

Submission by: Association of Counselling Psychologists (ACP)

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**The Social and Economic Benefits of Improving Mental Health
Productivity Commission Mental Health Inquiry (April 2019)**

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The author, on behalf of the Association of Counselling Psychologists (ACP), thank the Productivity Commission for the opportunity to contribute to the current Mental Health Inquiry. The Association of Counselling Psychologists (ACP) represents members across Australia, promoting and advocating counselling psychology as a field of psychological practice. Counselling psychologists can be found in a range of settings offering Medicare rebated treatment within government and non-government organisations, hospitals, educational institutions and private practice. Counselling Psychologists provide assessment, formulation, diagnosis, treatment and management of psychological problems across the whole spectrum of mental health disorders, including providing services to people with permanent, complex and significant disabilities at the moderate to severe end of the spectrum. The following submission does not address all the questions raised in the Productivity Commission Issues Paper. The Productivity Commission inquiry into improving mental health is broad ranging and covers a number of areas impacting on the mental health of the Australian population. This submission focuses only on addressing those questions within the scope and expertise of the profession of counselling psychology.

Counselling Psychology

Psychology as a discipline and profession has a fundamental role to play in mental health services. Psychology is a regulated health profession under the authority of the Australian Health Practitioner Regulation Agency (AHPRA) and the Psychology Board of Australia (PsyBA). Registration with the PsyBA is essential to practice as a psychologist in Australia, and psychologist titles are protected.

For general registration as a psychologist a four-year undergraduate degree in the science of psychology plus either a two-year supervised internship (known as the 4 + 2 pathway), or a

further one-year accredited Master Degree and one year of internship (known as the 5 + 1 pathway), is required. Psychologists with higher levels of education and training beyond a one-year Master Degree can be endorsed in nine areas of specialisation following the completion of a registrar program.

Counselling psychology is an area of practice that specialises in the assessment, diagnosis, treatment, and management of serious, chronic, and complex mental health disorders. The ACP represents those counselling psychologists who hold or are working towards, the minimum education and training for endorsement as a counselling psychologist as determined the PsyBA. ie at least an accredited two-year Master's Degree in counselling psychology, followed by a two-year registrar program. ACP full members have therefore completed a minimum of eight years of accredited education and training.

Accreditation of psychology education and training programs occurs via the Australian Psychology Accreditation Council (APAC) to ensure compliance with the Accreditation Standards for Psychology Programs (the Standards) (2019)

The Productivity Commission's Mental Health Inquiry provides an unprecedented opportunity for a comprehensive review of mental health services in Australia. The inquiry's broad approach to reviewing the provision of mental health services and inclusion of other psychosocial sectors, including education, housing, employment, social services and justice, is to be commended. This approach is consistent with a holistic philosophy which provides whole-person care that supports mental health alongside other biopsychosocial aspects, rather than mental health being addressed in isolation. Mental-health is about more than the absence of mental illness. Good mental-health is a key determinant of other outcomes. People are more than a diagnosis and effective mental health services recognise this. The current inquiry acknowledges the whole person and provides the potential for a much-needed paradigmatic shift in mental health care in Australia.

Overview – Systemic Issues

Is a paradigm shift needed in the way we view and deliver mental health services in general?

“Mental health and many common mental health disorders are shaped to a great extent by social, economic and physical environments in which people live”. (World Health Organization & Calouste Gulbenkian Foundation, 2014). Social determinants of mental health include education, employment and working conditions, built environment, physical environment, housing, gender, culture, ethnicity, safety, social connectedness, income, early childhood development, health and social services.

The Productivity Commission document clearly outlines the economic, societal and personal costs of the under delivery of appropriate person-centred mental health services on Australian society. It also highlights that the current system lacks effective outcomes in part due to a continuation of diagnostic specific siloed services, limited continuity of care and ultimately a lack of responsibility/accountability of service providers.

Naylor, Taggart and Charles (2017) argue that developing more integrated approaches to mental health should be a key priority given the close links between mental health and physical health outcomes, and the impact these have on the quality and costs of care. It is well established that when the mental health needs of people with physical health conditions are not adequately addressed, this increases costs and undermines patient outcomes.

The current mental-health care system results in identified gaps of support - which our most vulnerable members of society fall through regularly. That is, marginalised populations, LGBTQI+, Aboriginal and Torres Strait Islander peoples and people from CALD backgrounds. In addition, those with complex systemic needs who are at risk of developing mental health

concerns often struggle to receive the psychological and holistic care they need, and people with acute presentations are regularly discharged from inpatient care without adequate support systems in place. The burden and cost to Australian society and the economy is clearly evident.

Naylor, Taggart and Charles (2017) state that mental health care is often disconnected from the wider health and social care system – institutionally, professionally, clinically and culturally. Artificial boundaries between services mean that many people do not receive co-ordinated support for their physical health, mental health and wider social needs, and instead receive fragmented care that treats different aspects of their health and wellbeing in isolation. Figure 1 illustrates some of the groups of people who frequently suffer as a result.

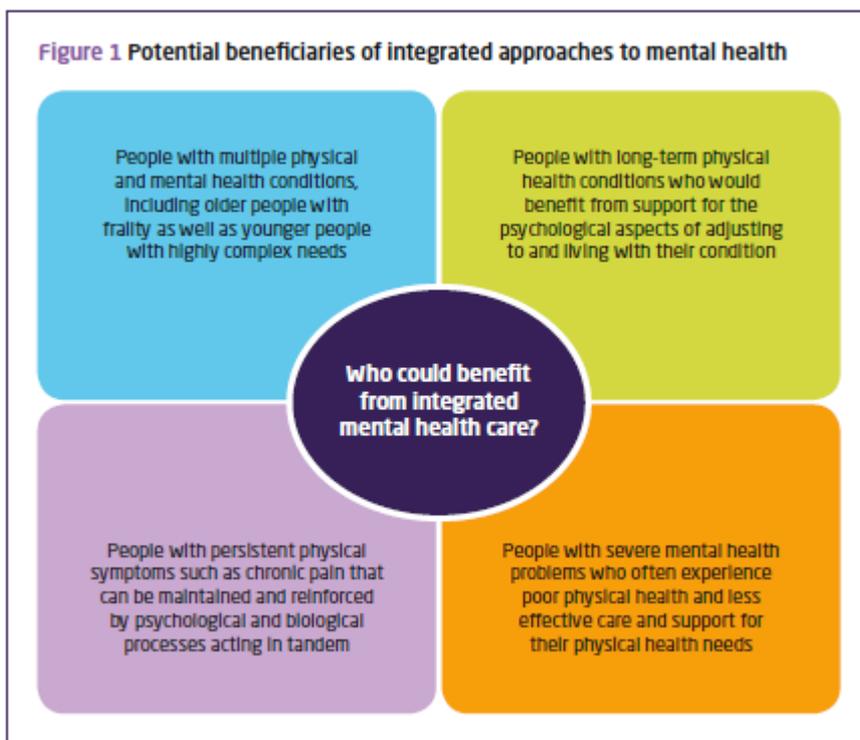


Figure 1

There are well documented fundamental problems with the over simplification of the current medical /psychiatric/ disease model where an individual's distress is seen as a form of pathology, with unidentified biological factors that link to symptom clusters and diagnosis. An individual is much more than their diagnosis.

Unfortunately, the biomedical process often results in a loss of individual agency, increased stigmatization and negative effects of medications. Diagnostic inflation is a well-researched phenomenon, whereby a large percentage of presentations for mental health concerns to front line GP's result in prescriptions for psychiatric medication with limited assessment, limited outcomes and/or no remittance of symptoms.

By strictly adhering to the biomedical model as a primary explanation of a person's distress, we risk dismissing the individual's circumstances and personal story. This approach focusses on what is wrong with the person, rather than what has happened to them.

We have lost sight of the multiple factors that may contribute to an individual's distress. Many of these factors are highlighted in the PC report. Addressing this shortfall in our current system requires a paradigm shift in all areas of mental health assessment, diagnosis formulation, treatment and evaluation to a holistic and systemic person-centred approach, that utilises a stepped model of care focussing on the individual's needs in relation to their own unique story.

Stepped care is an inherently recovery orientated model that identifies mental health as a continuum of psychological distress and recognises that all of us may move through these times of distress to wellness throughout the lifespan.

While the medical model needs to remain the centre-piece of health and mental-health care in Australia, we also need to take into account other non-symptom specific social determinant realities in an individual's life and apply a multifactorial approach to mental health.

This is particularly evident for marginalized communities including our Indigenous population.

“despite contemporary definitions of ‘mental health’ incorporating the notion of being ‘not simply the absence of mental illness’ and existing along a spectrum that includes ‘positive mental health’ currently the discipline is still predominantly focussed on psychopathology and mental health disorders, with the notion of positive mental wellbeing yet to be really well defined. We believe that situating mental health within an Aboriginal and Torres Strait Islander SEWB framework is more consistent with the view that Aboriginal and Torres Strait Islander concepts of health and wellbeing prioritise and emphasise wellness, harmony and balance rather than illness and symptom reduction”. (Dudgeon, Milroy & Walker, 2014, p. 64).

We are proposing the following models as a better way to understand and treat the person and their distress/diagnosis:

Integrated Mental Health Care Model

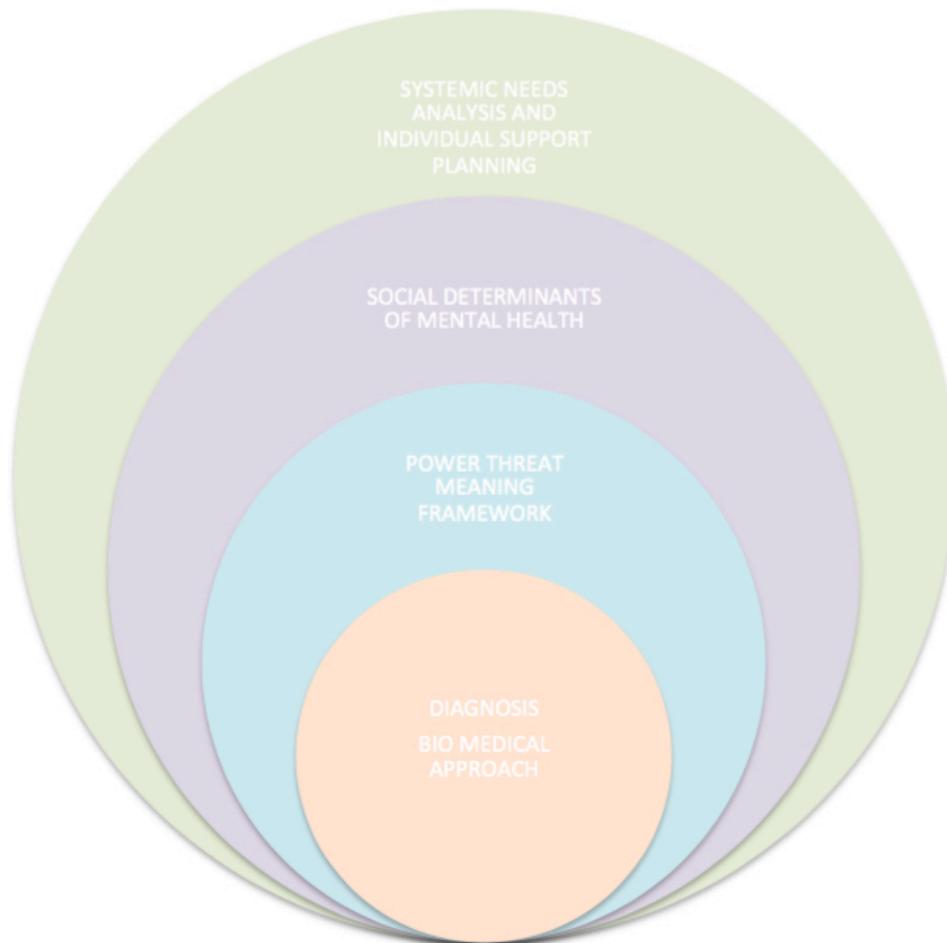


Figure 2: PTMF

Power Threat Meaning Framework

- The Power Threat Meaning Framework (PTMF) (Johnstone & Boyle, 2018) has been rigorously validated through collaboration with people with lived experience of mental health disorders. “In summary, this framework for the origins and maintenance of

distress replaces the question at the heart of medicalisation, ‘What is wrong with you?’ with four others: What has happened to you? (How has Power operated in your life?).

- How did it affect you? (What kind of Threats does this pose?).
- What sense did you make of it? (What is the Meaning of these situations and experiences to you?)
- What did you have to do to survive? (What kind of Threat Response are you using?)” (Johnstone & Boyle, 2018, p. 190-191).

“A key purpose of the PTM Framework is to aid the provisional identification of evidence-based patterns in distress, unusual experiences and troubled or troubling behaviour. In contrast to the specific biological causal mechanisms which support some medical disorder categories, these patterns are highly probabilistic, with influences operating contingently and synergistically. However, this does not mean that no regularities exist. Rather, it implies that these regularities are not, as in medicine, fundamentally patterns in biology, but *patterns of embodied, meaning-based threat responses to the negative operation of power*” (Johnstone & Boyle, 2018, p. 191).

Furthermore, the following is a narrative summary of the Foundational Power Threat Meaning Pattern: *“Economic/social inequalities and ideological meanings which support the negative operation of power result in increased levels of insecurity, lack of cohesion, fear, mistrust, violence and conflict, prejudice, discrimination, and social and relational adversities across whole societies. This has implications for everyone, and particularly those with marginalised identities. It limits the ability of caregivers to provide children with secure early relationships, which is not only distressing in itself for the developing child, but may compromise their capacity to manage the impact of future adversities. Adversities are correlated, such that their occurrence in a person’s past and/or present life increases the likelihood of experiencing subsequent ones. Aspects such as intentional harm, betrayal, powerlessness, entrapment and*

unpredictability increase the impact of these adversities, and this impact is not just cumulative but synergistic. Over time, the operation of complex interacting adversities results in a greatly increased likelihood of experiencing emotional distress and troubled or troubling behaviours. The form of these expressions of distress is shaped by available resources, social discourses, bodily capacities and the cultural environment, and their core function is to promote emotional, physical and social safety and survival. As adversities accumulate, the number and severity of these responses rises in tandem, along with other undesirable health, behavioural and social outcomes. In the absence of ameliorating factors or interventions, the cycle is then set up to continue through further generations.” (Johnstone & Boyle, 2018, p. 195). The above reinforces the need for preventative measures and early intervention at a systemic level to retard the development of mental health disorders and provide timely treatment – both of which are key objectives of this Productivity Commission inquiry.

Systemic Needs Assessment - Social Determinants Approach

Adapted from STREAM- Systemic Therapeutic Relational Empowerment and Advocacy Model (Smith, 2016).

A Systemic Needs Assessment (SNA) is a holistic and systematic process for determining and addressing needs, or "gaps" between current conditions and desired conditions for the individual. The discrepancy between the current condition and best outcome condition must be defined to appropriately identify the need (see figure 3).

A comprehensive report is completed that covers the following 8 domains of functioning and defines and highlights areas of support needed:

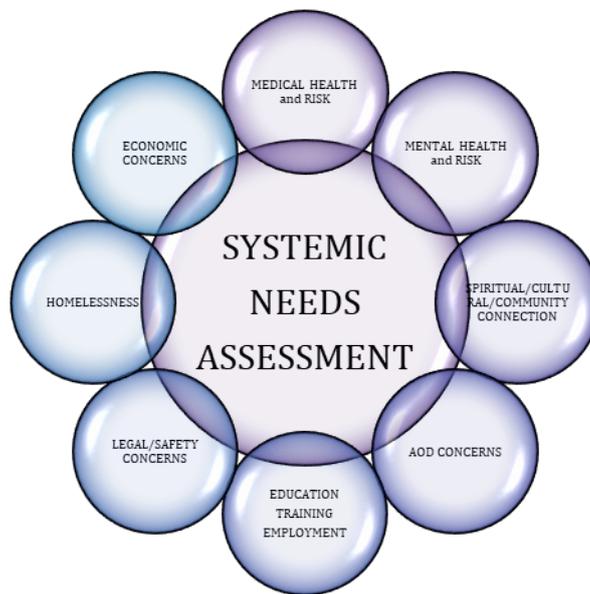


Figure 3

The SNA process also enables prioritization of the safety, psychological, physical and medical health needs of the individual.

Individual Support Planning (ISP)

Person centred care is realized through the development of Individual Support Plans (ISP) and actively facilitating connections and engagement, navigating, advocating, mentoring and supporting the client to systemically re-connect with all required support networks that meet the needs of the individual in an integrated process.

Regular review is vital to refining and retuning the ISP to meet the changing support needs of the individual over time over time and can be integrated into the stepped care model.

The circular flow diagram below highlights the development, implementation and review process of the ISP (figure 4):

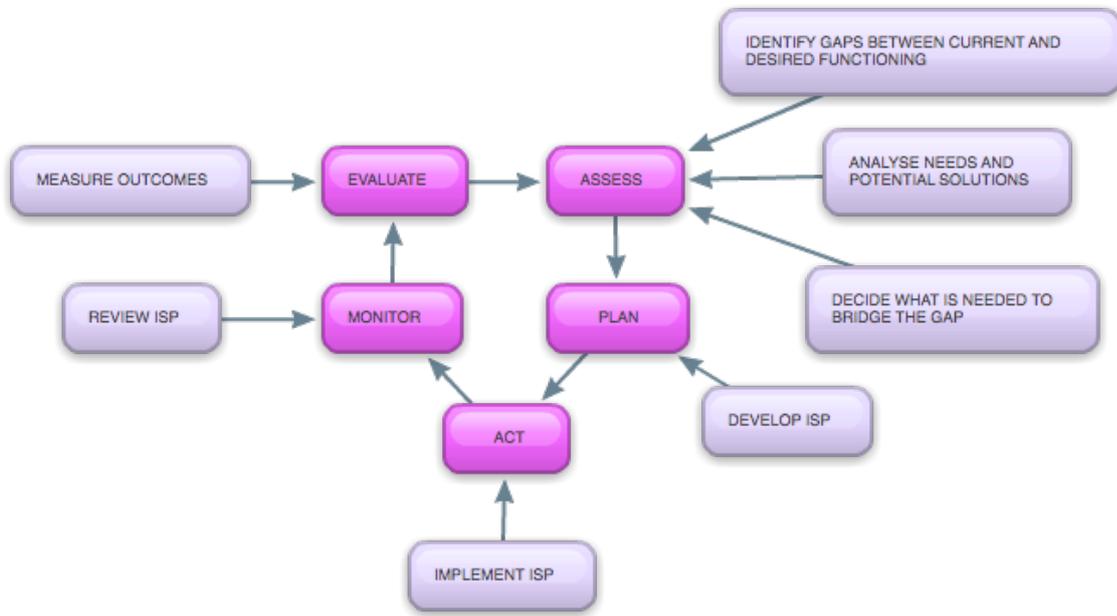
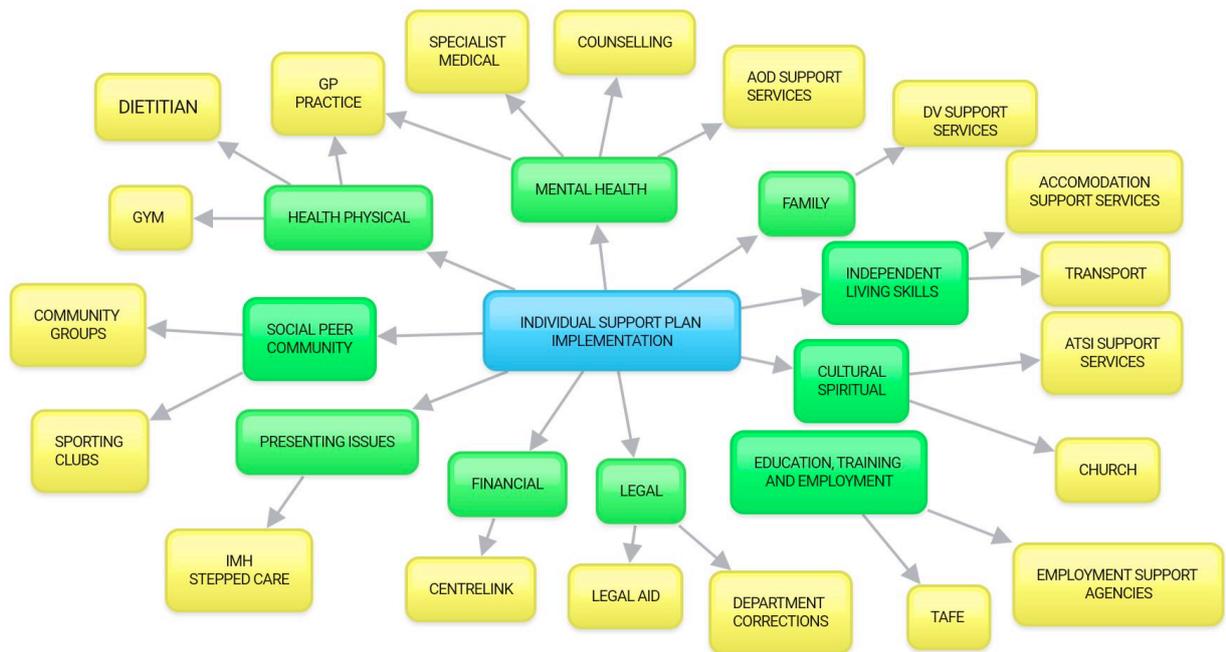


Figure 4

An example of an ISP and potential pathways to support solutions on all domains is as follows:



created with www.bubbl.us

Figure 5: Individual Support Planning Template

QUESTIONS BEING ADDRESSED BY THE PRODUCTIVITY COMMISSION ISSUES PAPER

QUESTIONS ON ASSESSMENT APPROACH: (p. 10)

Q. What suggestions, if any, do you have on the Commission's proposed assessment approach for the inquiry? Please provide any data or other evidence that could be used to inform the assessment.

- The Productivity Commission's inquiry into mental health care in Australia is timely and to be commended. The issues raised for consideration are significant and indicate that structural change is required. This implies both a paradigmatic shift in the approach to mental health care in Australia, and a renewed approach to the provision of services to include other social determinants of mental health. There are currently a number of effective mental health services in Australia (e.g. the Medicare Better Access Program). However, established mental health systems and services need to be refined and expanded to include a broader understanding of the underlying causes of mental health disorders and the various factors that contribute to recovery. There is room for improvement and a need to ensure efficiencies in terms of health, economic and productivity outcomes. Please see previous section: "Overview – Systemic Issues" for further elaboration.

QUESTIONS ON STRUCTURAL WEAKNESSES IN HEALTHCARE: (p. 13)

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

- Please see previous section: “Overview – Systemic Issues” above.

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

- The medical model fails to account for social determinants of health and mental health and wellbeing. Long term improvement in population mental health requires a paradigmatic shift that considers the biopsychosocial aspects of mental illness and a health system based on collaborative care. Please see previous section: “Overview – Systemic Issues” for further elaboration.

QUESTIONS ON SPECIFIC HEALTH CONCERNS: (p. 16)

Q. Should there be any changes to mental illness prevention and early intervention by healthcare providers? If so, what changes do you propose and to what extent would this reduce the prevalence and/or severity of mental illness? What is the supporting evidence and what would be some of the other benefits and costs?

- Yes there should be changes to mental illness prevention and early intervention by healthcare providers.
- With regard to psychology services provided under the Medicare Better Access Program, currently under scrutiny as part of the MBS Review, new item numbers allowing for individuals and groups to access preventative/early intervention psychological services would enable people to seek appropriate and timely

community-based psychological services, rather than having to wait, and risk becoming significantly unwell and distressed.

- There are a number of research papers postulating the benefits of early intervention with regard to reducing severity and duration of episodes of mental illness where these issues tend to be episodic in nature such as Bipolar Mood Disorder (e.g. Berk, Brnabic, Dodd, Kelin, Tohen, Malhi, Berk, Conus & McGorry, 2011; Berk, Hallam, Malhi, Henry, Hasty, Macneil, Yucel, Pantellis, Murphy, Vieta, Dodd & McGorry, 2010; Berk, Malhi, Hallam, Gama, Dodd, Andreatza, Frey & Kapczinski, 2009; Conus, Macneil & McGorry, 2013; Muneer, 2016; Taylor, Bressan, Pan Neto & Brietzke, 2011).
- Research also suggests that early intervention – both in terms of age and stage of illness - may lead to lower rates of recurrence following recovery in depressive disorders (Clarke, Rohde, Lewinsohn, Hops & Seeley, 1999 & Jarrett, et al, 2001).
- Hetrick, Parker, Hickie, Purcell, Yung and McGorry (2008) argue that “the identification of the subsyndromal and prodromal stage of depressive disorders provides the opportunity for early intervention” and that stage-appropriate treatment, “may delay or prevent onset, reduce severity, or prevent progression in the course of the depressive disorder.” In addition, it is suggested that by identifying and treating depressive disorders early – other comorbid disorders such as substance abuse and suicidality, may be reduced.
- There is also considerable evidence for better long-term prognosis for individuals when treatment is accessed soon after initial symptom presentations (e.g. early intervention for psychosis). In addition, when detected and treated early, treatment options, other than drug therapies (i.e. CBT), can be effective (Bechdolf, Wagner & Klosterkotter, 2006; Phillips et al., 2009). There is an implied cost saving associated

with early intervention and the use of non-drug therapies. According to the most recent web report from Mental Health Services in Australia (MHSA) last updated on 22 March 2019, four million people received mental health-related prescriptions in 2016-17.

- GPs, school psychologists and employee services are best placed to undertake the early identification of disorders such as psychosis, Bipolar Disorder and Major Depression. Adequate training in the identification of subsyndromal and prodromal symptoms and appropriate referral pathways for these groups is essential.
- The “Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform” final report provides an outline of the cost savings of early intervention and recommends three specific areas of need, namely: “people with physical and mental health co-morbidities”, “groups at risk of prolonged mental ill-health” and “e-mental health interventions” (Mental Health Australia and KPMG, 2018, p. 57).
- This same report notes that “ROI for mental health is greatest where the interventions are provided to those with mild or emerging mental health conditions.” (Mental Health Australia and KPMG, 2018, p. 58). Psychology services provided under the Medicare Better Access Program are primarily aimed at this cohort – the implication being that the Better Access Program has the potential for the greatest ROI in mental health services in Australia. As stated above, reform of this program, as part of the MBS Review, is currently underway and aims to improve economic and outcome efficiencies.
- In addition, The Department of Health (2010) paper on “Effect of Better Access on interactions between GPs and psychologists” reports that the Better Access Program

has led to improved patient outcomes by encouraging collaborative practice between GP's and psychologists. The implication of this being that people are able to access community-based services through Better Access and, through collaborative care between their GP and psychologist, achieve positive outcomes – avoiding more severe symptomology and protracted inpatient treatment.

- While early intervention soon after first episode/diagnosis/return of symptoms is essential to avoid more complex, long term mental health disorders, appropriate intervention in the early years of life also has the potential to ameliorate the development of more severe symptoms and provide both health and economic benefits.
- Currently, parents and families of patients with a mental health diagnosis cannot access subsidised interventions. This limitation is problematic for several reasons: (i) parent-focused interventions are a core feature of various evidence-based treatments for childhood mental health conditions (e.g., David-Ferdon & Kaslow, 2008; Evans, Owens, & Bunford, 2014; Eyberg, Nelson, & Boggs, 2008; Keel & Haedt, 2008; Silverman, Pina, & Viswesvaran, 2008); (ii) the cost-benefit pay-off is higher with parent and family inclusion in child and adolescent treatments (Haine-Schlagel & Walsh, 2015; Karver, Handelsman, Fields, & Bickman, 2006); and (iii) there is clear evidence that early intervention is optimally achieved when parent and family-based intervention packages are delivered at developmentally appropriate times (Britto et al., 2017). Parental participation in child treatments consistently produces improvements in childhood treatment outcomes (Dowell & Ogles, 2010). Moreover, when offered in community and group settings, parenting-based interventions are more cost-effective than child-only treatments since they reduce the risk of repeat admissions and referrals (Duncan, MacGillivray, & Renfrew, 2017; Lo, Das, & Horton, 2017; Mihalopoulos et al., 2015; Wright et al., 2015).

- The inclusion of new MBS item numbers enabling parents and kinship groups to access psychology services could lead to improved outcomes for children and family groups.

Q. What changes do you recommend to healthcare to address the specific issues of suicides and comorbidities among people with a mental illness? What evidence is there to support your suggested actions and what types of improvements would you expect in terms of population mental health, participation and productivity?

- There are several organisations across Australia involved in researching and conducting prevention and postvention activities related to suicide and mental health.
- Suicidal ideation and attempts can occur within the context of several mental health disorders (e.g. depression, Bipolar Disorder, PTSD, substance abuse, personality disorders), and risk levels can change quickly. In such situations, removing barriers to accessing appropriate treatment is central to saving lives.
- Two suggestions are made here to assist with this issue:
 - Allow phone sessions to be included in the MBS list of items for psychological services irrespective of the residential address of the client and their treating psychologist (currently, phone sessions are only available for clients in sufficiently rural and remotely locations). A common complaints made by clients about using suicide phone lines and websites is that they have to speak to a stranger – this is a considerable barrier at point in time when an individual already feels utterly overwhelmed. Being able to speak to someone with whom they have a pre-existing relationship may make a significant difference to whether they reach out for help.

- Improve collaborative care models within mental health services in Australia, (e.g. approve an MBS item for psychologists to be involved in case conferencing). This would assist in comprehensive support, case conceptualisation and treatment alignment between psychologists working in a private practice setting and other mental/health services when they have a client in common. Increased alignment across services is more likely to result in collaborative, consistent and cohesive mental health care and reduce the risk of clients falling through the 'gaps'. Collaborative care models are consistent with current policy recommendations from a number of different sources (*Investing to Save – KPMG and Mental Health Australia report*, p. 62, 2018).

Q. What healthcare reforms do you propose to address other specific health concerns related to mental ill-health? What is the supporting evidence and what would be some of the benefits and costs?

- While the medical model is central to effective healthcare, expanding the model to include social determinants of health and mental health would lead to a more holistic focus and approach to healthcare. In addition, particularly in the case of more complex and severe health and mental health disorders – collaborative care models are essential to overcome the silos that currently exist between physical and mental health services. A simple example of overcoming this distinction would be the implementation of mental health 'check-ups' with GP's along with physical health 'check-ups'. GP's could regularly monitor their patients' mental health through the standard application of screening questionnaires (e.g. once every six to 12 months). For those patients identified as 'at risk', referral to psychologists through the Better Access Program provides a simple and accessible pathway for patients to receive timely intervention to avoid longer term and more complex presentations.

- See also *Investing to Save – KPMG and Mental Health Australia report, 2018*.

Q. What overseas practices for supporting mental health and reducing suicide and comorbidities should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?

- The UK Improving Access to Psychological Therapies (IAPT) stepped-care programme began in 2008, and has transformed the treatment of adult anxiety disorders and depression in England. Over 900,000 people now access IAPT services each year, and the King's Fund Report: A Five Year Forward View for Mental Health committed to expanding services further, alongside improving quality (Naylor, Taggart and Charles, 2017; National Collaborating Centre for Mental Health, 2018).

QUESTIONS ON HEALTH WORKFORCE AND INFORMAL CARERS: (p. 17)

Q. What could be done to reduce stress and turnover among mental health workers?

- Increased leave entitlements, financial incentives, supported professional development opportunities, self-care initiatives (work-life balance, flexible working hours), and access to Employee Assistance Programs.

Q. How could training and continuing professional development be improved for health professionals and peer workers caring for people with a mental illness? What can be done to increase its take up?

- Training and professional development offered as a condition of employment.
- Further training and professional development mandatory for retaining registration (as is the case for psychologists currently).

- Accreditation of training and professional development providers.
- Utilise EAP's and the training and professional development they offer.
- Collaborative training courses between and for different professional groups, e.g. GPs training psychologists and vice versa; people with lived experience training professionals.

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

- Establish an MBS item for carers to access psychological therapy (individual and group), if needed, in recognition of long-term 'caring' as a significant psychosocial stressor.
- Costs would be minimal against the benefits associated with reduced rates of burn-out, the development of support networks and the reduced burden to the public purse associated with the informal care of people with mental health disorders (as opposed to inpatient care and/or formalised care through outpatient programs or paid carers).

QUESTIONS ON HOUSING AND HOMELESSNESS: (P. 19)

Q. What approaches can governments at all levels and non-government organisations adopt to improve:

- ***support for people experiencing mental illness to prevent and respond to homelessness and accommodation instability?***
- ***integration between services for housing, homelessness and mental health?***

- *housing support for people experiencing mental illness who are discharged from institutions, such as hospitals or correctional facilities?*
- *flexibility of social housing to respond to the needs of people experiencing mental illness?*
- *other areas of the housing system to improve mental health outcomes?*

Q. What evidence can we draw on to assess the efficiency and effectiveness of approaches to housing and homelessness for those with mental ill-health?

Q. What overseas practices for improving the housing stability of those with mental illness should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?

QUESTIONS ON SOCIAL SERVICES: (p. 21)

Q. How could non-clinical mental health support services be better coordinated with clinical mental health services?

(The above questions are answered below)

Underlying Issues:

- The absence of safe and secure accommodation can have a severe and negative impact on a person's physical, mental, social and emotional wellbeing. Shelter and safety are basic human rights and integral to the lower levels of Maslow's Hierarchy of Needs (Maslow, 1943).



- Anecdotal reports suggest that throughout many regions in Australia, despite being assessed as eligible for “priority listing” due to mental health concerns, people may be waitlisted for several years before being offered a home. Unfortunately, demand outstrips supply.
- The public housing system is often difficult to navigate and lacks appropriate resources in terms of both advocacy and staffing. The assessment process can be lengthy and complex. Anecdotally, many people give up as services are “too difficult to navigate”.
- This is particularly detrimental to people with mental health issues from vulnerable sectors of our community, that is, Aboriginal and Torres Strait Islanders, people who are socially isolated, people who are unemployed, and at-risk youth. Centrally coordinated housing services that meet emergency, short term and longer term needs are required, along with a high level of understanding and flexibility for people with mental health disorders - particularly when inpatient care can jeopardize their chances of accessing appropriate housing support.
- There is a severe shortage of emergency accommodation. In addition, it appears that people are regularly referred from acute mental health care facilities directly to

Emergency Accommodation Services. This is inappropriate and represents a fracture in the continuum of care and duty of care process. Clients who are mentally unwell and prematurely discharged from acute care facilities into inappropriate accommodation represent a risk for completed suicide or multiple presentations to ED – placing further pressure on emergency departments and the health budget.

- Social welfare services remain siloed. There does not seem to be any clear links or accountability/responsibility between the Department of Housing (DoH), Centrelink, the Health Department, specialist services, non-government service providers and private sector services who support individuals through the MBS. Individuals with complex mental health needs are required to navigate these various departments and services themselves. A centralised system with facilities to support this cohort is urgently needed.

Possible Solutions:

- Consider Finland’s “Housing First Model”.
- Since the mid 1980’s tackling homelessness has almost continuously been a focus of Government programs in Finland. During recent years homelessness in Finland has decreased (Pleace, Culhane, Granfelt, & Knutgard, 2015).
- The Finnish Housing First approach was introduced to address homelessness. Permanent housing based on a normal lease was seen as a fundamental solution for homeless people. Individually tailored support services, increasing the supply of affordable rental housing and preventive measures were also part of the approach. Since then, hostels have been converted into supported housing units with independent flats for the tenants. New systems to support people and to improve integration in their neighbourhoods have been developed. Homeless policies have

been based on the Housing First approach since 2008. The government's PAAVO programs (2008-2015) targeted long-term homeless people (Pleace, Culhane, Granfelt, & Knutgard, 2015).

- “As an overall assessment, it can be stated that the main goal of the programme, the permanent reduction of long-term homelessness on a national level, has been reached with the help of a carefully planned, comprehensive cooperation strategy. Programme work in accordance with the Housing First principle is proof of the fact that with sufficient and correctly allocated support, permanent housing can be guaranteed even for the long-term homeless in the most difficult position. The significant financial investment allocated to the programme by municipalities, organisations and the state as well as the extensive, long-term national and local cooperation have made it possible to integrate the development of housing and services both on a general level and also by taking the needs of different target groups into account.” (Pleace, Culhane, Granfelt, & Knutgard, 2015, p.104).
- Shift to a new systemic needs assessment approach (e.g. Power Threat Meaning Framework) to clearly identify “homelessness and loneliness” as part of the spectrum of possible risk factors.
- Dramatically increase public housing stock. Employ building companies that will undertake vocational training programs for long term unemployed and at risk groups within the community.
- Utilise a Psychologically Informed Environments (PIE) approach. Basically:

“We need to express the complex issues underpinning and maintaining homelessness as an interaction between individuals and their environment. One way in which this can be done is through psychologically informed environments.” (Maguire 2017, para. 2).

“ So what is a PIE? Well, at its most basic it is an environment that makes use of methods, which are informed by psychological theories and frameworks. This could be at any level, from the way in which hostel staff members think about the problems that their residents face, or how risk protocols and policies are written. Right up to the way in which a building is constructed and configured.” (Maguire 2017, para. 3)

“Psychological theories can be incredibly useful in describing how people may think, feel and behave given a set of experiences and environmental factors. For staff, understanding how we think and feel about the way a person is behaving, may enable us to be more considered in our reaction. It’s useful to understand generally how trauma, e.g. in childhood, warzones or everyday life, can affect the way people cope with difficult situations, so that we are less likely to make judgements about behaviours we find difficult or challenging.” (Maguire 2017 para. 4)

Q. Are there significant service gaps for people with psychosocial disability who do not qualify for the NDIS? If so, what are they?

- There are currently gaps for those who have significant psychosocial difficulties/disability who do not qualify for the NDIS. They do not meet psychiatric diagnostic specific criteria but have significant deficits in psychosocial functioning. These individuals have difficulty accessing support, accessing further and higher education, finding gainful employment, living independently and accessing sustained housing.

Q. What continuity of support are State and Territory Governments providing (or plan to provide) for people with a psychosocial disability who are ineligible for the NDIS?

- Currently there seems to be no continuity of care. The system is still siloed due to diagnostic specific eligibility criteria.

Q. Are the disability support pension, carer payment and carer allowance providing income support to those people with a mental illness, and their carers, who most need support? If not, what changes are needed?

- Disability support pensions and carer payments are inadequate. Anecdotal reports imply that it is difficult to meet eligibility criteria for many individuals with mental health disorders and their carers. Assessment processes are not person centred. They are long winded, require multiple appointments, are complex to understand and require that only departmental staff are able to “deem” eligibility based on medical/psychiatric diagnostic specific criteria.
- The current system does not recognize mental health on a continuum and that deficits in functioning (including capacity to work) can be episodic in nature and fluctuate over time and in severity. It preferences the medical model of psychiatric diagnosis. To base assessments on biomedical psychiatric diagnostic criteria is clearly out of step with current research around mental health and even at odds with the current holistic functional psychosocial disability assessment through the NDIS. *“Mental health conditions for which the impact of the impairment varies over time (episodic) can remain across a person’s lifetime and can be considered likely to be permanent.”* (NDIS, 2018, p. 2).
- The required psychiatric diagnostic labelling also increases stigmatization and reduces the hope and agency of the individual inferring “I have this illness/diagnosis for life.”
- The system is also punitive in nature. Anecdotal reports suggest that many individuals are being denied payments due to an inability to meet established criteria i.e. attending review appointments and completing paper work within restrictive time

constraints. Deficits in functioning usually relate directly to mental health issues, for example, anxiety, stress, poor independent living skills, reduced cognitive functioning, illiteracy, homelessness, poverty etc.

Q. Is there evidence that mental illness-related income support payments reduce the propensity of some recipients to seek employment?

- No. It is likely that reduced propensity to seek employment could be explained by an absence of hope and support to assist the individual to change their situation.
- An individual's capacity to seek and maintain employment over time is impacted by a number of factors. Mental illness-related income support payments are essential for those who most need assistance in our community. Reducing or limiting support payments only increases financial stress and detrimentally affects functional capacities on many psychological and well-being domains.

Q. How could mental illness-related income support payments better meet the needs of people whose capacity to work fluctuates over time?

- The current system and reporting requirements penalize those individuals who may be making progress towards employment but may have to reduce hours in times of increased distress. It is important to tailor payments to make allowances for this phenomenon during recovery. Current reporting processes tend not to support the recovery model in mental health.
- Payments being "earnings specific" in the short term is problematic. That is, support payments should be consistent and part of a longer term recovery plan that suits the individual's needs.

QUESTIONS ON SOCIAL PARTICIPATION AND INCLUSION: (p. 22)

Q. In what ways are governments (at any level) seeking to improve mental health by encouraging social participation and inclusion? What evidence is there that public investments in social participation and inclusion are delivering benefits that outweigh the costs?

- Government initiated social participation and inclusion programs vary across locations and levels of government.
- Some local governments provide social participation and inclusion programs at community and recreation centres, e.g. Living Stronger Living Longer programs at gymnasiums.
- At the Federal level, programs such as Family Mental Health Support Services are offered and provide early intervention support to children and young people up to age 18 years who are showing early signs of, or are at risk of developing, mental illness.
- The *Mental Health Statement of Rights and Responsibilities* (Australian Government, 2012) sets out a vision for the way those experiencing mental health disorders can be assisted. Part II: Non-discrimination and social inclusion states:
“(3) Non-discrimination and social inclusion are fundamental to the mental health of the whole community. There is a recognised correlation between severe mental illness, low socio-economic status and social exclusion.”
“(4) Mental health consumers have the right to social inclusion and participation in social life on an equal basis with others without discrimination of any kind.” (Australian Government, 2012, p. 7).

Q. What role do non-government organisations play in supporting mental health through social inclusion and participation, and what more should they do?

- Act-Belong-Commit (Mentally Healthy WA) is an evidence-based mental health program aimed at increasing individual and community wellbeing by focussing on increasing connections between community members (<https://www.actbelongcommit.org.au/>). It was started in Western Australia and has now expanded to other states and further. Programs of this nature – being both promotional and preventive and focussing on increasing community engagement and social inclusion - are in line with Maslow’s Hierarchy of Needs (see above) and reinforce the benefits of such endeavours. Social connectedness is a basic human need, and, by implication, contributes to positive mental health outcomes.
- The Recovery College service model, due to be trialled in Western Australia in 2019, has been shown to be inclusive, to address the power differential between practitioners and clients, to promote social participation and reduce psychological isolation, i.e. due to peer to peer interactions (Perkins, Meddings, Williams, & Repper, 2018).

Q. Are there particular population sub-groups that are more at risk of mental ill-health due to inadequate social participation and inclusion? What, if anything, should be done to specifically target those groups?

- There are certainly some groups within the community that struggle with social isolation and exclusion. These include: Indigenous Australians, rural and remote communities (including farmers) new immigrants, economically disadvantaged people, refugees and people with both mental and physical disabilities. Appropriately trained practitioners are required to work with these communities and facilitate social participation and inclusion – along with referrals to specific mental health services as needed.

Q. What indicators are most useful to monitor progress in improving mental health outcomes through improved social participation and inclusion?

- Given that social participation and inclusion is a primary human need, one would expect a number of positive outcomes following improvement in this area as indicated by the following:
 - Lower rates of hospital admissions for mental health issues.
 - Reduced suicide rates.
 - Decreased utilisation of mental health services e.g. the Better Access Program.
 - Reduction in the rate of prescription for psychotropic medication.
 - Reduced homelessness.
 - Changes in Medicare refunds for mental health consultations, and improvement in other direct measures of mental health and wellbeing, e.g. K10, MMPI, PAI.

QUESTIONS ON JUSTICE (p. 24)

Q. What mental health supports earlier in life are most effective in reducing contact with the justice system?

- A holistic approach which underscores the values of safety, basic needs and wellbeing of communities and individuals is an important factor in reducing future contact with the justice system. People from low socioeconomic or minority groups (particularly Australian Aboriginal and Torres Strait Islander groups) are vulnerable to coming into contact with the justice system. There has been an overrepresentation of such groups in the justice system, likely because of early contact with antisocial role modelling, substance abuse, physical and sexual abuse and other trauma, poverty and

displacement. Supports that are culturally appropriate and assist people holistically, by tending to basic needs such as the provision of adequate living conditions, are required in addition to community-based mental health interventions, such as parenting programs and substance abuse interventions. Many individuals who offend have had parents who came into contact with the justice system themselves or who have substance use issues, therefore, a high level of support to pregnant mothers (and their immediate supports, such as partners) may ameliorate the stress that is likely to lead to a continuation of the negative feedback loop in these families.

- Due to the transgenerational nature of trauma and the higher level of incidence of mental illness in children of parents with a mental illness, engaging new or would-be parents in parenting programs, trauma counselling and other mental health services, would increase the likelihood of better adjustment to parenting, and decrease likelihood of mental disorders such as post-natal depression and hence lead to lower stress levels for the child and parent/s. It is often best for the young child to remain with their mother even when she is incarcerated or experiences psychosocial or mental health problems.

Therefore, these mothers can be engaged in parenting programs, psychological treatment and other support services to enhance their life, as well as be provided with adequate placement following sentencing. Ideally, prisons that are structured to accommodate mothers and their children, as well as mimic daily life in the community provide the best environment for such women.

- Childhood trauma is another significant factor underpinning later offending (as a juvenile and adult). There is a high number of children who experience physical and sexual abuse in Australia. A high number of abused children grow up to depend on

drugs and alcohol as a coping mechanism for numbing them from the emotional toil of trauma, hence predisposing them to act in antisocial ways.

- Supporting these children and providing them with age appropriate treatment (such as play therapy for trauma) as soon as practicable can assist in restoring the child on a normal developmental trajectory and decreasing the risk of the child developing a mental disorder or re-enacting the victim/perpetrator role by victimising others as an adult. There may also be a discrepancy between court provided victim support services and community and post court engagement services. As children who have at least one supportive caregiver or parent are much more likely to overcome symptoms associated with such trauma, it may be beneficial for the supporting caregivers to be engaged in psychological treatment to educate them about these issues and also provide treatment if the parents are themselves experiencing mental health problems.
- Family treatment may also be beneficial. For example, family systemic approaches with young offenders appreciate the social context into which the youth returns, with these interventions more likely to maintain positive changes. Such programs in the Western Australian justice system were abandoned due to a withdrawal of funds, possibly due to the difficulties of implementation (e.g. attending offenders' homes). Parent training programs and programs addressing parent abuse have had some preliminary implementation in Australia, but there has a requirement for further research into this area. (Youth Justice Review and Strategy – Meeting needs and reducing offending by P Armitage and Professor J Ogloff 2017, Victoria (published on justice.vic.gov.au)

Q. To what extent does inadequate identification of mental health and individual needs in different parts of the justice system increases the likelihood, and extent, of peoples' future interactions with that system?

- There is a high number of individuals suffering from mental health problems and mental illness who come into contact with the justice system. Many of these individuals are not diagnosed adequately due to limited contact between mental health care providers and the justice system. While the Justice Department has increasingly sought to assess most offenders, many only undergo such processes when their risk of reoffending is high, or their offences are of a serious nature. Therefore, for some of those who may appear to be at lower risk (but with persistent mental health issues) may slip through the gaps, be left untreated and reoffend. The prioritisation of high-risk and high-need offenders has led to others whose risk and needs may remain unaddressed, particularly in the current climate of prison overpopulation and high incarceration rates. Further, similar to the high-risk offenders, only highly distressed individuals with already diagnosed mental illness (such as due to private clinic/GP diagnosis or following a psychiatric sentencing assessment) may receive immediate psychological and psychiatric treatment. Those individuals who are deemed to be coping are likely to be overlooked for individual intervention. Therefore, their problems are left unaddressed and they present the same risk of recidivism as they have upon initial justice system contact.
- In addition, offenders may be assessed to inform sentencing, however, these assessments are treated confidentially and future caregivers or treatment providers may not have access to such information. There is no specialist psychological assessment service to screen all offenders for mental health problems and disorders. As a result, the offending individual may not receive appropriate treatment unless they have had an assessment for different reasons (e.g. for sentencing) and been identified

and flagged as requiring specific mental health treatment. Individuals who receive shorter sentences are often overlooked for offender specific programs and other treatment. As a result, they are likely to reoffend in a similar manner. Even if offences are considered to be of a generalist and minor nature (e.g. non-violent offences), repeated offending presents considerable costs to society and fuels an antisocial undercurrent in the community; possibly breeding the propensity for further offending.

Q. Where are the gaps in mental health services for people in the justice system including while incarcerated?

- Unfortunately, resources are limited and the number of psychological treatment sessions provided for individuals with a history of severe trauma is often inadequate. There is also a lack of specialist psychological groups to provide appropriate treatment to prevent re-offending.
- The focus of the justice system is largely to prevent recidivism by addressing a number of criminogenic factors, of which mental illness is one such factor. As a result, there is a prevalence of offender specific intervention aimed to provide skills and psychoeducation to reduce reoffending, address substance abuse and address violent or sexually abusive behaviour through cognitive-behavioural based programs. While these interventions have been found to be effective, most of the studies conducted follow offenders up to five years post sentence. There is a risk that underlying psychosocial factors (e.g. poor affect regulation due to childhood trauma) remain unresolved, leading to a cyclic pattern of reoffending.
- As early trauma experiences are common amongst offending individuals with mental health problems and disorders, it is paramount that this be addressed. Some staff who

provide counselling in prisons may not be adequately trained to provide such interventions. In addition, counselling services in prisons are often limited due to a focus on suicide and self-harm prevention and other crisis interventions. As noted previously, due to the overpopulation of prisons, crisis intervention seems to predominate the Prison Counselling Services.

- While offending individuals in the community may be assessed as requiring trauma specific psychological intervention, there are few such psychologists working in the justice system. While offending individuals may seek external treatment, many are from low socio-economic backgrounds and cannot afford the services of a private psychologist specialising in trauma. Even when the psychologist is able to bulk bill the client, 10 sessions is inadequate to address a lifetime of trauma and marginalisation that some of these individuals have experienced.

Q. What interventions in the justice system most effectively reduce the likelihood of re-offending, improve mental health and increase prospects for re-establishing contributing lives? What evidence is there about the long-term benefits and costs of these interventions.

- The current interventions in place aimed to reduce recidivism rates largely include programs based on the ‘What Works’ literature including the Risk-Need-Responsivity model which address identified criminogenic factors associated with offending. For example, there have been a variety of programs addressing sexual and violent offending, sometimes specifically aimed at various groups, for example Indigenous offenders or those with intellectual disabilities. There have been programs addressing various types of violent behaviours, such as those more specifically aimed at men perpetrating spousal/partner abuse. Although there are programs for women, they are often developed based on male offending literature and lack cultural sensitivity. As a result, these programs are consistently in need of modification. Other programs, such

as cognitive skills and substance abuse are aimed at generalist offenders or adjunct problems. Programs are also administered according to the risk-need model, with higher risk offenders being more likely to access such programs than low risk offenders. Further, the programs provided vary in intensity, with high intensity programs being most appropriate to address high risk-needs. The programs that are in place to address violent and generalist offending do well to reduce the risk of recidivism, at least in the immediate term. However, evidence is still building in regard to the efficacy of current treatment of offenders, particularly those suffering from mental health problems. As a result, continuous research and its application in the development of offender treatment needs to continue. Offenders who experience a holistic approach to treatment, by addressing the relevant criminogenic needs while being responsive to their mental health problems, may have better overall outcomes and become productive members of society (Egan, 2013).

- A positive role model of a prison system can be found in Scandinavian countries where imprisonments rates are low, recidivism is low and prison conditions are the most humane in the world. While considerable financial investment was made to lead to such changes, the positive outcomes and low prisoner numbers are likely to be most cost effective due to savings in legal, social and health (including mental health) costs associated with imprisoning offenders who consistently reoffend (Pratt, 2008).

Q. What are the main barriers to lowering the over-representation of people living with a mental illness in the justice system and what strategies would best overcome them?

- The key barriers to decreasing the number of individuals with a mental illness in the justice services include;
 - the lack of holistic approaches to address offending behaviours and mental health
 - the difficulty of addressing mental health issues within regional and remote areas

- a lack of mental health treatment within the justice system (including in prison and the community)
 - insufficient availability of substance use treatment for offenders in the community
 - a lack of connectedness between community-based support organisations, mental health organisations and the justice system
 - a shortage of family, systemic and social approaches to target offending and mental health issues.
- Connecting justice and mental health services and focussing on treatment rather than punitive measures appears to be most effective in reducing mental health problems. Incentives such as the START (Mental Health) Court in Western Australia is an example of a holistic support and intervention program that assists those suffering from mental illness who have offended. Services within this program include legal, psychological, social and practical, with individuals experiencing a positive relationship with the professionals involved leading to positive preliminary outcomes. The extension of such programs is likely to yield positive results and decrease the number of individuals with mental illness who also offend.
 - Implementing regional specific services and increasing psychological treatment in these areas would also be of benefit. Increasing incentives for experienced and endorsed psychologists to travel to regional areas may lead to higher quality of services to these areas.
 - Increasing specialist psychologists who are qualified to work with complex trauma and mental health disorders and who have an understanding of social, developmental and cultural issues (specifically forensic, clinical and counselling psychologists) is likely to increase the quality of services targeting offenders with mental health problems and disorders. There could be a separate service within prisons (as well as in the

community justice services) that employs or contracts such professionals to solely address the mental health difficulties and address the impact of trauma that the offender may have experienced, rather than a primary focus on recidivism risk, which often leads individuals to feel misunderstood and stereotyped. Connecting and identifying external psychologists who may be able to assist low risk offenders with milder mental health problems may also be beneficial. Further, the implementation of a Medicare based model for the treatment of trauma specific or mental health co-morbid disorders (for example depression and substance abuse) allowing for access to a greater number of annual psychological treatment sessions is likely to bridge the gap between milder forms of mental illness and severe mental health issues with co-morbid problems such as drug use and offending.

- While there are a number of organisations targeting substance use in the community, many of these are struggling to meet the demands for treatment, which can mean that offenders seeking to address substance abuse in the community may be waitlisted.
- Another approach to consider could be group mindfulness/relaxation and meditation sessions conducted in prisons (and even in the community) as an adjunct to offender relevant treatment and assist in affect regulation and stress management.
- The justice system could seek to develop and reintroduce family and systems-based interventions in order to address greater systemic issues and prevent lifetimes of offending by juveniles who come into contact with justice services, and who are embedded within antisocial networks.

Q. To what extent do inconsistent approaches across states and territories lead to inefficient ineffective or inequitable outcomes for offenders and their families?

- Each state and territory in Australia implement different approaches and services leading to difficulties in comparing outcomes of interventions across Australia, limiting further research and the development of new approaches.
- At times there has been a lack of communication between states, leading to a lack of knowledge about proposed interventions and delaying their implementation. For example, there has been a great deal of research conducted within the justice system in Victoria, but less so in other states. Other states, such as Western Australia may find it difficult to implement certain strategies developed elsewhere due to a different population group and the geography of the region.
- Approaches in one state, for example family and systems-based services, may be experiencing development and growth, but are not rolled out in other states leading to a lack of effective treatment options on a national basis.

QUESTIONS ON CHILD SAFETY (p. 25)

Q. What aspects of the child protection programs administered by the Australian, State and Territory Governments are the most effective in improving the mental health of people in contact with the child protection system?

- The Commonwealth of Australia (2009) released the *National Framework for Protecting Australia's Children 2009 – 2020* that guides the early intervention and child protection responses of each state and territory and provides indicators through which outcomes can be measured.
- Early intervention and family support services are provided by state and federal organisations. However, each state and territory is responsible for the child protection

matters of their residents. Due to all national, state and territory services being guided by the *National Framework for Protecting Australia's Children* (Commonwealth of Australia, 2009), all operational frameworks and policies emphasise the best interests of the child, supporting families in their communities, early intervention and prevention, cultural sensitivity, multidisciplinary teams and inter-agency cooperation. There is a lot of scope for psychologists to work in all areas within these federal and state systems as the philosophy and competencies of psychologists align with the aims and principles of these services.

- Resources for each national, state and territory's policies and frameworks:

Federal

Australian Government Department of Social Services (2015)

ACT

ACT Government Department of Community Services (2017)

<http://www.communityservices.act.gov.au/ocyfs/children/child-and-youth-protection-services>

NSW

New South Wales Government Department of Health (2013)

<http://www.health.nsw.gov.au/parvan/childprotect/Pages/counselling.aspx>

<https://www.health.nsw.gov.au/parvan/childprotect/Pages/default.aspx>

NT

Northern Territory Government Department of Children and Families (n.d.)

<https://territoryfamilies.nt.gov.au/about/publications-and-policies>

QLD

Queensland Government Department of Communities, Child Safety, and Disabilities Services (2018)

<https://www.csyw.qld.gov.au/childsafety/child-safety-practice-manual>

SA

<https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/child+protection>

<https://www.childprotection.sa.gov.au/department>

TAS

Tasmanian Government Department of Health and Human Services (2016, 2018)

VIC

Victorian Government Department of Human Services (2007)

<http://www.cpmanual.vic.gov.au/our-approach/best-interests-case-practice-model>

WA

Western Australia Government Department of Communities (2018)

Western Australian Government Department of Health (2015)

<https://www.dcp.wa.gov.au/Organisation/Pages/PolicyFrameworks.aspx>

- While the policies, procedures and services in the federal jurisdiction and within each state and territory appear to be guided by the same principles (outlined in the National Framework), the structure of organisations and the services provided are very diverse. To fully answer this question in relation to all child protection services in Australia, would be an entire submission in and of itself! We do not think it is within the scope of the current inquiry to go into that much detail.

Q. What, if any, alternative approaches to child protection would achieve better mental health outcomes?

- Parental mental health has been shown to be a predictor of children becoming involved in child protection systems and of negative child mental health outcomes (Darlington & Feeney, 2008; Jeffreys, Rogers, & Hirte, 2011; O'Donnell et al., 2015; Sheehan, 2005). This is recognised in supporting outcome three of the *National Framework for Protecting Australia's Children* (Commonwealth of Australia, 2009):

“risk factors for child abuse and neglect are addressed”. O’Donnell et al (2015) consider the parental diagnoses that are linked with the greatest risk of child protection contact. However, the *National Framework for Protecting Australia’s Children’s Indicators* (Australian Institute of Health and Welfare [AIHW], 2018) shows that the number of parents with mental health issues has increased between 2009 and 2018. No analysis exists as to whether this increase is greater than population growth. Regardless, more could be done to improve parental mental health to decrease contact with the child protection system, and promote better outcomes where children do become involved with the system.

- The fourth action plan of the National Framework for Protecting Australia’s Children (Commonwealth of Australia, 2018) suggests four priority areas:
 - 1) Improving outcomes for Aboriginal and Torres Strait Islander children at risk of entering, or in contact with, child protection systems.
 - 2) Improving prevention and early intervention through joint service planning and investment.
 - 3) Improving outcomes for children in out-of-home care by enhancing placement stability through reunification and other permanent care options.
(The Royal Australian and New Zealand College of Psychiatrists (2015) recommend assessment and treatment principles for improving outcomes for children in out-of-home care. These suggestions include working in multi-disciplinary teams.)
 - 4) Improving organisations’ and Governments’ ability to keep children and young people safe from abuse.
- The *National Framework for Protecting Australia’s Children Indicators* (AIHW, 2018) only presents national data; each state and territory is responsible for structuring and implementing child protection services independently; so, it is difficult to determine which services are achieving better outcomes.

- Despite policy and procedural guidelines that aim for continuity of care and interagency co-operation, often service provision between early intervention/prevention services and child protection agencies are fragmented and not well co-ordinated. Fragmented services and lack of trauma-informed services can result in re-traumatisation for families who have already experienced chronic and complex trauma (Wall, Higgins, & Hunter, 2016). It is therefore suggested that continuity of care throughout all stages of contact with the child protection system be improved to achieve better outcomes for children and their families. (Clinical and counselling psychologists have training and skills in working with trauma and could contribute to delivering trauma-informed services.)
- Victorian Auditor-General's Office [VAGO] (2018) found that staff in the child protection workforce in Victoria suffered negative mental health outcomes impacted by:
 - a) long and unpredictable working hours,
 - b) repeated exposure to trauma, violence and, on occasion, death,
 - c) difficult interactions with the public, and;
 - d) high professional expectation.

It is likely that this is the case in all child protection workforces, although there is little research/evidence currently available in other states or territories.

Enhancing the mental health of the child protection workforce is likely to increase the ability of workers/services to work collaboratively, work with complex needs, and achieve better outcomes for families and children.

VAGO (2018) suggested that there needs to be more child protection employees to reduce workloads and increased support for child protection employees to promote better mental health in the workforce. Two (of four) recommendations to better support child protection workers are:

- 1) Mental health training for all child protection workers, and
- 2) Better avenues to report/respond to mental health concerns; there are six avenues suggested, two of which are access to psychological counselling (EAP) and improving responses to critical incidents that cause distress.

QUESTIONS ON EDUCATION AND TRAINING (p. 26)

Q. What are the key barriers to children and young people with mental ill-health participating and engaging in education and training, and achieving good education outcomes?

- There are many possible factors that seem to act as barriers to children and young people with mental ill-health participating and engaging in education and training, and that disrupt their capacity to achieve positive educational outcomes. They include:

Within primary and secondary school settings - the capacity and skills the teacher has to manage symptomatic behaviours in the classroom. Behaviours are often seen/labelled as 'disruptive' 'naughty' and 'oppositional'. These labels may lead to stigmatization. In some cases, 'acting-out' behaviour can be explained by underlying mental-health condition(s) that need to be understood and taken into account.

A lack of support provided to the parents of children with mental health disorders. As a result, family stresses increase, sibling issues increase, marital stresses increase and the trickle-down effect likely further exacerbates the child's mental health symptomology and engagement with education.

Social and cultural factors – as cited in the *The Mental Health of Children and Adolescents. Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing* (2015).

Lack of motivation to learn which may result from environmental factors, such as family values.

Lack of intrinsic motivation affected by emotional factors such as:

- Lack of confidence
- Negative self-evaluation
- Fear of inadequacy, failure
- Shyness
- Impulsivity
- Boredom
- Not relating to teacher

Or mental health factors such as:

- Emotional dysregulation
- Feeling unsafe in the classroom, especially for children who have experienced abuse
- Children who have experienced trauma are unable to concentrate and stay focused – often labelled ADHD
- Depression
- Insecure attachment – problems connecting to others or in severe cases
- Anxiety

Young people do not necessarily understand that they need help. Young people's behaviour is an expression of their neurological need, consequently, they adapt and develop coping behaviours to deal with situations in the least painful way. Adolescents in particular, are often not motivated to seek help.

Parents are often not willing to accept that their child may have a mental health problem that is interfering with their learning.

Parents may not be willing to take their child outside the school environment for psychological help, or be hampered by time constraints, financial issues, or a lack of motivation.

Teachers not well trained in child development and emotional health of children.

Teachers not trained in the importance of creating a “safe classroom” for children.

The education system in Australia does not adequately focus on the mental health of students as an integral aspect of the school curriculum. Many students who are underachieving would benefit from more time being spent on achieving emotional wellbeing in their primary school years. More school psychologists are urgently required Australia-wide. A focus on the psychological wellbeing of primary-aged children as an integral aspect of the school curriculum would not only lead to improved educational outcomes, it would additionally provide the opportunity for a preventative focus in mental health care Australia-wide.

Q. Is there adequate support available for children and young people with mental ill-health to re-engage with education and training?

- Unfortunately, not.
- School psychologists, while having the most appropriate training and experience to assist children and young people with mental ill-health to re-engage with education

and training, unfortunately have a number of competing demands on their time and are often not in a position to provide adequate support to this cohort.

- More school-based psychologists are urgently required Australia-wide.
- Psychologists can assist teachers with in-class behaviour management skills and with understanding behaviours related to mental health conditions. Increased access to in-class assistance for teachers by psychologists could lead to more positive educational outcomes for children with mental health disorders.
- The social and emotional wellbeing of primary and high school students needs to be viewed as a priority. Mental ill-health affects all areas of learning.
- Having organisations external to schools supporting young people, such as Headspace, is ineffective in the absence of a collaborative care model.
- Given that primary and high school aged children spend approximately 6 hours per day at school, there is an opportunity to educate children about mental health; to assess and provide early intervention treatments; and improve educational outcomes for children at risk of mental health disorders – but only if there is a more organised approach to dealing with mental health issues within the school environment.

Q. Do students in all levels of education and training have access to adequate mental health-related support and education? If not, what are the gaps?

- No - there is significant inconsistency in support provided between schools – both public and private. Unfortunately, access to psychological support is often most limited

in low socioeconomic areas and for families without the means to fund private support.

- University counselling services are in a unique position to identify and respond to mental health issues and disorders being experienced by tertiary level students. This is particularly relevant for prevention and early intervention programs (e.g. Early Episode Psychosis). However, they are often short-staffed and unable to provide adequate services to students due to limited resources and a lack of funding.

Q. How effective are mental health-related supports and programs in Australian education and training settings in providing support to students? How effective are programs in educating staff, students and families, on mental health and wellbeing? What interventions are most effective? What evidence exists to support your assessment?

- Mental health-related supports and programs in Australian educational and training settings are limited in the support they provide to students.
- Social and emotional learning needs to be made a priority. The education system needs to create a space in the curriculum for mental health promotion and prevention programs.
- Mental health interventions need to be process based and delivered differently to academic subjects.
- Interventions need to be attuned to the young person; to assess the need that their behaviour is meeting and then find a way of satisfying that need in a healthier way (as per the PTMF).

- The most effective interventions are evidence-based with research to support their efficacy. This has been well documented (Fox, Southwell, Stafford, Goodhue, Jackson, and Smith, 2015)
- According to Firth et al. (2008) who conducted an evaluation of a Beyondblue three year, school-based project to promote student mental health in three Australian states, successful implementation of a program depends on being able tailor it to the needs of each school and adequate resourcing.

Q. Do teachers and other staff in schools and education facilities receive sufficient training on student mental health? Do they receive sufficient support and advice, including on the quality and suitability of different approaches, to adequately support students with mental ill-health?

- In 2015 Beyondblue conducted a survey of 600 principals and teachers in NSW. The results were telling. Basically, all those surveyed indicated that they considered mental health as important as academic achievement. However, nearly a quarter did not believe it was their responsibility to address the mental health concerns of their students and nearly half responded that they did not have the time to focus on assisting their students to achieve positive mental health outcomes. In addition, the survey identified that teachers do not believe they have the necessary resources to manage the mental health concerns of their students and only a third indicated that their school provide professional development and/or training in this area (Beyondblue, 2015).

Q. What overseas practices for supporting mental health in education and training should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?

- Programs such as the UK-based Talented Teacher Programme seek to increase teachers' confidence and skillset in managing students with mental health issues (Haywood, Cartegen Farias, Ahmed & Tanner, 2016).
- The current "Be You" program lead by Beyondblue and launched in 2018, is an excellent example of an evidenced-based approach to improving the mental health of school-aged children. However, it is an imperative to ensure that such programs are implemented across schools in a fair and consistent manner.
- As reported by Fox et al. (2015) the international picture is not much better than Australia. Early intervention has not been systematically adopted in any country. Like Australia, programs are implemented and evaluated as a one off; rarely as a whole school approach and are often discontinued.

QUESTIONS ON GENERAL EMPLOYMENT AND SUPPORT (p. 28)

Q. What examples are there of employers using general disability support measures (through supported wages and assistance to provide workplace modifications) to employ people with a mental illness? How could such measures be made more effective to encourage employers to employ people with a mental illness?

- Disability Employment Service Providers state that there are a number of large organisations (e.g. large retail companies, hospitals, universities) who employ people with disabilities; however, information related to the sorts of general disability support measures that were being employed for people with mental illness was not readily available. A conversation with a University Equity officer showed that in large organisations at least, several measures were available to support employees with mental health issues, including counselling through an EAP, mentors in the workplace,

time-out where required, modified job requirements and amended work contracts where necessary. It is noted that these measures are more easily implemented by large organisations that have the infrastructure and financial resources to deal with general disability support measures – the same is not necessarily true for smaller businesses.

- Support measures can only be effective if BOTH employers and potential employees are aware of those measures. An internet search reveals that there are a large number of government bodies, government-funded bodies, NGOs and self-funded community groups (DSC, DCA, Disability Employment Services, Centrelink, NDIS, Beyond Blue, Black Dog, etc) that directly support or provide information about disability/mental illness. Information is scattered and fragmented and this makes it extremely difficult for prospective employers of people with mental illness, to find out about available support measures.
- Much of the information relating to workplace mental health for employers is very broad and uses vague terms such as “provide support.” While policy is very specific about what employers are not allowed to do (e.g. discriminate) it is not particularly helpful in providing specifics about what **to do** to provide such support for an employee with a mental illness. Moreover, if a small business is inclined to employ someone with a mental illness, **is it not easy to find information** about what the Government will do to facilitate that, to offset the potential financial costs of employing someone with an existing mental illness.

The National Inquiry on Employment and Disability Interim Report 2004 - by the Human Rights Commission, states:

- *One of the major barriers facing employers relates to perceptions about the financial costs that may accompany the employment of people with disability.*

- *A one-stop-information-shop should fulfil a variety of functions regarding that potential financial burden.*
- *First, sometimes employers assume that the costs are greater than they really are. In the United States, a survey of over 700 users of the Job Accommodation Network (JAN) found that more than 70 per cent of accommodations cost less than \$500.[32] Thus it seems that while employers may believe that workplace accommodations will cost thousands of dollars, they are more likely to cost hundreds. However, unless there is a place for employers to go to clarify the actual cost, it will be difficult to remove the perception that a great expense is involved.[33]*
- *Second, there are a variety of government assistance packages that seek to defray the cost of taking on a person with disability (see further below). If an employer is unaware of: (a) the existence of the government package; (b) the extent of that assistance; (c) the eligibility criteria for that assistance; and (d) what needs to be done to access that assistance; then the impact of those incentives is greatly reduced.[34]*
- *The DEWR JobAble website has a Fact Sheet on Employer Incentives in its 'Employer' portal, although it is not very obviously displayed. [35] The United States EARN and Job Accommodation Network (JAN) websites provide examples of alternative ways to display the information.[36].*

Q. Are there other support measures that would be equally or more cost effective, or improve outcomes?

- While there is a lot of information about how to “support” people with mental illness in the workplace, most of this information relates to “monitoring” mental health in the workplace (e.g. “Are you OK?” and providing guidance to management about what to look for and how to manage mental health issues in the workplace.) These initiatives relate to the mental health/illness of current employees, and while helpful in

potentially changing culture, does not actively encourage the employment of people with an existing mental illness. The incorporation of mental health into workplace culture needs to be extended to the active employment of people with mental illness, if the notion of workplace diversity is to be truly meaningful. In short, it is recommended that a single source of easy access information be created **and promoted** to ensure that large and small businesses alike are aware of the support measures available to them.

Most large organisations have policies covering mental illness as part of OHS, however mental illness is frequently dealt with by referring sufferers to the Employee Assistance Program (EAP). This is problematic since EAPs are frequently limited to 3 to 4 sessions, which may help with superficial problems, but is not sufficient to provide ongoing support to people with ongoing mental health issues. It is recommended that financial support is provided to employers to enable them to **adequately** provide psychological support to their employees when required.

- Some organisations now incorporate training to educate management about mental illness and how to best help employees who suffer from mental illness in the workplace, and there is abundant evidence to show that this has an effect. This training needs to be encouraged to change workplace culture – there is still pervasive stigma (including internalised stigma) associated with mental illness. Financial incentives such as subsidised workshops, might improve the uptake of this form of training, which would have long-term benefits in terms of productivity (reduced absenteeism and presenteeism).
- To assist employees with mental health issues, organisation can make workplace modifications such as mentoring (similar to the digital industry mentoring program for young people provided by Headspace), amended work contracts (additional leave

during times of mental illness, reduced working hours, reduced KPIs) workplace training for mental illness. However, this requires both adequate infrastructure and financial resources. Small business employs roughly 44% of working Australians. Government may give financial incentives, such as tax breaks, for organisations (particularly small businesses) who employ people with mental illness, to offset the cost of supporting them in the workplace. The creation of a competitive, high profile and well publicised Government award for organisations that support of people with mental illness, may also encourage both small and large businesses to employ such people. The fact that ROI for employers who establish positive mental health practices in the workplace is between 2-11% (depending on the size of the company and associated variable) needs to be promoted to both big and small business, since this affects their bottom line.

QUESTIONS ON MENTALLY HEALTHY WORKPLACES (p. 30)

Q. What types of workplace interventions do you recommend this inquiry explore as options to facilitate more mentally healthy workplaces? What are some of the advantages and disadvantages of the interventions; how would these be distributed between employees, workers, and the wider community; and what evidence exists to support your view?

- Harvey, Joyce, Tan, Johnson, Nguyen, Modini, & Groth, (2014) suggest that strategies are needed at the individual, team, and organisational level and recommend the following:
 1. Designing and managing work to minimise harm: improve flexibility around working hours, encourage employee participation, reduce risk factors, ensure safety of work environment.

2. Promoting protective factors at an organisational level to maximise resilience: build a psychosocial healthy climate, enhance organisational justice, promote team based interventions, provide manager and leadership training
 3. Enhancing personal resilience: provide evidence-based resilience and stress management training. Incorporate coaching and mentoring and worksite physical activity.
 4. Promoting and facilitating early help-seeking: Wellbeing checks that include detained post-screening procedures, and EAP.
 5. Supporting workers recovery from a mental illness: provide training regarding supervising and support, facilitate partial sickness absence, provide return-to-work programs, encourage individual placement support for those with a severe mental illness.
 6. Increasing awareness of mental illness and reducing stigma: provide mental health education and training to all staff
- From the employee's perspective:

Work-life balance.

A work place which provides a favourable environment can be beneficial for individuals overall mental health (Fossey & Harvey, 2010; Barak, Travis, Pyun, & Xie, 2009). Work can provide a sense of purpose, community and acceptance, and opportunities for development.

The negative personal consequences of high strain jobs can be mitigated by effective support in the workplace (Harvey et al., 2014).
 - From the employer's perspective:

Reduce absenteeism, increased presenteeism, increased employee engagement and productivity (Harvey et al., 2014).

Wellbeing is positively related to work performance (Wright & Cropanzano, 2000) and job satisfaction (Wright, Cropanzano & Bonnet, 2007).

Providing support that includes high quality feedback, variety, and learning opportunities have been found to be positively associated with work engagement (vigour, dedication, and absorption) (Halbesleben, 2010).

- Harvey et al. (2014) recommend implementing strategies in a staged, individualistic, and regularly reviewed manner.
 1. Establish commitment and leadership support
 2. Conduct situational analysis
 3. Identify and implement appropriate intervention strategies
 4. Review outcomes
 5. Adjust intervention strategies

Q. What are some practical ways that workplaces could be more flexible for carers of people with a mental illness? What examples are there of best practice and innovation by employers?

- Provide the option for flexible working hours - chosen by the employee.
- Provide workplace education around mental illness to management and staff.
- Provide options for carers leave/sick leave for people caring for someone with a mental illness.
- Adjust work duties to meet the needs of the employee and employer.

Q. How can work place interventions be adapted to increase their likelihood of having a net benefit for small businesses?

- Mental illness has been noted to play a large factor in absenteeism, sick leave, and reduce work capacity (Harvey et al, 2014). Therefore, a more mentally healthy work place may increase productivity, presenteeism, and job satisfaction.
- Avoiding work related burn out may reduce staff turn-over, therefore reducing time and resources spent on training and severance packages.

QUESTIONS ON FUNDING ARRANGEMENTS (P. 36)

Q. What have been the drivers of the growth in mental health expenditure in Australia? Are these same forces likely to continue driving expenditure growth in the future? What new drivers are likely to emerge in the future?

- The following have contributed to increased demand (and therefore expenditure) in mental health treatment.
 - 1) increased awareness of mental health/illness through initiatives such as Beyondblue,
 - 2) increased access and availability through Better Outcomes, PHN coordinated care and Better Access,
 - 3) initiatives that reduce stigma and encourage sufferers to seek mental health treatment, and
 - 4) increased awareness of the benefits of mental health treatments.
- One of the main drivers of growth on mental health expenditure in the past has been expenditure on psychiatric medicines subsidised through the PBS. This has been reduced through the introduction of Medicare funded Better Access to Mental Health Care initiative. Increased awareness of mental health issues as well as social issues, for

example, domestic violence and family abuse, which have significant impact across all levels of society and mental health will be drivers for future expenditure. Funding initiatives will need to be driven by systemic principles incorporating the impact of different contexts that may not be directly identified by focusing purely on categorical diagnoses. Practitioners should be skilled at being able to identify a person's uniqueness and the contributing factors to their symptomatology and that two people sharing the same diagnosis may come from different contexts that might require different approaches. Future funding should also incorporate research into effective therapeutic approaches for various mental health issues and more complex and serious disorders. The current focus on a limited number of approaches may not necessarily meet the needs of the consumer.

- Other drivers will be the investment in electronic communication and information technology in the delivery of certain services and streamlining communication between service delivery providers and government departments.
- Funding mental health services that focus on prevention, education and early intervention should be a priority.
- Funding should be driven on the basis of increasing access for consumers.

Q. How could funding arrangements be reformed to better incentivise service providers to deliver good outcomes, and facilitate coordination between government agencies and across tiers of government?

- Offer rebates to service providers within the MBS based on the training they have completed (whether this is training to registration, endorsement, or other professional

development). It is assumed that higher-level training increases practitioner knowledge, skill-base and competency and will therefore lead to improved therapeutic outcomes.

- Factor in the complexity of client’s presenting issues in relation to the rebate offered.
- Funding could be allocated to offer free or subsidised training in particular treatment techniques which would in turn lead to improved outcomes.
- 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.

Q. Are the current arrangements for commissioning and funding mental health services — such as through government departments, PHNs or non-government bodies — delivering the best outcomes for consumers? If not, how can they be improved?

- While PHNs are viewed as having the potential to provide “world-class, person-centred healthcare” (Booth et al., 2016, p. 4), they are only one aspect of a fully-integrated mental-health care system. Acute and recovery services are beyond the scope of PHNs and remain the responsibility of government and private service providers. In addition, psychology services delivered through the MBS provide an essential option for both GPs and consumers – and the opportunity for those who can afford it to subsidise their own mental health care.
- The Australian Government, Department of Health (2010), undertook an evaluation of the Better Access initiative. The results show “that Better Access consumers

experience clinically significant reductions in levels of psychological distress and symptom severity upon completing treatment. Consumers reported a decrease from high or very high levels of psychological distress at the start of treatment to more moderate levels of psychological distress at the end of treatment.” (Australian Government, 2010, para. 2.6).

- “The same outcomes were achieved whether the consumer was male or female, young or old, or wealthy or financially disadvantaged.” (Australian Government, 2010, para. 2.6).
- While it was reportedly difficult for the evaluation to determine the cost-effectiveness of the Better Access program, the typical cost of psychological care was substantially lower than cost-modelling for optimal treatment for anxiety and depression (Australian Government, 2010).
- In addition: “Bulk-billing levels also increased as the level of relative socio-economic disadvantage increased.” (Australian Government, 2010, para. 2.3). This implies that the initiative is reaching consumers in lower socio-economic areas and providing access to psychological services for people in at-risk groups within Australian society.
- Obviously increased mental health funding implies the opportunity to better meet need – particularly in acute care services and for those most at risk, i.e. marginalised groups and residents in rural and remote communities.
- In addition, as mentioned above (see previous section: “Overview – Systemic Issues”), the siloed nature of mental health care in Australia needs to be addressed through the provision of funding aimed at improving communication and collaboration between services.

Q. How does the way the Medicare Benefits Scheme operate impact on the delivery of mental health services? What changes might deliver improved mental health outcomes?

- See the Report from the Mental Health Reference Group for recommendations regarding improving mental health outcomes as part of the Medicare Benefits Scheme Review.

QUESTIONS ON MONITORING AND REPORTING OUTCOMES: (P. 37)

Q. Does Australia have adequate monitoring and reporting processes to assure compliance with national standards and international obligations?

- All registered mental health professionals across both private and public service settings have an ethical and professional responsibility to be adequately trained and competent to appropriately select, administer, evaluate, and report on key outcomes relevant to the person or persons receiving mental health care. Such informal and formal assessment processes are typically governed by the regulatory board of the given profession and any relevant Codes of Ethics.

Q. Which agency or agencies are best placed to administer measurement and reporting of outcomes?

- Typically, most measurement and reporting of therapeutic outcomes remain the responsibility of the individual mental health service provider. As such, it is recommended that standardized measurement and reporting occur across all agencies, public and private, to ensure that the monitoring of consumer progress and wellbeing is represented across all sectors of mental health care (from low to high intensity care).

Q. What does improved participation, productivity and economic growth mean for consumers and carers? What outcomes should be measured and reported on?

- The relationship between individual mental health and participation/productivity/economic growth is bidirectional and mutually reciprocal such that measurable stability or progress in one is directly correlated with subsequent advancements in the other. According to biopsychosocial and systems perspectives, individuals both influence and are influenced by the broader systems changes that occur around them. Individuals with good mental health are more likely to active in their community and social surrounds, take collective responsibility for people and tasks around them, and measurably contribute to Australian society and its economy. Similarly, systems which promote positive preventative mental health approaches and support individual and group-level engagement in employment, volunteering, and leisure activities are more likely to improve and stabilise the mental health of individuals (consumers and carers) who operate within that system.

- Outcomes to be measured and reported on a routine basis should include:
 - Rates of therapeutic retention (including no-shows and drop-outs).
 - Number of sessions required to achieve desired outcomes (making note of baseline functioning/presentation, any relevant diagnoses and presence of comorbidities, and interventions utilised).
 - Nature and effectiveness of the therapeutic alliance.
 - Global wellbeing (as opposed to symptom specific measures) - this is more consumer focused.

Q. What approaches to monitoring and reporting are implemented internationally? What can Australia learn from developments in other countries?

- Feedback Informed Treatment (FIT) originated in the 1980s and since then has been recognised and utilised on an international scale as a means of gathering consumer feedback on the therapeutic alliance, process of therapy, and consumer's overall wellbeing and progress (Duncan, Miller & Sparks, 2004; Prescott, Maeschalck, & Miller, 2017). Developed by a team of researchers including Scott Miller and Barry Duncan, the standardised Outcome Rating Scale (ORS) and Session Rating Scale (SRS) measures facilitate this culture of feedback recognised as crucial for understanding whether desired client outcomes are being attained (Duncan, Miller & Sparks, 2004; Prescott, Maeschalck, & Miller, 2017). FIT has a positive effect on consumer retention (including no-shows and drop-outs), number of psychological sessions required to achieve desired outcomes, and effectiveness of treatment (Duncan, Miller & Sparks, 2004; Prescott, Maeschalck, & Miller, 2017).
- Although not a national mandate or recommendation, anecdotal evidence indicates that the FIT model is currently being adopted by a number of psychologists across both private and public sectors who have recognised its utility for monitoring and inviting discussions on various elements of the therapeutic alliance, client symptomatology, and progress towards client goals. It is anticipated that a continued shift towards such internationally-recognised, evidence-informed monitoring and reporting practices will improve the effectiveness of interventions at the individual level, empower clients to adopt a more active role in evaluating and improving the mental health services available to them, aid funding decisions dependent on the chronicity of mental health disorders and presentations, and offer more rich data for informing mental health policy.

Q. To what extent is currently collected information used to improve service efficiency and effectiveness?

- Information collected by government agencies such as Mental Health Services in Australia (MHSA) is presumably providing valuable insights into the prevalence of mental health disorders and establishing directions for policy and treatment priorities.
- At an independent practice level, depending on the nature of the service, the collection of information to evaluate the efficiency and effectiveness of the service being provided to clients may not be mandatory. However, evidence indicates that global wellbeing measures and FIT scales can improve service provision and client outcomes (Duncan, Miller & Sparks, 2004; Miller, Duncan, Brown, Sorrell, & Chalk, 2006; Prescott, Maeschalck, & Miller, 2017).
- FIT scales provide real time feedback on the efficacy of treatment and continually monitor a number of therapeutic factors to ensure that the psychological service being provided is aligned with the client's own therapeutic goals (Duncan, Miller & Sparks, 2004; Prescott, Maeschalck, & Miller, 2017). When individuals are able to access treatments that are tailored to their needs through "formal, real-time feedback" improvements are noted "in both retention and outcome" (Miller et al., 2006, p. 5). The implication being that utilising FIT scales to continually monitor the efficacy of treatment provides a method by which this information is being used to improve service efficiency and effectiveness at an individual and overall practice level.

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