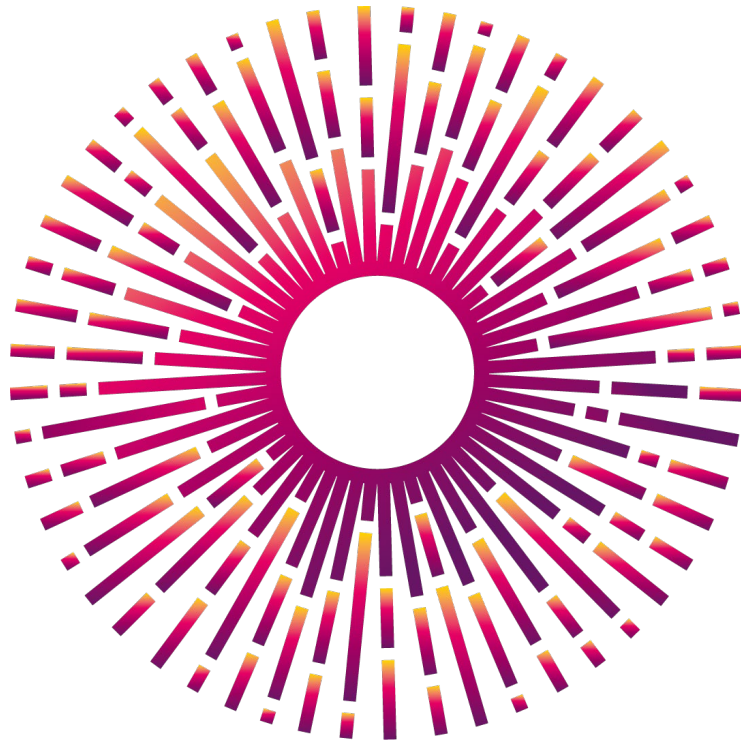




# Productivity Commission Inquiry into Mental Health

Submission from the Australian Institute of Family  
Studies





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## Glossary

Abbreviation	Description
AGRC	Australian Gambling Research Centre
AIFS	Australian Institute of Family Studies
BNLA	<i>Building a New Life in Australia</i> : The Longitudinal Study of Humanitarian Migrants
CALD	Culturally and linguistically diverse
GP	General practitioner
HILDA	Household, Income and Labour Dynamics in Australia Survey
LSAC	<i>Growing Up in Australia</i> : The Longitudinal Study of Australian Children
MBS	Medicare Benefits Schedule
NAPLAN	National Assessment Program – Literacy and Numeracy
NWCCMH	National Workforce Centre for Child Mental Health
PTSD	Post-traumatic stress disorder
TTM	<i>Ten to Men</i> : The Australian Longitudinal Study on Male Health



## Overview

The Australian Institute of Family Studies (AIFS) welcomes the Productivity Commission's Inquiry into Mental Health. This is a submission to the Commission's call for responses to the Draft Report (released in October 2019). Our responses are informed by the expertise of the researchers at AIFS, and align with the work we undertake to improve the lives of families in Australia.

AIFS is the Australian Government's key family research body and advisor on family wellbeing. We create and communicate knowledge to accelerate positive outcomes for families – when families thrive, Australia thrives. Our work aims to increase understanding of the factors helping or hindering the wellbeing of Australia's families, thereby building the evidence about 'what works for families' to inform policy and practice. We undertake and publish primary research across a broad range of issues affecting Australian families, including mental health. This research encompasses quantitative, qualitative and mixed-methods approaches to data collection, analysis and dissemination. We manage a number of major, large-scale longitudinal studies, and also regularly conduct policy and program evaluations. In our day-to-day work, and as a delivery partner of the National Workforce Centre for Child Mental Health (Emerging Minds), we directly translate research evidence to improve the mental health of Australian children and families.

As detailed in the Productivity Commission's Draft Report, there are several key issues relating to mental health that span identification, prevention, intervention and support systems and impact the experiences of Australian children and families. To achieve the goal of good mental health and wellbeing for all Australians, a systematic and coordinated evidence-based approach for decision making is required. Undertaking and translating high-quality and relevant research is vital to generating such evidence, thereby achieving the best possible outcomes for all people in Australia through better healthcare service delivery and policies.

This submission includes six broad responses and feedback to four information requests from the Productivity Commission.

Our responses expand on current evidence in the Draft Report, and are largely underpinned by our expertise and knowledge of relevant research gaps in Australia. In this context, we have drawn primarily on our own research related to the mental health and wellbeing of Australian families. Our responses focus particularly on the experiences and needs of vulnerable groups. They highlight the need to understand the pathways of intergenerational mental health, and underline the important interconnectivity between socio-demographic, economic, social, physical, biological and psychological factors that influence mental health and wellbeing outcomes. They also focus on how, when and where people engage with mental healthcare and what types of barriers impede access to professional support in Australia. We intend for this evidence to be informative in guiding the Commission's own final recommendations and in highlighting issues of particular interest and concern for Australian families.

Our responses are centred around the view that there is a sustained, high need in Australia for the creation, maintenance and dissemination of quality research on mental health. This evidence is crucial for high-level decision making and policy development. Specifically, our responses indicate a need for:

1. a more informed and evidence-based understanding of the intergenerational effects of mental health
2. a greater focus on recognising, and adjusting for, the unique experiences and mental health needs of disadvantaged and marginalised children and families
3. improvements to the employment and education participation and outcomes of children and families experiencing mental ill-health



4. a reconsideration of the current mental healthcare system and its accessibility for all Australians (including improvements regarding the mental health literacy of the general community, and accessibility and affordability of mental healthcare services, especially for disadvantaged Australians)
5. improved understanding of the intersections between gambling, mental ill-health, and other co-occurring issues to inform integrated prevention and harm reduction approaches
6. continued and expanded investment into Australian research with a focus on mental health.

Our submission also includes feedback regarding four information requests from the Draft Report for: information on out-of-pocket costs for mental healthcare (3.2); the utility of online treatment for culturally and linguistically diverse (CALD) people (6.1); under-utilised datasets (25.1); and data-sharing mechanisms (25.3). Broadly, our responses detail:

1. The linkage of existing datasets enables the provision of information on out-of-pocket costs for mental healthcare. Recent work commissioned by the Parenting Research Centre for the National Workforce Centre for Child Mental Health looked at the use of Medicare Benefits Schedule (MBS) healthcare services among Australian children; this work could be expanded to also analyse out-of-pocket expenses for mental healthcare use.
2. CALD communities experience high levels of stigma and mental ill-health but service uptake can be low. We highlight the need for online treatments that are accessible to a diverse audience (e.g. by eliminating language and cultural barriers), and for additional research to identify the specific mental health needs, including online mental health treatment, of a new cohort of recent humanitarian migrants to Australia.
3. There is a need to expand the utility of currently under-utilised datasets; for example, by increasing funding, 'discoverability' and data linkage capabilities.
4. Data-sharing mechanisms, including data linkage, are promising but are not currently being utilised to their full potential in Australia. The establishment of a national data infrastructure could lead to more streamlined data linkage.

## Responses to the Productivity Commission's Draft Report on Mental Health

### *Response 1: Improve knowledge about intergenerational mental health effects*

#### Key message

It is imperative that mental healthcare in Australia consider intergenerational health trajectories. In this context, AIFS welcomes the recommendation by the Productivity Commission to extend existing physical development checks on children aged 0–3 to include social and emotional wellbeing. We also support the recommendation to expand information programs for parents on children's social and emotional development. Based on the evidence, we think these interventions have great potential to improve children's social-emotional wellbeing and prevent mental health illness later in life by considering the family context.

We would also support expanded research capacity in Australia to more comprehensively study intergenerational mental health effects within families. In particular, it is essential to better understand the experiences and needs of children and families where someone in their



environment (i.e. other family members) is experiencing mental ill-health. Important groups to focus on include young carers, refugees and Indigenous communities.

In Australia, there are diverse contexts and situations in which families interact and care for each other, such as grandparents caring for young children and young children being carers of family members (Baxter & Warren, 2016; Warren & Edwards, 2017). We would like to underline the importance of considering mental health in the context of families and the intergenerational effects on mental health between grandparents, parents, children and siblings.

In particular, young carers have been identified as a priority group for policy makers in Australia. PricewaterhouseCoopers' baseline valuation report informs the Australian Priority Investment Approach to Welfare and has identified young carers as a key cohort for intervention due to their high lifetime welfare costs (PricewaterhouseCoopers Australia, 2016). The report indicates that young carers (aged 24 years and under) receiving carers' payments are particularly vulnerable to the risk of long-term welfare dependency. Indeed, over 60% of this cohort have not studied beyond high school; low levels of education can lead to young carers becoming welfare dependent. Estimates indicate that over 60% of young carers will be receiving income support in 10 years, and around 50% will be receiving income support in 20 years.

From our research using linked National Assessment Program – Literacy and Numeracy (NAPLAN) data, we know that, in 2014, 9% of 14–15 year olds had caring responsibilities for a household member, and approximately 20% of those were caring for a household member on a daily basis (Warren & Edwards, 2017). Being a young carer has a significant and substantial detrimental effect on school outcomes (Year 9 NAPLAN Scores for Reading and Numeracy), particularly for those with a high burden of care. Our research showed that boys who spent at least two hours per day caring for a household member were estimated to be behind by 1.9 years of schooling for Reading, and by 1.3 years for Numeracy. For girls, there was no significant effect on Numeracy scores but, for Reading, girls who spent at least two hours per day caring for a household member were estimated to be behind by 1.4 years of schooling (Warren & Edwards, 2017).

Other evidence also suggests that parents' mental health and wellbeing and behaviours affect children's wellbeing, and that there can be differential effects for mothers and fathers. For example, parent drinking and adolescent drinking are strongly related (Homel & Warren, 2017). Specifically, for resident mothers and fathers who were current drinkers, consuming alcohol at a risky level was associated with increased rates of adolescent drinking. Results suggested that a mother's drinking was more strongly associated with drinking for boys, while a father's drinking was more strongly associated with drinking for girls.

Our research using data from *Growing Up in Australia: The Longitudinal Study of Australian Children (LSAC)* has further shown that parents' mental health and parenting practices play a critical role in children's wellbeing in childhood and adolescence. Recent research commissioned by Emerging Minds: National Workforce Centre for Child Mental Health (NWCCMH)<sup>1</sup> showed that, among children aged 4–13, increasing the frequency of warm and consistent parenting, and reducing the frequency of hostile parenting practices, improves the social-emotional wellbeing of children at any stage in childhood. Further, the mother's mental health problems during pregnancy, as well as the mother's moderate or high levels of psychological distress during childhood, were associated with higher levels of social-emotional difficulties in the child in the pre-school years.

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<sup>1</sup> This research was commissioned by Emerging Minds through the National Workforce Centre for Child Mental Health. The National Workforce Centre for Child Mental Health is funded by the Australian Government Department of Health under the National Support for Child and Youth Mental Health Program. The Parenting Research Centre fulfilled the role of Contract and Project Manager for this work in collaboration with the Australian Institute of Family Studies (AIFS). This research is currently in preparation for publication.



Similar indicators of intergenerational mental health effects have been found using data from *Building a New Life in Australia: The Longitudinal Study of Humanitarian Migrants* (BNLA) to explore the effects of refugee parents' mental health and behaviours on their children's wellbeing in the first years after arriving in Australia. Specifically, the mental health and parenting behaviours of refugee parents (Bryant et al., 2018), and their prolonged grief (Bryant et al., 2019), directly affected their children's wellbeing. These findings again demonstrate the universal pathways in which mental health difficulties can be passed through generations.

In consideration of these findings, a better understanding of the impact of caring responsibilities on physical and mental health outcomes is needed, especially the effects of ongoing or longer-term caring responsibilities. Existing longitudinal studies could be leveraged to investigate such issues over time. In addition, a qualitative research approach could be beneficial for improving our understanding of the specific experiences and needs of young carers in Australia now and in the future.

## **Response 2: Recognise the unique needs and experiences of, and provide tailored services and supports for, disadvantaged and marginalised communities**

### **Key message**

The serious and potentially long-term mental ill-health outcomes resulting from experiences of disadvantage, especially systemic or prolonged disadvantage, should be considered during the development, implementation and modification of mental health policies and programs. Further, the creation of stable housing solutions could result in positive outcomes for those with mental ill-health and those from vulnerable groups, as well as for children whose development and wellbeing may be adversely affected by housing instability in early life.

Our research at AIFS repeatedly demonstrates the multifaceted effects that disadvantage, especially when cumulative, can have on a range of outcomes, including mental health. For example, LSAC findings indicated that Aboriginal and Torres Strait Islander children experience additional risks due to adverse educational, occupational, social and health outcomes experienced throughout childhood (Baxter, 2013; Forrest & Edwards, 2015; Priest, Baxter, & Hayes, 2012). The unique needs of such groups should be considered when designing, implementing and modifying mental health policies and programs.

The Productivity Commission's Draft Report acknowledges that people from CALD backgrounds, particularly refugees, may face many challenges regarding their mental health. Research using BNLA data has shown that refugees experience high levels of psychological distress and post-traumatic stress disorder (PTSD; Chen, Hall, Ling, & Renzaho, 2018). This is due, in part, to pre-migration experiences but also to the difficulties of the settlement process. Research by Chen and colleagues (2018) showed that settlement stressors compounded the effects of pre-migration trauma on mental health problems. In particular, loneliness and social integration stressors had a negative effect on mental health and exacerbated the negative effect of pre-migration experiences on mental health problems. Therefore, any strategy directed at improving the mental health of migrants in general, and refugees in particular, needs to incorporate psychosocial support along with settlement services. Further research involving humanitarian migrants in Australia is necessary to identify which psychosocial supports are most effective in supporting the wellbeing of this population.

With reference to *Reform Area 3* in the Draft Report (investment in long-term housing solutions for those with severe mental illness), housing conditions have consistently been shown to be related to a variety of developmental outcomes, including physical health, socio-economic wellbeing and learning. For example, several large-scale studies from the United States have





shown that higher levels of residential mobility have a negative influence on children's wellbeing. This is mainly due to disruptions to social connections, particularly if children have to move schools and make new friends (Dockery et al., 2010; Harkness & Newman, 2005; Jelleyman & Spencer, 2008; Michael, 2002). Much of our research has also demonstrated the detrimental effects of unstable accommodation on individual and family health and wellbeing. Using LSAC data, a study of associations between housing conditions and children's developmental outcomes found that, while overcrowding had the largest negative impact for learning outcomes, frequent moves, renting (versus owning), and housing affordability stress were shown to be negatively associated with children's social and emotional wellbeing (Dockery, Ong, Colquhoun, Li, & Kendall, 2013).

In addition to unstable accommodation, housing-related stress due to factors such as affordability and availability further compound the negative effects that housing problems can have on wellbeing. LSAC findings indicated that 10–14% of children were living in a household experiencing housing stress at any particular point in time, with those living in rental accommodation much more likely to be in households experiencing affordability stress (Warren, 2018a). In 2014, around one-third of children whose families were living in private rental accommodation were living in a household experiencing housing affordability stress. At age 2–3, 6% of children were living in overcrowded households. By age 6–7, this percentage had increased to around 9% and, at age 14–15, 8% of study children were living in overcrowded housing. By age 0–1, 17% of children had moved at least once. By age 14–15, only 22% had remained in the same home for their entire life – 22% had moved once and 56% had moved house at least twice since birth.

Given the above findings, the creation of stable and safe accommodation options in Australia would likely lead to positive mental health outcomes, especially among vulnerable and disadvantaged groups. Providing secure housing early in life could lead to better development and wellbeing outcomes.

### **Response 3: Improve employment and education participation and outcomes for those with mental ill-health**

#### **Key message**

Better understanding is needed of how mental ill-health affects children's and adults' engagement with education and employment. We support undertaking additional research on this topic, and leveraging available research datasets and expertise to maximise positive outcomes. There is evidence to suggest the value in exploring the efficacy of school resilience programs in Australian institutions to support children in their pursuit of education and to provide additional assistance to children at risk of school disengagement.

Evidence strongly suggests that those with mental ill-health find it more difficult to engage in education and employment and, when they do, they often report more negative associated outcomes or dissatisfaction (Family and Community Development Committee, 2012). For children of school age, school transitions can be very challenging and this can affect their engagement with school. Along these lines, LSAC data have shown that children who report experiencing social-emotional difficulties before or during the transition from primary to secondary school are significantly more likely to also experience problems in secondary school (Maguire & Yu, 2015). LSAC data have also indicated that substantial numbers (40%) of children aged 10–11 years felt 'fairly worried' or 'very worried' about starting high school (Vassallo & Swami, 2019). If not addressed, these worries may exacerbate mental health problems and lead to disengagement from school.





In addition to expanding the pathways for identifying and supporting those with mental health difficulties, it is important to preventatively foster resilience in adolescents; for example, by facilitating social connectedness and reducing loneliness. Research using LSAC data showed that resilience was higher among adolescents who had at least one close friend that they could communicate with or trust in relation to problems (Evans-Whipp & Gasser, 2019a). This research also showed that resilience was higher among adolescents who had family support or who had a greater sense of belonging at their school (Evans-Whipp & Gasser, 2019a). Resilience-building programs could therefore include components to improve social skills and school engagement.

To assist these efforts, it's recommended that holistic preventative approaches be considered that take into account physical activity, diet and sleep, given that these factors have also been shown to be related to mental health and wellbeing among young people (Evans-Whipp & Gasser, 2019a, 2019b; Gasser, Evans-Whipp, & Terhaag, 2019). For example, in LSAC, insufficient sleep (i.e. not meeting recommended sleep guidelines) was associated with symptoms of anxiety and depression, as well as unhappiness at ages 12–17 (Evans-Whipp & Gasser, 2019b). Diversified approaches to fostering wellbeing and resilience might result in better outcomes and take pressure off already over-burdened mental healthcare systems.

Research indicates that engagement in employment can also be negatively affected by mental ill-health. For example, LSAC data have shown that children (especially boys) who experience social-emotional difficulties at an earlier age are less likely to be employed at age 14–15 years (Baxter & Warren, 2017). Further, BNLA findings have demonstrated that refugees with health difficulties were significantly less likely to be employed (Centre for Policy Development, 2017). More research is needed to explore experiences of employment – including barriers to employment – among those who experience mental ill-health across the lifespan.

## Response 4: Increase healthcare use, help seeking and mental health literacy among at-risk Australians

### Key message

There are serious gaps in healthcare use, help-seeking and mental health literacy among many Australians, especially those who are disadvantaged. We need improved understanding of how people use healthcare, and of what the barriers and enablers to service use are. This could help improve service design and access to services. A comprehensive research strategy would be one way of helping to build this understanding. Funding and evaluation of targeted national public health campaigns could also improve mental health literacy for at-risk Australians and reduce the stigma associated with mental ill-health.

Understanding patterns of healthcare use, help seeking and the factors that affect these health behaviours is crucial to identifying knowledge gaps and addressing barriers to professional support. A significant body of research exists on mental healthcare use; however, there is still a paucity of knowledge about patterns of mental healthcare use and factors affecting service access over time. Longitudinal studies such as LSAC, BNLA and *Ten to Men: The Australian Longitudinal Study on Male Health (TTM)* collect data on healthcare use and mental health literacy among certain sub-populations. Data linkage (e.g. with MBS datasets) offers opportunities for exploring complex usage behaviours and translating these findings for policy makers, service providers and other key decision makers.

Low levels of mental health literacy among humanitarian migrants (May, Rapee, Coello, Momartin, & Aroche, 2014; Slewa-Younan et al., 2014), together with a high incidence of mental health problems among this group, highlights scope for improvement. The latest wave of BNLA



shows that 38% of respondents who met the criteria for likely PTSD<sup>2</sup> and 26% of those with probable serious mental illness<sup>3</sup> reported they 'did not need help for emotional problems'. Help seeking for emotional problems is relatively low among humanitarian migrants. In the BNLA sample (at Wave 5), only 51% of those meeting the criteria for PTSD and 59% of those who were likely to have a serious mental illness received help for emotional problems in the last 12 months (Slewa-Younan, Rioseco, Guajardo, & Mond, 2019). It is important to note that, for some communities, strong religious or spiritual beliefs about mental health may prevent them from seeking professional help (May et al., 2014; Slewa-Younan et al., 2014). Increased awareness of mental health conditions and effective treatments among migrant families and communities, as well as improved access to culturally appropriate services, is therefore required.

Healthcare use among those from disadvantaged backgrounds is generally low. Analyses of LSAC data have shown that there are significant differences in children's use of healthcare services depending on household income (Warren, 2018b). For example, in early childhood and also in the primary school years, children in families in the top half of the equivalised income distribution were more likely to have seen a general practitioner (GP) in the previous 12 months than those in households in the lowest 25% of equivalised household income. In the primary school years and in adolescence, the likelihood of having been to a specialist was also higher among those from families in the top quarter of equivalised household income, than those in the lowest quarter. Further, compared to families in the lowest quartile of equivalised household income, the odds of reporting difficulties accessing health services were significantly lower for those in the top half of the income distribution. This difference was especially evident for adolescents, with the odds of reporting difficulties with access 56 percentage points lower for those in the top half of the income distribution, compared to those in the lowest income quartile.

Recent research (commissioned by the NWCCMH) investigated patterns of health and support service use among Australian children aged 4–5 to 12–13 years (Warren, Quinn, & Daraganova, in press). This study used MBS data and self-report responses from LSAC children to explore whether children at risk of experiencing poor social-emotional wellbeing and psychological adjustment demonstrated different patterns of service use compared to other children. The research highlighted the utility of longitudinal primary and secondary linked data sources to investigate specific health concerns among the general population and certain sub-groups over time. The ability to identify gaps in service provision and access is also integral to effectively preventing, caring for and treating health concerns; this study demonstrated that current Australian data sources have the capacity to inform timely and appropriate responses to health issues.

Both data sources pointed to elevated rates of contact with frontline services among Australian children at risk of experiencing psychological adjustment issues such as hyperactivity, emotional symptoms, and conduct and peer problems across all ages. For example, the MBS data indicated that the usage rates of paediatricians, GPs specifically for mental health concerns and psychologists were consistently – and significantly – higher among children at risk of experiencing psychosocial adjustment issues. Despite this, findings indicated that substantial proportions of children at elevated risk of experiencing poor social-emotional wellbeing and psychological adjustment were not accessing services more likely to specifically address these issues in children, such as psychiatric and behavioural therapy services, paediatricians and psychologists.

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<sup>2</sup> PTSD symptoms were assessed with the PTSD-8, which is derived from the Harvard Trauma Questionnaire (HTQ).

<sup>3</sup> Measured with the Kessler Screening Scale for Psychological Distress (K6). Respondents with high levels of distress (scores of 19 or above in a 6 to 30 scale) were classified as likely to have a serious mental illness.



## Response 5: Improve understanding of the intersections between gambling, mental ill-health and other co-occurring issues to inform integrated prevention and harm reduction approaches

### Key message

We support the collection of comprehensive information about trends in gambling consumption, related harms and mental ill-health via a proposed National Gambling Reporting System (NGRS; to be piloted by AIFS in 2020). A scaled-up NGRS would provide regular (annual) and systematic monitoring of trends within and across Australian jurisdictions, via cross-sectional surveys of people who gamble, interviews with professionals who work in the gambling and allied health sectors, and analysis of secondary data sources. The NGRS would identify emerging issues warranting further investigation and help to inform the development and implementation of evidence-based policy and practice responses to reduce co-occurring gambling (and related) harms and mental ill-health in the community.

Gambling is a major public policy issue in Australia, affecting the health and wellbeing of individuals and families in a range of ways. Recent estimates suggest that Australians lose approximately \$25 billion on legal forms of gambling every year, representing the largest per capita losses in the world (Queensland Government Statistician's Office (QGSO), 2019). The social costs of gambling, including adverse effects to mental, physical, emotional, relationship and family wellbeing, were estimated at around \$7 billion in Victoria alone in 2014–15; of these costs, emotional and psychological harms accounted for approximately \$1.127 billion. The cost of emotional distress due to suicidal ideation was estimated to be approximately \$289 million, with \$176 million attributable to depression linked to problematic gambling (Browne et al., 2017). Further, gambling-related harms not only negatively affect the people directly involved but also their families, peers and the wider community. Goodwin, Browne, Rockloff, and Rose (2017) estimated that, on average, six others are directly affected by a person gambling at high-risk levels, with three others and one other affected by those gambling at moderate- and low-risk levels, respectively.

The growing evidence base on the intersectionality between mental health conditions and gambling-related harm (and other co-occurring issues such as alcohol and other substance misuse) was previously described in the 2019 *'Focusing on Prevention' Joint Submission to the Productivity Commission Inquiry into Mental Health* (VicHealth and Partners, 2019), and the Victorian Responsible Gambling Foundation's (VRGF) *Submission to the Royal Commission into Victoria's Mental Health System* (Victorian Responsible Gambling Foundation (VRGF), 2019). These submissions highlighted findings from prevalence studies (Hare, 2015) and systematic reviews and meta-analyses of population surveys (Lorains, Cowlshaw, & Thomas, 2011) that there was a high prevalence of mental health conditions among those who experience harm from gambling.

These findings are further supported by other published and unpublished research conducted by the Australian Gambling Research Centre (AGRC) at AIFS. For example, a recent study of young Australians (aged 18–35 years) who wager online found that one in four (25%) were classified as experiencing some level of psychological distress (as measured by the Kessler 10 Scale; unpublished AGRC data). Another study found that people who wager online scored significantly lower on personal wellbeing when compared to the Australian general population (as measured by the Personal Wellbeing Index; Jenkinson, Khokhar, Tajin, Jatkar, & Deblaquiere, 2019). Further, our research found that alcohol consumption as a co-occurring behaviour with online wagering was associated with greater levels of self-reported negative impacts on mental health (unpublished AGRC data). Other qualitative research conducted with people who gamble using



land-based electronic gambling machines (EGMs or 'pokies') found that almost all participants, along with their significant others, reported decreased mental health related to gambling in their lives (Rintoul & Deblaquiere, 2019).

Despite the growing evidence base regarding the intersections between mental ill-health, gambling and other co-occurring issues, gambling-related harm is not currently mentioned in Victorian public health, mental health or suicide prevention plans; as noted in the VRGF's (2019) *Submission to the Royal Commission into Victoria's Mental Health System*. To reduce the harms associated with the co-occurrence of gambling, related behaviours and mental health conditions, and contribute to appropriate policy responses, better understanding of the causes, interactions and long-term effects of such co-morbidities is required.

## Response 6: Continue and expand investment of research in Australia with a focus on mental health

### Key message

An important avenue for increasing understanding of the key issues detailed in the above sections is continued funding of research that investigates issues relevant to mental ill-health and the needs of diverse populations. In this context, AIFS supports the recommendation in the Draft Report that the government should continue to 'fund the Australian Institute of Family Studies to establish new cohorts of the Longitudinal Study of Australian Children at regular intervals' (Draft Report, Vol. 1, page 87). To improve our capability to detect and monitor issues related to mental health that affect certain sub-groups, we suggest expanding this recommendation to include other studies, such as BNLA and TTM.

In general, we need to recruit new cohorts to allow for the inclusion of emerging generations and evolving communities in Australia. This is necessary for the in-depth investigation of specific trajectories and any changes over time that affect diverse sub-populations. It also allows us to study generational shifts that affect the development and wellbeing of all Australians.

Other important forms of research to consider funding include the mapping and evaluation of existing services for people with mental ill-health, in addition to piloting new approaches developed in consideration of the best available evidence.

Longitudinal studies afford unique opportunities to detect, monitor and learn about diverse health issues at different ages and over the life course to create a robust evidence base for informing appropriate service delivery and policy improvements in response to dynamic social environments. Such studies provide researchers with the ability to explore causal processes and relationships and changing patterns over time, which aids in identifying optimal 'window' periods for the timely implementation of prevention and intervention efforts. In Australia there exists a rich set of longitudinal datasets, which can be used to detect, monitor and investigate mental health issues. These include studies undertaken by AIFS (e.g. LSAC, BNLA and TTM) and other projects targeting different sub-populations such as the Australian Longitudinal Study on Women's Health and the Household, Income and Labour Dynamics in Australia (HILDA) Survey.

The creation and maintenance of studies such as these requires secure, ongoing funding and resourcing investment to collect and monitor data quality, in addition to supporting stakeholders and data users to make the most of collected data. We therefore agree with – and support – *Draft Recommendation 18.11* for funding to establish new cohorts of LSAC at regular intervals. As noted in the Draft Report, the majority of those who develop mental ill-health experience symptoms before the age of 25. LSAC has been used to identify early childhood risk factors for self-harm and suicidality in teenage years, such as early childhood temperament, parent–child conflict and a poor sense of belonging at school (Daraganova, 2017). Further, childhood is punctuated by a big range of significant life events and transitions, such as puberty and changing



schools, that can be particularly challenging to navigate. Mental ill-health is not uncommon during these periods and a significant proportion of children experience on-going difficulties (Maguire & Yu, 2015; Mullan, 2014; Warren & Yu, 2016). To identify, prevent, manage and treat such issues effectively and in a timely manner, longitudinal research is vital for informing our understanding of the development and progression of mental ill-health to identify early risk and protective factors, and to highlight what services and supports do – or do not – work for young children and their families.

In addition to continued and expanded investment in longitudinal studies, we would welcome governmental support for other research approaches to improve our understanding of – and address – mental ill-health and poor wellbeing in Australia. This could include the mapping and evaluation of existing services for people with mental ill-health, qualitative research to enhance our understanding of barriers and enablers to professional support for mental health, and the piloting of new approaches developed in consideration of the best available evidence.

## Responses to information requests in the Draft Report

In addition to the above, we would like to respond to four information requests identified in the Draft Report:

- out-of-pocket costs for mental healthcare (3.2)
- online treatment for CALD people (6.1)
- under-utilised datasets (25.1)
- data-sharing mechanisms (25.3).

AIFS' capability includes a dedicated Data Linkage team that specialises in data management and sharing mechanisms. Issues of data security, access and data quality are crucial to maximising the utility of national and administrative datasets, especially when they are linked across institutions and jurisdictions. The responses to these information requests rely heavily on our data management and linkage expertise.

### Information request 3.2 — Out-of-pocket costs for mental healthcare

Recent research at AIFS using linked LSAC-MBS data allowed in-depth investigation of service use patterns among LSAC children, with a focus on MBS service use according to risk of experiencing poor social-emotional outcomes. One area not investigated by this research was out-of-pocket costs for MBS service visits; however, these data are available. Future analyses could focus on financial costs to families using various MBS mental health services, including those provided by GPs and also mental health-specific professionals such as psychologists. Such research would be particularly valuable for identifying system gaps and barriers and future needs in relation to the provision of mental health services.

### Information request 6.1 — Supported online treatment for culturally and linguistically diverse people

Given high levels of stigma experienced by CALD communities and a high prevalence of mental illness among humanitarian migrants, online treatments could potentially increase the use of services among disadvantaged and marginalised groups such as these. As outlined in the





Productivity Commission's Draft Report, supported online treatments have helped thousands of Australians improve their mental wellbeing.

BNLA findings indicated that the majority of humanitarian migrants have access to the internet; 82% of households had home internet access at Wave 3, and over half of respondents with access to the internet went online on a daily basis (at the last wave of data collection, only 11% did not use the internet). Despite high access to the internet among humanitarian migrants and refugees, their uptake of online services is low. For example, at Wave 5 of BNLA, only 40% reported paying bills online and 49% used the internet to browse information. This compares to high (80%) levels of use to connect with family and friends back home.

Language barriers are likely to play an important role here. Indeed, after most BNLA respondents had lived in Australia for four years or longer, one-third reported being unable to read English well, and 18% reported being unable to read English at all. Any online treatment would therefore require extensive development in terms of ensuring the use of suitable language and cultural appropriateness. In addition to language and cultural barriers, work needs to be done with CALD communities to improve mental health literacy and their navigation of Australia's healthcare systems.

To tailor appropriate and accessible mental health treatments for CALD groups, online or otherwise, it is necessary to have up-to-date data on their specific health needs. Along these lines, there is potential for further analysis of data collected during the first five waves of BNLA; however, the composition of the Australian humanitarian program has changed since the commencement of BNLA, highlighting the need for research involving new cohorts of recent arrivals. Further investigation of factors that have helped humanitarian migrants in Australia to overcome mental health challenges is also required.

## Information request 25.1 — Under-utilised datasets

As noted above, in Australia there are a number of longitudinal datasets that are used to examine issues related to mental health, including LSAC, BNLA, the Australian Longitudinal Study on Women's Health, TTM and HILDA. Overall, these data assets are under-utilised in relation to mental health research for numerous reasons, including:

- limited funding and resources to maximise use of the data, including promotion and user support (e.g. data-user workshops)
- a lack of 'discoverability' of the data and absence of centralised infrastructure
- limited utility; for example, due to a lack of data linkage.

To illustrate this: there are data available from five waves of BNLA data collection, yet existing research using any BNLA data is lacking. In particular, the longitudinal nature of the data as well as information at the couple or family level have not been fully utilised. In general, there is a dearth of research focused on improving the mental health of humanitarian migrants in Australia. To date, most studies in this discipline have focused on descriptively establishing the poorer mental health of individual humanitarian migrants and the influence of pre-migration factors, as well as settlement stressors, on mental health. Only one study has documented mental health at the family level, focusing on the effect of parents' PTSD on their parenting practices and their children's emotional wellbeing (Bryant et al., 2018).

Although the research currently available is undoubtedly important, a systematic analysis of the environmental, individual and family factors that affect the mental health of humanitarian migrants and their families is warranted to understand the particular needs of this group, and to inform approaches to supporting and enhancing their wellbeing. Co-design at the front end of study development and implementation (e.g. in consultation with humanitarian migrants and people with





mental ill-health) is fundamental to creating good research; while providing resourcing for Knowledge Translation activities can maximise dissemination and the impact of research at the back end.

Prioritising data linkage with pertinent datasets would be a step towards addressing the under-utilisation of data in the mental health field in Australia. Health data linkage provides the opportunity to transform data (including census, survey and administrative sources) into more robust and comprehensive data assets that enable, enhance and inform research and policy development.

## Information request 25.3 — Data sharing mechanisms to support monitoring

Following on from the above, while there have been notable developments in arrangements and procedures for data linkage in Australia, there is still room to implement more effective and efficient data linkage processes. Currently, cross-jurisdictional data linkage, in particular, requires protracted approval and data release processes and can be prohibitively expensive. While advances are being made towards establishing national data infrastructure (e.g. early developments in formulating linked Commonwealth and state/territory health data), the emerging federated data system is not yet operational. It is essential that the eventual national linkage system is accessible, efficient and cost-effective. This can be achieved through the following mechanisms:

- a scoping activity to identify current projects related to mental health and suicide prevention
- formalised processes to report on findings including data to one central agency
- the establishment of a data management and surveillance monitoring agency to oversee the proposed monitoring and reporting role.

Such a data linkage system would enable researchers to optimise the benefits of Australia's rich data assets. Linked datasets will afford opportunities to answer novel questions and explore issues of particular policy and governance concern to much greater specificity, drawing on administrative and self-reported data.

## Final comments

This document is a submission to the Commission's call for responses to the Draft Report (released in October 2019). Our responses are informed by the expertise of researchers at AIFS, and align with the work we undertake to improve the lives of families in Australia. We identified numerous knowledge and research gaps to address mental ill-health among the general population and specific sub-groups in Australia. Expansion of Australia's research capacity and expertise is an important step to addressing such gaps and to improving mental health and wellbeing in Australia.



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