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Submission to the Productivity Commission Inquiry into Mental Health and Suicide Prevention

December 2019 (Final Draft)

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About the College

ANU prides itself on its international reputation for health and medical sciences research and education. Our influential outreach activities include a national role in promoting research-driven public policy, and strong connections to fundamental biosciences.

Research areas

Mental health and cognition - We take an interdisciplinary approach, including world-class behavioural research with applications in e-health, mental health and wellbeing across the lifespan, chronic disease management, social psychology and perceptual psychology. ANU is a global leader in mental health, collaborating with governments, foundations and service providers.

Population health - ANU is striving to improve health outcomes through discovery, education and translation into effective health policy and practice. ANU is one of two Australian universities rated 'well above world standard' for public health and health service research in the 2012 Excellence in Research for Australia evaluation.

Health policy - Our highly regarded work in this area is breaking down barriers to health care such as access, costs and insufficient resources in Australia and globally. Our expertise spans epidemiology, economics, regulation, informatics and health care with a clear public policy translation emphasis.

Combating diseases and conditions - Our researchers are tackling complex diseases such as cancer, infection and immunity, diabetes, obesity, vision loss, neurological diseases and other conditions. We combine expertise in basic discovery, clinical medicine and practice through our hospital and health provider partnerships, and translation into policy to improve the health outcomes for all people.

About this Submission

The College wishes to congratulate the Productivity Commission for its willingness to investigate one of the most important and neglected areas of Australian health care. While there have been many reports and inquiries over past decades, the College is mindful of the specific and important opportunity this Inquiry represents, to set mental health properly in the context of social and economic development. We hope the suggestions made below help the Commission further strengthen the ideas and recommendations made in the Inquiry's final report.

On this basis, we present some ideas which reflect both the College's expertise and represent opportunities to further strengthen recommendations made in the draft report.

Staff at the College are available to the Commission to further elucidate the points raised in this submission or provide any other assistance.

Recommended Areas for Further Consideration

Mental Health Research Funding

One of our key considerations and concerns in relation to the draft report is in relation to funding for mental health and related research. The draft provides very limited consideration of research funding mechanisms. There are very few funding opportunities for mental health research, and success rates with major funders are exceedingly low for mental health research (Batterham et al 2016 and Christensen et al 2011). The model for establishing a clinical trials network for mental health requires careful consideration. The majority of existing clinical trials networks connect hospital services, which is an irrelevant setting for the vast majority of people experiencing mental ill health. A large proportion of people experiencing mental illness do not seek any clinical care. A clinical trials network would need to account for this challenge, connecting community-based services, primary care services and directly to consumers living in the community.

Issues surrounding mental health research funding are further complicated when considering the systemic issues associated with it. Existing mechanisms for funding, like the NHMRC, tend to have a clinical or medical focus. As such, research tends to be less likely to receive funding if it has a psychosocial or public health focus, which leads to limited opportunities for health eco-systems, lived experience, or preventative research. These areas of research are critical to placing mental health and illness in its proper social context, understanding causes and contributors to recovery (Furst et al 2019 and Banfield et al 2014).

Suggestions for the Final Report:

- The final report should call for the development of a new national mental health research strategy, taking into account health eco-system, lived experience, and preventative approaches, to guide funding priorities in a transparent manner.
- There should be some consideration to a mechanism to ensure mental health gets a fair share of total research funding.

Assessment Tools

There is little consideration in the draft recommendations of the potential benefits of more accurate and targeted assessment tools. The wholesale use of the K10 as a measure of psychological distress (including in the minimum dataset) may be irrelevant for many services and is a relatively weak proxy for specific mental health outcomes. More accurate measures of psychological distress exist (Batterham et al 2018). Recommendations for inclusion of accurate screening measures for specific mental health problems may also be beneficial, as would recommendations around more routine assessment of suicidal thoughts and behaviours. Furthermore, the use of (better) metrics of functioning and recovery may be more relevant than symptom measures in many service settings.

Regional decision-making

This suggestion relates to Information Request 23.1 in relation to the Architecture of the Future Information System. The focus of the draft report is on the 'Renovate' or 'Rebuild' models. While the Rebuild model seems sensible and more potent, we must be careful to avoid an undesirable separation between mental and physical health issues, given they often go hand in hand. Recommendation 22.1 (page 99) is where the Commission suggests that as part of a new national agreement the Council of Australian Governments

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

This recommendation is understandable given the focus here is on clearer governance. However, many people with mental illness also have physical co-morbidities and chronic conditions, such as diabetes, cardio-vascular disorders and the like. These are the main contributors to reduced life expectancy among this population. It is not possible to put the consumer at the centre of care while splitting physical from mental health, even if the aim is to create some administrative or financial simplicity. Contemporary thinking in good mental health care is focusing more on issues of integration. This recommendation promotes separation.

The draft report also places considerable stock in the capacity of activity-based funding to drive the development of community and hospital-avoidance focused mental health services, particularly those provided by the non-government sector. This contention deserves much more investigation.

Suggestions for the Final Report:

- The Rebuild model should be further crafted to ensure it avoids undesirable separation of the mental and physical health needs of people.
- The role of activity-based funding in providing the necessary structures and incentives to drive non-hospital care should be examined in more detail.

Mapping

There is another important issue here, which concerns the extent to which local regional decision-makers have the tools, skills and resources to properly plan and model the mental health system they need to address population needs (Salvador-Carulla et al 2005, 2007 and 2017). A key gap in the draft report was the failure to refer to the Atlases of Integrated Mental Health Care generated by the Centre for Mental Health Research, ANU (often working with partner organisations).

These Atlases use an international classification system developed by members of CMHR in collaboration with an international panel of experts in mental health care assessment and allow comparisons of the patterns of mental health care across different regions and countries.

This system has been used in over 34 countries (Romero et al, 2019) and the mapping in Australia now covers more than 50% of the Australian population and are part of a sophisticated suite of decision support tools which regional planners will need if they are to do better. More information on the Atlas and mapping can be found here: <https://rsph.anu.edu.au/research/projects/atlas-mental-health-care>.

Atlas evidence indicates that Australia is not following a community care approach in comparison with EU countries. There are major missing links that prevent setting up coherent pathways of care for consumers with moderate to severe mental health problems. The data reinforces the image of Australia as a hospital-based system with low access to mental health care. The data supports the recommendation of the National Mental Health Commission's 2014 report for significant investment in community services.

The data also reveals major regional differences in the pattern of service delivery, with significant differences in workforce profiles and service availability across different Primary Health Networks and between (and within) rural and urban areas. The Atlas permits formal and standardised comparisons between Australia and other countries.

In comparison to eight EU nations, Australia has some significant differences, including in relation to:

- Residential care (Hospital and community)
 - Higher number of acute wards per 100,000 pop but similar number of beds
 - Higher number of high intensity community residential beds but lower number of beds
 - Lower number of subacute (beds and services)
 - Absence of alternatives to hospitalization
 - Lower number of low intensity supported accommodation and community accommodation
- Outpatient care
 - Lower number of community mental health centres
 - Higher number of health and social outpatient care, mainly mobile
 - Higher number of emergency services (outpatient acute non mobile care)
- Day care
 - Lower number of day care and nearly absence of many types of day care
 - Similar number of low skilled low intensity low structured day care (social club)
 - Dearth of day care
 - Low structured day care
 - Low employment care mostly focused on supported accommodation
- Accessibility services
 - Nearly absent in Europe, where this type of care is provided as an integrated module in community mental health centres and other organisations. In Australia these services are provided by separate organisations

- High differences in Australia in care coordination, information and other accessibility across PHNs

The Atlas can drive useful comparisons. The figures below compare mental health service provision in 11 Primary Health Networks and 10 health districts in 8 European countries, per 100,000 population, for hospital and community residential care (Figure 1); outpatient and emergency care (Figure 2); and day care (Figure 3).

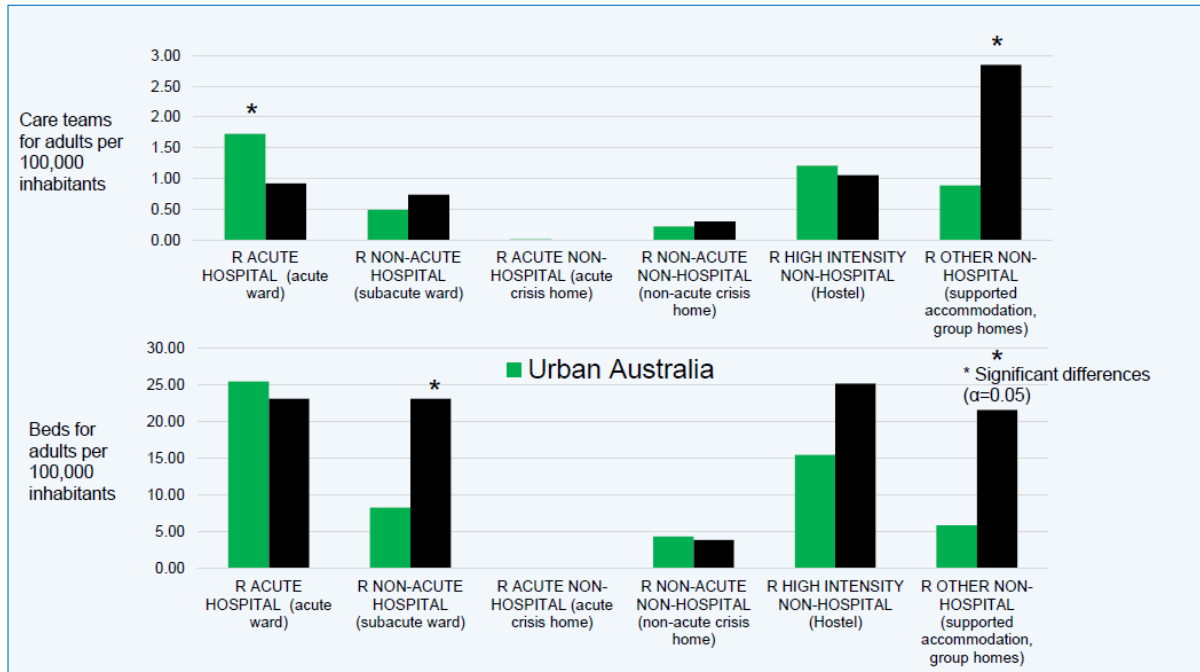


Figure 1 – Hospital and Residential Care

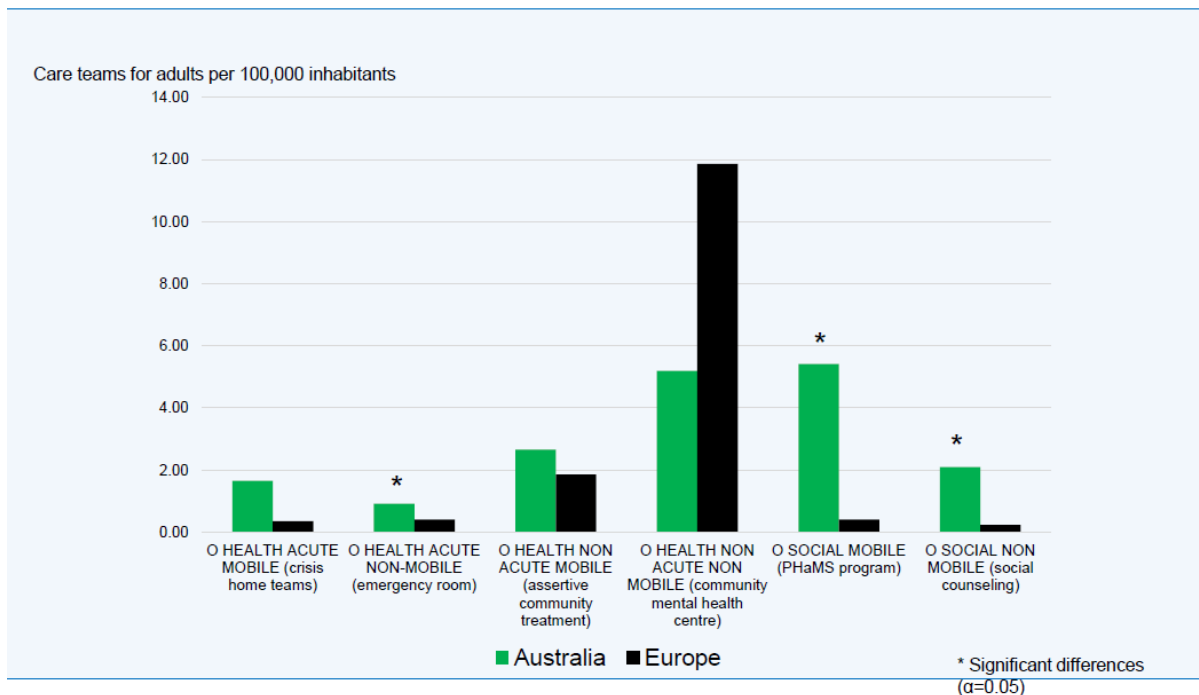


Figure 2 – Outpatient and emergency care

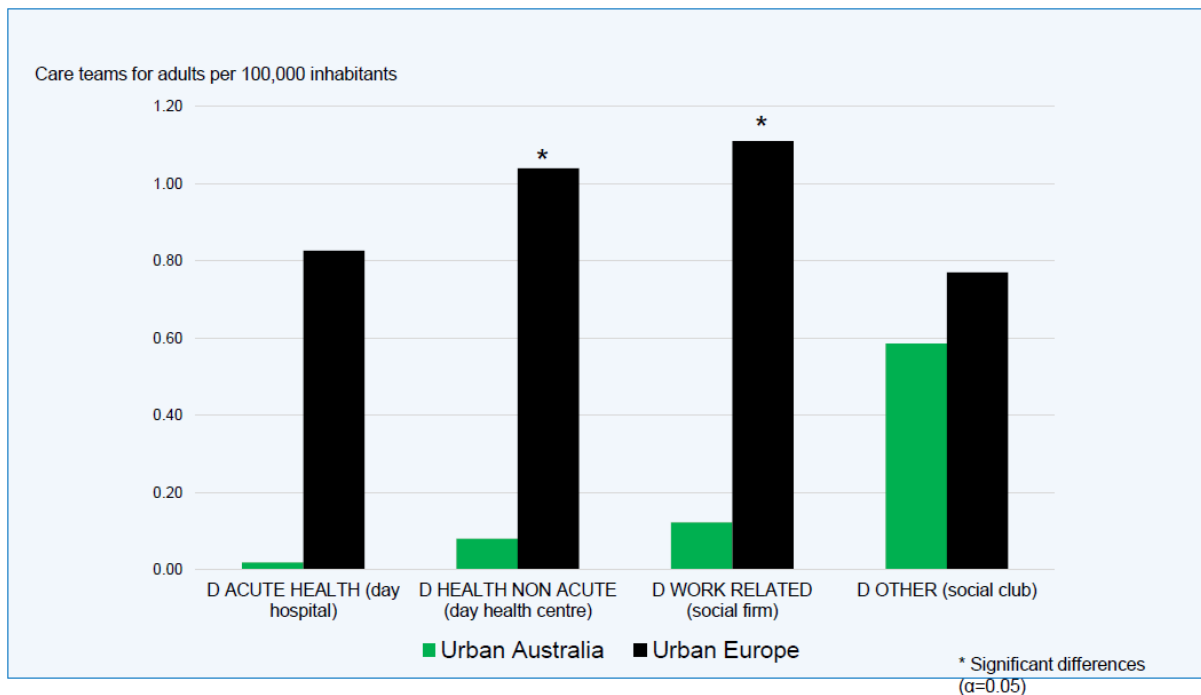


Figure 3 – Day Care

The draft report does refer to the National Mental Health Service Planning Framework. The support from CoAG for the Framework is acknowledged.

However, a recent project undertaken by the ANU suggests that the Framework has some important limitations, particularly that it does not permit useful regional and international comparisons to be established.

Its cost and complexity are affecting its utility among decision-makers. Licences to use the Framework are not being bought. Regions are operating with bespoke systems or with nothing. This is an undesirable approach to planning mental health in the 21st century.

We note that subsequent to the release of the draft report, the Commission has sought and received a comprehensive briefing on the Atlas from Professor Salvador-Carulla.

Suggestions for the Final Report:

- That the Productivity Commission (PC) recommends the Atlas be used to map the whole of Australia.
- A key focus of the mapping should be on psychosocial and community services.
- That the PC final report recommends an independent national stocktake of approaches to mental health planning and decision-making, ensuring a transparent and publicly accessible approach which fully reflects the social determinants of mental health.
- The PC could also recommend that as part of the stocktake, a scoping paper is developed to identify the range of decision-support tools, systems and skills necessary to make regional mental health planning a practical reality.

- The PC should embrace the concept of health eco-system research, in order to properly place the future development of mental health in proper context.

Consumer Engagement

We strongly agree with draft recommendation 22.3. However, consumer and carer engagement is likely to remain tokenistic in many settings unless it is properly resourced, and agencies are accountable for implementing strong systems to enhance meaningful participation.

Suggestions for the Final Report:

- That the PC recommend obtaining detail about how to build the organisational and staffing infrastructure necessary to ensure the representative, professional and strategic engagement of consumers (and carers) in all aspects of mental health planning and decision-making.

Stepped care

Comments here pertain to recommendations 5.3 and 6.1.

While stepped care models have promise, there is limited Level 1 (RCT or meta-analysis) evidence that stepped care is more effective or cost-effective than traditional forms of care (Van Straten et al, 2015).

The recommendation would benefit from the inclusion of a call to resource research and evaluation to assess the efficacy, safety, cost-effectiveness and implementation of stepped care models.

Stepped care is also predicated on the capacity to very closely monitor individual clients, to ensure they are on the right 'step' according to their needs and to determine the right time to shift between steps. This level of monitoring is not currently operating in Australia.

Suggestions for the Final Report:

- That the PC recommend a detailed review of approaches to organising mental health care, across the whole spectrum of needs, from self-care to forensic care, including the issue of monitoring and movement of consumers across this spectrum.

Link-me trial

In relation to recommendation draft Finding 5.1, it is worth noting that there is a range of other decision support tools for General Practitioners (GPs) that may be similarly effective to Link-me (Anderson et al 2019 and Kurian et al 2009).

Online programs

Recommendation 6.1 suggests that online treatments should be integrated with GP services but neglects the issue that many people who use online services either do not have a GP or do not want to engage with health services regarding their mental health. Furthermore, many health professionals are reluctant to recommend or support online treatments.

A paper cited in the review summarises the challenges around integration of online services (Batterham et al 2015).

Suggestions for the Final Report:

- That the PC recommend detailed research into how best to integrate online mental health programs as genuine elements in a more complete 'stepped care' response to mental illness. Critical here is the interface between online and face to face therapies.

Mental health training

We agree with recommendation 11.5 but would also like to emphasise that there is a particular gap around suicide prevention training for doctors as demonstrated by Chan et al 2014. This should be considered as part of future training needs.

Social & emotional learning programs; wellbeing leaders

These comments pertain to recommendations 17.3, 17.5. While social and emotional learning programs could be beneficial, there are limited programs with Level 1 evidence of effectiveness for reducing mental health symptoms or mental illness. Well-resourced, rigorous evaluations (preferably RCTs) of any such program should be undertaken before scaling up. In contrast, there is strong evidence that Cognitive Behavioural Therapy-based programs (including online programs such as Climate Schools) can have preventative effects on depression and anxiety outcomes in adolescents (Calear & Christensen 2010 and Werner-Seidler et al 2017). Indeed, a previous school-based trial has indicated that a CBT approach is significantly more effective than a non-specific emotional wellbeing approach (Pössel et al 2013).

In addition, the promotion of social and emotional learning programs above the delivery of evidence-based mental health prevention programs in schools that directly target anxiety, depression and suicide perpetuates the stigma surrounding mental health and send the message to young people that mental health issues are shameful and thus shouldn't be discussed or directly targeted. Young people need to be made aware of mental health problems, how to seek help for them and given the skills and strategies to directly prevent and treat them.

Similarly, there is limited evidence that wellbeing leaders (or pastoral care coordinators) have direct effects on mental health outcomes for young people, with considerable costs involved in resourcing such a program.

Considerable caution should be taken in implementing programs that have limited Level 1 evidence of effectiveness for mental health outcomes.

Suggestions for the Final Report:

- That evidence-based program that directly target anxiety, depression and suicide should be implemented in schools, as well as evidence-based social and emotional learning programs.
- That the wellbeing leader concept be carefully evaluated before resource-intensive national implementation is considered.

Stigma reduction

As stated in recommendation 20.1 stigma reduction in mental health is an important goal. However, there is a need for further research, as there are few programs that have demonstrated reliable change in individual attitudes in the long term. Furthermore, without changing broader attitudes around mental health and help-seeking, such as preferences for self-reliance, poor outcomes including delays in help seeking may not change.

Suggestions for the Final Report:

- That the PC support new research into the effectiveness of comparative approaches to mental health stigma reduction, focusing both on disorder-specific stigma and the stigma associated with seeking help.

Suicide and Aftercare

As stated in recommendation 21.1, universal aftercare is highly important. However, there remains a need to evaluate which elements of aftercare are most effective for whom, and identify optimal implementation models for aftercare services. Furthermore, it may be noted that aftercare is likely to be less effective if it is not complemented by a range of other programs, such as training of frontline workers, greater access to evidence-based treatments, and reducing access to lethal means, along with systems to evaluate and implement these programs.

Early Childhood

Addressing family resources, particularly time and money, to ensure equitable access to parent education programs. Recommendation 17.2 suggests that state and territory governments should expand the provision of parent education programs through child and family health centres.

Research on enrolment and engagement in preventative parenting education programs have found that lack of time and scheduling conflicts are the top barriers to participation and retention (Dumas, Nissley-Tsiopinis, & Moreland, 2007; Gross, Julion, & Fogg, 2001).

One study found that mothers who reported the lowest levels of time constraints were approximately three times more likely to enrol in a program than those who reported the highest time constraints (Dumka, Garza, Roosa, & Stoerzinger, 1997).

The program Raising Successful Children Program, an eight session preventative parent program designed for high-risk minority parents from low-income-inner city communities, considered time-related barriers to attendance by scheduling sessions at times convenient to parents, providing transport to families to and from the session, providing meals for all family members, and providing child care (Dumka et al., 1997). The participation rate for this program was 70%, much higher than in comparable projects. The SafeCare® Dad to Kids (Dad2K) program found that having a home-based program with flexible scheduling meant employed and unemployed fathers were equally able to prioritise program participation (Rostad, Self-Brown, Boyd Jr, Osborne, & Patterson, 2017).

The Success Through the Incredible Years Program, a five-year study of relatively low-cost behavioural programs for young children at risk of long-term conduct problems, incorporated measures to reduce time-related barriers to success (Foster, Johnson-Shelton, & Taylor, 2007). Time-costs accounted for 5-20% of total cost of the parenting program (Foster et al., 2007). While program costs could be reduced by not offering time-saving options (e.g. childcare and meals), this would likely affect the participation rate, and authors warn that ignoring non budgetary time costs can lead to bad policy decisions (Foster et al., 2007). While offering monetary incentives for attending parenting programs was found to increase enrolment, they were less effective in retention (Dumas, Begle, French, & Pearl, 2010; Pfitzner, Humphreys, & Hegarty, 2017).

Furthermore, the Family Wellbeing Framework developed by the Department of Social Services describes the interaction of factors impacting on family resources and function that are relevant to children's health outcomes. They list income and time, among others, as significant resources required for families to function and essential to children (Department of Social Services, 2018).

Suggestions for the Final Report:

- To strengthen the Productivity Commission's recommendation, it is vital that parent education programs consider the influence of family resources, particularly time and money, to ensure fair and equitable access to the program and resources.

[Expansion of LSAC funding to include analysis of existing data](#)

These comments pertain to recommendation 17.6 and the Longitudinal Study of Australian Children (LSAC).

There are 11 key research questions that guides the study, clustered around the themes of child and family functioning, health, childcare, and education such as:

- What factors influence a child's physical health and development over time? What is the effect of physical health on a child's overall wellbeing and on other specific outcomes, and how does this influence change over time?

- What are the impacts of children's use of time on individual outcomes (such as physical fitness and obesity, family relationships, social skills, and learning)? How does the impact of different patterns of time use change over time?

The LSAC includes a large variety of direct measures used in conjunction with indirect measures such as physical activity and BMI, which intersect with mental health. The vast array of measures enables detailed investigation into multiple factors and their complex interactions that affect children's health. Importantly, the findings from the LSAC have been instrumental in guiding and informing public policy and assisted in the development of the government Paid Parent Leave scheme and in childhood education and care.

Suggestions for the Final Report:

- The draft report already recommends the Australian Government fund the Australian Institute of Family Studies to establish new cohorts of the Longitudinal Study of Australian Children at regular intervals. We suggest the Productivity Commission's recommendation should be extended to include not just the funding of new cohorts but, the detailed analysis of existing data to take advantage of the wealth of data already collected.

Young adults

Inclusion of evidence from the LSAC on multiple factors pertaining to students' mental health are incorporated in preventative measures Part IV: Early intervention and prevention

Recommendation 18.2 to improve the student mental health and wellbeing strategy is welcomed. However, it is important to ensure that prevention programs address the social and economic drivers impacting on health and that programs are evidenced based.

The consideration and integration of the main drivers impacting on mental health is key to preventative programs and mitigating harm. Again, the LSAC serves as a vital resource for understanding the complex suite of factors and issues that contribute to students' mental health. It enables valuable insight into aspects such as education, family, employment, finances and social activities that are key to providing a holistic understanding of mental health in students. Due to the wealth of data the LSAC provides, the incorporation of this evidence into preventative strategies is crucial.

Suggestions for the Final Report:

- The Commission's recommendation should be expanded to ensure that evidence from the LSAC on the multiple drivers that effect student's mental health is integrated into preventative strategies.

Activities That Support the Mental Health and Wellbeing of Students

Counselling

At Information Request 3.1, the draft Report requests information or methodologies that would help in estimating the cost of activities undertaken by educational institutions in supporting mental health and wellbeing. Listed below are a range of activities undertaken in the university sector for which data would be available for calculating cost and cost-effectiveness. The importance of this range of initiatives is underscored by research indicating high levels of psychological distress among university students worldwide, including in Australia. For example, research has found that 84% of students from Australian universities report elevated levels of psychological distress, and that the proportion of students reporting “very high” levels of psychological distress is significantly higher than in the general population (19% compared to 3%) (Stallman, 2010).

The most common approach to supporting the mental health and wellbeing of university students is via *student counselling services*. Data indicate that these services are unable to meet the mental health needs of students (Stallman, 2012), and compare unfavourably with international standards, with key problems including very high counsellor to student ratios, lower average number of consultations per student, and lower mental health qualifications of counsellors.

Suggestions for the Final Report:

- We strongly support the Report’s draft recommendation 18.2 targeting student mental health and wellbeing in tertiary education institutions but would request the inclusion of strategies for the appropriate resourcing of student counselling services.

Uni Clinic and Online Services

In addition to student counselling services, those universities offering postgraduate programs in clinical psychology will typically have *Psychology Clinics* that function as placements for provisional psychologists to develop their clinical skills. University students comprise a significant proportion of the clients seen in these clinics, which can provide cost-effective care since clients are seen by provisional psychologists (under the close supervision of experienced clinical psychologists).

As an example, the Psychology Clinic at the Australian National University (ANU) offers individual assessment and treatment for key issues affecting the student population, such as depressive disorders, anxiety disorders, psychotic disorders, bipolar disorders, substance-related disorders, eating disorders, personality disorders, somatic symptom disorder, interpersonal difficulties, grief, university transition and work-related stress, procrastination, perfectionism, identity concerns, self-harm, and sleep difficulties.

Further broadening the reach of access to evidence-based approaches, the ANU Psychology Clinic offers skills-based group programs specifically targeting students including a Mood Management group, a Social Success group, a Sleep group, and an Emotional Regulation group. Broadening the reach of access to mental health and wellbeing support even further, the ANU Psychology Clinic has recently expanded to offer an e-Therapy Clinic designed to provide Psychological Treatments via video conferencing to remote areas of southern NSW. Services are provided through primary health networks and closely aligned with the Rural Clinical School of the ANU Medical School. Interventions focus on treating high prevalence conditions (e.g., anxiety and mood disorders) with mild to moderate severity/complexity. As such, these efforts go some distance to offering services to the underserved sector of the Australian population labelled as the “missing middle” in the Report. Moreover, this initiative is also supporting recommendations by the Report that greater capacity for appropriate online access to clinical services be enhanced.

A key contribution in this regard is not only service provision, but the robust training of psychology students to understand the unique skills and challenges of delivering services remotely and online as well as the unique aspects of remote mental health.

Suggestions for the Final Report:

- In this vein, in addition to draft recommendation 6.1, we suggest the Report also highlight the need for both electronic mental health services *and* robust training in the provision of online services.

Courses

In addition to clinical service delivery, some universities include *academic courses* designed to specifically target student mental health and wellbeing. For example, the Research School of Psychology at the ANU offers a course entitled “The Wellbeing Formula: The Science and Practice of Making a Good Life” (PSYC1005). The rationale for this course’s introduction was explicitly to provide an additional strategy to enhance student wellbeing, especially in the context of the overstretched student counselling services in Australian universities (Stallman, 2012). Specifically, the knowledge and practical skills taught in the course are designed to support student wellbeing using evidence-based strategies. This course has been comprehensively evaluated using both quantitative and qualitative approaches, which can contribute to establishing its cost-effectiveness.

Psychological health and safety in workplace health and safety (WHS) laws

These comments relate to recommendation 19.1.

Psychosocial aspects of work are strongly associated with mental health. Psychosocial job characteristics include high job strain (i.e. a combination of high work demands/intensity concurrent with low autonomy at work), inadequate supervisor support, low job security (e.g. precarious work and underemployment), non-standard work schedules, long work hours, workloads and work pressure and workplace bullying (Harvey et al., 2017; Stansfeld & Candy, 2006).

For example, workplace bullying is common in Australia with 7% of employees reporting current bullying and almost 50% reporting that they have been bullied at some point in their working life (Butterworth, Leach, & Kiely, 2016).

Bullying is associated with 2-3-fold increases in anxiety and depression (Butterworth et al., 2016) and there is evidence of an association with suicidal ideation (Leach, Poyser, & Butterworth, 2017).

Long hours and excessive workloads are a major factor underlying burnout, low back pain and musculoskeletal injuries. LaMontagne et al. 2008 found that the combination of excessive workloads and lack of autonomy (job strain) accounted 13.2% of depression rates among employed men [95% CI 1.1, 28.1] and 17.2% [95% CI 1.5, 34.9] among employed women. Estimation of job strain-attributable cases (21,437) versus "mental stress" compensation claims (696) suggest that claims statistics underestimate job strain-attributable depression by roughly 30-fold. Job strain and associated depression risks represent a substantial, preventable, and inequitably distributed public health problem. The social patterning of job strain-attributable depression parallels the social patterning of mental illness, suggesting that job strain is an important contributor to mental health inequalities.

Currently WHS efforts take a reactive stance on psychosocial hazards. They usually respond to psychosocial hazards after they create an injury or claim. There is no preventative strategy, or clear guidance on when psychosocial risks in the workplace become hazardous. Managers and supervisors, regulators and unions lack guidance on assessing or preventing psychosocial hazards.

In order to address some of these concerns, a recent review (Boland 2018) recommended to:

Amend the model WHS Regulations to deal with how to identify the psychosocial risks associated with psychological injury and the appropriate control measures to manage those risks.

Suggestions for the Final Report:

- The final report of the PC Inquiry should consider adopting Boland's recommendation, focusing on reducing psychosocial adversity at work via WHS regulations and guidelines, taking a proactive and preventive stance to prevent injury and support workplaces to ensure workplaces are mentally healthy environments for Australians.

Other Suggestions for the Final Report

Greater focus on young adults

We welcome the draft report's focus and recommendations in relation to the prevention and intervention of young adults. However, we would encourage the government to place a greater emphasis on the prevention of mental health disorders of young adults to further strengthen the report.

For young adults aged 16-24 years, mental health problems and disorders are responsible for the highest burden of disease accounting for almost 50% of all burden of disease for this age group (Australian Institute of Health and Welfare, 2011). In 2007, 9% of all young Australians experienced high or very high levels of psychological distress and approximately one in four reported at least one mental disorder in the preceding 12 months (Australian Institute of Health and Welfare, 2011).

As recognised by the Commission, university students are a particularly vulnerable group within this age range. Current evidence suggests that the prevalence of mental health problems is significantly higher in the student population and that they are more likely to report high or very high level of psychological distress compared to the general population (Browne, Munro, & Cass, 2017; Stallman, 2010).

However, whilst it is integral to combat mental health within the student population, it is equally important to consider preventative strategies accessible to all young Australians and not just those in tertiary institutions. Thus, population level strategies from a health system perspective should be considered.

In order to address the declining health status of young people in Australia, it is important to develop and implement population level prevention strategies that consider the diverse range of factors contributing to mental disorders.

The LSAC provides a plethora of national level data on many aspects and influences on young people's lives including academic, financial, social and family pressures. This survey provides the opportunity to investigate different risk trajectories for differing groups and enables the development of more nuanced and directed preventative strategies.

Suggestions for the Final Report:

- To strengthen the Commission’s report, a greater emphasis should be placed on the development of population level preventative strategies informed by evidence from the LSAC on the diverse range of factors influencing mental health in young adults.

Implementing a population health perspective

We welcome the draft report’s recommendation to invest in services beyond health. In addition to this, we encourage the government to recognise the population-level distribution and drivers of health. The interim report has a strong emphasis on individuals with mental illness. However, we believe that adding a population level approach would strengthen the report further. As well as identifying individuals at the highest risk of developing mental disorders, population health approaches seeks to understand the drivers of distributions of risk and disease (see Figure 4 - adapted from Rose, 2008) and ensure the overall distribution is optimal to support health for the greatest number of people.

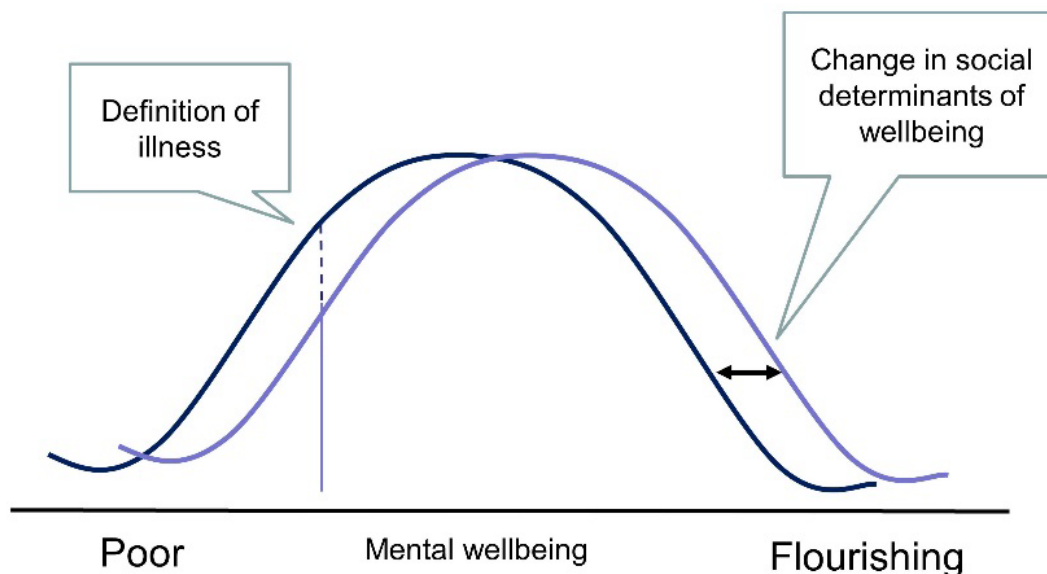


Figure 4. Shifting the Curve: Population distribution of mental health problems.

This approach recognises that high-risk individuals are only a small proportion of the overall population and so account for a small burden of disease. Thus, the greatest social and economic benefits will only be realised by shifting the distribution of risk in a positive direction with mass population health strategies (Rose, 2008).

This necessarily requires an understanding of how health is shaped by (and subsequently impacts) broader social determinants. Conversely, inattention to broader social drivers, for example, increases in poverty rates or the number of working poor, instability in incomes, job security and living arrangements, will at a population level push the curve backwards. This shifts the large group of people in the ‘middle’ towards greater likelihood (and occurrence) of clinical illness.

A population health approach considers the complex interactions of many interrelated factors such as the conditions, resources, opportunities and constraints within which people live, work, grow and age that affect mental health. Incorporating this system approach will facilitate both prevention and intervention strategies by making them widely accessible and relevant and equitable at the population level.

Suggestions for the Final Report:

- That the Australian Psychological Society and the Public Health Association of Australia are tasked with developing a National Mental Health Prevention plan that includes action to address the social determinants of mental health in Australia.
- Increased funding opportunities for public health practitioners, epidemiologists, and social scientists to apply multi-disciplinary approaches to develop, identify and implement effective preventative policies for mental health that focus on whole of population strategies and social and economic determinants.

The Role of Psychologists and Clinical Psychologists

While the Report states that the number of psychologists in Australia is adequate, there are a number of constraints and biases on their utilisation as well as existing structural limitations which result in major deficits in the quality of service provision, gaps in the types of services provided, and restrictions in equitable access to specialist mental health services.

- 1) The current MBS system incentivises psychologists to provide fee-for-service interventions either as focused psychological strategies or as psychological interventions. Besides the distortion these incentives create in who services are targeted towards (as noted in the Report), these incentives result in a “treatment focus” and a lack, or underutilisation, of psychologists in other important mental health services such as co-design, delivery, and training other health professionals in the delivery of prevention and early intervention strategies. Psychologists’ training and skills should equip them well to be at the forefront in these aspects of future mental health care and will require a considerable workforce given that these are population-wide interventions (as shown in Figure 5 below).

The implementation of the Report’s Draft Recommendation 17 on prevention and early intervention will require strategies and training to shift the focus of the psychological workforce towards also using their skills and knowledge to (1) identify and address factors which increase risk to mental health problems not only in children but across the lifespan (e.g., parental/maternal depression; harsh parenting; family violence; substance misuse; isolation) and (2) advocate to change social norms that act as deterrents to effective early intervention and prevention (e.g., seeing community support for at-risk parents and families as a key part of the solution to reducing the negative mental health impact of early childhood adversity).

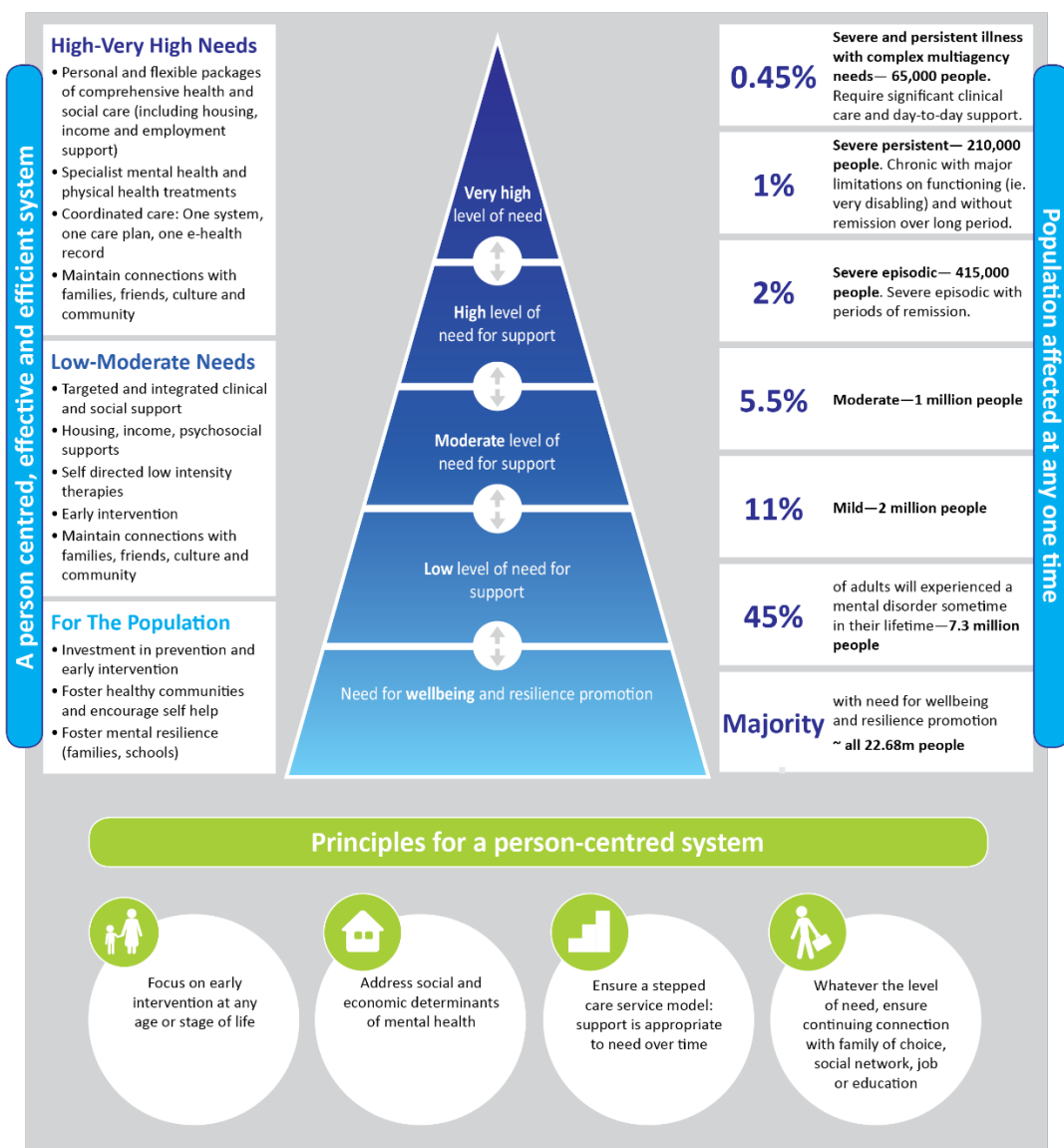


Figure 5. Proposed mental health system architecture (National Mental Health Commission, 2014).

Given the central importance of psychological science in these strategies, there is a key role to be played by the University sector in supporting the implementation of the Report’s recommendations around prevention, early intervention, and cross-sectorial involvement by co-designing science-based programs and evaluations with local agencies and partners with an interest in and engagement with people across the lifespan, from children and families to older adults.

- 2) The MBS system has also promoted the growth of psychologist numbers in primary care working as sole practitioners or in group practices of psychologists, which has not been matched by efforts to retain or recruit experienced psychologists and clinical psychologists in the public mental health system. As a result, public mental health services have fewer resources to develop psychological intervention programs which meet the needs of people who are not being provided with services under Better Access. At the same time, the core business of public mental health services in terms of providing services for the most seriously mentally ill Australians is adversely impacted because specialist clinical psychologists play an important role in the provision of psychological interventions to this group.

The implementation of the Report's recommendations directed at the delivery of proper treatment for people with moderate to severe mental disorders (the missing middle) will require strategies to enhance collaborative and integrative care (in both public and primary care systems) as well as personalised treatment approaches as more evidence accumulates to optimise treatment selection for disorders such as major depression, eating disorders, bipolar disorders, and obsessive-compulsive disorder. In regards to psychological treatments, the current 10 session limit for MBS rebates for all disorders (other than eating disorders) disregards the evidence about the optimal "dosage" for psychological problems for some clients where co-morbidity and complexity are the norm, which increases stress on patients seeking help for these problems and limits treatment effectiveness. The Report's recommendation to increase the number of sessions available under MBS for psychological interventions for certain disorders recognises this but also needs to consider the level of competencies of the practitioners who will deliver these extended interventions and the support offered to practitioners by the setting in which they work. Moreover, merely increasing access to clinicians operating alone (as encouraged by fee for service) fails to spur the development of the collaborative care necessary to respond effectively to complexity and comorbidity (Institute of Medicine 2006).

- 3) The adequate numbers of psychologists noted by the Report also masks real issues in the quality of this workforce. The modal standard for registration as a psychologist in Australia is a four-year Bachelor's degree. This is significantly below international standards for registration or licensing of individuals as practicing psychologists in order to provide psychological treatments. The US, Canada, the UK, and most European countries all require at least six years of university-based education as the basic standard for accreditation of psychologists and clinical psychologists before they can practice. The US, Canada, and the UK also have a longer doctoral level qualification as the requirement. This gap represents an ongoing challenge to the reform recommendations of the Report.

- 4) The draft Report notes that many of the initiatives and major changes in the delivery of mental health care, particularly in psychological interventions, in Australia such as Better Access and Headspace have been implemented without a corresponding plan to ensure evaluation of their impacts and accountability for their benefits and harms. It is important that changes resulting from the reform agenda and recommendations of the Report be independently evaluated. For example, the Report's support for the rapid expansion of applications aimed at translating cognitive-behavioural and other psychological interventions to digital platforms in the absence of a regulatory framework for ensuring the quality and efficacy of these platforms in order to protect consumers, risks repeating previous failed innovations. The integration of these modes of delivery into the mental health system needs to be done in a way that prioritises accountability and evidence over advocacy. For example, a recent study (Larsen et al., 2019) found that, of 46 apps which claimed effectiveness at diagnosing a mental health condition, improving symptoms, or enhancing self-management of the condition, only two described any evidence to support the use of the app and only one included a citation to published literature to allow peer review of the claims. None referenced a certification or accreditation processes. Thus the Report's recommendations in this regard need to be accompanied by the introduction of an independent body to evaluate and accredit mental health devices such as apps and online treatment programs in line with the accreditation of practitioners who deliver psychological assessments and interventions in-person or via technology such as videoconferencing.
- 5) Many researchers have documented the quality gap in mental health care in Australia (e.g., Jorm, 2015; 2019). Sawyer et al. (2019) noted that only 12% of children and adolescents with a mental disorder had direct contact with a health professional to allow provision of minimally adequate treatment, while Hobbs et al. (2015) reported that only 16% of adults with a mood or anxiety disorder received minimally adequate treatment. While there are many reasons for these shameful figures, improving the models of training of health practitioners in mental health (e.g., nurses and GPs) as the Report suggests must take a central role in reducing this quality gap.

Psychologists' training and skills will equip them well to be at the forefront in upskilling other professionals in psychological assessment and treatment. The university sector will be a key partner in the reform agenda to reduce this quality gap.

Suggestions for the Final Report:

Given the factors above, together with the recommendations already made in the draft report, the Inquiry's final report could point to a model in which the role of psychologists (and especially clinical psychologists whose training matches that of international standards) will be more fully utilised so that they can:

1. use their skills and knowledge to work with partners to develop and evaluate prevention and early intervention programs across the lifespan;
2. work in collaborative models of care, especially for moderate-severe mental health problems in private *and* public settings, and resourced to see patients for the required number of sessions for effective treatment;
3. utilise their training in the scientist-practitioner model to work with partners to incorporate accountability into their practice;
4. apply blended models of delivery of psychological interventions incorporating technological approaches (e.g., videoconferencing) as informed by the science; and
5. play a pivotal role in upskilling other health professionals in psychological prevention, assessment, and treatment.

Mental Health Treatment Plans

The Report requests further information regarding Mental Health Treatment Plans (MHTP) (Information request 5.2), including whether an MHTP Review be required to access additional sessions or whether a new referral will suffice. At that stage in the treatment process, the treating clinician will have a deep understanding of the patient's condition. They will have reported outcomes and provided a rationale for continuing treatment with additional sessions. As such, it may be more efficient for referring GPs to provide a referral for the additional sessions, rather than requiring them to complete the formal MHTP Review. This issue could be considered as part of broader consideration of accountability in relation to the provision of mental health services under Medicare (Rosenberg and Hickie 2019).

The Need to Build a Strong Evidence Base and Evaluative Feedback

At many junctures, the Report advocates for reforms suggested and supported by scientific evidence. In addition, it recognises that many areas of knowledge are weak and that a stronger evidence-base is required. Finally, the Report acknowledges the crucial role of the empirical evaluation of mental health systems and the efficacy of mental health interventions and reforms.

We strongly endorse the Report's recognition of clinical science as an invaluable tool towards the efficacious, ethical, and efficient development and distribution of mental health resources. However, we also recommend that the Report go further in recommending methods by which these outcomes can be achieved. For example, crucial to achieving evidence-informed care is the need for embedding personnel with appropriate training and expertise within clinical enterprises so that evaluative tools can be seamlessly integrated with practice. Given its emphasis on training empirical and analytic skills under the Scientist-Practitioner model, psychology is well-positioned to supply the workforce needed to achieve better evaluation outcomes.

In addition, we encourage the Report to also emphasize the need for governments to adequately resource mental health evaluation efforts in order that clinicians, administrators, and policy makers have the very best data on which to base the very best decisions and initiatives.

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