHN	Mental Health Nurse
MHR:CS	Mental Health Respite: Carer Support
MHTP	Mental Health Treatment Plan

NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NGO	Non-government organisation
NHRA	National Health Reform Agreement
NMDS	National Minimum Data Sets
NMHC	National Mental Health Commission
NMHSPF	National Mental Health Service Planning Framework
OECD	Organisation for Economic Co-operation and Development
PBS	Pharmaceutical Benefits Scheme
PHaMs	Personal Helpers and Mentors
PHN	Primary Health Network
PIR	Partners in Recovery
PORTS	Practitioner Online Referral Treatment Service
QALY	Quality-adjusted life-year
RACGP	Royal Australian College of General Practitioners
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCA	Regional Commissioning Authority
SEL	Social and emotional learning
WHS	Workplace health and safety
YLD	Years lived with disability
YLL	Years of life lost

OVERVIEW

Key points

Australia's mental health: a generational shift is needed

- In any year, approximately one in five Australians experiences mental ill-health. While most people manage their health themselves, many who do seek treatment are not receiving the level of care necessary. As a result, too many people suffer additional preventable physical and mental distress, relationship breakdown, stigma, and loss of life satisfaction and opportunities.

- The treatment of mental illness has been tacked on to a health system that has been largely designed around the characteristics of physical illness. But in contrast to many physical health conditions

  – mental illness tends to first emerge in younger people (75% of those who develop mental illness, first experience mental ill-health before the age of 25 years) raising the importance of identifying risk factors and treating illness early where possible.

  – there is less awareness of what constitutes mental ill-health, the types of help available or who can assist. This creates need for not only clear gateways into mental healthcare, but effective ways to find out about and navigate the range of services available to people.

  – the importance of non-health services and organisations in both preventing mental illness from developing and in facilitating a person's recovery are magnified, with key roles evident for — and a need for coordination between — psychosocial supports, housing services, the justice system, workplaces and social security.

  – adjustments made to facilitate people's active participation in the community, education and workplaces have, for the most part, lagged adjustments made for physical illnesses, with a need for more definitive guidance on what adjustments are necessary and what interventions are effective.

- The cost to the Australian economy of mental ill-health and suicide is, conservatively, in the order of $43 to $51 billion per year. Additional to this is an approximately $130 billion cost associated with diminished health and reduced life expectancy for those living with mental ill-health.

A path for maintainable long term reform

- Changes recommended are substantial but they would set Australia on a path for maintainable long term reform of its mental health system. Priority reforms are identified and a staged reform agenda is proposed.

Reform area 1: prevention and early intervention for mental illness and suicide attempts

- Consistent screening of social and emotional development should be included in existing early childhood physical development checks to enable early intervention.

- Much is already expected of schools in supporting children's social and emotional wellbeing, and they should be adequately equipped for this task through: inclusion of training on child social and emotional development in professional requirements for all teachers; proactive outreach services for students disengaged with school because of mental illness; and provision in all schools of an additional senior teacher dedicated to the mental health and wellbeing of students and maintaining links to mental health support services in the local community.

- There is no single measure that would prevent suicides but reducing known risks (for example, through follow-up of people after a suicide attempt) and becoming more systematic in prevention activity are ways forward.

Reform area 2: close critical gaps in healthcare services

- The availability and delivery of healthcare should be reformed to allow timely access by people with mental ill-health to the right treatment for their condition. Governments should work together to ensure ongoing funded provision of:

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Key points (continued)

- services for people experiencing a mental health crisis that operate for extended hours and which, subject to the individual's needs and circumstances, provide an alternative to hospital emergency departments
- acute inpatient beds and specialised community mental health bed-based care sufficient to meet assessed regional needs
- access to moderate intensity care, face-to-face and through videoconference, for a duration commensurate with effective treatment for the mental illness
- expanded low intensity clinician-supported on-line treatment and self-help resources, ensuring this is consistently available when people need it, regardless of the time of day, their locality, or the locality choices of providers.

Reform area 3: investment in services beyond health

- Investment is needed across Australia in long-term housing solutions for those people with severe mental illness who lack stable housing. Stable housing for this group would not only improve their mental health and inclusion within the community, but reduce their future need for higher cost mental health inpatient services.

Reform area 4: assistance for people with mental illness to get into work and enable early treatment of work-related mental illness

- Individual placement and support programs that reconnect people with mental illness into workplaces should be progressively rolled out, subject to periodic evaluation and ongoing monitoring, to improve workforce participation and reduce future reliance on income support.
- Mental health should be explicitly included in workplace health and safety, with codes of practice for employers developed and implemented.
- No-liability clinical treatment should be provided for mental health related workers compensation claims until the injured worker returns to work or up to six months.

Reform area 5: fundamental reform to care coordination, governance and funding arrangements

- Care pathways for people using the mental health system need to be clear and seamless with: single care plans for people receiving care from multiple providers; care coordination services for people with the most complex needs; and online navigation platforms for mental health referral pathways that extend beyond the health sector.
- Reforms to the governance arrangements that underpin Australia's mental health system are essential to inject genuine accountability, clarify responsibilities and ensure consumers and carers participate fully in the design of policies and programs that affect their lives.
  - Australian Government and State/Territory Government funding for mental health should be identified and pooled to both improve care continuity and create incentives for more efficient and effective use of taxpayer money. The preferred option is a fundamental rebuild of mental health funding arrangements with new States and Territory Regional Commissioning Authorities given responsibility for the pooled resources.
  - The National Mental Health Commission (NMHC) should be afforded statutory authority status to support it in evaluating significant mental health and suicide prevention programs. The NMHC should be tasked with annual monitoring and reporting on whole-of-government implementation of a new National Mental Health Strategy.
  - These changes should be underpinned by a new intergovernmental National Mental Health and Suicide Prevention Agreement.

Overview

Why this inquiry?

This inquiry is about the mental health and wellbeing of Australia's population, the prevention and early detection of mental illness, and treatment for those who have a diagnosed condition.

Through the lens of participation and contribution, this inquiry examines how people with or at risk of mental ill-health can be enabled to reach their potential in life, have purpose and meaning, and contribute to the lives of others. This benefits individuals. But it also enhances the wellbeing of the wider community through 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 living standards.

Almost half of all Australian adults will meet the diagnostic criteria for a mental illness at some point in their lives, and one-in-five Australians will meet the criteria in a given year (figure 1). Mental illness affects people of all ages, but it tends to first emerge in younger Australians — 75% of those who develop mental illness, first experience mental ill-health before the age of 25 years. Improving mental health of Australians requires focussing on what can be done to prevent mental illness from developing, and identifying and intervening early — early in life and early in the development of a condition. But this focus must be coupled with addressing the needs of those who already have mental illness and who require additional care and support to have fulfilling lives.

This inquiry is about a generational change. Community awareness about mental illness has come a long way, but the mental health system has not kept pace with needs and expectations of how the wellbeing and productive capacity of people should be supported. The treatment of, and support for, people with mental illness has been tacked on to a system that has been largely designed around the characteristics of physical illness. And while service levels have increased in some areas, progress has been patchy. The right services are often not available when needed, leading to wasted health resources and missed opportunities to improve lives.

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

Prevalence with age (common conditions)

Prevalence with age (less common conditions)

Household characteristics of people with mental illness

Suicide rates

Psychological distress by engagement type

Psychological distress in Aboriginal and Torres Strait Islander people
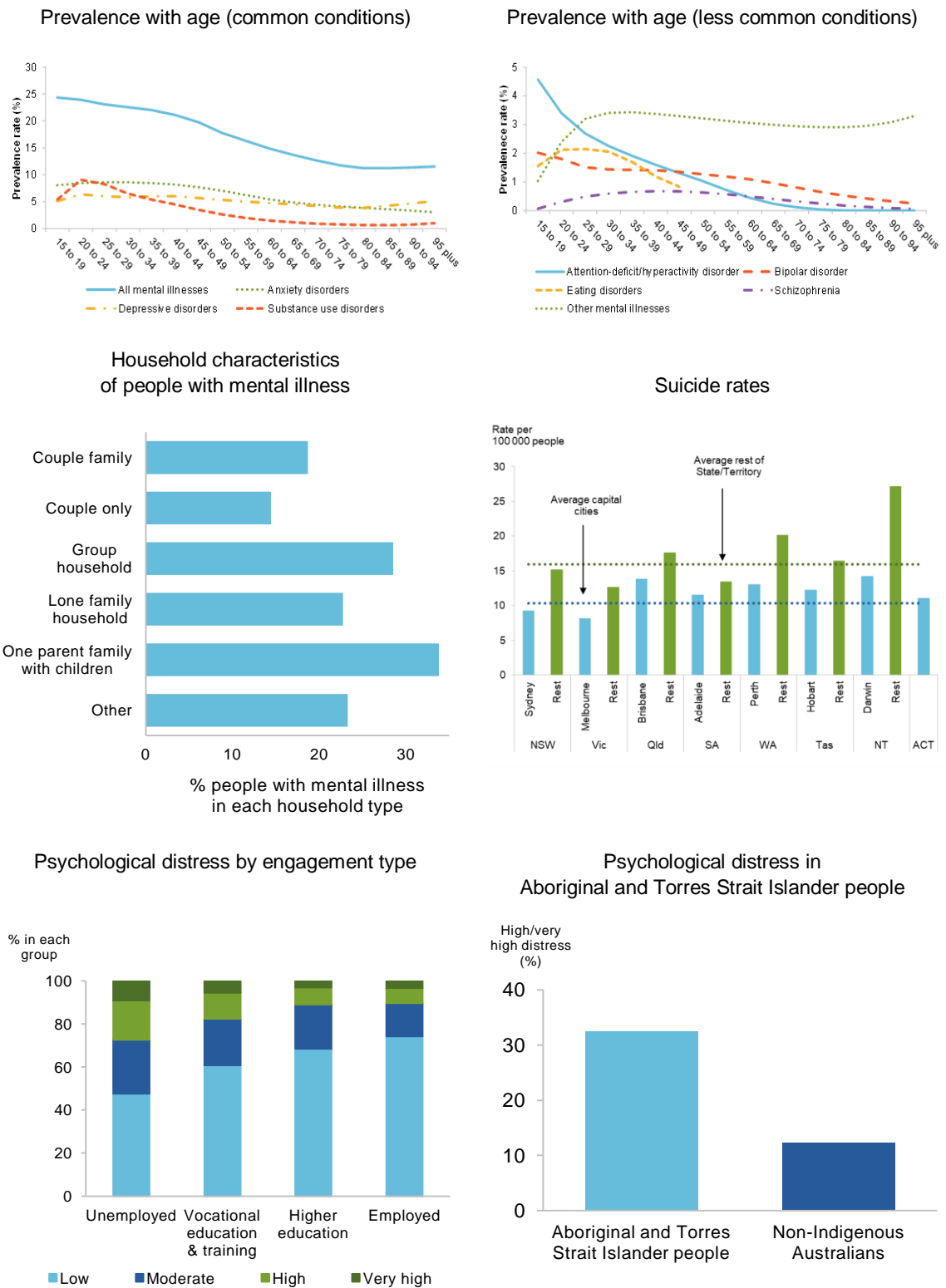
Key factors driving poor outcomes in Australia's mental health system include:

- under-investment in prevention and early intervention, meaning that too many people live with mental ill-health for too long

- a focus on clinical services which often overlooks other determinants of, and contributors to, mental health, including the important role played by carers, family and kinship groups, and providers of social support services

- difficulties in finding and accessing suitable support, sometimes because the relevant services do not exist in the regions where the people who need them live

- the support people do receive is often well below best practice, is not sustained as their condition evolves and circumstances change, and is often unconnected with the clinical services received

- stigma and discrimination is directed at both those people with mental illness and those who support them

- a lack of clarity across the tiers of government about roles, responsibilities and funding, leads to both persistent wasteful overlaps and yawning gaps in service provision, with limited accountability for mental health outcomes.

These are long-standing problems that are documented in numerous reports written over the past decades. Substantial reform of Australia's mental health system is needed and there is no quick fix.

Reform direction

This draft report presents a long term reform agenda. The changes needed are substantial but the recommended reforms would set Australia on a path for maintainable long term reform of its mental health system.

Many reforms will need to be implemented in stages. The feasibility of later reforms may depend on the success of earlier reforms. Some reforms require trialling and inevitable fine-tuning before they can be implemented on a national scale. And major changes, such as many of those presented in this draft report, require continuous feedback and learning, to make sure that the reforms are working to improve the lives of Australians.

While existing resources can be deployed more efficiently and effectively, additional taxpayer funding would likely be needed to engender long-term reform of the mental health system. This will require Governments to make choices as to 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.

The Commission has suggested priorities based on:

- reforms that could be implemented quickly, often deploying existing resources to bring about immediate benefits for those already experiencing mental illness. These are

typically interventions that have a sound evidence base indicating that they can cost-effectively deliver significant benefits either to a small group in the population or community-wide. They involve comparatively little disruption to other parts of the community, a redirection of existing funding or relatively small additional expenditure. For example, mandatory follow up when a person is discharged from hospital after a suicide attempt has been proven to reduce the risk of the person making another attempt on their life and is a reform that could be quickly implemented.

- reforms that should be started in the short term, but with the understanding that benefits, while potentially substantial and widespread, may not be evident for many years into the future. In some cases, these reforms may require agreement between multiple governments, multiple parts of a government, or additions to the workforce needed to deliver the relevant services. Such reforms are often staged over time and it is important to ensure that intermediate actions are consistent with and focussed on the goal of the reform. For example, the introduction of wellbeing leaders in schools will involve identifying, training and deploying a relevant workforce and developing resources for these leaders.

- reforms that are likely to be beneficial, but where further evidence and evaluation is needed. For example, some existing mental health services require evaluation, and potential changes to these services need to be trialled.

Unsurprisingly, many of the reforms recommended in this inquiry draft 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. The Commission's draft recommendations create institutions and mechanisms that would promote and support mental health in the community, are flexible enough to allow support to adjust as individual circumstances and needs change, and can systematically evaluate whether progress is being made to improve peoples' lives.

The reforms outlined in this draft report provide incentives for key players to work together without relying simply on the goodwill of committed staff. And they present a way for governments to coordinate within, and improve, a mental health system that fails far too many people. We recommend reforms to the roles of the Australian and State and Territory Governments in funding mental health services. As the delivery of many of Australia's mental health services is, appropriately, at a regional level, alternative options are presented for the funding and regional commissioning of services and supports.

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

- 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

- improving the consumer and carer experience of the mental healthcare system to ensure the care received is timely, is consistent with treatment needs and does not impose undue burden on either the consumer or their carer

- 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 recovery

- improving incentives for people to remain engaged in education and stable employment; reforms designed to support and enable those Australians with mental health problems to reach their potential in life, have purpose and meaning, and contribute to the lives of others

- reforming the behind-the-scenes arrangements and incentives to ensure services for people in need are as seamless and timely as possible.

For each reform area, reform actions are identified to start either in the short term or later, with the priority actions shown in bolded type. These priorities may be adjusted in the presentation of the inquiry final report, after feedback from inquiry participants and further work on estimating the costs and benefits of reform options.

The effectiveness of the proposed changes would be amplified, were we also able to reduce stigma, and generate a change in community culture around how mental ill-health is understood and the way we respond to those who experience these difficulties.

How much could reform benefit Australia?

The costs of mental ill-health and suicide are large and pervasive, and are borne not just by those people with lived experience of poor mental health and of caring, but 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 living with mental ill-health

- the lost opportunities and lower living standards that arise when young people disengage from education and when those with mental ill-health 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 group of its people.

It is not necessary to quantify the cost of mental ill-health and suicide to know that it imposes damaging and costly impacts on the lives of individuals and the community as a whole. But quantifying these costs helps to identify where reform efforts should be focussed.

Data and measurement limitations mean that our estimates for the cost of mental ill-health cannot be complete. Nevertheless, the Commission has estimated that, conservatively, the cost to the Australian economy of mental ill-health and suicide is in the order of $43 to $51 billion per year (table 1). There is also an approximately $130 billion per year additional cost associated with diminished health and reduced life expectancy for those living with mental ill-health.

Table 1   **Estimated cost of mental ill-health and suicide**
2018-19

Cost category	$ billion per year
Australian Government expenditure	
healthcare (includes prevention)	3.6
other portfolios (eg. employment, psychosocial support)	1.3
State and Territory Government expenditure	
healthcare (includes prevention)	6.9
other portfolios (eg. education, housing, justice)	4.4
Individual out-of-pocket expenses	0.7
Insurer payments for healthcare	1.0
Informal care provided by family and friends	15.0
Loss of productivity and reduced participation	9.9-18.1
Cost to economy (excluding the cost of diminished health and wellbeing)	**43-51**
Cost of diminished wellbeing (for those living with mental ill-health or self-inflicted injuries, and/or dying prematurely, including those who die by suicide)	**130**
Other costs that overlap with (and cannot be added to) the above	
Costs to the economy of suicide and suicide attempts (excludes the costs of pain and suffering of the individual and their family and friends)	16-34
Income support payments for those with mental ill-health and carers	9.7

These costs have been rising over time. Despite the rising expenditure on healthcare, there has been no clear indication that the mental health of the population has improved. A reformed system that leads to better mental health requires reprioritising and coordinating expenditure over time, as much as an increase in expenditure.

At the draft report stage, the benefits of some key recommended reforms have been modelled, in terms of people's additional capacity to work and earn higher wages and in terms of their improved health-related quality of life. We cannot readily quantify the broader community benefits associated with improved mental health, and in this sense, the benefit estimates should be viewed as lower bounds.

Benefits could not be modelled for all draft recommendations. In some cases, this was because the reforms aim to improve processes or system architecture, where benefits are diffuse. In other cases, draft recommendations propose the use of trials because the evidence-base about the effectiveness of a policy intervention is still emerging. Similarly, it was not possible at this stage to determine the cost of all recommended reforms. It is intended that the cost-effectiveness of all key recommended reforms will be included in the inquiry final report.

Those reforms that were able to be quantified at this stage were estimated, conservatively, to be likely to provide a boost to Australia's economy of around $100 million for some small-scale reforms up to $5.6 billion for larger reforms, in each year in the long term, through the increased economic participation of people with mental ill-health. Of course, some of the reforms with larger benefits, such as improving the social and emotional wellbeing of young Australians, which could provide substantial benefits in quality of life and income opportunities, would not be fully realised for some time.

Across those reforms for which benefits have been estimated, total benefits were estimated to be up to $11 billion per year as a result of the increased economic participation of people with mental ill-health — noting that this does not take into account the costs incurred to achieve these reforms. The annual benefits of improved health and life expectancy for those living with mental ill-health were estimated to be the equivalent of between 4.6 and 6 years of healthy life per 1000 working-age people. 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 and families, and those who are well now but may one day seek help for themselves or someone they know.

The costs necessary in order to achieve the estimated benefits are an important consideration in determining priority areas for reform. These will be determined once we refine the recommended interventions in response to feedback from inquiry participants.

1. Early help for people

Start now	Start later
Incorporate social & emotional wellbeing checks into existing physical development checks for 0 to 3 year olds	Monitor & report on progress toward universal screening
All schools assign a teacher to be their mental health and wellbeing leader	Expand parent information programs on child social & emotional development
COAG-developed strategic policy on social and emotional learning in the education system, including development of national standards for teacher training	Strengthen skills in workforces of early childhood education and care, and schools to support child social and emotional development
Implement a new national stigma reduction strategy	Use data on wellbeing of school students to build evidence base for future interventions
Reduce stigma amongst health professionals	Evaluate best practices for partnerships between traditional healers and mainstream mental healthcare for Aboriginal & Torres Strait Islander people
Follow-up people after a suicide attempt	
Identify local priorities and responsibilities for suicide prevention	Apply lessons from suicide prevention trials
Indigenous organisations empowered as preferred providers of local suicide prevention activities for Aboriginal & Torres Strait Islander people	

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, some 40% of those with mental ill-health have never accessed mental health services nor seen their GP about their condition, with young people particularly unlikely to seek help. 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 ill-health may percolate throughout their life, reducing the wellbeing and standard of living of the affected individuals and often those around them.

Early identification of risks in families and children

Early identification of risks in children offers the greatest potential for improving health, social and economic outcomes. Young Australians with mental ill-health miss opportunities to develop the skills they need for long-term academic outcomes (figure 2) and post-school opportunities.

The existing physical development checks of Australia's 1.25 million 0 to 3 year olds in community health services can be expanded to incorporate social and emotional wellbeing

aspects of development, so that any necessary assistance can be provided to both the child and parents/carers.

Attendance at preschool and school can present the first opportunity for some parents and carers to become aware of social and emotional development issues emerging in their children. Schools are already expected to play a major part in supporting children's social and emotional wellbeing, and 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. To address this, initial training of early childhood educators and of teachers should include 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.

Identification of children at risk is simply a starting point. Schools need to be effective gateways for students and their families to access help.

The introduction of senior school leader positions for student wellbeing could go a long way toward: improving the early identification and treatment of mental ill-health in young people; helping to maintain a continued engagement of those with mental ill-health in their own education; helping create workable linkages between schools and healthcare pathways; and raising awareness of mental wellbeing in the community.

All schools (primary and secondary, over a certain size, or in groups, when small or geographical spread) should be required to provide a suitably trained full-time senior teacher with responsibility for the mental health and wellbeing of students, including maintaining links to mental health support services in the local community. This approach has been trialled and is being rolled out across UK schools with early signs of success. It has already been adopted in some schools in at least three Australian States. The cost of these senior leader positions is estimated to be up to $660 million per year in public schools, or up to $975 million in public and private schools. Training senior teachers for the new role would take time, but should be started in the short term.

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 on child wellbeing. Data that has already been collected on the wellbeing of school students should be used to build an evidence base for future interventions.

Figure 2   **Students with mental ill-health fall behind in school**

Years fallen behind (Year 3, Year 5, Year 7, Year 9): Reading, Spelling, Numeracy, Grammar, Writing
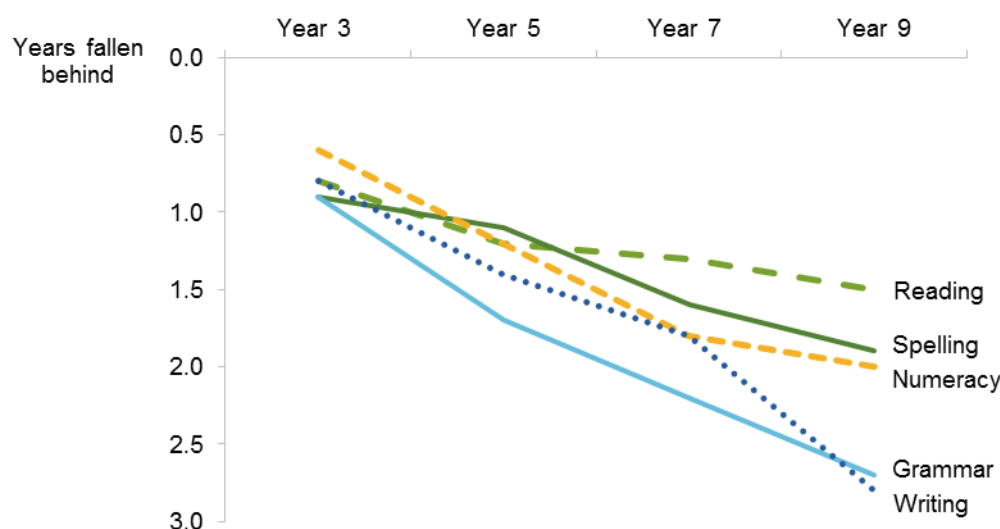
Cultural barriers to improving mental health and wellbeing

Culture 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 they 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 carer. For example, stigma can limit the scope for those with mental ill-health to re-engage with their community or workplace, slowing recovery and increasing the burden of ill-health.

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. Stigma associated with depression and anxiety has declined to some extent, although severe mental illnesses — such as psychosis and borderline personality disorders — remain poorly understood by society and are highly stigmatised, particularly in publicised issues of public safety.

Effective stigma reduction requires an ongoing commitment over a long time period in order to ensure that any reductions in stigma persist. The National Mental Health Commission should develop and drive the implementation of a renewed national long-term stigma reduction strategy that: targets stigma reduction messages for different audiences; focusses on the experiences of people with those mental illnesses that are poorly understood by the community; addresses different aspects of stigma including the desire for social distance, and perceptions of danger and unpredictability; and identifies and draws on a small number of national ambassadors for mental health.

Stigma within the health system can compromise diagnosis and treatment. Stigma reduction programs, including interactions between health professionals and mental health consumers on an equal footing outside of a clinical setting, should be rolled out in a staged manner, into the initial training and continuing professional development requirements of mental health professionals.

Given the cultural diversity within Australia, the training of all clinicians should include measures that instil an understanding of how peoples' cultural background affects the way they describe their mental health and their compliance with treatment options. The Australian Government should also evaluate best practices for how partnerships between traditional healers — who protect and heal the physical, emotional and social wellbeing of individuals and communities — and mainstream mental health services can best 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 is 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. For every death by suicide, as many as thirty people attempt suicide and are hospitalised due to intentional self-harm. 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.

Only a very small proportion of those with mental illness self-harm or have suicidal thoughts, and not all people who suicide had a mental illness. However, up to 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 responsibility and accountability for follow-up is unclear and inconsistent.

A recent study concluded that adequate aftercare could reduce the prevalence of suicide attempts that reach hospital emergency departments by about 20% and all suicide deaths by 1%. This is equivalent to preventing 34 people per year from dying by suicide, and a further 6000 people per year from attempting suicide that results in some level of incapacity for them. It is estimated that effective aftercare can provide a long-term return of investment of between 6:1 and 36:1 for every dollar spent, depending on the extent of aftercare provided and the income earned by people whose suicide or suicide attempt was prevented.

A program to provide access to timely, effective aftercare for every person who presents to a hospital, GP or other service following a suicide attempt or in suicide distress should be provided as soon as possible. Aftercare should include support prior to discharge or leaving the service, as well as immediate and sustained follow-up support.

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 instead of a fragmented and uncoordinated 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.

Suicide prevention programs for Aboriginal and Torres Strait Islander people should 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.

Beyond the short term, the linkage of data on agreed risk factors for suicidal behaviour could be useful in preventing some suicides. This may require, however, Australia to place a higher priority on preserving someone's life, than on preserving their privacy.

2. Improving peoples' experiences with mental healthcare

Start now	Start later
Expand clinician-supported online treatment options	Expanded online portal for consumers, with timely & linked-up referral processes
Provision of acute & non-acute beds & ambulatory services that reflect regionally assessed needs	Access to face-to-face psychological therapy at a level commensurate with treatment needs
Improve the ED experience & provide alternatives	Strengthen the peer workforce
Provision of child & adolescent mental health beds separate to adults	Incentivise family-focused & carer-inclusive care
Mental health expertise as support to police & paramedics	Incentivise psychiatric advice to GPs
Navigation platform for mental health referral pathways	Single care plan with electronic sharing of information
Care coordinators for consumers with the most complex care needs	
Expand mental health nurse workforce	
Widen access to psychological therapy & psychiatric assessment by video	
Rigorous evaluation of Better Access	

Those with mental illness and their carers face a complex system of healthcare and broader social supports. A well-functioning mental health system would:

- deliver prevention and early intervention activities that reduce the incidence of mental ill-health and improve the wellbeing of individuals

- provide healthcare that varies in line with the nature and severity of the individual's mental ill-health, is flexible to the changing clinical needs of the individual, and recognises the importance of addressing the individual's non-clinical needs

- provide and facilitate access (that is affordable, culturally appropriate, timely and available regardless of whether you live in an urban or regional part of Australia) to necessary psychosocial supports, stable housing, assistance at school or work, income support, carer supports, and other relevant services that support recovery for those with mental ill-health and their carers

- deliver care that is seamless and joined-up regardless of how the individual first enters the mental health system, without significant gaps either at a point in time or, as needs change, across time and locality.

The current Australian mental health system falls well short of this benchmark.

Services are often unconnected. All those who interact with Australia's mental health system — consumers, carers, service providers and funders — should have clarity around who can and is providing what services to which groups of people and under what conditions. Not every consumer will have their needs met at their first point of contact with the mental health system. There should be clear pathways to facilitate access to healthcare and other services, consistent with the level of expertise, intensity and duration required for that person's level of need.

There are significant service gaps. From the point of view of people needing care, an improved system would mean access to services that are consistent with their treatment needs when they need them; continuity of care, based on effective information flows between clinicians and other services; and person-centred care that accommodates individual needs. Implementing person-centred care consistently across the mental health system will be a significant cultural shift. This shift will require structural changes to aspects of the mental health system (including online navigation platforms), workforce training, a more holistic approach to families and carers and an increased focus on monitoring and improving outcomes for consumers.

This inquiry has recommended reforms to improve the mental health system using a stepped care model (figure 3). Under stepped care, the intensity of services provided for individuals should vary with their level of need. While there are multiple levels within a stepped care approach, they are neither uni-directional, nor siloed steps — rather, they are a spectrum of service interventions. Stepped care has been adopted nationally in Australia, and while its use is widely accepted, its implementation has proved challenging.

Figure 3   **Stepped model of care**
Estimated number of people requiring each level of care

Complex care

1.4% of population
350 000 people

Clinical care using a combination of GP care, psychiatrists, mental health nurses & allied health

Inpatient services Psychosocial supports

Single care plan & care team

Care coordinator

High intensity care

1.6% of population
400 000 people

Psychiatric care

Single care plan & care team

Moderate intensity care

6.5% of population
1.6 million people

Mix of GP and MBS-rebated psychological treatment

Low intensity care

4.9% of population
1.2 million people

GP

Clinician-supported online treatment

Group therapy

Self-management

26% of population
6.4 million people

Self-help information & resources

Online navigation platforms for service providers

Non-health supports

- Income support
- Housing support
- Disability services

- Aged care services
- Justice services
- Early detection & intervention programs (outside health)

- Education & training
- Employment services
- Cultural services

Re-orienting health services to people

Mental healthcare services are characterised by two 'poles', reflecting the level of government providing the service funding. One pole represents services for people with mild and moderate symptoms and impairment who can be treated online or in primary care by GPs or psychologists (mainly Australian Government funding under the MBS), and the other represents those requiring specialist treatment and often hospitalisation (mainly State and Territory Government funding).

There is a large service gap between these two poles, sometimes referred to as the 'missing middle'. Up to one million people typically have symptoms that are, too complex to be adequately treated by a GP and the limited MBS-rebated individual sessions with allied mental health providers (predominantly psychologists). But their condition also does not reach the threshold for access to State or Territory funded specialised mental health services, private psychiatrists or private hospitals due, for example, to long waiting lists or very high out-of-pocket costs. Too often, the necessary services exist but are being absorbed by people whose needs would be met just as well by lower intensity services.

For people self-managing or needing low intensity treatment

Resources for self-help

Many Australians with mild mental illness are able to manage their mental health themselves without formal clinical intervention and without significant impact on their relationships or engagement in study or employment, so long as they can access relevant information. People needing resources for self-help should have ready access to evidence-based information and assistance through publicly available sources, including pamphlets, telephone services, and online information. There is much already available, but its effectiveness and accessibility would be improved through a well-advertised national phone-line to assist in locating relevant services and supports, and an expansion in online portals to include more information on e-health, telehealth and group therapy services and mental health pathways in local communities.

Clinician-supported online treatment as a flexible option for people

Beyond self-help, there should be an expansion in low intensity treatment options that would allow those with mild symptoms to get quick access to help, at a time and location of their choice, and minimise their need for medical intervention.

People needing low intensity care, those at risk of mental illness, some with a mild mental illness, or people with symptoms that have not yet reached a diagnostic threshold, should be able to access appropriate care directly through evidence-based clinician-supported online treatment. Where relevant, this on-line treatment can complement treatment received through a GP.

Clinician-supported online mental health treatment has the potential to substantially increase treatment coverage of those living with mental ill-health. Internet-based treatment allows consumers to undertake treatment at a place and time that is suitable and convenient to them. 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, with 14% of course registrations undertaken on a weekend.

It is 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 living with high prevalence mental illness (such as anxiety and depression) when they are experiencing mild to moderate symptoms. There is also some evidence that supported online therapy may be effective in complementing specialist mental health treatment for severe and less prevalent conditions, such as schizophrenia and bipolar disorder. Online treatment carries the added benefit of fidelity of the treatment (avoids individual providers administering their own personal version of the intervention), could be made culturally appropriate, and be cost effective to provide to a large number of people.

Around 20 000 people accessed supported online mental health services in 2018, with about 4000 of these receiving clinician-supported online treatment. This treatment can be integrated into the stepped care model with an expanded capacity to accommodate use by up

to 150 000 people. Currently approximately two thirds of this group are likely to be accessing MBS-rebated psychological therapy (including through headspace centres), while one third are not currently receiving any care for their condition.

Summary online treatment information provided back to referring clinicians

To further integrate online treatment into the stepped care model, for those people referred to the service by a clinician, treatment information should be provided back to the referring clinician. More generally, online services should annually publish summary output for clinicians on the use of their services, treatment provided, and any measurable outcomes.

For people needing moderate intensity treatment

Re-target face-to-face psychological therapy

Clinical evidence shows that people experiencing moderate mental illness typically benefit from face-to-face therapy with a mental health specialist. Approximately 1.3 million people currently receive MBS-rebated sessions of face-to-face psychological therapy (individual or group) each year. Such therapy is a key element in a stepped care model of mental health care. A strength of the Better Access program is its ability to fund services at comparatively low cost. It provides psychological therapy services at a much more economical per-session rate than a block funded service without financial incentives to drive efficiency. However, there are problems with the current system.

First, while there is strong clinical evidence that individual psychological therapy can be effective, there is little evidence on the overall effectiveness of the current MBS-rebated psychological therapy program (the Better Access program). The Better Access program should be rigorously evaluated as soon as practical to ensure that it is delivering cost-effective benefits for those who need it.

Second, Better Access is poorly targeted. The Commission estimates that more than a third of people currently accessing MBS-rebated individual psychological therapy (including through headspace centres) could have their treatment needs equally well met through services that are of lower intensity, but which offer the consumer a lower treatment burden (in terms of time and cost).Targeting could be improved to make sure that the right people are receiving the right treatment. The Better Access program should be aimed primarily toward those people with moderate to high intensity needs who stand to gain the most from face-to-face psychological therapy.

Retargeting Better Access will only succeed if supported by GP referrals. Primary Health Networks (PHNs) should be tasked with promoting and monitoring GP assessment and referral practices in line with a stepped care model of mental health.

Third, the Better Access program is inflexible. Currently, a person can only access up to 10 individual MBS-rebated psychological therapy sessions in a calendar year. The average number of sessions used per person across all consumer groups is currently only 4.6 sessions. However, the Commission estimates that, as part of a stepped care model, approximately 10%

of the people who are best treated through the Better Access program would benefit from an increase in the session cap. A trial on the number of MBS-rebated psychological therapy sessions should be undertaken to assess the merits of increasing the current 10 individual plus 10 group sessions per calendar year to up to 20 flexible sessions (either individual or group) over a 12 month period, with re-referral required after 10 sessions.

Fourth, mental health treatment plans are currently used in place of standard referrals. Approximately 1.32 million consumers have a mental health treatment plan written for them by their GP, and 1.26 million follow through to use MBS-rebated psychological therapy. However, psychologists report these plans are largely not useful to them, only 440 000 plans get reviewed and there is no evidence that mental health treatment plans have improved mental health outcomes. We are seeking more information on: what value mental health treatment plans have for consumers (particularly as not all consumers are provided with a copy of their plan); why GPs need an additional MBS-rebate (over and above a longer consult rebate) for completion of a plan; and what audit arrangements could practically be put in place to ensure referral practices are in line with the stepped care model.

For people without access to face-to-face psychological therapy

Ironically, access can be an issue with Better Access. Use of the program is disproportionately by people in Australia's large urban centres (figure 4). This reflects the location of most psychologists and psychiatrists. Group sessions and sessions via tele-health are significantly underutilised.).

Many people with moderate (or higher) intensity needs either live in regional parts of Australia without ready access to a psychologist or simply have difficulty (such as for reasons related to their mental illness, transport access, or family scheduling) getting to a face-to-face psychological therapy session. Access to video-psychological therapy should be widened (with associated changes to MBS rules) to allow people — regardless of whether they currently reside in areas designated as 'telehealth areas' — to access MBS rebates for psychological therapy via videoconference. To ensure efficacy of the treatment provided, at least 3 out of each 10 sessions for those in metropolitan areas and large regional centres should be face-to-face, including at least one of the first four, with no restriction on how far apart the individual and their clinician reside.

Figure 4   **Regional access to low and moderate intensity care services**

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

% of population
accessing MBS-rebated
mental health services

10
8
6
4
2
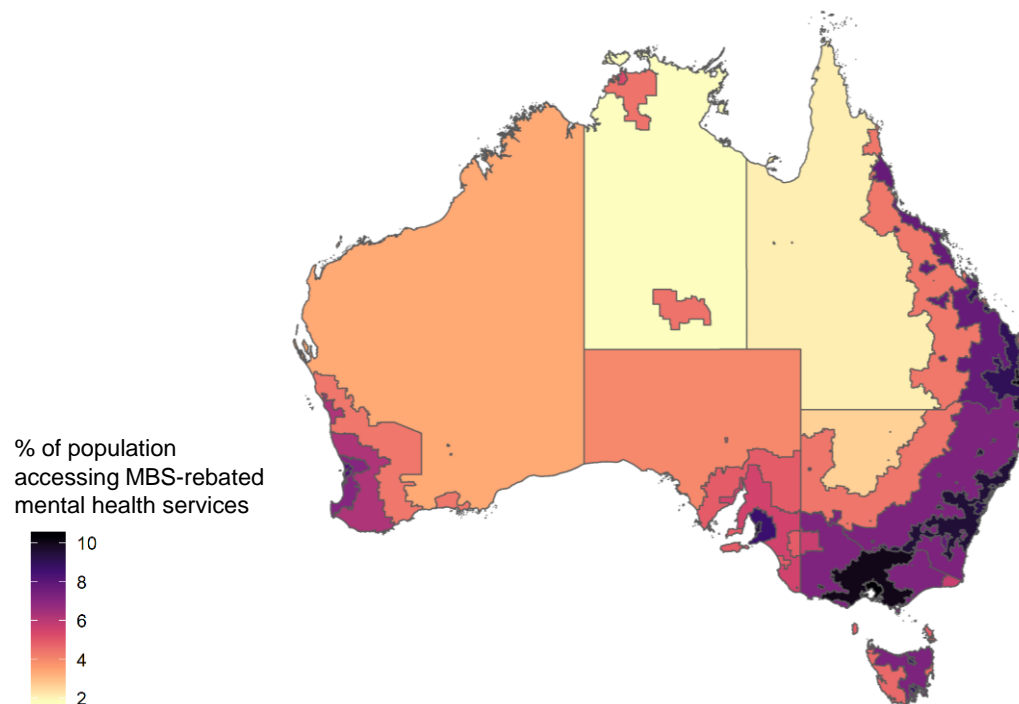
Users of supported online treatment are geographically widespread

% of population
accessing MindSpot

0.25
0.20
0.15
0.10
0.05
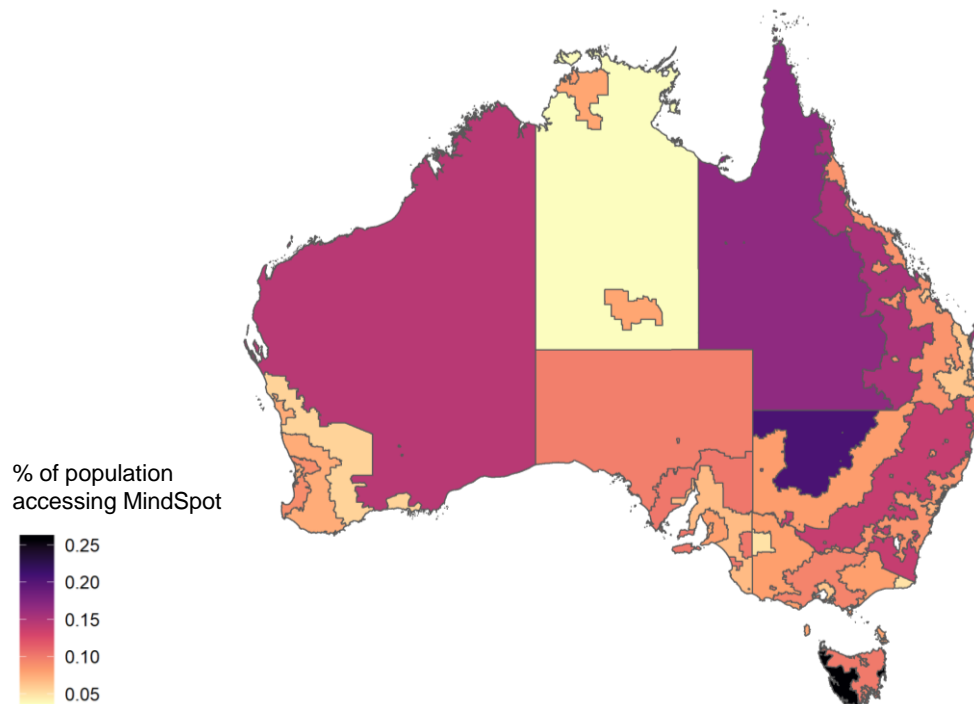
Improving access to other specialist moderate intensity services

Other people with moderate intensity needs will also require access to specialist assistance (such as from psychiatrists, mental health nurses, social workers, dieticians or occupational therapists) through the MBS or community ambulatory services from time to time. Access to psychiatric care is particularly constrained, with high costs and long wait times in some areas. In the long term, more psychiatrists in some specialty areas and localities are needed. Supplementing this, the Australian Government should create an MBS item that allows psychiatrists to provide general advice over the phone to a GP on diagnosis and management issues for an individual who is being managed by the GP.

For people needing high intensity treatment

People with more severe forms of mental illness require high intensity, often multi-disciplinary care, from specialist services delivered through MBS-rebated or government salaried psychiatrists and expanded community-based clinical services, with service continuity between primary care and acute/specialist care.

Improving the ED experience and providing 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 after hours and in sparsely populated areas.

While only 4% of ED presentations were for mental health, this group comprised 19% of patients waiting in EDs for inpatient beds and 28% of those delayed from leaving the ED due to an inpatient bed not being available. 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 as likely to arrive by police or correctional services vehicles; and twice as likely to be in ED for more than 8 hours.

While reforms are underway at some hospitals, the typical ED experience exacerbates the distress of those with a mental illness, frustrates and diverts emergency clinicians, paramedics and police, and is very expensive. In some cases, people transported by police to EDs or mental health facilities are not admitted because mental illness is considered not to be the primary impairment (drugs or alcohol are involved), the person is behaving violently or mental health inpatient beds are not available.

Timely availability of crisis support services can prevent or reduce emergency department 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.

While some other States have similar services, all State and Territory Governments should fund and implement mechanisms for police, health and ambulance services to respond to mental health crisis situations in a coordinated manner, including by embedding mental health expertise in police and emergency service communication centres to provide real-time support for the individual whom police and emergency services are responding to, advise on how the individuals with mental illness can be managed and appropriate referral pathways, and coordinate deployment of co-responder resources to prioritised cases.

Complementing this, State and Territory Governments should aim to provide more and better alternatives to EDs for people with mental health problems, including peer- and clinician-led after-hours services and mobile crisis services. This may include providing separate spaces in or near EDs for mental health patients, or otherwise creating a more de-escalating environment. The 'Safe Haven' spaces created in Melbourne and more recently in Queensland provide an effective model for this. When Emergency Departments are built or renovated, the design should take account of the needs of people with mental health problems.

Inpatient beds for all who need hospitalisation

The demand for acute inpatient mental health beds would be reduced by: measures that prevent people's conditions deteriorating to the point where they need acute hospital care; and by accommodating more people with persistent, severe and complex mental illnesses in community treatment and residential care, so that these people can live in the community, instead of having to remain in an acute hospital bed for extended periods. However, as not all hospitalisations are avoidable; acute inpatient beds will still be needed.

Areas of high population growth may need to increase their number of acute inpatient beds in order to match supply with demand, even after filling gaps in non-acute services which lead to avoidable hospital admissions. Lack of mental health inpatient beds for children and adolescents seems to be a particular short fall in some States and Territories. All States and Territories should provide child and adolescent mental health beds that are separate to adults. Where it is not possible to provide these beds in public hospitals, States or Territories should contract with private facilities, or if suitable given the individual's condition, provide care as hospital-in-the-home.

Specialised mental healthcare in-community

For many people, a first step either to receive more intensive care as an alternative to being admitted to a hospital psychiatric ward, or after discharge from a psychiatric ward before returning home, would be sub-acute residential care within the community. There are approximately 3400 non-acute mental health beds in the public sector — an estimated half of that likely to be required. Increasing the number of these beds would improve the path of care for individuals in need. Individuals who are best treated in community would face fewer delays in discharge from hospitals, and as acute in-patient beds in hospitals become

available, this will reduce waiting times in ED. 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 with, hospital acute care.

For people with complex health and social needs

Between 190 000 and 250 000 Australians with episodic or persistent severe mental illness have significant complex needs arising from their illness. Their needs are complex because of:

- the presence of both mental and physical health conditions, sometimes including substance abuse, requiring coordination between primary care and specialist mental healthcare and coordination with other clinical service providers (treating the physical illness)
- impaired psychosocial functioning due to the severity of the mental illness, where coordination is required between the disability support provider (including the NDIS) and the clinical treatment system
- social adversity, such as poverty, unemployment, social isolation, housing instability or complex family situations where coordination is required with the relevant social service providers.

Even with the best clinical treatment, episodic or persisting mental illness can result in the need for psychosocial and other supports, such as stable accommodation, income and vocational support, to assist the person to live as independently as possible in the community.

But when the gaps in healthcare services are greater, dealing with the complexity of needs becomes more critical to health and socioeconomic outcomes for people. For example, Aboriginal and Torres Strait Islander people in urban areas can face additional service gaps that arise because of a lack of culturally capable services and discrimination; those in remote communities can face further service gaps associated with lack of availability or continuity in the trained workforce, while coping with additional complexity in needs.

Improving outcomes for people with complex needs is about ensuring they have access to the services needed (both clinical and broader), when they are needed, with effective information flows and coordination between clinicians and other services.

Structural reforms to deliver the changes needed

Navigation platforms

To assist clinicians and other providers in the health system, and 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 — to locate services

and supports suitable to people with mental health problems, online navigation platforms should be established. These navigation platforms should be created at a regional level and act as centralised online and phone platforms for clinicians and care coordinators into mental health and physical clinical and non-clinical care. The HealthPathways portal model, which is already used by most PHNs, could be used as the basis for the navigation platforms.

Linkages through the online navigation platforms should be able to identify services available and directly book consumers into a service. For services outside the scope of the navigation platforms (such as Centrelink), there would need to be direct contacts with the services to facilitate support. The navigation platforms would need to be supplemented by more accessible and situation-specific online information and resources for consumers and carers.

Care plans

Consumers requiring intensive clinical treatment, especially those with more complex care needs, typically require a team of service providers involved in their care — the size of the team and its composition depend on the individual's needs. The greater and more complex the needs, the larger and more diverse the team of providers. A single care plan is needed 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 update; and financial arrangements that incentivise this to occur.

A single care plan developed by the individual's primary treating clinician and covering physical and mental health can help address the issues raised by comorbidity. Physical ailments are more common when a person has a mental illness and can contribute to early death. For example, compared to people without mental illness, those with mental illness are 18-36% more likely to have musculoskeletal problems and 10-23% more likely to have asthma. One Australian study estimated that physical illnesses cause almost 80% of the gap in average life expectancy between people with a mental illness and the whole population, compared to 14% of the gap being due to suicides.

Substance use comorbidity is common for individuals with some types of mental illness, and where relevant care plans will need to cover drug and alcohol issues. Further, a large proportion of people who present for substance use treatment display symptoms of mental disorders (while not meeting the full criteria for a diagnosis of a disorder). For effective treatment there should be an alignment between mental health and alcohol and drug policies.

Care coordinators

Consumers with the most complex mental health needs (up to approximately 460 000 people) should have both a single care plan developed with and for them and a care coordinator provided to oversee the implementation of the plan. This will avoid gaps in support services that can lead to a deterioration in mental health and, potentially, unnecessary hospitalisation.

Care coordinators would work directly with the consumers, their 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 the most complex cases, the care coordinator would need to 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 a significant number of government funded programs offering care coordination services to people with a mental illness — including through the NDIS, and care coordination programs commissioned by PHNs or provided by State or Territory Governments. However, the coordination of care is often ad hoc, relies on personal contacts of individuals rather than established networks, suffers from variable skilled care coordinators, 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.

As an interim goal, all those with a severe and persistent mental illness and complex needs requiring support from multiple agencies should have efficient and effective care coordinating services (that is, approximately 64 000 people). Ultimately, all people with mental illness and high intensity needs, using a mix of clinical and non-clinical services, should have access to a care coordinator (up to 460 000 people nationally, depending on needs and use of existing care coordinator services). The expenditure associated with this is likely to lead to some cost savings elsewhere in the health system, as demonstrated by past programs, where care coordination led to reductions in hospital admissions.

A health workforce that can deliver the changes needed

There are many health professionals who can help people to improve their mental health and address any physical comorbidities they may have. Only some of these professionals — psychiatrists, psychologists, mental health nurses and mental health peer workers — specialise in mental health. Those that have more general roles include: GPs, general nurses, and a mix of allied health professionals such as dieticians, occupational therapists, physiotherapists, Aboriginal health workers, social workers and counsellors.

There is considerable disparity in health workforce numbers between urban and regional areas, and potentially 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 — such as psychiatrists specialising in child and adolescent mental health and people with expertise in treating eating disorders — in a number of jurisdictions.

Clinicians at initial entry points to the health system

GPs are the front-line service for mental healthcare in most urban and regional parts of Australia, representing a key referral gateway into services and an important point for the ongoing monitoring of individuals' physical, and potentially mental, health. Australians have almost 20 million GP consultations per year for mental health problems, with mental health being one of the main reasons people go to their GP.

Yet there can be significant delays in getting a GP appointment in some (urban and regional) areas, appointments can be very time consuming (sitting in waiting rooms) and expensive, and not everyone views their GP as a useful or easy person with whom to discuss their mental health. Furthermore, some GPs lack knowledge and skills in mental health and require considerably more training in identifying risks, diagnosing conditions, assessing and recognising the physical health consequences of prescribed treatments, and connecting patients with other services (such as online mental health services and allied health services).

Proposed changes as a result of the current MBS review (if adopted) would increase the number of ways for GPs to be reimbursed for treating people with mental illness. We have also recommended changes to motivate an increase in care coordination between clinicians and to provide scope for GPs to consult with designated carers and family of a person with a mental illness. The recommended navigation platform and improved access to advice for GPs from psychiatrists should also improve GP links to other health and non-clinical supports for those with a mental illness. To provide more incentive for GPs to improve their mental health training, the merits of introducing a specialist registration system for GPs with advanced specialist training in mental health should be independently assessed.

Aboriginal health practitioners and health workers comprise a relatively small proportion of the health workforce but play an important role in providing culturally capable care to Aboriginal and Torres Strait Islander people. There is a well-developed system of training for these workers, including in mental health. We are seeking more information on ways to expand their career opportunities, including scope for transition-to-practice arrangements for those wishing to move into more general mental health clinical or non-clinical roles.

Mental health specialists

Among those providers who work specifically in mental health in Australia, we see scope for a greater role for mental health nurses and mental health peer workers, although there are notable gaps in some other specialities that should be addressed to improve consumer outcomes. We found no evidence of a need for more psychologists (indeed, Australia has one of the largest workforces, per population, of psychologists in the world).

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. Measures to promote this include 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 UK. The merits of introducing a specialist registration system for nurses with advanced qualifications in mental health also should be assessed.

Additional funding is likely to be needed to address the need for more mental health nurses in all parts of Australia, and in Indigenous communities in particular.

Overall, the number of psychiatrists for Australia's population is at the low end of rates in other developed countries. This is less of a concern in adult mental health treatment in urban areas, but the profound difficulty of those in need of psychiatrists for children and adolescents, in aged care and in regional and remote areas, should be addressed. Governments should collectively ensure that the National Mental Health Workforce Strategy, currently being developed, includes actions: to raise the number of funded training placements and supervisors, with State and Territory Governments to do so in public sector health facilities, and the Australian Government to contribute to funding more positions in regional and remote areas; and increase the availability of supervision for trainees, including through remote models of supervision for trainees outside major cities.

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. 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 utilised, 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 role and value of peer workers should be developed and implemented in collaboration with the relevant professional bodies.

3. Improving peoples' experience with services beyond the health system

Start now	Start later
Govts to commit to no discharges from care into homelessness	Mental health training and expanded tenancy support services for frontline housing tenancy workers
Additional supported housing places for people needing care on a regular basis	Develop disability justice strategies to ensure rights of people with psychosocial disabilities are protected during their interactions with justice system
Work toward meeting the gap in long term housing for people with mental illness who are persistently homeless	Improve rigor of mental health screening in correctional facilities and actively plan for care continuity post-release
Standards of care in correctional facilities to be equivalent to care in community	Ensure legal representation & non-legal advocacy services for those subject to involuntary mental healthcare
Ensure culturally capable mental healthcare for Aboriginal and Torres Strait Islanders in correctional facilities	
Funding cycles for all psychosocial services to be at least 5 years	
Improve eligibility requirements, availability & suitability of psychosocial supports	

There are a range of services beyond the health sector that support people (usually those with severe mental illness) to live satisfactory lives within the community, including psychosocial supports and housing services (services related to education and employment are discussed separately further below). 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 mental ill-health.

Of course, many people without mental illness also interact with housing, justice and other non-health services. In making our recommendations we have been cognisant of the issues that might arise were we to recommend reforms in some of these services that extend beyond people with mental illness.

For people needing psychosocial supports

Even with optimal treatment some mental illnesses do not fully remit and result in persisting or episodic impairment with the individual, and often carers, requiring psychosocial support (such as respite services, assistance with transport or with household management and finances) to live as independently as possible in the community. 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.

Approximately 690 000 people have a severe mental illness, and while for some their illness is of short duration, many require psychosocial support. Approximately 21 700 of these people currently receive psychosocial supports under the NDIS, and a further 42 300 are considered likely to be eligible for psychosocial supports under the NDIS but are not yet receiving them. While some other people currently receive psychosocial supports funded through either the Australian or a State/Territory Government, there remains a massive gap between assessed needs and services provided or taken up.

For those people who are eligible for the NDIS, the psychosocial disability stream 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.

Participants of other Australian Government-funded psychosocial supports should continue to receive support, should they require it, regardless of whether or not they have tested their eligibility for the NDIS. For people not receiving NDIS funding, Governments should provide certainty on the long-term funding of psychosocial supports beyond the period to June 2022 that these supports will be funded by the Australian Government. To further enhance 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.

For people needing housing services

Suitable housing (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, substandard quality).

Accommodating people in the community rather than in hospitals

The costs of not adequately addressing the accommodation needs of people with mental illness is evident through increased expenditure on these people in the health sector and in some cases, in the justice system. The proportion of health sector expenditure related to mental health patients rotating through hospital ED departments, and accommodating people with mental illnesses in the most expensive forms of care (hospital acute inpatient facilities) for time periods beyond that required for their effective treatment is difficult to determine. But surveys suggest that around 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 5).

Programs that support people's discharge out of acute mental healthcare or prisons can prevent people becoming stuck in institutional care or being discharged into homelessness.

Figure 5   **Average daily ongoing cost of accommodation per person**
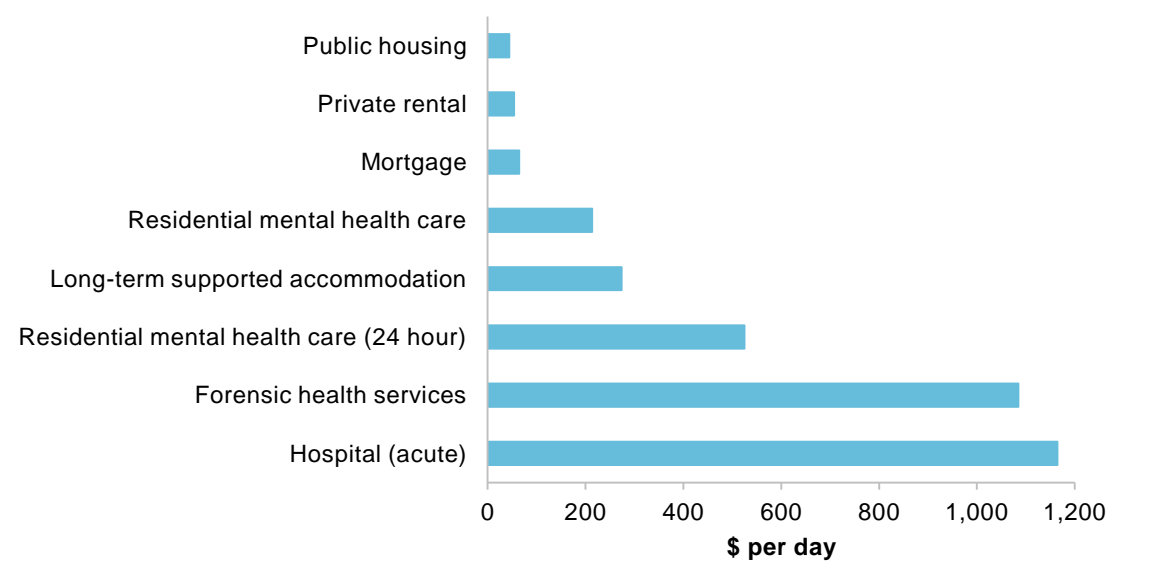
For those people with a mental illness that is severe but necessitating low to moderate intensity care on a regular basis, supported housing places (integrated housing and mental health supports to people with mental illness) in the community provide long-term housing stability, scope to actively interact with the community and provide life satisfaction. There are currently 5 200 supported housing places across Australia. But an estimated 8 000 to 12 000 additional places are required to accommodate individuals with severe mental illness who are at significant risk of housing instability.

The cost of providing additional supported housing for this group of people — through a mix of social housing, private rentals or head-leasing of private rental properties — is estimated to be in the order of $200 to $700 million per year. The final cost may be lower than this, to the extent that some proportion of people may have capacity to fund part of their housing costs and for some, stable housing would reduce their use of healthcare, justice or community services. Each State and Territory Government, with support from the Australian Government, should actively work towards meeting the gap in supported housing places in their jurisdiction.

Reducing homelessness for those with severe mental illness

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. The cost of providing accommodation for about 13 000 to 17 000 people with mental illness in need of longer-term housing is estimated to be $234 to $352 million per year. Where such measures have been undertaken

on a smaller scale previously (in Australia and overseas), there have been 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

A need for mental healthcare at all stages of the justice system

People with mental illness are overrepresented in every part of the justice system. Among police detainees, around 43% of males and 55% of females were reported to have a previously diagnosed mental disorder; while around 40% of prison entrants have been told they have a mental health disorder at some stage in their life (including substance use disorder) — double the rate of the non-prison population. Mental illness is particularly common among female prisoners, and at a much higher level among those Aboriginal and Torres Strait Islander people who are in prison. While the majority of prisoners with mental illness spend relatively short periods of time in custody before returning to the community, inadequate healthcare in prisons and poor transition support services are likely to raise the burden on the community healthcare system and increase recidivism.

For the benefit of those people with mental illness who progress further into the justice system (as either offenders or victims), 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.

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 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 standards of mental healthcare in correctional facilities to ensure they are equivalent to the standards upheld in the community.

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. For example, people who are represented when appearing at a mental health tribunal have a substantially lower likelihood of being subject to an application for involuntary 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.

4. Increasing the participation of people with mental illness in education and work

Start now	Start later
Effective outreach for disengaged school students	Staged rollout of Individual Placement & Support programs to job seekers with mental illness
Tertiary education institution registration linked to having effective student mental health & wellbeing strategy	Eligibility criteria for Carer Payment and Carer Allowance that account for the differences between mental and physical illness
Improve employment support program assessment tools for people with mental illness	WHS agencies to work with employers to collect & disseminate information on effectiveness of workplace programs & interventions
Increase the appropriateness of job plans for those people with mental illness who are using employment services	
Amend model WHS laws to elevate the importance of psychological health & safety	
Develop codes of practice to assist employers to better manage psychological risks in their workplace	
Provision of no-liability clinical treatment for mental health related workers compensation claims	
Review insurance industry practices for people with mental illness	

Improving outcomes for school-age children with mental ill-health

In any given year, about 188 000 school-aged children with a social and emotional disability require some adjustment to their education (representing 26% of all children requiring adjustment due to disability, and nearly 5% of all children attending school). These adjustments include, for example, changes to teaching methods within the classroom and support provided by specialist staff.

It is a legal requirement for schools to provide these adjustments. And in general schools quickly and appropriately provide adjustments for physical disability. However, we have heard that the same is not the case for adjustments relating to social and emotional disability. There can be substantial differences in how well schools implement these adjustments, depending on the resources available and staff skills.

Education adjustments are a relatively low cost way to help improve engagement with education. And this engagement can significantly improve outcomes over a child's life. Governments should ensure that students with mental illness (and indeed, all student with a disability) have timely access to the support they require. State and Territory Departments of Education should evaluate the quality of adjustments implemented in schools. Application processes for disability funding should be reviewed and simplified, with the default position being that a student receives the support necessary to remain engaged in their education.

For students who are at risk of disengagement or who have become disengaged from education due to either their own mental illness or that of a family member, services to support their continuity in, or return to, school should be funded. 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.

The recommended senior teacher with responsibility for the mental health and wellbeing of students, that is discussed above, would have an important role in ensuring children with mental illness get the supports they need within their school and are linked into mental health support services in the local community. Coordination of team-based care for children diagnosed with severe mental illness should be funded for case conferencing that includes the child's school.

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. However, of all age groups, young adults have the highest rates of mental ill-health — 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 ill-health in tertiary students — more so than physical health problems —are associated with poorer engagement in education, lower average grades, and higher drop-out rates. While young people with mental ill-health are less likely to enter tertiary education and tertiary students are more likely to experience mental health problems than the general population, participation in some years of post-school education increases employment prospects and consequent socioeconomic status, and has been found to be associated with reduced odds of being depressed. Psychological distress has been found to be particularly high among international undergraduate students, and under-reporting (associated with differing cultural views of mental ill-health) 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 and actively create a learning environment that does not undermine the mental health of its participants. This strategy should be included as a requirement for the institution's registration.

The Commission is seeking views from inquiry participants on whether tertiary institutions could play a more active role in promoting the use of online services for student mental health. We are also seeking information on difficulties international students may face accessing mental health services in Australia, and views on whether tertiary institutions should be required to take responsibility for ensuring their international students have sufficient private healthcare cover.

For young adults who are disengaged

Around 12% of Australia's 15 to 24 years olds seeking help for mental health problems were not engaged in employment, education or training. Those not engaged are more likely to be male, in their mid-20s, have a history of criminal charges, risky cannabis use, higher levels of depression, poorer social functioning, greater disability and economic hardship, and a more advanced stage of mental illness than those who are engaged.

For those young adults 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 re-engaging young people with either education or work. The program has been found very effective overseas for adults with severe and complex mental illness, and is currently being trialled for youth with less severe mental illness at a number of sites across Australia. The placement rate of young people into education or work has been about 72%, with about 20% of those in the program placed into education. Depending on the final outcomes of the youth trial, the IPS youth focused services should be established and co-located within community mental health services.

Workplaces that work for all

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 that 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 living with a mental illness to work productively and fruitfully creates economic costs for the individual (lost income) and the community more broadly (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 individuals.

At least 3 million working Australians either have mental ill-health or are carers of someone with mental ill-health. Among those with mental ill-health, the rate of absenteeism of these people from work is, on average, around 5 percentage points higher and the rate of presenteeism 5 to 8 times higher than for other Australians without reported mental health problems. Approximately 36% of workers with mild-to-moderate mental health problems and 56% of those with severe problems report having trouble doing their job properly due to their health problems. Estimates for the cost of workplace absenteeism and presenteeism due to mental ill-health range from $13 billion/year up to $17 billion/year, with 70-80% of this cost attributed to absenteeism. As with physical ill-health, the costs of mental ill-health 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 are proposing ways to strengthen these and provide additional clarity on what is expected.

Explicit inclusion of mental health in workplace health and safety

Less attention has been provided to psychological hazards in the workplace than traditional 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. 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 to psychological health and safety.

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 to capture benefits of reduced absenteeism and presenteeism in their workplace.

Reforms to workers compensation schemes

While only around 6% of all workers compensation claims in Australia are for work related mental health conditions, the cost of these claims are typically around three times the cost of other workers compensations claims and involve significantly 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). In some schemes, there can be delays in providing treatment while liability is being determined, which in turn delays recovery and return to work.

Return to work outcomes are improved through early identification and treatment of mental ill-health. 'No liability' medical treatment should be provided for mental health related workers compensation claims until the injured worker returns to work or up to a period of six months following lodgement of the claim.

The Commission is seeking further information from inquiry participants as to how the provision of medical treatment should be funded for workers with mental health related workers compensation claims. Options include increasing workers compensation insurance premiums, a levy based on employment, or direct government funding. Between 11 000 and 13 000 people return to work earlier than otherwise as a result of accessing no liability medical treatment. This includes around 7 200 who have their mental health-related claims for workers compensations upheld. The estimated cost of this reform measure is $17 to $48 million per year, generating potential income benefits of approximately $121 million per year.

For those 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.

The current employment support programs in Australia — jobactive and Disability Employment Services (DES) — tend to stream participants with mental ill-health (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 they are required. The assessment tools for these programs 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.

As an alternative to jobactive and DES for those with mental illness, Individual Placement and Support (IPS) programs should be rolled-out on a staged basis, allowing for the incorporation of lessons learned at each stage, across Australia. This model involves rapid job search with a 'place-train' focus, ongoing support from case workers after employment is found and consistent communication between employment specialists. IPS programs were developed in the US for people with severe and complex mental illness and implemented on a small scale in Australia. The Commission estimated that approximately 50 000 job-seekers with mental illness could benefit from participation in IPS.

For those people 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 (or that of an individual they are the carer for). 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 the recovery and continued social inclusion of the individual.

Approximately 380 000 people with a mental illness receive income support through the Disability Support Pension, the Newstart Allowance or Youth Allowance. A further 75 000 Australians receive Carers Payment to support someone who has a psychological or psychiatric condition as their primary illness, while a number of other carers of people with mental illness receive DSP, Age Pension, Newstart Allowance or Youth Allowance. Approximately one third of DSP recipients have a psychosocial disability as their primary disability, but some estimates suggest that more than half of all DSP recipients have a mental illness.

Approximately 170 000 people with either a self-reported or diagnosed mental illness participate in an employment support service — the majority of these people either receive the Newstart Allowance or no income support (figure 6). While DSP recipients with psychological or psychiatric disabilities may work while continuing to receive a benefit, very few do so.

This largely reflects that, given the eligibility criteria, DSP recipients have a limited capacity to work. While there may be some disincentives to work presented by the design of the DSP (such as the income taper rate and work hour limits), the Commission has not at this stage

recommended changes be made to these, in part due to lack of evidence. Further, any changes would impact on the broader DSP cohort beyond just those with mental illness. There may also be cases where people find it hard to demonstrate they have been fully diagnosed and treated in order to be eligible for DSP. The recommendations of this report for improved access and quality of mental health services should partly address this concern.

Job plans, where required as part of the mutual obligation requirements for Newstart Allowance and Youth Allowance recipients, can be problematic for people with mental illness. Inquiry participants advised that, contrary to intentions, plans are often not adequately tailored to participants and in some cases have devolved to be a purely administrative function, with participants allowed just two business days to consider their plan, and some encouraged to sign their plans without reading them. People with a mental illness can apply for a 'temporary incapacity' exemption if they are unable to work (or complete another work-like activity) for more than eight hours per week due to a medical condition. Approximately 17% of Newstart Allowance recipients with a recorded psychological or psychiatric condition receive an exemption on this basis.

Figure 6   **Use of employment services by people with mental illness**
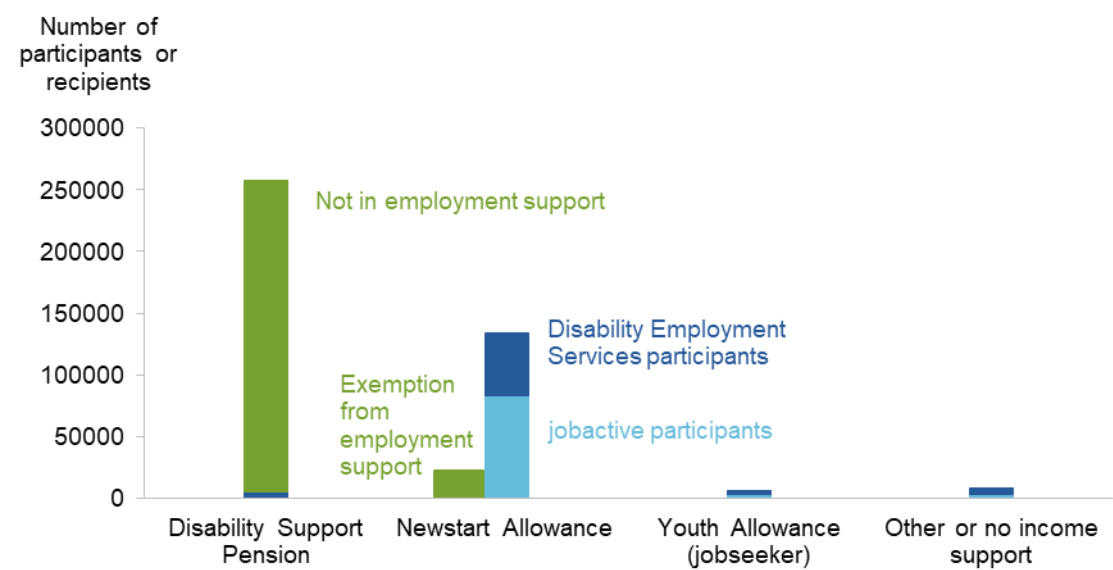
The Australian Government should ensure that employment services providers are meeting their obligations to provide personalised job plans that go beyond compliance, targeted at job seekers with complex needs. This should include extending the period of time that participants have to consider and propose changes to their job plan and greater flexibility in the application of the targeted compliance framework for those participants experiencing mental illness.

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 or volunteer should be evaluated over a month rather than each week, and the restriction on study 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 ill-health 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, 45% had their application declined due to mental health, 34% received the product with exclusions for mental illness, 16% received the product with increased premium for mental illness, and 8% received the product without exclusions or additional premiums.

Insurer practices on 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 reviewed. We are seeking views on any barriers to employers with high risk workplaces purchasing (community-rated) income protection insurance on behalf of their employees that would cover loss of income because of mental illness.

5. Reforming the funding and commissioning of services and supports

Start now	Start later
Include consumers and carers in all mental health program development	Link regional mental health funding to volume of regional MBS rebates for allied mental healthcare
COAG to develop a new National Mental Health & Suicide Prevention Agreement that • **establishes clear funding, data sharing and service delivery responsibilities** • **creates RCA governance arrangements** (if adopted)	NMHC to be given statutory authority Strengthen national leadership, guidance and the coordination of mental health program evaluations and research
Expedite National Strategic Framework for Aboriginal & Torres Strait Islander Peoples' Mental Health &Social & Emotional Wellbeing	Use data collections to evaluate what works well, encourage continuous improvement and inform funding decisions and consumer choices
Determine targets for key outcomes, & set data collection, monitoring & evaluation arrangements consistent with targets	Responsibility for all (non-NDIS) psychosocial & carer supports to be with states and territories
COAG to develop new whole-of-govt strategy to align health and non-health sectors on improving mental health outcomes	
Review regulations preventing insurers from funding community mental health care	
Review proposed activity-based funding classification for mental healthcare	

A range of the reforms canvassed in this draft report, including care coordination and navigation, and the integration of seamless care through the stepped-care model, will involve institutional change covering different tiers of Government. Both tiers will remain responsible for the outcomes of the mental health system. However, the success of reform will, in part, depend on improved clarity as to which level of Government is responsible for funding which services and how that funding translates into incentives for services to be provided (or not provided) to particular people in a particular manner. Success will also depend on the creation of a strong, evidence-based feedback loop so that program effectiveness can be evaluated with the results being used to help determine which activities are funded in the future.

Improving government coordination

To deliver seamless care and support for an individual as their mental health circumstances change requires improved coordination over funding and service delivery by all levels of Government. This includes greater clarity over who is taking responsibility for what. While inevitably there will be 'grey areas', to minimise both service duplication and service gaps,

pragmatic governance arrangements to enable the various parts of the mental health system to come together as envisaged under the Fifth National Mental Health and Suicide Prevention Plan are needed.

Broadly speaking, the Australian Government has generally taken responsibility for primary mental healthcare and State and Territory Governments have taken responsibility for acute mental healthcare (public hospital mental healthcare). Fundamentally, this will not change under our proposed reforms. However, the 'missing middle' reflects the failure of clarity and coordination where primary and acute mental health care meet.

A clearer division of responsibilities between tiers of government is required to avoid these interface problems. In broad terms:

- activities that need local knowledge, expertise and flexibility in order to plan and deliver intended outcomes should be the responsibility of a sub-national level government — follow-up care for people who have been discharged from hospital after a suicide attempt is one such activity;

- activities that need national coordination or consistency in order to effectively, efficiently or equitably achieve intended outcomes should be the responsibility of the Australian Government — provision of infrastructure to enable dissemination of funding, information, online diagnosis or treatment is one example of this.

However, in practice, even these broad areas of responsibility will be blurred. The necessary interlinkages between the mental health system and the broader systems of health, community and Indigenous services, social security, public housing, justice and employment relations necessitate some flexibility around boundaries for reform in mental health.

Nothwithstanding, reform will aid both transparency and the allocation of responsibility and accountability. Agreed roles and responsibilities of Governments should form the basis of a new intergovernmental agreement on funding.

Table 2   Proposed government responsibilities in mental health

	State and Territory Governments	Australian Government
Health	Hospital and community health services Drug and alcohol services Place based suicide prevention	Online mental health supports and education MBS funded health services Population-level suicide prevention
Education and training	In-school services in public schools Parenting support in community settings Perinatal mental health screening and support for new parents Mental health information and backup for ECEC service providers Government funded VET student services	Funding for in-school services in independent and Catholic schools Online and phone-based parenting support University student services and some VET student services
Specialised services	Psychosocial supports (outside NDIS) # Carer supports (outside NDIS) # Indigenous services # Justice services for offenders and victims	Psychosocial supports (NDIS) Income support for those unable to sustain employment or study Indigenous services # DES and jobactive
Housing	Tenancy support services Integrated supported housing services Homelessness services (including Housing first)	Long-term supported accommodation (NDIA)

current shared responsibility

Funding and institutional reform

Current funding arrangements in the mental health system contribute to poor consumer outcomes and a mix of services that is inefficient. For example, they provide few incentives at a local hospital level to minimise hospitalisations and avoid repeated presentations to emergency departments. Beyond the healthcare system, funding for other supports such as psychosocial services is extremely 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, which is leading to duplication, inefficiency and unnecessary red tape.

Reforming funding arrangements in the health system and for psychosocial and carer supports to create the incentives to deliver services that are more consumer-oriented, should be a priority for governments. In part this will require recognition that improvements to the mental health system can result in both costs and benefits beyond the healthcare system, and that these benefits may occur over time. In particular expenditure in some parts of the mental health system today (such as in-community supported residential mental healthcare) would not only generate benefits in the wellbeing of those with severe mental illness but generate long term economy-wide benefits. Funding that is efficient and creates effective incentives will require both intra-government and inter-government coordination and cooperation.

Improved clarity over funding and responsibilities requires institutional reform in the mental health system. The Commission is presenting two options in this inquiry draft report:

Option 1 Renovate model

The renovate model is largely a continuation of the current approach, with some changes that would give more flexibility to PHNs by relaxing centrally imposed restrictions on their funding pools and enabling them to contract with Medicare-funded clinicians to better meet the needs of consumers in their region. To prevent cost shifting, the size of a PHN's mental health funding pool would be linked to the volume of Medicare rebates for allied mental healthcare in their region.

Public hospital and community mental health services would remain the responsibility of State and Territory Governments. Community mental health services (currently block funded) would be activity-funded, which should improve their productivity and negate incentives for Local Hospital Networks to preference hospital-based over community-based care. In addition, psychosocial supports (outside of the NDIS) and individual placement and support (IPS) employment services would become solely a State and Territory Government responsibility, with the Australian Government providing additional funding to support this.

Option 2 Rebuild model

The rebuild model would 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 purpose of RCAs is to create a seamless mental healthcare system that offers continuity of service for people with mental ill-health and fills gaps in service provision. RCAs would 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. These new bodies will be responsible for allocating all mental healthcare, psychosocial and carer supports (with the exception of those for people receiving NDIS funding).

To enable this change, the following Australian Government funding should be pooled and transferred directly to the RCAs:

- payments by State and Territory Governments for mental healthcare under the National Health Reform Agreement

- funding for PHN-commissioned mental healthcare (PHNs would no longer commission mental healthcare under the rebuild model)

- the additional payments proposed for psychosocial and carer supports.

The size of each RCA's funding pool would be linked to the volume of MBS rebates for allied mental healthcare in their region and each RCA would be permitted to contract with MBS-subsidised allied mental professionals, so as to create a single budget from which all such mental healthcare in a region would be funded.

The Rebuild model is the Commission's preferred option.

Rather than creating institutional arrangements that enable two tiers of government to operate as one, the Rebuild model would allocate responsibility for mental healthcare to a single level of government. This avoids practical difficulties that have emerged when governments have tried collaborative funding. In the Commission's view, State and Territory Governments are better suited to establish RCAs and be responsible for their operation, as they have a more firmly embedded role in the health system, and they are also responsible for other major services such as housing, education and justice, which all need to collaborate to support improved mental health and wellbeing. Where regional expertise has become established in PHNs, it would be important to draw on this to assist in the operation of the RCAs.

The rebuild model should help to build a people-oriented mental health system, as it creates strong incentives to invest in prevention and early intervention and avoid costly hospitalisations. Of course, while roles and responsibilities are clarified under the rebuild model, all levels of government will remain involved. For example, even if State and Territory Governments establish RCAs, the Australian Government would retain its responsibility for welfare payments and MBS rebates for mental healthcare.

A key component of the rebuild model (and any other model) is developing a National Mental Health and Suicide Prevention Agreement, separate from the existing National Health Reform Agreement. This agreement would codify Australian, State and Territory Government responsibilities, and facilitate transfers of funds from the Australian Government to the State and Territory Governments that outlast the government of the day. In return, it obliges State and Territory Governments to comply with a new monitoring, reporting and evaluation framework.

The Commission recognises that this reform involves major changes in the way the mental health system is funded and governed. We are seeking feedback from inquiry participants and will be conducting further analysis on these issues; a complete governance and funding model will be presented in the inquiry final report.

Getting bang from the taxpayer buck

Many of the reforms recommended in this inquiry draft report would involve governments spending more taxpayer funds on mental health. But even under current spending levels, governments are obligated to ensure taxpayer funds are used as efficiently and effectively as possible. Throughout this report, we report numerous instances in the mental healthcare system where this is not occurring.

Improvements can be made across the system. For example, improving the efficiency of public community mental health services is desirable and necessary, given the expanded role that our recommendations would have for them. It is not just taxpayers who are losing out. The Commission estimated that, across Australia, only 29% of staff time at community mental health services was spent on consumer-related activities (with or without the consumer present). This falls well short of an agreed national benchmark (that 67% of staff time in community mental health services be related to consumers). Extending activity-based funding to community mental health services should both improve their efficiency and reduce incentives to prioritise hospital-based care.

The Commission supports using activity-based funding to fund both hospital-based mental healthcare and community mental health services to improve incentives across the healthcare system. However, implementing this approach requires care to ensure that funding reflects underlying costs and that reform does not itself create perverse incentives.

Monitoring, evaluation and reporting for improved outcomes

Improved monitoring, reporting and evaluation are needed to support the reforms to the mental health system outlined in this draft report. Accountability for outcomes and the creation of a 'learning system' can only be achieved through a comprehensive and nationally-consistent monitoring and reporting framework.

A key change supporting this would be a focus on better using and publishing data that is already collected. Vast amounts of data are collected throughout the mental health system, but the system as a whole is data rich but information poor: there is limited use of data to either improve consumer 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 underutilised.

The mental health system as a whole needs to move toward collecting data on the impacts of mental illness on the functional capacity of people and the outcomes of programs (rather than just activity data) where at all possible. Long time frames and the interaction of multiple services to improve outcomes complicate this, but there is agreement on some basic indicators and additional outcome measures are proposed. The intention is that this data will feed back in to policy and program development, through an enhanced understanding of which programs

are effective in delivering improved consumer outcomes and represent a reasonable investment of taxpayer funds.

Some key data collections should be expanded and updated and priorities should be established for ensuring data that data collected is translated into useful, and publicly available, information.

The role of the National Mental Health Commission (NMHC), which already reports on some mental health indicators, should be expanded, so that it can report on whole-of-government shared outcome indicators. Shared outcome indicators should be used to support joint responsibility and funding programs across different portfolios, including health, housing, human and social services, education and training, employment and justice. The NMHC should also monitor and report on system performance and government expenditure on mental health. Performance of mental health services at a regional level should be publicly reported on nationally by the AIHW.

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 but also that programs achieve their intended goals, and contribute positively to mental health and wellbeing. The role of the NMHC should include preparing and publishing a rolling three-year schedule for evaluation of 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. The evaluation processes should explicitly provide a means by which lessons garnered during program delivery can be incorporated into ongoing program improvements.

To support the NMHC in these new roles and to allow it to report independently on whole-of-government implementation and performance of mental health programs, the NMHC should be afforded statutory authority status as an interjurisdictional body.

DRAFT RECOMMENDATIONS AND FINDINGS

PART I The case for major reform

DRAFT FINDING 2.1 — THE STATE OF MENTAL HEALTH IN AUSTRALIA

Mental illness is the second largest contributor to years lived in ill-health, and almost half of all Australians will experience mental illness at some point in their life. Compared to other developed countries, the prevalence rate of mental illness in Australia is above the OECD average.

DRAFT FINDING 3.1 — THE COST OF MENTAL ILL-HEALTH AND SUICIDE TO AUSTRALIA

The costs of mental ill-health and suicide are pervasive, reflecting costs incurred in healthcare, education, housing, justice, work, family and friends, and the quality of life of consumers and their carers.

The direct economic costs of mental ill-health and suicide in Australia are estimated to be in the order of $43 to $51 billion in 2018-19. These estimates are apportioned as follows:

- direct expenditure on healthcare and other supports and services ($18 billion)
- lower economic participation and lost productivity ($10 to $18 billion)
- informal care provided by family and friends ($15 billion)

The cost to individuals of the diminished health and wellbeing of living with mental ill-health was a further $130 billion.

These estimates do not include some broader social effects such as the cost of stigma or lower social participation.

INFORMATION REQUEST 3.1 — EDUCATION ACTIVITIES THAT SUPPORT MENTAL HEALTH AND WELLBEING

We are seeking information or methodologies that would help us to estimate the cost of activities undertaken by educational institutions in supporting mental health and wellbeing of students.

DRAFT FINDING 26.1 — MODELLED BENEFITS OF SOME KEY PROPOSED REFORMS

Improvements to people's mental health increases their likelihood of employment and their expected income, while also improving their health-related quality of life. In the long-run, the economic benefits from some key proposed reforms are likely to be between $8.8 to $11.5 billion dollars per year.

PART II   Reorienting health services to consumers

Healthcare access

REFORM OBJECTIVE:

A range and quantity of treatment options that allows people timely access to culturally appropriate mental healthcare at the right level for their condition

DRAFT RECOMMENDATION 5.9 — ENSURE ACCESS TO THE RIGHT LEVEL OF CARE

The Australian, State and Territory Governments should reconfigure the mental health system to give all Australians access to mental healthcare, at a level of care that most suits their treatment needs (in line with the stepped care model), and that is timely and culturally appropriate.

DRAFT RECOMMENDATION 5.2 — ASSESSMENT AND REFERRAL PRACTICES IN LINE WITH CONSUMER TREATMENT NEEDS

In the short term (in the next 2 years)

Commissioning agencies (PHNs or RCAs) should promote best-practice in initial assessment and referral for mental healthcare, to help GPs and other referrers match consumers with the level of care that most suits their treatment needs (as described in the stepped care model).

In the medium term (over 2 – 5 years)

Commissioning agencies (PHNs or RCAs) should establish mechanisms for monitoring the use of services that they fund to ensure that consumers are receiving the right level of care. If service use is not consistent with estimated service demand, commissioning agencies may need to make changes to initial assessment and referral systems (or work with providers to do so).

DRAFT RECOMMENDATION 5.3 — ENSURING HEADSPACE CENTRES ARE MATCHING CONSUMERS WITH THE RIGHT LEVEL OF CARE

headspace centre funding should be conditional on centres following the stepped care model.

In the medium term (over 2 – 5 years)

headspace grant funding for individual centres should be made conditional on centres meeting targets for the proportion of young people referred to low-intensity services. The targets set by commissioning agencies (PHNs or RCAs) for each centre should depend on the full range of relevant characteristics of the young people they see. The targets should start low and increase over time.

DRAFT FINDING 5.1 — THE LINK-ME TRIAL MAY IMPROVE ASSESSMENT AND REFERRAL PRACTICES

The decision support tool, developed as part of the ongoing Link-me Trial, can improve GP assessment and referral practices by identifying the mental health needs of people going to the GP and providing the GP with tailored treatment recommendations.

The extent to which this tool leads to clinical benefits and cost savings relative to usual care, should be used to inform actions taken by governments and commissioning authorities (PHNs or RCAs) to ensure that consumers are matched with the level of care that most suits their treatment need, in line with the stepped care model.

DRAFT RECOMMENDATION 5.6 — PRACTITIONER ONLINE REFERRAL TREATMENT SERVICE

Commissioning agencies could learn from the success of Practitioner Online Referral Treatment Service (PORTS) in Western Australia in improving accessibility and effectiveness of online mental healthcare treatment options.

In the medium term (over 2 – 5 years)

Commissioning agencies (PHNs or RCAs) in other States and Territories should consider implementing the PORTS model, or incorporating aspects of the PORTS model into their services.

DRAFT RECOMMENDATION 5.8 — INCREASE CONSUMER CHOICE WITH REFERRALS

In the short term (in the next 2 years)

The Australian Government should amend the MBS regulations for referrals to require:

- that general practitioners and other referrers advise people that they can use an alternative to any provider mentioned in a referral to a specialist or allied health professional
- that all referrals to specialists and allied health professionals include a prominent and easy to understand statement advising people that they can use an alternative to any provider mentioned in the referral.

DRAFT RECOMMENDATION 6.1 — SUPPORTED ONLINE TREATMENT OPTIONS SHOULD BE INTEGRATED AND EXPANDED

The Australian Government should facilitate greater integration and use of supported online treatment, into the stepped care model as a low intensity service, for people living with mental ill-health with mild to moderate symptoms.

In the short term (in the next 2 years)

- Funding should be expanded for services to accommodate up to 150 000 clients per year in supported online treatment.

- Supported online treatment programs offered should each have a strong evidence base for their efficacy and be offered to children, youth and adults.

- To aid integration of healthcare services, supported online treatment should have the option for outcomes data to be forwarded to a nominated GP or other treating health professional. Online service providers should annually publish summary output on use of their services, treatment provided, and other measurable outcomes.

In the long term (over 5 – 10 years)

- A review of supported online treatment services as a low intensity option should be undertaken. This review should assess whether there are any barriers to take up, the effectiveness of the services contracted and future funding options.

INFORMATION REQUEST 6.1 — SUPPORTED ONLINE TREATMENT FOR CULTURALLY AND LINGUISTICALLY DIVERSE PEOPLE

The Productivity Commission is considering recommending the expansion of supported online treatment to cater for people from culturally and linguistically diverse backgrounds. We seek views on:
- *the merits of such a proposal*
- *in what circumstances would the delivery of supported online treatment be cost-effective*
- *what constraints would need to be considered*
- *which language or cultural group should be the focus of any trial expansion.*

DRAFT RECOMMENDATION 6.2 — INFORMATION CAMPAIGN TO PROMOTE SUPPORTED ONLINE TREATMENT

In the short term (in the next 2 years)

The Australian Government should instigate an information campaign to increase awareness of the effectiveness, quality and safety of government-funded clinician-supported online therapy for treatment of mental ill-health for consumers and health professionals.

DRAFT RECOMMENDATION 5.5 — ENCOURAGE MORE GROUP PSYCHOLOGICAL THERAPY

Changes should be made to MBS rules to encourage more group therapy.

In the short term (in the next 2 years)

- The Australian Government should change MBS rules so that group therapy is allowed with a minimum of 4 people (instead of 6 people), and with less than 4 people, as long as the course of group therapy began with at least 4 in the group.

- The Australian Government should create new Medicare items for group sessions that run for 'at least 90 minutes' and 'at least 120 minutes'.

- The Australian Government should clarify — and communicate with referrers and providers — that unless explicitly stated otherwise, referrals for MBS-rebated Psychological Therapy Services and Focused Psychological Strategies can be used for either group therapy or individual therapy — at the discretion of the psychological therapist receiving the referral after discussion with the consumer.

DRAFT FINDING 5.2 — THE EFFECTIVENESS OF MBS-REBATED PSYCHOLOGICAL THERAPY

Despite evidence for the clinical effectiveness of psychological therapy, there is no well-resourced and rigorous evaluation of the effectiveness of MBS-rebated psychological therapy (Psychological Therapy Services and Focused Psychological Strategies).

The clinical evidence suggests that of those people with mental illness *who are best treated* through individual face-to-face psychological therapy, most need more than 10 sessions (the current MBS limit) for their condition to significantly improve.

More flexibility around the number of rebated sessions available per year would mean more people with mental illness could get the treatment they need, but this would need to be trialled.

DRAFT RECOMMENDATION 5.4 — MBS-REBATED PSYCHOLOGICAL THERAPY

MBS-rebated psychological therapy should be evaluated, and additional sessions trialled.

In the short term (in the next 2 years)

The Australian Government should commission an evaluation of the effectiveness of MBS-rebated psychological therapy. As part of this evaluation, the Australian Government should undertake trials allowing up to 20 sessions of individual or group therapy in total over a year for consumers whose clinical condition requires more than the current 10 sessions. The trials should allow a GP to re-refer a consumer after the first 10 sessions rather than the present 6 sessions.

The Australian Government should change the MBS so that the maximum number of sessions of MBS-rebated psychological therapy (Psychological Therapy Services and Focused Psychological Strategies) is per 12-month period, as opposed to per calendar year.

In the medium term (over 2 – 5 years)

Based on the results of these trials and evaluation, the Australian Government should determine whether to:

- roll out the trialled changes above
- continue funding psychological therapy through the MBS, or whether some other mechanism is more appropriate
- make any other changes to increase the effectiveness of MBS-rebated psychological therapy.

INFORMATION REQUEST 5.1 — LOW-INTENSITY THERAPY COACHES AS AN ALTERNATIVE TO PSYCHOLOGICAL THERAPISTS

We are seeking information on the gains from having a greater share of treatment provided by low-intensity therapy coaches. This includes:

- *improvements in mental health outcomes and/or the cost-effectiveness of therapy for consumers and the wider community*
- *the groups of consumers that would most benefit.*

DRAFT RECOMMENDATION 5.7 — PSYCHOLOGY CONSULTATIONS BY VIDEOCONFERENCE

Widening access to psychology consultations by videoconference.

In the short term (in the next 2 years)

- The Australian Government should change MBS rules so that videoconference can be used for MBS-rebated Psychological Therapy Services and Focused Psychological Strategies by consumers residing in metropolitan areas, regional centres and large rural towns (Monash Modified Model areas 1–3) in addition to those residing in small and medium rural towns, remote and very remote communities (Monash Modified Model areas 4–7).

- For consumers in areas 1–3, at least 3 out of each 10 sessions must be face-to-face (including at least one out of the first four), and there should be no restriction that the consumer and clinician must be at least 15 kilometres away from each other.

DRAFT RECOMMENDATION 7.2 — PSYCHIATRY CONSULTATIONS BY VIDEOCONFERENCE

In the short term (in the next 2 years)

- The Australian Government should introduce a new suite of time-tiered items for videoconference consultations to regional and remote areas (RA2–5), as recommended by the MBS Review Psychiatry Clinical Committee, removing item 288 from the MBS.

- In addition, the Australian Government should add new items for videoconference consultations mirroring existing items for psychiatric assessments (item 291) and reviews (item 293), that are available in major cities (RA1) as well as in regional and remote areas (RA2–5), and that are paid at the same rate as items 291 and 293.

Healthcare — improvements for people receiving care in hospitals

REFORM OBJECTIVE:

In-patient services that reflect the treatment needs of consumers

DRAFT RECOMMENDATION 7.1 — PLANNING REGIONAL HOSPITAL AND COMMUNITY MENTAL HEALTH SERVICES

In the short term (in the next 2 years)

State and Territory Governments should determine, through regional service planning, the numbers of public acute mental health beds in hospitals, specialist mental health community treatment services and subacute/non-acute mental health bed-based services that would meet the specific needs of each region and undertake to provide these on an ongoing basis.

DRAFT RECOMMENDATION 8.1 — IMPROVE EMERGENCY MENTAL HEALTH SERVICE EXPERIENCES

In the short term (in the next 2 years)

- State and Territory Governments should provide more and improved alternatives to hospital emergency departments for people with acute mental illness, including peer- and clinician-led after-hours services and mobile crisis services.

- State and Territory Governments should consider best practice approaches to providing paramedics with access to mental health resources when undertaking medical assessments in the field.

- Public and private hospitals should take steps to improve the emergency department experience they provide for people with a mental illness. This could include providing separate spaces for people with mental illness, or otherwise creating an environment more suitable to their needs.

In the long term (over 5 – 10 years)

- State and Territory Governments should, when building or renovating emergency departments, design them to take account of the needs of people with mental illness.

DRAFT RECOMMENDATION 8.2 — CHILD AND ADOLESCENT MENTAL HEALTH BEDS

In the short term (in the next 2 years)

State and Territory Governments should provide child and adolescent mental health beds that are separate to adult mental health wards. If it is not possible to provide these beds in public hospitals, State and Territory Governments should contract with private facilities, or provide care as hospital-in-the-home.

Healthcare workforce

REFORM OBJECTIVE:

A health workforce with capacity to deliver mental health treatment and care

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DRAFT RECOMMENDATION 11.1 — THE NATIONAL MENTAL HEALTH WORKFORCE STRATEGY

The forthcoming update of the National Mental Health Workforce Strategy should align health workforce skills, availability and location with the need for mental health services.

In the short term (in the next 2 years)

The Australian Government should ensure that its development of a new National Mental Health Workforce Strategy includes the following actions.

- Set the objective of achieving a health workforce which aligns the skills, cultural capability, availability and location of mental health service providers with demand. This goal should be given effect by integrating the workforce strategy with service and infrastructure planning.

- Quantify the future supply of specific skills and health professions under a business-as-usual scenario, and the extent to which this will fall short of what is needed.

- Specify what will be done to address any forecast shortages in skills or professions, and quantify the expected timing and reduction in those shortages.

- Include a commitment to implement the recommendations that this inquiry has made on specific skills and professions, including a more efficient allocation of tasks.

- Set targets to attract and retain workers, and establish a system to monitor and report progress in achieving the targets.

This work should also inform the workforce development program which is being undertaken for the National Mental Health and Suicide Prevention Plan.

DRAFT RECOMMENDATION 11.2 — INCREASE THE NUMBER OF PSYCHIATRISTS

In the medium term (over 2 – 5 years)

The Australian, State and Territory Governments should collectively develop a national plan to increase the number of psychiatrists in clinical practice, particularly outside major cities and in sub-specialities with significant shortages, such as child and adolescent psychiatry.

This should be done in collaboration with the Royal Australian and New Zealand College of Psychiatrists, and form part of the broader National Medical Workforce Strategy which is currently being developed.

The plan should include actions to:

- raise the number of funded training placements and supervisors, with State and Territory Governments doing so in public sector health facilities, and the Australian Government contributing funding for more positions in the private sector and rural and remote areas

- increase the availability of supervision for trainees, including by considering interventions recommended in the 2016 report by the National Medical Training Advisory Network (titled *Australia's Future Health Workforce – Psychiatry*) such as remote models of supervision for trainees outside major cities.

The size of the targeted increase in psychiatrists should be based on assessments of future workforce needs to be undertaken as part of broader workforce planning by governments, including for the National Mental Health Workforce Strategy (draft recommendation 11.1).

DRAFT RECOMMENDATION 5.1 — PSYCHIATRIC ADVICE TO GPs

In the medium term (over 2 – 5 years)

The Australian Government should introduce an MBS item for psychiatrists to provide advice to a GP over the phone on diagnosis and management issues for a patient who is being managed by the GP. The effectiveness of the new item should be evaluated after several years.

INFORMATION REQUEST 7.1 — FREEING UP PSYCHIATRISTS FOR PEOPLE WHO NEED THEM MOST

What additional steps, if any, should be taken to support private psychiatrists to increase the number of consultations involving new patients?

DRAFT RECOMMENDATION 11.3 – MORE SPECIALIST MENTAL HEALTH NURSES

In the short term (in the next 2 years)

- Accreditation standards should be developed for a three-year direct-entry (undergraduate) degree in mental health nursing, similar to the option already available to midwives. The new standards should be developed by the Australian Nursing and Midwifery Accreditation Council in consultation with stakeholders, including the Australian College of Mental Health Nurses and the Nursing and Midwifery Board of Australia. Nurses who complete the three-year direct-entry degree would be registered as having an undergraduate qualification in mental health and (if the above recommendation results in a specialist registration system for nurses with advanced training in mental health) be distinguished from registered nurses with a post graduate degree in mental health.

In the medium term (over 2 – 5 years)

- The merits of introducing a specialist registration system for nurses with advanced qualifications in mental health should be assessed. The assessment should be independent and be commissioned by the Australian, State and Territory Governments through the COAG Health Council. If specialist registration is found to have merit, the COAG Health Council should direct the Nursing and Midwifery Board of Australia to provide it with a formal proposal to amend the registration arrangements for nursing to recognise nurses who have specialist qualifications in mental health.

DRAFT RECOMMENDATION 11.4 — STRENGTHEN THE PEER WORKFORCE

Governments should strengthen the peer workforce.

In the short term (in the next 2 years)

- The National Mental Health Commission should, when submitting its finalised national guidelines on peer workers to governments for approval in mid-2020, recommend how the guidelines should be supported by work standards for particular areas of practice.

- The National Mental Health Commission should, by the end of 2019, submit a recommendation to the Australian Government on how to establish of a professional organisation to represent peer workers. This should include advice on how governments should, if at all, make a financial contribution, such as by providing seed funding to establish the professional organisation.

In the medium term (over 2 – 5 years)

- The Australian, State and Territory Governments should, in consultation with stakeholders, develop a program to educate health professionals about the role and value of peer workers in improving outcomes. The program will need leadership to improve workplace cultures.

- The Australian Government should, in consultation with State and Territory Governments and other stakeholders, commission a national review to develop a comprehensive system of qualifications and professional development for peer workers. This should consider of how peer worker qualifications would be recognised as prior learning for health professional qualifications.

DRAFT RECOMMENDATION 11.5 — IMPROVED MENTAL HEALTH TRAINING FOR DOCTORS

Improve medical practitioners' training on medication side effects and consider specialist registration for GPs who have advanced specialist training in mental health.

In the short term (in the next 2 years)

- Continuing professional development requirements for GPs and psychiatrists should incorporate best-practice approaches to managing the side effects of medication prescribed to treat mental illness. To ensure this is the case, the Australian Government should request the Australian Medical Council to review current CPD requirements and make any changes necessary. This should be done in consultation with stakeholders, including the Medical Board of Australia and relevant colleges for GPs and psychiatrists.

- The merits of introducing a specialist registration system for GPs with advanced specialist training in mental health should be assessed. The assessment should be independent and be commissioned by the Australian, State and Territory Governments through the COAG Health Council. If specialist registration is found to have merit, the COAG Health Council should direct the Medical Board of Australia to provide it with a formal proposal to amend the registration arrangements for GPs to recognise those who have specialist qualifications in mental health.

DRAFT RECOMMENDATION 11.6 — MENTAL HEALTH SPECIALISATION AS A CAREER OPTION

Governments and specialist medical colleges should take further steps to reduce the negative perception of, and to promote, mental health as a career option.

In the short term (in the next 2 years)

The Australian, State and Territory Governments should, in collaboration with specialist medical colleges, act to reduce the negative perception of, and to promote, mental health as a career option by:

- exposing health students and practising health professionals to people with a mental illness (and their carers) outside a clinical environment to help break down negative perceptions

- rebalancing where trainees undertake clinical placements and internships to a more representative mix of settings, including in the private sector and settings other than inpatient units.

DRAFT RECOMMENDATION 11.7 — ATTRACTING A RURAL HEALTH WORKFORCE

In the short term (in the next 2 years)

The Australian, State and Territory Governments should make working in rural and remote areas a more attractive option for health professionals by reducing professional isolation, increasing opportunities for professional development, and improving the scope to take leave. This should include:

- greater use of videoconferencing, subject to the availability of communications infrastructure, for health workers to remotely participate in professional development activities and meetings and conferences with peers

- expanding initiatives such as the Rural Locum Assistance Program to fund visiting health professionals to temporarily stand in for rural and remote health workers, including psychiatrists, while they attend professional development activities, meetings and conferences with peers, and take leave.

INFORMATION REQUEST 11.1 — ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH WORKERS

The Productivity Commission is seeking information from participants on any barriers impeding career progression for Aboriginal and Torres Strait Islander health workers, including barriers to the ability to move to broader health professions, such as mental health nursing.

PART III Reorienting surrounding services to people

Care integration and coordination

REFORM OBJECTIVE:

Care pathways for people using the mental health system that are obvious and joined up

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DRAFT RECOMMENDATION 10.1 — CONSUMER ASSISTANCE PHONE LINES

Assistance phone lines offering support for people with mental ill-health and their carers should facilitate better exchanges of information between service providers.

In the medium term (over 2 – 5 years)

- In its funding contract with existing assistance phone lines, the Australian Government should require providers to implement timely referral processes that minimise the need for consumers to repeat information.

- The phone line that will be part of the Australian Government's mental health portal, Head to Health, should use a similar approach to referrals. The range of services listed on Head to Health should be expanded. The Australian Government can also consider funding an advertising campaign, to raise community awareness of the phone line and the online portal.

DRAFT FINDING 10.1 — DIGITAL RECORDS WOULD FACILITATE INFORMATION SHARING

Expanding the use of digital records in the mental healthcare system would facilitate greater information sharing and improve consumer experience. Existing digital health record systems, such as My Health Record, can provide an adequate platform for information sharing between providers of mental healthcare services.

DRAFT FINDING 10.2 — SUPPORTING COLLABORATION BETWEEN SERVICE PROVIDERS

A range of approaches to collaboration, including co-location, alliances and networks, can improve service delivery and benefit consumers.

Depending on the scale and type of services involved, providers could consider formalising links using memorandums of understanding to create clear accountability structures and overcome barriers to collaboration.

DRAFT RECOMMENDATION 10.2 — ONLINE NAVIGATION PLATFORMS TO SUPPORT REFERRAL PATHWAYS

Commissioning agencies should ensure service providers have access to online navigation platforms offering information on pathways in the mental health system.

In the short term (in the next 2 years)

- All commissioning agencies (PHNs or RCAs) should, either individually or collaboratively, develop and maintain an online navigation platform, including detailed mental health referral pathways. The HealthPathways portal model, which is already used by most PHNs, can be used to contain this information.

- Access to these platforms should be expanded beyond health, in particular to schools and psychosocial service providers. Each commissioning agency should also, either individually or collaboratively, fund a small dedicated team supporting the users of the online platform.

In the medium term (over 2 – 5 years)

- All online navigation platforms should incorporate the ability to book consultations with service providers directly from the platform.

DRAFT RECOMMENDATION 10.3 — SINGLE CARE PLANS FOR SOME CONSUMERS

Governments should support the development of single care plans for consumers with moderate to severe mental illness who are receiving services across multiple clinical providers.

In the medium term (over 2 – 5 years)

The Department of Health should:

- develop and promote protocols for sharing consumer information between service providers, and allocating responsibility for plan development, follow-through and updating the consumer's primary treating clinician (unless otherwise agreed by their treating team)

- amend the MBS to include a specific item to compensate a clinician overseeing a single care plan for their time.

DRAFT RECOMMENDATION 10.4 — CARE COORDINATION SERVICES

All people with severe and persistent mental illness who require care coordination services due to their complex health and social needs should be receiving them. Governments should set a national benchmark for all commissioning authorities, to ensure such services are available and any gaps are addressed.

In the short term (in the next 2 years)

All commissioning authorities should:

- assess the number of people who require care coordination services in their region of responsibility, and the extent to which they are already accessing effective care coordination through existing programs, including the National Disability Insurance Scheme (NDIS)

- streamline care coordination arrangements and ensure that people with a severe and persistent mental illness and complex needs requiring support from multiple agencies have access to effective care coordination.

In the medium term (over 2 – 5 years)

All commissioning agencies should ensure that care coordination programs are available to match local needs, including for those people with severe and persistent mental illness and complex needs who do not qualify for the NDIS, and people with severe mental illness who require care coordination only for brief periods of time.

DRAFT RECOMMENDATION 12.1 — EXTEND THE CONTRACT LENGTH FOR PSYCHOSOCIAL SUPPORTS

In the short term (in the next 2 years)

The Australian, State and Territory Governments should extend the funding cycle length for psychosocial supports from a one-year term to a minimum of five years.

DRAFT RECOMMENDATION 12.2 — GUARANTEE CONTINUITY OF PSYCHOSOCIAL SUPPORTS

Requirements for continued access to psychosocial support should be changed so that anyone who requires it is able to access it, including former participants of Australian Government-funded psychosocial supports.

In the short term (in the next 2 years)

- Should someone choose to apply for the National Disability Insurance Scheme (NDIS), they should continue to be supported during the application process
- Should someone choose not to apply for the NDIS, they should be allowed to continue to access support through the National Psychosocial Support Measure, should they require it, until it has been phased out

In the medium term (over 2 – 5 years)

- For those who did not apply for the NDIS, the psychosocial support commissioning agencies should conduct an evaluation of barriers and remove them as necessary
- When the National Psychosocial Support Measure is phased out, participants should either be shifted onto the NDIS, if appropriate, or access the replacement psychosocial support.

DRAFT RECOMMENDATION 12.3 — NDIS SUPPORT FOR PEOPLE WITH PSYCHOSOCIAL DISABILITY

The National Disability Insurance Agency (NDIA) should continue to improve its approach to people with psychosocial disability.

In the short term (in the next 2 years)

- The NDIA should complete the evaluations of the psychosocial disability stream trial sites in Tasmania and South Australia, and incorporate improvements into the stream, as soon as possible
- The psychosocial disability stream should be fully rolled out across all National Disability Insurance Scheme sites by end-2020
- Incorporate the lessons learnt from the Independent Assessment Pilot into the National Disability Insurance Scheme access and planning processes by end-2020.

Carers and families

REFORM OBJECTIVE:

Increased support for the wellbeing and role of carers and families of people with mental illness

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DRAFT FINDING 13.1 — POTENTIAL IMPROVEMENTS TO INCOME SUPPORT FOR ALL CARERS

The existence of a Carer Payment, Carer Allowance and Carer Supplement that all achieve similar objectives, but have arbitrary differences in eligibility, contributes to an income support system that is complex and not well understood by carers.

DRAFT RECOMMENDATION 13.1 — REDUCE BARRIERS TO ACCESSING INCOME SUPPORT FOR MENTAL HEALTH CARERS

In the short term (in the next 2 years)

The Australian Government Department of Social Services (DSS) should complete its review of the Adult Disability Assessment Tool used to assess eligibility for Carer Payment and Carer Allowance. DSS should:

- publish its analysis and findings from the review and field testing process
- consult with carers and health professionals before setting revised weightings for the new questions and the minimum score required to be eligible for each payment
- expand the list of persons who can complete the health professional questionnaire to include psychologists and social workers.

In the medium term (over 2 – 5 years)

DSS should amend eligibility criteria for Carer Payment (adult) and Carer Allowance (adult). Amendments should include:

- replacing the requirements for 'constant care' and 'care and attention on a daily basis' with a requirement to provide 'regular care'
- replacing the 25 hour per week restriction on work, study and volunteering with a 100 hour per month restriction on work and volunteering only
- replacing the requirement that care must be provided in the home of the care recipient with a requirement that care must usually be provided in the home of the care recipient
- removing the eligibility restriction for Carer Allowance that states that for carers who do not reside with their care recipient to be eligible, they must provide care that relates to the care recipient's bodily functions or to sustaining their life and for more than 20 hours per week.

DRAFT RECOMMENDATION 13.2 — EMPLOYMENT SUPPORT FOR MENTAL HEALTH CARERS

In the short term (in the next 2 years)

- The Australian Government Department of Social Services should evaluate its Carers and Work program to identify how to effectively support mental health carers to enter or maintain employment.

- A working group consisting of both Department of Social Services and Department of Employment, Skills, Small and Family Business representatives should use the evaluation to inform the development of guidelines that jobactive providers can use to tailor their services to the needs of current and former mental health carers.

In the medium term (over 2 – 5 years)

The Australian Government should require designated staff who are delivering the mainstream jobactive program and the Career Transition Assistance, Mid-Career Checkpoint and Transition to Work programs to undertake training to apply these guidelines.

DRAFT RECOMMENDATION 13.3 — FAMILY-FOCUSED AND CARER-INCLUSIVE PRACTICE

Family-focused and carer-inclusive care requires mental health services to consider family members' and carers' needs and their role in contributing to the mental health of consumers.

In the short term (in the next 2 years)

- Where this is not already occurring, State and Territory Government mental health services should routinely collect responses to the Carer Experience Survey. The data collected should be sufficient for each Local Hospital Network to compare and assess the level of carer-inclusive practice across its services.

- The Australian Institute of Health and Welfare should use the data to report publicly on survey take-up rates and survey results at the state and territory level.

In the medium term (over 2 – 5 years)

- To improve outcomes for children of parents with mental illness, the National Mental Health Commission should commission a trial and evaluation of the efficacy of employing dedicated staff to facilitate family-focused practice in State and Territory Government mental health services.

- The Australian Government should amend the MBS so that psychologists and other allied health professionals are subsidised:

  – to provide family and couple therapy, where one or more members of the family/couple is experiencing mental illness. These sessions should count towards session limits for psychological therapy

  – for consultations with carers and family members without the care recipient present. Consistent with existing items that are available to psychiatrists, there should be a limit of four subsidised consultations with carers and family members per 12 month period.

Income support

REFORM OBJECTIVE:

Income support for people with mental illness and their carers that is accessible and does not discourage work, study or volunteering activity

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DRAFT RECOMMENDATION 14.1 — EMPLOYMENT SUPPORT ASSESSMENT MEASURES

Assessment tools for jobactive and Disability Employment Services participants should be more relevant to job seekers with mental illness.

In the short term (in the next 2 years)

The Departments of Social Services; Human Services; and Employment, Skills, Small and Family Business should review the jobactive and Disability Employment Services assessment tools to increase their relevance for job seekers with mental illness. The review should consider:

- providing more specific guidance to job seekers answering the Job Seeker Classification Instrument about the types of medical illnesses or disabilities relevant to employability
- adding a short-form mental health diagnostic instrument to the Job Seeker Classification Instrument
- a new instrument for predicting employment likelihood based on a blend of administrative and self-reported data, and using more sophisticated analytical tools
- supplementing the Employment Services Assessment with the Personal and Social Performance Scale or similar instrument.

DRAFT RECOMMENDATION 14.2 — TAILOR ONLINE EMPLOYMENT SERVICES

Ongoing development of the New Employment Services should consider the needs of participants with mental illness.

In the short term (in the next 2 years)

As part of the national rollout of New Employment Services, and drawing on evidence of the trial underway from 2019 to 2022, the Department of Employment, Skills, Small and Family Business should:

- assess the potential for online peer group support for participants with mental illness as part of the Digital First software

- consider adaptation of the use of the Job Seeker Classification Instrument so that anyone reporting a mental illness is referred for personal assessment before being allocated to Digital First

- ensure participants with inadequate digital literacy and/or mental illness maintain access to face-to-face services

- ensure scope for participants to inform service providers of relapse in mental illness in a timely manner.

DRAFT RECOMMENDATION 14.3 — STAGED ROLLOUT OF INDIVIDUAL PLACEMENT AND SUPPORT MODEL

The Individual Placement and Support (IPS) model of employment support should be extended beyond its current limited application through a staged rollout to (potentially) all State and Territory Government community mental health services, involving co-location of IPS employment support services.

The Commission is seeking further feedback on whether this should occur through partnerships between dedicated IPS providers and community mental health services, or direct employment of IPS specialists by community mental health services.

In the short term (in the next 2 years)

- Governments should thoroughly trial and evaluate the IPS program to better establish the factors that influence its cost-effectiveness (for example, the impacts of local labour market conditions and participant characteristics).

- The program should initially be open to all non-employed consumers of community mental health services who express a desire to participate and meet the other requirements of the IPS model. Participation in the program should fulfil mutual obligation requirements for income support recipients.

In the medium term (over 2 – 5 years)

Subject to these trials, the IPS program should be rolled out gradually with data shared across jurisdictions and a mechanism for diffusion of best practice. If the net benefits of the program apparent in the small scale trials are not replicated as the program is scaled up, its design (and if necessary, its desirability) should be re-appraised.

INFORMATION REQUEST 14.1 — INDIVIDUAL PLACEMENT AND SUPPORT EXPANSION OPTIONS

The Productivity Commission is seeking further information about the pros and cons of the two distinct options for expanding the Individual Placement and Support (IPS) model of employment support. The options are:

- *direct employment of IPS employment specialists by State and Territory Government community mental health services. This could be supported by additional Australian Government funding*

- *a new Australian Government-administered contract for IPS providers, based on fee-for-service compensation and subject to strict adherence to the IPS model (including that a partnership is in place with a State and Territory Government community mental health service).*

What are the pros and cons of each option? Which is your preferred option and why? If the direct employment option is pursued, how should State and Territory Local Hospital Networks be funded to deliver the service?

INFORMATION REQUEST 14.2 — INCENTIVES FOR DSP RECIPIENTS TO WORK

In relation to the Disability Support Pension (DSP), the Productivity Commission seeks feedback on the costs, benefits and risks of:

- *increasing the income threshold at which recipients begin to lose their payments and the value of the taper rate after that threshold*

- *increasing the weekly hour limit above which no DSP is payable from 30 hours to 38 hours (ordinary full time hours of work), but retaining the requirement that a person will lose eligibility for the DSP if they work for more than 30 hours per week for more than two years.*

DRAFT RECOMMENDATION 14.4 — INCOME SUPPORT RECIPIENTS' MUTUAL OBLIGATION REQUIREMENTS

In the short term (in the next 2 years)

The Departments of Human Services; Social Services; and Employment, Skills, Small and Family Business should:

- provide greater flexibility in the application of the Targeted Compliance Framework for jobseekers experiencing mental illness

- assess more systematically whether employment service providers are meeting their obligations to provide personalised Job Plans that go beyond compliance, targeted at job seekers with complex needs

- consider extending the period of time that job seekers with more complex needs have to consider and propose changes to their Job Plan beyond two business days.

Preventing housing issues from arising

REFORM OBJECTIVE:

Housing services that actively prevent people with mental ill-health from experiencing housing issues or losing their home

DRAFT RECOMMENDATION 15.1 — HOUSING SECURITY FOR PEOPLE WITH MENTAL ILLNESS

Housing services should increase their capacity to prevent people with mental illness from experiencing housing issues or losing their home.

In the medium term (over 2 – 5 years)

- Each State and Territory Government should offer and encourage the use of mental health training and resources for social housing workers. Training should incorporate awareness about how to identify early warning signs of mental illness and the benefits of early intervention. It should also provide advice on appropriate interventions to stabilise existing tenancies for people with poor mental health, such as connecting tenants to mental health services or care coordinators.

- State and Territory social housing authorities should review their policies relating to anti-social behaviour, temporary absences and information sharing to provide consideration for people with mental illness, so as to reduce the risk of eviction.

- Each State and Territory Government, with support from the Australian Government, should ensure that tenants with mental illness who live in the private housing market have the same ready access to tenancy support services as those in social housing by meeting the unmet demand for these services.

In the long term (over 5 – 10 years)

- State and Territory Governments should monitor the impacts of forthcoming reforms to residential tenancy legislation, including no-grounds evictions, and assess the potential impacts for people with mental illness who rent in the private market.

Housing supply

REFORM OBJECTIVE:

Long-term stable housing solutions for those people with severe mental illness

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DRAFT RECOMMENDATION 15.2 — SUPPORT PEOPLE TO FIND AND MAINTAIN HOUSING

Housing and homelessness services should have the capacity to support people with severe mental illness to find and maintain housing in the community.

In the short term (in the next 2 years)

- Each State and Territory Government, with support from the Australian Government, should commit to a nationally consistent formal policy of no exits into homelessness for people with mental illness who are discharged from institutional care, including hospitals and prisons.

- Governments should ensure that people with mental illness who exit institutional care (particularly hospitals or prisons) receive a comprehensive mental health discharge plan, and services have the capacity to meet their needs. These programs should integrate care coordination and access to accommodation.

- The National Disability Insurance Agency should review its Specialist Disability Accommodation strategy and policies with a view to encouraging development of long-term supported accommodation for National Disability Insurance Scheme recipients with severe and persistent mental illness.

- Each State and Territory Government, with support from the Australian Government, should work towards meeting the gap in the number of 'supported housing' places for those individuals with severe mental illness who are in need of integrated housing and mental health supports.

  - Governments should provide (either themselves or outsourced to non-government organisations) a combination of long-term housing options for this cohort to support the diverse needs for mental health support and tenancy security.

- Each State and Territory Government, with support from the Australian Government, should work towards meeting the gap for homelessness services among people with mental illness in their jurisdiction. This could include increasing existing homelessness services as well as scaling up longer-term housing options such as Housing First programs.

  - Housing First programs should target people who experience severe and complex mental illness, are persistently homeless, and are unlikely to respond to existing homelessness services.

  - This would require governments to invest in homelessness services that make long-term housing available specifically for these programs.

Justice system

REFORM OBJECTIVE:

Increased importance at each stage of the justice system on identifying people at higher risk of mental illness, enabling early care intervention and ensuring effective links back into the community for continuity of care on release

DRAFT FINDING 16.1 — PREVENTION AND EARLY INTERVENTION TO REDUCE CONTACT WITH THE CRIMINAL JUSTICE SYSTEM

There is some evidence that investment in prevention and early intervention is a strategy that can reduce offending. Governments locally and internationally have acknowledged this with expenditure on such approaches. However, further research and evaluation is required to improve and refine these initiatives.

DRAFT FINDING 16.2 — POLICE RESPONSES RELY ON COMMUNITY MENTAL HEALTH SERVICES

The effectiveness of police responses to mental health related incidents relies heavily on mental health services being available in the community. Police responses are limited by a 'bounce back' problem — where individuals referred to mental health services by police are unable to access appropriate treatment and care, and are discharged without support. Police can respond multiple times to the same individuals experiencing mental health crises.

DRAFT RECOMMENDATION 16.1 — SUPPORT FOR POLICE

A systematic approach should be implemented to support police respond to mental health crisis situations.

In the short term (in the next 2 years)

All State and Territory Governments should implement initiatives that enable police, health and ambulance services to collectively respond to mental health crisis situations. The approach undertaken in Queensland should be considered.

The initiatives should ensure that:

- mental health professionals are embedded in police communication centres to provide real-time information on the individual to whom police are responding, to advise on responses and referral pathways, and to prioritise deployment of co-responder resources

- police, mental health professionals and/or ambulance services (draft recommendation 8.1) are able to co-respond to mental health crisis situations if necessary

- roles and responsibilities of all service providers are clearly defined

- approaches are tailored to meet the needs of particular groups, such as Aboriginal and Torres Strait Islander people.

DRAFT FINDING 16.3 — COURT DIVERSION PROGRAMS

All State and Territory Governments have implemented court diversion programs that aim to support people with mental illness access appropriate mental health treatment and social support. Court diversion programs differ across States and Territories and include court liaison services, mental health courts, integrated support services and Victoria's Neighbourhood Justice Centre. All programs have demonstrably reduced recidivism rates and some have improved mental health.

However, the success of court diversion programs can depend on coordination of mental health court diversion programs with relevant agencies, particularly health and housing. Additional research and evaluation in this area would assist to improve existing and future programs.

DRAFT RECOMMENDATION 16.2 — MENTAL HEALTHCARE STANDARDS IN CORRECTIONAL FACILITIES

National mental health service standards should apply to mental healthcare service provision in correctional facilities to the same level as that upheld in the community.

In the short term (in the next 2 years)

The Australian Commission on Safety and Quality in Health Care should review the National Safety and Quality Health Service Standards to ensure that it applies to mental health service provision in correctional facilities.

DRAFT RECOMMENDATION 16.3 — MENTAL HEALTHCARE IN CORRECTIONAL FACILITIES AND ON RELEASE

Mental health screening and assessment of individuals in correctional facilities should be undertaken to inform resourcing, care and planning for release.

In the medium term (over 2 – 5 years)

- All State and Territory Governments should undertake mental health screening and assessment of all individuals (sentenced or unsentenced) on admission to correctional facilities, and on an ongoing basis where mental ill-health is identified.

- The mental health information obtained from the screening and assessment needs to be comprehensive enough to inform resourcing of mental health services in correctional facilities. Where appropriate, authorities should share this information with community-based mental health services to enable individuals with mental illness to receive continuity of care on release.

INFORMATION REQUEST 16.1 — TRANSITION SUPPORT FOR THOSE WITH MENTAL ILLNESS RELEASED FROM CORRECTIONAL FACILITIES

We are seeking further information on transition support for individuals with mental illness released from correctional facilities (on parole or not) that link them to relevant community services. This includes information on the benefits of transition support and the extent of transition support that should be provided.

INFORMATION REQUEST 16.2 — APPROPRIATE TREATMENT FOR FORENSIC PATIENTS

The Productivity Commission is seeking further information about those held in correctional facilities who are eligible for forensic mental healthcare, but are unable to access it due to capacity constraints. In particular, we are seeking information about the likely indirect costs and benefits to the wider community from increasing access to forensic mental healthcare.

DRAFT RECOMMENDATION 16.4 — INCARCERATED ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

In the short term (in the next 2 years)

- State and Territory Governments should ensure Aboriginal and Torres Strait Islander people in correctional facilities have access to mental health supports and services that are culturally appropriate. These services should be:
  – designed, developed and delivered by Aboriginal and Torres Strait Islander organisations where possible
  – trauma-informed, particularly when services are delivered to Aboriginal and Torres Strait Islander women
  – focused on practical application particularly for those on remand or short sentences who need the skills on release to reintegrate.

- State and Territory Governments should work with Aboriginal and Torres Strait Islander organisations to ensure Aboriginal and Torres Strait Islander people with mental illness are connected to culturally appropriate mental healthcare in the community upon release from correctional facilities.

Advocacy

REFORM OBJECTIVE:

Ensure advocacy for people scheduled under mental health Acts

DRAFT FINDING 16.4 — HEALTH JUSTICE PARTNERSHIPS

Approaches to integrate health and legal services, such as health justice partnerships, show promise in helping people access legal support early and thereby reduce risks to mental health. Existing analysis suggests health justice partnerships can help people access legal support early and improve mental health, but empirical evidence is lacking.

DRAFT RECOMMENDATION 16.5 — DISABILITY JUSTICE STRATEGIES

In the medium term (over 2 – 5 years)

All State and Territory Governments should continue to develop disability justice strategies to ensure the rights of people with mental illness are protected and promoted in their interactions with the justice system. Disability justice strategies should consider how people with mental illness can be better supported to:

- initiate legal proceedings
- participate in the justice system
- access other appropriate support in the community, where required.

In the long term (over 5 – 10 years)

All State and Territory Governments should implement their disability justice strategies.

DRAFT RECOMMENDATION 16.6 — LEGAL REPRESENTATION AT MENTAL HEALTH TRIBUNALS

In the medium term (over 2 – 5 years)

State and Territory Governments should adequately resource legal aid services to assist people appearing before mental health tribunals and other tribunals that hear matters arising from mental health legislation. This could be addressed through broader legal aid funding or providing a specific legal aid grant.

DRAFT RECOMMENDATION 16.7 — NON-LEGAL INDIVIDUAL ADVOCACY SERVICES

In the medium term (over 2 – 5 years)

State and Territory Governments should ensure that non-legal individual advocacy services are available for all individuals subject to involuntary treatment under mental health legislation. In particular, services should:

- focus on facilitating supported decision-making by individuals subject to orders
- be resourced to provide assistance to all individuals who require it
- integrate with rather than replace legal advocacy services.

PART IV   Early intervention and prevention

Early childhood

REFORM OBJECTIVE:

Better use of childhood services to identify and enable early intervention for social and emotional development risks

DRAFT RECOMMENDATION 17.1 — PERINATAL MENTAL HEALTH

Governments should take coordinated action to achieve universal screening for perinatal mental illness.

In the short term (in the next 2 years)

- The Australian Institute of Health and Welfare should expand the Perinatal National Minimum Data Set, to include indicators of mental health screening, outcomes and referrals. This data should be reported by State and Territory Governments.

- State and Territory Governments should use the data to evaluate the effectiveness of health checks for infants and new parents, and adjust practice guidelines in accordance with outcomes.

In the long term (over 5 – 10 years)

- The National Mental Health Commission should monitor and report on progress towards universal screening.

- State and Territory Governments should put in place strategies to reach universal levels of screening for perinatal mental illness for new parents. Such strategies should be implemented primarily through existing maternal and child health services, and make use of a range of screening channels, including online screening and outreach services.

DRAFT RECOMMENDATION 17.2 — SOCIAL AND EMOTIONAL DEVELOPMENT IN PRESCHOOL CHILDREN

Services for preschool children and their families should have the capacity to support and enhance social and emotional development.

In the short term (in the next 2 years)

- State and Territory governments should use existing guidelines to expand early childhood health checks, such that they assess children's social and emotional development before they enter preschool.

- State and Territory departments of education should ensure that all early childhood education and care services have ready access to support and advice from qualified mental health professionals.

- The Australian Children's Education and Care Quality Authority should review the pre service training programs for early childhood educators and teachers to ensure qualifications include specific learning on children's social and emotional development.

In the medium term (over 2 – 5 years)

- State and Territory departments of education, as the regulators responsible for early childhood education and care, should review the quality improvement plans of all services to ensure they include professional learning for staff on child social and emotional development.

- Where this is not already occurring, funding for backfilling should be made available to enable early childhood education and care staff to attend accredited professional development, to support their knowledge of child social and emotional development and mental health.

- State and Territory Governments should expand the provision of parent education programs through child and family health centres.

DRAFT RECOMMENDATION 17.3 — SOCIAL AND EMOTIONAL LEARNING PROGRAMS IN THE EDUCATION SYSTEM

Governments should develop a comprehensive set of policy responses to strengthen the ability of schools to assist students and deliver an effective social and emotional learning curriculum.

In the short term (in the next 2 years)

- The COAG Education Council should develop a national strategic policy on social and emotional learning in the Australian education system. This policy should include:
  – a clear statement on the role of the education system in supporting mental health and wellbeing, and the role of schools in interacting with the mental health system
  – a commitment to cooperate with the COAG Health Council in the implementation of mental illness prevention policy, and a clear delineation of responsibility, to prevent overlap and confusion in policy development
  – guidelines for the accreditation of initial teacher education and professional development courses for teachers, which will include social and emotional learning. These guidelines should be developed by the Australian Institute of Teaching and School Leadership
  – guidelines for the accreditation of external social and emotional learning programs offered to schools. These guidelines could be developed by an expert advisory panel.

In the medium term (over 2 – 5 years)

- State and Territory departments of education should use the national guidelines to accredit social and emotional learning programs delivered in schools.

- State and Territory teacher regulatory authorities should use the national guidelines to accredit initial teacher education programs and professional development programs for teachers. Ongoing learning on child social and emotional development and wellbeing should form part of professional development requirements for all teachers. This should include the social and emotional wellbeing of Aboriginal and Torres Strait Islander children.

DRAFT RECOMMENDATION 17.4 — EDUCATIONAL SUPPORT FOR CHILDREN WITH MENTAL ILLNESS

The education system should review the support offered to children with mental illness and make necessary improvements.

In the short term (in the next 2 years)

- The Disability Standards for Education are due to be reviewed in 2020. The upcoming review should:
    - include specific consideration of the way the standards affect students with mental illness and their educational outcomes.
    - examine application processes for adjustments and consider any necessary improvements.
- MBS-rebated health professionals treating children should be required to include recommendations for parents/carers and teachers in their report to the referring medical practitioner.

In the medium term (over 2 – 5 years)

- The Australian Government should use data collected by schools as part of the National Consistent Collection of Data on School Students with Disability to evaluate the effectiveness of its disability funding structures for children with social-emotional disability.
- State and Territory departments of education should review the funding for outreach services supporting students who have disengaged from education due to mental illness to return to school. Services should be expanded such that they are able to support all students who are at risk of disengagement or have disengaged from their schooling. Departments should put in place clear policies for outreach services to proactively engage with students and families referred to them, once the student's attendance declines below a determined level, and monitor their implementation.

DRAFT RECOMMENDATION 17.5 — WELLBEING LEADERS IN SCHOOLS

All schools should employ a dedicated school wellbeing leader, who will oversee school wellbeing policies, coordinate with other service providers and assist teachers and students to access support.

In the short term (in the next 2 years)

- State and Territory Governments should review existing programs that support school wellbeing initiatives, and establish which funding could be redirected towards the employment of school wellbeing leaders in government schools.

In the medium term (over 2 – 5 years)

- All schools should have a dedicated wellbeing leader. In larger schools, this should be a full-time position.

- Where government schools can demonstrate that they already employ a staff member in an equivalent position, and are delivering effective mental health and wellbeing programs, they should be able to access the equivalent funding to be used for additional investment in social and emotional wellbeing.

INFORMATION REQUEST 17.1— FUNDING THE EMPLOYMENT OF WELLBEING LEADERS IN SCHOOLS

The Productivity Commission is seeking input on funding mechanisms for the employment of wellbeing leaders in schools.

- *What existing funding could State and Territory Governments redirect towards employing wellbeing leaders in government schools?*

- *To what extent should the Australian Government contribute to funding their employment in non-government schools?*

- *What would be the number of students enrolled in a school above which a full-time school wellbeing leader would be required?*

DRAFT RECOMMENDATION 17.6 — DATA ON CHILD SOCIAL AND EMOTIONAL WELLBEING

Governments should expand the collection of data on child social and emotional wellbeing, and ensure data is used (and used consistently) in policy development and evaluation.

In the short term (in the next 2 years)

- the Australian Government should fund the AIHW's work to finalise the development and implementation of an indicator of child social and emotional wellbeing. Where jurisdictions do not collect the required data, the AIHW should work with Departments of Health to implement data collection. Data should be collected and reported annually.

- State and Territory departments of education should use existing school surveys to monitor the outcomes of wellbeing programs implemented in schools. These should be used to identify schools that require additional support to implement effective wellbeing programs.

In the long term (over 5 – 10 years)

- The Australian Government should fund the creation of an education evidence base, including an evidence base on mental health and wellbeing. This should include funding networks of schools to trial and evaluate innovative approaches.

- The Australian Government should fund the Australian Institute of Family Studies to establish new cohorts of the Longitudinal Study of Australian Children at regular intervals.

Young adults

REFORM OBJECTIVE:

Environments in which young adults can remain engaged and mentally well

INFORMATION REQUEST 18.1 — GREATER USE OF ONLINE SERVICES

Should tertiary institutions play a more active role in promoting the use of online services for student mental health? To what extent could (and should) an increase in the use of online services in tertiary institutions be used to improve information on, and practical support for, the mental health of student populations?

DRAFT RECOMMENDATION 18.1 — TRAINING FOR EDUCATORS IN TERTIARY EDUCATION INSTITUTIONS

In the short term (in the next 2 years)

The Australian Government should amend the Higher Education Standards Framework (Threshold Standards) 2015 and the Standards for Registered Training Organisations (RTOs) 2015 to require:

- all teaching staff to undertake training on student mental health and wellbeing
- all tertiary education providers to make available guidance for teaching staff on what they should do if a student approaches them with a mental health concern and how they can support student mental health.

INFORMATION REQUEST 18.2 — WHAT TYPE AND LEVEL OF TRAINING SHOULD BE PROVIDED TO EDUCATORS

What type and level of training should be provided to teaching staff to better support students' mental health and well-being?

DRAFT RECOMMENDATION 18.2 — STUDENT MENTAL HEALTH AND WELLBEING STRATEGY IN TERTIARY EDUCATION INSTITUTIONS

In the short term (in the next 2 years)

The Australian Government should amend the *Higher Education Standards Framework (Threshold Standards) 2015* and the *Standards for Registered Training Organisations (RTOs) 2015* to require all tertiary education institutions to have a student mental health and wellbeing strategy. 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.

This strategy should cover:

- how they will meet their requirements under the *Disability Discrimination Act 1992* (Cth) and *Disability Standards for Education 2005* (Cth)

- how they will meet their requirements under the *Higher Education Standards Framework (Threshold Standards) 2015*, *Standards for Registered Training Organisations (RTOs) 2015* and *National Code of Practice for Providers of Education and Training to Overseas Students*, including information on their internal and external support and the partnerships with providers of external supports

- ensuring on-site counselling services, where available, provide appropriate links into the broader health system and are adequately resourced to meet the needs of students who require these services

- the prevention and early intervention support institutions provide

- training and guidance for staff.

In the medium term (over 2 – 5 years)

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 this information to tertiary education providers.

DRAFT RECOMMENDATION 18.3 — GUIDANCE FOR TERTIARY EDUCATION PROVIDERS

In the short term (in the next 2 years)

To supplement guidance being developed for universities to address student mental health, 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. This should include best-practice interventions that institutions could adopt to build students' resilience and support their mental health.

Workplaces

REFORM OBJECTIVE:

Develop and support mentally healthy workplaces

DRAFT RECOMMENDATION 19.1 — PSYCHOLOGICAL HEALTH AND SAFETY IN WORKPLACE HEALTH AND SAFETY LAWS

Psychological health and safety should be given the same importance as physical health and safety in workplace health and safety (WHS) laws.

In the short term (in the next 2 years)

The model WHS laws (and the WHS laws in those jurisdictions not currently using the model laws) should be amended to ensure psychological health and safety in the workplace is given similar consideration to physical health and safety.

- All WHS legislation should clearly specify the protection of psychological health and safety as a key objective.

- Necessary amendments should be made to ensure that the relevant legislation and regulation addresses psychological health and safety similarly to physical health and safety.

DRAFT RECOMMENDATION 19.2 — CODES OF PRACTICE ON EMPLOYER DUTY OF CARE

In the short term (in the next 2 years)

Codes of practice should be developed by Workplace Health and Safety authorities in conjunction with Safe Work Australia to assist employers meet their duty of care in identifying, eliminating and managing risks to psychological health in the workplace. Codes of practices should be developed to reflect the different risk profiles of different industries and occupations.

DRAFT FINDING 19.1 — RETURN TO WORK IS MORE DIFFICULT IN SMALLER BUSINESSES

Return to work for those with a psychological injury or mental illness is difficult if the injury or illness was related to personal conflict or wider cultural issues in that workplace that have not been addressed prior to return to work. These difficulties are more acute for smaller businesses operating from a single location, as unlike larger organisations that have multiple sites, the business is unable to provide return to work at a different location.

DRAFT RECOMMENDATION 19.3 — LOWER PREMIUMS AND WORKPLACE INITIATIVES

In the medium term (over 2 – 5 years)

Workers compensation schemes should provide lower premiums 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.

DRAFT FINDING 19.2 — THE ROLE OF WORKERS COMPENSATION IN ADDRESSING MENTAL HEALTH

Workers compensation arrangements can most effectively deal with mental health claims and improve outcomes for employers and employees by providing for:

- early intervention
- early treatment
- successful return to work.

DRAFT RECOMMENDATION 19.4 — NO-LIABILITY TREATMENT FOR MENTAL HEALTH RELATED WORKERS COMPENSATION CLAIMS

In the short term (in the next 2 years)

Workers compensation schemes should be amended to provide clinical treatment for all mental health related workers compensation claims, 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 self-insurers.

DRAFT RECOMMENDATION 19.5 — DISSEMINATING INFORMATION ON WORKPLACE INTERVENTIONS

In the medium term (over 2 – 5 years)

WHS 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. They should then advise employers of effective interventions that would be appropriate for their workplace.

DRAFT FINDING 19.3 — EMPLOYER ASSISTANCE PROGRAMS (EAPs)

Employer Assistance Programs (EAPs) are reported to be highly valued by at least some employers and employees. The type and level of EAP services an individual business requires to meet its needs and those of its employees is best determined by the business itself.

The services provided by EAPs, as well as concerns around the reliability of services and the reputation of providers, would be enhanced through further evaluation of their outcomes. To facilitate this, the EAP industry could:

- develop mechanisms to enable individual businesses and EAP service providers to evaluate outcomes for that business
- invest in research to improve external evaluation and benchmarking of best practice in the wider provision of EAP services.

Are there any barriers to employers — in sectors where there is a higher risk of workers developing a work related psychological injury or mental illness — purchasing income protection insurance (including for loss of income relating to mental ill-health) for their employees on a group basis to enable their employees to access this insurance at a lower cost?

Social inclusion

REFORM OBJECTIVE:

Action and strong leadership on stigma reduction in the community and in the health workforce, and active responses to the cultural context of people

DRAFT FINDING 20.1 — SOCIAL EXCLUSION IS ASSOCIATED WITH POOR MENTAL HEALTH

Social exclusion is strongly associated with poor mental health. People with mental illness are more likely to be socially excluded, and people facing social exclusion for other reasons are likely to subsequently experience poor mental health.

People likely to experience both social exclusion and poor mental health include those on lower incomes and with poor access to material resources, single parents, Aboriginal and Torres Strait Islander people, people who live in public rental accommodation, and people who do not complete secondary school.

DRAFT RECOMMENDATION 20.1 — NATIONAL STIGMA REDUCTION STRATEGY

A national stigma reduction strategy can direct efforts to reduce stigma towards people with mental illness that is poorly understood in the community.

In the short term (in the next 2 years)

The National Mental Health Commission should develop and drive the implementation of a national stigma reduction strategy that focuses on the experiences of people with mental illness that is poorly understood in the community. The strategy should:

- rely on the leadership and direction of people with lived experience, including as national ambassadors for mental health
- promote meaningful interactions between people with and without mental illness
- focus on the experiences of people with mental illness that are poorly understood by the community, including those with schizophrenia and borderline personality disorder
- target stigma reduction messages for different audiences, and address different aspects of stigma, including the desire for social distance, and perceptions of danger and unpredictability
- develop an evidence base of effective anti-stigma activities, including through the trial and assessment of different interventions in different areas
- recognise that effective stigma reduction requires a sustained commitment to ensure that reductions in stigma persist.

The strategy should actively target stigma and discrimination directed towards people with mental illness by health professionals, including by developing contact interventions that involve interactions between health professionals and mental health consumers, on an equal footing outside of a clinical setting. Stigma reduction programs should initially be included in training programs for mental health nurses, with the aim of developing evidence as to their effectiveness.

Australian Governments should recognise their commitments to reducing stigma and discrimination made under the Fifth National Mental Health and Suicide Prevention Plan, and should support the National Mental Health Commission in developing and implementing this strategy.

In the medium term (over 2 – 5 years)

Stigma reduction programs should be incorporated in the initial training and continuing professional development requirements of all mental health professionals, subject to periodic evaluation as to their appropriateness and effectiveness.

DRAFT RECOMMENDATION 20.2 — AWARENESS OF MENTAL ILLNESS IN THE INSURANCE SECTOR

In the short term (in the next 2 years)

- The Financial Services Council should update the mental health training requirements for insurers in Life Insurance Industry Standard 21, in consultation with a national consumer and carer organisation to reflect contemporary thinking about mental illness. The Financial Services Council should also:

  – expand the coverage of Life Industry Standard 21 to include all employees of covered insurers so as to ensure the industry as a whole has a better understanding of mental illness

  – publish data they receive on industry compliance with the Standard

  – rollout the Standard to superannuation funds and financial advisory group members.

- The Australian Securities and Investments Commission should evaluate the operation and effectiveness of the insurance industry Codes of Practice and industry standards that relate to the provision of services to people with mental illness. The evaluation should consider whether the insurance industry:

  – has removed blanket exclusions relating to mental illness

  – differentiates between types of mental illness, takes into account the history, severity and prognosis of individual applicants or claimants and uses up-to-date prevalence, prognosis and pricing information to assess risk and make decisions about claims

  – has implemented standardised definitions of diagnosed mental illnesses that are used to assess risk

  – meets maximum timeframes for the resolution of insurance claims consistently, and whether these timeframes are adequate

  – has implemented industry guidelines that require claimants and applicants be provided with written advice when insurance coverage is declined or a claim refused on the basis of mental illness.

  Where these changes have not been achieved, regulatory changes to ensure that these changes are put in place should be recommended. This review should occur within two years.

- The Office of the Australian Information Commissioner should review whether the protocols for insurer access to clinical records have resulted in more targeted requests for clinical information and whether they give sufficient protections to people with histories that include seeking psychological treatment or counselling. This review should be conducted in 2022 after the protocols have been operating for two years.

DRAFT RECOMMENDATION 20.3 — TRADITIONAL HEALERS

Traditional healers have the potential to help improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people.

In the medium term (over 2 – 5 years)

- The Australian Government should evaluate best practices for partnerships between traditional healers and mainstream mental health services for Aboriginal and Torres Strait Islander people.

- This evaluation should incorporate the knowledge and views of Aboriginal and Torres Strait Islander people and seek to improve the evidence about how a partnership between traditional healers and mainstream mental healthcare can most effectively support Aboriginal and Torres Strait Islander people with mental illness and facilitate their recovery in their community.

DRAFT FINDING 20.2 — SOCIAL AND EMOTIONAL WELLBEING OF ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

The social and emotional wellbeing of Aboriginal and Torres Strait Islander people is profoundly influenced by their connection to land, culture, spirituality, family and community, in addition to the broader social determinants of health and wellbeing. The accumulated effects of traumatic experiences over many generations, and racism and discrimination that are endemic in many communities, can impede efforts to improve wellbeing.

Improvements in mental health of Aboriginal and Torres Strait Islander people require improvements in the conditions of daily life as well as actions to promote healing of past traumas and address discrimination.

Government actions that support inclusion and empowerment of Aboriginal and Torres Strait Islander people to positively shape and control their futures are likely to improve social and emotional wellbeing both for Aboriginal and Torres Strait Islander people and the broader community.

Suicide prevention

REFORM OBJECTIVE:

Reduce suicide deaths and intentional self-harm

DRAFT FINDING 21.1 — THE COST OF SUICIDE AND NON-FATAL SUICIDE ATTEMPTS IS HIGH

Suicide and suicide attempts create enormous social and emotional impacts on individuals, families and the broader Australian community. The quantifiable cost of suicide and non-fatal suicide attempts in Australia is estimated to be $16 billion to $34 billion each year. The vast majority of these costs are due to lost productivity resulting from suicide deaths and permanent incapacity from non-fatal suicide attempts.

DRAFT FINDING 21.2 — SCHOOL-BASED AWARENESS PROGRAMS CAN BE COST-EFFECTIVE

School-based suicide prevention awareness programs can be effective at reducing suicide attempts and are likely to be cost-effective. Governments can encourage the use of these programs by accrediting evidence-based programs through the process outlined in draft recommendation 17.3.

DRAFT RECOMMENDATION 21.1 — UNIVERSAL ACCESS TO AFTERCARE

In the short term (in the next 2 years)

Australian, State and Territory Governments should offer effective aftercare to anyone who presents to a hospital, GP or other government service following a suicide attempt. Aftercare should be directly provided or referred, and include support prior to discharge or leaving the service, as well as proactive follow-up support within the first day, week and three months of discharge, when the individual is most vulnerable.

DRAFT RECOMMENDATION 21.2 — EMPOWER INDIGENOUS COMMUNITIES TO PREVENT SUICIDE

In the short term (in the next 2 years)

- The Council of Australian Governments Health Council should develop a renewed *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* and associated *Implementation Plan* to guide suicide prevention activities in Indigenous communities.

- Indigenous organisations should be the preferred providers of local suicide prevention activities for Aboriginal and Torres Strait Islander people. For all organisations providing programs or activities into Indigenous communities, the requirements of performance monitoring, reporting and evaluation should be adapted to ensure they are appropriate and reflective of the cultural context.

DRAFT RECOMMENDATION 21.3 — APPROACH TO SUICIDE PREVENTION

Australia's approach to suicide prevention holds promise, but there are opportunities to improve going forward.

In the short term (in the next 2 years)

- The proposed National Mental Health and Suicide Prevention Agreement (draft recommendation 22.1) should identify responsibilities for suicide prevention activities across different levels of government and across portfolios to create a truly whole-of-government approach to suicide prevention. Responsibilities should be informed by, and consistent with, the *National Suicide Prevention Implementation Strategy* under development.

- The *National Suicide Prevention Implementation Strategy* should be extended to include strategic direction for non-health government portfolios that have influence over suicide prevention activities.

In the medium term (over 2 – 5 years)

- The National Mental Health Commission should assess evaluations of current trials that follow a systems approach to suicide prevention. It should consider whether the evidence shows if these approaches are likely to be successful at reducing suicide rates and behaviours in Australia. If so, this approach should be implemented across all Australian regions.

PART V   Pulling together the reforms

Governance, responsibilities and consumer participation

REFORM OBJECTIVE:

To inject genuine accountability for system outcomes, to clarify responsibilities for program funding and delivery, and to ensure consumers and carers participate fully in the design of policies and programs that affect their lives

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DRAFT RECOMMENDATION 22.1 — A NATIONAL MENTAL HEALTH AND SUICIDE PREVENTION AGREEMENT

All stakeholder groups, including government, should know which tier of government is responsible for funding particular services and is accountable for mental health outcomes that are attributable to the provision of those services.

In the short term (in the next 2 years)

COAG should develop a National Mental Health and Suicide Prevention Agreement between the Australian, States and Territory Governments that:

- sets out the shared intention of the Australian, State and Territory Governments to work in partnership to improve mental health and suicide prevention outcomes for all Australians

- recognises the importance of separating funding and governance arrangements of mental health from those of physical health to strengthen the accountability of individual jurisdictions for mental health outcomes

- specifies the responsibility of each tier of government to fund and deliver particular mental health services and supports, and suicide prevention activities to ensure maximum separation in responsibilities and maximum coverage of consumer and carer needs

- introduces new funding and governance arrangements between both tiers of government for mental health services and supports, including the mechanism for establishing funding allocations

- includes consumers and carers as key partners in developing the agreement

- recognises the role of non-health supports in meeting consumer and carer needs, particularly psychosocial supports

- sets out clear and transparent performance reporting requirements

- sets out the governance arrangements for the proposed Regional Commissioning Authorities, if recommended and accepted by all governments.

The COAG Health Council should be responsible for developing and implementing the proposed National Mental Health and Suicide Prevention Agreement.

DRAFT RECOMMENDATION 22.2 — A NEW WHOLE-OF-GOVERNMENT MENTAL HEALTH STRATEGY

A national strategy that integrates services and supports delivered in health and non-health sectors should guide the efficient allocation of government funds and other resources to improve mental health outcomes over the long term.

In the short term (in the next 2 years)

The Council of Australian Governments (COAG) should amend the terms of reference of the COAG Health Council to enable it to include other COAG Councils in policy discussions and decisions, or ministers responsible for portfolios that do not have a relevant COAG council, where this is necessary to cement cross-portfolio commitment to reforms directed at the social determinants of mental health and suicide prevention.

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.

The COAG Health Council should develop a new whole-of-government *National Mental Health Strategy* to improve population mental health over a generational time frame. In developing the new strategy, the COAG Health Council should:

- collaborate with relevant health and non-health portfolios of Australian, State and Territory Governments, consumers and carers, and the private sector

- redraft its mental health vision statement to better balance the outcomes desired by consumers and carers with the level of ambition it has for mental health reforms

- ensure that it is a single document that has the demonstrable support of consumers and carers, for whom it exists.

The National Mental Health Commission should be responsible for monitoring and reporting on the strategy's implementation annually.

The COAG Health Council should ensure that progress in implementing the strategy is independently reviewed and improvements recommended every five years.

The COAG councils should ensure that all national, and State and Territory agreements and strategies that affect mental health outcomes explicitly articulate how they contribute to meeting the aims of the *National Mental Health Strategy* and how they will demonstrate progress in meeting these aims. Similarly, the new *National Mental Health Strategy* should include corresponding links to other strategies that support it.

DRAFT RECOMMENDATION 22.3 — ENHANCING CONSUMER AND CARER PARTICIPATION

Consumers and carers should have the opportunity to participate in the design of government policies and programs that affect their lives.

In the short term (in the next 2 years)

- The Australian, State and Territory Governments should ensure that they collaborate with consumers and carers in all aspects of mental healthcare system planning, design, monitoring and evaluation.
- COAG should instruct the National Mental Health Commission to monitor and report on total expenditure by individual jurisdictions on systemic advocacy in mental health that is provided by peak representative bodies.

In the medium term (over 2–5 years)

The Australian, State and Territory Governments should strengthen systemic advocacy by:

- extending the funding cycle length for peak bodies to a minimum five years to improve business planning and capability development
- concluding contract renewals at least one year before expiry
- reporting their total funding to peak bodies that represent mental health consumers and carers through the annual Report on Government Services.

DRAFT RECOMMENDATION 22.4 — ESTABLISHING TARGETS FOR OUTCOMES

Accountability for mental health outcomes should include measurement against predetermined performance targets.

In the medium term (over 2 – 5 years)

The COAG Health Council should agree on a set of targets that specify key mental health and suicide prevention outcomes that Australia should achieve over a defined period of time.

To ensure these targets reflect an appropriate balance of ambition and reality, it should develop a process for setting them that, among other things, involves collaboration with consumers and carers. Following this collaborative process, the COAG Health Council should publish the targets and an explanation of how they were set.

DRAFT RECOMMENDATION 22.5 — BUILDING A STRONGER EVALUATION CULTURE

A robust culture of program evaluation should inform the allocation of public funds across the mental health system to ensure that they are deployed most efficiently and effectively.

In the medium term (over 2 – 5 years)

The National Mental Health Commission (NMHC) should have statutory authority to lead the evaluation of mental health and suicide prevention programs 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.

- The NMHC should be an interjurisdictional body. The COAG Health Council should communicate its support to the NMHC in taking on the proposed broad-ranging evaluation role.

- The NMHC should be governed by a skills-based Board of multiple persons. It should be granted full powers to act in the interests of the NMHC in fulfilling its statutory functions, including powers to appoint and remove a Chief Executive Officer.

- The NMHC should continue to work closely with the Australian Bureau of Statistics, the Australian Institute of Health and Welfare, and the Australian Commission on Safety and Quality in Health Care to minimise duplication in monitoring and reporting.

- The NMHC should not advocate, defend or publicly canvass the merits of governments' or oppositions' policies.

As part of its annual planning cycle, the NMHC should prepare and publish a rolling 3-year schedule of program evaluations. To this end, the NMHC should:

- develop a consultation process and consult with, at a minimum, State and Territory Government health/mental health departments, the Australian Government's Department of Health, the Department of Social Services, the National Indigenous Australians Agency, and consumer and carer peak bodies

- in consultation with key stakeholders, develop and publish a process for prioritising policy and program evaluations, including decision-making criteria.

INFORMATION REQUEST 22.1 — GOVERNANCE ARRANGEMENTS FOR NMHC

The Productivity Commission is seeking views on the form the National Mental Health Commission should take as an interjurisdictional statutory authority and the nature of its governance arrangements to enable it to effectively lead evaluations of mental health and suicide prevention programs funded by the Australian Government, State and Territory Governments, and other programs that have strong links with mental health outcomes, including those in non-health sectors.

Funding

REFORM OBJECTIVE:

To incentivise investment in those services that best meet the needs of people with mental illness and their carers and promote more efficient use of taxpayer funds

DRAFT RECOMMENDATION 23.1 — REVIEW PROPOSED ACTIVITY-BASED FUNDING CLASSIFICATION FOR MENTAL HEALTHCARE

In the short term (in the next 2 years)

The Independent Hospital Pricing Authority should review the Australian Mental Health Care Classification to determine:

- whether the structure of the Australian Mental Health Care Classification and the variables within it should be refined or changed (especially the 'phase of care' variable)

- if the 'phase of care' variable is retained, how the variable can be refined to improve inter-rater reliability

- if a new costing study is required

- a revised timeframe for implementing the classification.

As an interim measure, the Independent Hospital Pricing Authority should consider developing a classification system for community ambulatory mental healthcare services based on hours of care provided.

DRAFT RECOMMENDATION 23.2 — RESPONSIBILITY FOR PSYCHOSOCIAL AND CARER SUPPORT SERVICES

In the medium term (over 2 – 5 years)

State and Territory Governments should take on sole responsibility for commissioning psychosocial and mental health carer support services outside of the National Disability Insurance Scheme. The Australian Government should provide funding to support the new and expanded roles that State and Territory Governments are taking on, and continue to administer the Carer Gateway's service navigation and information services for all carers.

DRAFT RECOMMENDATION 23.3 — STRUCTURAL REFORM IS NECESSARY

The Australian Government and State and Territory Governments should work together to reform the architecture of Australia's mental health system to clarify federal roles and responsibilities and incentivise governments to invest in those services that best meet the needs of people with mental illness and their carers. There should be greater regional control and responsibility for mental health funding.

INFORMATION REQUEST 23.1 — ARCHITECTURE OF THE FUTURE MENTAL HEALTH SYSTEM

The Productivity Commission has proposed two distinct models for the architecture of the future mental health system:

- *The Renovate model, which embraces current efforts at cooperation between Primary Health Networks (PHNs) and Local Hospital Networks (LHNs).*

- *The Rebuild model, under which State and Territory Governments would establish 'Regional Commissioning Authorities' that pool funds from all tiers of government and commission nearly all mental healthcare (Regional Commissioning Authorities would take over PHNs' mental health commissioning responsibilities and also commission more acute mental healthcare) and psychosocial and carer supports (outside the NDIS) for people living within their catchment areas.*

At this stage, the Rebuild model is the Commission's preferred approach.

How could the Rebuild model be improved on? Are the proposed governance arrangements appropriate? Should RCAs also hold funding for, and commission, alcohol and other drug services?

If you consider the Renovate model or another alternate approach is preferable, please describe why, and outline any variations you consider would be an improvement.

DRAFT RECOMMENDATION 24.1 — FLEXIBLE AND POOLED FUNDING ARRANGEMENTS

MBS-rebated and regionally commissioned allied mental healthcare should be funded from a single pool, and commissioning agencies should be able to co-fund MBS-rebated allied mental health professionals. State and Territory Government agencies should be permitted to co-fund MBS-rebated out-of-hours GP services where this will reduce mental health-related emergency department presentations

In the short term (in the next 2 years)

The Australian Government Minister for Health should issue a direction in relation to section 19.2 of the *Health Insurance Act 1973* (Cth) that allows State and Territory Government agencies to provide additional funding to MBS-rebated out-of-hours GP services, with the agreement of PHNs. The Australian Government should direct PHNs to approve these requests if there is a reasonable prospect that additional out-of-hours GP services would yield reductions in mental health-related emergency department presentations.

In the medium term (over 2 – 5 years)

MBS rebates for allied mental healthcare should be explicitly linked to commissioning agencies' (PHNs or RCAs) mental health funding pools, so as to create a single budget from which all primary allied mental healthcare would be funded.

Once this linkage has been established, the Minister for Health should issue a direction in relation to section 19.2 of the *Health Insurance Act 1973* (Cth) that:

- allows commissioning agencies (PHNs or RCAs) to provide additional funding to allied mental health professionals whose services receive MBS rebates
- allows other Australian, State and Territory Government agencies to provide additional funding to MBS-rebated allied mental health professionals with the agreement of commissioning agencies (PHNs or RCAs).

DRAFT RECOMMENDATION 24.2 — REGIONAL AUTONOMY OVER SERVICE PROVIDER FUNDING

In the short term (in the next 2 years)

The Department of Health should cease directing PHNs to fund headspace centres, including the headspace Youth Early Psychosis Program, and other specific service providers. PHNs should be able to continue funding headspace services or redirect this funding to better meet the needs of their local areas as they see fit.

In the medium term (over 2–5 years)

There should be no requirements that commissioning agencies (RCAs or PHNs) have to fund particular service providers.

DRAFT RECOMMENDATION 24.3 — THE NATIONAL HOUSING AND HOMELESSNESS AGREEMENT

In the medium term (over 2 - 5 years)

As part of the next negotiation of the National Housing and Homelessness Agreement, the Council of Australian Governments should increase the quantum of Australian Government funding for State and Territory Government-provided housing and homelessness services. State and Territory Governments should use this additional funding to expand their provision of housing and homelessness services for people with mental illness.

DRAFT RECOMMENDATION 24.4 — TOWARD MORE INNOVATIVE PAYMENT MODELS

In the long term (over 5 – 10 years)

The Australian Government should establish a Mental Health Innovation Fund to trial innovative system organisation and payment models. Commissioning agencies (PHNs or RCAs) could apply for additional funding to trial new models under the proviso that they have them independently evaluated and share the findings.

As part of these trials, and with appropriate governance arrangements in place, commissioning agencies (PHNs or RCAs) should be permitted to cash-out Medicare Benefits Schedule rebates for allied mental health professionals in their regions and administer this funding through a means of their choosing.

DRAFT RECOMMENDATION 24.5 — PRIVATE HEALTH INSURANCE AND FUNDING OF COMMUNITY-BASED HEALTHCARE

In the short term (in the next 2 years)

The Australian Government should review the regulations that prevent private health insurers from funding community-based mental healthcare with a view to increasing the scope for private health insurers to fund programs that would prevent avoidable mental health-related hospital admissions.

DRAFT RECOMMENDATION 24.6 — LIFE INSURERS AND FUNDING OF MENTAL HEALTHCARE

In the short term (in the next 2 years)

The Australian Government should permit life insurers to fund mental health treatments for their income protections insureds on a discretionary basis. The Australian Securities and Investments Commission should work with the life insurance industry on the preconditions necessary for this to occur.

Monitoring, reporting and evaluation

REFORM OBJECTIVE:

To promote accountability and to continuously drive system improvements

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INFORMATION REQUEST 25.1 — UNDER-UTILISED DATASETS

The Productivity Commission is seeking further information about what specific datasets are being under-utilised, the reasons why specific datasets are being under-utilised including examples of existing barriers, and what potential solutions can be practicably implemented to improve use of specific datasets.

DRAFT RECOMMENDATION 25.1 — A DATA LINKAGE STRATEGY FOR MENTAL HEALTH DATA

In the medium term (over 2 – 5 years)

The Australian, State and Territory Governments should task the Mental Health Information Strategy Steering Committee with developing a strategy to improve data linkage in mental health including:

- identifying high-priority data linkage projects
- assessing the barriers to implementing such projects
- advising on solutions to address them.

DRAFT RECOMMENDATION 25.2 — ROUTINE NATIONAL SURVEYS OF MENTAL HEALTH

In the long term (over 5 – 10 years)

The Australian Government should support the ABS to conduct a National Survey of Mental Health and Wellbeing no less frequently than every 10 years.

The survey design should enable consistent comparisons across time, and aim to routinely collect information on:

- prevalence of mental illness
- service use by people with mental illness, and
- outcomes of people with mental illness and their carers.

The survey design should ensure that it adequately represents vulnerable population sub-groups who may have diverse needs. Opportunities for linking the survey data with other datasets should be considered.

DRAFT RECOMMENDATION 25.3 — STRATEGIES TO FILL DATA GAPS

High-quality and fit-for-purpose data should be collected to drive improved outcomes for consumers and carers.

In the medium term (over 2 – 5 years)

- The Australian, State and Territory Governments should complete Action 24 in the Fifth National Mental Health and Suicide Prevention Plan to update the statement on National Mental Health Information Priorities. The priorities should consider data gaps identified in this inquiry, in particular for mental health services provided by general practitioners, private providers and non-government organisations, and vulnerable population sub-groups.

In the long term (over 5 – 10 years)

- The Australian, State and Territory Governments should develop and adequately fund strategies to address identified data gaps and information priorities. This should include consultation on how best to:
    - collect the data in a way that imposes the least regulatory burden to ensure data is high-quality and fit-for-purpose
    - publish the data in ways that are useful to policy makers, service providers and consumers.

INFORMATION REQUEST 25.2 — PROPOSED INDICATORS TO MONITOR PROGRESS AGAINST CONTRIBUTING LIFE OUTCOMES

The Productivity Commission is seeking information on what additional indicators should be considered to monitor progress against Contributing Life Outcomes and whether routine data is available for the Commission's proposed indicators.

INFORMATION REQUEST 25.3 — DATA SHARING MECHANISMS TO SUPPORT MONITORING

The Productivity Commission is seeking information on whether formal mechanisms would be required to support the National Mental Health Commission to undertake its proposed monitoring and reporting role in mental health and suicide prevention. If formal mechanisms would be required, what mechanisms would be preferred?

Monitoring and reporting should be more focused on outcomes for consumers and carers and broadened beyond health portfolios.

In the short term (in the next 2 years)

- The National Mental Health Commission (NMHC) should conduct monitoring and reporting on mental health and suicide prevention outcomes, activity and reforms across portfolios. This should include monitoring and reporting on:
  - outcome areas derived from the Contributing Life Framework for people living with mental illness, their carers and suicidal behaviour annually
  - mental health and suicide prevention expenditure (including in non-health sectors), with the frequency of reporting to be determined by the NMHC
  - the progress of mental health reforms (including strategies and plans) annually.
- The NMHC should consult with stakeholders, including consumers and carers, Aboriginal and Torres Strait Islander representatives and sector experts in finalising the set of indicators to monitor progress against outcomes.
- The NMHC should consult with stakeholders and sector experts to identify what expenditure across which sectors should be reported on.
- The NMHC should continue to monitor and report on progress against mental health reforms under the National Mental Health Strategy.

In the short term (in the next 2 years)

- The Australian, State and Territory Governments should authorise the Australian Institute of Health and Welfare (AIHW) to report all data relating to the performance of mental health and suicide prevention services at a regional level, as defined by commissioning agencies (PHNs or RCAs), as well as at a State and Territory, and national level.
- The AIHW should ensure that this data is readily accessible to the public, including as historical time series, to maximise their use for planning and research.
- The Australian Government should continue to provide AIHW with additional resources to establish service performance reporting at the regional level and to make this data more accessible.

DRAFT FINDING 25.1 — MONITORING AND REPORTING AT THE SERVICE PROVIDER LEVEL

Monitoring and reporting at the provider level can improve transparency and accountability, and potentially service quality, through:

- publishing data that informs consumer choice and drives self-improvement
- benchmarking analyses, where services are able to regularly compare their performance relative to similar services, that prompt discussions and information sharing.

However, there are several challenges including data limitations and risks of unintended consequences, such as gaming.

Governments would need to address these before the potential benefits of a national approach to monitoring and reporting of service providers were to be realised.

DRAFT RECOMMENDATION 25.6 — STANDARDISED REGIONAL REPORTING REQUIREMENTS

In the short term (in the next 2 years)

The Australian, State and Territory Governments should provide commissioning agencies (PHNs or RCAs) with guidance and support to enable them to implement standardised monitoring and reporting requirements for commissioned services, with minimal undue regulatory burden.

DRAFT RECOMMENDATION 25.7 — PRINCIPLES FOR CONDUCTING PROGRAM EVALUATIONS

In the short term (in the next 2 years)

The COAG Health Council should agree to a set of principles by which the National Mental Health Commission would undertake its evaluation function, as set out in draft recommendation 22.5. These principles should be set in consultation with relevant stakeholders.

DRAFT RECOMMENDATION 25.8 — REQUIRING COST-EFFECTIVENESS CONSIDERATION

In the medium term (over 2 – 5 years)

The Australian Government should consider the expected cost-effectiveness of all mental health programs or interventions *before* funding is provided. Allocation of funding should only be considered for programs or interventions that are expected, on the basis of evidence provided in the funding request, to be cost-effective.

DRAFT RECOMMENDATION 25.9 — A CLINICAL TRIALS NETWORK SHOULD BE ESTABLISHED

In the short term (in the next 2 years)

The Australian Government should fund the establishment of a national clinical trial network in mental health and suicide prevention. In developing this network, the Australian Government should consult with bodies that work in this area including the National Medical and Health Research Centre and the Australian Clinical Trials Alliance.

PART I — The case for major reform

1   Inquiry background and approach

How this inquiry contributes …	• This inquiry proposes a package of reforms that would support the mental health of Australians to enable them to reach their potential in life, have purpose and meaning, and contribute to the lives of others. This has benefits for individuals and the whole community.

- The inquiry differs from past reviews by extensively considering how:

  – reforms outside of healthcare — including in workplaces, education, justice systems, housing and social services — would improve mental health

  – funding and governance of services can be used to reform the way services are delivered and are experienced by people

  – better mental health would benefit not only individuals but also the wider community through greater social and economic participation, productivity and economic growth.

- This is a draft report. It has been publicly released to give you an opportunity to provide feedback on the Commission's analysis and draft recommendations. You can do this by sending a written submission or brief comment by **23 January 2020,** or by participating in public hearings (dates, locations and how to register for hearings will be on the Commission's website).

1.1 Why this inquiry?

Mental health means different things to different people at different points in their life, but it is indisputably important to everyone. The capacity to enjoy life, cope with and bounce back from stress and sadness, set and fulfil goals, and build and maintain relationships with others, are all key aspects of being mentally healthy and participating in the community.

Almost half of all Australians experience difficulties with their mental health at some point in their life; one in five meet the diagnostic criteria for an anxiety, mood or substance use disorder in a given year (ABS 2008). For most people, the symptoms of mental ill-health are mild and temporary, and they continue to participate in social activities and workplaces, albeit with a reduced contribution. For other people, mental ill-health more significantly impairs their social and economic participation. This affects not only the person experiencing mental illness, but also their carers, family and friends.

Across the community, mental illness is the largest contributor to years lived in ill-health for people under 50 (AIHW 2019c). While this is similar to the average experience of developed countries (OECD 2012, 2014b), it nonetheless remains unacceptably high for a society that cares about the wellbeing of its people.

The Productivity Commission has been asked to undertake an inquiry into the role of mental health in supporting social and economic participation, and enhancing productivity and economic growth (these terms are defined in box 1.1). This includes making recommendations, as necessary, to improve population mental health in order to realise benefits from higher social and economic participation and contribution over the long term.

By examining mental health from a participation and contribution perspective, this inquiry has considered how people can be enabled to reach their potential in life, have purpose and meaning, and contribute to the lives of others. This benefits individuals and the whole community.

The Commission acknowledges the many reviews of mental health in Australia that have been conducted over the years. This inquiry differs from past reviews in a number of important ways.

- It takes a holistic view, within the health care system but also across the many other systems and services that support mental health and wellbeing, and puts forward reforms that have the potential to reinforce each other to maximise benefits for individuals and the community.

- This inquiry looks both at the way services should be delivered and at the funding structures that determine incentives for service providers and governments. Aligning the incentives faced by all system participants — governments, service providers, employers and consumers of services — is an essential part of successful reform.

- Alongside estimates of current and future costs incurred by governments in the delivery of mental health services and supports, this inquiry also presents the longer term benefits

in terms of workforce participation and incomes that are likely to stem from improvements in population mental health. This supports the long term approach required across the system to achieve better mental health and wellbeing.

Box 1.1   Definition of key terms

Mental health is a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Mental illness or **mental disorder** is a health problem that significantly affects how a person feels, thinks, behaves and interacts with other people. It is diagnosed according to standardised criteria.

Mental health problem refers to some combination of diminished cognitive, emotional, behavioural and social abilities, but not to the extent of meeting the criteria for a mental illness or disorder.

Mental ill-health refers to diminished mental health from either a mental illness/disorder or a mental health problem.

Consumers refers to those people who access mental health and/or psychosocial support services, including online self-help resources. In this report, 'consumers' does not include the broader population who may benefit from measures to prevent mental health problems arising.

Social and economic participation refers to a range of ways in which people contribute to and have the resources, opportunities and capability to learn, work, engage with and have a voice in the community. Social participation can include social engagement, participation in decision making, volunteering, and working with community organisations. Economic participation can include paid employment (including self-employment), training and education.

Productivity measures how much people produce from a given amount of effort and resources. The greater their productivity, the higher their incomes and living standards will tend to be.

Economic growth is an increase in the total value of goods and services produced in an economy. This can be achieved, for example, by raising workforce participation and/or productivity.

Source: AIHW (2018h); DoH (2013d); Gordon et al. (2015); PC (2013, 2016b, 2017e); SCRGSP (2018a); WHO (2007).

1.2   What affects Australians' mental health and wellbeing?

This inquiry is about the mental health of all Australians, not only people with a diagnosable mental illness. This encompasses different population groups (figure 1.1):

- well population — about 60% of Australians remain in this category over a 12-month period and, as a community, we want to keep them that way into the future

- at-risk population — about 23% are deemed to be at risk of experiencing an episode of mental illness because, in the past 12 months, they had emerging symptoms, a mental illness prior to the last year, or were exposed to another risk factor. An important goal for this inquiry is to identify ways to reduce the risk for this group

- population with mental illness — the remainder (about 17%) experienced an episode of mental illness in the past 12 months. This covers a spectrum of illness severity across mild, moderate or severe conditions. Mild conditions are those that can be either self-managed or managed within primary care, while moderate conditions require specialist support. Only about 3% of Australians experience a severe mental illness in a given year, necessitating hospitalisation or treatment from specialist community mental health teams. Roughly one-third of these people have a persistent disorder or complex needs.

Figure 1.1   Distribution of mental health among the Australian population[a]

Spectrum of mental illness in Australia

Episodic **0.46m**
Persistent **0.25m**
Complex needs **0.07m**

Well population	At risk	Mild	Moderate	Severe
15.2m	**5.8m**	**2.3m**	**1.2m**	**0.8m**
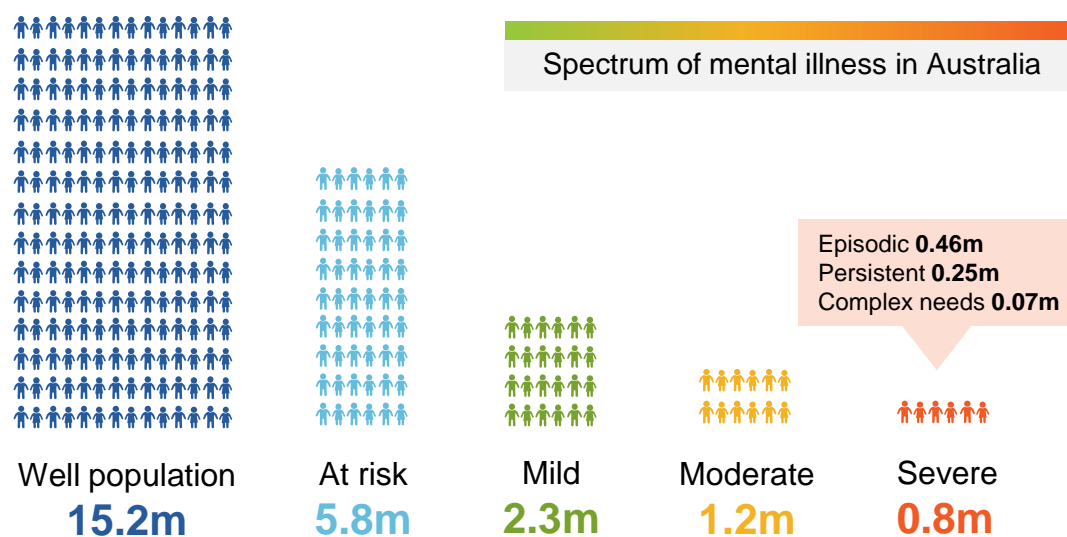
a Estimated number of people (adults and children) in each group based on their mental health over the 12 months up to 31 March 2019. People were categorised as having a mental illness (mild, moderate or severe) if they had an episode of mental illness within the 12-month period. They were categorised as being at-risk if they had emerging symptoms of a mental illness within the 12-month period, or an episode of mental illness before the 12-month period, or were children of parents with mental illness. Calculations are based on population estimates.

Source: Productivity Commission estimates based on prevalence rates published in the Fifth National Mental Health and Suicide Prevention Plan (COAG Health Council 2017a) and NMHC (2014e); and population statistics published by the ABS (*Australian Demographic Statistics*, Cat. no. 3101.0).

Mental health and wellbeing are influenced by a wide range of factors, which may act to protect a person's wellbeing or increase their risk of experiencing symptoms of mental illness (figure 1.2). The interactions between specific factors and individual mental health are complex, and change over time (WHO 2012).

Individual attributes, such as a history of physical and mental illness or stressful life events, may increase the risk of a person experiencing mental illness. Positive engagement with family, friends and the wider community and the ability to manage economic circumstances and gain access to economic and social opportunities through education are often seen as factors that protect a person's mental health and wellbeing (WHO 2012).

Figure 1.2   The many interconnected determinants of mental health
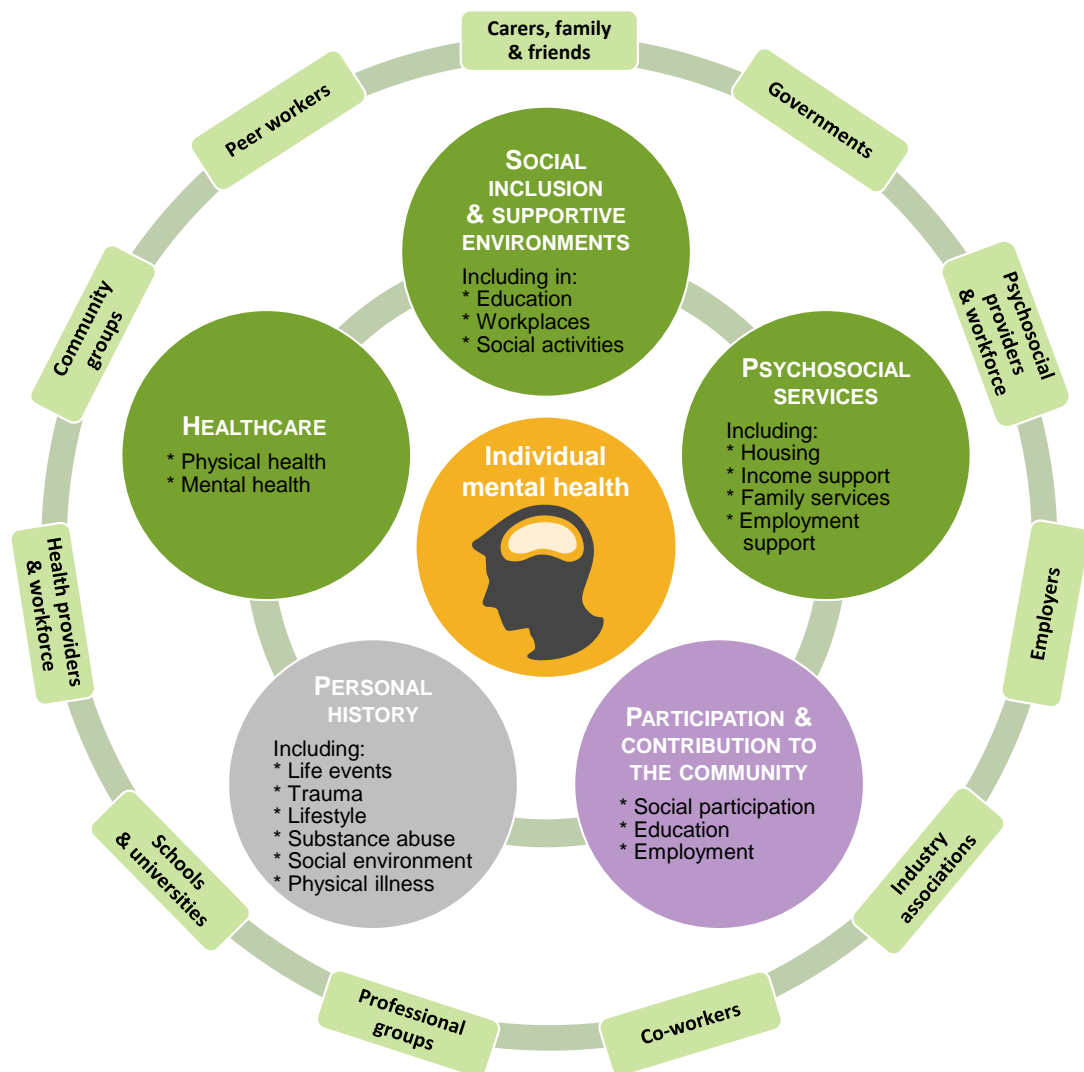
The presence and relative importance of these factors change over the life course (figure 1.3). In particular when they influence early life experiences, these factors can have life-long effects on mental health. Extensive research has established the link between adverse childhood experiences and mental health in adulthood (Bellis et al. 2019). On the other hand, people with more positive experience of childhood and adolescence are typically better

placed to deal with the choices and challenges of adulthood. The ability to balance between work and time with family and friends, deal with unemployment, participate in the wider community rather than being excluded or isolated have an impact on an individual's mental health.

Figure 1.3   **Risks to mental health over the course of life**

Setting	Home/family	School	Media/information	Work	Community
Environment	Low socioeconomic status	Adverse learning environment	Poor access to services / Adverse media influences / Neighbourhood violence/crime	Discrimination and stigma	Social exclusion / Poor civic amenities
Community	Poor housing/living conditions	Peer pressure		Job intensity or insecurity	
Family	Parental mental illness / Substance abuse in pregnancy	Difficulties at school / Trauma or maltreatment	Family violence or conflict	Unemployment / Debt/poverty	Bereavement
Individual	Insecure attachment / Malnutrition	Poor nutrition / Low self-esteem	Psychoactive substance abuse	Criminal or anti-social behaviour / Physical ill-health / Harmful alcohol use / Elder abuse	Family detachment

| Prenatal period and early childhood | Childhood | Adolescence | Adulthood | Old age |

Source: Adapted from WHO (2012).

As well as environmental factors, genetics can play a role in determining the risk that a person will experience mental illness at some point during their life. The exact role that genes have continues to be studied, but researchers believe that a combination of many different genes interact with each other to determine the risk of mental illness. People with a low genetic risk of developing a mental illness generally need a higher level of exposure to environmental risks to develop symptoms of mental ill-health. On the other hand, a person with a high genetic risk requires a smaller disruption to their environment to act as a trigger for mental illness.

Key risks can affect some people more than others

Although most people will be exposed to some of the risk factors associated with mental illness at some stage of their life, some people are likely to have longer exposure to multiple risk factors and an increased risk of developing a mental illness.

Submissions to this inquiry, as well as an extensive body of research, have pointed to three risk factors — isolation, exposure to trauma and socioeconomic disadvantage — as major contributors to increased risk of mental illness among vulnerable population groups. These factors not only increase the risk of a person developing a mental illness, but they also reduce the likelihood for them to engage with support services.

Isolation is created not only by geography

Isolation has many causes. It is often geographic, and affects those who live in rural and remote areas. People may be at higher risk of mental illness due to low rates of access to services, higher risks from weather events or natural disasters as well as occupational risks associated with farming and mining (CRRMH, sub. 465; QAMH, sub. 247; RRMH, sub. 97; RDAA, sub. 475). People living in isolated parts of Australia may experience stronger stigma that means they are less likely to seek help for their mental health (RRMH, sub. 97). For those who do seek help, services are often difficult to come by due to staffing shortages (RFDS, sub. 361; RFW, sub. 323; TeamHEALTH, sub. 155). The Commission makes a range of recommendations to improve access to services in rural and remote regions, including an expansion in e-mental health services (chapter 6).

Isolation is not exclusively defined by geography and also poses a risk for those living in regional and urban areas. Older people and those without access to transport can easily become isolated in their own homes. For some in culturally and linguistically diverse (CALD) communities, language barriers can contribute to isolation. Cultural norms and taboos around mental illness may affect those seeking help (Mental Health Australia, Federation of Ethnic Communities' Councils of Australia (FECCA) and National Ethnic Disability Alliance (NECA), sub. 524). Consequently, mental health problems may not be addressed until a later stage, or in some cases, not at all. The LGBTIQ community is also more likely than the general population to face stigma, discrimination, social exclusion, homophobia, transphobia, stereotyping, ostracising and harassment (ACON, sub. 381; National LGBTI Health Alliance, sub. 494; PHAA, sub. 272; Thorne Harbour Health, sub. 265).

Discrimination can create a sense of isolation. The impact of being different, being excluded and the more subtle forms of discrimination such as being 'left out' or avoided can impact on mental health and lead to delay or avoidance in seeking treatment. Almost half of Aboriginal and Torres Strait Islander people who have experienced discrimination have reported feelings of psychological distress (ABS 2011). Discrimination can act as a risk factor for the development of depression and anxiety. Chapter 20 discusses in detail the issues of isolation and social exclusion.

Exposure to trauma can have implications across generations

Some people are more likely than others to be exposed to a high level of trauma, and therefore are at higher risk of mental illness. For some, this may be an occupational hazard — emergency service workers (police, ambulance, fire fighters) and military personnel are at particular risk of being exposed to trauma resulting in post-traumatic stress disorder (PTSD) (chapter 19). For others, it is due to their exposure to traumatic events of war and violence. For example, refugees to Australia are at higher risk of mental illness, due to their experiences of living in refugee or displaced person camps or exposure to armed conflict (FASSTT, sub. 293; Cabrini Outreach, sub. 464).

Aboriginal and Torres Strait Islander people have a higher risk of being exposed to trauma, including intergenerational trauma (chapter 20). A number of submissions highlighted the trauma experienced by Aboriginal and Torres Strait Islander people over generations, due to loss of land and colonisation, suppression of languages and culture, the breakdown of traditional roles within communities, the forced removal of children from families, high levels of incarceration and the ongoing experience of racism (for example, AMSANT sub. 434; VACSAL, sub. 225).

Socioeconomic disadvantage has strong links to mental health and wellbeing

Entrenched economic disadvantage remains a reality for a large number of people — about 700 000 people in Australia have been in income poverty for at least the past four years. Unemployed people, those with disability and Aboriginal and Torres Strait Islander people are at higher risk of income poverty and deprivation (PC 2018c).

People experiencing financial stressors, such as low income or poverty, and/or compromised financial security, such as being unemployed or having excessive debt, are at increased risk of developing a mental illness (Heekin and Polivka 2015). Data shows that people living in the most relatively disadvantaged areas of Australia reported significantly higher levels of psychological distress and mental illness than those living in the least disadvantaged areas (Enticott, Meadows and Shawyer 2015).

The entrenched social disadvantage experienced by a number of Aboriginal and Torres Strait Islander communities places their members at an increased risk of developing mental illness. For example, the lack of adequate housing, educational opportunities and employment experienced by those living in some Aboriginal and Torres Strait Islander communities can be both a cause of mental illness and barrier to recovery (TeamHEALTH, sub. 155). Housing issues can have particularly significant consequences:

> This worsening housing reality in many Aboriginal communities is interrelated with mental health in many ways – increasing urban drift from overcrowded and under-resourced communities, further contributes to rates of homelessness as well as disconnection from country, family and culture, and increases associated mental and emotional ill-health. (AMSANT, sub. 433, p. 8).

For Aboriginal people in remote communities in the NT, chronic housing shortages and overcrowding have been a long standing issue with severe consequences for health and mental health. (TeamHEALTH, sub. 155, p. 8)

The socioeconomic disadvantages experienced in some Aboriginal and Torres Strait Islander communities has been linked to substantially poorer outcomes for young people, including very high rates of youth suicide (AMSANT, sub. 434).

The compounding effect of risk factors

In many cases, these factors combine to create entrenched disadvantage, and drastically increase risk to mental health. For example, an older person living alone, with a chronic illness from a migrant background with limited English and few social contacts is exposed to multiple risk factors and at increased risk of developing mental illness.

Aboriginal and Torres Strait Islander communities are often at risk from the combined effect of multiple risk factors. In some remote Aboriginal and Torres Strait Islander communities, people may have little employment and educational opportunities, poor housing and few facilities. In addition, they may also be affected by intergenerational trauma, as well as being directly exposed to discrimination and numerous stressful events — all of which raise the risk of mental illness.

1.3 Defining the scope of the inquiry

This inquiry's terms of reference (provided at the front of this report) were developed by the Australian Government in consultation with State and Territory Governments. They provide a very broad scope for the inquiry by mentioning a wide range of issues to consider, without limiting consideration of any other matters relevant to improving population mental health. While no area was explicitly out of scope for this inquiry, it was necessary for the Commission to consider the extent to which broad-ranging issues could be addressed by an inquiry focused on mental health.

The social and economic circumstances of people's lives have a substantial influence on their mental health (WHO 2014). While acknowledging this important link, this inquiry focuses on improving the way systems and government services can support people with mental illness across all walks of life, and contribute to population wellbeing. For example, while this inquiry has examined how to improve accommodation options for people discharged from mental health inpatient services, and strengthen mental health services for people without stable accommodation, broader community-wide problems of homelessness and housing stress were beyond this inquiry's scope.

In defining the scope of this inquiry, the Commission considered which mental health conditions, determinants of mental health, and ways to support mental health were to be

included, given the objectives of this inquiry and range of providers of supports. A further consideration was to minimise duplication with other past and concurrent reviews.

Coverage of different mental health conditions

The range of conditions which clinicians define as a mental illness is extensive (APA 2013; WHO 2004). For the purpose of determining reform options for governments, the Commission has taken a slightly narrower view of which conditions are within scope for this inquiry. Intellectual disabilities, autism spectrum disorders and neurocognitive disorders such as dementia were excluded, except where a person has these in combination with a mental illness that is within the inquiry's scope (table 1.1). This does not mean that the conclusions of this inquiry are irrelevant to people who have the excluded disorders (indeed, many of the conclusions will be relevant). Rather, the services and supports that target those disorders are not a focus for this inquiry.

People suffering from substance use disorders commonly experience mental illness as well (DoH, sub. 556). While the Commission has not assessed the broader policies relating to substance use disorders, this inquiry does consider the experiences of people with mental illness and substance use disorders in accessing mental health care and support (chapter 9).

Table 1.1   **This inquiry's coverage of mental disorders**

In-scope[a]	Out-of-scope[b]
• Psychosis (including schizophrenia)	• Dementia
• Mood disorders (including depression and bipolar disorder)	• Intellectual disability
• Anxiety disorders (including panic and compulsive disorders)	• Autism spectrum disorders
• Personality disorders	
• Child behavioural disorders	
• Eating disorders	
• Substance use disorder	

a This list is not exhaustive. **b** Only out-of-scope in cases where a person does not also have a mental disorder which is in-scope.

Source: Adapted from APA (2013) and QCMHR (2019).

More than just healthcare

This inquiry devotes substantial attention to the health system — both mental and physical health services have been considered because many people with mental ill-health also experience physical ill-health. Healthcare includes primary care delivered by GPs, nurses

and allied health professionals; online supported treatment; specialised mental health services delivered by psychiatrists, psychologists and other allied mental health professionals; residential mental health services and hospital services (chapters 5 to 9). The inquiry has also considered in detail the funding and governance arrangements affecting the delivery of mental health care services (chapters 22 to 24).

However, this inquiry differs from previous reviews by considering in depth how reforms outside of healthcare — including in workplaces, education, justice system, housing and social services — can improve mental health, and hence social and economic participation. The rationale for this broad approach is that there are many different factors influencing individual mental health and these can interact with each other to either reinforce or diminish wellbeing (figure 1.2). Therefore, the effectiveness of specific reforms, such as improved care in emergency departments, can depend on how other determinants of mental health are being addressed, such as housing and social supports to sustain recovery after leaving hospital.

The Commission has considered a number of different systems and services that either support people with mental illness or contribute to population mental health and wellbeing. These include:

- education (chapters 17 and 18) — most mental illnesses begin during childhood or adolescence (chapter 2). Early childhood education centres, schools, colleges and universities therefore represent an initial point for potential identification of risk factors for mental illness (and direction toward any necessary services) as well as an avenue through which mental health and wellbeing can be regularly promoted

- workplaces and employment services (chapters 14 and 19) — workplaces can be both a cause of mental stress and an enabler of economic and social inclusion that improves mental wellbeing. Measures that improve participation of those with mental illness (and their carers), and reduce the mental stress of workplaces in general, are likely to be beneficial to both the individual workers and the broader community. Currently, the rate of workforce participation among people with diagnosed mental illness is well below the participation rate of those without mental illness

- housing and homelessness services (chapter 15) — mental ill-health has a two-way relationship with accommodation instability. Stress about the cost, quality and accessibility of stable accommodation can contribute to poor mental health. Poor mental health can make it difficult to retain or maintain stable housing. About one-third of people who access homelessness services also experience mental ill-health

- justice system and corrective services (chapter 16) — the share of people with mental illness is much higher in prisons than in the general population, with mental disorders compounding the likelihood of reconviction. Among other issues, this inquiry has explored how to improve mental health services for those within the justice system and the reintegration of people with mental illness back into the community

- social inclusion and psychosocial supports (chapters 12 and 20) — for those whose mental ill-health has a significant detriment on their capacity to undertake everyday

activities (such as grocery shopping and paying bills), social support services may be available. Some of these services not only assist those with mental ill-health in undertaking these activities, but also expand the social interaction and inclusion of people who might otherwise have limited opportunities to participate in their community, and provide relief to carers.

Learning from past reviews — and examining progress so far

This inquiry has been mindful of the many other reviews — both past and current — that have contributed to the evidence base on mental health in Australia (for example, CARC 2018; HREOC 1993; KPMG and Mental Health Australia 2018; Medibank and Nous Group 2013; Mendoza et al. 2013; NMHC 2014e; Richmond, Sainsbury and Conoulty 1983).[1] Some of the issues considered in this inquiry are also being examined by the Royal Commission into Victoria's Mental Health System.

In considering the scope of this inquiry, the Commission took account of potential overlap with other reviews. On this basis, it was decided that this inquiry would not assess:

- the National Disability Insurance Scheme (NDIS) because it had been examined in other reviews by the Productivity Commission (2011, 2017d, 2019c). However, this inquiry has examined the interface between the NDIS and other services for those with mental illness, and any new developments which have significant implications for population mental health, participation and productivity

- support specifically for military personnel and veterans because the Commission recently conducted a separate inquiry on compensation and rehabilitation for veterans (PC 2019a)

- mental illness associated with a terminal condition, because the Commission examined end-of-life care in an inquiry on human services (PC 2017c)

- aged care accommodation choices, because the Australian Government has established a royal commission into the aged care sector (Morrison 2018; Royal Commission into Aged Care Quality and Safety 2019). However, this inquiry has examined the role of mental health in improving the social and economic participation of older people.

The Commission has, however, considered the relevant recommendations of past reviews, and the extent to which they have been implemented and achieved their intended outcomes. Many previously identified problems have yet to be fully addressed, despite a long history of efforts by governments to improve outcomes, indicating that it has been challenging to make significant progress (Doggett 2018).

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[1] To illustrate the extent to which mental health has been reviewed previously, WentWest (sub. 445) identified at least 12 major national reviews from 2006 to 2017 (equivalent to one every 12 months), 15 Commonwealth Parliament inquiries from 2006 to 2018 (one every 10 months) and many more reports by state and territory agencies. ConNetica Consulting (sub. 450) stated that there were no fewer than 14 inquiries or independent reviews in 2018 alone (more than one a month).

In some cases, recommended reforms have been accepted but subsequent implementation has meant that the benefits envisaged have not been achieved. In other cases, necessary changes to policy have not occurred and service gaps have not been addressed. And across the community, while there is an increased awareness of the prevalence (but possibly not the consequences) of more common mental disorders (anxiety and depression), stigma and discrimination are still barriers that prevent people from accessing the support and treatment they need.

1.4 What we heard from the community

Following receipt of the inquiry's terms of reference in late November 2018, the Commission commenced an extensive consultation process across Australia. This resulted in over 300 meetings, participation in forums run by specific interest groups, and a number of presentations at various conferences and other events (appendix A). Consultations were held in all states and territories, and included visits to regional areas.

The inquiry has also received over 550 submissions and 185 brief comments from individuals and organisations. The many parties who contributed to this inquiry include consumers of services and their carers, providers of psychosocial supports in the community, education bodies, industry groups, associations representing particular professions, Aboriginal and Torres Strait Islander representatives, groups focusing on the justice system, healthcare providers across the spectrum from primary care to acute services and emergency departments, academics and other members of the community. There was also extensive consultation with a range of departments within the Australian, State and Territory Governments, including those responsible for healthcare, education, justice, employment and social services.

This process of community input yielded clear messages about the mental health system that people want — one that provides person-centred services that take into account their lived experience and intervenes early to prevent symptoms from escalating. It also highlighted the persistent problems that have exacerbated mental ill-health in Australia. The key overarching themes raised in consultations included:

- under-investment in prevention and early intervention
- suitable support being difficult to find and access, including because there is none
- a focus on clinical services, which often overlooks other determinants of mental health
- the support people do receive is often well below best practice, sometimes causing harm
- stigma and discrimination is directed at those who need or provide support
- fragmented responsibilities and funding, and limited accountability mechanisms, such as public reporting, enable the above problems to persist indefinitely.

There is under-investment in prevention and early intervention

A sizeable proportion of mental-ill health could be avoided by greater investment in actions that prevent mental illness or intervene early to support people with emerging symptoms (AFMH, sub. 374; Black Dog Institute, sub. 306; Connect Health & Community, sub. 94; HSU, sub. 237; Anthony Jorm, sub. 45; Mental Health Victoria, sub. 479; NMHC, sub. 118; NSWNMA, sub. 246; Primary Health Networks, sub. 377; RANZCP, sub. 385; WAAMH, sub. 416; WA Mental Health Commission, sub. 259).

This inquiry has explored how prevention and early intervention could be strengthened through a range of interventions, including those currently delivered through the education system (chapter 17), as well as the role of communities and workplaces in prevention and early intervention (chapters 19 and 20). The inquiry also examined ways prevention and early intervention could be better incorporated into homelessness services (chapter 15) and the justice system (chapter 16).

The Commission has considered how prevention and early intervention could be improved in healthcare (chapters 5 to 8). This includes addressing a major gap in mental health services between low-intensity and acute care — sometimes termed the 'missing middle' — that would help people with moderate to severe disorders to avoid crises in their mental health that lead to emergency department attendances, encounters with police, and being scheduled for involuntary treatment (Black Dog Institute, sub. 306; Inner South Family and Friends, sub. 129; Mental Health Australia, sub. 407; Name withheld, sub. 8; NCOSS, sub. 143; Orygen and headspace, sub. 204).

Difficulties in finding and accessing suitable support

Many inquiry participants with lived experience of mental ill-health, their carers and families told the Commission that it is difficult to find and access suitable support.

Too often this is because needed support is not available. The gap in clinical services between low-intensity and acute care is an example of this. But under-resourcing is also apparent for many other forms of support, including primary care, where annual limits on Medicare-funded psychology sessions are often inadequate; emergency departments, where people must wait for long periods in settings that are unsuitable for those experiencing an episode of mental illness; and housing and psychosocial supports, where people with severe mental illness may not be able to access the support they need (AMA, sub. 387; Black Dog Institute, sub. 306; Mental Health Victoria, sub. 479; RANZCP, sub. 385; RAV, sub. 326; VCOSS, sub. 478).

The provision of services that do exist is often inequitable. People from higher socioeconomic backgrounds and those who are better-informed tend to receive a disproportionate share of services, compared with people living in low socioeconomic areas or outside large cities, rather than it being based on need (Cichello et al. 2019). This partly reflects a significant mismatch between the geographic distribution of the health workforce

and where people live (ASMOF, sub. 233; Gateway Health, sub. 42; NMHC, sub. 118; RFDS, sub. 361; RDAA, sub. 475; Michelle Smith, sub. 126).

A further barrier to finding and accessing help is the very complex nature of the mental health system, which encompasses a wide range of different services, providers, professions and settings that may be needed to support a person's mental health. This complexity tends to make it harder for individuals to find the help they need, particularly at a time when they are least able to search for and choose between many options. A common concern is that this problem has been exacerbated by a lack of effective initiatives to make it as easy as possible for people to find the best services for them, such as through a single website or help line, or services that can assist with system navigation (Anglicare NT, sub. 53; Connect Health & Community, sub. 94; MHCC, sub. 214; Lorna MacKellar, sub. 406; Merri Health, sub. 120; Name withheld, sub. 8, sub. 104; Primary Health Networks, sub. 377; Youth Mental Health, North Metropolitan Health Service, sub. 99).

Clinical focus often overlooks other determinants of mental health

The lack of prevention and early intervention reflects a reactive approach to mental health, which has tended to focus on clinical services to diagnose and treat people once they have an episode of mental illness. These clinical services have also tended to dominate policy debates and reviews on how to improve mental health.

The clinical focus often overlooks the many socioeconomic and related determinants of mental health and how they can interact with each other to affect wellbeing. This diminishes the effectiveness of clinical interventions, where, for example, clinical care attempts to treat mental illness while some of the risk factors — such as homelessness, social exclusion and financial stress — are ignored.

This can also lead to an over-reliance on clinical care when other interventions and supports would be more effective. For example, there is growing recognition in Australia and overseas that social prescribing, where primary care services refer patients to community-based activities that can include volunteering or group learning, has the potential to improve outcomes for people with a mental illness (CHF, sub. 496; AIAA, sub. 472).

Service provision can be well below best practice

The support that people do receive is often well below best practice, due to low rates of adherence to evidence-based care by clinicians who treat mental illnesses:

> Harris et al. (2015) estimated that less than half the Australian adults who are treated for mood or anxiety disorders receive minimally adequate treatment (with the others receiving even less than this minimal standard). It should be noted that this is 'minimally adequate treatment', not treatment of the quality recommended in clinical practice guidelines …

> Sawyer et al. (2019) found that only 11.6% of children with mental disorders had sufficient contact with professionals to meet the criteria for minimally adequate treatment, with the rest either untreated or getting less than the minimal standard. (Anthony Jorm, sub. 45, p. 3)

This affects the outcomes achieved from the mental health care treatment, as well as the return on the large scale investments made by government in mental health. A significant increase in Medicare funding of psychological services since the early 2000s has not led to a clear improvement in population mental health (Anthony Jorm, sub. 45).

From the point of view of those experiencing mental illness, their families and carers, poor practices have devastating results: long-term hospitalisation, at times far away from family supports, and significant amounts of time trying — and failing — to find help for loved ones (for example, Name withheld, sub. 8, 58, 66, 81, 392; Lorna MacKellar, sub. 406; Anonymous parent, sub. 399)

Many people access multiple care and support services, either within the mental health system or across a number of systems. Outcomes for these people are often affected by a lack of coordination across different services, providers, professions and settings. People need to tell their stories time and time again, there is very limited sharing of information between service providers, and pathways in the mental health system are very challenging to navigate — even for those working in the system (Anglicare Sydney, sub. 190; ACT Government, sub. 210; Connect Health & Community, sub. 94; SAMHC, sub. 477). Service coordination is also often lacking following discharge from hospital, such as after a suicide attempt (One Door Mental Health, sub. 108; Name withheld, sub. 23).

People with mental illness continue to be affected by stigma and discrimination

Negative attitudes towards people experiencing mental ill-health, and those who care for them, has exacerbated the cost of mental ill-health in Australia (Canberra Mental Health Forum, sub. 62; Gateway Health, sub. 42; MHCC, sub. 214; Name withheld, sub. 66; VCOSS, sub. 478; Windana, sub. 56). The level of stigma in the community associated with depression and anxiety has declined to some extent, although severe mental illness — such as schizophrenia and psychosis — remain poorly understood and highly stigmatised (chapter 20).

This manifests itself in various ways, including:

- a reluctance for people to seek help because they are ashamed to be experiencing mental ill-health, particularly in smaller communities where it is difficult to receive care without others being aware of this (CMHA, sub. 449; RRMH, sub. 97; Outback Futures, sub. 107; WAAMH, sub. 416). Based on 2007 data, it has been estimated that only 43% of people with a mild mental disorder receive any treatment (ABS 2008). While this figure is likely to have increased in recent years, access gaps remain

- consumers not being respected or listened to when seeking support, and carers' views being disregarded (WAAMH, sub. 416)

- delayed diagnosis and treatment of physical ailments due to 'diagnostic overshadowing' in which health professionals assume that all symptoms are related to mental illness, rather than the patient having a physical illness (Canberra Mental Health Forum, sub. 62; Allan Fels, sub. 303; NMHC, sub. 118; VCOSS, sub. 478; Wellways Australia, sub. 396).

Governance arrangements allow problems to persist indefinitely

Many of the problems in the mental health system are well known, and have been raised repeatedly in past studies and reviews going back many years. But despite many attempts at reform, governance and funding arrangements have remained very fragmented, with limited accountability through mechanisms such as public reporting (Anglicare NT, sub. 53; AMA, sub. 387; CAHS, sub. 255; Flourish Australia, sub. 330; Merri Health, sub. 120; Mind Australia, sub. 380; Name withheld, sub. 66; RACGP, sub. 386; RANZCP, sub. 385; Uniting Vic.Tas, sub. 95; WA Mental Health Commission, sub. 259; WentWest, sub. 445). These enable problems to persist indefinitely because it is unclear who should be held to account and what outcomes they should achieve.

Multiple funders — including the Australian, State and Territory Governments, private health insurers and individuals — are needed to sustain the breadth and scale of provided support, but there is no clear delineation of responsibility. Governments have sought to address the problems of fragmented responsibilities and funding in many ways. For example, in 2017, governments agreed to a renewed five-year program of cross-jurisdiction coordination on a broad range of mental health policies under the auspices of the Fifth National Mental Health and Suicide Prevention Plan (COAG Health Council 2017a). But this is still a work in progress and results so far have been mixed.

Gaps in monitoring, reporting and program evaluation continue to limit the accountability of governments and service providers. Vast amounts of data are collected in all parts of the system, and yet meaningful measures of mental health system activity and outcomes remain missing or out of date (chapter 25). For example, little is known about what outcomes are achieved from the large share of services provided by general practitioners and psychologists working in private practice. Beyond healthcare, there is also limited measurement of the effectiveness of services.

1.5 Developing a reform agenda to respond to community concerns

The draft recommendations in this report stem from extensive consultation with interested parties and analysis of a wide range of evidence. In formulating the draft recommendations,

the Commission has taken a people-oriented view, considering the broad range of consumer needs, identifying and addressing both gaps in services and barriers that people face in accessing treatment and support.

The draft recommendations are based on three key principles:

- The mental health system (including, but not limited to, health care) should be people-oriented, putting the consumer, their carers, their family, their kinship group at the centre. Achieving this requires meaningful use of co-design, culturally responsive care and understanding the importance of lived experience. It also requires the articulation of clear pathways — people should not get lost in the system, and they should not fall through cracks.

- The mental health system should prioritise prevention and early intervention. This makes sense from both a community wellbeing perspective and a long-term economic perspective. Prevention of mental illness is a task that extends far beyond healthcare providers, into our schools, workplaces and communities, and, for those most vulnerable, into homelessness services and prisons. The system should support people to maintain their mental health and wellbeing, and for those displaying early symptoms of mental illness, it should offer prompt care and assistance that facilitates recovery.

- The mental health care system should be adequately funded to eliminate service gaps but services should also be making efficient and effective use of taxpayer funds. The governance and funding structures that underpin the mental healthcare system should be enablers of people-oriented system, rather than being supplier-centric.

This inquiry approaches mental health as a systemic issue, where many different areas (including schools, workplaces, housing and social services) can support mental health; the effectiveness of interventions in one area often depends on what is done in other areas; and improvements in mental health benefit not only the individual concerned but also the wider community.

Therefore, each of the draft recommendations seeks to resolve a specific issue, but also to contribute towards the creation of a coherent system. For example, reforms to healthcare (chapters 5 to 8) were considered in the context of supporting changes to the health workforce (chapter 11), care coordination (chapter 10), allocation of responsibilities between entities (chapter 22), funding arrangements (chapters 23 and 24), and monitoring and reporting (chapter 25). Some of the recommended reforms can be implemented independently, but the most substantial improvement to population mental health and wellbeing would come from taking a holistic approach to reform.

While seeking to improve the consumer experience, the Commission has also given extensive consideration to the underlying institutional arrangements that dictate the way consumers and providers interact. The draft recommendations seek to address the complex issues of governance and funding in the mental health care system, to align the incentives of funding bodies, service providers, employers and individuals, and to overcome the fragmented nature of service provision.

Incentives matter in the provision of mental health services as much as they do in any other part of the economy. The Commission has come across many examples of dedicated individuals achieving substantial improvements in their area of responsibility, despite the many barriers to success. But to make a system-wide change will require more than the goodwill of individuals; it relies on designing funding structures that incentivise all participants in the mental health system to implement a people-oriented approach. For example, in the current system, there are only limited incentives to minimise avoidable hospitalisations, as well as limited services that can support people with mental illness living in the community.

Stakeholders have argued that a barrier to reform has been that the organisations funding them see few of the benefits (Knapp and Iemmi 2016). This might be because an investment by one organisation (such as a health department) generates benefits which are largely seen in other organisations (such as reduced demands on agencies providing housing, justice and education). It may also be the case that the benefits to individuals are so far into the future, that they are hard for the funder to identify. The Commission has sought to design governance and accountability mechanisms that help to overcome these problems (chapters 22 and 25).

Estimating the costs and benefit of draft recommendations

The Commission has conducted extensive quantitative analysis, both to ascertain and quantify existing gaps in the system and to establish the costs and possible benefits of recommended reforms.

This involved analysing data from a wide range of sources to better understand the complex relationships between mental health and economic and social participation. This included data from the Australian Institute of Health and Welfare (AIHW); Household, Income and Labour Dynamics in Australia survey (HILDA); and Australian Government's Multi-Agency Data Integration Project (MADIP), which links administrative data on Medicare, income support payments and other Commonwealth programs. Further, the Commission used the National Mental Health Service Planning Framework (NMHSPF) — a service planning tool jointly funded by the Australian, State and Territory Governments — to estimate the severity distribution of mental disorders across the lifespan and the associated need for specific types of clinical and psychosocial support services.

The first step taken by the Commission was to determine current expenditure levels and mental health outcomes against which to compare reforms. This involved:

- quantifying the nature and extent of mental ill-health in Australia, including its prevalence and how illness severity varies across the population (chapter 2)

- estimating the many different costs that mental ill-health imposes on individuals, carers and the wider community, including through lower participation (chapter 3).

For some of the draft recommendations included in this report, the Commission estimated the possible costs involved, as well as the expected benefits that will be realised through greater economic participation. Due to data limitations, this was not possible for all draft recommendations.

Finally, the Commission also examined the benefits of reforms in terms of improved quality of life (appendix G contains a description of the Commission's modelling work).

A roadmap to a people-oriented system

This report contains more than 80 draft recommendations, across the wide range of government services and systems. Taken in its entirety, this draft report presents a roadmap to a people-oriented mental health system. Achieving the full scale of reform will require significant time and government resources — but there are substantial benefits to these reforms, including increased productivity and income across the economy. Given inevitable resource constraints, recommended reforms will have to be prioritised and implemented in stages. The Commission has sought to prioritise reforms based on their expected community net benefit. These priorities may be adjusted in the presentation of the inquiry final report, after feedback from inquiry participants and further work on estimating the cost of implementing reform options. In addition, for each recommendation, the Commission has specified the expected timeframes for implementation.

Draft recommendations in each part of the mental health system are described in detail across the report:

- Part I presents the current state of mental health in Australia — and describes the Commission's framework for developing a system to improve mental health and wellbeing for individuals and the community.

- Part II focuses on the healthcare system, including primary, acute and online supported healthcare as well as improving services in the 'missing middle'. It also considers the implications of reform for the mental healthcare workforce.

- Part III considers the range of other government services that support people with mental illness and their carers, and how to improve their effectiveness in supporting mental health and wellbeing. This includes psychosocial supports, income and employment support, housing and homelessness and the justice system.

- Part IV looks at the broader systems that support people's mental health and wellbeing, including in education (from early childhood through to tertiary institutions), workplaces and the community. It also considers the complex questions around suicide prevention.

- Part V puts forward the Commission's draft recommendations in the areas of governance, funding, monitoring and evaluation across the mental health system. These are the foundations of a people-oriented system, the benefits of which are also summarised.

1.6 How to get involved in the remainder of this inquiry

This is a draft report. It has been publicly released to give interested parties an opportunity to provide feedback on the Commission's analysis and draft recommendations.

We welcome your feedback and any suggestions you may have on how potential reforms should be implemented to make best use of limited taxpayer dollars, be most effective in delivering improved mental health outcomes, and increased social and economic participation for both consumers and their carers.

You can provide feedback on this report by emailing a written submission or brief comment to the Commission by 23 January 2020. You can also participate in public hearings, which will be held across Australia from November 2019 to February 2020. The dates and locations for hearings will be listed on the Commission's website, along with an online form for you to register your interest in participating as either a speaker or observer.

Following feedback from interested parties, the Commission will finalise the inquiry report and send it to the Australian Government by the end of May 2020.

2   Australia's mental health

The state of Australia's mental health …	• Mental illness affects almost one-half of the population at some point during their lives and is the second largest cause of health related disability in Australia. • Around half of the total impact of mental illness on years of life lost to disability is attributed to anxiety and depressive disorders, stemming from their high prevalence and the many years people live with these illnesses.
Reforms require consideration of …	• Not everyone with mental illness is affected in the same way or has the same support needs — treatment and supports need to be tailored to the individual and their circumstances. • Mental illness often emerges when people are comparatively young. • High comorbidity rates are very common and these are associated with worse health outcomes, increased healthcare costs, and a diminished quality of life. • There are unique challenges facing some groups, including: young people, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, people living in social isolation (including in remote parts of Australia), and those in the LGBTIQ community.

2.1   The prevalence of mental ill-health in Australia

Many Australians experience difficulties with their mental health. Mental illness is the second largest contributor to years lived in ill-health and is the fourth largest contributor (after cancer, cardiovascular, and musculoskeletal conditions) to a reduction in the total years of healthy life for Australians (AIHW 2019c). Almost half of all Australian adults will meet the diagnostic criteria for a mental illness at some point in their lives, and one-in-five Australians will meet the criteria in a given year (figure 2.1) (ABS 2008). However while the data on prevalence rates is comprehensive, it is over a decade old which supports a need to collect mental health data more regularly and to evaluate how outcomes have changed over time (chapter 25). In August 2019, the Australian Government announced the Intergenerational Health and Mental Health Study, which aims to collect new data on the prevalence of mental illness in 2021.

Figure 2.1   **Around 45% of adult Australians have experienced mental illness[a,b,c]**
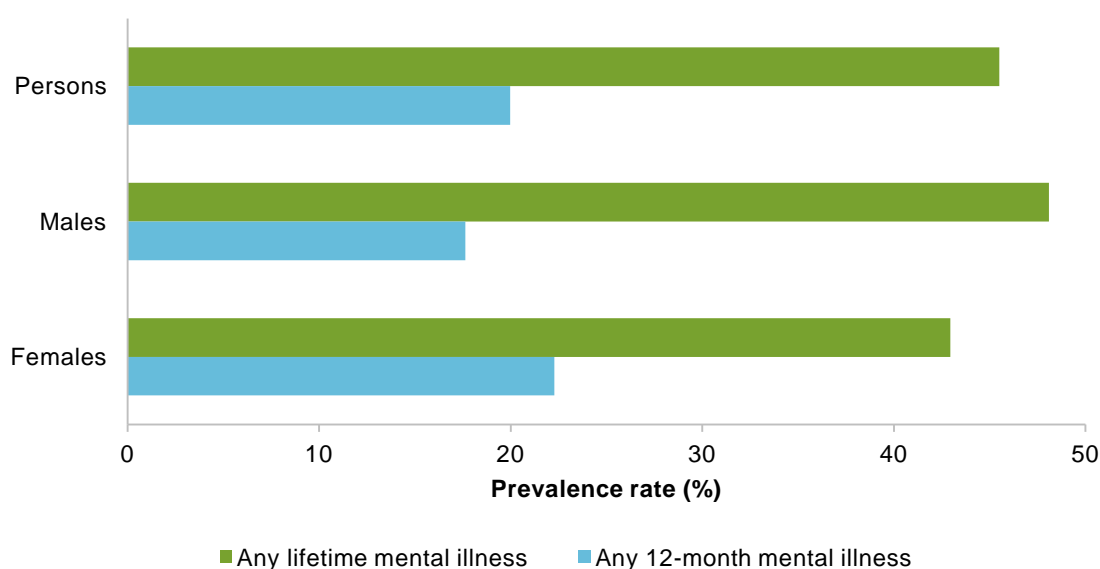
a Data is for adults aged 16-85 in 2007. While very dated, this survey remains the most recent source of data for mental illness prevalence in Australia. **b** An individual is counted as having a lifetime mental illness if they have experienced mental illness at some point during their life, and is counted as having a 12-month mental illness if they have experienced mental illness in the previous 12-months. These categories are not mutually exclusive. **c** Includes substance use disorders.

Source: ABS (*Microdata: National Survey of Mental Health and Wellbeing, Basic and Expanded CURF, 2007*, Cat. no. 4326.0.30.001).

The reported prevalence rates are likely to be underestimates as parts of the population are not included in the main population surveys (for example, people who are homeless or in nursing homes), and those who are surveyed may be reluctant to disclose a condition (Takayanagi et al. 2014). Among people with mental illness, not all will seek treatment for their condition, which could also lead to under-representation in treated populations (Our World in Data 2018). There are also people who experience poor mental health who do not meet the diagnostic criteria for a mental illness, but their condition may still have a substantial negative impact on their life.

Among developed countries, the prevalence of mental illness in Australia is comparable to the United States and New Zealand (figure 2.2). The cross-country differences could reflect a number of factors — for example, data collection standards (box 2.1), the effectiveness of the healthcare system in identifying and treating mental illness, the degree of stigmatisation and awareness of mental illness in the broader population, the available workforce, accessibility, and funding. Although some of the factors associated with mental illness will be systemic and unique to a country, cross-country differences can help to identify effective measures taken up by countries to reduce the prevalence of mental illness.

Figure 2.2 **Prevalence rates of mental illness in developed countries[a,b,c,d]**
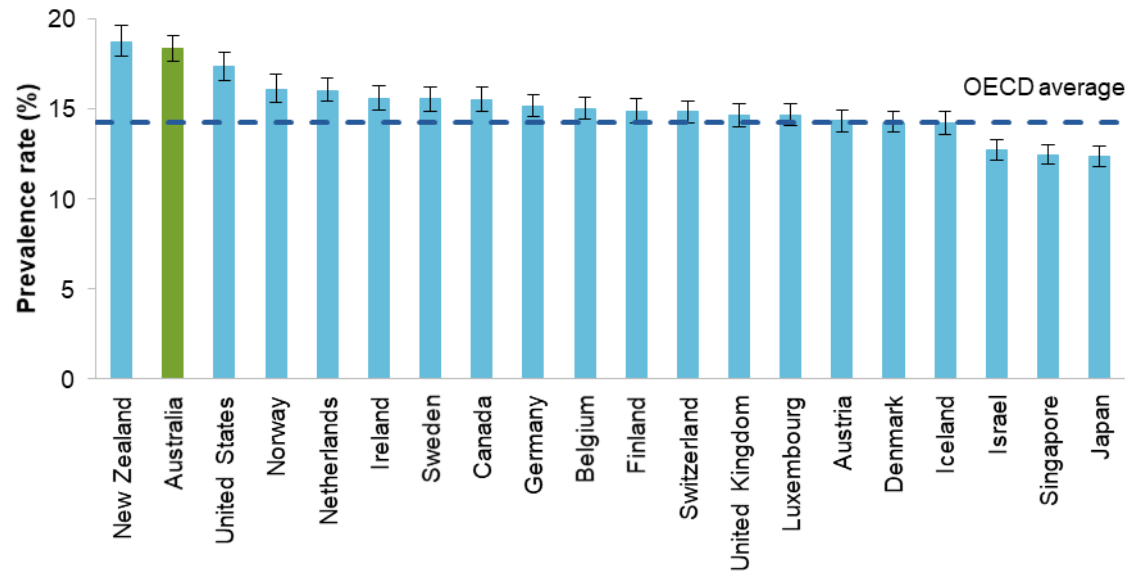
a Age-standardised point prevalence rates in 2017. **b** The developed countries shown here are those with the highest Human Development Index (HDI) with data available on prevalence rates. **c** Does not include substance use disorders. **d** The rates are modelled rather than being collected from a survey and have confidence intervals around them.

Source: Institute for Health Metrics and Evaluation (2019).

Box 2.1   Sources of prevalence rates

The prevalence rate for mental illness varies according to the source. This means that the rates can differ depending on how data is collected and interpreted, whether conditions are self-reported, and the diagnostic criteria used.

National Survey of Mental Health and Wellbeing 2007

The National Survey of Mental Health and Wellbeing (NSMHWB) surveyed households in Australia in 2007. The survey used the World Health Organization's Composite International Diagnostic Interview, version 3.0 (WMH-CIDI 3.0), which provides an assessment of mental illness based on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV); and the WHO International Classification of Diseases, Tenth Revision (ICD-10). Based on responses to the questions, survey respondents are then assessed if they have met the criteria for a particular mental illness, the severity level, and whether it was a 12-month or lifetime mental illness. The survey focused on collecting data on high prevalence mental illnesses (anxiety disorders, mood disorders, and substance use disorders), and therefore, it did not cover, for example, eating disorders and psychotic disorders.

National Health Survey

The National Health Survey (NHS) is an Australian household survey which collects data on a broad range of health conditions, including mental illness. The mental illnesses covered by the NHS are broader in scope compared to the NSMHWB, covering additional mental illnesses such as behavioural disorders (ADHD and conduct disorder) and schizophrenia. However the survey relied on respondents to identify whether they had a particular condition, rather than using diagnostic criteria.

Global Burden of Disease Study

The Global Burden of Disease Study (GBD) is an international epidemiological study, describing mortality and morbidity across a range of health conditions at global, national, and regional levels. The GBD synthesises a large number of input sources to create these estimates — as such, the prevalence rates from the GBD are not directly collected through a survey, but are modelled by aggregating information. This can have some advantages over surveys — for example, households surveys may not always be population-representative as parts of the population may be under-sampled.

Sources: ABS (2008); ABS (2018e); Institute for Health Metrics and Evaluation (2019).

Mental illness can affect people during all stages of life (figure 2.3). Young people (aged 16-25) have the highest prevalence rate of mental illness and the effects of mental illness on young people can be devastating — poor educational and social outcomes early in life can have the largest aggregate effects on society over a lifetime (chapter 17). However, the prevalence of mental illness declines with age.

Figure 2.3   **Mental illness begins early in life and tends to decline with age[a,b,c,d,e]**
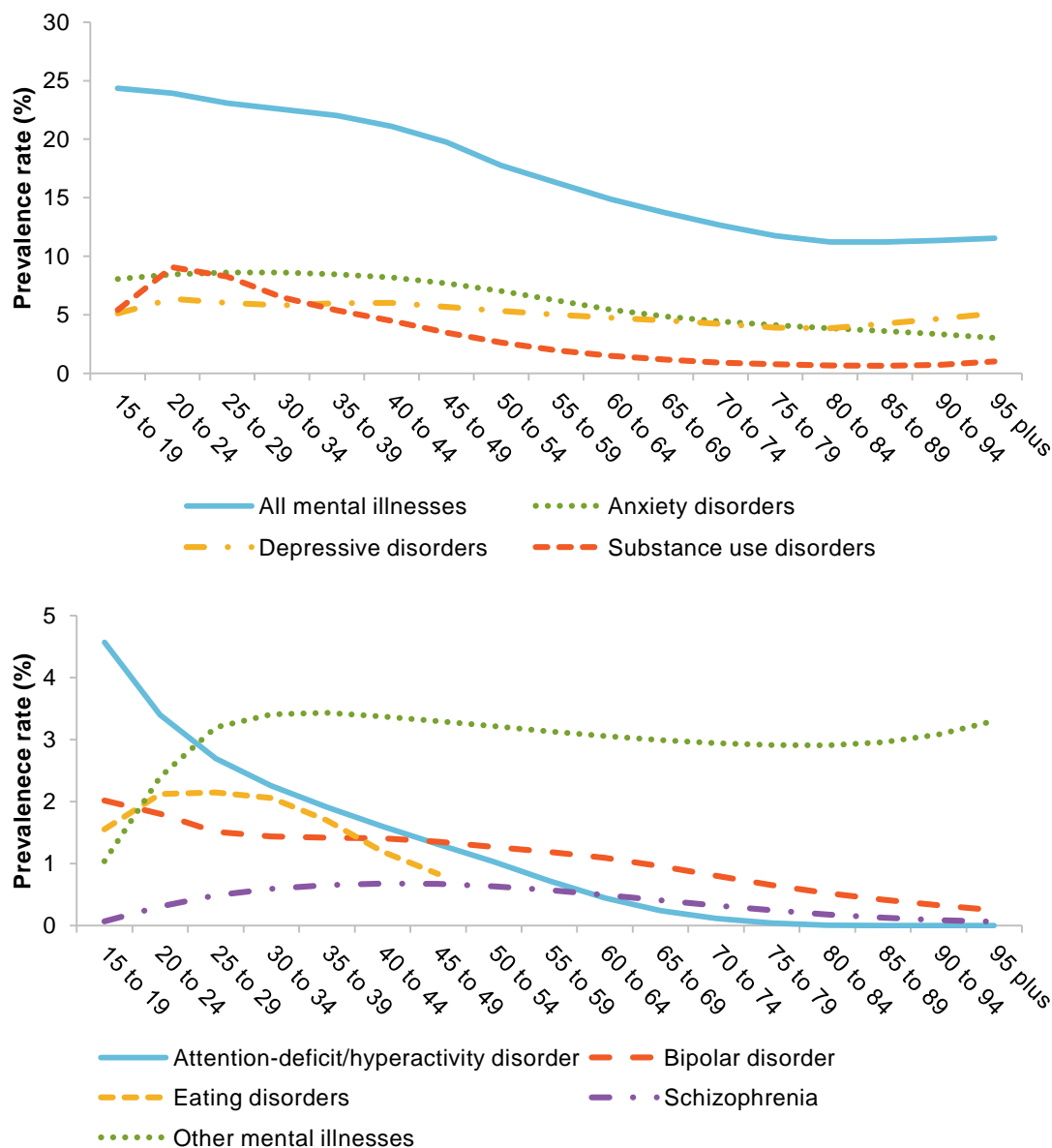
a Point prevalence rates in 2017. b The scales in the two figures are different — the top figure contains mental illnesses with higher prevalence rates. c The rates are modelled rather than being collected from a survey and have confidence intervals around them. d The modelled rates for eating disorders are not available for ages 50 and above. e Substance use disorders are not included in 'All mental illnesses'.

Source: Institute for Health Metrics and Evaluation (2019).

The decline of the prevalence rate with age can potentially be explained by the variation in risk factors across age groups. For example, on average, older people can differ from young people in marital, education, and employment status. Another possible explanation is cohort effects — older age groups may have higher levels of resilience and be less affected by some risk factors compared to younger cohorts (Jorm 2000). Physiological and psychological changes over life could also lead to lower prevalence rates at older ages. This could be through decreased emotional responsiveness, increased emotional control, and psychological immunisation (where people develop resistance to adverse events through repeated exposure) (Jorm 2000).

Suicidality and mental illness

Poor mental health can also be associated with suicidality — the collective term for suicidal ideation, suicide plans, and suicide attempts (chapter 21). While suicidality is more common in people with mental illness, it is not confined solely to this group. Mental illnesses such as anxiety, mood, impulse-control disorders, and substance use disorders have been found to be strong predictors of suicide attempts (Nock et al. 2010). In the first few months after being discharged from a psychiatric facility, the suicide rate can be 100 times the global suicide rate (Chung et al. 2017).

While suicide accounts for a relatively small proportion of all deaths in Australia, it is the leading cause of premature mortality and years of potential life lost (figure 2.4), with each instance resulting in an average of 37 years of life lost (ABS 2019a). More than one-third of deaths among people aged 15-24 are due to suicide and it is the leading cause of death for Australians aged 15-44 (ABS 2019a).

Mental illness affects everyone differently

Mental illness is a broad term that covers a wide range of health conditions. These are discussed in detail below. However, broadly, mental illness are

> … characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. (APA 2013)

Mental illness is not homogeneous between individuals — no two people will have the same underlying factors or experience, and to be effective, the treatment of a mental illness usually should be tailored to an individual's needs.

Figure 2.4   **Intentional self-harm accounts for the highest number of years of potential life lost[a,b]**
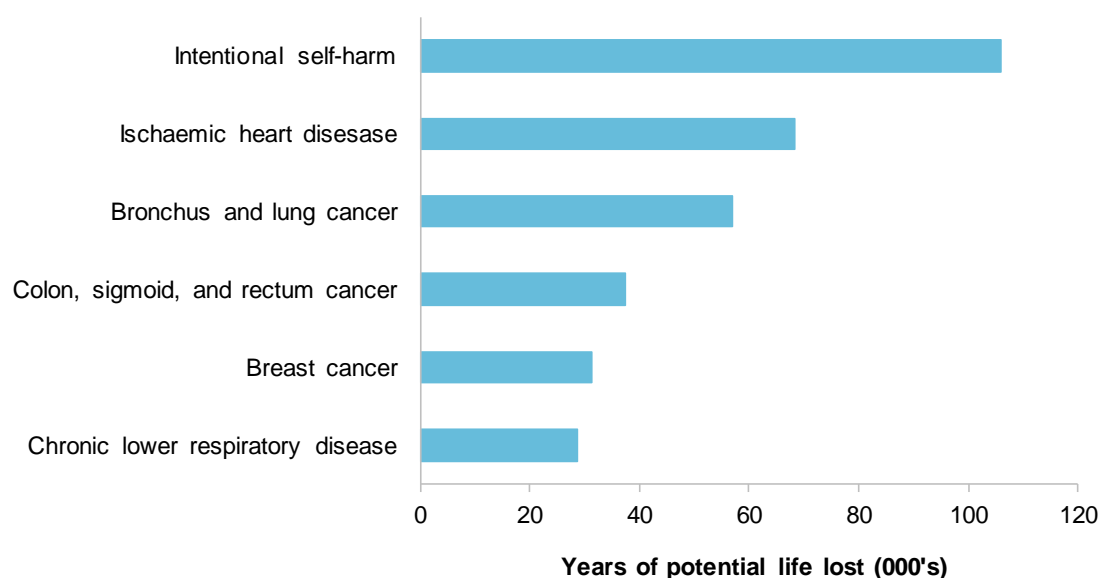
a Deaths in 2018. **b** Years of potential life lost are calculated as the difference between the age at time of death and the life expectancy at that age.

Source: ABS (*Causes of Death, Australia, 2018*, Cat. no. 3303.0).

While heterogeneity is evident in the wide range of different mental illnesses, it is sometimes more useful to report a breakdown by the severity of the effect that the illness may have on a person's life (box 2.2). Two people experiencing the same type of mental illness can find that their daily functioning is impacted in different ways — the impairment to their everyday life may be small for one person, and large for another person. This suggests that the severity of a mental illness is critical in understanding the impact on individuals, families, and society as a whole.

In Australia, over a 12-month period, it is estimated that 3.1% of the population (775 000 people) have a mental illness that is severe, 4.6% of the population (1.1 million people) have a mental illness that is moderate, and 9% of the population (2.2 million people) have a mental illness that is mild (chapter 1).[2] It is estimated that one-third of adults in the severe group have a persistent mental illness, requiring ongoing services to address their residual disability (Whiteford et al. 2017).

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2   These prevalence rates are based on the NMHSPF severity definitions.

Box 2.2   Classifying mental illness in terms of severity

National Survey of Mental Health and Wellbeing, 2007

The National Survey of Mental Health and Wellbeing (NSMHWB) categorises the severity of mental illnesses into three categories: severe, moderate and mild. The measure of severity is a summary of the impact of mental illnesses experienced in a 12-month period on a person's daily life. Only individuals who had an episode of mental illness within the 12 months are considered.

The Sheehan Disability Scale (SDS) is used to help determine the severity distribution in the population. Participants are asked about the level of interference during the worst period of symptoms in the preceding 12 months on four life domains: home management, ability to work, ability to form and maintain close relationships with other people, and social life. The responses are then transformed into a scale of mild, moderate, and severe for each domain.

Individuals are classified as severe if, in addition to having experienced a mental illness within the previous 12 months, they have also experienced one of:

- an episode of mania

- attempted suicide

- severe role impairment on at least two domains of the disorder specific SDS or overall functional impairment at a level equivalent to a Global Assessment of Functioning score of 50 or less.

Individuals are classified as moderate if they have experienced moderate role impairment in one domain on the SDS, and the remaining individuals are categorised as mild.

National Mental Health Service Planning Framework

The National Mental Health Service Planning Framework (NMHSPF) uses an alternative categorisation of severity levels. Severity levels differ by the amount and type of care required for an individual, which is estimated from the level of symptoms and impairment. The five levels are severe, moderate, mild, early intervention, and relapse prevention.

- *Severe*: diagnosed illness in a 12-month period, and severe impairment, including those where the diagnosis itself requires significant impairment or other diagnoses combined with severe impairment or risk. It includes all those admitted to specialist mental health units or to general hospitals or residential aged care facilities with primary mental illness diagnoses, as are all those receiving care from specialise community mental health teams.

- *Moderate*: diagnosed illness and service demand in a 12 month period, where the illness is chronic and/or causes moderate disability but not falling into the severe group, whose illness can be adequately managed in enhanced primary care with some specialist support, including a small minority who also need community support services.

- *Mild*: diagnosed illness and service demand in a 12-month period, whose illness can be adequately managed within primary care; including clinician-led e-therapies.

- *Early intervention*: clinical indications not reaching the diagnostic criteria for a diagnosed disorder, who have a service demand in a 12 month period.

- *Relapse prevention*: those with a lifetime but not 12-month diagnosis, who have a service demand in a 12-month period.

Source: Slade et al. (2009); University of Queensland (2016b).

There is also a large proportion of the population (23.1%) who are at-risk of mental ill-health (chapter 1). About half of these people will have had a previous mental illness and may require help to prevent relapse, while the remainder may require early intervention to prevent symptoms developing to a full scale illness. The Contributing Lives Review (NMHC 2014e) found that the greatest inefficiencies in the mental health system come from a lack of prevention and early intervention, as this would reduce the future need for more complex and costly interventions. It also found that early intervention and intervening at the right time could lead to significant cost savings throughout a person's lifetime, highlighting the importance of a life course approach to prevention, early intervention, and recovery.

There are individual characteristics other than age which are correlated with the prevalence of mental illness (figure 2.5). People who:

- have more children tend to have a higher prevalence rate, which suggests that additional children can lead to more stress

- live in couple-only households have the lowest prevalence rate among different household structures, while single parents have the highest prevalence rate

- are studying (post-high school) or unemployed have higher prevalence rates

- have been homeless or in jail at some point during their life have prevalence rates twice that of the rest of the population

- are renters tend to have higher prevalence rates compared to those who own their house, with prevalence rates dipping further down if the mortgage has been paid off

- are born in Australia have higher prevalence rates compared to those who were born overseas. But within the population who were born overseas, there is a clear difference in prevalence — those born in a non-main English speaking country have a prevalence rate around 5% lower compared to people born in English speaking countries. This may suggest cultural differences and views towards acknowledgment and reporting of mental illness between English and non-English speaking countries.

However, the Commission recognises that the data behind these statistics is over a decade old and does not necessarily reflect the current situation. But this highlights that, at least in the past, exposure to different environmental factors has been correlated with the prevalence of mental illness.

Individuals who have experienced a severe mental illness in the past 12 months are more likely to have accessed mental health services compared to those with a mild or moderate mental illness (figure 2.6), but there is still a substantial proportion of people with a severe mental illness who do not access treatment — around 40% have not accessed services in the past 12 months, and 25% have not accessed any services during their life. However, this data is over a decade old and was collected only briefly after the introduction of Better Access, which is likely to have now lifted treatment coverage over time.

Figure 2.5   **Prevalence differs by characteristics[a,b]**
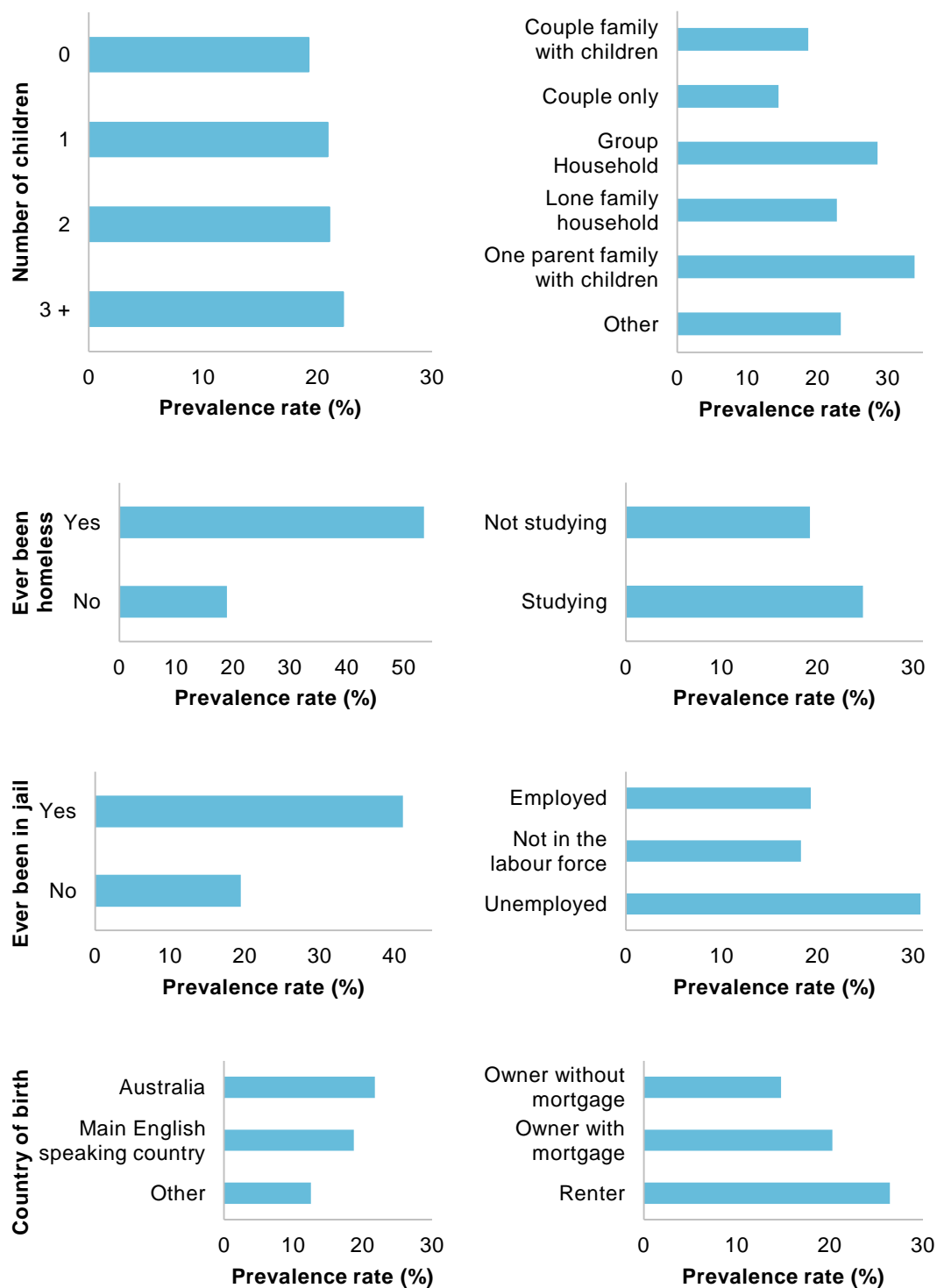
a 12-month prevalence rates for adults aged 16-85 in 2007. **b** Studying refers to post-high school studies.

Source: ABS (*Microdata: National Survey of Mental Health and Wellbeing, Basic and Expanded CURF*, 2007, Cat. no. 4326.0.30.001).

Figure 2.6   Mental health service use differs by severity levels[a,b,c,d]
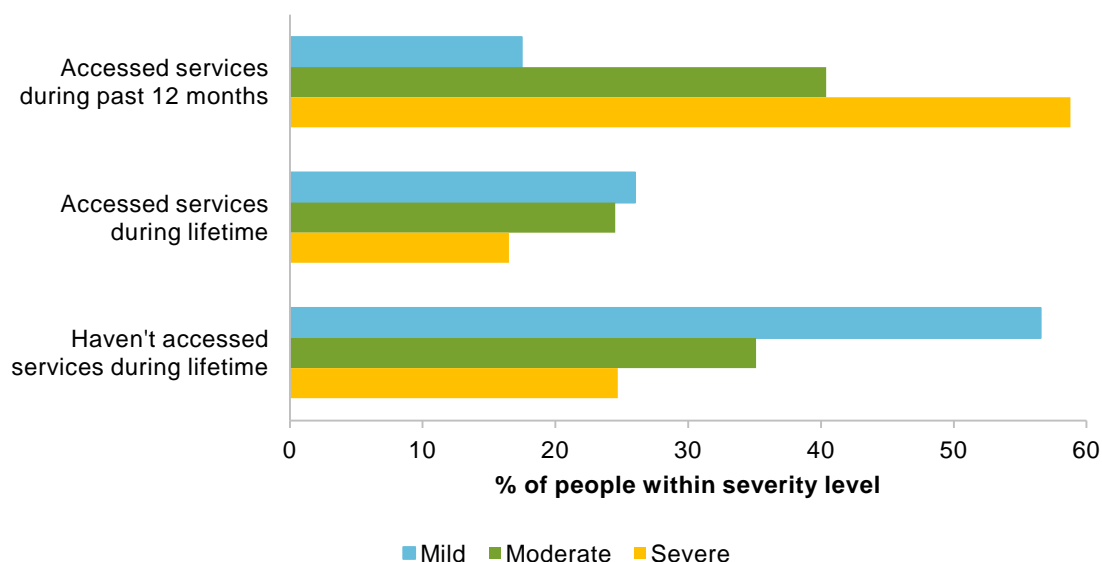
a Adults aged 16–85 years in 2007. **b** Includes substance use disorders. **c** The population in the figures are people who have had a mental illness in the past 12-months. **d** Services are for mental health and include consultations and hospitalisations. This could include seeing a GP, psychiatrist, psychologist, or mental health nurses.

Source: ABS (*Microdata: National Survey of Mental Health and Wellbeing, Basic and Expanded CURF*, 2007, Cat. no. 4326.0.30.001).

Types of mental illnesses

Although there are many different types of mental illnesses which can affect everyone differently, they are usually grouped together based on their symptoms and the effect that they have on people's lives (figure 2.7).

Mood disorders

Mood disorders (also known as affective disorders) are conditions in which a person's mood is distorted, interfering with everyday functioning. Some examples of common mood disorders are depression and bipolar disorder. Depression (and related disorders) are characterised by the 'presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's ability to function', while bipolar disorders are where individuals experience both elevated periods of depression and hypomania (APA 2013).

Figure 2.7   Mental illness affects people differently[a]

Mood disorders

Abnormalities of emotional state

Affects **6%** of Australian adults

Eating disorders

Unhealthy preoccupation with eating

Affects **9%** of Australian adults

Anxiety disorders

Intense and debilitating anxiety

Affects **14%** of Australian adults

Personality disorders

Behaviour which deviates markedly from the expectations of the individual's culture

Affects **7%** of Australian adults

Psychotic disorders

Delusions and hallucinations

Affects **0.5%** of Australian adults

Substance use disorders

Impaired control over use of substances

Affects **5%** of Australian adults

Childhood behavioural disorders

Disorders with onset during childhood

2% of children and adolescents have conduct disorder

a 12-month prevalence rates for mood, anxiety, substance use disorders, psychotic disorders, and childhood behavioural disorders. Lifetime prevalence rates for personality disorders and eating disorders.

Source: ABS (2008); Jackson and Burgess (2000); Lawrence et al. (2015); Morgan et al. (2011); NEDC (2012).

Mood disorders can impact on people in different ways. For example, depression can deprive a person of their ability to enjoy life, and cause them to view life through a negative lens — this can go on to affect a person's responsibilities, work or study, close relationships, and their social life.

Anxiety disorders

Anxiety disorders are disorders which 'share features of excessive fear and anxiety and related behavioural disturbances' (APA 2013). Some examples of anxiety disorders are panic disorder, agoraphobia, social phobia, and posttraumatic stress disorder. Anxiety is not necessarily a bad thing — for example, it can increase levels of alertness and performance before an important competition. But high anxiety can have the opposite effect, reducing the level of performance and a person's ability to rationally think and plan, and potentially lead to distress and disability (Andrews et al. 2018).

Schizophrenia and other psychotic disorders

Schizophrenia and other psychotic disorders are a group of mental illnesses defined by abnormalities in one or more of the following: delusions, hallucinations, disorganised thinking, grossly disorganised or abnormal behaviour, and negative symptoms (APA 2013). Hallucinations can lead to a person seeing or hearing voices of a non-existent person, and delusions are fixed beliefs which are not amenable to change in light of conflicting evidence.

Schizophrenia was the most common psychotic disorder, accounting for 47% of diagnoses (Morgan et al. 2011). Of the mental illnesses in scope for this inquiry, schizophrenia has the highest disability weight suggesting that it potentially has the most devastating effects on life outcomes (AIHW 2019d).

Eating disorders

Eating disorders are mental illnesses, characterised by eating or eating-related behaviour becoming an unhealthy preoccupation of someone's life, impairing their physical health or psychosocial functioning (APA 2013). Some examples of eating disorders include anorexia, bulimia, and binge-eating disorder. Many people with an eating disorder do not realise they have a problem, or if they do, they may go to extraordinary lengths to hide the signs of their behaviour or deny that they have a problem. Eating disorders tend to have a high rate of comorbidity with mood and anxiety disorders, are more prevalent in young females (APA 2013), and are estimated to have the highest mortality rates among non-substance use mental illnesses (Chesney, Goodwin and Fazel 2014).

There are psychological, physiological, and social risk factors which may increase the likelihood of an eating disorder developing, as well as behaviours and traits. Some risk factors include dieting, weight and shape concerns, self-esteem issues, sociocultural norms, media exposure, and weight discrimination (APA 2013).

Personality disorders

Personality disorders are an enduring pattern of inner experience and behaviour which deviate markedly from the expectations of the individual's culture, are pervasive and inflexible, have an onset in adolescence or early adulthood, and lead to distress or impairment (APA 2013). Some examples of personality disorders are antisocial personality disorder, borderline personality disorder, narcissistic personality disorder, and obsessive-compulsive personality disorder. Unlike mood disorders, personality disorders tend to be stable over time, whereas mood disorders are transient and involve changes in behaviour which arise as a response to specific additional stressors.

Childhood behaviour disorders

Childhood behavioural disorders are a group of disorders which typically have their onset in the developmental period. Some examples of neurodevelopmental and behavioural disorders include attention-deficit hyperactive disorder (ADHD), conduct disorder, and oppositional defiant disorder. These disorders are usually characterised by developmental deficits which can affect personal, social, academic, or workplace functioning. People with these disorders typically have problems with self-control of emotions and behaviours, which can manifest as inattention, impulsivity, and a lack of concern for the rights of others (APA 2013).

Substance use disorders

Substance use disorders are a group of conditions in which the use of substances (for example, alcohol or drugs) lead to significant impairment. They are characterised by cognitive, behavioural, and physiological symptoms indicating that a person continues to use a substance despite substance-related problems (APA 2013). Some of the behaviours which arise due to a substance use disorder include:

- impaired control; taking the substance for longer than intended, spending a lot of time obtaining and using the substance, and cravings for the substance,

- social impairment; a failure to meet work, school, and home obligations, and a reduction in social and recreational activities,

- risky use; the recurrent use of substances in situations where it can be physically hazardous.

There are environmental factors which can increase the likelihood of developing a substance use disorder. Some of these factors include ease and exposure to substances, neighbourhood disadvantage and disorder, barriers to treatment, and racial and socioeconomic inequities (Mennis, Stahler and Mason 2016).

Comorbidities

Comorbidity is the presence of two or more health conditions existing simultaneously in a person at a point in time. Comorbidities are associated with worse health outcomes, complex clinical management, increased healthcare costs, and a diminished quality of life (Valderas et al. 2009). Comorbidity may involve more than one mental illness, which may be a substance use disorder, or a mental illness and one or more physical conditions (chapter 9).

People with a greater number of comorbid health conditions tend to be more disabled, distressed and require more service utilisation for their mental illness (AIHW 2012a) (Andrews, Slade and Issakidis 2002). Aside from the additional health problems, comorbidities can affect or be influenced by other aspects of life. Compared to people with only physical conditions, people with both mental and physical conditions are more likely to be unemployed, have lower levels of educational attainment, and be living by themselves (ABS 2015d).

People with mental illness have a relatively high rate of physical illnesses (SCRGSP 2019i). For people with mental illness, 59% report having a co-existing physical illness (figure 2.8). This is elevated compared to the rest of the population — for those without mental illness, the prevalence rate of a physical illness is 48% (ABS 2008).

Figure 2.8   **More people with mental illness also have a physical illness[a]**
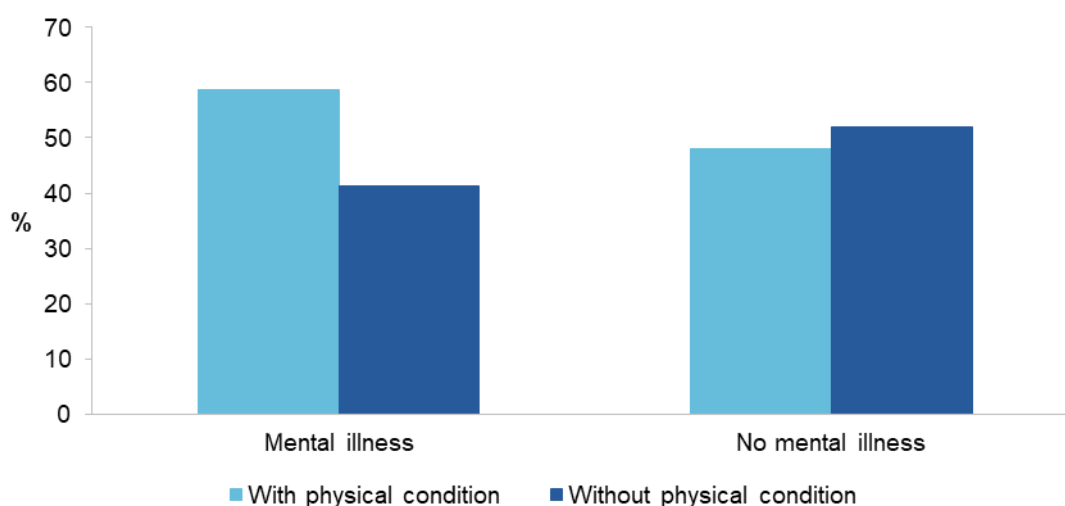
a Physical condition is defined as a medical condition, illness, injury or disability that the person had or received treatment for in the 12 months prior to the survey.

Source: ABS (2008).

Comorbidities between mental and physical conditions are associated with a lower life expectancy compared to the rest of the population (RANZCP 2016b). Almost 80% of the difference in average life expectancy between people with mental illness and the whole population is due to deaths from physical conditions (rather than from other causes) — this

compares to around 14% caused by suicide (Lawrence, Hancock and Kisely 2013). While there have been advancements in research and healthcare, physical health outcomes have not changed for those with mental illness, and the years of life lost due to physical conditions for people with mental illness may be increasing (Firth et al. 2019).

Physical comorbidities have a larger correlation with increased psychological distress for males compared to females. For females, a physical comorbidity marginally increases the prevalence of high psychological distress (from 12.3% to 13.2%), but for males, the prevalence more than doubles (from 5.1% to 11.7%) (AIHW 2012a).

2.2 What is the reduction in years of healthy life lived due to mental illness?

Health conditions come in a range of forms — physical, mental, a combination of both — but commonly, they lead to the loss of healthy years of life. Some conditions have a larger impact than others. One way to measure the impact of different health conditions is by considering:

- how many years of healthy life a person may expect to lose due to the condition (*years lived with disability*), and

- how many years of life are prematurely lost due to the condition (*years of life lost*).

Together, the years lived with disability and the years of life lost make up what has been termed the 'burden of disease' (box 2.3). The Commission has used this terminology as it is the standard technical term but appreciates that for some stakeholders the term is stigmatising.

This health loss represents the difference between the current health status of the population and the ideal situation where everyone lived a long healthy life. This approach captures both the quantity and quality of life affected by illness, and reflects the magnitude, severity and impact of disease and injury within a population. With less years lived in disability, people have more opportunities to engage with society, whether it be through the community or work.

Box 2.3   Burden of disease – what are DALYs, YLDs, and YLLs?

A disability-adjusted life year (DALY) is a measure of the impact of a disease. One DALY corresponds to a loss of one year of healthy life. The loss of healthy life can come in two forms.

First, people can experience illnesses while they are living, and in most cases, they eventually recover. But the time spent living with the illness can be thought of as years lived with disability (YLD). This is calculated using $YLD = I \times DW \times L$, where I is the incident number of cases, DW is the disability weight of the illness, and L is the average duration of the case until remission or death. The disability weight of a disease is a number between 0 and 1 which reflects the severity of a disease.

Second, illnesses can lead to a person dying earlier than expected. The additional years that the person would have lived is the years of life lost (YLL) due to premature mortality. This is calculated using $YLL = N \times L$, where N is the number of deaths due to the illness, and L is the remaining life expectancy at the time of death

Together, YLDs and YLLs sum to make up DALYs.

Potential adjustments to the standard calculation

The Australian Burden of Disease Study 2015 (2019) included additional adjustments for comorbidity of diseases, as the available data on prevalence rates and disability weights do not consider comorbidities. If each disease were to be considered in isolation, the YLD would tend to be overestimated due to double counting people with multiple illnesses.

Sources: AIHW (2019c); World Health Organization (2019c).

As a whole, mental and substance use disorders make up 12% of the total health loss in Australia, behind cancer, cardiovascular diseases, and musculoskeletal conditions (AIHW 2019c). However, they represent the second highest proportion of years lived with disability in Australia (figure 2.9).

Figure 2.9   **Mental illness is the fourth largest cause of overall health loss and the second highest cause of disability[a,b]**
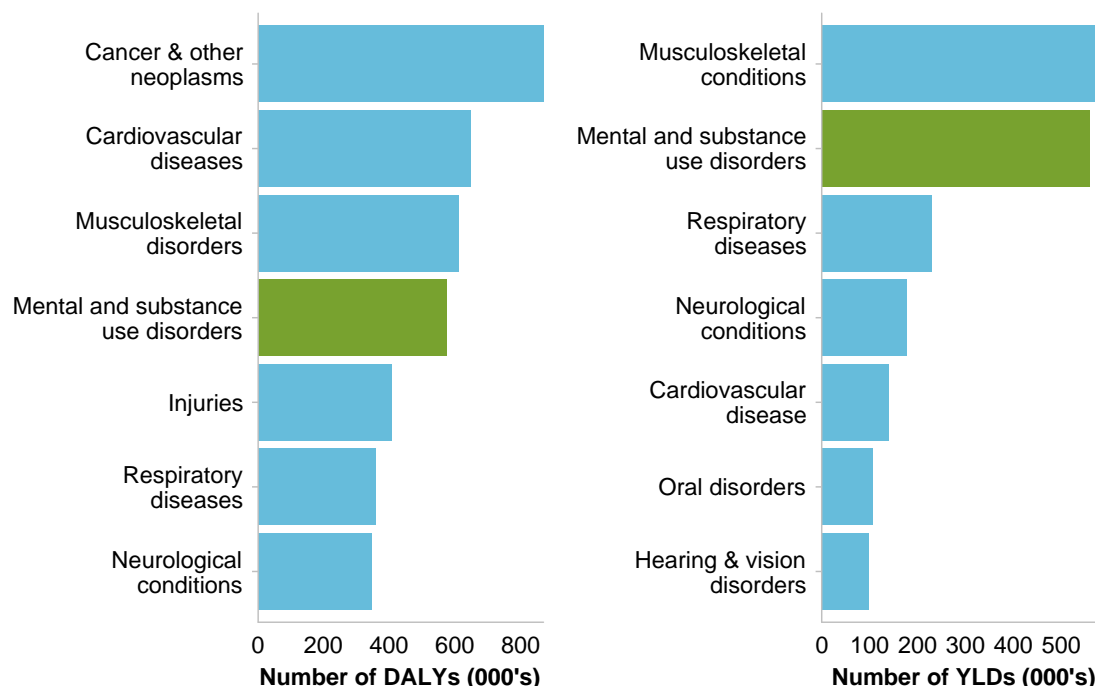
a The illnesses on these two figures are those with the highest DALYs and YLDs respectively. **b** Suicide is not included within mental and substance use disorders — it is included within injuries.

Source: AIHW (2019c).

Anxiety and depressive disorders are the most common form of mental illness, accounting for approximately half of the health loss due to mental illness. The health loss is distributed almost evenly between males and females, but the types of mental illness contributing to health loss differ between males and females. Females have a greater health loss due to anxiety, depressive, and eating disorders, whereas males have a greater health loss due to substance use disorders and schizophrenia (figure 2.10). Across age groups, the health loss from mental and substance use disorders peaks during early adulthood (between ages 20-35), averaging around 30% of the total health loss (AIHW 2019c).

While suicide is not counted as a mental illness, there is evidence that around two-thirds of the health loss attributed to suicides are due to mental and substance use disorders (Ferrari et al. 2014). When suicide is included in the picture alongside mental illnesses, it is the biggest contributor to the health loss for males (figure 2.9).

The health loss from mental illness also varies across the country and population. People living in major cities tend to lose more years of healthy life to anxiety and depressive disorders than those living in remote areas, but the years of healthy life lost due to suicide can be more than twice as large in very remote areas (AIHW 2019c). There are large differences across socioeconomic groups — of all disease groups, mental illnesses had the

second largest difference in years of healthy life lost between people in the bottom income quintile and those in the top income quintile (an age-standardised rate of 27.7 compared to 17.4), suggesting that income disparities could be correlated with mental health.

Figure 2.10   **The health loss varies by mental illnesses and gender[a,b,c,d]**

Females

Males
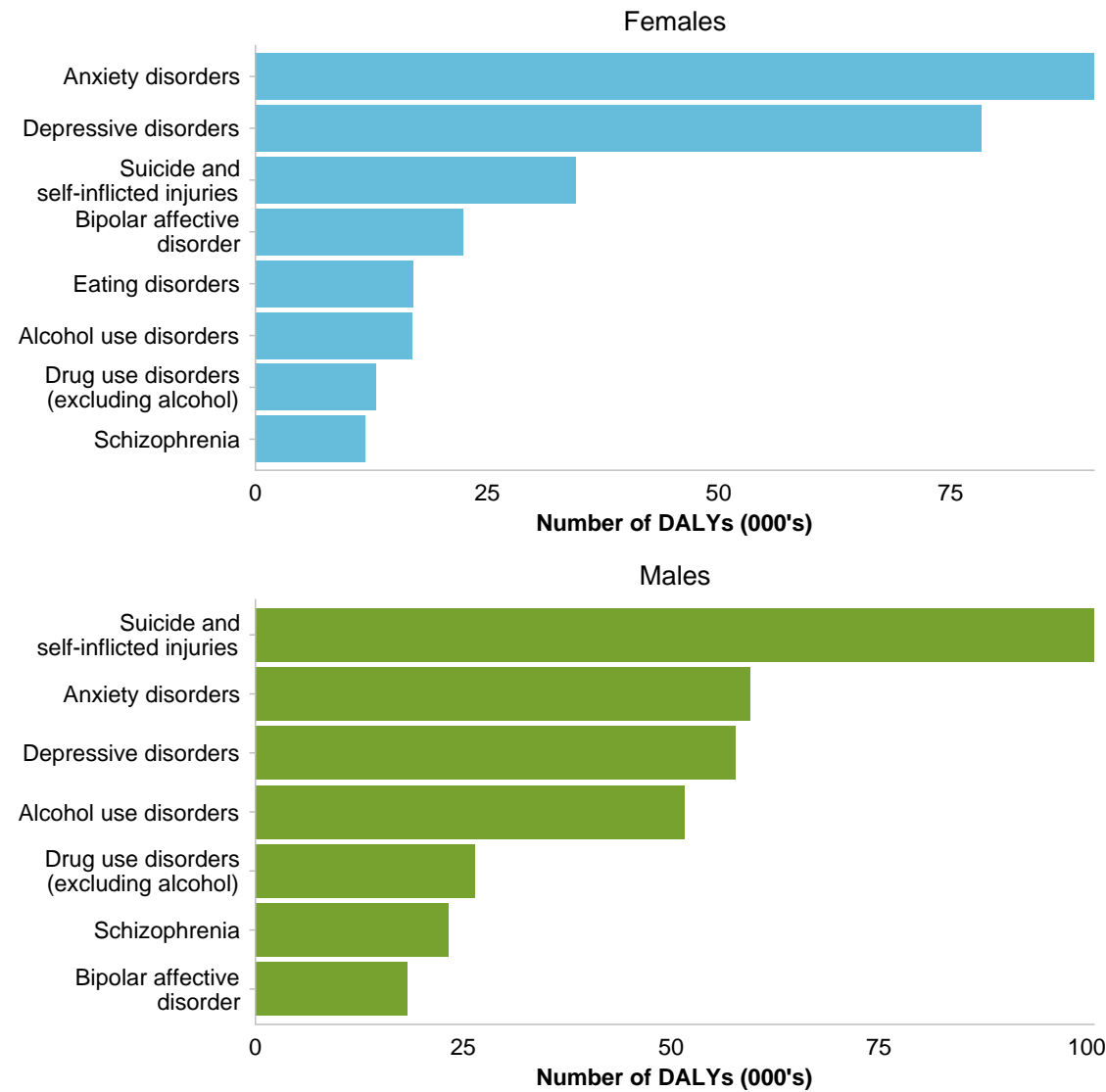
[a] When breaking down DALYs into YLDs and YLLs, YLDs make up 95%, while YLLs constitute around only around 5% (except in the case of suicide and self-inflicted injuries). [b] Suicide is not included within mental and substance use disorders — but it is included in this figure as there is evidence that two-thirds of the DALYs for suicide can be attributed to mental illness. [c] The mental illnesses here are not exhaustive — they are ones which have the highest DALYs. [d] The two figures have different scales.

Source: AIHW (2019c).

Over time, the overall rate of years of healthy life lost in Australia has fallen (between 2003 and 2015), but mental illness is one of the disease groups where the rate has risen over time, only behind neurological diseases (AIHW 2019C). Compared to other developed countries,

Australia has the second highest proportion of the total health loss attributed to mental illness (figure 2.11).

Figure 2.11   Mental illness as a proportion of the total health loss[a,b,c,d]
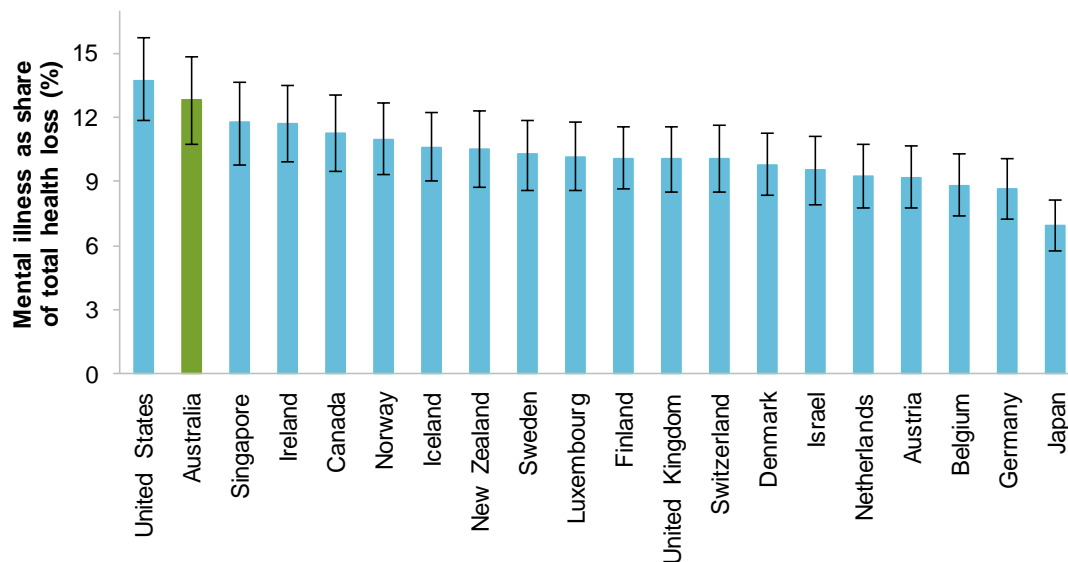
[a] The proportions are for 2017. [b] The developed countries shown here are those with the highest Human Development Index (HDI) with data available on prevalence rates. [c] Include substance use disorders. [d] The rates are modelled and have confidence intervals around them.

Source: Institute for Health Metrics and Evaluation (2019).

2.3   Different groups have different needs and outcomes

Young people

The effects of poor mental health can persist over an individual's entire lifetime, and so intervention at a young age is crucial (chapter 17). Most mental illnesses experienced in adult life begin during childhood or adolescence, with 64% of mood and anxiety disorders and half of those with psychosis having their onset before the age of 21 (COAG Health Council 2009) (Morgan et al. 2012). Poor mental health can result in absences from school, which could lead to lower levels of connectedness with their peers and poorer educational outcomes (Goodsell et al. 2017). In turn, this can result in reduced opportunities for employment in the future, and the associated negative externalities can spill-over to society.

While the majority of Australian children and adolescents have good mental health, it is estimated that 14% of Australians aged 4-17 had a mental illness in the previous 12 months (Lawrence et al. 2015). The prevalence rate was higher for males than females across all

mental illnesses except for major depressive disorders (figure 2.12). ADHD is the most common mental illness for young males with a prevalence rate of 10.4%, while anxiety was the most common for females with a prevalence rate of 6.8%.

Mental health problems in children can go unnoticed as they may not be able to identify their own problems, and adolescents are less likely to seek help, leading to a tendency to suffer in silence (WHO 2018). Additionally, parents are also not good at identifying signs and symptoms of mental illness — for example, the parent reported rate of major depressive disorders can be underestimated by up to half of the adolescent reported rate (Lawrence et al. 2015). This means that the true prevalence of mental illness amongst young people is likely to be higher than what the data collected from surveys would suggest.

Household demographics potentially play a role in determining mental health for young people. Family composition, income bracket, parent/carer employment, and location are correlated with the prevalence of mental illnesses, but whether these relationships are causal remains a question (Lawrence et al. 2015). Children and adolescents living with their original family have a lower prevalence rate compared to those who are not, and the prevalence rates of children and adolescents living in a household within the highest income bracket are around half of those in the lowest income bracket.

Figure 2.12   **Mental illnesses begin early in life**[a,b]
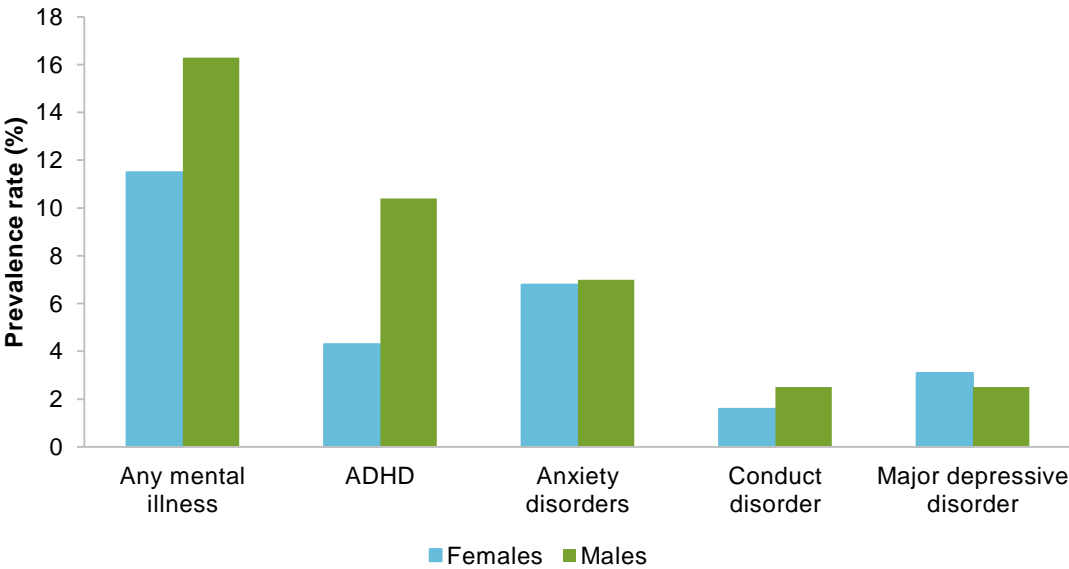
a 12-month prevalence rates in 2013-14. **b** The population here are aged 4-17 years.

Source: Lawrence et al. (2015).

Similar to what is observed in the general population, the prevalence rate tends to fall as the severity of the mental illness rises — with one exception, the prevalence rate of a severe major depressive disorder is higher than one which is mild or moderate (Lawrence et

al. 2015). Severe mental illnesses are more likely to be present (or at least diagnosed) in 12-17 year olds compared to 4-11 year olds (figure 2.13). These two features can stem from the identification problem — major depressive disorders are less transparent compared to other mental illnesses, such as ADHD or conduct disorders. Additionally, children may not understand their symptoms and problems they are experiencing, and parents and clinicians may be wary of these diagnoses for children.

Eating disorders can develop at any age, but the onset typically is during the adolescent years, and they are the second leading cause of mental illness for young females (NEDC 2012). Extreme dieting can make it 18 times more likely for young females to develop an eating disorder within 6 months, with an estimated 20% prevalence rate within 12 months (NEDC 2016).

Self-harm is twice as common for young females compared to males, with around 15% of females having self-harmed at some point in their life (figure 2.14). In particular, major depressive disorders appear to be correlated with self-harm — almost 50% of females with a major depressive disorder had self-harmed in the past (Lawrence et al. 2015).

Suicide is the leading cause of death for young people aged between 15-24 (ABS 2019a). While suicidal ideation is more common among young females, young males are more than twice as likely to have taken their own lives, which is similar to what is observed in the general population, where males are more likely to choose deadly means.

Figure 2.13 Depressive disorders among younger people tend to be severe, and severity tends to rise with age[a,b]

Prevalence rate by severity level

Severity breakdown of young people with mental illness
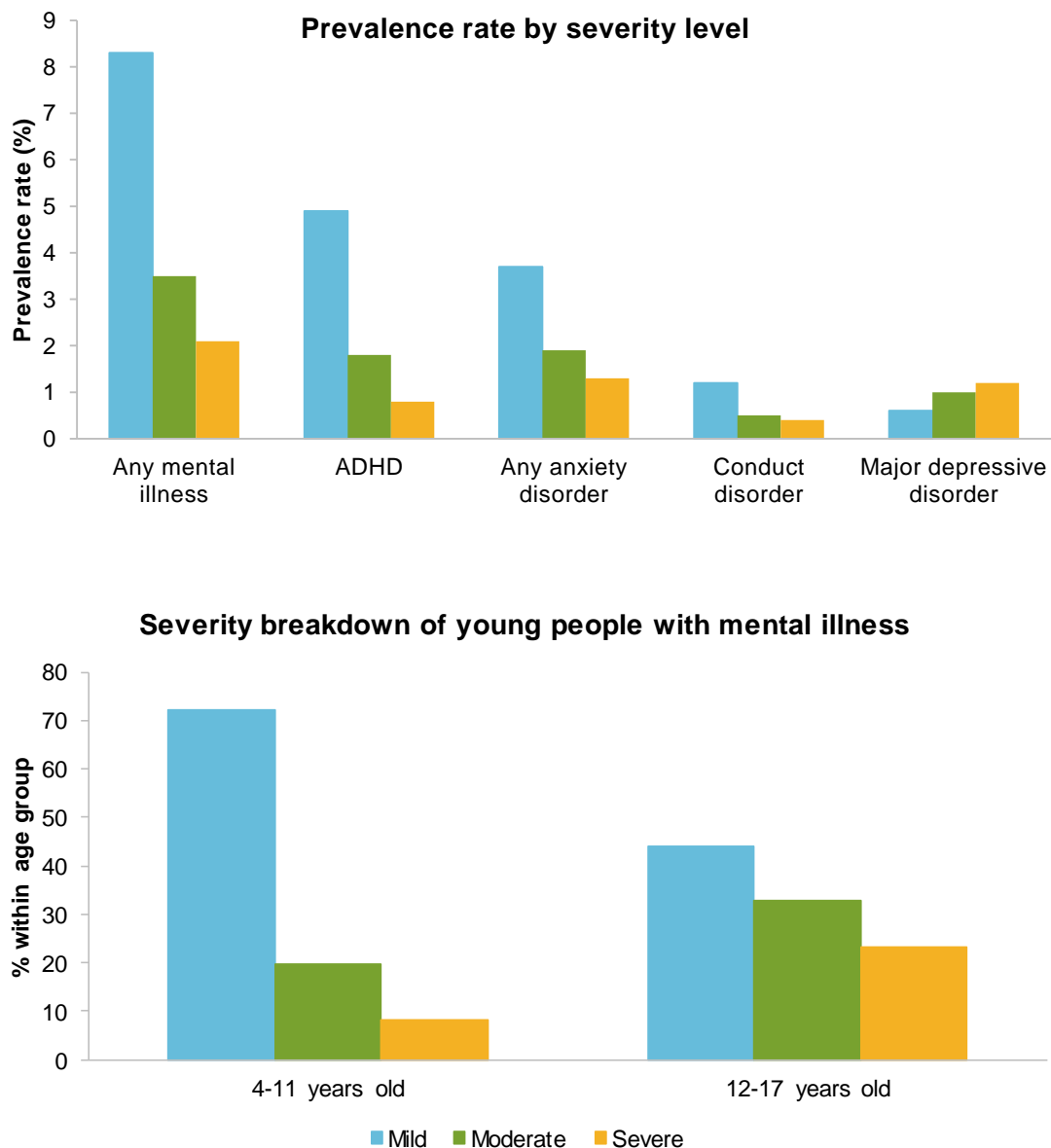
[a] 12-month prevalence rates in 2013-14. [b] The population in the top figure are aged 4-17.

Source: Lawrence et al. (2015).

Figure 2.14 Self-harm and suicidal ideation is more common among young females[a]
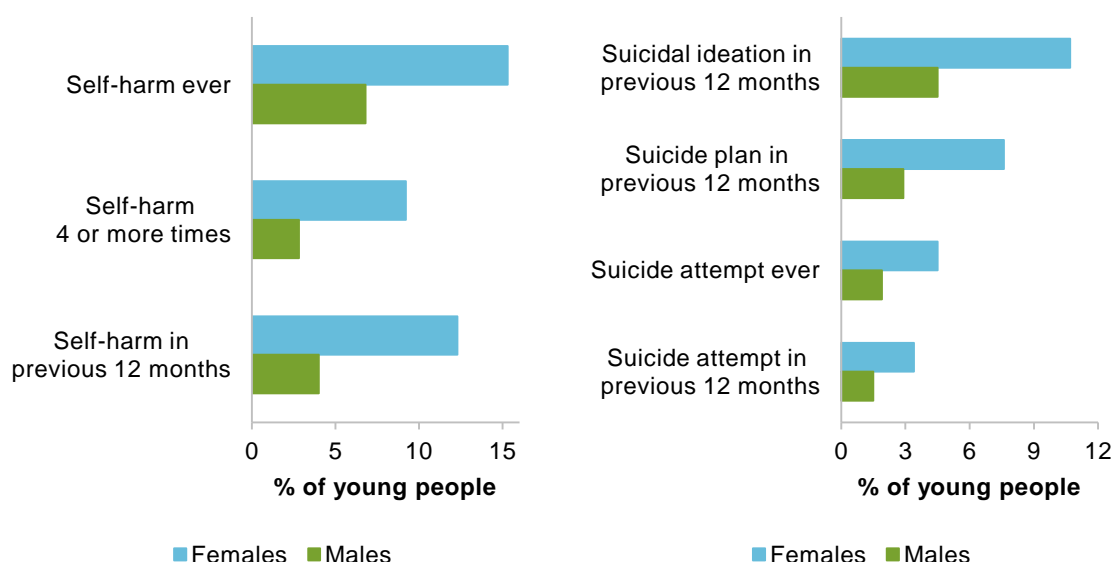
Source: Lawrence et al. (2015).

Aboriginal and Torres Strait Islander people

For Aboriginal and Torres Strait Islander people, more so than for many other demographic groups, mental health and mental illness are considered to be only a part of social and emotional wellbeing (chapter 20). The broader concept of social and emotional wellbeing recognises the importance of connection to land, culture, spirituality, family and community to people's wellbeing.

Widespread disadvantage and health inequity have contributed to comparatively poor social and emotional wellbeing outcomes for many Aboriginal and Torres Strait Islanders (AIHW 2018b). There are also unique risk factors — including intergenerational trauma, racism, and discrimination — faced by Aboriginal and Torres Strait Islander people which can increase the likelihood of mental ill-health.

Aboriginal and Torres Strait Islander people are two and a half times more likely than non-Indigenous Australians to experience high or very high levels of psychological distress (figure 2.15), with nearly one-third of Aboriginal and Torres Strait Islander people reporting having high to very high levels of psychological distress. This increases to 60% if the person has been diagnosed with a long-term mental health condition (ABS 2016c). Aboriginal and Torres Strait Islander people with poor mental health can find it more difficult to access culturally sensitive and appropriate health services and find full-time employment. Full-time

employment rates of Aboriginal and Torres Strait Islander people with mental illness are on average 10% lower compared to other Aboriginal and Torres Strait Islander people (ABS 2016c).

Figure 2.15   Psychological distress can be two and half times as common for Aboriginal and Torres Strait Islander people[a]

Rates of high/very high psychological distress
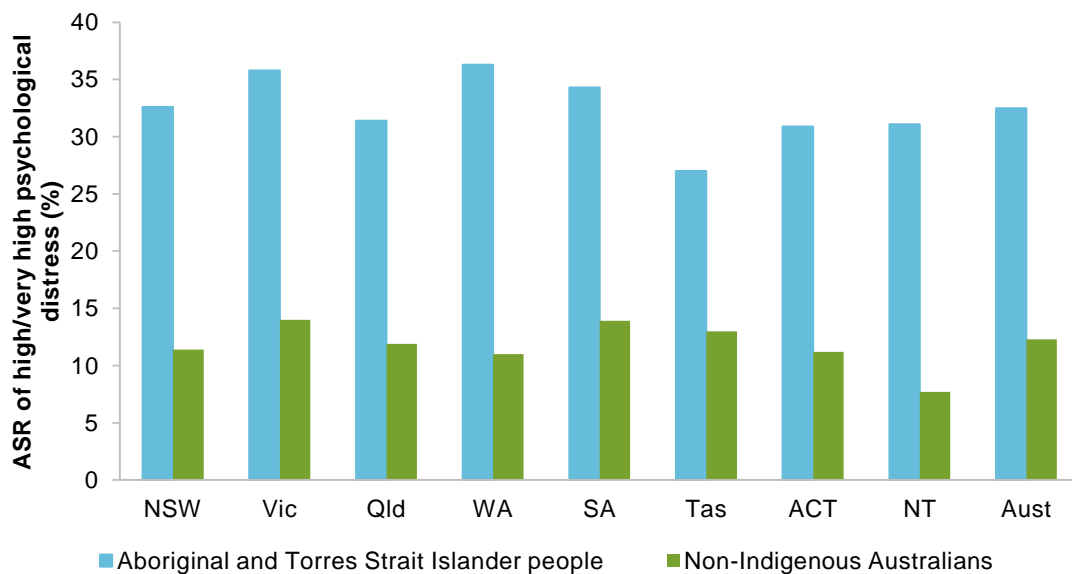
a Levels of psychological distress are derived from the Kessler Psychological Distress Scale (K5), where scores between 12-25 are categorised as high/very high psychological distress. **b** Rates are age standardised.

Source: SCRGSP (2019).

Although Aboriginal and Torres Strait Islander people are less likely to consume alcohol compared to non-Indigenous Australians, they are more likely to drink at high-risk levels (AIHW 2011a). High rates of alcohol use during pregnancy can lead to foetal alcohol spectrum disorder, with prevalence rates up to 12% in high risk Indigenous communities (Fitzpatrick et al. 2015). Substance abuse, alongside poor mental and physical health, can increase the likelihood of domestic violence (AIHW 2016a). Aboriginal and Torres Strait Islander women are more likely to be victims of domestic violence compared to non-Indigenous women, with hospitalisation rates up to 32 times higher (AIHW 2018f).

Aboriginal and Torres Strait Islander people are twice as likely to be hospitalised for mental health-related problems across some age groups (AIHW 2015a), and between 2004–2017, hospitalisation rates for mental health-related conditions increased for Aboriginal and Torres Strait Islander people, while remaining stable for non-Indigenous Australians (figure 2.16).

Aboriginal and Torres Strait Islander people are over-represented in suicide statistics and face unique factors that can increase the risk of suicide (chapter 21). Suicide rates for

Aboriginal and Torres Strait Islander people have increased by 44% between 2009–2018, and in Western Australia are almost three times as high as suicide rates for non-Indigenous Australians in that State (figure 2.17) (ABS 2019a).

Figure 2.16   Hospitalisation rates for mental health-related conditions[a,b]
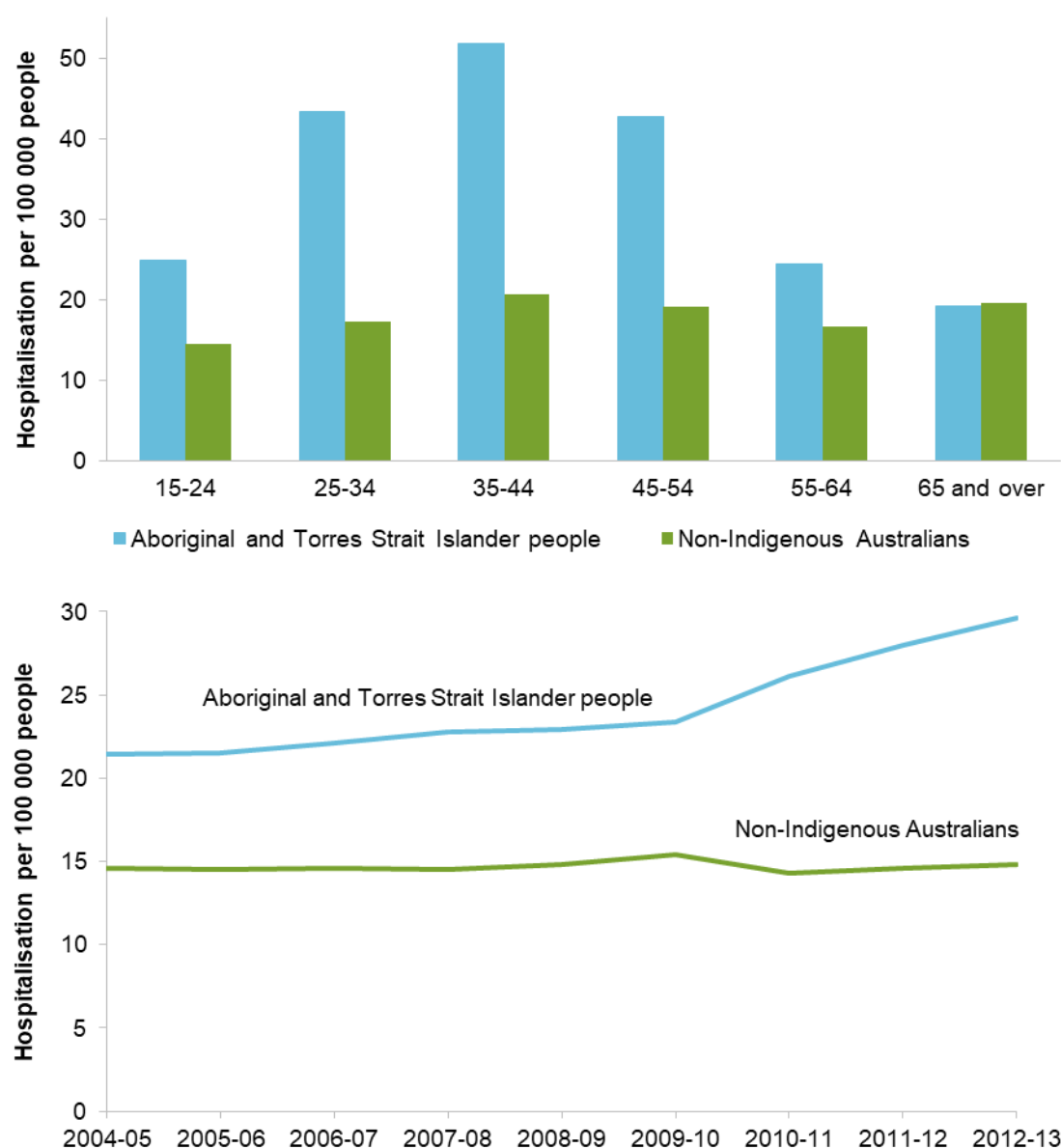
a Based on principal diagnosis. b The top figure is for 2012-13.

Source: AIHW (2015a).

Suicide rates for Aboriginal and Torres Strait Islander people are higher compared to non-Indigenous Australians[a,b]
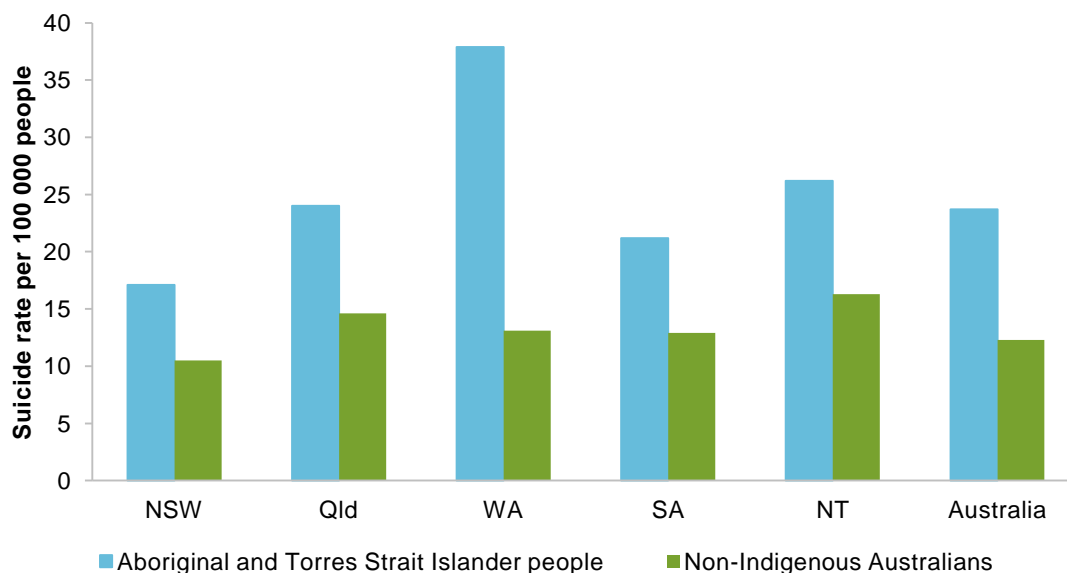
a Data for Victoria, Tasmania and the ACT have been excluded, in line with national reporting guidelines. **b** Suicide rates are age-standardised.

Source: ABS (*Causes of Death, Australia, 2018*, Cat. no. 3303.0).

Unlike the general population, suicide rates for Aboriginal and Torres Strait Islander people are highest during early to mid-life, and then falling among the older age groups. Suicide is the leading cause of death for young Aboriginal and Torres Strait Islander people (aged between 15-34), with a median age at death of 29.5 compared to 45.4 for non-Indigenous Australians, and suicides in this age group account for more than two-thirds of deaths by suicide by Aboriginal and Torres Strait Islander people (ABS 2018a).

Lesbian, gay, bi, trans, intersex, queer, and gender diverse (LGBTIQ) Australians

While many LGBTIQ people do not experience depression or any other mental health problem, some LGBTIQ people face stigma, discrimination, harassment, and abuse which can result in an elevated prevalence of mental illness (chapter 4). LGBTIQ people experience anxiety and mood disorders at higher rates than heterosexual people (ABS 2008) and are at greater risk of suicide and self-harm (Rosenstreich 2013). More than twice as many homosexual/bisexual Australians experience anxiety disorders as heterosexual people, over three times as many experience mood disorders, and almost twice as many experience substance use disorders (figure 2.18) (ABS 2008). LGBTIQ Australians are also more than twice as likely to have high or very high level of psychological distress compared to heterosexual people (11% compared to 23-28%) (AIHW 2018b).

Figure 2.18   Homosexual and bisexual people are more likely to experience mental illness[a,b]
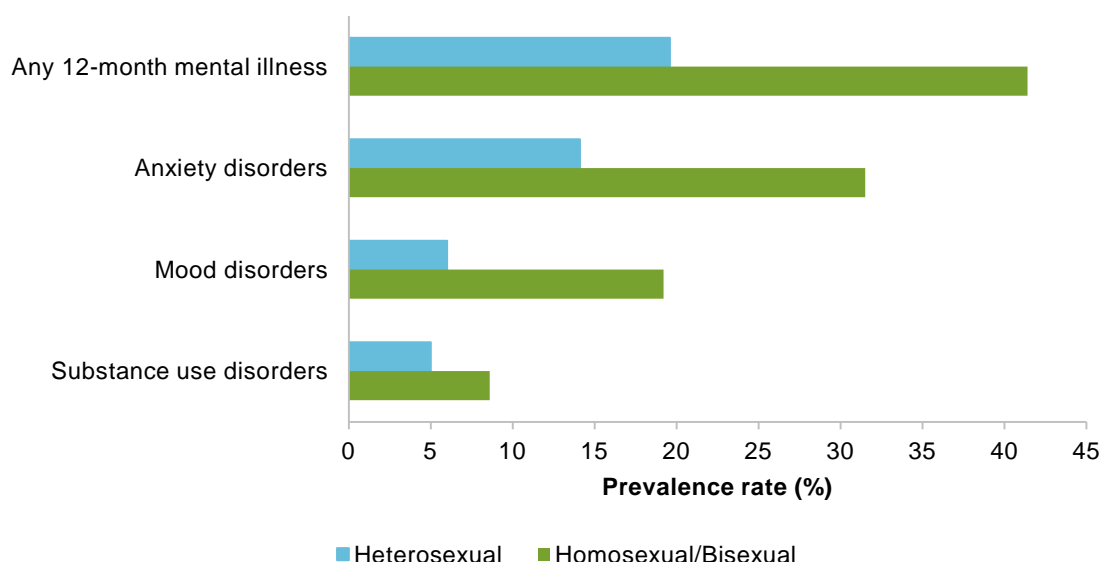
a 12-month prevalence rates. b Adults between ages 16-85 in 2007.

Source: ABS (*Microdata: National Survey of Mental Health and Wellbeing, Basic and Expanded CURF*, 2007, Cat. no. 4326.0.30.001).

Compared to heterosexual people, homosexual and bisexual people are more likely to drink in excess and are more likely to have used an illicit drug (AIHW 2018a), with findings suggesting that illicit drug use is three times as common and risky drinking is around one and a half times more common (AIHW 2017c). This behaviour could reflect the use of illicit substances and alcohol as a coping device against discrimination and additional stress they experience (Leonard, Lyons and Bariola 2015).

LGBTIQ people have a higher risk for suicidal behaviour compared to the general population (Skerrett, Kolves and De Leo 2015), with studies finding 20% of trans Australians and 15.7% of lesbian, gay and bisexual Australians reporting suicidal ideation (Rosenstreich 2013). However, data collected on suicides about the LGBTIQ population is poor because characteristics such as gender identity and sexuality are not typically present in death records (National LGBTI Health Alliance, sub. 494). Additionally, there may also be people who have not 'come out' before taking their own lives, which would further underestimate the already elevated suicide rate for LGBTIQ people.

Young LGBTIQ people are especially at risk — in particular, same-sex attracted young people are six times as likely to have attempted suicide compared to their heterosexual peers (Rosenstreich 2013). Almost half of young trans people had attempted suicide and 80% had self-harmed (Stauss et al. 2017). Homophobic abuse experienced by young people has been linked to substance-abuse, self-harm, and suicide attempts. Those who had experienced both verbal and physical abuse had suicidality rates between 20-40% higher than an LGBTIQ person who had never experienced abuse (Hillier et al. 2010).

Living in regional and remote areas

Living in regional and remote areas carries along a set of unique risk factors for mental illness, including isolation and environmental events such as droughts and bushfires (chapter 4).The prevalence rate of mental illness in regional areas is similar to those in urban areas, but males in regional and remote areas experience higher levels of psychological distress than those living in major cities (AIHW 2008).

A stark difference between urban and regional living becomes apparent when comparing suicide rates. The suicide rate in regional areas has been consistently higher over time compared to those in major cities (ABS 2019a), and suicide rates tend to increase with remoteness (AIHW 2019g) (figure 2.19), with suicide rates in very remote regions almost twice that of the national average. There is likely to be some correlation with the higher suicide rate for Aboriginal and Torres Strait Islander people given that a large proportion of people residing in remote areas of Australia are Aboriginal and Torres Strait Islander people.

The rate of use of mental health services tends to be lower in remote areas (figure 2.20), which is partly driven by the small mental health workforce in these areas (in both absolute and relative terms) (AIHW 2019n), with substantial differences across different types of providers (figure 2.21). The low service utilisation rates in regional and remote areas could be indicative that these services are not appropriate or easily accessible (Royal Flying Doctor Service, sub. 361).

Figure 2.19   Suicide rates tend to be higher in remote areas[a,b]

Age standardised suicide rate per 100 000 people
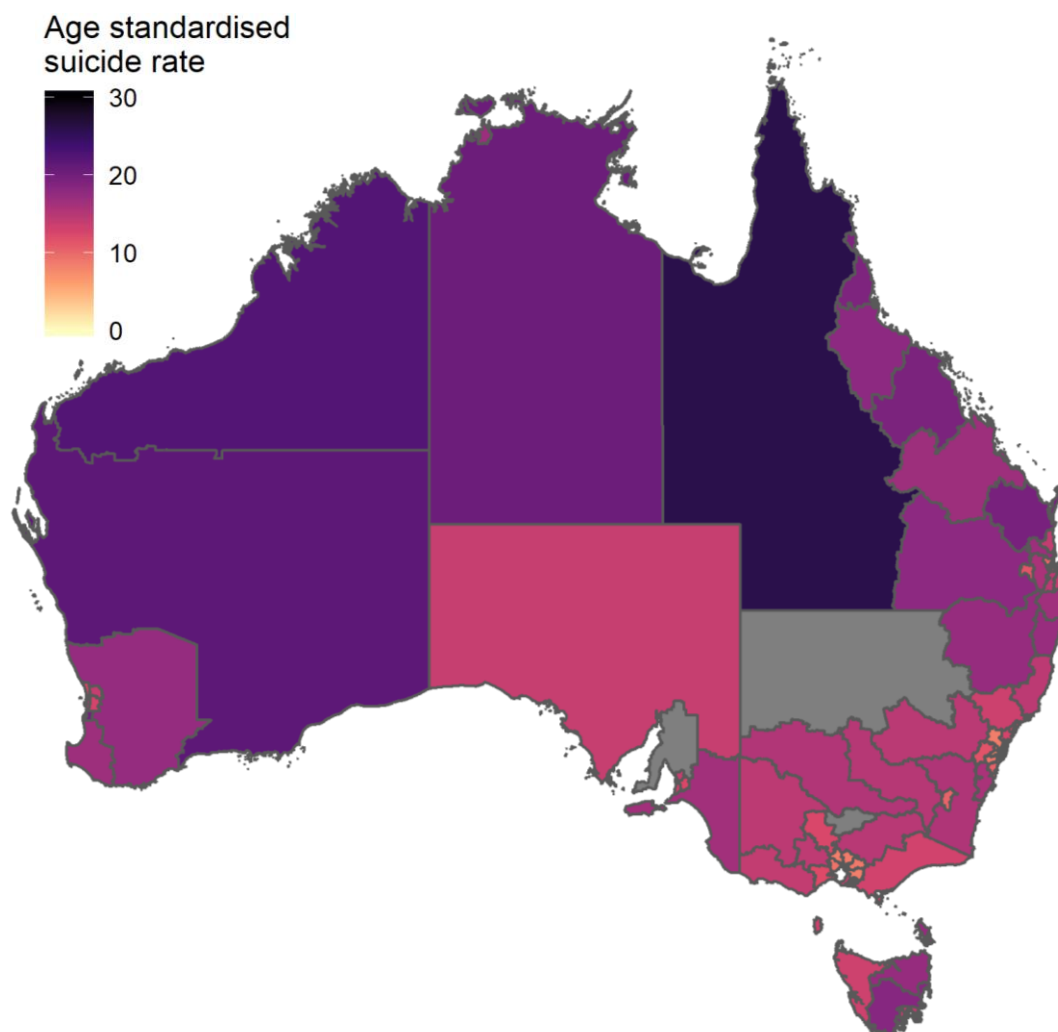
a Based on suicide data between 2013–2017. Regions are Australian Statistical Geography Standard (ASGS) 2016 SA4. **b** Grey regions are where data is not available.

Source: AIHW (2019g).

Figure 2.20 **Mental health related service use is lower in regional and remote areas[a]**
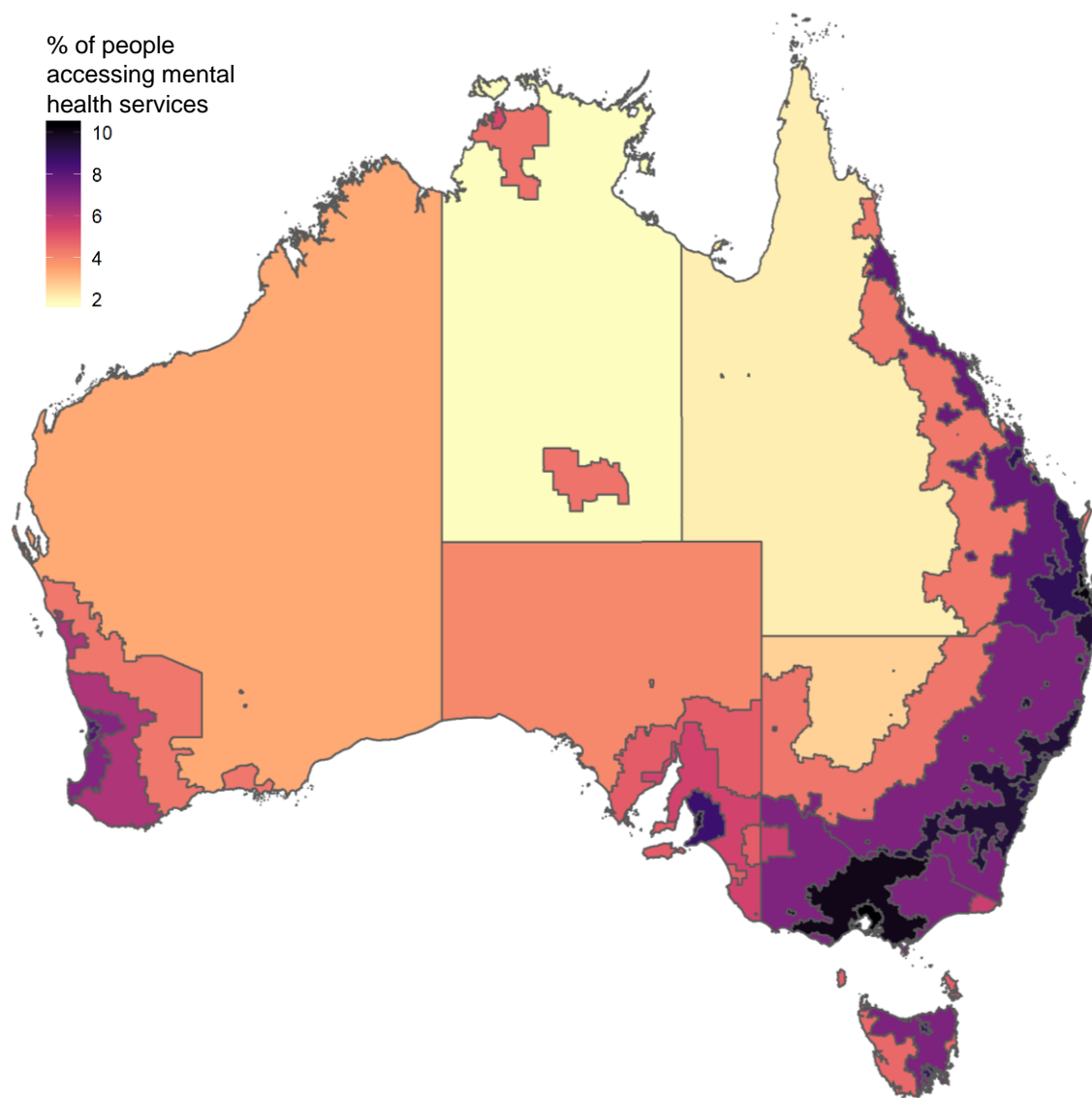
[a] Based on 2016 MBS services data. Regions are Australian Statistical Geography Standard (ASGS) 2016 Remoteness categories.

Source: Commission estimates using ABS (*Microdata: Multi-Agency Data Integration Project*, Australia, Cat. no. 1700.0).

Figure 2.21   MBS-subsidised mental health services by provider type[a,b]
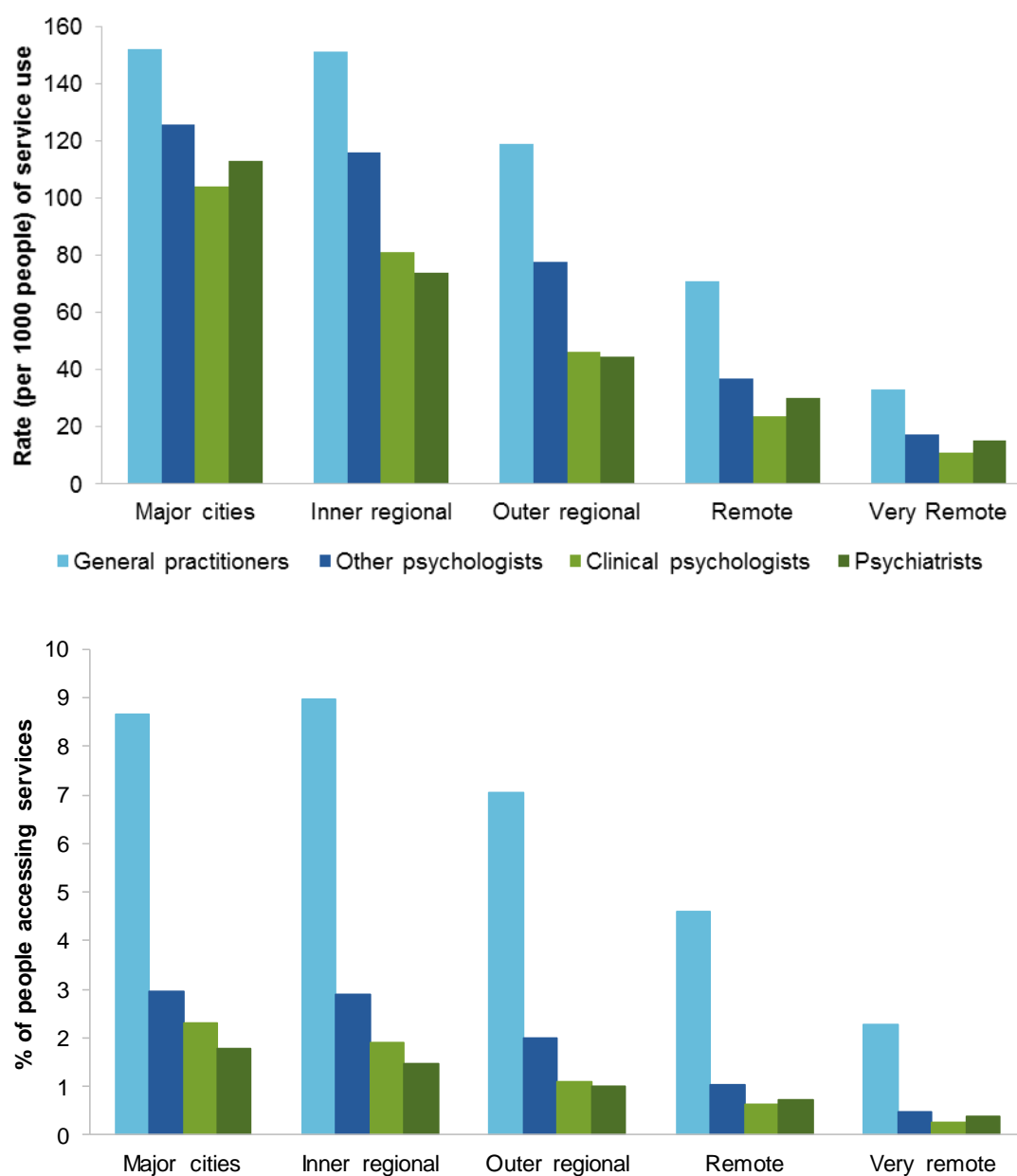
a Data is for 2017-18. **b** Regions are Australian Statistical Geography Standard (ASGS) 2016 Remoteness categories.

Source: AIHW (2019ae).

Culturally and linguistically diverse (CALD) people

The culturally and linguistically diverse (CALD) population represents Australians who are born overseas, have a parent born overseas, or speak a variety of languages. Cultural aspects have been suggested to play a role in determining mental health, which can act as both risk factors and protective factors (chapter 4). In some CALD communities, mental illness is stigmatised with young people not wanting to admit that they have a mental illness due to shame from family and others around them (Western Australian Department of Local Government, Sport and Cultural Industries, sub. 78). A lack of information due to language barriers and culturally capable services can also be a deterrent to access of mental health services (Victorian Government, sub. 483). In some communities, there is significant stigma and taboo attached to mental illness and in seeking help (Mental Health Australia, FECCA and NECA, sub. 524).

There is limited data on mental health within the CALD population, but the 2007 National Mental Health Survey (ABS 2008) suggests that at an aggregate level, the prevalence of mental illness in the CALD population is lower than that of the general population. However this does not take into account other factors which contribute to mental illness. For example, a person's original country can affect whether or not they have a mental illness, in particular if they were from a war-torn country. Immigrants and refugees would also be expected to differ in mental illness prevalence, given the different circumstances surrounding their arrival. For example, some studies have found that refugees in Australia had higher rates of mental illnesses, in particular post-traumatic stress disorder, compared to Australian-born people (Shawyer et al. 2017), and there is evidence that high levels of psychological distress is more common among humanitarian migrants (figure 2.22). It has been suggested that young CALD people are particularly vulnerable to environmental risk factors that impact negatively on their mental health (Australian Human Rights Commission, sub. 491).

Figure 2.22   Humanitarian migrants are more likely to have high psychological distress compared to the general population[a,b]
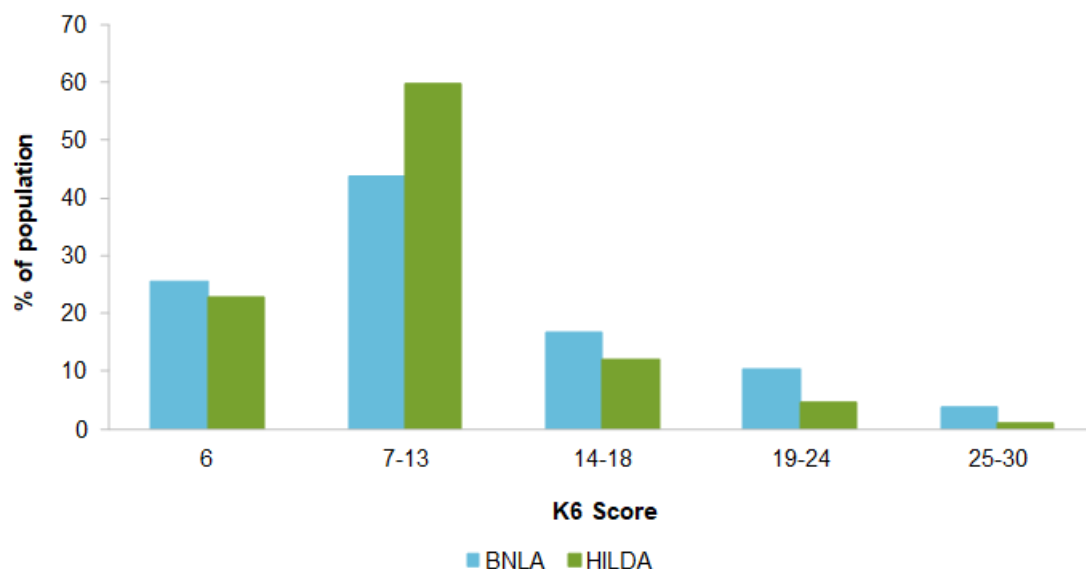
[a] Data presented are the latest waves of BNLA (wave 4, conducted in 2016-17) and HILDA (wave 17, conducted in 2017-18). BNLA is a survey on humanitarian migrants, whereas HILDA is a survey representative of the whole population. [b] A higher K6 score corresponds to higher levels of psychological distress, where a score of 19 or higher suggests the presence of a probable serious mental illness.

Sources: Building a New Life in Australia: The longitudinal study of humanitarian migrants, wave 4; Housing, Income and Labour Dynamics in Australia, wave 17.

DRAFT FINDING 2.1 — THE STATE OF MENTAL HEALTH IN AUSTRALIA

Mental illness is the second largest contributor to years lived in ill-health, and almost half of all Australians will experience mental illness at some point in their life. Compared to other developed countries, the prevalence rate of mental illness in Australia is above the OECD average.

3   What mental ill-health and suicide are costing Australia

The cost of mental ill-health and suicide is large and pervasive …

- It is not possible to measure the true cost of mental ill-health and suicide on the lives of people with lived experience, their families and friends, and the community.

- In 2018-19, the cost to the economy of mental ill-health and suicide in Australia ranged from $43 to $51 billion.

  - Direct expenditure on mental healthcare and support services is in the order of $18 billion. Much of the Government expenditure on mental healthcare related services is directed at the acute end of the mental ill-health severity spectrum.

  - Lower economic participation and lost productivity is estimated to be between $10 and $18 billion.

  - The total annual cost of replacing the support provided by carers of those with mental ill-health is about $15 billion.

  - These estimates exclude unquantifiable impacts such as those arising from stigma or lower social participation.

- The cost of disability and premature death due to mental ill-health is equivalent to a further $130 billion.

- The quantifiable cost of suicide and suicide attempts is estimated to lie between $16 and $34 billion.

- These estimates of the cost of mental ill-health should be considered preliminary — with better information from inquiry participants and other sources, estimates will be refined.

- The lifetime impacts of a poor transition from school to tertiary studies or work due to mental ill-health are profound. Not participating in education and work during the formative years of 18 to 24 strongly influences a person's economic and social participation and life outcomes. These costs have not been quantified in monetary terms.

3.1 Impacts of mental ill-health and suicide

Mental health determines people's capacity to lead contributing lives — to develop and use their skills and talents, work productively and fruitfully, maintain a secure place to live, cope with the normal stresses of life, and have strong and supportive social connections. A person with mental ill-health may fail to achieve some, or all, of these important elements of life. This results in lost opportunities and costs.

Many, if not all, in the community bear these costs to some extent, including people with lived experience of poor mental health and their families and friends, governments (through current and future tax payers), employers and insurers. The nature of these costs varies considerably (figure 3.1).

- Resources expended on healthcare and other services and supports are relatively visible. It includes time and effort spent by family members and friends in caring and supporting people with mental ill-health.

- Lost opportunities and lower living standards are less visible than resources expended. They manifest in terms of young people spending less time in education which inhibits their ability to develop their skills and talents. Mental ill-health also affects people's work outcomes (such as having reduced hours of work, not being able to work, or being less productive when at work). As a result, people with mental ill-health often have lower incomes and employers bear the cost of employees being absent from, or less productive at, work in terms of lower output. The education and labour market outcomes of carers are also affected.

- Social and emotional costs can also be somewhat hidden. Mental ill-health can reduce the range of life experiences and enjoyment of activities undertaken, can add tension and stress to relationships, and in some cases can lead to premature death. Some carers experience a deterioration in their own physical and/or mental health.

Beyond these impacts that mental ill-health imposes on various parties, the community as a whole loses from not having the unique and valued contribution of a group of its people. And this group is not small, accounting for about 20% of the population each year.

It is not necessary to quantify the cost of mental ill-health and suicide to know that it imposes damaging and costly impacts on the lives of these people, their family and friends, governments, business and collectively as a society. We have heard the lived experience in submissions, brief comments and consultations during this inquiry. We have also heard from those who work in the sector, who are committed to achieving better outcomes for those with mental ill-health and their families and friends.

There are challenges in estimating the cost of mental ill-health and suicide, particularly when the aim is to measure it in monetary terms. This is true even for costs such as government expenditure on healthcare and other support services, due to a fragmented system that makes gathering data difficult. Where we have limited data, costs need to be estimated and a range of assumptions made. There are some costs that are particularly difficult to measure, such as

pain and suffering. Converting these to monetary values is to some people incomprehensible or objectionable.

Nevertheless, there are benefits in quantifying the dollar value of the full range of costs of mental ill-health and suicide (box 3.1). The Commission quantified, where possible, each category using Australian, State and Territory Government data, estimates from research literature and the Commission's own assessments. Cost calculations are outlined in appendix E.

Figure 3.1   **Costs of mental ill-health to the community**ᵃ

Resources expended on human services	Reduction in incomes & living standards	Social & emotional costs
Healthcare Expenditure on diagnosis, treatment & recovery	**Lower economic participation** Individuals & carers spend less time working or in education	**Lower social participation** Less contact with family & friends, lower community involvement
Other services & supports Expenditure on education employment, housing, justice & social services	**Lost productivity** People produce a lower rate of output when at work	**Pain & suffering** Diminished health, reduced emotional resilience, increased distress & premature death
Informal care Time and effort provided by family & friends to support individuals	**Cost of collecting taxes to provide services** Taxes alter prices, change behaviours & lowers output	**Stigma & discrimination** Reduced rights, limited choices & poor treatment by others

a Financial support payments (such as the Disability Support Pension and carer payments) are not included because they are a transfer between different members of the community, rather than a cost to the community as a whole. The cost of collecting taxes to fund transfer payments, and publicly funded human services, are included because this is a cost to the whole community.

| Box 3.1 | **Why is measuring costs important?** |

Quantifying the cost of mental ill-health and suicide in monetary terms is a useful tool to:

- provide a universal measure of the 'significance' or 'importance' of the problem. Knowing the estimated costs can be a motivating force to unify all stakeholders to work together to deliver the necessary solutions

- help shed light on the nature of costs. In the process of calculating costs, it is important to consider the way these costs come about (figure 3.1). Understanding this helps to identify the types of solutions and interventions that may be needed

- ensure all types of costs are considered so that sufficient resources are invested to avoid these costs as much as possible

- identify the relative sources of the costs. Knowing that one type of cost is larger than another can help identify where reform efforts should be focused.

3.2 Monetary cost of mental ill-health and suicide

The cost of mental ill-health and suicide is large and pervasive, reflecting costs incurred in healthcare, education, housing, justice, work, and the impact on the quality of life of people. In 2018-19, the quantifiable cost of mental ill-health and suicide ranged from $43 to 51 billion:

- the direct cost of healthcare expenditure and other services and supports was $18 billion

- the cost of lost productivity due to lower employment, absenteeism and presenteeism range from $10 to 18 billion

- the informal care provided by family and friends was valued at $15 billion.

Additional to this is approximately a $130 billion cost associated with diminished health and reduced life expectancy for those with mental ill-health. These estimates do not include some unquantifiable effects such as the cost of stigma or lower social participation (draft finding 3.1).

The Commission estimated that the cost of suicide and suicide attempts in Australia that can be quantified lies between $16-$34 billion in 2018 (chapter 21 and appendix E). The vast majority of this arises due to lost productivity resulting from suicide deaths and permanent incapacity from non-fatal suicide attempts. The estimates exclude non-quantifiable costs, such as the pain and suffering of family and friends associated with the loss of an individual. This is a separate estimate and cannot be added to other estimates due to a double counting of costs.

Our aggregate estimate of the cost of mental ill-health should be considered preliminary — as we believe we will be able to refine it, with better information from inquiry participants and other sources. For example, despite educational institutions dedicating considerable resources to supporting the mental health and wellbeing of children and young people, the

Commission is unable to estimate the overall cost of these activities (appendix E). Our preliminary estimate reflects some standalone programs with a specific mental health focus. For our final report, we aim to have a more comprehensive estimate of education expenditure that supports the mental health of students.

INFORMATION REQUEST 3.1 — EDUCATION ACTIVITIES THAT SUPPORT MENTAL HEALTH AND WELLBEING

We are seeking information or methodologies that would help us to estimate the cost of activities undertaken by educational institutions in supporting mental health and wellbeing of students.

Income support payments are not included in our cost framework because they are transfers between different members of the community, rather than a cost to the community as a whole (figure 3.1). Nevertheless, from a government fiscal perspective, income support payments represent a substantial outlay that must be funded (box 3.2). This is something that will become increasingly harder to do in the context of an ageing population.

Box 3.2 **Income support represents significant outlays**

The Australian Government provides a range of income support payments to assist people with mental ill-health and their carers. These include the Disability Support Pension (DSP), Newstart Allowance, Youth Allowance, carer payments, and Cares Allowance (chapters 13 and 14). In 2018-19, $9.7 billion in income support payments were estimated to be related to mental ill-health, representing about a quarter of their total (appendix E).

The DSP accounts for about 60% of mental health related income support payments. Once an individual with a psychological or psychiatric primary medical condition begins receiving the DSP, on average, it is predicted that they will receive some form of income support (including the age pension) for about 47 years. This represents much of their future life.

The McClure review (2015) recommended reducing future liabilities associated with long-term income support dependence by targeting investments to build people's self-reliance. The Australian Government has since been trialling innovative methods to tackle the complex policy issue of long-term income support dependency (DSS 2019s).

The capacity to reduce the prevalence or the severity of mental ill-health through prevention, early intervention and better investment in evidence based treatments and services, will also have flow on effects to the size of future government income support payments.

Government expenditure concentrates on acute services

While both tiers of government share responsibility for mental health care and other support services, State and Territory Governments provide the bulk of services for people with

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mental ill-health. This expenditure is concentrated at the more acute end of the mental ill-health severity spectrum.

Total Australian, State and Territory Government expenditure on mental health related services, including alcohol and other drug services, was estimated to be about $10 billion in 2018-19. This estimate should be considered conservative as not all services that relate to mental health are included due to the way health service information is collected at the source (appendix E). State and Territory Government outlays on mental healthcare account for about two-thirds of total government expenditure, primarily on public hospital and community healthcare. This represents expenditure on treating and accommodating people with mental ill-health in the most expensive forms of care such as hospital acute inpatient facilities (including emergency departments) and secure forensic care (chapter 15). Using 2016-17 data, the Australian Institute of Health and Welfare, estimated that combined government mental health expenditure represented about 7.4% of total health expenditure and has been relatively stable around this level since at least 1992 (AIHW 2019n).

Government support for mental ill-health extends beyond healthcare to a range of programs and services that help support people, such as housing, education, employment services, along with the police and court systems. Expenditure on these support services that is attributable to mental ill-health is about $6 billion.

Large expenditure is inevitable to some extent. In addition, some expenditure represents preventative investment with longer-term benefits. Nevertheless, other expenditure is avoidable or could be better invested.

The clear dominance of expenditure on people with severe and complex mental ill-health suggests there is merit in examining whether these costs could be reduced by investing earlier, in health promotion, prevention and early intervention, along with the suitable support services, such as housing. A number of the following chapters demonstrate that, with stronger focus on prevention and management in concert with a less fragmented system, current government expenditure on mental health and support services could yield improved benefits for consumers, their families and the community more widely (chapters 5–25).

Moreover, underinvestment in treatment, and delays and barriers in accessing the needed care results in costs to the person and society. Despite evidence demonstrating the effectiveness of mental health treatment, it is estimated that just over half of the people with mental illness do not access services (Whiteford et al. 2014a). Among other consequences, this manifests in people taking time off work or not functioning effectively while at work (see below). Further, when some do eventually access treatment, on average 8 years after the onset of symptoms, it is more likely to be for more severe mental health conditions, that tend to be more costly in treatment (ReachOut and EY 2015).

Consumers can face sizable out-of-pocket costs

Consumers accessing treatment for mental ill-health can face sizable out-of-pocket costs. These can represent the full cost of a service or a shared payment, over and above any amount paid by the Australian Government (via Medicare) or a private health insurance fund (AIHW 2018g). Potential examples of out-of-pocket costs include:

- the gap between the fee for a general practitioner consultation (such as to prepare a mental health plan) and the amount rebated by Medicare

- the cost of prescription medicines to consumers after the subsidy under the Pharmaceutical Benefits Scheme has been applied

- the cost of private prescription medicines (those not under the Pharmaceutical Benefits Scheme)

- the gap between the fee for a psychologist or psychiatrist consultation and the amount rebated by a person's health fund and/or Medicare

- the full cost of a psychologist consultation not covered by Medicare, for example, after a consumer has exhausted their Medicare entitlement

- the gap between the fee for private hospital in-patient treatment and the amount rebated by the person's health fund

- the cost of traveling to and from appointments.

Data on the out-of-pocket costs of consumers of mental healthcare is limited. Based on administrative data, out-of-pocket costs for consultations and medication (that had an associated government subsidy) for people with mental ill-health was $700 million in 2018-19. Co-payments in addition to Medicare Benefits Schedule and Pharmaceutical Benefits Scheme are just two possible sources of out-of-pocket costs. The Commission is seeking more information on out-of-pocket costs.

INFORMATION REQUEST 3.2 — OUT-OF-POCKET COSTS FOR MENTAL HEALTHCARE

We are seeking more information on the out-of-pocket costs of mental healthcare that consumers or their carers incur. We are interested in surveys that have been undertaken, particularly if they capture costs outside of the government funded healthcare system, such as estimates of the cost of travel to services, medications not covered by the Pharmaceutical Benefits Scheme and consultations outside the Medicare Benefits Schedule.

Out-of-pocket costs have a direct impact on access to healthcare with a considerable proportion of Australians reporting that they do not see a doctor and/or did not get recommended care because of the cost. An estimated 44% of Australians with mental ill-health stated that they skipped healthcare treatment for this reason. In particular, people with depression, anxiety and other mental health illnesses were 7.7 times more likely to skip treatment than people without a chronic health condition, after adjusting for age, gender and

education attainment (Callander, Corscadden and Levesque 2016) (access barriers to treatment, including costs are covered, in chapter 6).

Lost opportunities to work fruitfully carry great costs

The lost opportunities experienced by those with mental ill-health to work productively and fruitfully carry great costs for the individual (in terms of lost income) and the community more broadly (in terms of lost output or reduced productivity).

The impact of mental ill-health on productivity and output is significant, as the effects of mental ill-health fall mainly on people during their working lives. In contrast, the impact of most other health issues commonly affect older individuals. About three million Australians who are employed either have a mental health condition, or are carers of someone with a mental health condition. The high prevalence of physical health problems that coexist with mental ill-health (either contributing to the mental ill-health or as a consequence of it) can further impact the work capacity of people with mental ill-health (chapter 19).

Productivity losses are, in economic terms, the value of production that is lost when people with mental ill-health alter their work patterns as a result of their health condition, temporarily or permanently. People may work less than they otherwise would, either being employed less or not at all, being absent more often (absenteeism) or being less productive while at work (presenteeism). They may also retire or die prematurely. Broken work patterns or less time working mean that people with mental ill-health have fewer opportunities to save for retirement through the superannuation system, and therefore, are usually dependent on the age pension.

On average, people with mental ill-health are absent from work for between 10 to 13 days a year, and about 3 days per worker per year are lost because of presenteeism due to mental ill-health. This results in a cost of between \$13 and \$17 billion per year. The Commission estimates that the economic loss, due to the effects of mental ill-health on participation and productivity, ranges from \$10 to \$18 billion (appendix E).

Lower workforce participation rates due to mental ill-health can also impose greater costs on the health system because a job is more than a source of income. Being employed can improve mental health and mentally healthy workplaces are important to maintain the mental health of those who work there. Employment provides opportunities to socialise, a source of self-esteem and a sense of purpose of making a contribution. This broader purpose for work is highlighted in a number of submissions, including Friends of Callan Park:

> The value of meaningful work to people experiencing mental illness goes beyond financial gain and independence. The ability to lead a productive life contributes manifestly to a person's self-esteem, feelings of worth and ability to sustain relationships. The costs to our society if participation rates are not improved — entailing isolation and alienation — cannot simply be measured in dollars, but rather in societal tragedies such as generational disadvantage and increasing rates of family breakdown and suicide. (sub. 198, p. 3)

The value of these social and emotional aspects of work are acknowledged and considered in our analysis of reform options, but are not quantitatively captured in the analysis.

DRAFT FINDING 3.1 — THE COST OF MENTAL ILL-HEALTH AND SUICIDE TO AUSTRALIA

The costs of mental ill-health and suicide are pervasive, reflecting costs incurred in healthcare, education, housing, justice, work, family and friends, and the quality of life of consumers and their carers.

The direct economic costs of mental ill-health and suicide in Australia are estimated to be in the order of $43 to $51 billion in 2018-19. These estimates are apportioned as follows:

- direct expenditure on healthcare and other supports and services ($18 billion)
- lower economic participation and lost productivity ($10 to $18 billion)
- informal care provided by family and friends ($15 billion)

The cost to individuals of the diminished health and wellbeing of living with mental ill-health was a further $130 billion.

These estimates do not include some broader social effects such as the cost of stigma or lower social participation.

3.3 Lifetime impacts of early setbacks

Young people whose mental ill-health results in them missing the opportunity to fully develop their skills and talents, while at school or in post-school education, creates long-term losses. These losses arise from reduced regularity in school attendance, difficulties performing consistently in a school learning environment, and leaving formal education early due to mental ill-health.

Some of the impacts of these lost educational opportunities are reflected in the labour market cost estimates above. But these are a snapshot of one year and they do not convey the full picture of how these costs can change a young person's life trajectory (figure 3.2). In his submission, Mr Davis powerfully expressed how mental ill-health reversed his daughter's learning path:

> Our daughter was intellectually bright (across Science, Maths and English) … She had an inquiring mind and an innate aptitude to learn things … She was also creative. A very competent writer, developing stories well beyond her years. Based on the performance of our other children and our daughter's early performance, we would have expected an ATAR in the high 90s. However, BPD [borderline personality disorder] gradually eroded and stole her functionality and capability as she progressed through adolescence, high school and onto tertiary study … In short — she should have been able to grow into a positively contributing member of society, not just in an economic sense — but in a creative and intellectual sense, rather than having an outlook of significant welfare and health system dependency. (sub. 133, p. 5)

While this analysis sits outside our quantified cost estimate, it is another important piece of evidence used to inform our reform agenda.

Figure 3.2   **Life's trajectory: the lived experience of one young person**

Functional Performance
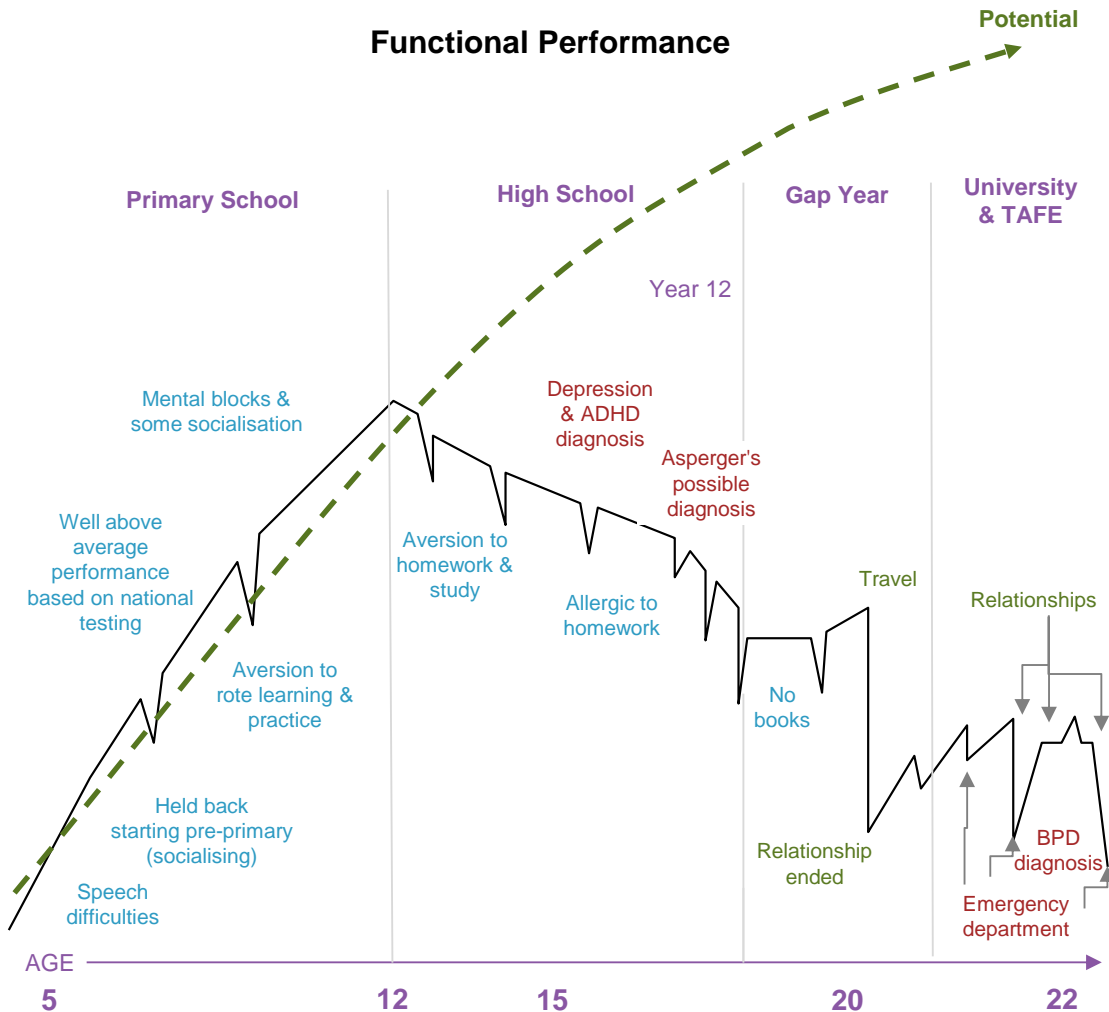
Source: Adapted from Robert Davis, sub 133.

The years between 18 to 24 are an important transition point in a person's life, typically from school to tertiary education and/or work. But it is also a time when mental health issues first emerge, potentially disrupting this transition process (chapters 2 and 18). Those affected may fail to complete high school, find employment or enrol in further education or training.

- Approximately 19% of 15 to 24 year olds were 'not in employment, education or training' and experiencing mental ill-health (O'Dea et al. 2014). This is almost twice the rate found among the general population of youth in Australia. Furthermore, being 'not in education, employment or training' at the age of 16 is a predictor for being 'not in employment, education or training' at the age of 18 years, and it is also a strong predictor of chronic unemployment in adulthood (O'Dea et al. 2014).

- According to the 2007 National Survey of Mental Health and Wellbeing, 25% of people who had not completed school had an anxiety, mood or substance use disorder in a given year compared to 20% of people who have completed school (DoH 2009a).

- 32% of people with psychosis completed high school, compared with 53% in the general community (NMHC 2014e, p. 23).

The origin of these poor transitions is sometimes rooted in missed opportunities to develop skills while in the earlier years of learning. Students with mental ill-health are less connected and engaged with their schooling, attend school less often and have poorer academic outcomes than their peers. Over time, students with mental disorders fall further behind such that by Year 9 they are, on average, several years behind their peers (1.5 to 2.8 years) (figure 3.3). Students with mental disorders have more absences from school. In Years 7 to 12 students with a mental disorder missed an average of 24 days per year compared with 11 days for students without a mental disorder (Goodsell et al. 2017).

Figure 3.3   **Students with mental ill-health progressively fall behind in school**

Average years fallen behind in schooling, by test domain and year level[a]
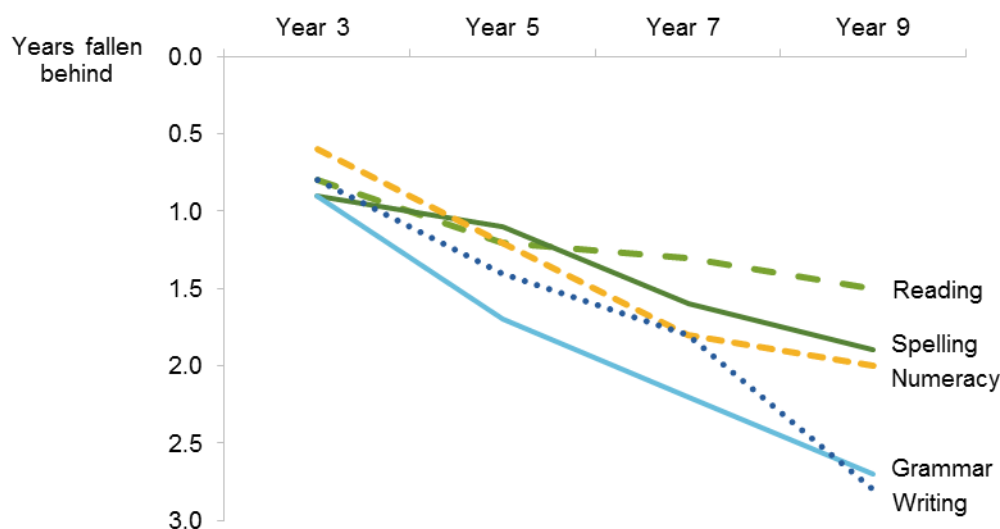
[a] For students with a mental disorder, the average number of years of schooling which they are behind when compared to those with no mental disorder.

Source: Goodsell et al (2017).

For those young people with mental ill-health that manage to transition to further education, they are more likely to be absent from their classes, have lower academic achievement or not complete their qualifications.

- Renner et al. (2015) found that, in students at an Australian university, higher levels of psychological distress and a history of mental health problems were associated with more

'days out of role' (that is, days that students were unable to work, study, or manage daily activities specifically because of psychological distress) in the past month.

- Australian and international research have found that increased mental health problems and higher levels of psychological distress are associated with lower grade point averages (Stallman 2010).

- Karmel and Nguyen (2008) found that, once other student characteristics were controlled for, mental illness had a relatively larger impact on completion rates than other disability types. Polidano and Mavromaras (2010) found that students with a mental illness drop out of vocational education and training at a greater rate if they are unable to access help.

Even starting tertiary level study and not completing a qualification is undesirable. It can create or reinforce a sense of failure, bring an end to otherwise positive social interactions, and result in students wasting their own resources (in time and effort, as well as money). Taxpayer funding is also expended, but not put to best use. Students who do not complete their tertiary studies receive minimal financial benefit from units that they have completed. Instead they may leave with 'debt and regret' (PC 2019d).

Not participating in education and work, during the formative years of 18 to 24, strongly influences a person's economic and social participation and outcomes later in life. These include lower employment rates and incomes, reduced health and wellbeing and decreased social participation (chapter 18). Given that mental ill-health can profoundly effect a person's lifetime outcomes, it is important that interventions in early childhood, during the school years and through the transition to adulthood are effective. Reform in this area is paramount (chapters 17 and 18).

4 The way forward — creating a people-oriented system

Creating a people-oriented mental health system matters because …	• A mental healthcare system that places the consumer at its centre is likely to provide better quality, more efficient healthcare. • Beyond health, there are many other government services that can contribute to better mental health and wellbeing but are currently operating in uncoordinated silos. • Taking a coordinated approach that prioritises people's needs will enable these services to provide a comprehensive set of services focused on prevention and early intervention.
Successful intervention requires …	As a priority: • Governments should remove the barriers to accessing mental healthcare — including addressing service gaps, lack of coordination and workforce shortages. Additional actions governments need to take include: • Empowering consumers to take part in the mental health system, from making decisions about their own care to contributing to policy design. • Supporting service providers to deliver culturally appropriate care that prioritises the preferences of individuals. • Aligning governance, funding, accountability and policy planning functions, towards the goal of a people-oriented system.

I am deeply affected by my mental and physical health challenges, and it has enormous consequences on my financial and mental well-being. Right now, I want to be heard, really heard. (comment no. 59, consumers)

Governments spend billions of dollars on mental health services and roll out countless programs and policies; thousands of doctors, nurses, allied health professionals, emergency responders and many others work tirelessly to assist consumers; there are many online resources and phone lines offering information and support. And yet a consistent theme in the consultation undertaken by this inquiry, and the others that came before it, is of a mental health system that is severely hampered by funding and workforce shortages, that is not responsive to individual needs, where many people cannot access services and fall through the gaps.

In the existing mental health system, people's voices are not heard. In this draft report, the Commission envisions a system that is oriented to people's needs, adapts as these needs change and provides comprehensive clinical and non-clinical support. Achieving this requires substantial reform, including improvements to the consumer experience in the mental health system (section 4.1); empowering people to take an active part in the system, from making decisions about their own care to participating in policy design (section 4.2); and designing incentives that will promote better planning, coordination and service delivery (section 4.3). This chapter summarises the Commission's framework for mental health system reform, as well as key recommendations that will enable governments and service providers to progress towards a people-oriented system.

4.1   The goal — a people-oriented system

The terms of reference for this inquiry tasked the Commission with taking a very broad view of mental health. This encompassed not only the healthcare system, but also many other systems that people interact with and that have the potential to contribute to mental health and wellbeing, such as education, housing and justice. In formulating draft recommendations that respond to the terms of reference, the Commission's overarching goal has been advancing reform towards the creation of a people-oriented mental health system. This includes both a healthcare system that places at its centre the needs of the consumers of its services, and ensuring that all other relevant systems focus on addressing people's needs and supporting their mental health and wellbeing.

The current mental health system is far from being people-oriented. There are many reasons for this, including inefficient and arbitrary funding mechanisms; deeply rooted organisational cultures and unclear responsibilities and governance structures; and insufficient resourcing. Responsibility for creating a people-oriented mental health system is primarily in the hands of governments, although service providers and employers also have a role to play.

Governments — Commonwealth, State and Territory — are responsible for planning, funding, monitoring performance and holding providers accountable. They must set expenditure priorities that will improve wellbeing across the population. This extends beyond the health sector — investments in services such as housing and the justice system will have measurable effects on mental health, as will supporting social inclusion and tailoring support to the needs of job seekers.

Service providers across the healthcare and community services sectors currently operate in silos, driven by inefficient funding arrangements and organisational cultures. To support a consumer-oriented system, they must change this approach to one that is based on collaboration between clinical and non-clinical services, as well as working together with consumers, their carers and families. They must create clearly articulated pathways for consumers interacting with the mental health system, starting with a 'no wrong door' approach.

Employers are bound by law to create a work environment free from physical and psychological hazards. This is important not only for about 20% of the workforce that is affected by mental ill-health, but for all employees. Maintaining employment can help protect an individual from developing a mental illness, and can aid the recovery of those who develop symptoms, but impediments in workplace health and safety legislation and the stigma that still surrounds mental illness can make this unnecessarily difficult.

From a consumer's point of view, however, it is not the division of responsibilities that matters, but how these responsibilities translate into action and change their experience of the mental health system. In this regard, the Commission's proposed reforms fall into three categories:

- improving prevention and early intervention — the need to improve efforts to prevent mental illness, or intervene early when symptoms emerge, was among the most common concerns raised in submissions to this inquiry. We propose reforms that would improve the prevention, early detection and intervention for mental ill-health. Further, we propose changes that would alter how governments, service providers and workplaces support people with mental illness to increase their capacity to maintain or improve their mental health, and enable their continued contribution to society.

- addressing the service gap — too often, people cannot access the help they need in the mental health system. This draft report identifies the key service gaps and makes recommendations to address them over time, such that the full spectrum of individual need is catered for. This is a particularly high priority in the healthcare sector, where some consumers find that the services they require are unavailable.

- meaningful gateways and pathways — consumers should have the confidence that no matter their initial point of engagement with the mental health system, they will be referred to the service they need. Key gateways into the mental health system, such as hospital emergency departments, GPs, school counsellors, and providers of social services, should have the resources, skills and support they require to assist individuals and their families.

Prevention is so much better than a cure

> The inability to provide my child with early diagnosis (or any clear diagnosis) and total failure for any early intervention to assist development into adulthood has created a young person who struggles to cope with daily life or work. Our inability to understand mental health issues at an early age and to offer early intervention [and] assistance has been an absolute failure with the system and to my child, and for many more! We explored numerous health professionals while being on a constant round-a-bout of story after story, high financial expense and further impact on family. (Name withheld, sub. 66, p. 2)

The main focus of Australia's mental health system is providing primary, acute and specialist care to people with mental illness. However, there is a significant evidence base to show that promotion, prevention and early intervention are much more cost effective and can keep people healthier and living in the community — which is often what people with mental illness, their carers and families want to achieve (NMHC 2014e). Therefore, a consumer-oriented system would put a significant emphasis on promotion, prevention and early intervention — as they empower consumers to maintain their own mental health and wellbeing, and they address the needs of those at risk of mental illness before their condition deteriorates (box 4.1).

Box 4.1 **What do we mean by promotion, prevention and early intervention?**

Promotion, prevention and early intervention are complementary sets of actions intended to improve mental health across the population.

The focus of mental health promotion is on strengthening protective factors that support psychological wellbeing. For children, this can include life skills programs and programs that create positive environments both in the home and at school (WHO 2018).

Prevention programs build on these protective factors and focus on reducing risk factors associated with an increased risk of mental illness. There is a wide range of programs that fall in this category, such as removing or minimising exposure to risks present in the community, public awareness campaigns about mental symptoms, and screening at-risk groups and individuals (WHO 2004).

Early intervention can be considered from three perspectives: treatment and support that is offered early in life, early in illness and early in episode. Early intervention programs assist a child, young person or adult through the early identification of risk factors and/or the provision of timely treatment for problems that can alleviate potential harms caused by mental illness (DoH 2015).

Initiatives to promote mental health have been rolled out across the education system and in many workplaces, but the success of these programs has been hampered by numerous factors. For example, while school teachers are expected to deliver a compulsory curriculum intended to raise awareness of mental health and develop resilience, they receive limited training and support. Similarly, workplaces, and small businesses in particular, may find it difficult to interpret their legal obligations to support staff mental health and wellbeing and facilitate the return to work of employees affected by mental illness. The Commission

proposes addressing these issues by improving the skill sets of teachers and creating clearer pathways within the education system for students at risk of mental illness (chapter 17); and tasking workplace health and safety authorities with assisting employers to fulfil their obligations, by developing codes of practice and assessing the effectiveness of workplace preventions programs (chapter 19).

Some prevention efforts have targeted specific risk factors for mental illness, such as supporting the social and emotional development of disadvantaged children. To reach a larger proportion of the population, the Commission's recommendations to prevent future mental illness focus on supporting people at important transition points, such as moving from school to tertiary education or employment (chapter 18). There has also been an ongoing focus on suicide prevention — current suicide prevention trials hold promise, and the Commission recommends evaluating and expediting the roll out of successful trials that take a place-based view of the various activities that can contribute to suicide prevention (chapter 21).

The broader risk factors for mental illness include deeply entrenched social, economic and environmental challenges that lie outside the scope of this inquiry. Nonetheless, particularly for vulnerable consumers, every interaction with government systems can contribute to preventing mental illness. For example, the justice system supports those incarcerated by offering mental health programs but there are severe shortcomings; the Commission recommends further consideration of in-prison services, the transition out of prison and into the community, and the supports needed to keep people with mental illness out of prison (chapter 16). There are also opportunities to improve the support offered to people with mental illness to find and maintain employment, which is likely to aid their recovery (chapter 14).

Many consumers reflected on the importance of intervening early — either early in a person's life, early in their illness, or early in an episode for those with chronic illness — to minimise the monetary and emotional cost of mental illness:

> There are so many gaps in the current mental health system. I strongly believe that early intervention is critical, as I believe that carers need more support. And they need to be believed. (comment no. 28, carers and family members)

> [G]etting mental health care and the right support early can reduce the help required later in life and allow mental health to be more understood and accepted (comment no. 56, consumers)

Intervention early in life requires identification of factors that may have negative effects on children's social and emotional development. Such identification should occur through existing health checks offered to all infants and young children; the Commission recommends expanding the supports offered to parents so they can better understand the social and emotional development of their children and know when and where to seek help. Strengthening teachers' knowledge of social and emotional development can assist them in identifying school students at risk and supporting them in accessing help (chapter 17). Beyond the school years, tertiary education providers should do more to support their students, and prioritise their mental health and wellbeing. Providers are already required to

cater for students with mental illness; the Commission recommends that they develop clear strategies, including measurable targets, on how this will be achieved (chapter 18).

Filling the gaps in existing services

> I could not find suitable support in Australia. I was horrified. It has led to another level of distress - the difficulty of finding adequately low stigma, thorough, considered, knowledged, well-rounded, responsiveness from anyone - friends, family, social workers, GPs, counsellors, psychiatrist or psychologists. (comment no. 16, comments from users of the mental health system)

While there is currently a multitude of mental health services and programs, many gaps remain, particularly for those consumers whose symptoms are not acute enough to require hospitalisation, but cannot be effectively managed using Medicare-rebated services. In this draft report, the Commission makes a number of recommendations to address service gaps, and create a consumer-oriented mental healthcare system. Such a system should be:

- responsive — services should reflect the preferences of consumers, their families and carers, and be delivered in ways that are sensitive to consumers' cultural backgrounds

- accessible — Australians should have timely access to care based on their needs, not ability to pay, in all regions

- well-coordinated — providing continuity of care, and coordination between mental and physical healthcare, psychosocial supports and other services. Service providers should articulate care pathways that support the recovery of people affected by mental illness.

- effective — both in terms of using evidence-based treatments that are shown to be effective in improving consumers outcomes, and cost-effective, representing value for money for individuals and the wider community.

These principles form the basis of a stepped care model for the delivery of mental healthcare. The concept of stepped care, where the level and type of care matches individual needs at any particular time, is not new. The Primary Health Network guidance document, produced by the Australian Government's Department of Health (DoH 2016b, p. 2) defines stepped care as 'an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs. While there are multiple levels within a stepped care approach, they do not operate in silos or as one directional steps, but rather offer a spectrum of service interventions.' Despite ongoing attempts at implementing a stepped care model, the consumer experience reflects a system that is still far from this goal.

The Commission has proposed a number of reforms in this report that will facilitate a shift to stepped care, including:

- funding supported online treatment and telehealth services that offer evidence-based, comprehensive information and advice to consumers experiencing mild to moderate mental illness, and are backed up by outreach services as required (chapters 5 and 6)

- expanding the range of publicly funded low-intensity services for adults, which can provide early intervention for consumers at risk or with milder symptoms (chapter 5)

- ensuring acute services for children and adolescents are available in all jurisdictions (chapter 8)

- increasing the availability of specialist community-based mental health treatment and support services, to prevent or reduce emergency department presentations and unnecessary hospitalisation (chapters 7 and 12).

Implementing these recommendations will build on existing mental healthcare services, to offer a continuum of care across the range of consumer needs (figure 4.1). It will give consumers the choice to access mental healthcare online, face-to-face, individually or in group settings, as well as improving the experience of people who are affected by both physical and mental ill-health (chapter 9). Those who require more complex care will be able to access it in the community, rather than cycle through repeated hospital admissions.

Figure 4.1   **Stepped model of care^a**
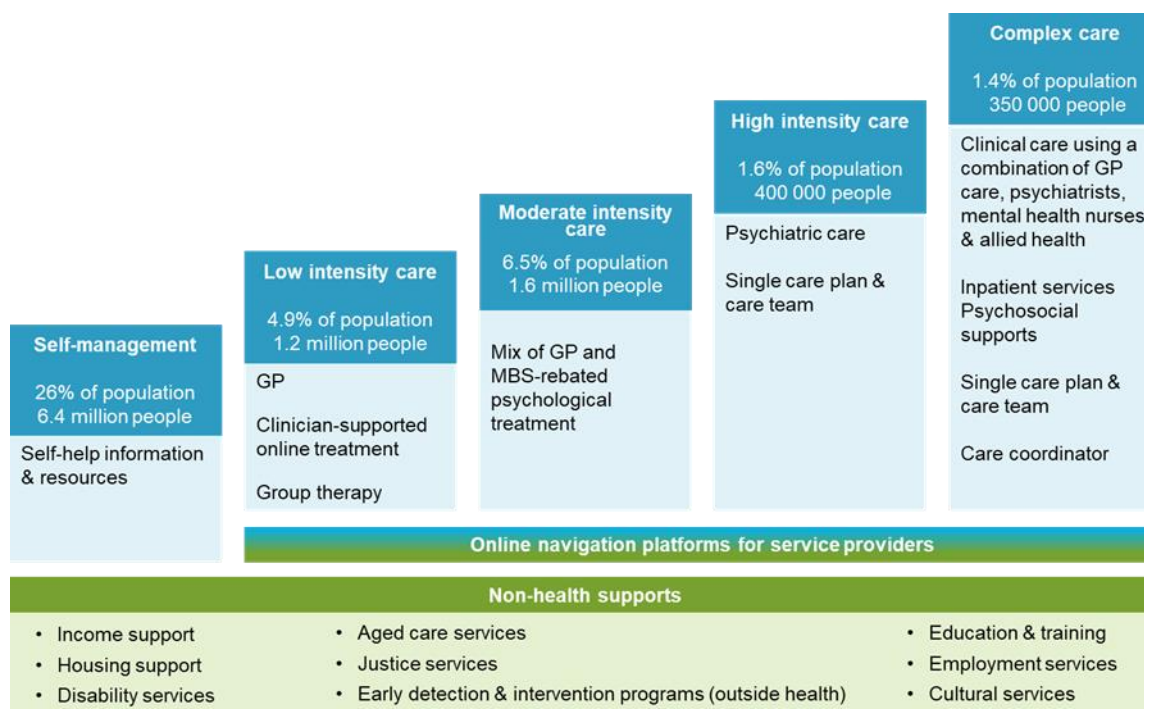
a Percentages are the proportion of the population who require care in each need group. The estimated number of people within each group is based on Department of Health (sub. 556).

Clinical care represents only part of the services required by consumers with more complex needs. For example, psychosocial services enable consumers with severe mental illness to live in the community, and support their recovery. However, not all consumers who require these services are able to access them. The Commission recommends improvement to the planning and funding of psychosocial support services, which will make them accessible to

all consumers who require them (chapter 12). Consumers with complex needs may also require assistance to access suitable housing. This draft report recommends providing a range of housing solutions, to support people with mental illness to find and maintain suitable housing, and expand the availability of supported housing for those who need it (chapter 15). About 30% of people in hospital with mental illness could be discharged if suitable accommodation, clinical and community supports were available (chapter 7); this would support the recovery of those consumers, as well as freeing up capacity in hospitals for other people who need to be admitted.

Carers play a vital role in supporting the recovery of many people with mental illness, but their needs are not always considered by the mental health system. They are often excluded from discussions on their care recipient's needs, and not made aware of services that can assist them. Supports for carers are often better suited to the needs of those caring for someone with a physical illness, and mental health carers are missing out on the types of assistance they need. The Commission recommends addressing these issues, by proposing changes to income support for carers, and improving incentives for mental health services to better include carers in their practice (chapter 13).

People with mental illness still encounter stigma and discrimination, including when interacting with the health system, and the Commission recommends the development of specific education programs to address this. Beyond the health system, inclusive communities can make a substantial difference to people's lives and contribute to their mental health and wellbeing. The Commission makes a number of recommendations to support social inclusion and combat stigma, including the development of a national strategy as well as social enterprises (chapter 20).

Gateways and care coordination to create meaningful pathways for consumers

> [T]he major concerns I have about mental health care are how difficult it is to navigate the system and find appropriate care, the expenses associated with care and also a serious lack of knowledge about perinatal mental illness through all levels of the system. … . My family and I had to spend many days and hours trying to find the right professionals that would be able to help, and this came at a cost as I had ended up having to pay for private care away from my home town. (comment no. 37, comments from users of the mental health system)

In the current mental health system, gateways and pathways to treatment and support are inconsistent and confusing, and consumers and carers must navigate a complex space while relying at times on conflicting information and advice. This draft report presents a model of navigation and coordination services to assist both consumers and service providers in finding the right support at the right time.

Navigating the system can be a daunting task even for those working within it. Therefore, the Commission recommends that GPs, as the most common gateway into the mental health system, have access to online navigation platforms that offer detailed information on local

pathways and services for people with mental illness. Such platforms already exist in parts of Australia, and their use and functionality should be expanded.

There are many other entry points into the mental health system — social workers, teachers, courts or housing providers may refer people to mental health services, and they should all be able to use the online platforms to locate the most appropriate pathways for the people they work with — be this a psychologist looking for an alcohol and other drugs rehabilitation facility for their client, a social housing worker looking for psychosocial support for their tenant, or a school principal looking to refer a family to parenting support services.

Currently, referrals and collaboration between services can hinge on local networks and relationships. In effect, finding the right service at the right time can come down to luck and postcode. The Commission proposes to tackle these issues in two ways.

First, the mental health system should embed the use of single care plans for consumers with moderate to severe mental illness when treatment and care is required from a range of health practitioners. Such plans should be stored electronically, accessed by all relevant practitioners and overseen by a primary treating clinician. Where these clinicians are paid by Medicare, they should be able to access MBS rebates for the time spent developing and progressing the single care plan (chapter 10).

Second, more intensive care coordination is required to assist people with severe and persistent mental illness who also need the support of other types of government services, such as housing or employment. Numerous care coordination programs exist in parts of the mental health system, but their operations are often ad hoc. While some people who require care coordination miss out, others have multiple care coordinators. The Commission recommends streamlining service provision, which is likely to yield savings, while also ensuring that people with severe and persistent mental illness and complex social needs have access to the care coordination services they need.

Care coordinators should work directly with consumers who have severe and persistent mental illness and complex needs. Coordinators will bring together the consumer, their carer, their clinicians (or clinical coordinator) and other services providers the consumer is in contact with, to decide on the type of services needed and provide assistance in accessing those services. The level of treatment and support will be adjusted according to need — for the most complex cases, the care coordinator will need to bring together a care team, comprising the various services the individual requires, and put in place a detailed plan for their support. One of the most important roles of the care coordinator will be facilitating a flow of information between the various service providers (chapter 10).

4.2 Empowering consumers to take an active part in the mental health system

Every Australian is a potential user of the services that form part of the mental health system. To be able to maintain a focus on the individual while addressing the needs of the community, the mental health system should embed the principles of consumer participation and holistic assessment of consumer need. This benefits consumers as well as service providers — a consumer-oriented system provides more efficient healthcare, by understanding consumer needs, avoiding unnecessary hospitalisation and making better use of technology (PC 2017e).

The mental health system has been working towards this goal for many years. There are numerous frameworks, standards and policy documents, outlining practical measures to implement inclusive, culturally appropriate practice that can be tailored to the wide range of people and groups accessing mental health services (for example, ACSQHC 2018; Dudgeon, Milroy and Walker 2014; MHIMA 2014). There are also many types of interventions, programs and support services, aiming to cater for the needs of specific population groups (for example, DoH, sub. 556).

There is very little evidence on which to base an overarching assessment of the effectiveness of the system in responding to diverse needs:

> Data gaps also continue to exist in the extent to which the mental health system is meeting the needs of communities, for example Indigenous Australians, rural, remote and very remote communities, people from culturally and linguistically diverse backgrounds, and people who identify as lesbian, gay, bisexual, transgender or intersex. (DoH, sub. 556, p. 51).

Nonetheless, submissions to this inquiry reflect a mental health system that often gives little always consideration to the needs and preferences of consumers, their carers and families, and the social and environmental factors that may be contributing to their mental illness. In part, this is likely because addressing the social determinants of mental illness — such as inequality and entrenched disadvantage — requires a very large scale government response, far beyond the scope of any one provider or organisation within the mental health system. But there are a number of ways for the consumer and carer voice to be heard and respected within the mental health system, which are likely to make a difference to consumer outcomes.

Giving consumers a voice in system design – and their own treatment

Empowering consumers to take an active part in their treatment and recovery has been a theme of mental health system reform since the commencement of the National Mental Health Strategy in 1992 (National Mental Health Strategy Evaluation Steering Committee 1997). Although much has changed, this is still work in progress.

A key shift in mental health policy (and indeed, health policy more broadly) has been the increased emphasis on regional planning, rather than taking a top-down approach. Regional planning can enable a tailoring of services to community needs as well as presenting an opportunity for individuals and communities to be involved in the design of the services they require and in their delivery. The Commission considers that this co-design approach, at all levels of system planning, should be an integral part of mental health system governance (chapter 22).

The Aboriginal Medical Services Alliance NT (AMSANT, sub. 434) pointed to research indicating that increased community control and participation over decisions affecting their life was integral to improving health and psychological wellbeing of Aboriginal and Torres Strait Islander people. To this end, it called for health services to be provided by Aboriginal and Torres Strait Islander organisations, where possible, or in partnership with mainstream organisations. The Commission sees merit in strengthening the ability of Aboriginal controlled organisations to provide mental health services in Aboriginal and Torres Strait Islander communities (chapter 21 and 24). More broadly, this draft report contains a range of recommendations intended to align the mental health system to the needs of Aboriginal and Torres Strait Islander people (box 4.2).

Box 4.2   Aligning the mental health system to the needs of Aboriginal and Torres Strait Islander people and communities

Aboriginal and Torres Strait Islander people experience mental ill-health at far higher rates than other population groups, and despite significant efforts, the mental health system has not managed to achieve a notable improvement in outcomes. The improvements in mental health services discussed in this draft report are likely to address some of the service gaps affecting Aboriginal and Torres Strait Islander people. However, a more comprehensive response requires a concerted effort across the system, from considering the educational needs of Aboriginal and Torres Strait Islander children (chapter 17) to services provided by the justice system (chapter 16). Examples of specific initiatives include:

- recognising the conceptual underpinnings of social and emotional wellbeing for Aboriginal and Torres Strait Islanders, which extend to connections to culture, country, spirituality and ancestors, body, mind and emotions, family and kinship as well as community (chapter 20)

- increasing the numbers of Aboriginal and Torres Strait Islander health workers and improving their career pathways (chapter 11)

- expanding the role of Aboriginal controlled organisations in the planning and delivery of mental health services (chapters 21 and 24)

- a broader recognition of the needs of Aboriginal and Torres Strait Islander communities in the governance structures of the mental health system (chapter 22)

- and improving the social participation of Aboriginal and Torres Strait Islander people (chapter 20).

Further, the Commission sees a need for strengthening systemic advocacy, through organisations that represent the needs of people with lived experience of mental illness, their carers and families. These organisations can often give a voice to consumers who are most

disadvantaged, and therefore less likely to participate in formal consultation and co-design processes (chapter 22).

On an individual level, giving consumers a choice between different types of mental health support services — delivered online, over the phone, face-to-face in individual or group settings — empowers them to take an active part in their own recovery. And by making the mental health system more accessible and easier to navigate, the Commission's draft recommendations give consumers and carers the ability to access the services they require in a form that suits them (chapters 5, 6, 10, 13).

Setting individual treatment goals and monitoring outcomes can also play a role in people's recovery from mental illness. For vulnerable consumers, this would be part of care coordination processes (chapter 10). The Commission's recommended monitoring and evaluation framework places a substantial emphasis on reporting consumer outcomes, and ensuring the mental health system focuses on improving the outcomes for all types of consumers, regardless of age, location, and their unique combination of risk and social factors that may affect mental health and wellbeing. This framework also recognises different concepts of wellbeing, such as Aboriginal and Torres Strait Islander approaches to mental health and wellbeing, to ensure governments and service providers measure and report on outcomes that matter to consumers (chapter 25).

Overcoming cultural barriers to treatment

For many consumers, active participation in their care remains impossible in a system that does not speak their language or understand their cultural background. The vast majority of mental health services that are currently provided in Australia take a mainstream approach to service provision, one that does not always cater to the needs of individual consumers.

Cultural and language differences can create substantial barriers for people to access the support and care they need for their mental health. For example, some cultures do not have a word for mental health and the stigma attached to mental illness in general was a key reason it was not discussed in these communities (DLGSC, sub. 78). Language difficulties can make it hard for consumers to access and interact with service providers. For those with little or limited English, there are clear difficulties in communicating and explaining their symptoms and in turn accurately diagnosing their condition (Mental Health Australia, Federation of Ethnic Communities' Councils of Australia (FECCA) and National Ethnic Disability Alliance (NECA), sub. 524).

Aboriginal and Torres Strait Islander people's understanding and experience of mental health are very different to that of non-Indigenous society (AMSANT, sub. 434). The physical and mental wellbeing of Aboriginal and Torres Strait Islander people for thousands of years was supported through their beliefs, practices and way of life. Cultural factors such as social connectedness and sense of belonging, culture, spirituality and ancestry, living on or near traditional lands, and passing on of cultural practices also act as protective factors (chapters 1 and 20).

Healthcare for Aboriginal and Torres Strait Islander people is often designed to meet the needs of people from non-Indigenous communities and their understanding and experiences of treating mental illness. For example, it can be difficult to diagnose mental illness where testing is formulated based on answers from the non-Indigenous population. For those Aboriginal and Torres Strait Islander people living in remote communities, the need to relocate to larger towns and centres for treatment away from their community can result in further deterioration in their mental health (HREOC 1993).

There have been some innovative initiatives taken to more effectively address the specific needs of Aboriginal and Torres Strait Islander people. For example, 'words for feelings' products have been developed in the form of illustrated posters and conversation cards printed in both Pitjantjatjara and Ngaanyatjarra to assist Aboriginal and Torres Strait Islander people from these language groups to find the right word to express their feelings. These are used as tools by health professionals and families to assist people with talking about their feelings, thoughts and wellbeing (NPY Women's Council 2019).

Routine screening tools used to diagnose mental illness are not always well suited to the needs of Aboriginal and Torres Strait Islander people, as questions can be misinterpreted in translation and scores do not reflect people's level of psychological distress. Working in conjunction with Aboriginal and Torres Strait Islander people and health services, researchers have developed a screening tool that contains culturally appropriate questions asking about mood, appetite, sleep patterns, energy and concentration levels that can better determine mental health problems that may have previously been overlooked or dismissed (The George Institute 2019).

A range of approaches are required to provide services that are more tailored to the needs of these communities, rather than trying to have these consumers adapt to the 'off the shelf' mainstream initiatives and services. This may include employing people from the community to provide safe and culturally appropriate care — including people with lived experience (chapter 11). In addition to overcoming cultural barriers, having members of the same community involved in service provision is likely to play a role in overcoming some of the stigma attached to mental illness and encourage those with mental health problems to seek earlier assistance. This is likely to be particularly important in Aboriginal and Torres Strait Islander communities (DLGSC, sub. 78).

The need for cultural capability among the mental health workforce is not limited to recognising the needs of people from cultural and linguistically diverse (CALD) backgrounds. It applies equally to other groups in the population, which may be facing difficulties in accessing mainstream mental healthcare services, such as the LGBTIQ community (Thorne Harbour Health and Rainbow Health Victoria, sub. 265).

Peer workers with lived experience, and in particular bilingual and bicultural peer workers, can enable the mental health system to better meet the needs of these consumers (Mental Health Australia, Federation of Ethnic Communities' Councils of Australia (FECCA) and National Ethnic Disability Alliance (NECA), sub. 524). Peer workers can provide a shared perspective in the provision of treatment. If those peer workers are from the same community

or group, they may be more culturally capable in meeting the needs of these consumers. For example, the Western Australian Department of Local Government, Sport and Cultural Industries (DLGSC) called for the:

> … adoption of customised multilingual communication strategies and give the end-user a voice, particularly the lived experience voice, through employment of peer workers, consumer and carer representatives including people from diverse population groups. (sub. 78, p. 2)

Responding to cultural needs cannot remain solely the responsibility of specific workers within the mental health system:

> It is also vital that the workforce more generally reflects the community it serves, that staff are culturally competent, and that staff are aware of when and how to engage interpreters for people with low levels of English language proficiency and who speak languages other than English. (DLGSC, sub. 78, p. 7)

The entire mental health workforce (including GPs, nurses, specialists, allied health professionals and others) should be trained to deliver culturally appropriate care. These types of training programs have existed for many years across the health sector, but reviews have failed to identify measurable changes in consumer outcomes as a result of cultural competency training for health professionals. This is in part due to limited tracking of health outcomes (Jongen, McCalman & Bainbridge 2018). It also emphasises the need to ensure that workers not only attain skills, but also work in environments that enable them to put them into practice.

Investing in the cultural competency of the broader mental health workforce supports better outcomes for consumers and providers. There are three reasons for this: first, the population is becoming increasingly diverse and the mental health system needs to change with it if it is to deliver improved consumer outcomes. Second, stronger cultural competency in the mental health system will encourage additional groups to seek treatment. And finally, cultural competence can enhance the outcomes of evidence-based treatment (Whaley & Davis 2007). These factors complement each other to strengthen consumers' capacity to recover from mental illness and increase their social and economic participation, as well as increasing the efficiency and effectiveness of the mental health system.

4.3   Systemic changes needed to create a people-oriented system

To change the way consumers experience the mental health system requires reform to the institutional arrangements that form the foundation of the system. From a consumer point of view, it is immaterial whether a doctor is employed by a State-funded hospital or paid by the Commonwealth via Medicare; regardless of funding structures and institutional arrangements, consumers expect timely, affordable, quality care and respect as a person. The Commission's consultations and analysis identified six building blocks that form the foundation of the mental health system: governance; monitoring, reporting and evaluation;

funding; planning and coordination; and workforce development (figure 4.2). Changes are necessary in each of these components to improve the mental health system.

Figure 4.2   **The building blocks of a people-oriented mental health system**

Services and workforce that have the capacity to respond to the full spectrum of population needs

Coordination of services, including health, housing, education, social services

Planning of services that respond to community needs

Funding – quantum and structure that creates the right incentives

Monitoring – how we are travelling

Governance – who is responsible for what

A new governance and monitoring framework

The lack of coherent governance structures is a key reason for the disjointed service delivery that consumers experience in the mental health system — there is no clear delineation between the responsibilities of governments in different parts of the system, and as a result, there is limited accountability.

Addressing the fragmentation that is a common feature of the existing mental health system requires a new governance model. The model proposed by the Commission will clarify the roles and responsibilities of the Australian Government and State and Territory Governments and set them out in a new intergovernmental agreement. Such an agreement will signal a commitment made by all governments to mental health reform, and position mental health as a priority for policy and funding across all portfolios (chapter 22).

Accountability for outcomes should be one of the core principles for this agreement; this can only be achieved through a comprehensive and nationally-consistent monitoring and reporting framework. Vast amounts of data are collected throughout the mental health system, but the system as a whole can be described as data rich but information poor: key indicators are out of date, there is limited use of data to improve consumer outcomes, and some important data items (such as patient-reported experience and outcome measures) are rarely collected.

The Commission recommends updating and expanding key data collections, as well as setting out priorities for improving the use of the data being collected. Shared outcome indicators should be used to support joint responsibility and funding programs across different portfolios, including health, housing, human and social services, education and training, employment and justice. Further, evaluation should be embedded into program design, not only to ensure that public funds are spent efficiently but also that programs achieve their intended goals, and contribute positively to mental health and wellbeing.

Data is not just a tool for policy makers. Access to data empowers consumers and carers to make informed decisions about their own treatment. However, governments would need to address several challenges, such as data limitations and the risks of unintended consequences, before provider level data could be made available to consumers (chapter 25).

Detangling the complex web of funding arrangements

Current funding arrangements in the mental health system contribute to poor consumer outcomes. In the health system, they create disincentives to the provision of community-based care; there are also no incentives to minimise hospitalisations and avoid repeated presentations to emergency departments. Beyond the health system, funding for other supports such as psychosocial services is extremely fragmented and based on very short cycles, which make it harder to deliver quality services. Reforming funding arrangements in the mental health care system, to create the incentives that will underpin consumer-oriented services, should be an urgent priority for governments.

In this draft report, the Commission presents two options (summarised below and discussed in detail in chapter 24) for funding reform in the mental health system. The two options for funding reform are the renovation model and the rebuilding model.

The renovation model

Under the *renovation* option, current Commonwealth-State roles and responsibilities are largely maintained but there is closer integration of services provided by existing funding sources. Current funding overlap will be addressed through the creation a primary care funding pool and changes to the funding of community and acute care services.

The primary care pool will be the responsibility of the Australian Government, and will bring together the funding currently allocated through Medicare and Primary Health Networks (PHNs). Primary mental healthcare would remain funded through Medicare, but PHNs' budgets would be linked to the volume of Medicare spending in their regions. PHNs would be granted the ability to contract with Medicare-funded clinicians to better meet the needs of consumers in the region they are responsible for.

Public hospital and specialist community mental health services would remain the responsibility of State and Territory Governments. Community mental health services

(currently block funded) would be activity-funded using an improved classification system developed by the Independent Hospital Pricing Authority (chapter 23). This would improve efficiency and help address the disincentives to minimise avoidable hospital admissions. In addition, psychosocial supports (outside of the NDIS) and individual placement and support (IPS) employment services would become solely a State and Territory Government responsibility, with the Australian Government providing additional funding to support this.

The rebuild option

The *rebuild* option proposes that most mental health funding is held in regional funding pools controlled by each State and Territory Government under arrangements approved by the COAG Health Council and administered by Regional Commissioning Authorities (RCAs). The purpose of RCAs is to create a seamless mental healthcare system that offers continuity of service and fills gaps in service provision. RCAs would 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.

These new bodies would allocate mental healthcare, psychosocial and carer supports (with the exception of consumers using NDIS funding) and IPS employment supports funding in the region they will be responsible for. To enable this change, Australian Government mental healthcare payments to State and Territory Governments under the National Health Reform Agreement would be discontinued, with this funding instead flowing directly to the RCAs. The RCAs' funding pool would also comprise all funding allocated to PHN-commissioned mental health services, as well as prospective Medicare funding and additional payments proposed for psychosocial, carer and employment supports. MBS-rebated mental healthcare delivered by allied health providers would remain funded via Medicare, but with these payments drawn from the Australian Government's contributions to the RCAs pools and the RCAs granted the ability to contract with Medicare-funded clinicians.

The rebuild model is the Commission's preferred option at this stage. Rather than creating institutional arrangements to enable two levels of government to operate as one, this model allocates responsibility to a single level of government. This avoids possible pitfalls that emerge when governments decide to collaborate; some of these are evident in the current attempts at co-commissioning (chapter 23). In the Commission's view, State and Territory Governments are better suited to establish RCAs and be responsible for their operation, as they have a more firmly embedded role in the health system, and they are also responsible for other major services such as housing, education and justice, which all need to collaborate to support improved mental health and wellbeing.

The Commission recognises that this model involves major changes in the way the mental health system is funded and governed. We are seeking feedback from inquiry participants and will be conducting further analysis on these issues; a complete governance and funding model will be presented in the final report of this inquiry in May 2020.

Putting the pieces together – planning, coordination and workforce development

Mental health policy and service delivery are often ad hoc and lack cohesion and coordination. The Commission's recommendations seek to create strong incentives for coordination across all service providers. Within the mental healthcare system, aligning funding structures and pooling governments' funding commitments — either via the renovation or the rebuilding models — will enable local authorities to plan and implement the services needed by consumers, while avoiding duplication and inconsistencies.

The availability of a well-trained mental health workforce is the cornerstone of implementing many of the Commission's recommendations. There are substantial challenges in developing a workforce to address the needs of consumers. The workforce available today comprises thousands of committed and capable doctors, nurses, allied health professionals, non-clinical staff and many others; but there are still substantial shortages in clinical professions, especially mental health nurses and psychiatrists, as well non-clinical roles, such as peer workers.

Poor planning has also seen inefficient allocation of skills across the mental health system — such as using face-to-face therapists when e-mental health would be just as effective and an underutilisation of nurses for clinical tasks that do not require a doctor. Compounding these issues have been a lack of accessibility, with people with mental illness unable to find mental health professionals in their area; a negative workplace culture that stigmatises people with mental illness; and the technological challenges of data linkages and information sharing between service providers (chapter 10 and 11).

The Commission has made a range of recommendations intended to boost the number of mental health nurses, for example by creating additional pathways for training and promoting the profession to existing nurses and nursing students. Similarly, the Commission has made recommendations to support an increase in the numbers of psychiatrists and peer workers, and expand the mental health workforce in rural and remote areas, by reducing professional isolation and increasing opportunities for professional development (chapter 11).

Over time, implementing the stepped care approach to mental health care will necessitate further changes to the workforce. For example, new guidelines may be required for GPs, to support the increase in use of low-intensity treatment options, and additional staff will be required to enable the expansion of online and telehealth treatment options (chapters 5, 6, 11). A holistic approach to workforce planning, which considers current and future supply and demand, is necessary to achieve improvements in the mental health system.

PART II — Re-orienting healthcare services to consumers

5   Primary mental healthcare

Primary mental healthcare matters because …	• Primary care is the first gateway for many people to access treatment in the health system and provides one of the strongest points for intervention. • Access to the right treatment when needed is a key goal, but some consumers are not able to get the necessary care in a way that is timely, affordable, manageable (given their condition), and culturally appropriate. • MBS-rebated sessions for individual psychological therapy are an important part of the suite of current treatment options. – But while there is strong clinical evidence that therapy can be effective for consumers, there is little evidence of the overall effectiveness of the program, which is being delivered to 1.3 million Australians. • Many consumers are receiving fewer treatment sessions than needed, because of the time, effort and cost of getting treatment; many others are being provided with more intensive treatment than their condition necessitates. • GPs, as both gateways and gatekeepers, need more support in assessing, treating, referring and managing people with mental ill-health.
Successful intervention requires …	• There should be a well-resourced and rigorous evaluation of the effectiveness of the MBS-rebated psychological therapy program. • While the evaluation is being conducted, trials allowing up to 20 MBS-rebated sessions of individual or group psychological therapy per person over a 12-month period, for consumers whose clinical condition requires more than the current 10 sessions, should be undertaken. • To support referral to low intensity therapy, funding for headspace centres should be made conditional on meeting targets for referral to such services. • PHNs should be required to actively promote best-practice in initial assessment and referral for mental healthcare, and monitor whether service use in their region accords with this. • The criteria for accessing MBS-rebated therapy should be changed to make it more attractive for psychological therapy providers to provide group therapy, as well as increasing access to MBS-rebated psychological therapy by videoconference. • Support for GPs should be made available through a new MBS item number for psychiatrists to provide advice to a GP over the phone on diagnosis and management issues for a person who is being managed by the GP.

Primary mental health services are the entry level to the health system for people not requiring emergency mental healthcare (box 5.1). This chapter focuses on services that are mainly provided face-to-face with a health professional. (Online mental health services are examined in chapter 6.)

Primary healthcare is provided to a diverse group of people — those seeking help for the first time, those receiving a series of treatments for a mild or moderate condition, and those with more severe disorders who are being helped to maintain their recovery and avoid relapse.

Many in these groups are not receiving the treatment and support their condition requires. There are gaps in services, and problems with accessibility, lack of choice, and inadequate direction of consumers to the most appropriate types of care for their condition. These problems and the proposed solutions to them is the focus of this chapter.

Box 5.1 Primary mental health services

Primary mental health services are provided to people with mental ill-health (most often those with disorders of mild or moderate severity) who do not receive treatment in hospital (chapter 8), or from a psychiatrist or a State or Territory community mental health service (chapter 7). This range of services extends from online self-help (chapter 6) to an extended series of face-to-face therapy sessions with a health professional such as a psychologist.

The organisations and professions that provide primary mental health services are diverse. They include public and private sector health providers, and can be delivered by healthcare professionals such as GPs, nurses, psychologists and other allied health professionals.

The most recent available data indicates that the number of people using primary mental health services each year includes:

- 3.9 million people receiving a mental health-related prescription from their GP (AIHW 2019q, table PBS.3)
- 1.3 million people receiving MBS-rebated psychological therapy (individual or group) (Commission estimates based on unpublished MBS data)
- 190 000 people accessing services commissioned by Primary Health Networks (including psychological therapy and low-intensity cognitive behavioural therapy delivered by coaches) (DoH 2019k, p. 19)
- 90 000 young people receiving help through headspace centres (DoH 2019k, p. 17)
- 4000 using supported online treatment (MindSpot Clinic 2019).

The number of people obtaining help is not the sum of the above values as many people access multiple services.

In 2017-18, 76% of public funding for primary mental health services was through the MBS, with most of this being for care provided by GPs and psychologists. The remaining 24% of public funding was given to Primary Health Networks to commission services (AIHW 2019o; unpublished data supplied by the Department of Health).

5.1 GPs are the front line of consumer-focused care

People with mental-ill health usually go to their GP first. In 2015-16, consumers had roughly 18 million GP consultations regarding psychological problems (Britt et al. 2016, p. 19). A 2019 survey suggested that psychological issues are one of the main reasons that Australians go to the GPs (RACGP 2019, p. 3).

There are about 29 000 GPs spread around Australia (DoH 2017c). The distribution of GPs is generally well-aligned with population, although there are *more* GPs per 100 000 people in remote and very remote areas than in cities and regional areas (chapter 11). However, access to GPs for mental healthcare in outer regional and remote areas for care is likely to be worse than in major cities because they must perform many other health functions, as suggested by data on the overall medical practitioner workforce by region (AIHW 2016b). This results in generally longer GP waiting times in these areas (ABS 2018f, table 6.2). Access to mental health professionals like psychologists or psychiatrists is even less in these areas because they are relatively more concentrated in cities and larger regional centres (chapter 11).

GPs fill several important roles in mental healthcare: assessing, treating, referring and managing. GPs use a range of diagnostic tools (such as patient questionnaires) to assist in assessing mental health. Accurate assessments are vital to ensure people get the right treatment or referral. GPs are also well placed to assess the mental health of the broader population — including those presenting with physical health problems — and facilitate treatment for those that need it. GPs see nine out of ten Australians in a year (AIHW 2019l). And of the people they see most often, those with more serious physical health problems, are among the most likely to have a *mental* health problem (chapter 9).

GPs use several treatments for mental ill-health. They often provide 'psychoeducation' to people presenting with less severe problems. This includes teaching people simple techniques (such as breathing exercises for anxiety), or providing information about how lifestyle changes can improve mental health (such as improved diet or more exercise). GPs also provide therapy. In 2018, GPs had more than 60 000 consultations *recorded* as therapy — including as psychological therapy[3] under the Better Access program (about 30 000 sessions), as family group therapy (about 10 000) and as pregnancy support counselling (about 21 000) (Commission estimates based on unpublished MBS data).[4] GPs often treat with medication — about 15% of the population received a mental-health-related prescription from their GP in 2017-18 (box 5.1). Three quarters of these were for antidepressant medications (AIHW 2019q, table PBS.3).

GPs are responsible for referring people to more specialised services when they need them. In this role, they act both as a gate*way* (connecting people with services) and a gate*keeper*

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[3] 'MBS-rebated psychological therapy' is defined in this report as comprising both Psychological Therapy Services and Focused Psychological Strategies.

[4] The true number of consultations including therapy may be much higher, as only certain types of consultations are *recorded* as therapy.

— as MBS rebates are only provided for consultations with a psychiatrist or psychological therapist where there has been a referral from a GP (or psychiatrist or paediatrician). GPs' gateway/gatekeeper role in mental healthcare is discussed below.

Finally, GPs are responsible, in conjunction with their patient, for managing and coordinating the healthcare of most people with mental ill-health (excepting where this is provided as part of specialist mental healthcare). This role covers consumers' mental *and* physical healthcare. A holistic approach is crucial because of the many links between poor mental health and poor physical health (chapter 9). Chapter 10 proposes a range of reforms aimed at improving coordination of care, including single care plans.

Performing each of these roles well is difficult. However, despite the extensive knowledge and experience required to do so, and the frequency at which GPs see people with psychological problems, many GPs have received only limited training in mental health (chapter 11 proposes some changes to GP training). More support would help GPs provide best-practice care.

GPs need information about services (including non-clinical services) in their area so they are able to connect consumers with the right services. The HealthPathways infrastructure is set up to do this, but PHNs must invest in HealthPathways so that it contains up-to-date information.

Additionally, consumers would benefit if GPs were able to access timely advice from a psychiatrist, to help them with assessment, treatment, referral or care management. Timely psychiatric advice is particularly important in the context of long waiting times for assessment consultations with a psychiatrist (chapter 7).

GPs should have timely access to psychiatric advice

The Royal Australian College of General Practitioners (RACGP) called for a psychiatric advice service across Australia.

> GP access to support and advice from relevant mental health specialists (eg psychiatrists) on the management of patients with mental health-related issues is valuable but largely missing from the current system. General practice registrars, early career GPs, and rural and remote GPs may find particular benefit in such consultation services. (sub. 386, p. 7)

Such a service has some merit. It would better meet consumers' needs for good advice, fill some of the gaps in GP's knowledge, and could reduce the need for referrals of people to (more costly and burdensome) psychiatric assessments.

There are, and have been, psychiatric advice services that provide lessons about any new Australia-wide service.

A previously-funded (and now terminated) national service, known as GP Psych Support, was seen as beneficial by GPs (box 5.2). However, its use was very limited, and its costs per

call were very high relative to standard psychiatry consultations.[5] Any new service would have to be affordable and have greater usage, while avoiding excessive demands on the relatively small psychiatrists' workforce.

Box 5.2   GP Psych Support

From 2004 to 2013, the Australian Government funded GP Psych Support, a free national advice service linking GPs to psychiatrists by phone, fax or email within 24 hours. It was managed by the RACGP, with the phone/fax arm of the service delivered by McKesson Asia-Pacific (now Medibank Health Solutions).

Each year, funding for the service was approximately $900 000. The service fielded about a thousand requests, equating to $900 per inquiry (RACGP, pers. comm., 23 July 2019).

About two thirds of inquiries to the service related to depression and anxiety. About three quarters of inquiries were related to medication (Bradstock et al. 2005, p. 90). Of GPs responding to a survey about the service:

- 99% said they would consider using the service again

- more than 85% rated the service better than other sources of advice on mental healthcare, in terms of accessibility, reliability and the appropriateness of the advice given

- more than 70% said that contact with the service had increased their knowledge and confidence in managing mental health problems, and had improved the quality of care they provided to their patients

- more than half reported an increased willingness to manage 'more complex mental health problems' (Bradstock et al. 2005, p. 90).

Following the discontinuation of the national service, other services with limited geographical reach have sprung up. This includes a subscription service run by the Black Dog Institute, but with only limited coverage. The largest such service is the GP Psychiatry Support Line, which has been jointly commissioned by 8 PHNs across New South Wales and the ACT. However, in its first year of operation (2018-19), the GP Psychiatry Support Line had a cost per service of about $750, due to low service volume (Commission estimate based on Coordinare, pers. comm. 19 July 2019). In addition, extending that arrangement to all PHNs is probably not realistic given the coordination costs involved.

The introduction of a new MBS item for phone advice from a psychiatrist to a GP would avoid these coordination costs, while providing a national service. A GP could either contact a psychiatrist that they know and trust, or go through a service provider whose function is to arrange psychiatric services over phone or videoconference (several such services are already operating). The advantage of a fee-for-service approach is that it can fund both types of approaches.

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[5]   The average fee charged by private psychiatrists for a consultation lasting less than 15 minutes was about $66 (including both the MBS rebate and the co-payment).

Psychiatrists who are providing ongoing care should be expected to provide advice to the consumer's GP as part of standard care. The MBS item should therefore be restricted to consumers who are being managed by the GP.

While the Australian Government should create such an MBS item and make GPs aware of it, given the lessons of the past, it would be prudent to evaluate the service for its cost-effectiveness after several years of operation.

DRAFT RECOMMENDATION 5.1 — PSYCHIATRIC ADVICE TO GPs

In the medium term (over 2 – 5 years)

The Australian Government should introduce an MBS item for psychiatrists to provide advice to a GP over the phone on diagnosis and management issues for a patient who is being managed by the GP. The effectiveness of the new item should be evaluated after several years.

5.2 Matching consumers with the right level of care

Under stepped care (chapter 4), a consumer presenting to the health system should be matched to the level of care that most suits their treatment needs (DoH 2019k). However, currently consumers do not have easy access to low-intensity mental health services. Many are being referred for individual psychological therapy when they would have their needs better met through more accessible, lower cost and lower intensity services.

The least intensive level of care is self-management, in which consumers are able to manage their own mental health distress or symptoms. They can be supported in this by automated digital therapies (chapter 6), or by information and education about mental health, often found online or provided by a GP. Other self-management tools include online peer support forums, and in-person support groups in the vein of Alcoholics Anonymous.

Low-intensity services are the next step up.

> [They] are designed to be accessed quickly (without the need for a formal referral e.g., through a third-party service or provider), easily (through a range of modalities including face to face, group work, telephone and digital interventions) and typically involve few or short sessions. (DoH 2019k, p. 38)

Low-intensity services include clinician-supported online treatment, telephone support services, and low-intensity cognitive behavioural therapy (LiCBT). We also consider group therapy to be low-intensity (though some others do not). Group therapy places a similar treatment burden on the consumer as individual therapy (in terms of time, effort and cost of going to sessions), but it uses resources more efficiently because a single clinician (sometimes with a helper) can provide therapy for up to 10 consumers at a time.

After medication, individual psychological therapy is the most common treatment for mental illness in Australia.

- 1.3 million people received MBS-rebated individual therapy in 2018 (Commission estimates based on unpublished MBS data) (box 5.3).

- 56 000 received individual psychotherapy at headspace centres (headspace, pers. comm., 17 July 2019).

- Up to 190 000 people received individual therapy through PHN-commissioned services (DoH 2019k, p. 16).

Box 5.3   **Psychological therapy under Medicare**

There are various psychological therapy items in the MBS ('psychological therapy' is defined as comprising both Psychological Therapy Services and Focused Psychological Strategies). They were introduced as part of the *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative* — a range of GP, allied health and psychiatrist MBS items, which were introduced together in 2006 (DHS 2018e).

Psychological therapy items can be provided by a clinical or registered psychologist, or by an approved social worker, occupational therapist or by a GP who has completed additional mental health training. The MBS rebate is different for individual and group therapy, and for individual therapy it varies according to session length and where the session is held. The rebates for clinical psychologists are higher than for other providers (DHS 2018e).

To be eligible for MBS-rebated psychological therapy, a person must be referred by a GP, a psychiatrist or a paediatrician; must be diagnosed as having a mental disorder; and for GP referrals, the GP must complete a Mental Health Treatment Plan (MHTP) (DHS 2018e).

In a calendar year, consumers can receive up to 10 sessions of individual psychological therapy as well as up to 10 sessions of group psychological therapy. However, consumers can only be referred for up to 6 sessions at a time. After this, the consumer must return to the referring doctor for a new referral. If a consumer is mid-way through a course of treatment at the end of a calendar year, they do not need to get a new referral to complete the course of treatment (DHS 2018e).

In 2018, the Australian Health Minister announced that people with anorexia nervosa and other severe psychological eating disorders would be able to access up to 40 sessions a year (Hunt 2019b).

In 2018, about 1.3 million consumers received almost 5.7 million psychological therapy sessions under Better Access, averaging 4.6 sessions each (Commission estimates based on unpublished MBS data). About 5.3 million of these were delivered by clinical or registered psychologists. Less than 1% of sessions were group sessions. And less than 0.1% of sessions were conducted with telehealth (Commission estimates based on unpublished MBS data).

Far fewer people receive low-intensity treatment.

- 7000 people received group therapy in 2018 (Commission estimates based on unpublished MBS data).

- 2000 received LiCBT through NewAccess (Commission estimates based on Beyond Blue, pers. comm., 19 July 2019).

- 4000 people received supported online treatment (chapter 6).

- about 200 000 – 400 0000 people received short-term support over the phone, through services like Beyond Blue or Lifeline (DoH 2019k, p. 18).[6]

- 30 000 people used eheadspace (some received therapy, some support) (DoH 2019k, p. 18).

Low-intensity services are not yet filling their allotted space in the stepped care system. The MBS Review Mental Health Reference Group (2018, p. 52) 'noted both the cost-effectiveness and the access advantages of digital mental health and other low-intensity solutions', and recognised the need to increase the uptake of low-intensity treatments. Beyond Blue described the need to fill this gap as 'putting the missing steps in stepped care'.

> Low intensity prevention and early intervention services – like coaching, digital and self-guided interventions – are cost effective and deliver what most people need. Yet this system is still in its infancy despite the evidence. (sub. 275, p. 5)

The Commission estimates that roughly 450 000 people — slightly more than a third of people currently accessing MBS-rebated psychological therapy (including through headspace centres) — could have their needs better met through low-intensity services (Commission estimates based on the Household, Income and Labour Dynamics in Australia survey wave 17 and custom MBS data). Consumers would continue to receive appropriate care, but with a lower treatment burden, both in terms of their time and cost.

Clinician-supported online treatments are central to this rebalancing towards low-intensity therapies. When psychological therapy was added to the MBS in the mid-2000s, supported online treatment was only in its infancy; it is now ready to be rolled out more widely. Clinician-supported online therapy is a cost-effective treatment for many consumers, (chapter 6).

Provision of clinician-supported online services falls well short of consumer needs. Given its cost-effectiveness and accessibility advantages, the Australian Government should prioritise its provision above other low-intensity services (chapter 6). In addition, the Australian Government should increase awareness among clinicians and people with mental ill-health about the availability and effectiveness of supported online treatment and other e-mental health services (chapter 6).

Other low-intensity services will also play a role. Section 5.3 proposes a range of recommendations to increase the provision of group psychological therapy under the MBS.

The benefits of increasing the role of LiCBT are less clear cut. LiCBT involves a vocationally certified 'coach' (rather than a tertiary-qualified psychological therapist) delivering a standardised structured program that they have been trained to deliver under supervision. It is best known under the NewAccess banner in Australia, and under the Improving Access to Psychological Therapies banner in the United Kingdom. NewAccess

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[6] 160 000 for Beyond Blue plus Lifeline.

has so far struggled with scale, and has failed to demonstrate cost-effectiveness (box 5.4). Nevertheless, there is potential for a greater share of therapy to be provided by low-intensity therapy coaches, and this may in some cases be more cost-effective than seeing a psychological therapist. The Commission is seeking further input from participants on this topic.

Commissioning agencies (PHNs or Regional Commissioning Authorities (RCAs) — chapter 24) are well placed to continue to investigate and experiment with different low-intensity services, and to commission the services that are best suited to the population in their region. However, they should continue to be limited to commissioning services that have an established evidence base (DoH 2019k).

Box 5.4　　**NewAccess**

NewAccess was developed by Beyond Blue and commenced in Australia in 2013. In NewAccess, consumers have an initial assessment (of up to 60 minutes) followed by up to five 30 minute sessions with their NewAccess coach. Coaches receive 7 weeks initial intensive training and 12 months of on-the-job training (Beyond Blue, pers. comm., 19 July 2019). The burden on consumers is relatively low — it can be delivered online or over the phone (as well as in person), it is free to consumers, and no referral is required. It is aimed at people with low to moderate needs, especially those who are not currently accessing mental health services, including 'hard to reach groups' such as men and people living in regional and remote communities (Cromarty et al. 2016). It is currently provided by 12 PHNs across the ACT, New South Wales and Queensland.

A 2015 evaluation of NewAccess (EY 2015) found strong positive effects on mental health outcomes. Two outcomes measures were used — PHQ9 measure for depression (scored 0–27) and the GAD7 measure for anxiety (scored 0–21) — with higher scores indicating greater severity.

Among all clients completing an initial assessment, the average PHQ9 score was 12.46 (SD=5.68), and the average GAD7 score was 11.55 (SD=5.11), while average final scores (including those who dropped out after 2 or more sessions) were about 50% lower for both measures (EY 2015, p. 46). 47% of clients showed a reliable reduction in both measures (a reduction of 5.2 or more on the PHW9 and 3.5 or more on the GAD7), and a further 29% showed a reliable reduction in one measure, and no reliable change in the other (EY 2015, p. 114).

However, NewAccess has so far struggled with service volume, and has failed to demonstrate cost-effectiveness. In the 12-months to March 2019, the highest number of sessions provided at *any* of 9 sites was 1230, and the average number of sessions per site was just 763 (Beyond Blue, pers. comm., 19 July 2019). For comparison, Beyond Blue told us that a single full-time NewAccess coach can provide about 1125 session per year (Beyond Blue, pers. comm., 19 July 2019).

Beyond Blue provided us with information about two PHNs' contracts for provision of NewAccess up to June 2020. The contracts are each for a fixed amount that does not depend on the number of sessions delivered (Beyond Blue, pers. comm., 13 August 2019). The implied cost per session is $143–$164.[7] However, the contracts assume significant increases from current service volumes. If the two PHNs instead have service volumes equal to the highest recorded for any site in the year to March 2019 (1230 sessions), the cost per session would be $207–$323.

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[7]　Assuming the average number of sessions per client remains at 3.8 (EY 2015, p. 128).

A sometimes overlooked aspect of a person-centred approach to mental healthcare is the acceptability of the treatment to the consumer, not just the likely clinical outcomes from different treatment options. The *right* treatment for a consumer depends crucially on the consumers' engagement with the treatment. Where low-intensity care is appropriate, it is preferable that the options considered with the consumer include multiple low-intensity services. In the language of stepped care, this could be described as choice along the step, not choice between steps — an approach endorsed by the Australian Department of Health (DoH 2019k, p. 33).

The Australian Department of Health's National PHN Guidance on Initial Assessment and Referral for Mental Healthcare suggests that referrers undertake an initial assessment, in partnership with consumers, 'to determine suitable and appropriate treatment choices/options' (DoH 2019k, p. 10). The assessment spans eight domains (including symptom severity and distress, risk of harm, functioning, and engagement and motivation), with the results indicating an appropriate level of care for the consumer (ranging from 'self-management' to 'acute and specialist community mental health services'). The Guidance is not a substitute for professional knowledge and clinical judgement, but is a useful guide to assist in determining the right level of care for a consumer.

PHNs share responsibility with clinicians for matching consumers to the right services. PHNs already play a role in providing information to GPs and other referrers so that they are comfortable referring people to low-intensity services within the PHN. This involves, for example, providing education sessions for GPs about new services, or sharing information about local psychological therapists running group sessions. PHNs also have a responsibility for 'monitoring the use of services to detect patterns indicating under-use (e.g., low intensity) and overuse of other interventions (e.g., psychological therapies)' and then initiating corrective action if required (DoH 2019k, pp. 54–55).

The Commission has proposed changes (the 'rebuild' model, chapter 24) that would better align incentives for commissioning agencies (PHNs or RCAs) to monitor and improve referrals in their area. If these changes are not adopted, the Australian Government should encourage PHNs to align referrals in their area with the stepped care model, for example by including this in key performance indicators for PHNs, or by tying funding to these outcomes.

PHNs also have a more direct role in assessment and referral in their role as providers and commissioners of *intake* services (DoH 2019k, p. 47). Consumers may self-refer to a PHN, or may be referred by a GP, or by other local social services. In line with the Department of Health's Guidance, PHNs' referral and assessment processes should accord with stepped care (DoH 2019k, p. 54).

DRAFT RECOMMENDATION 5.2 — ASSESSMENT AND REFERRAL PRACTICES IN LINE WITH CONSUMER TREATMENT NEEDS

In the short term (in the next 2 years)

Commissioning agencies (PHNs or RCAs) should promote best-practice in initial assessment and referral for mental healthcare, to help GPs and other referrers match consumers with the level of care that most suits their treatment needs (as described in the stepped care model).

In the medium term (over 2 – 5 years)

Commissioning agencies (PHNs or RCAs) should establish mechanisms for monitoring the use of services that they fund to ensure that consumers are receiving the right level of care. If service use is not consistent with estimated service demand, commissioning agencies may need to make changes to initial assessment and referral systems (or work with providers to do so).

Is the GP gateway working for consumers?

GPs are the first port of call for many consumers with mental ill-health, and are the common gateway to more specialised mental healthcare. In general, the GP gateway works well for consumers. GPs often know their patients well and usually have their trust, they are experts in triage, and can provide referrals to a variety of services. However, even with improvements, the GP gateway will not work for everyone. For example, consumers in regional areas often find it difficult to see a GP because of long waiting times (ABS 2018f, table 6.2).

Self-referral provides a part solution. A GP referral is usually not required for self-help services or low-intensity services. However, if consumers do not know about these services, they cannot access them. For this reason, the Commission is not only recommending greater promotion of online mental health services, but also steps to improve Head to Health, Australia's online mental health portal (chapter 6).

Some participants suggested that consumers should be able to self-refer for MBS-rebated psychological therapy in order to improve access. However, there is a risk that, without seeing a GP, consumers will not receive a medical assessment or the comprehensive healthcare they may need. For example, GPs (unlike allied health professionals) can prescribe medication, which may be appropriate for some consumers in conjunction with, or

as an alternative to, psychological therapy (NICE 2011). There may also be an increased risk of excessive use by some consumers if GPs do not perform a gatekeeper role, with taxpayers footing the bill for therapy that is not clinically necessary.

Roughly 30–40% of consumers referred to one Australian psychological therapy program were also taking mental health medication (Bassilios et al. 2016, p. 9). The Independent Private Psychiatrists (sub. 473, pp. 8–9) argued that GPs should retain their gatekeeper role so that people with more severe disorders — who may not be identified as such by psychologists — receive appropriate care.

In addition, consumers in a stepped care service model should receive treatment of the intensity they need (in terms of the treatment impact on the consumer, and the resources employed). Achieving this is partly the responsibility of the GP in their gatekeeper role. And while self-referral would increase access for some consumers who need help of this kind, it would also increase access for consumers who would be better matched with less intensive treatment (such as supported online treatment, discussed in chapter 6).

On balance, the Commission does not support allowing self-referral to MBS-rebated psychological therapy. However, PHNs currently have discretion to allow self-referral to the therapy services that they commission (DoH 2016b, p. 5), which are aimed at providing access to government-funded therapy for under-serviced groups, such as people who are homeless (box 5.5). PHNs are well placed to weigh the associated risks against the need to overcome access barriers for consumers in their area and should continue to exercise this discretion. These programs tend to have assessment processes aimed at determining whether people are suited to the program.

The GP gateway may also be improved using screening tools in GP waiting rooms. The ongoing Link-me Trial has developed a Decision Support Tool — delivered through digital tablet in GP waiting rooms — which identifies the mental health needs of people going to the GP, and provides them with tailored treatment recommendations. The trial is testing whether this leads to clinical benefits and cost savings relative to usual care (Fletcher et al. 2019). The Black Dog Institute provides a similar tool to GPs on a subscription basis. These tools are able to augment the judgement of GPs, including for early detection and intervention, and for people presenting with non-mental-health problems. And because 9 out of 10 Australians visit their GP in a year (AIHW 2019l, p. 4), the tools could provide near universal screening if rolled out widely.

> **Box 5.5   PHN-commissioned psychological therapy**
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> PHN-commissioned psychological therapy programs provide treatment for people with mild to moderate mental illness and have barriers to accessing mainstream treatment options. Typically, clients must reside or work in the PHN catchment, be socioeconomically disadvantaged, usually in addition to having another contributing factor (such as living in a regional or remote area, or being homeless, an Aboriginal and Torres Strait Islander, a part of an LGBTIQ community, or an asylum seeker). The Australian Government recommends that PHNs cap at 12 the number of psychological sessions available under these programs, except for in 'exceptional circumstances' (DoH 2019m, p. 3).
>
> These services are intended to complement the Better Access program. Each PHN has a Primary Mental Health Care Flexible Funding Pool with which to fund these services. Funding is partially offset by the quantum of Better Access services provided within a PHN (chapter 24).
>
> PNHs have more flexibility when commissioning services than provided under the Medicare Benefits Schedule. They may hire allied health professionals on a salary, or through a subcontracting arrangement. This gives PHNs a capacity to pay clinicians more if needed to provide services in some areas. They can also combine psychological therapy with a broader range of service providers, such as mental health nurses and Aboriginal and Torres Strait Islander health workers. PHN-commissioned therapy services also have the opportunity for more oversight and accountability (and for tighter control of service providers) relative to Medicare.
>
> PHNs have had responsibility for these services from 2016, replacing the Access to Allied Psychological Services (ATAPS) and Mental Health Services to Rural and Remote Areas programs) (DoH 2019k, p. 16).

> **DRAFT FINDING 5.1 — THE LINK-ME TRIAL MAY IMPROVE ASSESSMENT AND REFERRAL PRACTICES**
>
> The decision support tool, developed as part of the ongoing Link-me Trial, can improve GP assessment and referral practices by identifying the mental health needs of people going to the GP and providing the GP with tailored treatment recommendations.
>
> The extent to which this tool leads to clinical benefits and cost savings relative to usual care, should be used to inform actions taken by governments and commissioning authorities (PHNs or RCAs) to ensure that consumers are matched with the level of care that most suits their treatment need, in line with the stepped care model.

Mental Health Treatment Plans

GPs must complete a Mental Health Treatment Plan (MHTP) for a patient before they are eligible for MBS-related psychological therapy (box 5.6). Consumers may also have their MHTP formally reviewed by their GP on a return visit. A separate but related requirement that consumers must return to their GP after six sessions of therapy for a re-referral in order to access more sessions — is discussed in section 5.3.

Box 5.6	What is in a Mental Health Treatment Plan?

Medicare rules require that a **Mental Health Treatment Plan** incorporates an assessment of the patient, including:

- recording the patient's agreement for the GP Mental Health Treatment Plan service
- taking relevant history (biological, psychological, social) including the presenting complaint
- conducting a mental state examination
- assessing associated risk and any co-morbidity
- making a diagnosis and/or formulation
- administering an outcome measurement tool, except where it is considered clinically inappropriate.

In addition to an assessment of the patient, preparation of the Plan must include:

- discussing the assessment with the patient, including the mental health formulation and diagnosis or provisional diagnosis
- identifying and discussing referral and treatment options with the patient, including appropriate support services
- agreeing goals with the patient — what should be achieved by the treatment — and any actions the patient will take
- provision of psycho-education
- a plan for crisis intervention and/or for relapse prevention, if appropriate at this stage
- making arrangements for required referrals, treatment, appropriate support services, review and follow-up
- documenting this (results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date) in the patient's GP Mental Health Treatment Plan.

A **Mental Health Treatment Plan** *Review* must include:

- recording the patient's agreement for this service
- a review of the patient's progress against the goals outlined in the GP Mental Health Treatment Plan
- modification of the documented GP Mental Health Treatment Plan if required
- checking, reinforcing and expanding education
- a plan for crisis intervention and/or for relapse prevention, if appropriate and if not previously provided
- re-administration of the outcome measurement tool used in the assessment stage, except where considered clinically inappropriate.

Source: DoH (2019h, pp. 103–105).

In 2018, 1.33 million consumers had an MHTP written for them by their GP (Commission estimates based on unpublished MBS data). About 1.26 million of these consumers went on to receive MBS-rebated psychological therapy, and about 440 000 had their plan reviewed (Commission estimates based on unpublished MBS data).

There are some indications that MHTPs are not being used as an effective tool for managing care. A recent consumer experience survey indicated that 'care planning was often delivered in a perfunctory manner that satisfied requirements of government administrative [arrangements] but not those of the consumers, with comments that the process felt like a "tick box" exercise to satisfy bureaucracy' (CMHR, sub. 148 attachment 1, p. 11). The Institute of Clinical Psychologists (sub. 447, pp. 10–11) argued:

> … Clinical Psychologists by the nature of their training, have considerable expertise in the assessment and treatment of mental illness. The MHTPs provided by GP's are of little assistance to Clinical Psychologists who have specific training in mental health diagnosis and are competent to develop and implement appropriate treatment. Omitting this requirement would redirect funding from administration to treatment and improve patient care.

About 90% of GPs have undertaken a short mental health training course[8] that entitles them to a higher MBS rebate for MHTPs and MHTP Reviews than they would be for standard consultations lasting the same amount of time. For consultations lasting 20–40 minutes, the rebate is about $20 more for an MHTP consultation than for a standard consultation. For consultations lasting more than 40 minutes, the rebate is about $30 more for an MHTP consultation than for a standard consultation. In addition, the MBS rebate for an MHTP *Review* is similar to the rate for a standard consultation of 20–40 minutes, but with no requirement that the review lasts longer than 20 minutes.

It is not clear that the MHTP and MHTP Review are working as well as they could to encourage best-practice care, or that they are providing sufficient benefit to consumers to justify the higher MBS rebates. We are seeking input on changes that would ensure best-practice GP assessment, referral and management of consumers, in line with stepped care.

The MBS Review Mental Health Reference Group (2018, p. 25) recommended that MBS-rebated psychological therapy should be expanded beyond consumers with a mental disorder, to people who are considered at risk of developing a mental disorder in the next year. While some people at risk of developing a mental disorder could benefit from MBS-rebated psychological therapy, this change could greatly increase referrals to MBS-rebated psychological therapy when self-management or low-intensity service would be more appropriate. This is especially likely if alternative clinical thresholds for access to MBS-rebated psychological therapy are not introduced.

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[8] The training needed to receive these additional rebates must be completed once and takes just 6–7 hours, and it is now compulsory for all trainee GPs (chapter 11).

INFORMATION REQUEST 5.2 — MENTAL HEALTH TREATMENT PLANS

How should the requirements of the Mental Health Treatment Plan (MHTP) and MHTP Review be changed to ensure that GPs assess, refer and manage consumers in line with best practice (as laid out in the Australian Department of Health's guidance)?

- *What should be added to the MHTP or MHTP Review to encourage best-practice care?*

- *Are there current unnecessary aspects of the MHTP or MHTP Review that should be removed?*

- *Are there additional or alternative clinical thresholds (to a mental disorder diagnosis) that a consumer should meet to access Psychological Therapy Services or Focused Psychological Strategies?*

- *Should consumers continue to require a MHTP for therapy access if being referred by a GP?*

- *What new clinical thresholds, if any, should be introduced to access additional sessions beyond the first course of therapy? Should these be part of or separate to the MHTP Review? Should a MHTP Review be required to access additional sessions, instead of just a new referral?*

- *How could audits be used to ensure that clinicians are assessing, referring and managing patients in line with best-practice and the stepped care model?*

- *What information should clinicians be required to give the consumer when completing a MHTP or MHTP Review? Should they be required to give the consumer the completed and reviewed Plan?*

- *Should GPs continue to receive a higher rebate for MHTPs and MHTP Reviews than for standard consultations?*

headspace centres should be leaders in stepped care

headspace centres house GPs, psychological therapists, and other staff, who provide a range of services to young people aged 12–25, with a focus on mental health (box 5.7).

Low-intensity services are likely to be appropriate for a substantial proportion of consumers attending headspace centres, although the data available provides only a partial view. About half of young people presenting at headspace centres have either mild to moderate symptoms, or no symptoms, of 'mental health problems' (headspace, pers. comm., 16 October 2019). And while about 70% of headspace centre consumers have high or very high levels of distress (headspace sub. 204), this leaves about 30% with low or moderate distress. The Department of Health's Guidance on Initial Assessment and Referral indicated that people with mild or moderate symptoms and distress *may* be suited to low-intensity services, depending on their assessment on other domains such as functioning and risk of harm (DoH 2019k, pp. 38–39).

Box 5.7   What are headspace centres?

headspace centres aim to be accessible, youth-friendly, integrated service hubs for 12–25 year olds. The first 10 headspace centres opened in 2006, and by June 2019, there were 110 headspace centres across Australia (Orygen and headspace sub. 204). About 90 000 young people visit a headspace centre each year (DoH 2019k, p. 17).

headspace centres cover mental health, alcohol and other drugs, physical and sexual health and social and vocational participation. In 2013-14, 'mental health and behaviour' was the main reason for presenting to headspace for just under three quarters of clients (Rickwood et al. 2015b, p. 534). Services are provided on site by a range of providers, including GPs, youth workers, and vocational workers, with most mental health services provided by psychologists and other allied health workers (Rickwood et al. 2015b, p. 536).

Most psychological therapy delivered through headspace centres attracts Medicare Benefits Schedule funding and follows MBS rules (box 5.3). However, so that psychological therapy is accessible to young people, the vast majority of headspace centres provide sessions free to the consumer (without a co-payment).

headspace centres receive funding from multiple sources. In 2013-14, the MBS accounted for about 46% of funding, and the 'headspace grant' (block funding from the Australian Government) accounted for 36% (Hilferty et al. 2015, p. 88).

Headspace has published a Psychosocial Assessment for Young People, which covers ten domains and is intended for use by clinicians in headspace centres (Parker, Hetrick and Purcell 2013). In addition, guidance from headspace's head office proposed the use of lower intensity options for the management of anxiety and depression — including self-help, psychoeducation and lifestyle advice, group therapy, and online guided self-help (such as MoodGYM and e-couch, discussed in chapter 6) (headspace 2019a, 2019b). Orygen and headspace (sub. 204) stated that digital and online services 'should be viewed as a key component of a stepped care continuum – providing a first point of contact for mental health problems, as well as an adjunct support to face-to-face interventions.'

However, relatively few consumers attending headspace centres *appear* to be matched with lower intensity services. Of the young people presenting to headspace centres with a mental health problem, 75% received engagement and assessment but over 60% received at least one individual therapy session — that is, approximately 80% of those assessed were referred on to treatment that was *not* low intensity.

In addition, around 10% of those people with mental ill-health received a session of psychoeducation, 8% received a physical health, sexual health, alcohol and drug, or vocational session, 3% received group work, and 16% received other types of services (headspace, pers. comm., 16 October 2019). However, available data at a national level is limited. For example, referrals to services outside of headspace (including eheadspace) are not accurately reported.

eheadspace provides a range of services (many lower intensity), including one-on-one online chat, email or phone calls with a clinician, online group chats, and information related to

mental health. In 2013-14, 30% of young people that been to a headspace centre had also used eheadspace in the past year (Hilferty et al. 2015, p. 83). But Hilferty et al. found that:

> … young people use eheadspace to access information about centre-based services. In addition, eheadspace often fulfils the function of holding young people steady while they are waiting to access centre-based treatment and/or provides support to young people that are unable to attend a centre. (2015, p. 85)

This suggests that the headspace centre workforce tends to view eheadspace as a placeholder, rather than as an appropriate lower intensity alternative to individual psychological therapy (with the exception of young people that are unable to attend a centre).

headspace centres are well placed to continue to lead the rebalancing towards lower intensity services. Their young consumers are comfortable with technology, and more likely to engage with online services like eheadspace or clinician-supported online treatments, several of which are designed for young people (chapter 6). And they are well placed to run group therapy sessions, because (compared with most private psychology practices) they have a large flow of consumers, which makes it easier to find enough consumers for a group. Evidence supports the use of group therapy to treat depression and anxiety in children and young people (NICE 2013a, 2013b; Zhou et al. 2019). In addition, headspace centres can more easily observe how many consumers are being matched with individual therapy compared with lower intensity service, and support their clinicians to refer in line with stepped care.

In addition to reducing the treatment burden on some consumers, a shift to lower intensity services would free up resources to provide individual psychological therapy to others (and reduce waiting times). Orygen and headspace (sub. 204, p. 29) told us:

> In late 2018, Headspace National undertook a national survey of headspace centres (total of 103 centres at the time). There were 90% of centres reporting that wait times are a major concern, with average wait times comprising: 10.5 days for intake session, 25.5 days for first therapy session, and 12.2 days for second therapy session.

It is likely that assessment and referral practices in some headspace centres are in line with a stepped care approach. But the data available (albeit limited) suggests that more could be done in some other headspace centres to match consumers with the right level of care.

headspace grant funding for individual centres should be made conditional on centres meeting targets for the proportion of young people referred to lower intensity services. The targets set for each centre should depend on the full range of relevant characteristics of the young people they see, including their severity of conditions, risk of harm, and environmental factors, as set out in the Department of Health's Initial Assessment and Referral Guidance (DoH 2019k). The targets should start low and increase over time to give headspace centres time to adjust their practices, although no changes may be needed for some headspace centres.

In all cases, the decision to refer a young person to low-intensity services (as well as *which* low-intensity services), should be made in consultation with the young person, and consider their motivation to undertake different types of treatment.

Chapter 24 proposes that control over headspace funding should shift from the Australian Government (box 5.7) to regional commissioning agencies — initially PHNs and ultimately Regional Commissioning Authorities (if they are established). If this draft recommendation is accepted, regional commissioning agencies (rather than the Australian Government) should be responsible for setting the targets.

5.3 Improving psychological therapy to meet consumer needs

There is good evidence that individual psychological therapy can be an effective treatment of mental illness (Lambert 2013, p. 176). However, much of this evidence is collected in clinical trials under controlled conditions, and it is acknowledged that 'the strongest findings for the benefits of psychological therapy involve the efficacy of treatments in controlled conditions' (Lambert 2013, p. 193). And the further that real world conditions depart from the controlled conditions of a trial, the smaller is the treatment effect relative to the trial (Lambert 2013, p. 193). In other words, implementation matters.

Some consumers receive psychological therapy from their GP. As discussed in section 5.1, GPs delivered psychological therapy in at least 60 000 consultations in 2018. About a thousand GPs have done the necessary training to provide MBS-rebated psychological therapy through Better Access (GPMHSC sub. 395, p. 6).

Beyond GPs, there are three main avenues through which consumers can receive government-funded psychological therapy in primary-care settings: MBS-rebated psychological therapy (from psychologists, social workers and occupational therapists in private practice); providers working in headspace centres; and PHN-commissioned

psychological therapy programs. The creation and growth of these three avenues (mainly from the mid-2000s) has dramatically increased access to psychological therapy for consumers (Commission estimates based on unpublished MBS data), with each avenue catering to a different group. MBS-rebated psychological therapy is the largest (catering to the general population), providing services to roughly 1.3 million people a year. headspace centres (catering to young people aged 12-25 years) and PHN-commissioned services (catering to hard-to-reach consumers) each provide services to roughly 100 000 people a year (DoH 2019k, p. 19).[9]

As well as catering to different groups, the three avenues differ in their effectiveness, their cost to consumers, and their cost to taxpayers (summarised in table 5.1 and figure 5.1). While consumers have generally benefitted from the access provided by this three-way mix of services, there are measures that could improve the effectiveness of the therapy, provide greater consumer choice and accessibility, and increase value for their money.

First, as noted above, there is clinical evidence on the effectiveness of the types of psychological therapy provided to consumers under the MBS-rebated program. However, outcome data to determine the effectiveness of the program as a whole has not been systematically collected. While individual clinicians may collect relevant outcome data, for example, to report to a consumer or a GP, there are no guidelines to ensure that this data is created and collected. The data that is created is generally not available for evidence-based evaluation and, even if it were available, it is unlikely to be consistent and robust.

The absence of data limits the ability of the government to robustly evaluate and, potentially, extend MBS-rebated psychological therapy.

MBS-rebated psychological therapy has only been formally evaluated once (Pirkis et al. 2011). However, this study suffered from significant shortcomings in its ability to estimate program effects — including having a potentially biased sample of providers and consumers (Allen and Jackson 2011; Hickie, Rosenberg and Davenport 2011). A host of researchers (Berk 2019; Hickie, Rosenberg and Davenport 2011; Jorm 2018; Mihalopoulos 2019), along with the Royal Australian and New Zealand College of Psychiatrists (sub. 385), have called for a new evaluation of the effectiveness of MBS-rebated psychological therapy.

Given the size and expense of MBS-rebated psychological therapy, a new, well-funded and rigorous evaluation is warranted.[10] As part of this evaluation, relevant outcome data from an appropriate sample of clinicians would need to be collected and analysed.

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9   Better Access and PHN-commissioned services estimates excluding services delivered through headspace centres. Some people may receive services through more than one program.

10   As a very rough indication of the cost of such an evaluation, an independent evaluation of headspace by Hilferty et al. (2015) cost just under $2 million (DoH 2016b).

Table 5.1 Cost and effectiveness of psychological therapy programs

Program type	Target population	Total average cost per session	Average cost to consumers per session	Effectiveness (percent reduction in K-10 score)
MBS-rebated (box 5.3)	General population	$139[a]	53% of sessions had a co-payment, averaging $65[a]	No rigorous evaluation of effectiveness
headspace centres (box 5.7)	Young people aged 12–25	$264[b]	Mostly free	8%[c]
PHN-commissioned therapy (box 5.5)	Underserviced groups	No published data	Mostly free	No rigorous evaluation of effectiveness
ATAPS[k]	Underserviced groups	$57-$631[d]	14% of sessions had a co-payment, averaging $18[e]	26%[f]
PORTS Tele-CBT (box 5.9)	Financial hardship, geographical disadvantage	$87[g]	Free	38%[h]
NewAccess (box 5.4)	Low–moderate needs, those not currently getting help	$143–$323[i]	Free	51% (PHQ9) 53% (GAD7)[j]

[a] 2018, Commission estimates based on unpublished MBS data. [b] 2017-18 cost of occasion of service, which includes some costs related to community awareness activities (Orygen and headspace sub. 204, p. 18). [c] 2013-14 from (Hilferty et al. 2015, p. 4). [d] Costs from 2008-09, which varied between regions. The Australian Department of Health attributed the variation partly 'to the often significantly higher cost of providing services to remote parts of Australia as well as to the additional costs incurred targeting groups of people who are difficult to reach and may not otherwise access mental health services' (DoH 2010). [e] 2007–09 data from (Bassilios et al. 2016, p. 9). [f] 'Tier 1' consumers from (Bassilios et al. 2016, p. 10). [g] Average cost is across all PORTS service contacts for 2018-19 (WA Primary Health Alliance, pers. comm., 3 October 2019). [h] (Titov et al. 2019a, p. 12). [i] Range in average cost per session estimates is described in box 5.4. [j] Our calculations based on (EY 2015, p. 46). [k] The Access to Allied Psychological Services (ATAPS) program was the precursor to PHN-commissioned therapy.

Better Access's great strength is its ability to fund services at comparatively low cost. It provides psychological therapy services at a significantly cheaper per-session rate than headspace and PHN-commissioned programs. This lower cost is driven by the administrative efficiency of Medicare, the flexibility built into the system, and the minimal amount of 'infrastructure' (such as formal assessment processes) surrounding the services. Because of this efficiency, Better Access should continue to be the delivery vehicle for most individual psychological therapy, pending a new, rigorous evaluation of its effectiveness.

headspace has been well evaluated and found to be only modestly effective (Hilferty et al. 2015; Rickwood et al. 2015a; and table 5.1). Hilferty et al. (2015, p. 2) compared those receiving treatment at headspace centres with a matched control group receiving no treatment, and found that headspace had a 'small program effect' on client outcomes. Despite this, the Australian Government continues to fund the opening of new headspace centres, which are only nominally under the control of PHNs. There is no rationale to keep funding for headspace centres siloed from other regionally planned and funded services (as discussed

in chapter 24). In addition, as noted above, funding of headspace centres should be tied to targets for greater use of supported online treatment and group psychological therapy, and other self-help or low-intensity treatments.

PHN-commissioned psychological therapy plays an important role in meeting the needs of consumers who are currently underserved. However, the current level of funding is insufficient to plug the holes in the provision of MBS-rebated therapy (discussed below), and the funding mechanisms available to PHNs are limited. The Commission proposes giving PHNs more flexibility to fund individual psychological therapy in those areas where accessibility of services has lagged the treatment needs of people (chapter 23).

Figure 5.1   **Cost of providing psychological therapy programs[a]**

Total cost per service, including government and consumer costs
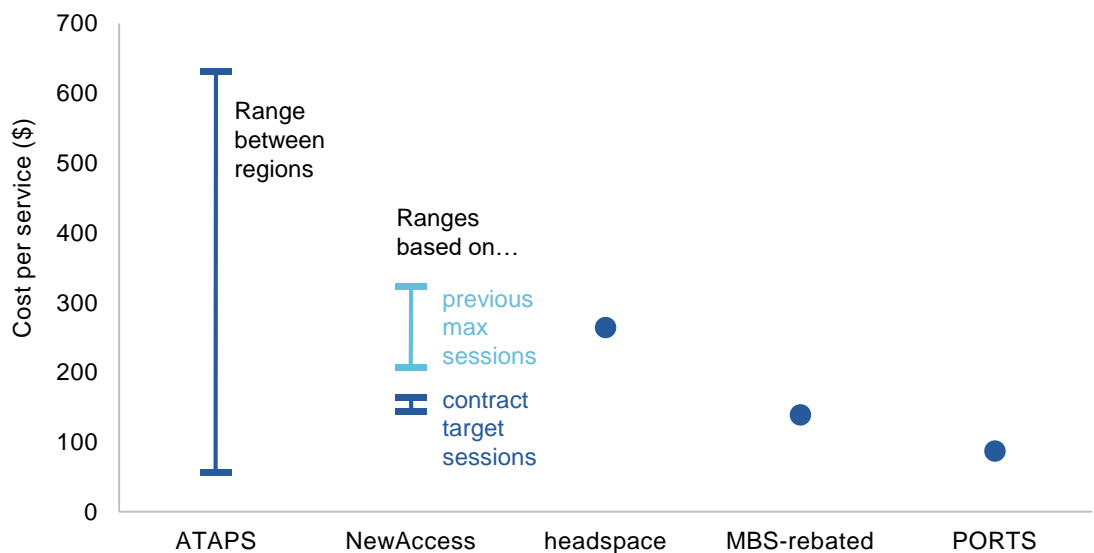
a For MBS-rebated therapy, calculated as the average rebate plus the average co-payment. For all other programs, calculated as total program cost divided by the number of services. Average cost per service for headspace, MBS-rebated therapy, and PORTS. Detail around estimates described in table 5.1. Ranges in NewAccess session costs are described in box 5.4.

Source: Provided in table 5.1.

More sessions should be available for those who need them

How many treatment sessions do people need?

Clinical evidence shows that consumers respond to individual psychological therapy differently, and recover at different rates — some quicker, some slower, some not at all. And consumers tend to stop therapy once they (along with their psychological therapist) feel they are well enough that they no longer need to continue, which may be before they have fully

recovered (figure 5.2). Baldwin et al. (2009, p. 209) found that consumers who have fewer sessions, and who get better at a faster rate, are on average less ill to begin with.

Figure 5.2   **Consumers respond differently to psychological therapy**
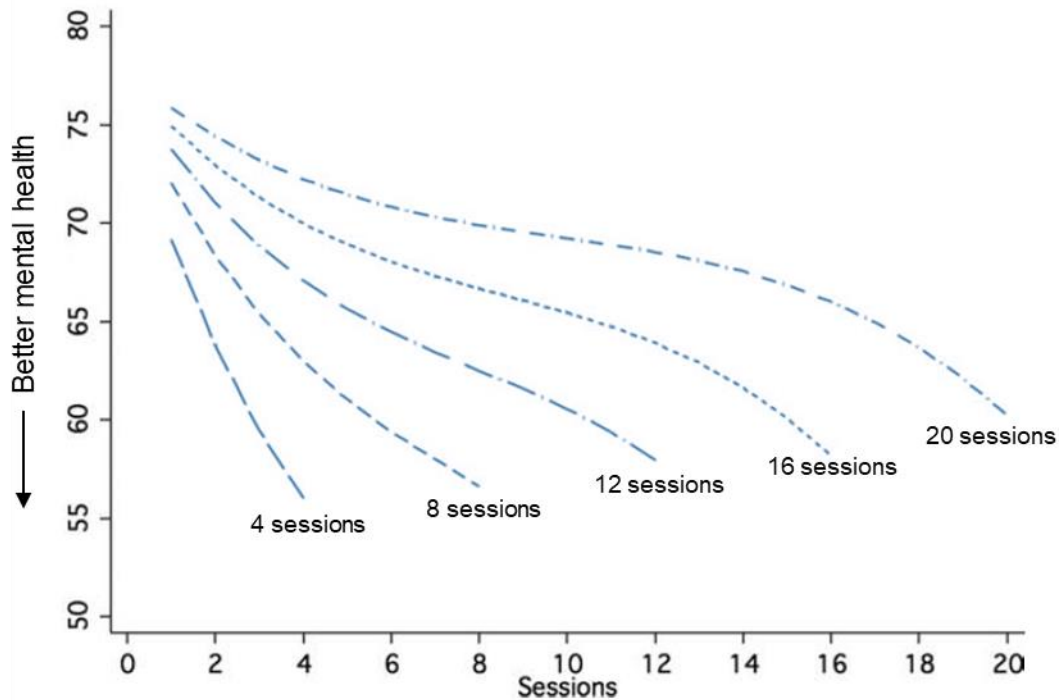
Source: Baldwin et al. (2009, p. 207).

After 3–5 sessions, only the consumers most responsive to psychological therapy have recovered. As the number of sessions increases, less-responsive consumers are also able to reach recovery, but the number recovering diminishes with each additional session. Different studies find that varying proportions of the client pool have recovered after 5, 10, 20 or 50 sessions, depending partly on how recovery is defined (Anderson and Lambert 2001; Harnett, O'Donovan and Lambert 2010; Howard et al. 1986; Kadera, Lambert and Andrews 1996; Lambert, Hansen and Finch 2001). But a constant finding is that a substantial proportion of clients recover between sessions 10 and 20.

It is worth noting that recovery is not the only aim of psychological therapy. In some cases, preventing deterioration of the person's condition may represent success.

How many sessions are people getting?

Consumers can currently access up to 10 MBS-rebated individual psychological therapy sessions a year. For PHN-commissioned therapy, the Australian Government recommends that PHNs cap individual therapy to 10 or 12 sessions a year, advising that 'only in

exceptional circumstances should the session cap be exceeded'. Another barrier, specific to MBS-rebated therapy, is the need for a new referral after 6 sessions.

While these restrictions might be acting as barriers to effective treatment, they only affect a minority of consumers. For example, of consumers accessing MBS-rebated individual therapy, we estimate that about 10% would get more than 10 sessions if the 10-session limit was removed. And that about 2% of them are dropping out after six sessions because of the requirement for a new referral (Commission estimates based on unpublished MBS data).

Most consumers are not constrained by the service limit, and do not receive sufficient psychological therapy to achieve a significant and sustained improvement in their condition. Many just get one or two sessions before they drop out (figure 5.3). Aboriginal and Torres Strait Islander people were more likely than the overall population to have only one session (22% compared with 17%) (Commission estimates based on ABS 2019e). On average, consumers received 4.5 sessions of *individual* therapy in 2018.

Figure 5.3   **Many consumers have only a few individual sessions[a]**
2018
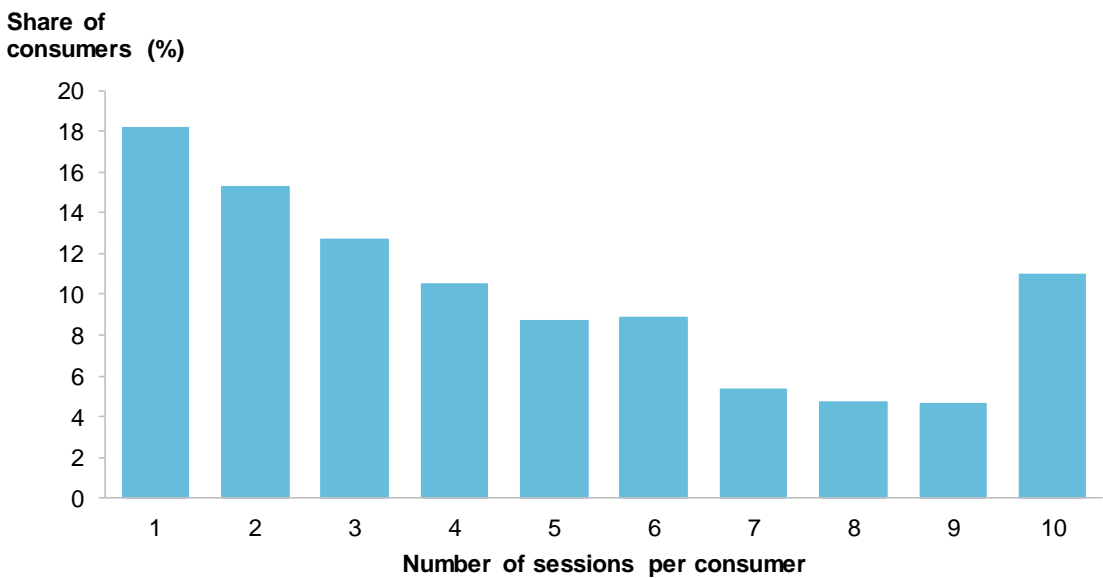
a MBS-rebated Psychological Therapy Services and Focused Psychological Strategies, including MBS-rebated therapy provided through headspace centres. The number of sessions is limited to 10 individual sessions per consumer per calendar year.

Source: Commission estimates based on unpublished MBS data.

People stop therapy before they are better for several reasons.

- Therapy can impose a significant burden on the consumer. Just over half of sessions have a co-payment, and those that do average $65. There are other incidental costs — such as lost income, childcare and travel. These amount to about $60 for attending just one face-to-face psychological therapy service (Anderson et al. 2016). One reason for consumers preferring low-intensity treatments, where appropriate, is that the burden on them is lower. To help reduce the burden of individual therapy, we propose that more consumers should be able to access it via videoconference.

- Some consumers do not establish the necessary therapeutic rapport with the psychological therapist to which they are referred, and then drop out. Less than 3% of those who received MBS-rebated psychological therapy in 2018 went to more than one provider (Commission estimates based on unpublished MBS data). Increased consumer choice of therapist — an imperative explored further below — would better sustain a strong 'therapeutic alliance'.

- Some consumers may feel they are not getting benefit from treatment. Psychological therapists could do more to demonstrate the benefit of therapy, for example by regularly measuring consumer outcomes and sharing these with consumers (Gondek et al. 2016).

Session limits for psychological therapy should be raised

Notwithstanding that most consumers did not use the available quota of sessions, many consumers and carers complained that current session limits were insufficient and should be raised (for example, comment no. 2, service providers and mental health workers; comment no. 19, interested persons; comment no. 12, carers and family members) (box 5.8). This echoes findings from the 2014 National Mental Health Commission Review, where the session quota was the primary source of complaint about mental health services by both the public at large and clinicians (NMHC 2014c, vol. 3, pp. 11, 14).

Higher session limits that are in line with the clinical evidence for treatment of mental disorders should increase the scope for more people to get the help they need, although there are divergent views about how best to increase session limits.

The MBS Review Mental Health Reference Group (2018, pp. 34–36) recommended a three-tiered system, with 10 sessions available annually for the first tier, 20 for the second tier, and 40 for the third tier. They were not prescriptive about what would qualify someone for a higher tier, although a re-assessment and re-referral from the GP would be required to move up a tier. The Australian Psychological Society (2019) and the Institute of Clinical Psychologists (sub. 447, p. 13) have made similar recommendations.

Box 5.8   Participants views on the 10 session MBS limit

One carer told us:

> My daughter … was discharged from Headspace and we then found a fabulous psychologist who has really made a difference with her varied and many issues. The visits were initially weekly, then fortnightly and this frequent therapy has been a real stabilising influence to my daughter's quality of life. Now that NDIS have ceased the core funding for psychology therapy, we have been forced to utilise the 10 sessions allocated by Medicare in a Mental Healthcare Plan. This means that instead is seeing her therapist fortnightly, she has gone to every 4-5 weeks. I have seen how this has impacted on my daughters mental health. Anybody can access the Medicare funded sessions, but why can't there be more funded sessions for those with a diagnosed mental illness when those sessions form the basis of their treatment? Once the ten sessions are used, it means $150 out of pocket for each essential therapy session. This is a constant source of frustration, stress and angst. (comment no.12, carers and family members)

This sentiment was echoed by clinicians. The RACGP (sub. 386, pp. 12–13) told us that the limit of 10 sessions, or six sessions without a review:

> … does not adequately cover the complex mental healthcare needs of some patients, particularly Aboriginal and Torres Strait Islander peoples. Excessive out-of-pocket costs results in patients often having no alternative treatment options, requiring them to cycle back to their GP for assistance. The RACGP urgently recommends the adoption of greater flexibility on the number of sessions to enable appropriate access to mental health care.

And the Institute of Clinical Psychologists in Private Practice (sub 447, p. 12) told us that:

> The current restriction of psychological therapy to 10 sessions per annum irrespective of mental health condition runs the risk of relapse and/or exacerbation of symptoms where treatment is left incomplete. For patients with moderate to complex needs it has created a situation where it can be unethical to even begin treatment, because it could not be properly delivered.

The NSW Government (sub. 551, p. 15) told us that the 10-session limit:

> … results in patients rationing their sessions, or running out of sessions prior to the threshold for effective therapy being reached. It also results in patients inappropriately relying on pharmacotherapy alone (or with no other strategies) without adequate access to the necessary psychological therapies for recovery from mental illness.

However, the proposed upper limit of 40 sessions was premised on the view that consumers with severe and complex mental illness did not receive adequate care through other mechanisms (MBS Review Mental Health Reference Group 2018, p. 36). It would be better to remedy that deficiency through increased funding for state and territory community mental health services (chapters 7 and 23), recognising that high-need consumers are often best served by state and territory mental health services (DoH 2019k, p. 18). These team-based services are better able to facilitate coordinated care among multiple providers, as required by these consumers (chapter 7). In this setting, longer courses of psychological therapy can be provided if required.

Several factors suggest that in practice a limit of 20 sessions per year would strike a reasonable balance between the desire to help more consumers recover with psychological therapy, and the need to allocate limited resources to where they are likely to provide the most benefit (including the limited number of psychological therapists). The limit would apply to both individual and group sessions in combination (group therapy is discussed

below). The National Institute for Health and Care Excellence (NICE) in the United Kingdom, which uses rigorous processes and evidence to establish what healthcare provides good value for money, recommends up to 20 sessions for a range of common mental disorders (figure 5.4). Originally, the Better Access program allowed up to 18 MBS-rebated psychological therapy sessions a year.[11] The limit was reduced from 18 to the current level of 10 in 2012, motivated by budgetary pressures (Littlefield 2017). The National Mental Health Commission's 2014 Contributing Lives Review recommended that the number of available sessions under Better Access be increased to 16 in a calendar year, but that those consumers identified as likely to require the additional sessions be referred to clinical psychologists (Littlefield 2017).

These changes to the MBS should be trialled and evaluated. The evaluation should also inform the clinical thresholds to be used for consumer access to MBS-rebated therapy, and to additional sessions after an initial course of treatment.

Any trial would also require that relevant outcome data be collected and analysed. Given that the data requirements are likely to significantly overlap, and to avoid unnecessary delay, it makes sense for the trial to run simultaneously with the evaluation of the Better Access program.

Finally, there would also be benefits in moving from the current arbitrary system of a allowing each consumer a limited number of sessions per calendar year, to allowing each consumer a limited number of sessions per *12-month period*, beginning from the date of the initial referral. This would ensure a more equitable distribution of sessions. The MBS Review Mental Health Taskforce (2018, p. 74) made the same recommendation.

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[11] Consumers were allowed 12 sessions, and an additional six sessions under 'exceptional circumstances' (where 'exceptional circumstances' essentially meant that a person's GP thought their condition or care circumstances had changed enough that they needed more sessions). (Explanatory Statement, *Health Insurance Act 1973, Health Insurance (Allied Health Services) Amendment Determination 2012 (No. 1)* (Cth)).

Figure 5.4   Psychological therapy sessions recommended by NICE

Number of sessions for psychological interventions recommended by NICE clinical guidelines for mental disorders[16]

	Number of sessions*																			
Disorder and intervention	1	2	3	4	5	6	7	8	9	10†	11	12	13	14	15	16	17	18	19	20
Social anxiety disorder																				
CBT (Heimberg protocol)	16 sessions‡																			
CBT (Clark and Wells protocol)	14 sessions‡																			
Generalised anxiety disorder																				
Supported self-help treatment	5–7 sessions																			
CBT	12–15 sessions																			
Manual-based applied relaxation	12–15 sessions																			
Panic disorder (with or without agoraphobia)																				
CBT	4–14 sessions																			
Obsessive–compulsive disorder																				
CBT + response prevention	10 sessions																			
Post-traumatic stress disorder																				
Trauma-focused CBT	8–12 sessions‡																			
Depression																				
Guided self-help	6–8 sessions																			
CBT	16–20 sessions																			
Interpersonal therapy	16–20 sessions																			
Alcohol use disorder																				
Individual CBT§	12 sessions																			
Behavioural therapy§	12 sessions																			
Social network or environment-based therapies§	8 sessions																			
Behavioural couples therapy§	12 sessions																			
Bulimia nervosa																				
CBT for bulimia nervosa	16–20 sessions																			

CBT = cognitive behavioural therapy. NICE = National Institute for Health and Care Excellence. * These figures do not include initial assessment sessions, which are typically required to confirm and refine diagnosis.[4] † Signifies the current cut-off of Better Access sessions. ‡ Some sessions longer than 60 minutes recommended. § Recommended in conjunction with pharmacotherapy for moderate to severe presentations. ◆

Source: Crome and Baillie (2016, p. 343).

The number of sessions allowed per referral should also be raised

MBS rules specify that consumers must return to the referring clinician for a new referral after a maximum of six sessions of MBS-rebated psychological therapy (no such re-referral is required for PHN-commissioned therapy.) When consumers return, GPs will sometimes undertake an MHTP Review, although the need for a re-referral and the role of the MHTP Review can be considered separately (the MHTP Review is discussed in section 5.2).

The arguments for such early re-referral are not compelling. Requiring a re-referral aims to prevent consumers from getting care they do not need, but ignores the capacity of the consumer or the clinician to cease treatment where that is the case. Moreover, the additional barrier to continuing treatment is also likely to deter some consumers from getting care they do need.

Equally, while encouraging collaboration and communication between the psychological therapist and GP has considerable value, this is unlikely to be achieved through a regulatory requirement as it fails to take into account consumer preferences and the clinical judgments of therapists and GPs. Collaborative care is required *where clinically relevant*, such as where there is a change in the consumer's condition, or at the end of a course of treatment (Jorm 2011).

Clinicians considered that the requirement for re-referral after six sessions posed the risk of adverse clinical outcomes:

> This review may not always be clinically necessary and may provide low-value care in situations where the referring practitioner has ongoing communication with the provider of mental health services, and/or knows that the patient will require further sessions without modification of the referral. (MBS Review Mental Health Reference Group 2018, p. 32)

> This process disrupts treatment, redirects funding from treatment to administration, and provides little if any benefit in treatment planning for Clinical Psychologists. Omitting this requirement for MBS items for clinical psychology would not compromise patient care, as Clinical Psychologists are trained and ethically bound to report to the referrer when clinically indicated, and at termination of treatment. (Institute of Clinical Psychologists, sub. 447, p. 11)

In addition, the Australian Psychological Society told us that the re-referral after six sessions can interrupt a course of group therapy, which regularly run for 8 or 10 sessions (APS sub. 543, attachment 1, pp. 2–3).

Given the drawbacks of the current requirements, the Australian Government should trial an increase (from 6 to 10) in the maximum number of MBS-rebated sessions available with a single referral — as proposed by both the MBS Review Mental Health Reference Group (2018, p. 28) and the Australian Psychological Society (2019). This change would give psychological therapists more flexibility to deliver optimal care for consumers. Where they see the need, therapists would still be able to send a consumer back to their GP for a consult, and GPs would still be able to request a consultation with the consumer. And therapists should be required to communicate with the GP at the end of a course of treatment *and* where clinically indicated. Such a system, based on clinical judgement and communication, is currently in place for GP referrals to psychiatrists, for example.

Finally, we agree with the MBS Review Mental Health Reference Group that 'the referring practitioner should use their discretion, and discuss with the consumer, when setting the referred number of sessions for any course of treatment.' (2018, p. 82). That is, referring practitioners should still be able to refer consumers for fewer sessions than the maximum allowed.

DRAFT FINDING 5.2 — THE EFFECTIVENESS OF MBS-REBATED PSYCHOLOGICAL THERAPY

Despite evidence for the clinical effectiveness of psychological therapy, there is no well-resourced and rigorous evaluation of the effectiveness of MBS-rebated psychological therapy (Psychological Therapy Services and Focused Psychological Strategies).

The clinical evidence suggests that of people with mental illness *who are best treated* through individual face-to-face psychological therapy, most need more than 10 sessions (the current MBS limit) for their condition to significantly improve.

More flexibility around the number of rebated sessions available per year would mean more people with mental illness could get the treatment they need, but this would need to be trialled.

DRAFT RECOMMENDATION 5.4 — MBS-REBATED PSYCHOLOGICAL THERAPY

MBS-rebated psychological therapy should be evaluated, and additional sessions trialled.

In the short term (in the next 2 years)

The Australian Government should commission an evaluation of the effectiveness of MBS-rebated psychological therapy. As part of this evaluation, the Australian Government should undertake trials allowing up to 20 sessions of individual or group therapy in total over a year for consumers whose clinical condition requires more than the current 10 sessions. The trials should allow a GP to re-refer a consumer after the first 10 sessions rather than the present 6 sessions.

The Australian Government should change the MBS so that the maximum number of session of MBS-rebated psychological therapy (Psychological Therapy Services and Focused Psychological Strategies) is per 12-month period, as opposed to per calendar year.

In the medium term (over 2 – 5 years)

Based on the results of these trials and evaluation, the Australian Government should determine whether to:

- roll out the trialled changes above
- to continue funding psychological therapy through the MBS, or whether some other mechanism is more appropriate
- make any other changes to increase the effectiveness of MBS-rebated psychological therapy.

More group therapy should be available for consumers

While it is not appropriate for some conditions and some people, group therapy is effective for many. In a summary of the literature, Burlingame et al (2013, p. 664) concluded:

> Taken together, the last decade of research … continued to provide clear support for group treatment with good or excellent evidence for most disorders reviewed (panic, social phobia, OCD, eating disorders, substance abuse, trauma related disorders, breast cancer, schizophrenia, and personality disorders) and promising for others (mood, pain/somatoform, inpatient).

The survey also examined whether there was a difference in effectiveness between individual therapy and group therapy:

> The "no difference conclusion" is more or less confirmed for mood disorders, panic disorders, personality disorders, schizophrenia, and eating disorders … Although there may be some disorders where the individual format seems more promising (e.g., specific trauma-related disorders), format equivalence [between individual therapy and group therapy] is convincingly supported, as are the economic advantages. (Burlingame, Strauss and Joyce 2013, pp. 664–665)

Compared with individual therapy, group therapy is very cost effective. It is funded through the MBS on a per-person basis. The total MBS rebate received by a psychological therapist running a group session increases with the number of people in the group (with a maximum of 10). However, the per-person MBS contribution is much lower than for individual therapy. For example, in October 2018 the MBS rebate for an individual session with a clinical psychologist was about $127, while for group therapy it was about $32 per person (DoH 2019h). In addition, group sessions are less likely to have a co-payment than individual sessions (45% compared with 53%), and where there is a co-payment, it tends to be lower (averaging $40 compared with $65) (Commission estimates based on unpublished MBS data). All up, the total cost per person for group therapy (including the MBS rebate and any co-payment) is about one-third the cost of individual therapy regardless of the number of people in a session or the provider type (Commission estimates based on unpublished MBS data).

Group sessions can increase consumer access to treatment, as, by definition, it allows each psychological therapist to treat many more consumers. For the same reason, group therapy typically attracts higher MBS payments for the therapist than individual therapy, although running group sessions can involve additional administrative costs and overheads (APS sub. 543, attachment, p. 2).

However, group therapy is underutilised. In 2018, there were about 40 000 sessions of group therapy sessions rebated under the MBS, compared with close to 5.7 million sessions of individual therapy, or *less than 1%* of the total (Commission estimates based on unpublished MBS data). The MBS Review Mental Health Reference Group argued that 'the uptake of group work items in the MBS should be higher, given the proven effectiveness of group therapy and the greater access to services it provides' (2018, p. 41).

There are several barriers to increased provision of group therapy. Foremost among these is the current MBS rule that group therapy must include at least six participants. The Australian Psychological Society has highlighted the difficulty of getting 6 people to attend, particularly with high drop-out rates (APS, sub. 543, p. 2). The Commission has found no evidence that therapy in bigger groups is more effective than in smaller groups. A meta-analysis by Burlingame et al (2013) found 'no significant differences' in the 'degree of improvement' due to group size. The MBS Review Mental Health Reference Group (2018, p. 40) and the Australian Psychological Society (APS 2019a, p. 40) have both recommended lowering the limit from six to four.[12]

As MBS funding for group therapy is on a per-person basis, smaller groups are likely to be just as cost-effective from the Australian Government's perspective as larger groups, so long as it does not lead to pressure to raise the per-person payment.

Against that background, there are good grounds to reduce the lower limit for group therapy from six to four people. In addition, so that participant drop out does not deter the creation or continuation of group therapy, MBS rules should allow group therapy with less than four people to continue, as long as the course of group therapy begun with at least 4 in the group.

Another barrier to group therapy is the perception that individual therapy is the default for referrals. The Australian Psychological Society told us (sub. 543, attachment 1, p. 3):

> Eligibility for the Better Access group therapy services requires that the referring practitioner specify that the referral is for group (not individual) items. Individual therapy services is the default if not specified. This requires clients to return to their GP for a separate referral for group items.

However, this requirement is not a part of the MBS. The Australian Government Department of Health (pers. comm. 17 October 2019) advised that if the referral does not specify either individual or group therapy, then the psychological therapist receiving it has the discretion to provide either therapy type (if appropriate), in consultation with the consumer.

A further barrier is that the rebate does not vary with session length. Currently, there is a standard MBS rebate for group therapy, which requires that the session length is at least 60 minutes. But many group sessions go for longer (APS, sub. 543, attachment 1, p. 2) with clinical evidence supporting durations of up to 120 minutes (National Collaborating Centre for Mental Health (UK) 2010, p. 216). Introducing MBS item numbers for longer sessions has been proposed by the APS (APS 2019a, p. 40), and is likely to increase both the quality and number of group sessions being provided.

Finally, the expansion of therapy types funded under Medicare, and the introduction of an additional item for group therapy with more than 10 participants would encourage more group therapy, though any change here would require *sufficient evidence*. Both of these changes were proposed by the MBS Review Mental Health Reference Group (2018).

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[12] The APS recommended that the limit be lowered to three in regional and remote areas.

Consumer access

Under the 2018 National Healthcare Agreement, all governments agree to 'provide all Australians with timely access to quality health services based on their needs, not ability to pay, regardless of where they live in the country' (AIHW 2018o). But someone's ability to pay, or where they live, does currently affect their access to psychological therapy.

Many participants emphasised that the out-of-pocket cost of face-to-face treatment with a psychological therapist was a significant barrier to accessing treatment (for example, ACT Government, sub. 210; CMHR, sub. 148; ESSA, sub. 91; Healing Foundation, sub. 193; NCOSS, sub. 143; RANZCP, sub. 385; ReachOut Australian, sub. 220; RFDS, sub. 361; and Victorian Government (2019b, pp. 23–24). Consumers only rarely pay out-of-pocket for PHN-commissioned psychological therapy, or therapy provided through a headspace centre. But in 2018, 53% of MBS-rebated therapy sessions had co-payments averaging $65 (Commission estimates based on unpublished MBS data). The degree to which this affects consumers' capacity to pay is mitigated by clinicians' targeted use of bulk billing. Pirkis et al. found that:

> … those with greatest levels of financial need were the biggest beneficiaries of bulk-billed services. The proportion of services that were bulk-billed increased as the level of remoteness and level of relative socio-economic disadvantage increased. The average co-payment decreased as level of relative socio-economic disadvantage increased (from $38 to $33). The average co-payment was higher among people in remote areas ($37) and people in capital cities ($37) than those in other regions ($31-$33). (2011, p. 8)

Nonetheless, where bulk billing is not provided, co-payments can add up over six or ten sessions, and will be unaffordable for some.

A particular focus of complaints was the need to pay the full price for sessions of individual psychological therapy beyond the 10-sessions-per-year limit (for example, Clive Kempson, sub. 84, p. 1; comment no. 12, carers and family members).

The uneven regional availability of psychologists (chapter 11) — the main providers of psychological therapy — also limits access to services in some locations. Major cities and big regional towns ('inner regional') have much greater provision of MBS-rebated psychological therapy than other regions (Meadows et al. 2015). Even within cities, services tend to be clustered in the inner suburbs.

Areas with low socioeconomic status are also underserved relative to areas with high socioeconomic status,[13] despite people in low socioeconomic areas often having *more* need for psychological therapy (Meadows, Enticott and Rosenberg 2018).[14] Between 2007 and 2011, areas with high socioeconomic status averaged about 160 MBS-rebated sessions per 1000 people, while areas with low socioeconomic status averaged about 90 MBS-rebated sessions per 1000 people (Meadows et al. 2015).[15] Therapy targeted at underserviced groups only partially compensates for this imbalance. In 2011-12, people on low incomes[16] averaged just over 20 psychological therapy sessions per 1000 people through the Access to Allied Psychological Services (ATAPS) program (the forerunner to PHN-commissioned therapy), while people not on low incomes averaged about 4 sessions per 1000 people (Productivity Commission estimates based on Bassilios et al. 2013).

Several policy responses would improve access to psychological therapy.

- First, the PHNs have been tasked with commissioning psychological therapy for people in underserviced groups, including those who may not be able to afford the co-payments associated with MBS-rebated services. This is a crucial role, but PHNs need help to carry it out. Chapter 23 proposes giving PHNs more flexibility and more funds, to ensure that individual psychological therapy is available to all those who need it.

- Second, consumers that continue in psychological therapy beyond the current 10-session-per-year limit for MBS-rebated therapy face a considerable financial burden. Increasing the session limit to 20 sessions per person per 12-month-period — as discussed earlier — would significantly reduce this burden.

- Third, many consumers that seek or are referred to psychological therapy would be well served by low-intensity services. We are proposing changes that would increase access to low-intensity services across Australia, including a suite of changes to encourage the provision of group therapy.

- Finally, greater use should be made of psychological therapy delivered by phone or videoconference. This has been shown to work just as well as face-to-face therapy for

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[13] As defined by the ABS Socio-Economic Indexes for Areas (SEIFA) quintiles.

[14] Proxied by the proportion of the population with a very high K10 distress score.

[15] Psychological therapy includes all sessions with clinical psychologists, registered psychologists, social workers and occupational therapists (Meadows et al. 2015).

[16] Low incomes are defined, for this purpose, as the bottom 40% of all incomes.

many people with mental illness (chapter 6 and Cuijpers et al. 2019). And it can be delivered remotely, promising greater convenience for consumers, and a more even distribution of services despite the uneven distribution of the psychological therapy workforce.

The PHN-commissioned Practitioner Online Referral Treatment Service (PORTS) in Western Australia provides a valuable example of easily accessible and effective treatment (box 5.9). Consumers referred to PORTS and assessed as being suitable are given the option of undertaking a brief course of structured 'Tele-CBT' over the phone. They receive up to four sessions, each lasting 20–40 minutes and delivered by the same psychological therapist. This service is easily accessible across Western Australia, although the therapists are based in Sydney.

PORTS Tele-CBT has been shown to be highly effective. For consumers who had three or more sessions, there was an average reduction in symptoms of about 38% (Titov et al. 2019a, p. 12). Consumers who completed the alternative treatment offered (the Mindspot clinician-supported online intervention — chapter 6) had similarly positive results (Titov et al. 2019a, p. 10).

Although not perfectly comparable, PORTS costs substantially less than most PHN-commissioned therapy, and even costs less on average than MBS-rebated therapy (table 5.1). In 2018-19, PORTS delivered almost 25 000 service contacts at an average cost of about $87. This is down from an average cost of about $243 per service contact in its first 18 months (ending June 2018), which included the costs of establishing the service (WA Primary Health Alliance pers. comm., 3 October 2019). If volumes continues to rise, the cost per service contact should continue to fall.

From November 2017, people in small and medium regional towns, remote and very remote communities (Monash Modified Model areas 4–7) have been eligible for MBS-rebated psychologist sessions by videoconference. When introduced, consumers were required to have some face-to-face consultations as part of the course of treatment to facilitate a personal connection with the mental health professional (at least three out of ten sessions, and at least one out of the first four) (DoH 2019a, p. 1). But these restrictions were removed in September 2018, so that consumers in areas 4–7 can now have *all* their MBS-rebated psychological therapy sessions via videoconference with a psychological therapist anywhere in Australia. Consumers rarely face a co-payment for these sessions. And services such as Call to Mind have sprung up to help connect GPs and consumers with therapists (Call to Mind 2019). While it is too early to determine the extent to which these changes increase access, they appear to offer a promising solution to the difficulty of accessing face-to-face psychological therapy in these areas.

Box 5.9 **Practitioner Online Referral Treatment Service (PORTS)**

PORTS is commissioned by the WA Primary Health Alliance, which runs all three PHNs in Western Australia, and co-designed with Mindspot (chapter 6). On referral from GPs, it provides psychological assessment, treatment, and consultation services across the state to adults (aged 16 years and up) with anxiety, depression and substance use problems. It is aimed at patients experiencing financial and/or geographical disadvantage, or some other barrier to accessing care (Titov et al. 2019a, pp. 3–4). Reflecting these eligibility criteria, in the first 18 months of operation almost half of patients were in the lower two quintiles of socioeconomic disadvantage (Titov et al. 2019a, p. 8).

PORTS offers two treatments to consumers assessed as suitable:

- a brief telephone-delivered intervention, based on strengths-based CBT ('Tele-CBT'). Treatment is delivered by the same psychological therapist at a pre-scheduled time over one to four structured sessions, each lasting 20–40 minutes

- a clinician-supported online CBT intervention (a version of the Mindspot Wellbeing Course). A hardcopy workbook version is also available. Again, each patient works with the same therapist throughout treatment, who provides brief weekly therapy using a combination of secure email and telephone contact.

Both these services are lower intensity than face-to-face psychological therapy in that the treatment burden on the consumer is lower. They are free to the consumer, the time commitment is less, and treatment is more easily accessible. However (unlike NewAccess LiCBT) all therapists are mental health professionals (primarily registered psychologists), and psychiatrists provide consultation, supervision, and training (Titov et al. 2019a, p. 5). Patients and GPs can also contact therapists during business hours. Therapists work from the Mindspot Clinic at Macquarie University in Sydney.

During PORTS first 18 months of operation, about 25% of those referred to PORTS receive information or an assessment, but did not require or chose not to have any further treatment (Titov et al. 2019a, p. 8). Close to 20% were referred on to other services, including crisis services, or for face-to-face therapy. The referrals to face-to-face services occurred where a person or their GP indicated a preference, or where PORTS' therapists concluded face-to-face care was more appropriate because of symptom complexity, language, cultural reasons, or cognitive impairment (Titov et al. 2019a, p. 8). Of those that began treatment through PORTS, 64% completed the Tele-CBT, and 61% completed the Mindspot Wellbeing Course (Titov et al. 2019a, p. 8).

Since launching in 2017, over 700 GPs from across Western Australia have registered with PORTS, and more than 3000 consumers have received PORTS services (MindSpot, sub 178, p. 13). The service was co-designed with GPs and integrated into practice software to help GPs quickly refer consumers to care. The service also provides feedback back to GPs about their patients' progress.

However, as described above, accessing psychological therapy can also be challenging for consumers in metropolitan areas, regional centres and large regional towns, where the MBS does not currently fund psychological therapy by videoconference (Monash Modified Model areas 1–3). There may be few affordable providers in their area, or they may live relatively close to a psychological therapist, but struggle to get to a face-to-face session because of work or family commitments, or because their mental illness makes it hard for them to leave

the house. The requirement to attend all sessions in person can also make it harder to maintain sufficient attendance during a course of group therapy.

These consumers (in areas 1–3) should also be able to access MBS-rebated psychological therapy by videoconference. However, as a personal connection with the therapist is valuable, at least three out of every ten sessions should be face-to-face, including at least one out of the first four sessions. This replicates arrangements for delivery of psychological therapy by videoconference for areas 4–7. However, for consumers in areas 1–3, there should be no requirement that the consumer and clinician are at least 15 km apart at the time of consult, as this would unnecessarily undermine the benefits of the reform.[17]

DRAFT RECOMMENDATION 5.6 — PRACTITIONER ONLINE REFERRAL TREATMENT SERVICE

Commissioning agencies could learn from the success of Practitioner Online Referral Treatment Service (PORTS) in Western Australia in improving accessibility and effectiveness of online mental healthcare treatment options.

In the medium term (over 2 – 5 years)

Commissioning agencies (PHNs or RCAs) in other States and Territories should consider implementing the PORTS model, or incorporating aspects of the PORTS model into their services.

DRAFT RECOMMENDATION 5.7 — PSYCHOLOGY CONSULTATIONS BY VIDEOCONFERENCE

Widening access to psychology consultations by videoconference.

In the short term (in the next 2 years)

- The Australian Government should change MBS rules so that videoconference can be used for MBS-rebated Psychological Therapy Services and Focused Psychological Strategies by consumers residing in metropolitan areas, regional centres and large rural towns (Monash Modified Model areas 1–3) in addition to those residing in small and medium rural towns, remote and very remote communities (Monash Modified Model areas 4–7).

- For consumers in areas 1–3, at least 3 out of each 10 sessions must be face-to-face (including at least one out of the first four), and there should be no restriction that the consumer and clinician must be at least 15 kilometres away from each other.

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[17] such a restriction currently exists for consumers in areas 4–7

Consumer choice

Choice of health provider is valuable to consumers. It has intrinsic value, lets people satisfy their individual preferences (for example, for a provider that bulk bills, or in a particular area) (PC 2017c, chapter 10). Under some circumstances, consumer choice can also drive service improvements (PC 2017c, chapter 10).

Choice is particularly important in the context of therapy, where it can help 'promote a strong therapeutic alliance' between the consumer and the psychological therapist (MBS Review Mental Health Reference Group 2018, p. 22). A strong therapeutic alliance is a key ingredient to effective psychological therapy (Lambert 2013).

The National Mental Health Commission highlighted 'limited choice' as a key problem in the mental health system, and argued that the system should be aiming for 'enhanced choice of providers' (NMHC 2014c, pp. 8–9) — a goal that the Australian Government endorsed in its response (DoH 2015, p. 7). Finally, the right to choice is held up as a guiding principle for health systems, such as in the Victorian *Mental Health Act 2014*:

> Persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected. (Victorian Government 2019b, p. 11)

Current MBS rules allow consumer choice whenever the consumer is given a referral. For example, consumers can take a referral specifying one psychologist (named in the referral) to a different psychologist of their choosing. But many clinicians who write or receive referrals do not know this. And even fewer consumers understand this right when they are given a referral. Many people are also unaware of their right to go to a second, different psychological therapist with the same referral.

The Commission has previously made a suite of recommendations aimed at increasing consumer choice among private health providers, which the Australian Government is yet to implement (PC 2017c, chapter 10). These recommendations aimed to clarify — for both clinicians and consumers — the consumer's right to choose their provider. For example, we proposed that when making a referral, GPs (and other referrers) should be required to tell consumers they have a choice. And that all referrals should include a clear and simple advisory statement, advising consumers of their right to choose their provider.

DRAFT RECOMMENDATION 5.8 — INCREASE CONSUMER CHOICE WITH REFERRALS

In the short term (in the next 2 years)

The Australian Government should amend the MBS regulations for referrals to require:

- that general practitioners and other referrers advise people that they can use an alternative to any provider mentioned in a referral to a specialist or allied health professional

- that all referrals to specialists and allied health professionals include a prominent and easy to understand statement advising people that they can use an alternative to any provider mentioned in the referral.

DRAFT RECOMMENDATION 5.9 — ENSURE ACCESS TO THE RIGHT LEVEL OF CARE

The Australian, State and Territory Governments should reconfigure the mental health system to give all Australians access to mental healthcare, at a level of care that most suits their treatment needs (in line with the stepped care model), and that is timely and culturally appropriate.

6 Supported online treatment

Supported online treatment matters because …	• Clinician supported online treatment is an effective treatment option for those with low-intensity needs. • It has the potential to increase treatment coverage of those people living with mental ill-health by reducing a range of access barriers associated with face-to-face treatment, such as stigma, geography and inconvenience.

Successful intervention requires …	As a priority:
	
	• Greater integration and use of supported online treatment in the stepped care system as a low-intensity service for children, youth and adults by:
	
	   – increased funding and provision for supported online treatment to accommodate up to 150 000 participants
	
	   – an information campaign for consumers and health professionals to raise awareness of the quality and safety of the treatment and to increase the take-up of services.
	
	Additional action required includes:
	
	• Over the long term, a review of supported online treatment as a low-intensity option, including an assessment of barriers to take up, effectiveness of services and funding options.

Supported online mental health treatment has the potential to not only treat those with low-intensity needs in a more cost-effective manner, but it can also increase treatment coverage of those people living with mental ill-health, and complement other treatments people may be receiving.

The Commission has recommended that supported online treatment has greater prominence in the stepped care model as a low-intensity treatment option (chapter 5). This approach aims to better match treatment needs with what is recommended and received, in a more cost-effective approach than the current options. People living with mental ill-health can access effective treatment that has lower cost burdens on the taxpayer and, in some cases, for themselves. Supported online treatment offers scope to improve the mental health system by utilising fewer skilled mental health workers, thereby increasing the availability of these workers to assist other people living with mental ill-health.

Supported online treatment is also a fundamental element of reducing the 'treatment gap' for those with mild to moderate mental ill-health, and ultimately reducing the duration and severity of mental ill-health for these people. The treatment gap is the difference between the number of people who need care and those who receive care. Online treatment offers access to treatment for those who do not currently engage with the mental health system. It is more than just another tool that will 'help' people living with mental ill-health. It can provide effective treatments that are critical to the future successful operation of the mental healthcare system. Without integration of online treatment into the stepped care system, other solutions, such as more funding for traditional mental health treatment services, will fail because of other problems in the system, such as access barriers and workforce shortages (chapter 11).

This chapter outlines the nature of supported online mental health treatment, which represents one option in the e-mental health suite of services (box 6.1). It then proceeds to examine the benefits this treatment offers, compared with traditional face-to-face services, and the range of implementation barriers that would need to be considered in any broader roll out of this treatment.

E-mental health refers to the use of the internet and other digital technologies to facilitate engagement in, and the delivery of, mental health information and services, including suicide prevention, primarily to consumers but also carers and the broader public. It includes services delivered via phone, web chat, video, websites (including social media), applications and software, wearable devices, sensors and robots. They may be self-guided or involve real time or delayed interaction with a person, including peer support. Consequently, e-mental health covers a wide assortment of information and services delivered in a multitude of forms.

E-mental health, and the internet more broadly, also plays an important role for people living with mental ill-health and their family and friends to search for information (chapter 10), encourage help-seeking behaviour (chapters 17 & 18), engage in online support groups and seek crisis help. These are valuable tools that can help people living with mental ill-health as they receive treatment.

6.1   What is supported online mental health treatment?

Online mental health treatments are a range of automated internet programs which are used to provide treatment directly to people (table 6.1). A key element that distinguishes these treatment programs is whether they are self-guided or have some clinician support. Three major providers of supported online treatment in Australia are: Mental Health Online (MHO), MindSpot and THIS WAY UP. Each has a slightly different approach.

For some treatment, clinician support is embedded in the program (MindSpot and MHO, for example, provide the clinical support), while in other programs (such as THIS WAY UP) the participants are supported by their general practitioner, psychologist, psychiatrist or other health professionals (CRUfAD 2019; Thomas, Seabrook and Foley 2019; MindSpot, sub. 178).

Some programs offer the option between being a supported service or one that is self-guided. In the latter case, people seeking treatment receive the same therapy but the consumer undertakes the structured learning without the oversight of a health professional. Self-guidance is popular, with approximately 90% of MHO and 83% of THIS WAY UP consumers choosing this option (CRUfAD 2019; Thomas, Seabrook and Foley 2019).

The nature of online clinician support used in internet programs is different to face-to-face therapy. Support online usually involves delayed interaction via email or phone, depending on the stated preference of the participant on registration or the nature of the program. A clinician may spend time reading and providing feedback to written tasks or time may be spent in contact with a participant. Nevertheless, the clinicians providing support have similar qualifications to those providing face-to-face therapy. For example, MHO employs therapists that are either registered psychologists, or provisionally registered psychologists undertaking training in clinical psychology (Thomas, Seabrook and Foley 2019).

Treatment programs generally offer internet delivered cognitive behavioural therapy (CBT), as much of the research about effectiveness has focused on internet-based CBT (section 6.3). Nevertheless, other types of therapy have been delivered to a lesser extent, such as interpersonal therapy and positive psychology (Andersson and Titov 2014) (table 6.1). There are also a range of apps and programs, while not treatment, that promote people's mental wellbeing in the general population through, for example, mindfulness and mood tracking. The distinction between treatment and health promotion and prevention, nevertheless, is often blurred.

Supported online treatment programs are usually designed for people with mild to moderate depression, anxiety and stress. But they are also suitable for people wanting to build good mental health (Andersson and Titov 2014; Black Dog Institute 2018a; Titov et al. 2017).

What happens when you sign up for supported online treatment?

People interested in commencing supported online treatment programs undertake a self-administered assessment (for example, MindSpot or MHO) or an assessment is undertaken by their referring mental health clinician (such as, THIS WAY UP). This is to confirm that the programs are suitable for the participant, to recommend education programs that are most suitable to them and in some cases, to provide a baseline of symptoms for future comparison. In programs with self-administered assessment, some consumers only complete this assessment and choose not to proceed with the online treatment (Titov et al. 2017). The assessment process can provide valuable feedback to the consumer (Thomas, Seabrook and Foley 2019). It is important to note that participants answering an online questionnaire does not constitute a diagnosis. People who are acutely suicidal are generally not eligible for supported online treatment (Titov et al. 2017).

On commencement of treatment, participants undertake structured online education programs. These programs offer interactive learning activities to help consumers understand their mental health disorder and learn strategies to improve thoughts and behaviours, and their mental health. THIS WAY UP, for example, uses comic-based slides to make them relatable, engaging and readable. The structured learning can include real-life stories of recovery. THIS WAY UP described their treatment course in the following way:

> Each course follows a similar structure — a comic-based story of a fictional character learning about their symptoms and how to manage mental health problems through to remission. Each course has been developed and continually refined with end-users to maximise relatability, engagement and readability. For example, the Coping with Stress course slides were written at a grade 7 English reading level. (CRUfAD 2019, p. 6)

Consumers may receive homework assignments which they are expected to complete before commencing the next learning module. Some courses have a 'waiting' period between lessons to allow time for participants to practice what they have learned. Online treatment usually requires a commitment of a number of weeks to gain benefit. THIS WAY UP noted:

On average, each lesson is designed to take about 20 minutes to read and will require 3-4 hours in between lessons to complete the suggested practice activities. The courses are flexible and self-paced but designed to be completed within 12 weeks at most. From our research we know that to achieve better outcomes, it is best to do one lesson every week or two to allow time to practise between lessons. (CRUfAD 2019, p. 7).

Programs also have automated reminders for the next lesson or to support people staying 'on track' to finish a program.

Supported online programs generally track the outcomes of participants. These programs require participants to regularly complete questionnaires relevant to their mental health problems, which allows a clinician to monitor progress, safety and outcomes (Andersson and Titov 2014). Some programs have the option for GPs and other health professionals to receive the results of these questionnaires, depending on the preference of the participant or the requirements of the program.

While this description provides a general overview of supported online treatment, the nature of programs can be quite diverse (Andrews et al. 2018). The content may vary according to diagnosis (such as anxiety) and within a diagnosis group (such as specific courses for social phobia and generalised anxiety). Some courses are transdiagnostic: aimed at a group of diagnoses, such as depression and anxiety, rather than just one, such as generalised anxiety disorder. Furthermore, supported online treatment can be integrated into a triage system (for example, Practitioner Online Referral Treatment Service) and provide support to general practitioners who may not always know the best treatment options available (chapters 5 and 10).

Table 6.1   **Selected online mental health treatment programs**

Program	Developer	Mental ill-health	Type	Population	Therapy	Cost	No. courses	Course length
Mental Health Online	Swinburne University	anxiety, depression	supported self-guided	adults	CBT	free	7	12 weeks
MindSpot	Macquarie University	stress, anxiety, worry, low mood, depression, PSTD, obsessive behaviour	supported	adults, Indigenous, young adults older people	CBT	free	7	8 weeks
THIS WAY UP	St Vincent Hospital	depression, anxiety	supported self-guided	adults[a]	CBT	$35-59 free	18	13 weeks
Brave	b	anxiety	supported self-guided	3-7, 8-12, 12-17 year olds (with parent involvement)	CBT	free	4	10 weeks (based on one session per week)
Cool Kids Chilled Out	Macquarie University	anxiety	supported	3-6, 7-12, 13-17 year olds	CBT	$710	2	n.a
MyCompass	Black Dog	stress, anxiety, depression	self-guided	Adults	CBT, problem solving therapy, interpersonal psychotherapy & positive psychology	free	14	n.a
BITE BACK	Black Dog	wellbeing	self-guided	13-16 years old	positive psychology	free	1	6 weeks
HeadGear	Black Dog	common mental disorders	self-guided	Employees male dominated industries	behavioural activation & mindfulness	free	1	n.a
MoodGym	ANU	depression, anxiety	self-guided	15-25 year olds	CBT	free	1	n.a
e-couch	ANU	depression, anxiety, relationship breakdown, and loss & grief	self-guided	adults and youth	CBT, interpersonal therapies, relaxation & physical activity	free	1	n.a

[a] one program available for teenagers. [b] University of Queensland, Griffith University, the University of Southern Queensland, Griffith University and UniQuest. **n.a** not applicable as the online treatment is self-guided.

6.2 Why focus on supported online treatment?

Supported online mental health treatment has the potential to not only treat those with low-intensity needs in a cost-effective manner (chapter 5), but it can also increase treatment coverage of those people living with mental ill-health, and complement other treatments people may be receiving.

Improving treatment coverage of those living with mild to moderate mental ill-health

Supported online treatment is critical to reducing the treatment gap — that is, the difference between the number of people who need care and those who receive care — for those with mild to moderate mental illness (Batterham et al. 2015; Burns, Liacos and Green 2014).

It offers scope to improve the mental health system by providing online treatment to those who do not currently engage in the mental health system. While increasing funding for the supply of current treatment options may appear to be part of the solution, this alone will not be an effective avenue in reducing the treatment gap because:

- there are access barriers to traditional treatment that will not necessarily be overcome by more of the same face-to-face services

- there are workforce constraints: the number of health professionals that would be needed to overcome the existing treatment gap is extremely large and it would take years to train them to provide treatment, given existing qualification requirements (ReachOut and EY 2014).

Furthermore, the expansion of online treatment could potentially occur in a shorter time frame, as highlighted by ReachOut Australia:

> … given the high level of unmet need that exists right now, it is our position that we should be utilising the well-established, evidence-based online services that already operate in Australia to add more capacity to the overall mental health system, and quickly. By promoting and integrating these services into the broader mental health system we can deliver real help, right now, to the many thousands of people who need it, while we simultaneously continue the longer-term work of reforming and building the broader mental health system. (ReachOut and EY 2015, p. 18)

Complementing other treatment modes

Supported online treatment can also be used to improve consumers' interaction with the mental health system. For example, supported online treatment can provide a way for consumers to stay engaged with other therapy, by using the programs to practise the skills and techniques they are learning in traditional therapy sessions. THIS WAY UP emphasised the benefits of combining treatment types:

To suit the individual's needs, learning styles, and priorities, we do not require our users to choose our service over another. Indeed, our courses are often used as an adjunct tool that is combined together with face-to-face sessions. This allows the clinicians in the community to focus treatment sessions on complex clinical tasks and to address specific client concerns and advanced clinical interventions, rather than expending session time on standard psycho-education and fundamental CBT skills. (CRUfAD 2019, p. 9)

The providers of THIS WAY UP found that 78% of survey respondents of a recent pilot indicated that they were receiving at least one other treatment, in addition to completing their online course, including 56% receiving face-to-face therapy and 44% using medication for their mental health condition (CRUfAD 2019). In their report, they noted the benefit of skill development gained from online courses that can complement other treatments:

As the majority of our course users are currently engaged in other treatments and/or services, it is likely that our users choose to complete our programs to enhance and optimise their current care rather than completing our programs out of necessity because they have no other treatment option. Anecdotal feedback from users and research participants suggests that some have a long history within the mental healthcare system but still find our courses beneficial. This is likely because our courses teach coping skills outside of the interpersonal context of face-to-face care and the interpersonal factors which may at times become a barrier to therapeutic progress. (CRUfAD 2019, p. 16)

About 30% of MHO users are currently accessing other mental health support. Most were seeing a psychologist or psychiatrist or receiving support from their general practitioner (Thomas, Seabrook and Foley 2019).

The first steps have been taken with the e-mental health strategy

Serious consideration of e-mental health treatment as an option is possible for two broad reasons.

First, wide-scale internet access and a proliferation of smart devices and platforms that serve to connect people to each other and to services, mean that online mental health treatment is technically feasible on a sizeable scale (box 6.2).

Second, there is a growing body of evidence that shows e-mental health treatment is just as effective as traditional face-to-face services for some mental health disorders, in particular high prevalent mild to moderate disorders, such as depression and anxiety (section 6.3). The National Mental Health Commission (2014a, p. 47) outlined:

Significant advances occurring in e-mental health provide the opportunity to encourage a society where self-help is more fully integrated in the system, and that people know where to go and how to get access to the specific information and support they need. It does not obviate the need for face-to-face care when necessary, but it does reduce the need for expensive services for those things which people can do for themselves, or with their families or other support people.

> **Box 6.2** **Internet connectivity is integral to daily life**
>
> The use of the internet is fully integrated into most people's lives with Australian's accessing the internet at home as well as through mobile devices (which are generally accessible anywhere, including at home).
>
> Almost all Australians have access to the internet at home. Internet access is almost universal for households with children under 15 years, with 97% having access to the internet in 2016-17 (ABS 2018d). While lower, internet coverage among households without children under 15 is still common, with 82% having access.
>
> Mobile devices also play a fundamental role in people's daily lives. For example, approximately 90% of Australians are estimated to own a smartphone. Furthermore, as people have moved towards larger data allowances on their mobile phone plans (over 5 GB per month), the range of activities they are capable of using mobile devices for has increased (Deloitte 2019).
>
> In addition to access to smart technologies, there is evidence, especially among younger people, that usage is frequent. ReachOut Australia highlighted that the digital world, for young people, is an 'extension of who they are' and that 88% of teenagers go online more than once a day, 86% have home broadband; and 80% use a smartphone (ReachOut, sub. 220, p. 16). About half of Australian smartphone owners will check their phones within 15 minutes of waking (Drumm, White and Swieggers 2016).
>
> Not only are mobile devices being used for more activities, people are changing the way they interact with people and how they access information. Indeed, nearly 30% of mobile users do not regularly use their phone to make voice calls but are communicating more through the data-based communications channels enabled by smartphones (such as, instant messaging platforms) (Lifeline, sub. 87). This has implications for the nature of potential mental health treatment services offered digitally.
>
> While the maturing of the internet over the last 30 years has facilitated online mental health information and treatment, unreliable coverage and slow internet connection in some areas, usually outside the main cities, is a potential barrier for any expansion of this form of treatment.

Consistent with these developments, the Australian Government has progressively supported the use of e-mental health services, as an accessible and cost-effective alternative or adjunct to face-to-face care (Australian Government 2012).

In 2006, the Australian Government invested in e-mental health through the development of a number of projects under the *Telephone Counselling, Self Help and Web-based Support Programme* (now known as *Teleweb*). The early investment focused on expanding telephone counselling service centres as well as providing information, counselling and online self-help programs (Department of Health and Ageing 2006).

In 2012, the Australian Government released the *E-Mental Health Strategy for Australia* highlighting the need for further expansion of e-mental health services, including expanded youth-focused telephone and online counselling service (via headspace), an online e-mental health portal to provide pathways to services (Head to Health), and the establishment of a virtual clinic providing supported online treatment (MindSpot) (Australian Government 2012).

In the intervening years, a number of the Australian Government's initiatives have been introduced, and in particular, the supported online treatment clinic, MindSpot, has been proven to be effective in treating mild to moderate, high prevalent disorders (section 6.3). The Australian Government has also provided funding for other supported online treatment services under the Teleweb program.

The Australian Government has also begun awareness raising of e-mental health services via eMHPrac (e-Mental Health in Practice). This initiative aims to raise health practitioner awareness and knowledge of Digital Mental Health. eMHPrac provides free training and support in its use to GPs, allied health professionals and service providers (eMHprac 2019a).

While these represent the first important steps in expanding supported online treatment for people living with mental ill-health, it is now time to integrate this treatment into the stepped care system with expanded capacity. In recent years, a number of organisations have also advocated for this approach. For example, in 2014, the National Mental Health Commission recommended the implementation of more integrated e-mental health solutions with primary care (NMHC 2014a). Similarly, ReachOut Australia (2015) noted that to make the most of e-mental health, it is time to integrate online services into the broader mental health system and promote their use to health professionals and the community.

But such significant change is yet to materialise and many of the supporting structures needed for a successful, integrated and mature e-mental health system have experienced problems in their development that need to be overcome (such as consumer awareness, health professional understanding and support, and reliable internet access) (section 6.4 and chapter 10).

6.3 Benefits of supported online treatment

Reduces barriers to engaging with and accessing mental health services

There are a range of reasons why people living with mental ill-health do not access services.

Not all people with mental ill-health require treatment (for example, those with mild or transient mental ill-health. Indeed, studies have shown that as many as 50% of previously untreated individuals, who met the criteria for mental disorders, may have improved without treatment in a 12-month period (Harris et al. 2014). Others expressed the preference to manage their condition without professional assistance, and may need only information to help them do this (Harris et al. 2014). As such, a 100% treatment rate should not be expected for all people living with mental ill-health.

Others, however, can face barriers in engaging and accessing face-to-face services. These barriers include stigma and embarrassment, lack of knowledge about mental health, geographic issues, impracticality of accessing treatment, affordability of treatment and past

experience. People living with mental ill-health often face not one, but a number of access barriers.

These barriers can lead to substantial delays in getting the help that is needed. For example, the delay between onset of illness and access to treatment is, on average, 6.9 years for those experiencing anxiety and mood disorders to recognise that they have a disorder, and a further 1.3 years to get help after developing this recognition (ReachOut and EY 2015). A participant to the inquiry noted their experience:

> I was first diagnosed with depression in 2013, however it took me a very long time to acknowledge I had a problem and to seek help, and for many years I self-medicated with one, two, three or more glasses of wine a night. (comment no. 30, consumers)

Lack of treatment and delays in accessing treatment results in significant costs to the person and society (chapter 3).

Supported online treatment can help break down some of these barriers by allowing people to undertake treatment at a place and time that is suitable and convenient to them, while still having the professional guidance when required. For example, MHO stated that:

> The most common barrier that online mental health services can overcome is a preference for anonymity and a self-management–based approach. Financial constraints, convenience and lack of other available services were also reasons endorsed by a significant minority. (Thomas, Seabrook and Foley 2019, p. 16)

Overcoming stigma as a barrier to accessing face-to-face services

Stigma and embarrassment about living with mental ill-health can prevent people from seeking help from health professionals (chapter 20). Many participants remarked how stigma stopped them from looking for treatment for their mental ill-health (for example, Canberra Mental Health Forum, sub. 62; Mental Illness Fellowship of Australia, sub. 343; Outback Future Experience, sub. 107; Public Health Association of Australia, sub. 272; Queensland Alliance for Mental Health, sub. 247; ReachOut Australia, sub. 220; Royal Flying Doctor Service, sub. 361).

This stigma may be the person's own shame of having mental ill-health or concern about what other people may think, and the potential consequences of such a disclosure, for example discrimination at work or in applying for insurance (chapter 20). Stigma received from those in the healthcare system can also lead to people choosing to not access treatment or to disengage from treatment (Canberra Mental Health Forum, sub. 62).

While not addressing the attitudes and behaviours that underlie stigma, online treatment options have a level of anonymity, reducing the embarrassment and shame that individuals may experience in seeking face-to-face treatment. For example, about 32% of people who sought treatment from the MindSpot online clinic did so because of reasons due to privacy, anonymity, stigma or that face-to-face treatment is too confronting (Titov et al. 2017). Furthermore, 28% of people who participated in a treatment program had not previously accessed mental health treatment. About 41% of people who sought online treatment from

MHO state they had a preference for anonymity and 15% stated they wanted minimal therapist contact (Thomas, Seabrook and Foley 2019). Over 30% of MHO participants had never accessed other mental health services.

Even with supported online treatment, consumers can maintain a level of control over the degree of anonymity, as they can specify their preferred nature of contact with a clinician. For example, while consumers of MindSpot services are recommended to receive assessment results via phone and email, it is possible to receive these results via post or email only. About one-third of participants reported that they do not want to be contacted by phone (MindSpot Clinic 2019). THIS WAY UP also noted that consumers can choose their preferred level and mode of contact without impact on the effectiveness of outcomes:

> … in our clinician-guided programs, we advise users and clinicians to determine mutually appropriate levels of contact during program duration, in order to suit each users' unique circumstances and preferences. The nature of contact in our programs is flexible, and in our effectiveness studies (> 20 evaluations completed), we have found that email, online forum participation, text-messaging, phone and face-to-face contact are all effective methods of contact. (CRUfAD 2019, p. 14)

Stigma associated with mental ill-health, can involve multiple dimensions and while present in all communities, is more prevalent in some groups.

- In small communities, issues of stigma and privacy may be heightened given the increased visibility in the community when accessing services or the possibility people will know health professionals in a personal capacity (Queensland Alliance for Mental Health, sub. 247; Rural and Remote Mental Health, sub. 97; Volunteering Australia, sub. 412).

- Aboriginal and Torres Strait Islander people's understanding and experience of social and emotional wellbeing are very different to that of Western society (chapter 4). Orygen and headspace emphasised that stigma among young Aboriginal and Torres Strait Islander people is one of a number of barriers to access for headspace services (sub 204).

- Due to ongoing perceptions and experiences of stigma and discrimination, lesbian, gay, bisexual, trans and gender diverse, intersex and queer Australians also face access barriers to mental health services. Thorne Harbour Health (sub. 265) reported that about one-third of the lesbian, gay, bisexual, trans and gender diverse, intersex and queer Australians surveyed reported usually or occasionally hiding their sexual orientation or gender identity when accessing services.

Supported online treatment has been embraced by some of the communities that can face additional access barriers to treatment (figure 6.1). For example, approximately 8% of people participating in a MindSpot course identified as being lesbian, gay, bisexual, trans and gender diverse, intersex, which is higher than those identifying in the population (3%).

As many people living with mental ill-health do not seek treatment via health professionals due to stigma, the ability to self-refer and undertake treatment online is also reduces the access barriers to treatment (Andersson and Titov 2014; Titov et al. 2017). Self-referral is common, particularly for those programs that are promoted online. For example, about 60%

of consumers who sought treatment with MindSpot were self-referred (table 6.2). Similarly, 40% of people participating in a program with THIS WAY UP used self-referral methods such as internet searches, other websites or advertising. MHO noted that Google Analytics data show that the main source of web traffic to their site is web search and the Australian Government Head to Health website (Thomas, Seabrook and Foley 2019).

Figure 6.1   **Selected demographic characteristics of users of online treatment[a]**
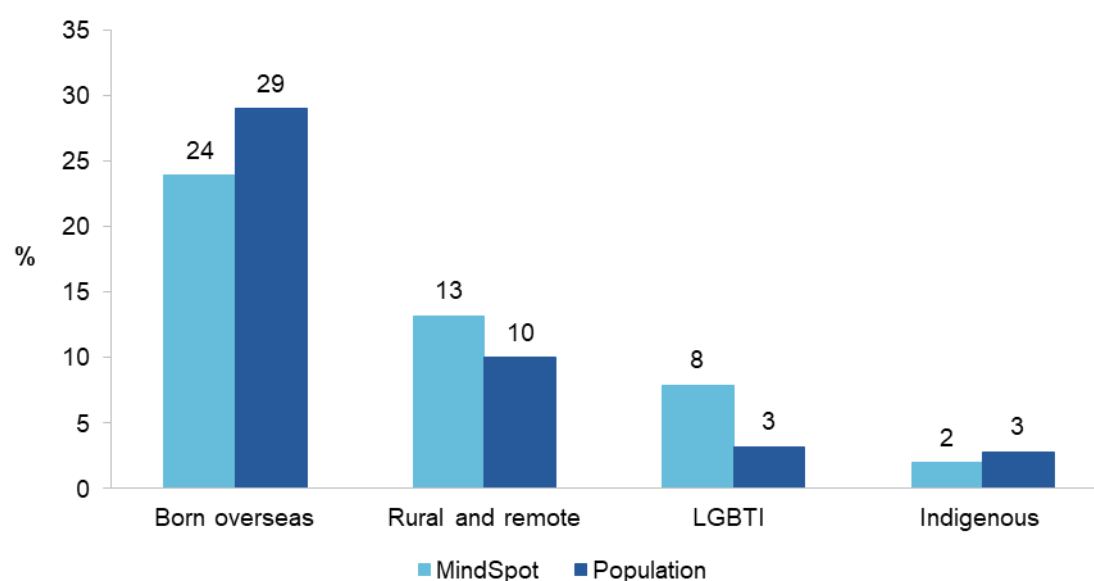
[a] LGBTI - lesbian, gay, bisexual, trans and gender diverse and intersex

Source: MindSpot Clinic (2019); ABS (2015b, 2017a, 2019f); Wilson and Shalley (2018).

Table 6.2   **Referral pathways to supported online treatment**

Pathway	THIS WAY UP	MindSpot
	%	%
Internet browsing or search[a]	35	50
Health professional	38	20
Friend or family member or word of mouth	8	10
Social media[a]	-	5
Traditional media[a]	-	3
From media or an advertisement[a]	5	-
Other	14	13

[a] Self-referral pathways

Source: MindSpot Clinic (2019); CRUfAD (2019).

Reducing geographic access barriers

Access to mental health services for those living in regional and remote areas of Australia is lower than those living in major cities (chapter 11). Those living in regional and remote areas may only have a very small number of services (if any) that they can access. This can lead to waiting lists, unsuitability or no services on offer in a town, requiring people to travel distances to access mental health services which incurs additional costs and takes time. Sometimes even travel is not an option as there are no services in neighbouring regions. The Royal Flying Doctors Service (sub. 361) submitted that 201 local government areas (out of 564) did not have a registered psychologist in 2016.

Supported online treatment has the ability to overcome geographic barriers to access, with consumers in regional areas able to receive treatment based in another city (figure 6.2). MindSpot, for example, a clinician-supported online treatment is 'moderated' out of the Macquarie University in Sydney, while 40% of users are from regional and remote areas (MindSpot, sub. 178). Furthermore, about 10% of consumers of MindSpot indicated that they access online services because of difficulty in accessing local face-to-face services or there were none that exist in the local area (MindSpot Clinic 2019). Over 45% of participants of MHO lived in regional and remote areas, with this proportion of users increasing by, on average, 5% per year over the past four financial years to 2018-19 (Thomas, Seabrook and Foley 2019). About 9% of participants of MHO state that they used the service because 'nothing else was available'. But given these responses cannot be cross classified by locality, they may include some people residing in metropolitan areas that also could not access services (see below).

Improving the convenience or practicality of treatment services

Attending face-to-face treatment services can be inconvenient. Location issues are not solely a regional and remote issue, even those living in major cities can struggle to find a suitable mental health professional in a location and at a time convenient to them. Traveling to services can take time and require time off work. THIS WAY UP noted that:

> … our online programs also service a large number of Australians living in major cities where the population density means that the demand for mental health services far outweighs the supply, and where long waiting lists in both public and private health care facilities are common place, and the breadth and depth of services can vary across health networks. (CRUfAD 2019, p. 15)

Traveling to a face-to-face service may be impractical for some people living with mental ill-health due to the nature of their symptoms. For example, a person living with mental ill-health may, at times, have difficulty leaving their house or getting out of bed, making traveling to an in-person treatment service unworkable. The Mental Illness Fellowship Australia (sub. 343, p. 28) submitted that the impact of the symptoms from anxiety and trauma may require 'significant support' to attend appointments where they are 'exposed to strangers and may feel threatened, judged or vulnerable'.

Figure 6.2   Consumers can access supported online treatment from anywhere in Australia[a]

Postcode location of MindSpot consumer 2018
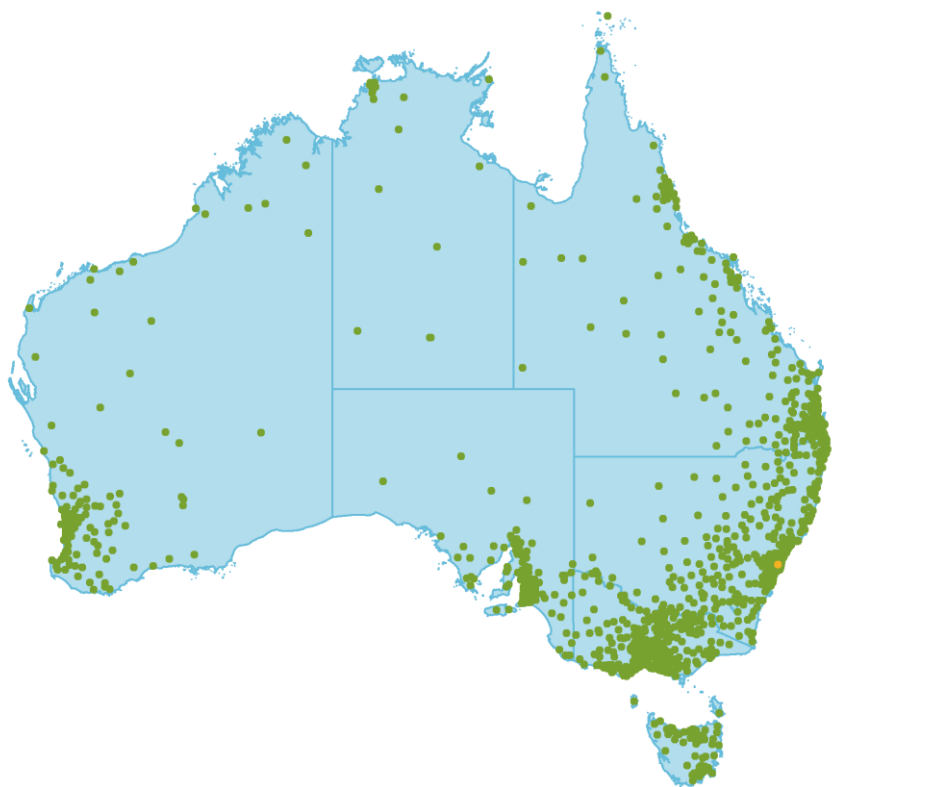
a The postcode location of MindSpot users is denoted by the green dots. MindSpot is located in Sydney, denoted by a yellow dot.

Source: MindSpot (sub. 178).

Internet-based treatment can help break down the barriers of inconvenience or impracticality by allowing people to undertake treatment at a place and time that is suitable and convenient to them. For example, online treatment options are generally available 24 hours, 7 days a week, and treatment can be accessed when and where it is safe and suitable to the consumer. THIS WAY UP noted that almost half of course registrations were made outside of normal business hours (9 am to 5 pm), with similar proportions for the times when subsequent lessons were completed (figure 6.3). They also noted that '[i]ndividuals access the website and courses at all days of the week, and more specifically 14.4% of registrations were done on a Saturday or a Sunday' (CRUfAD 2019, p. 15). Alliance Australia (sub. 213, p. 5) submitted that:

> Online access to support for employees has been investigated by Accenture with their 2018 report *Supporting mental health in the workplace: The Role of Technology*, and revealed that respondents valued digital and mobile resources for the ability to access support outside of typical business hours and from home.

Figure 6.3 **Registration for online courses occurs at all times of the day**
Time of registration for THIS WAY UP online course
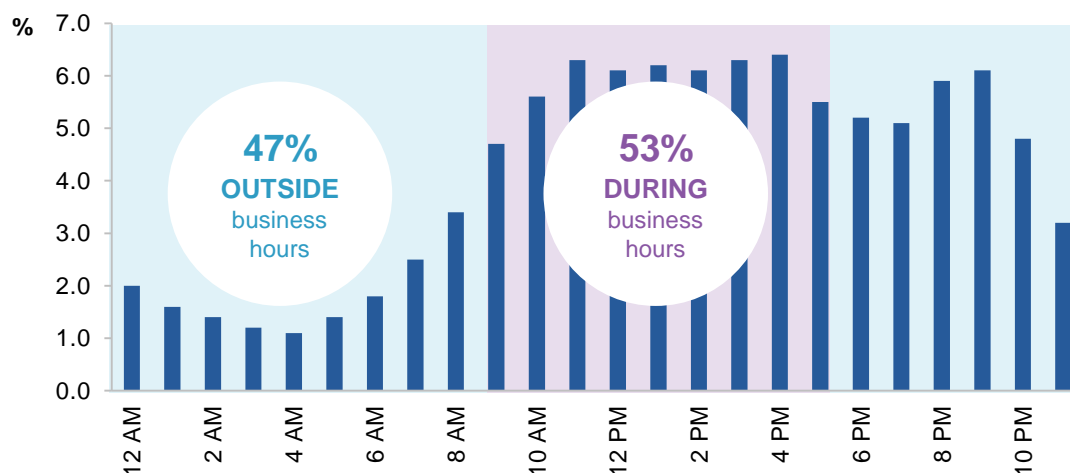
Source: CRUfAD (2019).

The convenience of treatment is of great importance to consumers. For example, almost a quarter of participants stated that the main reason for seeking treatment with MindSpot was because 'I can access online support immediately, at a time that suits me' (MindSpot Clinic 2019). In their report, THIS WAY UP noted:

> Qualitative feedback from our users suggests that work and study commitments (including shift and seasonal work), carer duties, national and international travel, and transport and mobility limitations (especially for our youngest and oldest users) make online CBT options appealing. (CRUfAD 2019, p. 16)

Evidence from the United Kingdom, reports that one of the reasons university students use technology for mental health is that it is available at night, when other sources of help are harder to access or not available (Accenture 2018).

The convenience of online treatment may mean that participants are more likely to complete the course compared with face-to-face treatment, which can be difficult to attend over a longer period of time (CRUfAD 2019). Automatic reminders and notifications are generally part of the online mental health treatment to help users stay on track with their course, and seek additional mental health support, if needed.

Providing a low cost treatment option

People accessing face-to-face treatment can pay sizable out-of-pocket costs (chapter 5). These out-of-pocket costs can impact on the affordability of treatment. Many participants have emphasised that the out-of-pocket cost of face-to-face counselling with a psychologist or other allied health professional is a significant barrier to accessing treatment (for example, ACT Government, sub. 210; Centre for Mental Health Research, sub. 148; Consumers

Health Forum of Australia, sub. 496; Exercise and Sports Science Australia, sub. 91; Healing Foundation, sub. 193; NSW Council of Social Service, sub. 143; ReachOut Australia, sub. 220; Royal Australian and New Zealand College of Psychiatrists, sub. 385; Royal Flying Doctor Service, sub. 361). One participant's experience highlights how cost, along with the logistics of attending appointments, stopped them from continuing treatment:

> At the time I was working part-time and had three young children. Getting to the psychologist appointment was complicated between work, arranging for child care and it was an hour drive to the appointment, making it a three hour round trip. Out of pocket costs were $100 per visit, plus child care. I managed three appointments (all of which were very useful and informative) before deciding it was adding to my stress levels rather than improving them. (comment no. 30, consumers)

Another participant highlighted that face-to-face CBT was only possible because their parents paid the out-of-pocket costs:

> Despite the Medicare rebates, six sessions cost over $660. I was fortunate enough to have the financial backing of my parents to make this work for me, but I am all too wary that there are many other patients who would have seen the gap and given up. (comment no. 4, consumers)

Low-cost supported online treatment provides access to those who may not be able to afford out-of-pocket costs of face-to-face treatment. For example:

- About 13% of MindSpot consumers indicated that the main reason for seeking treatment online was that they could not afford to pay to see someone, or the costs due to travel are too high (MindSpot Clinic 2019). A similar proportion of participants of MHO courses indicated that financial constraints were a reason for using online treatment (Thomas, Seabrook and Foley 2019).

- About 11% of those accessing treatment with MindSpot indicated that they were unemployed at the time of registration — which is considerably higher than the general population (figure 6.4). MHO also reported disproportional number of users not in paid employment (Thomas, Seabrook and Foley 2019).

A number of the supported online treatment programs have been developed by the university sector with various funding sources from the Australian Government. Consequently, these government funded supported online treatment programs are either free or offered at a low cost to all participants (table 6.1).

Figure 6.4   Participants of supported online treatment: labour force status

MindSpot participants[a]   *People living with mental ill-health*
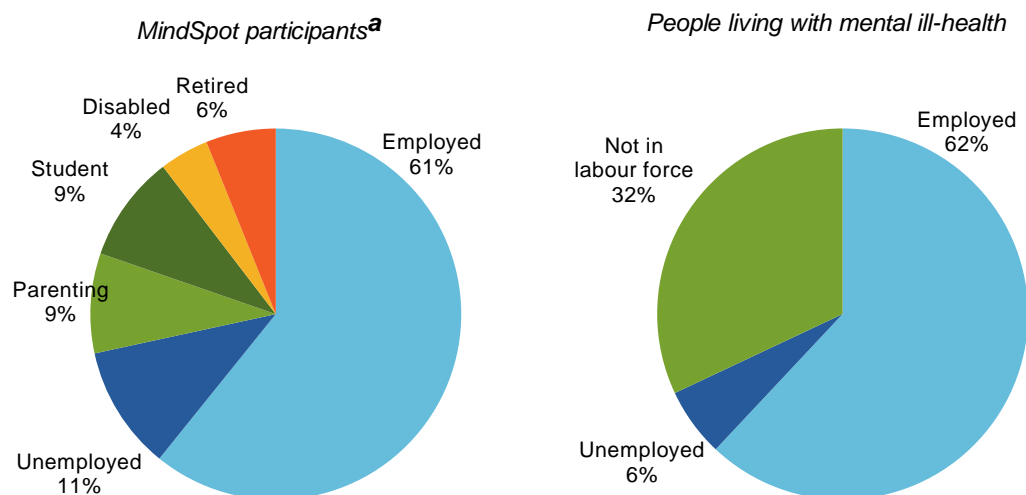
[a] Average rate over the period July 2015 to December 2018.

Source: MindSpot Clinic (2019); ABS (National Health Survey: First Results 2017-18, Cat. no. 4364.0.55.001).

Options that overcome past experience

Some consumers are dissatisfied with their experience when they have sought help in the past, including with the way they were treated, the lack of outcomes or confusion in navigating the mental health system. Online treatment can provide an option for those that have disengaged with the mental health system due to past experience. For example, 10% of consumers of MindSpot stated that they sought online treatment because 'face-to-face treatment had not helped me, or I need additional support' (MindSpot Clinic 2019)). Although, MHO noted that less than 2% of users indicated 'dissatisfaction with previous face-to-face services' as the reason for seeking help online (Thomas, Seabrook and Foley 2019).

Alleviates demand for mental health professionals in treatment

Online treatment uses a comparatively small amount of clinician time to provide treatment for most participants. For example, the average amount of clinician time per participant per MindSpot course was between 2-3 hours, with an average of 25 minutes of clinician time for an assessment. This is about a quarter of the time required for equivalent face-to-face care (Titov et al. 2017). Supported online treatment provided by MHO is about 2 hours per 12 week CBT course which is less than an estimated 8 hours for 10 sessions of face-to-face CBT under Better Access (Thomas, Seabrook and Foley 2019). Similarly, THIS WAY UP

found that it used only a fraction of the clinician time (about 8 to 16%) per treatment compared to the clinician time for face-to-face treatment:

> Similar to what we have found in our RCTs and effectiveness studies, the TWU courses only require a fraction of our clinicians' time to deliver (typically 10 minutes per fortnights vs. 60–120 mins per fortnight for face-to-face treatment). (CRUfAD 2019, p. 17)

In a meta study of online CBT, five studies reported that, on average, clinicians spent 7.8 times the amount of time on face-to-face subjects than on online patients (Andrews et al. 2018) (table 6.3).

Table 6.3   A comparison of clinician time used in therapy: online vs face-to-face

Study	Country	Supported online CBT	Face-to-face CBT
		Minutes per treatment	Minutes per treatment
Andersson et al. (2013)	Sweden	36	290
Kiropoulos et al. (2008)	Australia	352	568
Carlbring et al. (2005)	Sweden	150	450-600
Andrews et al. (2011)	Australia	18	240
Bergström et al. (2010)	Sweden	35	360

Source: Andrews (2018).

In a review of low-intensity mental health interventions, the Centre for Rural and Remote Mental Health (2017) found that, compared with high-intensity interventions such as face-to-face treatment, supported online treatment reduced the amount of time the practitioner is in contact with the patient, via fewer and/or shorter sessions, and individuals' having a greater reliance on self-help materials.

A flow on benefit of requiring lower mental health professional time is that it potentially 'releases' these professionals, who are in short supply in some fields and locations, to focus on individuals with complex, severe and potentially life threatening disorders (Hickie, Rosenberg and Davenport 2011). The 2014 National Mental Health report highlighted this benefit of online interventions:

> … e-mental health increases reach and frees up time to use clinical treatment for those people with very complex needs, such as eating disorders, major depression and anxiety, drug and alcohol addictions and psychoses. (NMHC 2014f, p. 188)

Provides an effective treatment option

There is a large and growing body of evidence showing that online mental health treatment is an effective intervention for certain disorders and for a range of groups. As many of these

trials, and those services offered as part of routine care, have focused on CBT, that is the main focus of this section.

Effective for high prevalence mental illnesses

It is well-established that supported online treatment is an effective intervention for people living with high prevalent mental ill-health (such as anxiety and depression) when they are experiencing mild to moderate symptoms (Andrews et al. 2018; Newby et al. 2016). For example, of those undertaking an supported online treatment program, the average improvement in mental health was moderate to large (approximately 0.8 standard deviation improvement in mental health) (Andrews et al. 2018). The longer term effects (9-18 months after trial completion) suggest an effect size somewhat smaller (approximately 0.2 standard deviation improvement in mental health). Given a sizable proportion of people participating in supported online treatment would have not otherwise had treatment, the relevant *counter-factual* or control group in many cases is no treatment. Consequently, the improvement in mental health resulting from supported online treatment is a gain that would not have otherwise happened.

The effectiveness of supported online treatment has also translated from clinical trials to routine care in some cases. In general, trial studies suffer from the risk that participants or other factors would not be the same as those in routine care, calling into question the size of the effectiveness (if not the efficacy itself) when the treatment intervention is provided to a broader population. Despite this possibility, the results from eight research studies of the effectiveness of supported online treatment in routine care were consistent with those of trials (Andersson and Titov 2014). There are a range of factors considered important in the successful translation of supported online treatment from trials into routine care (box 6.3).

Online treatment should not be considered an inferior option to traditional face-to-face treatment. A meta study of nine reviews, for example, indicated that supported online treatment was as effective as face-to-face therapy (Andrews et al. 2018). In addition to online therapy being equally effective as face-to-face CBT, it carries additional benefits such as fidelity of treatment. Clinician-delivered CBT is difficult to standardise because factors unique to each clinician-patient interaction can alter how and what treatment is delivered. Elements of CBT can be omitted and each individual clinician can introduce 'drift' by administering their own personal version of the intervention. However, clinician variability for supported online treatment is less likely because courses can be distributed as they were designed (Andrews et al. 2018). Nevertheless, more research is needed about the optimum frequency and form of clinician support (Andersson and Titov 2014).

> **Box 6.3   Successful supported online treatment clinics in routine care**
>
> Internationally, five clinics have successfully provided supported internet cognitive behavioural therapy as part of routine care for anxiety and depression: Internet Psychiatry Clinic (Sweden), Internetpsykiatrien Clinic (Denmark), eMeistring clinic (Norway), Online Therapy Unit (Canada), and MindSpot (Australia).
>
> These clinics were deemed 'successful' because they have provided effective treatment to large numbers of patients, and have progressed from pilot or project models to permanent services with sustainable funding. They provide supported internet CBT interventions validated in clinical trials, primarily to treat depression and anxiety disorders, as well as studies designed to monitor the effectiveness of the intervention in the general population (routine care). Each clinic provides clinician assessment of symptoms and delivers supported online CBT.
>
> There were eight factors identified as contributing to the successful delivery of internet based CBT in routine care in these five clinics:
>
> 1. developing strong clinical, information technology and organisational governance at the outset
>
> 2. having strong links with funding bodies, local health services and universities
>
> 3. being specialised and centralised health care units
>
> 4. offering programs that were validated in clinical trials before deployment in routine care
>
> 5. monitoring patient satisfaction and using patient advice and feedback to improve clinic procedures
>
> 6. developing systems to monitor quality care, in particular the regular monitoring of progress in treatment and supervision of clinicians
>
> 7. accepting self-referrals as well as referrals from health professionals, eliminating a barrier to care, and potentially attracting better informed and more motivated patients
>
> 8. developing efficient processes for conducting online and telephone assessments, and providing systems for training and supervising clinicians to manage large volumes of referrals.
>
> A limitation of this analysis, as acknowledged by the authors, is that it is based on examples of supported online treatment and does not include other models of online treatment, including self-guided online treatment or blended models of care.
>
> *Source*: Titov et al. (2018).

The effectiveness of supported online treatment compared to completely self-guided treatment programs consistently show that treatments with support lead to better outcomes (Andersson and Titov 2014; Cuijpers et al. 2019). There are important advantages of supported online treatment compared with self-guided treatment, including:

- a clinician can help determine the suitability of a treatment program for a participant

- the treatment can be tailored and advice individualised following consultation with a clinician

- clinician support can increase adherence and prevent dropout

- a clinician can actively assist participants to access other services that may be required, including social, health and crisis services (Andersson and Titov 2014).

While the existing body of evidence is largely for the effectiveness of CBT for high prevalent mild to moderate disorders, there is also some evidence that specifically designed supported online therapy may be effective in complementing specialist mental health treatment for severe and less prevalent disorders, such as schizophrenia and bipolar disorder (Thomas, Seabrook and Foley 2019). Given the developing and fast moving nature of this field, policy makers should continue to review the evidence for the effectiveness of treatment of people living with less prevalent, and more complex mental ill-health. The importance of evidence is paramount. MHO caution against making assumptions about who can benefit from online treatment:

> We have also, more anecdotally, noted that digital mental health is often automatically assumed to be just for younger people, and just for people with less severe mental health problems, rather than the full range of persons who might be able to benefit from digital resources. (Thomas, Seabrook and Foley 2019, p. 15)

Effective for a wide variety of groups in the community

Supported online treatment programs are effective for particular groups, such as women with peri-natal depression and anxiety, Aboriginal and Torres Strait Islander people, children and youth, and older people, with a number of programs specifically designed for these groups (box 6.4). Programs tailored to individual groups help overcome the lack of specialised treatment available for these groups. One participant noted that her experience with finding professionals suitably experienced in post-natal depression:

> Many of the health professionals that I sought care from or was referred to simply did not have the education and skills to provide care specific to the perinatal period. My family and I had to spend many days and hours trying to find the right professionals that would be able to help, and this came at a cost as I had ended up having to pay for private care away from my home town. (comment no. 37, consumer)

While people who were born overseas participate in general courses, there are few supported online treatments that are designed for people living with mental ill-health in languages other than English (MindSpot Clinic 2019). One such exception is the MindSpot Wellbeing Course for depression and anxiety which was translated into Arabic and adapted for cultural relevance for a trial (Kayrouz et al. 2016). This small trial found large improvements in the participants' mental health.

The adaptation of supported online treatment into languages other than English faces a number of barriers. First, the course needs to be translated into the target language and adjusted for cultural relevance. While a feasible task, the time and effort needed to adapt a course may be considerable. Second, for supported online treatment, there needs to be therapists available to provide support in the target language who also have the necessary clinical training. This may be a major constraint in rolling out effective non-English programs. THIS WAY UP offers a course in Chinese for people living with depression. This course potentially circumvents this problem if the referring clinician is fluent in this language as well. Finally, even if programs were offered in other languages, there may remain issues

of recruitment of patients, reflecting relatively low levels of mental health literacy of culturally and linguistically diverse people (Kayrouz et al. 2016).

Box 6.4   Evidence of online treatment program effectiveness for particular groups

Perinatal women

In a randomised controlled trial that evaluated a therapist-assisted six-session online CBT intervention, MumMoodBooster, for women with a clinical diagnosis of post-natal depression. Post treatment, depression symptom severity scores were significantly lower for the intervention group compared to the treatment as usual, with 79% of women in the intervention group no longer meeting diagnostic criteria for depression at 12 weeks (Milgrom et al. 2016).

A trial of Canadian women with post-natal depression found that, following a course of therapist-assisted online supported CBT, symptoms of postpartum depression decreased more for participants than compared to those participants in the waitlist control group (Pugh, Hadjistavropoulos and Dirkse 2016).

Children and adolescents

Some online treatment programs have been shown to reduce anxiety in children and adolescents. A review of 27 studies of online CBT for young people aged 12 to 25 reported a reduction in anxiety symptoms (Pennant et al. 2015) Programmes for children and adolescents that are available in Australia include the Brave Program and THIS WAY UP's TeenSTRONG. Dalton et al.(2017) concluded that the Brave Program for children and adolescent anxiety also has strong evidence to support its efficacy.

Aboriginal and Torres Strait Islander people

The proportion of Aboriginal and Torres Strait Islander people participating in supported online treatment programs is similar to the general population. For example, approximately 2% of people participating in a MindSpot course identified as being Aboriginal and Torres Strait Islander, which is similar to those identifying in the population (2.8%) (ABS 2017a; MindSpot Clinic 2019).

MindSpot's supported online programs have been found to be effective in treating anxiety and depression in Aboriginal and Torres Strait Islander people, and outcomes were similar to those of non-Indigenous patients (Titov et al. 2019b). The Indigenous Wellbeing Course is a version of the Wellbeing Course, with the same core content, but has been modified by an Indigenous mental-health worker in consultation with a range of other Aboriginal and Torres Strait Islander groups and individuals. In this study, Aboriginal and Torres Strait Islander people had higher symptom scores (at the beginning), were more likely to live in a remote location, and a third reported no previous contact with mental health services. Those Aboriginal and Torres Strait Islander people who participated in the treatment had similar rates of completion and similar reductions in symptoms to non-Indigenous patients.

Older people

Based on clinical evidence, older adults can obtain large and clinically-significant benefits from supported online treatment (Titov et al. 2015b). MindSpot offers supported online treatment, Wellbeing plus, which is tailored to adults aged 60 and over to help manage symptoms of depression and anxiety.

There are, however, gaps in the research literature relating to the effectiveness of supported online treatment for culturally and linguistically diverse people.

INFORMATION REQUEST 6.1 — SUPPORTED ONLINE TREATMENT FOR CULTURALLY AND LINGUISTICALLY DIVERSE PEOPLE

The Productivity Commission is considering recommending the expansion of supported online treatment to cater for people from culturally and linguistically diverse backgrounds. We seek views on:
- *the merits of such a proposal*
- *in what circumstances would the delivery of supported online treatment be cost-effective*
- *what constraints would need to be considered*
- *which language or cultural group should be the focus of any trial expansion.*

While supported online treatment is effective for many groups, it may not be suitable for all people living with mental ill-health, including people:

- who lack skills and confidence to use computers or other technology (such as a smart phone) to access online treatment. Attempting to use an online service may cause distress

- with limited English proficiency. In their report, THIS WAY UP noted that the Coping with Stress course slides were written at a grade 7 English reading level (CRUfAD 2019). Analysis of the text in the MindSpot courses found that the content could be understood by most grade 5 students (Titov et al. 2015a)

- who are in crisis or have suicide ideation

- taking benzodiazepine and/or atypical antipsychotics (Abbott 2016; CRUfAD 2019; Titov et al. 2017).

Some evidence on cost-effectiveness

Internet based mental health treatment is often claimed to be cost-effective or cost-saving. While the evidence is not as extensive as the effectiveness of supported online treatment, the evidence base does support this claim to some extent.

Cost-effectiveness analysis is an important tool as it helps decision-makers assess and potentially improve the performance of their health systems. It indicates which interventions provide the highest 'value for money' and helps them choose the interventions and programmes which maximise health outcomes for the available resources (WHO 2019).

Based on a study of MindSpot for people with mild to moderate symptoms of depression and anxiety who have accessed care, MindSpot costs less than the comparator group (minimum adequate treatment usual routine care) with an increase in quality-adjusted life years. The average cost of MindSpot was estimated to be $392 in 2014 dollars for an 8-week treatment course supported by a clinician. This compares with the cost of consultations of $410 for a person receiving minimum adequate treatment in usual routine care (Lee et al. 2017b).

Given the strong evidence of effectiveness of supported online treatment for mild to moderate, high prevalent mental ill-health, the Commission recommends that these treatment services should be further integrated and expanded into routine care. Services should be expanded by 150 000, comprising:

- 50 000 people who previously did not access any services

- 100 000 people making greater use of supported online treatment as a low-intensity treatment option.

The Commission would like to work with inquiry participants to refine our service level demand estimate prior to the final report.

The evidence to date on cost-effectiveness of supported online treatment also validates the expansion of this treatment. Nevertheless, government policy regarding supported online treatment would be better informed with a greater evidence base of the cost-effectiveness of this treatment (chapter 25).

In the short to medium term, funding for an expanded number of supported online services should be grant funded (as the sector is now). However, with a maturing of a number of providers in the sector, consideration should be given to overall funding having an activity component. This would allow funding to increase as the service treated more people and, if the expansion was slower than anticipated, some funding would not be received.

To further integrate online treatment into the stepped care model, for those people referred to the service by a clinician, treatment information should be provided back to the referring clinician. More generally, online service providers should annually publish summary output for clinicians on use of their services, treatment provided, and any measurable outcomes (draft recommendation 6.1).

To encourage take-up of supported online treatment, there is merit in offering programs free of charge to the consumer to remove cost access barriers. Nevertheless, there is some evidence of greater engagement and adherence to completing the treatment program when the consumer pays a small fee (CRUfAD 2019). The Commission will investigate this issue prior to the release of the final report.

DRAFT RECOMMENDATION 6.1 — SUPPORTED ONLINE TREATMENT OPTIONS SHOULD BE INTEGRATED AND EXPANDED

The Australian Government should facilitate greater integration and use of supported online treatment, into the stepped care model as a low intensity service, for people living with mental ill-health with mild to moderate symptoms.

In the short term (in the next 2 years)

- Funding should be expanded for services to accommodate up to 150 000 clients per year in supported online treatment.

- Supported online treatment programs offered should each have a strong evidence base for their efficacy and be offered to children, youth and adults.

- To aid integration of healthcare services, supported online treatment should have the option for outcomes data to be forwarded to a nominated GP or other treating health professional. Online service providers should annually publish summary output on use of their services, treatment provided, and other measurable outcomes.

In the long term (over 5 – 10 years)

- A review of supported online treatment services as a low intensity option should be undertaken. This review should assess whether there are any barriers to take up, the effectiveness of the services contracted and future funding options.

Inquiry participants frequently highlighted the scope to offer more treatment online. Nevertheless, they emphasised that any increase in provision of treatment via online methods should be offered in addition to traditional treatment methods (such as face-to-face treatment), with consumers having the choice (box 6.5). It is for these reasons that the Commission recommends that supported online mental health treatment is one choice among a range of low-intensity treatment options (chapter 5). Furthermore, it is not proposed by the Commission that policy settings would override the ability of a GP or other health professional to refer consumers to undertake face-to-face consultations, if that is what best matches the treatment needs of the consumer.

Box 6.5   Selected participants' view online treatment as but one option

Centre for Mental Health Research

The provision of online treatment programs, as well as face-to-face interventions, is important. (sub. 148, p. 7)

NSW Council of Social Services

In addition, while telehealth and digital solutions certainly have a place in promoting and servicing mental health, they do not replace the need for people to be able to access face-to-face services.(sub. 143, p. 10)

National Mental Health Commission

Digital technology can also be useful for remote service provision and as an adjunct to the workforce in rural and remote areas, including as a method of providing distance education and training, and e-supervision to health professionals. However, these should not be a substitution for face-to-face care. (sub. 118, p. 24)

Queensland Alliance for Mental Health

In summary, digital therapies should supplement, but not make redundant, remote, practitioner-based services. (sub. 247, p. 7)

Rural and Remote Mental Health

Although there are many ways of communicating with people living and working in rural and remote Australia, including various tele-health and internet-based platforms, there is and will continue to be a need for face-to-face communication. (sub 97, p. 13)

BrainStorm Mid North Coast

We do not believe that tele-health is a substitute for face-to-face services with a health care professional. Tele-health services may offer an adjunct to physical services but not a replacement. (sub. 309, p. 10)

6.4   What could limit the take-up of supported online treatment?

While supported online treatment could be a suitable form of intervention for people living with mild to moderate mental ill-health, there are a range of reasons consumers may not take up this option.

Happy to use 'Dr Google' but prefer face-to-face treatment

For all health matters, consumers are receptive to using the internet for *information*. In 2016-17, 46% of internet users accessed health services or research, increasing from 22% in 2014-15 (ABS 2018d). Consistent with this, about 28% of surveyed GP patients had sought health information online and 17% obtained information related to problems managed by the GP in 2013 (Wong et al. 2014). While the 'Dr Google' experience of gathering information about health concerns is commonplace (1 in 20 google searches are health-related), people also seek support from other internet users via 'chat rooms', online discussion forums, blogs, or social media (ABC 2017; BetterHealth Channel 2014).

Consumer willingness to use digital information for mental health also appears to be widespread. The Mission Australia and Black Dog Institute youth survey showed that the internet was a source of information, advice and support that most young people felt comfortable turning to (85 to 90% surveyed) (Ivancic et al. 2014). An early evaluation of MindSpot noted that, of those who completed an assessment, only 30%, proceeded on to treatment. The two main reasons for this was that the participants were seeking an assessment or information about local mental health services (Titov et al. 2015a).

The evidence of consumers' openness to receiving mental health *treatment* online, however, is limited (and what is available is somewhat dated and sometimes based on small samples). This makes it difficult to determine the acceptability of online treatment to consumers and the likely capacity of take-up (box 6.6). However, studies that examined consumer preference found a preference for face-to-face therapy over online treatment, but not an aversion to this option (Meurk et al. 2016). People who preferred traditional face-to-face services viewed them as more helpful, more personal, and also preferred that body language can be assessed, a trusting environment, the help-seeker knows who they are talking to and there is customised feedback (Bradford and Rickwood 2014; Klein and Cook 2010).

More generally, consumers have raised concerns about online mental health applications, including that they are overwhelmed by choice of online options and have no real method of determining the quality and safety of the applications on the market, with privacy a key concern of consumers. When consumers are uncertain or overwhelmed by the information they have access to, they can often default to the status quo, in the case of mental health treatment, this is usually face-to-face services or no treatment.

Ultimately, the aim is to develop methods to assure people that supported online treatment is safe and effective, to increase the trust and confidence of consumers and carers, leading to greater adoption rates of these services that can potentially deliver benefits.

One method is through a certification framework. The Australian Government is currently in the process of developing safety and quality standards and a certification framework for e-mental health services. A consultation process was held in the first half of 2019. A draft certification framework is expected to be released in the first half of 2020. The Commission supports the principle of a framework as its aim is to improve information and decision making of consumers. However, a well-known challenge of any certification or standards framework is to provide consumers' with information and greater certainty, while ensuring they are flexible enough to encourage investment and innovation in the sector.

Another method of providing greater assurance of the safety and effectiveness of supported online treatment is through a consumer information campaign (draft recommendation 6.2). Ideally, this would use multiple avenues including websites, brochures, the media, and intermediaries such as schools and libraries. One challenge posed for the effectiveness of information campaigns is reaching consumers in the target group — that is, people living with mental ill-health with mild to moderate symptoms. An understanding of the barriers to engagement with supported online treatment would help assist a successful information

campaign and ultimately the uptake of supported online treatment. This may provide an opportunity for co-design with people with lived experience (chapter 22).

Box 6.6   **Preference for face-to-face mental health treatment is strong**

All consumers

Klein and Cook (2010) found that 77% of respondents preferred face-to-face treatment services and only 10% indicated that they would not use online mental health (services sample size=218). They also found evidence that those who had previously accessed online counselling were more likely to prefer online services than other respondents.

Based on a Relationships Australia survey (2018), about one-third of women (32%) and men (33%) reported that they do not prefer to use online mental health services over other in-person forms of support. Just over half of female respondents (52%) and 45% of male respondents stated they would prefer to use more than one form of mental health support.

Young people

Mission Australia and ReachOut (2018) found that 53% of young people nominated face-to-face services as their preferred service type, followed by 44% indicating online, 21% suggesting phone and 13% stated that they would not seek help from any of these.

Mission Australia and Black Dog Institute (2014) found that 62% of young people with a probable serious mental illness would feel uncomfortable seeking support from online counselling.

Bradford and Rickwood (2014) found that of the 231 adolescents surveyed (who were living in Canberra in 2011), 59% preferred face-to-face help, with 24% preferred not to seek help and 16% stating online help was their first preference.

Ellis et al. (2014) conducted an online survey of about 1000 young people aged 16 to 24 years in 2010 to explore attitudes and behaviours in relation to mental health and technology use. Participants were asked to indicate their preference for receiving mental health information and support through technology. The top two responses were: 1) website with information and/or fact sheets (males: 48%; females: 60%) 2) website with online clinic (males: 39%; females: 49%).

Unreliable coverage and slow internet speeds may inhibit take-up

While at an aggregate level, internet connectivity is widespread and increasingly mobile, some people do not have access to reliable internet coverage. Several participants noted that a lack of telecommunications infrastructure is a barrier to using the existing services, especially for regional and remote areas. Many focused on unreliable internet coverage or slow internet speeds. NSW Council of Social Services, for example, submitted that:

> With a growing range of education, information, government, and community services moving online, internet access and connectivity is increasingly regarded as an essential service. Online and telehealth services have the potential to improve access to mental health services for people in regional and rural areas. However, telecommunications and internet connectivity remains an issue in many regional and remote areas, rendering telehealth services unavailable for many of these communities. (sub. 143, p. 10)

Similarly, the Queensland Alliance for Mental Health highlighted that online services would be ineffective if not supported by internet accessibility, a situation that they submitted currently exists for remote Aboriginal and Torres Strait Islander communities:

> Internet access is another critically important part of telehealth services. It is no good providing these services if internet accessibility is so bad that it doesn't allow a continuous connection, or if it becomes too expensive for people to get access to adequate internet services. There is also a lack of internet access for most Aboriginal and Torres Strait Islander people living in remote communities. Any strategy for delivering more telehealth services would need to address the challenge of providing these services in remote Aboriginal and Torres Strait Islander communities. (sub. 247, p. 7)

Problems with internet reliability is hindering the roll out of some mental health programs. Outback Futures submitted that:

> Outback Futures is in the process of rolling out and supporting a number of new, innovative internet platforms in schools, community organisations, homes and more, with assistance & personal training from the Outback Futures' team. A number of specific issues have made this a difficult process, such as, poor bandwidth, agency or Government restrictions and limited technical understanding. This has led Outback Futures to be looking into providing these groups with personal devices set up specifically and solely to support these programs. (sub. 107, p. 11)

The 2018 Senate inquiry into accessibility and quality of mental health services in rural and remote Australia documented the intermittent and unreliable telecommunications infrastructure, including landline telephones, mobile phones and internet access. It concluded that it was limiting telehealth as a viable option to address the barriers of distance, travel time and availability of services (CARC 2018).

The Commission, in its 2017 inquiry into the telecommunications universal service obligation, found that certain groups of people with particular needs may experience gaps in the availability and accessibility of telecommunications services following the full roll-out of National Broadband Network infrastructure, and in the absence of further government intervention. The groups most likely to experience difficulties include: people with disability and life threatening conditions; people living in remote Aboriginal communities; some older people; people who are homeless; and users of telehealth, distance education and emergency services within the National Broadband Network satellite footprint who do not have adequate mobile coverage (PC 2017f).

The Commission noted that although advances in technology are expected to improve accessibility, government intervention is likely to be warranted to target the particular needs of these identified groups. However, government intervention is not always justifiable, even where there is solid evidence of market gaps, including particular user needs. This is because the intervention may not generate value for money for the wider community and may involve high costs relative to the benefits it is trying to achieve in the first place (PC 2017f). In the situation where intervention is not justified, potentially in very remote communities, supported online treatment may not be a practical low-intensity treatment option.

Nevertheless, online material can be made available via post for those with limited internet reliability, as is the current practice of MindSpot (Titov et al. 2018).

Concerns held by health professionals

Dissemination of supported online treatment into the stepped care model depends, in part, on the willingness of practitioners to refer patients to these treatment modes.

Health professional referrals to supported online treatment are an important pathway for consumers, with between 20 to 40% of referrals coming from health professionals(CRUfAD 2019; MindSpot Clinic 2019; Thomas, Seabrook and Foley 2019). Referrals to online health treatment are much higher for the THIS WAY UP courses (than, for example, MindSpot) as these courses were initially designed to be used alongside face-to-face treatment to facilitate self-management. The online platform, therefore, allows clinicians in the community to monitor and supervise their clients undertaking the online courses (CRUfAD 2019). In recent years, there has been a concerted effort to educate and inform mental health professionals of the existence and effectiveness of online treatment, potentially lifting referral rates to programs such as MindSpot (MindSpot Clinic 2019).

Nevertheless, there is some evidence that health professionals are not recommending supported online treatment as much. This could be due to lack of knowledge or concerns about these options (Andersson and Titov 2014).

Some have reservations about the efficacy of online treatment. The General Practice Mental Health Standards Collaboration (sub. 395), for example, submitted that e-mental healthcare was, at times excessively and persistently, promoted as a solution to barriers in treatment that was not evidence based. Similarly, some members of the Royal Australian College of General Practitioners (sub. 386) have expressed concerns about the evidence base of some online interventions. There is also the concern that lower quality treatment will primarily be offered to lower socio-economic groups, reinforcing inequality of access to treatment. The General Practice Mental Health Standards Collaboration stated:

> This may perpetuate inequitable provision where people in poorer areas may be offered an online service while better positioned and resourced citizens may receive face-to-face services with better demonstrated effectiveness due to availability of services. (sub. 395, p. 6)

Another concern is that online treatment requires the consumer to have a range of skills for it to be successful. In particular, the level of motivation of the consumer along with their capacity and willingness to undertake online treatment is important. The General Practice Mental Health Standards Collaboration (sub. 395) and the Royal Australian College of General Practitioners (sub. 386), for example, expressed concerns about the patient literacy and mental functioning needed for this therapy to be effective. Health professionals have also expressed concerns that patients either do not have internet access or the technology skills needed to access online treatment (Thomas, Seabrook and Foley 2019).

Some practitioners held concerns that technology would interfere with their ability to develop a rapport with their patient. In a focus group with community mental health service practitioners on integrating the use of technology with face-to-face session, MHO found that practitioners expressed concern about technology interfering with how they were accustomed to doing their work and their ability to maintain the therapeutic relationship (Thomas, Seabrook and Foley 2019). Some therapists value the visual and audio cues in a face-to-face consultation that help develop this relationship (Abbott 2016).

The Black Dog Institute indicated that the reservations from health professionals is due to a lack of support to help guide referrals:

> Despite programs to support health professionals e.g. eMental Health in Practice Program, there has been a failure to engage clinicians and give them something that helps guide e-health selection and use. This results in mismatched expectations about what digital therapeutics can do in general practice. (sub. 306, p. 25)

GPs and other mental health professionals generally rely on a range of information sources to help support people living with mental ill-health and be able to refer them to the most suitable service. Some digital resources are available (such as Head to Health and HealthPathways) but they are underutilised due to lack of awareness and technological barriers (chapter 10).

The Commission is recommending a number of changes that will support greater use of supported online treatment in the stepped care model, including:

- better-quality information through improved access to online navigation platforms to support better referral pathways by GPs (chapter 10)
- improved funding models to align incentives for referring practitioners to choose treatment options that better match treatment needed with that recommended, in the most cost-effective approach (chapter 5)

In addition to these recommendations, the Australian Government should deliver an information campaign to health professionals to provide an evidence base for the effectiveness of online treatment, as well as information regarding safety of the treatment offered, to increase the take-up of government funded clinician supported online treatment (draft recommendation 6.2).

DRAFT RECOMMENDATION 6.2 — INFORMATION CAMPAIGN TO PROMOTE SUPPORTED ONLINE TREATMENT

In the short term (in the next 2 years)

The Australian Government should instigate an information campaign to increase awareness of the effectiveness, quality and safety of government-funded clinician-supported online therapy for treatment of mental ill-health for consumers and health professionals.

6.5 Estimating the gains from expanding supported online treatment

Despite increased investment in mental health services and evidence showing the effectiveness of treatment, there is a treatment gap for people living with mental ill-health — that is, there is a difference between the number of people who need care and those who receive care. It is estimated that about 46% of the people living with a mental illness access services, while the National Mental Health Service Planning Framework have assessed that approximately two-thirds of the population living with mental ill-health should be receiving treatment (QCMHR 2019; Whiteford et al. 2014a; Commission estimate).

Supported online treatment is fundamental to reducing the 'treatment gap' for those with mild to moderate mental ill-health, and ultimately reducing the duration and severity of mental ill-health for these people. Online treatment has the ability to reduce a number of barriers to accessing care (such as stigma and location), increase the up-take of treatment without placing large demands on the need for additional health professionals.

The Commission has estimated that approximately 50 000 additional people could participate in supported online treatment each year as a result of overcoming these access barriers, with an estimated benefit of $226.9 million. While this represents only a small percentage of those with mild mental ill-health that are not currently accessing care at all, it recognises that it will take some time for both consumers and professionals to increase their acceptance of this form of treatment. Also, there are a range of other low-intensity treatment options that are being introduced or expanded that will have some take-up from the group who are currently not seeking treatment (chapter 5).

7 Specialist community mental health services

Specialist community mental health services matter because …	• Far too many people are missing out on the specialist community mental health services they need. • There are hundreds of people in acute hospital beds whose admission could have been avoided, or who could be discharged if the less acute services they needed were available. • People often wait months for a psychiatric assessment, meaning delays in receiving the right care. • Choice of health provider is valuable to people — especially to promote a strong 'therapeutic alliance' between consumers and clinicians — but too few consumers are aware that the MBS allows them to choose their psychiatrist.
Successful intervention requires …	As a priority: • The provision of more community ambulatory services and subacute/non-acute bed-based services, with each region's needs determined by regional service planning. Additional actions required include: • That psychiatric assessments by videoconference are made available to all consumers, regardless of where they live. • That for most consultations, psychiatrists no longer receive additional payments for doing them by videoconference. • That people referred to a psychiatrist are advised the referral allows treatment by any psychiatrist they might choose.

Specialist community mental health services are clinical services which are more specialised and intensive than primary care (chapter 5), but less intensive than acute hospital or emergency care (chapter 8) (box 7.1). Up to 835 000 Australians receive specialist community mental health services each year — 435 000 from State and Territory providers (2019a), and 400 000 from psychiatrists in private practice (with an unclear number receiving both) (AIHW 2019u).

People who benefit from specialist community mental health services are diverse. They have a range of underlying conditions, and their illness can vary in severity, as well as in complexity and persistence over time. Some of these people have never been so unwell with a mental illness as to require admission to hospital. Others have spent time in hospital experiencing severe episodes of mental illness, but specialist community mental health services are vital to provide treatment and support in the community and limit the need for inpatient treatment.

Box 7.1   Specialist community mental health services

Specialist community mental health services comprise:

- specialist clinical ambulatory (out-patient) services, which can be provided:
    - by psychiatrists working in private practice ('private psychiatric care')
    - in community or outpatient clinics, or as outreach services in a person's home or an aged care facility ('community ambulatory'). Community ambulatory services are mostly provided by Local Hospital Networks (LHNs)[18], or government-contracted community-managed organisations
- 'non-acute' bed-based services — used to refer to both subacute and non-acute beds — which can be provided:
    - in the community ('community residential')
    - on the grounds of public hospitals, but separate from acute hospital beds

Acute hospital care (chapter 8) is not considered part of specialist community mental health.
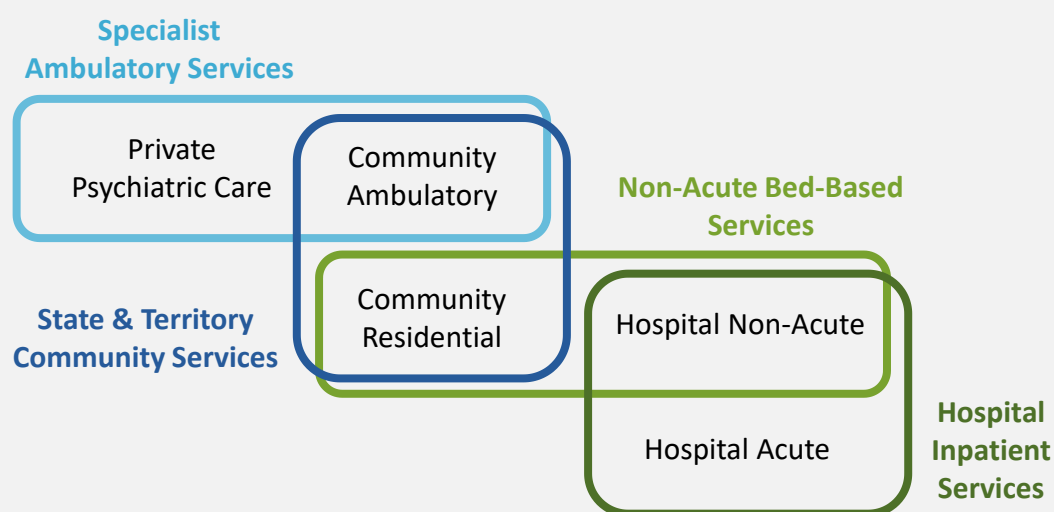
7.1 Consumers must be matched with the right care

Under the stepped care model (chapter 4), a person presenting to the health system should be matched to the level of care that most suits their treatment needs (DoH 2019k, p. 9). The Australian Government Department of Health has published guidance that outlines which factors should be considered in deciding which type of treatment suits a person's current needs (while recognising that consumers should have a say in any referral decision) (DoH 2019k). The appropriate service depends *especially* on the severity of their symptoms and distress, their risk of harm to themselves and others, and the effect of their mental illness on their functioning (as well as other factors) (DoH 2019k, pp. 36–43).

Consumers needing specialised clinical services almost always need services from multiple providers. People with less complex or severe illnesses might need services from two or three individual providers (such as a GP, a psychiatrist and/or a psychologist), while those with the most complex or severe illnesses might need additional services (such as mental health nurses, social workers, peer workers and employment and housing support workers). With numerous service providers delivering treatment, support and interacting with the consumer, coordination between service providers becomes increasingly important.

Specialist community mental health services can vary in how well they facilitate multiple providers working together as a team. Private outpatient psychiatric care — subsidised under the Medicare fee-for-service model (box 7.2) — is not structured to facilitate coordination between more than a few providers:

> In relation to people with more complex or severe problems, mental healthcare is optimally organised through a multidisciplinary team, comprising, for example, a psychiatrist, a psychologist, a GP, a mental health nurse, a social worker, a peer worker, an employment support worker, a housing officer and others. This fact, and together with the inability of fee-for-service to generate this kind of teamwork, has already been acknowledged by the Department of Health. (Rosenberg and Hickie 2019a)

State and Territory community mental health services, on the other hand, are organised to provide care involving multiple providers. While this distinction is widely recognised, a dearth of State and Territory community mental health services mean that many people with more severe and complex mental illness are nonetheless often referred for private psychiatric care. Others are simply denied the care they need.

This chapter describes the experiences of those who miss out on specialist community mental health services (section 7.2). It then identifies specific service gaps, the benefits from addressing them, and a way forward (section 7.3). Finally, various options to improve access to private psychiatric services are considered (section 7.4). Throughout the chapter, the focus is on clinical services — the psychosocial services that are typically needed in conjunction with clinical services (sometimes called community support services) are discussed in chapter 12.

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18 Some jurisdictions have their own local names for the areas and administrative units known nationally as Local Hospital Networks. For example, in New South Wales they are known as 'Local Health Districts', in Queensland they are known as 'Hospital and Health Services', in South Australia they are known as 'Local Health Networks', and in Tasmania they are known as 'Tasmanian Health Organisations' (AIHW 2019c).

> **Box 7.2   Fee-for-service and alternatives for larger care teams**
>
> In Australia, most primary mental healthcare is funded on a fee-for-service basis. GPs, psychiatrists and allied health professionals receive a fixed fee from Medicare for each time-limited service that they offer, and have the option of charging the consumer an out-of-pocket payment on top of this.
>
> Fee-for-service funding is simple to administer and encourages clinicians to be highly productive as the clinician only receives payment for services directly related to treatment of the consumer. However, fee-for-service funding:
>
> - can encourage over-servicing (PC 2017b). Clinicians face incentives to maximise the number of sessions they spend with a consumer. The payments received are not however tied to the consumer's recovery
>
> - does not incentivise team-based care, as only time spent with the consumer is remunerated (Rosenberg and Hickie 2019b). Additional case conferencing payments (where the 'service' is time spent with coordinating with other clinicians) can overcome this somewhat, but can be cumbersome for larger teams.
>
> Hence, fee-for-service is an appropriate payment model for treatment involving one or two clinicians, but less suited to managing consumers with conditions that require ongoing support and coordination between larger teams of providers.
>
> Team-based care can be more effectively promoted by payments to an organisation or coordinator that then employs or contracts individual clinicians (often on a salaried basis). Public hospitals and community mental health services are funded in this way.
>
> The question is then: *On what basis should organisations or teams of providers be paid?*
>
> - 'Block funding', under which payments are not linked to services or outcomes, is simple to administer but does not encourage productivity among providers.
>
> - 'Activity-based funding', where providers are paid according to the number and mix of consumers that they treat, encourages higher productivity but is more complex to administer. It can also encourage providers to skimp on care quality, and to avoid prevention and early intervention.
>
> - 'Bundled payments' are similar to activity-based funding, but the providers are paid to provide care for a set period of time and often across multiple settings. They are more complex again to administer, but can neuter some of the downsides to activity-based funding.
>
> Payment models for team-based care are discussed in chapter 23.

7.2   The missing middle

There are significant gaps in the availability of mental health services — one of these is the gap which some have termed the 'missing middle' between primary and acute/specialist care (box 7.3). The missing middle particularly affects people whose illnesses are too complex or enduring to be treated in primary care, but are not considered severe enough to meet the high threshold to access constrained specialist mental health services. For people in the missing middle, the gap in care options — especially gaps in the availability of specialist community mental health services — can cause their condition to worsen, and lead to personal suffering, avoidable visits to Emergency Departments (EDs) and hospitals, and a reduction in their capacity to participate socially and economically (box 7.4).

Box 7.3   **What others have said about the missing middle**

- Young people with more moderate to severe and complex mental health issues are slipping through the gaps in care. Described as the 'missing middle' these young people need more specialised, intensive and extended care than is currently available within primary care, however, they are not yet acutely or severely ill enough to reach the high threshold for access to state-funded acute and continuing care. (Orygen and headspace sub. 204, p. 4)

- The missing middle in the mental health system is 'a key treatment gap for people with moderate mental illness. This particularly affects people whose illnesses are too complex or enduring to be treated in primary care, but not considered severe enough to meet the high threshold to access constrained specialist mental health services. The missing middle also affects people with episodic mental health needs and those lacking ongoing support following an acute mental or physical health episode or traumatic experience, where a lack of available services and continuity of care impedes on their recovery and increases the likelihood of further crisis presentations … the "missing middle" is also present for children and young people. (Victorian Government 2019b, pp. 23–25)

- [After having 10 subsidised sessions of psychological therapy in a year] it becomes very difficult to get care until you are in a bad enough place to be eligible for hospital. And for that, you need to be in a really, really bad place. Mental health professionals and politicians know all about this problem. In the sector it's called "the missing middle". I call it "The Vast Wasteland". (Eastly 2018)

- … [10 sessions of psychological therapy a year] is insufficient to meet the needs of people with moderate to severe mental health conditions. This group of people represent a huge blindspot, a devastating chasm in care that successive governments have never addressed: the "missing middle". This missing middle is characterised by the hundreds of thousands of Australians, both young people and older adults, whose illnesses are too complex, too severe and/or too enduring for primary care alone to be sufficient (McGorry 2019).

- Looking across the continuum from Commonwealth to State funded services, there are rising access rates for people with mild/moderate mental illness but very low levels of access for what we term the 'missing middle'. These are the vulnerable populations with combinations of moderate mental illness and complexity; drug and alcohol, comorbid physical conditions and social issues (WentWest sub. 445, p. 28)

- While the Commonwealth has parachuted various siloed programmes into the mental health system, the states and territories have been pulling back their community-based mental health services, resulting in a growing gap between what GPs do and what services are provided in hospitals.-.The "missing middle" is causing enormous system failure, with people falling through the gap between GPs and primary healthcare on the one hand, and emergency departments and hospitals on the other hand. (NMHC 2014e, p. 33)

- This is part of a problem that has been described as the 'missing middle' in mental healthcare, whereby there is little in the way of affordable, accessible support for people with poor mental health in the community before a problem becomes acute and requires hospitalisation. (NSW Council of Social Services 2016, p. 19)

- It is widely accepted that on closing the asylums, Australia failed to invest in an alternative model of community mental health care. This means that for people seeking mental health assistance, there are few alternatives between the GP's surgery and the hospital emergency department. … It is this middle ground of community support that is missing in Australia's approach to mental healthcare. (Rosenberg 2015)

> **Box 7.4   How consumers and carers experience the missing middle**
>
> - Six months prior to this hospital admission, I had run out of the 10 Medicare-rebated sessions for the year by April, and was told I would have to wait till next year to get more. Eight months away. I had already been told by two psychologists that I needed a psychiatrist. But it turns out finding a psychiatrist is a lot like finding a soulmate. Except with a much smaller dating pool. … Eventually, after weeks of phone calls and internet wormholes (all while periodically feeling like I want to die) I was lucky enough (and stubborn enough) to find a psychiatrist who happened to be accredited with a private hospital, that happened to do a treatment program that was suitable. In other words, all of my ducks lined up in a cosmic row. (Eastly 2018)
>
> - With access to sessions limited, I was not able to get the help needed. The care plan sessions concluded and I was still struggling, feeling lost and in a dark place. With no income I could not continue to access the services I needed. Fortunately for me, I stumbled upon a free counselling service run by the local council. (Clive Kempson sub. 84, p. 1)
>
> - Intense withdrawal symptoms were experienced and he was admitted to hospital, medication changed again, monitored several weeks then discharged again when clearly unwell due to lack of beds available (Name Withheld, sub. 63, p. 1)
>
> - The mother baby unit I spent time in when suffering post-natal depression and psychosis was seriously life-saving. There is only 1 [mother baby unit] for the whole of South Australia, nowhere near enough beds to meet demand. (comment no. 38, consumers)
>
> 'Once discharged and thrust outside the walls that have managed her exclusion (detachment) and provided a sanctuary, the local Child and Adolescent Mental Health Service (CAMHS) begins outpatient family support: i.e. only one meeting per week for 1 hour: This just isn't practical and fuels the adolescent's vulnerability. It's like quitting a crippling addiction, "cold turkey". (Name withheld, sub. 392, p. 19)
>
> - The clinicians emphasised strongly, repeatedly and unanimously that my brother needed to be discharged to a transition program, such as a rehabilitation facility "when a bed became available" and NOT directly to his flat. (Name Withheld, sub. 58, p. 2)
>
> - You only got to see the [visiting medical officer], who I might add was a psychiatrist, once every 3 months unless you contacted the office to request an extra visit. Sometimes we were told that he was too busy even after the schools deputy principal wrote letting them know of the erratic behaviours and the concerns they had in managing it and us providing evidence of him being transported to the mental health unit at Canberra hospital. (Name Withheld, sub. 81, p. 1)

7.3   Addressing gaps in community services

Many consumers will continue to miss out on the care they need until there are sufficient specialist community mental health services. Remedying this requires 'filling the gaps' in current community ambulatory and non-acute bed-based services provided by State and Territory Governments. This section describes the relevant gaps, the benefits of addressing them, and how this should happen.

State and Territory community ambulatory services

In 2017-18, community ambulatory services were provided to about 435 000 people and involved 9.5 million 'service contacts' (AIHW 2019e). Such services are government-funded specialised clinical mental healthcare provided in the community. They are mostly provided in a clinic, and include outpatient services and day programs provided by hospitals (but not bed-based care). They can also be provided in a person's home.[19]

The provision of community ambulatory services over time is indicated by the number of clinical staff[20] providing such services per 100 000 population. This grew during the first decade of this century, from 35 to 48 full-time equivalents (FTEs) per 100 000 population, but from 2011-12 has declined slightly (figure 7.1).

Figure 7.1   **State and Territory community ambulatory services[a]**
Clinical staff per 100 000 population
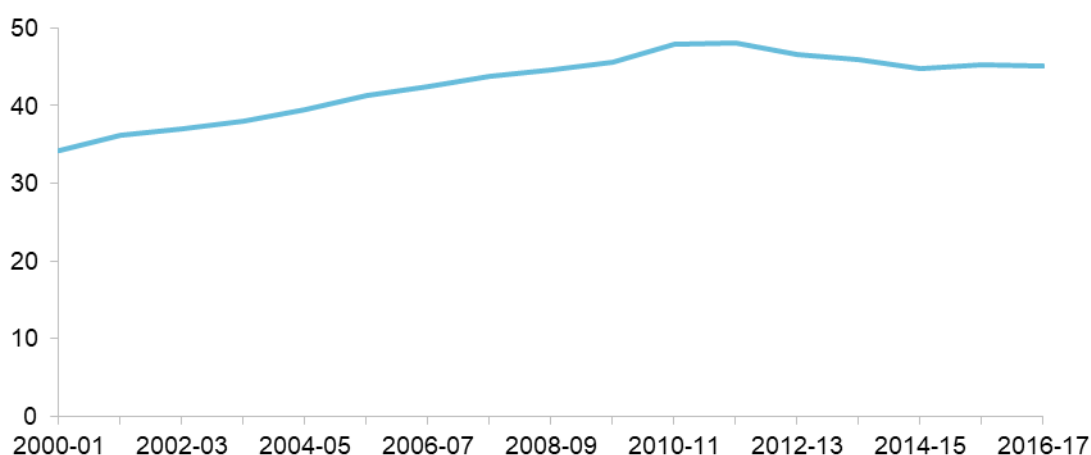
a Numbers shown are for full-time equivalent staff, and exclude support staff. Note that forensic services are included in this figure, but are excluded in calculations presented below.
Source: AIHW (2019ab, table FAC.43).

To gauge the extent to which current community ambulatory services fall short of what is required to meet peoples' needs, the size of the workforce providing such services can be compared with benchmarks generated by the National Mental Health Service Planning Framework (NMHSPF). The NMHSPF was initially developed by the NSW and Queensland Governments to estimate the level and mix of mental health services needed to meet the

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[19] The clinical services discussed here are distinct from psychosocial services (also sometimes called community support services), which are examined in chapter 12. Crisis assessment and treatment (CAT) services are also a form of community ambulatory care, but they are examined in chapter 8 with other acute and crisis services.

[20] This covers a range of professions, including case managers, psychiatrists, social workers, occupational therapists, psychologists, and drug and alcohol workers.

needs of Australia's population. It is currently maintained by the Queensland Centre for Mental Health Research, with funding from the Australian, State and Territory Governments (University of Queensland 2016a).

In 2016-17, the workforce providing State and Territory community ambulatory services in Australia was 28% below the relevant NMHSPF benchmark (measured in terms of full-time equivalent workers). The shortfall was greatest in percentage terms for services specifically targeted at children and adolescents (32%) and older persons (47%) (figure 7.2).

Figure 7.2   **The shortfall in State and Territory community ambulatory services**
2016-17
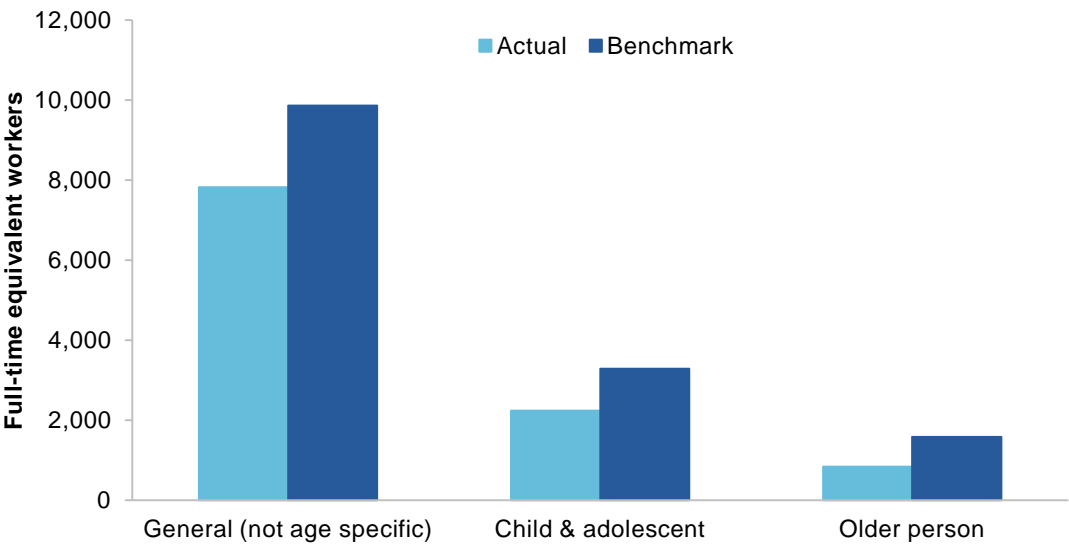
Sources: AIHW (2019ab) and Commission estimates using the National Mental Health Service Planning Framework.

The WA Mental Health Commission has published a similar comparison for Western Australia using a modified version of the NMHSPF which accounts for Western Australia's demographic differences. This showed that, in 2017, Western Australia provided about 2.3 million hours of community ambulatory and that this was about 12% below the benchmark of 2.6 million hours (WA MHC 2019, p. 54).

Views expressed by participants in this inquiry also indicate that community ambulatory services available to people across Australia falls short of what they need. For example, the Independent Private Psychiatrists Group stated that services are generally being rationed so that people only receive care if they are experiencing the most severe symptoms of mental illness.

> Public psychiatric services … are almost exclusively directed to those people who are acutely suicidal, and those with acute psychoses … The State and Territory (public) mental health

services have drifted over the last thirty years, from being available to most Australians, to being available only to a minority of those suffering significant mental illness. Services in this sector tend to be provided on an episodic treatment basis, rather than a long-term treatment and follow up basis. This, despite the fact that most people using public mental health services will suffer ongoing or recurrent mental illnesses. (sub. 473, p. 9)

The Adult Psychiatry Imperative consortium made a similar observation in a submission to the Royal Commission into Victoria's Mental Health System.

> The threshold for entry (in terms of acuity and complexity) to community mental healthcare has … risen through the efforts of mental health services to manage increased demand, thereby limiting opportunities for early intervention (in illness or in episode) and tending to lead to caseloads being dominated by people with multiple complex needs and /or presenting risks to self or others and/ or illnesses which are difficult to treat. … public mental health services only see 'the most unwell' people, creating significant service problems in other parts of the mental health system. (2019, p. 36)

Moreover, the Commission heard from inquiry participants that people experiencing severe symptoms of mental illness often have to wait two or three months to receive community ambulatory services (BPD Community, sub. 74; Niall McLaren, sub. 44).

The shortfall in community ambulatory services is widely recognised, having been identified in numerous past studies and reviews. In 2014, the National Mental Health Commission recommended a reallocation of Australian Government acute hospital funding into more community-based psychosocial, primary and community mental health services (NMHC 2014c, p. 16). And a 2006 Australian Senate inquiry recommended that up to 400 new community mental health centres be established across Australia (Hickie and Rosenberg 2018). Neither of these proposals have been adopted by governments.

There have been some efforts by governments to fill the gaps in community ambulatory services but it has not been enough to meet the needs of the population. For example, the Victorian Government changed funding arrangements for its specialist mental health services to incentivise them to provide more community-based treatment services. However, the new funding will only provide each new community-based client with a maximum of 6 hours treatment per year, compared to the nationally recommended level of 72 hours (VAGO 2019a, pp. 10–11).

Non-acute bed-based services

Non-acute bed-based services are provided to people whose needs are more complex, and require higher levels of support, than can be provided through community ambulatory (non-bed-based) services. Non-acute bed-based care incorporates both specialist clinical and psychosocial services, with staff available on site 24 hours a day. The care may be delivered in a hospital (as admitted care) or as community residential care (box 7.5). In 2016-17, Australia had 3436 non-acute mental health beds (AIHW 2019ab).

For older people, this type of care is often provided in aged-care facilities. This report does not consider residential aged care in any detail, given that it is being addressed by the current Royal Commission into Aged Care Quality and Safety. However, some non-acute services in aged-care facilities are included in the data analysis below.

Accommodation and support services — where the focus is on long-term housing and supporting the psychosocial needs of people with mental illness, rather than providing clinical care — are discussed in chapter 15.

Box 7.5   What is non-acute bed-based care?

We use the term 'non-acute' to refer to both subacute and non-acute care. When others draw a distinction between subacute and non-acute, the key difference is that non-acute is provided over an extended period, with an expected length of stay in excess of 6 months (QCMHR 2016, p. 204). Non-acute services can aim for improvement over the long term, or to maintain a certain level of functioning without deterioration over an extended period. Subacute care comprises:

- **Step up/step down** — provided for people who have recently experienced or who are at increasing risk of experiencing an acute episode of mental illness. The person usually requires higher intensity of treatment and care to reduce symptoms and/or distress that cannot be adequately provided in the person's home but does not require the treatment intensity provided by acute inpatient units. People may access these services by:

  - *'stepping down'* from a period of treatment in an acute inpatient unit to allow continued treatment in a supportive environment aimed at achieving further symptom reduction and recovery from the acute episode

  - *'stepping up'* from the community when experiencing an increase in symptoms/distress to receive treatment in a supportive environment designed to prevent further deterioration and relapse and so avoid admission to hospital.

- **Rehabilitation** — community residential rehabilitation services have a primary focus on improving functioning and helping people live independently in the community of their choice. People admitted to rehabilitation services have complex needs associated with a mental illness. Clinical symptoms, while severe, are usually relatively stable.

- **Intensive care services** — provided on hospital campuses, for medium-term recovery-oriented treatment and rehabilitation in a safe, secure, structured environment for people with unremitting and severe symptoms of mental illness and an associated significant disturbance in behaviour which precludes them receiving support safely in a less restrictive environment (QCMHR 2016, p. 195).

There are significant gaps in non-acute bed-based services across Australia, which means that many people do not receive the care they need.

To gauge the extent to which services fall short of what is required to meet peoples' needs, the number of available non-acute beds can be compared with benchmarks generated by the NMHSPF. This comparison shows that, in 2016-17, Australia had 3436 non-acute mental health beds in the public sector, which was less than 60% of the NMHSPF benchmark of

5852 beds. The shortfall in beds was almost all in community non-acute beds (shortfall of 2185 beds), rather than hospital non-acute beds (shortfall of 231 beds) (figure 7.3).

Figure 7.3   **The shortfall in public non-acute mental health beds[a]**
2016-17
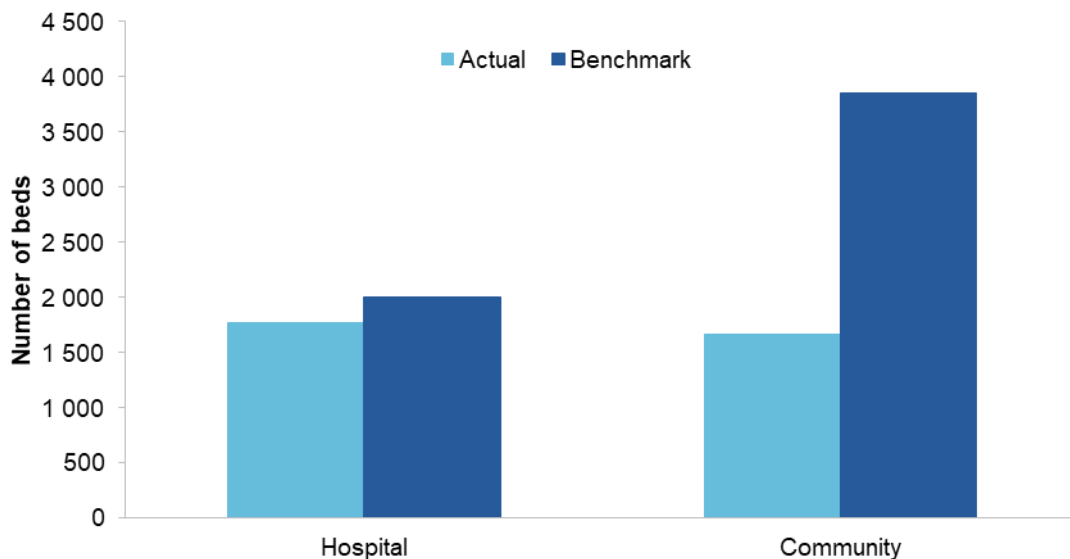
a Includes subacute and non-acute beds as defined by NMHSPF.

Source: (AIHW 2019ab) and Commission estimates using the National Mental Health Service Planning Framework.

A similar comparison by the WA Mental Health Commission using a modified version of the NMHSPF showed that, in 2017, Western Australia also had a shortfall of beds. In particular, there were:

• 328 community mental health beds, which was about 80% of the benchmark

• 79 hospital non-acute beds, about 50% of the benchmark

• 48 hospital-in-the-home beds, about 65% of the benchmark (WA MHC 2019, pp. 60, 69).[21]

There are differences between jurisdictions. For example, Victoria, Queensland and Western Australia have made significant recent outlays on step up/step down units (MHCC 2018b, p. 10; Victorian Government 2019b, p. 12). In contrast, there are 'only a handful' of step up/step down facilities available in NSW (MHCC, sub. 214, p. 16). The NSW Mental Health Commission (NSW MHC 2014a, p. 55) has noted that New South Wales is 'overly reliant on hospitals in the delivery of mental healthcare, spending less per capita on community mental healthcare than any other State or Territory'.

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21 Hospital-in-the-home services are a substitute for acute and non-acute hospital beds

The Productivity Commission expects that much of the need for long-term non-acute 24-hour-staffed residential beds can be met under the National Disability Insurance Scheme, but development to date has been slow (chapter 15).

How should gaps in community mental health be addressed?

The Productivity Commission considered a wide range of options for addressing the service gaps identified, but determined that State and Territory Governments and LHNs are best placed to continue to provide community ambulatory and non-acute bed-based services, and to fill the service gaps identified above. They have experience providing (and contracting for) such services, and are best able to ensure consumer-focused care, with coordination and integration between services of this type. They are also best placed to decide which services (and service models) are required in each region, responding to the needs of the population and with knowledge of services that are already available on the ground.

There have, however, been valid questions asked about the efficiency of some State and Territory Government community mental health services. These are discussed in chapter 23, which also proposes changes to funding arrangements to incentivize greater efficiency. Efficiency would also be boosted by the recommendation in chapter 22 for the National Mental Health Commission to be given responsibility for leading the evaluation of mental health and suicide prevention programs. Improving efficiency would mean that more services could be provided with a given level of resources, and would partly address the service gaps identified above.

In addition, the sole responsibility of the State and Territory Governments for providing community ambulatory and non-acute bed-based care should be clarified. This would make it clear who needs to address current service gaps, promote integration of services, and minimise overlap between services provided by different levels of government (chapter 23).

DRAFT RECOMMENDATION 7.1 — PLANNING REGIONAL HOSPITAL AND COMMUNITY MENTAL HEALTH SERVICES

In the short term (in the next 2 years)

State and Territory Governments should determine, through regional service planning, the numbers of public acute mental health beds in hospitals, specialist mental health community treatment services and subacute/non-acute mental health bed-based services that would meet the specific needs of each region and undertake to provide these on an ongoing basis.

The benefits of addressing these service gaps

Greater provision of community ambulatory and non-acute bed-based services would improve the lives of people with mental illness, their families and carers. It would also benefit the wider community by reducing the need for more costly acute healthcare and enabling more people to lead contributing lives, with greater employment, productivity and social participation. This section summarises the health benefits, with later chapters covering other benefits from improved mental health, and chapter 26 quantifying potential improvements more comprehensively.

Improving consumers' mental health and wellbeing

The lack of services in the community often results in consumers experiencing symptoms for longer, with a higher risk of deterioration in their illness with resulting social isolation and loss of employment.

The benefits of community ambulatory care to a consumer's mental health depends on what care they need. Some consumers only need relatively short-term care in the community, entering and exiting care within a year. Just over half of people receiving such care in 2016-17 experienced significant improvement, 41% experienced no change, and 7% deteriorated (AIHW 2019j; table KPI.1).[22]

Other consumers need community ambulatory care on a long-term and ongoing basis because they have a persistent or episodic mental illness. Only a quarter of people receiving such services in 2016-17 experienced significant improvements in their mental health, just under 60% had no change (which indicated stability for a person with persistent mental illness), and 17% deteriorated (AIHW 2019j; table KPI.1). The Australian Government Department of Health has noted that stability may be a good outcome for people with severe and persistent mental illness:

> … the focus of care [for many people] is further reductions in symptoms and increases in functioning, but for others the focus is more about helping the person maintain their current state of wellness and averting deterioration … [In the latter case] 'no clinical change' can be a good result because it indicates that the person has maintained their current level and not experienced a worsening of symptoms. (DoH 2013a)

Non-acute step up/step down services have a positive effect on consumers' mental health, although the positive effect may be less than that achieved with a similar-length stay in a public hospital.[23] Victorian data shows that consumers using step up/step down care had, on average, smaller improvements in their mental health — measured using the Health of the

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[22] This (and the paragraph immediately below) excludes 'brief ambulatory episodes' and those 'that end because of admission to hospital or residential mental healthcare'

[23] 14.7 days is the average length of stay for mental health patients with specialised psychiatric care in public hospital in 2017-18 in Victoria (AIHW 2019h; table ON.4) compared to about 18 days average stay in a Victorian step up/step down unit (VIC DHHS 2016, p. 1).

Nation Outcome Scales (HoNOS) — than mental health consumers in hospital, likely due to the greater level of symptom severity in those admitted to hospital (and therefore more scope for improvement). However, adults using step up/step down care facilities also had worse health on discharge than people discharged from hospital, even though they had better health on admission (figure 7.4).

Figure 7.4   **Improvement in mental health for consumers in hospital compared to consumers in step up/step down care, Victoria[a]**
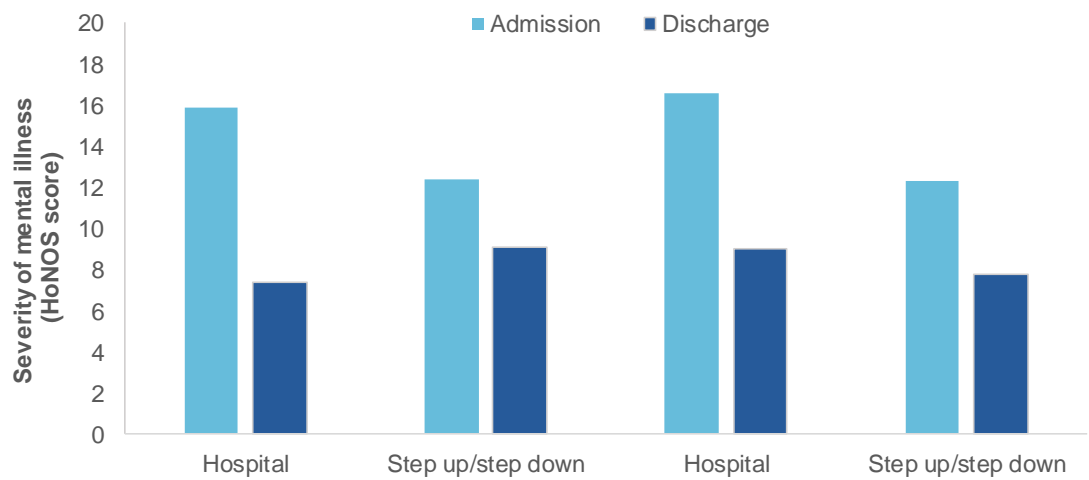
a A higher HoNOS score means a more severe level of mental illness.
Source: VIC DHHS (2016, p. 11).

In a submission to the Royal Commission into Victoria's Mental Health System, The Adult Psychiatry Imperative consortium argued that a shortfall in Victorian Government specialist community services had led to people being discharged prematurely.

> In an effort to manage the increasing pressures and demand, [Victorian] community mental health services have increasingly adopted an episodic approach to delivery of care so that patients are often discharged once the acute crisis has diminished. While this approach to care is suitable for patients whose care can mostly be well-managed in the primary care sector, it is inappropriate for patients who are experiencing frequently relapsing mental health conditions and/or those requiring more sustained input to support their recovery (beyond symptomatic recovery). (2019, p. 38)

Treatment in the community allows consumers to participate in the community and living a contributing life. Receiving treatment in a hospital makes it difficult or impossible to work, and long hospital stays make it harder to maintain meaningful social connections. Participation in community activities is also necessarily limited. The Consortium of Australian Psychiatrist–Psychologists said:

> There is robust evidence to show that participation in community – be it in a workplace, volunteering or participation in community groups – is associated with greater well-being, reduced symptoms of mental illness, greater social contact, greater independence, improved self-esteem, lower relapse rates, and better quality of life. (sub. 260, p. 6)

Chapters 14 and 20 of this report consider programs to encourage employment and improve social participation.

Reducing the need for more costly acute care

The lack of specialist community mental health services mean that consumers are missing out on the care they need, making it more likely that they present at an emergency department (ED), or need to be admitted to an acute hospital bed (Mental Health Victoria, sub. 479). It also raises costs by increasing the length of (expensive) stays in hospital because the lack of needed support in the community means people cannot be discharged when they should be (box 7.6).

This relationship between expenditure on community mental health services and mental health ED presentations is shown in figure 7.5. Between 2004-05 (the earliest year for ED data) and 2011-12, per capita community mental health expenditure was rising, and mental health ED presentations were fairly stable. But from 2011-12 to 2016-17, community mental health expenditure decreased, and mental health ED presentations increased. This suggests that greater community expenditure does reduce ED presentations. However, other factors have also been driving more mental health ED presentations up (chapter 8).

Box 7.6 **What others have said about how a lack of community services leads to higher emergency and acute health costs**

The Australasian College of Emergency Medicine:

> Due to the twin pressures of increasing demand and failure to provide adequate care in the community, EDs have become a major and often default entry point for people seeking access to mental healthcare. Often by the time people present to an ED, their potentially preventable or manageable condition is very serious and they are in crisis. (sub. 516, p. 3)

> … it is likely that many mental health presentations to emergency departments occur as a result of chronic underfunding in community [ambulatory] treatment settings. (2018, p. 10)

The Victorian Government:

> Without appropriate community-based care dedicated to meeting the needs of each individual, the system risks increased inpatient readmissions, generating more demand on our hospitals and people becoming entrenched in the justice system. (2019b, p. 24)

The NSW Mental Health Commission:

> Because there is inadequate care in the community, people are readmitted to hospital. For the mental health system, it creates a vicious circle: the lack of care in the community increases pressure for expensive inpatient mental healthcare, which draws more money from community-based services. (2014, p. 55)

Orygen and headspace:

> There is a group of young people with more moderate to severe and complex mental health needs who are falling through the gaps in care between our primary and tertiary mental health systems. These young people are at high risk of: presenting to emergency departments at crisis point, or contact with police and ambulance services. This level is rising rapidly, as documented by [the Australian Institute of Health and Welfare] and in the media. (sub. 204, p. 20)

Figure 7.5 **Community mental health services expenditure and ED presentations**
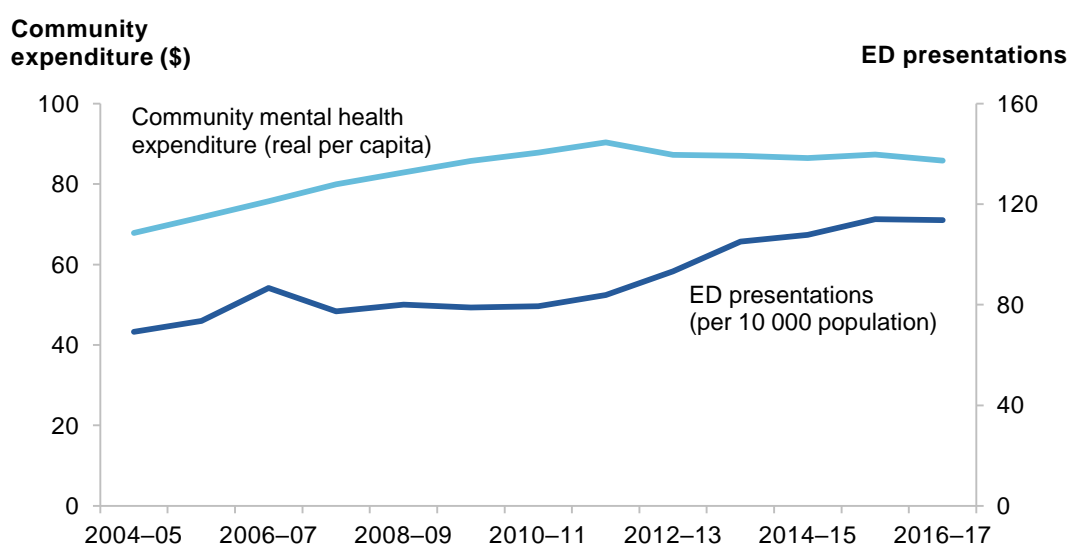
Source: AIHW (2019v, table ED.1, 2019e, table EXP.4).

Delayed discharge

Up to several thousand people in acute hospital beds could be adequately treated outside hospital if appropriate community services and accommodation were available (box 7.7). The lack of community rehabilitation and step up/step down beds, as well as supported housing, and housing more generally (chapter 15), means consumers are sometimes kept in acute beds longer than they should be, sometimes for months. Discharge can also be delayed from subacute or non-acute inpatient facilities, if appropriate community services are lacking. Most people experiencing delayed discharge need both accommodation and clinical treatment — either separately (community ambulatory services along with accommodation support), or together (non-acute community residential care).

While the data is patchy, across States and Territories roughly 30% of mental health inpatients could be discharged if appropriate clinical and accommodation services were available (box 7.7). This translates to roughly 2000 people in hospital beds when less intensive care is more appropriate.[24]

While some people experience delayed discharge, others are being discharged from acute beds too early (chapter 8). While this may seem paradoxical, early discharge and delayed discharge can co-exist. Where beds are being taken up by longer stay patients due to delayed discharge, there are effectively fewer beds available for people who *need* acute care. When under pressure to accommodate the same number of acute patients with not enough beds, hospital staff may discharge some early.

> Poor access to community care delays discharge or leads to people being discharged from hospital without appropriate out-of-hospital care. (Mental Health Australia, sub. 538, p. 8)

The financial consequences of delayed discharges from admitted care due to a lack of community services can be illustrated by comparing the daily cost of caring for a person in the different settings. In 2016-17, the average daily cost of:

- an acute public inpatient bed was $1212 (SCRGSP 2019i, tables 13A.36 & 13A.40)

- community residential care with 24-hour staff was $530, although this does not fully account for reach-in services from State and Territory providers (SCRGSP 2019i, tables 13A.36 & 13A.40)

- community ambulatory care was $325 (AIHW 2019j; table KPI.7).

Even where housing is required along with community ambulatory services, providing both in the community is often less expensive than providing both in more acute settings (chapter 15).

These average costs indicate that, as well as improving outcomes for those consumers involved, there are *potential* savings associated with providing the necessary community

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[24] Based on 7175 public mental health hospital beds (AIHW 2019n), an occupancy rate of 95% (in line with data for Victoria — chapter 8), and assuming 30% of patients could be discharged.

services to reduce delayed discharge. As costs vary between and within jurisdictions, further analysis is required to estimate these potential savings. However, in the short term, instead of the benefit being realised as a reduction in expenditure, it is likely that other people who are currently missing out on acute care — because they are not being admitted, or are being discharged early (chapter 8) — would be provided the care they need. In the longer term, it is likely that fewer beds per capita would be needed to meet acute care needs.

Box 7.7   The extent of delayed discharge

We asked the States and Territories: 'What proportion of mental health inpatients could be discharged from hospital/acute care if appropriate supported accommodation was available?' The **ACT** indicated that 'approximately 7%' of current inpatients could be discharged if appropriate accommodation was available. The **Northern Territory** told us:

> Anecdotally an estimate of 25% average of all inpatient clients could be discharged earlier if appropriate accommodation was made available. On current ward census today this figure is 35% (State and Territory Governments Survey)

Published estimates were available for some other States, although some are less current than others:

In **Queensland** in 2004, hospitals indicated that 30% of mental health consumers did not need hospitalisation if other supports were available. Difficulty accessing suitable support and accommodation was the key factor preventing discharge (SCMH 2006, p. 189).

In **South Australia**, a 2004 Homeless and Housing Taskforce indicated that there were 505 patients in 10 mental health inpatient units on Census day in South Australia who could have been discharged immediately if more intermediate treatment, rehabilitation support and accommodation services were available in South Australia (SCMH 2006). At the time, South Australia had only about 640 public sector mental health beds (AIHW 2019ab, table FAC.15). The South Australian Department for Health and Wellbeing (pers. comm. 29 July 2019) told us that while a similar survey has not been carried out recently, there are likely to be far fewer patients in this category now, due to spending on non-acute beds, supported accommodation and social housing.

In **Western Australia**, a 2009 survey found that 40% of individuals occupying mental health inpatient beds at any given time could be discharged if appropriate community services were available (WA MHC 2015a, p. 21). We understand this figure is now significantly lower, though still substantial, due partly to spending on step up/step down care.

In **New South Wales**, a 2012 NSW Ombudsman report (2012, p. 3) found that 'long-term and highly supported accommodation are in short supply' and are contributing to persons overstaying in hospital settings.

> The conservative estimate is that around one-third of people currently living in mental health facilities in NSW could be discharged to the community, if appropriate accommodation and supports were available. (NSW Ombudsman 2012, p. 67)

In **Victoria**, a 2019 report by the Victorian Auditor-General (2019b, p. 10) found that, although it was not possible to put a number of clinically unnecessary stays,

> '[y]oung people are routinely getting 'stuck' in [child and youth mental health services] inpatient beds when they should be discharged, because they cannot access family or carer support and/or services such as disability accommodation or child protection and out-of-home care.'

7.4   Improving access to private psychiatric care

About 400 000 Australians received some private psychiatric care in 2017-18 (AIHW 2019u). And access to private psychiatrists has been improving. For example, the number of people receiving at least one *standard outpatient* consultation with a psychiatrist has risen from about 250 000 in 2008, to about 340 000 in 2018 (Commission estimates based on unpublished MBS data).[25]

But many people have difficulties accessing private psychiatric services, due primarily to a shortage of psychiatrists, and their concentration in major cities (chapter 11). Out-of-pocket costs are also a barrier for some consumers, and timely access to an assessment consultations is a particular issue. This section details these issues and then proposes some solutions.

Private psychiatrists provide services in hospital as well as in the community. If consumers that are seeing a private psychiatrist require acute inpatient care, and they have private health insurance, they are typically admitted to a private psychiatric hospital. In 2017-18 about 8% of private psychiatric patients were admitted to a private hospital (AIHW 2019u). The funding of private psychiatric hospital care is discussed in chapter 24.

Out-of-pocket costs are a barrier to private psychiatric care for many consumers

Unlike State and Territory community mental health services, consumers often bear part of the cost of private psychiatric care. In 2018, about two-thirds of consultations with psychiatrists working in private practice involved an out-of-pocket cost (co-payment) for the consumer. This averaged from $74 to $155, depending on the type of consultation (table 7.1). In 2018, total co-payments for outpatient services were about $100 million, while MBS benefits paid were a little over $300 million (Commission estimates based on unpublished MBS data).

Out-of-pocket costs can be a major barrier for people experiencing mental illness as many have low incomes. In a 2012 survey, private psychiatrists said that 20% of their consumers were on a government pension and 45% were not working (Independent Private Psychiatrists, sub. 473, p. 12).

However, some psychiatrists price discrimination between consumers by charging a co-payment to wealthier consumers but not to others (such as those with a Healthcare Card).

> … doctors have a latitude in their fee-setting to discount some financially disadvantaged consumers, whilst charging some well off consumers a higher fee. In this way, there is a built-in economic management towards equity, which is exercised by most doctors, when given the capacity to do so. (Independent Private Psychiatrists, sub. 473, p. 20)

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[25] Here and throughout this chapter, the term 'psychiatric consultations' is used to refer to standard psychiatric consultations only. It does not include consultation in hospital, or in places other than consulting rooms (such as aged care facilities).

Table 7.1 The cost of common Medicare psychiatry items
2018

Item number	Description	Total services	Total MBS rebates paid	Average rebate per service	Services with a co-payment	Average co-payment (for services with positive co-payment)
		Number	$ million	$	%	$
291	Assessment and management plan	42 602	17	389	21	122
296	Initial consultation	117 919	27	233	74	155
302	Standard consultation, 15–30 minutes	218 927	18	82	59	74
304	Standard consultation, 30–45 minutes	605 390	77	128	65	85
306	Standard consultation, 45–75 minutes	611 237	119	195	67	86
308	Standard consultation, more than 75 minutes	35 226	7	205	36	96

Source: Productivity Commission estimates based on Commission estimates based on unpublished MBS data.

Moreover, the Medicare Safety Net provides higher Medicare rebates once total annual co-payments reach certain thresholds. This can make private psychiatric care more affordable to some people.[26]

Timely access to private psychiatric care

Even for those who can afford co-payments, it can be hard to find a local psychiatrist working in private practice — consumers often have to wait six weeks or more for their first consultation. This is partly due to a shortage of psychiatrists, particularly outside of major cities and in specialities such as child psychiatry (chapter 11).

Timely access to initial psychiatric *assessment* is particularly important, but currently lacking. Many people whose psychological condition has recently deteriorated require a psychiatric assessment (even if they do not need ongoing psychiatric care). Long waiting periods before an initial psychiatric assessment means diagnosis and treatment are also delayed.

'Assessment consultations' (MBS item 291) are for psychiatrists to assess people in a one-off consultation, and devise a management plan to be carried out by a GP or psychologist. Depending on the assessment, a person that *does* need ongoing psychiatric treatment could also be referred on to another private psychiatrist, or for treatment in a public mental health

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[26] The Medicare Safety Net provides extra rebates once total co-payments reach $470 in a calendar year. The Extended Safety Net provides rebates that are higher again, and starts at about $680 for concession card holders and families receiving Family Tax Benefit A, and at about $2130 for others (DHS 2019).

service. Item 291 attracts a higher Medicare rebate — the average rebate paid in 2018 was $389, and almost 80% of these consultations had no co-payment (table 7.1 above). MBS item 293 allows for the same psychiatrist to review the person.

Lack of access to these consultations is a common complaint among GPs seeking an assessment for their consumers, despite their use having grown considerably over the last decade (along with item 293, which allows the same psychiatrist to review the person down the track) (figure 7.6). The Royal Australian College of General Practitioners (sub. 386, p. 7) stated that:

> Anecdotally, the experience of GPs referring to psychiatrists is that both public and private referrals are hard to organise. This is because psychiatrists provide talking therapies rather than consultation–liaison service to help diagnose and manage the patient's complex medication regimens. Medicare Benefits Schedule item number 291 was designed to address this problem; however, this is difficult to achieve in practice. GP experience with this item number is that psychiatrists are often unwilling, or do not have the time, to do this.

Figure 7.6   Psychiatric assessments are rising

Number of MBS item services per year
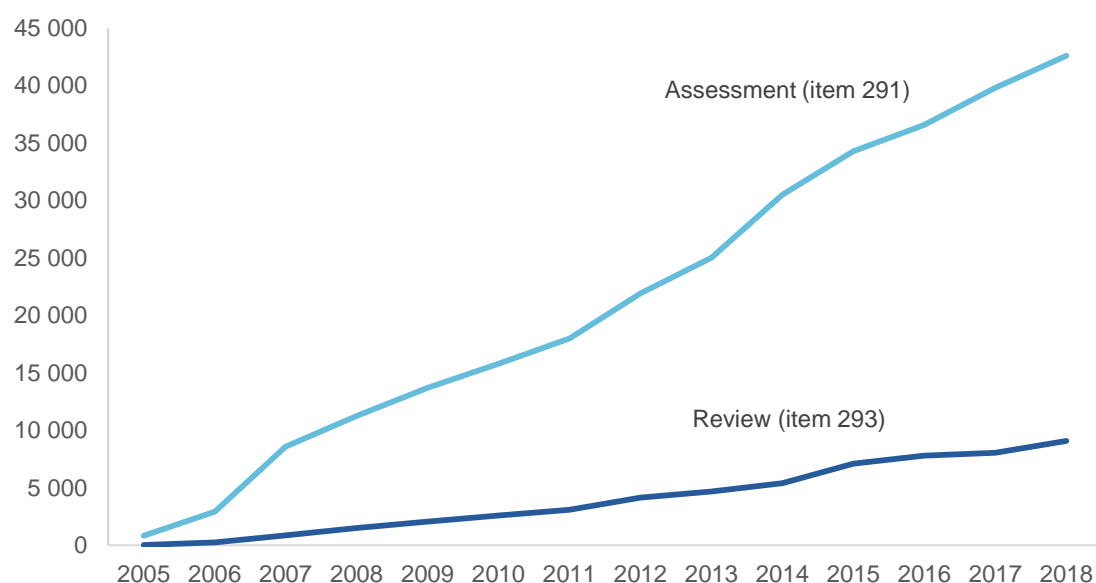
Source: Commission estimates based on unpublished MBS data.

Access to private psychiatric care is dependent on how psychiatrists divide their time between new and established patients. This is because the shortage of psychiatrists, along with the limited increase in the number of psychiatrists from year to year (chapter 11), means that the *total* number of private psychiatric consultations provided each year is fairly stable (AIHW 2019u). This total must be divided among new and established patients. In recent years, psychiatrists have been spending less time with established patients — average outpatient consultations per consumer have fallen over time — from about 7 in 2000 to about

5 in 2018 (Commission estimates based on unpublished MBS data). This helps explain why the number of consumers having at least one consultation with a private psychiatrist has risen.

It may be possible to further improve access to psychiatric care by providing alternative services to support consumers that have many psychiatric consultations in a year. -In 2018, among consumers who had at least one standard outpatient consultation with a private psychiatrist, the median number of consultations was just three. But 10% of these consumers had more than 10 outpatient consultations — accounting for just under 40% of total consultations (figure 7.7). And some consumers have dozens of consultations. About one thousand people had more than 50 such consultations — adding up to more than 80 000 consultations, or 5% of the total (Commission estimates based on unpublished MBS data). While people referred for *psychological therapy* are currently allowed only up to 10 individual sessions in a year (chapter 5), people that are referred to a *psychiatrist* are essentially eligible for an unlimited number of sessions in a year, although after 50 sessions in a year the MBS rebate is lower, and depends on the consumer's condition.[27]

Figure 7.7   Psychiatrist consultations in a calendar year[a]

% consumers by number of sessions, 2018
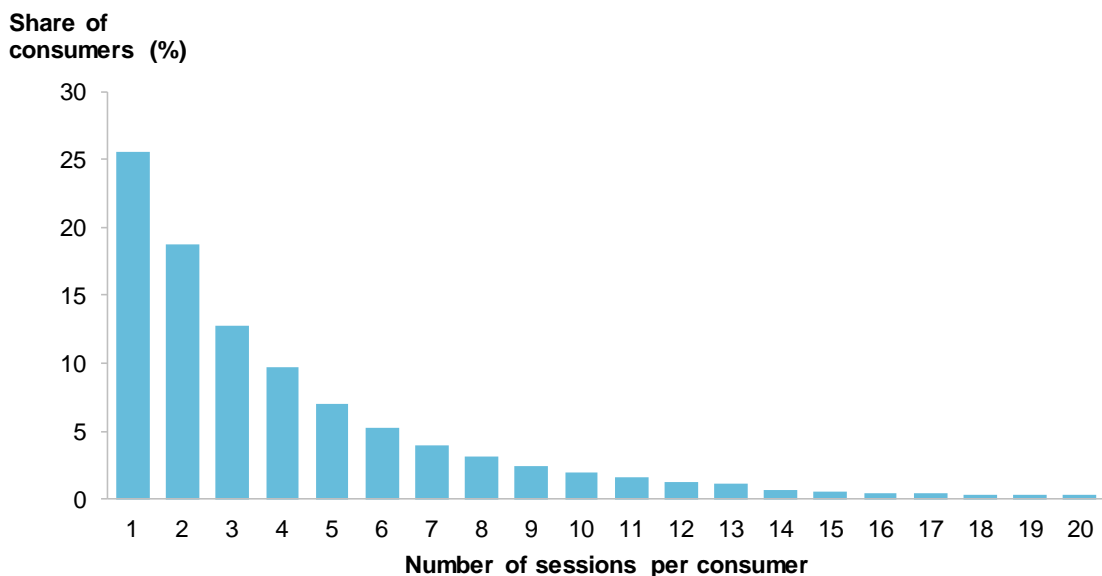
a Includes standard psychiatric consultations only. Does not include consultations in hospital, or in places other than consulting rooms (such as aged care facilities).

Source: Commission estimates based on unpublished MBS data.

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[27] The decrease in the Medicare rebate is less for some disorders with high severity or impairment and where the evidence base for long-term psychotherapy was said to have been established (item 319). These disorders and other indicators of severity are listed in the MBS (DoH 2019a).

The MBS Review Mental Health Reference Group (2018, p. 38) has suggested that some consumers have more consultations with a private psychiatrist than they need, because they cannot access enough sessions of MBS-rebated psychology therapy. Chapter 5 proposes trialling a higher session limit for individual psychological therapy (up to 20 per year instead of 10). If implemented, this change could reduce excess demand for psychiatrist consultations.

Some people with persistent mental illness whose clinical treatment is from a private psychiatrist would greatly benefit from long-term coordinated care provided by a multidisciplinary team of health and psychosocial professionals. This is rarely available outside the State and Territory mental health service system, access to which is severely constrained Addressing the service gap in State and Territory community mental health services (section 7.3) would mean that these people could receive the coordinated allied health and support services they need from State and Territory services. Even where the patient continued to receive their clinical treatment from a private psychiatrist, this change would free up some of the private psychiatrist time to see other consumers.

INFORMATION REQUEST 7.1 — FREEING UP PSYCHIATRISTS FOR PEOPLE WHO NEED THEM MOST

What additional steps, if any, should be taken to support private psychiatrists to increase the number of consultations involving new patients?

Videoconferencing can improve access to psychiatric care

Videoconferencing can improve access to private psychiatric services, in cities as well as in regional and remote areas. Since 2012, consumers residing in regional and remote areas[28] have been able to use videoconference to access various psychiatric consultations (including psychiatric assessment and review consultations). Use of videoconference consultations has risen from about 10 000 in 2012 to about 60 000 in 2018 (Commission estimates based on unpublished MBS data). Almost all of these consultations are bulk-billed. A handful of private providers connect people around Australia with psychiatrists for videoconference consultations. They include both not-for-profits (the Black Dog Institute) and for-profit companies (Call to Mind, PSYCH2U and Dokotela).

However, videoconference consultations with a psychiatrist currently attract an additional MBS rebate equal to 50% of the standard MBS rebate for that consultation type. The total value of these rebates has risen with their use — from $2.4 million in 2012 to $15.3 million in 2018 (Commission estimates based on unpublished MBS data).

The MBS Review Psychiatry Clinical Committee has recommended that these additional payments be removed (MBS Review Psychiatry Clinical Committee 2019, p. 22). They

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[28] RA2–5, based on the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications

noted that the payments were intended as a time-limited incentive to accelerate the adoption of videoconferencing. The Productivity Commission agrees that this purpose has been served, and supports the recommendation of the Committee to remove item 288, and create a new suite of telehealth items, which are mostly remunerated at the same rate as standard consultation items. However, the Committee also recommended that the MBS Review Taskforce 'should consider recommending an incentive payment, or another similar funding mechanism be instituted, to continue to stimulate services in regional and remote areas'. However, the need for such an incentive has not been demonstrated.

Videoconferencing can also help overcome barriers to accessing psychiatric care in cities. In its August 2019 Report, the MBS Review Psychiatry Clinical Committee recommended the introduction of a new suite of MBS items for psychiatry consultations by videoconference for consumers living in major cities (RA1) (MBS Review Psychiatry Clinical Committee 2019, p. 24). The items would be paid at the same rate as existing consultations, and be limited to 12 services per consumer per year. In addition, the items would be limited to consumers who would benefit from videoconference consultations:

> … for reasons of either severe physical disability, a mental health disorder that prevents them from attending a face-to-face consultation, or psychosocial stress (for instance if a patient cannot take time off from work). (MBS Review Psychiatry Clinical Committee 2019, p. 24).

Orygen and headspace (sub. 204, p. 58) have also proposed greater use of 'telepsychiatry outside of remote and rural areas where difficulties accessing psychiatrists are evident'.

Psychiatry by videoconference is not a perfect substitute for face-to-face psychiatry, but it is a close substitute (Chakrabarti 2015; O'Reilly et al. 2007). And it has a range of other benefits:

- it is easier to link up consumers with specialised needs with a psychiatrist of the appropriate sub-speciality (such as a neuropsychiatrist or forensic child psychiatrist) (Hilty et al. 2018; Ye et al. 2012)

- it may be better than face-to-face for some consumers, such as those that have suffered trauma (Yellowlees, Chan and Parish 2015)

- it can improve timeliness of treatment. Telepsychiatry provider Call to Mind will set up a bulk-billed psychiatric assessment consultation within a week or so for most consumers, where they would usually wait many weeks or even months for the same type of consultation face-to-face (Chan, Parish and Yellowlees 2015)

- it can be convenient for psychiatrists, and may encourage psychiatrists to provide more hours of care. Call to Mind (sub. 499, p. 2) told us:

> Telehealth allows for more efficient use of the current medical workforce. Since starting Call to Mind, we have received a lot of interest from psychiatrists and psychologists who are eager to work, but find the standard pathways of public mental health services or individual private work to be inflexible and limited. Many of our psychiatrists are either young parents on leave or returning to work or part-time employees in public services looking for additional clinical time.

Psychiatric assessment consultations appear particularly well suited to videoconference. In 2018, about 8500 consumers had a psychiatric assessment by videoconference, and about 1500 consumers had their assessment *reviewed* by videoconference. Together, they account for 17% of all psychiatric consultations by videoconference (Commission estimates based on unpublished MBS data).

To improve access to psychiatric assessment consultations, consumers in major cities should also be able to access these consultations via videoconference. However, they should not attract an additional payment as they do currently in regional and remote areas. Allowing videoconferencing in major cities for psychiatric assessment consultations was supported by the RANZCP in their recent submission to the MBS Review (RANZCP 2018, pp. 14–15).

DRAFT RECOMMENDATION 7.2 — PSYCHIATRY CONSULTATIONS BY VIDEOCONFERENCE

In the short term (in the next 2 years)

- The Australian Government should introduce a new suite of time-tiered items for videoconference consultations to regional and remote areas (RA2–5), as recommended by the MBS Review Psychiatry Clinical Committee, removing item 288 from the MBS.

- In addition, the Australian Government should add new items for videoconference consultations mirroring existing items for psychiatric assessments (item 291) and reviews (item 293), that are available in major cities (RA1) as well as in regional and remote areas (RA2–5), and that are paid at the same rate as items 291 and 293.

Greater consumer choice can also improve access

Consumer choice can also improve access to psychiatric care, and has value to consumers in any case. Giving consumers greater choice of private psychiatrists could help improve the likelihood they would find one with co-payments they can afford, who is available to see them when they need to be seen, and with whom the consumer is able to develop a therapeutic repour (as discussed in chapter 5).

Draft recommendation 5.8 in chapter 5 aims to clarify current regulations that allow consumers to take their referral to an alternative provider, including mandating clear text on referrals that clarifies this for consumers. It would apply to (and improve) choice of psychiatrist where that profession was deemed necessary by the GP, as well as choice of psychological therapist. It should also promote discussion between the GP and consumer regarding why a particular provider was chosen by the GP.

This recommendation stemmed from previous work the Productivity Commission had undertaken on consumer choice across all of healthcare (PC 2017c, chapter 10).

8 Emergency and acute inpatient services

Emergency and acute inpatient services matter because …	• Emergency departments (EDs) are not working for people with mental illness — they are high stimulus environments, and people with mental illness must often wait many hours before they receive treatment. • Many of these people would be better served outside the hospital environment, although few alternatives are available. • Restricted access to acute inpatient mental health beds has led to problems such as long waiting times to be admitted through an ED, and pressure on hospitals to discharge people early to free up beds. • Some jurisdictions do not have the dedicated child and adolescent mental health beds required to provide safe and high-quality acute treatment.
Successful intervention requires …	As a priority, action should be taken to ensure: • More and improved alternatives to EDs for people with mental illness, including peer- and clinician-led after-hours services and mobile crisis services. • Paramedics are provided with access to mental health resources when undertaking medical assessments in the field. • Acute mental health beds are provided on an ongoing basis at the levels determined by regional service planning to be necessary to meet specific needs of each region. • All State and Territory Governments provide child and adolescent mental health beds which are separate to adults.

The draft recommendations included in previous chapters will go a long way towards intervening earlier to support people with mental illness and prevent unnecessary hospitalisation. However, there will still be cases in which people experiencing an acute episode of mental illness will need to go to hospital, either for treatment in the emergency department or to be admitted to acute services in hospitals.

Many people have shared with the Commission the experiences they have had going to hospital as a person with mental illness or as a carer (for example, Name withheld, sub. 16, 392; David Clark, sub. 205; Laurence West, sub. 541). Some of these experiences reflect the challenges of delivering mental healthcare through emergency and inpatient services:

> I wasn't treated with the respect and dignity I deserved nor are many MENTALLY ILL patients in the Emergency Room. As it is not the place for us. It is designed for PHYSICAL ILLNESS.

> I have a MENTAL ILLNESS that I have managed since my diagnosis, I have learned to understand it. Hence why I KNEW EXACTLY WHAT I NEEDED FOR TREATMENT. TWO MEDICATIONS. TWO MEDICATIONS! I didn't even take up a bed, I slept on the couches in the "meeting room" with my mother being forced to 'watch me' as the hospital was short staffed. (Jade Weary, sub. 436, p. 2)

8.1   Crisis and emergency services

In 2017-18, Australians attended an emergency department (ED) almost 290 000 times due to mental illness (AIHW 2019v). The attendance rate per head of population has risen over the last decade, with most of this increase having occurred over the 5-year period from 2010-11 to 2015-16 (figure 8.1).

Figure 8.1   Mental-health related ED attendances per head of population[a]
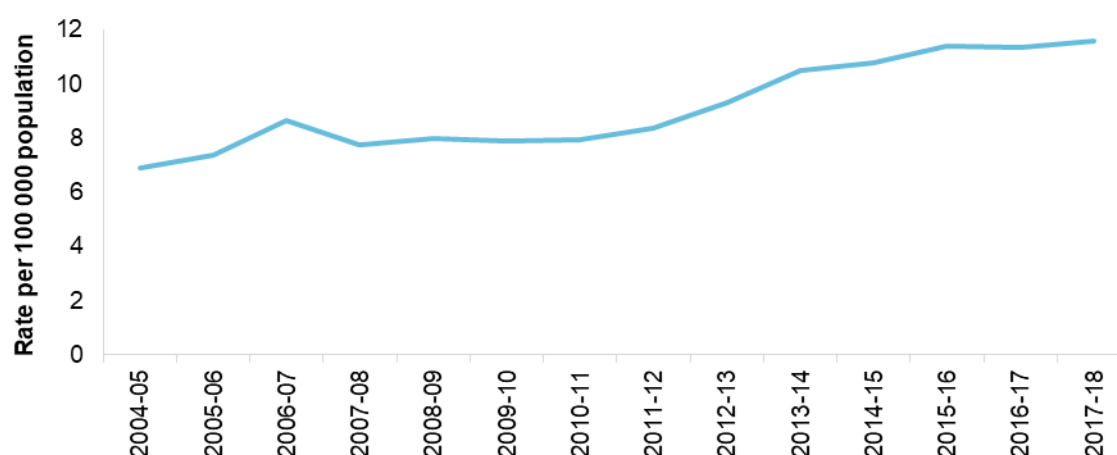
a Public hospitals only.

Source: AIHW (2019aa).

A range of factors have caused the growth in ED attendances. This includes insufficient investment in community ambulatory (outpatient) services to prevent people with a mental illness needing emergency treatment for a crisis (chapter 7), and a lack of alternatives to EDs for people who are experiencing a crisis, particularly after-hours (Jenkins and Katz 2015; Sawyer and Patton 2018). Moreover, the AIHW (2019v) has reported that mental health-related ED attendances due to psychoactive substance abuse accounted for about 30% of the increase in such attendances from 2008-09 and 2017-18.

Compared to people with other health conditions attending an ED, people with mental illness are less likely to be either a child or be elderly (figure 8.2). Conversely, Aboriginal and Torres Strait Islander people were more likely to attend ED due to mental illness. Aboriginal and Torres Strait Islander people accounted for 11% of mental-health related ED attendances compared to 7% of attendances for other causes (AIHW 2019aa).

Figure 8.2   ED attendances by cause and age, 2017-18[a]
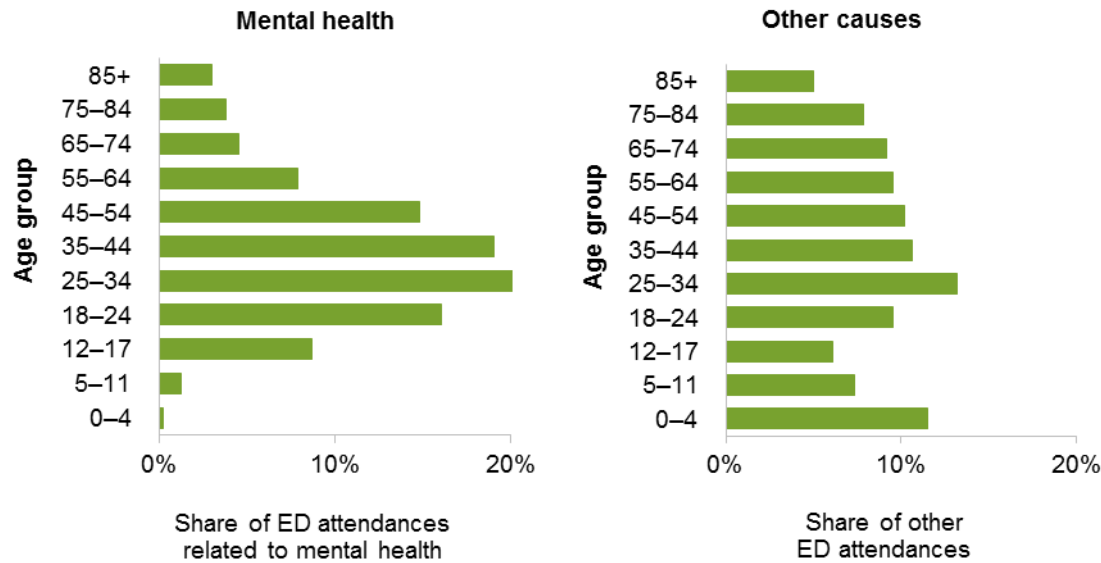
a Public hospitals only.
Source: AIHW (2019aa).

EDs are not working for people with mental illness

People with acute mental illness require an environment that is calm, offers privacy and makes them feel safe (for example, Jade Weary, sub. 436). In contrast, EDs are typically high-stimulus environments with bright florescent lights, lots of noise, little privacy, and can be crowded and at times appear chaotic. These stimuli can increase agitation, worsening the symptoms of mental illness. Some people may also become aggressive or violent, requiring them being sedated, secluded or restrained.

The Australasian College of Emergency Medicine (ACEM) told the Commission that unsuitable ED environments make people experiencing mental illness more likely than other patients to leave before their treatment is completed and against medical advice (ACEM 2018b, sub. 516).

People with mental illness who do wait until their treatment is completed often have to endure more time in the ED than other patients. Patients attending an ED with a mental illness:

- spend a median time of around 3.5 hours in the ED, compared with a median of just under three hours for all patients (AIHW 2019aa, 2019a)

- are twice as likely as other patients to stay for more than 8 hours (ACEM, sub. 516)

- regularly experience instances of three or more days in an ED, according to ACEM (sub. 516), which argued that patient safety requires that people who need to be admitted are done so within 8 hours of being assessed for admission.

For some people with mental illness, using the services of the emergency department is due to the lack of accessible services in the community. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) noted that:

> If the emergency department is overwhelmed by mental health presentations, as it is in many parts of Australia, it indicates upstream and/or downstream difficulties. (sub. 385, p. 10)

In chapter 7, the Commission has proposed reforms to improve access to upstream community ambulatory services, which would reduce the number of people who have no alternative but to attend an ED. Such patients have made up a large and growing proportion of ED attendances. For example, from 1995 to 2005, one ED had experienced a 10-fold increase in patients who could have been treated in community settings if the services had been available. It was also reported that these patients now accounted for 80% of mental-health related ED attendances (ACEM 2018a). The Commission has also proposed reforms to improve upstream services available through primary care and e-mental health (chapters 5 and 6).

Improving upstream mental health services would help to prevent a deterioration in mental illness, and hence reduce demand for downstream admitted hospital services. The supply of inpatient services currently struggle to meet demand, leading to a major problem with 'access block' in EDs. This is where patients have been admitted into an ED but are delayed from leaving the ED due to an inpatient bed not being available (discussed further below in section 8.2).

Reducing the number of people with mental illness in EDs may also lead to cost savings in hospitals. In 2015-16, the average cost per attendance of managing a patient with a severe mental disorder in an ED was close to $760, compared to around $700 across all patients (IHPA 2017).

Offering improved alternatives to EDs

In addition to increasing the availability of the community mental health services, State and Territory Governments should aim expand the range of alternatives to EDs for people experiencing mental illness. Such alternative models — including after-hours services and mobile crisis services — can significantly improve the experience of people with mental illness.

After-hours services

Half of all mental health attendances at EDs are after-hours (Doggett 2018). Some of these people do not need acute hospital care and could instead be treated in alternative after-hours services if they were available.

One option is more after-hours GP clinics. For example, the Australian Government announced $28 million funding in June 2019 for four new 'urgent care' clinics (employing GPs and nurses) in Perth to provide timely alternative care pathways for unscheduled care, with extended opening hours (Hunt 2019d). The effectiveness of such clinics in assisting people with a history of mental illness depends on having after-hours access to patient records, such as through My Health Record, because the treating clinician may not have seen the patient previously.

Another option is for more headspace centres to open after-hours, although this would only focus on younger people and so would not be a universal solution. Currently, headspace centres are typically closed on weekends and only open from 9am to 5pm during the week, although some stay open later on selected weeknights.

After-hours services can also be staffed by peer workers, rather than clinical staff. For example, the Safe Haven Cafe operates near the ED in St Vincent's Hospital, Melbourne. The cafe offers respite in a warm, caring and respectful environment to people needing mental health support, as well as social connection, but not necessarily acute care. It is based on a model successfully trialled in the United Kingdom, which was developed by and for consumers (St Vincent's Melbourne 2018). In June 2019, the Queensland Government announced that it was allocating almost $11 million over the following 4 years to fund safe haven cafes in some of its hospitals (Miles 2019).

An evaluation of the cafe in St Vincent's Hospital found that it reduced mental health-related ED presentations, with almost 40% of those attending the cafe saying they would have gone to the ED if the cafe did not exist (PWC 2018a). It was also found to improve patient experiences and social connections in the local community. However, the café is currently only open for a limited number of hours (Beyond Blue 2018b; St Vincent's Melbourne 2018). It is not open late on Friday and Saturday nights, which are peak times for mental health crises.

Alternatives to EDs could — in addition to improving the wellbeing of people experiencing mental ill-health — save money and help EDs work better for other patients. However, the

financial incentive is diluted by Australia's fragmentation of health funding responsibilities between governments. In particular, State and Territory Governments (which fund public hospitals, and therefore would be the main beneficiaries of any reduction in spending on ED services) are precluded from contributing to MBS-rebated clinical services in the community, such as those that would help people to avoid needing to visit an ED.

In chapter 24, the Commission has proposed that State and Territory Government local hospital networks be allowed to co-fund services which currently receive public funding exclusively from the MBS. This would include allied health services and out-of-hours care from GPs, provided that the Australian Government's local primary health network supports such co-funding.

Mobile crisis services

In 2017-18, almost half of all mental health ED attendances arrived by ambulance, which was nearly twice the rate for all patients (AIHW 2019aa). Greater mental health expertise among first responders, and improved access to ED alternatives, could help some people with mental illness to avoid EDs.

For example, in 2015 the NSW Ambulance Service implemented the Mental Health Acute Assessment Team program, which involves specially trained paramedics and mental health nurses providing medical assessment at the scene before a decision is made on the best course of care. This could be to contact a GP, follow-up with a community-mental-health team, or admit the patient to a mental-health facility. Between 2015 and 2017, about 50% of mental health-related callouts resulted in patients bypassing EDs in favour of more appropriate care (WSLHD 2017). Ambulance Victoria is also trialling mental health nurses in its ambulances to help ambulance officers deal with mental health emergencies, and has seen a reduction in the number of people coming into EDs (ACEM 2018a).

Crisis assessment and treatment (CAT) services can also divert people from unnecessary attendance at EDs. They are staffed by people with backgrounds in medicine, nursing, social work and psychology. Clinicians may also be accompanied by a peer worker. CAT teams provide mobile assessment and treatment, including in people's homes. They are skilled at de-escalation, and can often keep someone having a mental health crisis from needing the ED.

However, delivering CAT services has challenges. Responding to multiple calls with fixed resources puts pressure on the crisis team and there can be safety issues (SCMH 2006). Most CAT services operate over extended business hours, rather than being a 24-hour service, and rarely use any capacity they may have for site visits. Moreover, occupational health and safety concerns have led to restrictions on CAT staff going alone to potentially unsafe community locations at night, such as remote private residences.

One option which could address some of these issues is the Police, Ambulance and Clinical Early Response (PACER) model. This centres on a dedicated joint police and mental health

secondary response activated by police, targeted to times of greatest demand and offering on-site and telephone mental health assistance (Allen Consulting 2012). Similar models are considered in chapter 16. Moreover, the Commission proposes increased funding for community treatment in chapter 24, which could include CAT services, depending on regional priorities.

Improving the experience for people who attend EDs

While more alternatives are required, some people with mental illness will continue to need emergency clinical care in an ED. For these patients, the ED experience should be improved.

The RANZCP argued that the design of EDs need to be significantly changed.

> … emergency departments require significant structural redesign of specific spaces for mental health, to ensure that individuals with mental illness can seek help in a calm, safe and private environment. (sub. 385, p. 10)

This could involve a dedicated space in EDs for people experiencing mental illness, which:

- provides a calmer environment for the person
- allows for longer periods of observation and assessment
- reduces the need for restraint because there is perimeter security
- creates a safer and calmer environment for other patients elsewhere in the ED.

Separate mental health units within EDs have recently been trialled with some success in hospitals in Western Australia. Similarly, in May 2018, the Victorian Government announced that it would invest $100 million to create six units in hospitals across the state, to be termed crisis hubs (Andrews 2018). Not only does the creation of separate units require substantial funding (albeit potentially outweighed by the benefits), hospitals may not be able to add a new mental health unit within their existing building footprint.

A lower-cost alternative is to make existing EDs more suitable to the needs of people with mental illness. For example, there is evidence to support:

- sensory modification techniques, which could be as simple as giving the patient bubble wrap or a stress ball to play with
- having peer workers in EDs to support mental health patients
- employing nursing assistants with basic training in dealing with people with mental illness as an alternative to security guards
- increasing natural light, surfaces and colours. (ACEM, sub. 516)

There are also options which do not require modifying the physical environment of an ED. For example, Royal Prince Alfred Hospital in Sydney has successfully trialled an extended hours mental health liaison nurse service based in its ED. The team of nurses see people

presenting with mental health problems and begin the process of helping to manage and coordinate care. This has been shown to provide prompt and effective access to specialised mental health services by determining the cause and treatment needed for a mental health crisis, and removing a significant workload from ED nursing and medical staff (ACEM, sub. 516).

There are a variety of options to improve ED experiences for people experiencing mental illness. Some can be implemented quickly and at relatively low cost, while others, such as redesigning the physical layout of EDs, are higher-cost options, which may have to be implemented over the longer-term. Which approaches are implemented, and when, is a decision that should be made at a local level to reflect regional circumstances, including the available resources, space, personnel, and patients coming through the doors.

DRAFT RECOMMENDATION 8.1 — IMPROVE EMERGENCY MENTAL HEALTH SERVICE EXPERIENCES

In the short term (in the next 2 years)

- State and Territory Governments should provide more and improved alternatives to hospital emergency departments for people with acute mental illness, including peer- and clinician-led after-hours services and mobile crisis services.

- State and Territory Governments should consider best practice approaches to providing paramedics with access to mental health resources when undertaking medical assessments in the field.

- Public and private hospitals should take steps to improve the emergency department experience they provide for people with a mental illness. This could include providing separate spaces for people with mental illness, or otherwise creating an environment more suitable to their needs.

In the long term (over 5 – 10 years)

- State and Territory Governments should, when building or renovating emergency departments, design them to take account of the needs of people with mental illness.

8.2   Acute inpatient mental health services

Acute inpatient mental health services involve an admission to hospital for short-term treatment of an acute episode of mental illness, characterised by recent onset of severe clinical symptoms which have the potential for prolonged dysfunction or risk to self and/or others (AIHW 2019aa).[29]

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[29] Acute inpatient mental health services are sometimes provided in a patient's home. The Tasmanian Government (sub. 498) offers this option in southern Tasmania for people in an acute phase of mental illness, where appropriate.

This section focuses on a widely held concern that access to acute inpatient services is constrained by a lack of inpatient beds. Current demand for acute mental health beds has to some extent been affected by a lack of community ambulatory services (discussed in chapter 7) and non-acute bed-based care.[30] The other key issue raised by inquiry participants about acute inpatient services was the funding arrangements for private hospitals and patients, and associated role of private health insurance. That is considered in chapter 24.

In 2016-17 (the most recent published data), there were almost 10 200 specialised mental health beds in Australia. This equated to 42 beds per 100 000 people. Around 70% of these were in the public sector (29 beds per 100 000 people), of which most were for acute care (21 beds per 100 000 people). The availability of public sector beds varied between jurisdictions (figure 8.3). Data on private sector beds are not reported at a state and territory level, or separately for acute versus non-acute bed-based care.

Figure 8.3   **Specialised mental health beds per 100 000 population, by jurisdiction, 2016-17**
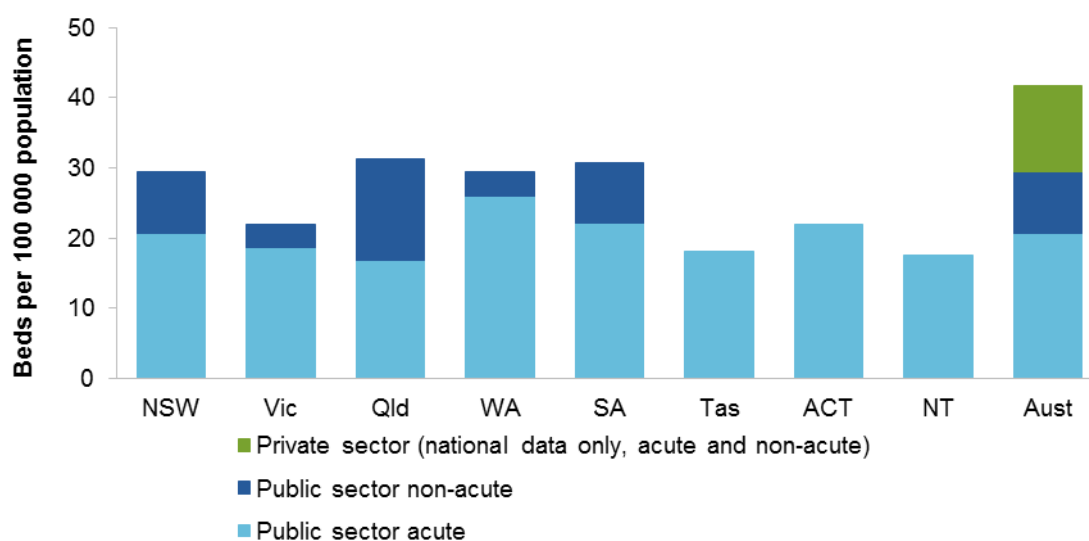
Source: AIHW (2019ab).

At a national level, around a quarter of all public sector mental health beds are reserved for particular groups: older person services (14% of beds in 2016-17), forensic services (9%), and youth, child and adolescent services (5%).

The per capita supply of public sector acute beds has been constant since the early 1990s (figure 8.4). In contrast, there was a significant decline in the per capita supply of public sector non-acute beds up until the end of the 1990s, when the last of the public mental

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[30] Non-acute bed-based care focuses on rehabilitation and improving the functioning of people with mental illness to live independently in the community (chapter 7). Acute care focuses on reducing the symptoms and impairment caused by an episode of severe mental illness.

healthcare facilities, referred to as 'institutions' or 'asylums', were being closed down (chapter 15).

Figure 8.4   **Specialised mental health beds per 100 000 population**
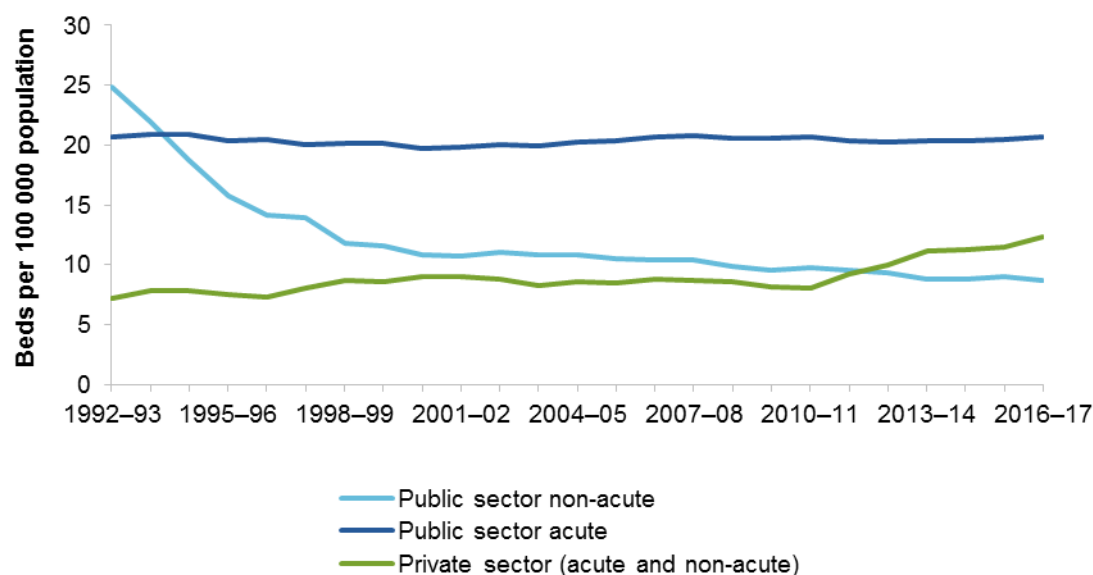
Source: AIHW (2019ab).

The other notable trend in the public sector has been a shift of beds from stand-alone psychiatric hospitals to specialised psychiatric units or wards in general hospitals. The share of public sector mental health beds in general hospitals grew from around one-quarter in 1992-93 to more than three-quarters by 2016-17.

In the private sector, there has been a long-term upward trend in the number of specialised mental health beds, reaching a total of around 3000 by 2016-17. Most of the growth has occurred since 2010-11, with the per capita supply of private hospital mental health beds growing since then by an average annual rate of 7.4% per annum up to 2016-17.

Participants' views and estimates on bed shortages

Many inquiry participants expressed the view that there are insufficient acute mental health beds (for example, Australian Medical Association, sub. 387; Australian Salaried Medical Officers Federation, sub. 233; Consumers Health Forum, sub. 496; Mental health Victoria, sub. 479). This was often linked to the problems in EDs discussed in section 8.1. Specifically, when patients attending an ED need to be admitted for acute care, too often they have to endure a long wait until an inpatient bed becomes available. Sometimes they may even be transferred to another hospital with an available bed (Connect Health & Community, sub. 94) or be offered a service that lacks the intensity of clinical treatment and supervision necessary.

ACEM quantified the problem by submitting results from a survey of 65 EDs it conducted in December 2017, which revealed that:

- While only 4% of presentations were for mental health, this group comprised 19% of patients waiting for inpatient beds and 28% of those experiencing access block.[31]

- The rate of access block varied from state to state, and was much higher in Western Australia (66.7%) than the national average.

- Two-thirds of EDs had patients waiting in the ED longer than 24 hours, with 23% of respondents reporting waits of longer than 72 hours.

- The maximum length of stay for an ED patient with a mental health presentation was 145 hours, or six days. (sub. 516, p. 4)

The RANZCP noted the problems that a lack of inpatient beds had caused at the ED of one NSW public hospital.

> … $4 million in one year was spent on using security to provide one-to-one supervision of mental health patients waiting for beds. The same unit has days where up to 28 admitted patients wait in the emergency department for a psychiatric bed. (sub. 385, p. 10)

Addressing the unacceptable situation for mental health patients and staff in EDs requires consideration not only of how to improve service delivery when patients arrive at an ED, but also how to prevent patients deteriorating to the point where ED and hospital services are needed. Draft recommendations in chapters 5–7 to improve mental health services available outside of hospitals would enable more people to stay healthy and living in the community, and therefore reduce the number of people needing acute inpatient mental health beds. Reforms proposed elsewhere in this report would also increase non-acute mental health beds, which would reduce the demand for acute beds. However, not all hospitalisations are avoidable and so acute inpatient beds will still be needed to some extent.

The Queensland Centre for Mental Health Research (QCMHR) provided this inquiry with estimated benchmarks for the mental health services required to meet the needs of Australia's population. The benchmarks suggest that only a relatively small increase in acute beds would be required if it was accompanied by efforts to fill major gaps in other services (box 8.1). This is because filling those gaps would address an under-provision of services that prevent acute episodes of mental illness and support recovery from such episodes, thereby reducing the need for more acute beds.

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[31] ACEM defined access block as the situation where a patient has been admitted to hospital through an ED but is delayed from leaving the ED due to an inpatient bed not being available.

The Queensland Centre for Mental Health Research (QCMHR) at The University of Queensland is responsible for maintaining and updating a model — called the National Mental Health Service Planning Framework (NMHSPF) — which quantifies the mental health services needed to meet the needs of Australia's population. The model was initially developed by the NSW and Queensland Governments, and is funded by the Australian, State and Territory Governments.

NMHSPF benchmarks indicate that a comprehensive range of mental health services which met the needs of the Australian population in 2019-20 would require the public sector to provide a combination of:

- 3% more acute beds than existed in 2016-17

- 81% more non-acute beds than in 2016-17

- 45% more community ambulatory (outpatient) services (measured in terms of full-time equivalent workers providing services) than in 2016-17.

The estimated number of needed acute beds in 2019-20 was calculated on the assumption that readmission rates remain around the average over 2015 to 2017.

The benchmarks generated by the NMHSPF are based on national averages, so it was not possible to identify how any needed changes would vary between states and territories.

The WA Mental Health Commission has published an analysis of the gap between existing and needed services in its jurisdiction (WA MHC 2015a, 2019). The results suggest that Western Australia would, in 2025, need 8% fewer public sector acute beds than in 2017, provided it also implemented a significant planned increase in community ambulatory and non-acute hospital services. The above mentioned ACEM survey results, showing that Western Australia had the highest rate of access block in late 2017, raises significant doubts about the ability to reduce its acute beds.

Other states and territories have not published similar analyses but available data indicate that they have even fewer public sector acute beds per head of population than Western Australia (figure 8.3). While such cross-jurisdiction comparisons may be partly distorted by differences in how jurisdictions define and classify beds, they suggest that other states and territories should also be cautious about considering a reduction in acute beds.

Options to address concerns about access to mental health beds

The Commission considered whether there is scope to use existing mental health beds more efficiently than currently, thereby increasing the number of inpatients who could be cared for with current resources and reducing the need for more beds.

It does not appear that there is much potential for existing beds to be used more intensively by Victoria's adult mental health services. It already has an average bed occupancy rate of around 95%, compared to the 85% rate often nominated as best practice in mental health to

avoid many patients having access problems (Consortium of Australian Psychiatrists-Psychologists, sub. 260; DHHS 2019a; DHHS and VIC DHHS 2017; Jones 2013).

Data on occupancy rates in other jurisdictions are not available, but another measure of efficiency — average length of stay — is reported nationally and this also provides little evidence of unused capacity in the system. On the contrary, the average length of stay for public mental health services in Australia has been falling — from 15 days in 2010-11 to 13 days in 2016-17 (AIHW 2019j).

Victoria's chief psychiatrist, Neil Coventry, was recently reported as stating that the declining length of stay in his state was due to pressure to 'move people through before perhaps they're really ready to be able to discharged' (Bennett 2019). Similarly, a number of participants in this inquiry suggested that a shortage of beds has led to pressure on hospital staff to discharge patients prematurely to make beds available for new patients (for example, Consortium of Australian Psychiatrists-Psychologists, sub. 260; Olav Nielssen, sub. 37; Nielssen et al. 2017).

The NSW Nurses and Midwives Association (sub. 246, p. 11) described the issue as follows.

> … admitted patients are being discharged so their bed can be made available for those more acutely ill waiting in the emergency department (EDs) or in the community. The inpatient near discharge is often deemed less acutely ill and discharged early due to the urgency of a bed being required, but without the discharge planning required due to the emergency of the situation.

However, declining length of stay in hospitals is not always associated with the need for readmission. For example, the rate of unplanned readmissions for mental health patients has remained stable at around 15% since the mid-2000s (AIHW 2019j). Readmission rates are much higher for mental illness admissions than for surgery admissions, for example, but this may be explained by the episodic nature of mental illness.

One way that additional acute patients might be able to be treated within existing resources is to provide a greater share of care as hospital-in-the-home services. For example, the WA Government is planning to have the equivalent of about 180 hospital-in-the-home beds by 2025 (WA MHC 2019). Such services are suitable for a minority of patients whose acute episode is very likely to be short term, they have a carer at home, required visits from health professionals are not so frequent as to be impractical and uneconomic compared to being treated in a hospital, and any workplace health and safety concerns for professionals in visiting a patient's home are manageable.

The Commission also considered how Australian bed numbers compare with those overseas. The per capita provision of (acute and non-acute) mental health beds in Australia of 42 per 100 000 people (figure 8.3) is significantly below the OECD average of 71 beds (OECD 2019). To match the OECD average, Australia would have to increase its per capita supply of mental health beds by 69%. However, such a simple calculation overlooks cross-country differences in health systems and data definitions. Moreover, the OECD (2014a, p. 1) has previously praised Australia for 'leading the way in innovative

approaches to delivering mental health services, including a decisive shift away from hospital care'.

The RANZCP (sub. 385) urged this inquiry to recommend minimum and optimal benchmarks for specialised mental health beds per 100 000 population. The Consortium of Australian Psychiatrists-Psychologists (sub. 260) went further by calling for a specific increase in public hospital inpatient beds to at least 50 per 100 000 people, which would be an increase of over 70% from the 2016-17 level of 29 per 100 000.

> Our groups have extensively analysed and reviewed KPIs [key performance indicators], and Australia is encountering major quality and safety issues on ED boarding, out-of-area admissions, high occupancy rates, high 28-day readmission rates, increasing rates of incarceration and an increased risk of suicide in community settings. These adverse effects worsen as total bed numbers fall below a critical range of 50–60 public sector beds per 100 000 for people with SMI [serious mental illness]. (Consortium of Australian Psychiatrists-Psychologists, sub. 260, p. 11)

The precise number of beds required is a technical issue for clinical and planning experts and may vary between regions, so this inquiry has opted not to recommend a specific level. The benchmarks generated by the NMHSPF suggest that, in 2019-20, a total of 11 075 public sector mental health beds are needed (4874 acute and 6201 non-acute). The exact number to provide is ultimately a matter best determined through integrated service planning at a local level, taking account of the relevant population and what services exist to prevent avoidable hospital admissions. Which organisations should be responsible for such planning is an issue that is considered in chapter 24.

Mental health beds for young people

In 2016-17, about 5% of mental health beds in the public sector were specifically for children, adolescents and youth (AIHW 2019aa). This conceals significant differences between states and territories, with two jurisdictions — Tasmania and the ACT — having no beds specifically for young people (figure 8.5). The Northern Territory opened its first young persons' mental health facility in early 2016 with 5 beds, attached to the Royal Darwin Hospital (Sorensen 2016).

Figure 8.5   **Mental health beds specifically for young people, by jurisdiction, 2016-17ª**
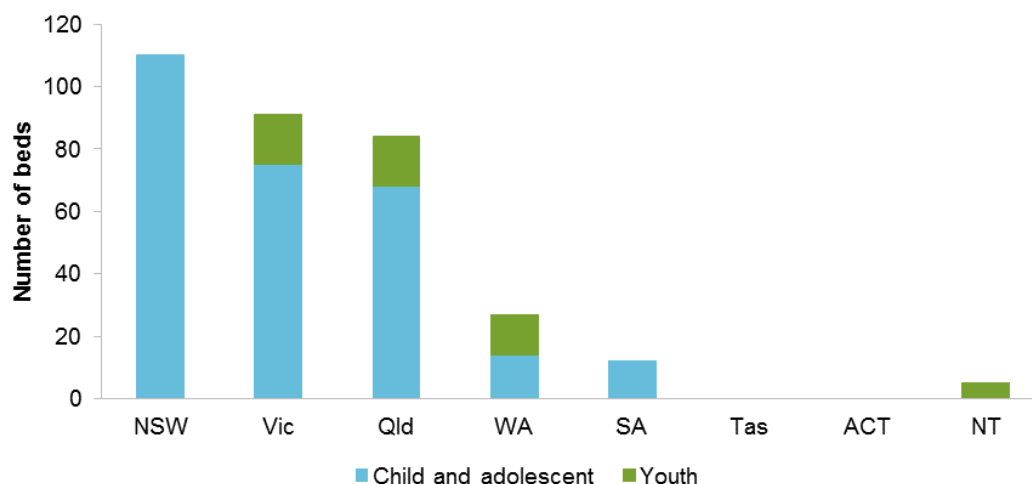
a Public sector specialised mental health hospital beds. Child and adolescent beds are primarily targeted at people aged under 18 years, and youth beds at those aged 18-24 years.

Source: AIHW (2019ab).

When there are no dedicated mental health beds available for children and adolescents, there is a risk that they will be placed in either:

- adult mental health wards, where their safety may be threatened by adult patients

- paediatric wards, where staff may have few skills in mental health.

No children or adolescents should be placed in an adult mental health ward. If it is not possible for a public hospital to provide child and adolescent mental health beds that are separate from adults, the relevant State or Territory Government should contract with private facilities or provide hospital-in-the-home care for children and adolescents.

DRAFT RECOMMENDATION 8.2 — CHILD AND ADOLESCENT MENTAL HEALTH BEDS

In the short term (in the next 2 years)

State and Territory Governments should provide child and adolescent mental health beds that are separate to adult mental health wards. If it is not possible to provide these beds in public hospitals, State and Territory Governments should contract with private facilities, or provide care as hospital-in-the-home.

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9   Physical and substance use comorbidities

Mental health and physical health comorbidities matter because …	• Many people with mental illness experience poor physical health and substance use disorders, which can have serious consequences up to and including premature death. • Physical illness is a risk factor for developing a mental illness and having a mental illness can create or contribute to a deterioration in physical health. • Wider systemic problems, including fragmentation in the delivery of mental healthcare, and physical health or treatment substance use, lead to poor consumer outcomes.
Successful intervention requires …	• Integrated funding and governance, which span health and non-health sectors. • Coordinated person-centred care, which brings together services for mental ill-health, physical ill-health, and alcohol and substance use. • Specialist staff with skills and experience to work in complex multidisciplinary care environments. • More data to support planning and commissioning of services targeting physical and substance use comorbidities. • Evaluations of programs to improve provision of services to people with physical and mental healthcare needs.

9.1   Physical comorbidities

People experiencing mental ill-health have a relatively high rate of physical illness compared with the rest of the population. About 60% of adults who experience an episode of mental illness in a given year also have at least one physical health problem, compared with less than 50% of adults without a mental illness (chapter 2). This pattern is evident across a range of physical illnesses and it is also consistent with that observed in other countries (Duggan 2015; RANZCP 2015; Te Pou 2014; WHO 2018).

For Australian adults who experience an episode of mental illness in a given year, having the additional burden of a physical comorbidity is associated with:

- lower quality of life — they are about 70% more likely to report high levels of psychological distress if they have a physical comorbidity

- greater disadvantage — they are over 30% more likely to live in an area in the lowest quintile for socioeconomic status

- decreased ability to function — they are about 2.5 times more likely to have been unable to work or carry out their normal activities for more than 7 out of the past 30 days

- reduced workforce participation — they are almost 20% less likely to be employed (AIHW 2012a).

Physical ailments are not only more common, but also tend to result in early death when a person has a mental illness. It is estimated that physical illnesses cause almost 80% of the gap in average life expectancy between people with mental illness and the whole population, compared with 14% of the gap being due to suicides (Lawrence, Hancock and Kisely 2013). Moreover, many of the physical illnesses that people with mental illness die from have effective treatments that are commonly used by the rest of the population — heart disease, respiratory disease and some cancers (Harris et al. 2018; NSW MHC 2018; RANZCP 2015). The annual cost of comorbidities associated with premature death in people with a serious mental illness is substantial and, in 2014, was estimated to be about $15 billion by the Victoria Institute of Strategic Economic Studies (RANZCP 2016b).

Why is physical health worse for people with mental illness?

The mechanisms underlying the relationship between mental and physical health are not completely understood, but the literature points to multiple causes of physical comorbidities which are, to some extent, avoidable (Harris et al. 2018; NSW MHC 2018; RANZCP 2015).

- The characteristics of mental illness increase the likelihood that a person will experience known risk factors for physical ill-health, including being sedentary, lacking motivation, experiencing cognitive impairment, or having a disorganised lifestyle. This can lead to problems such as a lack of exercise, poor diet, failure to maintain oral hygiene, unawareness of physical symptoms and limited motivation or capacity to access and adhere to effective physical healthcare (Duggan 2015; RANZCP 2015).

- Mental illness is associated with high rates of smoking, alcohol and other drug use (AIHW 2012a; RANZCP 2015), as discussed in section 9.2.

- Health professionals can fail to address the physical problems of people experiencing mental ill-health due to 'diagnostic overshadowing', which views all symptoms as being related to mental illness (NMHCCF 2016; RANZCP 2015; Canberra Mental Health Forum, sub. 62; Mental Health Council of Tasmania, sub. 314; NMHC, sub. 118; Victorian Council of Social Service, sub. 478). Clinicians working in mental health may also not consider physical health to fall within the scope of their role and those specialising in physical health may be reluctant to treat clients with a mental illness. Stigma and discrimination can also lead to sub-optimal treatment for physical ill-health (chapter 20).

- Some treatments for mental illness can lead to poor physical health. In particular, anti-psychotic medications can cause significant weight gain, increasing the risk of obesity, diabetes, cardiovascular disease and metabolic syndrome (Duggan 2015; NMHCCF 2016; NSW MHC 2018; RANZCP 2015, 2015; Te Pou 2014).

- The systemic problems identified throughout this report with service coordination, and difficulties in finding and accessing support, are important factors. People with mental illness may need services from multiple professions to support their mental and physical health. With little assistance to navigate their way to these services (where they exist), they can miss out on needed services. When services are received, a lack of coordination can result in worse physical and mental health. For example, there may be little consideration of the trade-offs between medications prescribed by a psychiatrist and potential adverse impacts on physical health, which general practitioners treat.

The relationship between physical and mental illnesses can be a two-way causation. Physical illness is itself a risk factor, which makes people with physical illness more prone to developing a mental illness and vice-versa (Community Mental Health Australia, sub. 449; Justin Kenardy, sub. 6). While this may make it more difficult to improve health outcomes, it may also increase the benefit from doing so.

What has been done so far to address physical comorbidities?

Governments and service providers have been aware of the comorbidity problem for some time and have sought to address it in various ways. For example, the NSW Government has targeted the issue since at least 2009, when it introduced the Linking Physical and Mental Health program (NSW MHC 2018). It published advice to inform consumers and carers of the importance of addressing physical needs and what to expect from mental health services (NSW Health 2009a, 2009b, 2009c). This was accompanied by a directive and guidelines for providers on actions they must take for consumers to receive sufficient physical healthcare, which were updated in 2017 (NSW Health 2017b, 2017c).

Bodies representing individual health professions have also sought to foster improvements. For example, the Royal Australian and New Zealand College of Psychiatrists (2015, 2016b)

published reports promoting reforms to improve the physical health of people with mental illness, including calls for psychiatrists to work with other health professionals and to not limit their role to the symptoms of mental illness. It has also published advice for people with mental illness on how to improve their physical health, including by asking their doctor about the benefits and risks of medications (RANZCP 2017e).

Efforts to address the issue recently gained momentum through two national initiatives. The *Equally Well National Consensus Statement* (NMHC 2016) aims to bridge the life expectancy gap between people living with mental illness and the general population. More than 50 organisations support the statement, including all State and Territory Governments, numerous Primary Health Networks (PHNs) and organisations representing specific health professions, consumers, carers and non-government service providers. Under the statement they act to deliver:

1. a holistic, person centred approach to physical and mental health and wellbeing

2. effective promotion, prevention and early intervention

3. equity of access to all services

4. improved quality of health care

5. care coordination and regional integration across health, mental health and other services and sectors which enable a contributing life

6. the monitoring of progress towards improved physical health and wellbeing. (NMHC 2016, p. 7)

The other national initiative is the *Fifth National Mental Health and Suicide Prevention Plan*, which identifies physical comorbidities as a priority area for government action by:

- committing to the six elements of the *Equally Well Consensus Statement* (action 14)

- having up-to-date guidelines and other resources for health services and professionals on how to improve the physical health of people with a mental illness (action 15)

- working with PHNs and Local Hospital Networks (LHNs) (or equivalents) to ensure that the treatment of physical illness for people with mental illness is (action 16):

  – included in their joint local service planning and clinical governance activities

  – reflected in the roles and responsibilities documented in local service agreements

- commencing regular national reporting on the physical health of people living with mental illness (action 17).

In its summary of progress against the Plan, the National Mental Health Commission (2018a) indicated that while many government agencies reported that they were 'on track', each action had at least one agency that reported its progress as being 'behind schedule'.

How should physical comorbidities be addressed?

Reducing the burden of physical comorbidities among people with mental illness requires a range of measures, given the multiple causal pathways discussed above. Although evidence for specific interventions evidence is still developing (Duggan 2015; NSW MHC 2018; Te Pou 2014), commonly recommended initiatives include:

- building individuals' capacity to have control over their physical health, such as by supporting them to exercise, ask about risks associated with psychiatric medications, and be proactive in seeking physical healthcare and adhering to treatment regimes

- ensuring that health professionals take responsibility for the physical health of their patients with mental illness, including by routinely screening and monitoring physical health and by closely collaborating with other clinicians and allied health professionals

- addressing stigma and discrimination among healthcare providers that causes them to downplay the need to treat the physical ill-health and provide lower-quality treatments

- addressing the difficulties people face in finding and accessing support, such as by assisting them to access services and by filling gaps in the availability of allied health services, such as dieticians and alcohol and other drug counsellors

- improving coordination and integration of mental and physical healthcare across all services, providers, professions and settings.

9.2 Substance use comorbidities

Substance use (alcohol and other drugs) disorders often co-occur with other mental health disorders. It is an area inhabited by some of the most vulnerable people in Australia (Penington Institute, sub. 264, p. 3). In 2007, about one in three Australians with a substance use disorder also had an anxiety disorder and about one in five had an affective disorder (Teesson, Slade and Mills 2009, p. 608). The strength of this association varies between drug types. At the upper end in 2013, the majority (58%) of adults who had used methamphetamines for non-medical purposes in the previous 12 months had at least moderate psychological distress (AIHW 2014, table S5.18). Substance use comorbidities are more prevalent among some population subgroups, such as Aboriginal and Torres Strait Islander people (Wilkes et al. 2014, p. 129).

As with physical comorbidities, there is a strong reciprocal association between substance use and mental ill-health (Mattick and O'Brien 2008). About 12% of those with an anxiety disorder and about 18% of those with an affective disorder also had a substance use disorder (Teesson, Slade and Mills 2009, p. 608). The reasons for the strong association are complex.

> The overlap between drug misuse and mental health is not confined to acute episodes. Instead, drug use and mental health form part of a complex web of causality that can include inherited predisposition, poverty, experiences of trauma, lifestyle factors and cultural background. (Penington Institute, sub. 264, p. 4)

The rate of substance use comorbidity among people who seek treatment is so high that it is considered 'the expectation, not the exception' (SCMH 2006, p. 366). A systematic literature review of the prevalence of comorbid mental health disorders in people presenting for substance use treatment in Australia found rates ranging from 47% to 100% (Kingston, Marel and Mills 2016). In addition, a large number of people who present for substance use treatment display symptoms of mental disorders, while not meeting the full criteria for a diagnosis of a disorder (Marel et al. 2016, p. xi).

In addition, substance use comorbidity creates a worse impairment and worse prospects for recovery than either condition alone (Alcohol and Drug Foundation, sub. 288 p. 5; SANE Australia, sub. 130, p. 5). It presents complexities for clinicians, who may mistake symptoms of one condition for another and hence make a misdiagnosis that delays proper treatment (Alcohol and Drug Foundation, sub. 288, p. 8). People with dual diagnosis commonly experience poorer physical health, greater levels of disability and increased risk of suicidal behaviours than those with substance use disorders only (Prior et al. 2017). In addition, clients presenting with comorbid mental health conditions often have a variety of other family and social problems, such as housing, employment, welfare and legal problems (Marel et al. 2016, p. xi). This can lead to social isolation and higher levels of distress for their families and carers (VIC DHHS nd).

How have Governments responded to substance use comorbidity?

Each State and Territory Government takes a different approach to dealing with substance use comorbidity. For example, Queensland and Western Australia have joint mental health and alcohol and other drug strategies, and their mental health commissions are responsible for both mental health and alcohol and drug policy. The Queensland Mental Health Commission provides strategic direction and delivers public health promotion activities, while the WA Mental Health Commission is directly involved in commissioning and delivering services. Both States had closer integration as their goal when implementing joint strategies and giving responsibility to their mental health commissions (Faragher 2014; Queensland Government 2012, p. 3). For example, the Queensland Government stated:

> Strategic planning at the state and national levels has emphasised that building strong partnerships between mental health and substance misuse services and providing for the integration of care is essential to the delivery of effective treatment for people with co-occurring substance misuse issues and mental illness. (Queensland Government 2012, p. 3)

The Victorian Dual Diagnosis Initiative, which commenced in 2001, includes programs to develop the capacity for services and clinicians to recognise and respond effectively to substance use comorbidity. The Victorian Government's expects organisations to:

> … screen all clients for dual diagnosis issues and either assess or arrange for an assessment of people who screen positively. Those, for whom an assessment indicates the presence of dual diagnosis issues, should then have an integrated treatment plan developed which outlines how both substance use and mental health needs will be met. If the treatment involves two organisations, then the expectation is that the two organisations work to the one treatment plan. (AHA 2011, p. 3)

An evaluation of the Victorian Dual Diagnosis Initiative in 2011 found that although progress on specific actions had been variable, it had nevertheless made significant progress, including successfully promoting the message that 'dual diagnosis is everyone's business' and breaking some barriers between services (AHA 2011, pp. 3–5). The Victorian Government (sub. 483, p. 47) has continued to introduce initiatives, including creating two new specialist rehabilitation services.

Nationally, substance use comorbidity has been a focus area for about 20 years. The National Comorbidity Project, launched in 2000, brought together the National Drug Strategic Framework and the Second National Mental Health Plan (DoH 2009b). This Project identified several areas for action, including greater collaboration between services and building the capacity for services to improve their response to comorbid mental health and substance use problems. This was followed by the National Comorbidity Initiative in 2003-04, which funded several research projects (Australian Government 2003, p. 175).

The *Fifth National Mental Health and Suicide Prevention Plan* acknowledges the importance of jointly considering substance use comorbidities in system and service planning. It commits governments to implementing the plan with reference to work committed to under the National Drug Strategy (COAG Health Council 2017a, p. 8). Moreover, it includes an action item that serves to better integrate mental health services for Aboriginal and Torres Strait Islander people with alcohol and other drug services:

> Governments will work with PHNs and LHNs to implement integrated planning and service delivery for Aboriginal and Torres Strait Islander peoples at the regional level. This will include: … collaborating with service providers regionally to improve referral pathways between GPs, ACCHSs, social and emotional wellbeing services, alcohol and other drug services and mental health services … (COAG Health Council 2017a, action 10, p. 33)

PHNs are responsible for commissioning both mental health services, and alcohol and other drug services. Their objectives in planning and commissioning drug and alcohol treatment services funded under the *National Ice Action Strategy* are to 'promote linkages with broader health services, to better support integrated treatment and referral pathways to support clients with comorbid mental health disorders' (Australian Government 2017c, p. 2). Although the focus of the *National Ice Action Strategy* is methamphetamine use, its funding is available for addressing the impact of alcohol and other drugs more broadly (ANAO 2019b, p. 17; Australian Government 2017b, p. 2).

The *National Drug Strategy 2017–2026* (DoH 2017e) is the national framework for preventing and minimising alcohol, tobacco and other drug related health, social and economic harms among individuals, families and communities. It identifies people with mental health conditions as a priority and recognises the importance of collaboration and coordination across jurisdictions, portfolios and services. It comprises several sub-strategies that provide direction and context for specific issues, including the:

- *National Ice Action Strategy 2015* (PM&C 2015a)

- *National Aboriginal Torres Strait Islander Peoples Drug Strategy 2014–2019* (Intergovernmental Committee on Drugs 2014)

- *National Alcohol Strategy 2018–2026* (DoH 2018f).

How do current approaches measure up?

Some inquiry participants reported that mental health services remain ill-equipped to deal with the comorbid substance use problems, despite all the government strategies. In their view, government policies and funding arrangements perpetuate a siloed approach, which makes comorbidity difficult to treat.

> Numerous stories were told of South Australians who had been turned away from mental health services because they had a substance abuse problem, or turned away from Drug and Alcohol Services SA (DASSA) services because they had a mental health issue. These stories came from individuals, their families and carers, service providers within Mental Health Services or DASSA, professional groups and other organisations who had sought input from their communities. Similar issues were raised in both metropolitan and country areas, and in a variety of settings. (South Australian Mental Health Commission, sub. 477, p. 14)

> The artificial separation of mental health and drug and alcohol services is one of the most frustrating aspects of emergency management of mental health patients. (Australian Medical Association, sub. 387, p. 12)

A lack of resources to accommodate people with high needs is one reason why services may be turning people away. The Australian Psychological Society (sub. 543, p. 25) suggested that funding issues have led public mental health services to implement rigid eligibility criteria that mean they turn away people with comorbid substance abuse issues. Other participants to this inquiry also advocated more funding (box 9.1).

The alcohol and drug sector may also have funding issues, which could lead to people with comorbid mental health problems being turned away. Modelling suggests there is a large unmet demand for alcohol and drug treatment, with demand estimated to range from about 412 000 people up to about 756 000 people and current treatment capacity estimated to be about 200 000 to 230 000 people (Ritter, Chalmers and Gomez 2019, p. 42).

To some extent, separate governance and funding arrangements present barriers to service integration. For example, the PHNs must submit separate work plans (which use different data collection methods and standards) for activities that are funded separately. In addition, funding allocations that cover different time periods also inhibit the ability of PHNs to commission these services together. The PHN Advisory Panel on Mental Health heard similar concerns from stakeholders consulted for its review of the progress of mental health reform being implemented through PHNs.

> The need for a stronger focus on integrating mental health and alcohol and drug services and suicide prevention services, and social and emotional wellbeing services with mental health was a consistent theme, albeit that the separate funding and reporting structures inhibit PHNs in achieving the desired level of integration. (Primary Health Network Advisory Panel 2018, p. 7)

Box 9.1   **Participant views on the resourcing of comorbidity services**

Orgyen said:

> headspace centres have struggled to adequately address AOD [alcohol and other drug] issues in young people attending, despite acknowledging the need and this being a core service stream. This is largely due to inadequate funding to specifically support this pillar of the service. (sub. 204, p. 30)

The Royal Australian and New Zealand College of Psychiatrists said:

> Modelling suggests that currently Australian services meet between 26.8% and 56.4% of demand for alcohol and drug treatment (Ritter, Chalmers, Gomez, 2019). This demonstrates the urgent need for expansion of alcohol and other drug services. (sub. 385, p. 9)

The Australian Medical Association said:

> There is a major need for a significant increase in Dual Diagnosis (those with mental illness also suffering alcohol and drug use disorders) assessment and management, education, training and staffing … A massive increase in alcohol and drug rehabilitation facilities and programs is required. Currently the wait for dual disability intervention is often well over a month or even unavailable for those with severe dual diagnosis. (sub. 387, p. 12)

Jesuit Social Services recommended:

> Increase funding for specialist dual diagnosis programs which provide integrated care to the significant number of clients who experience alcohol and drug and mental health comorbidity. (sub. 441, p. 18)

Some treating staff lack the skills to confidently and appropriately deal with people who have substance use comorbidity. The University of Sydney's Matilda Centre for Research in Mental Health and Substance Use (sub. 280, p. 9) reported that alcohol and drug workers 'feel overwhelmed and fearful when treating people with comorbid mental disorders, as their knowledge and the resources available to them are inadequate'. Similarly, the Alcohol and Drug Foundation (sub. 288, p. 9) considered the most effective way to improve treatment of comorbid problems was to 'improve the understanding and skills of staff in drug treatment and mental health services so that they can address both adverse health conditions'. And the SA Mental Health Commission (sub. 477, p. 14) reported that people with comorbid substance use problems were being turned away from mental health services due to a lack of training for staff.

Improving the training of staff and professionals should increase the effectiveness of treatment and make services less reluctant to take on people with comorbidities, and have the added benefit of lowering their stress levels.

There are best practice guidelines for the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (Marel et al. 2016). Participants to this inquiry suggested that these guidelines, and the accompanying training, be included as part of a national minimum qualification framework for alcohol and drug workers (The Matilda Centre for Research in Mental Health and Substance Use, sub. 280, p. 15).

There are also other ways to raise the skills of service staff, and raise awareness of substance use comorbidity. The Victorian Dual Diagnosis Initiative has used several programs, including:

- a set of reciprocal rotations, where clinicians are placed into an organisation in the other sector for 12 weeks

- Randomised Coffee Trials ('RCTs'), which paired an alcohol and other drug worker with a mental health worker to have a relaxed conversation, with the expectation that the workers provide feedback to their organisations about what they learned through the conversation (Croton 2019).

9.3 What more should be done to address comorbidities?

It was clear from inquiry submissions that a holistic, person-centred care approach is key to addressing mental ill-health, physical ill-health and substance use comorbidities. Participants stressed that comorbidities cannot be addressed in isolation. Moreover, there should be no barriers that prevent individuals from seeking help and no scope to exit clients 'out of the system' prematurely or into homelessness.

There are already many reports, studies and policy statements directed at improving comorbid mental ill-health. The Equally Well initiative and the Fifth Plan specified a long list of individual interventions for implementation and gave structure to reform efforts across Australia. Many submissions also contained examples of programs and services that were successfully addressing substance use comorbidities.

But realising the benefits from these initiatives could, as with past efforts, become constrained by wider systemic problems. These problems include fragmented responsibilities and funding, stigma and discrimination, and suitable support being difficult to find, access or unavailable. While some interventions specified by Equally Well and the Fifth Plan seek to address those issues from the viewpoint of physical and substance use comorbidities, a wider reform agenda would maximise the potential to improve the lives of people living with mental ill-health and support their recovery.

Rather than recommending yet more interventions targeted at comorbidities, wider systemic reforms would be important enablers for addressing these issues. In fact, the need to address comorbidities strengthens the case for reforms recommended elsewhere in this report 'to enable seamless cross sector engagement in cases where complexity and co-occurring conditions are evident' (Victorian Alcohol and Drug Association, sub. 403, p. 5). These recommendations would give the current reform agenda on comorbidities, such as that

stemming from Equally Well and the Fifth, the foundations they need to be much more effective than past efforts to address the issue.

Integrated funding and governance

A more integrated funding and governance model, which spans health and non-health sectors, would facilitate developing holistic and person-centred care models for addressing comorbidities. Better integration between mental health, physical health and substance use services to address long-standing comorbidity issues is a key reform sought by numerous participants, including: Central Australian Aboriginal Congress, sub. 336; Black Dog Institute, sub. 306; Consumers Health Forum of Australia, sub. 496; Jesuit Social Services, sub. 441, p. 4; Justice Health Unit – University of Melbourne, sub. 339, p. 6; PHN Cooperative, sub. 377, p. 6; Relationships Australia South Australia, sub. 420, p. 4; South Australian Mental Health Commission, sub. 477, p. 14; Victorian Government, sub. 483; Windana, sub. 56; and Youth Mental Health – North Metropolitan Health Service, sub. 99. As the WA Network of Alcohol and other Drug Agencies (sub. 102, p. 2) put it:

> … the policy, planning and service commissioning environment must support service integration that delivers outcomes through multiple specialist service collaborations and care coordination. This form of service integration both recognises, and supports the sustainment of, the strengths of each respective specialist sector.

Chapters 23 and 24 consider structural reforms to the mental health system that address fragmented responsibilities and funding across mental health services. These reforms are not especially focussed on comorbidities, but the Commission is seeking further feedback from stakeholders on how alcohol and other drug services should be funded were it to pursue a more ambitious reform option.

Coordinated care

Mental health services should not be systematically turning away people with substance use comorbidity. Increasing communication and coordination between services would assist in people getting the care they need. In this respect, the National Mental Health Commission has previously outlined two recommendations that remain relevant.

> We must have a mechanism to test compliance with 'No Wrong Door' practices and ensure they do not exclude or discriminate against people with co-existing mental health and substance misuse problems. (NMHC 2013, p. 25)

> Develop clear integrated care pathways for people with mental illness and a substance use disorder to bring together the too-often uncoordinated approach between mental health and substance use services. (NMHC 2014e, p. 106)

More coordinated care should be available for consumers with comorbidities, which brings together services for mental ill-health, physical ill-health, and alcohol and substance use. Although there is some community support for separate pathways for people presenting with

drug-induced psychosis or drug and alcohol related mental illness (as communicated to the South Australian Mental Health Commission, sub. 477, p. 14), in the main, there is broad support for a more integrated approach (Council to Homeless Persons, sub. 145); Dieticians Association of Australia, sub. 232; Private Mental Health Consumer Carer Network (Australia) Limited, sub. 49; Uniting Vic/Tas, sub. 95; and Western Australian Association for Mental Health, sub. 416).

There are opportunities to improve coordination of services to better assist people with comorbidities and meet previously unmet treatment needs (Victorian Government, sub. 483, p. 19). In particular, it is important to close service gaps to avoid people falling between the cracks and build the capacity of providers to address people's comorbidies *within* the different service sectors. Participants pointed to a wide variety of approaches for achieving coordination, including through:

- cross-sector partnerships, collaborations and/or amalgamations (VicHealth and Partners, sub. 131, p. 21; Victorian Government, sub. 483; WA Mental Health Commission, sub. 259, p. 2; WA Network of Alcohol & other Drug Agencies, sub. 102)

- supported re-entry into the community following treatment in hospitals and residential rehabilitation facilities (Foundation for Alcohol Research and Education, sub. 269; Windana, sub. 56)

- earlier and improved identification of comorbidities (Foundation for Alcohol Research and Education, sub. 269; Justin Kenardy, sub. 6; Victorian Council of Social Services, sub. 478)

- wider use of evidence-based interventions that focus on longer term recovery (Black Dog Institute, sub. 306).

To overcome service silos, public health services should do more to assist consumers to navigate to appropriate services. People with comorbidities should not be left to face potential gaps between different services alone. As outlined throughout this report, the mental health system is complex and can be difficult to navigate for health professionals, consumers, carers and families.

Chapter 10 outlines several ways to improve integration and coordination that would benefit many people with comorbidities. These recommendations are aimed at improving consumer experience through improving system navigation, promoting coordinated care, including reducing barriers to coordination and facilitating effective information sharing. They are directed at health professionals, and consumers and carers. Chapters 5–8 also make recommendations that move closer to best practice in the provision of healthcare, including by filling gaps in available services.

Specialised workforce development

In addition to effective coordination, the provision of holistic care for people with mental health comorbidities frequently depends on the experience and skills of specialist staff. As

explained by Uniting Vic.Tas, this is especially important for consumers with substance use comorbidities.

> The mental health status of these clients often means they lead chaotic and disorganised lives and find it challenging to keep appointments so specialist staff are needed who can work across both issues and do so in a flexible way. (Uniting Vic.Tas, sub. 95, p. 11)

However, there are too few staff operating in these complex and challenging environments, particularly in rural areas (Uniting Vic.Tas, sub. 95). In addition, those in these environments may not have the necessary depth of training or experience that is necessary. The South Australian Mental Health Commission heard through its Youth Advisory Group and Culturally and Linguistically Diverse Community Forum that:

> Mental health clinical service providers stated that part of the reason for this is that many staff feel inadequately trained to manage people presenting with alcohol and other drug related psychoses/ other mental health concerns. (South Australian Mental Health Commission, sub. 477, p. 14)

Further, even when these services are available, there is a broader social issue of ensuring those who most need these services feel comfortable in accessing them.

> Stigma around AOD use remains considerably higher than for mental health issues, and lack of understanding about what treatment entails or fear of judgement result in many young people not seeking help or disclosing an AOD issue to a clinician to ensure a timely and effective treatment approach is taken to respond to the comorbidity. (Orygen and headspace, sub. 204, p. 30)

Chapter 11 recognises the many different health professions which can help address physical and substance use comorbidities and makes recommendations to fine tune the national mental health workforce strategy. This includes quantifying skill shortfalls and specifying actions to address these issues. Chapter 20 recommends a National Stigma Reduction Strategy to counter the stigma and discrimination experienced by people with mental illness. It is not easy to change widely held negative attitudes, which foster stigma and discrimination, or to remove entrenched boundaries between different professions to achieve more coordinated care. However, the Commission is recommending a sustained commitment that addresses different aspects of stigma that are poorly understood by the wider community, such as substance use disorders.

Stronger evidence and accountability

The high prevalence of physical and substance use comorbidities among people with mental ill-health and ongoing challenges in meeting their treatment and recovery needs close monitoring. A high proportion of these people are among the most disadvantaged and vulnerable in our society. While submissions included examples of programs that are effectively addressing comorbidities, much evidence points to service gaps and unmet needs.

A prerequisite for addressing long-standing systemic problems that impede treatment of comorbidities is a more comprehensive evidence base. System improvement is constrained by a lack of data to track an individual's path through the healthcare system and to assess

the nature and extent of comorbidity (Black Dog Institute, sub. 306, p. 3). More specifically, there is a need to recognise the complexities, implement changes with demonstrated effectiveness and undertake research where there is limited evidence on what works.

Participants identified various opportunities to fill information gaps and promote stronger accountability for outcomes. For example, the Western Australian Association for Mental Health (sub. 416, p. 16) recommended an exploration of whole-of-government key performance indicators of cross-sector collaboration and coordination that addresses physical comorbidities. And the Foundation for Alcohol Research and Education (sub. 269, pp. 5–6) recommended reviewing the commissioning of alcohol and drug treatment services by PHNs and collecting mental disorders under the Alcohol and Other Drug Treatment Services National Minimum Data Set — an annual collection of data on alcohol and other drug treatment services, their clients and types of substances and treatments used.

Chapter 25 sets out a comprehensive framework for monitoring and program evaluation in mental health and related sectors, among other things. This is to ensure that decision makers have the right data available for planning and commissioning purposes, and to promote accountability for consumer and carer outcomes at a population level. The framework also aims to improve the monitoring and evaluation of outcomes at an individual level. The additional data and knowledge generated through a stronger evaluation culture are especially important for driving and informing the development of more holistic/ less siloed approaches to address comorbidities. In addition, chapter 22 recommends the establishment of targets for key mental health and suicide prevention outcomes.

10   Towards integrated care: linking consumers and services

Improving care integration matters because …	• Consumers' ability to access the services they need, when they need them, is a cornerstone of a consumer-oriented system. This ability is currently hampered by the overly complex nature of the mental health system. • Limited information sharing and coordination between providers often leads to delayed treatment and poorer outcomes. • Care coordination for people accessing multiple services can improve their recovery process. But existing programs are inconsistent, leading to overlapping services for some consumers, while others miss out.
Successful intervention requires …	As a priority for commissioning authorities: • Ensure that all people with severe and persistent mental illness and complex needs who will benefit from the services of a care coordinator have access to one. • Expand the use of online navigation platforms for service providers, including detailed information on mental health pathways. Additional actions required include: • Improving the efficacy of the entry points into the mental health system. • Actively promoting information sharing between providers and the use of single care plans, to be shared electronically, for consumers who access multiple services.

The delivery of integrated care has been on the agenda for the mental health system for many years. In its response to the 2014 National Mental Health Commission review, the Australian Government reiterated its commitment to:

> Moving from fragmentation, duplication and service gaps on the ground associated with current national and state programme delivery to a system that is planned, integrated, coordinated and delivered at a regional level. (DoH 2015, p. 7)

Five years later, progress towards this goal appears limited.

> Unfortunately, a lack of integration and coordination continues to exist within – and between – our systems of care. Individuals often journey between silos of intervention, including hospital wards, systems in housing, education and employment, and community and non-government services. And many of these supports only cater to discrete aspects of an individual's needs, overlooking whole-of-life considerations across the spectrum of need, potentially leading to no overall improvement to their quality of life. (DoH, sub. 556, p. 11)

Integrated and coordinated care can take many forms, and some are present in parts of the mental health system (box 10.1). But the ability to deliver integrated and coordinated care is often hampered by fragmented approaches to planning and funding service delivery, and unclear division of responsibilities between different levels of government (PC 2017b). The Commission recommends an overhaul of institutional arrangements and funding mechanisms to address these issues (chapters 22 to 24).

From the point of view of the consumer, integrated care means:

- person-centred care that accommodates individual needs
- access to the services they need when they need them, and
- continuity of care, based on effective information flows between clinicians and other services (Banfield et al. 2017).

Implementing person-centred care consistently across the mental health system requires a significant cultural shift. Factors enabling this shift include aspects of the mental healthcare system (addressed in chapters 5 to 9); workforce training (chapter 11); a more holistic approach to families and carers (chapter 13); and an increasing focus on monitoring and improving consumer outcomes (chapter 25).

This chapter address the two other aspects of the consumer experience of integrated care — accessibility of services and continuity of care.

Improving the consumer experience

In the current mental health system, many consumers face substantial difficulties accessing the services they require, navigating waiting lists and eligibility requirements, and telling their stories time and time again to new providers when their circumstances change. This is a frustrating process for consumers and their carers. It involves significant time costs, and

often results in delays in receiving care and support, or not receiving support at all (for example, Anglicare NT, sub. 53; Lorna MacKellar, sub. 406; Robert Davis, sub. 133; box 10.2).

Box 10.1   Defining integrated and coordinated care

Integration refers to individuals and organisations in different areas and sectors working together and aligning their practices and policies to deliver high quality mental healthcare and achieve good outcomes (Bywood, Brown and Raven 2015). The Commission, in its 2017 Productivity Review, defined integrated patient-centred care as involving 'the entire health care system, such that all services — community, primary, secondary, tertiary (and quaternary) — are integrated to achieve good health outcomes and to efficiently deliver a high quality of service to people over their lives' (PC 2017b, p. 4).

This can encompass both vertical and horizontal integration. In the context of mental health, vertical integration refers to integration between the different levels of healthcare (for example, primary, secondary and tertiary healthcare), whereas horizontal integration refers to integration across different sectors and providers (for example, between physical and mental health services). Integration between the health sector and non-health sectors, such as housing and employment, can be vertical and horizontal (Oliver-Baxter, Brown and Bywood 2013).

There is no single model of integration. There are multiple ways to make a system more integrated and integration generally exists on a continuum, from informal information sharing and communication right through to a fully integrated system with one organisation meeting all consumer needs (Bywood, Brown and Raven 2015).

Coordination is a form of integration, which refers to different entities or providers working together to ensure that a consumer receives all the different types of care they need in an organised and efficient manner. There are different models of care coordination — some may involve only referrals and exchanges of information between clinicians, while in other cases a dedicated coordinator or a care team help the consumer to navigate the mental health system and connect them with all the supports they require (PC 2017b; WA DoH 2019).

Across the mental health system, there have been numerous attempts at integrating care to improve the consumer experience. Examples include:

- joint regional planning and commissioning of mental health services between the Australian and State and Territory Governments by Primary Health Networks and Local Hospital Networks (Primary Health Networks, sub. 377)

- alliances and networks, such as the Western Australian Primary Health Alliance, which oversees the commissioning functions of the three Western Australian PHNs (WA PHA 2019) and the Hunter New England Integrated Care Alliance (HNECCPHN 2019)

- co-location of services, or 'hubs' or 'one-stop-shops' such as headspace services (Orygen and headspace, sub. 204)

- shared care plans

- shared information and communication technology (ICT) infrastructure

- care coordination and team-based care for people with mental illness and severe and complex needs (box 10.7).

Box 10.2　The road to nowhere: inquiry participants' views on navigating the mental health system

Consumers and carers report that they find the mental health system difficult to navigate. These difficulties begin when consumers and carers first decide that they need support and are looking for a gateway into the system:

> Looking at where to start to look for mental health services is overwhelming. I would do a google search on my mobile phone to source support. Navigating the system to try and find the right thing for yourself is difficult. (mental health carer, quoted in Connect Health & Community, sub. 94, p. 18)

Once consumers and carers are in the system, they can find it difficult to access help:

> … people did not know where to go for assistance with mental health concerns ranging from mild distress to crisis to ongoing community support, or that once contact was made, the service system was difficult to navigate. Over and again people spoke to the critical nature of being able to access the right support at the right time without having to knock on several service providers' doors or jump through hoops to provide the services they need. This applied to people experiencing mental distress and also to their families, carers and friends. (SAMHC, sub. 477, p. 6)

> Carers have reported to us that they find the mental health service system complex to navigate and distressing when they are dealing with multiple professionals across the public and private health systems, private practitioners, and community based mental health service providers. (MHCA, sub. 489, p. 10)

Navigating the system is particularly difficult for some groups, including people from cultural and linguistically diverse groups, Aboriginal and Torres Strait Islander people, or other groups experiencing disadvantage:

> The current mental health system is a medical model where the client's needs are understood mainly in relation to clinical supports. It is left to individuals and families to navigate between the different agencies to access other supports to and to resolve any service gaps or issues. For many people experiencing mental illness, it is difficult to do this because of complex and often overlapping needs e.g. financial and housing stress and vulnerabilities, such as relationship breakdown and trauma. Some have low literacy levels, or English as a second language and they may not understand entitlements, what supports are available or what they can expect from providers. (Anglicare Sydney, sub. 190, pp. 20–21)

> Strategies are required to assist Aboriginal and Torres Strait Islander people to effectively navigate the mental health system […], to connect to appropriate support, particularly in regional and remote areas where service infrastructure is sparse. (Healing Foundation, sub. 193, p. 2)

Inquiry participants reported that service providers and people working in the system can also find it difficult to navigate:

> The complexity of navigating the system and reporting to agencies imposes a major burden on the time and attention of all those concerned. This burden constitutes a cost imposed on patients and unpaid carers, and is not reflected in conventional economic measures. The burden is large in individual cases, and very likely also in aggregate. The same type of burden is carried by professionals (social workers, doctors, and others), who expend substantial effort and time in referring patients to relevant services and in assisting them with various kinds of paperwork. This can involve an inefficient use of resources, and a distraction from the vocational focus of the individuals concerned. Some of this effort probably is unavoidable, given that patients themselves are often unable to navigate the system for themselves; even so, improvement ought to be possible, through both attention to system design … and careful review of case-management arrangements. (Name withheld, sub. 23, p. 2)

Making the system more accessible, and improving the links between its individual parts, requires a number of different approaches. These approaches come together to create clear pathways for consumers interacting with the mental healthcare system (figure 10.1).

Figure 10.1 **The Commission's model of consumer pathways in the mental healthcare system**
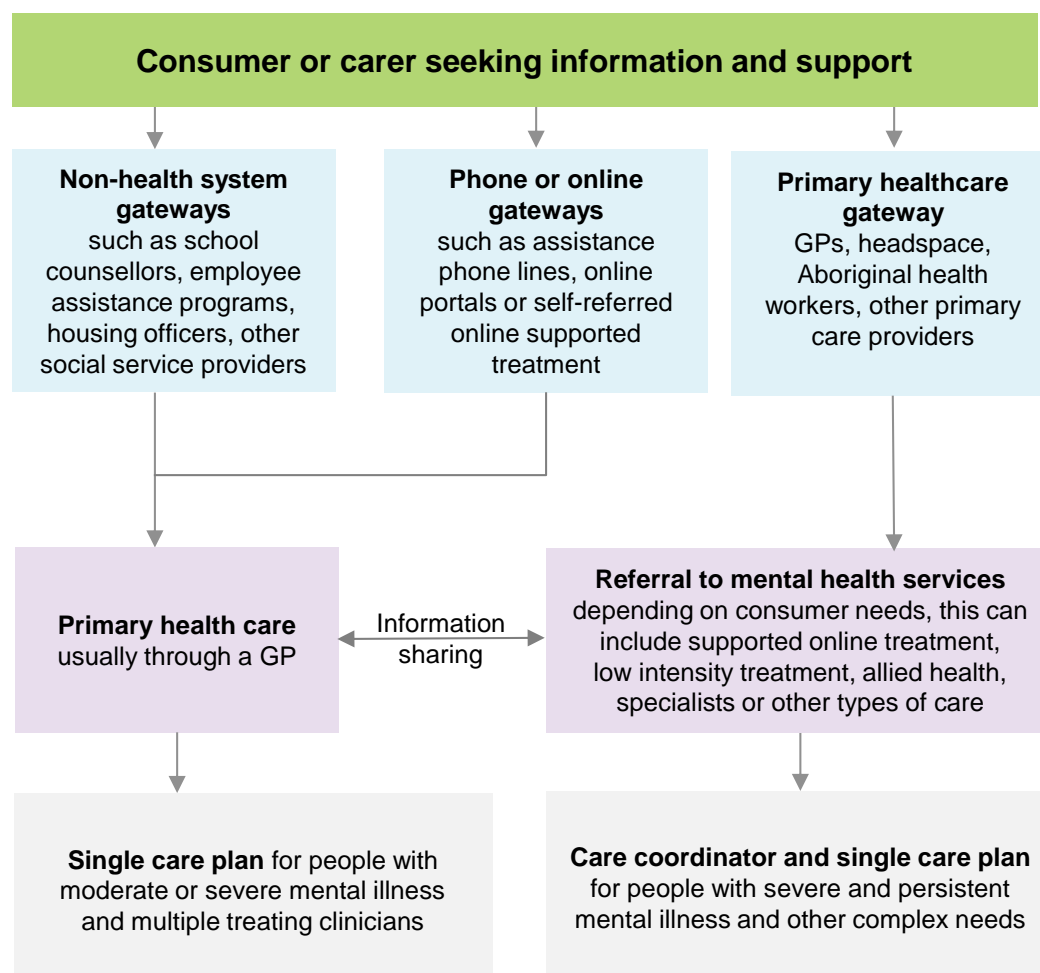
First, the initial point of contact between consumers and the mental health system — be it a phone line, website, GP or school counsellor — should give consumers accurate information suited to their needs. In the case of phone lines or online portals, the wide range of options available can be confusing and overwhelming. Similarly, service providers themselves need assistance in navigating the complex and often convoluted referral pathways of the mental health system (section 10.1).

Second, for those consumers already 'in the system' and receiving care from multiple providers, the barriers to information sharing between providers and a lack of coordinated care planning can slow their recovery. In the more complex cases, consumers may require the services of a dedicated care coordinator (section 10.2).

Finally, there are several different institutional approaches to improving provider coordination, including co-location, service alliances and memorandums of understanding.

These institutional approaches can assist in creating a culture of coordinated care (section 10.3).

Improving the way people access and navigate the mental health system is an important part of achieving a consumer-oriented system (chapter 4). In some cases, local service providers make substantial efforts to provide coordinated care and support consumers in finding the support they need. However, existing shortcomings in the mental health system can make it very difficult for these efforts to succeed, and there is no nationally consistent, systematic approach to supporting consumers to navigate the system. The draft recommendations in this chapter seek to address this gap.

10.1 Helping consumers find services

In a time when information is more accessible than ever, it is perhaps surprising that consumers and carers have difficulty finding the mental health services they need. Nonetheless, confusion and a lack of information are substantial barriers to accessing mental health services. For example, 40% of parents whose children had a mental disorder were not sure where they could find help (Lawrence et al. 2015).

Like many other problems in the mental health system, these difficulties have been identified in numerous past reviews and there have been many attempts to address them. For example, the National Mental Health Commission stated in its 2014 review that a successful mental health system would have a 'no wrong door' approach, and consumers would be referred onto the appropriate service for their needs, regardless of their initial point of entry into the mental health system. While parts of the system are working towards a 'no wrong door' approach, this is far from the norm (box 10.3).

For some people, their first interaction with mental health services is through an online search or a conversation with one of the many phone lines available. For most people, however, their first port of call is a face-to-face consultation, most commonly with a GP, although people can also be referred to mental health services by teachers, housing support workers, social workers and others. Submissions to this inquiry suggest that all of these gateways are letting consumers down (box 10.2).

Box 10.3   The 'no wrong door' approach

The 'no wrong door' approach is often used in the context of integrated care, to describe a situation where people 'can access a tailored combination of supports wherever they first ask for assistance' (NMHC 2014f, p. 183). This approach is particularly important for people who require support from multiple services, such as those with a substance use disorder as well as a mental illness (NMHC 2014f).

The 'no wrong door approach in the mental healthcare system can be implemented in different ways, including equipping all providers of health and other services with the skills to recognise mental illness and assist consumers in accessing services; or ensuring that there are specialised staff in all primary care clinics (Orygen 2018a; RACGP 2016). Both approaches present substantial challenges, and have not been implemented consistently.

Participants' views on the 'no wrong door' approach

> The current service system is fragmented and confusing with no single entry point. Mental health services need to support people to access appropriate support services. Mental health services need a 'no wrong door' approach and 'one stop shop' approach. (Youth Mental Health – North Metropolitan Health Service, sub. 99, p. 11)

> The first step in delivering an integrated service is for the service at which the client first presents to take responsibility for identifying all of the client's needs. Thus, a common feature of our client-focused services is that they employ a 'no wrong door' approach. This means that the responsibility of providing care to address the whole range of a person's needs, either directly or by referral, falls on the care provider/service where the person first presents. (Relationships Australia, sub. 103, p. 23)

> Given the relatively low NT population, and vast geographic areas it should be possible to implement a no wrong door approach to [improve] integration and reduce fragmentation in the mental health system, to link systematically clinical and community mental health services and programs. (NT Mental Health Coalition, sub. 430, p. 28)

> Implement models and funding incentives to ensure a 'no wrong door' approach offering people with mental health issues and carers and families or people at risk appropriate assessment, treatment and/or referral in the setting first encountered. (Mental Health Commission of NSW, sub. 486, p. 20)

Finding the right information — online or over the phone

An online search for mental health services yields a multitude of phone lines and websites, offering information, support and, in some cases, crisis intervention. Some have been in operation for a very long time, and have very recognisable brands. Lifeline Australia (sub. 87) is one example — its suicide prevention hotline receives a call every 32 seconds. From a consumer point of view, however, Lifeline is one of a very large number of support services. For example, the Victorian Government's Better Health Channel (2018) lists more than 20 different helplines consumers can choose from. These telephone lines help consumers and carers find services appropriate to their needs, including offering targeted information for a particular condition, age range or geographic area. However, inquiry participants have raised concerns about consumers' and carers' ability to work out which gateway is the right one for them.

> The fragmentation starts at the beginning of an individual's journey into the system, and is well-illustrated by the website for this very Inquiry … , where there are six different numbers

offered for counselling. Why are there so many? The answer is that each one has a slightly different focus, and are run by different organisations with different funding models. (Dr Matthew Macfarlane, sub. 2, p. 1)

In 2014, the National Mental Health Commission found that there was duplication in some areas of online and telephone support (for example, in the emergency/crisis calls and youth areas) and that the current system of multiple call lines and online services is confusing for consumers (NMHC 2014e). The review concluded that:

> Telephone helplines and other online services are not integrated, do not have common standards and are linked to few clinical pathways. Typically they experience major delays, confusing or conflicting notions of duty of care and/or subcontracting or referral to other agencies with technical, personnel or clinical capacity …

> There is limited availability of warm transfers, meaning that users generally need to re-tell their story when they are referred to another service. There is further potential for callers to be caught in a loop of being referred back and forth between services.

> A streamlined approach will reduce duplication and increase efficiency and effectiveness of the mental health helpline sector. This will reduce confusion about the service offerings available and create a clear line of sight for individuals about what is available for them. By retaining the expertise of existing large and nationally recognised helplines and community-based brands and organisations, a limited number of first points of contact can be established, with simpler 'warm' transfers to the most appropriate service. (NMHC 2014e, pp. 125–126)

In response to the 2014 review, the Australian Government announced it would implement a new digital mental health gateway, which would be the first point of service for people looking for information, advice or an online psychological service, and would include a centralised telephone and web portal (DoH 2015). Since then, the Australian Government has launched Head to Health, a digital mental health gateway, which includes information on services and resources for consumers and carers. The website uses an automated triage system to assist people with sifting through the hundreds of resources listed (DoH nd). As it has only been launched in 2017, Head to Health is yet to be evaluated. It remains one of many portals available online, and stakeholders have suggested that the community makes only limited use of it (Black Dog Institute, sub. 306).

In the 2018-19 Budget, the Australian Government committed $4.7 million for the continued operation of Head to Health. Future improvements to Head to Health include a plan to expand the list of providers that are included, which is currently limited to Australian Government-funded organisations, and a certification framework to assess the quality of resources listed on the website (DoH 2018b; NMHC 2018a).

Realising the potential of Head to Health

There is substantial potential to develop Head to Health as a central point of information for consumers, by making better use of the information collated and managed in other parts of the mental health system. Some State and Territory Departments of Health, primary health networks (PHNs) and other organisations maintain websites that list mental health services

available in specific areas, and allow consumers to search for local providers. As local commissioning authorities[32] develop clearer pathways for consumers in the mental health system (see below), this will enable them to create online registries of services available in their areas of responsibility. These can be linked to Head to Health, which would be the national gateway, assisting consumers to find local services based on these regional registries.

The 2018-19 Budget also stated that 'funding will … be provided to the 'Head to Health' Telephone Support Service in 2019-20' (DoH 2018h, p. 66). In its submission to this inquiry, the Department of Health (sub. 556, p. 23) confirmed that 'a telephone channel, as an alternative to the website, is expected to be implemented later this year'.

Very little information is available on the intended service model of the Head to Health telephone channel. The Commission considers that such a phone line should act as a referral service that does not replace existing phone lines, but provides a simple entry point into the mental health system. Its main goal would be to reduce confusion among consumers and the need to call different numbers before they find the service they require. The central phone line should be able to refer consumers to a wide range of supports, extending beyond the limited range currently listed on Head to Health. For example, the central phone line should be able to link consumers to national supports, or local crisis teams, depending on need. The line should have extended hours of operation, as pointed out by the SA Mental Health Commission: 'any access point also needs to recognise that 'mental health doesn't stop at 5pm on a Friday', and that 24/7 access to appropriate support is required' (sub. 477, p. 6).

Further, referrals from the national phone line to other services should be made in such a way as to minimise the need for the consumer to tell their story again. The phone line should use active, 'warm' referrals. This requires that the person making the referral initiates contact with the organisation they are referring the consumer to, and explains their circumstances and the reasons they believe the consumer will benefit from the service (QMHC 2015a). The Department of Health should incorporate the requirement for 'warm' referrals in its funding contracts with existing phone lines supporting people experiencing mental ill-health.

The Australian Government should also fund an accompanying advertising campaign to raise community awareness of both the Head to Health website and its future phone line.

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[32] These can be PHNs or regional commissioning authorities, as described in chapter 24.

DRAFT RECOMMENDATION 10.1 — CONSUMER ASSISTANCE PHONE LINES

Assistance phone lines offering support for people with mental ill-health and their carers should facilitate better exchanges of information between service providers.

In the medium term (over 2 – 5 years)

- In its funding contract with existing assistance phone lines, the Australian Government should require providers to implement timely referral processes that minimise the need for consumers to repeat information.

- The phone line that will be part of the Australian Government's mental health portal, Head to Health, should use a similar approach to referrals. The range of services listed on Head to Health should be expanded. The Australian Government can also consider funding an advertising campaign, to raise community awareness of the phone line and the online portal.

Support for the system's gate keepers – from GPs to teachers

The sheer scale of the mental health system makes the provision of up-to-date information a challenging task — even for those people who work within the system:

> … an important, but fixable, barrier to integrated and collaborative service provision is simply that all participants (users and service providers) do not have ready access to comprehensive and contemporary information about who can give what help and where or by what channels. (Relationships Australia, sub. 103, p. 19)

The list of professions that act as gateways into the mental health system includes clinicians and allied health professionals, and those who facilitate entry of consumers to the mental health system via non-health pathways — such as teachers, aged care workers and Aboriginal and Torres Strait Islander service providers. Many of them rely on personal networks to find support for people who seek help. They can also use online registries, such as the Beacon registry for e-health applications (Black Dog Institute, sub. 306). There is, however, a risk that such registries could become outdated (see below).

PHNs are working to support service providers to make better referrals. Most PHNs around Australia, some in conjunction with State and Territory Departments of Health or other providers, have developed online platforms to provide information to GPs and other clinicians about referral pathways. These websites are based on the HealthPathways model developed in New Zealand, and include detailed information on pathways that can be tailored to consumer needs (Spiller 2015). Not all HealthPathways portals include mental health pathways, but there are examples of detailed portals with a large range of information (figure 10.2).

Figure 10.2   Example of a pathway for a person with mental illness in a HealthPathways portal

Assessment

Making the diagnosis

The diagnosis of bipolar disorder is complex, can be time-consuming, and is ideally made by a psychiatrist.

Consider the phase and type of bipolar disorder:

- ➕ Acute mania or hypomania
- ➕ Acute bipolar depression
- ➕ Mixed episode
- ➕ Rapid cycling

Acute assessment

1. If suspected mania or hypomania, ask about ➕ behavioural changes that are out of character for the patient.
2. Perform ➖ mental health screening.

> **Mental health screening**
>
> Look for:
>
> - severity of symptoms.
> - level of functional impairment.
> - degree of insight.
> - presence or absence of psychosis.
> - ➕ risk to self or others.
> - medication compliance.
> - use of alcohol, prescription drugs, or drugs of abuse.
> - amount and quality of support from family and community services.

3. Assess risk to determine the most appropriate course of management. There is no quantifiable measure of risk – it is useful to th of it as a continuum, however some people will continue to use the Brief Risk Assessment 🔗. Ultimately, the decision is based on clinical judgement.
4. If the patient is cooperative, examine to consider ➕ other causes (especially in patients with onset aged > 40 years), and assess ➕ complications.
5. Consider pathology tests e.g., FBC, LFT, TFTs, therapeutic drug monitoring, urine drug screen, and STI screening.
6. Obtain corroborative information where possible, especially if suspected psychosis or concerns about harm.
7. Decide whether the patient needs specialist assessment or can be ➕ managed safely in the community.

Source: WA Primary Health Alliance (pers. comm. 4 October 2019).

Pathways included in these platforms are developed in consultation with local service providers, to reflect their agreed model for consumer referrals within the local health system (DoH, sub. 556). Developing the pathways is a beneficial process in its own right, as it brings a range of providers together, thinking about a continuum of care and the ways each of them can contribute to people's recovery. It can uncover, and possibly help to overcome, different eligibility criteria for service access and possible duplication or gaps in service delivery. Further, this regional process of pathway development will encourage local providers to use the portal, as they contribute to its design and it includes information that is relevant for them. These benefits have been evident in the process of developing HealthPathways in New Zealand (Timmins and Ham 2013). The discussions between providers are a crucial part of developing the pathways, and where these are missing, implementation and take up encounter substantial risks (Stokes et al. 2018).

Evaluations of HealthPathways platforms in Australia have found that they were generally well received by GPs, but also underutilised due to lack of awareness and technological barriers:

> Barriers to implementation were lack of integration with existing GP systems, the inability to make electronic referrals from within HealthPathways, gaining broad penetration across general practices, the busyness of GPs and specialists and limited capacity to write new pathways and to capitalise on redesign opportunities identified in the development process. (Gray et al. 2018, p. 69)

> The main barrier to using [HealthPathways] was forgetting to use it. (Gill et al. 2019, p. G)

This type of care navigation platform can provide valuable information to service providers, increase the efficiency of referral processes and lead to substantial cost savings. Looking at referral pathways developed in Mackay, a recent evaluation found that the use of HealthPathways reduced inappropriate referrals from GPs to specialists, generating savings well in excess of implementation costs. The use of four pathways (out of 544 listed on the platform) led to estimated saving of $442 000 per year by reducing unnecessary referrals to specialists; the cost of maintaining the portal was about $370 000 annually.[33] Systemic savings could be much more substantial — if HealthPathways was used for all relevant referrals, it has the potential to save $3.6 million each year in health costs in the Mackay area alone (Blythe, Lee and Kularatna 2019).

Larger-scale evaluations in Canterbury, New Zealand, where the use of HealthPathways is widespread, have shown a reduction in hospital admissions due to improved integration in primary care, better use of hospital capacity and a substantial decline in patient waiting times (Gullery and Hamilton 2015; Timmins and Ham 2013).

As most PHNs have developed a HealthPathways platform, expanding these platforms where required to included detailed mental health pathways appears to be a cost-effective way to deliver information to health professionals. Access to these platforms should be expanded beyond health, in particular to schools and psychosocial service providers, where dedicated staff could use them to locate supports for people who need them. Other types of service providers that would benefit from access to the navigation platforms include maternal and child health nurses, tertiary institution counselling services, Centrelink social workers and public housing tenancy managers.

The next step for these information platforms is seamless integration with healthcare management software, to enable the creation of single care plans based on the consumer's pathway, and booking appointments with providers directly from the portal — rather than a consumer, carer or care coordinator having to make the booking. This already occurs in some areas in New Zealand, and has contributed to the benefits realised from the HealthPathways platforms. A range of application programming interfaces (APIs) are being developed in Australia to allow for greater functionality of the HealthPathways platforms

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[33] There was also a cost of about $283 000 to establish the HealthPathways portal (Blythe, Lee and Kularatna 2019).

(HealthPathways nd). Once developed and rolled out, such functionality will increase the usage rates and effectiveness of the platforms, minimising the risks that consumers fall through the gaps when referred from one service to another.

One risk of investing in comprehensive information systems is that the information may quickly become outdated, and as a result, the target audience will not use the portals as intended. Maintenance of current information, even for local pathways covering a specific region, can be a costly exercise, but is paramount if the platforms are to become a useful resource that is used routinely by clinicians and other providers (PC 2017b). Therefore, there should be a small dedicated team whose role will be to ensure information is kept up to date, and to support users of each HealthPathways platform.

A number of PHNs already employ such teams to develop and update their HealthPathways. These teams comprise GPs, who develop the clinical information, and administrative staff, who are responsible for mapping the pathways (Spiller 2015). Such teams could also assist service providers who do not usually use the services, such as Centrelink social workers (chapter 14).

If PHNs are replaced with regional commissioning authorities (chapter 24), the responsibility for expanding and maintaining the HealthPathways platforms could be transferred to the new body.

DRAFT RECOMMENDATION 10.2 — ONLINE PLATFORMS TO SUPPORT BETTER REFERRAL PATHWAYS

Commissioning agencies should ensure service providers have access to online navigation platforms offering information on pathways in the mental health system.

In the short term (in the next 2 years)

- All commissioning agencies (PHNs or RCAs) should, either individually or collaboratively, develop and maintain an online navigation platform, including detailed mental health referral pathways. The HealthPathways portal model, which is already used by most PHNs, can be used to contain this information.

- Access to these platforms should be expanded beyond health, in particular to schools and psychosocial service providers. Each commissioning agency should also, either individually or collaboratively, fund a small dedicated team supporting the users of the online platform.

In the medium term (over 2 – 5 years)

- All online navigation platforms should incorporate the ability to book consultations with service providers directly from the platform.

10.2 Enabling coordination and continuity of care

Care coordination is an important part of a consumer-oriented system, based on information sharing between all service providers involved in a person's care and joint planning of assistance and treatment. When care coordination is lacking, this can have substantial effects on consumer outcomes:

> A mental health system that is not sufficiently connected exposes affected individuals, their families and carers, and their communities to increased risks of adverse health and social outcomes. For individuals living with anxiety or depression, a lack of integration and coordination between mental health services may frustrate their efforts in finding appropriate care and, over time, impact on their ability to remain gainfully employed. For individuals living with severe or chronic mental disorders, it may limit their ability to break the cycle of prolonged illness and dependency, ongoing discrimination and psychosocial disability. This increases their risk of poverty, isolation, marginalisation and homelessness. (DoH, sub. 556, p. 10)

Depending on consumer need, and the number of providers supporting the consumer, the mental health system should take a tiered approach to care coordination. This includes:

- information sharing — for all consumers, information sharing between service providers is the foundation of coordinated care. This can mitigate the need for consumers to retell their story every time they meet a new service provider, or act as an information conduit between various providers. While some digital information is being shared, much more can be achieved (draft finding 10.2)

- single care plans — people with moderate to severe mental illness who access multiple clinical supports (either due to the severity of their mental illness or a physical co-morbidity) would benefit from team-based care (chapter 7). Teams should develop single care plans, which will be accessible to all providers and allow them to coordinate care and interventions (draft recommendation 10.3).

- care coordinators — people with severe and persistent mental illness and complex social or health needs should have both a single care plan and a care coordinator to oversee the implementation of the plan. These care coordinators would work directly with the consumers, their carers, clinicians (or clinical coordinator) and providers from other sectors, to establish the types of services needed and provide assistance in accessing and coordinating those services (draft recommendation 10.4).

These different forms of coordination are directly linked to each other, and enable the implementation of a stepped care model, where care and support services are introduced or withdrawn as individual needs change. It would also allow the mental health system to focus more on a recovery-oriented approach — rather than dealing with crises, healthcare providers would have access to the service components necessary for care plans that support clients in stabilising their condition and improving their wellbeing.

Facilitating effective information sharing

Many consumers and carers access multiple services when receiving care and support; for example, 59% of people with a long-term mental illness report having a co-existing physical illness (chapter 2).[34]

Information sharing between sectors and providers can improve efficiency and ensure that consumers and carers experience continuity of care. But in the existing mental health system, there are substantial barriers to routine information sharing between service providers, including:

- limitations, or perceived limitations, imposed by legislation

- information management systems that do not support data sharing, and

- cultural barriers to sharing information and collaboration (PC 2017a).

Over the years, the Australian Government has made a number of attempts to improve the sharing of health data — mostly recently, by the creation of digital health records. My Health Record has been gradually rolled out since 2016, and by early 2019, 90% of Australians had a digital health record (ADHA 2019). There are also examples of jurisdictional digital health records, such as the eMR in NSW (Mental Health Commission of NSW, sub. 486.)

Stakeholders in this inquiry were divided in their views on the usefulness of a single digital health record for people with a mental illness (box 10.4). While some raised concerns about the quality of the information involved, others called for broadening the scope of digital health records to encompass all parts of the mental health system, including non-clinical and other support service providers.

Such integrated information management systems are likely to be very costly and complex to implement (PC 2017a). The existing system of digital health records provides an adequate platform for information sharing between mental healthcare providers — if it is used consistently, and records are current and comprehensive.

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[34] In comparison, for those without a mental illness, the prevalence rate of a physical illness is 48% (chapter 2).

Box 10.4   **Participant views on digital health records**

Digital health records are becoming increasingly common across the health system, although there are still barriers, such as misinterpretation of legislation and concerns about data security, that curtail potential benefits. Some participants in this inquiry were unequivocal in their support for digital health records. For example, the Mental Health Commission of NSW (sub. 486, p. 30) stated:

> Electronic medical records support improved communication and sharing of information between health care providers. Perceived barriers to legally sanctioned information sharing must be overcome.

Others raised concerns about the quality of information included by service providers, as well as privacy concerns:

> While there is an argument to be made for a single comprehensive clinical record as a means of centralising health information, the usefulness of such an instrument relies heavily on the quality of the information provided by services and programs. Since qualitative health data can be subjective and lack detail, and there can be administrative delays in finalising and uploading key resources such as discharge summaries, it is not so much the concept as the implementation of this measure that will determine its success in coordinating care. (ACT Mental Health Consumers Network, sub. 297, p. 8)

> The use of electronic health records for mental illness poses many concerns and we do not believe e-health records should be compulsory or phased in as a necessary part of the stepped care model … Some of these concerns include privacy, data retention and confidentiality. The use of e-health records needs to be matter of individual choice, and not implemented without consent by the service provider. (Brainstorm Mid North Coast sub. 309, p. 3)

Some stakeholders argued for the need to create a joint digital record that would go beyond healthcare, to include psychosocial services and other types of support:

> As part of improving integrated service delivery, there were also calls from people with lived experience and their families, and service providers for a shared data tool, both between government sectors and between government and NGOs, so that service users did not have to re-tell their stories over and over again. It was recognised that there may be privacy concerns around this, and that any shared database would require some level of client and/or carer consent. (SAMHC, sub. 477, p. 31)

> Noting the links between mental health, alcohol and other drug use, family and domestic violence, and homelessness, DLGSC also encourages establishment of appropriate information sharing mechanisms between sectors to enable appropriate and effective service delivery to those affected. (DLGSC, sub. 78, p. 3)

Others suggested that the mental health system required a fully integrated ICT system:

> We believe that having an integrated ICT system has the potential to enable acute, primary, and community service providers to access more accurate and detailed clinical information to identify families at risk and inform clinical decision-making. It is essential for service coordination across the continuum of care, and could assist interagency communication across organisational boundaries, and provide evidence of outcomes. It also has the ability to integrate clinical and financial information across services, which is important for monitoring cost effectiveness. (RASA, sub. 420, p. 25)

> … an integrated, streamlined and centralised information exchange portal providing a communication and referrals system for medical practitioners, emergency service workers, social services, the justice system, the education system and mental health support organisations [is needed] to adequately support people with mental health disorders and conditions. An example of how this portal could be used would be for police, ambulance and mental health services to keep one another advised and up to date regarding a person who is experiencing a mental health crisis and displaying aggressive behaviour so they can understand the situation and can respond in an appropriate manner. (Martha Henderson, sub. 65, p. 3)

Single care plans for consumers accessing multiple clinical services

Digital health records that allow different healthcare providers to share information will be helpful in many cases, but people with moderate to severe mental illness, who access a larger number of clinical services, are likely to require single care plans.

A single care plan brings together all aspects of clinical care within the health sector (as opposed to shared care plans, where multiple plans are developed independently by the various clinicians the consumer interacts with and are shared between these clinicians). Such plans would be agreed on by the consumer, their carer (if applicable) and all the various service providers. 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 needs, housing needs, community inclusion needs, the role of their carer or kinship group, and reintegration into education or the workforce. Plans may include some short-term input from providers of social services where relevant, but not ongoing coordination of health and social services (care coordination in more complex cases is discussed below).

Single care plans are likely to be most beneficial for people with co-existing physical health conditions, including substance abuse, which require coordination between primary care, specialist mental healthcare and other clinical service providers (chapter 9).

This concept is well established in mental health services — for example, the 2010 National Standards for Mental Health Services include a requirement for a 'current individual interdisciplinary treatment, care and recovery plan, which is developed in consultation with and regularly reviewed with the consumer and with the consumer's informed consent, their carer(s) and the treatment, care and recovery plan is available to both of them' (AHMAC National Working Group on Mental Health Policy 2010, p. 25) The need for a comprehensive care plan was reiterated in the 2018 National Safety and Quality Health Service Standards (ACSQHC 2018c).

The National Mental Health Commission's 2014 review recommended that a single care plan and eHealth record be implemented for those with complex needs. It stated that this approach 'gives public sector, NGO and private providers a vehicle to enable a whole-of-person approach to the care and support of people with complex needs' (NMHC 2014e, p. 70). The review recommended that over time, the integrated care and support should extend beyond the health system and single care plans might include, for example, employment or housing services.

The current PHN guidance on primary mental healthcare services for people with severe mental illness states that, in the longer term, PHNs will be expected to:

> … promote the use of a single multiagency care plan for people with severe and complex mental illness, to help link providers across multiple services involved in an individual's care and to promote a medical home approach (DoH nd, p. 1)

There are examples of PHNs actively promoting the creation of single care plans. The Eastern Melbourne PHN is part of the Eastern Mental Health Service Coordination Alliance, which uses care plans when treating consumers in the Eastern Metropolitan regional of Melbourne. The plan includes the consumer's identified goals, collaborative actions to be taken against the goals and roles and responsibilities of those involved in providing care (EMHSCA 2018). The Northern Territory PHN is working towards the implementation of an electronic shared care planning tool, that will support single care plans (NT PHN 2018). Some PHNs are participating in the Department of Health trial of Health Care Homes, which provide coordinated care for patients with chronic illness (including mental illness) based on an electronic shared care plan (SEMPHN 2019a).

Inquiry participants were supportive of the use of care plans (for example, Samaritans, sub. 121). Relationships Australia (sub. 103, p. 14) highlighted the implications for consumers when single care plans are not put in place:

> Individualised interagency care plans that go with the client would be very helpful. This would include clear protocols over who is responsible for what, procedures to negotiate gaps, and short, medium and long term strategies for supporting clients, particularly those with severe and complex mental health issues. The absence of such a consistent approach often leads to crisis situations and presentations to what is often the only available alternative – busy Emergency Departments, and treatment approaches not always well matched to client needs.

The effective development and operation of a single care plan would necessitate:

- protocols for sharing consumer information between service providers, as discussed above, and obtaining consumer consent for the creation of a single care plan

- clear accountability structures to allocate responsibility for plan development, follow-through and update, and

- financial arrangements that incentivise this to occur.

The Commission envisages that the consumer's primary treating clinician (or a nominated member of the clinical team treating someone with severe and complex mental illness)

should have the responsibility for the development of a single care plan, once they have established that this will be beneficial for the consumer. The consumer and, if relevant, their carer, should be directly involved in the development of the treatment plan, including selecting specific service providers and setting treatment outcomes.

In many cases, the primary treating clinician will be the consumer's GP. The Medicare Benefits Schedule (MBS) should include a dedicated item number, to enable GPs to be reimbursed for the time required to create a single care plan. The single care plan should be developed in consultation with the other service providers involved in the consumer's care, and all should be responsible for updating on the progress of their treatment over time using a shared electronic tool (My Health Record can be used for this purpose). The MBS should also include an item number to reimburse GPs for reviewing the plan periodically against pre-determined outcomes that will be agreed by the care team and the consumer.

Depending on individual circumstances, a wide range of care providers may need to contribute to the single care plan or update it with new information — either by accessing a digital health record, or in a face-to-face discussion. This is likely to be part of the routine care provided to the consumer (similar to the way psychologists are required to update referring GPs on the course of treatment under existing MBS guidelines).

Submissions to this inquiry argued for specific case conferencing items for psychologists to be added to the MBS, to reimburse them for the time taken to discuss treatment progress and outcomes.[35] The Association of Counselling Psychologists (sub. 522, p. 60) stated that providing funding to engage in case conferencing would improve care:

> Provide funding to service providers for engaging in case consultations with a client's other healthcare providers (GP, psychiatrist, psychologist etc …). This would encourage a more collaborative approach to mental health care and a more informed treatment approach for the client.

The need for case conferencing rebates under the MBS is currently being considered as part of the MBS review conducted by the Department of Health. The report from the mental health reference group did not include recommendations to change the case conferencing funding arrangements under the MBS, although it noted anecdotal evidence showing that 'mental health professionals already hold case conferences, but generally do this during non-billable hours (e.g., lunch break)' (MBS Review Mental Health Reference Group 2018, p. 97).[36] The Commission considers that the MBS review is best placed to consider the broader question of case conferencing rebates.

Consumers with more complex needs are treated by community-based mental health services, which are funded by State and Territory Governments. For these clients, single care

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[35] For example, AusPsy, sub. 460; APS, sub. 543; Jayne Wells, sub. 219; Leanne McGregor, sub. 481; Melissa Noonan, sub. 393.

[36] The report from the General Practice and Primary Care Clinical Committee did include a recommendation to create new MBS items that would rebate attendances at case conferences for allied health professionals (GPPCCC 2018).

plans are likely to be particularly important, given the severity of their symptoms and the likelihood that they require treatment and support from multiple providers. Therefore, the creation of a single care plan should be part of their routine care protocols, rather than attract separate funding.

DRAFT RECOMMENDATION 10.3 — SINGLE CARE PLANS FOR SOME CONSUMERS

Governments should support the development of single care plans for consumers with moderate to severe mental illness who are receiving services across multiple clinical providers.

In the medium term (over 2 – 5 years)

The Department of Health should:

- develop and promote protocols for sharing consumer information between service providers, and allocating responsibility for plan development, follow-through and updating the consumer's primary treating clinician (unless otherwise agreed by their treating team)

- amend the MBS to include a specific item to compensate a clinician overseeing a single care plan for their time.

Care coordinators for consumers with complex needs and severe mental illness

Consumers with the most complex mental health needs should have both a single care plan and a dedicated care coordinator who works alongside the clinical team to oversee the implementation of the plan.

Complex mental health needs arise when a consumer is diagnosed with a severe and persistent mental illness, and also requires disability services due to an ongoing psychosocial disability, or social services, due to other adverse circumstances, such as unemployment or homelessness. These consumers often interact with a large number of service providers, within and beyond the health system (box 10.5). In these cases, a care coordinator can ensure that the consumer accesses the services they need and does not 'fall through the cracks' in the system. This can support consumers' wellbeing and prevent unnecessary hospitalisations.

Box 10.5 Challenges faced by consumers with complex needs

It is not unusual for consumers of mental health services to interact with more than one service provider. Robert Parker (sub. 12) provided a case study of 'JS', a 40 year old male with chronic schizophrenia who potentially required 12 different services.

Example of services required by 'JS'

Service	Delivered by	Funded by
Hospital and community mental health care	Hospital and mental health service	State and Territory Governments
Specialist psychiatric review	Mental health service and private psychiatrist	Australian, State and Territory Governments
Medication	Hospital pharmacy and PBS	Australian, State and Territory Governments
Primary care	General Practitioner and Aboriginal Community Controlled Organisation	Australian Government
Housing	State or Territory Government Department and Non-Government Organisation	Australian, State and Territory Governments
Psychological/trauma focused care	Psychologist (MBS) and Aboriginal Community Controlled Organisation Social and Emotional Wellbeing Worker	Australian Government
Crisis line and online mental health support	Crisis line and Beyond Blue	Australian Government
Drug and alcohol treatment	State or Territory Government Department and Non-Government Organisation	Australian, State and Territory Governments
Forensic (prison)	Prison medical service	State and Territory Governments
Forensic (community)	Community corrections	State and Territory Governments
Community integration and workforce participation		Australian, State and Territory Governments
National Disability Insurance Scheme support	National Disability Insurance Scheme	Australian, State and Territory Governments

Source: Adapted from Robert Parker (sub. 12, pp. 2–3).

There is scope to improve care coordination

There are already a significant number of government funded programs offering care coordination services to people with mental illness, including through the National Disability Insurance Scheme (box 10.6). However, the coordination of care is often ad hoc; while not all consumers who would benefit from a care coordinator have access to one, the Commission has heard of cases where consumers have multiple care coordinators, with overlapping responsibilities:

> I have lost count [of] how many case managers I have had between my employer, Comcare, rehab provider etc. The system doesn't allow for continuity of care. This leads to having to repeat oneself so many times that in itself contributed to the continued downward spiral. (comment no. 8, consumers)

Jesuit Social Services notes that there may be a number of caseworkers from several organisations supporting a person with multiple and complex needs. Care coordination can be unclear and the sharing of information inconsistent, even when regular meetings are scheduled between caseworkers supporting the person. (Jesuit Social Services, sub. 441, p. 19)

Box 10.6   Examples of mental healthcare coordination in Australia

There are numerous examples of existing care coordination services that people with severe mental illness may be eligible for.

Primary health networks (PHNs) are expected to commission clinical care coordination services for people with severe mental illness (DoH nd). One example of a PHN-commissioned initiative is the Mental Health Integrated Complex Care program. Commissioned by the South East Melbourne Primary Health Network, the program is intended to assist consumers with severe mental illness and complex needs who need coordination of their care over an extended period of time. Services are matched to individual needs and can include clinical nursing services, family support and liaison, clinical and non-clinical care coordination and liaison, and improved access to psychiatrist and psychological care (SEMPHN 2019b).

The Integrated Team Care program is also funded through PHNs, and supports Aboriginal and Torres Strait Islander people with chronic disease, which can include mental illness. In addition to care coordination services, it also assists mainstream services in delivering culturally competent care (DoH, sub. 556).

Three PHNs are participating in the Link-Me trial, which includes an assessment of needs conducted in GP practices (chapter 6). Where required, people with severe or complex needs are referred to a care navigator, who works with them and their GP to develop a care plan and ensure that all parts of the plan are working together well (DoH, sub. 556; NC PHN nd).

Some care coordination programs are funded by State Governments. For example, as part of the Victorian Multiple and Complex Needs Initiative, a care plan coordinator works with the consumer to develop a personalised care plan, which aims for stable housing, health, wellbeing and safety, and increased social connectedness. Services can include mental health services, housing services, drug and alcohol services, disability and health services, justice and correctional services, and services provided by Aboriginal community-controlled organisations (VIC DHHS 2019a). Similar programs, focusing on coordination of health services, exist in other jurisdictions as well (for example, WA DoH 2019).

The introduction of the National Disability Insurance Scheme (NDIS) has changed the provision of care coordination services for some people with a psychosocial disability. Partners in Recovery (PIR) is an Australian Government program, which provides care coordination services to people with a severe and persistent mental illness who have complex needs. Funding for PIR is transitioning to the NDIS, and those with NDIS funding can use it to access care coordination services. However, a recent report by the National Mental Health Commission (2019c) pointed to low rates of uptake of support coordination services in NDIS plans. The transition to the NDIS is discussed in detail in chapter 12.

Submissions to this inquiry have raised two main concerns regarding existing care coordination programs. First, not all people who need and would benefit from care coordination services are receiving them. Second, the care coordination services that do exist are predominantly focused on clinical supports, despite the fact that consumer need spans a much wider range of services.

There are no reliable estimates of the number of consumers with severe and persistent mental illness who may need care coordination services, nor of the number of consumers who receive care coordination services from existing programs (figure 10.3). Nonetheless, evidence suggests service gaps exist. For example, only a small proportion of people with a psychosocial disability who are on the National Disability Insurance Scheme (NDIS) has been accessing support coordination services. This is despite the fact that these people often need assistance in accessing support services and navigating the system (NMHC 2019c). More broadly, in its review of progress made in the implementation of the Fifth National Mental Health and Suicide Prevention Plan, the National Mental Health Commission (2018a, p. 22) found that '[d]espite ongoing efforts by governments and service providers, many people with severe and complex mental illness still do not receive the supports they need'.

In 2018, many of the relevant stakeholders (the Australian Government's Department of Health, State and Territory Departments of Health, and PHNs) reported to the National Mental Health Commission that their work to improve coordination was 'on track'. Initiatives undertaken included agreements to provide psychosocial supports, commissioning new services and assisting GPs (NMHC 2018a).

The National Mental Health Commission found substantial barriers preventing further progress towards better coordination of care. These included:

- the transition to the NDIS and the ensuing confusion around who can access psychosocial support services (including care coordination), were significant barriers to coordinated care for both State and Territory Departments of Health and PHNs. This issue is explored in detail in chapter 12, including recommendations to remedy the current situation

- structural weaknesses within the mental health system, including inconsistent shared care protocols, and the lack of defined referral pathways, and

- other issues such as resistance to change among providers and insufficient funding (NMHC 2018a).

Figure 10.3 The gap in the availability of care coordination services

How many people need care coordination …	… and how many people access services
64 000 people with severe and persistent mental illness who have complex, multi-agency needs[a]	**64 000 people** are expected to access coordination services through the NDIS[d]
290 000 people with severe and persistent mental illness who also have a psychosocial disability and/or complex social needs[b]	**Unknown number of people** accessing care coordination programs funded by State and Territory Governments
460 000 people who require psychosocial support in addition to clinical services[c]	**Unknown number of people** accessing care coordination programs commissioned by PHNs and funded by the Australian Government

a These estimates refer to the 2017-18 financial year and are based on Whiteford et. al (2017). **b** Chapter 12 discusses this group, and psychosocial services, in detail. **c** This is the estimated number of people requiring care coordination and liaison in 2017-18, based on the Mental Health Service Planning Framework. The Framework regards this as a clinical service, which may also include liaising with non-clinical services (QCMHR 2016). **d** The expected number of people with a psychosocial disability as their primary disability participating at the NDIS, when it is fully rolled out. These people may choose to access care coordination services as part of their NDIS package (chapter 12).

Source: NMHC (2019c); QCMHR (2016); Whiteford et. al (2017).

Addressing these barriers requires a nationally consistent approach, based on a common benchmark for service delivery. The goal of the mental health system should be to ensure that all consumers with severe and persistent mental illness, who access multiple support services, have a single care plan and a care coordinator to oversee it — and this should be the benchmark against which service delivery levels are assessed. All local commissioning authorities need to ensure these services are available in the region they are responsible for, by either employing care coordinators directly or commissioning care coordination services. The care coordinators should work directly with the consumer, their carer (if applicable) and service providers to ensure that all required supports are available to the consumer when

they need them. This includes non-clinical support, such as housing, employment and education.

Who should the care coordinators be?

Existing care coordination services employ staff with a wide range of skill sets — social workers, mental health nurses, GPs, psychologists, psychiatrists, occupational therapists and Aboriginal and Torres Strait Islander health workers. There is also a very wide range of training programs focusing on care coordination, including short online courses, VET-level qualifications and units delivered as part of university degrees (myskills nd; Primary Health Tasmania 2016; Victoria University 2019).

The Commission's model of care coordination focuses on connecting clinical and non-clinical supports for consumers and helping facilitate the navigation between them. Tasks the care coordinator would be required to undertake could include:

- helping to develop and implement the consumer's care plan

- working with the different service providers (including clinical and non-clinical) to ensure the consumer is getting the care they need

- helping to link the consumer with other services that might be needed but could be outside the care plan

- for people admitted to hospital, oversee the implementation of a comprehensive discharge plan,[37] and

- providing advice and guidance for the consumer, their carer and family members through the process.

While clinical skills may be helpful, perhaps the most important skill required from a care coordinator is the ability to relate to their client:

> … care coordination is most importantly about building a positive working relationship with a person in order to develop care plans that address their needs, strengths, and goals. (AASW, sub. 432, p. 3)

An evaluation of Partners in Recovery, a psychosocial support program based around care coordination delivered by 'support facilitators', found that staff working directly with clients had a wide range of backgrounds, but their personal skills were particularly important:

> The interpersonal skills of Support Facilitators are crucial for developing effective relationships with clients, carers and service providers … Effective Support Facilitators reportedly persist in the face of challenges, are resilient and have a positive attitude. They are also required to be lateral thinkers, able to respond to opportunities as they arise, and develop creative and innovative solutions within service system constraints. It is also vital that Support Facilitators are patient as sometimes it can take some time to develop an effective relationship with a client and to see

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[37] If the person lives in a different region from where they are admitted to hospital, a local care coordinator would ensure the relevant information is shared with the care coordination services closest to the person's home.

progress towards meeting their objectives in their Action Plan. Support Facilitators also need to be independent and non-judgemental in their approach with clients. …

Support Facilitators require a base level of skills including knowledge of the health and welfare sectors and experience working with people with mental illness. … Some Support Facilitators are clinically trained in mental health, while others have community development or other services experience. … Some [Partners in Recovery] Organisations suggested clinical training in mental health should be a mandated requirement of both the Support Facilitator role and intake officer to ensure staff had the appropriate knowledge and skills to manage risks. (Urbis 2015c, pp. 19–20)

Some care coordination programs funded by governments in the past were staffed by mental health nurses. For example, the Mental Health Nurse Incentive Program (MHNIP) had a care coordination component, but nurses employed as part of the program also provided ongoing therapy as well as information and support on managing physical illness (DoH 2012).

However, the care coordination model envisaged by the Commission does not include clinical intervention. Evaluations of similar model have suggested that care coordinators should be recruited from outside of the existing mental health workforce, and hold vocational qualifications (Brophy et al. 2014). Vocational qualifications can give care coordinators the skills to navigate the mental health system, and support a culture of collaboration that puts the consumer needs at its centre. At the same time, given the substantial shortages of professionals with a clinical background in mental health (chapter 11), the Commission believes that an expectation that all care coordinators have clinical training is likely to create significant barriers to successful implementation of the care coordination model. The Commission's approach does not require a clinical background for the care coordinators.

A staged implementation approach

Part of the challenge facing local mental health services in implementing care coordination initiatives is a lack of clarity on the extent of demand for services. Programs implemented to date, such as the MHNIP, have been 'supply-driven', and services were expanded only when accredited staff became available (DoH 2012). At the same time, the multitude of different programs offering care coordination makes it difficult to know how many consumers are already receiving services and what gaps remain.

The lack of data is a challenge when planning the implementation of the care coordination model. To overcome this, the Commission proposes as staged implementation approach.

The first step involves local commissioning authorities undertaking a comprehensive audit of care coordination services available in their region, and building a clear picture of demand levels and services available, including those funded through the NDIS.

As an interim goal, all local commissioning authorities should ensure that the most vulnerable consumers — those with a severe and persistent mental illness and complex needs requiring support from multiple agencies — are using efficient and effective care

coordinating services. Estimates based on 2015 data put the number of consumers in this group at 59 000 (Whiteford et al. 2017), and by 2017-18, the number is estimated to have increased to 64 000 nationally (figure 10.3). Given the many programs designed to offer this group care coordination services, it is likely that a substantial proportion of these people already have a coordinator (including through the NDIS, which is expected to support 64 000 people with psychosocial disability when its rollout is completed). In fact, some are likely to have multiple providers with care coordinator roles, occasionally working in parallel to each other. Therefore, the audit of existing services is likely to yield cost savings, as services are streamlined. This will also be beneficial for consumers, who will have one initial point of contact for all their coordination needs, rather than having to navigate between different services.

Ultimately, local commissioning authorities would be expected to ensure that all people with severe and persistent mental illness who require care coordination services due to their complex health and social needs are receiving them. Not all people in this group will be eligible for the NDIS — about 290 000 have severe and persistent mental illness and require some type of social services, but will not meet NDIS eligibility criteria (chapter 12). There is also a larger group, estimated to comprise about 460 000 people nationally, who have severe mental illness and will require support that will include coordination, often for short periods of time (figure 10.3).

Based on the data available, estimates of the annual cost to employ care coordinators could reach up to $1.8 billion for 460 000 potential consumers.[38] However, actual expenditure is likely to be far lower than the maximum amount estimated here. There are a number of reasons for this:

- many people (up to 64 000) are expected to access care coordination services funded through the NDIS, once it is fully rolled out

- there will also be those already receiving care coordination services, and for some, there will be multiple care coordinators. Streamlining services will lead to cost savings

- many people are unlikely to require a care coordinator for the full year, given the episodic nature of some mental illnesses. Therefore, the caseloads used in this cost calculation overestimate demand for services (as they assume no churn of consumers).

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[38] These calculations assume a caseload of 20 and $80 000 annual salary per care coordinator. The caseload figure was suggested as the upper bound of an effective caseload for a Partners in Recovery support facilitator (Urbis 2015). This calculation assumes each client accesses the care coordination services for the entire year, and there is no churn.

The skills levels of a care coordinator role in the Commission's model would be similar to those included in the Social, Community, Home Care and Disability Services Industry Award 2010 for a social and community services employee level 4, and therefore attract an annual wage of $67 286 (as at October 2019) (FWC 2019). This is exclusive of superannuation and other benefits to the employee, as well as costs incurred by the employer as a result of adding a new staff member. Therefore, the calculation above assumes annual cost of employment of $80 000.

This expenditure is also likely to lead to cost savings elsewhere in the health system, as demonstrated by past programs, where care coordination led to reductions in hospital admissions (DoH 2012).

DRAFT RECOMMENDATION 10.4 — CARE COORDINATION SERVICES

All people with severe and persistent mental illness who require care coordination services due to their complex health and social needs should be receiving them. Governments should set a national benchmark for all commissioning authorities, to ensure such services are available and any gaps are addressed.

In the short term (in the next 2 years)

All commissioning authorities should:

- assess the number of people who require care coordination services in their region of responsibility, and the extent to which they are already accessing effective care coordination through existing programs, including the National Disability Insurance Scheme (NDIS)

- streamline care coordination arrangements and ensure that people with a severe and persistent mental illness and complex needs requiring support from multiple agencies have access to effective care coordination.

In the medium term (over 2 – 5 years)

All commissioning agencies should ensure that care coordination programs are available to match local needs, including for those people with severe and persistent mental illness and complex needs who do not qualify for the NDIS, and people with severe mental illness who require care coordination only for brief periods of time.

10.3 Enabling the delivery of integrated care

Transitioning to a model of mental healthcare that is based on collaboration and integration represents a substantial cultural shift, compared to the siloed nature of existing services. Achieving such as cultural shift requires action on multiple fronts, from information management systems to workforce training (chapter 11). There are also a number of organisational approaches that can be effective in promoting greater integration in the mental health system. Three relatively common examples are:

- co-location of services

- partnerships and alliances, and

- memorandums of understanding (MOUs).

Each of these approaches can lead to clinical and non-clinical benefits for services and consumers, through improved communication, greater mutual understanding and empathy, reduced red tape and improved service efficiency (Whiteford et al. 2014b).

Co-location or community hubs

One option to improve integration of services is to have services 'co-located', for example at community hubs, bringing together more than one service in the one physical location (Bonciani et al. 2018). This can include clinical and non-clinical services, such as co-locating physical health, mental health, drug and alcohol and vocational support services. There are many examples of successful co-location of mental healthcare and other services (box 10.7).[39]

In recent years, there has been increasing interest and investment in co-located services. For example, the Australian Government announced in the 2019-20 Budget that it would be dedicating $114.5 million over five years (from 2020-21 to 2024-25) to fund a trial of eight walk-in community mental health centres (DoH 2019o). Mental Health Victoria (sub. 479) has commissioned KPMG to examine the options for Adult Community Mental Health Hubs with multidisciplinary teams including clinical and non-clinical workers drawing on stepped care approaches to provide a range of services including peer support, counselling, alcohol and drug programs, housing and employment.

Inquiry participants strongly advocated for the benefits of co-located services[40] and community hubs, which may offer a wider range of non-clinical services.[41] The Health Services Union (sub. 237), for example, called for the development of 'recovery and wellbeing hubs', which would encompass physical and mental health clinics, community and social services as well as a community and social enterprise space.

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[39] Other examples include LikeMind (MHCC, sub. 214), the Logan and Southern Moreton Bay Islands Mental Health and Wellbeing Hub (Relationships Australia, sub. 103), Mindgardens Neuroscience Network (sub. 64) and the Visy Cares Hub (Hobsons Bay City Council, sub. 176).

[40] For example: Connect Health & Community (sub. 94); cohealth (sub. 231); Hobsons Bay City Council (sub. 176); Moonee Valley City Council (sub. 106); NMHCCF (sub. 476); QNMU (sub. 229).

[41] For example: Brainstorm Mid North Coast (sub. 309); Mental Health Victoria (sub. 480), VACSAL (sub. 225).

Box 10.7   **Examples of co-located services**

headspace

headspace is probably the most well-known example of co-located mental health services in Australia. Along with online, school and other services, headspace has over 100 centres across Australia that provide services to people aged 12–25 years. While the exact services at each headspace centre may vary, they generally include clinical mental health services, physical and sexual health services provided by GPs, drug and alcohol services, and work and study services (headspace 2019c).

An evaluation of the headspace model published in 2015 found that headspace centres are effective in providing young people with an entry point to the mental health system and they help many young people access different types of services in the one location. However, there were gaps in the services accessible at many headspace centres, including the provision of family based services, the expansion of outreach services and the provision of more GP services (Hilferty et al. 2015). The headspace model is discussed in detail in chapter 5.

Floresco

The Floresco centres in Ipswich (established 2014) and Toowoomba (established 2017) provide mental health related services to people aged 18–64 years (QLD Health 2019b; QMHC 2019a). The Ipswich Floresco Centre was established by a consortium of four NGOs — two mental health service providers, a disability support provider, and a tenancy advice and advocacy service. The Queensland Government funded the consortium to deliver community-based psychosocial support services, including personalised support, group support, mutual support and self-help, and family and carer support. The Centre used a number of other strategies to support service integration, including:

- shared processes and systems, including a single intake and assessment process, a single care plan, a shared client information system and a single practice manual of policies

- a collaborative governance committee that included the four NGOs, the local public mental health service, and several other local community service providers (Beere et al. 2018).

The Ipswich Floresco Centre was evaluated and found to be operating effectively as a one-stop mental health service hub. There were also statistically significant improvements in self-reported mental health outcomes. However, it had encountered a range of barriers to service integration, which resulted in several planned features not yet working as planned, including:

- co-location of public mental health service staff had not proved feasible

- the shared client information system was not being used by all co-located service providers, resulting in clients sometimes having to tell their story multiple times

- there were no GP services and the availability of private mental health practitioners had been inconsistent

- the benefits of the different specialities of the NGOs had not been realised as the mental health support workers employed at Floresco did not have any training in the specialty areas of the employing organisations (Beere et al. 2018).

The key benefit of co-located services is that they bring together multiple services into one location — in effect, a 'one-stop-shop' — making it easier for consumers to access services they need. Other possible benefits of co-located services include:

- facilitating coordination and cooperation and improving information and resource sharing between staff and services

- enabling clearer and easier referral pathways between services, and potentially reducing the need for consumers to tell their story multiple times

- improving staff knowledge of other types of sectors and services (for example, mental health workers can gain a better understanding of the services provided by employment service providers) (EMHSCA 2017).

Evaluations of co-located services have identified key factors that contribute to their success. These include commitment from leadership, staff buy-in and willingness to embrace change, regular monitoring and evaluation of service effectiveness, learning from previous co-location initiatives and agreements to clarify roles and responsibilities. Some of the challenges with the implementation of co-location include a lack of trust, logistical issues, risk management, resource constraints (including funding, time, workloads and technology), and gaps in service provision (EMHSCA 2017).

Co-location of services is not sufficient on its own to deliver coordinated services. Providers also need to put in place specific processes, such as the use of single care plans (see above) to maximise the benefits of services working together (Mauro et al. 2016).

Regional partnerships and networks

Often it may not be possible or practical to co-locate multiple mental health services (for example, in rural and remote areas, where co-location may hamper accessibility of services). Partnerships, alliances and networks provide another means of service integration, whereby different types of services can be coordinated to provide consumers with better integrated care. Agreements between different services to collaborate may vary in their level of formality, from an informal handshake agreement to refer consumers to each other, to more formal agreements that are backed up by documentation such as MOUs setting out responsibilities and expectations.

Often alliances and networks will have a geographical component — services in a local area will form agreements to provide consumers within the area with referral services in order to reduce the barriers associated with finding the right services, particularly for consumers who require several different services. Others may be formed around a shared goal that the alliance or network hopes to promote in the mental health space (box 10.8).

Partnerships, alliances and networks are most effective when there is clarity of responsibility or accountability. In some cases, partnerships may break down if there is a lack of mutual understanding of expectations or shared perspective. Hence, in some situations there may be a need for more formalised links between parties.

Box 10.8   **Examples of regional networks**

No Wrong Door Mental Health Charter

The No Wrong Door Mental Health Charter (Mental Health Commission of NSW, sub. 486) is a commitment by organisations in South Western Sydney to a 'no wrong door' approach for recovery-oriented practice. The 'no wrong door' approach means that all services are committed to the individual's needs, either by providing direct services or by linkage and care coordination, so that a range of services are available from multiple points of entry, rather than sending a person from one agency to another (box 10.3).

Organisations that sign the Mental Health Charter are provided with:

- access to an online portal, which assists communication and collaboration between services, facilitates referral exchange when a service cannot be provided by the initial organisation, or when a consumer requires multi-agency support

- mental health first aid training to build capacity of services in recognising signs and symptoms of common mental illnesses and how to provide support to someone in a crisis situation

- an invitation to the annual No Wrong Door Sector Collaboration Forum, as well as other opportunities for collaboration and partnership (No Wrong Door nd).

Tasmanian Suicide Prevention Community Network (TSPCN)

The TSPCN consists of community members, service providers, organisations and government representatives collaborating to reduce the rate and impact of suicide in Tasmania. Some of its activities include sharing information on initiatives to promote mental health, reduce stigma, suicide prevention, early intervention and post intervention; and developing resources to assist the community and service providers to refer people to the most appropriate service for their needs (Relationships Australia, sub. 103).

Agreements and MOUs

A more formalised approach to partnership agreements is the memorandum of understanding (MOU). A MOU is a documented agreement between two or more parties that sets out how their partnership agreement will operate. Typically, it establishes a framework for collaboration between the organisations, for example around referrals and information-sharing, and outlines the common goals or vision of the parties to the MOU (NFP Law nd). Though MOUs are non-legally binding documents, they provide structure to the collaborative process (Community Door nd).

MOUs can support large scale collaborations. For example, the Eastern Mental Health Service Coordination Alliance (EMHSCA) is a collection of 25 services and organisations operating in the Eastern Metropolitan Region of Melbourne that work together to provide coordinated care to people with mental ill-health and their carers.[42] The collaboration is

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[42] Services include mental health care, alcohol and other drugs, community health, family and other community services, housing and homelessness and primary care partnerships.

formalised by a MOU, which sets out the principles, protocols and working arrangements to facilitate integrated practice across the participating services (EMHSCA 2016).

The use of MOUs can help ensure clients do not miss out on treatment and support:

> One of the biggest risks in the referral of clients to external services is the potential for clients to 'fall through the gaps' and disappear from treatment altogether. People with comorbid conditions in particular often have difficulty navigating their way through the available services. The act of trying to navigate the health care system has been likened to a roundabout with many points of entry and many options regarding the direction to be taken. Therefore, it is crucial that the referral process focuses on linking the client with services as smoothly as possible. This may be assisted by the development of formal links between services regarding consultation, referral pathways, and collaboration, such as a memorandum of understanding. (Comorbidity Guidelines 2019)

MOUs can be drawn up between many parties. For example, they can be shared between service providers and a government body, different government departments (School-Link, box 10.9), or some combination of these (NSW Health 2018a; QLD Health 2019a).

Box 10.9   The School-Link Initiative

The NSW School-Link Initiative is a partnership between NSW Health and the Department of Education and Communities (DEC) to work together to improve the mental health, wellbeing and resilience of children and young people in NSW. The partnership between Health and DEC commenced in 1999 and was formalised in 2009 through a memorandum of understanding.

School-Link aims to ensure:

- early identification of mental health issues for children and young people
- provision of evidence-based early intervention programs in schools
- early access to specialist mental health services.

The initiative aims to equip school and TAFE staff with skills to identify and manage emerging mental health issues in their students and to strengthen their understanding of where to refer young people for the help they need.

NSW Health funds the employment of School-Link Coordinators to implement the School-Link Initiative across approximately 3000 NSW schools and TAFEs in partnership with teachers, school counsellors and specialist mental health staff.

Source: NSW Government (sub. 551); NSW Health (2015, 2017a).

Some of the barriers impeding successful service collaboration include a lack of shared perspective or mutual understanding, unclear accountability, and 'turf issues' arising from differences of opinion between service providers and disagreements regarding areas of responsibility (Whiteford et al. 2014b). MOUs, while enabling partnerships, alliances and networks, can also help in overcoming some of these barriers and improving the efficacy of co-location.

DRAFT FINDING 10.2 — SUPPORTING COLLABORATION BETWEEN SERVICE PROVIDERS

A range of approaches to collaboration, including co-location, alliances and networks, can improve service delivery and benefit consumers.

Depending on the scale and type of services involved, providers could consider formalising links using memorandums of understanding to create clear accountability structures and overcome barriers to collaboration.

11 Mental health workforce

An effective health workforce matters because …	• There is a lack of needed skills, most evident in shortages of psychiatrists in some areas and mental health nurses, and under-utilisation of peer workers.
	• There is an inefficient allocation of skills, evidenced by psychologists providing very low-intensity interventions.
	• Health workers are disproportionately concentrated in major urban areas.
	• Negative workplace cultures in some health services exposes workers to stigma, stress and burnout and leads to high staff turnover.
Successful intervention requires …	• Increasing the number of locally-trained mental health nurses by introducing an undergraduate degree in mental health nursing, and recognising specialist mental health qualifications as part of nurse registration.
	• Training more psychiatrists in Australia by raising the number of training placements and availability of supervisors for trainees.
	• Strengthening the peer workforce through a more comprehensive system of training, work standards, an organisation to represent this workforce, and a program to build support for the value of peer workers among other health professions.
	• Better workforce planning by governments to align service provider skills, availability and location with demand.
	• Encouraging more GPs in rural and remote areas to undertake advanced specialist training in mental health.
	• Incorporating best-practice approaches to managing medication side effects in continuing professional development requirements for GPs and psychiatrists.
	• Reducing negative perceptions of mental health as a career option, such as by offering students in health disciplines more internships in settings other than inpatient units.
	• Making rural and remote locations more attractive for health professionals, including expanding the availability of locums for workers when they are on leave or undertaking professional development.

This chapter considers how reforms targeted at the health workforce could improve access to, and the quality of, healthcare for people experiencing mental ill-health.

There are many different health professions that can help people to improve their mental health or address the physical and substance use comorbidities they may have (box 11.1). Some professions specialise in mental health, while others treat a wider range of people but are nonetheless important to those experiencing mental ill-health. GPs have a vital role in managing the overall health of people with a mental illness and referring them for specialist treatment when needed. Allied health professions and dentists provide specialised forms of care which people with more severe mental conditions often need, particularly to address their relatively high rate of physical ailments (chapter 9).

Box 11.1   Health professions most relevant to people with mental ill-health

Medical practitioners are registered by the Medical Board of Australia and include the following.

- **GPs** provide primary healthcare in community settings. They are often the first point of contact for someone with a health problem; may provide lower-intensity psychological therapies; and play an important role in managing a patient's overall health needs, including referring patients for specialist treatment when needed.

- **Psychiatrists** are medical practitioners specialising in the diagnosis and management of mental illness using psychological and medical treatments.

Psychologists are registered with the Psychology Board of Australia and provide assessment and therapy to people experiencing mental ill-health.

Nurses perform tasks in the assessment and management of patients, and are registered with the Nursing and Midwifery Board of Australia.

- Three types of nurses are registered — **enrolled nurses** (diploma-level training), **registered nurses** (undergraduate degree) and **nurse practitioners** (post-graduate).

- This group can include **specialist mental health nurses** who have undertaken advanced training in mental health.

Peer workers are employed on the basis of their lived experience.

- **Consumer peer workers** use their lived experience of mental illness and recovery to provide emotional and practical support to people with a mental illness.

- **Carer peer workers** play an analogous role for carers of people with a mental illness.

Allied health professions are university qualified practitioners with specialist expertise related to physical or mental health. They include psychologists and the following professions.

- **Occupational therapists** assist people with daily living and work skills.

- **Social workers** help people deal with personal and social issues through counselling and community engagement.

- **Pharmacists** dispense, and provide advice on, medicines used to treat mental and physical conditions.

The **Aboriginal and Torres Strait Islander health workforce** emerged in response to a need to provide more culturally capable support for Indigenous people whose health needs were not being met by mainstream services. The workforce includes clinical and non-clinical roles. Those who provide clinical services are registered with the Indigenous Health Practice Board of Australia.

Low-intensity therapy coaches, such as cognitive behavioural therapy coaches, provide psychological interventions and support for mild mental disorders. They do not undertake university training and are not a registered profession.

There are also many other health professions that are sometimes involved in the care of people experiencing mental ill-health. For example, dentists and dieticians may be needed to treat physical conditions arising from mental illness or its treatment.

The number of health workers providing mental healthcare services varies significantly between clinical professions (figure 11.1).[43] The largest profession primarily providing mental health services are nurses working in mental health settings, followed by psychologists. In comparison, there are relatively few psychiatrists and occupational therapists.

Figure 11.1   **Number of health workers providing clinical services, by selected professions, 2017[a]**
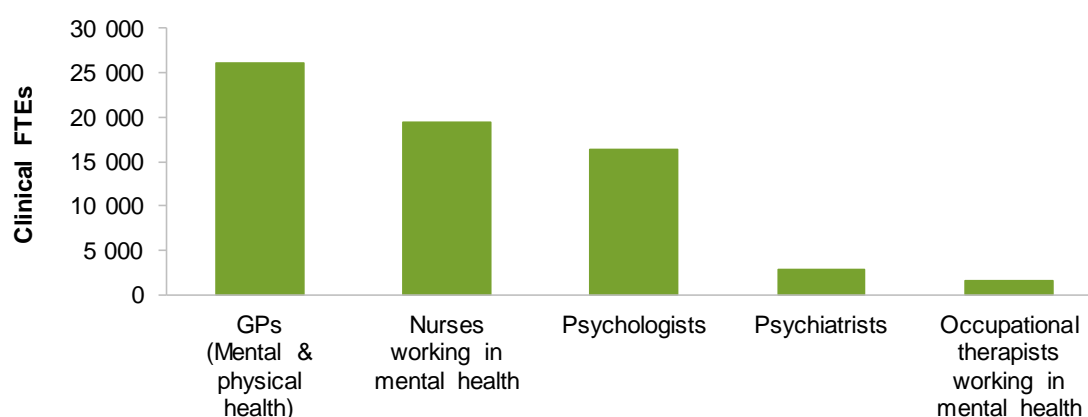
a Measured as clinical full-time equivalents (FTEs), which quantifies total hours worked in clinical roles (diagnosis, care or treatment) in terms of number of full-time workers. The number reported for GPs is for all clinical services, not just those related to mental health. Nurses were deemed to be working in mental health if their job area was mental health or their job setting was a community or residential mental health service. Occupational therapists were considered to be working in mental health if their job scope was mental health.

Source: DoH (2019v).

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43 It is not possible to quantify all of the professions serving people with a mental illness because data is not collected in some cases, or available data does not identify the extent to which the more general professions serve people with a mental illness.

11.1 Why reform the health workforce?

The structure and composition of the current health workforce reflects the deficiencies in mental health services identified in other chapters of this report, such as large gaps in the availability of many types of services and an over-emphasis on acute care.

This is evident in a lack of individuals with the needed skills across the workforce as a whole, which can be partly attributed to a failure to train and employ sufficient people in clinical professions, especially mental health nurses and psychiatrists (detailed later in this chapter). It is also due to a failure to broaden the mix of skills to include non-clinical roles, such as the support that peer workers can provide to people experiencing a mental illness (discussed further below), and the navigation services and care coordination that consumers may need (chapter 10).

A further problem has been the inefficient allocation of skills to particular roles. For example, using face-to-face therapists when e-mental health would be just as effective (chapter 5); highly-trained professions (psychiatrists and clinical psychologists) providing psychological interventions for mild mental disorders which could be just as effectively delivered by low-intensity therapy coaches (chapter 5); and underutilisation of nurses for clinical tasks that do not require a medical professional.

Compounding these issues has been a mismatch between the location of the health workforce and where people with a mental illness live. Psychiatrists are the most geographically concentrated profession, with 88% located in major cities in 2017, compared with 72% of the Australian population (figure 11.2).

Figure 11.2 **Geographic distribution of selected health professions compared to Australian population, 2017[a]**

Figure 11.2 **Geographic distribution of selected health professions compared to Australian population, 2017[a]**
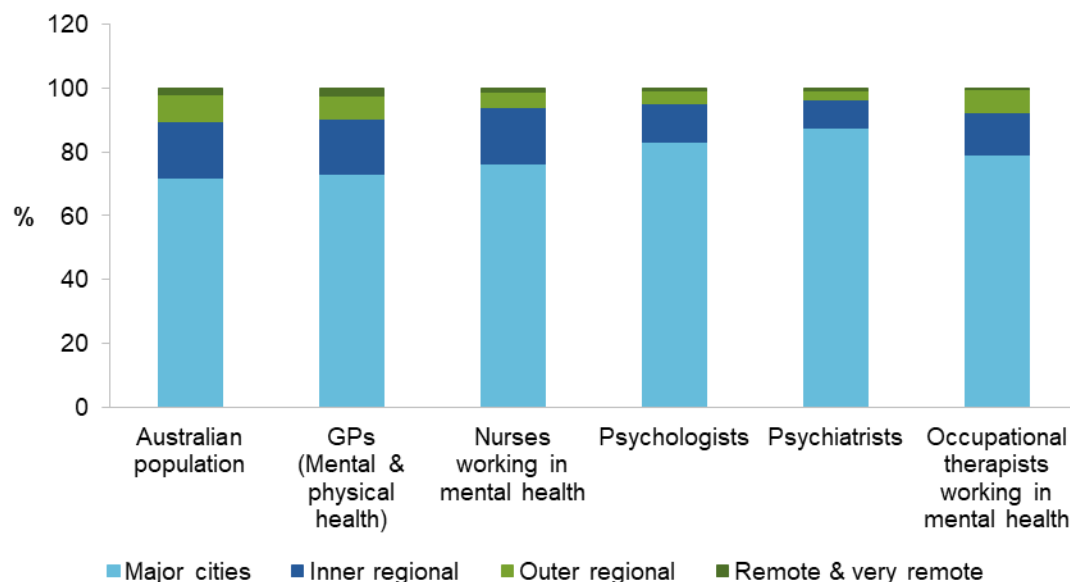
[a] Health professions measured in terms of number who were employed. All employed GPs, psychologists and psychiatrists were included irrespective of what roles they were performing. Nurses were deemed to be working in mental health if their job area was mental health or their job setting was a community or residential mental health service. Occupational therapists were considered to be working in mental health if their job scope was mental health.

Source: DoH (2019v).

This makes it harder for people outside major cities to access care, and places a relatively high burden on the health professionals who do work in those areas. The consequences are evident in the per capita provision of clinical services by specific professions, which tends to decline as remoteness increases (figure 11.3). This is a major factor behind the lower rate of mental health services received per head of population in remoter areas (chapter 2).

The exception is GPs, who are more heavily concentrated in remote and very remote areas than in cities and regional areas. Despite the comparatively high number of GPs outside of major cities, there remain difficulties in access to GPs for mental health care in rural and remote parts of Australia and longer GP waiting times in these areas (ABS 2018f). In part, this may reflect the very broad role that GPs often fill in rural and remote areas, whereby they perform a wide variety of health functions — as suggested by the data on the overall medical practitioner workforce by region (AIHW 2016b). Further, it is acknowledged that have a GP in your locality does not equate with that GP either having skills in diagnosing and treating mental illness or being culturally capable.

What is also not known, but is of interest to the Commission, is the extent to which turnover of GPs in rural and remote areas may be higher than in urban areas, making it difficult for people to build rapour and establish a longstanding link with their GP.

Figure 11.3   Provision of clinical services per capita, by region and selected professions, 2017ᵃ
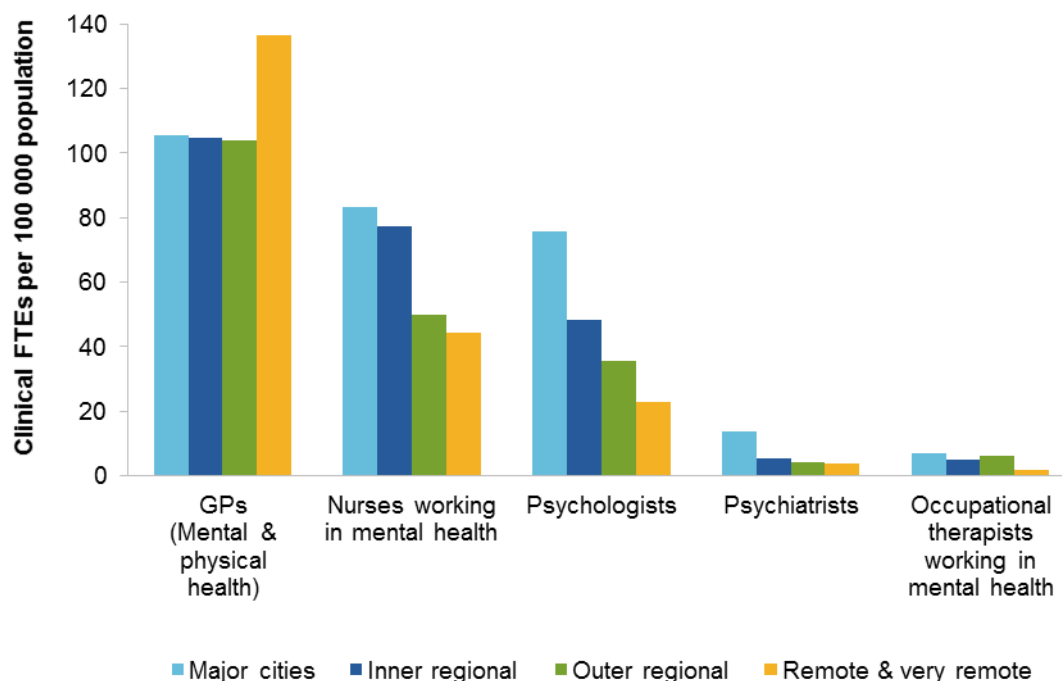
ᵃ Measured as clinical full-time equivalents (FTEs) per 100 000 population, which quantifies total hours worked in clinical roles (diagnosis, care or treatment) in terms of number of full-time workers per head of population. The number reported for GPs is for all clinical services, not just those related to mental health. Nurses were deemed to be working in mental health if their job area was mental health or their job setting was a community or residential mental health service. Occupational therapists were considered to be working in mental health if their job scope was mental health.

Source: DoH (2019v).

Finally, a negative workplace culture in some settings and providers is reflected in commonly expressed views that health professionals providing mental health services often experience stigma, stress, burnout and high turnover. This is undesirable not only for health professionals and providers but also because it could adversely affect the quality of care received by consumers (Centre for Transformative Work Design, sub. 342; DoH, sub. 556; NSW Nurses and Midwives' Association, sub. 246).

11.2 Improving the quantity, mix and allocation of skills across the health workforce

In chapters 5 to 9, the Commission has proposed a redesigned mental health system based on a stepped model of care. To deliver this redesigned model, the health workforce will need to have a:

- greater quantity and wider mix of skills — such as in providing peer support, navigation services, care coordination, and low-intensity psychological treatment

- more efficient allocation of skills to specific services — such as a greater reliance on low-intensity therapy coaches (and e-mental health) to provide psychological interventions and support for mild mental disorders.

Opportunities to allocate skills more efficiently should be explored because the training of some health professions (especially medical practitioners) requires a lot of resources and time, and their remuneration is higher than other health professionals. It is not ideal to be relying heavily on these professionals for tasks that can be effectively done by others in the health workforce. For example, the cognitive behavioural therapy (CBT) coaches that deliver low-intensity therapies under the New Access program take about one year to train, compared with 6 years for registered psychologists (table 11.1). Similarly, many clinical services can be done by nurses rather than medical practitioners. Shifting to a more efficient allocation of skills would mean that more people can be treated within the resources available to the community, and that the stepped system of mental health services proposed by the Commission would be implemented more rapidly.

There is a limit to which there can be a reallocation of roles. For many clinical services, the required skills are highly specialised ones that map to a single, or small number of, professions. For example, specialised psychiatric treatment is delivered by psychiatrists; peer support is provided by people who have lived experience of mental ill-health; and specific allied health services often require a specialist in the relevant discipline, such as a dietician, exercise physiologist, pharmacist or physiotherapist.

The remainder of this section considers how to improve the quantity, mix and allocation of skills across the health workforce through reforms targeted at:

- general workforce planning

- specific skills or professions, with the section focusing first on those with the most severe workforce shortages — psychiatrists and mental health nurses.

Table 11.1 Training requirements for selected health professions

	Minimum qualification	Minimum duration
Medical practitioners		
GPs	Post-graduate	8 years
Psychiatrists	Post-graduate	11 years
Nurses		
Enrolled nurses	Diploma (TAFE)	1.5 years
Registered nurses	Undergraduate	3 years
Specialist mental health nurses[a]	Post-graduate	4 years
Nurse practitioners[b]	Post-graduate	8 years
Psychological therapists		
CBT coaches[c]	Vocational training	1 year
Psychologists (general registration)[d]	Post-graduate	6 years
Clinical psychologists[e]	Post-graduate	8 years
Other allied health		
Occupational therapists	Undergraduate	4 years
Social workers	Undergraduate	4 years
Dieticians	Undergraduate	3 years
Exercise physiologists	Undergraduate	4 years
Pharmacists	Undergraduate	5 years
Other professions		
Aboriginal and Torres Strait Islander Health Practitioners	Diploma (TAFE)	1.5 years
Peer workers	Lived experience of having a mental illness or being a carer	—

a Specialist mental health nurses have to first become registered nurses and then typically complete an additional graduate diploma or master's degree in mental health. **b** Nurse practitioners can diagnose and treat patients. They must be registered nurses, have 3 years of experience at the clinical advanced nursing practice level, and complete a master's degree. **c** Coaches in the New Access program undertake 12 months of training, starting with a 6-week intensive course. **d** General registration as a psychologist requires 6 years of training, either through a 4+2 pathway (4 years of study in psychology and a 2-year supervised internship) or 5+1 pathway (5 years of study and a 1-year internship). **e** Clinical psychology is 1 of 9 specialities that can be recognised on a practitioner's registration through an area-of-practice endorsement. A minimum 8 years of training is now required, comprising 4 years of general study in psychology, a 2 year master's degree in clinical psychology, and 2 years of supervised practice in a registrar program.

Sources: AHPA (2019a); AIHW (2018m); DAA (2019); NMBA (2016); PBA (2016); RANZCP (2017d).

General workforce planning

Governments have a major role in funding, commissioning and delivering health services, and so undertake workforce planning to forecast the future level and mix of skills needed, and plan how to meet this through interventions such as subsidised training places and the hiring and location of people working in public sector health providers (box 11.2).

Box 11.2   Examples of health workforce planning by governments

Governments have produced many health workforce planning documents relevant to the provision of services for people experiencing mental ill-health. They include the following.

- National Mental Health Workforce Strategy (2011)
- NSW Health Professionals Workforce Plan (2012–2022)
- Victorian Mental Health Workforce Strategy (2016)
- Queensland Medical Practitioner Workforce Plan (2016)
- SA Rural Health Workforce Strategy (2019–2022)
- WA Mental Health, Alcohol and Other Drug Workforce Strategic Framework (2018–2025)
- Tasmanian Strategic Framework for Health Workforce (2013–2018)
- ACT Health Workforce Plan (2013–2018)
- NT Primary Health Care Workforce Needs Assessments (2019)

Further examples are in development, including a NSW Psychiatry Workforce Plan (NSW Government, sub. 551) and a new National Mental Health Workforce Strategy (Hunt 2018b).

Governments have committed to various initiatives to improve their workforce planning, given the issues identified in section 11.1 above, such as skill shortages, lack of emphasis on peer support and difficulties in accessing services in regional and remote areas.

At a national level, the Australian, State and Territory Governments have, under the auspices of the National Mental Health and Suicide Prevention Plan, been undertaking work to produce a workforce development program to guide strategies to address future workforce supply requirements and drive recruitment and retention of skilled staff (to be completed by 2022) (COAG Health Council 2017a).

The Australian Government has also announced that a new National Mental Health Workforce Strategy is to be developed (DoH, sub. 556; Hunt 2018b).[44] This is expected to be an input to the workforce development program for the National Mental Health and Suicide Prevention Plan, and involve estimating future workforce needs and identifying approaches that governments can implement to attract, train and retain the workforce required to meet future demand for mental health services. The strategy will be developed

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[44] A more general National Medical Workforce Strategy is already under development. This is to be completed by the end of 2020.

by a taskforce which includes representatives of consumers, carers, health professions and peak bodies, as well as experts in labour economics and education (DoH, pers. comm., 29 July 2019). A National Medical Workforce Strategy is also under development and is due to be finalised by the end of 2020 (DoH 2019j).

The above mentioned initiatives are an opportunity for governments to revise their general workforce planning in ways that facilitate the quantity, mix and allocation of skills needed (including cultural capability) to deliver the redesigned system of mental health services proposed by this inquiry.

DRAFT RECOMMENDATION 11.1 — THE NATIONAL MENTAL HEALTH WORKFORCE STRATEGY

The forthcoming update of the National Mental Health Workforce Strategy should align health workforce skills, availability and location with the need for mental health services.

In the short term (in the next 2 years)

The Australian Government should ensure that its development of a new National Mental Health Workforce Strategy includes the following actions.

- Set the objective of achieving a health workforce which aligns the skills, cultural capability, availability and location of mental health service providers with demand. This goal should be given effect by integrating the workforce strategy with service and infrastructure planning.

- Quantify the future supply of specific skills and health professions under a business-as-usual scenario, and the extent to which this will fall short of what is needed.

- Specify what will be done to address any forecast shortages in skills or professions, and quantify the expected timing and reduction in those shortages.

- Include a commitment to implement the recommendations that this inquiry has made on specific skills and professions, including a more efficient allocation of tasks.

- Set targets to attract and retain workers, and establish a system to monitor and report progress in achieving the targets.

This work should also inform the workforce development program which is being undertaken for the National Mental Health and Suicide Prevention Plan.

Psychiatrists

Psychiatrists generally treat people with more severe forms of mental illness. It has been an ongoing challenge to ensure there is a sufficient supply of these highly specialised medical practitioners to meet demand for them. Shortages are particularly evident outside major cities and for sub-specialities such as child and adolescent psychiatry.

Increasing the supply of psychiatrists through training involves a long lag time as they take a minimum of 11 years to train (including general medical training). Australia has therefore

relied heavily on attracting overseas-trained psychiatrists to supplement locally trained practitioners. In 2015, more than 40% of new accredited psychiatrists obtained their specialist qualification outside Australia (DoH 2017f).

Nevertheless, there have been reforms to Australia's psychiatric training in recent years which are expected to increase the supply of locally trained practitioners over the longer term. Most notably, the system of training was revamped in 2012 to reduce an apparent bottleneck to people progressing from basic to advanced training (box 11.3). It was estimated that the new training program would reduce an expected shortfall in psychiatrists in 2025 from roughly 450 to 75 practitioners (full-time equivalents) (DoH 2016a).

Box 11.3   How psychiatrists are trained in Australia

Psychiatrist training is a postgraduate medical course for medical practitioners. Entry requirements are completion of a medical degree, at least one year of general medical training, and general registration as a medical practitioner. Trainees who successfully complete the program are eligible to become fellows of the Royal Australian and New Zealand College of Psychiatrists, which qualifies them to practise independently as consultant psychiatrists.

In 2012, a new competency-based approach to training psychiatrists was announced (the 2012 fellowship program). Trainees work as registrars in hospitals and clinics, where they are supervised by experienced psychiatrists, as well as completing a number of exams and assessments. The program takes a minimum of 5 years to complete and involves 3 stages.

- Stage 1 (basic level adult psychiatry) — 1 year in an approved adult psychiatry rotation, including a minimum 6 months in an acute setting.

- Stage 2 (mandatory and elective rotations) — 2 years in an approved training program, including 2 mandatory 6-month rotations (in consultation-liaison psychiatry and child and adolescent psychiatry) and 2 elective 6-month rotations in any of 5 other areas of psychiatry (addiction, adult, forensic, Indigenous and old age).

- Stage 3 (advanced elective rotations) — 2 years in an approved training program, including 4 elective 6-month rotations in 1 or more of 9 areas of practice (addiction, adult, child and adolescent, consultation-liaison, forensic, Indigenous, old age, research/academic and psychotherapy).

The individual stages were phased in over time, with stage 1 commencing in January 2013, stage 2 in 2014, and stage 3 in 2016. The earliest that trainees entering the new program in January 2013 could attain fellowship was January 2018.

In addition to general training, the Royal Australian and New Zealand College of Psychiatrists offers certificates of advanced training in 7 areas of practice to enable fellows and stage 3 trainees to extend their skills. The 7 areas offered are addiction, adult, child and adolescent, consultation-liaison, forensic and old-age psychiatry, and psychotherapies.

Sources: DoH (2016a); RANZCP (2017a, 2019a).

The workforce modelling to be done for the National Mental Health Workforce Strategy (draft recommendation 11.1 above) should include more up-to-date forecasts of the extent to which Australia is on track to have sufficient psychiatrists to provide needed services.

Data available to this inquiry up to 2017 show a gradual upward trend in the number of employed psychiatrists and the amount of time they spent providing clinical services (table 11.2). Moreover, this outpaced population growth. It is likely that a large part of the increase, but not the majority, has been from overseas trained practitioners, given past reliance on this group.

Table 11.2   **Employed psychiatrists, 2011 to 2017[a]**

	2011	2012	2013	2014	2015	2016	2017	Average annual growth
	no.	no.	no.	no.	no.	no.	no.	%
Total numbers								
No. of employed psychiatrists	2 836	2 913	2 953	3 066	3 127	3 244	3 369	2.9
FTEs	na	na	2 845	2 966	3 011	3 160	3 268	3.5
Clinical FTEs	na	na	2 330	2 439	2 487	2 608	2 715	3.9
Numbers per 100 000 population[b]								
FTEs	na	na	12.3	12.6	12.6	13.1	13.3	1.9
Clinical FTEs	na	na	10.1	10.4	10.4	10.8	11.0	2.3

a FTEs means full-time equivalents. Clinical FTEs indicate the amount of clinical services provided in terms of full-time psychiatrists. **b** Based on Australian population at 30 June in the relevant year. **na** Not available.

Source: AIHW (2018m).

The effects of the revamped training model will not be fully reflected in the number of new psychiatrists for a few more years, given the long duration of training. The actual time taken to complete training is often more than the minimum 5 years (in addition to 6 years of medical training) due to factors such as people training part-time or taking breaks. For newly appointed fellows in 2016, the average time taken to complete their psychiatric training was 7.3 years (RANZCP 2017a).

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) (2019b) has been monitoring the growth rate of trainees to maintain an average annual increase of 3.3% per annum to avoid an undersupply of psychiatrists by 2030.[45] From 2012 to 2018, the actual trainee intake grew in some years and fell in others, but the annual rate of growth over the whole period (in compound terms) was 4.3%. This suggests that progress is being made in reducing future shortages below what they would otherwise be. But more needs to be done. In particular, there is little sign of the most acute shortages declining, that is in rural and remote areas and sub-specialities such as child and adolescent psychiatry.

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[45] The 3.3% target is based on estimates of future workforce needs up to 2030 that were produced for the former National Medical Training Advisory Network (now the Medical Workforce Reform Advisory Committee) (DoH 2016).

Unlike other medical professions, there is no formal cap on training places for psychiatrists. Rather, constraints on training more people have been the supply of suitable applicants, number of training placements and availability of supervisors.

The RANZCP has for some years been actively promoting careers in psychiatry to medical graduates and junior doctors through its Psychiatry Interest Forum (PIF) using educational events, career guidance, online resources and newsletters. The College also targets secondary schools to raise awareness of psychiatry as a career. Almost 80% of people who commenced training in 2018 had been Psychiatry Interest Forum members, which was up from 46% in 2017 and 36% in 2016. Approximately 16% of all medical students and prevocational doctors who joined the PIF between 2013 and 2018 transitioned to the RANZCP training program between 2014 and 2018 (RANZCP, pers. comm., 16 September 2019).

However, inquiry participants were concerned that doctors continue to be discouraged from specialising in psychiatry because training placements are often in the most stressful settings in the public sector, particularly inpatient units. The RANZCP has noted that:

> A widespread negative perception of working in inpatient units prevails because they are high pressure environments. The pressure is created by the mix of high acuity patients, physical and verbal violence from patients, constant pressure to discharge patients to meet National Emergency Access Targets, and workforce shortages, particularly during on-call periods. The amount of on-call work has steadily increased and is now a problem – registrars (trainees or HMOs) are now working 8–9 hours per day on the weekend. The sum of these factors militates against being able to receive adequate support and the cumulative effect results in burnout. (RANZCP 2017c, p. 42)

Options to create a more positive work environment in such settings are discussed in section 11.3 below.

The public sector will have to remain a major provider of training placements, given the large share of psychiatric services it provides. State and Territory Governments (through their local hospital networks) should therefore increase the number of funded placements in their facilities, including for advanced training in sub-specialities with significant shortages such as child and adolescent psychiatry. The precise increase should be informed by assessments of future workforce needs as part of broader workforce planning by governments, including for the National Mental Health Workforce Strategy (draft recommendation 11.1 above).

There should continue to be efforts to increase training placements in the private sector and rural and remote areas. The Specialist Training Program and the Integrated Rural Training Pipeline have been important contributors. These are Australian Government initiatives to fund training placements outside the traditional public teaching hospitals in metropolitan areas.[46] The RANZCP has been funded to deliver the equivalent of 160 full-time psychiatric

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[46] The STP also funds the RANZCP to promote careers in psychiatry to medical graduates and junior doctors through its Psychiatry Interest Forum.

training places under the Specialist Training Program (with 71 of these to be in the private sector and 50 in rural areas) and a further 34 rural-focused training posts under the Integrated Rural Training Pipeline (DoH, sub. 556). The Australian Government has also funded positions in Tasmania's public health system for 3 full-time trainees and 1.3 supervisors as part of the Training More Specialist Doctors in Tasmania project. (DoH, pers. comm., 23 August 2019).

Additional training placements will be of little benefit if there are not also more supervisors of trainees. A 2016 report for the Australian Government by the National Medical Training Advisory Network (titled *Australia's Future Health Workforce – Psychiatry*) recommended that this be addressed by:

- adopting strategies to identify and develop new supervisors, including in the private sector and remoter locations

- developing resources — such as online modules and peer support activities — to provide extra support for supervisors, including in rural and remote areas

- consideration of blended and remote models of supervision so that trainees can receive appropriate supervision in regional and remote areas. (DoH 2016a).

The Commission has seen little evidence of any of these recommendations having been adopted by governments or other stakeholders. One exception is a project that the RANZCP recently decided to undertake to review current supervision resources. This will lead to the identification of which resources need to be developed, based on gap analysis, education rationale, supervisor and trainee needs, and improvements that can be made to the supervisor accreditation and training process (RANZCP, pers. comm., 16 September 2019).

With respect to the proposal to consider remote models of supervision, there will be a limit to which this could substitute for face-to-face support of trainees, but there is probably scope to do more than currently. This option needs to be considered more thoroughly by governments and professional bodies, given the relatively small number of psychiatrists outside major cities who can potentially act as supervisors in those locations (other options to increase the health workforce in remoter areas are considered in section 11.4 below). A similar issue applies to advanced training in areas such as child and adolescent psychiatry due to a shortage of current practitioners in those fields of practice.

DRAFT RECOMMENDATION 11.2 — INCREASE THE NUMBER OF PSYCHIATRISTS

In the medium term (over 2 – 5 years)

The Australian, State and Territory Governments should collectively develop a national plan to increase the number of psychiatrists in clinical practice, particularly outside major cities and in sub-specialities with significant shortages, such as child and adolescent psychiatry.

This should be done in collaboration with the Royal Australian and New Zealand College of Psychiatrists, and form part of the broader National Medical Workforce Strategy which is currently being developed.

The plan should include actions to:

- raise the number of funded training placements and supervisors, with State and Territory Governments doing so in public sector health facilities, and the Australian Government contributing funding for more positions in the private sector and rural and remote areas

- increase the availability of supervision for trainees, including by considering interventions recommended in the 2016 report by the National Medical Training Advisory Network (titled *Australia's Future Health Workforce – Psychiatry*) such as remote models of supervision for trainees outside major cities.

The size of the targeted increase in psychiatrists should be based on assessments of future workforce needs to be undertaken as part of broader workforce planning by governments, including for the National Mental Health Workforce Strategy (draft recommendation 11.1).

Mental health nurses (MHNs)

The term 'mental health nurse' (MHN) is used here to refer to nurses who primarily support people experiencing mental ill-health. There are several different types of nurses who can serve this role (box 11.4). And they can work in a range of settings, including hospitals, community mental health services, and GP clinics.

Box 11.4   The different types of nurses who work in mental health

The following types of nurses can be involved in supporting people experiencing mental ill-health.

- **Enrolled nurses** are trained in the vocational education and training system with a focus on practical skills, and report to either a registered nurse or other person with higher qualifications.

- **Registered nurses** are university trained (undergraduate degree), and over a longer period than enrolled nurses (3 years full-time), so have a more extensive set of skills.

- **Specialist MHNs** have advanced training in mental health that gives them specialist skills in supporting people with a mental illness. This specialisation is not recognised under Australia's current registration system for nurses and so there are no legislated training standards. However, a national credentialing program has been established by the Australian College of Mental Health Nurses which requires candidates to first become a registered nurse and then complete a graduate diploma or master's degree in mental health.

- **Nurse practitioners** are authorised to diagnose and treat health conditions, order tests, prescribe medications, make referrals, and access Medical Benefits Scheme rebates for some services, provided they work in a collaborative arrangement with a medical practitioner, such as being employed by them. Nurse practitioners must be registered nurses, have 3 years of experience at the clinical advanced nursing practice level, and have completed a master's degree.

Providers of mental health services can usually employ any of the above types of nurses. A notable exception is public-sector mental health services in South Australia, where enrolment in, or completion of, a specialist mental health qualification is required under the relevant enterprise agreement.

There is a shortage of MHNs

In 2017, roughly 7% of employed nurses (22 159 nurses) indicated that they were principally working in mental health. Of these, 94% (20 792 nurses) spent the majority of their time in a clinical role (AIHW 2019p).

There was a widespread view among inquiry participants that many more nurses are needed in mental health, particularly in primary and community health settings (for example, ACMHN, sub. 501; CRRMH, sub. 465; NSWNMA, sub. 246; QNMU, sub. 229). This is consistent with the findings of past reviews and studies. For example, in its 2014 review of mental health programs the National Mental Health Commission identified addressing MHN shortages as an urgent priority (NMHC 2014c). Modelling by Health Workforce Australia predicted a shortfall of between 11 500 and 18 500 MHNs by 2030 (HWA 2014b). This was the largest shortage of nurses in percentage terms among all the different areas of healthcare which it modelled.

The most recent data available to this inquiry indicate that little progress has been made in addressing the shortage of MHNs. They show that the employment of MHNs has essentially been static since 2013 at roughly 85 full-time equivalents per 100 000 population (figure 11.4).

Figure 11.4 **Number of MHNs per 100 000 population[a]**
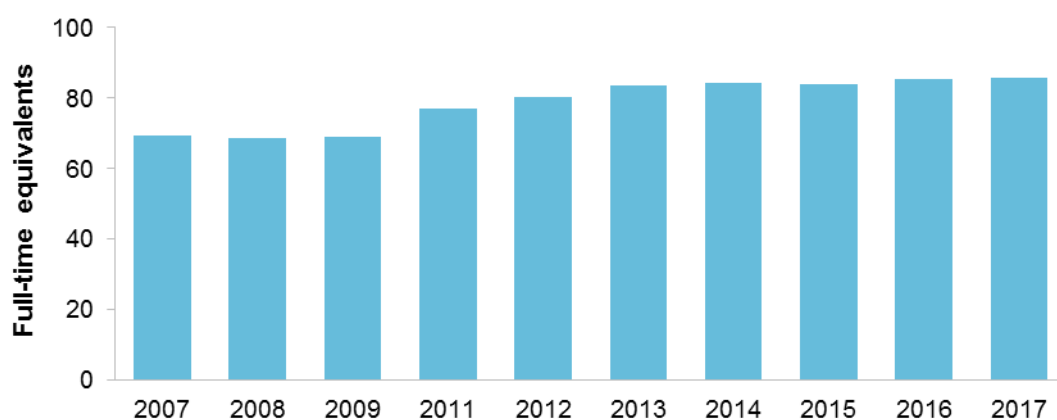
a Employed nurses who principally worked in mental health. No data were available for 2010.

Source: AIHW (2019p).

It will be challenging to even maintain the current number of MHNs under existing policy settings because the workforce is ageing, probably due to a low rate of new entrants to the profession, and so future retirements could be high compared with nurses in other areas of healthcare (ANMF, sub. 317).

Mental health skills among MHNs

Some inquiry participants were concerned that nurses working in mental health do not always have the right skills to support people experiencing mental ill-health (for example, NSWNMA, sub. 246).

In 2017, close to 85% of MHNs did not have a specialist mental health qualification (AIHW 2019m). The current training standards for general nurses do require them to have received some instruction on mental health issues, but this only has to be delivered within units on broader subjects. This could change for registered nurses in the near future because the accreditation body for nurse training — the Australian Nursing and Midwifery Accreditation Council — has proposed an update to the training standards which would include a discrete unit on mental health (ANMAC 2019). Existing enrolled and registered nurses can improve their mental health skills through on-the-job and off-site training. Options to further improve the mental health skills of nurses are considered below.

Among the minority of MHNs who had specialist mental health qualifications in 2017:

- roughly one-third were registered nurses with a post-graduate qualification in mental health under the credential practice program of the Australian College of Mental Health Nurses (ACMHN, sub. 501)

- the remaining two-thirds only had a nursing qualification in mental health and so were not qualified to work as general nurses. This group likely covers people who trained in

Australia prior to the introduction of generalist nursing degrees, and overseas-trained nurses from countries that have specialist training pathways at an undergraduate level (such as the United Kingdom).

The number of MHNs with post-graduate specialist training in mental health was on an upward trend until 2016, after which it began declining (figure 11.5). This matches the timing of the Australian Government's Mental Health Nurse Incentive Program, which funded the employment of MHNs in primary and community care settings from 2007 until the program was phased out from 2016 to 2017.

Figure 11.5 **Specialist mental health nurses by type of training** [a]
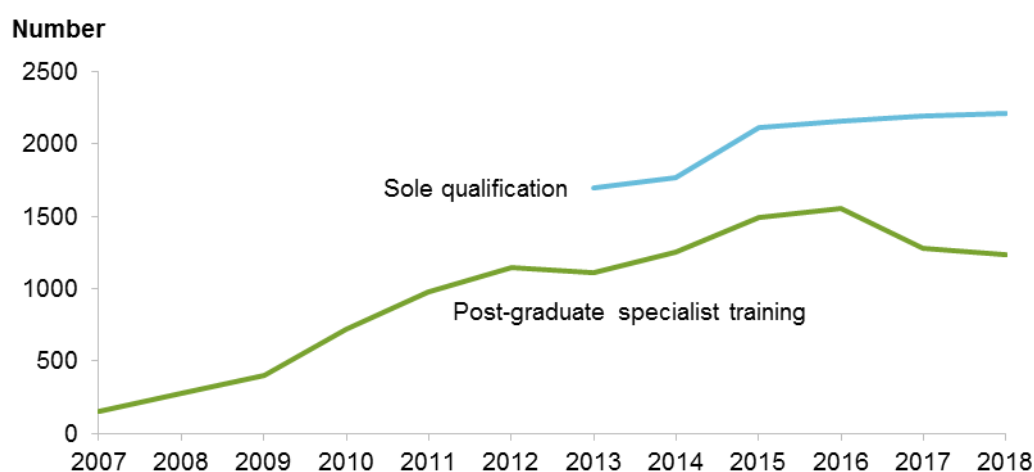
a Sole qualification in mental health refers to nurses whose registration indicated they were not qualified to work as a general nurse. Post-graduate specialist training in mental health refers to nurses who were credentialed by the Australian College of Mental Health Nurses. Data for nurses with a sole qualification in mental health were only available from 2013. The number of post-graduate specialists in 2008 was estimated as a linear interpolation of 2007 and 2009 values.

Sources: ACMHN (2018); NMBA (2019).

The Australian Government reallocated its funding for the Mental Health Nurse Incentive Program, and a range of other mental health programs, to a flexible funding pool for primary health networks (PHNs) to commission services to meet local needs. The ACMHN (sub. 501) noted that that this has led to significant differences emerging between regions in how MHNs are utilised, and caused some disruption to the MHN workforce.

Nevertheless, there is a case for allowing services and the associated workforce to be tailored to local needs because circumstances can differ markedly between regions. This should be accompanied by sufficient funding to meet those needs if the workforce and other resources are used efficiently. Reforms proposed in later chapters, particularly with respect to funding and commissioning services, would facilitate a shift towards this ideal, including on the employment and use of MHNs with the right skills. The proposed reform of workforce planning above, and reforms specific to MHNs proposed below, would also facilitate

improvements, including by shifting the mix of skills held by MHNs closer to what is needed by people experiencing mental ill-health.

Registering mental health as a specialisation within nursing

Many inquiry participants mentioned stigma, unsupportive workplace cultures, and a high risk of verbal and physical abuse from patients as deterrents to nurses choosing a career in mental health (for example, ANMF, sub. 317; NSW NMA, sub. 246). These concerns are not unique to nurses and so are considered collectively for all health professions in section 11.3 below. But there is one nurse-specific reform which could help to improve perceptions of a career in mental health — recognising mental health as a speciality for nurses by including it as an endorsement on their registration.

Under current registration arrangements, a specialist qualification in mental health is only recorded in a negative way to indicate when a nurse has limited scope of practice due to not also having general training in nursing (resulting in a registration notation of 'sole qualification in mental health').

Using registration arrangements in a more positive way to recognise all nurses with specialist mental health qualifications (including those who also have general training in nursing) would signal that their skills are valued and help promote mental health nursing as a career option. It would also assist with workforce planning by gathering information on all specialist mental health nurses when they regularly renew their registration, including on their qualifications, location and settings in which they work.

There would be costs associated with introducing and administering this change and they need to be weighed against the benefits. Such an assessment would have to be prepared by the Nursing and Midwifery Board of Australia and submitted to the COAG Health Council, which is responsible for approving the introduction of specialities within registered health professions (COAG Health Council 2014).

In 2014, the Nursing and Midwifery Board of Australia considered the option of having a system of specialist registration for the nursing profession and concluded that this was not warranted (NMBA 2018). It found a lack of evidence that this would improve consumer outcomes or reduce risk to the public and observed that specialist nursing groups already had processes that enabled specialist nurses to be identified by employers and others.

A further concern expressed by participants in this inquiry was that adding a specialist MHN category to nursing registration would be a reversal of the shift to national registration of nurses in 2010 and would set an undesirable precedent for other specialities. Prior to 2010, registration arrangements in some jurisdictions included a specialist category for mental health nurses, and returning to such an approach could provide a precedent for registering other nursing specialties, of which there may be more than 50.

However, the Commission considers that the benefits of adding a specialist MHN category to nursing registration are very likely to outweigh the costs. This is because the current number of nurses working in mental health is well below what is needed; it should be a highly valued specialisation (given the high prevalence of mental illness and its cost to the community), but it is instead poorly perceived as a career option; and the data regularly gathered through registration renewals would for the first time give workforce planners the information they need to formulate strategies to increase the number of specialist MHNs.

A three-year direct-entry degree in mental health nursing

As noted above, post-graduate training is currently required to gain a specialist MHN qualification in Australia. This is in contrast to people who do specialist training in midwifery, who have three education and registration pathways — a direct-entry (undergraduate) qualification focusing on midwifery, a combined nursing and midwifery degree, or a post-graduate midwifery qualification for registered nurses. The direct-entry option was introduced in 2000, partly due to concerns about workforce shortages (Mason 2013; Stuhlmiller 2005) and it is now offered at 20 Australian universities.

A similar approach could be used for specialist MHNs by introducing a three-year direct entry degree in mental health nursing and recognising this as a way to qualify for registration as a specialist MHN. This would also have similarities with the UK model of specialist undergraduate training in mental health nursing (box 11.5). Inquiry participants told the Commission that UK nurses who have done such training are highly valued as recruits by providers of mental health services in Australia.

Box 11.5   The UK model of undergraduate mental health nursing

In the United Kingdom, nursing students typically undertake a 3-year undergraduate degree that specialises in one of four fields: adult, children's, learning disability or mental health nursing.

Students typically undertake at least 12 months of generalised nursing studies, often with nursing students from other fields. Mental health nursing students then undertake specialised mental health units and clinical placements in their second and third year.

Nursing students in other fields can also opt into the mental health field after a general first year (Happell 2009). More recently, students at selected universities have been able to undertake a 'dual field' degree that involves specialising in two areas, although this typically adds an additional year of study.

There are over 3000 undergraduate places annually for mental health nursing at more than 110 tertiary institutions (Health Education England 2019). Unlike Australia's general approach to registering nurses, graduates are eligible for a mental-health-specific registration with the UK Nursing and Midwifery Council. In 2018, 13% of all UK nurses were registered as having specialist training in mental health (Royal College of Nursing 2019).

A review of England's mental health workforce reported that mental health training courses were oversubscribed and had comparable degree attrition rates to other nursing fields (Health Education England 2017).

As noted above, the Nursing and Midwifery Board is required to demonstrate that there is a net benefit from changing registration arrangements for nurses. The following issues would have to be considered for a direct-entry degree.

- Curriculum design — this would involve a trade-off between specialist mental health content and training in other nursing skills. There is a risk that the skills of nurses with a direct-entry degree will be so specialised that they are unable to attend to many of the physical as well as mental health needs of consumers. This has implications for registering the scope of practice of these nurses, and could limit their employment to large service providers, such as hospitals, which have sufficient resources to also hire other nurses to manage physical health.

- Practice standards and accreditation requirements — practice standards would have to be developed for nurses with a direct-entry degree, with input from a range of interested parties, including the ACMHN and Nursing and Midwifery Board. The accreditation body for nurse training — the Australian Nursing and Midwifery Accreditation Council — would need educational standards against which to assess the direct-entry degrees offered by education providers. At present, it does not even accredit the existing post-graduate specialist training in mental health because this is not recognised under current registration arrangements for nurses.

- Clinical placements — more will likely be needed in mental health settings. Such placements have historically been in public-sector inpatient units, which can be among the most stressful work environments in mental health and so discourage students from specialising in the discipline. It would be desirable to develop broader opportunities for placements, including in primary, community and private-sector settings.

While such issues would need to be considered closely, the examples of midwifery in Australia and nurse training in the United Kingdom, combined with the shortage of MHNs in this country, provides a strong case for introducing a 3-year specialist degree in mental health nursing and recognising this as one of the pathways to being registered as a specialist MHN.

In August 2019, the Australian Government was due to receive the final report of a broader review of nursing education led by Emeritus Professor Steven Schwartz (Australian Government 2019b; McKenzie 2019a). The Australian Government had not released the report, or its response to it, at the time of writing this draft inquiry report, so the Commission was not able to factor them into its training-related recommendations above. They will be considered in this inquiry's final report next year.

Recruiting overseas-trained MHNs

Australia has often relied on overseas-trained workers to address health workforce shortages. Both public and private health services recruit overseas-trained nurses through employment and recruitment agencies (Ohr, Parker and Joyce 2010). The ACMHN (sub. 501) identified examples in the media of international recruitment for public mental health positions in

Tasmania and the ACT. NSW Health noted that it recruits experienced registered nurses from overseas, typically to fill positions in mental health, or in rural and remote locations (NSW Health 2019).

However, the number of skilled-migration visas granted to nurses who intend to work in a mental health setting has been small relative to the size of Australia's MHN workforce (table 11.3). In recent years, approximately half of these migrants obtained their qualification in the United Kingdom (ANMAC 2018).

Table 11.3   **Skilled-migration visas granted to mental health nurses, 2018-19[a]**

Visa type	Description	Cost[b]	Processing time[c]	Number granted[d]
Temporary				
407	Training visa[e]	$310	10 months	0
482	Temporary Skill Shortage[f]	$2 645	22 days	85
485	Graduate work visa[g]	$1 650	4 months	na
489	Skilled Regional (Provisional) visa[h]	$4 045	na	7
Permanent				
186	Employer Nomination Scheme	$4 045	15 months	41
187	Regional Sponsor Migration Scheme	$4 045	21 months	6
189	Skilled Independent Points-tested	$4 045	7 months	30
190	Skilled Nominated	$4 045	10 months	20

a Individuals classified as a registered nurse (mental health) using Australian and New Zealand Standard Classification of Occupations code 254422. **b** Minimum cost. **c** Time taken to process 75% of applications. **d** 2018-19. **e** Up to 2 years. **f** Medium term, up to 4 years. **g** Up to 18 months. **h** Must be sponsored by state/territory or family. The 489 visa replaced the previous 457 visa, the main temporary visa type held by mental health nurses currently in Australia. **na** Not available.

Source: Department of Home Affairs (2019).

It is not clear that there is scope to significantly increase the recruitment of overseas-trained MHNs to such an extent that it would substantially address the shortages in Australia. The Commission did not come across any evidence that the application process for, and conditions attached to, skill-migration visas had been a major constraint on the number of MHNs coming to Australia. What the Commission did hear from inquiry participants is that there is a global shortage of MHNs and that the United Kingdom, a major source of MHNs coming to Australia, has sent representatives to this country to recruit nurses to move in the opposite direction.

This suggests that training more MHNs within Australia, and providing them with attractive career opportunities, will have to be the primary means of addressing workforce shortages. Nevertheless, immigration remains a useful option that should be used to the extent that it can be cost effective. This should be considered as part of the Australian Government's

forthcoming development of a new National Mental Health Workforce Strategy (discussed above as part of general workforce planning, and the subject of draft recommendation 11.1).

Scholarships for post-graduate mental health nursing education

There is a role for scholarships in encouraging nurses to undertake specialist training in mental health. The cost of training can be a barrier to nurses investing in developing skills that are in short supply, and a post-graduate qualification may not necessarily lead to greater remuneration in the near term.

Many employers already offer scholarships to their registered nurses to undertake post-graduate mental health qualifications. For example, the Victorian Government offers up to $3000 for registered nurses working in its health system (VIC DHHS 2019c). And a private psychiatric hospital in Melbourne told the Commission that it funds half the cost of post-graduate training in mental health for its nurses and provides study days off work under its enterprise agreement.

This is a way for providers of mental health services to address workforce shortages by agreeing to share some of the benefits from having a more skilled workforce. There is not as strong a role for the Australian Government in this regard because it is not generally an employer of nurses in mental health settings. Moreover, the Mason (2013) review of health workforce programs for the Australian Government highlighted the potential for the Commonwealth to create duplication and confusion for nurses with state and territory scholarship programs.

Hence, any additional scholarships for nurses to undertake post-graduate training in mental health should largely remain a matter to be determined by State and Territory Governments in response to specific workforce needs. They are best placed to judge the appropriate number of scholarships to offer and the funding to offer each trainee, based on the benefits from having a more skilled nursing workforce.

In the short term (in the next 2 years)

- Accreditation standards should be developed for a three-year direct-entry (undergraduate) degree in mental health nursing, similar to the option already available to midwives. The new standards should be developed by the Australian Nursing and Midwifery Accreditation Council in consultation with stakeholders, including the Australian College of Mental Health Nurses and the Nursing and Midwifery Board of Australia. Nurses who complete the three-year direct-entry degree would be registered as having an undergraduate qualification in mental health and (if the above recommendation results in a specialist registration system for nurses with advanced training in mental health) be distinguished from registered nurses with a post graduate degree in mental health.

In the medium term (over 2 – 5 years)

- The merits of introducing a specialist registration system for nurses with advanced qualifications in mental health should be assessed. The assessment should be independent and be commissioned by the Australian, State and Territory Governments through the COAG Health Council. If specialist registration is found to have merit, the COAG Health Council should direct the Nursing and Midwifery Board of Australia to provide it with a formal proposal to amend the registration arrangements for nursing to recognise nurses who have specialist qualifications in mental health.

Peer workers

A professional workforce of peers who provide support and advocacy for people with mental ill-health and their carers is a relatively new and still developing concept. It is supported by growing evidence that peer workers can facilitate better outcomes because having lived experience gives them a unique ability to develop trusting relationships with clients and provide them with hope (for example, Cherrington et al. 2018; Davidson et al. 2012; HWA 2014c; Lawn, Smith and Hunter 2008; Trachtenberg et al. 2013) (Australian Red Cross Society, sub. 490; Mission Australia, sub. 487; NMHCCF, sub 476; Wellways Australia, sub. 396).

There are already numerous examples of peer workers working in Australia (box 11.6). They are most often employed in admitted settings, public community mental health services, community managed organisations and disability services. Their different experiences will lend them to assisting in different fields, for example suicide prevention, perinatal mental health and the issues faced by military veterans.

> **Box 11.6   Australian examples of peer workers**
>
> **Connect Beyond Blue** provides a low-intensity service for adults in the Greater Dandenong region with, or at risk of, mild to moderate depression and/or anxiety. The peer workers, or mentors, in the program speak a range of languages (Beyond Blue, sub. 275).
>
> **Flourish Australia** operates a community-based mental health support model with workers and volunteers, all of who have lived experience of mental ill-health. The service was launched in 2011 in Hervey Bay, Queensland (Flourish Australia, sub. 330).
>
> **Mind Australia** (sub. 380) has 65 people in designated peer roles. They are employed at all levels of the organisation, and include consumer and carer peers.
>
> The **NSW Government's Peer Supported Transfer of Care initiative** gives people discharged from mental health services up to 6 weeks of support by an experienced and qualified peer worker to help them successfully transition back into the community. The peer workers are based in community mental health teams (NSW Government, sub. 551).
>
> The **Peer Support Worker program** provides peer support services to people in inpatient wards in Bloomfield hospital in Orange. This involves 7 full-time peer workers who work across a range of specialist mental health wards. An additional peer worker is based in the emergency department (Mission Aust, sub 487).
>
> **Roses in the Ocean** is building a lived-experience workforce to contribute to suicide prevention. Its peer support program contributes to a better understanding of the perspectives of people with mental health conditions (Rosie in the Ocean 2019).
>
> **St Vincent's Hospital** in Melbourne has a peer worker employed in its emergency department and a nearby safe haven cafe (ACEM, sub. 516).
>
> The **Western Sydney Recovery College** provides education to assist people in their recovery and increase knowledge, skills and awareness of mental health within the community. The courses are delivered by peer facilitators with lived experience of mental illness, and are co-designed with clinicians (Wentwest sub. 445).

The total number of peer workers employed in Australia is not known because historically there has not been a comprehensive data collection.[47] What is known is the number working in state and territory specialised mental health services. In 2016-17, there were 125 consumer peer workers and 42 carer peer workers (in full-term equivalents) in these settings (AIHW 2019ab). The Commission understands that there are many more peer workers employed by non-government service providers. For example, Flourish Australia (sub. 330) employ about 200 peer workers across their services.

Inquiry participants highlighted a number of problems that have hindered the development of a peer workforce and its effectiveness.

- Role confusion — the role of peers workers is not always clearly defined, leading to confusion about their scope of practice, responsibilities and how other health professions are expected to work with them.

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[47] A national ongoing data collection on peer workers has recently been developed as one of the actions for the National Mental Health and Suicide Prevention Plan.

- Low support for value of the role — peer workers are often under-valued, marginalised, discredited and sometimes bullied by the people they work with because of scepticism about the abilities of people with lived experience of mental illness, their professionalism and validity of their qualifications.

- Re-traumatisation — by advocating for the people they support, peer workers can be repeatedly exposing themselves to the risk of re-traumatisation if the professions they work with do not value and understand the role of peers.

- Few opportunities for career development and advancement — there is rarely a career path for peer workers to have the basis for a long-term vocation in mental health services.

- Underdeveloped system of qualifications and professional development — there is currently only one specialised qualification (a Certificate IV in Mental Health Peer Work offered through the TAFE/VET sector).

In 2014, the National Mental Health Commission recommended that some of these issues be addressed by developing national guidelines on peer workers (NMHC 2014f). The NMHC recently commenced work on preparing such guidelines as part of its contribution to the National Mental Health and Suicide Prevention Plan.

> This project will support the peer workforce through the development of formalised guidance for multiple audiences, including governments, employers and the peer workforce about support structures and other steps that are required to sustain and grow the workforce. In the development of the guidelines, the project is seeking to explore a range of topics, including role delineation, key roles and functions, guiding principles for peer workers, minimum training, career progression pathways, peer supervision and mentoring, and principles for employment (such as reasonable adjustment, remuneration and safe workplaces). (NMHC 2018c, p.3)

A steering committee of stakeholders has been established to oversee the project and had its first face-to-face meeting in July 2019, with the aim of having a set of guidelines ready for endorsement by the Mental Health Principal Committee by mid-2020.[48]

Various peer workforce frameworks have already been produced in recent years, or are in development, at a service provider, regional and state level (NMHC 2018c). The NMHC aims to build on these to ensure greater national consistency and move towards professionalisation of the peer workforce.

The remainder of this section considers what further reforms are needed to address the barriers to developing an effective peer workforce.

Build support for the value of peer workers

Addressing the low support for the role of peer workers will require a combination of leadership to foster improved workplace cultures, educating health professionals about how

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[48] The Mental Health Principal Committee comprises jurisdictional directors of mental health and related Commonwealth mental health policy senior officials.

peer workers can improve outcomes for their patients, and further demonstration on the ground that such benefits are real (such as through more trials and pilots).

Governments have an important role in this regard, given that they are major funders and providers of mental health services. But non-government service providers will also need to drive improvements in their workplaces. And professional bodies, including the medical colleges, should play a role in changing attitudes in their professions. Governments should take a leadership role in supporting and coordinating the efforts of all the parties.

Greater acceptance of the role of peer workers would also be facilitated by this inquiry's proposed reforms to reduce the stigmatisation of people with a mental illness (chapter 20).

More developed system of qualifications and professional development

The underdeveloped system of qualifications and professional development for peer workers needs to be addressed to facilitate a more professional workforce, career pathways, and greater acceptance among other professions of the value of peer workers. It should foster even better outcomes for people who are supported by peer workers. This will require expanding training options to more than just the existing Certificate IV qualification. Consideration should be given to a graduate training program, including more on-the-job traineeships and recognition of prior learning in granting peer work qualifications.

The Australian Government should, in consultation with State and Territory Governments and other stakeholders, commission a national review to recommend a comprehensive system of qualifications and professional development for peer workers. This should include consideration of how peer worker qualifications would be recognised as prior learning to enter (or credit towards) training for other health professions.

There may also be a role for governments and other service providers to provide scholarships to facilitate people with lived experience of mental illness to participate in peer worker training (WA MHC, sub. 259). The National Rural Health alliance (sub. 353) stated that a lack of affordable training can be a barrier to becoming a peer worker.

Implement improvements at the 'coal face'

In addition to the NMHC's work to set national guidelines, service providers will need to clearly define the role of peer workers, their scope of practice and their career pathway.

While implementation is largely a role for service providers at a local level, there could be a case for governments to set national competencies or standards to guide what service providers do. This is a matter that will become clearer as the NMHC develops its national guidelines on peer workers. Therefore, the NMHC should, when submitting its finalised guidelines to governments for approval in mid-2020, also recommend how the guidelines should be supported by national standards in particular areas.

Occupational representation for peer workers

To ensure there is consideration of the perspectives of peer workers in developing policy changes, there needs to be a professional group to represent peer workers. This may have to be funded by governments initially, but over time the peer workforce could contribute financially and by participation in advocacy for their profession.

The NMHC recently funded the Private Mental Health Consumer Carer Network to produce a feasibility study on a national peer workforce organisation. The NMHC received the report in January 2019 and is currently considering its next steps (Kaine 2018; NMHC 2019b). It should provide a recommendation to the Australian Government by the end of 2019 on how to facilitate a national peer workforce organisation, including possibly the amount of needed seed funding to establish the organisation.

DRAFT RECOMMENDATION 11.4 — STRENGTHEN THE PEER WORKFORCE

Governments should strengthen the peer workforce.

In the short term (in the next 2 years)

- The National Mental Health Commission should, when submitting its finalised national guidelines on peer workers to governments for approval in mid-2020, recommend how the guidelines should be supported by work standards for particular areas of practice.

- The National Mental Health Commission should, by the end of 2019, submit a recommendation to the Australian Government on how to establish of a professional organisation to represent peer workers. This should include advice on how governments should, if at all, make a financial contribution, such as by providing seed funding to establish the professional organisation.

In the medium term (over 2 – 5 years)

- The Australian, State and Territory Governments should, in consultation with stakeholders, develop a program to educate health professionals about the role and value of peer workers in improving outcomes. The program will need leadership to improve workplace cultures.

- The Australian Government should, in consultation with State and Territory Governments and other stakeholders, commission a national review to develop a comprehensive system of qualifications and professional development for peer workers. This should consider of how peer worker qualifications would be recognised as prior learning for health professional qualifications.

GPs

As discussed in chapter 5, GPs have a central role in supporting people experiencing mental ill-health. That role would continue under the redesigned system of stepped care this inquiry has proposed in other chapters. GPs would remain the first point of contact for many people and manage their overall mental and physical health. And GPs would continue to refer people to specialist mental health services as needed, consistent with a stepped model of care (including e-mental health services, psychologists and psychiatrists). Indeed, the Commission's draft recommendations elsewhere in this report would increase the specialist services that GPs could refer people to.

The Commission has made some draft recommendations later in this chapter (section 11.4) to improve access to specialist services outside major cities, but it is likely that GPs in rural and remote areas would continue to have fewer referral options. Hence, there would still be a need for a different skill set among rural and remote GPs. This is already reflected in distinct training pathways for GPs wishing to practise in rural and remote areas, which include doing a year of specialist training in a discipline such as mental health (box 11.7). The Australian Government has announced funding over 4 years from 2019-20 to rationalise these pathways into a nationally consistent approach to be called the National Rural Generalist Pathway (McKenzie 2019b). Specialist training in mental health would remain an option.

More broadly, there are various forms of mental-health-related training offered to GPs, ranging from training components in medical school to continuing professional development (CPD) when qualified and practising (box 11.7). This includes 2 levels of training required to claim the maximum possible MBS benefits under the Better Access program. In chapter 5, the Commission has recommended changes to how this program operates. But this inquiry has not found a compelling case to change the Better Access training itself.

Nor does the Commission see a strong case for increasing the amount of mental-health-related training that every single GP is required to do, given that GPs practise within a system of stepped care where people are referred on to specialist services when needed.

However, the Commission is concerned about the many cases it heard of GPs not assisting their patients as well as they could to manage the sides effects of mental health medications. This should be addressed through a continuing professional development (CPD) course that educates GPs about best-practice approaches to managing medications.

The Commission is also concerned there is little incentive for rural and remote GPs to undertake advanced specialist training in mental health, given that it could partly address the shortage of specialists outside major cities. The Commission understands that few trainees looking to obtain rural and remote GP qualification choose to do their one year of advanced specialist training in mental health. Other specialisations, such as obstetrics, have been more popular. GPs only need to do the much shorter mental health training required under the Better Access program to be eligible to claim MBS rebates for mental health services.

Box 11.7   Mental health training for GPs

Medical training

As part of their medical degree, students must complete compulsory mental health components as an introduction to psychiatry. Trainees are not required to undertake activities related to mental health when they become interns or resident medical officers.

GP training

Vocational training for medical graduates wishing to specialise in general practice is provided under the Australian General Practice Training program. This gives students the option of training for a fellowship of either the Australian College of Rural and Remote Medicine (ACRRM) or the Royal Australian College of General Practitioners (RACGP).

Training for the ACRRM fellowship takes 4 years if done full-time. The final stage of the course requires 1 year of 'advanced specialised training' in 1 of 11 specialities, with mental health being an option.

Training for the RACGP fellowship takes 3 years if done full-time. Trainees can choose to combine this with an additional 1 year of 'advanced rural skills training' in 1 of 9 specialties, with mental health being an option. Successful completion of the extra training leads to a fellowship in Advanced Rural General Practice, in addition to the RACGP fellowship.

Better Access training

The Better Access program (chapter 6) has associated training requirements for GPs.

- **Level 1 (mental health skills)** — training on mental health assessment, treatment planning and review of mental health issues (takes 6 to 7 hours and can be done online or face to face). This is now compulsory for all trainee GPs and has been completed by about 90% of practising GPs. Completion of the training allows GPs to claim higher MBS rebates for preparing mental health treatment plans.

- **Level 2 (focused psychological strategies skills)** — training on the provision of psychological interventions, such as cognitive behaviour therapy (involves a minimum 20 hours of training, with at least 12 hours face to face or live interactive and 8 hours interactive structured learning). Completion of this training is a prerequisite for GPs to claim MBS rebates for focused psychological strategies.

Continuing professional development (CPD)

The standards and accreditation body for GP training recommends that GPs do at least 1 mental-health-related CPD activity every 3 years. Such CPD is only mandatory for GPs who claim MBS rebates for focused psychological strategies. Every 3 years, they have to do CPD to build on their original level 2 training for the Better Access program.

The incentive for GPs to do specialist training in disciplines other than mental health is reinforced by training subsidies the Australian Government provides for skills maintenance and upskilling under the Rural Procedural Grants Program. GPs who practise in the specialities of surgery, obstetrics, emergency medicine or anaesthetics in a rural or remote location are eligible for $2000 per day of further training in those disciplines (up to a maximum of 10 days annually).

The review that led to the Australian Government's decision to fund a new National Rural Generalist Pathway recommended that the Rural Procedural Grants Program be reformulated as a broader scheme which supports all the additional skills required by rural GPs, including in mental health (National Rural Generalist Taskforce 2018). In response, the Australian Government has decided to implement a more limited expansion of the program which will, from 2020, allow GPs who practise emergency medicine to access grants to maintain their skills in emergency mental health services (DoH, sub. 556).

The review for the National Rural Generalist Pathway also recommended that registration arrangements for GPs be expanded to include a public register of their additional specialist skills, and that GPs have access to MBS specialist item numbers when providing care in areas of accredited additional skills. No decision has been made to implement these recommendations.

Using registration arrangements to recognise GPs with advanced specialist training in mental health would be similar to what the Commission has proposed above for mental health nurses (draft recommendation 11.3). It would signal to GPs that having specialist skills in mental health is valued, help promote it as a career pathway, and assist workforce planning by gathering information on specialist skills when GPs regularly renew their registration. Again, a case for changing registration arrangements would have to be prepared by the registration body (Medical Board of Australia) and submitted to the COAG Health Council for approval.

DRAFT RECOMMENDATION 11.5 — IMPROVED MENTAL HEALTH TRAINING FOR DOCTORS

Improve medical practitioners' training on medication side effects and consider specialist registration for GPs who have advanced specialist training in mental health.

In the short term (in the next 2 years)

- Continuing professional development requirements for GPs and psychiatrists should incorporate best-practice approaches to managing the side effects of medication prescribed to treat mental illness. To ensure this is the case, the Australian Government should request the Australian Medical Council to review current CPD requirements and make any changes necessary. This should be done in consultation with stakeholders, including the Medical Board of Australia and relevant colleges for GPs and psychiatrists.

- The merits of introducing a specialist registration system for GPs with advanced specialist training in mental health should be assessed. The assessment should be independent and be commissioned by the Australian, State and Territory Governments through the COAG Health Council. If specialist registration is found to have merit, the COAG Health Council should direct the Medical Board of Australia to provide it with a formal proposal to amend the registration arrangements for GPs to recognise those who have specialist qualifications in mental health.

Psychology

Some inquiry participants claimed there is a shortage of psychologists. In previous chapters, the Commission proposed reforms to facilitate greater use of e-mental health and low-intensity therapy coaches. These reforms could address the misallocation of psychologists to milder disorders. Whether there would be a shortage of psychologists under this redesigned system is a matter to be determined by the workforce modelling to be undertaken as part of development of the National Mental Health Workforce Strategy (draft recommendation 11.1 above).

However, the Commission has not seen convincing evidence of a pressing need to significantly increase the supply of psychologists, especially compared with mental health nurses and psychiatrists. A similar conclusion was reached in a Victorian Government report on the psychology workforce in that state. It found that a lack of funding for psychologist positions in the community, rather than a shortage of psychologists, explained why demand for psychological services was not being met (VIC DHHS 2018c).

It currently takes 6 years to qualify for general registration as a psychologist (figure 11.6). Applicants must complete either:

- 4 years of study in psychology and a 2-year supervised internship (4+2 pathway)

- 5 years of study in psychology and a 1-year supervised internship (5+1 pathway).

More advanced training is required to obtain an area-of-practice endorsement, which indicates that a registrant has specialist qualifications in a particular area. There are 9 different specialities that can be endorsed, but clinical psychology is by far the most common, with 28% of psychologists holding this endorsement in 2016, out of a total of 42% with an area-of-practice endorsement (DoH 2018i).[49] A minimum 8 years of training is now required to be endorsed as a clinical psychologist: 4 years of general study in psychology, a 2-year master's degree in clinical psychology and 2 years of supervised practice in a registrar program (Australian Clinical Psychologists Association, sub. 359).

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[49] The 9 areas of practice that can be endorsed are clinical neuropsychology, clinical psychology, community psychology, counselling psychology, educational and developmental psychology, forensic psychology, health psychology, organisational psychology, and sport and exercise psychology.

Figure 11.6   **Pathways to registration as psychologist**
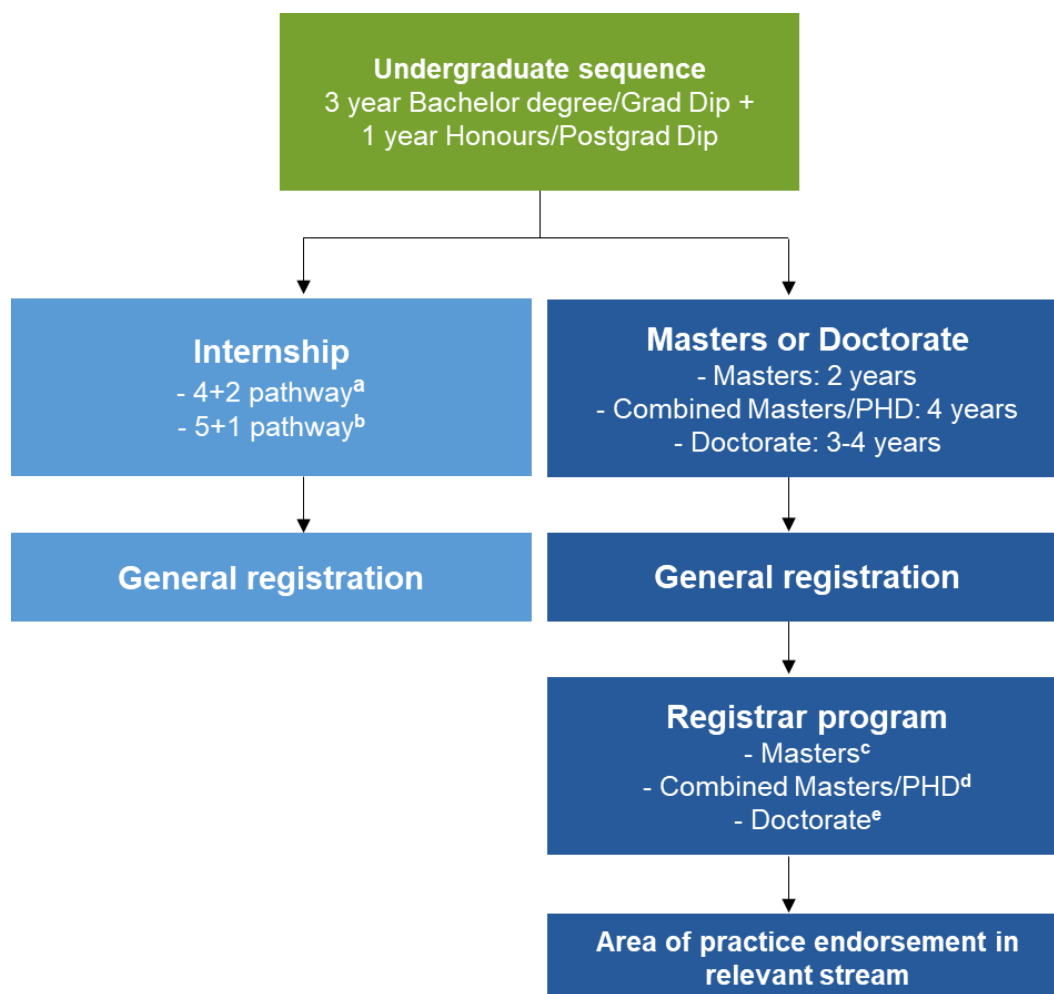
a Two years supervised practice after completing the undergraduate sequence. b One year Grad Dip/Masters plus one year supervised practice after completing the undergraduate sequence. c Two years supervised practice post-Masters, 80 hours supervision plus 80 hours CPD. d One and a half years supervised practice post-Masters/PhD, 60 hours supervision plus 60 hours CPD. e One year supervised practice post-PhD, 40 hours supervision plus 40 hours CPD.

Source: APS (2019b).

There has been a significant increase in the number of people studying psychology at university over the past decade, but it has not translated into similarly rapid growth in registered psychologists.[50] This is often attributed to the limited availability of supervised internships after completing the required 4 or 5 years of study. The situation was not helped

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[50] From 2008 to 2017, the full-time equivalent student load for 3-year bachelor degrees in psychology grew by 78%, honours degrees by 250% and professional postgraduate programs by 61%. Just under 10% of students enrolled in psychology programs in 2017 completed postgraduate training towards professional registration as a psychologist. (HODSPA, sub. 362)

by a major decline in the number of approved supervisors when transitional arrangements expired in 2018 (HODPSA, sub. 362).[51]

The bottleneck associated with internships will to some extent be addressed by a recent decision to phase out the 4+2 pathway, thereby reducing to 1 year the length of internships under the remaining 5+1 option.[52] This could significantly increase the number of internships that available supervisors can provide over the long term. It will probably take time for this to become apparent because the 4+2 pathway will not be completely phased out until the end of 2028, and universities could need time to equip themselves to provide an additional year of training to students who previously would have done a 2-year internship.

Providers of psychology education told the Commission they were concerned that undergraduate psychology is not funded by students and taxpayers at a similar level as training for other allied health professions (HODSPA, sub. 362). Furthermore, they claimed that limits on staff to student ratios made it difficult to cover their costs and meet the demand from potential students. However, education providers have been still been able to significantly increase the number of students they train in psychology in the past decade. Moreover, it is not clear why the cost of training psychologists should be similar to other allied health professions and so warrant similar funding.

Education providers were was also concerned that they are being required to pay for supervised internships by some governments. On the other hand, the Victorian Government has noted that expecting registered psychologists or their employers to bear the cost of supervising trainees discourages them from providing internships (VIC DHHS 2018c). This raises a complex question beyond the scope of this inquiry about how the cost of training health professions should be distributed between trainees, employers, internship supervisors and taxpayers. In some cases, the traditional role of the public sector in providing services has been transferred to non-government organisations, but there has not been a commensurate increase in the latter group's role in training the workforce.

There are some straightforward options that could be pursued to increase the supply of psychologists — such as taxpayer-funded scholarships or income-contingent loans to cover the cost of supervised internships. However, there is no compelling evidence of a significant shortage to warrant these measures.

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[51] In 2013, 8500 psychologists were approved to provide supervision under transitional arrangements up to 30 June 2018. Of these, 2900 did not update their approval when the transitional arrangement expired. (PBA 2019a)

[52] The Psychology Board of Australia has announced that the 4+2 pathway will be phased out to reduce the regulatory burden of psychology training. It will not accept applicants who begin a 4+2 program after June 2022 and will retire that pathway to general registration at the end of 2028. (PBA 2019b)

Occupational therapists and social workers

Occupational therapists (OTs) work with people with a variety of conditions caused by injury, psychological or emotional illness, developmental delay and the effects of ageing. They assist in developing and maintaining people's skills to carry out their everyday tasks (occupations) such as work/school, self-care, leisure and play (NSW Government 2017).

OTs must be registered with the Occupational Therapy Board of Australia in order to practise (and meet the Board's registration standards), which requires them to hold a degree in health sciences or applied science specialising in occupational therapy, or a postgraduate qualification (NSW Government 2017).

Across Australia in 2017 there were approximately 17 000 registered and employed OTs (DoH 2019s). Of this workforce, roughly 1600 full-time equivalents (FTE) were clinical workers in mental health or drugs and alcohol (DoH 2017c). Clinical OTs tend to be concentrated in major cities (seven FTE per 100 000 of the population), however inner regional areas (five per 100 000 of the population) and outer regional areas (six per 100 000 of the population) have similar density levels. There are far fewer clinical OTs practising in remote locations — only two FTE per 100 000 of the population in remote or very remote locations (DoH 2017c).

Occupational Therapy Australia (sub. 141) confirmed this trend, pointing to recruitment and retention difficulties in regional and remote areas (particularly for senior and experienced workers) while also noting an oversupply of part-time and casual workers. Along with undersupply issues, Occupational Therapy Australia raised concerns that GPs and other health workers may misunderstand the role of OTs in mental health, mistakenly assuming they are not approved providers of Better Access services.

Social workers support people to make change in their lives to improve their personal and social wellbeing by identifying issues that require change and connecting people with support such as secure housing or family therapy. They have knowledge of human behaviour and development, life cycle stages, families and social networks, disability and health, including mental health (AHPA 2019b).

Mental health social workers help individuals to resolve psychological problems, the associated social and other environmental problems and improve their quality of life. This may involve family as well as individual counselling, and group therapy. Social workers recognise the broader implications of an individual having a mental illness and the impact on friends, family, work and education (AASW 2019).

Unlike OTs, social workers do not need to be registered. They must complete a bachelor degree in Social Work, or a two-year Master of Social Work if they have already obtained a previous tertiary qualification. Although not a requirement for practice, social workers may

gain accreditation with the Australian Association of Social Workers (AASW). Those already specialising in mental health must have:

- current membership with the AASW

- evidence of meeting the Accredited Mental Health Social Worker Continuing Professional Development requirements

- at least two years' (post-qualifying) supervised social work practice experience in mental health or related field within the past five years, and show how this experience meets the standards outlined in AASW *Practice Standards for Mental Health Social Workers 2014*

- a testimonial from an employer or supervisor. (AASW 2019)

Data limitations and the lack of required registration mean it is difficult to get an accurate picture of the number, type and distribution of social workers across Australia. However, the AASW (sub. 432) reported that it represents approximately 11 500 social workers nationwide, of which a subset would be engaged specifically in mental health.

There are differences in the practising requirements of several allied health practitioners. For example, while OTs and social workers need a degree or postgraduate qualification, only OTs must be registered. Counsellors must also be registered and hold a bachelor level qualification to be fully qualified, but can obtain entry level roles in the industry with just a Diploma of Counselling. Peer workers on the other hand require only the relevant lived experience as a consumer or carer. Additional qualifications are available, such as a Certificate IV in Mental Health Peer Work, but are not mandatory.

Though these differences exist, they are not necessarily problematic and may simply reflect differing expectations of the roles performed by each worker.

Aboriginal and Torres Strait Islander health workers

Aboriginal and Torres Strait Islander health workers comprise a relatively small proportion of the health workforce who play an important role in providing culturally capable support for the Australians they serve. They are employed by a variety of different service providers, including Aboriginal community controlled health organisations, Aboriginal medical services, hospitals, State and Territory Governments, and GP clinics.

The responsibilities of Aboriginal and Torres Strait Islander health workers differ markedly between employers and settings, but often involve non-clinical tasks, such a community liaison and engagement, advocacy, health promotion and education, cultural education and brokerage, community development and disease prevention. However, a subset of the workforce — Aboriginal and Torres Strait Islander health practitioners — are qualified and registered with the Aboriginal and Torres Strait Islander Health Practice Board to provide clinical services.

In 2016, there were almost 480 employed Health Practitioners and about 870 other Health Workers.[53] The total number of employed health workers increased by 25% from 2006 to 2016. This was slower than growth in the general population of Aboriginal and Torres Strait Islanders, resulting in a decline in the per capita supply of health workers from 221 to 207 per 100 000 population in the decade up to 2016. However, this may partly reflect measurement difficulties in determining the population of Aboriginal and Torres Strait Islanders (Wright, Briscoe and Lovett 2019).

Health Workforce Australia identified a range of issues faced by Aboriginal and Torres Strait Islander health workers (HWA 2014a). This included limited career opportunities, lack of understanding of the role and capabilities by other health professions, high turnover, and professional isolation from peers for those health workers in remote locations.

The extent to which some of these issues can be addressed is limited. For example, there is limited scope to create a career pathway for a specialist role targeted at a small proportion of the population. However, some progress has been made in improving how other professions view the role. For example, the RANZCP (2016a) issued a statement acknowledging the value and skills Aboriginal and Torres Strait Islander health workers bring to the practice of psychiatry. There is now also a well-developed system of qualifications for Aboriginal and Torres Strait Islander health workers, including a university degree specialising in mental health (box 11.8).

Governments provide various forms of support for people to train as Aboriginal and Torres Strait Islander health workers, including support targeted at increasing mental health skills. For example, the Victorian Government has a traineeship program for 10 Aboriginal people to be employed in its area mental health services, and be provided with training and clinical placements over 3 years, while concurrently completing a university degree in mental health (VIC DHHS 2018a). The NSW Government has previously offered similar support to develop a workforce of Aboriginal mental health workers.

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[53] There were 474 employed Aboriginal and Torres Strait Islander health practitioners in 2016, according to data recorded in the National Health Workforce Dataset (DoH 2017a). Deducting these from the total number of Aboriginal and Torres Strait Islander health workers recorded in the 2016 census (1347 according to Wright, Briscoe and Lovett 2019) gives the number of other Aboriginal and Torres Strait Islander health workers (873).

Box 11.8   Aboriginal and Torres Strait Islander health worker training

Vocational training

There is a hierarchy of vocational qualifications for Aboriginal and Torres Strait Islander health workers health workers which branches into 2 separate streams at Certificate IV and Diploma levels. The qualifications are:

- Certificate II in Aboriginal and/or Torres Strait Islander Primary Health Care

- Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care

- Certificate IV in either:

  – Aboriginal and/or Torres Strait Islander Primary Health Care

  – Aboriginal and/or Torres Strait Islander Primary Health Care Practice

- Diploma in either:

  – Aboriginal and/or Torres Strait Islander Primary Health Care

  – Aboriginal and/or Torres Strait Islander Primary Health Care Practice

- Advanced Diploma of Aboriginal and/or Torres Strait Islander Primary Health Care.

The Certificate IV qualification in primary health care practice must now be completed in order to become a registered Aboriginal and/or Torres Strait Islander Primary Health Practitioner. Some existing registered practitioners have a lower qualification due to grandfathering arrangements.

University education in mental health

Charles Sturt University provides a Bachelor of Health Science (Mental Health) exclusively for Aboriginal and Torres Strait Islander students. It is an undergraduate course that allows students to exit after 1 year (full-time) with a diploma, 2 years with an associate degree, or 3 years with a degree.

Clinical placements are a compulsory part of the course (lasting 3 weeks in the first year, 6 weeks in the second year, and 8 weeks in the third year). The study component is done entirely online, rather than on campus.

Source: Australian Government (2019e); Charles Sturt University (2019).

Given the issues facing Aboriginal and Torres Strait Islander health workers identified by Health Workforce Australia (discussed earlier), additional information is needed on the extent of barriers to increasing the number of these health workers and their career progression (including the scope for transition-to-practice arrangements for those wishing to move into broader mental health clinical or non-clinical roles), as well as proposals to overcome barriers.

11.3   Fostering more supportive work environments

A career providing mental health services is often viewed as being an unattractive option for various reasons. For example, some settings, such as public hospital inpatient wards, can be high-stress environments, including the risk of verbal and physical abuse from patients (RANZCP 2017c). Moreover, mental health has historically not been a funding priority compared with other areas of healthcare, such as cancer treatment, creating the impression that it is not valued and more often placing health professionals in situations where they cannot provide the care that their patients need.

This leads to workforce shortages because it is difficult to attract and retain workers. The RANZCP reported that many psychiatrists are choosing to work exclusively in the private system because of a lack financial rewards; overwork and stress from workforce shortages; feeling undervalued; increasing bureaucracy and paperwork; lack of basic administrative support which reduces time available for clinical work; and increased risk of violence and abuse from aggressive patients (RANZCP 2017c).

Some of the underlying issues would be addressed by draft recommendations elsewhere in this report, such as to reduce the stigmatisation of people with mental ill-health (chapter 20), redesign the health system so that more effective care can be provided (chapters 5 to 9) and improve how mental health services are funded (chapter 23). But there also needs to be interventions specifically targeted at fostering more positive and supportive work environments in mental health.

This should include organisational leadership to improve workplace culture, raise job satisfaction, reduce stigma and promote a positive work culture. For example, the RANZCP and NSW Health have been collaborating on a plan to improve workforce culture in psychiatry, enhance psychiatric leadership and focus on other drivers of burnout among psychiatrists.

There is also scope to redesign roles and workplaces to reduce stress for patients and the health workforce that supports them. For example, the physical environment in emergency departments can be stressful for people experiencing mental ill-health. In chapter 8, the Commission has recommended changes that could include providing separate spaces for mental health patients and, when emergency departments are built or renovated, the design should take account of the needs of people with mental health problems.

Health professionals working in remoter areas face the particular challenges of isolation from peer support and limited opportunities to take time off to undertake professional development or have holidays because there are few other people to provide services.

Achieving more positive and supportive work environments in mental health would, through word of mouth and demonstration effects, gradually reduce the negative perception of mental health as a career option and a sector for other health professionals to coordinate with. To further speed this up, actions should also be taken to:

- expose health students and practising health professionals (both within and outside mental health) to people with a mental illness (and their carers) outside a clinical environment to break down negative perceptions about them. One example is the program run by Recovery Camp (2019)

- rebalance where mental health trainees do internships to a more representative mix of settings. As noted above, this has been an issue in psychiatry, prompting efforts to increase training placements in the private sector and beyond the stressful environment of inpatient units in the public sector (DoH 2016a; RANZCP 2017c).

DRAFT RECOMMENDATION 11.6 — MENTAL HEALTH SPECIALISATION AS A CAREER OPTION

Governments and specialist medical colleges should take further steps to reduce the negative perception of, and to promote, mental health as a career option.

In the short term (in the next 2 years)

The Australian, State and Territory Governments should, in collaboration with specialist medical colleges, act to reduce the negative perception of, and to promote, mental health as a career option by:

- exposing health students and practising health professionals to people with a mental illness (and their carers) outside a clinical environment to help break down negative perceptions

- rebalancing where trainees undertake clinical placements and internships to a more representative mix of settings, including in the private sector and settings other than inpatient units.

11.4 Addressing the mismatch between where consumers and the health workforce are located

As noted above in section 11.1, the geographic distribution of the health workforce (except GPs) tends to be more concentrated in major population centres than the Australian

community as a whole. As a result, mental health services are generally harder to access, and more likely to not exist, in regional and remote areas.

Part of the answer to this issue is to improve access to automated e-mental health services (chapter 6) and care provided remotely by health professionals using telehealth technologies, when appropriate and effective. But there will still need to be an increase in the number of health professionals providing services in regional and remote areas, particularly in professions with significant shortages. That is the focus of this section.

Why is the health workforce less likely to work in remote areas?

A key driver behind the lack of health professionals in rural and remote areas has been that working in those areas has been less attractive from both a professional and personal perspective. There can be professional isolation because there are fewer peers and support networks from whom to seek advice on clinical practice and learn from. Moreover, the workload can be higher and less flexible because there are few, if any, other local practitioners that patients can go to. This limits opportunities to take time off to undertake professional development activities (including those required to maintain registration) and network with peers. From a personal perspective, it can reduce the scope to take breaks from work at a time of their choosing. There also tend to be fewer job opportunities for partners in rural and remote areas and for schooling options for families.

Another important driver has been that the training of health professionals often occurs in major cities. This is relevant because people tend to build lives within their local community during their years of training and so can find it hard to leave once they are qualified. This creates a further barrier to increasing the health workforce located in rural and remote areas.

Making rural and remote workplaces more attractive

Part of the answer to health workforce shortages in rural and remote areas is to make it a more attractive place to work from a professional perspective. The above mentioned problem of professional isolation should be reduced by providing more support and opportunities for peer interaction. This could include greater availability of help lines for rural and remote GPs to consult city-based psychiatrists about how best to help individual patients (chapter 7).

There is also potential for greater use of videoconferencing, subject to the availability of communications infrastructure, to remotely participate in professional development activities and meetings and conferences with peers. More opportunities for physical attendance at such activities should also be considered.

This needs to be complemented by greater availability of visiting health professionals to temporarily stand in for rural and remote health workers, given the workload problems that can exist in finding time away from treating patients. This would also help improve the

work-life balance of the health workforce, including by increasing the scope to take breaks from work at a time of their choosing.

This could build on existing initiatives, such as the Australian Government's Rural Locum Assistance Program, which funds locums to stand in for rural obstetricians, anaesthetists, nurses, midwifes and allied health practitioners when they do continuing professional development or take leave (Rural LAP 2019). There are also programs to help source locums, which are managed by rural workforce agencies at a state and territory level, such as the NSW Rural Doctors Network (2019), Rural Workforce Agency Victoria (2019), and Health Workforce Queensland (2019).

DRAFT RECOMMENDATION 11.7 — ATTRACTING A RURAL HEALTH WORKFORCE

In the short term (in the next 2 years)

The Australian, State and Territory Governments should make working in rural and remote areas a more attractive option for health professionals by reducing professional isolation, increasing opportunities for professional development, and improving the scope to take leave. This should include:

- greater use of videoconferencing, subject to the availability of communications infrastructure, for health workers to remotely participate in professional development activities and meetings and conferences with peers

- expanding initiatives such as the Rural Locum Assistance Program to fund visiting health professionals to temporarily stand in for rural and remote health workers, including psychiatrists, while they attend professional development activities, meetings and conferences with peers, and take leave.

Incentivising the health workforce to practise in remoter locations

Governments use various incentives to encourage health professionals to work in rural and remote areas. One of the broad approaches has been to make working in those locations a condition of gaining professional registration, eligibility to bill Medicare, or being given a supported place in medical school (box 11.9). Many of the health professionals subject to such requirements have been overseas-trained medical practitioners, leading to them accounting for a significant proportion of GPs in rural and remote areas. There is probably limited scope to expand this much further because, among other reasons, additional supervision and support can be needed to help overseas-trained medical practitioners align with Australian clinical practices and understand the local culture of patients.[54]

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[54] A further issue is that the Australian Government is gradually reducing the overall number of overseas-trained doctors allowed to enter the country to work in primary healthcare in order to reduce an oversupply of GPs in metropolitan areas over the longer term (DoH 2019g).

| Box 11.9 | **Government programs that require health professionals to work in a rural or remote area** |

Governments require medical practitioners to work in (often rural or remote) regions where there are workforce shortages through various initiatives, including the following.

- Distribution Priority Areas (DPAs) — international medical graduates wishing to work as a GP, and Australian-trained bonded doctors with return-of-service obligations, are required to work in a Distribution Priority Areas location to be eligible for Medicare funding (DoH 2019d).

- Districts of Workforce Shortage (DWS) — non-GP specialist international medical graduates (including psychiatrists), whose specialty is considered to be adequately serviced in metropolitan areas, can be required to work in a region with a shortage of specialists to be eligible for Medicare funding (DoH 2019e).

- Bonded Medical Places — provides students with supported places at medical schools in return for working in a DPA or DWS after graduating (DoH 2018a).

- Five-Year Overseas Trained Doctor Scheme — enables international medical graduates to reduce the time they have to work in a DPA or DWS if they are practising in a rural or remote location (RDWA 2019).

- Limited registration for an area of need — this is a restricted registration for doctors that only allows them to work under supervision in a (usually rural or remote) region where there is a shortage of medical practitioners (MBA 2018).

- The rural pathway of the Australian General Practice Training Program — at least half the available training positions each year are allocated to the rural pathway, which restricts registrars to undertaking training outside major cities.

Financial incentives are also used to encourage health professionals to work in rural and remote areas. This includes subsidies that the Australian Government pays to medical practitioners to provide primary care in rural and remote areas (General Practice Rural Incentives Program) and to general practices in those areas to employ nurses or allied health professionals (Practice Nurse Incentive Program) and undertake quality improvement and capacity expansion activities (rural loading for Practice Incentives Program).[55] There are also increased MBS rebates for medical practitioners who bulk bill services for children and concession card holders in rural and remote areas.

State and Territory Governments also have a financial lever through their funding of positions for health workers in public sector providers. In draft recommendation 11.2 above, this inquiry has recommended that State and Territory Governments increase the number of funded training placements and supervisors for trainee psychiatrists in public sector health providers. Moreover, in other chapters of this report the Commission has proposed an expansion of services to fill major gaps in available care, which will likely require public sector providers to hire more health professionals outside major cities.

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[55] From January 2020, the General Practice Rural Incentives Program and Practice Nurse Incentive Program will be reformulated as components of a Workforce Incentive Program.

In cases where it has been difficult to have health professionals permanently based in a rural or remote area close to patients, governments have made several efforts:

- Remote provision of services: the Australian Government expanded the Better Access program in 2017 to include MBS rebates for psychological services provided by videoconference to people in rural and remote areas (DoH 2019a, 2019b). There are also MBS items for telepsychiatry (chapter 7).

- Visiting health professionals: locums and fly-in-fly-out workers by public sector service providers were used as a substitute for a permanent local workforce. The Australian Government also funded mental health services provided by the Royal Flying Doctor Service where telehealth technology was not available or too costly (DoH, sub. 556).

A drawback of using a visiting workforce is that patients may not have continuity of care with the same health professional over time, which can be a significant issue for people experiencing mental ill-health. This has prompted senior members of the medical profession to express concerns about an increasing reliance on locum psychiatrists in public sector service providers, particularly in rural and remote locations (Fitzsimmons 2019).

There are legitimate concerns about ongoing use of visiting locums when there is a sufficiently large local population to keep a local workforce fully employed. But in the most sparsely populated regions, the only viable option for face-to-face contact can be a visiting health professional, or for patients to travel to a population centre.

In conclusion, there are a wide range of incentives already used to encourage health professionals to work in rural and remote locations, and the reforms proposed elsewhere in this report to expand services will be an opportunity to fund more local positions. The Commission has therefore decided not to recommend additional workforce incentives at this time.

Training a workforce more likely to practise in remoter locations

There is evidence that health professionals are more likely to work in rural and remote locations if they did their training there, or had resided there prior to training elsewhere (for example, Kwan et al. 2017; McGrail, Russell and Campbell 2016). Governments have for many years sought to capitalise on this by supporting the provision of health professional training in rural and remote areas, and training more people from those areas (box 11.10 provides examples of recent Australian Government programs).

Box 11.10   **Examples of Australian Government support for rural and remote training and trainees**

The Australian Government has supported people from rural and remote areas to train as health professionals, by:

- funding scholarships, such as the Health Workforce Scholarship Program, which focus on improved access to services needed in rural and remote areas. These scholarships support an increase in skills, capacity and/or scope of practice of privately employed health professionals committed to rural service (including doctors, nurses and allied health professionals) and in some cases require a rural return of service obligation

- requiring the equivalent of at least 25% of a university's Commonwealth-supported medical students to come from a rural background (under the Rural Health Multidisciplinary Training Program)

- setting a 25% target for the share of students that medical schools must enrol from rural and remote areas under the Rural Health Multidisciplinary Training Program.

The Australian Government has also facilitated the provision of health professional training in rural and remote areas, by supporting:

- medical schools outside major cities, such as at James Cook University in Townsville, and a foreshadowed Murray-Darling Medical Schools Network of 5 universities in New South Wales and Victoria

- rural-based training pathways for GP registrars, with the implementation of the National Rural Generalist Pathway

- distance education and supervision for trainee GPs in remote areas through the Regional Vocational Training Scheme

- short term and long term specialist training placements in rural and remote areas under the Specialist Training Program and the Integrated Rural Training Pipeline (a component of the Specialist Training Component). Both components include psychiatrist trainees

- 26 regional training hubs based outside major cities to support medical students intending to practise rurally so they can complete as much of their medical training as possible within regional and rural areas

- rural primary care rotations for rurally-based interns and postgraduate second-year doctors through the Rural Junior Doctor Training Innovation Fund, building on existing state and territory rural junior doctor networks.

Source: DoH (2017d, 2017g, 2018c, 2018j, 2018l, 2019q); RVTS (2019).

In 2018, the Australian Government announced a range of changes under the banner of a Stronger Rural Health Strategy that are increasing its support for rural-based training and trainees over time (DoH 2018k). This included specifying targets for:

- 50% of GP training to be outside major cities in each year from 2018-19 to 2021-22

- an increase in Specialist Training Program activity in rural areas from 40% in 2018-19 to 45% by 2020-21, and maintained at that level in the following year.

In draft recommendation 11.2 above, this inquiry has recommended that the Commonwealth further increase the number of training placements and supervisors it funds for trainee psychiatrists, many of which could be in rural areas as part of the Specialist Training Program. This inquiry has also recommended consideration of remote models of supervision for trainee psychiatrists to raise the number who are able to train outside major cities.

And, as noted above, State and Territory Governments will, in accordance with workforce needs in their health providers, need to consider the number of scholarships they offer to nurses to attain specialist post-graduate mental health qualifications. This includes those targeted at rural and remote training and trainees.

Beyond this, the Commission is not recommending changes in addition to the increasing support that the Commonwealth already plans to implement in coming years for rural and remote training and trainees.

PART III — Re-orienting surrounding services to consumers

12 Psychosocial support

Psychosocial supports matter because …	• Psychosocial supports — which include a range of services to help manage daily activities, including recovery in the community and participation in education and employment — are vital for the wellbeing of many people with severe and complex mental illness.
	• The psychosocial support sector is characterised by ad hoc funding arrangements, lack of coordination and cooperation and is difficult for consumers and carers to navigate. This leads to inefficiencies in the delivery of support.
	• Transition of service provision to the National Disability Insurance Scheme (NDIS) has left significant service gaps for many of those people with psychosocial disabilities who do not qualify for the NDIS.
Successful intervention requires …	• Changing access arrangements to psychosocial supports, such that consumers can choose whether or not they wish to apply for the NDIS, and are no longer required to prove their ineligibility before receiving support.
	• Improving the experience of people with psychosocial disability on the NDIS in terms of access and the availability and suitability of supports. The National Disability Insurance Agency (NDIA) should incorporate lessons learned from the Independent Assessment Trial in their rollout of the psychosocial disability stream.
	• Streamlining psychosocial funding arrangements and extending funding cycle lengths beyond annual contracts for providers to a minimum of five years.
	• Clarifying the interface between the NDIS and the mental health system to ensure people who need support are not falling between gaps in services caused by uncertain boundaries and funding.

Psychosocial support helps people experiencing or recovering from mental illness to achieve higher levels of wellbeing and to increase their social and economic participation. Using the National Mental Health Service Planning Framework, the Commission estimates that approximately 684 000 people require some type of psychosocial support in 2019.

In Australia, some psychosocial supports are delivered through the National Disability Insurance Scheme (NDIS) — an Australian Government scheme that funds long-term care and support for people with severe or profound disabilities — and some through non-NDIS programs with funding from the Australian, State and Territory Governments.

The provision of psychosocial supports, which has long been affected by inefficient and duplicative funding arrangements, is currently in a state of transition. The NDIS transition, whilst providing for some, has left a significant gap in service provision for many. Of the approximately 684 000 people with a severe mental illness requiring some psychosocial support, some 64 000 will access individualised supports under the NDIS and approximately 330 000 will require less intensive assistance often for short periods of time. The remaining 290 000[56] represents the subset of those with severe and persistent mental illness that is most in need and their supports are funded more directly by the Australian Government or a State and Territory Government (DoH 2017b).

This chapter discusses psychosocial supports for people with mental illness. Section 12.1 discusses what psychosocial supports are, why they are important, and who accesses them. Section 12.2 discusses how the delivery of mainstream psychosocial supports has been affected by issues arising from funding arrangements and the impact of the transition to the NDIS. Section 12.3 provides a brief overview of the NDIS, discusses the experiences of people with psychosocial disability within the NDIS as well as what is currently being done to improve their experiences. Finally, section 12.4 discusses the gaps in psychosocial support provision in Australia, and solutions to improve the delivery of non-NDIS supports, including through improvements to the interface between the NDIS and mainstream supports.

This chapter discusses solutions to problems posed by the funding of psychosocial supports outside of the NDIS as well as improvements in the access to, and use of, NDIS supports for participants with psychosocial disability. These matters must be acted on with some urgency due to the timeline of the transition to the NDIS. Discussed in less detail here are longer-term measures to improve psychosocial supports, as these require a systemic approach. These matters are explored in detail in other chapters, including reforms to governance in the mental health system (chapter 22), overhauling funding arrangements (chapter 23) and the integration and coordination of services (chapter 10).

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[56] Department of Health estimates this at approximately 282 000 in 2016. The estimation obtained using the ABS Estimated Resident Population to incorporate population growth is about 290 000 in 2018-19 (DoH 2017a).

12.1 Programs and services that support recovery

Psychosocial disability describes disabilities that may arise from mental illness.[57] While not everyone who has mental illness will experience psychosocial disability, the social and economic participation of those who do can be severely affected.

People with a psychosocial disability often rely on a wide range of psychosocial support services provided by government and non-government organisations. Supports can include those that assist with participating in community, managing daily tasks, undertaking work or study, helpline and counselling services, advocacy and promotion, finding accommodation and improving connections with friends and family (CMHA 2012; NWMPHN 2019). Some examples are illustrated in figure 12.1.

Figure 12.1 **How do psychosocial supports provide help?**
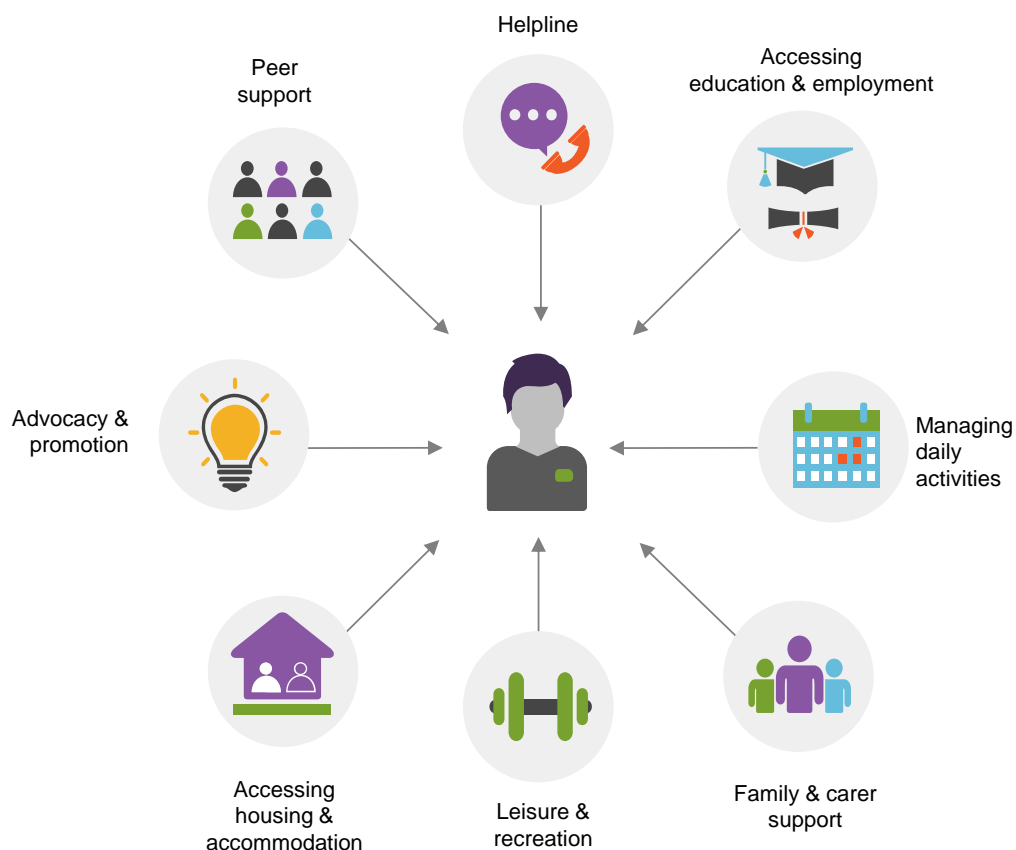
Source: Community Mental Health Australia (2012); North Western Melbourne PHN (2019).

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[57] A psychosocial disability is an impairment or restriction, arising due to mental illness, that can limit, for example, an individual's ability to function, think clearly, enjoy full physical health or manage their social and emotional welfare

Anglicare Australia illustrated some psychosocial supports that people can receive and their benefits:

> A 35 year old Caucasian female had diagnoses of bipolar and borderline personality disorders. She has three children and was living in public housing. She has experienced childhood trauma and adult rape and frequently self-harmed and has made serious suicide attempts.
>
> She was referred to Anglicare Central Queensland. The support she received helped manage finances, establish goals and she also received individual counselling for her trauma. After eight months of receiving support, she had not been hospitalised for four months, had re-established her relationship with her children and maintained housing. One year on, she achieved full time employment and increased her wellbeing. (adapted from sub. 376, pp. 17–18)

Supports may be provided through individual, group and community programs (box 12.1).[58]

Box 12.1   Examples of programs providing psychosocial support

There is a broad range of programs funded by Australian and State and Territory Governments. Two examples of Australian Government-funded psychosocial supports were Personal Helpers and Mentors (PHaMs) and Support for Day to Day Living in the Community (D2DL) programs.

PHaMs provided assistance to people with severe functional limitations resulting from a mental illness to participate economically and socially in their communities. PHaMs services provided coordinated access to support services such as housing support, employment and education, independent living skills courses and clinical services (AIHW 2019r). The D2DL program provided funding to organisations that provided structured and socially-based day activities that help to improve the quality of life of individuals with severe and persistent mental illness. These activities included cooking classes, vocational activities, creative arts and social outings (DoHA 2010).

Funding for PHaMs and D2DL transitioned to the NDIS on 1 July 2019 (DoH 2019t; DSS 2019q). Providers of these programs received an extension of funding to support participants, who had not yet transitioned, to transition over to the NDIS (Fletcher and Hunt 2019)

Examples of State-funded psychosocial support includes supportive housing (e.g. the Housing and Accommodation Support Initiative in New South Wales, Tasmania and the Northern Territory), psychosocial rehabilitation and support services, centre-based day care, individualised supports (e.g. Individualised Community Living Strategy in Western Australia), coordination and case management services (e.g. Lead Support Coordination Service in Tasmania, Integrated Services Response Program in the ACT).

Other examples of programs providing psychosocial support include: social inclusion programs, community and drop-in centres, advocacy programs, individual psychosocial rehabilitation and support services and clubhouses.

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[58] This chapter will not be discussing psychosocial supports that are covered in detail in other chapters, such as services aimed at carers (chapter 13), housing (chapter 15), suicide prevention (chapter 21) and care coordination (chapter 10).

Who uses psychosocial supports?

Department of Health (DoH) estimated that without accounting for consumer turnover[59], approximately 90–95 000 people were receiving psychosocial disability support from Australian, State and Territory Government-funded programs (DoH 2017b).

People accessing psychosocial supports are as diverse as the programs supporting them. Commonly recorded mental illness diagnosis categories were: mood disorders, anxiety disorders and schizophrenias (figure 12.2). For most, severe mental illness results in functional impairment and the person may require assistance with day to day living tasks, living safely in the community and achieving their goals (for example, users of Personal Helpers and Mentors (PHaMs) and Support for Day to Day Living in the Community (D2DL)).

Figure 12.2   **Common mental illness diagnoses of psychosocial support users[a,b]**
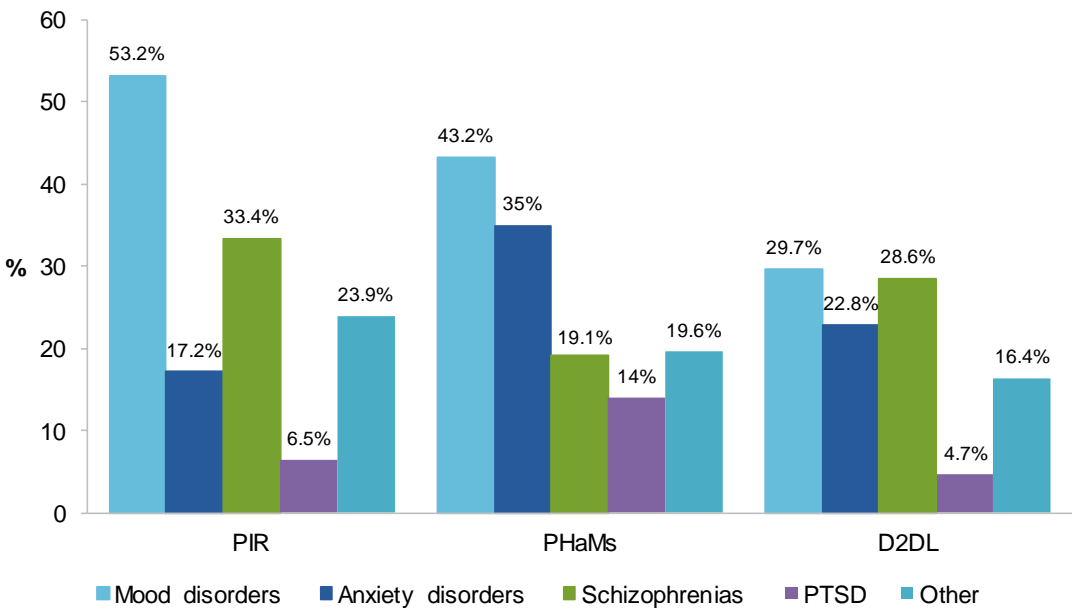
a Participants may be in more than one category and totals sum to greater than 100%. For Partners in Recovery (PIR) and PHaMs, organisations list all diagnoses, while for D2DL, many organisations only keep primary diagnoses, so the number of participants with each diagnoses may be an underestimation for D2DL.
b Diagnostic data is based on 2678 individuals for PIR, 2257 for PHaMs and 1127 for D2DL.

Source: Community Mental Health Australia and University of Sydney (2019b).

While users of psychosocial supports are predominantly people who have mental illness with severe and complex needs, there is a proportion of people with moderate mental illness who

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59 It is unlikely that clients will be on one program for the full length of a calendar year. As such, the number of people being serviced at any one time may deviate from the 90–95 000 figure.

also require some psychosocial supports (Mental Health Australia, sub. 407, p. 24). Users of psychosocial supports also often have major comorbidities and present complex diagnoses. For example, in 2014-15, an estimated 37.5% of PHaMs participants had a co-morbid disability (AIHW 2019r).

Why are psychosocial supports important?

Psychosocial supports play a vital role in enabling those living with moderate to severe mental illness in the community to live well, to recover in the community and to counter the stigma and discrimination they may face that results in social exclusion (Duff et al. 2011; Tew et al. 2012; Victorian Government 2019b). Psychosocial supports can help people achieve independence, increase control over daily life, and promote self-determination (MHCC, sub. 214). Further, as noted by Catholic Social Services Australia (sub. 202, p. 14), psychosocial supports are 'not only important for … daily living, functioning and social participation, they are also important foundations to support the effectiveness and success of acute and chronic interventions'.

The provision of psychosocial support not only directly benefits the psychosocial capability of users, but is also associated with benefits to the wider community and the governments which fund mental health services. Shifting funding priorities from downstream, costlier services such as hospitals and income support to upstream services such as community and primary health care services can create cost savings (NMHC 2014e). As the National Mental Health Commission (2014e, p. 28) identified:

> … for people with complex needs, such as a person with severe bipolar disorder, optimal care (based upon greater GP contact, increased support from community mental health teams and continued access to care coordination and psychosocial supports) can yield savings over nine years of $323,000, with about half of that saving being directly to the states through reduced acute care costs (admissions) … and about one-third to the Commonwealth.

Psychosocial supports can be cost effective as they may reduce demand for more expensive interventions. In their absence, people's needs can easily escalate to costlier services:

> When these supports are unavailable or break down they can exacerbate or even become the precursor to a period of illness that requires an emergency response that is expensive, can be distressing for consumers and their families, and may contribute to further disengagement with the system. (Mental Health Australia, sub. 407, p. 22)

Currently, there is an overreliance on emergency departments (EDs) and admission to acute or inpatient facilities due to a lack of community mental health support that could intervene early (Fels 2018; Mental Health Commission of New South Wales, sub. 486, p. 11; WA MHC 2015a). This is discussed further in chapter 8.

Who provides psychosocial supports?

Non-Government Organisations (NGOs) — sometimes referred to as the 'community-based sector' are the main providers of psychosocial supports in Australia (Smith 2015b). These community mental health supports[60] complement clinical treatment to improve consumer outcomes:

> Australia's community mental health (CMH) services are distinct from, yet complement clinical mental health services … CMH services focus on supporting the recovery goals of consumers through various psychosocial approaches. CMH services offer holistic, person centred support with the many life domains which impact on mental health. (ASU, sub. 177, p. 3)

These supports can address a wide range of needs:

> The community sector in the Northern Territory is made up of community managed, non-government, not for profit organisations who work in social and community service delivery, sector development and advocacy … While a number of organisations are funded to provide targeted services to people with mental illness, many social service organisations support people with mental illness indirectly through the provision of a wide range of social services including homelessness support, children, youth and family support services, alcohol and drug support, employment services and other health and wellbeing services. (NTCOSS, sub. 408, p. 1)

An accurate estimation of the size of the sector is difficult. A national mental health NGO landscape survey was conducted by the National Health Workforce Planning & Research Collaboration (NHWPRC 2011). It found that in 2009-10, there were 798 organisations providing psychosocial supports nationwide. The total psychosocial support workforce numbered 15-26 000, with many working part-time — equivalent to around 12 000 full-time employees (CMHA 2012). There has been further growth since (figure 12.3).

Psychosocial support workers were primarily non-clinical — owing to the non-clinical nature of psychosocial supports — and predominantly female (72%). Most were also skilled workers — 43% of respondents had a bachelor degree or higher tertiary qualification and 34% of workers had a vocational qualification, with the majority of these being at the Certificate IV and Diploma levels (NHWPRC 2011). Results from more recent surveys of the sector found that in Victoria, 90% of paid staff have a diploma or above (CMHA 2017; VCOSS, sub. 478, p. 22), and that in 2014-15, there were 47 NGOs delivering psychosocial supports across Western Australia with an average of 3.92 (paid) full-time equivalent staff (WA MHC 2016). There are also a significant number of volunteers and peer workers in the sector (peer workers are discussed further in chapter 13).

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[60] Note that 'community mental health supports' are also sometimes referred to as 'community mental health services'. They are distinct from those Local Hospital Network-delivered community mental health services that are clinical in nature.

12.2 The delivery of psychosocial supports and the transition to the NDIS

There is a plethora of psychosocial supports across Australia, funded by both the Australian Government and State and Territory Government. As a result, even prior to the NDIS, funding for psychosocial supports was a complex web of different streams. States and Territories held the primary responsibility for psychosocial support services, such as the Housing and Accommodation Support Initiative in New South Wales, the Community Support Scheme in South Australia and the Lead Support Coordination Service in Tasmania. State and Territory Governments were responsible for funding, delivering and/or managing specialised mental health services that were then delivered through NGOs. Meanwhile, the Australian Government held responsibility only for the oversight and funding of a range of services and programs that were primarily provided or delivered by private practitioners or NGOs (DoH 2017h). Examples of such programs were Partners in Recovery (PIR), PHaMs and D2DL.

The funding arrangements now are largely similar, though there is also some funding from the NDIS (for eligible participants). The NDIS is partially funded by States and Territories (to varying degrees) through funding that was previously used on psychosocial supports. Most Australian Government funding is now administered through the 31 Primary Health Networks (PHNs) to commission, not provide, psychosocial supports.

Total expenditure on psychosocial supports (approximated by specialised mental health service grants to NGOs)[61] has greatly increased over the last quarter of a century, from approximately $42 million in 1992-93 to $424 million in 2016-17. The growth in spending on psychosocial supports has outpaced overall growth in specialised mental health services — more than tripling in proportion from 2.1% in 1992-93 to 7.5% in 2016-17 (figure 12.3).

There are too many funding channels

Many psychosocial support providers receive funding from both Commonwealth and State and Territory Governments. Sourcing funding for an organisation from a variety of funding streams allows that organisation to reduce the risk of not being able to continue delivery of some of its functions if one funding source dries up. However, inquiry participants reported that the multiple funding channels for psychosocial support may lead to poorer consumer outcomes. Specifically, multiple funding channels have diminished the coverage and quality of psychosocial supports; and have led to excessive administrative burden, a lack of coordination and cooperation between providers and government, and difficulties navigating the system for consumers.

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[61] Service types included in 'grants to non-government organisations' are non-health departments, counselling, advocacy, accommodation, community awareness/health promotion, prevention, independent living skills, education, employment and training, group and mutual support, care coordination, service integration, recreation, respite and self-help (AIHW 2018, Table EXP.15, EXP.16)

Figure 12.3   **Spending on psychosocial supports (specialised mental health service expenditure provided as grants to NGOs)**

Recurrent expenditure in 2016-17 in constant prices[a,b]
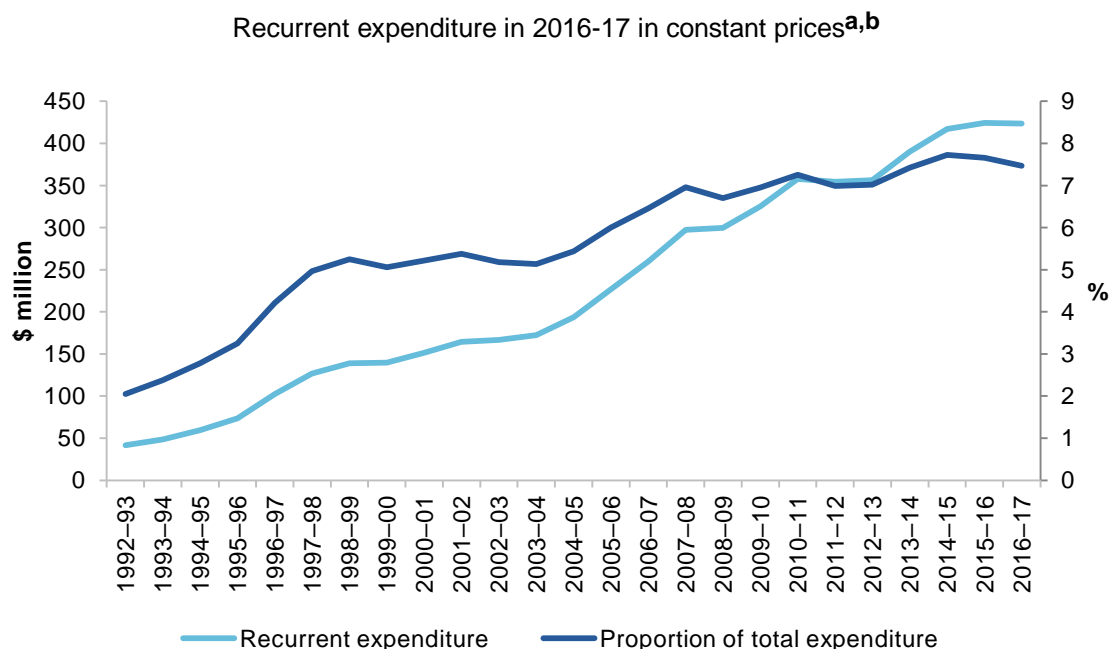
As a proportion of total State and Territory expenditure on specialised mental health services in 2016-17

a Constant prices, referenced to 2016-17 and are adjusted for inflation. **b** Amounts and proportions given are at the National level from 1992-93 to 2016–17

Source: Australian Institute of Health and Welfare (2018, Table EXP.3).

Excessive administrative burden

Inquiry participants have argued that the current funding arrangements lead to significant reporting and compliance costs. When funding for one organisation comes from various funding streams, there are greater compliance requirements to keep abreast of, or apply for, continuance of funding. This is because different programs, agencies and levels of government may require different reporting at different times and frequencies. These inconsistent compliance obligations result in significant red tape and draw resource away from front-line services (NMHC 2014e). There have also been criticisms raised that 'reporting requirements for funding [are] often onerous, [focusing] too much on outputs rather than outcomes' (MHCC ACT, sub. 517, p. 27).

This compliance burden is further exacerbated by a lack of economies of scale. The psychosocial supports sector is dominated by a few large NGOs operating nationwide and a large number of small NGOs. According a 2011 NGO landscape survey, 42% of NGOs nationwide providing mental health services are very small (0–10 paid staff) (NHWPRC 2011). The reporting requirements can be particularly onerous for smaller organisations.

However, the difficulties are not limited to smaller entities:

> Without national incentives to have contracts with the same specifications and performance reporting, community organisations that have a national footprint … face a future where they are overwhelmed by contract administration if their service is to be available across the country. (Grow Australia, sub. 194, p. 4)

Since the establishment of the PHNs, there is the additional burden for some service providers to report to multiple PHNs. Nationwide, there are 31 PHNs all commissioning psychosocial supports and each has another set of compliance and reporting requirements. For example, Aftercare, a national mental health charity, operates in 16 PHNs with close to 30 State-based organisations, each with different strategies, tender processes, reporting requirements and stakeholder complexities (sub. 480, p. 10). The lack of standardisation in reporting requirements is discussed in chapter 25.

Further, there is a lack of policy coordination between the Australian, and State and Territory Governments' roles. This is not a new issue, as the National Mental Health Commission review (2014e, p. 81) addressed:

> Concerns also were raised about the lack of clarity in Commonwealth and state and territory roles, including that the Commonwealth's direct funding of local service providers has been without proper consultation, local planning and engagement, and has created even greater uncertainty for people with lived experience and providers, and even more confusing pathways for people with lived experience.

The Commission has considered the creation of Regional Commissioning Authorities (RCAs) that pool Australian and State and Territory funds and purchase or commission most of the services for a geographical region (chapter 24). The creation of a centralised body in

each region, such as RCAs, would help centralise the reporting requirements for NGOs. RCAs would also need to be mindful of any onerous administrative burden on smaller organisations and should look to streamline the reporting requirements or look to create different reporting requirements by size, similar to the approach taken by the Australian Securities and Investments Commission and the Australian Taxation Office.

Lack of coordination and cooperation

Inquiry participants argued that the current funding arrangements do not incentivise coordination and cooperation between providers as NGOs have to compete for funds.

> … competition between services [is] driven by questionable assumptions that competitive tendering is a necessary and sufficient pre-condition of innovation and efficiency; typically, however, grants of funding also call on services to act collaboratively — artificially creating a competitive dynamic that can undermine achievement of the policy objectives. (Relationships Australia (National), sub. 103, pp. 11–12)

Other participants agree, with the NSW Government (sub. 551, p. 24) having expressed concerns that 'while these … arrangements have benefits, they can deter providers from planning, working together and coordinating care for patients'. The SA Mental Health Commission (sub. 477, p. 33) also found that the current arrangements 'can impact the ability of NGOs to work together or share innovative practice which may be in the best community and client interests'.

However, contracting, when done well, involves some level of competition between NGOs. The tender process should encourage innovation and the system must be flexible enough to allow for this, including the potential for bids by consortia of NGOs. While the aspect of competition should not be removed completely from the tender process, there must be care taken to manage it so that it does not interfere with the ability of NGOs to cooperate with each other. Some States have taken steps to address the issue (discussed below).

The Commission observed that the lack of coordination and cooperation between NGOs also manifests as a lack of awareness of what other programs are doing in the same space, which further exacerbates the duplication and overlap of services and creates gaps (EMHS, sub. 152, p. 3; Greg Franklin, sub. 287, p. 2; Innowell, sub. 153).

There is also a disjoint between services in the psychosocial and clinical spheres, and between NGO-provided psychosocial supports and government-provided supports (Mental Health Legal Centre, sub. 315). These divides are a serious problem for consumers who require services from multiple sectors for their mental illness. The Mental Health Community Coalition of the ACT (sub. 517, p. 23) stated that 'professional cultural barriers often prevent better integration between clinical and non-clinical mental health services.' As the SA Mental Health Commission stated (sub. 477, p. 30):

> In some cases there was said to be a 'shaky and tenuous collaboration between NGOs and government', particularly between State MHS and NGO providers of non-mental health specific services for homelessness, employment, disability and aged care support.

There have been some initiatives to help remedy the situation. For example, the Northern Territory Department of Health is funding the development of an industry-led workforce strategy for human service sectors, including community mental health, which would require major NGOs in the sector to cooperate with each other (NTHSIP 2019). In Western Australia, the creation of the WA Primary Health Alliance, to oversee the commissioning functions of the three Western Australian PHNs, has the potential to increase cohesion in the provision of supports (WA PHA 2019).

The Commission further discusses possible solutions to deal with coordination between clinical and non-clinical providers in chapter 10, the multiplicity of funding channels in chapter 23, and policy coordination in chapters 22 and 23.

Consumer challenges

The complicated funding system not only causes difficulties for providers but also for the consumers who require the psychosocial supports and their carers. Navigating the complex and messy system is difficult, given the sheer number of NGOs and the siloed nature of the sector. As expressed by Anglicare NT (sub. 53. p. 5):

> The fragmented and complex mental health system makes it incredibly difficult for community members to navigate. Mental health services in Australia are provided by public services (state/territory government departments), NGOs and/or community controlled organisations … often there is no easy way to identify the nuanced differences between services.

Inquiry participants have raised suggestions to make psychosocial supports easier to navigate, including co-located services and a 'no wrong door' approach. Chapter 10 discusses various ways to make the system easier to navigate, including improved provision of information and better coordination between service providers.

Short funding cycles hamper the effectiveness of psychosocial supports

NGOs providing psychosocial supports receive a substantial portion of their funding via short term government contracts. The Commission has heard that annual funding is widespread in the sector. Shorter funding cycle lengths create certainty for governments as they provide a regular interval for the government to assess the quality of the services being provided and greater flexibility to change funding priorities (PC 2017c, pp. 245, 262).

But very short funding cycles have adverse consequences for both the NGOs providing services and for the continuity of care available to people with ongoing mental illness (box 12.2). WayAhead Mental Health Association NSW stated:

> As a small NFP [not-for-profit] working in the mental health sector, our biggest barrier to program development, partnerships and outcome measurement is the annual funding cycle. Relying on one-year funding rather than 5-year funding restricts long-term planning and the sustainability of our programs. So much effort is put into ensuring we will receive funding for

the next financial year, that we are at risk of losing sight on why we are providing certain services. If we had longer term funding, we could put much more effort into ensuring we are delivering the outcomes we are being funded to do and be more accountable for the funds we receive. (sub. 310, p. 6)

Staffing difficulties are a common concern associated with short-term funding arrangements. With excessively short funding time frames, providers are operating in a climate of constant uncertainty. Inquiry participants spoke of the difficulties faced in attracting and retaining qualified staff in an environment lacking job security, in turn leading to high staff turnover (box 12.2)[62]. This is particularly pertinent for services targeting marginal and/or regional and remote communities where there already exists greater barriers to attract qualified staff.

In this environment, providers may find it difficult to develop stable and therapeutic relationships with their consumers, or they may need to place them in short-term temporary care arrangements while they seek more short-term funds (SAMHC, sub. 477). This leads to uncertainty for both the provider and consumer. The consumer could experience the loss of a support worker and the possibility of multiple transitions of care, leading to elevated levels of psychological stress and the risk of an escalation of their needs (box 12.2)[63].

There is also an inherent mismatch between the short-term nature of current funding arrangements and the long term investment required to improve psychosocial outcomes (Aftercare, sub. 480; WentWest, sub. 445; box 12.2). Stakeholders spoke of the challenges involved with building awareness and trust in the community and trying to invest in long-term partnerships with a contract expiry looming. They also submitted concerns that overly short-term arrangements do not facilitate better planning, implementation and outcomes measurement for existing programs or the creation of new programs (cohealth, sub. 231).The short-term nature of the funding arrangements also diverts resource away from the delivery of services they were contracted for (SAMHC, sub. 477). Faced with short-term contracts, providers are allocating scarce time and resource on re-tendering for funding instead of delivering and improving services.

Previous reviews have also noted the issue of short contract cycles. In particular, the Commission's 2017 Human Services inquiry recommended that default contract lengths be extended to seven years for most contracts and ten years for service delivery in remote Aboriginal and Torres Strait Islander communities (PC 2017c, pp. 263, 282). At the end of this period, contracts should be retendered to find a balance between providing continuity and retaining the benefits of periodic contestability (NMHC 2014e; PC 2017c, p. 261).

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[62] This issue is also raised in the following submissions: Aftercare, sub. 480; Anglicare NT, sub. 53; Kim Devlin, sub. 158; Merri Health, sub. 120.

[63] Also raised in the following submissions: EACH, sub. 227; Kim Devlin, sub. 158; Merri Health, sub. 120.

Box 12.2 Participants' views on cycle length

HelpingMinds:

The implications of short-term funding arrangements for the NGO sector have major implications for clients, staff and organisations. Continuity of care is severely affected on a cyclical basis, during and up to the time at which contracts are renewed of renegotiated. The lack of job security, perceived or otherwise, forces staff to seek alternate employment due to the uncertain, and often late, contract negotiations. Clients are, therefore, left with short term, temporary care arrangements that lead to higher levels of psychological distress. The consequences being acute presentations to hospital emergency departments and lengthy inpatient stays.

Longer term funding will also enable organisations to develop programs that target vulnerable and marginalised groups, such as the LGBTQI+ community, Aboriginal people, and people from CALD backgrounds … Given that these organisations are often small in nature and lack the resource needed to develop business strategies within short timeframes, the need to resource and fund tender submissions significantly reduces their capacity to deliver grassroots care. A further encumbrance being that these cohorts need staff with specialist skillsets – recruitment for short-term contracts is always challenging. (sub. 470, p. 4)

NSW Council of Social Services:

If services are to respond effectively to the ongoing and diverse needs of their local communities, particularly in regional and remote areas, we need to remove funding uncertainty and allow time for better planning, implementation and outcomes measurement. The health and community services sector, including those working both directly and indirectly in mental health, is now operating in an increasingly complex environment impacted by the rollout of the NDIS, competition, commissioning and contestability, and the interaction between state and federal funding. This continues to put significant pressure on the sector's capacity to respond to the growing and diverse needs of the broader community, let alone remain sustainable. (sub. 143, p. 16)

SA Mental Health Commission:

… the short term funding models for NGOs and also for specific regional or Aboriginal programs, leads to difficulty attracting and retaining staff and can result in lack of continuity of service provider, inability to forward plan, inability to build relationships which may be critical to longer term program outcomes, and difficulty collecting data to inform these longer term outcomes. (sub. 377, p. 13)

NT Mental Health Coalition:

The uncertainty associated with short-term funding cycles results in a sector which is not equipped to invest in building the long-term partnerships necessary for integrating between services and across professions. Reaching out beyond the mental health sector is even less likely. (sub. 430, p. 5)

Organisations providing mental health support need to work with communities over the long term, building trust, local workforce and community capacity … At a minimum, agreements covering codesigned services should extend for at [least] 5 years (preferably longer) before any fundamental changes are suggested by government funders. (sub. 430, p. 32)

Volunteering Australia:

… there are many organisations working in community mental health that are restricted by short-term grants and funding cycles. These funding arrangements don't allow for the strategic workforce planning required to operate successful programming and service delivery. Volunteering Australia stresses that long-term, ongoing funding is necessary to ensure the best outcomes for consumers. (sub. 412, p. 3)

Longer term contracts would help to mitigate many of the problems discussed. As stated by participants (box 12.2), greater continuity facilitates stability and creates certainty for the providers, which in turn facilitates stability and certainty for consumers. This is especially important to aid in recovery for psychosocial conditions. Providers also have the opportunity to improve their service delivery with the ability to think longer term and make investments in staffing, relationship building and new initiatives that are necessary to deliver effective services (PC 2017c; Relationships Australia, sub. 103).

Some governments have also recognised that this is an issue and have begun introducing changes. In January 2019, the Australian Government announced that commencing in July 2019 there would be three-year funding for PHNs to replace the annual funding cycle to offer greater job security for staff and continuity of care for patients (Aubusson 2019; Hunt 2019a). At the State and Territory level, the Northern Territory Department of Health is reforming the way it funds NGOs and has lengthened funding agreements to five years based on standard contracts. The NT Mental Health Coalition has welcomed this change (sub. 430, p. 34):

> The community mental health sector is encouraged by the NT Department of Health's move to five year Service Agreements and notes that the NT Primary Health Network is working towards three year funding agreements. Longer-term funding arrangements will have a positive impact on staff retention, make programs more sustainable, and have a flow-on effect of strengthening cross-sectoral and inter-sectoral collaboration.

The NT Mental Health Coalition (sub. 430, p. 32) further states that, 'At a minimum, agreements covering co-designed services should extend for at [least] 5 years.' Providers concur, with WayAhead (sub. 310, p. 6) recommending that, 'across all governments, grants … should be for a minimum of 5 years' and Aftercare (sub. 480, p. 11) recommending 'the development of longer-term funding investment models (5–10 years).'

Considerations must also be made to manage the risks to efficient use of taxpayer funds that may come with longer-term cycles. To enable adequate performance management by Government of the funded providers, the incorporation of safeguards such as formal reviews of service effectiveness into grants should assist in managing the risk of poor provider performance (PC 2017c, p. 262). A shorter contract could be granted in the case of exceptions, such as pilot programs.

The use of short contracts to give Governments flexibility to alter funding priorities would, in the Commission's view, be less of a concern were Governments to recognise the long term needs of consumers for psychosocial supports. Short term priorities can still be achieved in the context of long-term partnerships, with adequate performance management arrangements in place (chapters 24 and 25).

Overly short funding cycles are not a problem unique to the psychosocial support sector and these are discussed in chapter 23. Although it is difficult to identify an ideal contract length, it is clear that the current length, often annual, for many programs is far too short to provide effective support for those receiving psychosocial supports. The Commission suggests a minimum five-year term as a starting point which many in the sector have advocated for.

DRAFT RECOMMENDATION 12.1 — EXTEND THE CONTRACT LENGTH FOR PSYCHOSOCIAL SUPPORTS

In the short term (in the next 2 years)

The Australian, State and Territory Governments should extend the funding cycle length for psychosocial supports from a one-year term to a minimum of five years.

Impact of the transition to the NDIS on psychosocial supports

The NDIS transition is having a significant impact on the availability of psychosocial supports. Funding for many Australian, State and Territory Government-funded supports is transitioning, or has already transitioned, to the NDIS. However, not every person who has been accessing psychosocial support services is eligible for the NDIS.

There were approximately 282 000 Australians who required psychosocial disability support services in 2016, but only about 90–95 000 people were receiving such supports from Australian, State and Territory Government-funded programs (DoH 2017b). This suggests there existed a very large service gap. This is unlikely to be addressed by the NDIS, as only 64 000 people are expected to access individualised supports when the scheme is fully rolled out (figure 12.4).

As the NDIS is rolled out in each State and Territory, the funding for a number of Australian Government-funded community-based mental health programs has been transferred to the NDIS due to the close alignment of program and NDIS goals (Australian Government 2018a; DSS 2016e). Of the 17 programs being transferred, four are targeted at mental illness:

- Partners in Recovery (PIR)

- Personal Helpers and Mentors (PHaMs)

- Support for Day to Day Living in the Community (D2DL)

- Mental Health Respite: Carer Support (MHR:CS).

Figure 12.4   **The level of need and funding for psychosocial support**[a,b]

PHN funding for commissioned services

NPS-M funding $20m + $20m per year

NPS-T funding $121m (2019–20)

775 000[c] Severe mental illness

290 000 Psychosocial disability with reduced functional capacity

64 000[d] Fit the eligibility criteria of the NDIS

State and Territory programs $439m[e]

CoS funding $36.6m per year

PIR, D2DL, PHaMs, MHR:CS

NDIS $1.4 bn[e]
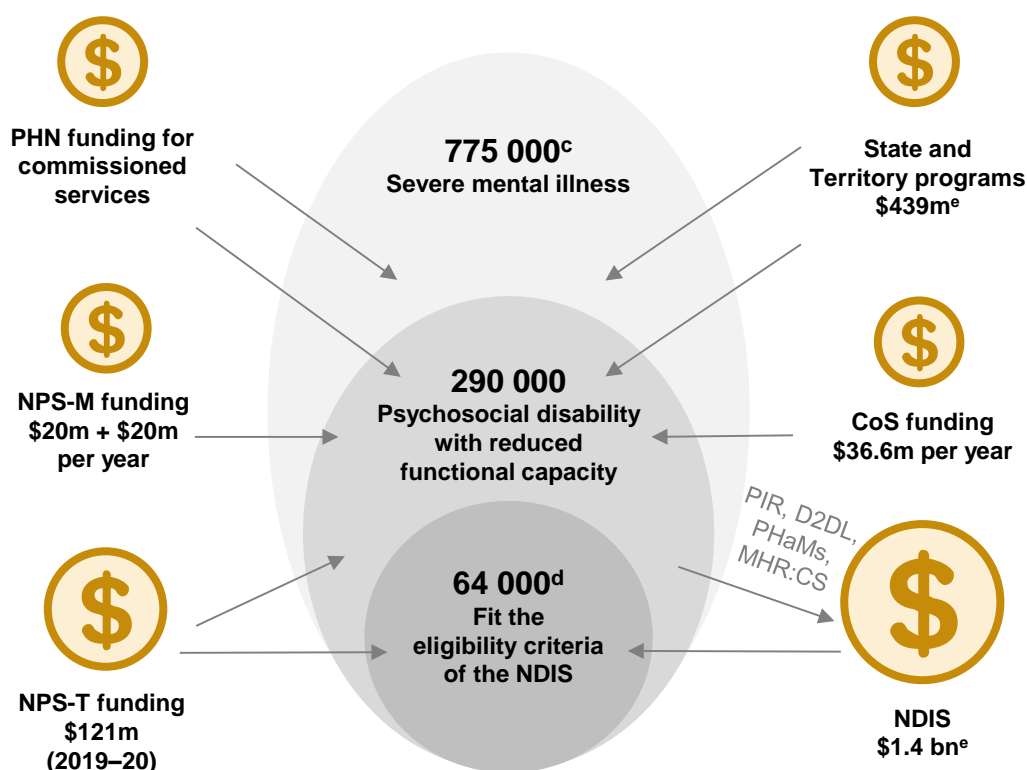
a Figures for CoS and NPS-M are inflation adjusted. **b** The arrow leading from the second circle to the NDIS purse also indicates the transfer of funding from the State and Territory programs to the NDIS. **c** 775 000 people are estimated to have severe mental illness in 2019. However, 684 000 people, some of whom have moderate mental illness, are estimated to need psychosocial support. **d** State and Territory program funding is inflation adjusted using the CPI health inflator to bring to 2018-19 dollars. **e** Calculated using total number of participants with a primary psychosocial disability and average committed supports over 2018-19. Details on calculation are given in appendix E

Source: DoH (2019p).

The first three were intended for people with severe mental illness impacting functioning, whilst the latter was for carers of people with severe mental illness. Approximately 30 100 people received support through PIR, PHaMs and D2DL in 2018 (unpublished data supplied by DSS and DoH)[64] and approximately 40 600 carers were supported by MHR:CS in 2014-15 (DSS 2016b). From 1 July 2019, no new clients were accepted to these programs from areas where the NDIS had been rolled out.

The transition process has exacerbated all existing challenges for consumers and providers of psychosocial supports.

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[64] Derived from 2018 calendar year PIR and D2DL and 2017-18 financial year PIR and MHR:CS client levels.

A range of supports is available during the NDIS transition …

There are three major source of funding to support people with psychosocial disability in the transition to the NDIS (DoH 2019p):

- Continuity of Support (CoS)

- National Psychosocial Support Measure (NPS-M) (DoH 2019u)

- National Psychosocial Support Transition (NPS-T)[65] (Fletcher and Hunt 2019).

The specific source of funding used in each individual case is dependent upon whether or not the person was previously in receipt of Australian Government-funded psychosocial support (figure 12.5).

Figure 12.5 **How are people accessing psychosocial support during the transition?**
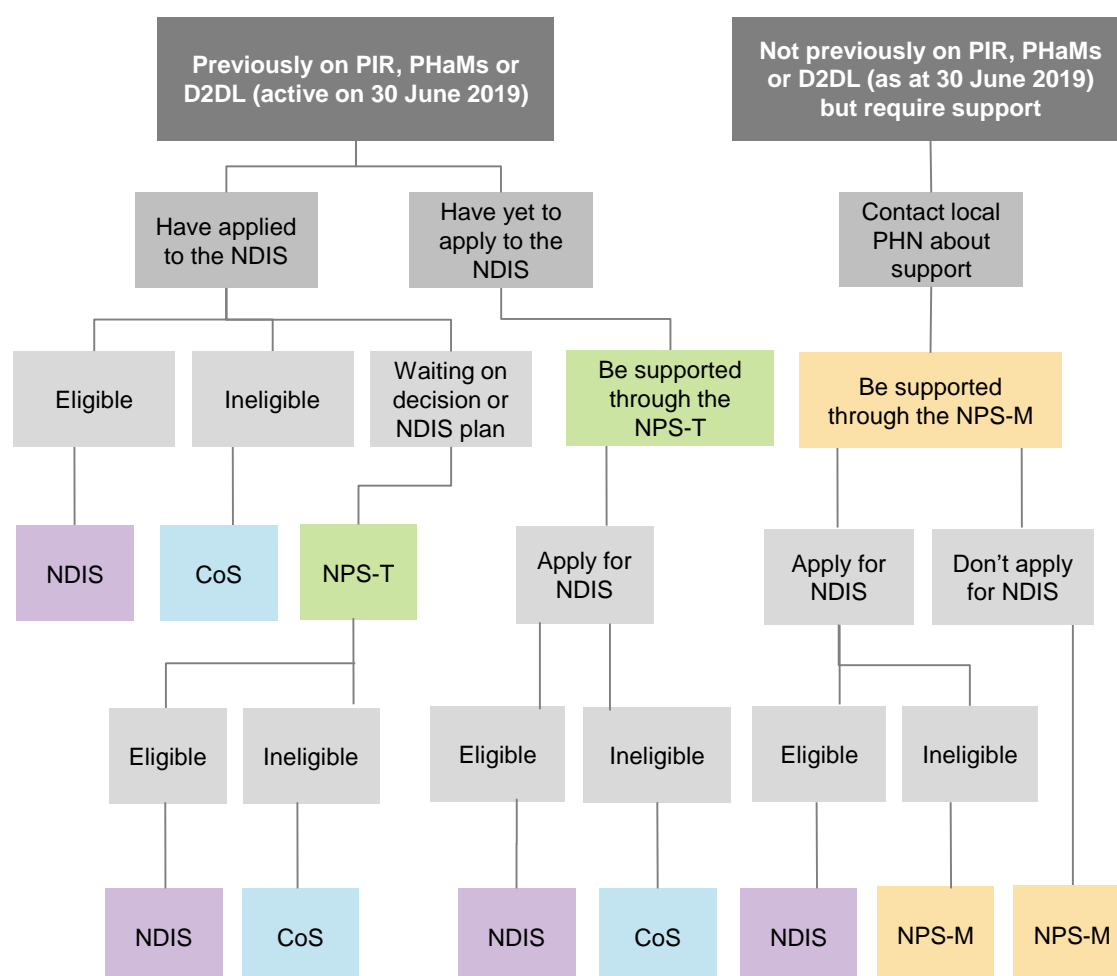
Source: DoH (2019f); South Eastern Melbourne PHN (2019c).

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[65] Also sometimes referred to as the Transition Support Program or the Psychosocial Extension Program.

Former clients of PIR, PHaMs and D2DL who have been deemed eligible and accepted for the NDIS are able to use their individual funding to purchase psychosocial support services, where these are available. For those who have been through the application process and have been deemed ineligible for NDIS support, CoS-funded programs were made available (DoH 2019c). CoS is also available for those former clients who do not meet NDIS age or residency requirements.

For those who were in the process of applying or had yet to apply, access to support may be available through programs commissioned by PHNs through the NPS-T (DoH 2019p; Fletcher and Hunt 2019). The latter was created in recognition of delays in the rollout of the NDIS — with fewer clients transitioned than expected — and intended to ensure that clients could continue to be supported and were given additional time needed to transition (Fletcher and Hunt 2019).

The Australian and State and Territory Governments have also provided funding through the NPS-M to support those who did not previously access their support through PIR, PHaMs or D2DL. This includes those who were formerly on a State and Territory program or are new to accessing psychosocial supports entirely. They can remain on programs funded by the NPS-M regardless of whether or not they choose to test eligibility for the NDIS. Former clients of programs other than PIR, PHaMs and D2DL who have applied but have either been rejected or have yet to hear back are also supported through the NPS-M.

MHR:CS and the Integrated Carer Support Service — which MHR:CS clients were transferred over to — are discussed in chapter 13.

… however, there is uncertainty

Despite the commitment of governments to continue providing support to participants in programs that are being rolled into the NDIS, the changes have been poorly communicated. Just a few months prior to the announcement of extensions, many providers had little knowledge of what supports would be provided in place of the transitioning programs and about the timeline for transition:

> … the Commission is concerned about the psychosocial support options for those who are found ineligible to access the scheme, or who choose not to test their eligibility or drop out of the process. It is currently unclear what support services will be available for this group, particularly when both Commonwealth and state/territory funding for mental health services is being redirected to the NDIS. (NMHC, sub. 118, p. 19)

> It is unclear how people experiencing mental illness and seeking support for the first time after 1 July 2019 will access community-based supports, particularly where those clients do not wish to participate in the NDIS approach to funding and support, or are deemed ineligible for this. (Anglicare Australia, sub. 376, p. 55)

> It remains unclear what the purpose of the [NPS] funding is, which programs will be funded under the measure, the nature and extent of the support that will be provided, and which consumers will be eligible for funding … (ASU, sub. 177, p 4)

In addition, it is unclear what the long-term arrangements are for people accessing psychosocial supports outside of the NDIS. Currently, NPS-M is only funded until the end of June 2021 and CoS until June 2022. Under the existing split of government obligations, funding arrangements are a decision of the Australian Government, which has yet to set out plans for what will happen after this.

A recent Joint Standing Committee (JSC) on the NDIS report recommended that (JSC 2019):

> … the Australian Government extend funding for PIR, PHaMs and D2DL programs until 30 June 2021 and make public by 30 June 2020 how it intends to deliver longer-term arrangements for existing program clients not eligible for the NDIS.

The funding for the PIR, PHaMs and D2DL programs has been extended to June 2020, but these programs are no longer accepting new clients. The Commission reiterates support for the Australian Government to make public long-term arrangements for those not eligible for the NDIS.

The transfer (to varying extent) of State and Territory funding over to the NDIS, but not the transfer of State and Territory program clients, is of concern. After committing the funds spent on existing psychosocial support for severe and permanent mental illness, it became apparent that some former clients were not eligible for the NDIS. Each State and Territory has withdrawn their funding to different extents. For example, the Commission has heard that Victoria has transitioned most of its funding for psychosocial support (from the Mental Health Community Support Service) into the NDIS (ASU, sub. 177, p. 5; Primary Health Networks, sub. 377, p. 4; Uniting Vic.Tas, sub. 95, pp. 3–4; Victorian Government 2019b). The Victorian Council of Social Services (sub. 478, p. 19) noted:

> … as [the] changeover [to the NDIS] occurs, Victoria faces a looming gap in mental health rehabilitation funding. Neither the NDIS nor the Victorian Government has committed to funding these services into the future, as rehabilitation is outside the scope of the NDIS. Victoria redirected all its community-based mental health services funding to the NDIS.

One of the key benefits providers and consumers see in the delivery of some of the transitioning programs, such as PHaMs and D2DL, is that they do not require a formal mental illness diagnosis in order to be accessed (Kaplan and McGrath 2018). This enabled a softer entry point for those who otherwise may not have approached traditional mental health services. It also allowed the programs to operate on a 'no wrong door' approach, welcoming people in and assisting them in finding the support that they require (Kaplan and McGrath 2018). The no wrong door approach is further discussed in chapter 10. With the arrival of the NDIS, many programs which have a no wrong door approach are being phased out. One Door Mental Health (sub. 108, p. 7) noted:

> While the sector experiences increasing barriers to access, there is a concurrent reduction in the aspects of the mental health system that provide low barrier to entry services, which are vital for ensuring that those who cannot, or choose not to, engage in the complex processes required … to access the NDIS, have an alternative way [with minimum complexity of requirements] to access support … The importance of this should not be underestimated not only from an access point of view, but also the added value of the formation of a community of peers.

The uncertainty around the transition creates difficulties for providers when planning or recruiting and retaining qualified staff. The announcement to extend funding (from the NPS-T) to previous providers of PIR, PHaMs and D2DL was made just three months' prior to the date when all funding for the Commonwealth programs was initially slated to cease, at which point 'many workers are already seeking employment elsewhere as organisations [were] unable to provide guarantees of employment after this date.' (One Door Mental Health, sub. 108, p. 11).

The chaos and confusion caused by the transition has been significant — especially to those who rely on these psychosocial supports. Given how difficult the changes have been to keep abreast of even for professionals working in the sector, it is unsurprising that the whole process has and is distressing for vulnerable people with mental illness. As said by a GP:

> Understanding how and what support is available would be great. In my sector the NDIS has us baffled. The system changes and it can be very hard to learn how to navigate the new system and I don't have a mental health issue to make it harder. (ASMOF, sub. 233, p. 10)

Despite the continuity of support measures introduced by government, people requiring psychosocial support are uncertain of whether they will be able to access them at all without first testing their ineligibility.

Testing 'ineligibility'

The Commission has heard from inquiry participants that previous clients of the Australian Government-funded psychosocial supports (PIR, PHaMs and D2DL) are being asked to test their eligibility for the NDIS — and have their application turned down — before they are given access to CoS (Anglicare Australia, sub. 376; EACH, sub. 227; MHCC, sub. 214; OTA, sub. 141; QAI, sub. 116). This test is being applied regardless of the consumer's likelihood of being eligible for NDIS.

The NDIS provides services for people with the most severe mental health needs. There are many programs that do not exclusively serve this demographic and are being phased out, such as those that do not require an upfront clinical diagnosis of mental illness. Aftercare estimates that from their client base (sub. 480, p. 19):

- 30–40% of PHaMs clients will be ineligible or refused for NDIS (including a small percentage declining to apply);
- around 30% of PIR clients will be ineligible or refused.

Stakeholders argue that, as a result, some people with severe mental illness are being needlessly required to engage in the NDIS application process to access continued supports (CMHA and USYD 2019b). Queensland Advocacy Incorporated raised concerns that the process to apply for the NDIS is not only 'expensive [and] time-consuming,' but the 'the long waits of up to nine months or more can also be 'emotionally exhausting, if not psychologically damaging' to the very people it is intended to support (sub. 116, p. 14).

It is also unknown whether the National Disability Insurance Agency (NDIA) will be able to test every former PIR, PHaMs and D2DL participant prior to the expiration of extension funding in June 2020. Indeed, inquiry participants have expressed that 'it is unlikely that all people will have their NDIS eligibility tested and determined by the time that funded programs are due to cease' (MIFA, sub. 343, p. 14). The requirement to test ineligibility adds to the workload of the NDIA, which already sees long wait times for applications to be processed (typically between three to nine months). From late 2018 to mid-2019, the proportion of former PIR, PHaMs and D2DL participants who had applied but whose application outcome was still pending or unknown increased from 5.9% to 17.7% (CMHA and USYD 2019a).

Many former participants of PIR, PHaMs and D2DL are deciding not to have their eligibility tested. Providers expressed concern that this risks their clients' ability to access continuity of support measures:

> … many clients with mild to moderate mental illness have been unable to or do not wish to establish the clinical relationships necessary to obtain medical documentation to establish a life-long diagnosis, which is necessary to ensure continuity of supports. Clients have chosen to disengage from support services rather than endure the lengthy process of NDIS rejection and review … this will likely result in increased severity of mental illness symptoms and impacts for these clients, their informal supports and other service systems. (Anglicare Australia, sub. 376, pp. 51–52)

For some care recipients, it is possible that losing the support they have come to depend on will undermine the progress they have made on their recovery and/or induce a deterioration of their psychosocial functioning (Anglicare Australia, sub. 376, pp. 52–54).

Ensuring people can access required psychosocial supports

Consumers who require psychosocial support should be able to obtain it without enduring a long and difficult application process. According to the current policy, former clients of PIR, PHaMs and D2DL must first apply for the NDIS and be rejected before they can access support through CoS, while those who were not former clients do not need to do so and can access support through the NPS-M. This requirement may have come about in an attempt to encourage transition to the NDIS for those eligible as only those who are not eligible for the NDIS should have their support provided outside the NDIS and the only way to know is to test their eligibility.

However, it must be the case that someone can access the support they require, regardless of previous access to psychosocial supports and regardless of whether or not they have applied for the NDIS. Without it, people may either choose to disengage from the system or they may unnecessarily endure a long and overwhelming application process, risking damage to the recovery of the person.

This issue was previously raised by the JSC on the NDIS inquiry into *The provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition* (JSC 2017):

> The Committee recommends clients currently receiving mental health services, including services under Commonwealth programs transitioning to the NDIS, namely Partners in Recovery (PIR), Personal Helpers and Mentors (PHaMs), Day to Day Living (D2DL), and Mental Health Respite: Carer Support (MHR:CS), should not have to apply for the NDIS to have guarantee of continuity of supports and access services.

This recommendation was not supported in the Australian Government response. At the time, the Australian Government believed it to be in the best interests of all former clients of PIR, PHaMs and MHR:CS to test eligibility as they would be able to do so with the assistance of familiar support workers and, should they be eligible for the NDIS, receive a higher level of support that is guaranteed for life (Australian Government 2018a). However, the current processes in place have led to poor consumer outcomes and mass uncertainty in the sector, even amongst professionals, and many consumers do not want to apply to transition (Mission Australia, sub. 487).

The Commission considers that eligibility for psychosocial supports should be based on two principles:

- the decision to apply must be the consumer's, should they have the capacity to make such a decision (figure 12.6), and

- the policy must be effectively communicated to PHNs, providers and users of psychosocial supports.

As per figure 12.6, people should be supported throughout the transition, until the landscape has cleared. By 2022, there should be an evaluation of the NPS-M to better understand why potentially eligible applicants are not applying. The NPS-M must run for a sufficiently long period until either RCAs are operational under the *Rebuild* model or the *Renovate* model has been implemented and the evaluation can be complete. Following such an evaluation, there can be work to remove the barriers to applying for the relevant group so that they may be eventually shifted into the NDIS. Those who remain ineligible for the NDIS will then be on RCA or State and Territory-commissioned programs.

Figure 12.6 **Eligibility for psychosocial supports**
From a consumer perspective
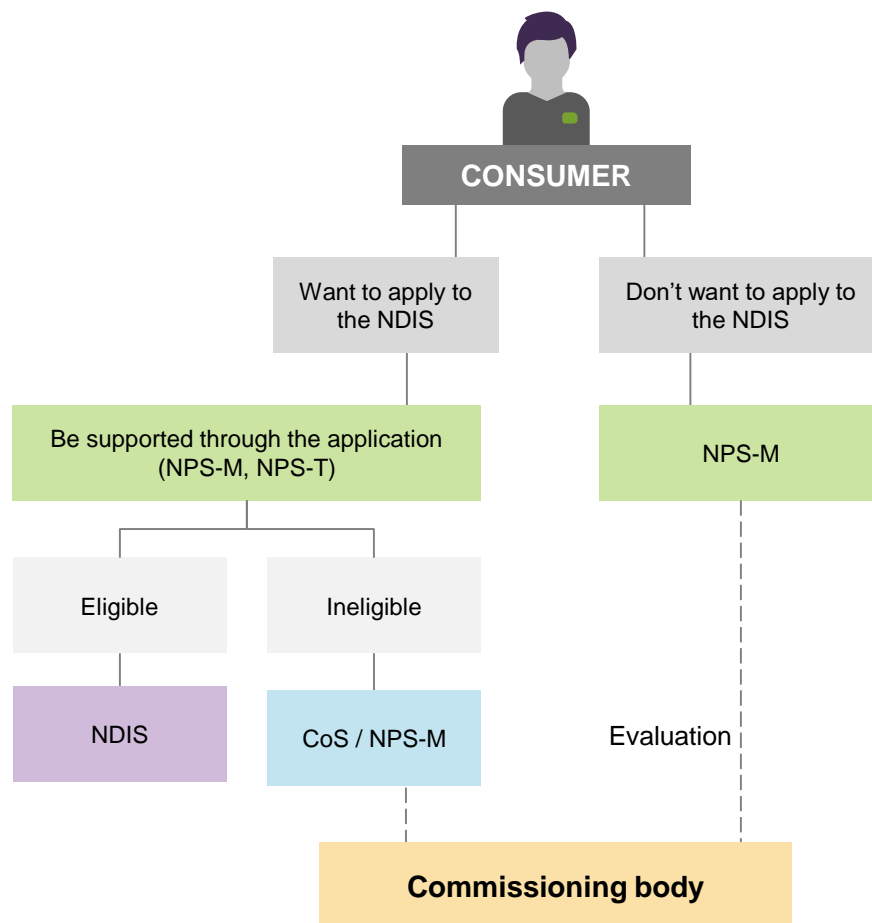
People with psychosocial disability, or otherwise, requiring psychosocial support should be free to apply for the NDIS only if they wish to access the NDIS and not be motivated to do so only to pass a requirement to access CoS. The decision must ultimately come to the consumer. As such, the requirements for former participants to continue accessing supports should be altered to allow for this.

DRAFT RECOMMENDATION 12.2 — GUARANTEE CONTINUITY OF PSYCHOSOCIAL SUPPORTS

Requirements for continued access to psychosocial support should be changed so that anyone who requires it is able to access it, including former participants of Australian Government-funded psychosocial supports.

In the short term (in the next 2 years)

- Should someone choose to apply for the National Disability Insurance Scheme (NDIS), they should continue to be supported during the application process

- Should someone choose not to apply for the NDIS, they should be allowed to continue to access support through the National Psychosocial Support Measure, should they require it, until it has been phased out

In the medium term (over 2 – 5 years)

- For those who did not apply for the NDIS, the psychosocial support commissioning agencies should conduct an evaluation of barriers and remove them as necessary

- When the National Psychosocial Support Measure is phased out, participants should either be shifted onto the NDIS, if appropriate, or access the replacement psychosocial support.

12.3 Improving the delivery of psychosocial supports in the NDIS

For people with psychosocial disability, the application process and supports received from the NDIS may not always meet their objectives. The NDIS funds long-term disability care and support for people with severe or profound disabilities. Central to the NDIS is the understanding that individuals' support needs are different and participants should be able to exercise choice and control over the services and support they receive (PC 2017d).

The NDIS operates under the *National Disability Insurance Scheme Act 2013* (Cth) (NDIS Act), and is administered by the NDIA. Funding for the NDIS is shared between the Australian and State and Territory Governments.

In 2011, the Commission recommended that people with psychosocial disability be supported through the NDIS on the basis of their support needs and care requirements (PC 2011). The eligibility requirements for people to access the NDIS are given in box 12.3.

Box 12.3   **Psychosocial disability requirements**

A prospective participant will meet the disability requirements if each of the following requirements in section 24 of the NDIA Act is met:

- the prospective participant has a disability that is attributable to one or more intellectual, cognitive, neurological, sensory or physical impairments or to one or more impairments attributable to a psychiatric condition (s. 24(1)(a))

- the prospective participant's impairment/s are, or are likely to be, permanent (s. 24(1)(b))

- the prospective participant's impairment/s result in substantially reduced functional capacity to undertake, or psychosocial functioning in undertaking, one or more of the following relevant activities:

  - communication

  - social interaction

  - learning

  - mobility

  - self-care

  - self-management (s. 24(1)(c))

- the prospective participant's impairment/s affect their capacity for social or economic participation (s. 24(1)(d))

- the prospective participant is likely to require support under the NDIS for their lifetime (s. 24(1)(e)).

Impairments that vary in intensity (for example, because the impairment is of a chronic episodic nature) may be permanent and a prospective participant may still require support under the NDIS for their lifetime despite the variation (s. 24(2)).

Is the NDIS working well for people with psychosocial disabilities?

The NDIS has the potential to substantially benefit people with psychosocial disability. It presents an opportunity for people with psychosocial disability to increase their social and economic participation through NDIS funded supports (NDIA 2019d). In addition, the NDIS gives the scheme participant choice and control over how their supports are provided (PC 2017d; Warr et al. 2017).

However, people with psychosocial disability often have a less positive experience with the NDIS (PC 2017d). Several problems have been raised concerning the NDIS, including:

- the application process to gain access to the NDIS can be overwhelming

- comparatively poorer experiences upon entering the Scheme for some participants

- many choosing not to apply for the NDIS even though they would likely be eligible

- the unclear interface between the NDIS and the mainstream services.

Fewer people are in the Scheme than expected

The NDIA estimated that by full rollout of the Scheme (2019--20), there will be 460 000 participants, with 13.9% (64 000 people) expected to have a primary psychosocial disability (NDIA 2016c, 2017a). As of June 2019, the NDIS had 259 000 participants, and 8.8% (21 700 people) had a primary psychosocial disability (NDIA 2019b) (figure 12.7).

The proportion has been steadily rising over time, reflecting improvements in access to the Scheme for people with psychosocial disability. In particular, the proportion is much higher in jurisdictions where the NDIS has been around for longer, such as Victoria (12.7%) and the ACT (12.4%), where it is approaching the national target of 13.9% (figure 12.7). However, in many States it is significantly below target. A lower number of people with psychosocial disability participating in the NDIS may place additional pressures on the mainstream mental health system (as discussed in section 12.2).

Application rates are lower than expected

The relatively low proportion of people with a psychosocial disability in the Scheme arises from both low application rates and comparatively low rates of success for those who do apply.

According to an independent Commonwealth Mental Health Programs monitoring project (henceforth referred to as the CMH monitoring project)[66], only 48% of participants across the Australian Government-funded psychosocial support programs — PIR, PHaMs and D2DL — applied for the NDIS between August 2018 and June 2019. The two most cited reasons were that the client was still collecting evidence for an application (22%) or that the client did not want or intend to apply (19%) (CMHA and USYD 2019b, p. 9).

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[66] Community Mental Health Australia (CMHA) and The University of Sydney collected and analysed data available regarding the transition of clients from PIR, PHaMs and D2DL to the NDIS (CMHA and USYD 2018, 2019b, 2019a). Provider organisations from each of the three programs across each State and Territory provided non-identifiable data regarding clients who were transitioning or otherwise to the NDIS.

Figure 12.7   **NDIS participants with a primary psychosocial disability[a]**
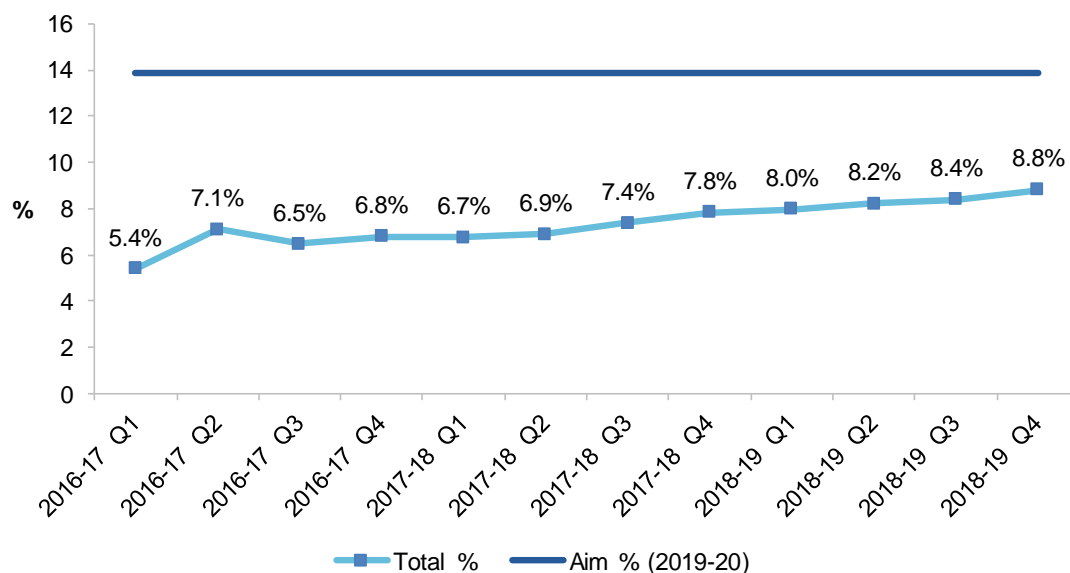
Proportion of participants with a primary psychosocial disability by state[b]
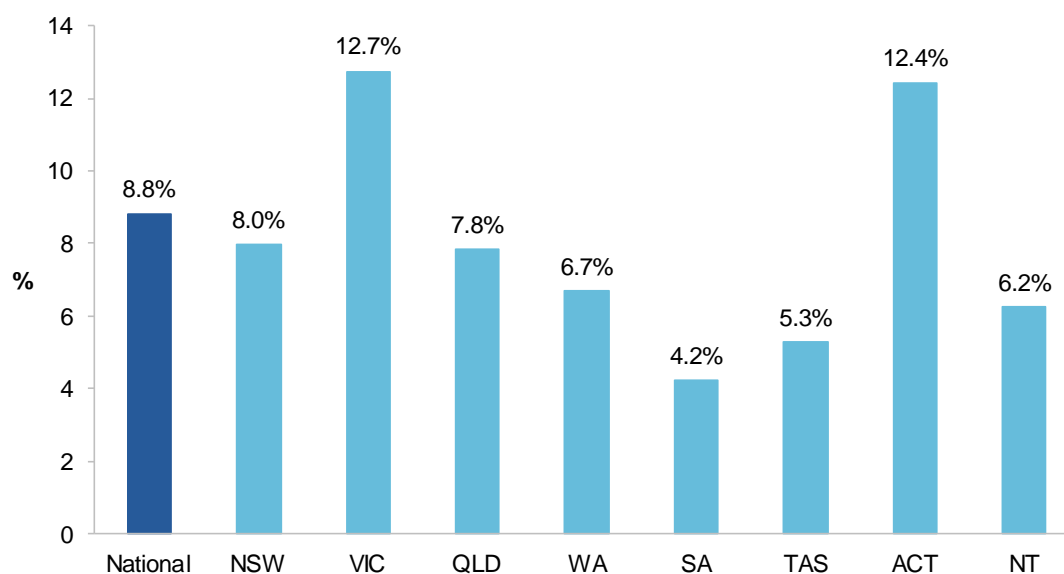
a Prior to the 2018-19 financial year, the figures indicate the proportion of *active* participants, while in the 2018-19 financial year the figures indicate the proportion of *all* participants. The 14% target is intended to apply at full scheme. **b** This data is for 2018-19 Q4.

Source: NDIA (2016a, 2016b, 2017d, 2017e, 2017b, 2017c, 2018c, 2018d, 2018a, 2018b, 2019a, 2019b).

Figure 12.8   **NDIS Application rates across PIR, PHaMs and D2DL**[a]
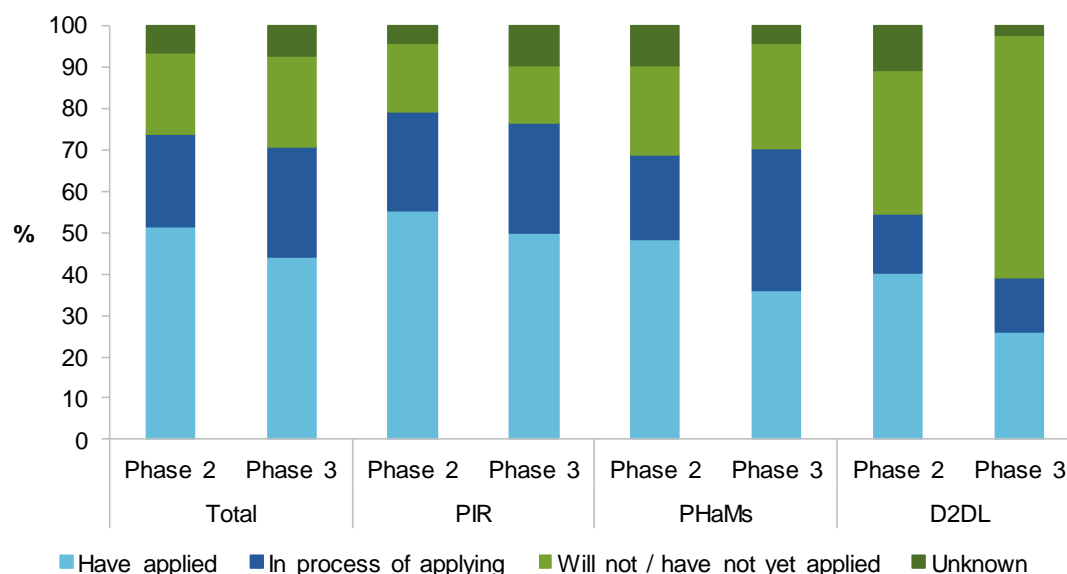
a A small number of clients are living in areas where NDIS is yet to be rolled out.

Source: Community Mental Health Australia and The University of Sydney (2018, 2019b).

These findings were consistent with advice provided by inquiry participants. For example, Anglicare Australia (sub. 376, p. 54) stated that clients are reluctant to be tested for a range of reasons, including:

- not identifying as having a 'permanent' disability, as their illness is episodic,

- not being at a point in their mental wellbeing where connecting with a formal application, assessment and planning process is possible for them to contemplate, and

- a lack of understanding or scepticism about the benefits of an NDIS package.

It is important to note that, as part of the transition, people who were previously on PIR, PHaMs and D2DL are contacted by the NDIA and invited to test their eligibility for the Scheme. However, some are unable to be contacted, or withdraw from the application process (NMHC 2019c).

A complex application process

Stakeholders contend that the high percentage of people who said they were still collecting evidence (22% in the CMH monitoring project) speaks to the complexity of the application criteria and the barriers that continue to exist for those with psychosocial disability. They have also suggested that consumers' unwillingness to apply for the NDIS highlights that there is ongoing work required to demystify the Scheme and reduce the burden of applying

for those who may benefit from participating in the Scheme (CMHA and USYD 2019b; MHA 2018b, 2018a; USYD and CMHA 2018).

The NDIS application process can be time-consuming and especially daunting for people with psychosocial disability (Lorna MacKellar, sub. 406; MHCSA and LELAN, sub. 380; OTA, sub. 141). Current providers of non-NDIS psychosocial supports have described some major challenges of collecting the evidence required by the NDIA, including:

- GPs or specialists lack an understanding of NDIS, the client or psychosocial disability

- limited or lack of evidence available due to limited service engagement

- clients' fluctuating mental health and thus ability to manage the application process

- the cost of gaining expert evidence

- barriers and time delays in accessing data from other services

- resource limits of program staff to help collect evidence (CMHA and USYD 2018, 2019b, 2019a).

Some have also expressed concerns over the costs and difficulties associated with applying:

> The cost to undertake assessments for reports can be crippling for many people, and that actually becomes a real gamble that for too many people doesn't pay off (QAI, sub. 480, p. 14).

People with a severe and complex mental illness often struggle to advocate for their own support needs and hence find it especially difficult to engage in the NDIS application process (Anglicare Australia, sub. 376; Inner South Family and Friends, sub. 129). The Victorian Government (sub. 483, p. 13) suggested an 'uplift in funding for advocacy services for people living with mental illness who may not be well placed to self-advocate due to their condition'.

The introduction of a specialised psychosocial disability stream is evidence that the NDIA is aware of the unique needs and challenges of those with psychosocial disability and this is an area that may gradually improve (Fletcher and Henderson 2018; MHA 2018a; Quinlan 2018). Details of the specialised stream are further discussed later.

Interpretation of eligibility requirements

Inquiry participants have stated that many people with psychosocial disability are finding it difficult to prove their eligibility, contributing to lower participation rates. Acceptance rates for people with psychosocial disability are noticeably lower than many other disability categories. For example, from the beginning of rollout until December 2017, only 81.4% of all applicants with psychosocial disability were accepted into the NDIS compared to 98.8% for people with autism (JSC 2017).[67] The CMH monitoring project found that, from August

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[67] The approval rate was reported as the total number of participants in a quarter as a percentage of total access determinations.

2018 to June 2019, of those who had applied from PIR, PHaMs and D2DL, 28% were deemed ineligible by the NDIA (CMHA and USYD 2018, 2019b).

Figure 12.9 **Approval rates by disability type**
Quarter 1 2013-14 to Quarter 2 2016-17
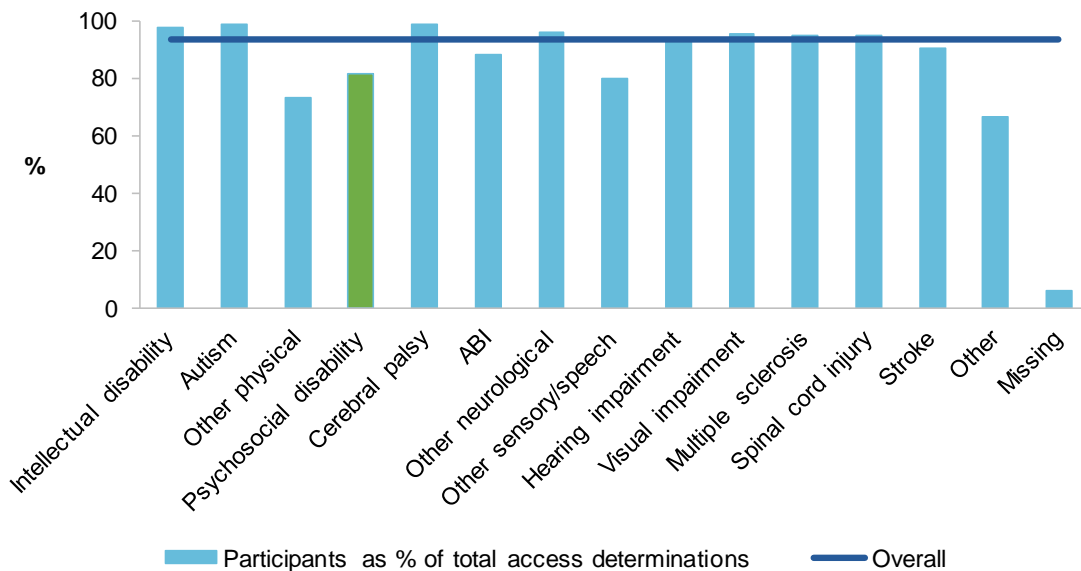
Source: NDIA (2016b).

There are debates over the threshold for access. Some inquiry participants believe that there have been many rejections even in cases where the applicant has a good claim to become a NDIS participant (Anne Mill, sub. 348, pp. 2–3; Peter Kent, sub. 352, pp. 16–17). Some common reasons for ineligibility that the NDIA have given include: insufficient evidence of functional impairment or disability, the functional impairment or disability is lifelong, or the impairment or disability could not be treated elsewhere (CMHA and USYD 2018, 2019b).

Long wait for application outcome

For participants of PIR, PHaMs and D2DL the typical waiting time between application to assessment outcome was three to nine months (CMHA and USYD 2018, 2019b). As noted by the Mental Illness Fellowship of Australia (sub. 343, p. 14), 'an emerging issue is the number of NDIS applications that are now stalling in the system, resulting in protracted decisions about the eligibility of participants'.

Inquiry participants have raised the concern that significant waiting times hamper a person's recovery, as it can be emotionally exhausting and psychologically damaging (Lorna MacKellar, sub. 406; QAI, sub. 116). In particular, significant delays in access to support may lead to 'increases [in the] risk of deterioration, relapse and results in discharge delays from bed-based mental health treatment services' (Victorian Government, sub. 483, p. 12).

To reduce these risks, people with psychosocial disability are able to access supports before and while testing eligibility through the NPS-M (DoH 2019f). However, there may be a large difference in the level of funding per person on the transition supports as opposed to PIR and PHaMs, with an even larger difference when contrasted with the NDIS.[68] The funding is unlikely to be sufficient for adequate support:

> While new funds have been identified to replace transition programs, providers report these are insufficient to cover statewide needs in WA … (WAAMH, sub. 416, p. 10)

Many applicants are likely to have severe mental illness and require a much higher level of support akin to either the Commonwealth programs or even the NDIS, but are waiting several months or even a whole year for this.

It is important that people applying for the NDIS who require support are not disadvantaged by the application process and still receive the appropriate level of support they may require through non-NDIS services while they are waiting for an application result.

What about those who get accepted into NDIS?

Overall, participant satisfaction with the NDIS is high at 90% (NDIA 2019b). However, there is evidence that the experience of people with psychosocial disability accepted into the NDIS can be marred by inappropriate plans and difficulties finding services (USYD and CMHA 2018).

Unsuitable plans

Some have argued that many people with psychosocial disability are receiving unsuitable plans. Issues include disproportionate funding packages, unskilled planners who lack understanding of psychosocial disability and its inherent episodic nature, as well as a lack of appropriate supports and coordination.

The funding allocated to NDIS participants can be greatly disproportionate to the level of need. Mind Australia noted a 'lack of consistency between the [functionality or disability] scores and ultimate package size for those who have plans with Mind.' (sub. 380, p. 44).

The NT Mental Health Coalition said that 'variability in skills of planners working with people with psychosocial disability results in supports being included in a plan for an individual that do not reflect their goals, ability or the availability of services' (sub. 430, p. 32). The Victorian Government (sub. 483, p. 12) stated that NDIS planners also do not 'adequately, or flexibly, [consider] the impacts of psychiatric crisis and [the] fluctuating needs of participants with a psychosocial disability'. This may result in 'significantly lower than expected proportion of

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[68] According to Commission estimates, funding per client per year was roughly $10–12 000 on PIR and $6–7 000 on PHaMs. The NDIA places the average per participant expenditure for PIR, PHaMs and D2DL to be roughly $6 500 and under the Victorian MHCSS to be $11 000. Through the NDIS, the average committed funding per active participant with psychosocial disability was $38 900 (NDIA 2019e).

capacity building supports in plans, resulting in lost opportunity to improve participants' functional capacity and recovery' (sub. 483, p. 12). Further, providers such as Anglicare Australia submitted that:

> … for people with psychosocial disability who have been successful in applying to the NDIS, there are still gaps in the service model. Poor assessment by the NDIA often results in no or low support available to people with psychosocial disability in their NDIS plans for daily living support' which are essential to recovery. (sub. 376, p. 55)

Once a person has met the requirements for eligibility and received their plan, some experience difficulties in navigating the complex system. Anglicare Australia (sub. 376, p. 55) expressed concern that people with severe and complex mental illness are 'unable themselves to navigate and use their NDIS funding.' The Victorian Government (sub. 483, p. 12) stated that few NDIS plans include allocations dedicated to 'coordination of support' despite the major benefits it would confer.

That some participants' plans may be unsuitable is reflected in the particularly low utilisation rates (the share of a participant's budgeted supports that has been used) for those with psychosocial disabilities (figure 12.10). In a submission to the Commission's 2017 study into NDIS Costs (PC 2017d, p. 101), the NDIA suggested that utilisation rates would reach a steady state of 80–95% (NDIA 2017f, p. 70). So far this is not the case, especially for participants with a psychosocial disability, whose utilisation rates are lower than all other scheme rates. However, it is important to note that the utilisation rate gap between psychosocial disability participants' plans and all scheme participants' plans tends to decrease over time as plans are reviewed (figure 12.10).

Inquiry participants have raised concerns that when the packages are not being used, package values can decrease at the next review. This is especially concerning when considered in light of the episodic nature of psychosocial disability.

> [the NDIS disability support model] has a peculiar incentive where people may be 'punished' for their condition improving, by packages being stripped back. This model does not really respect the episodic nature of mental illness. (ACT Government, sub. 210, pp. 12–13)

> [an issue impacting on participants is the] significant reductions in plans post review due to plan underspend or because the participant is viewed as 'stable' (with the resultant risk that withdrawal of disability supports will negatively impact on the participant's ongoing capacity to manage their life circumstances and or self-manage their mental illness and its impacts). (Victorian Government, sub. 483, p. 12)

Figure 12.10 **Utilisation rate of committed supports[a,b,c,d]**
From 1 October 2017 to 30 September 2018

Utilisation rate by plan number

Utilisation rate by age group
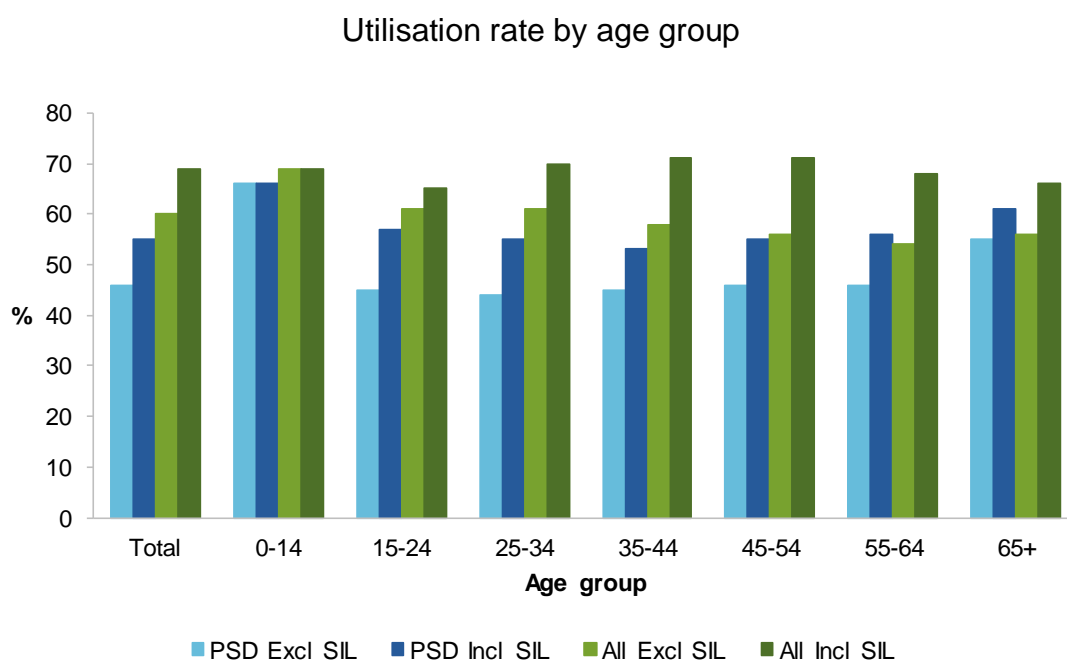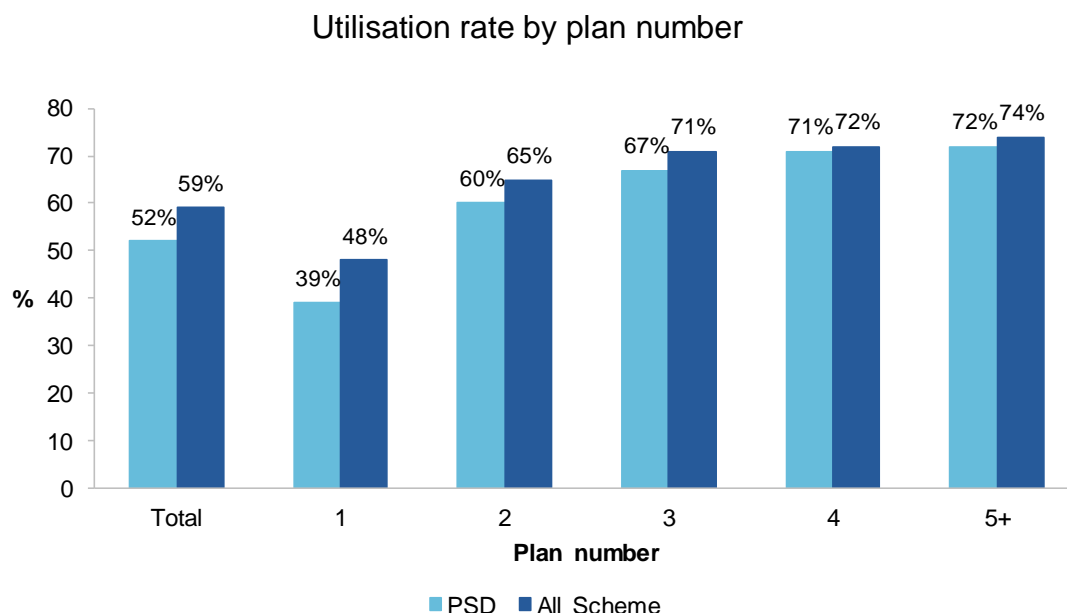
a PSD stands for psychosocial disability. **b** Plan number refers to which plan a participant is on. For example, a new participant would be on plan number one. Following a plan review, that participant would then move onto plan number two, and so on. **c** Plans are generally for one year periods, but can vary according to individual circumstances. **d** Supported Independent Living (SIL) assists and/or supervises daily tasks to develop skills to live independently.

Source: Unpublished data provided by the NDIA.

Inherent to the episodic nature of psychosocial disability is fluctuations in the mental illness of the individual. Rapid deterioration in an individual's mental health is not uncommon. It is important that a participant's NDIS plan is able to quickly respond to changes in their level of need, both during periods of health and illness. The COAG Disability Reform Council (DRC) Mental Health Senior Officers Working Group recently recommended enhancements to the NDIS' planning and supports processes to increase responsiveness to the episodic nature of psychosocial disability. Work is underway by the NDIA — adapting current practices to quickly adjust plan budgets and supports to reduce waiting times for unscheduled reviews and increase planner discretion for top-up funding where increases in disability are associated with a deterioration in mental health. This is expected to be completed by June 2020 (COAG DRC 2019a, 2019b).

Difficulty obtaining required supports

Despite being successful in receiving a NDIS plan and funding for supports, participants sometimes find it difficult to purchase needed support as it may not exist in their community or may be ill-suited to the community's needs (VCOSS, sub. 478). This is especially the case in remote communities with lower population densities (CRRMH, sub. 465; NT Mental Health Coalition, sub. 430; RRMH, sub. 97).

The issues surrounding acquisition of supports stem from two major reasons. The first is that the prices set by the NDIA for services may be too low. Inquiry participants raised concerns that providers are unable to meet the prices set by the NDIA (ACT Government, sub. 210; VCOSS, sub. 478). Anglicare Australia (sub. 376, p. 55) noted that 'many organisations have discontinued providing such daily living support services as the price set by the NDIA is simply unfeasible'. In addition, many inquiry participants have stated that the low pricing has led to workers leaving the sector or providers decreasing the quality of services (VCOSS 2018; box 12.4).

The Victorian Government (sub. 483, p. 11) recommended that the Australian Government work collaboratively with the State and Territory Governments to 'review current NDIS price settings as a pathway to independent price setting to ensure the sustainability of a specialist psychosocial disability workforce and quality and safety outcomes for participants with a primary psychosocial disability'. Initiatives undertaken by the NDIA thus far to ease the pricing concerns are discussed later.

The other major reason for difficulty obtaining required supports is that there may be 'thin' markets, with a low number of buyers and sellers. In this case, the buyers are the participants with a psychosocial disability and the sellers are providers of psychosocial supports. The NDIS market model does not work particularly well in thin markets and, as a result, many people are not able to access services and supports that they are funded to receive (Inner South Family and Friends, sub. 129; NT Mental Health Coalition, sub. 430; TeamHEALTH, sub. 155; Victoria Legal Aid, sub. 500).

Box 12.4 Low NDIS prices leading to workers leaving the sector

One Door Mental Health:

> While the NDIS does not directly set the amount a service provider can pay an employee, the NDIS price for services are lower than what is needed to maintain the current skill of the workforce. Provisions for basic support items allow for the employment of only minimally qualified staff. The displacement of qualified staff to other sectors is currently impacting on the ability for providers to recruit good staff and is likely to have indications for the provision of quality community mental health programs. (sub. 108, p. 11)

Health Services Union:

> … in Victoria, the MHCSS program enabled funded service providers to offer SCHADS Award wages at Levels 4 and 5 of the Award, whilst NDIS funding was capped on the assumption of Level 2 of the Award … Inadequate [remuneration] together with training, workforce planning, resourcing and support deficiencies, contribute to poor retention rates across the sector. (sub. 237, pp. 22–23)

Queensland Alliance for Mental Health:

> The current pricing under the NDIS is set below current sector awards — in response, NDIS providers are employing staff without the appropriate qualifications or formal training due to award constraints. For example, the Social and Community Services Queensland Award states that a psychosocial support worker with a tertiary qualification or Certificate IV, must be paid at level 3 and above. With the current NDIS pricing, these award rates cannot be met. (sub. 247, p. 10)

Mental Health Community Coalition of the ACT:

> The downward pressure on wages in community mental health services since the introduction of the NDIS should not be underestimated … we are seeing the emergence of a market where the least qualified and lower paid workers are employed in NDIS services, while more qualified and highly paid workers are employed in non NDIS services. This is concerning given that the NDIS is for people with the most severe and enduring disability. (sub. 517, p. 19)

Australian Services Union:

> Under block funding arrangements, case-workers were paid at Level 4 of the SCHADS Award, however as clients transitioned to the NDIS, Anglicare SA have claimed they can no longer afford to continue paying these workers at level 4. Workers were offered jobs back, but with a pay cut, at level 2 of the Award. Of the 43 workers, 25 workers have now left Anglicare by taking redundancies or having their contract paid out, with others choosing to take roles at level 2 … We are concerned that workers leaving the mental health sector and moving in to different sectors will affect Australia's capacity to deliver mental health support now and in the future. (sub. 177, p. 6)

Victorian Council of Social Services:

> The NDIS pricing model is contributing to the challenge of securing a highly skilled workforce. Recent survey data from the sector indicates half of disability service providers are considering reducing service quality because of NDIS pricing. (sub. 478, p. 21)

Mental Health Coordinating Council:

> The NDIS price levels for working with people with complex needs are low and pose challenges to deliver safe and quality services that are economically viable. (sub. 214, p. 8)

While some consumers are only able to use a portion of their package as there are not enough suitable services in their region to use the rest, some NDIS providers are pulling out of unviable NDIS markets, leading to even fewer services for consumers to pick from.

This issue is especially prevalent in rural and remote settings. As outlined by a recent Senate Standing Committee report (SCCA 2018, p. 99):

> … many rural and remote Australians have experienced issues applying for the NDIS and accessing appropriate mental health services through their NDIS plan. These issues included 'tyranny of distance' issues … and a lack of appropriate support services.

There are concerns that where there are few psychosocial supports available in a community:

> … many people with a psychosocial disability have to leave their communities to access these supports. Their mental health condition can then be affected by their social isolation and loss of connection to land and natural supports. (NT Mental Health Coalition, sub. 430, p. 31)

This inequitable access often disproportionately affects Aboriginal and Torres Strait Islander people whose cultural needs may also not be met by mainstream services.

Where there is insufficient market supply of providers or in cases where providers have failed to provide care, responsibility to remedy the situation falls to the NDIA (NMHC 2018b, 2019c). It is responsible for providing alternative providers to scheme participants under Provider of Last Resort (POLR) arrangements. That is, the NDIA will directly commission and procure disability supports for participants. As part of these arrangements, contingency funding should be available when crises arise for NDIS participants and crisis and respite accommodation must be able to be secured at short notice (OPA Victoria 2018).

The Productivity Commission's 2017 NDIS Costs report, as well as several Joint Standing Committee inquiries, have called on the NDIA to publish a POLR policy (JSC 2017, 2018b, 2018a, 2019; PC 2017d). These remarks have been echoed by the Australian National Audit Office and in an Independent Pricing Review by McKinsey & Company (ANAO 2016; McKinsey & Company 2018).

The NDIA and the DSS have commissioned the NDIS Think Markets Project, which aims to develop a framework for dealing with thin markets. Consultations were held earlier this year and results have yet to be released from these consultations (EY 2019). Previously, the NDIA also worked with States and Territories to develop a POLR policy, part of what is known as the Maintain Critical Supports project (JSC 2018b). However, there has been limited public information available on the project and its outcomes (VCOSS 2019).

As of 2019, there are still no clear POLR arrangements (JSC 2019), with the only exception being the Northern Territory which has put in place some POLR systems (Victoria Legal Aid 2017). The Productivity Commission supports the public release of a POLR framework to help inform the appropriateness and effectiveness of market interventions.

While the NDIA has yet to release a POLR framework, it has made increases to the prices of NDIA supports to encourage market development. Following a number of pricing reviews and consultations, the NDIA has initiated increases in prices from 1 July 2019, with increases in psychology therapy supports and attendant care across the States and Territories, albeit by

different amounts. In addition, a conditional loading has been made available to providers to assist providers in transforming their business as the NDIS market evolves (NDIA 2019a).[69]

What has the NDIA been doing to make things better?

The NDIA has acknowledged that changes are needed to improve outcomes for people with psychosocial disability and has introduced a number of initiatives. Aside from the pricing increases discussed above, there has also been the development of a 'psychosocial disability stream' and the Independent Assessment Pilot.

Psychosocial disability stream

The new stream has been in development since late 2018 (Fletcher and Henderson 2018). As part of the stream, several working groups have been formed with various levels of government, various agencies and peak organisations representing consumers and carers to address recommendations to improve the responsiveness to participants, families and carers (NDIA 2019e).

Improvements so far include:

- foundational psychosocial disability training for NDIA planners and Local Area Coordinator staff to better understand psychosocial disability This training was completed in June 2019 and the training has been incorporated into the standard induction training for all new staff

- the rollout of the Complex Support Needs Pathway, which commenced in March 2019, to provide specialised support for people who require additional support to access and engage with the NDIS and have a greater need for coordination of multiple services

- more consistent contact points, improvements in the consistency and robustness of functional assessments, the provision of customised support for people with psychosocial disability to better respond to specific disability requirements and the piloting of a new Typical Support Package for participants with a psychosocial disability (NDIA 2018b, 2019a, 2019b, 2019e).

From 30 April 2019, streamlined access for people with psychosocial disability became available to prospective participants from State programs in all States and Territories. As part of the streamlined access process, prospective participants can (NDIA 2019e):

- verbally begin their access request with a support worker or a trusted other person

- provide consent for their support worker or a trusted other person to be the NDIA contact for the duration of the access process

- where required, re-test access to the NDIS with the support of a trusted person.

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[69] The loading begins at 7.5% in 2019–20 and will steadily reduce over five years (NDIA 2019a).

These improvements to the stream were first introduced in Tasmania and South Australia in November 2018, followed by Victoria and New South Wales in conjunction with the implementation of the Complex Support Needs pathway (NDIA 2018b). The NDIA is currently evaluating the Tasmanian and South Australian sites.

Pilot to improve access and planning decisions

The Independent Assessment Pilot was a voluntary assessment process for people with autism spectrum disorder, intellectual disability and psychosocial disability who were seeking access to the NDIS, new participants who had yet to develop a plan and those who were approaching a scheduled plan review (NDIA 2019c). It was aimed at improving the consistency, accuracy and reliability of access and planning decisions for participants with the targeted disability types (NDIA 2019a). Participants of the pilot underwent a functional impact assessment with an independent assessor using standardised assessment tools (NDIA 2018b, 2019c).

The Independent Assessment Pilot took place between November 2018 and April 2019 in New South Wales. Initial results showed a high level of engagement (opt-in rate of 70%) and participant satisfaction after completing assessments was also high (91% were satisfied or very satisfied) (NDIA 2019b). Feedback from planners and local area cooridnators was also positive. The NDIA has recommenced the pilot in October 2019 across a larger number of disability cohorts.

DRAFT RECOMMENDATION 12.3 — NDIS SUPPORT FOR PEOPLE WITH PSYCHOSOCIAL DISABILITY

The National Disability Insurance Agency (NDIA) should continue to improve its approach to people with psychosocial disability.

In the short term (in the next 2 years)

- The NDIA should complete the evaluations of the psychosocial disability stream trial sites in Tasmania and South Australia, and incorporate improvements into the stream, as soon as possible

- The psychosocial disability stream should be fully rolled out across all National Disability Insurance Scheme sites by end-2020

- Incorporate the lessons learnt from the Independent Assessment Pilot into the National Disability Insurance Scheme access and planning processes by end-2020.

12.4 Improving the delivery of psychosocial supports for people not in the NDIS

Australia has long suffered a shortfall in the provision of psychosocial supports, even prior to the advent of the NDIS. As previously discussed, only about 90–95 000 people were

receiving psychosocial supports from government-funded programs in 2016, well short of the 282 000 estimated by the National Mental Health Service Planning Framework (DoH 2017b). The introduction of the NDIS and the simultaneous withdrawal of funding for community mental health services by many states has likely worsened this gap in Australia's psychosocial support provision (cohealth, sub. 231, p. 17).

The large service gap that existed before the NDIS, and is becoming more acute, can be bridged in two ways. The first is to make the existing funding work more efficiently, while the second is to increase funding overall.

To help existing funding work more efficiently, the Commission has proposed that State and Territory Governments take on sole responsibility for the commissioning of psychosocial supports outside of the NDIS (chapter 23). This approach would clarify ambiguous governmental roles and decrease the number of separate funding streams to the benefit of providers of psychosocial supports. A single level of government would have visibility of the psychosocial support landscape and therefore overcome the issues around assessing need and planning around the need. This would also help to determine how much the funding needs to increase by in order to address needs.

While system changes can improve funding efficiency, the overall level of funding may need to increase as well. As previously discussed, there was a large service gap and improvements in efficiency will only go so far to bridge the gap. Needs should be assessed using an evidence-based framework, such as the National Mental Health Service Planning Framework, and funding levels should be matched to that level of need.

Interface with other services

To ensure that people receive the most appropriate supports for their needs, an important consideration is the boundaries, or the 'interface' between the NDIS and the mental health system, where the two systems meet and interact. Each system has different roles and responsibilities in the provision of mental health services in Australia.

A seamless interface between the Scheme and other services is a particularly important nexus for enhancing the social and economic participation of people affected by mental illness. It is a requirement that the support received by a NDIS participant is most appropriately provided and funded by the Scheme and not by another service or system (NDIS Act s. 34(f)). The NDIS is not intended to replace mainstream psychosocial support services, but to work alongside them (ANMF, sub. 317). NDIS supports are designed to complement the mainstream services, such as health, education, corrections, housing, justice, transport and safety (NDIA 2019e). It must be the case that incentives do not exist for individuals or service providers to preference one system over another. Otherwise, there may be undue pressure on one system to provide for too many people or some may miss out.

Creating an effective interface between the NDIS and the rest of the mental health system has been difficult as inter-system policies and operational guidelines were not established prior to rollout (Summer Foundation 2018).

The boundaries remain unclear

Interactions between the NDIS and mainstream services are guided by the 'Principles to Determine the Responsibilities of the NDIS vs Other Service Systems' (COAG 2015). The principles outline many of the linkages with supports that lie outside of the NDIS.

Despite the multitude of documents and legislation setting out boundaries that exist,[70] inquiry participants have stated that the interface remains underdeveloped, inhibiting agencies in reaching agreement on responsibility for service provision and clients missing out (CHA, sub. 463; NT Mental Health Coalition, sub. 430; Victoria Legal Aid, sub. 500). As acknowledged by the Victorian Government, 'Unclear delineation between the NDIS and mental health system … [has resulted] in scope creep, gaps in service provision and duplication of services' (sub. 483, p. 11).

Previous reviews have noted similar issues. The 2018 JSC inquiry *Market readiness for provision of services under the NDIS* found that the principles are subject to interpretation and lack clarity (JSC 2018b). The resulting boundary issues and funding disputes that have emerged affect access to services for NDIS participants and people with a disability who are not eligible for the NDIS (JSC 2018b, 2019).

The Commission's 2019 Review of the National Disability Agreement (PC 2019c) found that unclear service boundaries opened the door for strategic behaviour by the Australian, State and Territory Governments and the NDIA as they each have an incentive to use the uncertainty to cost-shift from mainstream services to the NDIS and vice-versa (PC 2017d, pp. 247–248). The NDIA has also reported instances of possible cost-shifting, scope creep and service gaps, including reports that mainstream services have refused entry to people they consider likely to be eligible for the NDIS and issues around a lack of accessible public transport options leading to an overreliance on NDIS-provided transport (NDIA 2017f, p. 81).

Recommendations from previous reviews include that the National Disability Agreement should set out the responsibilities of the Australian, State and Territory Governments to provide disability services outside the NDIS (PC 2019c) and that there should be work with the Council of Australian Governments Disability Reform Council to address boundary and interface issues (JSC 2018b, pp. xi–xii).

There is work underway by the Council of Australian Governments Disability Reform Council Mental Health Senior Officer Working Group to address a number of interface

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[70] Examples include: NDIS (Supports for Participants) Rules; Mainstream Interface Working Arrangements (for each State and Territory); Bilateral agreements between NDIA and some governments; and Practice Guidelines (by NDIA and some States and Territories).

issues between the NDIS and the mainstream mental health system (NDIA 2019e). In October 2019, the Senior Officers Working Group released an implementation plan for mental health and psychosocial disability interfaces to clarify and ensure that the principles are applied consistently to support the NDIS and the mental health system working closely together. This includes work on developing a nationally consistent approach to the coordination of roles and responsibilities of the NDIS and the mental health system in both hospital and community-based settings. This work is expected to be completed in December 2019 (COAG DRC 2019a, 2019b).

In future, it is important that the Australian mental health system reaches a stage where regardless of their NDIS status, people are able to access the supports they need.

13   Carers and families

<table>
<tr>
<td>Support for carers and families matters because …</td>
<td>

Almost 1 million carers provided regular assistance to a partner, family member or friend with mental illness in 2015.
This caregiving role provides great value to people with mental illness, carers and the broader community.
Caring also has costs — it affects some people's mental and physical health, social participation, career trajectory, educational attainment and financial security.
Carers are not the only ones affected by a family member's mental illness — children in families affected by mental illness may particularly need support.

</td>
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<tr>
<td>Successful intervention requires …</td>
<td>

Mental health professionals who are skilled and supported to provide family-focused and carer-inclusive care.
Carer support services that are accessible, effective and designed with input from carers.
Removal of barriers that affect mental health carers' access to Carer Payment and Carer Allowance.
A more effective service system for consumers that allows carers more choice about how much care they provide.

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Family members, partners and friends provide significant support to many people with mental illness, and this support is often critically important to their wellbeing and recovery. This caregiving role is often challenging, and as Mental Health Carers Australia (sub. 489, p. 3) noted:

> There are significant, well documented impacts on carers associated with the caring role, including but not limited to: emotional distress, depression, financial insecurity, employment insecurity and loss of connections with their own family, friends and community.

Governments assist carers by funding carer support services and income support payments. The Commission has heard that there is scope to improve access to these supports for mental health carers. Participants to the inquiry have also described how mental health professionals often fail to exchange information with carers that would contribute to the effectiveness of the support carers provide, and to the recovery of the person with mental illness.

Family and friends of people with mental illness who do not provide regular support and assistance may also be affected by the mental illness. Relationships within families and social networks can sometimes be strained as a result of the symptoms of mental illness, and children in families affected by mental illness may particularly need support.

This chapter examines reform options to improve supports for carers. Section 13.1 describes the experience of carers and family members of people with mental illness. Section 13.2 explores changes to income support payments for carers that would make them more accessible to mental health carers. Section 13.3 proposes improvements to carer support services and employment support services. Section 13.4 identifies how mental health services can better identify and support carers and family members of people with mental illness, and include carers as part of the care team.

13.1 Mental health carers provide a valuable contribution to the community

Who are mental health carers?

There were 2.7 million family and friend carers in Australia in 2015 — more than one in ten people (ABS 2015a). Approximately 976 000 (36%) Australians were caring for someone who had mental illness[71] (ABS 2016b) (figure 13.1). For 388 000[72] (40%) of these mental health carers, mental illness was the *main* condition of their main care recipient but for the majority of carers, mental illness was a comorbid secondary illness (ABS 2016b).

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[71] Of the 1.9 million carers who lived with their care recipient, 688 000 were caring for a person with mental illness, and of the people with mental illness that did not live with their carer, 38% had a mental illness.

[72] Diminic et al. (2017) found there were 240 000 carers of people whose main condition was mental illness. Their methodology differed in that they excluded carers of people with substance use disorder or under the age of 15 years.

The *Carer Recognition Act 2010* (Cth) defines a carer as someone who provides personal care, support and assistance to another individual who needs it because they have a disability, medical condition, mental illness or are frail and aged. They are typically relatives, partners or friends of the person needing support. Carers are also known as informal carers because the assistance they provide is on an unpaid basis. Paid carers and support workers are part of the formal mental health workforce (chapter 11).

A carer providing the most assistance to a person is called the primary carer. We know most about primary carers relative to other carers because the ABS Survey of Disability, Ageing and Carers focuses on them. There were approximately 242 000 people acting as primary mental health carers in Australia in 2015 — 72 000 (33%) were primary carers to someone whose *main* illness was a mental illness (ABS 2016b).[73]

Figure 13.1   **Who are Australia's mental health carers?**

976 000 people were mental health carers in 2015.
That's 4% of Australians and 36% of all carers.

... 388 000 people cared for someone whose *main condition* was a mental illness.

688 000 mental health carers lived with their care recipient:

12% were aged 15 to 24

18% were ageing carers - aged over 65 years

Carers were most likely to be providing care to their partner (39%), parent (31%) or child (18%).

41% lived outside a capital city

8% spoke a language other than English at home

23% had more than one care recipient

... 544 000 were of working age:

37% were employed full-time
23% were employed part-time
7% looking for work
34% not in the labour force

242 000 mental health carers were primary carers:

65% were female

33% cared for someone whose *main condition* was a mental illness

36% had been had been providing care for at least 10 years

40 hours of care provided on average per week

Source: Commission estimates using ABS (*Microdata: Disability, Ageing and Carers, Australia 2015*, Cat. no. 4430.0.30.002); Diminic et al. (2017).

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[73] This estimate only includes primary carers who co-reside with their care recipient.

Young carers are carers aged 25 years old and younger. Hamilton and Redmond (2019) reported that 5% of children aged 8 to 14 years old provided care to a family member who had mental illness or who were using alcohol or other drugs in 2014. These young carers were twice as likely as non-carers to speak a language other than English at home (Hamilton and Redmond 2019).

Inquiry participants described the types of support mental health carers provide:

> Mental health carers often act as the link between formal services and the person that they care for by encouraging help seeking behaviour, arranging appointments with services, contacting emergency services in crisis situations (MHCN, sub. 245, p. 16)

> Over her 3 years in Perth, one of us typically visited weekly to assist with cleaning, shopping, getting to class, Centrelink, Drs or psych appointments, general mood lifting and problem solving etc, and our other daughters provided 'respite' & 'crisis' accommodation when required … we saw how easily she would have slipped into homelessness without our support. Due to the BPD [borderline personality disorder], the challenge of dealing with these issues on her own was overwhelming and she would just avoid them. (Robert Davis, sub. 133, p. 11)

> My child (I believe) is one of the lucky ones. I have been the one to pick her up after suicide attempts, I have been the one to get her back after running away from a health practitioner session, I have been the one staying home making sure she ate, keeping the family together, dealing with outbursts and all the ups and downs that comes with it! I have been the one to research, fight and demand assistance for my child, to get people to listen. (Name Withheld, sub. 66, p. 3)

All carers typically provide a significant level of practical support. For mental health carers, this often includes navigating the complex mental health system and advocating for their care recipient to receive the services they need (Name Withheld, sub. 104). As a father in New South Wales (sub. 392, pp. 1, 9) put it:

> I am my daughter's advocate … My daughter constantly has stated … Nothing is working. Nobody is helping me.

How are mental health carers different from other carers?

Mental health carers have different needs and experiences compared with other carers due to characteristics associated with mental illness.

First, compared with carers of people with physical health condition as their main condition, mental health carers are more likely to provide emotional support and less likely to assist with activities of daily living, such as washing, dressing, or eating (Diminic et al. 2017). Emotional support does not just encompass providing encouragement, reassurance and managing behaviours. For mental health carers, this often includes the difficult tasks of guarding against self-harm and managing crises (Carers Victoria 2013). Parents described a very challenging part of their role — the vigilance needed to prevent their children from attempting suicide (Name Withheld, sub. 392; Robert Davis, sub. 133).

Sometimes, the symptoms of mental illness can strain relationships and this can make providing support more difficult and be very stressful.

> People with BPD experience relational dysregulation. This means that those who are closest to them are often subjected to the more extreme behavioural and emotional dysregulation. This is a burden that affects the mental health of these loved ones. (BPD Community, sub. 74, p. 3)

Further, the mental health caring role can be unpredictable. A characteristic common to mental illness is that symptoms are often episodic. Fluctuations in the duration and intensity of needs can make the caring role more challenging (Carers NSW, sub. 183; MHCTas, sub. 391; MIFA, sub. 343). A substantial share (27%) of primary mental health carers provided episodic care in 2015 but even for those providing continuous care, hours of care provided can increase significantly during an episode or crisis (ABS 2016b; Carers Victoria 2013). On days when they are not actively providing care, carers often remain on-call, in case support is required (Diminic et al. 2017).

Uncertain and sporadic care responsibilities can affect a carer's ability to juggle caring with employment and education (Mind Australia, sub. 380). Carers Australia described how:

> … structuring flexibility into jobs works best when carers are caring for people who, except in relatively unusual circumstances, have predictable care needs. Carers of people with unpredictable episodic conditions, especially when these episodes are frequent, may find it harder to plan their working responsibilities around their caring role. (sub. 372, p. 7)

Another differentiation of the carer's role is that mental illness typically has an earlier age of onset than many chronic physical illnesses (MHCN, sub. 245; Tandem, sub. 502). The toll on a mental health carer's life can be significant given that many are in this role for many years and often from a relatively young age.

Finally, stigma associated with mental illness can further complicate the role (Carers NSW, sub. 183; MHCTas, sub. 391). It contributes to isolation, a lack of understanding and reduced support from mental health services and the broader community, compared with what might be experienced by other types of carers:

> Many families, including carers within those families, find it hard to tell other people that they have a family member with a mental illness. They may feel that to do so would be a form of betrayal of that person. This is especially the case for carers in some culturally and linguistically diverse communities where, for cultural reasons, the level of stigma is very high. (Carers Australia, sub. 372, p. 7)

> Carers are still suffering isolation and poor health … Small town syndrome (stigma) for carers who live in rural towns is very real; they suffer in silence and eventually become a shadow in their own community. (LMMHCN, sub. 52, p. 2)

> [I]t is the stigmatisation and discrimination in the services that are supposed to be a support that hurts the most. From psychiatrists to nurses, to admin staff, help line personnel and social workers, discrimination is a unifying feature of the experience of all carers and people with BPD. (BPD Community, sub. 74, attach. 1, p. 1)

Differences in the roles and challenges faced by mental health carers compared with other carers translate into differences in the types of support they need from government, employers and the broader community.

Stigma contributes to 'hidden carers'

Hidden carers — people who do not identify as carers or who are not recognised as carers by service providers — often do not know that carer support services exist or how to access them.

Mental health carers often do not identify as carers, at least initially. People may associate the word 'caring' with the physical tasks related to assistance with daily living rather than the emotional and practical support that is more commonly provided by mental health carers. Also, care recipients may not realise their family member or friend is providing informal care.

The stigma associated with mental illness can lead to carers being less likely to talk about their situation with others. This means that informal supports and word of mouth about support services may be less common for mental health carers than other types of carers.

Certain types of carers are more likely to be hidden from services systems and miss out on support. Cultural norms about family responsibilities and stigma about mental illness leads to lower rates of service use among people from culturally and linguistically diverse backgrounds (Carers Victoria 2013; Diminic et al. 2017; MHCTas. sub. 391).

> In culturally diverse communities, care may involve the entire community and may provide additional challenges during the process of identifying who is a carer. (Tandem, sub. 502, p. 1)

Linguistically diverse carers may find it more difficult to learn information about support services or to engage with the complex terminology used for income support payment eligibility:

> Even Turkish speaking children did not know what the terms meant. Even the interpreters didn't know what some words meant, and I didn't understand some of the Turkish they were talking about. (Carers Victoria 2013, p. 58)

Young carers are another carer group who are more likely to be hidden from support and services, and often have unmet needs (Mind Australia, sub. 380; Tandem, sub. 502). They may not identify as carers or conceal their caring role because they:

- do not realise that what they do is any different to what occurs in other families

- fear anticipated stigma and bullying

- are concerned about intervention from child protection services (Hamilton and Redmond 2019).

It is reasonable that people identify as a mother or daughter or husband rather than as a carer. However, when they are not also recognised as a carer, then they can miss out on support

that would benefit them. For example, Mental Health Carers NSW (sub. 245, p. 18) described carers who 'prior to their contact with our organisation, did not know that they were eligible for income support based on their caring role, some of whom, had undertaken substantial caring responsibilities at significant personal cost for extended periods of time.'

To what extent is caring a choice?

Many carers value their caring role. Most have chosen to take on this role because they want to provide their loved one with support and because it is the best choice available for their family. The majority of primary mental health carers who were asked why they assumed a caring role stated it was due to family responsibility — 23% stated they had no other choice (ABS 2016b).

The decision to provide informal care depends on a range of factors, including: the person's preferences, their own situation (such as what type of job they have, whether they have child raising responsibilities), the needs of the person with mental illness and the availability and quality of appropriate formal care for that person. Hours of care provided by a carer also depends on these factors.

A *primary* caring role is typically equivalent to a full-time job. The average number of caring hours provided by all mental health carers (including primary carers) was 11 hours per week, whereas it was 40 hours per week for primary carers (Diminic et al. 2017). Time spent caring significantly reduces the time available for the carer to participate and thrive in the community, through employment, education and social interactions.

Some carers prefer to provide a significant level of care themselves regardless of services available or used by the consumer. Others would like to provide fewer hours if suitable service options were available. Several participants described how there was a lack of appropriate services available to meet the needs of their care recipient (LMMHCN, sub. 52; Mental Health Carers ARAFMI Illawarra, sub. 161; Name Withheld, sub. 66; Name Withheld, sub. 104; Name Withheld, sub. 392).

Tandem (sub. 502, p. 2) stated that mental health carers often have no option but to 'provide extensive social and practical support in the absence of support services'. When Diminic et al. (2017, pp. 89, 91) surveyed mental health carers, they heard that 'there is nowhere near enough support for mental health carers' and that carers were 'tired of filling … the shortfall in services'.

SANE Australia (sub. 130) and Mind Australia (sub. 380) observed that while the shift from institutional care to community-based care over recent decades is positive, it has resulted in an increased reliance on informal carers. The transition to the National Disability Insurance Scheme (NDIS) has reduced access to psychosocial supports for people not eligible for that program (chapter 12), and may be contributing to increased demand for informal care.

For young carers it is less clear that providing significant hours of care is their choice to make. The Commission heard from participants about many young carers who have taken on this role (Carers Victoria, sub. 461; HelpingMinds, sub. 470, Mind Australia, sub. 380). Carers Australia (sub. 372, p. 9) provided extracts from applications for the Young Carer Bursary program, which it administers, including this story from a 14 year old boy:

> It is just Mum, me and my brothers living at home. I have been caring for my family since I was 8 years old. Mum suffers from drug addiction and mental illness. Because Mum is sick, it is up to me to get my brothers up and ready for school, including making lunches, breakfast, getting them ready and getting them to school. I also have to take them to appointments, clean the house, make dinner. I also care for Mum which includes personal care, and providing heaps of emotional support. I get worried about keeping everyone safe and sometimes I can't sleep from worry and being scared.

Although the Commission is recommending changes to policies that directly affect carers (discussed below), carers will also benefit from reforms proposed elsewhere in this report that aim to improve access to the right mental health services, at the right time and place. A more effective service system for mental health consumers would give carers more choice in how much care they provide and reduce the stressors related to caregiving.

> … the best outcomes are achieved when caring is a choice, rather than a sacrifice made in the absence of any other satisfactory alternative to ensure that a loved one receives support. (MHCN, sub. 245, p. 3)

The benefits for carers from the draft recommendations elsewhere in the report are discussed in chapter 26.

The effects of caregiving

Benefits of caregiving

The value to the community of the informal care provided by mental health carers is immense. They provided over 200 million hours of care in 2015, which would have cost tax payers $13.2 billion to replace with formal support services that were fully-funded by government (Diminic et al. 2017).

For some people living with mental ill-health, the support they receive from family and friends is irreplaceable. Tandem (sub. 502, p. 3) pointed out that if 'a carer is no longer able to provide ongoing support, the person with mental illness can become more at risk of hospitalisation, homelessness and suicide'. Chamberlain and Johnson (2011) found that the ongoing support from family was an important factor in preventing young people with mental ill-health from becoming homeless.

The benefits of caring described above — reduced expenditure on government-funded services and reduced homelessness — are tangible and measureable. Other benefits for both carers and consumers, although very real, are more difficult to measure:

[Informal care] provides numerous intangible benefits which are difficult for formal services to replicate. The sense of personal connection and belonging generated by positive informal support networks is critical to the recovery process … Some carers report that caring can be a rewarding experience and many derive a sense of pride and accomplishment from their caring role. In some circumstances, relationships between family members can be strengthened when they are able to cooperate to overcome difficult circumstances. (MHCN, sub. 245, pp. 3, 8)

Costs borne by carers

Time and effort spent providing informal care imposes costs on some carers — including costs to their health and financial security. Mental Health Carers Tasmania (sub. 391) stated that the 'practical, physical, economic and emotional demands of supporting a loved one with a mental illness can be enormous'.

The costs of caregiving vary and many carers report little or no strain. Carers who provide care to someone with severe disability or who also work full-time are more likely to be significantly affected by their caregiving role (Carers Victoria 2013; Diminic, Hielscher and Harris 2018; Kenny, King and Hall 2014).

The physical, emotional and mental costs of caregiving

Edwards et. al. (2008) reported that carers experienced clinical levels of depression at a rate 77% higher than the general population. Being a carer of a person with mental illness or another cognitive or behavioural condition can be particularly stressful and have a larger effect on mental wellbeing (table 13.1).

The challenges faced by mental health carers were evident in the stories they shared with the Commission:

My husband and I have had many sleepless nights, whether because we are worried about what she might do to herself while we are asleep, or waking to hear her distraught hysterical crying. (Anonymous Parent, sub. 399, p. 3).

In the past 18 months I've observed my daughter's decline. It's a nightmare that evolves and it's getting more frightening … I'm already stretching my emotional and mental limitations. (Name Withheld, sub. 392, pp. 24, 29)

Carers are more likely than their peers to have physical health problems. Kenny, King and Hall (2014) found that females providing 20 or more hours of care per week had poorer physical functioning after two years as a carer relative to non-carers in an otherwise similar life situation. Edwards et al. (2008) found that 29% of carers were in poor health compared with 17% of the general population.

Table 13.1   The emotional and mental costs of caregiving

	Primary carers of people with:[a]					
Indicator	mental illness (main condition)	mental illness (secondary condition)	other behavioural or cognitive conditions	physical conditions	All carers[b]	Not a carer[b]
	%	%	%	%	%	%
Kessler 10 indicator of psychological distress:						
Low distress level	35	38	40	50	60	74
Moderate distress level	30	30	26	28	25	18
High distress level	17	19	22	14	11	6
Very high distress level	17	13	13	8	4	2
Effects explicitly attributed by carers to caring:						
Had a stress-related illness	12	17	15	7	..	..
Feels weary or lacks energy	35	39	50	31	..	..
Feels worried or depressed	33	34	33	23	..	..

a In 2015. **b** In 2007. **c** .. not applicable.

Source: Commission estimates using ABS (*Microdata: Disability, Ageing and Carers, Australia 2015*, Cat. no. 4430.0.30.002; *Microdata: National Survey of Mental Health and Wellbeing Basic and Expanded CURF* 2007, Cat. no. 4326.0.30.001).

Lower labour force participation and productivity

As expected, time spent caring means less time available for employment. Working age mental health carers were 24% less likely to be employed than non-carers, and were more likely to be working part-time (Diminic, Hielscher and Harris 2018, p. 65). It is not straightforward to attribute effects of caring on employment but some studies have attempted to do this. Bittman, Hill and Thomson (2007) found that caring results in fewer hours worked and lower labour force participation. Ciccarelli and Van Soest (2018) found consistent results for 15 European countries, and noted a larger effect on female carers.

Some carers would like a job or to work more hours (figure 13.2). There are a range of reasons why carers were not in work or were working part-time, including raising children and retirement. However, a third of unemployed mental health carers stated that they stopped work because of their caring role (figure 13.2).

Lower labour force participation has flow-on effects. At the community level, it reduces economic growth and tax revenue and can raise government expenditure on income support. On a personal level, it not only affects income, but also precludes other benefits of employment. For example, Mind Australia (sub. 380) described the social connection and feelings of empowerment and achievement that employment can provide.

Figure 13.2

Some statistics on labour market transitions and aspirations
Primary mental health carers[a]

| 41% | 35% | 33% | 42% |
| Employed carers who reduced working hours due to caring role | Part time carers who would like to work more hours | Unemployed carers who stopped work due to caring role | Unemployed carers who would like to work |
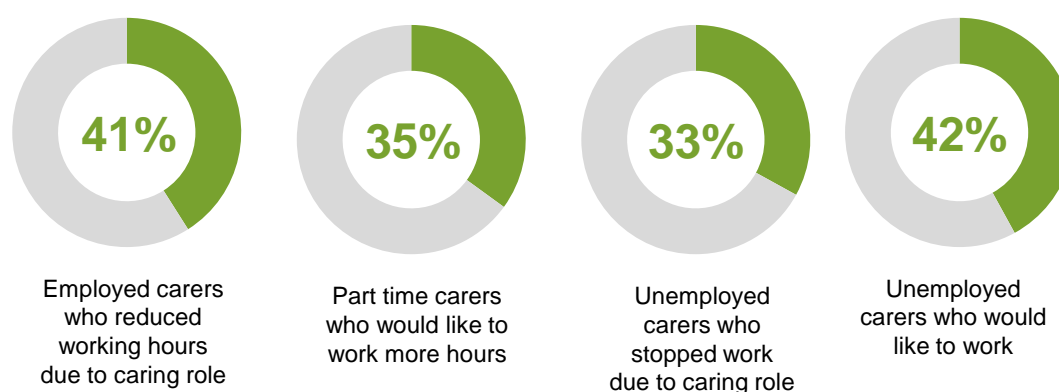
a For working-age co-resident primary carers of people whose main condition was mental illness.
Source: Diminic, Hielscher and Harris (2018), table 2.4.

Lower labour force productivity and educational attainment is also associated with caring. Mental health carers were more likely to be in low-skilled occupations than other types of carers and non-carers in 2015 (Diminic, Hielscher and Harris 2018). A survey undertaken by Carers Victoria (2013) found that the caring role affected some carers' performance at work and led others to switch to a lower paying job.

Absenteeism from work is higher for carers than non-carers. In 2007, 44% all mental health carers had experienced at least one day out of their job in the previous 30 days (Pirkis et al. 2010). For working aged primary mental health carers, 14% had had to leave work for three months or more to care (Diminic, Hielscher and Harris 2018). One carer described his experience juggling caring and work responsibilities:

> I have had to take significant time off work (have utilised a large portion of my accrued sick leave) and my wife has taken a year's leave without pay, so as we can afford our daughter every opportunity to support/care, manage flare ups, attend to appointments/meetings and reintegrate back into mainstream society (Name Withheld, sub. 392, p. 2)

Reduced engagement in education and work for young carers

Disruptions to education and employment due to caregiving responsibilities are particularly consequential for young carers. For young people in general, not being in education and/or work at such an important time of transition and skill development is associated with increased vulnerability to their career and broader wellbeing throughout their life (McClure, Aird and Sinclair 2015).

Several studies have found that young carers generally are at risk of poorer educational outcomes than their non-carer peers. Warren and Edwards (2016) found that difference in

Year 9 NAPLAN results between young carers with significant responsibilities and other children was equivalent to more than one year of schooling. Cass et al. (2011) reported that young carers (and potential young carers who did not identify as carers in the 2006 census) were less likely than their peers to be participating in either education or employment.

Outcomes are even worse for young mental health carers. Hamilton and Redmond (2019) found that children aged 8 to 14 years old who were caring for someone with mental illness were less engaged in school than non-carers and carers of people with a physical disability or chronic illness. Young mental health carers aged 5 to 14 years were more likely to not be attending school than other carers and non-carers of the same age (Diminic, Hielscher and Harris 2018). Labour force and education participation of young carers aged 15 to 25 years was also worse for young mental health carers compared with other carers and non-carers (Diminic, Hielscher and Harris 2018).

Poorer educational outcomes for young carers reflect lack of time to do their homework; being late to, or missing, school more often; worrying about their care recipient while at school; and lower participation in extra-curricular activities (Hamilton and Redmond 2019).

The effects of being a young carer are often compounded by other risk factors for poor educational attainment. Young carers aged 8 to 14 years old were twice as likely as non-carers to live in a materially deprived household (Hamilton and Redmond 2019). Some of these risk factors for school engagement, such as low household incomes, apply to children without caring responsibilities in families experiencing mental illness (discussed below).

Effects on income and financial hardship

Less time in formal employment affects carers' incomes and savings and can contribute to financial hardship (figure 13.3) (Carers Victoria, sub. 461; MHCA, sub. 489; MHCTas, sub. 391; Mind Australia, sub. 380; Tandem, sub. 502).

Compounding the negative effects of caring on income, carers also tend to incur expenses associated with their caring role that are over and above what can be covered by the income of the person they are caring for (Carers Victoria 2013). Costs include those related to healthcare for the person they are caring for, the cost of travelling to appointments, and property damage and debts associated with symptoms of mental illness (BPD Community, sub. 74; Carers Victoria, sub. 461; LMMHCN, sub. 52; Montelukast (Singulair) Side Effects Support and Discussion Group, sub. 197; Name Withheld, sub. 104; Robert Davis, sub. 133).

> I was hit with the harsh fact I had to quit my job to nurse my child around the clock, while accumulating regular considerable medical expenses, losses, and property damage repairs. (Carers NSW, sub. 183, p. 5)

> The whole process is time consuming and costs me a great deal of time off work, and with ongoing expenses out of my pocket that are not covered for mental health services, no one can

afford these on a disability pension. If I was not able to assist my child with these expenses, they would be unable to attend! (Name Withheld, sub. 66, p. 2)

More than a third of primary carers of people with mental illness or other cognitive and behavioural conditions experienced difficulties meeting everyday living costs (compared with a quarter of carers of people with a physical condition) (ABS 2016b).

Reduced social participation

Less time in work, increased time spent in the home providing informal care and stress can reduce time for social participation, strain relationships of the carer with their family and friends, or lead to social isolation (figure 13.4).

Figure 13.3   Financial costs of caregiving
Primary mental health carers who co-reside with their care recipient

Carers who had income decrease or expenses increase due to caring role — **60%**

Carers who had difficulty meeting everyday costs due to caring role — **35%**

Source: Commission estimates using ABS (*Microdata: Disability, Ageing and Carers, Australia 2015*, Cat. no. 4430.0.30.002).

Figure 13.4   Social costs of caregiving
Primary mental health carers who co-reside with their care recipient

27% had not participated in social activities away from home without their care recipient in the previous 3 months

28% relationship with their care recipient was strained

43% relationship with the other family members in their household was strained or they had less time to spend with them

31% had lost or were losing touch with existing friends
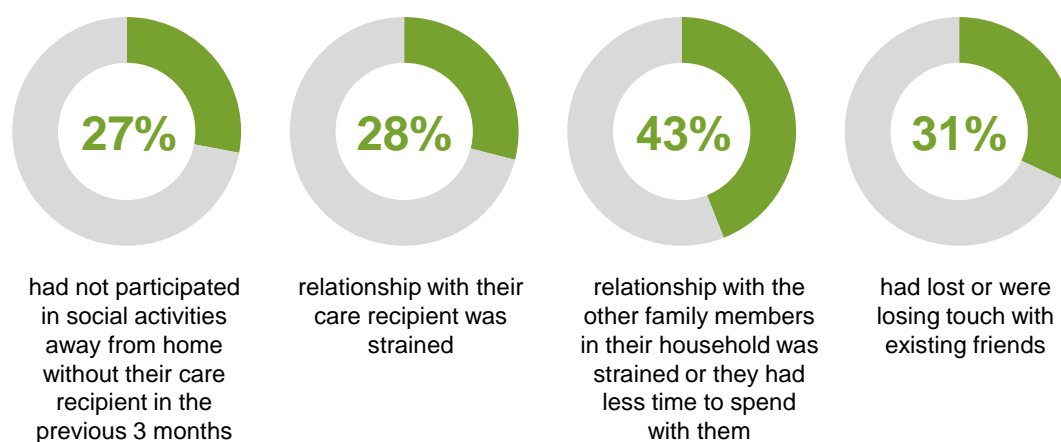
Source: Commission estimates using ABS (*Microdata: Disability, Ageing and Carers, Australia 2015*, Cat. no. 4430.0.30.002).

Figure 13.4   **Social costs of caregiving**
Primary mental health carers who co-reside with their care recipient

The costs associated with carers experiencing stress, poor health or financial hardship extend to carers' families and the broader community. Carers who do not receive support when they need it may come to need mental health services for themselves. Moreover, if burnt-out carers become unable to continue their caring role this would lead to greater demand for formal mental health services for the person receiving care.

Costs to families affected by mental illness

People may be affected by their family member's mental illness regardless of whether they are also carers. For example, children may face risks to their education due to the stressors related to growing up with a sibling with mental illness (Siblings Australia, sub. 124). Stigma associated with mental illness can affect any family member, not just carers.

Having a family member with mental illness can affect family relationships and dynamics (Robinson, Rodgers and Butterworth 2008). Parents described how their child's illness affected the household's relationships and functioning:

> It was an incredibly stressful period without any path forward that pushed both myself and my husband close to breaking point. It increased the arguments between us as we couldn't agree on how to solve the issue … Frequently when my husband got home from work he would just go straight to bed, without even eating dinner. Basic life tasks broke down — the housework piling up, eating takeaway and fast food rather than healthy home cooked meals, sometimes not leaving the house at all. (Anonymous Parent, sub. 399, p. 3)

> Throughout my child's struggle, I have found little understanding and support for myself and my other children – who have also suffered through this time. (Name Withheld, sub. 66, p. 2)

One of the most vulnerable groups are dependent children of a parent with severe mental illness. An estimated one fifth of children and young people live with a parent who has mental illness (Reupert, Maybery and Kowalenko 2012). The symptoms of and treatment for mental illness can disrupt parenting and a family's daily life, and risk factors associated with mental illness — such as insecure housing, poverty and lack of social supports — can contribute to adverse outcomes for children (Maybery et al. 2009; Mowbray et al. 2006; Reupert, Maybery and Kowalenko 2012; Rutter and Quinton 1984).

Adolescents aged 10 to 14 years in New South Wales whose parents had used state and territory mental health services in the five years prior were: more likely to enter out of home care, more likely to interact with the justice system, less likely to finish high school and more likely to have a alcohol and other drugs related hospital admission in the future (Taylor Fry 2018).

Government objectives and responsibilities

The Australian, State and Territory Governments have shared responsibilities for supporting mental health carers.

Governments have recognised the valuable contribution informal carers make to the community and the risks that informal care poses to their wellbeing. One of the directives under the *National Mental Health Policy 2008* (agreed to by all governments) states that the crucial role of carers 'will be acknowledged and respected and provided with appropriate support to enable them to fulfil their role' (AHMC 2009). According to the *Mental Health Statement of Rights and Responsibilities 2012* (Standing Council on Health 2012), carers and support persons have the right to:

- comprehensive information, education, training and support to facilitate their caring role

- receive services that assist them to provide care and support

- receive support for their own difficulties that may be generated as a result of caring

- participate in treatment decisions, and seek and receive additional information about the mental health consumer's support, care, treatment, rehabilitation and recovery (with the consent of the mental health consumer).

To recognise the importance of carers leading a meaningful and contributing life, the Fifth National Mental Health and Suicide Prevention Plan includes the proportion of mental health carers in employment as one of its 24 performance indicators (COAG Health Council 2017b).

Other commitments to support carers exist outside of mental health policy. The Australian Government and most State and Territory Governments, except Tasmania and the ACT have introduced legislation to recognise the contribution and role of carers. For example, the *Carer Recognition Act 2010* (Cth) states that all carers should have the same rights, choices and opportunities as other Australians.

These stated objectives provide a good basis for assessing the effectiveness of current programs and services for carers. Government supports for carers include:

- income support payments, namely the Carer Payment and Carer Allowance (section 13.2)

- carer support services, such as:

  – information about caring, mental illness and the service system

  – respite services

  – counselling and peer support (section 13.3).

Mental health services should also consider the needs of a consumer's family and carers, and families affected by mental illness may benefit from family support services or family therapy (section 13.4).

13.2 Income support payments for carers

Which income support payments are relevant to mental health carers?

Three quarters of primary mental health carers received a government pension, allowance or benefit in 2015, the most common being the Carer Payment and Carer Allowance (ABS 2016b). Some carers receive the Age Pension, Newstart Allowance or Youth Allowance instead of Carer Payment. Carers unable to meet the eligibility criteria for Carer Payment may apply for the Newstart Allowance and, because of their caring role, they may be exempted from mutual obligation requirements that typically apply to this payment (DSS 2019b). Some carers may also be eligible for the Health Care Card if they care for someone under the age of 16 (DSS 2018m).

Some State and Territory Governments also provide financial support to carers. For example, the Victorian Government funds Tandem, a mental health carers peak body, to administer the Mental Health Carer Support Fund, which provides financial assistance for costs associated with caring (Tandem 2018). Carers in Victoria also receive benefits associated with the Carer Card (Carers Victoria, sub. 461).

Carer Payment and Carer Allowance

Carer Payment and Carer Allowance are fortnightly income support payments for carers of a person with a severe disability or medical condition or who is frail due to old age. Approximately a third of all Carer Payment and Carer Allowance recipients cared for someone with a psychological or psychiatric condition as their main condition (table 13.2).

Expenditure on mental health carers was approximately $1.4 billion on Carer Payment and $711 million on Carer Allowance in 2017-18. As at December 2018, 198 500 carers of a person whose main condition was a psychological or psychiatric condition received *either* Carer Payment or Carer Allowance and 68 600 of these carers received *both* payments (pers. comm., DSS, 31 May 2019).

Both payments have two streams: one for carers of adults and one for carers of children below 16 years of age. Although rates of payment are the same, different rules and eligibility exist for the adult and child streams. For example, a carer who qualifies for Carer Payment (child) receives Carer Allowance automatically for that child but the same rule does not apply for Carer Payment (adult). This rule was implemented after a review of the child streams of carer payments in 2007 (Carers Victoria 2013). However, unlike the child version of the payments, the design of the adult versions of Carer Payment and Carer Allowance have not been comprehensively reviewed since 1999 (Campbell 2018).

Table 13.2   Receipt and funding of income support for carers
Mental health carers and all carers

	Care recipients of carers receiving a payment, as at March 2019[a]		Expenditure 2017-18	
	Any medical condition	*Main condition is psychological or psychiatric condition[b]*	*Any medical condition*	*Main condition is psychological or psychiatric condition[d]*
	persons	persons	$ million	$ million
Carer Payment	278 212	74 757 (27%)	5 390[c]	1 448
Carer Allowance	671 536	212 696 (32%)	2 246	711
Carer Supplement	na	na	591	188
Total	..	..	**8 227**	**2 347**

a This count of care receivers overestimates the number of carers receiving a payment *at a point in time* because some carers become eligible because of the care they provide to more than one person. Total number of people receiving Carer Payment, Carer Allowance and Carer Supplement *throughout* 2017-18 was 274 414, 622 423 and 642 537 respectively. **b** Based on medical condition listed first by applicant. **c** Includes Commonwealth Rent Assistance **d** Commission estimates based on the proportion of care recipients who have a psychological or psychiatric illness (27% and 32%). **e na** not available **..** not applicable.

Source: Commission estimates using DSS (2018f; 2019n).

The objective of the Carer Payment is to provide income support for people who are unable to support themselves through substantial paid employment due to the demands of their caring role (DSS 2019a). Carer Payment is classified as a pension and paid the highest rate of income support payments. As at 20 September 2019, the maximum rate was $933.40 for a single person per fortnight and $703.50 for a person in a couple — the same rate as the Age Pension and the Disability Support Pension (DSS 2019g).

Carer Allowance is an income supplement in recognition of the costs of caring (currently paid at $129.80 per fortnight) (DSS 2019f). Anyone who receives Carer Payment or Carer Allowance automatically receives the Carer Supplement — an annual lump sum payment of $600 for each eligible payment to assist with the costs of caring (DSS 2019d).

Eligibility for both payments is prescribed in the *Social Security Act 1991* (Cth). Table 13.3 summarises the eligibility rules relevant to the discussion below. Other details can be found in the Act, such as the eligibility for carers who have more than one care recipient.

Carer Payment is means tested — income and asset tests apply to both the carer and their care recipient. Taper rates apply so that the payment level reduces as fortnightly income earned increases. Over a fortnight, a single carer's payment is reduced by 50 cents for every dollar earned over $172. For couples, every dollar earned over $304 will reduce the Carer Payment in the same way (pers. comm. DSS, 27 March 2019).

Scope to improve payments for mental health carers

Despite there being a system of income support payments, some carers are experiencing financial hardship. In 2015, one in three primary mental health carers reported having difficulty in meeting everyday costs due to caring and one in four needed more financial assistance (figure 13.3 and table 13.5).

At a high level, the shortcomings raised about Carer Payment and Carer Allowance fell into two categories. Many participants, including Private Mental Health Consumer Carer Network (Australia) (sub. 49) and Carers Australia (sub. 372), described how mental health carers are disadvantaged from accessing Carer Payment and Carer Allowance relative to carers of people with a physical disability. BrainStorm Mid North Coast (sub. 309) and Caring Fairly (sub. 427) considered the level of payment to be insufficient, especially to enable carers to save.

Mental health carers are disadvantaged in accessing Carer Payment and Allowance

The design of the Adult Disability Assessment Tool (ADAT) and other eligibility rules related to frequency and location of care can disadvantage mental health carers from accessing income support.

The Adult Disability Assessment Tool

One of the main eligibility tools for the adult stream of the Carer Payment and Carer Allowance is the ADAT. The ADAT contains two questionnaires, one to be completed by the carer and another by a health professional treating the care recipient. Each multiple choice response in the questionnaires is given a score and the scores are summed to measure the amount of help the care recipient needs to undertake daily activities. The questions and scores are set by the Adult Disability Assessment Tool Determination 2018[74].

The two ADAT questionnaires each have three sections intended to capture the types and intensity of care that a carer provides to their care recipient. The first section assesses activities of daily living (ADLs) (including washing, dressing, or eating), the second relates to cognitive function and third asks about behaviours and symptoms related to mental illness.

Inquiry participants were critical of the ADAT's focus on ADLs relative to care tasks commonly performed by mental health carers (Brian Shevlane, sub. 147; Carers Australia, sub. 372; Carers NSW, sub. 183, Carers Victoria, sub. 461; Peter Heggie; sub. 72).

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[74] The children's equivalent of the ADAT is the Disability Care Load Assessment (Child) Determination 2010. Participants did not raise specific concerns about the assessment form for carers of children with a disability or serious illness.

The first section is narrow in its focus, with a large weighting to basic self-care and less focus on broader activities sometimes referred to as 'instrumental ADLs'. For example, the ADAT does not include questions about support required to organise and attend appointments or need for assistance with household chores.

Even so, the section on ADLs is often relevant to mental health carers because points are scored for coaching and supervision of these activities. However, this can be missed by carers and health professionals filling in the forms because some of the questions are not worded in a way that is relevant to mental health carers. For example, Mental Health Carers NSW (sub. 245) noted that 'cannot walk' does not adequately encapsulate 'needs emotional support to get out of bed'.

A Carers Victoria (2013) review of Carer Allowance and Carer Payment noted that the second section on cognitive functioning in the health professional's questionnaire is skewed towards symptoms of dementia but does not ask questions about symptoms of psychosis, such as hallucinations or delusions.

Participants described how the third section is narrow in the symptoms of mental illness that it asks about and the weightings may underestimate the intensity of care provided (Carers Victoria 2013; MHCN, sub. 245). Carers Australia (sub. 372, p. 4) stated that it is:

> … very difficult for the care needs of someone with an episodic mental illness to score a qualifying ADAT. For example, a person who is scored by a professional as sometimes depressed, sometimes withdrawn and sometimes aggressive will get an ADAT of 7, with a minimum score of 8 for Carer Payment and 12 for Carer Allowance required to qualify.

In contrast to the questions on ADLs, which ask about the level of support required to support the care recipient, questions on behaviour ask how often certain behaviours occur. This makes it harder for some mental health carers to reach the required score because the time they spend maintaining vigilance and supervision to *prevent* certain behaviours, such as self-harm, is not counted.

Finally, the health professional's report portion of the ADAT can be completed by a medical practitioner, registered nurse, physiotherapist, occupational therapist, member of an Aged Care Assessment Team or an Aboriginal health worker in a geographically remote area (DHS 2018c). Psychologists are not on this list but are listed on the equivalent form for care recipients under the age of 16 (DHS 2018b).

Restrictions on location and frequency of care

Carer Payment eligibility allows recipients to work, study or volunteer for up to 25 hours a week (including travel time). This is called the '25 hour rule'. In addition, temporary cessation of care provisions allow carers to take 63 full days off from constant care for any purpose throughout each calendar year.

Eligibility restrictions on location and frequency of care have been relaxed significantly since the payments were first introduced (Edwards et al. 2008). For example, rules were relaxed in 1993 to allow carers to work or study for 10 hours a week, and this increased to 20 hours in 1997 and then to the current limit of 25 hours in 2005 (Edwards et al. 2008).

Still, the existing package of eligibility restrictions on location and frequency of care may not be the best indicators of whether a carer (especially a mental health carer) is unable to support themselves through employment due to their caring role. Diminic, Hielscher and Harris (2018, p. 40) examined the relationship between hours of care provided and employment status for mental health carers and found that 'caring for as few as 10 hours per week was significantly related to not being employed compared to [caring for] fewer hours'. Although the Commission is sensitive to the need to prevent people from claiming benefits to which they are not entitled, this risk must be balanced against the objective of providing income support to carers who are unable to sustain substantial employment due to their caring role.

Regarding location of care, the rationale for the requirement that care must be provided *in the home of the care recipient* to be eligible for Carer Payment is unclear. Care activities that may be provided outside of the care recipient's home include emotional support provided by telephone, time spent out of the home attending appointments, and time spent paying bills or preparing meals. People between 15 and 64 years whose main condition is a mental illness were more likely to have a carer who did not reside with them in 2015 (38%) compared with physical conditions (33%) and cognitive or behavioural conditions (22%) (ABS 2016b).

There is an additional restriction on location of care for Carer Allowance that aligns poorly with the care tasks of mental health carers. For carers who do not reside with their care recipient to be eligible for this payment, they must be providing care that relates to the care recipient's bodily functions or to sustaining their life (s. 954A).

The eligibility restriction related to frequency of care disadvantages carers of people with episodic conditions. Several participants wanted the design of income support payments to carers to take this attribute, common to mental illness, into account (Carers Australia, sub. 372; MHCN, sub. 245; Tandem, sub. 502).

The only mention of episodic care in the carer application form is insensitive and unhelpful. It states that where the person's condition is episodic, questions should be answered as if the person is experiencing a 'good day', not a 'bad day' (DHS 2017). This assumes 'bad days' are more infrequent than 'good days'. The answers should instead reflect care usually provided.

The use of the term 'constant care' is also not helpful in the context of episodic care. The carer questionnaire clarifies that constant care 'means you provide personal care for a significant time each day (at least the equivalent of a normal working day) … care may include supervision and monitoring'. Although the Social Security Act specifies that this excludes the 25 hours a week that can be used to attend work or education and the 63 temporary cessation of care days, this is not clear from the wording in the form.

Participants objected to the 25 hour rule for several reasons, some of which apply to mental health carers more than other carers. The general criticism was that the restriction on hours of work, volunteering and education was a perceived disincentive for carers looking to enter the workforce or develop their career prospects (MHCN, sub. 245). Although temporary cessation of care provisions can be used to prevent carers from exceeding the 25 hour rule and having their payment cancelled, this may not be clear to carers considering a temporary increase in their hours of work or study (DSS 2019c).

Given that the Carer Payment is also means tested, the purpose of the 25 hour rule appears to be a check that carers are actually providing a significant amount of care. However, it is an imperfect control because (a) it asks carers about time spent on some activities but not all (such as leisure time) and (b) it does not account for the episodic nature of some mental health care needs.

Caring Fairly (sub. 427), Mental Health Carers Australia (sub. 489) and Tandem (sub. 502) were concerned about the effect this rule has on carers of people with episodic conditions. Some of these carers would be willing and able to work more than 25 hours a week when their care recipient is well but experience unpredictable periods where caring responsibilities intensify and financial support consistent with a pension is needed.

The 25 hour rule also ignores the fact that many mental health carers are effectively 'on-call' to the person for whom they are providing care, even when they are not actively providing care (Diminic, Hielscher and Harris 2018). With opportunities for online education and working from home now more prevalent, there may be periods where carers can provide a significant amount of care while working, studying or volunteering for more than 25 hours a week.

The effect of the 25 hour rule on young carers is particularly problematic (Mind Australia, sub. 380; One Door Mental Health, sub. 108). The rule may require school-aged and other young carers from low income families to choose between pursuing full-time education or receiving less income support for their family.

Reform options

The Commission has focused on identifying reform options that would reduce unreasonable barriers that affect mental health carers from accessing Carer Payment and Carer Allowance. Broader changes to Carer Payment, Carer Allowance and Carer Supplement may be warranted. But as any such reforms would affect all carers, not just mental health carers, they are considered beyond the scope of this inquiry. That said, the Commission has suggested principles that should be considered if there was a broader review.

The ADAT is clearly in need of reform. It is not appropriate for mental health carers for the reasons outlined above. Moreover, since the ADAT was developed in 1999, the importance of psychosocial support in supporting a person with a severe illness has received greater attention. For example, in 2001 the World Health Organisation released the first iteration of

the International Classification of Functioning, Disability and Health. This classification includes domestic responsibilities and a person's ability to look after their health and participate in the community as relevant to their overall functioning (WHO 2013a).

The Australian Government Department of Social Services (DSS) commenced a review of the ADAT and started field testing new questions in September 2016 (DSS 2018i). Field testing of questions with carers and health professionals continued into 2018. Mental Health Carers NSW (sub. 245) reported that the revised ADAT questions that were field tested are better suited to assess the care responsibilities of mental health carers. However, as of July 2019, the analysis of the ADAT field tests was ongoing and next steps for the review had not been announced (DSS, pers. comm., 16 July 2019). Once new questions are finalised, new weightings will also be required and these should be developed in consultation with carers and health professionals.

As part of the review, DSS should also update the list of professionals allowed to complete the health professionals report to include others of relevance to mental ill-health, such as psychologists and social workers. Both of these occupations work closely with people with mental illness and provide structured psychological therapies. A broad list of professionals is preferable because this improves the likelihood that the carer can bring the form to someone who has a good understanding of the carers' role and who has the skills to seek consent from the care recipient to share their personal information with the carer and Centrelink. It should not be assumed that these qualities exist in all health professionals (section 13.4).

Beyond the ADAT review, additional changes to the eligibility of Carer Payment and Carer Allowance are also warranted in order to create equitable access to these payments for mental health carers. Proposed changes are summarised in table 13.3. For example, the restrictions on location of care should be eased so that *some* care provided outside of the care recipient's home can be counted towards the care provided. The details of how much care provided outside the care recipient's home is appropriate should be determined by DSS in consultation with carers.

The 25 hour rule should not continue in its current form. The costs of preventing a carer willing and able to invest in their education from doing so are difficult to justify. Maintaining a restriction on work and volunteering hours only may assist with managing risks to the integrity of Carer Payment. However, there is need to allow more flexibility for people providing episodic care. A change to the time period over which work and volunteering is assessed would achieve this — that is, a change from 25 hours per week to 100 hours per month.

Table 13.3 **Current and proposed eligibility criteria for Carer Payment and Carer Allowance**

For carers of an adult with a serious illness or disability

	Current		*Proposed*	
Criterion	*Carer Payment*	*Carer Allowance*	*Carer Payment*	*Carer Allowance*
Frequency of care[a]	Constant care. Work, study and volunteering cannot exceed 25 hours per week.	Care and attention on a daily basis.	**Regular** care. **Work and volunteering** cannot exceed **100 hours** per month.	**Regular** care.
Expected duration of care	For a minimum period of 6 months unless the condition is terminal	For a minimum period of 12 months unless the condition is terminal	No changes proposed	No changes proposed
Place of provision of care[a]	In a private residence that is the home of the care recipient	In a private home that is the residence of the carer and care recipient *or* if the care recipient and carer do not co-reside, then the care must be in the care recipients home and must: relate to the care recipient's bodily functions or to sustaining their life, be provided for at least 20 hours a week and be received in a private home	Care is **usually** provided in private residence that is the home of the care recipient.	Care is **usually** provided in private residence that is the home of the care recipient.
Intensity and types of care	Minimum ADAT[b] score of 25 points, including 10 from the health professional's report	Minimum ADAT[b] score of 30 points, including 12 from the health professional's report	Minimum ADAT[b] score to be determined following review.	Minimum ADAT[b] score to be determined following review.
Income test	Equal to that for Age Pension[c]. Another test applies to care recipient's income.	Threshold is $250 000 in annual family income.	No changes proposed	No changes proposed
Assets test	For carer: same annual thresholds as Age Pension[d]. Care recipient: $705 300 (principal home excluded)	None applies.	No changes proposed	No changes proposed

[a] Carers are exempt from these criteria for up to 63 full days per year. [b] The ADAT is the Adult Disability Assessment Tool. [c] Payment ceases for before tax income earned over the fortnight above $2024.40 for a single person or $3096.40 for couples. [d] Single homeowner: $258 500; single non-homeowner: $465 500; couple & homeowner $387 500; couple & non-homeowner: $594 500.

Source: *Social Security Act 1991* (Cth), Department of Human Services (2018a).

A broader review of Carer Payment and Carer Allowance could benefit all carers. Mental Health Carers Australia (sub. 489) and Tandem (sub. 502) called for a review of the payments to understand the effect that their design has on participation in work and education. In addition to this objective, any review should also consider ways to make the income support system more coherent and flexible.

McClure, Aird and Sinclair (2015, p. 9) found that changes to the social support service system over time had led to 'complexities, inconsistencies and incoherencies'. Mental Health Carers NSW (sub. 245) had heard from carers that the complexity of the application process was a barrier to accessing income support. Carers Victoria (2013, p. 10) noted that:

> Bureaucratic complexity can bring its own barriers because it provides greater opportunity for misunderstandings and divergent interpretations of the legislation and its guidelines.

A review of Carer Payment should give consideration to the following elements proposed by McClure, Aird and Sinclair (2015) for the design of a new system of payments:

- clear and personalised information about how changes in earned income affect receipt of income support payments

- periodic discussions with an individual about their goals for economic and social participation.

To improve the simplicity of the system, carers might be better served by one payment, which is designed to meet the objectives of all three payments (Carer Payment, Carer Allowance and Carer Supplement).

DRAFT FINDING 13.1 — POTENTIAL IMPROVEMENTS TO INCOME SUPPORT FOR ALL CARERS

The existence of a Carer Payment, Carer Allowance and Carer Supplement that all achieve similar objectives, but have arbitrary differences in eligibility, contributes to an income support system that is complex and not well understood by carers.

DRAFT RECOMMENDATION 13.1 — REDUCE BARRIERS TO ACCESSING INCOME SUPPORT FOR MENTAL HEALTH CARERS

In the short term (in the next 2 years)

The Australian Government Department of Social Services (DSS) should complete its review of the Adult Disability Assessment Tool used to assess eligibility for Carer Payment and Carer Allowance. DSS should:

- publish its analysis and findings from the review and field testing process

- consult with carers and health professionals before setting revised weightings for the new questions and the minimum score required to be eligible for each payment

- expand the list of persons who can complete the health professional questionnaire to include psychologists and social workers.

In the medium term (over 2 – 5 years)

DSS should amend eligibility criteria for Carer Payment (adult) and Carer Allowance (adult). Amendments should include:

- replacing the requirements for 'constant care' and 'care and attention on a daily basis' with a requirement to provide 'regular care'

- replacing the 25 hour per week restriction on work, study and volunteering with a 100 hour per month restriction on work and volunteering only

- replacing the requirement that care must be provided in the home of the care recipient with a requirement that care must usually be provided in the home of the care recipient

- removing the eligibility restriction for Carer Allowance that states that for carers who do not reside with their care recipient to be eligible, they must provide care that relates to the care recipient's bodily functions or to sustaining their life and for more than 20 hours per week.

13.3 Social services for carers

The discussion on social services focusses on carer support services, which aid carers in their role, and employment support services.

Carer support services

Services for carers are provided by government mental health services, non-government organisations (NGOs) and for-profit providers. Some NGOs are carer-specific service providers and others are providers of psychosocial supports in general. Services are mostly government funded, but some are also funded via private donations and consumer charges (MHCN, sub. 245). Funding for carer support services has long been provided by both the Australian Government and State and Territory Governments.

Services provided vary widely between regions but typically include:

- **Information and education** — this includes practical information to help with service navigation as well as 'psychoeducation', the term given to interventions that aim to increase knowledge about the consumer's illness and treatments, provide carers with tools to be more effective in their role or improve family functioning (Lyman et al. 2014)

- **Counselling and peer support** — to meet the emotional and practical needs of carers. Counselling may be provided in person or via carer phone helplines. Peer support includes carer peer support groups and individual support from a carer peer worker. Carers with complex needs may receive case-management.

- **Respite (or replacement care)** — services provided to the care recipient that give the carer a temporary break from carer responsibilities. Respite helps with social and economic participation and prevents carers from becoming 'burnt out'.

The Australian Government and some State and Territory Governments fund specific carer support services for young carers (Cass et al. 2011). Types of supports are similar to those listed above, but they often also have a focus on supporting carers to remain engaged in education, training or employment. For example, Little Dreamers (2018) provides young carers with school holiday programs, an online support group, mentoring and information resources.

There have been studies in Australia and internationally that demonstrate the effectiveness of specific interventions, particularly psychoeducation. For example:

- a review of the evidence base for psychoeducation concluded that multifamily psychoeducation groups were 'associated with significantly improved problem-solving ability and a reduced burden on families, compared with control groups, among other strong outcome effects' (Lyman et al. 2014, p. 416)

- a randomised control trial of a structured group psychoeducation program for carers of people with borderline personality disorder demonstrated that this intervention improved family relationships and empowerment (Grenyer et al. 2019).

- a randomised control trial evaluated the efficacy of a brief version of an existing psychoeducation program for carers of people with an eating disorder, and found that it reduced carer burden, and improved self-efficacy, skills and knowledge (McEvoy et al. 2019).

- young people aged 13 to 17 who nominated caring adults to support them following suicidal ideation or attempt as part of the Youth-Nominated Support Team program were significantly less likely to die in the 16 years that followed, compared with a control group (King et al. 2019). Nominated carers were provided with psychoeducation and weekly support by telephone.

- a review of what works for mental health nurses in supporting carers of people with schizophrenia found that supportive family education reduced carer burden and that there was some evidence that peer support groups reduced burden and improved coping (Macleod, Elliot and Brown 2011).

However, there are few publicly available evaluations of the programs run in Australia. Therefore, it is not clear the extent to which the mix of services available here is effective and aligns with best practice.

Participants described how carer support services are valued by those that use them.

> I have found [ACT Carers] to be the most useful source of information and support, especially the educational workshops, access to counselling and respite care they provide to carers of loved ones with mental health issues. (Name Withheld, sub. 104, p. 2)

> Since Oct 2015, BPD Community has had a Family & Friend's Group meeting monthly. … The quarterly report for 2019 indicates a usefulness of the sessions at 90%, 98% indicated they felt more confident, 99% felt supported and 78% reported an improvement in their relationship with their loved one with BPD. (BPD Community, sub. 74, p. 6)

> It wasn't long before my health was affected. After several biopsies, I am a survivor, building up resilience thanks to the carer support connection, education and respite I used to benefit tremendously from, leading to my now volunteer advocacy position. (MHCN, sub. 245)

Australian Government funded programs for carers

Carer support services funded by DSS are in transition. Six programs providing carer support services are being wound up and replaced with the new Integrated Carer Support Service (ICSS) and funding from another two programs is being used to fund the NDIS (DSS 2018o, 2019l)[75]. Once transition is complete, total funding of the ICSS is expected to be $134 million in 2020-21 and then increase to $143 million in 2021-22 (DSS 2019h, p. 3) (box 13.1).

Box 13.1   Integrated Carer Support Service (ICSS)

The Integrated Carer Support Service has three components.

1. The Carer Gateway website and phone line is a service entry point for carers wanting information about caring and access to carer support services.

2. Additional digital carer support services have been available through the Carer Gateway since 1 July 2019, including phone counselling, self-guided coaching and online skills courses.

3. From April 2020, 10 lead organisations and their consortium partners (announced on 21 August 2019) will provide carer support services across the country, including carer support planning; tailored support packages; in-person counselling, peer support and coaching; and emergency respite care.

Source: DSS (2019l, 2019p); Ruston (2019).

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[75] Funding from an additional program, the Young Carers Respite and Information Services program, is transitioning in part to the ICSS and in part to the NDIS.

One of the programs that is being wound up due to the transition to the ICSS and NDIS, the Mental Health Respite: Carer Support (MHR:CS), was just for mental health carers whereas most of the others were for a broader range of carers or young carers. The MHR:CS provided mental health carers with relief from caring through in-home or out-of-home respite or social and recreational activities, counselling, practical assistance, case management and education and information (DSS 2019i). Approximately 41 000 carers were supported by the program in 2014-15 and funding allocated to the program was $64 million in 2015-16 (DSS 2016b).

Some of the services that were available under the MHR:CS program will be available under the NDIS as part of a participant's plan. Supports funded under the NDIS that may give carers a break from caring include short-term accommodation, personal care supports provided in the home and community-based activities (DSS 2018l). The NDIS also funds services that can build a carer's skills related to caring. The NDIS spent $1.2 million in 2018-19 on training for carers and parents of people with primary psychosocial disability, predominately on training in behaviour management strategies (National Disability Insurance Agency, pers. comm., 8 August 2019).

The Australian Government has committed to providing continuity of support through the ICSS to clients of the MHR:CS who are not eligible for the NDIS (DSS 2018l).

Despite this commitment, participants have raised concerns about the effect the NDIS and ICSS transition is having and will have on mental health carers' access to carer support services. Several issues were raised, including that the number of providers providing carer support services for mental health carers has reduced and the types of services provided has changed (Anglicare Sydney, sub. 190; cohealth, sub. 231; LMMHCN, sub. 52; Mind Australia, sub. 380; One Door Mental Health, sub. 108; Tandem, sub. 502).

Also, the NDIS has altered some State and Territory Government funding decisions related to carer support services (MHCTas, sub. 391). For example, the Queensland Department of Communities, Disability Services and Seniors transferred some of its funding for carer support services to the NDIS from 1 July 2019 (State and Territory Governments survey).

Further, participants were concerned that the NDIS' focus on the choice and control of participants, rather than carers will result in unmet needs for carers (MHCA, sub. 489; MHCTas, sub. 391; Mind Australia, sub. 380; One Door Mental Health, sub. 108). Support for carers is included within NDIS guidelines, but there is no formal assessment of carers' needs undertaken as part of the assessment process (PC 2019c).

One benefit of the ICSS being a comprehensive program for all carers, rather than many targeted programs, is that service providers will be able to be more responsive to carers' individual needs and prioritise carers most in need. Still, participants were concerned because ceasing the MHR:CS program means less funding is quarantined for mental health carers (MIFA, sub. 343).

It is too early to know how well the ICSS and NDIS will meet the needs of mental health carers.

In addition to the Australian Government's programs specifically for carers, some psychosocial support and family support services, such as the Partners in Recovery program and Family Mental Health Support Services, also provide carer support services (DoH 2019l; DSS 2019o). Funding for the Partners in Recovery program has transitioned to the NDIS — former clients are either supported through the NDIS or through continuity of support programs (chapter 12).

Services funded by State and Territory Governments

All States and Territories fund services that support carers and families of people with mental illness. Aggregating total expenditure is not straightforward but lower bound estimates are available. The Australian Institute of Health and Welfare reported that State and Territory Government expenditure on mental health family and carer support services delivered by NGOs totalled $23.9 million in 2016-17 (AIHW 2019o, table EXP.16).

The $23.9 million figure underestimates State and Territory funding for mental health carer support services for two reasons.

First, it does not include services directly delivered by government. For example, under the New South Wales Family and Carer Mental Health Program, in addition to the $6.5 million that was provided to 5 NGOs, $2.3 million was provided to local health districts (NSW Ministry of Health, pers. comm. 22 July 2019).

Second, this amount does not include all programs funded for a broader range of carers (not just mental health carers). This expenditure is not insignificant — for example the Victorian Government has committed approximately $12 million per year for four years from 2019-20 on additional funding for respite services (Andrews 2018; Carers Victoria 2019). However, the share of expenditure in these programs that is spent on mental health carers is not clear.

An investigation in 2016 into total expenditure on mental health carer support services had difficulties isolating funding specifically for mental health carers (Schess et al. 2018). This study reported a conservative estimate of $25 million in 2014-15 for State and Territory Government funding of services delivered by both government and non-government organisations. This study could not identify services funded by the Tasmanian Government, and an estimate for Queensland was not included in the total because the share of program funding specifically for mental health carers was not known.

Unmet need for carer support services

A substantial proportion of carers have unmet needs for carer support services. A quarter of all primary mental health carers needed additional assistance in 2015 (tables 13.4 and 13.5). Participants to the inquiry stated that there are barriers to accessing carer support services, for reasons including: poorly coordinated services and fragmented funding, difficulties navigating service access, and insufficient funding and services available to meet community

need (LMMHCN, sub. 52; MHCN, sub. 245; MHCTas, sub. 391; NT Mental Health Coalition, sub. 430; Tandem, sub. 502).

Table 13.4 **Need and receipt of assistance**
Primary mental health carers who co-reside with their care recipient, 2015

Primary carer need and receipt of assistance to care for main recipient of care	Count	%
Receives assistance and does not need further assistance	68 700	28
Receives assistance and needs further assistance	34 300	14
Does not receive assistance and needs assistance	25 700	11
Does not receive assistance and does not need assistance	113 000	47
Total number of primary mental health carers	241 700	100

Source: Commission estimates using ABS (*Microdata: Disability, Ageing and Carers, Australia 2015*, Cat. no. 4430.0.30.002).

Table 13.5 **The nature of unmet carer needs**[a]
Primary mental health carers who co-reside with their care recipient, 2015

All unmet sources of support for carers	%
More financial assistance	27
More emotional support	21
An improvement in carer's own health	19
More respite care	15
More physical assistance	12
More courses available on how to care for persons with particular disabilities	9
More aids/equipment to help in your role as a carer	6
More training on correct use of equipment or correct methods of lifting to prevent injury to carer	3
None of the above	1

a Multiple responses possible.

Source: Commission estimates using ABS (*Microdata: Disability, Ageing and Carers, Australia 2015*, Cat. no. 4430.0.30.002).

Up to a quarter of primary mental health carers may have unmet respite needs (table 13.6). In 2015, 10% of primary mental health carers had used respite; 62% do not need or want to use the service; the remaining 28% of carers faced barriers to access or were unaware of respite arrangements for carers.

Table 13.6 **Use of respite care and reasons not used**

Primary mental health carers who co-reside with their care recipient, 2015

Whether carer has used respite care and main reason if has not used respite care	*%*
Has used respite care	10
Does not need service	55
Carer does not want service	7
Recipient does not want service	10
Unaware of entitlement or services	10
Available services not suited to needs	2
Respite care services not available in area	2
No affordable services available	1
Other reason	3
Total	**100**

Source: Commission estimates using ABS (*Microdata: Disability, Ageing and Carers, Australia 2015*, Cat. no. 4430.0.30.002).

Participants' views, survey data and the poor wellbeing outcomes of mental health carers described in section 13.1 clearly suggest that there is a gap in services to support the wellbeing and role of mental health carers. And considering the cost of replacing the care they provide with formal services ($13.2 billion in 2015), it is in the interest of governments to identify how the needs of mental health carers can be better met (Diminic et al. 2017).

However, given the challenges in summing current expenditure on carer support services for mental health carers described above, the Commission has not been able to estimate the current level of unmet need for carer support services. Australian Government services are in transition, State and Territory Government funded services are fragmented and data available is not sufficient for this purpose.

The National Mental Health Service Planning Framework (NMHSPF) provides a benchmark of community need for mental health services. This model estimated that the supply of carer support services that would be required to meet community needs would cost $129 million in 2019-20.[76] This estimate is for mental health carers only and includes respite services and individual, group and peer support services. Separate to these service categories, the NMHSPF also estimates that mental health carers and other family members of people with mental illness would need to use $185 million worth of structured psychological therapies (such as psychoeducation counselling and family therapy).

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[76] The NMHSPF was initially developed by the NSW and Queensland Governments and is being revised by the University of Queensland, with funding from the Australian, State and Territory Governments, to quantify the level and mix of mental health services needed to meet the needs of Australia's population. NMHSPF estimates of services costs are indicative only, based on 2011 wages inflated to current prices.

Clarifying responsibilities for mental health carer support services

Where both levels of government partially fund carer support services, neither is accountable for ensuring that services are effective and meet community needs. The Commission noted this lack of clarity in policy responsibility for carer support services previously in its review of the National Disability Agreement (PC 2019c). Mental Health Carers NSW (sub. 245, p. 3) described how having both levels of government and multiple departments funding carer support services results in fragmented services and 'creates the potential for gaps in service provision to go unnoticed as well as for services to be duplicated needlessly'.

To improve accountability for carer support services for mental health carers, one level of government should take policy responsibility for these services. Chapter 23 includes a consideration of the level of government better suited to fund mental health carer support services, and proposes that these services sit with the State and Territory Governments (draft recommendation 23.2). The Australian Government should provide funding to State and Territory Governments to enable them to fulfil this role.

Funding levels should be based on an evidenced-based, transparent planning framework, such as the National Mental Health Service Planning Framework, and monitoring and evaluation should be incorporated into the design of the service programs.

Further, services for mental health carers should be funded by the same level of government that funds psychosocial supports (chapter 23). One of the reasons for this is that these services are partially substitutable — a significant shift in the supply of psychosocial support could reduce the demand for informal care.

This issue of substitution between formal and informal care is worth discussing in the context of young carers. There is evidence that young carers have limited choice about undertaking a caring role or may not realise that they are engaged in a caring role (Warren and Edwards 2016; Mind Australia, sub. 380). Siblings Australia (sub. 124) stated that focussing on the caring role can add to the risks for mental health problems for young carers. Young carers who would like to reduce the intensity of care they provide would benefit significantly from governments taking measures to fully meet the clinical and psychosocial support needs of their care recipients. The risks to their careers and wellbeing over their lifetime make it vital that State and Territory Governments take a prevention and early intervention approach to supporting young carers, rather than taking actions to mitigate against stress or poor school grades after the fact.

The Australian Government should continue to transition its carer support services to the ICSS. However, as State and Territory Government take on responsibility for mental health carer support services, the ICSS would no longer fund services for this cohort. An exception to this is the Carer Gateway, which should continue to be administered by the Australian Government for all carers.

The proposed change to policy responsibilities is only for carer support services for mental health carers. Income support services and employment support services for carers would

remain the responsibility of the Australian Government. Further, although the Commission cannot, in this inquiry, advocate that a similar approach is taken to supports for other carers (beyond mental health carers), there may be merit in more localised planning and funding of all carer supports.

To clarify, even carer support services for people caring for someone with psychosocial disability receiving support under the NDIS should be the responsibility of State and Territory Governments. Although the NDIS will likely have benefits for these carers, it is not designed to meet all of their support needs.

Employment support services for carers

Carers experience significant barriers to employment. The intensity of the caring role and lack of alternative formal services are two such barriers (MHCA, sub. 489; Tandem, sub. 502). Assuming the reforms proposed throughout this report are implemented by governments, resulting in improved access to formal services for care recipients, other barriers to employment would still remain, both while they are carers and after their caring role ends.

Many years spent caring can reduce confidence to re-enter the labour force and leave carers without the skills and work experience of their peers (MHCTas, sub. 391, Mind Australia, sub. 380). Assumptions that may be made by employers about time out of the workforce is another barrier to employment (cohealth, sub. 231). Carers may also have difficulties finding a job that offers work arrangements with the level of flexibility needed to accommodate caring responsibilities (Caring Fairly, sub. 427). The Australian Government's Priority Investment Approach to Welfare found that carers often end up on other income support payments after their caring role (and eligibility for Carer Payment) ends (PWC 2017).

Mind Australia (sub. 380) emphasised the importance of improving education and employment outcomes for mental health carers. Participants noted that employment and education can be a beneficial addition to a carer's life (if they have a manageable employment and caring workload).

> Employment and education can provide an opportunity for carers to spend time away from the caring role and to focus on other aspects of their identity and wellbeing. (MHCN, sub. 245, p. 21)

> For carers, work can be the best form of respite from caring. It is well established that carers can become very socially isolated. Work can provide them with the opportunity to socialise with other people and to have an identity and a focus beyond their caring role. (Carers Australia, sub. 372, p. 6)

Diminic, Hielscher and Harris (2018) posited that over half of all working aged primary mental health carers have a possible need for more employment-related support to maintain, improve or enter employment. For employed carers this included those providing over 40 hours of care per week, those who had reduced working hours to commence caring, those wanting to work more hours and those who wanted to make more use of special working

arrangements (such as leave and flexible hours). For carers not in employment, those who had left employment due to their caring role and those who reported wanting to work were included as possibly needing employment support.

Employment support services that are designed with mental health carers' circumstances and needs in mind should be available to carers and ex-carers who would benefit from them (Caring Fairly, sub. 427). Mental Health Carers Tasmania (sub. 391, p. 7) described how such services 'need to engage mental health carers in their return to employment by providing realistic information and practical skills which can be utilised to secure and maintain employment'.

Between 2015-16 and 2018-19, DSS funded a trial program specifically for mental health carers called the Carers and Work Program. DSS provided about $1.5 million annually to trial the program within four services (two in Victoria, and one each in Queensland and New South Wales) (DSS 2017). The Carers and Work program will not continue after the introduction of the ICSS.

The Commission is unaware of any plans to evaluate the trial. To not do so would be a wasted opportunity to learn more about what works to support carers to achieve their employment goals.

Other services that support carers to improve employment outcomes exist in some locations. For example, Carers Queensland (2019) is a registered training organisation and provides training to carers to work in the disability sector.

Participants have called for greater and more sustained investment in employment support for carers. Some suggested a program similar to the Carers and Work Program should be more widely available (Carers Australia, sub. 372; MHCTas, sub. 391; Mind Australia; sub. 380). Mental Health Carers Australia (sub. 489) suggested that mental health carers are involved in co-designing a new approach. Caring Fairly (sub. 427, p. 7) suggested that a:

> … new workforce participation program could be achieved (at least in part) through reforming, extending, and promoting tailored supports to unpaid carers through the government's existing Jobactive program … A pool of Jobactive providers should be identified and trained (in partnership with specialist organisations providing support to carers) to respond to the specific workplace needs of unpaid carers.

The national reach of jobactive providers could help with scaling up employment supports to mental health carers. The Senate Education and Employment References Committee examination of the jobactive program concluded that the Australian Government should examine the merits of providing more tailored career counselling and support services for carers (EERC 2019).

Other programs may also be relevant to carers. The Australian Government Department of Employment, Skills, Small and Family Business (DESSFB) funds jobactive providers to deliver tailored programs to job seekers outside of the mainstream jobactive program. The Career Transition Assistance program commenced 1 July 2019 for job seekers aged 45 years

and older. For young people (aged 15-21), there is the Transition to Work program, which provides intensive support to ready them for employment or education.

In May 2019, the Australian Government announced the $75 million Mid-Career Checkpoint initiative to support people looking to return from time out of the workforce for caring responsibilities (Liberal Party of Australia 2019). The initiative will be targeted at women aged 30 to 45, but men aged 30 to 45 who have undertaken leave to care for family members will also have the opportunity to participate (DESSFB, pers. comm., 31 July 2019).

Jobactive and these other three programs should explicitly include tailored support for mental health carers in their program design. In practice, this means requiring staff delivering these services to undertake training that enables them to better understand the experiences and needs of mental health carers.

Some carers and ex-carers may be interested in becoming a volunteer or paid carer peer worker. McClure, Aird and Sinclair (2015) recommended volunteering as one way job seekers can prepare for paid employment. Chapter 11 discusses peer workers, including ways to reduce barriers to becoming a peer worker.

DRAFT RECOMMENDATION 13.2 — EMPLOYMENT SUPPORT FOR MENTAL HEALTH CARERS

In the short term (in the next 2 years)

- The Australian Government Department of Social Services should evaluate its Carers and Work program to identify how to effectively support mental health carers to enter or maintain employment.
- A working group consisting of both Department of Social Services and Department of Employment, Skills, Small and Family Business representatives should use the evaluation to inform the development of guidelines that jobactive providers can use to tailor their services to the needs of current and former mental health carers.

In the medium term (over 2 – 5 years)

The Australian Government should require designated staff who are delivering the mainstream jobactive program and the Career Transition Assistance, Mid-Career Checkpoint and Transition to Work programs to undertake training to apply these guidelines.

13.4 Family-focused and carer-inclusive practice

Supporting families affected by mental illness

A recovery-oriented mental health system is necessarily responsive to, and inclusive of, mental health consumers' families (AHMAC 2013).

Family-focused care requires mental health services to consider family members' needs and their role in understanding and supporting the mental health of consumers. People who may need support include spouses, siblings or parents. Two elements of a more family-focused mental health system are discussed below — services for children of parents with mental illness and family therapy.

The NMHSPF estimates services needed to reduce the effects of mental illness on families. This model estimated that the supply of family support services that would be required to meet community needs would cost $57 million in 2019-20. The types of services included are information, family mediation and family oriented-counselling, and services for children of parents with mental illness. The model assumes that family support services would be partially funded by mental health departments and partially funded by general social services and child protection agencies. As discussed in section 13.3 above, the model also makes provision for $185 million worth of structured psychological therapies (such as psychoeducation counselling and family therapy) for carers and other family members of people with mental illness.

Children of parents with mental illness

The Australian Government funded Emerging Minds to implement the Children of Parents with a Mental Illness (COPMI) initiative for 15 years up until 2016 (Emerging Minds 2016). This work produced evidence-based resources and guidance to support children of parents with mental illness. The COPMI website has information resources that are targeted separately to parents, children and young people, family and friends, and professionals. Emerging Minds continues to produce COPMI related resources to assist health professionals with family-focused practice as part of its broader work program (Emerging Minds 2019b).

In addition to information resources, mental health professionals may need training and practical support to embed a focus on family into their practice.

Maybery et al. (2014) found that skills, knowledge and confidence to provide family-focused practice when treating a parent with mental illness varied between psychiatric nurses, social workers and psychologists employed by adult mental health services. Mental health professionals need certain skills to work sensitively and effectively with parents who may anticipate stigma associated with being a parent with mental illness or who fear actions by child protection departments.

Policy and procedures are needed at the organisational level. Emerging Minds (2019b) recommends that mental health services introduce key messaging about the importance of considering children's wellbeing as part of services' recruitment, induction and supervision processes. Reupert et al. (2012) stated that it:

> … is imperative that there are procedures to identify the parenting status of patients, to screen for competence in various domains (parenting, child wellbeing and family dynamics) and, at a minimum, to refer parents and/or children to appropriate services if required.

In addition, children may benefit from age-appropriate information about their family member's mental illness and referral to support services, such peer support groups and group recreational activities that provide respite.

Progress across these areas is evident for some States and Territories (box 13.2).

Box 13.2　Examples of efforts to improve family-focused practice

The Victorian Government commenced the Families where A Parent has a Mental Illness (FAPMI) strategy in 2007 to reduce the effects of parental mental illness on all family members, particularly dependent children. The strategy includes employing local FAPMI coordinators in each catchment area. FAPMI coordinator tasks include 'building capacity of the mental health workforce and partner agencies through education and training, referral pathways and procedure development to improve identification and support for parents and their children' (Falkov et al. 2016).

The Victorian FAPMI strategy also includes peer support services for young people with a parent or sibling with mental illness (Victorian Government, sub. 483). An evaluation of one of these programs called CHAMPS found that the intervention resulted in significant improvements in self-esteem, coping and connections within the family, and reductions in relationship problems (Goodyear et al. 2009).

The New South Wales Children of Parents with a Mental Illness Framework sets directions for its mental health services, such as the provision of services for families, strengthening the capacity of interagency partners and supporting the workforce to provide family-focused practice (NSW Health 2010). It provides detailed instructions on ways to achieve the directions, including the use of COPMI coordinators.

The Queensland Government has also produced a guideline for working with parents with mental illness and the ACT Government has a Children of Parents with a Mental Illness policy (ACT Health, 2013; QLD Health 2010).

A targeted preliminary evaluation of the Victorian Government's Families where A Parent has a Mental Illness (FAPMI) strategy was completed in 2012. It compared two catchment areas with a FAPMI coordinator with two catchment areas without a FAPMI coordinator (Maybery et al. 2012). The evaluation found that adult mental health clinicians in the catchment areas with a FAPMI coordinator provided more family-inclusive practice. These clinicians had greater knowledge and skills regarding the effects of parental mental illness on children and were more able to provide referrals to family support services. In catchments with a FAPMI coordinator, the staff of mental health services and family support services had greater access to secondary consultations, resources and training related to FAPMI.

Given the emerging evidence of improved practice seen in Victoria, the use of regional coordinators to facilitate improved outcomes for families where a parent has mental illness should be explored as an option for other States and Territories. A trial of this approach should be undertaken to determine its efficacy before adopting it more broadly.

The trial should assess the efficacy and cost-effectiveness of using COPMI facilitators to work with adult mental health services to improve their procedures, training opportunities

and networks with other relevant agencies. Their role would also involve working directly with individual care coordinators (chapter 10) and mental health professionals seeking advice about how best to support a family of one of their patients, and assist with service referral. The intent is for this vulnerable group of children to be represented by a dedicated and easily identifiable person that is an expert on their circumstances and needs.

Family therapy

Support for families to work through family conflict and strengthen relationships can help with a consumer's recovery. Evidenced-based interventions provided to the family are often an effective way to improve outcomes for families where someone has mental ill-health. For example:

- the Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia note that the evidence base for family therapy interventions for schizophrenia is strong (Galletly et al. 2016). Behavioural family therapy programs reduce carer burden and improve consumer mental health (Macleod, Elliot and Brown 2011)

- a review of family interventions for bipolar disorder found support for the efficacy of family treatment for young people and adults and found benefits for carers (Reinares et al. 2016).

- results from two randomised controlled trials suggested that family therapy as part of treatment for anorexia nervosa may be more effective than individual treatment in the short term (Fisher, Hetrick and Rushford 2010).

- family-based models of care are among the most effective approaches for treating both adults and adolescents with drug problems (Rowe 2012).

Assessments of the cost-effectiveness of three types of family interventions for schizophrenia and family-based treatment for anorexia nervosa found that they were value for money in the Australian context (Le et al. 2017; Mihalopoulos et al. 2004).

The Centre for Excellence in Child and Family Welfare (sub. 211) stated that the best interventions for children with emotional and behavioural needs are holistic, family-centred supports. Systemic interventions for families (family therapy and other family-based approaches such as parent training or parent implemented behavioural programmes) have been found to be effective for a range of issues including 'sleep, feeding and attachment problems in infancy; recovery from child abuse and neglect; conduct problems, emotional problems, eating disorders, somatic problems, and first episode psychosis' (Carr 2019, p. 153).

In addition, as family relationships are an important determinant of health for Aboriginal and Torres Strait Islander people (QMHC, sub. 228), family-based interventions may be particularly important for their social and emotional wellbeing. A recent study of ABS data on psychosocial factors associated with deaths referred to coroners revealed that relationship

problems with partners was the most common factor associated with suicide for Aboriginal and Torres Strait Islander peoples (ABS 2019j).

> Without peoples' links to culture and community, and without positive connections with family and friends, people's self-esteem, resilience and sense of individual and collective identity may suffer, to the detriment of their mental health and wellbeing. (Victorian Government 2019a)

The Bouverie Centre (2019) has developed a family therapy service tailored to the needs of Aboriginal families in Victoria, called *Workin' with the Mob*.

There are some barriers to families accessing family therapy. Relationships Australia (sub. 103) stated that there is under-recognition of the value of family therapies, and Relationships Australia Victoria (sub. 326) noted that these services are not funded through Medicare. Medicare funds sessions provided by medical practitioners, including GPs but not for allied health professionals (such as psychologists).

The list of acceptable strategies approved for use by allied mental health professionals for MBS-rebated psychological therapy does not include family interventions (DoH 2019h). The MBS Review Mental Health Reference Group (2018) recommended adding family interventions to the list of approved interventions that can be delivered by allied health professionals under the Better Access program.

Given the effectiveness of these approaches, the Commission sees merit improving access to family therapies under Medicare for families affected by mental illness. In addition to funding family-based interventions for people with mental illness, funding for sessions with family members without the patient present are discussed in the context of carer consultations below (draft recommendation 13.8).

A partnership model between carers and mental health services

Carer inclusive practice requires mental health services to provide treatment in partnership with carers. There are a range of actions governments should take to improve information sharing between carers and services about consumers, and to encourage mental health services to consider carers' views in decision-making.

Participants to the inquiry have raised concerns that their role, views and needs as carers or family are not being recognised and respected by mental health services (box 13.3).

Box 13.3   Participants views about scope for improvement to carer inclusive care

- Carers are not being given sufficient information about diagnosis, treatment or the mental health system.

- Carers' views about the consumer's history and care needs are not sought or are disregarded.

- They are excluded from care planning meetings and marginalised in decision-making processes.

- They are not being given enough information or support when the consumer is discharged from in-patient care.

- Carers are not given information about prescriptions (even though they may be assisting the consumer with taking medication).

- Mental health professionals blame carers and assume that carers are a cause of the consumer's problems.

- Carers needs are not considered or supported.

Source: ACT Government, sub. 210; BPD Community, sub. 74; Carers NSW, sub. 183; Carers Victoria, sub. 461; HelpingMinds, sub. 470; LMMHCN, sub. 52; Mental Health Carers ARAFMI Illawarra, sub. 161; MHCA, sub. 489; Name withheld, sub. 66; NT Mental Health Coalition, sub. 430; Private Mental Health Consumer Carer Network (Australia), sub. 547; Robert Davis, sub. 133; Tandem, sub. 502.

Supporting information sharing between services and carers

One of the most valued supports for carers is the opportunity to exchange information with mental health services about the consumer. Carers often have insights on how best to support the recovery and wellbeing of their care recipient and mental health services are disadvantaging consumers by not recognising this.

Frequently, the reason given for not engaging with carers is to protect the privacy of the consumer (Name Withheld, sub. 32; Name Withheld, sub. 63). However, there is a lot that services and clinicians can and should do to support carers and seek consent from consumers for sharing information (box 13.4). For example, protecting privacy is not a valid reason for not listening to the views of carers or for not providing carers with general information (Mind Australia et al. 2016).

To improve carer inclusive practice, services need to invest in the processes and skills that enable carers to be identified and consent to share information to be recorded. A two year post-implementation review of the introduction of the *Mental Health Act 2014* (WA) found that these are two areas of improvement needed to protect the rights of consumers and carers (WA MHC 2018).

Regarding skills, it is important that staff are trained how to exercise consumers' and carers' rights under mental health and privacy legislation. In certain circumstances, mental health professionals are obliged to share information with carers. For example, the *Mental Health Act 2014* (Vic) includes specific obligations for clinicians to consult with and inform carers

when a consumer is subject to compulsory treatment. The *Mental Health Act 2007* (NSW) enables consumers to nominate two 'designated care providers' and gives these carers rights. If no carer is nominated by the consumer, then the designated carer can be assumed in some circumstances (such as spouses of consumers).

Box 13.4   National Standards for Mental Health Services: Standard 7

The National Standards for Mental Health Services, which were agreed to by all Health Ministers, includes standard 7, which is related to carers. Some of the criteria within this standard that mental health services should meet include:

- having clear policies and protocols:
  - to enable staff to effectively identify carers as soon as possible in all episodes of care, and this is recorded and prominently displayed within the consumer's health record.
  - to address the issue of sharing confidential information with carers in accordance with privacy legislation and guidelines
- in circumstances where a consumer refuses to nominate a carer, the service reviews this status at regular intervals during the episode of care
- providing carers with a clear written statement and verbal explanation of their rights and responsibilities
- providing non-personal information about the consumer's mental health condition, treatment and ongoing care
- actively seeking information from carers in relation to the consumer's condition during assessment, treatment and ongoing care and recording that information in the consumer's health record
- engaging carers in discharge planning prior to discharge from all episodes of care.

Source: Australian Government (2010).

Several States and Territories have prepared guidelines to describe mental health services' responsibilities under mental health legislation, and to assist them to put it into practice. Examples include the Victorian Chief Psychiatrist (2018) guideline for working with families and carers, Queensland Health's (nd) fact sheets on information sharing and rights of family under Mental Health Act 2016, and the South Australian Office of the Chief Psychiatrist's (2017) plain language guide to the *Mental Health Act 2017* (SA).

In addition, mental health professionals may need additional skills to work effectively with carers and consumers in relation to identifying carers and information sharing. Several service providers and peak-bodies developed *A Practical Guide for Working with Carers of People with a Mental Illness*, which provides examples of strategies that services and staff can consider and questions staff might ask to improve carer-inclusive practice:

> Asking 'who are your carers?' rarely receives a positive outcome. … If you work in an acute inpatient unit, you might say 'Your husband/wife/partner brought you to hospital today. They seem very concerned about you. Would it be okay to nominate them as your primary carer? We

will agree what information you feel comfortable sharing with them. It seems like they will be important to have involved in any plans we make.' (Mind Australia et al. 2016)

This guidance is accompanied by free online training modules and a mobile application to help individuals and organisations to improve their skills and complete the self-assessment against the guide's Partnership Standards, and to allow organisations to access reports that describe how well it is implementing the standards (Private Mental Health Consumer Carer Network, sub. 550).

Regarding documentation, there are many options available to identify carers and record if and what information the consumer has consented to sharing with them. Providers can append a carer nomination form to a consumer's care plan, such as the one included in the appendix of *A Practical Guide for Working with Carers of People with a Mental Illness* (Mind Australia et al. 2016). If the service is using electronic medical records, equivalent fields for nominating carers and sharing information can be added this system. Alternatively, consumers can nominate carers in advance as part of development of mental health advance directives, advanced care plans or consumer wellness plans. Advance care plans can also be uploaded to a person's My Health Record.

The best option depends on the relevant provisions in the State and Territory mental health legislation. For example, the *Mental Health Act 2016* (Qld) requires Queensland's chief psychiatrist to maintain electronic records of advance health directives and appointments of nominated support persons. Some other states and territories, including New South Wales, Victoria and South Australia have prepared forms which enable carers to be nominated in line with their legislation.

Greater use of care coordination services (draft recommendation 10.4) and adoption of single care plans (draft recommendation 10.3) for people with complex needs will help with identifying carers and keeping track of requests and decisions related to consent to share information.

Given that there is guidance and training available to mental health professionals and numerous options for documentation related to carers and information sharing, the Commission has considered what more could be done to improve carer-inclusive practice.

Some participants suggested that there should be greater enforcement of quality standards to improve carer-inclusive care (MHCA, sub. 489; Private Mental Health Consumer Carer Network (Australia), sub. 547). However, many mental health services are already subject to quality standards that require carer-inclusive practice, either under the National Standards for Mental Health Services (NSMHS) (box 13.3) or the National Safety and Quality Health Service (NSQHS) Standards (ACSQHC 2018b; COAG Health Council 2017a). Although the NSQHS Standards are less explicit about facilitating information sharing with carers than the NSMHS, several of the actions in the Partnering with Consumers and Comprehensive Care Standards include carers.

Given the gap between quality standards in theory and the experiences reported by carers in practice, there should be greater monitoring and reporting of how well services are providing carer-inclusive care.

Fortunately, the first steps have already been taken to enable this. Under action 23 of the Fifth National Mental Health and Suicide Prevention Plan, State and Territory Governments agreed to implement surveys for monitoring consumer and carer experiences of care by 2021 (COAG Health Council 2017b). These surveys have been developed by the Australian Mental Health Outcomes and Classification Network (AMHOCN) and are known as the Your Experience of Service survey for consumers and the Carer Experience Survey (CES) (AMHOCN 2019b).

The CES survey was designed for State and Territory mental health services — inpatient and ambulatory. The survey includes questions to carers about whether they were identified as a carer and 'given opportunities to discuss the care, treatment and recovery of your family member, partner or friend (even, if for reasons of confidentiality, you could not be told specific information)' (AMHOCN 2016, p. 1).

Progress in rolling out of the survey varies from state to state. Most have not started collecting the surveys from carers, but Queensland and Victoria are working towards collecting the surveys during 2019, with reporting to follow (AMHOCN 2019a). The New South Wales Government made a paper-based version of the survey available in 2018 and is working towards an online version (Mental Health Carers NSW 2018). Local Hospital Networks receive the survey results at a service level and so are able to use it to drive quality improvement.

The CES should be collected routinely by services from carers and results should be used to drive continuous improvement in carer-inclusive practice. Greater use of and reporting against the CES will improve incentives to skill staff to identify carers and to get the forms for information sharing completed. Services that have good policies and procedures for carer-inclusive practice already in place will likely score well in the CES. If this is the case, services can use their results as evidence towards their next assessment against the NSQHS or NSMHS.

The CES results may identify shortcomings in carer-inclusive practice that relate to a service's culture rather than the absence of procedures and training opportunities. Promoting a carer-inclusive culture may take time but increasing transparency about where services are currently at, is a sound first step to encourage change.

Funding for carer consultations

Carers told the inquiry about the value they place on opportunities to talk to the health professionals treating their care recipient, to share their views and ask questions about symptoms and care:

> [There is] limited scope for case management meetings … GP's, Psychologists and Psychiatrists should be provided with Medicare codes to undertake case management meetings, more extensive communications with other professionals, and patient 'decision making' meetings (with their Advocates). (Robert Davis, sub. 133, pp. 8, 19)

> It's the lack of 'me' time that is concerning … As the carer, observer, navigator, therapist and father, you must afford 'me' the time to validate and clarify any embellishments or skewed reality that my daughter articulates. It also gives me the opportunity to discuss my feelings, views and understanding with respect to treatment, progress and prognosis. (Name Withheld, sub. 392, p. 22)

The Australian Government funds sessions without the patient present under the Medicare Benefits Scheme (MBS) in limited circumstances. MBS item numbers 348, 350 and 352 allow psychiatrists to consult with non-patients (including carers and multidisciplinary clinicians). These funded sessions are unlimited if undertaken in the course of initial diagnostic evaluation (first month) and limited to four sessions a year thereafter.

Claims for these items have increased significantly over the past 10 years (unpublished MBS data and RANZCP 2018). Psychiatrists claimed each of these items for between 15 500 and 25 000 people in 2018-19 and total benefits paid was $10.6 million (unpublished MBS data). RANZCP (2018) reported that 40% of these consultations relate to patients under the age of 25.

There are no equivalent MBS items for psychologists and allied health professionals when the consumer is not present. For psychologists providing psychological therapy funded by the MBS, a lack of funding for time spent with carers may be a barrier to achieving genuine partnership with them in the treatment of people experiencing mental illness.

The MBS Review Mental Health Reference Group (2018) stated that sessions for carers were a fundamental element of evidence-based best practice and that they enhanced collaboration and recognition of carers as valuable resources. Their draft report recommended that a new family and carer MBS item should be created for psychology and allied mental health professionals to parallel the item for psychiatrists with a 4-limit session per year. The Queensland Mental Health Commission (sub. 228) supported this recommendation by the Mental Health Reference Group and the Australian Psychological Society (2019) made the same recommendation.

The Productivity Commission agrees. A limit of four sessions per year is proposed due to the precedent set by the existing MBS items. However, in time, any limit should be aligned with latest evidence about what works to improve outcomes for carers and consumers. The average number of consultations per patient in 2018-19 was less than two for the existing MBS items (unpublished MBS data). However, RANZCP (2018) noted that a four session limit was insufficient for some client types:

> Working in this collaborative manner with carers has been stipulated as a basic requirement, particularly in the field of child and adolescent psychiatry, and intellectual and developmental disability psychiatry and geriatric psychiatry, and usually requires separate interview time at each substantial consultation.

Greater support for hidden carers and family members

Identifying and supporting young carers

Young carer support services cannot be properly planned for if the number of young carers is underestimated. The Survey of Disability, Ageing and Caring (SDAC) is a nationally representative survey for most carers, but likely underestimates young carers. The SDAC counted carers that were identified either by a responsible adult or a care recipient in the household, not by asking each household member (ABS 2015a).

The Longitudinal Study of Australian Children (LSAC) has identified young carers in Year 9 in 2013-14 and in Year 11 in 2015-16 (AIFS nd, 2019b). This data enabled the analysis by Warren and Edwards (2016). The Commission is proposing the Australian Government should fund the Australian Institute of Family Studies (AIFS) to establish new cohorts of LSAC at regular intervals (draft recommendation 18.11). The LSAC should continue to include questions to identify carers.

Schools also have a role to play in identifying young carers so that they can be provided with additional supports to stay engaged and succeed in education, and to facilitate referral to young carer support services. Diminic, Hielscher and Harris (2018, p. 49) noted that:

> … processes may be required in the school system to better identify those students that provide intensive care to a relative with mental illness, to allow for ongoing monitoring, additional assistance from teaching staff, and provision of support from school counselling services where need be to prevent disengagement or poor outcomes.

The Carer Gateway advises carers who are studying to talk with their school or tertiary education provider about ways they can help them to balance education and caring responsibilities, such as:

- permission to stay home from school or classes when [they] need to

- permission to use [their] phone to call home

- ways to catch up on work from home, such as catch-up lessons, take-home work, e-learning or note-taking services

- later deadlines for assignments (DSS 2019r).

This is not straightforward as the evidence suggests that young carers often do not tell people within the school setting about their caring responsibilities, for reasons including embarrassment or fear of anticipated stigma (Carers SA 2017; Crafter et al. 2017; Kaiser and Schulze 2015). There are programs available to help schools identify, understand and support young carers but access to these resources is not consistent across the country.

The Commission is proposing that each school employs a school wellbeing leader who will oversee activities to support mental health in schools (draft recommendation 17.5). The role of school wellbeing leaders should include supporting schools to better identify and support young carers.

Information for hidden carers before they reach a crisis

Some consumers do not seek treatment until they reach a crisis, which precludes their carers from being supported by mental health services. At this point, and prior to it, carers may feel underprepared and overwhelmed in their caring role (MHCN, sub. 245).

> Carers don't know what they want or need or where to go to find out what they may be needing in times of stress. (Mental Health Carers ARAFMI Illawarra, sub. 161, p. 2)

Ideally, carers would have resources to support them before a crisis occurs.

Although the Carer Gateway website is a useful service entry point for those with high levels of internet literacy, 22% of primary mental health carers in 2015 did not use the internet in the past 3 months (ABS 2016b). In future, carers should have access to a phone line that will be part of the Australian Government's mental health portal, Head to Health (draft recommendation 10.1) and GPs and other service providers will be able to find services through an online portal of mental health referral pathways (draft recommendation 10.2).

However, these services may not be appropriate for all mental health carers. Participants noted the potential benefits of outreach to carers to provide them with accessible information.

> … programs and benefits cannot make a difference if the majority of informal carers are not aware of them … There seems to be no consistency in providing information and little funding to Mental Health Carer organisations like Mental Health Carers Tasmania to support the dissemination of information across the community. (MHCTas, sub. 391, p. 4)

> Carers have identified a range of actions which could be undertaken (or need to continue) to support them … Plain-English, pictorial or translated information about carer and consumer services and organisations. (Carers Victoria, sub. 461, p. 8)

It is important that governments consult with carers about the types of information resources that would help them to discover and access support when they need it. The aim should be to reach carers not yet familiar with mental illness and mental health services and carers less likely to use internet resources. Different strategies may be needed to reach different types of carers, including Aboriginal and Torres Strait Islander carers and culturally and linguistically diverse carers.

Hardcopy resources could be part of the mix of information resources. For example, Mental Health Carers (ARAFMI) Illawarra (2018) designed *A Crisis Manual for Mental Health Carers: An Unexpected Journey*. This resource provides carers with information they might need to navigate the mental health service system and to exercise their rights as carers. Consideration about where to distribute hardcopy resources will be key to the effectiveness of this approach. The distribution strategy could consider schools, cultural service providers and community leaders, and primary health settings such as GPs and Aboriginal Community Controlled Health Services.

DRAFT RECOMMENDATION 13.3 — FAMILY-FOCUSED AND CARER-INCLUSIVE PRACTICE

Family-focused and carer-inclusive care requires mental health services to consider family members' and carers' needs and their role in contributing to the mental health of consumers.

In the short term (in the next 2 years)

- Where this is not already occurring, State and Territory Government mental health services should routinely collect responses to the Carer Experience Survey. The data collected should be sufficient for each Local Hospital Network to compare and assess the level of carer-inclusive practice across its services.

- The Australian Institute of Health and Welfare should use the data to report publicly on survey take-up rates and survey results at the state and territory level.

In the medium term (over 2 – 5 years)

- To improve outcomes for children of parents with mental illness, the National Mental Health Commission should commission a trial and evaluation of the efficacy of employing dedicated staff to facilitate family-focused practice in State and Territory Government mental health services.

- The Australian Government should amend the MBS so that psychologists and other allied health professionals are subsidised:

  – to provide family and couple therapy, where one or more members of the family/couple is experiencing mental illness. These sessions should count towards session limits for psychological therapy

  – for consultations with carers and family members without the care recipient present. Consistent with existing items that are available to psychiatrists, there should be a limit of four subsidised consultations with carers and family members per 12 month period.

14 Income and employment support

Changes to income and employment support programs matter because …	• Employment can improve the mental health of those with pre-existing mental illness. • People with mental illness are underrepresented in the workforce and face barriers to employment. • The Individual Placement and Support (IPS) model of employment support, while still subject to further evaluations, has resulted in increased numbers of people with severe mental illness finding and remaining in employment, compared with other programs. • For people with mild to moderate mental illness, the upcoming shift toward online employment support programs offers scope for employment support that better meets their needs — but ongoing policy development needs to recognise this. • Income support is an important safety net but there may be scope to improve the incentives for Disability Support Pension recipients to return to work.
Successful intervention requires …	As a priority: • The Australian Government should put measures in place to ensure jobactive participants who have a mental illness that inhibits their ability to undertake mutual obligation requirements receive Job Plans suited to their capacity. Additional Government actions include: • Better streaming of participants with mental illness into employment support programs via improved assessment tools. • Extending the IPS model of employment support beyond its current limited application through a staged rollout involving placing IPS employment support specialists in community mental health services — either through direct employment or through partnerships with Disability Employment Services.

The bulk of Australians with mental illness are able to manage their lives without a negative impact on their employment (Orygen Research Centre 2014). However, people with mental illness are underrepresented in the workforce. In 2017-18, 55% of working age Australians with a mental illness were employed, compared with 64% of the wider Australian workforce (ABS 2019g). Most would like to work (Consortium of Australian Psychiatrist-Psychologists, sub. 260; Merri Health, sub. 120; NSW Government, sub. 551; RANZCP, sub. 385). Joblessness lowers their mental wellbeing and increases poverty (Murali and Oyebode 2004; Wilkinson and Marmot 2003).

As for other jobless people, the Australian Government provides employment services to assist people with mental illness to find and keep jobs, and in the meantime provides income support to alleviate the impacts of joblessness on household incomes. Given their distinctive barriers to employment, the design of employment services and income support measures can affect labour market and wellbeing outcomes of people with mental illness in different ways compared with other jobless people. Australia achieves relatively poor labour market outcomes for people with mental illness compared with Organisation for Economic Cooperation and Development leaders such as Switzerland and the Netherlands (OECD 2015b, p. 30). This suggests potentially significant payoffs from improved policy for job seekers with mental illness — the prime focus of this chapter.[77]

14.1 The importance of income and employment support for people with mental ill-health

Employment is beneficial to mental health

Employment is beneficial to mental health. Llena-Nozal (2009) examined data from Australia, Canada, Switzerland and the United Kingdom and found that distress levels fell (representing an improvement in mental health) after people moved into employment and rose after respondents moved into unemployment. Another study found unemployment had a significant negative effect on mental health in each country studied (Australia, Germany, the United States and the United Kingdom) regardless of the unemployment duration and respondent's gender and age (Cygan-Rehm, Kuehnle and Oberfichtner 2017).

Other research has established specific mechanisms through which employment can improve mental health.

- Employment (and re-employment) can act as a restorative psychological process (McClure, Aird and Sinclair 2015; OECD 2012).

- Working gives people a sense of identity, increases social interaction and provides regular communication and shared experiences with people outside the individual's

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[77] Income support for carers of people with mental illness is discussed in chapter 13.

nuclear family, all of which are beneficial to mental health (Goodwin and Kennedy 2005; OECD 2012; Waghorn and Lloyd 2005; Wise Employment, sub. 186).

- The collective effort and purpose of work provides a sense of personal achievement (FCDC 2012; OECD 2012; Waghorn and Lloyd 2005).

- Structured routines improve mental health (OECD 2012).

- Increased employment of people with mental illness benefits more than these individuals — it also reduces the stigma of mental illness throughout the workforce (OECD 2012; Waghorn and Lloyd 2005).

- People with a psychotic illness list their key stressors to be unemployment, loneliness and lack of income, all of which can be addressed through employment (WISE Employment, sub. 186).

A range of other studies have established a positive association between employment and mental health, but not a causal relationship.[78] Examples include Clark (2003), Michon et al (2014), Modini et al (2016a), Stafford, Jackson and Banks (1980), Woodside, Schell and Allison-Hedges (2006). Similarly, correlations between unemployment and suicide (with suicide rates being higher for people unemployed than for people employed), further link mental health and employment status (Milner, Morrell and LaMontagne 2014; Rinaldi et al. 2008).

Notwithstanding this evidence, not all jobs are created equal. Jobs with good working conditions where workers receive appropriate supervision, stress management and social and emotional support, or jobs with high job satisfaction are more beneficial to mental health than others (Faragher, Cass and Cooper 2005; Modini et al. 2016a). Jobs with detrimental psychosocial environments (poor security, control and support) can adversely affect worker mental health (PHAA, sub. 272; as discussed in chapter 19). Working more hours may not always improve mental health — a recent UK study found that only 1-8 hours of work per week is required to gain the psychological benefits of employment (Kamerade et al. 2019). There is also a 'keeping up with the Joneses' effect — if unemployment is widespread (such as during a recession or in societies with entrenched unemployment), it has a reduced (negative) impact on mental health (Clark 2003; Thill, Houssemand and Pignault 2019).

Further evidence on the relationship between employment and mental health is outlined in appendix D.

People with mental illness face barriers to employment

Most people who experience mild to moderate mental illness are able to manage their lives without affecting their employment. But for some, especially those with more severe disorders, there are barriers to employment at the individual and community levels.

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[78] Without causal analysis, the apparent benefit of employment on mental health can be conflated with the adverse impact of an existing mental health condition on employment probability.

At an individual level, a person's mental illness can inhibit their ability to work. It can affect interpersonal, perceptual, affective and cognitive abilities, limiting potential employment options and the number of hours they are able to work (FCDC 2012). For example, schizophrenia may affect concentration and memory (FCDC 2012), while depression may reduce motivation levels and decision-making capacities (Peter Viney, sub. 149, p. 8). For severe episodic mental illnesses, feelings of frustration and helplessness about relapses can undermine work performance (Rutman 1994). The side effects of new medication or dosage changes — such as blurred vision, light headedness or tremors — can also negatively affect employment outcomes (Rutman 1994). The typically lower education levels of people with mental illnesses can further reduce employment opportunities (Cook 2006; Orygen Research Centre 2014; Waghorn et al. 2007).

While *on average*, mental illness affects work performance, this does not mean that this effect is true for any given individual or any given mental illness. Employers can sometimes use the existence of mental illness as a crude and inaccurate indicator of the employment or promotion potential of a job applicant. Moreover, they may generally discriminate against people with mental illness out of fear or prejudice, without an objective assessment of work capabilities (Cook 2006; Peter Viney, sub. 149, pp. 2-8). Even fear of discrimination may prevent people with mental illness from entering the workforce (Orygen Research Centre 2014). Once in employment, people with a psychosocial disability may not feel they can disclose their mental illness without it affecting future employment opportunities (AHRC 2016). This can mean that they seek less treatment or fail to request changes to workplaces, such as reduced hours of work or different tasks that might reduce the adverse impacts of their illness on performance. This leaves them more vulnerable to dismissal or poor career prospects. More generally, low community expectations of the work capacity of people with mental illness may be self-fulfilling — leading to poorer employer training and encouragement, weaker ambitions, and lower self-esteem — which, in turn, leads to worse job performance (Westcott et al. 2015).

Employment support can help overcome these barriers

The combination of individual and community barriers to employment suggest that the matching function of employment services may play a more important role for people with a mental illness than for other job applicants. The average job-ready unemployed person has the option of choosing between many jobs and many employers, which is why the current trial of digital matching services may work well. For those with mental illness (particularly severe mental illness), job outcomes are more sensitive to employer attitudes and the type of job in which the person can succeed. This should be reflected in the design of employment services.

Clinicians may also be able to improve outcomes by moving beyond just achieving good clinical outcomes (relief from symptoms) to also considering the functional outcomes of treatment (re-engaging people with their workplace and/or community) (Westcott et al. 2015). Some clinicians believe that employment will be harmful to their patients and do

not encourage them to find work (FCDC 2012), or believe employment is 'incidental' to the recovery process (Crawley, Fitzgerald and Graham 2007). This is not to suggest that work is appropriate for all people with mental illness or that clinicians should take the place of employment services — merely that clinicians may have greater scope to support the employment aspirations of people with mental illness.

Given the above evidence, *effective* employment services for people with mental illness have the potential for generating better health outcomes and lower health costs, as well as their usual benefits of a more productive economy, higher personal incomes and lower welfare dependence.

The key qualifier above is the imperative for effectiveness. Policy decisions about the form, funding and targeting of employment services depend on the net payoffs associated with variants of such services. Such a cost-benefit approach weighs up the beneficial impact of such services on employment (and its duration), wage income, healthcare savings and non-pecuniary gains against the costs of such services. This framework is particularly useful in deciding how far to move away from the generic provision of employment services to more intensive and targeted forms (section 14.4).

Income support is an important safety net

People with mental illness who are outside the labour force or unemployed will often require government-funded income support and access to concessions (such as lower-cost access to pharmaceuticals or more general benefits from having a health-care card). Australia has a well-developed social security system that is largely blind to the types of disadvantages that prompt disengagement from the labour market, but do take into account the permanence and severity of those disadvantages. For example, access to the Disability Support Pension (DSP) for people is not determined by the cause of disability (with some medical exceptions), but by the level and expected duration of disability and its impact on work capacity. Similarly, access to the temporary benefits provided by the Sickness Allowance depends on *any* legitimate medical condition. This is a sensible approach to welfare payments.

An ideal income support system should distinguish between people whose detachment from work is not a reflection of limited employability, and those who face barriers to employment, potentially due to their mental illness. The former are not considered in any detail by this report. The latter group will include people with:

- less severe mental illness, which constrains employability but to a much lesser extent than for those with severe conditions — such people would typically receive the Newstart or Youth Allowance

- temporary severe mental illness — with Sickness Allowance the relevant payment for those in work prior to its onset and after recovery

- permanent disability, where the likelihood of working consistently is low — the relevant income support for this group is the Disability Support Pension

- episodic severe mental illness, where it would be desirable for people to transition in and out of work, while providing certainty of adequate income support where employment was not realistic — the appropriate form of support for such people is more complex than for others and could vary considerably between people.

Whether payments are at a level that represents an adequate safety net is contentious (particularly in relation to the Newstart program), but as noted in section 14.5, that concern is not specific to people with mental illness and is outside the scope of this inquiry.

However, given the clinical benefits of employment for people with mental illness, there *are* grounds to look through the lens of people with mental illness at the arrangements for accessing various income support measures and for getting employment. Questions like 'I have an episodic mental illness. Will I get on to the DSP? How can I show that? Can I get work when I am well?' may help to identify flaws in the DSP or substantiate that it is working well. Of course, any design change that this lens might suggest has to also be assessed for its effects on people with other disabilities before any policy change should occur. These issues are the subject of section 14.5.

14.2 Current income and employment support programs

The four major income support payments (appendix B; table 14.1) of relevance to working age people with a mental illness are the:

- Newstart Allowance, an unemployment benefit for people required to search actively for a job
- Youth Allowance (job seeker), an unemployment benefit paid to job searchers aged under 22 years
- Youth Allowance (student and apprentice), a payment for full-time students or apprentices aged under 24 years
- DSP, a payment for people with enduring disabilities and a low probability of employment. It is paid at a higher rate than Newstart and Youth Allowance given that the prospects for future work to supplement the payment are low. In this respect, it is notable that the most common reason for exit from the DSP is the transition to the Age Pension. The majority of people on income support with a severe mental illness gravitate to the DSP given the often enduring nature of the associated disabilities.

The majority of Newstart and Youth Allowance (job seeker) recipients and some DSP recipients aged under 35 may be required to participate in employment support programs (appendix B; figure 14.1; table 14.1). Two key programs are:

- jobactive, a program for a wide cohort of participants looking for full-time employment
- Disability Employment Services (DES), a program for jobless people whose main barrier to employment is a disability.

Table 14.1   How many people receive income or employment support?

Number of income support recipients and employment support participants, and program costs (June 2018)

Payment or program	Cohort under consideration	Estimated cost of payments or program for cohort under consideration (2018-19)[a]
Income support payments		
Newstart Allowance	115 700 deemed to have a mental illness	$1.5 billion
Youth Allowance (job seeker)	6 500 deemed to have a mental illness	$61 million
Disability Support Pension	258 000 with a primary psychosocial disability	$5.7 billion
Employment support programs		
jobactive[b]	84 800 deemed to have a mental illness	$193 million
Disability Employment Services[b]	89 500 with a primary psychosocial disability	$323 million

a Estimate is the product of the total program cost (as provided in DSS and DJSB Portfolio Budget Statements for 2019-20) and the proportion of recipients/participants with a mental illness/psychiatric or psychological disability. **b** As at March 2019. **c** May include other non-DES disability employment services (valued at approximately $35 million in 2019-20).

Source: Productivity Commission estimates based on data.gov.au (DSS Payment demographics data – June 2018); DJSB (2019b); DSS (2019c); unpublished data from DSS and DESSFB.

Figure 14.1 **Income support recipients are split between jobactive and Disability Employment Services programs[a,b]**

Income support recipients deemed to have a mental illness or related disability by employment program, June 2018
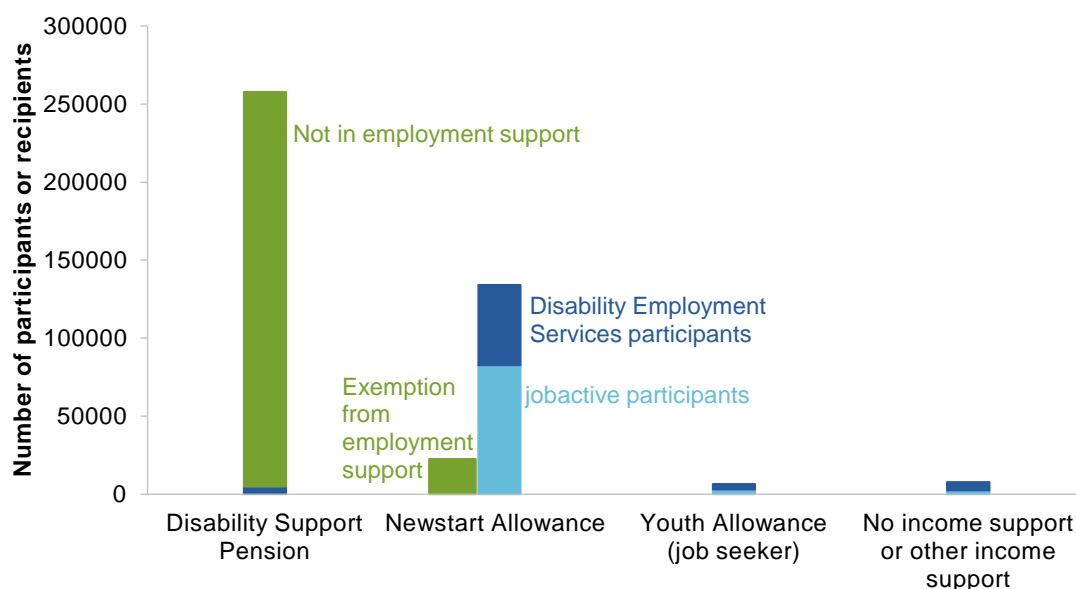
a Reported jobactive, Newstart Allowance and Youth Allowance recipients/participants are those with a mental illness as reported from Job Seeker Classification Index and/or Employment Services Assessment assessments and may not be directly comparable. Reported Disability Employment Services participants are those with a primary psychological or psychiatric disability as reported from ESAt assessment. Reported DSP recipients are those determined to have a primary psychological or psychiatric disability data based on the DSP assessment process. **b** Some Newstart Allowance recipients with an exemption from employment support are also recorded as Disability Employment Services or jobactive participants. **c** DES participants receiving on-going support are excluded. **d** DSP recipients not participating in employment support, or Newstart Allowance recipients exempt from employment support do not need to complete activity requirements.

Source: Unpublished data from DSS and DESSFB.

14.3 Improvements to the employment support system

Assessment and streaming processes

There are concerns that the two instruments — the Job Seeker Classification Index (JSCI) and the Employment Services Assessment (ESAt) (appendix B) — used by the Department of Human Services to stream jobless people into the different variants of employment services may too often misclassify people with a significant mental illness. This is problematic as it affects the supports people receive and their employment outcomes.

The JSCI is a brief assessment (usually conducted over the phone in less than five minutes (EERC 2019)) that relies on participants disclosing information about employment barriers, including mental health issues (EERC 2019). The most significant concern is that participants may be unwilling to disclose mental illnesses or the potentially debilitating nature of their

condition, which leads to them being inappropriately placed in a lower support stream than necessary.

Two aspects of the survey may accentuate the risk of non-disclosure. Participants are told that answering medical questions is voluntary. In addition, the JSCI does not pose any specific question concerning mental illness, but instead two broad questions relating to any disabilities or medical conditions that affect working hours or job type (Australian Government 2018b). People with mental illness may not always see their problem through a medical or disability lens, without more specific guidance about what comprises an illness. As such, there is evidence that the JSCI does not comprehensively assess participants' mental illness:

- yourtown (sub. 511, p. 8) submitted that '[the JSCI] has been found to not accurately stream clients, and as a result many clients with complex issues such as mental health, homelessness or post detention find themselves placed into Stream A, which is designed to assist job seekers with a high level of independence.'

- Estimates of the prevalence of mental health conditions for Newstart and Youth Allowance recipients (who make up the bulk of employment support participants), suggest 42% of Newstart and 29% of Youth Allowance recipients had a mental health condition in 2014-15 (ABS 2015c). This is substantially higher than self-reported statistics from the JSCI (14% and 7% respectively in 2018) (unpublished data from DSS).

In principle, the accuracy and precision of the JSCI in detecting mental illness that affects work capability could be enhanced by adding a validated mental health instrument to the broad question about the presence of disabilities or medical conditions (as suggested by the OECD 2015b). Crude calculations suggest that the aggregate costs of adding a short diagnostic tool (say of 10 questions) are not significant when set against other administrative costs of jobactive, and the personal and other costs of streaming people into the wrong programs. Nevertheless, the risk of adding further questions to the JSCI on mental illness is that there would be equivalent arguments for other refinements — such as more detail on other medical conditions or other factors impeding employment, which would start to overload the instrument in its current form. Online completion of the JSCI (currently being trialled) may lower the incremental costs of additional questions, but it will be important to assess whether an online (compared with face-to-face or phone-based) JSCI leads to better or worse identification of mental illness. Regardless, there are grounds, if nothing else, for more specific guidance to JSCI respondents about the kinds of disabilities or medical conditions that are relevant to the assessment (for example, specifically asking about the presence of anxiety or depression).

A more radical initiative would be to shift away from self-reported data and the current statistical model to the use of administrative data and more sophisticated statistical analysis (such as artificial intelligence and machine learning). Belgium and Austria have implemented employment profiling tools using these approaches (OECD 2018b).

Participants are referred to a more thorough assessment process — the ESAt — if the JSCI identifies barriers to employment. This is undertaken by an allied health professional and in

a face-to-face setting in about 80% of cases (SSCEEWR 2013). However, there are concerns that it is too generic and not adequately geared toward the needs of people with mental illness. Waghorn and Hielscher (2014, p. 3) proposed that it could be buttressed by including the mental illness-specific measures:

> [T]he DES eligibility classification system could be enhanced by providing assessors with specialised training in mental health, particularly psychosis. This could include developing a new assessment tool to classify the overall employment-related severity of psychiatric disability. Promising components of such a tool include the Personal and Social Performance (PSP) Scale, as well as measures of duration of illness and course pattern of illness. The last two in particular are brief and can be assessed from treatment history, and all three are correlated with employment status in the second national survey of psychosis. Such a tool could be developed by policy makers. If found reliable and valid, it could prevent much of the misclassification of people with psychiatric disorders that is so often reported by those involved with job capacity assessments.

Before adding instruments to the ESAt, consideration of context, training and costs is necessary. The Personal and Social Performance scale may be a viable option based on positive reviews of its reliability (Burgess et al. 2016) and ability to predict employment outcomes (Waghorn and Hielscher 2014). However, there may well be other equally suitable instruments.

Any assessment requires an assessor. Workforce shortages in regional and remote areas appear to hinder the use of ESAts, leading to inappropriate streaming toward lower levels of support and higher mutual obligation requirements (MORs) (NSSRN, sub. 283) — a matter considered further in section 14.5.

DRAFT RECOMMENDATION 14.1 — EMPLOYMENT SUPPORT ASSESSMENT MEASURES

Assessment tools for jobactive and Disability Employment Services participants should be more relevant to job seekers with mental illness.

In the short term (in the next 2 years)

The Departments of Social Services; Human Services; and Employment, Skills, Small and Family Business should review the jobactive and Disability Employment Services assessment tools to increase their relevance for job seekers with mental illness. The review should consider:

- providing more specific guidance to job seekers answering the Job Seeker Classification Instrument about the types of medical illnesses or disabilities relevant to employability

- adding a short-form mental health diagnostic instrument to the Job Seeker Classification Instrument

- a new instrument for predicting employment likelihood based on a blend of administrative and self-reported data, and using more sophisticated analytical tools

- supplementing the Employment Services Assessment with the Personal and Social Performance Scale or similar instrument.

Effectiveness of employment support services for people with mental ill-health

Many service providers and advocacy groups, and some service users have argued that standard jobactive services are inadequate for people with mental illness, and indeed can exacerbate their illness (box 14.1).

Box 14.1   Stakeholder views about program effectiveness

Advanced Personnel Management, a jobactive provider, told a recent Senate Inquiry that mental health issues 'are not currently being serviced appropriately' under jobactive (EERC 2019, p. 73).

yourtown, a jobactive provider, submitted that:

> [G]iven the structure and high case load of jobactive, it is extremely difficult to meet the mental health needs of young people who present with them through the program due to the lack of funding to support psychological and/or psychiatric interventions. (sub. 511, p. 8)

The NSSRN, a peak community organisation in the area of income support law, policy and administration submitted that:

> Job providers can assist people to actively engage and participate in the labour workforce. However, to do this effectively in the case of people living with mental illness, it is critical that the job provider have the expertise and capacity to understand their particular needs.

> In our members' experience, job providers which are not specialist Disability Employment Service Providers often do not have this capacity or expertise and are therefore unable to provide adequate support. For example, it is common for job providers to offer a person living with mental illness employment that is incompatible with their condition and negatively impacts on their mental health (sub. 283, pp. 4-5).

Users of jobactive services have criticised jobactive providers as being unhelpful to their job search or indicated that jobactive participation negatively affected their mental health:

> My new job plan now states I must "take responsibility" for finding my own work and to report (online) my attendances at all required activities. This begs the question. "What is the provider being paid to do?" (EERC 2019, p. 61).

> They seem to be stretched so thin, I'm sure that individually they're fine at their jobs but due to the sheer volume of people they need to deal with, you'd never know (ACOSS 2018, p. 57).

> Employment agency and Centrelink requirements continue to be the number one reason in forcing me to stop work/study/volunteer work (CHF, sub. 496, p. 41).

> … sometimes it has made me feel suicidal. I feel depersonalised and a failure in general. That I don't have the same rights as an employed person (ACOSS 2018, p. 13).

Submitters to this inquiry have also critiqued the effectiveness of Disability Employment Services providers, with one stating the program is 'uneconomic, inefficient and ineffective' (David Clark, sub. 205, p. 5).

It is certainly true that outcomes for jobactive participants with mental illness are worse than others. People deemed to have mental illness made up 13% of the jobactive cohort in February 2019 (DJSB, sub 302), but only just over 7% of job placements found between July 2015 and February 2019 went to participants with a mental illness (unpublished data from DESSFB). Additionally, 82% of jobactive participants with a mental illness have spent

more than 12 months in employment services (compared to 64% of the wider jobactive population (unpublished data from DESSFB).

Outcomes for people with mental illness in DES are also worse than those with other disabilities. People with mental illness comprised 40% of the DES cohort in June 2019 but only represented 20% of total employment outcomes for the month (inclusive of 4, 12 and 26 week placements) (LMIP 2019c).

However, such figures are misleading indicators of program effectiveness. Given the barriers to employment faced by people with mental illness, it is inevitable that this cohort in jobactive would achieve fewer outcomes than those without such illness. The issues are whether there is:

- a cost-effective way of improving outcomes for people with mental illness by improving screening and then streaming them into the second tier of jobactive (Digital Plus) or into DES

- scope to improve the design of existing employment support services to secure better outcomes.

Assessing the first of these questions requires a rigorous evaluation, which is beyond the scope of this inquiry. There are considerable technical problems in undertaking such an evaluation as well, since comparisons of outcomes for people with mental illness in DES and jobactive would need to control for the fact that the groups have different severities of mental illness.

The second question may at least be partly assessed by considering the outcomes of more intensive interventions for people with mental illness compared with existing interventions. The evidence from Individual Placement and Support (IPS) models provides one vein of such evidence (discussed later), while the qualitative evidence from participants in this inquiry (box 14.1) also suggest that re-design may produce better outcomes. As noted above, evidence from other OECD countries also demonstrate that it is feasible to get much better employment outcomes for people with mental illness.

Future of the jobactive program

The anticipated Australia-wide extension of the current trial of online provision of jobactive services to Newstart recipients (appendix B) would, on face value, have benefits for job seekers, including those with a mental illness. The new system offers the scope for more flexible activities that can meet mutual obligation requirements (the latter being likely of particular benefit to those with mental illness, as those participants who fail to meet requirements face punitive measures of payment cuts and suspensions) and for avoiding the costs of traveling for currently obligatory face-to-face meetings with service providers. Cost savings from an online-only service for job-ready job seekers (Digital First) may help finance more intensive support for job seekers with more complex needs. Digital First is also open to all Australians, which may improve job accessibility for people with mental illness

who are not on income support. Real time data from a digital service also has the potential for more sophisticated matching of job seekers to jobs — with this likely to be of greatest benefit for those where matching is currently crude (including those with mental illness).

While not planned as a feature of the system, a digital approach to job services also offers the scope for the low cost introduction of complementary employment services. A recent German study found that participants who have an online peer support group experience higher self-efficacy (belief in capacity to job search and find employment) and are more likely to acquire skills relevant to employment (Felgenhauer et al. 2019). The advantage of digital platforms is that the largest cost of any change is borne during the development phase, with the incremental costs close to zero for a developed service.

However, some commentators are concerned about the risks of the new model. Digital First is intended for people who are job-ready and digitally literate, but many people with mental illness may be allocated to this stream despite being ill-suited to it. As noted above, the evidence suggests that many people with a mental illness are not identified using the JSCI and will be expected to access employment services autonomously using Digital First. This suggests that where a job seeker provides additional evidence of illness (or signs of illness evident from a person's patterns of use of the app), it should be straightforward to shift from Digital First (no human support) to Digital Plus or Enhanced Services (where face-to-face assistance is available). It further reinforces the value of an improved capacity of the JSCI to determine the presence of mental illness in a job seeker.

In addition, 16% of jobactive clients who self-reported a mental illness are currently allocated to stream A jobactive services (DJSB, sub. 302). This is the lowest level of support — but one where face-to-face interactions still occur and may reveal more serious obstacles to employment than suggested by the JSCI. Were this group to be enrolled in Digital First, then there is no watchful human eye on the person's vulnerabilities, and the cost of misclassification for the person and society could be significant. It may be prudent not to allocate anyone disclosing a mental disorder to Digital First without further assessment of their capacity to seek a job unaided by any service provider.[79]

A further concern is that some people may struggle with the technology (the JSCI does not assess digital literacy), with adverse consequences for effective job seeking and a higher risk of accidentally breaching compliance requirements. In the consultation phase before commencement of the trial, stakeholders argued that payment suspensions or cancellations imposed for apparent non-compliance for someone using a purely digital system should be followed up in-person before they are applied (NESA 2018a; Nous Group 2018a). This would give providers the opportunity to review a participant's capacity to meet their activity requirements and ensure they do not face unduly severe financial penalties that are likely to contribute to a relapse in their mental illness. Participants moving between penalty zones under

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[79] Given that the model underpinning the JSCI would have to be re-estimated if mental health diagnostic questions were included, there may also be grounds to amend the model so that it takes account of the costs of misclassification (noting too that the last evaluation of the JSCI was in 2009). For example, using cost-sensitive machine learning classification — a widely employed approach where classification errors produces high costs.

the new compliance framework should have their activity requirements reviewed (DSS 2018b), which should take this into account.

The ongoing monitoring and evaluation of the New Employment Services Trial should cover these concerns so any deficiencies in the design can be addressed before the national rollout.

DRAFT RECOMMENDATION 14.2 — TAILOR ONLINE EMPLOYMENT SERVICES

Ongoing development of the New Employment Services should consider the needs of participants with mental illness.

In the short term (over next 2 years)

As part of the national rollout of New Employment Services, and drawing on evidence of the trial underway from 2019 to 2022, the Department of Employment, Skills, Small and Family Business should:

- assess the potential for online peer group support for participants with mental illness as part of the Digital First software

- consider adaptation of the use of the Job Seeker Classification Instrument so that anyone reporting a mental illness is referred for personal assessment before being allocated to Digital First

- ensure participants with inadequate digital literacy and/or mental illness maintain access to face-to-face services

- ensure scope for participants to inform service providers of relapse in mental illness in a timely manner.

14.4   Toward an Individual Placement and Support model of employment support

The dominant model for employment services of people with complex, enduring or severe mental illness — DES — is largely underpinned by a focus on meeting activity requirements and a funding model that inevitably requires large caseloads, which limits the capacity for truly tailored services. DES is less suited to this group, for whom getting and keeping a job will often require ongoing support and coordination with the person's clinical mental health services.

An emerging model that integrates employment with on-the-job training and clinical supports — so-called Individual Placement and Support (IPS) programs for people with mental illness — holds some promise for this subgroup of DES participants, as well as some DSP recipients who are not presently engaged with employment services. The IPS approach involves a rapid job search followed by on-the-job training (known as a 'place-train' focus), ongoing support from caseworkers after employment and tight integration between employment and clinical support (box 14.2).

Box 14.2 What is IPS?

The Individual Placement and Support (IPS) model comes in two broad forms — the ideal form as conceptualised by the model's designers and the real world models that have been implemented, which can vary from the 'ideal' model in some of the details while adhering to its fundamental features. Overall, success of the IPS model (and the capacity to evaluate it rigorously) has been ascribed to relatively high fidelity of real world versions to the original model (appendix B).

The central coordinator in the IPS model is an employment specialist, who delivers an individualised job search service for participants with mental illness, whilst working alongside participants' clinical team to coordinate care. Support is provided before, during and after a participant finds employment. Participants choose to enter the program and decide the focus of job searches, whilst receiving support to understand the impact of work on welfare payments.

IPS specialists offer hands-on, personalised support to participants. Caseloads are small (prescribed at 25 in the ideal model) and specialists are expected to spend most of their time (70% in the ideal model) engaging with the community or employers (which can include meeting with participants outside the office) (Lawlor and Perkins 2009). Work preferences of participants are prioritised and specialists take on the majority of the burden of job search, often meeting with employers before arranging job interviews for participants. Specialists are expected to develop a strong understanding of participant's work capacity and workplace requirements.

To do so, specialists work with clinicians to schedule job opportunities at viable times in a participant's treatment plan (for example, they would avoid job interviews shortly after a medication change). Specialists may also pass on participants' employment performance to their clinician if their health is deteriorating, and clinicians (due to strong relationship with participants) can ensure a participants long-term goals are being met (FCDC 2012; Rinaldi et al. 2008).

Participants receive support to prepare for and find work. Once in a job, they continue to receive support from their employment specialist (e.g. job coaching, career development or negotiating pay rises) (Becker et al. 2007).

Due to links between employment and income supports systems, mainstream employment support providers tend to spend most of their time working through income support activity requirements with participants and have little time to connect with employers (Bennett et al. 2018; EERC 2019). They tend not to liaise with participants' clinicians, place job search responsibilities on the participant (EERC 2019), and funding for on-going support is limited (e.g. quarterly on-going support funding is only available for ESS participants (DSS 2018g)).

IPS programs follow some key principles:

- competitive employment (employment in the mainstream labour market)
- open to anyone who wants to work — zero exclusion
- rapid job search
- counselling on the impacts of moving from welfare to work on income
- focus on client preferences in services and job searches
- integration with mental health treatment
- ongoing, time unlimited support (Bond, Drake and Becker 2012; Lexen, Emmelin and Bejerholm 2016).

The IPS model has not been widely adopted in Australia or elsewhere. There are two ways that the IPS model operates in Australia (box 14.3).

- 31 full-time equivalent IPS specialists are employed by the 14 headspace sites taking part in the headspace IPS trial and 4 full-time equivalents are employed by Orygen Youth Health (Waghorn et al. 2019).

- A further 53 full-time equivalent IPS specialists were employed by a DES provider operating according to IPS principles in partnership with a clinical mental health service (in practice, a community mental health service provided by a State or Territory Government) (Waghorn et al. 2019).

The first Australian IPS program was established in 2005, and in June 2018 there were a total of 88 full-time equivalent IPS employment specialists across the country, in the two operation models above (Waghorn et al. 2019; box 14.3). Assuming normal caseloads per specialist, this amounts to about 2000 clients — a very small share of job seekers with severe mental illness. By contrast, the current DES contract engages 134 non-government organisations delivering services from 4000 sites (Waghorn et al. 2019), with more than total 238 000 participants in June 2019 (LMIP 2019a).

Evidence underpinning the IPS model

Trials in Australia and abroad have shown that the IPS model outperforms conventional approaches, with superior vocational outcomes (greater employment of job seekers) and non-vocational results (improved mental health leading to reduced need for healthcare). The effects are often large — sometimes with employment rates of the order of 40 percentage points greater than conventional programs (table 14.2).

A Cochrane systematic review (the gold standard for meta analyses) of the effectiveness of various kinds of employment interventions for adults with severe and persistent mental illness found that the IPS model was more effective in securing competitive job outcomes than other interventions (Suijkerbuijk et al. 2017). Some evidence points to enduring outcomes, with a 12-year trial finding that IPS participants were better able to negotiate work conditions and transition between jobs than participants in the control group (Becker et al. 2007).

Notwithstanding that the IPS model leads to better employment outcomes and reduced healthcare costs when compared with conventional employment support models, its more labour-intensive nature means that it costs significantly more to administer, raising the issue of cost effectiveness. While few studies have examined cost effectiveness, global evidence suggests that its additional benefits exceed its additional costs (Cimera 2016; Hoffman et al. 2014; Knapp et al. 2013; Shi 2011; Vukadin et al. 2018). For example, a UK study found every £1 spent on IPS saved £1.41 compared to the counterfactual, partially driven by a fall in demand for healthcare and social security payments (van Stolk et al. 2014).

Box 14.3   Examples of the Individual Placement and Support model in Australia

Individual provider trials

In 2005, an Orygen Youth Mental Health centre in Melbourne directly employed an Individual Placement and Support (IPS) specialist to assist youth aged 15 to 25 years with mental illness in finding employment. Participants could receive up to 18 months of assistance, and the specialist also assisted participants to complete relevant income support payment activity tests.

The Mental Illness Fellowship Victoria (a Disability Employment Services (DES) provider) placed an IPS employment specialist in a community mental health team (St Vincent's Hospital) in Melbourne in 2006.

In 2006, the Hunter New England Mental Health Service supplied a part-time employment specialist to run an IPS program through a DES partnership with Castle Personnel. The employment specialist was located in healthcare services part-time. Their role expanded past employment search to also support participants into short vocational training courses (if they were deemed relevant to employment outcomes).

West Moreton Integrated Mental Health Services and the Park Centre for Mental Health partnered with Workline, a psychiatric disability employment service, in 2007. Two employment specialists worked across multiple offices to assist remote participants.

Worktrainers (DES provider), the Mental Illness Fellowship Victoria and the Victorian Government Mental Health Service partnered to form an IPS-style employment system in 2006. Their employment specialist worked full-time with all three departments within the Goulburn Valley.

Ruah Workright is a DES provider partnered with the Western Australia Mental Health Service. Two part-time IPS employment specialists work across two offices in Perth.

National trials

In 2016, the Australian Government commenced a 3 year, $13.6 million trial of an IPS program for younger people, delivered by 14 headspace locations across Australia. The Australian Government separately funds the evaluation of the program and 'fidelity' reviews — the latter to test that the funded activities do not vary significantly from those specified in the ideal model as discussed in appendix B. The trials employ a total of 31 employment specialists who have worked with 879 participants.

Available services for participants include job coaching, assistance finding community support services and Centrelink, education and employment opportunities, and ongoing support. Eligible participants must be: a person with a mental illness under the age of 25 years, a client of headspace in the trial site, have employment or education goals and be experiencing barriers to achieving said goals, and be willing and able to choose to participate in the program. The full results of the trial are yet to be released but a two-year extension and funding for an additional 10 trial sites was announced in January 2019. The placement rate of an education or employment outcome for 9 sites was 72% and the average placement rate for all 14 sites was 50%.

Source: DSS (2018k); Mental Health Council of Australia (2007)*; Orygen and headspace (sub. 204); Waghorn et al (2007, 2019).

Table 14.2   **Individual Placement and Support trial results**

From Australian trials and international meta-analyses

Reference	Location	Time frame	No. of participants	Findings
Parletta and Waghorn and (2016)	Australia	18 months	68 IPS, 107 control	• 11.5% more IPS participants achieved a job commencement, compared to the control group • IPS programs generated more net revenue than the control for those with more severe illnesses
Killackey et al (2008)	Australia	6 months	20 IPS, 21 control	• 36% more IPS participants found employment compared to the control group • 25% less of the IPS group's primary source of income was welfare (control group did not change) • IPS worked more weeks (8.63 vs 3.80), worked more hours per week (33.90 vs 22.50) and earned more during the course of the trial ($3615 vs $4449) despite earning $1.40 less per hour
Waghorn et al (2014)	Australia	12 months	106 IPS, 102 control	• IPS participants had were more likely to commence employment (31% and 43% of IPS participants employed at 6 and 12 months respectively, compared to 19% and 24% of control group participants)
Marshall et al (2014)	Meta-analysis (international)	6 months -12 years	Varies (17 studies considered)	• IPS consistently demonstrated higher rates of competitive employment, fewer days until first competitive job, worked more hours over more weeks and earned higher wages
Kinoshita et al (2013)	Cochrane review (Australia and international)	6 - 24 months	Varies (14 studies considered)	• IPS participants spent more time in competitive employment than control groups • IPS participants spent more time in paid employment than control groups
Suijkerbuijk et al (2017)	Cochrane review (Australia and international)	3 months - 5 years	Varies (48 studies considered)	• IPS and augmented IPS programs were the most effective interventions for people with severe mental illness to obtain and maintain employment (regardless of the trial duration) • IPS participants had better mental health in the long-term follow up (> 12 months) • IPS participants had better quality of life compared to participants who only received psychiatric care in the long-term

Obstacles to the use of the IPS model

Cultural and funding barriers appear to be the dominant constraints in the diffusion of the model, though each plays out in different ways for the two implementation pathways for IPS services.

Some public community mental health services do not consider vocational rehabilitation as part of their core business (Waghorn and Hielscher 2014). Those that do may be unwilling to devote their resource constrained funding towards it. There is also a federal issue here — State and Territory Governments, which are responsible for public community mental health services, could support an IPS model, but may be unwilling to do so because employment support is the responsibility of the Australian Government (Waghorn et al. 2019).

Take-up by DES employers looks ostensibly achievable. The DES model gives considerable flexibility in *how* providers deliver employment support services, with this applicable to all DES providers across Australia. However, an open question is whether the blended volume- and outcomes-based payments for DES providers are sufficient to fund the IPS model. Notwithstanding the impressions of DES providers, one assessment found that it *was* financially viable to adopt an IPS model within the 2010–2018 DES payment model, particularly when adopted for participants with more severe disabilities. (Parletta and Waghorn 2016). But this study did not consider the transition costs that conventional DES providers would bear in making such a switch (such as additional staff training and the need to co-locate with a community mental health service). It is not clear whether the higher outcome payments for the most hard-to-place job seekers announced as part of the DES Reform in 2018 would be sufficient to fund these transitional costs. Also, the significant benefits from reduced hospitalisation following adoption of the IPS model are largely captured by State and Territory Governments, and therefore not a very relevant factor in determining the level of desirable outcome payments. As in healthcare generally, value capture from programs that have benefits spread across different levels of government require cooperation.

There are several other obstacles to provision of IPS within the DES framework. The IPS model draws its client base from those seeking treatment in a community mental health service, many of whom will not be enrolled in DES services.[80] In addition, while some DES providers have allied themselves with clinical services, this represents as significant a cultural shift for employment providers as it does for clinical services.

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[80] Trials of the IPS model in Australia (DES and community mental health service partnerships) have featured sizeable proportions of participants that were DSP recipients, with many not previously receiving employment support. In a 2014 trial, 68% of the participants were DSP recipients and 74% had not received assistance with job seeking in the past year (Waghorn et al. 2014). In a 2016 trial, 24% of participants were DSP recipients (Parletta and Waghorn 2016).

The route to broader adoption of the IPS model

These obstacles do not preclude the wider adoption of the IPS model. Cultural shifts can be achieved through demonstrations and purposeful diffusion among those not yet familiar with the model. Also, the Australian and State and Territory Governments may be willing to cooperate where there are shared gains, or where the benefits are seen as big enough, if not equally shared. Notwithstanding its mixed success, had it worked as anticipated, many of the dividends from the Australian Government-funded Diabetes Care Trial would have accrued to State and Territory Governments through reduced hospitalisations. The current Health Care Home trial is of a similar ilk.

Three aspects are strongly in favour of the new model. There is good evidence of efficacy. The nature of the intervention has been very clearly defined (box 14.2) so that governments know what to implement with some precision. And the target group for the intervention is established (people with severe and persistent mental illness, often psychosis, receiving treatment through a community mental health service and who wish to work).

The big remaining questions are who should deliver and fund IPS services, how to roll out the program, and how to learn systematically from it — and for all governments, some comfort that the model is affordable.

Who should deliver Individual Placement and Support services?

Co-location of clinical and IPS staff is the norm under existing arrangements, but co-location alone may not be sufficient to drive integration due to differences between organisational cultures (Hutchinson et al. 2018) and issues of confidentiality, insurance and other legal issues that can inhibit communication (Waghorn et al. 2007). A single employer — likely the Local Hospital Network in an Australian context — may better promote integration between teams, as found in trials in the Netherlands and the United Kingdom (Hutchinson et al. 2018; Vukadin et al. 2018).

Moreover, there is some concern about the sustainability and transaction costs of relationships between a business or not-for-profit DES provider and a public community mental health service. For example, a DES and community mental health service partnership in Queensland performed well from 2010 to 2016, but declined in 2017 after changes in leadership and funding (Waghorn et al. 2019). A subsequent audit revealed that service had deviated from the optimal form of the IPS model, in part due to a reduction in integration between the DES provider and the community mental health service.

That said, neither the face validity of the single employer model nor one instance of declining performance by a DES provider is sufficient to compel adoption of one mode of delivering the IPS model. This suggests that offering an IPS model should not be closed off to a DES provider if it can find a community mental health service that wishes to ally itself with it. The deep connections that some DES providers have with employers might be an advantage.

Who should fund IPS services?

All levels of governments benefit from the IPS model, suggesting a cooperative funding model — perhaps through a national partnership. However, it may be that the 2018 funding model for DES — funded by the Australian Government — will at least kick-start provision of the IPS model through DES. That should not preclude the Australian Government from participating in joint funding of the 'single-employer' approach (where a Local Hospital Network employs an employment specialist to co-locate within community mental health services) – channelled through payments to the states and territories, especially given that this may ultimately be the best vehicle for program delivery.

Another complementary option would be for the Australian Government to trial a new type of DES for the relevant target group, based on fee-for-service compensation and subject to strict adherence to the IPS model. This would be particularly relevant if the current DES funding model is not well suited to that role.

At this stage, it is premature to be prescriptive about the funding options.

How should a rollout occur?

It would be unwise to implement a full scale rollout of the program.

A workforce of IPS specialists needs to be created and cultural animosity to linkages between clinical and employment services managed.

While the IPS model is the most evidence-based approach to providing employment support for people with severe mental health problems (as noted by Waghorn et al. 2019), the results principally relate to people with psychosis and may not generalise to all conditions. There is also some weak evidence that so-called 'augmented' versions of the IPS model — which include IPS with other interventions such as cognitive skills training — may further improve outcomes (Suijkerbuijk et al. 2017). This suggests that adaptations to the model will likely be needed as it is implemented for different groups or as the empirical evidence grows. There is, for example, evidence that the outcomes for job tenure (often relatively short) are improved if jobs match the job seeker's preferences (Lawlor and Perkins 2009), which should inform best practice implementation of the model.

Moreover, while there are many instances where the IPS model has been adopted, most have involved small numbers of participants. For example of the 48 randomised controlled trials underpinning the Cochrane systematic review, the average number of participants per trial was 182 (roughly half of which would receive the usual employment support service as a control group, while the other half received IPS style services). While it is hard to determine

the likely size of the target group for the IPS model under a full rollout (given voluntary enrolment, among other factors), it could be of the order of 50 000 job seekers.[81]

It has generally been hard to replicate the outcomes of small scale social programs when delivered to large populations. For instance, while it is possible to build up the workforce of IPS specialists, it is difficult to ensure that the last is as good as the first. Likewise, erosion of fidelity to the IPS model is a risk (Bond et al. 2016). Fidelity can be assessed by routine audits against established scales (appendix B). Ongoing monitoring of outcomes and periodic evaluation would be required to test that effectiveness is being maintained with program expansion and to identify potentially underperforming services.

While the numerous assessments of the IPS model have covered diverse populations (veterans, different ethnicities, young and older people), the small scale of each program has not been sufficient to test differences in the effectiveness of the model across different types of people and different conditions. Effectiveness for different types of people (and in different locations and macroeconomic conditions) should be subject to testing as the model is expanded, and may lead to variations in eligibility conditions. There is some evidence that people with less severe mental illness may also benefit from IPS. The current headspace trial for young people will provide some evidence on that score because this group typically have less severe illness. Whether the results for this group will translate to older people would need testing.

Systematic learning and 'comfort for funders'

While the concept of 'fidelity' with the original IPS model is a mechanism for avoiding the erosion of service quality by particular providers, it could stultify innovation and learning if it precludes any changes to the overall model. As noted earlier, there may be a role for augmented services, and there may be practices that increase the likelihood that a person stays in a job through more careful matching of job seeker preferences and available jobs.

Moreover, while the concept of 'zero exclusion' avoids cream-skimming by individual service providers, this should not stop adjustment of the eligibility criteria for the model as a whole as learning about effectiveness for different sub-groups becomes apparent. For instance, this may involve people with different severities of illness (widening eligibility) or excluding across all sites, categories of people where the benefits of interventions are likely to be significantly exceeded by the costs. For instance, if someone has an extreme mental

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[81] Some indicative numbers are available based on rough estimates of groups that receive treatment through community mental health services. In 2016-17 there were approximately 208 000 community mental health service patients, aged 18–44 (AIHW 2018). Not all patients were out of work. In 2010, the employment rate of Australians with psychosis was 22% in 2010 (similar to an employment rate of 28% for people with schizophrenia in Victoria in 2006) (FCDC 2012, p. 29; Morgan et al. 2012). If the former value was used as a rough estimate for all types of severe illness, then it would imply a population of about 162 000. Not all patients would need the IPS program (over other employment support options) because IPS is intended for patients with the most severe illness (those receiving medium to long-term treatment). This is approximately 41% of all patients, leaving about 96 000 potential IPS participants (AIHW 2018). Around 60% of surveyed people with schizophrenia want to work, leaving slightly more than 50 000 people (Waghorn and Hielscher 2014).

illness and has never been able to obtain a job despite repeated high-level support, at some point, the service might reasonably not be offered any longer.

Learning and re-calibration of the model requires systematic data collection shared between jurisdictions, explicit diffusion mechanisms for best-practice throughout Australia, and periodic nationwide evaluation. The institutions and processes for achieving this learning should be specified at the outset.

A monitoring and evaluation approach of this kind should provide comfort to funders that the program could be scaled up while maintaining the net benefits of the trials. If this is not apparent, there should be a re-think of the design of the scheme.

A further source of de-risking is to ensure that the rollout follows a realistic timetable. A lesson from the rollout of the National Disability Insurance Scheme was that its implementation timetable was far too ambitious, placing pressures on quality and giving false hope to people about the likely access to services (PC 2017d). While the desired timetable for a rollout should be subject to critical assessment, five years may be enough. However, there should be explicit recognition that the rollout should be paused if the initial planned implementation period looks unattainable.

DRAFT RECOMMENDATION 14.3 — STAGED ROLLOUT OF INDIVIDUAL PLACEMENT AND SUPPORT MODEL

The Individual Placement and Support (IPS) model of employment support should be extended beyond its current limited application through a staged rollout to (potentially) all State and Territory Government community mental health services, involving co-location of IPS employment support services.

The Commission is seeking further feedback on whether this should occur through partnerships between dedicated IPS providers and community mental health services, or direct employment of IPS specialists by community mental health services.

In the short term (over next 2 years)

- Governments should thoroughly trial and evaluate the IPS program to better establish the factors that influence its cost-effectiveness (for example, the impacts of local labour market conditions and participant characteristics).

- The program should initially be open to all non-employed consumers of community mental health services who express a desire to participate and meet the other requirements of the IPS model. Participation in the program should fulfil mutual obligation requirements for income support recipients.

In the medium term (over 2–5 years)

Subject to these trials, the IPS program should be rolled out gradually with data shared across jurisdictions and a mechanism for diffusion of best practice. If the net benefits of the program apparent in the small scale trials are not replicated as the program is scaled up, its design (and if necessary, its desirability) should be re-appraised.

INFORMATION REQUEST 14.1 — INDIVIDUAL PLACEMENT AND SUPPORT EXPANSION OPTIONS

The Productivity Commission is seeking further information about the pros and cons of the two distinct options for expanding the Individual Placement and Support (IPS) model of employment support. The options are:

- *direct employment of IPS employment specialists by State and Territory Government community mental health services. This could be supported by additional Australian Government funding*

- *a new Australian Government-administered contract for IPS providers, based on fee-for-service compensation and subject to strict adherence to the IPS model (including that a partnership is in place with a State and Territory Government community mental health service).*

What are the pros and cons of each option? Which is your preferred option and why? If the direct employment option is pursued, how should State and Territory Local Hospital Networks be funded to deliver the service?

14.5   Income support benefits and incentives

This section focuses on how the current suite of income support payments can meet the needs of people with a mental illness, provided that some access issues and incentives are addressed.

As noted earlier, those with mental illness who are not eligible for the DSP, but remain in need of income support, may receive either the Newstart or Youth Allowances. Submitters to this inquiry raised concerns regarding the adequacy of Newstart payments,[82] which have been further amplified through recent tightening of DSP eligibility criteria (box 14.4). For example:

> I am receiving Newstart, but it is not enough to live on. … I'm struggling to pay my rent, I have to choose between food, medicine and paying my bills. … Living like this, without enough money or support: it is unspeakably awful: it makes you feel like no-one cares, like you don't matter. I want to see my psychologist but I can't even afford to do that. I'm in a dark place. (Service consumer, ACT Disability, Aged and Carer Advocacy Service, sub. 493, p. 16)

> I have severe anxiety and OCD. My main struggles have been finding help and having enough money to live, … I'm on Newstart while my DSP application is assessed. I cannot afford a rental anywhere in Vic. I am 32 and I have been forced to move home, putting more financial strain on my mum, who already supports me a lot. Anyone without my level of family support would be homeless. (comment no. 34, consumers)

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[82] These included Anglicare Australia (sub. 376), ACOSS (sub. 270), cohealth (sub. 231), JA (sub. 398), Joe Calleja (sub. 422), Karen Donnelly (sub. 90), KLC (sub. 469), MHCT (sub. 314), Name Withheld (sub. 136), NSSRN (sub. 283), CCL (sub. 484), Mission Australia (sub. 487), QAI (sub. 116), Uniting VIC. Tas (sub. 95), Victoria Legal Aid (sub. 500), VCOSS (sub. 478) and the Consumer Health Forum of Australia (sub. 404).

Box 14.4   Impacts of changes to Disability Support Pension eligibility

Since 2012-13, tightening of the Disability Support Pension (DSP) eligibility criteria has reduced the number of successful applicants and the number of new DSP recipients with a primary psychological or psychiatric disability. New recipients with a primary or psychiatric disability fell by 37% over three years, although the *share* of new applicants with primary psychological or psychiatric disability remained relatively high (DSS 2016d).

The consequence was a sharp increase in the number of Newstart and Youth Allowance recipients who reported a mental illness (figure below), and an increase in the number of medical exemptions from mutual obligation requirements for people receiving the Newstart Allowance who reported a mental illness.

Trends in income support recipiency

Newstart Allowance or Youth Allowance recipients who reported a mental illness and DSP recipients with a primary psychiatric or psychological disability, 2008-09 to 2017-18
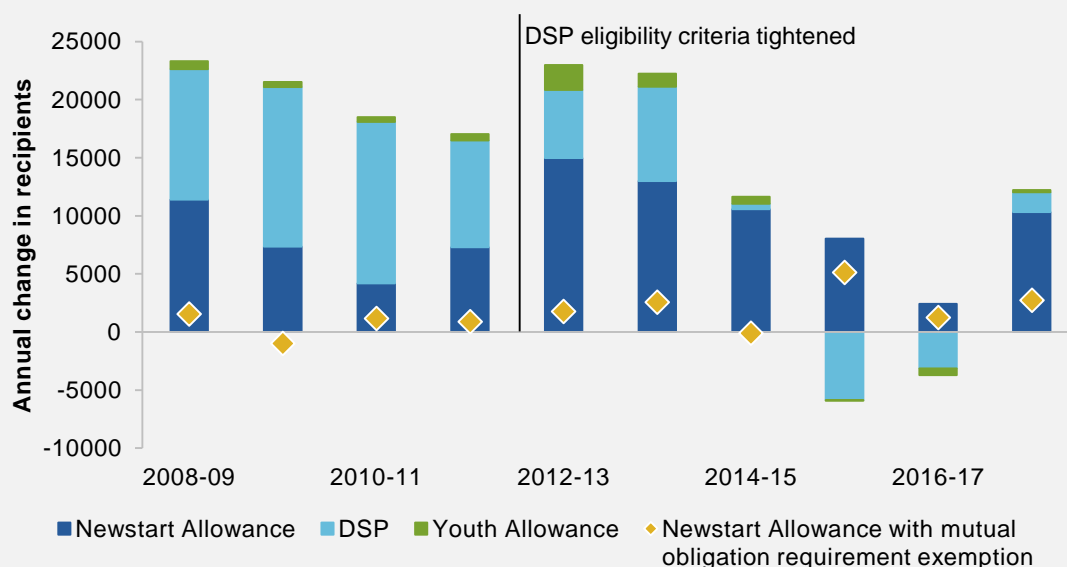
Source: Unpublished data from DSS.

The issue of adequacy for these payments relates to all recipients, not just people with mental illness, and is beyond the scope of an inquiry focussed on mental health. But also of relevance in determining the extent to which the income support system is meeting the needs of those with mental illness are whether:

- job seekers with mental illness on income support payments receive appropriate employment support

- the longer-term employment prospects of job seekers on Newstart or Youth Allowance are genuinely a step up from those on DSP — in effect that the eligibility criteria for the DSP are reasonably robust

- mutual obligation requirements are moderated (or abandoned) where they aggravate illness or are unlikely to improve work incentives (as discussed later).

The Commission's draft recommendations above about the JSCI and new employment support services should address the first of these. More generally, a higher-quality integrated mental healthcare system should reduce the duration or severity of mental illness amongst such recipients, which should further improve employability and job outcomes.

Eligibility criteria for the DSP

In considering eligibility criteria for DSP, an important point is that people *without* a primary psychological or psychiatric disability comprise two thirds of DSP recipients. This means that any changes to the design of the payment on behalf of those with mental illness must consider the implications for the broader population and for overall payment costs — although estimates suggest more than half of the DSP cohort have some mental illness (ABS 2015c; LMIP 2019b).

Access to the DSP is a multi-stage process requiring independent clinical evidence and assessment of job capacity (appendix B). The most prominent misgiving about eligibility criteria relates to the desirability of the requirement to prove that an illness or disability is fully diagnosed, treated and stabilised, and more likely than not to persist for more than two years (deemed a 'permanent' disability). Between 2012 and 2014, almost 43% of all claims were rejected on failing these criteria (DSS 2016d), although participants rejected on this basis may have otherwise been rejected on other grounds.

Read literally, the eligibility criteria seem to leave significant scope for people with major mental illness to be denied the DSP.

For instance, some inquiry participants were concerned that the 'fully stabilised' criterion would exclude people with severe but episodic mental illness, such as bi-polar disorder.[83] As is the case with any assessment, errors will sometimes occur. But, when closely scrutinised, this does not seem to be a likely consequence of any defect in the eligibility criteria. A stabilised condition 'has a specific meaning and does not mean stable in the usual sense of the word' (DSS 2015b). It is one where there are weak prospects that further treatment would significantly reduce the impact of an applicant's impairment on their functional capacity, which does not rule out episodic conditions (DSS 2016a). Indeed, job capacity assessors are explicitly instructed to consider 'the severity, duration and frequency of the episodes or fluctuations' (DSS 2015b) when determining the functional impact of an episodic condition.

Some inquiry participants also argued that the requirement to be 'fully diagnosed and treated' denies people access to the DSP because obtaining sufficient medical treatment and evidence can be challenging for people with mental illness (JA, sub. 398, p. 6; KLC, sub. 469, p. 18). However, the criterion does not, on face value, appear unreasonable. The formal requirement is that there is corroborating evidence showing the applicant has a

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[83] For example, Jobs Australia (sub. 398); Kingsford Legal Centre (sub. 469); and the National Mental Health Commission (sub. 118).

diagnosed mental illness, and records of past and continuing treatment, or a treatment plan for the following two years (DSS 2016a). The absence of such a requirement would leave the DSP open to people with conditions that would improve with proper treatment or where the diagnosis was unclear or not verified, which would be inconsistent with proper risk management.

There may well be cases where people find it hard to demonstrate they have been fully diagnosed and treated. The recommendations of this report for improved access and quality of mental health services should partly address this concern. Moreover, changes to limit errors by people implementing DSP-specific assessments (the Job Capacity Assessment and disability medical assessment), and implementation of better processes for determining eligibility promptly would be preferred to changing eligibility per se (section 14.6). The ANAO (2018) has made various recommendations in relation to this, and these have largely been acted upon. Finally, a safety valve for addressing errors are the various review processes (ANAO 2018).

There may be some scope to improve incentives for DSP recipients to work

While DSP recipients with psychological or psychiatric disabilities may work while continuing to receive a benefit, few do so.

- Only about 3% of recipients (with any type of disability) left the DSP to enter the workforce between 2001-02 and 2016-17 (PBO 2018), and approximately 8% of all DSP recipients reporting earning employment income in March 2019 (LMIP 2019c).

- Less than 2% of DSP recipients with a primary psychological or psychiatric disability are engaged with DES or jobactive (figure 14.1).

- The Department of Social Services estimates that, of the DSP recipient cohort aged 18 to 40 and with a primary psychological or psychiatric disability (as at 30 June 2017), only 15% will have transitioned off the payment after 10 years (with 5 percentage points of this explained by death of the recipient) (DSS 2019j).

This largely reflects that, given the eligibility criteria, DSP recipients have a limited capacity to work. Nevertheless, the design of the DSP provides relatively strong incentives for recipients to work at least some hours if they can:

- A DSP recipient who works and earns less than the income threshold of $174 per fortnight (about 8.9 hours of work per fortnight at the minimum wage rate) keeps their payment in full. They may also receive some income support if their earnings are more than this, but each dollar of additional earnings leads to a 50 cent reduction in the DSP payment. A DSP recipient may also be able to work up to 30 hours weekly and still be eligible for the DSP if earnings are below the maximum threshold.[84]

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[84] A DSP recipient can work more than 30 hours per week and remain eligible — for example, working over the Christmas period — but this must not be for a sustained period (DSS 2018e).

- A DSP recipient who works less than 30 hours per week but with earnings above the threshold for a DSP payment can still receive certain supplementary benefits and have their payment resumed if, within 2 years, their wage income falls below the maximum threshold.

Accordingly, it seems unlikely that the DSP discourages the *employment* rates of recipients. Possible caveats to this are if:

- people on the DSP fear that they will lose access to the payment if they work at all (Mental Health Commission of New South Wales, sub. 486, p. 12), which could occur through ad hoc eligibility reviews (as provided for in the 2014-15 and 2016-17 Budgets (ANAO 2018))

- a recipient is dissuaded from working because a prospective job requires them to work to a point where their income support payments are reduced, or because the prospect of earning less than $174 per fortnight does not justify the upfront effort of finding and commencing work.

However, a more reasonable concern is that the design of the DSP may discourage a recipient from earning at levels that are subject to the 50% taper rate. In other words, people may choose lower hours than they could work for, choose jobs with a set number of hours or avoid ones that pay higher wage rates — none of which are desirable outcomes.

There is some evidence that these settings create a barrier to hours worked because of the change in the behaviour close to the income threshold at which the taper rates becomes 50% (figure 14.2). However, the data available do not give a good indication of the size of the disincentive effect. To do that would require information on the difference in total hours worked with a 50% taper compared with some counterfactual rate (0%, 25% or other value below 50%), which is not revealed by the distribution shown in figure 14.2.

The potential solutions to this issue are to raise either the current income threshold after which the DSP begins to taper off, the rate at which it tapers off, or both. However, doing so would come with a fiscal cost, as recipients who are currently earning over $174 per fortnight would receive a larger payment (although this would be mitigated by the extent to which these recipients responded to the changed incentives by working additional hours). For example, raising the income threshold to $584.70 per fortnight (30 hours of work per fortnight at the minimum wage) would increase take home income for someone just earning at the threshold by $205 per fortnight or over 50%.

Figure 14.2   **Earnings of working Disability Support Pension recipients[a]**

Ratio of working DSP recipients' fortnightly wage and salary income to the income threshold at which the DSP begins to taper off, 2001–2017.

DSP recipients with employment income
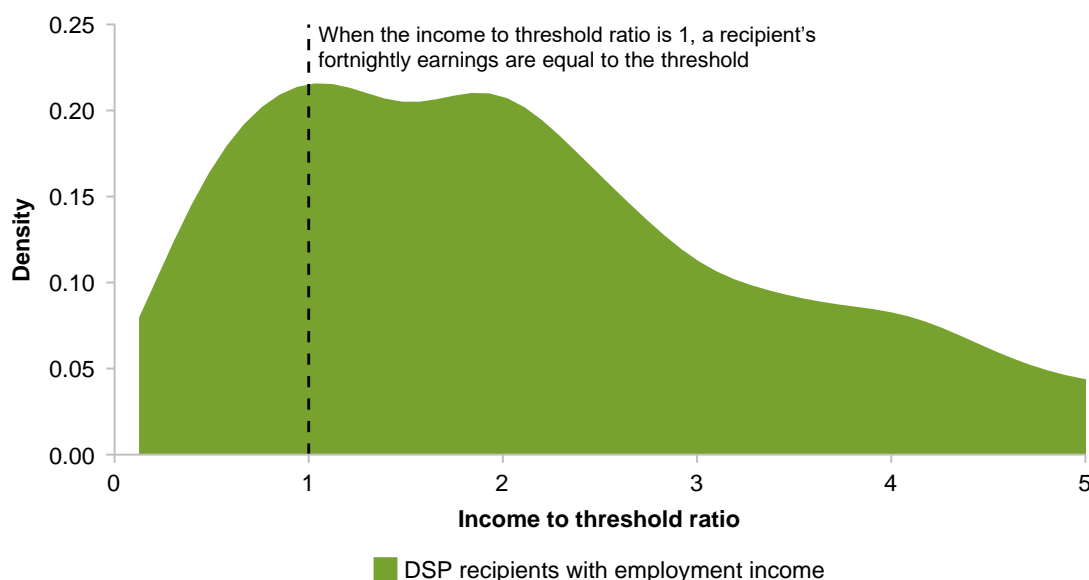
a The threshold for the imposition of taper rates for the DSP changes annually (increasing from $112 in 2001 to $174 in 2017). The figure shows the density of DSP recipients at a standardised fortnightly income to threshold ratio between 2001 and 2017, where a value on the x-axis of 1 shows a recipient's fortnightly earnings are equal to the threshold at the time. A value of more than 1 shows a recipient's fortnightly earnings are greater than the threshold, and vice versa.

Source: HILDA (Waves 1-17); DSS (2019e).

Based on minimum wages in 2017, crude estimates suggest that raising the income threshold to the level that would allow 30 hours of work per fortnight and lowering the taper to 40% thereafter for all DSP recipients would cost around $280 million in 2017 (based on analysis of HILDA data wave 17). Less marked changes would come at a lower cost — for example, raising the income threshold consistent with a 16 hour per fortnight limit without any change in the taper would cost around $100 million. Both initiatives would improve incentives to work with the associated wellbeing benefits. These benefits would apply to all DSP recipients regardless of their disability type. However, people with mental illness seem to benefit particularly from working, and there are potential flow-on benefits if working also reduces clinical treatment costs of this group.

A related issue is that a recipient would lose eligibility for the DSP after a sustained period of employment of more than 30 hours per week. This requirement is separate to the entry requirement to the DSP as it only applies to recipients. The rule means there is a substantial net cost for recipients when deciding whether or not to complete their 31st hour of work. The gain of an extra hour's wages could be as low as $19.49 (the minimum wage), but the loss would be the remainder of the fortnight payment (about $345 after means testing with the current taper), as well as any additional concessions for which the individual was eligible. There are few obvious fiscal costs from lifting the 30-hour rule to the ordinary hours of work

in the National Employment Standards (38 hours). Only a small number of DSP recipients transition to receiving only employment income, suggesting the fiscal costs of granting them a partial DSP payment is small, whilst generating a larger benefit of increased participation, if they are able to. If the number of hours recipients can work is increased, the condition that working over this weekly limit for more than two years should result in the cancellation of the payment could remain, to ensure those the payment is given only to those with a continuing inability to work.

While the above design changes look prospectively attractive, the Commission is seeking more information on the costs, benefits and any risks from changing thresholds, taper rates and the 30-hour limit before recommending changes, especially as such changes would relate to the entire group of DSP beneficiaries.

INFORMATION REQUEST 14.2 — INCENTIVES FOR DSP RECIPIENTS TO WORK

In relation to the Disability Support Pension (DSP), the Productivity Commission seeks feedback on the costs, benefits and risks of:

- *increasing the income threshold at which recipients begin to lose their payments and the value of the taper rate after that threshold*
- *increasing the weekly hour limit above which no DSP is payable from 30 hours to 38 hours (ordinary full time hours of work), but retaining the requirement that a person will lose eligibility for the DSP if they work for more than 30 hours per week for more than two years.*

Access to payments for part-time students

Mental illness is relatively commonplace among university and vocational education and training students, and can adversely affect educational attendance and outcomes, with lifetime impacts (chapter 2 and 18). If a student has, or acquires a mental illness, they may not be able to study full-time, which can affect their income support eligibility. As a default, student payments (Youth Allowance, Austudy and ABSTUDY) require students to undertake at least 75% of their course's full-time study load (DHS 2019h), but this can, on a sustained basis, be beyond the capacity of some students with mental illness (Michelle Smith, sub. 126; Name withheld, sub. 122). That said, if a full-time student receiving the Youth Allowance temporarily cuts back their study to less than 75% of their course's full-time load due to illness, they will remain eligible for the Youth Allowance, provided they have an intention to return to full-time study and remain enrolled in their course (DSS 2018d).

However, students with a mental illness who are not working or looking for work, and who intend to study part-time on an ongoing basis are not covered by student or job seeker payments, barring those with an illness severe enough to qualify for the DSP.

The following points should be considered when determining whether this cohort should qualify for income support.

- Extending income support to part-time students with a mental illness could allow people who would not otherwise study to do so on a part-time basis. This could raise their employment prospects (potentially working to close financial resource gaps between people with mental illness and the wider population and ensuring part-time students with mental illness and limited financial resources are able to choose between work and tertiary education).

- In some instances, it would be undesirable for a student to continue a prolonged period of training on a part-time basis if that results in poor quality qualifications or a high likelihood of subsequent dropping out. Part-time students face a high risk of not completing university studies — 40% of all part-time students will not complete their course within 8 years (Norton and Cherastidtham 2018). Either a job (that takes account potentially limited work capacity) or a shorter vocational course may be a better option until recovery, and a student headed down this path would be eligible for either Newstart Allowance or the Youth Allowance (job seeker).

- There would be a need to develop adequate eligibility requirements to ensure this arrangement was only available to people genuinely unable to participate in work or study due to illness. Stricter requirements (e.g. involving independent medical assessments) would reduce the risk of gaming, but could be expensive to administer. It would also be challenging to assess whether the 'correct' number of people were receiving the payment, as there is no obvious way in existing data collections to identify the cohort to whom it *should* apply.

On balance, the Commission does not currently see a compelling argument for extending income support eligibility requirements to students who intend to study part-time on an ongoing basis due to a mental illness, who are not working or looking for work.

14.6   Mutual obligation requirements

Income support recipients are required to comply with MORs to receive payments. These requirements aim to encourage job seekers to actively search for employment, improve their employment prospects or contribute to their community through government employment support programs. This applies to the majority of recipients of Newstart and Youth Allowance (for job seekers), as well as DSP recipients under the age of 35 years with an assessed work capacity of at least 8 hours per week. As such, the majority of DES and jobactive participants are income support recipients (figure 14.1).

Some inquiry participants and advocacy groups perceived the existing MORs as excessive (appendix B), though the extent of reasonable obligations should be determined by their effectiveness in encouraging job search, achieving job outcomes, their cost and their incidental effects on the wellbeing of job seekers subject to them. Notably, weakening of MORs must, to some extent, reduce the quantity of job searches participants complete. While

it is likely that more stringent MORs also impose stress on job seekers, little is known about the degree to which different intensities of MORs could precipitate clinically-defined mental illness in previously well job seekers.

Given this, and the broad labour market impacts of changes to MORs for all job seekers, this report considers MORs from a narrower perspective. There are good grounds to be much more cautious from a policy perspective in implementing stringent MORs for people with pre-existing mental illness, as there are good reasons and plausible evidence that this could aggravate the severity of their illness and increase distress (ADACAS, sub. 493; AMA, sub. 387; cohealth, sub. 231).

Existing policy setttings *already* recognise that a job seeker's illness or disability should be taken into account when setting MORs (box 14.5). The issue is whether these settings are reasonable for people with mental illness.

While, in principle, social security regulations provide many avenues for people with mental illness to avoid inappropriate sanctions, these avenues rely on being able to identify people experiencing significant mental illness. As noted earlier, the JSCI may not detect a clinically-relevant mental illness. This may not be corrected quickly through subsequent re-assessment. Consequently, people with mental illness may too often be allocated to the less supportive streams of assistance and exposed to the risk of sanctions when they fail to achieve unrealistic MORs. For example, a person with significant depression may not be able to attend a job appointment or notify their jobactive provider that they have failed to do so. Accordingly, they would acquire demerit points, with the ultimate risk being suspension of payment, and with a reasonable risk that their symptoms might worsen. Surveys of jobactive participants suggest that improperly tailored Job Plans with copious MORs can adversely affect the mental health of income support recipients with pre-existing mental illness (ACOSS, sub. 270; CHF, sub. 496; JA, sub. 298).

This highlights the importance of refining the processes for determining job seekers' obstacles to work to avoid misclassification errors — as recommended above. Some have argued the 'Targeted Compliance Framework' (TCF) that imposes such penalties should also be changed given its adverse impacts on some clients (EERC 2019). However, there are provisions in place to ensure job seekers with mental illness are not disproportionately affected by the TCF and any illness should be taken into account when the TCF is applied (box 14.5). The first step is to ensure that in its existing form the framework is applied to the appropriate job seeker populations. There may be grounds for changes to the TCF to the extent that it causes clinically relevant mental illness among job seekers without a pre-existing mental illness, but the evidence of this is, so far, anecdotal. Ongoing assessment of any such causal links would be worthwhile, but more general concerns about the TCF lie outside the Commission's line of inquiry.

> ### Box 14.5   Reduced mutual obligations for people with disability and illness
>
> Several measures aim to assist participants with limited capacity to meet MORs (including those with mental illness) and avoid unduly punitive financial penalties from the Targeted Compliance Framework. In particular, providers are instructed to consider a participant's mental illness when determining if a participant has a reasonable excuse for not completing MORs outlined in their Job Plan (DSS 2018a). This applies to the removal of demerit points and the reinstatement of payments if a mutual obligation failure has occurred.
>
> Participants with a worsening illness who are unable to complete MORs for an extended period can apply for a 'temporary incapacity' exemption. Applicants must provide a medical certificate (detailing a diagnosis and prognosis) and be unable to work or complete another work-like activity for more than 8 hours per week due to their medical condition (DSS 2018d). At June 2018, 17% of Newstart Allowance recipients with a self-reported psychological or psychiatric condition held an exemption on this ground (20 100 recipients) (unpublished data from DSS). This exemption is granted by Centrelink and lasts for a 13-week period, and may be extended for no more than 52 weeks in total without the provision of additional medical certificates, to be equivalent to the length of illness listed in the certificate (DSS 2018d). Subsequent extensions require an additional medical certificate. Long-term exemptions can be extended to 52 weeks (and sometimes by a further 6 months) if a participant has a serious illness, and is receiving treatment in a mental health institution (DSS 2018d). A person with a severe and permanent (as defined by eligibility criteria) mental illness, can apply for the Disability Support Pension at any time.
>
> More generally, participants should have a Job Plan that takes any barriers to employment and work capacity into account, and should receive a tailored plan based on individual characteristics. The expected level of mutual obligation varies with a person's assessed capacity. For instance, a participant with a partial capacity to work between 0-14 hours a week may be able to meet their mutual obligation requirements by attending a quarterly interview with the Department of Human Services to discuss their participation and meeting the terms of their Job Plan. Such participants can volunteer to accept a referral to a suitable program of assistance recommended by medical assessments, but cannot be penalised for not accepting a referral (DSS 2018c).

Jobs Australia suggested greater flexibility for participants with mental illness:

> [There is] value of providing greater flexibility in the application of the Targeted Compliance Framework (TCF) for jobseekers experiencing mental health concerns, with members indicating that the TCF can engender a greater level of stress for these jobseekers, detracting from their wellbeing and stability, generating barriers to employment. The utilisation of flexibility in how appointments are conducted (for instance, via phone or at a time when the office is less busy) can generate a more therapeutic environment. (sub. 398, p. 8).

Increased flexibility from providers is likely to be beneficial to all participants, not just those with mental illness.

Improving Job Plans

Job Plans fit in an awkward space. They are the primary means of recording all of the specific and quantifiable requirements expected of a job seeker to retain benefits (such as the number of job applications, enrolment in a particular course, specified voluntary work) (DSS 2015a). In that sense, they are a social security compliance document. Those obligations may be reduced based on circumstances, such as a limited capacity to work due to mental illness — again consonant with being a compliance instrument. Nevertheless, the plan must also take into account the job seeker's 'personal needs' and be focused on achieving sustainable employment — both more positive goals.

A survey undertaken for the Department of Jobs and Small Business (Thinkplace 2018, p. 73) found that job seekers strongly perceived plans to be 'a standard compliance activity more than anything else', rating 4.2 out of scale from 0 (no agreement) to 5 (full agreement). In contrast, jobactive clients only weakly agree a Job Plan 'considers my needs and requirements' (2.6 out of 5), or 'considers my ability to find work' (2.7). These perceptions echoed the National Employment Services Association judgment that the plans have devolved to be a 'purely … administrative function' (NESA 2018b, p. 19).

Where a job seeker needs little support to find a job that suits them, the quality of their interactions with jobactive providers and of the associated job plans are unlikely to matter much. However, for people with mental health issues — often comorbid with other obstacles to work — more personalised job plans are almost certainly needed. Many such job seekers will not have an illness serious enough to be covered by a scaled up IPS program (as recommended earlier), increasing the grounds for ensuring Job Plans are customised to the person.

However, the survey evidence cited above is based on a small non-representative sample of *all* job seekers, which is certainly not sufficient to conclude that job plans are of poor quality for the subgroup of people with more complex needs. One way of ensuring that such plans are meaningful for this group is to include the adequacy of plans as part of the quality assurance processes used by the Department of Employment, Skills, Small and Family Business. Though these assurance processes are generally good (ANAO 2017), data analytics could systematically check the degree to which job plans reflect the needs of those with more complex obstacles to employment (as shown through employment services assessments). This could then inform feedback to jobactive providers about lifting their performance.

Another (potentially complementary) way is to extend the amount of time that job seekers with more complex needs have to consider the terms of their Job Plan. Currently, participants have up to two business days 'think time' to consider their plan, and consult with a third party if they wish (although there is some anecdotal evidence this does not always occur (EERC 2019)). Extending this period to, say, one week would allow greater scope for the job seeker to discuss the plan with a clinician or carer and propose amendments. This could be reserved for job seekers identified as likely to require more intensive support (potentially

85 000 jobactive participants with a recorded mental illness (DJSB, sub. 302), or 185 000 Newstart Allowance recipients with a limited work capacity (LMIP 2019b)).

DRAFT RECOMMENDATION 14.4 — INCOME SUPPORT RECIPIENTS' MUTUAL OBLIGATION REQUIREMENTS

In the short term (in the next 2 years)

The Departments of Human Services; Social Services; and Employment, Skills, Small and Family Business should:

- provide greater flexibility in the application of the Targeted Compliance Framework for jobseekers experiencing mental illness

- assess more systematically whether employment service providers are meeting their obligations to provide personalised Job Plans that go beyond compliance, targeted at job seekers with complex needs

- consider extending the period of time that job seekers with more complex needs have to consider and propose changes to their Job Plan beyond two business days.

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15 Housing and homelessness

Housing and homelessness services matter because …	• Housing is a fundamental contributor to preventing poor mental health and promoting recovery for people with mental illness. • Many people with mental illness live in unsuitable housing situations that negatively affect their lives or limit their opportunity for recovery and management of their mental illness. • In some regions, there is a chronic shortage of short- and long-term supported housing for people with moderate and severe mental illness. • Some people with mental illness require support to find and maintain stable housing in the community.

Successful intervention requires …	As a priority:
	
	• State and Territory Governments should commit to
	
	   – a formal policy of no exits into homelessness for people discharged from institutional care, comprehensive mental health discharge plans, and services available in the community to meet the needs identified in the plans.
	
	   – working towards meeting the gap in supported housing places (that integrate housing, tenancy support and mental health services) for people who need regular mental healthcare and would otherwise be at risk of housing instability.
	
	   – working towards meeting the gap in homelessness services, with a focus on long term housing for people with mental illness
	
	      ··· services and housing places should first target people with severe and complex mental illness, who are persistently homeless.
	
	Additional actions required include:
	
	• Initiatives that can prevent people with mental illness from losing their home, such as expanding tenancy support services, should be developed.
	
	• Australian, State and Territory Governments should work towards increasing ongoing funding for the additional housing places outlined as a priority above.
	
	• The National Disability Insurance Agency should encourage development of long-term supported accommodation for people with severe and chronic mental illness who require 24/7 support.
	
	• Mental health training should be provided for frontline housing workers to identify, monitor and respond appropriately to tenants with mental illness.

Housing is an important contributor to preventing poor mental health and promoting recovery for people with mental illness. This chapter discusses the close relationship between housing and mental health (section 15.1), and examines ways to improve a range of housing and homeless supports for people with mental illness. The chapter is therefore structure on the basis that types of support and their intensity differ depending on the severity of mental illness and associated risk to housing (figure 15.1).

Figure 15.1   Chapter roadmap: housing supports according to housing risk

Section 15.2 *Lower risk*	Section 15.3 *Higher risk*	Section 15.4 *Homeless*
Preventing people from losing their housing, by improving: • tenancy support • training for housing workers • laws and policies	Support for people with severe mental illness to find and maintain housing through: • integrated supported housing • transition out of institutional care (such as hospital or prison) • long-term supported accommodation with 24/7 support	Support for people with mental illness who are homeless to find and maintai housing through: • homelessness services • 'housing first'

15.1   Housing and mental health are closely linked

Suitable and secure housing is important for all Australians. However, it is the link to mental health that is important for this report. Suitable housing is an important factor in preventing mental ill-health and often a first step in promoting long-term recovery for people with mental illness (Giuntoli et al. 2018; Robert Parker, sub. 12). Housing location, for example, influences whether people have ready access to other supports — such as family, friends and services — and alters their capacity to participate in the schools, employment and communities of their choice.

> Until the need for suitable shelter is met people cannot begin to think of employment, participation in their community or health. (Eastern Health – Murnong Adult Mental Health, sub. 187, p. 1)

Some of the benefits of suitable housing can be felt immediately, such as having a roof over one's head and an address to receive other supports. Other benefits may occur over a longer time horizon, such as improvements to mental health and finding employment.

Many people with mental illness live in unsuitable housing

Like most Australians, individuals with mental illness live in their own home, rent in the private market or live in social housing (figure 15.2). People with mental illness are more likely to live in single person households and tend to make up a greater proportion of households living in social housing and the private rental market compared with those who own their own home (ABS 2019h). Many of these individuals are able to live independently in the community, perhaps drawing on some support from family, friends, communities and governments as needed.

Figure 15.2   Most people with mental illness live in private housing

Total Australian population by level of psychological distress[a], 2017-18
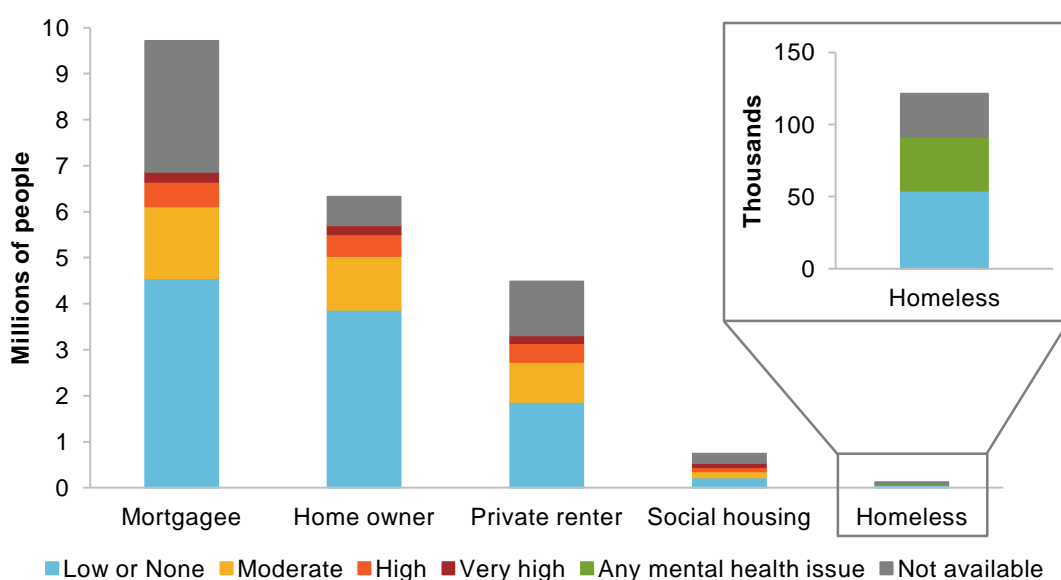
a This chart uses the K10 scale of psychological distress to indicate mental illness. K10 is commonly grouped into scores of Low (indicating little or no distress), Moderate, High or Very high. K10 data is not available for people who are homeless. Instead, this chart displays the number of people who accessed Specialist Homelessness Services, by whether they have a 'current mental health issue'. A person has a current mental health issue if they received mental health services in the last 12 months, were referred by a mental health service, reported 'mental health issues' as a reason for seeking assistance, had been in a psychiatric hospital or unit in the last 12 months, or a need was identified for mental health services during their support period.

Source: ABS (National Health Survey, 2017-18, Cat. no. 4324.0.55.001); AIHW (2019ac).

However, a significant proportion (about 16%) of Australians with a diagnosed mental illness were living in 'unsuitable' accommodation in 2016-17 (AMHOCN 2018). This included overcrowding, substandard facilities, risk of eviction, homelessness or other housing problems that may negatively impact people's lives (increasing the risk of developing mental illness) or limit their opportunity for recovery and management of their mental illness. Many people became homeless or vulnerable to living in unsuitable housing situations as a result of deinstitutionalisation in Australia, the effects of which are still felt today (box 15.1).

Box 15.1   **Deinstitutionalisation in Australia**

Prior to the 1980s, people who were treated for mental illness were often housed in large public mental healthcare facilities, commonly referred to as 'institutions' or 'asylums' (SCMH 2006). In the 1960s, Australia had about 30 000 acute care psychiatric beds.

Over time, changes to views about human rights, treatment and care for people with mental illness, among other things, led to a global push away from these institutions, towards care in the community. The closure of stand-alone psychiatric institutions is often referred to as 'deinstitutionalisation'. By 2005, the number of acute care psychiatric care beds in Australia fell to about 6000. The closure of these facilities was supposed to coincide with the development of community care and integration of acute psychiatric care facilities in general hospitals.

However, there is widespread agreement that these alternatives failed to keep up with the pace of deinstitutionalisation. Rather than receiving the care they needed to live in the community, many people fell through the cracks, entering homelessness or the justice system (or both).

> For many, deinstitutionalization was actually trans-institutionalization: a shift to nursing homes for older patients and jails for those discharged with inadequate supports. For others, the community meant shelters and the streets. (Kirkpatrick and Byrne 2009, p. 68)

Mental illness can affect peoples' ability to find and maintain housing

There are several reasons why mental illness can impact some peoples' ability to maintain their existing housing or find new housing.

Symptoms of mental illness can impact an individual's ability to independently manage housing tasks, such as budgeting, paying rent or utility bills on time, opening mail or maintaining a property. Symptoms can also lead to unsociable behaviour (such as aggression) that causes disturbances or conflicts with family, flatmates, neighbours, landlords and employers (Jones et al. 2014; MHCA 2009; Patterson et al. 2008).

> Symptoms are known to include paranoia, intense fear, anxiety, depression, delusions, mood swings, hallucinations, memory problems, confusion, and disordered thinking. Any of these behaviours may lead to eviction or other difficulties that put their housing at risk. (MHCA 2009, p. 21)

In some cases, people experiencing acute episodes of severe mental illness risk eviction while temporarily incapacitated in hospitals or other institutions (MHCA 2009; MHLC, sub. 315; SCMH 2006).

People with mental illness often face discrimination in the private rental market because they carry a stigma that they are relatively difficult tenants (CLBB, sub. 146; KLC, sub. 469). In one survey, 90% of people living with a mental illness believed they had been discriminated against at some time, particularly in the private rental market, forcing them to accept unsafe or substandard housing (SANE Australia 2008).

Discrimination can take many forms. Prospective renters who disclose or reveal their mental illness tend to be less likely to receive a response to their rental inquiries, be told that an

advertised unit is available, or be invited to inspect an available unit (Hammel et al. 2017). They are less likely to secure a private rental unless they can produce significant guarantees of support or references (Bleasdale 2007). Some carers may avoid telling agents about their loved one's mental illness altogether (Browne and Hemsley 2010).

> Many of our clients experience paranoia making it very difficult to sustain accommodation often leaving due to a perceived fear of being unsafe from others, some have been known to be evicted due to disconnecting lights, appliances and smoke detectors due to the belief they are monitoring devices, some clients can become hostile believing they need to defend themselves from others which also leads to eviction. (Eastern Health – Murnong Adult Mental Health, sub. 187, p. 2)

Mental illness can also indirectly affect an individual's housing situation, for example, impacting their ability to find and maintain employment, reducing their income and subsequent ability to afford adequate housing.

Not only can mental illness affect people's ability to find and maintain housing, this relationship can also run in the opposite direction. Housing issues, such as insecure tenure, affordability, poor housing conditions and homelessness can contribute to poor mental health (Singh et al. 2019; box 15.2). For example, 14% of Aboriginal and Torres Strait Islander people in remote areas said that overcrowding at home was a significant stress that could impact their mental health (ABS 2013).

Box 15.2   Housing issues can contribute to poor mental health

Research shows that various housing-related issues can contribute to poor mental health.

Insecure housing tenure is associated with poor mental health (Cairney and Boyle 2004). For example, studies have found that frequent moves can contribute to poor mental health (Bentley et al. 2018; Hulse and Saugeres 2008). That said, tenure may not necessarily cause poor mental health, but rather describe the underlying population in each tenure (Baker, Bentley and Mason 2013).

Poor housing conditions such as quality, hygiene, design, noise and pollution, can influence mental health (Bonnefoy 2007; Evans, Wells and Moch 2003; Guite, Clark and Ackrill 2006; Pevalin et al. 2017). For example, Wells and Harris (2007) found that overcrowding was particularly detrimental to mental health, and suggested that poor housing conditions can cause individuals to socially withdraw, which may lead to increased psychological distress.

Housing and rental affordability issues can have a significant impact on mental health, particularly for low- to moderate-income households and renters (Bentley et al. 2011; Mason et al. 2013; Reeves et al. 2016; Robinson and Adams 2008). In some cases, affordability concerns cause distress on par with marital breakdown and job loss (Taylor, Pevalin and Todd 2007). Substantial housing payments, particularly for low-income households, reduce income remaining for non-housing expenditure, such as food, transport and medical care (Bentley, Baker and Mason 2012). Housing affordability may also limit the locations people can live in, their proximity to services and can lead to homelessness. For example, Johnson et al. (2015) found that a 30% increase in the median market rent increased the risk of entry into homelessness by 20%.

(continued next page)

| Box 15.2 | (continued) |

Losing the psychological support associated with adequate housing can be detrimental to an individual's ontological security — that is, their sense of order, trust, continuity and security (Hulse and Saugeres 2008; Muir et al. 2018). A lack of safety, privacy, sense of belonging or social connectedness can lead to feelings of social isolation, anxiety and stress. For example, stigma associated with homelessness or some public housing can affect mental health (Atkinson and Jacobs 2008; Evans, Wells and Moch 2003). Further, mental ill-health related to poor housing may linger long after housing problems have improved (Pevalin et al. 2017).

Homelessness can be a particularly traumatic event. People who are homeless lose the physical and psychological supports associated with housing, have higher rates of interaction with the health and justice systems, and tend to have poor education and employment outcomes. Evidence shows that homelessness can exacerbate, or contribute to the onset of, mental ill-health (Brackertz, Davison and Wilkinson 2019; Scutella et al. 2014; Sullivan, Burnam and Koegel 2000). For example, Johnson and Chamberlain (2011) found that 16% of homeless people in a sample developed mental ill-health after they became homeless. Research tends to show elevated levels of psychosis, anxiety, depression, post-traumatic stress disorder and substance use disorder among people who are homeless (Muir et al. 2018).

There is no one-size-fits-all housing solution

Housing needs for people with mental ill-health depends on their age, culture, support networks and mental illness. For example, rooming houses with shared cooking, cleaning and bathroom facilities may be unsuitable or unsafe for people with severe mental illness (Allan Fels, sub. 303; Eastern Health – Murnong Adult Mental Health, sub. 187; MHLC, sub. 315). A range of housing options and supports are needed to provide flexibility that caters to the needs of the individual.

Many inquiry participants agreed that there is no one-size-fits-all housing solution for people with mental illness (ACT Mental Health Consumer Network, sub. 297; CHP, sub. 145; Eastern Health – Murnong Adult Mental Health, sub. 187; Jesuit Social Services, sub. 441; NT Shelter, sub. 333; SAMHC, sub. 477; TeamHEALTH, sub. 155; Uniting VIC.Tas, sub. 95).

There are currently many housing supports available to Australians, such as financial assistance to access the rental market, social housing and other supports to find and maintain housing (box 15.3). But some people — including some people with mental ill-health — end up in unsuitable housing or homeless despite these supports. For example, over 60% of homeless people with mental ill-health remained homeless even after accessing homelessness services, and almost 15% of those housed but at risk of homelessness, became homeless by the end of support (section 15.4).

Aged care is one type of housing support not examined. The Royal Commission into Aged Care Quality and Safety (2018) is currently examining ' … how best to deliver aged care services to people with disabilities residing in aged care facilities, including younger people … '.
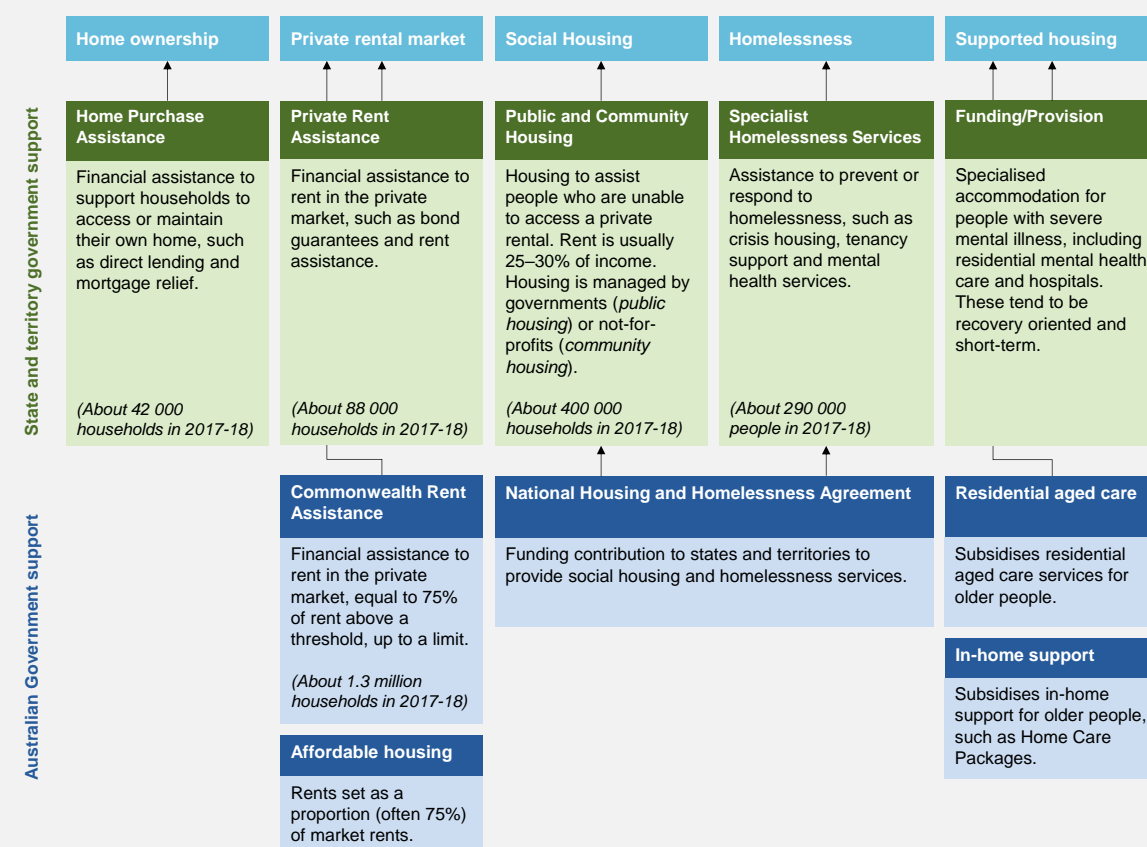
Box 15.3   What housing supports are available?

In Australia, governments provide many forms of housing support, such as financial assistance, social housing and homelessness services. Governments also provide specialised supported housing for people with severe mental illness and conditions to support their recovery and ability to live in the community, such as residential mental healthcare.

Under the National Housing and Homelessness Agreement, State and Territory Governments have primary responsibility for funding and delivering housing supports, with some funding and responsibilities shared by the Australian Government. State and Territory Governments are generally responsible for providing social housing and homelessness services, land use planning and development policy, and tenancy legislation and regulation. The Australian Government contributes some funding to State and Territory Governments for housing and homelessness services, and provides income support, Commonwealth Rent Assistance and some Australian Government housing and homelessness programs and services. Both levels of government also fund the National Disability Insurance Scheme which, in some limited cases, may contribute to the cost of accommodation for participants in need of specialised housing due to their disability.

Main housing supports in Australia

|	Home ownership	Private rental market	Social Housing	Homelessness	Supported housing
State and territory government support	**Home Purchase Assistance** Financial assistance to support households to access or maintain their own home, such as direct lending and mortgage relief. *(About 42 000 households in 2017-18)*	**Private Rent Assistance** Financial assistance to rent in the private market, such as bond guarantees and rent assistance. *(About 88 000 households in 2017-18)*	**Public and Community Housing** Housing to assist people who are unable to access a private rental. Rent is usually 25–30% of income. Housing is managed by governments (*public housing*) or not-for-profits (*community housing*). *(About 400 000 households in 2017-18)*	**Specialist Homelessness Services** Assistance to prevent or respond to homelessness, such as crisis housing, tenancy support and mental health services. *(About 290 000 people in 2017-18)*	**Funding/Provision** Specialised accommodation for people with severe mental illness, including residential mental health care and hospitals. These tend to be recovery oriented and short-term.
Australian Government support		**Commonwealth Rent Assistance** Financial assistance to rent in the private market, equal to 75% of rent above a threshold, up to a limit. *(About 1.3 million households in 2017-18)* **Affordable housing** Rents set as a proportion (often 75%) of market rents.	**National Housing and Homelessness Agreement** Funding contribution to states and territories to provide social housing and homelessness services.		**Residential aged care** Subsidises residential aged care services for older people. **In-home support** Subsidises in-home support for older people, such as Home Care Packages.

Source: AIHW (2018s, 2019i).

Keeping people in the community is generally more cost-effective

Housing and mental health supports that enable people with mental illness to live in the community can also be cost-effective where they help people to avoid spending time in relatively higher cost acute settings, such as residential mental healthcare or hospitals. For example, about 30% of mental health hospital inpatients (more than 2000 people) could potentially be discharged if appropriate clinical and accommodation services were available (chapter 7). The average ongoing cost of housing someone in the community, such as in a private rental or in social housing, is significantly lower than the cost of having someone either in hospital or a residential mental healthcare facility (figure 15.3).

This is a case of aligned interests. People with mental illness generally prefer to live independently in the community, where possible with available supports (Richter and Hoffman 2017). And governments have an incentive to support vulnerable people to live in the community, where housing is cheaper than more acute settings, such as hospitals.

Figure 15.3   Average daily ongoing cost of housing per person
2015-16 dollars
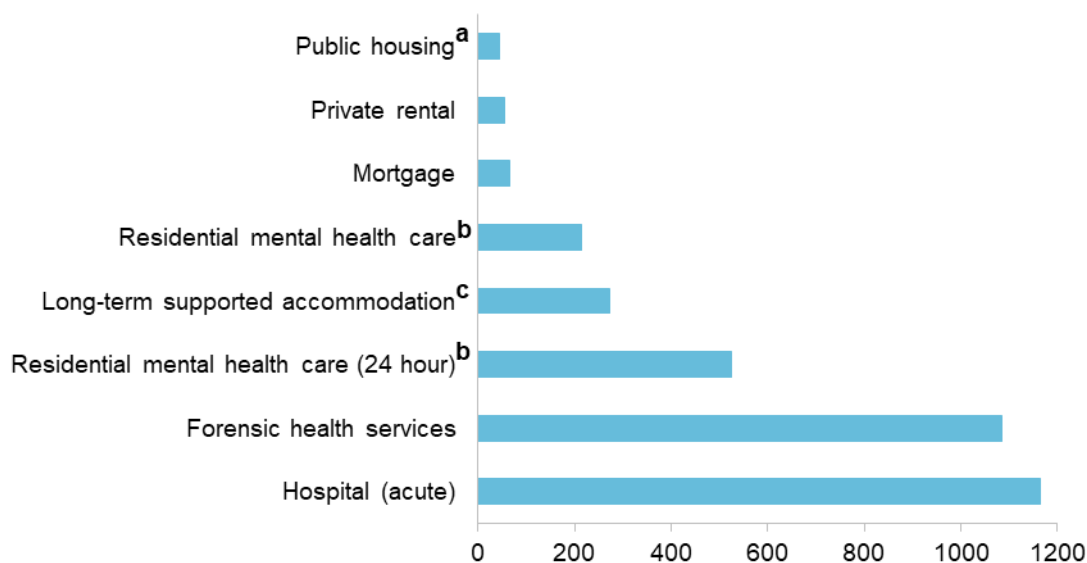
[a] Includes recurrent government expenditure plus rent collected. [b] The average cost of residential care does not fully account for reach-in services from State and Territory providers. [c] 24-hour supported living arrangements. Estimated costs based on the annual cost of support in the Haven model (section 15.3).

Source: Commission estimates based on ABS (*Housing Occupancy and Costs, 2015-16*, Cat. no. 4130.0; AIHW (2019o); SCRGSP (2019i, 2019j, unpublished data).

The two-way relationship between mental health and housing, implies that governments should take into account the population benefits of improved mental health and subsequent potential savings in other areas of expenditure, when considering expenditure on housing and mental health supports.

In this chapter, the Commission has proposed reforms to deliver a range of housing and related mental health supports to better meet the needs of people with mental illness in Australia. In aggregate, this would require Australian, State and Territory Governments to increase estimated expenditure by $447 million to $1.2 billion each year over the longer term. This is expected to improve population mental health, quality of life and economic participation. However, the net cost to governments is likely to be far lower — $122 million to $323 million each year — assuming improved housing leads to reductions in the use of other government services, such as healthcare or the justice system, over time.

15.2 Preventing housing issues

Most people with mental illness live in the community. Depending on their needs and available housing supports, this usually works well while they are managing their illness.

However, temporary episodes of relatively more severe symptoms of mental illness can increase an individual's risk of housing issues or losing their home. For example, episodes of depression or anxiety can impact peoples' ability to manage or afford rental payments. Alternatively, housing issues, such as poor housing conditions or insecure tenure, can contribute to or exacerbate mental ill-health, increasing the risk of future housing issues.

A range of supports already exist to assist people to maintain their home in the community. Many Australians currently receive financial assistance from governments to remain in private housing (box 15.3). And if a household struggles with their mortgage repayments as a result of mental illness, they can generally ask their lender for a hardship variation to make the loan more manageable, such as extending the loan period or temporarily postponing repayments (ASIC 2019). Further, many other existing instruments are designed to protect people's financial security, such as general income and employment support (chapter 14), workers compensation and income protection insurance (chapter 19).

But more can be done to deal with the specific issues faced by people with mental illness. While there are a range of general supports available, it can be difficult for people experiencing temporary episodes of more severe mental illness to find and access these supports. Tenancy support services can be expanded to help people with mental illness living in the private housing market to access assistance to maintain their housing. Further, measures in place to protect the tenancies of vulnerable people — such as awareness training, policies and laws — can be improved by showing greater consideration of the impact of mental illness on housing and vice versa. These supports and protections can improve the housing stability of people with mental illness.

Expand tenancy support services for private housing

Tenancy support services help people access housing or intervene early to stabilise their housing and prevent them from becoming homeless. These services are often provided to

people in social housing, and in limited circumstances to people in private housing. Tenancy support services do not specifically target people with poor mental health, but mental ill-health is a common reason for seeking support. Services can range from general housing advice to more intensive supports, including:

- help maintaining a tenancy — such as help with budgeting, support to access existing financial assistance, welfare benefits, tenancy advice, debt counselling, financial management and resolving rent arrears

- assistance to improve a tenant's economic participation, such as help to find employment

- linking tenants with broader support services, such as mental health services.

In Victoria, the Tenancy Plus program provides an example of these types of services (PC 2017c). The type of support offered varies depending on the needs of the tenant, but can include advice, help with legal issues, financial counselling and referrals to other services. Services are provided by non-government organisations and funded by the Victorian Government. Tenants in the private rental market cannot access Tenancy Plus.

In general, tenancy support services can be very effective at stabilising housing. An evaluation of several tenancy support programs across Australia found that between 81–92% of people maintained their existing tenancy, 8–17% of people moved home (for a variety of reasons) and less than 4% of people were evicted (Zaretzky and Flatau 2015). The vast majority of tenancies were sustained for 12 months or longer. This was considerably fewer evictions compared with public housing tenants who do not receive tenancy support services (over 16%).

Tenancy support services can also be cost-effective for governments in the event they prevent eviction, homelessness or a deterioration in mental health. For example, Zaretzky and Flatau (2015) estimated the average cost of assisting someone to maintain or access a tenancy was about $4200 per person (2017-18 dollars)[85] compared with about $11 600 per eviction event. In particular, preventing people from losing an existing home ($1900) cost significantly less than general support to access or maintain housing ($8400).

However, there is a gap in the availability of tenancy support services. In 2017-18, about 15% of people who tried to access services to assist them to maintain their housing had their need unmet (AIHW 2018t). Just under half of this group (over 5000 people) experienced mental ill-health (AIHW Specialist Homelessness Services Collection, unpublished data). It is unclear how many of these people were living in social housing or the private housing market. Therefore, the total cost of providing additional tenancy support services to meet demand across Australia for clients with mental ill-health was estimated to be $10 million to $45 million each year.[86]

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[85] Inflated using the ABS Producer Price Index (Cat. no. 6427.0) for Real estate services (number 672), June 2019.

[86] Total costs estimated using lower bound (about $1900 per person) and higher bound ($8400) estimates for the cost of tenancy support services, multiplied by the unmet demand for these services (about 5000 people).

Some inquiry participants recommended greater use of tenancy support services as a means of preventing homelessness among people with mental illness (Anglicare Sydney, sub. 190; NMHC, sub. 118; NT Mental Health Coalition, sub. 430; Uniting Vic.Tas, sub. 95).

While tenancy support services are generally associated with the social housing system, limited support services are also sometimes available for people in the private rental market — often called 'private rental brokerage services' (PC 2017c). Services may be funded and provided by governments, such as Housing Connect in Tasmania, or non-government organisations (Tually et al. 2016). These services can include providing information, advice, introductions, advocacy and support to help people with complex needs, such as mental illness, find and maintain housing.

Some participants suggested there was a need to increase the availability of these services to people in private housing as well as social housing (Australian Red Cross Society, sub. 490; CHP, sub. 145; NT Shelter, sub. 333). In 2017, the Commission found that there is limited accessibility of private rental brokerage services and recommended that State and Territory Governments should ensure that tenants renting in the private market have the same access to tenancy support services as those in social housing.

> Many support schemes targeted at social housing tenants are not made available to those renting in the private market and private rental support schemes are often ad hoc with gaps in their provision. (PC 2017c, p. 183)

The Commission reiterates the need to expand tenancy support programs in the private rental market to support people with mental ill-health to prevent housing issues and maintain their home. Further, these services should be easily accessible by people with mental illness who own their own home.

Mental health training for housing workers

Social housing workers and real estate agents play an important role on the ground to support people to maintain their tenancies. These frontline housing workers are often the first to identify vulnerable tenants and have an incentive to link tenants in with supports.

In some cases, there is a lack of understanding and knowledge within these roles to identify, monitor and respond to housing issues among people with mental illness. For example, there are opportunities to achieve better outcomes for vulnerable tenants in public housing.

> Early intervention is limited to giving tenants a short 'Help is Available' brochure that lists tenant support services at the start of each tenancy. Tenant support is typically not offered until disruptive behaviour incidents are reported. We found strikes were issued against tenants with complex mental health illness, family violence or inter-generational dysfunction. The [Department of Communities] does not direct resources towards early intervention for these tenants, instead following standard procedures to manage all disruptive behaviour. (OAGWA 2018, p. 8)

> The role of the social landlord now has housing officers dealing with tenant mental health, finance, and anti-social behaviour issues to the point of being quasi-case managers in some cases. However, [participants of a social housing officer workshop in Victoria] all agreed that this part of their role is not adequately reflected in their KPIs, training, or allocated work schedule … Workshop participants estimated that 60 per cent of their time is spent with this particular high needs cohort. (Brackertz, Davison and Wilkinson 2019, p. 10)

This lack of awareness extends to the private rental market. For example, it can lead to discrimination against prospective tenants with mental illness, potentially preventable evictions and, in some cases, blacklisting from future rental properties. And some people might not tell their landlord or real estate agent that they are experiencing mental ill-health for fear they will be evicted from their home.

> Real estate agents and landlords in this sector may have far less training or understanding of the multiple challenges faced by their tenants and fewer resources to handle difficult situations, and thus see eviction as a solution rather than a last resort. (Anglicare Australia, sub. 376, p. 31)

Several inquiry participants recognised the need to improve mental health training for frontline housing workers (ADACAS, sub. 493; Anglicare Australia, sub. 376; QFCC, sub. 85; Uniting Vic.Tas, sub. 95; University of South Australia, sub. 468; WentWest, sub. 445). While it is unlikely to be feasible to deliver mental health training to landlords and real estate agents in the private rental market, it is possible to provide mental health training to social housing workers. Some social housing workers are already offered mental health first aid training. Yet, there is scope to improve training resources and uptake to increase the capability of social housing workers to identify and respond to potential housing issues among people with mental illness.

Training should incorporate awareness about how to identify early warning signs of mental ill-health as well as suicidal distress. It should also communicate the benefits of early intervention, such as avoiding the costs associated with deterioration of housing issues or potential eviction. For example, a pilot program involving training for social housing workers in Queensland showed increased awareness and understanding of mental health and suicide among workers, recorded fewer incidences of tenancy problems, decreased use of emergency departments and improved mental health outcomes (Walter, Parsell and Cheshire 2017). In many circumstances, building trust and a greater awareness of a tenant's mental ill-health can support a more understanding relationship.

Training should also advise on effective ways to intervene to refer tenants with appropriate supports. This need not be costly or onerous, and can be as straightforward as connecting vulnerable tenants to existing tenancy support, mental health or suicide prevention services. For example, housing workers can use dedicated information portals to determine where best to direct tenants for support, or connect with the tenant's care coordinator (chapter 10).

Review social housing policies and private rental tenancy laws

In social housing and the private rental market, there is scope to improve policies that protect the housing of people with mental illness, to reduce their likelihood of housing instability and eviction.

Social housing policies: anti-social behaviour

Policies that govern how social housing providers manage anti-social behaviour of tenants can impact people with mental illness (Brackertz, Wilkinson and Davison 2018; Jones et al. 2014). These policies are generally in place to provide a safe and positive living environment for all tenants.

But if these policies are too strict or do not consider the circumstances of tenants with mental illness, tenants who exhibit episodes of unsociable behaviour as a symptom of mental illness may be issued with eviction warnings and potentially be evicted. This can cause further distress to tenant's mental health, their sense of housing stability and puts their housing at risk.

In some cases, the policies may be adequate, but poor implementation can cause unnecessary stress to tenants, and evictions may ultimately be overturned, causing unnecessary cost to government.

> Our review of 5 applications for termination where mental health concerns were involved found the Court did not agree to terminate the tenancies. The eviction process can cause unnecessary stress for tenants and support workers and unsuccessful eviction processes may be an inefficient use of Court and Departmental resources. (OAGWA 2018, p. 20)

Social housing policies: temporary absences

Temporary absence policies that restrict the time allowed for people to be absent from their dwelling can help to make sure the housing stock is being used efficiently and fairly, but can also increase the risk of eviction for people with mental illness.

In some cases, people experiencing acute episodes of severe mental illness may need to temporarily reside in a step-up mental health facility, such as hospital or residential mental healthcare (chapter 7). But if the housing policy does not allow longer absences, these tenants may be evicted while temporarily absent, causing additional stress and making it more difficult to find them a home when they recover (QAI, sub. 116).

For example, in New South Wales, the temporary absence policy allows people to be absent from their home for up to six months if they are hospitalised or require institutional care (NSW FACS 2019). But the tenant must make arrangements to continue to pay their rent and water usage, and satisfy the social housing provider that the property will be adequately cared for while they are away. Accomplishing these tasks may be difficult in cases where the tenant is experiencing an episode of mental illness.

> Wei was a long-term social housing resident with significant psychiatric illness. He lived alone with assistance from community-based mental health services. During his tenancy he was hospitalised for a period of almost 6 months. The social housing provider sent Wei an eviction notice for not occupying his premises in breach of their "allowable absences" policy. This was despite the hospital nursing staff telling the housing provider that more time was required, and that eviction would have a very serious negative impact on Wei's health. The eviction notice was not withdrawn until Kingsford Legal Centre assisted Wei to make a discrimination complaint, which was eventually resolved through conciliation. (KLC, sub. 469, p. 10)

Cases of temporary absence that are associated with mental illness will require special consideration of individual circumstances to prevent further housing stress and eviction.

Social housing policies: information sharing

In some cases, eviction due to a temporary absence may be a result of a lack of information sharing between mental health services and social housing authorities (or rental agents). For example, an audit of the public housing system's management of disruptive behaviour in Western Australia found that there was no formal information sharing arrangements between agencies and that current memoranda of understandings with different agencies are out of date.

> Staff are not routinely informed of the outcomes of referrals to mental health and child protection service providers for tenant support. This limits the [Department of Communities'] understanding and ability to effectively identify and help vulnerable tenants to succeed in public housing. (OAGWA 2018, p. 8)

Improving information sharing between these agencies (with agreement of the patient) can reduce the likelihood of eviction. This is particularly important upon admittance to an inpatient psychiatric facility and again prior to discharge. The Commission has recommended ways to improve coordination across services through formal information sharing arrangements in single care plans and using care coordinators (chapter 10).

Private rental tenancy laws

In the private rental market, there may be scope to reduce the risk of eviction and its associated stresses for people with mental illness.

Laws that allow 'no-grounds' evictions permit landlords to evict tenants without having to identify a particular reason, either at the end of a fixed-term lease, or at any time during a periodic lease. Several submissions expressed concern that no-grounds evictions create a substantial imbalance of power and can impose significant stress on renters (Anglicare, sub. 376; NT Shelter, sub. 333).

> The constant threat of 'no grounds' evictions also remains a source of real stress for renters. A 2019 survey by Tenants' Union NSW and Marrickville Legal Centre found over 60% of NSW renters report the possibility of a 'no grounds' eviction is a significant source of anxiety, and 90% report they would experience significant financial costs, emotional toll, anxiety and stress if forced to move. (NCOSS, sub. 143, p. 15)

Further, laws that govern minimum notice periods for rental terminations vary across Australia, but tend to be shorter than those internationally (PC 2019e). While notice periods are intended to give the party receiving the notice time to plan their future activities, shorter notice periods increase the difficulty of finding a new rental. This can be particularly stressful for people with mental illness.

In 2019, the Commission found that reforms to prohibit no-grounds evictions and extend notice periods for landlord-initiated evictions can improve the welfare of vulnerable private renters by increasing their certainty of tenure and providing more time to make alternative arrangements (PC 2019e).

Recent reforms in Victoria and New South Wales have sought to rebalance the interests of tenants and landlords within residential tenancy legislation. However, these reforms have not yet fully commenced, making it difficult to determine the likely effects of these changes on the private rental market. State and Territory Governments should monitor the impact of these forthcoming reforms to assess the potential benefits for people with mental illness to rent in the private market, including whether or not the reforms change the willingness of private landlords to rent to people with mental illness.

15.3 Supporting people with high needs to find and maintain housing

People with severe mental illness may find it more difficult to find or maintain suitable long-term housing in the community. In these cases, better integrated supports and financial assistance may be effective at helping people to live successfully in the community. And in circumstances where people can transition out of institutional care (such as hospitals) back into the community, support to find and maintain housing can reduce the risk of future housing problems.

Supported housing: integrated housing and mental health services

Integrated housing and mental health services (hereon described as 'supported housing') can be an effective way of providing support for people with severe mental illness. Supported housing programs integrate access to housing, tenancy (or psychosocial) support services and mental health services under the one umbrella. These programs can help people to find and maintain a home, prevent homelessness, aid recovery and be more cost-effective than

spending time in more acute settings, such as hospital. Supported housing can be achieved in either social housing, the private rental market or a hybrid of the two.

Social housing

Most states and territories have trialled (or are trialling) supported housing for people with lived experience of mental illness in a social housing setting (box 15.4). These programs generally involve a close partnership between social housing, tenancy support services and mental health services.

Where evaluations exist, results tend to show improved housing and mental health outcomes for participants. And in many cases, the cost of running the program is offset to some extent as participants reduce their use of relatively high cost services, such as hospitals. The Housing and Accommodation Support Initiative (HASI) is a key example (box 15.4). The Mental Health Coordinating Council (sub. 214, p. 16) stated that 'investment in additional HASI type services will return $1.20 per every dollar invested in the short term'.

Many submissions acknowledged the positive experiences associated with HASI (Beyond Blue, sub. 275; EMHS, sub. 152; Friends of Callan Park, sub. 198; Mental Health Victoria, sub. 479; Mental Health Commission of New South Wales, sub. 486; MHCC, sub. 214; Mission Australia, sub. 487; NCOSS, sub. 143; NT Mental Health Coalition, sub. 430; One Door Mental Health, sub. 108; RANZCP, sub. 385; Tasmanian Government, sub. 498; VCOSS, sub. 478; WayAhead Mental Health Association NSW Ltd, sub. 310).

However, there are several key barriers to accessing suitable social housing.

First, there is a significant shortage of social and affordable housing in Australia. Almost 190 000 people were on social housing waitlists as at 30 June 2017 (although this is likely to be an overestimate as some applicants may be on more than one waiting list) (AIHW 2018i). Households considered to be in greatest need (such as people who are homeless or living in unsuitable housing) may be placed on the priority waitlist for faster access to social housing, including many people with mental illness. While many on this list can access housing within three months, wait times of two years or more are not uncommon. Submissions noted that time spent on waitlists can exceed 10 years in some areas (Eastern Health – Murnong Adult Mental Health, sub. 187; TeamHEALTH, sub. 155; Shelter WA, sub. 200). Supply constraints mean that, in all jurisdictions, most entries into social housing come from the priority list.

Increasingly, the social housing system has focused on people who have difficulty finding and maintaining a tenancy for reasons other than affordability. This includes people with mental illness who seek greater stability of tenure, require assistance from support services and have experienced discrimination in the private rental market. Roughly 20% of all social housing tenants reported accessing mental health services (AIHW 2017d).

Box 15.4 Integrated supported housing programs across Australia

Several states and territories have trialled supported housing programs that are designed to support people with mental illness to find and maintain social housing. In general, these programs work by integrating social housing, tenancy (or psychosocial) support and mental health services. Only some of these programs have been evaluated.

Results tend to show that participants generally sustain housing, their mental health improves or remains stable, hospital usage falls and employment or training somewhat improves.

Results from integrated supported social housing programs around Australia

State or territory	Program	Sustained housing	Mental health	Hospital usage	Employment and training
NSW	Housing and Accommodation Support Initiative	90%	↑	↓	—
Qld	Housing and Support Program	83%	—	↓	↑
SA	Housing and Accommodation Support Partnership Program	93%	↑	↓	↑
WA	Individualised Community Living Initiative	**na**	↑	↓	**na**

na Not available.

Source: Bruce et al. (2012); Meehan et al. (2010); SA DoH (2013); Smith (2015a).

Housing and Accommodation Support Initiative

The Housing and Accommodation Support Initiative (HASI) in New South Wales provides an important example of how these programs integrate services and the potential benefits.

HASI is a partnership between NSW Health, Housing NSW, community housing providers and providers of tenancy support (Bruce et al. 2012). The scheme aims to provide stable housing integrated with clinical and psychosocial rehabilitation services to people with mental illness. Tenants receive:

- tenancy support services and rehabilitation services from non-government organisations

- clinical care services from specialist mental health services

- housing from social housing providers (HASI services are also available for private renters).

In 2009, about 1000 people received support through the HASI. An evaluation of the HASI in 2012 found several positive outcomes for participants:

- about 90% of participants successfully maintained their tenancy. And of the remaining 10% who ended their tenancies, most left for planned reasons, such as moving to other housing

- a 59% decrease in the average number of days each year in a mental health inpatient hospital

- an improvement in life skills, an increase in community participation and a reduction in behavioural issues among program participants.

The average (non-accommodation) costs of HASI was about $30 000 per person annually, depending on the level of support needed (not including the cost of clinical mental health services). However, this was largely offset by an estimated $27 917 reduction in costs as a result of reduced use of mental health inpatient hospitalisations.

Given these positive experiences, both the Northern Territory and Tasmania have begun piloting programs based on HASI (NT Shelter, sub. 333; Tasmanian Government, sub. 498). In its early stages, each of the 50 people who have received services from NT HASI have maintained their tenancy so far (NT Government, pers. comm., 21 August 2019).

As a result, many submissions expressed a need to increase the social housing stock (ACP, sub. 522; Anglicare Australia, sub. 376; APS, sub. 543; breakthru, sub. 112; cohealth, sub. 231; Jesuit Social Services, sub. 441; KLC, sub. 469; Mind Australia Limited, sub. 380; Uniting Vic.Tas, sub. 95; VCOSS, sub. 478).

> State and Federal governments [should] take immediate and concrete steps to alleviate housing stress, build more housing stock and provide support to sustain tenancies. (MHCT, sub. 314, p. 5)

Fixing the broader social housing system is beyond the scope of this inquiry. However, in 2017, the Commission recognised that the social housing system was 'broken'. It recommended a single system of financial assistance across both social housing and private housing (among other recommendations) to address the underlying problems (box 15.5). However, to date, no jurisdiction has adopted this recommendation.

Second, when eligible tenants do finally get access to social housing they have little choice over the home in which they live (PC 2017c). This can be detrimental for people with mental illness who would benefit from living close to support services. While jurisdictions seek to ensure tenants are offered properties based loosely on their needs and preferences, those that reject two offers — and in some cases, one offer — of a home are moved to the back of the waiting list. This is essentially a take-it-or-leave it allocation process that can lead to inefficient use of social housing assets. As at 30 June 2018, about 17% of public housing had two or more spare bedrooms, and 4% was considered overcrowded — in the Northern Territory, 54% of State Owned and Managed Indigenous Housing was overcrowded (AIHW 2019i).

Overcrowding can be detrimental to housing occupants' mental health, and is particularly stark in Aboriginal and Torres Strait Islander households. In part, this may be driven by strong connection to family and a culture of sharing accommodation, but may also be the result of persistent disadvantage and unstable accommodation (AIHW 2019a). From 2001 to 2016, the total number of Aboriginal and Torres Strait Islander households living in overcrowded dwellings increased from about 23 000 households to over 26 000 households. However, the overall proportion of Aboriginal and Torres Strait Islander households that were overcrowded fell from 16% to 10% over the same period. Efforts that improve the broader social housing system can be particularly beneficial for reducing overcrowding.

Giving people greater choice and control over housing can contribute to improved housing stability and better mental health outcomes (Aubry et al. 2016; Nelson et al. 2007; Srebnik et al. 1995). 'Choice-based letting' is one option recommended by the Commission to increase social housing tenants' choice over the home they are allocated (box 15.5). Another option is to use technology to facilitate swaps between social housing tenants. For example, 'chain letting' uses a matching algorithm to allow multiple households to find the maximum number of mutually beneficial swaps possible (Sharam et al. 2018).

> ### Box 15.5 Productivity Commission proposed social housing reforms
>
> In 2017, the Productivity Commission (2017c) inquiry into Reforms to Human Services found that social housing in Australia is broken. Below are two of its key recommendations for improvement.
>
> **One system of financial assistance**
>
> Tenants in social and private housing can receive vastly different rates of financial assistance depending on whether they rent in social or private housing. Social housing tenants often receive implicit financial assistance equal to the difference between the market rent for the property they live in, and the rent they actually pay. For example, the Commission estimated that households in public housing in Victoria receive on average about $50 per week more in financial assistance than if they received Commonwealth Rent Assistance (CRA).
>
> The Commission recommended implementing a single system of financial assistance. Tenants would receive a single package of assistance that is portable between private and social housing. At its base, all eligible households in both markets would receive CRA. Some households would also receive income support payments or National Disability Insurance Scheme funding that are currently used to contribute to housing costs. Where these programs and CRA are not sufficient to meet a household's rental payments, State and Territory Governments could pay a housing supplement to that household. This would bridge the gap between CRA, tenant contributions and market rent.
>
> **Choice-based letting**
>
> 'Choice-based letting' allows households to apply for available social housing properties. Applicants are ranked against selection criteria (such as waiting time, age and need) and the highest-ranked applicant is offered the property. This changes the allocation process from one driven by the housing provider to one driven by the preferences of the households. Choice-based letting has been implemented elsewhere, including the United Kingdom and the Netherlands.
>
> The Commission recommended that State and Territory Governments should introduce choice-based letting for tenants in social housing. While some governments are still looking at implementing this reform, none have done so.

Finally, navigating the administrative procedures for social housing can be particularly difficult for people with mental illness (APS, sub. 543; MHCA 2009). In a survey of people living with a mental illness, 90% of respondents reported complexity in applying for public housing that created difficulties for them (SANE Australia 2008). Once people are living in social housing, some may struggle to understand their tenancy obligations and what constitutes a breach (QMHC 2015b). Sowerine and Schetzer (2013) identified several other difficulties faced by people living with mental illness, including: offers of unsuitable housing based on needs (such as housing located far from health services); refusal to transfer to more suitable housing; complex processes to apply for priority housing on the basis of mental illness; and difficult treatment of people with previous evictions.

Increasing the number of social housing dwellings that provide supported housing can reduce the shortage of social housing, increase choice over where people live and provide assistance to help people navigate the administrative procedures involved in social housing. However, supported housing does not necessarily need to involve social housing. Another

option is to open up access to the private rental market. Several submissions noted that wrap around supports should be available regardless of whether people live in social or private housing (NT Mental Health Coalition, sub. 430; NT Shelter, sub. 333; Australian Red Cross Society, sub. 490).

Private rental housing

Supported housing in private rentals can provide significant benefits. The private rental market opens up a much larger pool of existing housing stock. This provides greater choice and opportunity for people to find housing that meets their needs and preferences, such as proximity to friends, family and support services. It can also provide an alternative to some people living in social housing, thus freeing up social housing places. The National Mental Health Commission (sub. 118) acknowledged that coordination with the private rental sector would facilitate access to an immediate and greater supply of homes.

People with mental illness can often rent successfully in the private market with the appropriate supports. For those with severe mental illness, supported housing can help to overcome many of the barriers they may face in accessing the private rental market, such as discrimination, difficulties managing housing tasks and unsociable behaviour (section 15.1).

However, tenancy support services (section 15.2) and similar psychosocial support services that provide more general support for people with mental illness (chapter 12) are either lacking, or are otherwise not integrated with housing and clinical mental health supports to form a well-coordinated service offering.

Further, rental affordability remains a key barrier for many Australians, particularly vulnerable tenants such as people with mental illness. In 2017-18, two thirds of low-income private rental households (or some 615 000 households) spent over 30% of their income on rent (PC 2019e). This can be problematic because the more people spend on the cost of housing, the less they have available to spend on other things (including healthcare) that may benefit their mental health. While governments provide some general financial assistance for renters, such as Commonwealth Rent Assistance, rental affordability for the most vulnerable people remains an issue (PC 2019e). Broader housing market initiatives that improve rental affordability can improve access to the private rental market for people with mental illness and reduce the risk of financial stress as a contributor to poor mental health.

There are some examples of supported housing programs for people with mental illness that overcome the issues of a lack of tenancy support and rental affordability by integrating services into a supported housing package and (further) subsidising rent (box 15.6). For example, Doorway is a rental subsidy housing model that targets people with mental illness and provides an integrated service offering. Doorway led to improved outcomes for participants, with the costs partially offset by an estimated reduction in health service usage. This program shows that integrating services is key. For example, building positive relationships with real estate agents and landlords is essential to avoiding discrimination associated with mental illness.

Over time, the levels of buy-in and engagement from landlords have grown to a point where many of them are active supporters of Doorway. (Nous Group 2014, p. 85)

Nevertheless, in some cases people with severe mental illness may still find it difficult to secure a private rental, even using these programs. This may be due to anxiety concerning lease length, stigma, absence of rental history, poor work history, making a poor first impression, poor literacy skills or reliance on financial assistance. Therefore, there is likely to be a need for a safety net to overcome these issues. This does not necessarily require government-owned social housing. 'Headleasing' is a potential step in-between.

Box 15.6   Private rental subsidy and wrap around support programs

Doorway

Doorway is a housing and recovery support program designed to improve the capacity of individuals with a severe and persistent mental illness who are homeless or at risk of homelessness to live independently in the private rental market (Nous Group 2014). The program provides client support services (such as tenancy support) and a housing supplement to subsidise rent where required. This housing payment supplements Commonwealth Rent Assistance. The program was initially funded for three years by the Victorian Government from 2011 to 2014.

An evaluation of Doorway estimated the cost of the housing supplement at $10 136, the cost of client support at $7937 and operational costs of $1228 per person each year (Nous Group 2014). About 85% of participants remained housed at the end of the evaluation period. Participants also showed improvements in mental health outcomes and greater interaction with others. Participants significantly reduced their use of health services, particularly bed-based mental health services, ambulatory care, emergency department presentations and hospital admissions. This led to an estimated $11 050 reduction in health service costs per person each year.

My Place

In Central Australia, the 'My Place' program, funded by the Northern Territory Government, supports people who have a mental illness and women and their children experiencing domestic and family violence to rent in the private market (NT Shelter, sub. 333; CAAHC 2019). The program provides rental subsidies and tenancy support to individuals to help them remain in the rental property. The program involves headleasing up to 30 properties from the private rental market and then sub-leasing them to participants for 12–24 months. During this time, a support worker will assist participants to build their skills and ability to manage a tenancy and link in with other supports.

Headleasing as a hybrid

A headleased property is one that is owned by private individuals or corporations and leased to another party (such as government agencies) who then enters into a separate lease with a tenant (box 15.7). Headleasing is a useful tool that State and Territory Governments can use more broadly to give social housing tenants a wider choice of home (PC 2017c). These arrangements already exist for some community housing and Defence housing in Australia.

Evaluating the use of headleasing more broadly is beyond the scope of this inquiry. But headleasing can be expected to help people with severe mental illness access stable, long-term housing in the private rental market (Mind Australia Limited, sub. 380). For example, Shelter WA (sub. 200, att. 1) recommended a concept where a non-government organisation headleases homes from private landlords and subsidises rent by charging tenants rent capped at 30% of income. The organisation would also provide support services and receive government funding to cover the gap between rental payments and market rent.

Box 15.7 **What is headleasing?**

A headleased property is one that is owned by private individuals or corporations, and leased to another party, usually a social housing provider. The social housing provider then selects a tenant and enters into a sub-lease with them. With a headlease, the private landlord is generally responsible for routine property maintenance, and the social housing provider is responsible for tenancy management (such as collecting the rent and passing on any maintenance requests). The social housing provider is usually liable (up to a cap) for any property damage after the application of the tenant bond and any insurance proceeds.

Headleasing arrangements already exists in several sectors. About 20% (12 500 properties) of all community housing properties are headleased from the private market (PC 2017c). Headleasing is also used in some States and Territories to assist women escaping domestic violence and as part of initiatives to find accommodation for the homeless. For example, Platform 70 is a Sydney-based program that headleases 70 units from the private rental market for people sleeping rough (MHCA 2013).

Headleasing can be beneficial for several reasons. First, this option provides more long-term flexibility over property type and location than building new public housing, providing more choice to tenants, this is particularly useful to enable tenants to live close to supports in housing designed to meet their needs. Second, governments can enter into long-term leases to provide stable accommodation for people with mental illness. Third, there is no need for upfront capital investment in building new homes. Fourth, if governments maintain some (or all) liability for property damage, the lower risk to landlords may reduce the likelihood of discrimination and unsociable behaviour acting as barriers to the private rental market for this cohort. Finally, governments acting as the headlease creates an opportunity to identify and respond to potential tenancy problems through tenancy support services.

The recurrent cost of headleasing is also likely to be similar to social housing for supported housing places. In particular, governments would incur the cost of rent during periods of vacancy and the cost of administering arrangements over time.

One way to increase the pool of this housing for use as supported housing is to engage private or philanthropic investors to develop eligible housing under a 'build-to-rent' model. Build-to-rent involves constructing large-scale residential unit developments designed for lease (as opposed to sale), which are held over a long-term investment horizon. Institutional investors looking for long-term fixed returns, such as superannuation funds, are likely to be interested in building supported housing with the promise of leasing these places to tenants

subsidised by governments. While build-to-rent is an established residential property asset class in the United States and multiple European nations, it is largely absent in Australia (PC 2019e).
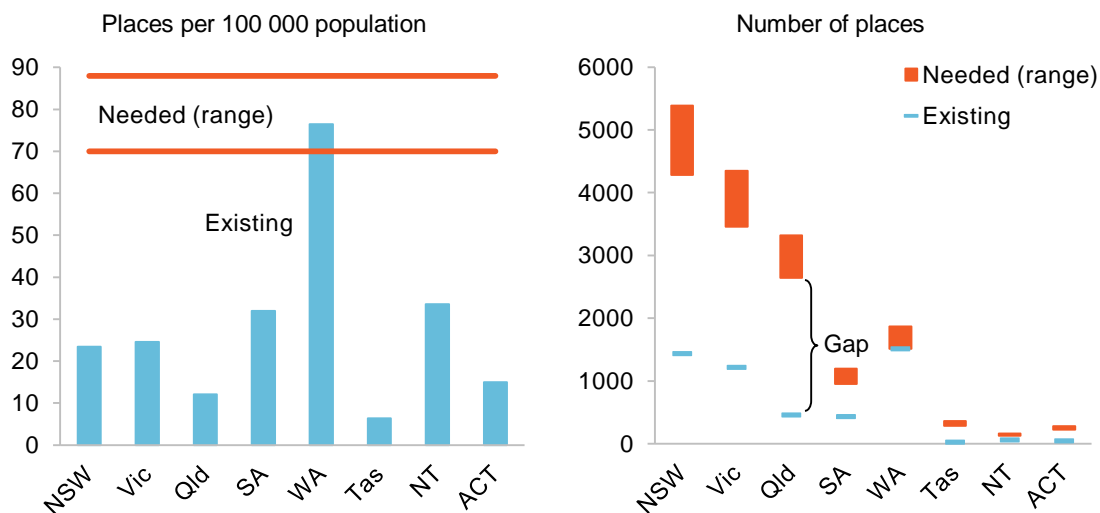
Filling the gap in the number of supported housing places

There is significant unmet demand for supported housing places in Australia (figure 15.4). In 2016-17, there were about 5200 supported housing places across Australia that provided integrated housing and mental health supports to people with mental illness (AIHW 2019ab).[87] Yet, about 13 000 to 17 000 people were estimated to need supported housing across Australia in 2016-17. This is a gap of about 8000 to 12 000 places. While these estimates are not exact, they are consistent with a broader understanding in the community that more supported housing places are needed.

> There are a number of mental health supported accommodation packages via [Housing and Support Packages (HASP)] but not currently enough to meet demand. [The Office of The Public Advocate] understands that South Australia has 36 HASP packages. There is sufficient demand to increase the number of HASP packages available. (OPA South Australia 2017, p. 4)

Figure 15.4   Gap in supported housing places across Australia^a

As at 30 June 2017

a The needed range was estimated using assumptions in Siskind et al. (2012) that the optimal number of supported housing places lies between 70 to 88 places per 100 000 population. Existing places are reported by the AIHW (2019ab). The gap in the number of supported housing places is the difference between the existing number of places and the estimated number of places needed (using population estimates for people aged 18 and over).

Source: Commission estimates based on ABS (Australian Demographic Statistics, June 2017, Cat. no. 3101.0); AIHW (2019ab); Siskind et al. (2012).

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[87] While this is the most consistent source of data available to measure the existing number of supported housing places, it is not necessarily an accurate reflection of a jurisdiction's mental health housing supports because not all schemes are in scope for this data collection.

Unless more supported housing places are developed, this gap can be expected to increase as the population grows. Currently, Western Australia is the only jurisdiction that falls within the estimated range of supported housing places needed, but continues to report a significant gap in community mental health services more broadly (WA MHC 2019). The National Mental Health Commission, in its proposed monitoring and reporting role (chapter 25) should regularly report on the progress of State and Territory Governments in meeting the gap in supported housing places in their jurisdiction.

The total cost of investing to meet the gap for supported housing places across Australia is estimated to be $200 million to $700 million each year.[88] Less than half of these costs make up the accommodation component — about $97 million to $196 million each year.

However, to the extent that supported housing avoids costs to other government services, the net cost to government is likely to be lower in the long run. For example, both the Doorway (about $11 050 per person each year) and HASI ($27 917) programs estimated significant reductions in average health service usage. This suggests the net cost to government is likely to be $76 million to $231 million each year.[89]

State and Territory Governments should develop or scale up existing supported housing programs that integrate housing, tenancy support and mental health services. A mix of supported housing options are likely needed to suit a variety of needs and preferences. Some people may have the capacity and preference to rent in the general private rental market through an integrated support housing program. Others may need the security of tenure offered through a headleased private rental property or social housing. Each State and Territory Government is best placed to plan their mix of supported housing places in their jurisdiction. Funding for this increased investment should primarily be met by the Australian Government through a renegotiation of the National Housing and Homelessness Agreement (chapter 24).

Improve transition out of institutional care

Some people with mental illness who have spent time in institutional care, such as hospital or prison, may find it difficult to find or return to housing back in the community once they are discharged. This is considered a high-risk juncture at which people may become stuck in institutional care, be discharged into homelessness or experience a relapse and quickly return to institutional care.

People who experience episodes of severe distress may benefit from spending a short period of time in hospital or a specialised mental health facility to support their recovery, with the

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[88] Total costs estimated by scaling up the recurrent cost of housing (about $11 900 to $16 900 per person each year) and non-housing supports ($12 700 to $43 500) in the Doorway and HASI programs (respectively) to meet the estimated gap in the number of supported housing places (inflated to 2017-18 dollars using CPI index numbers for Rents and Health, weighted average of eight capital cities, Cat. no. 6401.0).

[89] Net costs estimated by subtracting the total cost savings to health service usage estimated in the Doorway (about $15 300 per person each year) and HASI ($40 500) programs from total costs (inflated to 2017-18 dollars).

aim of getting them back home safely (chapters 7 and 8). However, some people remain stuck if there is a lack of housing or other supports available for them to return to living in the community. Over 2000 mental health hospital inpatients could potentially be discharged if appropriate clinical and accommodation services were available (chapter 7). The NSW Ombudsman (2012) found that a lack of appropriate accommodation was a key barrier preventing discharge of mental health inpatients, leading to bed block in hospitals and influencing staff to refer inpatients to inappropriate housing options.

Many others are discharged into homelessness. One survey found that almost 7% of participants who had been admitted to a psychiatric inpatient hospital in the previous year reported not being given any help and having nowhere to live on discharge (Morgan et al. 2011). And the Council to Homeless Persons (sub. 145, p. 5) found that:

> Acute mental health services report that approximately 25 per cent of patients are homeless prior to admission, and most are discharged back into homelessness because of a lack of suitable accommodation options.

There are several reasons why people may be discharged from acute mental healthcare into unstable housing or homelessness (Brackertz, Wilkinson and Davison 2018).

- Difficulty identifying people who are homeless or at risk of homelessness.

- Constraints on hospital capacity and time pressures can affect discharge assessments and lead to patients being discharged too quickly.

- Delays or lack of follow up after discharge. While follow up with a hospital liaison officer is common practice in Australia, there can be significant delays. Follow up is also only possible if the consumer has been discharged to a stable address.

- Difficulty accessing housing and community mental health services after discharge.

People with mental illness who leave prison are also at high risk of being discharged into homelessness. Nearly half of people leaving prison are expected to spend their first night in short-term or emergency accommodation (chapter 16). Although people on parole are released into suitable accommodation (as a condition of parole) those not on parole may be released immediately into homelessness. This cohort need a variety of coordinated supports to avoid homelessness, particularly stable longer-term accommodation and appropriate mental health services. Both parole officers and care coordinators may be well-placed to coordinate these supports (chapter 16). There are some examples of programs that provide supported housing for this cohort that have had some success in Australia and overseas, but more research is needed to evaluate different housing models for effectiveness and cost-effectiveness (Willis 2018).

In 2017-18, almost 1000 people with mental ill-health accessed homelessness services in while staying in institutional care, such as hospital or prison, but left their stay homeless (AIHW 2018t). Many more may have been discharged into homelessness without accessing support.

A clear and formal policy of 'no exits into homelessness' can put the onus on the discharging institution to prevent people being discharged into homelessness. In general, jurisdictions have formal policies or guidelines that dictate discharge and transfer of care from hospitals and prisons. However, many jurisdictions do not have a clear and explicit reference to prevent discharge into homelessness. For example, some jurisdictions told the Commission that they have informal policies that no person should be discharged into homelessness, or that mental health inpatients who are discharged with no fixed address are offered basic hotel accommodation for three nights (State and Territory Governments Survey). Several submissions discussed the need for formal, nationally consistent policies, of no exits into homelessness (Beyond Blue, sub. 275; FARE, sub. 269; NMHC, sub. 118).

The Commission considers that it is reasonable for each State and Territory Government to have a clear and formal policy that no person in their care, particularly hospitals or prisons, is discharged into homelessness. These policies should be clearly communicated to staff and reported against. This places the onus on State and Territory Governments to adequately fund programs and procedures to avoid discharge into homelessness. The cost of bed blocks in hospitals should not be an excuse for discharging people without adequate supports in place.

There are several examples of hospitals that have implemented programs that successfully avoid discharging patients into homelessness (box 15.8). Some programs provide time-limited housing and thus are more costly (such as Transitional Housing Teams), compared with other programs that just provide discharge planning and other supports (such as the Royal Perth Hospital Homeless Team). Successful programs tend have three key elements.

- Staff are trained to identify at-risk patients.

- Care coordinators (such as case managers) make thorough discharge assessments, well-ahead of discharge, and provide timely and assertive follow up after discharge.

- Patients have ready access to transitional housing that meets the long-term recovery needs of the individual.

Many inquiry participants recognised the importance of improving transition out of institutional settings to prevent people being discharged into homelessness or eventually back into these facilities (ACT Mental Health Consumer Network, sub. 297; APS, sub. 543; Beyond Blue, sub. 275; breakthru, sub. 112; CHP, sub. 145; FARE, sub. 269; FOCP, sub. 198; Mental Health Commission of New South Wales, sub. 486; MHCT, sub. 314; Mind Australia Limited, sub. 380; NT Mental Health Coalition, sub. 430; PPIMS, sub. 179; VCOSS, sub. 478; Victoria Legal Aid, sub. 500).

Box 15.8   Programs preventing discharge into homelessness

Programs that support people to transition out of mental health inpatient units and into the community through adequate discharge planning, care coordination and, in some cases, provision of temporary accommodation, can deliver a positive return on investment (costs and savings inflated to 2017-18 dollars using Consumer Price Index numbers for Health, weighted average of eight capital cities, Cat. no. 6401.0).

Transitional Housing Teams (Queensland)

In 2005, Queensland established a Transitional Housing Team to provide time-limited social housing and intensive support to clinically case-managed patients with mental illness (Siskind et al. 2014). Participants entered the program upon discharge from an acute psychiatric inpatient unit or from the community. Staff trained the participants in living skills, such as cooking and shopping, provided crisis management and coordinated with other services.

Results showed that participants experienced significantly fewer inpatient bed-days and improved living conditions. This reduced the average cost of health service use by about $36 200 per participant, and completely offset the $29 300 per participant cost of the program. Therefore, the program provided an estimated return on investment of about $1.24 per dollar invested (1.24:1).

Royal Perth Hospital Homeless Team (Perth)

The Royal Perth Hospital Homeless Team provides GP care, care coordination and discharge planning for patients who are homeless. The team is made up of a clinical lead, administration assistants, GPs, nurses and a caseworker.

An evaluation showed that contact with the team reduced emergency department presentations and mental health inpatient care (Gazey et al. 2019). Fewer patients also discharged themselves against medical advice. These improvements were estimated to reduce hospital use by about $7900 per patient. Given the average cost of the program was about $850 per patient, this represented a return on investment of about 9:1.

Housing Support Worker, Mental Health

In 2009, the National Partnership Agreement on Homelessness (NPAH) was established. One of the programs delivered under the agreement was the provision of Housing Support Workers who help people with severe and persistent mental illness who are either homeless or at risk of homelessness when discharged from a mental health inpatient unit.

Wood et al. (2016) estimated that this program reduced overall health costs by about $104 000 per person each year, largely as a result of fewer days in hospital and psychiatric care. These cost savings significantly outweighed the estimated cost of the program (about $11 900 per person, excluding housing costs). Therefore, the program delivered a positive return on investment of about 9:1. Compared with other homeless prevention programs tested, this group delivered the largest cost savings and was most likely to retain their tenancies.

The total cost of providing discharge support to help about 3000 people transition out of acute care and into suitable housing could be $3 million to $88 million each year.[90] This range reflects the fact that some people will need time-limited housing upon discharge from hospitals, whereas others may have access to housing but require relatively less expensive

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[90] Total costs estimated by scaling up the range of average program costs in box 15.8 to meet estimated demand.

support to maintain it. However, programs such as these are likely to present an overall saving for governments due to reduced use of health services, including hospital readmissions (box 15.8; Rudoler et al. 2018). Therefore, these programs could actually deliver an estimated net benefit to governments of $21 million to $276 million each year.[91]

State and Territory Governments have a financial incentive to develop, or scale up existing, mental health discharge programs that prevent discharge into homelessness. These programs should include care coordinators who are involved in pre-discharge planning and post-discharge follow-up support as needed. This could be at least every three months and up to one year post discharge (Beyond Blue, sub. 275; breakthru, sub. 112). This role could be filled by care coordinators (chapter 10). Further, these programs should offer dedicated transitional housing in each region for people who have exited institutional care. This specialised type of supported housing could be purpose-built or headleased from the private rental market.

Given the need for intensive care coordination, the transitional nature of this housing and the small number of people expected to access it, this type of program is likely to be best delivered through State and Territory Government mental health services, rather than the housing system. Further, the expected cost savings are likely to accrue to the mental health system directly.

Long-term supported accommodation for people with chronic severe mental illness

Some Australians live with severe and persistent mental illness. This can make it very difficult to live in the community over the long term, without ready access to a high level of housing and mental health supports.

Currently, many people rely on family or friends for support (chapter 13). And others pay to live in privately operated facilities that cater to people who are older or have a disability or a mental illness ('Supported Residential Services').

However, a subset of people with severe and persistent mental illness do not have the necessary social supports or financial capacity to access longer-term accommodation that provides the support needed to live in the community. These people may be effectively living (either permanently or for prolonged periods) in specialist mental healthcare facilities or hospital-like environments that cater for high levels of support (chapters 7 and 8). Yet, facilities, such as these, are generally designed for short- to medium-term stays, with the aim of supporting recovery and building skills to help people live in the community. Others spend time in and out of hospitals or homeless if they cannot access support.

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[91] Net benefits estimated by subtracting the range of total savings from programs in box 15.8 from total costs.

Notwithstanding, many of these people would prefer to live in the community. For people living with severe and persistent mental illness who want to live in the community, 'long-term supported accommodation' can give them the best opportunity to live a contributing life.

Long-term supported accommodation

Long-term supported accommodation is a specific form of supported housing for people living with severe and persistent mental illness who require mental healthcare, tenancy support services and daily living support to be available on-site 24 hours a day, 7 days a week. Mind Australia Limited (sub. 380) highlighted several potential housing needs for people living with psychosocial disability, who may require specialist long-term supported accommodation, including soundproofing and space for visitors. Specialist housing may involve individual or congregated living arrangements in purpose-built units or houses that provide space for on-site support.

> … in Australia and overseas there are models of housing that feature more flexible combinations of private and shared space, individual bedrooms with shared kitchen and living areas. Purpose built facilities have the advantage that they can also contain co-located health, employment support services and social participation opportunities to provide the supports that many people require to live independently and in communal settings. (AASW, sub. 432, p. 8)

Some State and Territory Governments are developing examples of long-term supported accommodation (ACT Government, sub. 210; Tasmanian Government, sub. 498). Non-government organisations (with government assistance) have also entered this space. For example, the Haven Foundation model has led to improved outcomes for many of its participants (box 15.9).

Long-term supported accommodation can also be more cost-effective compared with residential mental healthcare and hospitals. For example, the estimated recurrent (non-capital) cost of housing someone in the Haven is about $100 000 per person each year (Mind Australia Limited, sub. 380). This is significantly cheaper than the average annual recurrent cost of 24-hour staffed residential mental healthcare (about $193 000) and hospitals ($419 000) in 2016-17 (SCRGSP 2019i).[92]

The Commission estimates that about 3000 people could be living in non-acute 24 hour staffed accommodation across Australia in 2019-20, were sufficient places available.[93]

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[92] The average cost of residential care may be higher than this estimate as it does not fully account for reach-in services from State and Territory providers.

[93] Productivity Commission estimates using the National Mental Health Service Planning Framework. This projection is based on all other services being available.

The Haven provides long-term supported accommodation to people living with severe mental illness (Mind Australia Limited, sub. 380). Residents live in their own self-contained apartment, with independent kitchen and bathroom facilities, within in a block of units that also has some shared communal areas to encourage social interaction. The program provides 24/7 on-site psychosocial support staff to help residents to live successfully in the community.

Residents must meet strict eligibility criteria to live in the Haven, for example they must be diagnosed with a severe and persistent mental illness, receive a Disability Support Pension and be eligible for the National Disability Insurance Scheme (The Haven Foundation, pers. comm., 13 February 2019).

Residents enter into an open-ended lease with The Haven Foundation. They pay 25% of the Disability Support Pension and 100% of rental assistance to cover the cost of maintenance and repairs. Residents are responsible for paying their own utilities, such as electricity and water. Funding received under the National Disability Insurance Scheme covers the cost of on-site psychosocial and tenancy support.

An evaluation of the pilot Haven model in South Yarra found that tenants have experienced:

> … the reduced need for acute psychiatry or residential rehabilitation service care, has enhanced participation in vocational or educational opportunities, has strengthened the link with carers and family members, and has assisted in establishing new connections with members of the broader community. (Lee et al. 2013, p. 15)

The Haven is estimated to cost about $100 000 per person each year (Mind Australia Limited, sub. 380). This does not include an annualised cost of capital to fund the development of these units.

The first Haven site in South Yarra, Melbourne has 14 units. The model has subsequently been established in Frankston (18 units), with more sites in Geelong (16 units) and Laverton (16 units) expected to be completed by 2020, and one in Whittlesea in the pipeline.

However, the Commission understands there is a lack of long-term supported accommodation available. For example, some of the more than 2000 hospital inpatients with a mental illness could potentially be discharged if appropriate clinical and accommodation services were available (chapter 7).[94] And during 2017-18, 135 people had been living in residential mental healthcare for more than one year (AIHW 2019s). The SA Government (2018) estimated that 82 older adults living with enduring mental illness would require this type of housing by 2021, and that 36 long-term accommodation places would be needed to help fill the gap in existing services. Several submissions also acknowledged the need to develop more of this type of specialist housing (Mind Australia Limited, sub. 380; NAPP, sub. 495).

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[94] Although, some of this cohort may instead require transitional housing support upon leaving hospital, rather than long-term supported accommodation.

Making use of the NDIS to encourage accommodation development

Most people living with severe and persistent mental illness who require 24/7 mental health and housing support are likely to be eligible for disability funding under the National Disability Insurance Scheme (NDIS) (chapter 12). Under the NDIS, there are two streams of funding that can be used to help people find and maintain housing.

- Supported Independent Living (SIL) supports involve a person assisting with daily tasks to help people live as independently as possible, such as help cooking and budgeting.

- Specialist Disability Accommodation (SDA) involves specialist housing solutions for people with very high support needs. This may involve developing new accommodation or retrofitting existing dwellings to satisfy particular support needs.

SIL supports can help people with mental illness to manage their housing tasks. People who receive SIL supports may live in accommodation funded under SDA, or they may live in their own home, a private rental or social housing. However, unlike SDA, funding for SIL cannot be used to pay for the cost of housing, such as rent.

SDA funding can be used to encourage development of long-term supported accommodation for people with severe and persistent mental illness with very high support needs (box 15.10). SDA funding is limited in the number of people it is designed to support. The National Disability Insurance Agency (NDIA) projects about 6% of NDIS recipients are intended to receive this funding. This suggests that, of the estimated 64 000 people with long-term primary psychosocial disability expected to access the NDIS (chapter 12), about 4000 people will be eligible for SDA. This should accommodate the estimated 3000 people in need of this type of housing.

However, this housing solution is still in its infancy. As at 31 March 2019, just 348 participants with primary psychosocial disability received SDA funding (NDIA pers. comm., 8 August 2019). This is just 1.6% of current NDIS participants with primary psychosocial disability — far from the 6% target and significantly lower than the almost 4000 people projected. Ongoing funding for SDA is already budgeted (box 15.10), but SDA growth remains slow.

Growth in SDA may be slow for people with psychosocial disability for several reasons. First, barriers to accessing the NDIS has led to fewer people with psychosocial disability entering the scheme than expected (chapter 12). Second, the SDA sector has received limited private investment to date because of too much uncertainty over who needs, and is eligible to receive SDA funding, and where these people live (Beer et al. 2019). Third, newly developed SDA is restricted to housing five or fewer residents and is intended to reduce clustering of people living with long-term psychosocial disability (NDIA 2019b). This criteria potentially restricts the development of some successful congregated site models, such as the Haven model. Finally, there may be a perception in the community that SDA funding is only suitable for NDIS participants with a physical disability (Mind Australia Limited, sub. 380).

> **Box 15.10 Specialist Disability Accommodation**
>
> Specialist Disability Accommodation (SDA) refers to accommodation for eligible participants of the National Disability Insurance Scheme who need specialist housing solutions to help cater for their significant functional impairment or very high support needs (NDIA 2018). SDA is intended to ensure that participants do not pay more for housing because of their disability.
>
> SDA funding provides a return to investors to develop SDA to meet demand. Eligible participants receive ongoing payments throughout their lifetime to live in eligible SDA (in practice, SDA funding is paid to the SDA provider on behalf of the participant). Residents in SDA are still required to pay a reasonable rent contribution, limited to 25% of their Disability Support Pension plus applicable Commonwealth Rent Assistance (Beer et al. 2019). Some people may decide to develop their own SDA.
>
> As at 31 March 2019, 12 356 participants were in receipt of SDA funding, at a cost of about $127 million, and 2896 SDA dwellings were enrolled (NDIA 2019a). When the scheme is fully rolled out, about 28 000 households (6% of National Disability Insurance Scheme recipients) are expected to receive SDA funding. Funding is expected to reach about $700 million each year and is intended to attract an additional $5 billion in investment from the market to develop more than 12 000 purpose-designed dwellings.

There are several potential ways the NDIA can encourage development of SDA for people with mental illness. The NDIA can lift restrictions on the number of people who can share SDA in a congregated living environment. Mind Australia Limited (sub. 380) suggested that a separate funding stream of SDA for clients with psychosocial disability may be feasible, although this is unlikely to alleviate broader issues slowing growth in SDA. Beer et al. (2019) suggested several other ways the NDIA could encourage SDA development, including:

- support to increase investor certainty by building systems to estimate the number of people expected to be eligible to access SDA and where they live

- providing resources to assess and approve participants

- developing SDA policy about clients with complex, challenging or aggressive behaviours that may lead to significant property damage — these clients may not be an attractive investment proposition to SDA providers, but have some of the greatest needs.

The NDIA should review its SDA strategy and policies with a view to encouraging the use of SDA funding to develop long-term supported accommodation for people living with severe and persistent mental illness. As part of its review, the NDIA should:

- lift restrictions on the number of people who can reside in newly developed SDA

- develop and report estimates of the number of people living with psychosocial disability who are expected to be eligible to receive SDA funding, and where they live

- provide clarity about how the NDIA will deal with problems of liability concerning property damage for this cohort.

15.4 Responding to homelessness among people with mental ill-health

Mental health is closely related to homelessness (section 15.1). On one hand, the stresses of homelessness can contribute to poor mental health. On the other hand, mental illness can increase an individual's risk of homelessness. For example, Johnson and Chamberlain (2011) found that 15% of homeless people in a sample had mental ill-health prior to becoming homeless, and 16% developed mental ill-health after they became homeless.

Homelessness is not necessarily narrowly defined as 'rooflessness'. It includes a broader set of people, including people living in non-conventional accommodation ('sleeping rough'), living temporarily in short-term accommodation (such as shelters and hostels), and staying with family and friends ('couch surfing').

Eliminating homelessness altogether can be expected to improve population mental health. However, this inquiry focuses on responding to homelessness among people with mental ill-health. Prevention is a key avenue to reducing homelessness over time. Sections 15.2 and 15.3 discuss ways to prevent homelessness among people with mental illness. Where prevention fails, services can respond by helping people who are homeless to find and maintain housing.

State and Territory Governments are generally responsible for providing or funding a range of homelessness services (box 15.11). This section examines the effectiveness of existing homelessness services to support people with mental ill-health, and identifies areas for improvement, such as meeting demand for these services, improving service coordination and Housing First initiatives.

Box 15.11   What do homelessness services look like?

'Specialist Homelessness Services' (hereon referred to as homelessness services) include any type of service provided by an agency (government or non-government) aimed at responding to or preventing homelessness, including:

- accommodation provision (such as emergency accommodation or transitional housing)
- assistance to sustain housing and avoid eviction (tenancy support services)
- mental health services
- domestic or family violence services
- family or relationship assistance
- drug or alcohol counselling
- legal or financial services (AIHW 2018s).

A high prevalence of mental ill-health among the homeless

In Australia, there is a high prevalence of mental ill-health among the homeless population (box 15.12). A growing number of people are seeking assistance from homelessness services and a growing proportion of these people have mental ill-health (figure 15.5). The number of people accessing homelessness services with mental ill-health has almost doubled over the past seven years. By 2017-18, about one-third of people (about 81 000 people) accessing these services experienced mental ill-health, considerably higher than one-fifth of the general population (chapter 2).

This increase in the reported prevalence of mental ill-health amongst the homeless population does not necessarily mean the problem has worsened. Greater awareness and reduced stigma may improve identification and self-reporting of mental ill-health among homelessness service clients. Further, an increase may be the result of improved accessibility or targeting of services. Regardless, as the number of people accessing homelessness services grows, it becomes even more important for services to be effective and efficient.

A variety of risk factors can contribute to homelessness, including mental illness, drug or alcohol abuse, domestic violence, unemployment, relationship breakdown and housing affordability issues (Australian Government 2008). In many cases, mental illness coincides with one or more other risk factors. In 2017-18, over half of all homelessness service clients with mental ill-health also experienced domestic and family violence and/or problematic drug or alcohol use (AIHW 2018s). Aboriginal and Torres Strait Islander people are at significant risk of homelessness. In 2016, 1 in 28 Aboriginal and Torres Strait Islander people was homeless, and more than 1 in 5 homeless Australians were of Aboriginal and Torres Strait Islander descent (AIHW 2019a).


Box 15.12   Prevalence of mental ill-health and homelessness

Estimates of the prevalence of mental ill-health among the homeless vary significantly depending on the definition of homelessness and mental illness (Fazel et al. 2008; Fazel, Geddes and Kushel 2014). For example, including alcohol or drug dependence within the definition of a mental illness can significantly inflate prevalence estimates (Johnson and Chamberlain 2011).

When substance use disorders are excluded, prevalence estimates from Australian studies tend to cluster around one-third (ABS 2016a; Flatau 2007; Hodder, Teesson and Buhrich 1998; Johnson and Chamberlain 2011; Rossiter et al. 2003). This is broadly in line with international studies (Kirkpatrick and Byrne 2009; Kovess and Mangin Lazarus 1999; Vazquez, Munoz and Sanz 1997).

Looking at the question of prevalence in the reverse direction, several studies show that about 10–15% of people with a severe mental illness experienced homelessness within the past few years (Culhane, Averyt and Hadley 1997; Folsom et al. 2005; Morgan et al. 2011). Again, differing definitions of mental illness, such as severity, can change these estimates markedly. Yet, this is orders of magnitude higher than the 0.5% prevalence of homelessness among the general population (ABS 2018c).

Figure 15.5   **People accessing homelessness services**[a]

Number of people, by homeless state[b] and mental health[c] status
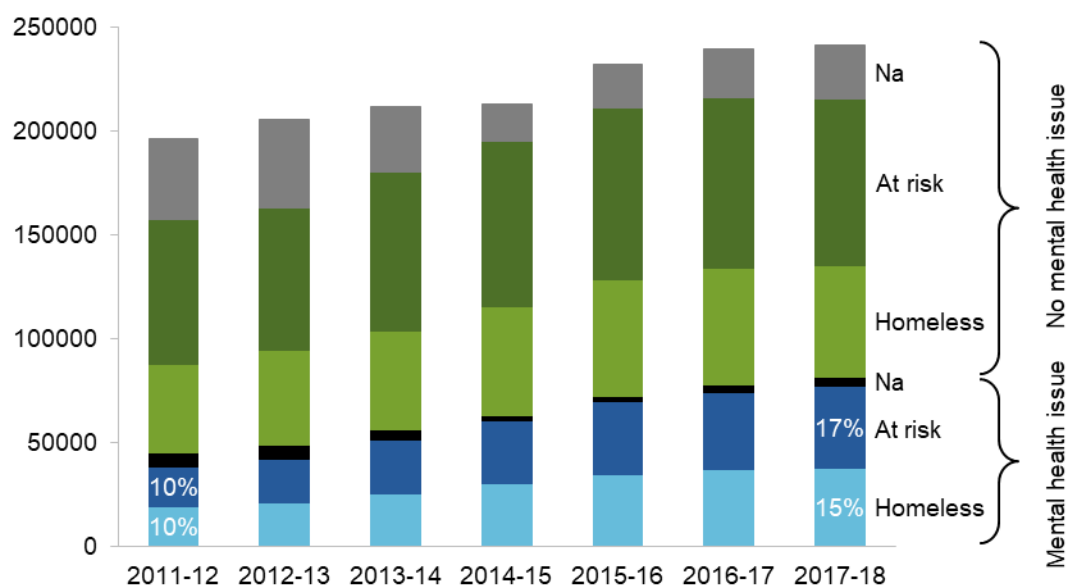
[a] Only includes people aged 10 years or older. Mental health status is not available for people aged below 10 years. [b] Homeless status when first seeking assistance. 'Homeless' means the individual is living in no shelter, improvised dwelling, short-term temporary accommodation or couch surfing. 'At risk' means the individual is living in social housing, private housing or an institutional setting. 'Na' means not available due to insufficient information. [c] AIHW defines a person as having a current mental health issue if they received mental health services in the last 12 months, were referred by a mental health service, reported 'mental health issues' as a reason for seeking assistance, had been in a psychiatric hospital or unit in the last 12 months, or a need was identified for mental health services during their support period.

Source: AIHW (2019ac).

## What is the cost of homelessness?

Homelessness can be devastating for individuals and the people close to them. It can be traumatic, stressful and have broader impacts on people's mental and physical health, employment, education and productivity. For example, one study found that over half of people sleeping rough had been attacked or beaten up since becoming homeless (Flatau et al. 2018).

Homelessness also imposes significant costs on government services (box 15.13). It directly impacts the cost of homelessness services. In 2017-18, government expenditure on homelessness services was over $900 million each year, an average of over $3000 per person (SCRGSP 2019k).

People with mental ill-health tend to use homelessness services more than average. This cohort had a median 72 days of support, almost twice as long (37 days) as the general homelessness services population (AIHW 2018s). They were also more likely to be persistent users of homelessness services (figure 15.6). This cohort came back to

homelessness services 2.4 times per client each year, compared with 1.7 times for the general homeless population.

Figure 15.6   **People with mental ill-health are more likely to be persistently homeless[a,b]**
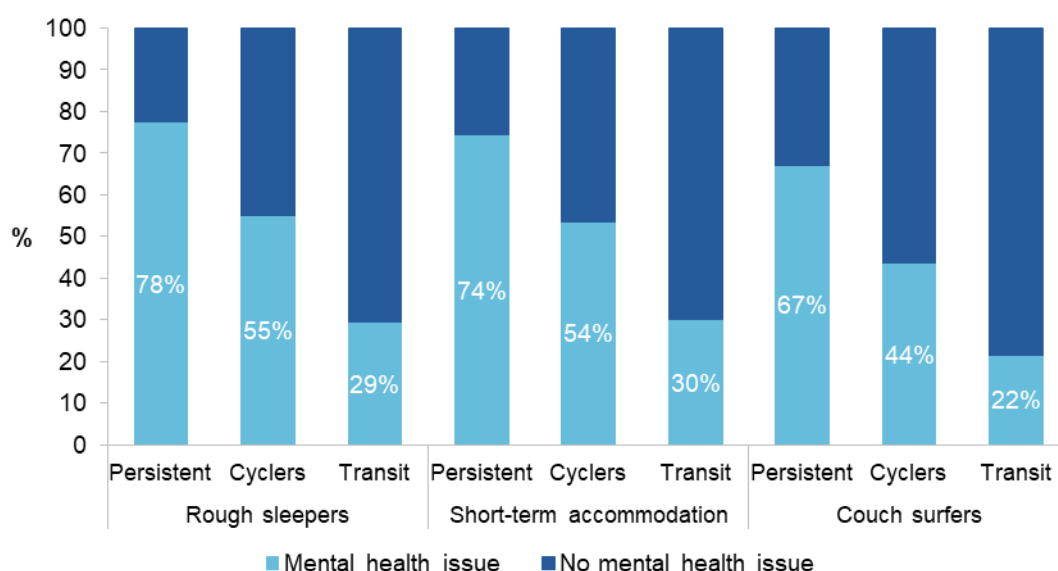
a People who have ever reported having a mental health issue. **b** 'Persistent' means clients who used homelessness services at least once every financial year between 2011-12 to 2014-15. 'Cyclers' means clients who used services at least once in 2011-12 and at least one more time before the end of 2014-15, but not in each financial year. 'Transit' means clients who used services only in 2011-12.

Source: AIHW (2018d, 2018r, 2019y).

People who are homeless also tend to have a greater impact on other government services, such as health, justice and welfare (box 15.13). For example Zaretzky et al. (2013) estimated the average annual cost of homelessness to other services was about $30 000 per person each year. The cost to the health system is likely to be significantly higher for homeless people with mental illness. For example Bruce et al. (2012) estimated the average cost of mental health inpatient hospitalisations was $47 425 per person each year. A case study highlights some of these impacts.

> Mr C is a man in his sixties who has been sleeping rough in the City for some time. … He has been assessed as having below average intelligence and went on to a Disability Support Pension due to a Psychological condition. He has been admitted to several emergency departments at different metropolitan hospitals over the past 2 years … He has had extensive involvement with Victoria Police since 1991 due to his antisocial behaviours and has been arrested over 30 times with convictions due to behavioural offences … (City of Port Phillip, sub. 540, p. 7)

Box 15.13   Homelessness increases costs of government services

Homelessness services

Government expenditure on State- and Territory-delivered homelessness services increased from $672 million in 2013-14 to $905 million in 2017-18 (SCRGSP 2019k). There are two key reasons for this increase over the five year period. First, the number of clients increased by 14%. Second, the average cost of services increased by 18% to $3134 per person in 2017-18. The growing proportion of clients with mental ill-health is likely to be a contributing factor as this cohort tend to need longer and more frequent periods of support.

While the Australian Government contributes some funding to States and Territories to deliver the bulk of homelessness services, it also provides about $23 million each year for Reconnect — its own grant-based program that assists young people aged 12–18 years old who are homeless or at risk of homelessness (DSS 2018n). Reconnect services can include counselling, mediation, outreach or specialised mental health services. An evaluation of this program found significant positive outcomes for clients (Mission Australia 2016).

Other government services

Health — People who are homeless have higher rates of infectious and chronic disease, substance use, assault and injury (D'Amore et al. 2001; Flatau et al. 2018; Hwang 2001; Morrison 2009). This increases their use of physical and mental health services. Homeless patients tend to use hospitals and ambulances more frequently and stay longer than other patients, increasing overall costs within the health system (Hwang et al. 2011; Mandelberg, Kuhn and Kohn 2000; Pearson, Bruggman and Haukoos 2007; Salit et al. 1998). People with mental illness and chronic rough sleepers tend to account for the majority of healthcare costs incurred by the homeless (Latimer et al. 2017; Zaretzky et al. 2017). For example, in a sample of homeless people, Poulin et al. (2010) found that 20% of people accounted for 60% of healthcare costs and that 81% of people in this group had a serious mental illness.

Justice — Homelessness is associated with greater interaction with the justice system (Greenberg and Rosenheck 2008). Rough sleepers are significantly more likely to have been in prison or juvenile detention, experience high numbers of police interactions, been a victim of crime, and face other serious legal issues (Flatau et al. 2018). Individuals with a history of homelessness or mental illness are more likely to be homeless upon release from prison, creating a 'revolving door' between homelessness and prison. Consequently, homelessness, particularly among those with a mental illness, can impose significant costs to the criminal justice system (Latimer et al. 2017; MacKenzie et al. 2016; Poulin et al. 2010; Zaretzky et al. 2013).

Employment, education and welfare — Homelessness and housing issues are associated with poor employment and education outcomes. In 2017-18, just 12% of homelessness service clients (aged 15 and over) were employed full-time or part-time; 48% were unemployed and 40% not in the labour force (AIHW 2018t). Further, almost half of all children aged 5–24 years old (whose education status was known) were not enrolled in any form of education. Poor employment and education outcomes can have long-term impacts on an individual's income, workforce participation and productivity. This increases welfare costs to government and reduces tax collected (Zaretzky et al. 2013).

Costs to other government services — Zaretzky et al. (2013) estimated that the average client of homelessness services used $29 450 more in other government services than the population average, each year (2010-11 dollars). This included costs to health ($14 507), justice ($5906), welfare ($6620), out of home care ($2342) and evictions ($75).

These costs can accumulate over a person's lifetime and are likely to be greatest for young people. For example, Baldry et al. (2012) estimated the lifetime cost of homelessness to government services ranged from $900 000 to $5.5 million per person. When people become homeless at a young age, their life trajectory can change course. They are less likely to be employed than people who become homeless later in life, primarily due to lower levels of education (Cobb-Clark and Zhu 2017). This can entrench homelessness and disadvantage, increasing the likelihood that this cohort will make use of government services over much of their lifetime.

How effective are homelessness services for people with mental ill-health?

The Productivity Commission uses two available indicators to measure the effectiveness of homelessness services for people with mental ill-health:

- accessibility of services

- ability of services to address client needs (SCRGSP 2019k).

The first indicator shows that many people cannot access the services they need (figure 15.7). Over half of all clients of homelessness services in need of long- and medium-term housing did not receive it. And about one-third of clients with mental ill-health needed, but did not receive, mental health services. While there is a clear need for short-term housing as a pathway to a longer-term solution for some people (Anglicare Australia, sub. 376), many submissions identified the need for people with mental ill-health to access long-term housing (APS, sub. 543; Beyond Blue, sub. 275; CLBB, sub. 146; Launch Housing, sub. 250; NMHC, sub. 118; Youth Mental Health, North Metropolitan Health Service, sub. 99). Further, the proportion of all clients with an unmet need for accommodation services grew from about 24% in 2013-14 to almost 33% in 2017-18 (SCRGSP 2019k).

The second indicator (ability of services to address client needs) uses two measures to show the extent to which the needs of people with mental ill-health are met when they receive homelessness services.

- The first measure uses the proportion of clients with an agreed case management plan. Clients with mental ill-health were more likely (72%) to have a case management plan than those without mental ill-health (55%) (AIHW Specialist Homelessness Services Collection, unpublished data). And the vast majority of people with mental ill-health achieved some or all of their case management goals. This suggests that clients with mental ill-health tend to receive individualised care.

- The second measure uses the proportion of clients who had their needs met — essentially the opposite measure of the first indicator of unmet need. This measure shows that although there was a high level of unmet need across the board, clients with mental ill-health were slightly more likely to have their needs met across all types of accommodation services, than clients without mental ill-health (figure 15.7).

Figure 15.7   Unmet need for homelessness services[a,b]

By mental health status and selected service type
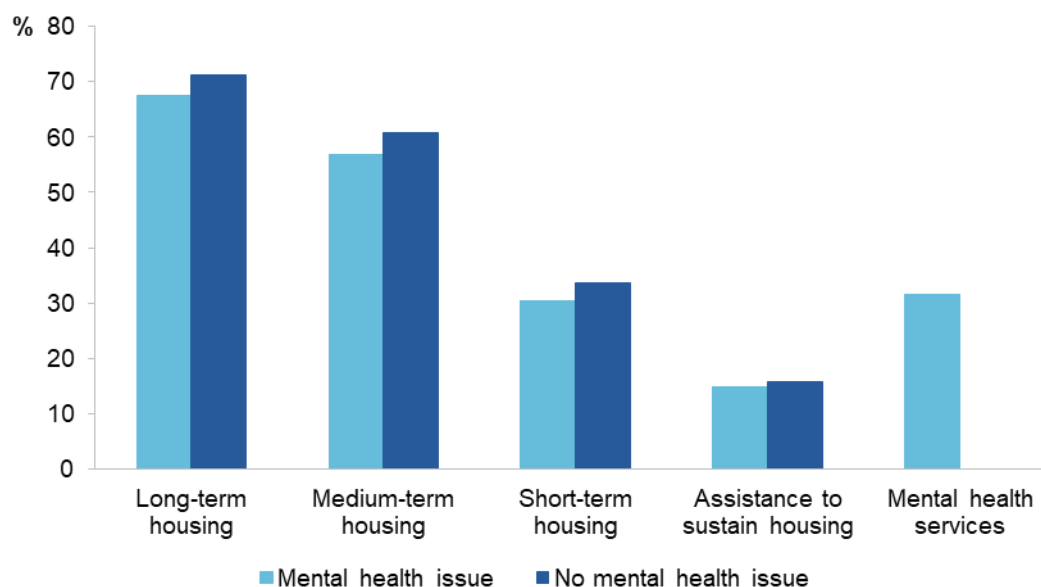
a 'Unmet need' means the person was identified as needing a service, but this service was not provided to them or they were not referred elsewhere. **b** Clients may have needs for more than one service.

Source: AIHW (Specialist Homelessness Services Collection, unpublished data).

The usefulness of homelessness services is reflected in many peoples' experiences. A baseline and follow-up survey of a sample of homelessness service clients found that:

> Overall, 81.0 per cent of respondents to the Follow-up Survey considered that the period of accommodation support received at the time of the Baseline Survey was very important, and a further 13.8 per cent considered it important. (Zaretzky et al. 2013, p. 3)

These indicators suggest that, in cases where homelessness services are accessible, they are reasonably effective at meeting peoples' needs, but there is a significant lack of services to meet demand. The high level of unmet need is likely to have contributed to poor outcomes.

Housing outcomes are particularly poor. In 2017-18, over 60% of people with mental ill-health who were homeless when they began a period of support from homelessness services, remained homeless by the end of support (AIHW 2018s). Further, almost 15% of those who were housed but at risk of homelessness when they began support, became homeless by the end of support.

There was also little change in the non-housing outcomes of homelessness services in the short term. For example, after completing a period of support, the proportion of clients with mental ill-health who were employed increased by about two percentage points, and the proportion participating in education or training decreased by about half a percentage point (AIHW Specialist Homelessness Services Collection, unpublished data).

Overall, it appears that homelessness services are currently limited in their effectiveness at supporting people with mental ill-health to exit homelessness. This may be a result of an under-provision of housing and mental health services, the limited effectiveness of the types of services available, or both. The rest of this chapter examines ways to improve the overall effectiveness of homelessness services for people with mental ill-health. This includes meeting the unmet demand for these services and improving the their effectiveness by through better coordination of services and the potential for Housing First initiatives.

Meeting the unmet demand for homelessness services

Meeting the unmet demand for homelessness services for people with mental ill-health, by increasing the availability of housing (particularly longer-term housing) and mental health services for this cohort, should go some way to improving outcomes. The level of unmet need provides a guide to the number of additional homelessness services needed in each State and Territory (figure 15.8). About 28 000 people with mental ill-health who were either homeless or at risk of homelessness, had an unmet need for long-term housing across Australia.

Figure 15.8 **Unmet need for selected services[a,b,c]**

Number of homelessness service clients with a current mental health issue, 2017-18
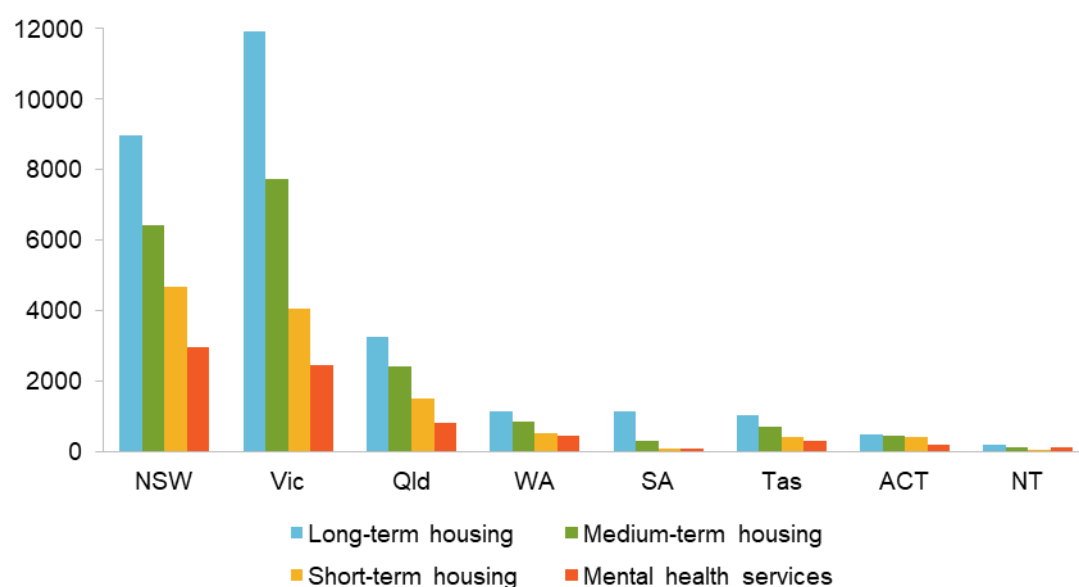
a 'Unmet need' means the person was identified as needing a service, but this service was not provided to them or they were not referred elsewhere. **b** Clients may have needs for more than one service. **c** AIHW defines a person as having a current mental health issue if they received mental health services in the last 12 months, were referred by a mental health service, reported 'mental health issues' as a reason for seeking assistance, had been in a psychiatric hospital or unit in the last 12 months, or a need was identified for mental health services during their support period.

Source: AIHW (Specialist Homelessness Services Collection, unpublished data).

However, this is likely to be an overestimate for two reasons. First, clients may be reported as needing more than one service. Second, adopting recommendations to reduce the incidence of homelessness among people with mental ill-health (sections 15.2 and 15.3) can be expected to reduce the level of unmet demand for this cohort in the future. For example, assuming that supported housing (between 8000 to 12 000 places) and housing for people discharged from hospitals (about 3000 people) reduces the need for long-term housing, the unmet need would be closer to 13 000 to 17 000 people.

Therefore, the cost of providing private rental accommodation or social housing for people with mental ill-health is estimated to be $234 million to $352 million each year.[95] That said, the final cost may be lower, given some proportion of people may have capacity to fund part of their housing costs. These costs do not include the cost of mental health services, which are considered more broadly throughout this report.

Homelessness services have also been shown to avoid costs to other government services. Zaretzky et al. (2013) estimated that homelessness services avoided about $10 400 per person in health, justice and welfare services for single women (2017-18 dollars) and $1600 for single men. This suggests that the net cost to government can be expected to be $57 million to $324 million each year.[96] The savings can be particularly large if programs successfully target people with a diagnosed mental illness, because this cohort tends to have higher healthcare costs (Zaretzky et al. 2017).

The Commission has focused on increasing the number of homelessness services for clients with mental ill-health. This will require service providers to effectively target these services, particularly housing, to clients with mental ill-health. This may be calibrated in different ways, such as requiring people to have a mental health diagnosis, have a care coordinator or receive a single care plan (chapter 10) to be eligible.

Under the National Housing and Homelessness Agreement, State and Territory Governments are generally responsible for providing homelessness services, and the Australian Government contributes some funding. Using this mechanism, the Australian Government should offer to increase its level of funding for homelessness services to be matched by State and Territory Governments (chapter 24).

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[95] Total costs estimated using the average cost of social housing (about $17 000 per person each year; includes recurrent government expenditure plus rent collected) and private rental accommodation ($21 000) (Commission estimates) multiplied by estimated demand (inflated to 2017-18 dollars using CPI index numbers for Rent, weighted average of eight capital cities, Cat. no. 6401.0).

[96] Net costs estimated by subtracting the total cost savings to health, justice and welfare service usage for single men and single women from total costs.

However, even with an increase in the availability of housing and mental health services, the current suite of homelessness services may still be limited in their effectiveness at improving outcomes, particularly for people with severe and complex mental illness. There is scope to supplement the current suite of homelessness services with specialised programs that have been shown to be effective at improving housing outcomes for this cohort.

Improve coordination of services

Homelessness services that are well coordinated with mental health and other services (such as drug and alcohol or family and domestic violence services) are more effective at supporting people who are homeless. Coordination becomes even more important for people with severe and complex mental illness.

However, in many cases, the agencies providing these services work independently from each other. Several participants expressed a need to better coordinate or integrate housing, homelessness, mental health and other services (Beyond Blue, sub. 275; cohealth, sub. 231; CHP, sub. 145; Launch Housing, sub. 250; Wellways Australia, sub. 396). A failure to coordinate is likely to mean each of the component services is less effective at supporting people who are homeless. Brackertz, Wilkinson and Davison (2018, p. 29) found that:

> Analysis of state, territory and federal housing, homelessness and mental health policies shows that they are essentially separate systems with little integration … This contributes to poor housing and health outcomes for people with lived experience of mental ill health.

Coordination of services can be particularly difficult for people who remain homeless for long periods of time. Without a residential address, peoples' ability to have a drivers' licence, open a bank account and receive income support payments is limited. Their access to clinical mental health services can also be reduced (VCOSS, sub. 478).

> The service eligibility criteria for step-up/step-downs [accommodation] require that a person has pre-existing accommodation or has secured accommodation in the community. Consequently, the services are not accessible to people who are homeless or who may have lost their accommodation during an extended hospital stay and are seeking to step-down into community services. (OAGWA 2019, p. 23)

Care coordination (such as case management) is an effective approach to service coordination that reduces homelessness and symptom severity for homeless people with severe mental illness (Brackertz, Fotheringham and Winter 2016; Coldwell and Bender 2007). This approach determines the optimal use of services for each individual, taking into account their circumstances and needs, to treat the person holistically. It involves someone who has responsibility for coordinating, facilitating and integrating the consumer's service needs. In cases where individuals have particularly high needs, care coordination can encompass a multidisciplinary team, more intensive contacts and direct provision of services. In Australia, there are some outreach programs that provide mental health and care coordination services for homeless people with severe mental illness (box 15.14).

Chapter 10 recommends the use of care coordinators for people with severe and complex mental illness. Care coordinators are well placed to work with these individuals and coordinate their homelessness, mental health and other services.

Box 15.14   Examples of outreach mental health and care coordination services

Some people who experience both severe mental illness and homelessness respond well to mental health and care coordination services if the support reaches out to them in the community. Below are two examples of outreach services that have led to positive outcomes.

Homeless Outreach Mental Health Service

In Melbourne, the Homeless Outreach Mental Health Service offers case management and mental health services to people with severe mental illness and a history of homelessness.

> Examples of positive outcomes from the program include: 86% of clients who were placed in stable housing have maintained it long term; 46% were linked to a GP where they previously weren't; and there was a 42% reduction in emergency department admissions. (cohealth, sub. 231, p. 16)

Homeless Healthcare

In Perth, the Homeless Healthcare model provides outreach healthcare to people who are homeless, such as mobile clinics at drop-in centres and nurse-led mobile outreach services. Psychiatric conditions are common among patients, such as depression (35%), anxiety (32%) and schizophrenia (9%).

An evaluation found this model produced significant benefits (Wood et al. 2018). About 42% of appointments were estimated to avoid an emergency department presentation. Once patients were housed for a year, the number of emergency department presentations more than halved, the number of inpatient admissions reduced by 29% and the average number of days admitted reduced from 7.0 to 4.2 days. These improvements were estimated to reduce the cost of hospital use by almost $10 000 per person in the year after being housed.

Housing First can be effective for people with severe mental illness

A small cohort of people with severe and complex mental illness, and prolonged homelessness, are not responding well to current homelessness services — a high proportion of persistent users of homelessness services have mental ill-health (figure 15.6). This is likely because current homelessness services place strict conditions on housing that effectively require treating the person to make them 'housing ready' before they can access housing, or evict them when they break the rules.

However, people with mental illness may find it difficult to become housing ready and adhere to specific conditions, such as treatment, prior to accessing housing. For example, symptoms of mental illness can create difficulties in managing housing tasks and following housing rules.

Housing First programs have been shown to improve outcomes for people with severe mental illness, who are persistently homelessness, and are unlikely (or failed) to respond

positively to existing homelessness services that place strict conditions on housing. Housing First involves providing rapid access to long-term housing that is not conditional on participants becoming housing ready or engaging with support services (box 15.15). Unconditional housing is an important distinction. Relaxing the conditions to access and maintain housing gives people with mental illness a better chance to remain housed. Housing First is likely to reduce the unmet need for homelessness services among this cohort.

Box 15.15   What is Housing First?

Beginning in the early 1990s with the Pathways to Housing program in the United States, the Housing First model is a response to homelessness that prioritises permanent and stable housing. The model is designed to support people who have severe mental illness, problematic drug and alcohol use and other chronic rough sleepers to access and maintain housing, work towards recovery and integrate with the community.

Housing First involves providing rapid access to long-term permanent housing. Once housing is secured, a multidisciplinary team of clinical and/or non-clinical support workers are available to provide mental health, tenancy support and other services. A key principle of Housing First is that the individual's permanent housing is *not conditional* on them actively engaging with support services. This is an important distinction to most other homelessness programs that make housing conditional on treatment, such as a requirement for individuals to comply with mental health programs or abstain from drug or alcohol use.

Source: Johnson, Parkinson and Parsell (2012).

Programs that follow the Housing First model are very effective at responding to homelessness among people with severe mental illness (table 15.1). Evaluations of Housing First models tend to show similar outcomes (Baxter et al. 2019; Ly and Latimer 2015; Pleace 2016; Tsemberis 2010; Woodhall-Melnik and Dunn 2015):

- most participants remain housed

- participants tend to reduce their use of government services, particularly healthcare

- non-housing outcomes — such as mental health, employment and quality of life — tend to remain relatively stable, or slightly improve, in the short-term.

That said, more evidence is needed to determine if longer-term outcomes improve and are sustained. Evaluations of Housing First programs tend to follow people for a few years to track their outcomes. This short time frame might explain why non-housing outcomes remain relatively stable. These programs primarily target chronic rough sleepers and people with very complex needs who are likely to take more time to recover and achieve their goals.

Experience overseas shows that Housing First can be successfully scaled up to reach more people and remain effective. In Finland, Housing First has been credited as a key policy contributing to a 25% reduction in long-term homelessness between 2008–2013 (Pleace et al. 2015). In Canada, the At Home/Chez Soi program showed that Housing First can be effectively implemented for over 1000 people across five cities (table 15.1). An evaluation of this program found that housing and quality of life outcomes significantly improved and

a reduction in the use of other services (such as health and justice) offset much of the program costs, particularly for the highest users of services.

> Over the two-year period after participants entered the study, every $10 invested in [Housing First] services resulted in an average savings of $9.60 for [high needs] participants and $3.42 for [moderate needs]. Significant cost savings were realized for the 10 per cent of participants who had the highest costs at study entry. … Over the two-year period following study entry, every $10 invested in [Housing First]services resulted in an average savings of $21.72. (Mental Health Commission of Canada 2014, p. 5)

Table 15.1 **Evaluation results of selected Housing First programs**

Program	Location	People	Housing sustained	Mental health	Quality of life	Health service use	Program cost*	Cost offsets*	Net cost (benefit)*
Pathways to Housing	USA	87	80%	—	na	↓	na	na	na
At Home /Chez Soi	Canada	1 158	62–84%	—	↑	↓	CA$22 257	CA$21 375	CA$882
MISHA Project	NSW	59	89–97%	—	—	↓	$13 683	$4424	$9260
Common Ground	NSW	52	>63%	↑	↑	↓	$60 904	na	na
Way2Home	NSW	31	90%	↑	↑	—	na	na	na
Common Ground	Qld	217	>68%	↑	↑	↓	$14 329	$27 429	($13 100)
Street to Home	Qld	42	95%	↑	—	—	na	na	na
50 Lives 50 Homes	WA	147	88%	na	na	↓	na	$9 182	na
Street to Home	Vic	57	70–78%	↑	na	↓	na	na	na

* Average per person expressed as dollars in the years and countries in which the studies were evaluated.
na Not available.

Source: Bullen et al. (2015); Conroy et al. (2014); Gulcur et al. (2003); Johnson and Chamberlain (2015); Mental Health Commission of Canada (2014); Parsell et al. (2015); Parsell, Tomaszewski and Jones (2013a, 2013b); Tsemberis, Gulcur and Nakae (2004); Vallesi et al. (2018).

There have been several small-scale trials of Housing First programs in Australia that have successfully housed several hundred people with severe mental illness (table 15.1). In some cases, trials showed a small net cost or even a potential net benefit to these programs. Governments have an incentive to invest in programs that provide net benefits or small net costs by targeting the highest users of health and justice services, particularly if those programs deliver significantly improved outcomes for people. While evaluations have shown positive results, governments have been slow to scale up these programs.

There is scope for governments to scale up trials of Housing First by increasing the availability of long-term housing set aside for Housing First programs. A lack of available long-term housing is a consistent theme throughout this chapter and a key barrier to

providing rapid permanent housing to individuals targeted for a Housing First program (Bullen and Baldry 2018). This can be done through a mix of social housing, private rentals or headleasing a number of private rental properties (section 15.3). For example, the majority of housing in the At Home/Chez Soi program was provided through private rental units, and social housing was offered where available (Mental Health Commission of Canada 2014).

While Housing First has shown success for highly targeted cohorts of people with severe mental illness, the principles of Housing First need not be applied to all homelessness services. Some people successfully meet their needs using the current suite of homelessness services. Further, some submissions noted that Housing First cannot meet the needs of everyone, such as those in need of institutional care (CHP, sub. 145) and may not address issues in regional areas (QAMH, sub. 247).

There was broad support for Housing First programs in submissions.[97] Scaling up Housing First programs provides the opportunity for governments to tailor programs to the most vulnerable cohorts at risk, potentially benefiting participants and increasing their rate of success. For example, the Council to Homeless Persons (sub. 145) recommended that Housing First needs to be tailored for young people and the NT Mental Health Coalition (sub. 430) identified the need for housing programs for Aboriginal and Torres Strait Islander people to be culturally appropriate.

15.5 Prioritising reforms

The Commission has identified several ways that housing and homelessness services can increase their capacity to prevent people with mental ill-health from experiencing housing issues and support people with severe mental illness to find and maintain housing, including those who are homeless.

As a priority, State and Territory Governments, with support from the Australian Government, should improve the transition for people with mental illness out of institutional care, particularly hospitals and prisons. There is a clear economic benefit to supporting this cohort, who tend to be higher users of health services.

Further, State and Territory Governments, with support from the Australian Government, should work towards providing supported housing, long-term supported accommodation and homelessness services. Meeting the unmet demand for these services is likely to take time. Therefore, governments should plan their approach for providing these services. This

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97 ACP, sub. 522; ACT Government, sub. 210; Anglicare Australia, sub. 376; APS, sub. 543; Beyond Blue, sub. 275; CHP, sub. 145; City of Port Phillip, sub. 540; Inner South Family and Friends, sub. 129; Launch Housing, sub. 250, att. 1; Mental Health Victoria, sub. 479; MHCC ACT, sub. 517; Mind Australia Limited, sub. 380; Mission Australia, sub. 487; Office of the Commissioner for Children and Young People WA, sub. 311; Private Mental Health Consumer Carer Network (Australia), sub. 49; QAMH, sub. 247; Shelter WA, sub. 200, att. 1; Tandem, sub. 502; VCOSS, sub. 478; Western Australian Mental Health Commission, sub. 259; Wellways Australia, sub. 396; Youth Mental Health, North Metropolitan Health Service, sub. 99.

approach should prioritise providing these services to people who have severe and complex mental illness and are homeless or at risk of homelessness. This cohort tends to be higher users of government services, such as health and justice services, and evidence suggests that adequately housing this cohort can improve their quality of life and lead to significant reductions in costs elsewhere.

DRAFT RECOMMENDATION 15.2 — SUPPORT PEOPLE TO FIND AND MAINTAIN HOUSING

Housing and homelessness services should have the capacity to support people with severe mental illness to find and maintain housing in the community.

In the short term (in the next 2 years)

- Each State and Territory Government, with support from the Australian Government, should commit to a nationally consistent formal policy of no exits into homelessness for people with mental illness who are discharged from institutional care, including hospitals and prisons.

- Governments should ensure that people with mental illness who exit institutional care (particularly hospitals or prisons) receive a comprehensive mental health discharge plan, and services have the capacity to meet their needs. These programs should integrate care coordination and access to accommodation.

- The National Disability Insurance Agency should review its Specialist Disability Accommodation strategy and policies with a view to encouraging development of long-term supported accommodation for National Disability Insurance Scheme recipients with severe and persistent mental illness.

- Each State and Territory Government, with support from the Australian Government, should work towards meeting the gap in the number of 'supported housing' places for those individuals with severe mental illness who are in need of integrated housing and mental health supports.

  – Governments should provide (either themselves or outsourced to non-government organisations) a combination of long-term housing options for this cohort to support the diverse needs for mental health support and tenancy security.

- Each State and Territory Government, with support from the Australian Government, should work towards meeting the gap for homelessness services among people with mental illness in their jurisdiction. This could include increasing existing homelessness services as well as scaling up longer-term housing options such as Housing First programs.

  – Housing First programs should target people who experience severe and complex mental illness, are persistently homeless, and are unlikely to respond to existing homelessness services.

  – This would require governments to invest in homelessness services that make long-term housing available specifically for these programs.

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16   Justice

The justice system matters for people with mental illness because …	• The prevalence of mental illness is high among prisoners. The majority are imprisoned for short sentences, and often cycle in and out. A lack of mental health and other supports when transitioning back to the community contributes to this.
	• The attributable cost of mental illness to Australia's criminal justice system is estimated to be $2.4 billion per year.
	• A person's contact with the justice system (at all stages) presents opportunities to intervene — the criminal justice system can act as a gateway towards mental healthcare.
	• People with mental illness are over-represented as victims of crime.
	• People living with mental ill-health are more likely to experience legal problems and face barriers to accessing justice.
Successful intervention requires …	As a priority:
	• Police should be supported with access to mental health resources when responding to mental health related incidents.
	• National mental health service standards should apply to mental healthcare service provision in correctional facilities.
	• Culturally capable mental healthcare should be available in correctional facilities for Aboriginal and Torres Strait Islander people.
	Additional actions required include:
	• Diverting more people with mental illness who make contact with the criminal justice system to mental healthcare and treatment to reduce their risk of future offending.
	• Improving the rigour of mental health screening and assessment processes in correctional facilities to inform resourcing, and planning for continuity of care post-release.
	• Developing disability justice strategies to ensure the rights of people with mental illness are protected in their interactions with the justice system.
	• Ensuring legal representation and non-legal advocacy services for those subject to involuntary treatment.

16.1 Interaction between the justice and mental health systems

State and Territory Governments are responsible for most policing and justice functions (Daly and Sarre 2017). The Australian Government is only involved when law enforcement extends into areas under the auspices of the federal parliament (such as people smuggling and drug importation), with the exception of the Australian Capital Territory, where the Australian Federal Police conducts policing functions.

This chapter focuses on how the justice system can better support people with mental ill-health who come into contact with it, including addressing their specific needs. It defines the justice system as the collection of interdependent agencies including the police, prosecution legal teams, courts, community corrections, custodial corrective services, victim support groups and defence legal teams. The system has been subject to many previous inquiries over a number of years, including those listed in box 16.1. This inquiry differs by analysing the system through the mental health lens in line with our terms of reference.

Box 16.1   Selected past reviews that involve mental health and the justice system

1991   Royal Commission into Aboriginal Deaths in custody

1999   Commission of inquiry into Abuse of Children in Queensland Institutions

2006   Senate Select Committee on Mental Health inquiry into a national approach to mental health

2011   Commissioner for Children and Young People inquiry into the mental health and wellbeing of children and young people in Western Australia

2015   Victorian Ombudsman investigation into the rehabilitation and reintegration of prisoners in Victoria

2016   Senate Standing Committee on Community Affairs inquiry into Indefinite Detention of People with Cognitive and Psychiatric impairment in Australia

2017   Royal Commission into the Protection and Detention of Children in the Northern Territory

2017   Royal Commission into Institutional Responses to Child Sexual Abuse

2018   Australian Law Reform Commission's inquiry into the incarceration rate of Aboriginal and Torres Strait Islander peoples

2018   Office of the Inspector of Custodial Services review of prisoner access to secure mental health treatment

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Interactions between the justice system and the mental health system occur in many circumstances and at different times. For example, police can respond to mental health crises in the community, mental health courts can divert individuals to treatment, individuals can receive mental health services while in the care of corrective services, victims of crime may need support accessing mental health services, and legal services can be embedded into healthcare settings to address mental health and legal issues.

In this chapter, draft recommendations are made to improve the lives of people with mental ill-health who interact with the justice system. It recognises three principal ways in which these interactions may occur: as offenders, as victims of crime and as people seeking access to justice. These interactions can pose particular challenges for people with mental ill-health. The chapter therefore focuses on analysing the following interactions:

- criminal justice system: the extent to which police, courts and corrective services support people with mental illness who come into contact with them

- victims of crime: the extent to which services support victims with mental illness

- access to justice: the ability for people with mental illness to resolve their legal problems and disputes, and the degree to which their ability to access justice is promoted and protected.

Definitions for a list of key terms used throughout this chapter are provided in box 16.2.

The majority of people with mental ill-health never make contact with the criminal justice system. As Forensicare (2019, p. 5) notes:

> Public perception of the interrelationship between mental illness and offending is disproportionate to the actual risks posed, with the majority of individuals living with mental illness never offending. Nevertheless, local and international evidence indicates that serious mental illness is a significant risk factor for offending.

However, people with mental illness are over-represented at all stages of the criminal justice system: police custody, courts and correctional facilities. This is also true in the United States and United Kingdom (Baldry, Dowse and Clarence 2012)."

Police custody and courts

There is a high prevalence of mental illness among people whom police have arrested and detained (police detainees) at police stations or facilities. For example, a national study of police detainees found that 43% of men and 55% of women reported a previous diagnosed mental illness (Forsythe and Gaffney 2012). Heffernan et al. (2003) found that 86% of detainees in a Brisbane facility had at least one substance use disorder[98], and 82% of men and 94% of women reported significant psychological distress. Baksheev et al (2010) found

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[98] The *Diagnostic and Statistical Manual of Mental Disorders* (APA 2013, pp. xxv–xxix) categories substance use disorders as a mental disorder.

that 76% of police detainees from two Melbourne police stations met the criteria for a mental illness diagnosis.

Comparable prevalence is observed at the court level. A Bureau of Crime Statistics and Research study found that 55% of court defendants had one or more psychiatric disorders (NSW LRC 2012). Similarly, over 50% of those going through a Western Australian Magistrates Court had a mental illness (Baldry 2014b).

Box 16.2   Definitions of key terms

Bail: refers to when an individual who is charged with an offence is allowed to stay in the community, but required to attend court at a scheduled future date (Legal Aid NSW 2015).

Correctional facility: these facilities hold prisoners under the responsibility of corrective services. They include government-operated prisons, privately-operated prisons, transitional centres and court cell complexes (SCRGSP 2019e).

Court diversion program: a program that allows magistrates or judicial officers to adjourn matters while defendants engage in support services. Diversionary programs provide services for people who have been accused or convicted in the summary jurisdiction, who require assistance with addiction or mental health (ALRC 2017b).

Criminal justice system: the criminal justice system refers to a 'collection of interdependent agencies' that deal with offenders. It consists of the police and prosecution, criminal courts and prisons, community corrections and probation and parole services (Daly and Sarre 2017).

Diversion: this term can have many meanings and is used inconsistently between jurisdictions. However, in this inquiry it refers to identifiable stages in the criminal justice system at which interventions can effectively, proportionately and responsively be provided to an individual in contact with it. This inquiry does not use the term diversion to mean detours, deviations or cessation of legal proceedings (Freiberg et al. 2016, p. 57).

Forensic patient: an individual alleged to have committed a crime who is deemed unfit to plead or unfit to stand trial. As a result, a forensic or criminal mental health detention order is placed on them (SCARC 2016).

Lower level offences: these refer to low-level summary offences. Summary offences are dealt with in local courts, usually before a magistrate alone. They usually carry a penalty of less than two years imprisonment (Baldry 2014a).

Juvenile: a juvenile is a person aged between 10 and 17 years of age who is subject to criminal justice proceedings (Richards 2011).

Remand: refers to individuals who are held in custody awaiting trial or sentencing (AIHW 2019ad).

Recidivism: refers to the proportion of adults released from correctional facilities or community orders who returned to corrective services with a new correctional sanction within two years (SCRGSP 2019b).

Correctional facilities

In 2018, about 40% of prison entrants had been told at some stage in their life that they have a mental illness (including substance use disorders) (AIHW 2019ad). This proportion is much higher than that estimated for the general population aged 18 years and over (22%), as reported by the ABS (2018e), although data is not directly comparable.[99]

Prevalence rates appear to vary significantly between jurisdictions, but data inadequacies can prevent comparisons. Some State and Territory Governments may not collect this data, and where survey data is available, sample sizes may be too small (table 16.1). For example, in the 2018 prisoner health survey, only 50 people were surveyed in Northern Territory prisons and only 42 people were surveyed in Tasmanian prisons (AIHW 2019). The most common diagnosis of mental illness received among prisoners is depression, for both men and women at 36% and 61%, respectively (JHFMHN 2015). This is followed by anxiety disorders and then drug abuse and dependence.

Table 16.1	**Prevalence of mental illness among prisoners[a]**
	States and territories, 2018
	Estimated prevalence %
New South Wales	**63%** had a previous diagnosis of a mental illness[b]
Victoria	**37%** were allocated a psychiatric risk rating at reception assessment[b]
Queensland	**39%** had a previous diagnosis of a mental illness
South Australia	**45%** of discharged prisoners identified receiving a mental health service[c]
Western Australia	**25%** had a previous diagnosis of a mental illness
ACT, Northern Territory, Tasmania	Reliable data was unavailable
Australia	**49%** of prison entrants ever told they have a mental illness[d]

a Small sample sizes and different methods to estimate prevalence limit robust comparisons between jurisdictions. **b** 2017-18 **c** 2016-17 **d** 2015 AIHW data rather than 2018 data was used as it includes all States and Territories.

Source: AIHW (2015b, 2019ad); Justice Health Forensic Mental Health Network (2018); South Australian Government unpublished data; Victorian Government, sub. 483.

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[99] Estimates of prevalence of mental illness among the general population and in prisoner populations are not directly comparable for several reasons. First, the data is obtained from different surveys — the ABS National Health survey (general population) and the AIHW prisoner health survey (prisoner population). The surveys ask different questions to derive estimated prevalence of mental illness. Second, population characteristics of survey samples may prevent like-for-like comparisons. For example, prisoner data is more likely to reflect a younger cohort than the general population data.

Women

Women entering prison are far more likely to report a history of mental ill-health than men (figure 16.1). In 2018, 35% of male prisoners reported having a previous diagnosis of mental illness compared with 65% of female prisoners (AIHW 2019ad). This disparity has persisted over decades (AIHW 2010; New South Wales Corrections Health Service 1997). Moreover, while female prisoners represent only about 8% of the total prison population, their numbers have grown by 85% in the decade to 2018 (ABS 2018g).

Figure 16.1   Estimated prevalence[a] of mental ill-health in general population and prison entrants,[b] by gender, 2018
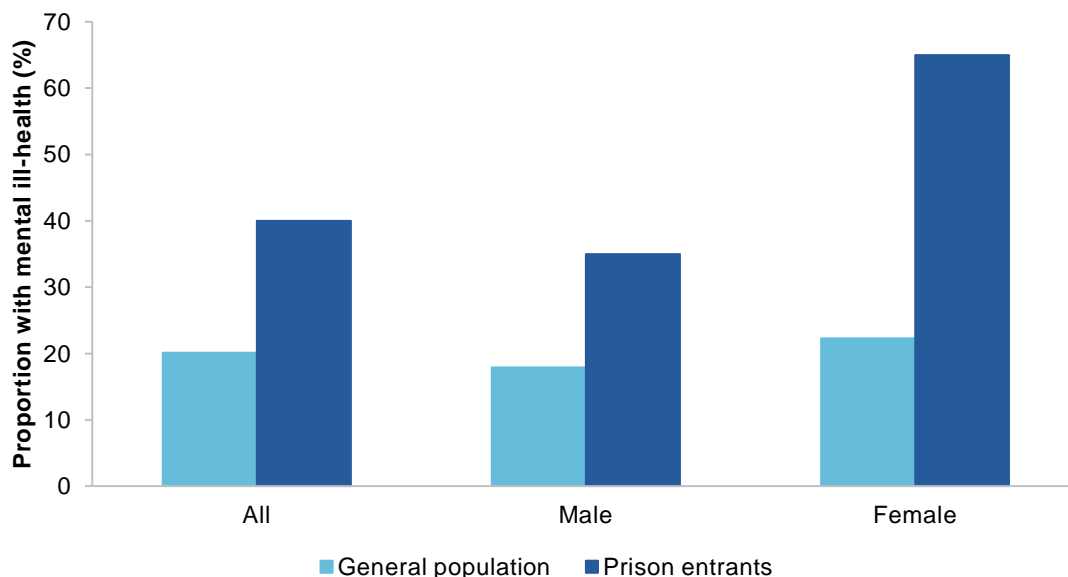
a ABS general population data estimates prevalence based on the number of people reporting they had a current and long-term mental and behavioural condition. Prison entrants data estimates prevalence based on the number of prisoners who had ever been told they had a mental health condition. **b** Data for the general population are not directly comparable to data for prison entrants.

Source: ABS (*National Health Survey 2017-18*, Cat. no. 4364.0); AIHW (2019ad).

Young people

The prevalence of mental illness among youth offenders is higher than for adult offenders. The latest New South Wales juvenile health survey found the majority (83%) of youth offenders met the threshold for at least one psychological disorder (JHFMHN 2017). The Victorian Youth Parole Board (VDJR 2018) annual survey also reported that a majority (53%) of young people involved with youth justice presented with mental health problems.

Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people make up about 2% of the adult population, yet represent 27% of the national adult prison population (ALRC 2017a). In 2016, Aboriginal and Torres Strait Islander women constituted 34% of the female prison population — making them 21 times more likely to be imprisoned than non-Indigenous women. In the youth justice system, Aboriginal and Torres Strait Islander youth represented between 55–63% of those in detention between June 2014 and 2018, although they only account for 5–6% of the general population aged 10–17 (AIHW 2018v).

Although accurate data on the prevalence of mental illness among Aboriginal and Torres Strait Islander people is difficult to obtain (McCausland, McEntyre and Baldry 2017) [100], evidence suggests mental health problems are highly prevalent among those in criminal justice systems. Human Rights Watch (2018) reported that 73% of Aboriginal and Torres Strait Islander men in prison and 86% of women have a diagnosed mental illness. Ogloff et al. (2013) established 72% and 92% of Aboriginal and Torres Strait Islander men and women in prison had received a lifetime diagnosis of mental illness. However, the AIHW's (2019ad) prison health survey found Aboriginal and Torres Strait Islander prisoners had lower rates of mental illness relative to non-Indigenous prisoners at 33% compared to 44% respectively.

Aboriginal and Torres Strait Islander youth in contact with the criminal justice system can have even higher rates of mental illness. In New South Wales, 87% of Aboriginal and Torres Strait Islander young people in custody had experienced a mental illness (JHFMHN 2017).

People in detention, awaiting trial or awaiting sentencing

The prevalence of mental illness among offenders in detention that are awaiting sentencing (remanded in custody) or sentencing is estimated to be larger than those sentenced (Ogloff et al. 2007). Although national information related to the mental health of this group is even more limited compared to the sentenced group, this view is consistent throughout the literature (Ogloff et al. 2007). In New South Wales, for example, it is estimated that at least half of those in detention awaiting trial have some form of mental illness and/or cognitive disability (Baldry 2014b). Moreover, this is a growing population (ABS 2018g) and has been increasing as a proportion of the prison population.

Notwithstanding this data, the Commission found there was limited data for estimating the prevalence of mental illness among individuals who make contact with the criminal justice system (box 16.3). This limits the extent to which research and analysis are able to support the development and improvement of interventions that target this population. However, there is scope to improve data collection as referred to in box 16.3, which the Commission supports.

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[100] Accurate data on the prevalence of mental illness among Aboriginal and Torres Strait Islander people in criminal justice systems is difficult to obtain for several reasons. Major factors include misdiagnosis or lack of recognition of certain disorders and under-diagnosis due to cultural bias in testing affecting accuracy (McCausland, McEntyre and Baldry 2017).

> **Box 16.3 Data availability**
>
> The Productivity Commission found there was limited data available for estimating the proportion of people with mental illness across all stages of the criminal justice system across all States and Territories. Further, there is a lack of national data oversight in this area. The AIHW have partly addressed this gap with its prisoner health survey (the first form of national oversight), but not all states and territories consistently participate in the survey.
>
> National data is even more scant for young people involved in the justice system (AIHW 2018n). There is no national set of standards to ensure this type of data is available and consistent across jurisdictions. Although some states (New South Wales and Victoria) conduct annual surveys of their youth justice populations, most do not. AIHW (2018n) recommended the development of a national data collection on the health of young people in the justice system, but ongoing support and funding for this collection has not been confirmed.

Drivers of over-representation

There are various explanations behind the over-representation of people with mental illness in the criminal justice system. Some include deinstitutionalisation without community supports, increased substance abuse, inadequate mental health services in the broader community and wider social determinants. However, evidence suggests that the over-representation of people with mental illness in the criminal justice system is complex and multi-factored. There is no simple correlation between mental illness and offending behaviour, although mental illness can form part of the background to offending (NSW LRC 2012).

Deinstitutionalisation (that is, the closure of dedicated mental health facilities such as asylums) is a widely cited reason why the prevalence of people with mental illness in the criminal justice system is so high. Many commentators believe that deinstitutionalisation was not adequately accompanied by more community-based mental health services (Human Rights Watch 2018; NSW LRC 2012). Internationally, the number of prison inmates more than tripled following deinstitutionalisation, which occurred between 1940 and 1995 (Ogloff et al. 2007). However, the drivers behind their over-representation appear more complex. One study suggested that deinstitutionalisation may only be responsible for 4–7% of the growth in the prison population between 1980 and 2000 in the United States (Calhoun 2018).

Increased use of illicit substances among those with mental illness has likely made a significant contribution (Butler and Allnut 2003). Consequences include increased drug-related mental illness (mainly associated with cannabis and amphetamine dependency) and increased comorbidities (drug dependency and another mental illness) (Ogloff et al. 2007). There is evidence that people with substance use comorbidities are at an increased risk of offending compared to those diagnosed with a non-substance mental illness alone (Smith and Trimboli 2010).

The limited capacity of mental health services to address the complex needs of those with mental ill-health and at risk of offending is another reason. Community-based mental health services often work best for those who have reasonable support networks in the community, which is often not the case for many offenders. Offenders tend to be poorly integrated into the community and have poor access to a range of support services including accommodation and mental health support (Ogloff et al. 2007). Related factors include a lack of adequate diversionary options in the community, inadequate specialist community forensic psychiatric services and a high threshold for admission to appropriate mental health facilities (Butler and Allnut 2003).

The over-representation of people with mental illness in the criminal justice system can also be partly explained by a multiplicity of social determinants, such as disrupted family backgrounds, family violence, abuse, unstable housing and low socio-economic backgrounds, healthcare inequalities, isolation, a lack of social support, and structural stigma and discrimination (ALRC 2017a; Baldry et al. 2015; NSW LRC 2012). While these are also associated with the general increase in incarceration rates, they often have a compounding effect for those with mental illness.

For Aboriginal and Torres Strait Islander people, the Australian Law Reform Commission (ALRC) found that drivers of incarceration can include inter-generational trauma, dispossession and displacement from traditional lands, weakening of culture, the separation of families through past government policies, and discrimination and racism (ALRC 2017a). These have all contributed to disadvantage, poor health and poor social outcomes for many Aboriginal and Torres Strait Islander people (ALRC 2017a). The majority of Aboriginal and Torres Strait Islander women who make contact with the criminal justice system have experienced physical and sexual violence, and/or trauma (ALRC 2017a, p. 375).

Profile of those with mental illness in correctional facilities

Complex needs

People with mental illness who make contact with the criminal justice system typically have complex needs. They often have 'dual diagnosis' (both mental and cognitive impairment), substance use comorbidities or multiple diagnosis (Baldry et al. 2015). Comorbidity in the criminal justice system is acknowledged as 'the rule rather than the exception' (Ogloff et al. 2007, p. 17).

Substance use disorder is common among the incarcerated population in Australia. A study undertaken in one Australian prison found that the prevalence of co-occurring mental disorder and substance use disorder within a 12-month period was 29% (Butler et al. 2011). It was significantly higher among women (46%) than men (25%).

There is also a high proportion of people with mental illness and an intellectual disability in correctional facilities. Of those with an intellectual disability, 68% also had a mental illness

or a substance use disorder (Baldry et al. 2015). Additionally, for Aboriginal and Torres Strait Islander people with mental illness in the criminal justice system, 77% had a substance use disorder and 36% also had a cognitive disability (Baldry et al. 2015).

Comorbidities and multiple diagnoses are prevalent among adolescents in custody as well. In New South Wales, for example, young people in juvenile custody have high levels of substance abuse, with about 80% reporting weekly use of illicit drugs and 98% reporting hazardous and/or harmful levels of alcohol consumption (JHFMHN 2018). In addition, 59% had attention or behavioural disorders and 17% had an IQ in the *Extremely Low* (intellectual disability) range. In Victoria, 58% of young people involved in youth justice had a history of alcohol and drug misuse, 41% had cognitive difficulties affecting daily functioning and 11% were registered with disability services (VDJR 2018).

Types of offences

The majority of people with mental illness in prison have been sentenced with what the criminal justice system regards as lower level offences (Baldry 2017), such as: non-violent property damage; theft; and drug possession and use (Forsythe and Gaffney 2012; OPA Victoria 2012). This is typically the case for women imprisoned who rarely commit serious offences (NSW MHC 2017). The New South Wales Law Reform Commission (2013) found that most offending by people with a mental health impairment (as defined in the State's mental health act) involved minor offences dealt with in the Local Court. Similarly, research by Victoria's Office of the Public Advocate (2012, p. 18) found that repeat users of its Independent Third Person program were largely involved in theft and theft-related crimes (figure 16.2).

## Recognising prison throughput and 'churn'

Understanding prison throughput for people with mental illness is critical for planning and resourcing effective transitions to the community. Many people cycle in and out over long periods of time (prison 'churn').[101] The Steering Committee for the Report on Government Services (2019a) publishes data on the 'recidivism rate' — the proportion of adults released from prison who return within two years. Nationally, the recidivism rate is 45.6%, but it varies considerably across jurisdictions (table 16.2).

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[101] Compared with annual census data, throughput data enables better monitoring of the flow of people into prison. Annual prison throughput is defined as the number of admissions to, and discharges from prison during a year. The throughput of prisoners far exceeds the number in prison on any given day. This is because the majority of prisoners spend a relatively short time in custody before returning to the community. Second, it captures the volume of unsentenced people in detention awaiting trial or awaiting sentencing and those serving short sentences (Baldry 2017). For example, the 2018 quarterly census data reported an average of about 42 600 prisoners, but the flow data reported around 68 100 prisoner receptions — almost 60% higher (ABS 2019). The rate at which sub-groups of people churn through prison can also differ substantially.

Figure 16.2   **Offence types for alleged offenders participating in the Independent Third Person program**[a]

Victoria, 2005 to 2010
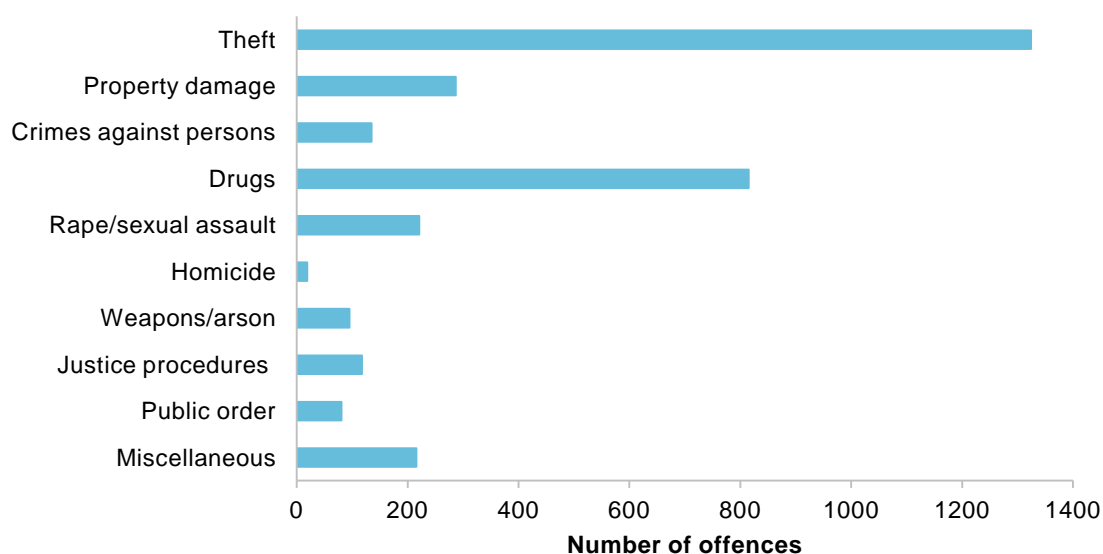
a The Independent Third Person program, managed by the Office of the Public Advocate in Victoria, provided trained volunteers to assist people who are believed to have cognitive impairments and mental illnesses during their interviews with Victoria Police.

Source: Office of the Public Advocate (2012).

Table 16.2   **Adults released from prison who returned within two years**

Nationally and by State and Territory, 2017-18

	%
New South Wales	50.8
Victoria	43.7
Queensland	42.7
South Australia	37.1
Western Australia	38.5
Tasmania	46.3
Northern Territory	55.9
Australian Capital Territory	44.2
Australia	**45.6**

Source: Steering Committee for the Report on Government Services (2019a).

Although there are no reliable estimates of throughput for people with mental illness (Justice Health Unit, sub. 339, p. 2), the majority of offenders with mental illness are sentenced for minor offences (Baldry 2017) and therefore incarcerated for short periods of time (as are the majority of other offenders). Data on sentence lengths for offenders with mental illness could not be obtained, but a study of mental illness among a sample of prisoners in New South Wales recorded median sentence lengths of 2.2 and 1.5 years for men and women, respectively (Butler and Allnut 2003, p. 13). Moreover, a high proportion re-offend and return within two years.

> There has been a concomitant rise in the rate and number of prisoners being released back to the community, noting that remand and short sentence prisoners make up the large majority of releasees. Many thousands of these releasees are back in prison within two years: on the prison conveyor belt cycling in and out. The majority of prisoners are from severely disadvantaged backgrounds, with serious health, mental health and disability concerns. (Baldry 2017, p. 2)

There are mixed conclusions on whether recidivism rates for offenders with mental illness are higher than for those without. Bonta et al. (1998) found that predictors of recidivism were the same for offenders with and without mental disorders. In contrast, Dias et al. (2018) found mental illness and substance abuse separately and jointly increased risks of recidivism. Smith and Trimboli (2010) found that the recidivism rate was only higher for prisoners with *both* a substance and non-substance mental illness, but not for those with a single diagnosis.

16.2 Criminal justice system

Commentators argue that the criminal justice system is costly and ineffective, given the high recidivism rates (ALRC 2017a; JSS 2014). Australia spends approximately $3.4 billion per year to house people in prisons (SCRGSP 2019e). Expenditure on police ($11.6 billion) and courts ($486 million) were also significant in 2017-18 (SCRGSP 2019f, 2019d).

There are particular concerns about how the system handles and treats those with mental ill-health, given the high prevalence of mental illness among prisoners (Human Rights Watch 2018). The New South Wales Law Reform Commission (2012, p. 39) concluded that 'prison is a high-cost intervention which is ineffective in reducing subsequent offending and inappropriate as a setting for effective mental healthcare'.

The direct costs of managing people with a mental illness in the criminal justice system are difficult to determine (NSW MHC 2017). The Commission estimates that about 15% ($2.4 billion) of expenditure on the criminal justice system nationally was attributable to mental ill-health in 2017-18 (table 16.3). This estimate is based on the *relative* prevalence of mental illness in prisons compared to the community, rather than the *actual* prevalence of mental illness in prisons (appendix E).

Table 16.3   Real recurrent expenditure on the criminal justice system
Nationally, 2017-18

	Total expenditure	Expenditure attributable to those with a mental illness
	$ million	$ million
Police	11 623	1764
Courts[a] (Magistrates' court excl. children's court)	486	74
Corrective services		
Prisons	3416	518
Community	591	90
Juvenile justice	3	<1
Total	**16 116**	**2446**

a Expenditure on magistrate's courts (excluding children's court) were only included, given the majority of people with mental illness are sentenced in magistrates courts. Excludes costs of lawyers.

Source: Steering Committee for the Report on Government Services (2019c, 2019d, 2019e, 2019f).

The indirect costs of imprisonment include disrupted housing and employment situations. These disruptions can be elevated for people with mental illness who often face additional stigma and disadvantage upon return to the community from prison (Baker 2014).

A person's contact with the criminal justice system at all stages presents opportunities to intervene. As such, the system can act as a gateway towards mental healthcare. Prisoners often under-utilise healthcare in the community for various, reasons, including costs of accessing healthcare and alcohol and drug issues (AIHW 2015b). In many cases, people enter prison with a mental illness that has previously gone undiagnosed and untreated (Victorian Government, sub. 483, p. 12).

Globally, governments are turning their attention to initiatives that intervene in earlier stages of the criminal justice system, to reduce the risk of incarceration later on. Specifically, there have been initiatives to refer and divert people with mental illness towards appropriate treatment to make this gateway effective.

> For people with mental disorders who have been charged with committing minor offences, the introduction of mechanisms to divert them towards mental health services before they reach prison will help to ensure that they receive the treatment they need and also contribute to reducing the prison population (WHO and ICRC 2018, p. 3)

In Australia, the focus is on pre-court responses, court responses, correctives services and forensic services.

Pre-court responses

Investing in prevention and early intervention

The rationale for investing in prevention and early intervention stems from evidence that many people who offend (including those with mental illness) come from backgrounds of social disadvantage (NSW MHC 2017). The Victorian Ombudsman (2015, p. 32) said that 'the relationship between disadvantage and imprisonment is clear … prisoners are far less likely to have finished school … and have dramatically higher rates of mental illness and acquired brain injury'. A UK study established that children with conduct disorder[102] (which is strongly associated with social disadvantage) incurred cumulative costs of public service use, as adults, that were 10 times higher than those without. Crime accounted for most of the cost (Scott et al. 2001).

Evidence suggests that prevention and early intervention programs can be more cost-effective (in reducing offending) than imprisonment, particularly programs targeting high-risk populations early in life (NZ OPMCSA 2018, p. 13). For example, a longitudinal evaluation of a US program supporting intellectual and social development for preschool children from disadvantaged backgrounds showed offending was significantly lower for program participants. It estimated that the program saved $7 for every $1 spent by the time participants were aged 27, and $16 for every $1 by age 40 (NZ OPMCSA 2018, p. 13; Parks 2000). An evaluation of a Canadian mental health program for children with identified behaviour problems saw an 18–33% reduction in offences (Farrington and Koegl 2015).

Some State and Territory Governments are investing in prevention and early intervention to mitigate risks of offending behaviour. For example, the New South Wales Government's *Their Futures Matter* (TFM) reform aims to support vulnerable children, young people and families, including those at risk of contacting the juvenile justice system (NSW TFM 2018). TFM coordinates and integrates all human services agencies, to provide wrap-around care solutions to address multiple needs including mental healthcare and accommodation.

Another approach that has emerged locally and internationally is 'justice reinvestment' (JR). JR first began in the United States, following recognition that many offenders come from, and return to, a small number of disadvantaged communities (SLCA 2013). JR involves funding strategies and programs that are tailored to those communities to address the causes of crime and mitigate risks of criminal justice contact, including treatment programs to address mental illness (Willis and Kapira 2018).

There is some evidence of success. For example, evidence suggests JR policies in Texas contributed to its stabilised prison population (compared to historical growth) and lower parole revocation rates (which fell by 29%) (SLCA 2013, p. 51; Willis and Kapira 2018, p. 21). However, broader evidence suggests that JR initiatives have not significantly reduced

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[102] Conduct disorder is the most common psychiatric disorder in childhood. It is a common reason for referral of children and adolescents to mental health services (Scott et al. 2001).

prison populations. JR is still in relative early stages of development in the United States and it is likely prison growth rates will take many years to shift (Willis and Kapira 2018).

There are several JR projects operating in Australia. Data from the *Maranguka Justice Reinvestment* project in Bourke, New South Wales has shown promising outcomes including an 18% reduction in the number of major offences reported and an 8% reduction in reoffending within 12 months of release between 2015 and 2017 (Just Reinvest NSW, sub. 440). However, whether these outcomes are attributable to the JR project is not yet known (KPMG 2018b).

The main challenges faced by JR approaches in Australia include: limited evidence on 'what works' to reduce offending and a lack of rigorous evaluation required to demonstrate their effectiveness. The Australian, State and Territory Governments will need to continue evaluating JR approaches to ensure initiatives are cost-effective and continuously improving.

DRAFT FINDING 16.1 — PREVENTION AND EARLY INTERVENTION TO REDUCE CONTACT WITH THE CRIMINAL JUSTICE SYSTEM

There is some evidence that investment in prevention and early intervention is a strategy that can reduce offending. Governments locally and internationally have acknowledged this with expenditure on such approaches. However, further research and evaluation is required to improve and refine these initiatives.

A systematic approach to supporting police interacting with people with mental illness

There are a number of reasons why people with mental illness interact with police. First, police and other emergency workers (chapter 8) can be called on to respond to mental health crisis situations under mental health legislation (box 16.4) Second, police can respond to people with mental illness who may be behaving irrationally or strangely in public spaces. Third, police can interact with people with mental illness who are suspected of committing a criminal offence (VAGO 2014).

Police spend a significant amount of time interacting with people with mental illness — about 10% of police time in New South Wales (NSW LRC 2012). In 2018, New South Wales police completed about 14 700 orders under section 22 of the *Mental Health Act 2007* (NSW) (NSW Police, unpublished data). In Victoria, it is estimated that police apprehend about 500 people (under the State's Mental Health Act) each month (Allen Consulting 2012). At least 20% of all mental health referrals to the emergency department come from police (Scott and Meehan 2017). In 2018, police-assisted mental health transports to hospital were about 1260 in Western Australia (WA Police, unpublished data) and 1130 in South Australia (SA Police, unpublished data).

Box 16.4   **Police have express rights under mental health legislation to apprehend individuals who appear to have mental illness**

All States and Territories have mental health legislation that authorises police to apprehend people who appear to have a mental illness, and transport them to appropriate treatment facilities (typically public hospital emergency departments). The relevant sections are listed below:

- New South Wales — *Mental Health Act 2007* (NSW), section 22

- Victoria — *Mental Health Act 2014* (Vic), section 351

- Queensland — *Mental Health Act 2016* (Qld), sections 369 and 371

- Western Australia — *Mental Health Act 2014* (WA), section 156

- South Australia — *Mental Health Act 2009* (SA), section 57

- Tasmania — *Mental Health Act 2013* (Tas), section 17

- Australian Capital Territory — *Mental Health (Treatment and Care) Act 2015* (ACT), section 80

- Northern Territory — *Mental Health and Related Services Act 1998* (NT), section 32A.

Police interactions have been increasing over time. For example, in New South Wales, police involvement with Mental Health Act related events increased over eight-fold over the 10 years to 2009 (figure 16.3). In Victoria, police facilitated about 14 000 'mental health transfers' to hospital, but attended 43 000 psychiatric and suicide related events in 2017-18, with the number of psychiatric events up 88% from 2014-15 (Victoria Police 2019, p. 3). In Western Australia, the number of police responses involving a mental health element increased from 4766 in 2007 to 18 902 in 2015 (Henry and Rajakaruna 2018).

Figure 16.3   **Number of Mental Health Act events**
New South Wales, 2000 to 2009
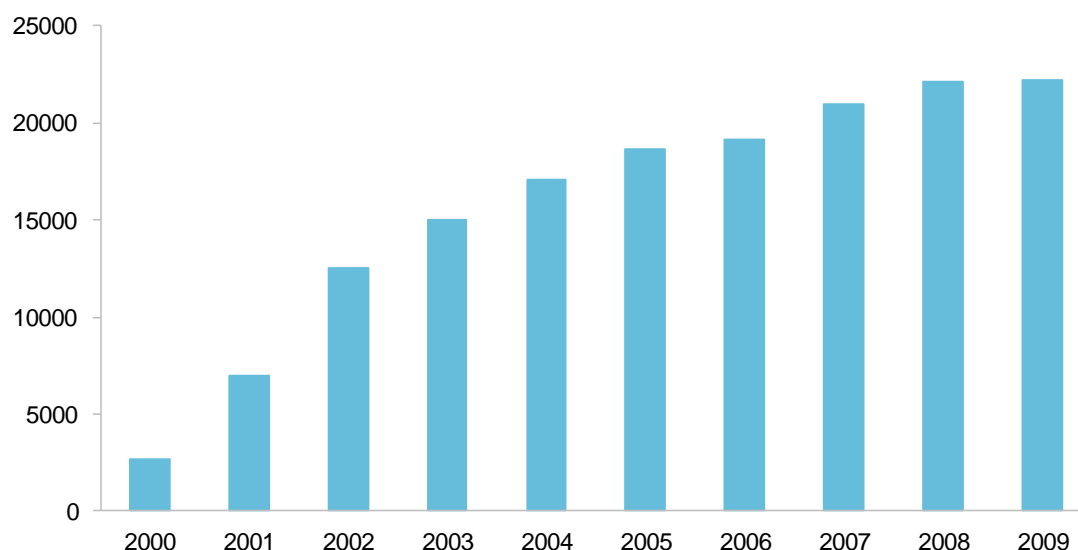
Source: Herrington et al (2009).

Despite these interactions forming a significant part of policing work, police are limited in ways with which to respond. Broadly, police have three options:

- transport the individuals to emergency departments

- if an offence has been committed, progress the matter to the next stage of the criminal justice system

- handle the matter informally (Godfredson et al. 2010).

Police are typically not mental health clinicians so cannot adequately 'triage' people with mental ill-health to appropriate supports although, as the 'front line', this is often expected of them. Crisis Assessment and Treatment (CAT) services exist in all States and Territories to address this limitation (chapter 8), but have been criticised for major time lags between police initially responding and their arrival on site (Henry and Rajakaruna 2018). Further, CAT teams are often reluctant to attend potentially violent situations due to concerns regarding their health and safety (SCMH 2006).

Notwithstanding, most State and Territory Governments have implemented initiatives to better support police responding to mental health related incidents (table 16.4). These generally fall into two categories (Puntis et al. 2018):

- 'crisis intervention teams' whereby police receive mental health training. New South Wales has implemented this approach

- 'co-response models' whereby mental health professionals and/or ambulance services directly assist police. Victoria, Queensland, Western Australia and the Australian Capital Territory have implemented co-response models, and New South Wales is trialling one (Henry and Rajakaruna 2018). Co-responder approaches can vary widely (box 16.5).

Evaluations of both types of models (crisis intervention teams and co-response) have shown benefits. Crisis intervention team models can help police gain more confidence in dealing with mental health consumers, and be more willing to engage and work with them (Herrington and Pope 2014). Co-response models can reduce police time spent on mental health related incidents, including time assessing and fewer referrals to emergency departments (Allen Consulting 2012).

> The [Western Australian Police Mental Health Co Response] program was independently evaluated by Edith Cowan University after three years in operation. The evaluation reported a reduced need for consumers to be transported to hospital by police from 70 percent to 25 percent. (National Mental Health Consumer and Carer Forum, sub. 476, p. 10).

Table 16.4 **Examples of programs to support police responding to mental health related incidents, by State and Territory Government**

	Program name	Description
New South Wales	Mental Health Intervention Team	A unit of specially trained police officers responding to mental health-related tasks and providing mental health training to others in the agency
	Police Ambulance Clinician Early Response Program	A dedicated mental health clinician conducting assessments in early stages of police responses to mental health crises. This program is currently subject to a six month trial
Victoria	Police Ambulance and Clinical Early Response	A police officer and a mental health clinician attend mental health-related police tasks as secondary responders
Queensland	Police Communications Centre Mental Health Liaison	Mental health clinicians are co-located in the Police Communications Centre. There are two full time clinical positions, supported by an on-call forensic psychiatrist
	Mental Health Co-responders program	Mental health staff accompany police and provide on-site clinical interventions
	Mental Health Intervention Project	A partnership between Queensland Police, Health and Ambulance Service to identify issues, discuss complex cases and develop preventative interventions, alternative referral pathways and review procedures
South Australia	na	na
Western Australia	Police Mental Health Co-Response Team	A mental health practitioner co-located in the Police Operations Centre facilitating access to advice, consultation, risk assessment and crisis management
Tasmania	Mental Health Officers	Mental Health Officers liaise with police and mental health services in the community, and provide advice to police officers and the executive on policy and strategy
Northern Territory	na	na
Australian Capital Territory	Mental Health Community Policing Initiative	Training is provided to frontline officers to help them understand how to recognise, relate and respond to incidents involving mental health consumers. Mental Health clinicians are also embedded into Police Operations Centres

Source: ACT Policing (2019); Henry and Rajakaruna (2018); NSW Government sub. 551; Queensland Police (2017); Queensland Government (2018a); Tasmania Police (2019). **na** Not available.

Co-response models with collaborative, inter-agency initiatives between police and health agencies are becoming a preferred approach (Henry and Rajakaruna 2018). Even with additional mental health training, police are not mental health professionals. Further, inter-agency responses can enable access to information from health databases informing options for triage and police responses to individuals (Henry and Rajakaruna 2018). However, their success can depend on establishing clear roles and responsibilities.

> **Box 16.5   Wide variation in co-response models**
>
> There is wide variation in the implementation of co-response models. A systematic review identified 19 models that differed according to:
>
> - operating times and days per week
> - whether or not the co-response unit was a first or second response option
> - whether the police officer and mental health worker were co-located
> - whether a mobile unit was dispatched or not
> - mode of transportation to the incident (marked or unmarked vehicle).
>
> The study acknowledged that differences are likely due to local context and need, however, imprecise reporting may be a factor too, such as data wrongly recorded or left unrecorded.
>
> Notwithstanding, the wide variation in co-response models should be recognised, as the name itself may misrepresent it as a single model, where in practice it is not.
>
> *Source*: Puntis et al. (2018).

Some States have multiple initiatives to support a more systematic approach. For example, in Queensland, three programs complement each other to improve police interactions with people with mental illness (box 16.6).

A systematic approach can support more efficient use of limited resource (health, police and ambulance services). For example, in Queensland, there is scope for mental health clinicians in police communication centres to have state-wide oversight of all mental health-related crises, enabling them to prioritise calls that co-responders should respond to. The Commission acknowledges that what works in one jurisdiction may not work in others, but sees merit in adopting such an approach.

Notwithstanding, the success of this approach may need to be tailored to meet the needs of particular groups. Participants to this inquiry highlighted that some Aboriginal and Torres Strait Islander people understand and experience mental health differently to many non-Indigenous Australians — placing more emphasis on the fact that mental health is but one facet of wellbeing (chapters 4 and 20). Some may also have negative attitudes toward police due to strong historical antecedents (ALRC 2017a).

Box 16.6 Case study: multiple co-responses in Queensland

In Queensland, multiple programs exist to improve interactions between police and people with mental illness. This ensures that police are better supported and people with mental health problems can be referred to appropriate mental health services.

1. **Police Communications Centre Mental Health Liaison Service** — a consultation liaison service that aims to augment local service provisions and facilitate linkages across police and mental health services (QLD FMHS 2016). Mental health clinicians are located in the police communications centre where triple zero calls are received and first response officers are dispatched. The mental health clinicians access and interpret clinical information for police for immediate use and advise them on how to manage the individual (including communication strategies, styles, triggers and strategies for de-escalation and engagement).

2. **Mental Health Intervention Project** — a tri-agency partnership between police, health and ambulance services to share expertise, resource and respond effectively to mental health crisis situations. The project's aim is to prevent and/or safely resolve mental health crisis incidents. Mental Health Intervention Coordinators have been established in each health district (QLD Health, QLD PS and QLD JAG 2008). They liaise between police, ambulance, mental health staff and other relevant stakeholders to ensure timely and appropriate response and relevant information is shared between parties in a time of crisis.

3. **Mental Health Co-Responders program** — mental health nurses work alongside Queensland police to respond to police call-outs (where mental health may be a factor) to provide assessment and advice. The nurse can work with individuals on-site to deescalate the situation and develop a care plan that suits their needs (QLD Government 2018b).

Source: Queensland Forensic Mental Health Service (2016); Queensland Health, Queensland Police Service and Queensland Department of Justice and Attorney-General (2008); Queensland Government (2018b).

DRAFT RECOMMENDATION 16.1 — SUPPORT FOR POLICE

A systematic approach should be implemented to support police respond to mental health crisis situations.

In the short term (in the next 2 years)

All State and Territory Governments should implement initiatives that enable police, health and ambulance services to collectively respond to mental health crisis situations. The approach undertaken in Queensland should be considered.

The initiatives should ensure that:

- mental health professionals are embedded in police communication centres to provide real-time information on the individual to whom police are responding, to advise on responses and referral pathways, and to prioritise deployment of co-responder resources

- police, mental health professionals and/or ambulance services (draft recommendation 8.1) are able to co-respond to mental health crisis situations if necessary

- roles and responsibilities of all service providers are clearly defined

- approaches are tailored to meet the needs of particular groups, such as Aboriginal and Torres Strait Islander people.

Responses to mental health crises will not be fully successful on their own. There is evidence of 'bounce back' problems, where mental health facilities do not admit people transported by police (NSW LRC 2012). There are several reasons for this including when:

- mental illness (as defined in the legislation) is not the primary impairment

- it is suspected that drugs or alcohol are involved

- the person is behaving violently

- the number of available mental health inpatient beds is limited.

An evaluation of Queensland's Mental Health Intervention Project found a substantial increase in the use of Emergency Examination Orders[103] (EEOs), from 2519 in 2002-03 to 6616 in 2009-10 (Meehan and Stedman 2012). But, a significant proportion of EEOs were deemed 'inappropriate' as individuals did not meet the 'criteria' for mental illness. In Victoria, one in five individuals who were transported by police for involuntary admission to hospital did not meet the criteria under the legislation, so were released (Ogloff et al. 2012). This is despite them having high rates of personality disorder, substance use

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[103] An EEO (within the Mental Health Act in Queensland) empowers police and ambulance officers (and psychiatrists) to transport patients to an Emergency Department or other authorised mental health service for assessment. Before initiating an EEO, police and or ambulance officers must reasonably believe that a person has a mental illness, and because of this there is an imminent risk of significant physical harm being sustained by the person or another individual.

disorders, intellectual disability and acquired or traumatic brain injury. However, the Commission estimates the number of individuals being transported to hospital and not admitted (due to not meeting the criteria) is relatively low nationally (less than 10 000 per year).

Police also often interact with the same individuals repeatedly (Clifford 2010). This point was reinforced during the Commission's consultations with police. In their view, these 'frequent presenters' do not receive adequate mental health and social support, contributing to repeat mental health crisis situations. Data on the number of frequent presenters is limited, but suggests they 'account for a large proportion of mental health act events' within a local area. At the extreme, it was estimated more than 100 events were related to a single individual over the past year (Herrington et al. 2009, p. 49).

As long as mental health services are under-resourced in the community, there will be increased demand for police to respond. Police responses to people with mental illness can only be effective if there are adequate treatment and support services for police to refer individuals to. Currently, people being transported to hospital emergency departments may not be eligible to access care or have to wait a long time for care.

DRAFT FINDING 16.2 — POLICE RESPONSES RELY ON COMMUNITY MENTAL HEALTH SERVICES

The effectiveness of police responses to mental health related incidents relies heavily on mental health services being available in the community. Police responses are limited by a 'bounce back' problem — where individuals referred to mental health services by police are unable to access appropriate treatment and care, and are discharged without support. Police can respond multiple times to the same individuals experiencing mental health crises.

Court responses and support

Court diversion programs

All States and Territories have developed court diversion programs that 'divert' people with mental illness away from the criminal justice system, to reduce the risk of recidivism. The ALRC defines court diversion programs as:

> … [those that] allow magistrates or judicial officers to adjourn matters while defendants engage in support services. Diversionary programs provide services for people who have been accused or convicted in the summary jurisdiction, who require assistance with addiction or mental health. (ALRC 2017b)

The Commission has used the word 'diversion' more broadly as a means of intervening to respond more effectively to individuals in contact with the criminal justice system:

> A better conceptual approach to schemes or programs currently labelled 'diversionary' is not to consider them as legal detours or deviations from a true path but as identifiable stages in the criminal justice continuum at which the law can intervene effectively, proportionately and responsively to an alleged crime and to the person who is alleged to have committed it. State actions at these junctures are therefore better described as 'interventions' rather than 'diversions'… Interventions can take many forms and take different forms for different purposes at different points of the criminal justice system. (Freiberg et al. 2016, p. 57)

This inquiry concentrates on two particular court diversion programs: court liaison services and mental health courts. All States and Territory Governments have adopted court liaison services, but only some have established mental health courts (table 16.5).

Table 16.5 **Court diversion programs, by State and Territory Government, 2015**

	Court liaison services	*Mental health courts*
New South Wales	NSW Health: Justice Health Forensic Mental Health Network, from 1999	None
Victoria	Victorian Institute of Forensic Mental Health (Forensicare), from 1994	Court Services Victoria from 2008
Queensland	Queensland Health: Forensic Mental Health Service	None [a]
South Australia	SA Health: Forensic Mental Health Service	Courts Administration Authority of South Australia, since 1999
Western Australia	Department of Health: State Forensic Mental Health Services	Start Court (adult program) and Links (children's program) from 2013
Tasmania	Department of Health and Human Services: Forensic Mental Health Service	Department of Health and Human Services: Forensic Mental Health Service and Magistrates Court of Tasmania, from 2007
Northern Territory	NT Health: Forensic Mental Health Service[b], from 2016	None
Australian Capital Territory	ACT Health: Division of Mental Health, Justice Health & Alcohol and Drug Services: Mental Health Forensic Services	None

a The Queensland Mental Health Court performs a different role to that of the Mental Health Court programs in other jurisdictions. It is a specialist court which primarily determines issues of fitness to plead and criminal responsibility. **b** Although services are limited. The Northern Territory's Forensic Mental Health Service conducts a small number of assessments in police watch houses and community mental health services can perform this service on an ad hoc basis.

Source: Davidson et al (2015); Davidson (2018); Richardson and McSherry (2010).

Court liaison services aim to identify people with mental illness who have been charged (Davidson 2015). These services seek to intervene as early as possible, often pre-trial or during the trial process. Services include conducting mental health assessments, providing clinical advice to the court and assisting courts to divert individuals to mental health treatment (Davidson et al. 2016). They can also provide short-term mental health support.

The extent to which court liaison services access mental health administrative data varies across jurisdictions. For example, court liaison services in the Australian Capital Territory, New South Wales, Queensland, Victoria and Western Australia can access mental health data bases (and an individual's mental health history or current treatment plan) to inform service delivery. This does not occur in other States and Territories (Davidson 2015).

Mental health courts offer a different model of court diversion and can operate alongside court liaison services. Specialised mental health courts provide a personalised approach that addresses the needs of defendants with mental illness. They exist in Victoria, Western Australia, South Australia and Tasmania. Underpinning these models is the principle of 'therapeutic jurisprudence', which seeks to use the law as a therapeutic agent (Davidson 2015). Queensland also has a mental health court, but its role differs in that it specialises in matters relating to forensic patients. For example, it makes decisions about unsoundness of mind at the time of the alleged offence, fitness for trial, or diminished responsibility in the case of a murder charge.

Eligibility requirements differ between jurisdictions. For example, in Victoria, offenders charged with a serious, sexual or violent offence are not eligible (Chesser and Smith 2016), whereas in Western Australia, the type of charge is not considered (box 16.7).

> **Box 16.7   Western Australia's Start Court Program**
>
> The Start Court in Western Australia is a solution-focussed court, adopting principles of therapeutic jurisprudence for people experiencing mental health problems. It consists of experts that provide legal support, clinical and corrections support (including nurses, psychiatrists, psychologists, social workers and community corrections officers), social and community support, and drug and alcohol support.
>
> The Start Court process aims to run as follows:
>
> 1. A Magistrate in any metropolitan court refers an accused person to the Start Court. If the accused meets the eligibility criteria they can continue through the application process that takes 1–2 weeks.
>
> 2. A clinical team conducts an assessment for inclusion, including interviews and screening. They finalise the assessment report, typically in about 3–4 weeks.
>
> 3. The accused is either accepted or not accepted into the program. To be accepted, the accused must enter a guilty plea, to at least a significant proportion of their charges.
>
>   During the program, the participant is required to 'check-in' to court weekly or fortnightly. An Individual Start Court Plan and outline of goals and strategies is developed and shared with the participant, their lawyer, the Magistrate and the Start Court Team. This may require the participant to attend appointments, including with a psychologist, a GP, a Mental Health Clinic, urinalysis, counselling or employment specialist.
>
>   The program stage takes approximately six months.
>
> 4. The participant graduates from the Start Court Program. Leading up to graduation, a Recovery Plan will be developed for the participant.
>
> 5. In sentencing, the Magistrate takes participation in the program into account.
>
> *Source*: Western Australia Department of Justice, Western Australia Department of Health and Western Australia Mental Health Commission (2018).

There are other types of court diversion programs that are available to individuals with or without mental illness. An example is the Court Integrated Services Program (CISP) that operates in Victoria (box 16.8), which provides case management support to individuals at the pre-trial or bail stage including mental health services and crisis accommodation. Another example is Victoria's Neighbourhood Justice Centre (NJC) (Morgan and Brown 2015). Based on a community justice model, it includes a multi-jurisdictional court and support services, such as mental health, drug and alcohol and financial counselling.

Box 16.8   **Victoria's Court Integrated Services Program**

The Court Integrated Services Program (CISP) operates in the Magistrates' Court of Victoria. It aims to improve treatment, court, sentence and recidivism outcomes. CISP offers a coordinated, team-based approach to the assessment and treatment of defendants at the pre-trial or bail stage. The services that it provides includes case management support and links to support services for drug and alcohol, crisis accommodation, disability support and mental health.

A typical CISP process for an eligible participant proceeds as follows:

1. A client is referred to CISP for initial eligibility screening.

2. A case worker completes a comprehensive assessment, including examination of criminal and legal history, the client's need for social and economic support, drug and alcohol use, and physical and mental health needs.

3. The client returns to court where an order is made that they participate in CISP in several ways. Some magistrates make a bail order with conditions relating to CISP, while others merely *recommend* CISP engagement. In addition, some magistrates may order participants to re-appear at a later date for a progress review.

4. The case worker develops a case management plan for the client. This involves referral to a range of treatment and support agencies, and includes a plan for continued supervision and monitoring.

5. At the end of the period of bail, the client returns to court, enters a plea (guilty or not guilty) and the sentencing outcome is determined. Participation in CISP may be taken into account in sentencing.

Source: Victorian Department of Justice and Regulation (2010).

Signs of improved outcomes, but more can be done

Evaluations of different court diversion programs show reduced recidivism rates among participants. In New South Wales, the recidivism rate was 12% lower for participants in their court liaison service (Albalawi et al. 2019). Evaluations of the mental health courts in Victoria, South Australia and Tasmania also found reduced rates (Chesser and Smith 2016; Lim and Day 2014; Skrzypiec, Wundersitz and McRostie 2004; WA MHC 2015b). In Victoria, CISP participants had recidivism rates of 35.9% compared to the control group's 49.5% (PWC 2009); and NJC clients had recidivism rates of 33% compared to the control group's 44% (Ross 2015).

The impact of these programs on mental health outcomes beyond repeat offending is less clear. However, some evidence points to success. International studies found that clinical outcomes of participants improved (Sarteschi, Vaughn and Kim 2011) and the Mental Health Commission of Western Australia (sub. 259, p. 18) noted that:

> A 2018 Evaluation of Start Court indicated positive results with 92 per cent of Start Court participants experiencing improvement in their health and wellbeing, and 68 per cent of Start Court participants show improvement in suicidality.

Notwithstanding evidence of their success in reducing recidivism rates and improving mental health, there are concerns that court diversion programs are not meeting demand (NSW MHC 2017). Inquiry participants highlighted that, in practice, the proportion of individuals diverted is small, with diversion opportunities not being maximised:

> In NSW, court diversion has also been shown to reduce re-offending rates amongst those with psychosis, particularly if mental health treatment is actually received (Albalawi et al., 2019). In our own research, however, the rate of diversion in NSW has been found to be just over 50% only (of those clinicians recommend for diversion) and diversion is employed less often for male offenders, younger offenders, and those of Aboriginal and/or Torres Strait Islander heritage (Soon et al., 2018), indicating that there is still work to be done to ensure diversion opportunities are maximised for all groups. (Kimberlie Dean, sub. 235, p. 3).

Several factors constrain access. Just Reinvest NSW (sub. 440) identified insufficient funding and a lack of appropriately trained staff. Distance is also a factor for people living in regional and remote areas (Davidson et al. 2016; AASW, sub. 432). Further, under-resourced mental health services in the community maybe unwilling or unable to accept referred individuals (VAGO 2014).

Coordination and planning at the agency-level, and at the program- and service-level is necessary for court diversion programs to succeed. Many people accessing these programs have complex needs and poor social determinants. As such, diversion to mental health services as well as other social supports and community services is necessary.

There is also room to improve the effectiveness and efficiency of these programs (Davidson et al. 2016, 2017). For example, there is a dearth of information (locally and internationally) on how court liaison services should be delivered, what models are most effective, and which groups benefit most from participating (Davidson et al. 2016, 2017). More data is necessary for research and program evaluations to drive improvements. Moreover, the data should be available for independent evaluation (chapter 25).

DRAFT FINDING 16.3 — COURT DIVERSION PROGRAMS

All State and Territory Governments have implemented court diversion programs that aim to support people with mental illness access appropriate mental health treatment and social support. Court diversion programs differ across States and Territories and include court liaison services, mental health courts, integrated support services and Victoria's Neighbourhood Justice Centre. All programs have demonstrably reduced recidivism rates and some have improved mental health.

However, the success of court diversion programs can depend on coordination of mental health court diversion programs with relevant agencies, particularly health and housing. Additional research and evaluation in this area would assist to improve existing and future programs.

Mental healthcare in correctional facilities

States and Territory Governments fund the delivery of both primary and specialised mental health services in correctional facilities. Individuals held in correctional facilities are not eligible to receive Medicare and PBS funded services and products (AIHW 2019ad; Cumming et al. 2018). Section 19(2) of the *Health Insurance Act (1973)* (Cth) states that Medicare benefits are not payable if services are provided by State Governments (such as prisons) (Cumming et al. 2018). Primary mental healthcare in correctional facilities is often managed by GPs, psychiatric nurses and psychologists (Tasmanian Custodial Inspector 2018). Psychiatrists typically provide oversight for those who have complex needs. Delivery of mental health services in correctional facilities differs across States and Territories (table 16.6).

Several reviews, inquiries and studies have highlighted key issues surrounding prison health, including mental health (ALRC 2017a; Commissioner for Children and Young People Western Australia 2011; Office of the Inspector of Custodial Services 2018; SCMH 2006; Victorian Ombudsman 2015). These include poor screening and assessment upon reception and inadequate mental health services, as discussed below.

Is mental illness identified and used to inform care?

Screening and assessment often occurs at reception to correctional facilities, although it can happen at other points throughout the criminal justice system (Schilders and Ogloff 2014). All jurisdictions routinely screen for mental ill-health on arrival to correctional facilities (Clugston et al. 2018).

The nature of screening and assessment processes varies between States and Territories. Each has its own set of questions that address mental health and cognitive impairment issues. There are also timing differences. For example, all Victorian prisoners (sentenced and unsentenced) must have a medical screening within 24 hours, with referral for further assessment if deemed at risk (Victorian Ombudsman 2015). In contrast, in Western Australia assessments are expected to be conducted within 28 days of sentencing (Office of the Inspector of Custodial Services 2019).

Table 16.6   Responsibility for mental healthcare in correctional facilities

State and Territory, 2016

	Responsible department(s)	Service model
New South Wales	Department of Health	Mental health services are provided by Custodial Mental Health, a service within NSW's Justice Health and Forensic Mental Health Network (JHFMHN)[a].
Victoria	Department of Justice and Regulation	Prison mental health services provide treatment and care at three prisons/remand centres[b], visiting consultant psychiatrists and nurse practitioners provide services to all publicly-run prisons, Forensicare delivers services at two prisons[c], Department of Justice and Regulation contracts primary health services.
Queensland	Department of Health; Department of Corrective Services	Health Hospital and Health Services provide specialist mental healthcare. Primary care is provided by the Health Offender Health Services. Corrective Services contracts private providers of primary healthcare in the two private correctional facilities.
South Australia	Department of Correctional Services	Visiting psychiatrists (coordinated by the forensic mental health service) provide care to prisoners and some forensic patients held in custody (via collaboration with Correctional Services). Psychology services are provided by Correctional Services, and primary healthcare is provided by the Prison Health Service.
Western Australia	Partnership between the Department of Health, Department of Corrective Services	The North Metropolitan Health Service provides specialist mental healthcare, the Mental Health and Alcohol and Other Drug Service provides mental health and addiction services, and Corrective Service provides psychology and counselling services.
Tasmania	Department of Health and Human Services; Corrective Services	Mental health services are provided from within a broader Mental Health and Statewide Services structure. Specialist services may also be provided by psychologists funded by Corrective Services.
Northern Territory	Department of Health	Forensic mental health services are provided, comprising specialist multidisciplinary clinical staff. These services include: at-risk assessments, advice regarding treatment and care and case management.
Australian Capital Territory	Department of Health; Corrective Services	Specialised mental health services are delivered by forensic mental health services, including: screening, assessment, care-planning and psychiatric care. Corrective Services provide mild to moderate psychological services.

a Except at Junee Correctional Centre (private prison) which contracts private health providers. **b** Melbourne Assessment Prison, the Dame Phyllis Frost Centre and the Metropolitan Remand Centre. **c** Port Phillip Prison and the Ravenhall Correctional Centre.

Source: Commission analysis based on Clugston et al. (2018).

The adequacy of screening and assessment processes in some facilities has been questioned. Practices to screen and identify prisoners with mental illness vary from use of validated systematic screening protocols to prison officials merely asking a few questions about mental health history (Schilders and Ogloff 2014). For example, in Tasmania, screening and assessment is not standardised and depends considerably on the goodwill and expertise of staff (Tasmanian Custodial Inspector 2018). The Tasmanian Government has established a

Prisoner Mental Health Task Force to examine processes and procedures relating to prisoner psychiatric care including assessments (TAS DOJ 2018).

In the Commission's view, formalised screening and assessment processes in correctional facilities are necessary to identify individuals with mental illness and provide information on what mental health services and care are needed. In addition, these processes need to be culturally appropriate, especially given the high rates of incarceration for Aboriginal and Torres Strait Islander people (Victorian Government 2009). JusTas reiterated the importance of properly screening and assessing the mental health of prisoners:

> … if the mental health problems or illnesses of offenders are not adequately identified at [the] beginning of their entry to custody or to prison, such mental health problems will go unaddressed and untreated and individuals will fall through the gaps in regard to receiving effective and appropriate mental healthcare. (JusTas, sub. 346, p. 11)

Is mental healthcare in correctional facilities equivalent to care in the community?

Even where mental health information is obtained through screening and assessment, it is not always used to inform the resourcing of treatment and care. The availability of resource influences decisions to refer prisoners onto further assessment and treatment (Schilders and Ogloff 2014). A 2014 study found that less than 1% of prisoners assessed as having an acute/severe mental illness were transferred to appropriate mental health services for further assessment and treatment (Schilders and Ogloff 2014).

There is a lack of mental health services available in correctional facilities. Several inquiries have highlighted that increases in prison populations have not been matched with increases in mental healthcare and services for prisoners (Human Rights Watch 2018; SCMH 2006; Sofronoff and Lynch 2016; Tasmanian Custodial Inspector 2018). In particular, specialised mental health services in prison are inadequate to meet the needs of prisoners with mental health problems (Victorian Ombudsman 2015).

Mental healthcare in correctional facilities should be equivalent to that in the community according to the *Guiding Principles for Corrections in Australia*, but this does not appear to be the case. An indicator measure of this is staffing profile for prison mental health services. The Sainsbury Centre for Mental Health estimated that 11 full-time equivalent (FTE) specialist mental health staff per 550 male prisoners as equivalent to community services plus an additional 3.2 FTE to provide a substance misuse service (Clugston et al. 2018). Based on these estimates, only Tasmania and the Australian Capital Territory are funding mental health services in correctional facilities at a level equivalent to that in the community (figure 16.4).

Figure 16.4 Estimates of funded and occupied clinical mental health staff (full time equivalent per 550 prisoners)

State and territories, as at 30 June 2016

Legend: ■ Estimated funded clinical FTE per 550 prisoners ■ Estimated occupied clinical FTE per 550 prisoners
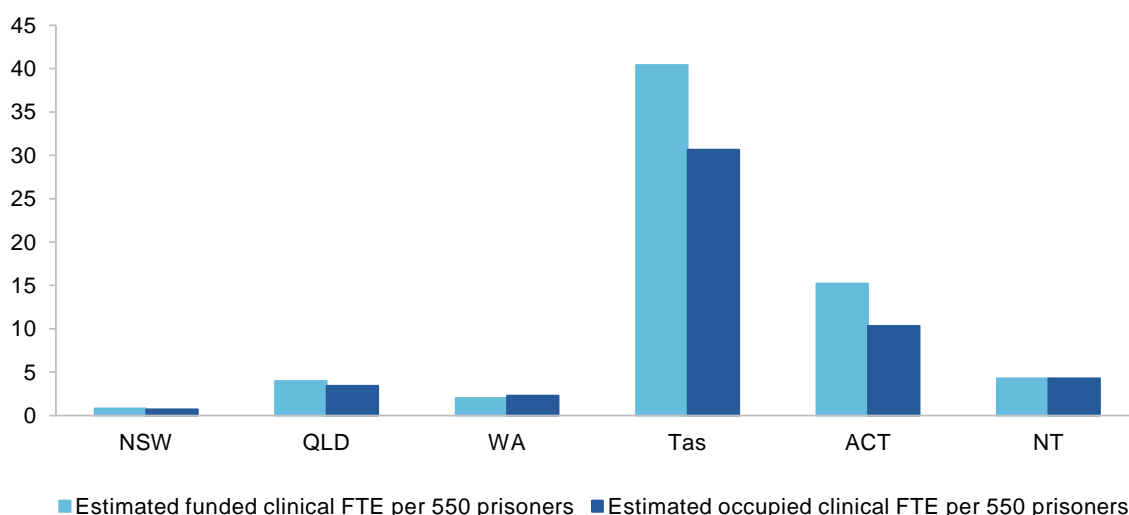
a Victoria did not respond to the survey and South Australia's mental health prison services are not specifically funded. **b** Occupied clinical full time equivalent (FTE) refers to staff occupying positions to deliver services. In Western Australia, the number of occupied clinical FTE is higher than the number of funded clinical FTE because additional 'team leader' staff were delivering services, but not included in the number of funded positions.

Source: Clugston et al. (2018).

The composition of mental health staff in prisons also varies across jurisdictions. For example, in Tasmania, the majority of clinical staff on an FTE basis is made up of general nurses, whereas in New South Wales, it is consultant psychiatrists (Clugston et al. 2018).

Participants to this inquiry, both government agencies and peak bodies, highlighted that access to mental healthcare is difficult for prisoners:

> Despite a high rate of mental health issues, it was indicated that access to a psychiatrist in prison was "virtually zero" unless the person was under a forensic psychiatrist — "ten minutes with a psychiatrist every six months does not help". Greater access to social workers and potentially to peer workers is likely to be beneficial, but resource are limited and provision of in-reach services was difficult due to lack of resource for supervision. (South Australian Mental Health Commission, sub. 477, p. 21).

> … complaints to the MHCC also suggest that people in the justice system are much more likely to raise concerns about their access to mental health services, with over one-fifth of complaints to the MHCC about forensic and prison mental health services being about delays in treatment (compared to 5 per cent of all complaints to the MHCC). This is unsurprising given the well-documented issues of service availability within prison settings. (Mental Health Complaints Commissioner Victoria, sub. 321, p. 4).

There is also a need to improve access to mental health supports whilst people are in prison. Many of our clients are unable to access clinical mental health supports whilst incarcerated due to long wait lists. In one prison we work, there are no permanent clinical mental health supports, only a visiting psychiatrist and psychologist. This means that people seeking mental health support are triaged and even the most severe needs often face wait times of up to a week which is insufficient, particularly for people experiencing psychosis. (Australian Red Cross Society, sub. 490, pp. 15–16).

There are several specific access issues that are significant.

- Mental healthcare can be even less accessible for individuals detained pre-trial and prisoners serving short sentences. Individuals detained pre-trial are often released without medical or mental health follow up as community services are not informed of their release (Stokes 2012). Prisoners on short sentences may also miss out on appropriate mental healthcare in prison due to long waiting lists (Sofronoff and Lynch 2016).

- Access to culturally capable mental healthcare in correctional facilities can also be limited, especially for inmates who are Aboriginal and Torres Strait Islanders. What constitutes effective and beneficial (or therapeutic) mental healthcare for Aboriginal and Torres Strait Islanders can be quite different to that for non-Indigenous Australians in both the nature of care and delivery approach (Baldry et al. 2015). This is discussed further below.

- There can also be significant barriers for young people in youth justice in accessing adolescent mental health services (Armytage and Ogloff 2017). Custodial facilities are often ill equipped to deal with their needs because of limited designated facilities.

Reviewing national standards of care

A range of local and international guidelines and principles cover the provision of mental healthcare in correctional facilities. Australia is signatory to international obligations that aim to protect the rights of those with mental ill-health (chapter 22). Locally, the *Guiding Principles for Corrections in Australia* represents a national intent about how States and Territory Governments develop practices, policies and performance standards relating to correctional services (CSAC 2018). A *National Statement of Principles for Forensic Mental Health* (2006) also guides mental healthcare for offenders (AHMAC 2006). Primary themes that emerge across these principles are listed in box 16.9.

However, health and mental healthcare provided in correctional facilities are not subject to national standards as Australian governments have not developed them.

[there is a] … lack of Commonwealth and State and Territory cooperation to establish and thereafter enforce national standards to protect, promote and maintain the health and well-being of people held in custody. (PHAA 2013, p. 2)

Box 16.9   **Main principles guiding correctional facilities in Australia**

Equivalence of care: those held in correctional facilities should receive healthcare, including mental healthcare that is equivalent to that available in the community with regard to professional, ethical and technical standards.

Early assessment: those held in correctional facilities should be assessed as soon as possible on admission to facilitate the identification and immediate management of mental health problems. This should be accompanied by appropriate treatment plans.

Timely treatment: those held in correctional facilities should have access to treatment for mental illness; resource and staffing should ensure that detainees receive timely access to high-quality mental healthcare.

Continuity of care: ongoing monitoring and care, as well as linking mental health services in correctional facilities with those in the community.

Transfer to hospital: mental health workers should play a role in identifying and arranging for those held in correctional facilities who require involuntary mental healthcare to be transferred to appropriate authorised mental health facilities.

Source: Tasmanian Custodial Inspector (2018).

National Safety and Quality Health Service (NSQHS) Standards have been developed that apply to health and mental health service organisations in the broader community, with oversight by the Australian Commission on Safety and Quality in Health Care (ACSQHC). The primary aim of the NSQHS Standards are to 'protect the public from harm and to improve the quality of health service provision' (ACSQHC 2017b, p. 1). A user guide has also been developed to support health service organisations implement the NSQHS Standards for mental health services (ACSQHC 2018c).

However, it is unclear whether the NSQHS Standards apply to mental health services provided in correctional facilities. The definition of 'health service organisation' does not explicitly include correctional facilities in the list of locations and settings in which healthcare is provided (ACSQHC 2017b, p. 72). Further, it is unclear if the NSQHS Standards would apply to services provided in correctional facilities given the additional challenges. For example, health professionals often need to balance a consumer's right to privacy and confidentiality against a need for safety and security (RACGP 2011).

In the context of this inquiry which is looking through the lens of mental health, the Commission supports the NSQHS mental health standards applying to correctional settings. This would ensure those held in correctional facilities receive safe and high quality mental healthcare that is equivalent to that expected in the community. This is particularly important given the high prevalence of mental ill-health among prisoners and consequential demand for mental health and healthcare. Setting safety and quality standards can provide a quality assurance mechanism (ACSQHC 2018c). Commentators have highlighted the importance of this.

> Mental healthcare in prisons should be aligned with the standards and approaches of community based mental health services which includes providing support to manage mental illness within

the general community setting of the prison and access to specialist mental health units as appropriate. (MHV and Mental Health Legal Centre 2019, p. 15)

The ACSQHC should review the NSQHS Standards to ensure that they apply to mental health services provided in correctional facilities.

DRAFT RECOMMENDATION 16.2 — MENTAL HEALTHCARE STANDARDS IN CORRECTIONAL FACILITIES

National mental health service standards should apply to mental healthcare service provision in correctional facilities to the same level as that upheld in the community.

In the short term (in the next 2 years)

The Australian Commission on Safety and Quality in Health Care should review the National Safety and Quality Health Service Standards to ensure that it applies to mental health service provision in correctional facilities.

Preparing for life after release from correctional facilities

People with mental ill-health who are released from correctional facilities into the community represent a particularly at risk group. They often have multiple needs for mental healthcare and social support. This report has highlighted the lack of support in the community for people with mental ill-health including, for example, barriers to accessing appropriate mental health treatment (chapter 7) and housing (chapter 15). These difficulties are magnified for those released from prison.

Commentators note that incarceration disrupts a person's housing, financial and employment situations, family responsibilities and other relationships and social connections (ALRC 2017a; Office of the Inspector of Custodial Services 2019). Mental illness elevates this disruption by compounding the stigma and disadvantage in returning to the community following imprisonment (Baker 2014). Further, Cutcher et al. (2014, p. 427) found that:

> Those reporting a diagnosed lifetime mental disorder experienced more disadvantage and ill health before incarceration and worse health and social outcomes after release.

Disruptions in mental health treatment during the period of transit into the community may further exacerbate these challenges. Those with mental illness can endure poor and sometimes fatal health outcomes after release (often within a year) (Victorian Ombudsman 2015).

Higher healthcare needs

People released from prison have higher rates of hospitalisation for mental disorders than the general population (Hobbs et al. 2006). Within this group, Aboriginal and Torres Strait

Islander people are at even greater risk (Hobbs et al. 2006). The rate of psychiatric hospitalisation for people with recent criminal justice involvement is over 12 times higher than those without (Kouyoumdjian et al. 2018). Compared with the general population, the likelihood of dying by suicide following release from prison was 14.2 times higher for women and 4.8 times higher for men (Willis et al. 2016).

Consequently, people released from prison account for disproportionately higher healthcare expenditure. The Justice Health Unit (sub. 339) noted that:

- people released from prison who have a mental illness and dual diagnosis (co-occurrence of mental illness and substance use disorder) were 2.5 to 5 times more likely to incur annual healthcare costs in the 90th percentile

- annual health service costs among people released from prison are more than 1.7 times higher than the general population.

Evidence suggests incarceration exacerbates poor mental and physical health outcomes for individuals with mental illness once they have returned back to the community (Cutcher et al. 2014). In examining associations between mental disorder and a range of outcomes for ex-prisoners six months after release, a large-scale longitudinal study established that housing, employment and recidivism outcomes are not significantly associated with mental disorder (adjusted for disadvantage before prison), but that poor mental and physical health outcomes, and risky substance use are (Cutcher et al. 2014).

Housing

Although housing outcomes may be unchanged, those released from correctional facilities can face barriers to continuing mental healthcare if they are released into homelessness and unstable accommodation. Often, securing stable accommodation is considered the single biggest issue after release for prisoners (QLD PC 2018). Nearly half (43%) of people leaving prison expected to spend their first night in short-term or emergency accommodation (Baker 2014). Many participants highlighted this.

> Our study of 2389 attenders at psychiatric clinics provided in homeless shelters in inner city Sydney found that a third had been released from prison to the homeless sector, and as many as 21% had lost a Housing Department tenancy, seen as the solution to homelessness. (Olav Nielssen, sub. 37, p. 1)

> [People released from prison] are highly vulnerable to homelessness (85% of the women we work with are released from prison into unsafe or unstable accommodation) (Jesuit Social Services sub. 441, p. 20)

> The prison mental healthcare provider Forensicare highlighted that linking a former prisoner to a community mental health service on release however can be difficult particularly when they do not have a permanent address or housing, which is the case for an overwhelming number of former prisoners. (Victorian Ombudsman 2015, p. 114)

Stable housing provides a foundation for further connection to mental health supports, as discussed in chapter 15. Often, people require suitable accommodation before they can begin to participate in the community, and seek healthcare and employment (Eastern Health, sub. 187).

Current responses to support reintegration

The level of support people receive after release from correctional facilities can depend on whether or not they are released on parole. The intent of parole is to ensure prisoners have access to supervised support while reintegrating into the community, before their prison term ends (QLD PC 2018). Individuals who are released without parole are not supervised in the community, but can often access transition support services.

People released on parole

All States and Territory Governments offer some form of early release (parole) from imprisonment that enables people to serve the remainder of their sentence in the community under supervision. Although parole systems differ across jurisdictions, generally they are designed to assist offenders reintegrate back into the community (Sofronoff and Lynch 2016). In some jurisdictions, the majority of prisoners are released on parole (NSW Department of Justice nd).

People on parole are often referred to services to address their needs, including alcohol and drugs, mental health and life skills (Sofronoff and Lynch 2016). In some instances, for parole to be granted, conditions such as securing suitable housing must be met (NSW Department of Justice nd).

Although offenders released on parole receive supervision and support in the community, those with mental illness can be 'under-identified and underserved' (Gelb, Stobbs and Hogg 2019, p. 99). Parole staff can lack the experience or have large caseloads that prevent them from adequately managing offenders with mental ill-health (Lurigio 2001). JusTas highlighted this issue:

> … [an ex-inmate at an Australian prison identified] that the parole officer assigned to him took on some of this role [to support him re-integrate into the community]. However, that they were often too busy and had too high a case load to spend more time with him. He states that a dedicated community support worker should be available to support ex-prisoners in the home. He highlighted that inmates suffering from mental health illnesses should have to, as part of their parole and to ensure mental stability, see mental health professionals regularly. If not for these social work and mental health professionals, spiralling of the mental illness may occur for the person, as it did for him. (JusTas, sub. 346, p. 15)

Inadequate support while on parole can lead to individuals with a mental illness having their parole order suspended or revoked. Although there is limited evidence of this in Australia, overseas studies found that offenders with a mental illness have a disproportionate risk of failing parole, and that often this is due to 'technical violations' as opposed to new offences

(Gelb, Stobbs and Hogg 2019; Livingston et al. 2008). Eno Louden and Skeem (2009) found that parolees with a mental disorder were more likely to return to custody (52.8%) compared to those without (29.7%).

The difficulties faced by people with mental illness on parole can be similar for other people with mental illness, including difficulties accessing specialised mental healthcare (chapter 7) and other social supports. Although in some cases difficulties can be more profound for people on parole, due to additional stigma and discrimination. The Commission has proposed that for consumers with the most complex mental health needs they should have both a care plan and a care coordinator (draft recommendation 10.4).

People released without parole

Those who are released without parole reintegrate into the community unsupervised and often receive less support. Although national data is unavailable, evidence suggests that people with mental illness are less likely to be released on parole (Schilders and Ogloff 2014), serving the entirety of their sentence in correctional facilities before release.

State and Territory Governments have developed a range of programs to support individuals reintegrate into the community. For example, the Australian Capital Territory's *Extended Throughcare Program* provides case management to ex-inmates for 12 months after release, giving support in five core areas: accommodation, health, basic needs, income and community connections (Griffiths, Zmudzki and Bates 2017). There are also more specific in-reach programs such as *Time to Work Employment Service*, which aims to assist prisoners find employment and reintegrate into the community upon release (DESSFB 2019b). *Time to Work Employment Service* has commenced in most States and Territories, and is expected to expand to all.

In terms of mental healthcare, the majority of State and Territory prison mental health services do not provide a mental health transition service for people leaving prisons but, instead, make referrals to a range of community services (Clugston et al. 2018). However, onward referral processes can vary substantially across Australia.

Some participants observed that coordination between mental health services in correctional facilities and the community is inadequate or lacking in many localities, despite pre-release discharge planning processes.

> … despite the fact that Australian correctional policy has for many years articulated a commitment to 'throughcare' to improve the continuity of care as people transition from prison to the community, little is done to maintain or build upon the success of custodial health services, after release from custody. (Justice Health Unit, sub. 339, p. 8).

> There is a poor intersect between effective mental healthcare in a custodial setting and in the community. Issues in relation to privacy and confidentiality and lack of shared information between agencies represent particular challenges. For example, dependence on medication during time in prison also presents challenges for people who may not be aware of exactly what medication they were taking while in prison. Although a discharge summary of medication is

meant to be provided to the person upon release, this is often lost in transit. For these reasons, strengthening the relationship between health services in prisons and community health and mental health services is particularly important. (Jesuit Social Services, sub. 441, p. 21)

People with mental illness leaving correctional facilities can face barriers to accessing care in the community. While these vary among individuals, common themes include individuals lacking knowledge about available services, facing difficulties making appointments, long waits and access issues (Baker 2014). Often this group experience stigmatisation, making accessing healthcare difficult. Further, many have needs that span multiple areas of service provision, such as mental health, disability and justice (Young et al. 2016).

The mental health information obtained from mental health screening and assessment in correctional facilities could be shared with community-based mental health services to enable individuals with mental ill-health to experience continuity of care on release.

INFORMATION REQUEST 16.1 — TRANSITION SUPPORT FOR THOSE WITH MENTAL ILLNESS RELEASED FROM CORRECTIONAL FACILITIES

We are seeking further information on transition support for individuals with mental illness released from correctional facilities (on parole or not) that link them to relevant community services. This includes information on the benefits of transition support and the extent of transition support that should be provided.

DRAFT RECOMMENDATION 16.3 — MENTAL HEALTHCARE IN CORRECTIONAL FACILITIES AND ON RELEASE

Mental health screening and assessment of individuals in correctional facilities should be undertaken to inform resourcing, care and planning for release.

In the medium term (over 2 – 5 years)

- All State and Territory Governments should undertake mental health screening and assessment of all individuals (sentenced or unsentenced) on admission to correctional facilities, and on an ongoing basis where mental ill-health is identified.

- The mental health information obtained from the screening and assessment needs to be comprehensive enough to inform resourcing of mental health services in correctional facilities. Where appropriate, authorities should share this information with community-based mental health services to enable individuals with mental illness to receive continuity of care on release.

Forensic services

Forensic patients (defined in box 16.2) represent a small sub-group of individuals who make contact with the criminal justice system. They are mainly treated in secure mental health

facilities. Many are detained under a forensic or criminal mental health order made under mental health legislation. There are about 2000 forensic patients nationally, although data quality varies across jurisdictions (table 16.7).

Table 16.7   Number of forensic patients/orders by State or Territory
As at 30 June 2018

	Estimated number of forensic patients/orders
New South Wales	616
Victoria	157
Queensland	811
South Australia	103[a]
Western Australia	38
Tasmania	46[b]
Northern Territory	na
Australian Capital Territory	na

a South Australian data is at 2015-16, as 2017-18 data was not available. **b** Tasmanian data is the number of orders made during the period 2005–June 2018. **na** Not available.

Source: Forensicare (2018); Queensland Department of Health (2018); NSW Mental Health Review Tribunal (2018); South Australia Department of Health (2016); Tasmania Law Reform Institute (2019) Western Australian Government (2018).

Forensic services face significant challenges. There are serious shortages of inpatient forensic mental health facilities in all States and Territories, in particular for young people (NT Mental Health Coalition Inc, sub. 430; Office of the Inspector of Custodial Services 2018; SCARC 2016). Legal Aid New South Wales (sub. 111, p. 4) submitted that forensic patients are being placed in prisons rather than hospitals, often due to a lack of available places in forensic facilities.

> [In New South Wales] 16% of all forensic patients are detained in custody … In our extensive casework experience, it is a common pathway for forensic patients to remain detained within a correctional centre on remand for around two years while waiting for court proceedings to be finalised.

Other inquiry participants raised concerns about the unmet demand for forensic care, as evident in the long wait times for prisoners who require transfers to forensic hospitals for appropriate mental healthcare.

> There is a two year wait for forensic patients to be transferred to these [Forensic Hospital] beds from custody. Forensic Hospital beds simply do not become available to sentenced prisoners or those on remand who need mental health treatment. Many people in custody would benefit enormously from the intensive and holistic mental health treatment that is available in the Forensic Hospital and other mental health facilities. (New South Wales Mental Health Review Tribunal, sub. 409, p. 5).

> A report released by the Western Australian Office of the Inspector of Custodial Services in September 2018 found that 61 per cent of all referrals to a mental health bed from a custodial

setting lapsed without a hospital placement. There are a significant number of people who should be held in a mental health facility but instead are finding themselves being held in prisons. (Law Council of Australia, sub. 492, p. 13).

While forensic patients make up a small proportion of offenders with mental illness, the care they require is highly specialised and costly — about $1100 per patient day on average across jurisdictions (AIHW 2018e). This compares to recurrent expenditure per prisoner per day of $302 (SCRGSP 2019e).

Knowledge about the mental health and care needs for forensic patients is limited. However, forensic patients released from secure care are likely to have much lower rates of reoffending compared to prisoners. Early findings from a study on forensic patients found that:

> … the 12-month rate of re-offending for released forensic patients is 6.3% for a cohort accrued over the past 25 years (Dean et al., submitted 2019); this compares to a rate typically over 40% for released prisoners in NSW. Our findings are consistent with those across jurisdictions internationally supporting the notion that forensic mental health services are effective at reducing post-release contact with the justice system, vital for supporting social and economic participation for this high-risk and high-needs group (Kimberlie Dean, sub. 235, p. 3).

Although costly, the evidence suggests that forensic mental health services are effective in reducing post-release reoffending (Kimberlie Dean, sub. 235).

INFORMATION REQUEST 16.2 — APPROPRIATE TREATMENT FOR FORENSIC PATIENTS

The Productivity Commission is seeking further information about those held in correctional facilities who are eligible for forensic mental healthcare, but are unable to access it due to capacity constraints. In particular, we are seeking information about the likely indirect costs and benefits to the wider community from increasing access to forensic mental healthcare.

The extent to which forensic orders are likely to lead to indefinite detention is a further issue. Most States have set limiting terms for forensic orders or mandatory reviews of orders on a regular basis, however, Western Australia, Victoria and the Northern Territory still allow for indefinite detention (SCARC 2016). The Senate Community Affairs References Committee recently conducted an inquiry into this issue, although a response from Government has not yet been made (DPO Australia 2018). The Commission recognises that indefinite detention is a complex issue, but a review of the relevant legislation in state jurisdictions is beyond the scope of this inquiry.

Addressing the needs of Aboriginal and Torres Strait Islander people

The incarceration of Aboriginal and Torres Strait Islander people, its causes and devastating effects have been the subject of a number of inquiries and Royal Commissions, the most recent being the ALRC inquiry in 2017 (ALRC 2017a).

Aboriginal and Torres Strait Islander people are grossly over-represented in the criminal justice system as noted in section 16.2 above (ALRC 2017a). A large proportion of those incarcerated are diagnosed with mental illness and cognitive disabilities (section 16.2).

> The issues pertaining to the needs of prisoners with mental illnesses and/or cognitive impairment are amplified for Aboriginal and Torres Strait Islander offenders given their significant overrepresentation in the criminal justice system. (Ogloff et al. 2013, p. 8)

However, in addition to the general issues raised in this chapter, mental health services for Aboriginal and Torres Strait Islander people in contact with the criminal justice system need to address three interconnected issues to be effective.

First, they need to be culturally appropriate. Services that place mental health within a broad holistic framework — known as social and emotional wellbeing (chapters 4 and 20) — are often limited in correctional facilities (Blagg et al. 2005; (eds) ;Dudgeon, Milroy and Walker 2014). A study on Koori prisoner mental health found that 'the current model of mental healthcare provided in prisons is not embedded within a culturally sensitive context and may not be meaningful to Koori people' (Ogloff et al. 2013, p. 16). Moreover, where these programs exist (such as healing programs), places can be limited (Ogloff et al. 2013).

Second, culturally capable care needs to deal with the specific underlying mental health problems facing Aboriginal and Torres Strait Islander people. This can differ from those facing other population groups. For example, Aboriginal and Torres Strait Islander women who are imprisoned can face greater barriers to accessing culturally appropriate mental healthcare, which is often inextricably linked with experiences of family violence, victimisation, sexual abuse and addiction (Blagg et al. 2005; Heffernan et al. 2015). The most common mental disorder for Aboriginal and Torres Strait Islander women imprisoned is Post-Traumatic Stress Disorder (PTSD) (Heffernan et al. 2015). However, few prison programs are specifically designed for Aboriginal and Torres Strait Islander women (COAG 2016). Moreover, mental health problems are often addressed by issuing medication, rather than preferred 'healing approaches' (Blagg et al. 2005). The NSW Council for Civil Liberties (sub. 484, p. 6) said that:

> … prisons do not appear to provide adequate support for people with mental health issues. It is reported that women with disabilities, particularly Aboriginal and Torres Strait Islander women with disabilities: experience higher rates of poverty, homelessness, domestic and sexual violence, and abuse than non-indigenous peers and peers without disabilities. Being put in custody often only heightens psychosocial disabilities associated with this trauma.

Third, many Aboriginal and Torres Strait Islander people are incarcerated for relatively short periods of time, on detention (awaiting trial or awaiting sentencing) or short sentences. Data shows median sentence lengths are shorter than for non-Indigenous prisoners (ALRC 2017a). Prison census data showed about 30% of Aboriginal and Torres Strait Islander people in prisons were detained pre-trial (ABS 2018g) and almost half were handed sentences of less than six months (ALRC 2017a). As the Human Rights Law Centre notes:

> … [inadequate access to programs] is felt most acutely by Aboriginal and Torres Strait Islander people in prison, who are more likely to be held on remand and be incarcerated for short periods,

and are therefore more likely to be in a situation where they are denied access to culture, community, education and mental health services. (Human Rights Law Centre 2019, p. 22)

Short periods of incarceration increase the importance of the justice system acting effectively as a gateway to culturally capable services in the justice system and as a link to these services in the community.

According to the ALRC (2017a), culturally appropriate programs for Aboriginal and Torres Strait Islander people should be:

- designed, developed and delivered by Aboriginal and Torres Strait Islander organisations where possible

- trauma-informed, especially where being delivered to women in correctional facilities

- focused on practical application particularly for those on remand or short sentences who need the skills on release to reintegrate.

Evidence suggests that mental healthcare provided by Aboriginal and Torres Strait Islander people or organisations are viewed as more accessible by Aboriginal and Torres Strait Islander people, including those who are incarcerated (Halacas and Adams 2015). Accordingly, where possible, care provided should be designed, developed and delivered by appropriate Aboriginal health service organisations.

A model of care that is growing in recognition is the Winnunga Holistic Health Care Prison Model operating in the Australian Capital Territory (box 16.10). Under this model, the Aboriginal Community Controlled Health Organisation (ACCHO), Winnunga Nimmityjah, provides dedicated in-reach health services, under a standalone and defined model of care (ACT Government, sub. 210). South Australia recently developed a Model of Care for Aboriginal Prisoner Health and Wellbeing drawing on the Winnunga Model's theoretical framework (Sivak et al. 2017).

In many instances, trauma-informed approaches should also be adopted. Many Aboriginal and Torres Strait Islander people in correctional facilities, particularly women, have experienced trauma. Approaches to trauma-informed care are well described internationally and locally (Heffernan et al. 2015). Historically these have been at odds with conventional approaches, but experiences internationally and in Australia are changing views. For example, the *Dilly Bag Program* in Victoria provides 'intensive assistance' to Aboriginal women in prisons who are recovering from traumatic experiences (ALRC 2017a).

Box 16.10   The Winnunga Holistic Health Care Prison Model

The Winnunga Holistic Health Care Prison Model (Winnunga Model) is the only published Australian model of care for Aboriginal prisoner health (Sivak et al. 2017). It was developed by Winnunga Nimmityjah Aboriginal Health and Community Service (Winnunga AHCS) in 2007 in anticipation of the opening of the Alexander Maconochie Centre in the Australian Capital Territory (Sivak et al. 2017).

The Winnunga Model addresses:

- Incarceration — provides holistic care during incarceration and planning for release

- Release from prison — provides post-release health service coordination, and family and community reintegration strategies

- Managing the cycle of incarceration — provides early family, and other intervention strategies.

In 2017-18, Winnunga AHCS provided 178 clients with 1281 occasions of service at the Alexander Maconochie Centre and Bimberi Youth Detention Centre. This represented a 26% increase in client numbers and a 75% increase in encounters from the previous year (Winnunga AHCS 2018).

Source: Poroch et al. (2011); Sivak et al. (2017); Winnunga Nimmityjah Aboriginal Health and Community Service (2018).

In the Commission's view, State and Territory Governments should continue working with Aboriginal and Torres Strait islander organisations to ensure that Aboriginal and Torres Strait Islander people in correctional facilities with mental ill-health are connected to Aboriginal health services in the community following release. The Koori Prisoner Mental Health and Cognitive Function Study (2013) highlighted the importance of this. As outlined earlier, the transition between correctional facilities and community can be very challenging, especially for those Aboriginal and Torres Strait Islander people who have substantially higher hospital admission rates (including for mental illness) following release from prison (Hobbs et al. 2006).

16.3 Victims of crime

People with mental illness are also over-represented as victims of crime. Contrary to widespread beliefs, evidence suggests that they are *more* likely to be a victim of crime than a perpetrator (OPI 2012). Notwithstanding, in many instances, they are both. New South Wales' data shows that the majority (85%) of offenders with mental illness and cognitive disabilities have experienced at least one instance of victimisation (becoming a victim) and over half (65%) have been the victim of violent crime (Dowse et al. 2016).

Prevalence of mental illness is high among victims of crime

Rates of mental illness are higher among victims of crime compared to the general population (NSW MHC 2017). This is evident in Australia (figure 16.5) and overseas (Knapp and Iemmi 2016). Teplin et al. (2005) found that persons with severe mental illness were about 11 times more likely to be a victim of crime compared to the general population, with this association strengthening in line with severity of mental illness (Teplin et al. 2005).

Increased victimisation is likely to result from the interaction of mental illness with other risk factors (such as disengagement from services and drug misuse), rather than from the presence of mental illness alone (Dowse et al. 2016). An Australian study of individuals with psychosis found the odds of victimisation were heightened for specific groups of victims with mental illness, including those who were homeless, had a history of substance abuse and had poorer social and occupational function (Chapple et al. 2004).

The most common victimisation experiences for people with mental ill-health are violent crimes. They are more likely to be victims of violent crime compared to those without mental ill-health (Baksheev et al. 2013). The most commonly reported crime among victims with mental illness was assault for both men and women (Pettitt et al. 2013). Although women reported more sexual and domestic violence compared to men.

Figure 16.5   **People with mental ill-health are over-represented among victims of crime[a]**

% of victims of crime who have a mental health condition, compared with the general population

a Victim of assault or break-in in the last 12 months.

Source: ABS (2015b).

The high prevalence of mental illness among victims of crime means that their interaction with victim services (provided by justice departments) can serve as a gateway to mental health and other support services. Establishing links between victim support and mainstream mental health services is necessary to ensure this is efficient and effective.

Supporting victims with mental illness to access mainstream services

State and Territory Governments acknowledge the mental health needs of victims of crime, with each jurisdiction funding victim services that provide counselling (among other supports such as financial assistance) (Chan et al. 2013). Victim services have become increasingly formalised as State and Territory Governments progressively assume greater roles in providing these services (Freeman and Smith 2014). In some States, the number of counselling applications made by victims has been increasing. For example, in New South

Wales, 16 730 counselling applications were lodged in 2017-18 — almost double the number reported five years earlier (NSW Department of Justice 2018).

However, it is desirable for victim services to serve as a gateway to appropriate care in the community. First, timely access to support can be important to prevent mental health and social outcomes from deteriorating. For those with mental illness, the trauma of victimisation can exacerbate existing conditions, leading to critical mental health incidents (Law Council of Australia 2018, p. 25). The impact of crime on victims with mental illness can have adverse impacts on their social outcomes as well:

> … for many people with complex needs [mental illness and cognitive disabilities], victimisation is understood as having multiple flow-on effects across their lives. Victimisation experiences that are not adequately recognised and addressed are seen to ultimately lead to further issues including homelessness, problematic substance use and poor mental health. (Dowse et al. 2016, p. 62)

Second, although victim schemes provide counselling services, they may not be adequate for all victims with mental illness. As noted above, severe mental illness can be prevalent among victims, with evidence suggesting that those with more severe mental illnesses having even higher rates of victimisation (Dowse et al. 2016). Further, victims with mental illness (like other victims) are more likely to experience risk factors such as homelessness, substance abuse and poorer social outcomes, compared to non-victims (Chapple et al. 2004). Counselling services alone may not meet the needs of all victims with mental illness, particularly if they are short-term services. For example, the New South Wales' victim counselling services limits counselling to 22 hours (Victim Services (NSW) 2019), although they can approve more hours.

Finally, victims with mental illness may need support to access mental health services and other community supports. Several reasons can contribute to this, including limited awareness of mental health services and difficulties in communicating and attending appointments (Dowse et al. 2016; McCart, Smith and Sawyer 2010). It is unclear what proportion of victims of crime receive mental health services, however, some overseas studies suggest use is relatively low among victims after the crime has been reported (New and Berliner 2000; Norris and Kaniasty 1990).

For these reasons, it is desirable that State and Territory Governments ensure that this gateway to appropriate mental healthcare and other support is efficient and effective. An approach to ensure this has been proposed in section 16.5.

Barriers to reporting crime and accessing legal rights

Although victims with mental illness can face barriers accessing appropriate care in the community, they can also face barriers reporting crime and thereby accessing their legal rights. Low rates of crime reporting are evident for victims of crime more generally (McCart, Smith and Sawyer 2010), but victims with mental illness can face additional barriers associated with their illness. For example, their mental illness can impact their ability to

explain and retell events properly. Further, victims with mental illness may mistrust or fear authority and the justice system generally (Law Council of Australia 2018). This is often due to previous bad experiences and interactions, discouraging them from reporting crime.

Moreover, where victims with mental illness do report crime to the police, they may not be taken seriously (Karras et al. 2006). Victoria Police (2019, p. 14) said that 'victims/survivors with mental health conditions [who] report abuses to organisations including hospitals and police … may have their story seen as a false report, and/or not have their case proceed to court'. This is because police may view victims with mental illness as 'unreliable informants about their life experiences' (Victoria Police 2019).

Victims of crime with mental illness can also face barriers accessing their legal rights even after reporting the offence. For example, those with mental illness who are victims of crime may face difficulties participating in the victims claims process. Victims with mental illness often have no knowledge of entitlements under victim compensation schemes (Karras et al. 2006). In cases where proceedings have commenced, processes that are not 'trauma-informed' can re-traumatise victims (VLRC 2018). Slow and complex claims processes can further affect their mental health (Collie 2019).

In summary, victims of crime with mental illness can face barriers reporting crime and accessing legal rights. Approaches to promote access to justice and improve justice outcomes for people with mental ill-health, including victims of crime are discussed in the next section.

16.4   Access to justice

People with mental ill-health can find themselves requiring assistance with legal and justice processes in several ways. Legal issues can range from fines, evictions and government payments to criminal charges and as victims (Coumarelos et al. 2012). They can also interact with the justice system as a result of mental health legislation. State and Territory Governments have powers to submit people to involuntary hospitalisation, detention and/or mental health treatment under general mental health laws and in the context of forensic orders, where a defendant is not fit to plead in response to criminal charges (section 16.3).

This section discusses issues where people with mental illness may be denied access to justice and proposes reforms to address them. For the purposes of this inquiry, the Commission uses the term 'access to justice' to mean: ensuring people can effectively resolve their legal issues. It relates to the previous sections insofar as people with mental illness who are offenders and victims interact with the justice system which determines their legal outcomes. However, this section covers a broader range of interactions.

Legal issues experienced by people with mental ill-health

People living with mental ill-health are more likely to find themselves dealing with legal issues than the general population. In 2012, people with disability (physical or mental) were more than twice as likely to experience legal problems (Coumarelos et al. 2012). Of those with a physical or mental disability, 61% had experienced legal problems, compared to 47% of those who did not report any disability. Further, many often face multiple legal problems. As such, people with a physical or mental disability 'stood out' as having a high prevalence of legal problems (Coumarelos et al. 2012).

Legal issues faced by people with mental illness often reflect their financial and social disadvantage, and the incapacity that may be caused by their illness (Karras et al. 2006). These include: legal issues relating to mental illness (such as those under mental health acts and adult guardianship issues); discrimination in relation to employment, education and insurance; housing issues; social security issues and domestic violence and as victims of crime. However, evidence suggests that individuals with mental and physical disabilities are relatively more vulnerable to experiencing legal issues across many different areas including issues related to credit/debt (Coumarelos et al. 2012).

Early intervention — health justice partnerships

Individuals with physical or mental disability tend to seek advice regarding their legal issues, but often face difficulties resolving or finalising them (Coumarelos et al. 2012). There can be multiple reasons for this, including:

- poor knowledge about legal rights and available remedies (Balmer et al. 2010)

- communication problems (Karras et al. 2006)

- health and other non-legal needs that prevent them from resolving legal issues (Coumarelos et al. 2012).

This group is more likely to speak to non-legal advisors about issues that may have legal consequences and, in many instances, approach health or welfare advisors (Coumarelos et al. 2012). However, non-legal services can face challenges in assisting people identify a legal issue or contact relevant legal advisors. They often can lack legal knowledge or knowledge about where to refer the individual (Karras et al. 2006).

Unresolved legal issues can lead to poor mental health outcomes. The most frequent adverse consequence of legal problems is that it leads to stress-related ill-health (Coumarelos et al. 2012). Evidence suggests that there is a significant and strong association between legal problems and mental illness, with people frequently attributing mental illness to legal problems (Pleasence and Balmer 2009). Moreover, legal problems can cause or exacerbate mental illness as well (Coumarelos et al. 2012). The relationship between mental ill-health and legal issues is therefore bi-directional and 'mutually reinforcing' (NSW MHC 2016) —

people with mental illness can face more legal problems compared to the general population, and experiencing legal problems can contribute to deteriorating mental health.

Recognising the interlinked nature of mental health and legal problems, coupled with evidence that individuals often first seek legal advice from non-legal services, there has been movement towards a more 'integrated' approach to better support individuals in need (Coumarelos et al. 2012). Health justice partnerships (HJPs) (also known as medical justice partnerships) embed legal services into healthcare settings. HJPs are early intervention programs at their core, providing a holistic approach to addressing vulnerable individuals who have mental health and legal issues (NSW MHC 2016).

In Australia, there are 48 HJPs in operation, with most located in New South Wales and Victoria (figure 16.6). The structure and nature of HJPs can vary substantially, reflecting differences in local needs. However, common elements include their promotion of integration, early intervention, systemic change and person-centred services. In terms of the legal support they provide, it can vary across a spectrum of needs: from 'advocating for public housing tenants to address untreated mould' to 'assisting people with accumulated fines or debt' (Health Justice Australia 2019, p. 2).

Figure 16.6   Health Justice Partnerships in Australia

Number in operation, by State and Territory, 2017

Source: Adapted from Health Justice Australia (2018).

Qualitative evaluations of HJPs suggest they can improve outcomes, but rigorous evaluations are lacking. Existing analyses suggests that HJPs can improve access to legal advice, build capacity among health professionals to identify legal issues and improve health outcomes for consumers (Ball, Wong and Curran 2016; Beeson, Mcallister and

Regenstein 2013; Redfern Legal Centre 2015). However, the Commission has found a lack of rigorous evaluations that assess the impact of HJPs, particularly in Australia. HJPs appear to offer a promising approach, but more empirical evidence needs to be developed to support the expansion of HJP and improve understanding of elements required for success.

Further, funding constraints and concerns over sharing consumer information can challenge the operation of HJPs. Youth Law Australia (sub. 433) said that the greatest barrier to establishing a national HJP was funding — noting that a well-resourced program would require professional staff with training in identifying legal issues. Kingsford Legal Centre (sub. 469) also submitted that lack of funding was restricting their ability to provide specific mental health legal services. Further, concerns have been raised over sharing client information between health and legal services. This can impede communication within HJPs, and limit their ability to operate as intended (Speldewinde and Parsons 2015).

Notwithstanding, many inquiry participants indicated their support for HJP approaches including Victoria Legal Aid (sub. 500), Mental Health Legal Centre (sub. 315) and the Australian Psychological Society (sub. 543).

The Productivity Commission sees value in better integrating legal and health services, and observes that many programs show promise. However, before they can be expanded more widely, more empirical evidence needs to be developed to analyse the impact of HJPs and similar initiatives. The Australian, State and Territory Governments could coordinate and fund evaluations of HJPs to improve the evidence base for these programs. HJPs could be an area prioritised for further evaluation and research (chapter 25).

DRAFT FINDING 16.4 — HEALTH JUSTICE PARTNERSHIPS

Approaches to integrate health and legal services, such as health justice partnerships, show promise in helping people access legal support early and thereby reduce risks to mental health. Existing analysis suggests health justice partnerships can help people access legal support early and improve mental health, but empirical evidence is lacking.

Participating in the justice system

People with mental illness often face barriers to participating in the justice system. These barriers can prevent people from: initiating legal proceedings in the first instance; as well as effectively participating in proceedings once they have commenced (Karras et al. 2006).

Initiating legal proceedings

People with mental illness can face barriers to initiating legal proceedings. Many people with serious mental illness are financially disadvantaged, and therefore more reliant on legal aid, community legal centres and pro bono legal advice (Karras et al. 2006). It is well recognised

that resource constraints exist in the legal assistance sector including specialist disability legal services (Law Council of Australia 2018; PC 2014). This has particular implications for people with mental illness who may require more intensive support. For example, they may have difficulties communicating, requiring more time with lawyers (Karras et al. 2006). In some instances, legal services may have to refer people with mental illness on to other services because they do not have resource to assist themselves.

Different initiatives aim to address barriers to initiating legal proceedings for those with mental ill-health. This includes the establishment of specialist mental health legal centres that employ solicitors with communication skills necessary to work with people who have a mental illness (Karras et al. 2006). Examples include Victoria's Mental Health Legal Centre and Western Australia's Mental Health Law Centre. Additionally, legal aid and community legal centres are providing training on mental illness to their solicitors, including on how to identify mental illness and how to work with people with mental illness (Karras et al. 2006).

Participating in legal proceedings

People with mental illness can face barriers to participating in legal proceedings due to the inflexible and adversarial nature of courts. The ACT Government (2019b, p. 10) stated that the justice system 'is at its core an adversarial one … as such it is not a system designed for people who experience any degree of complexity in demonstrating legal capability such as people with [physical and mental] disabilities'. And Karras et al. (2006, p. 153) said:

> … it is apparent that people with a mental illness have particular needs that must be addressed during the legal process. They might need more time to communicate, breaks in proceedings in order to address anxiety and stress, and clarification of the process itself.

Legal processes that offer alternative dispute resolution (ADR) can be more informal and flexible, however, they often rely less on legal representation, which may not be beneficial for people with mental illness (Karras et al. 2006). Many people with mental illness do not participate as effectively in the legal system (at court and in ADR) without appropriate legal representation. Another approach to address this is to provide case management throughout the legal process. Case management can provide an individualised service, increasing the participation of individuals. Additionally, it can improve the efficiency of proceedings by reducing delays (Karras et al. 2006).

Negative attitudes and stigma within the legal system can also act as an additional barrier. The Law Council of Australia (2018, p. 34) found that 'people with [mental and physical] disability continue to face negative stigma, prejudice and discrimination, which creates significant barriers to accessing justice'. This prejudice against people with mental illness can be seen across multiple areas in the justice system including police and courts. For example, people with mental illness are often not viewed as 'credible' victims (section 16.4) or witnesses (Karras et al. 2006).

Providing adequate training to staff working in the justice system can help challenge negative stereotypes about mental illness (Law Council of Australia 2018). The importance of training in ensuring access to justice for people with mental disabilities is recognised internationally and locally. However, there are concerns that training currently received by workers in the justice system is inadequate (Law Council of Australia 2018). In some States, independent support is provided to victims who may have mental ill-health report crime. For example, Victoria's *Intermediary Pilot Program* places communication specialist intermediaries in police interviews with victims and at court. The program aims to support individuals with a range of needs including mental ill-health and complex trauma (Victoria Justice and Regulation 2018; Victoria Police 2019).

The need for disability justice strategies

There are a range of different programs and initiatives that can alleviate the barriers discussed above, including: establishing mental health legal centres, case management, providing adequate training to staff working in the justice system and involving independent intermediaries in police interviews and courts. Recognising that a range of initiatives and programs exist to promote access to justice for people with mental illness, assessment of these programs is beyond the scope of this inquiry.

It is desirable for State and Territory Governments to adequately fund and support programs that have been shown to be effective in promoting access to justice for people with mental illness. A mechanism through which this could be achieved is through 'disability justice strategies'. The Australian Human Rights Commission (2014, p. 6) recommended State and Territory Governments each develop a 'Disability Justice Strategy' that provides a holistic, over-arching response and sets actions to implement. Not all jurisdictions have established these strategies. It is unclear why. In the Commission's view, State and Territory Governments should develop and implement disability justice strategies to ensure the rights of people with mental illness are promoted in the justice system.

Notwithstanding, in some circumstances, justice systems can be gateways to appropriate care in the community for some people with mental illness (sections 16.3 and 16.4). This should be acknowledged in disability justice strategies to holistically support the needs of people with mental illness. The Australian Capital Territory's *Disability Justice Strategy 2019–29* has 'better service delivery' as a focus area, including effectively linking the justice system with human services in the community to provide more 'complete' services and supports, benefiting the individual (ACT Government 2019a).

Legal representation in mental health tribunals

All State and Territory Governments have mental health legislation that enables the involuntary commitment and treatment of people suffering acute psychiatric illness (RANZCP 2017f). This can include enabling persons to be subject to involuntary electro-convulsive treatment.[104] In most cases, mental health tribunals determine whether or not compulsory mental health treatment (as set out in legislation) applies to persons appearing before them. In South Australia and the Australian Capital Territory, civil and administrative tribunals hear these applications (RANZCP 2017f). This chapter uses 'mental health tribunal' as an umbrella term that covers all tribunals that deal with matters under mental health legislation.

Concerns have been raised that people appearing before mental health tribunals often do not have legal representation. Victoria Legal Aid (sub. 500, p. 15) said 'data from the Victorian and New South Wales Mental Health Tribunal Annual Reports indicates that legal representation was provided in 15% of hearings in the Victorian Mental Health Tribunal … [compared to] 70% of hearings in the NSW Mental Health Tribunal.'

Evidence suggests that outcomes can be materially different if people are legally represented. The Law Council of Australia (2018) found that approval rates for electro-convulsive treatment can drop from 70% to 50% if the person is legally represented. There may be several reasons for this, but it is likely that legal representation can help people with mental illness better present their cases. People with mental illness can often face difficulties representing themselves, either because of their illness itself or other communication barriers (Law Council of Australia 2018). As noted in the previous section, this can apply to more informal and flexible settings (such as tribunals) as well as in courts (Karras et al. 2006).

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[104] Electro-convulsive treatment is a medical procedure that is used to treat a range of mental illnesses. The treatment induces controlled seizures by placing small electrodes at specific locations on the head.

A lack of legal aid can be a key reason why people with mental illness cannot access legal representation in mental health tribunals. The Mental Health Law Centre in Western Australia, Queensland Advocacy Incorporated and the Northern Territory Legal Aid Commission have stated they face difficulties providing assistance to individuals most in need (including those appearing before mental health tribunals) due to low levels of resourcing (Law Council of Australia 2018; Northern Territory Legal Aid Commission, sub. 410). In this regard, a review of South Australia's mental health act said increased legal assistance should be considered (Corkhill 2014). Even where mental health-focused legal assistance services are provided, resourcing constraints in the broader justice system can place pressure for expedient resolution of cases (Law Council of Australia 2018).

Given persistent difficulties in lifting the resourcing of the overall legal assistance sector, one option is for State and Territory Governments to provide grants to legal assistance providers specifically for cases under mental health legislation. This could be modelled on the approach taken under the National Disability Insurance Scheme (NDIS), where funding (that is separate from other legal aid funding) is made available to legal aid commissions for NDIS Appeals. In particular, grants decisions are made with consideration of the applicant's capacity to self-represent or obtain other legal assistance (DSS 2018j).

DRAFT RECOMMENDATION 16.6 — LEGAL REPRESENTATION AT MENTAL HEALTH TRIBUNALS

In the medium term (over 2 – 5 years)

State and Territory Governments should adequately resource legal aid services to assist people appearing before mental health tribunals and other tribunals that hear matters arising from mental health legislation. This could be addressed through broader legal aid funding or providing a specific legal aid grant.

Advocacy for people receiving involuntary treatment

The aims of State and Territory mental health legislation — although expressed differently — are to ensure that people are provided treatment and care with minimal restriction to their freedom (*Mental Health Act 2014* (WA)). Mental health legislation can be viewed as a 'catalyst for reform', seeking to promote supported-decision making, less restrictive treatment, autonomy, dignity, holistic care and the meaningful involvement of carers (VMHT 2019, p. 4).

Victoria Legal Aid submitted to this inquiry that where individuals are at risk of, or subject to, compulsory treatment, their participation in treatment decisions should be actively promoted. This can ensure treatment imposes the least possible restriction of an individual's freedom, as intended by mental health legislation. Although treating professionals and others may aim to objectively consider the 'best interests' of the individual subject to the order, it is important to, wherever possible, support that person to represent their wishes in decision-making (Victoria Legal Aid, sub. 500, attach. 1). This is aligned with the broader principle that consumers should be involved in their treatment (ACSQHC 2017b).

However, in practice, individuals subject to compulsory treatment may face difficulties participating in treatment decisions. Consumers (under treatment orders) have identified instances where mental health services have not provided treatment information, or adequately explained treatment to them (Victoria Legal Aid, sub. 500, attach. 1). Victoria's Mental Health Complaints Commissioner (2019, p. 36) said that:

> [it] is clear from complaints to the MHCC that many people receiving treatment, particularly compulsory inpatient treatment, do not receive sufficient support to exercise their right to make decisions about their mental health treatment.

Individual non-legal advocacy services can ensure the rights of people subject to compulsory treatment orders are better protected. They are provided by professionals from a range of backgrounds (including consumer advocacy and social work) who can empower patients, by advising on their rights, representing their wishes in day-to-day decision making, and identifying and addressing issues (WA MHAS 2019; Victoria Legal Aid, sub. 500, attach. 1). However, it should be recognised that non-legal advocacy services compliment legal services. They are not a substitute. For example, non-legal advocates are not trained to interpret mental health legislation and cannot provide legal representation at hearings.

All State and Territory Governments fund non-legal advocacy services which assist people who are subject to, or facing the prospect of, involuntary treatment. However, service delivery models can differ across jurisdictions.

- New South Wales and Victoria provide these services through parts of the state legal aid commissions (separate to the legal teams).

- Queensland and Tasmania provides these services through separate incorporated entities with both State and Australian Government funding.

- South Australia and the ACT provides these services through their Office of the Public Advocate.

- Western Australia provides these services through the Chief Mental Health Advocate, which is a statutory office.

- The Northern Territory provides these services through its Community Visitor Program.

It is difficult to assess the effectiveness of non-legal advocacy services consistently and holistically. However, in 2017, Victoria Legal Aid commissioned an evaluation of the Individual Mental Health Advocacy (IMHA) service. The evaluation was primarily qualitative, and cannot be used to determine a positive causal effect of the service. However, consumers valued the service, even where their desired outcomes were not met in tribunal processes (Victoria Legal Aid, sub. 500, attach. 1). The majority of consumers reported their capacity to self-advocate was improved through working with the IMHA.

Despite non-legal advocacy services being highly valued by consumers subject to compulsory treatment, there are concerns these services are unable to meet consumer demand, due to under-resourcing. For example, the evaluation of the IMHA found barriers to its continued success were particularly around resourcing (Victoria Legal Aid, sub. 500, attach. 1). The IMHA needs 'twice as many advocates' to ensure access within the current system. In Western

Australia, individuals are appointed an advocate as soon as they are subject to an involuntary hospitalisation or treatment order (unless they opt out) (*Mental Health Act 2014* (WA)). However, concerns of under-funding have been raised (WA MHAS 2018).

There is merit in State and Territory Governments ensuring non-legal advocacy services are adequately funded. This would facilitate supported decision-making by individuals subject to orders and provide assistance to individuals who require it. There should be consideration to integrate non-legal advocacy with legal advocacy, rather than replace it. Non-legal advocates are not lawyers and are not trained in interpreting mental health legislation. As discussed in the previous section, legal representation can ensure individuals receive the best presentation of their case (before the mental health tribunal) in the first instance.

The cost of non-legal advocacy services would vary depending on the number of involuntary treatment orders made. The number of compulsory orders varies by State and Territory (table 16.8), although are consistently small as a proportion of the population.

Table 16.8   **Estimated involuntary treatment orders, 2017-18[a]**

	Estimated number of involuntary treatment orders
New South Wales	5676
Victoria	6127
Queensland	4324
South Australia	840
Western Australia	4154
Tasmania	429
Northern Territory	444
Australian Capital Territory	607

a These are estimates based on statistics from State and Territory Government annual reports and are not directly comparable. There are variations across jurisdictions in the way involuntary treatment orders are defined. For example, in Queensland they are referred to as 'treatment authorities' and in the Northern Territory they are referred to as 'order for involuntary detention mental illness' and 'community management order'.

Source: Australian Capital Territory Civil and Administrative Tribunal (2018); New South Wales Mental Health Review Tribunal (2018); Northern Territory Mental Health Review Tribunal (2018); Queensland Department of Health (2018); South Australia Civil and Administrative Tribunal (2018); Tasmania Mental Health Tribunal (2018); Victoria Mental Health Tribunal (2018); Western Australia Mental Health Advocacy Service (2018).

The Commission has estimated the cost of funding non-legal advocacy services by referring to expenditure by Western Australia's Mental Health Advocacy Service (WA MHAS). The expenditure for the WA MHAS was $2.7 million in 2017-18, with the cost of advocates comprising 70.4% of this (WA MHAS 2018, p. 50). Given that the WA MHAS issued 4154 involuntary treatment orders during that period (WA MHAS 2018), the estimated cost of advocates per order is less than $500 on average. The cost of non-legal services is therefore estimated to be relatively small compared to the likely cost of the individual's mental health treatment.

DRAFT RECOMMENDATION 16.7 — NON-LEGAL INDIVIDUAL ADVOCACY SERVICES

In the medium term (over 2 – 5 years)

State and Territory Governments should ensure that non-legal individual advocacy services are available for all individuals subject to involuntary treatment under mental health legislation. In particular, services should:

- focus on facilitating supported decision-making by individuals subject to orders
- be resourced to provide assistance to all individuals who require it
- integrate with rather than replace legal advocacy services.