



Australian Government
Productivity Commission

Mental Health

Productivity Commission
Inquiry Report
Volume 2

No. 95, 30 June 2020

© Commonwealth of Australia 2020

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

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

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

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

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



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An appropriate reference for this publication is:

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

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The Productivity Commission

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

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

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

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PART I – THE CASE FOR MAJOR REFORM

1 Inquiry scope and our approach

How this Inquiry contributes ...

- This Inquiry recommends extensive reforms to improve the mental health of all Australians to enable them to realise their potential in life and have the opportunity to make the contribution they want to their community. Everyone stands to benefit from a reformed mental health system, not just those who currently experience mental ill-health.
 - The Inquiry heard from many individuals and organisations throughout Australia about the persistent problems in our mental health system and also about what is working well. Despite numerous past inquiries and reviews of various aspects of the mental health system, there remains considerable need and scope for reform.
 - This report assesses how:
 - reforms in healthcare and beyond — in workplaces, education, the justice system, housing and social services — would improve mental health and wellbeing
 - funding and governance arrangements for mental health services can be used to reform the way services are delivered and experienced by people
 - improved mental health would benefit not only individuals but also the wider community, through higher social and economic participation, productivity and economic growth.
 - Prevention of mental ill-health and early intervention when help is needed, underpin all reforms. Accordingly, ensuring the right services are available when people need them has been a key focus. This is integral to creating a mental health system that is person-centred and can be readily ramped up and down as individual and community stressors and needs change.
 - The recommended changes are substantial and involve a cultural shift, but would set Australia on a path for sustainable, generational reform of its mental health system.
-

1.1 Why this Inquiry?

Mental health is important to everyone. Although it means different things to different people at different points in their life, the capacity to enjoy life, cope with and be resilient in response to stress, set and fulfil goals, and build and maintain relationships are key aspects of being mentally healthy and participating in the community.

Mental ill-health affects too many of us. Almost half of all Australians aged 16–85 years have had a mental illness at some point in their life and about one in five adults have experienced mental illness in a given year (ABS 2008). Most people with mental ill-health experience mild and temporary symptoms and continue to participate in social activities and work, albeit with reduced capacity. For others, mental ill-health significantly impairs social and economic participation, with flow-on effects to carers, family and friends. Mental illness is the largest contributor to years lived in ill-health for people aged under 50 years (AIHW 2019c). While this is similar to the average experience of developed countries (OECD 2012, 2014b), it nonetheless remains unacceptably high for a society that cares about the wellbeing of its people and has the capacity to assist them.

The Australian Government asked the Productivity Commission to inquire into the role of mental health in supporting social and economic participation, and enhancing productivity and economic growth (as defined in box 1.1). By examining mental health from a participation and contribution perspective, this Inquiry has considered how people can be enabled to lead a life that is meaningful to them, and to contribute to the lives of others. These improvements to mental health benefit both individuals and the whole community.

The Productivity Commission acknowledges that many reviews of mental health have been conducted in Australia. This Inquiry differs from past reviews in several important ways.

- It takes a holistic view within the healthcare system and across the other systems and services that support mental health and wellbeing, and puts forward reforms that have the potential to reinforce each other to increase benefits for individuals and the community.
- The Inquiry considers the differences between how services are delivered and *should be* delivered, and assesses the funding arrangements that shape incentives facing service providers and governments. Aligning the incentives faced by all system participants — governments, service providers, employers and consumers and their families — to focus on person-centred care is an essential part of the recommended reforms.
- Estimates for the costs and benefits of key recommended reforms have been presented where possible. We estimated the costs to taxpayers and society of implementing our recommended reforms and the benefits of higher workforce participation, incomes and population mental health (measured by quality-adjusted life years) that would result were they implemented.

Box 1.1 Definitions of key terms

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

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

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

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

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

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

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

Psychosocial support services offer people experiencing mental ill-health assistance with managing daily activities, rebuilding and maintaining connections, building social skills and participating in education and employment. Some services aim to maintain a person’s current level of independence, while others work to support people to develop or regain skills that would enable them to participate fully in their community.

Economic growth is an increase in the total value of goods and services produced in an economy. Raising workforce participation and/or productivity, for example, can achieve this.

Source: AIHW (2018d); chapter 17; DoH (2013d); Gordon et al. (2015); PC (2013, 2016b, 2017e); SCRGSP (2018); WHO (2007).

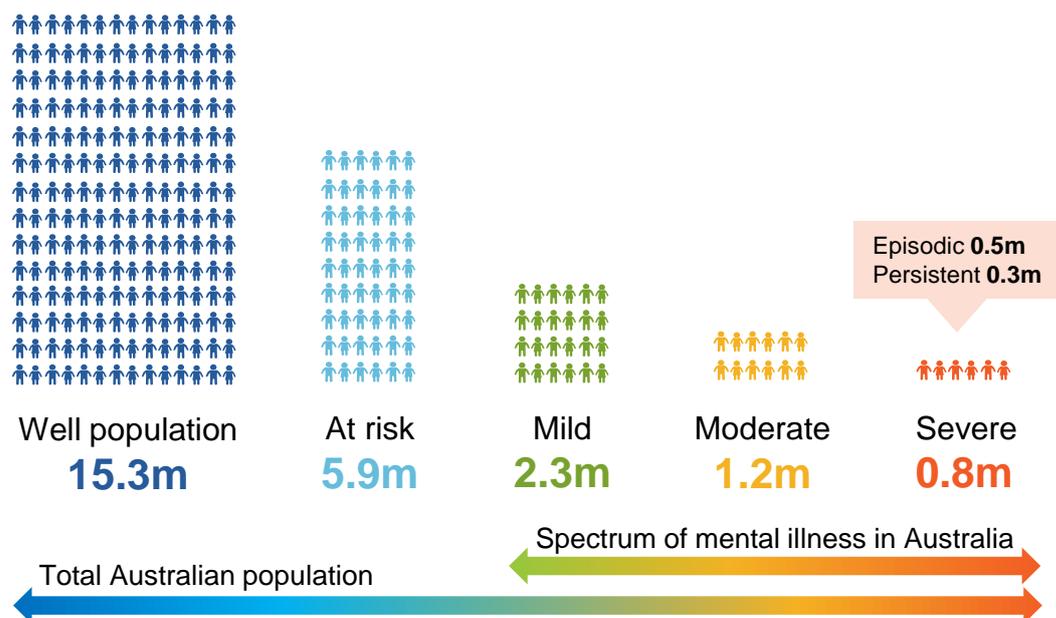
1.2 What affects mental health and wellbeing?

This Inquiry is about the mental health of all Australians, not only people with a diagnosable mental illness (figure 1.1). Broadly speaking, at any point in time there are three groups of Australians: the well population, the at-risk population, and the population with mental illness. Over their life, people can move between these groups as their wellbeing fluctuates or they are exposed to risk factors.

- Well population — about 60% of Australians were in this category over the past 12 months. Prevention and early intervention can help maintain and expand this group over time.

- At-risk population — about 23% were deemed to be at risk of experiencing an episode of mental illness because they had emerging symptoms over the past 12 months, had a prior mental illness, or were exposed to another risk factor. An important goal for this Inquiry is to identify ways to support this group and reduce their risk of mental illness.
- Population with mental illness — about 17% of people experienced an episode of mental illness over the past 12 months, their condition being: mild (9%), moderate (5%) or severe (3%).¹ Mild conditions can be either self-managed or managed within either primary care or community service settings. Moderate conditions can require specialist support, including psychosocial support services and specialist mental healthcare. Severe conditions typically necessitate hospital-based care or treatment from specialist community mental health teams and a range of community services to support their recovery (NMHC 2014c). Roughly one third of people with a severe condition have a persistent disorder or complex needs (Whiteford et al. 2017).

Figure 1.1 Distribution of mental health among the Australian population^a



^a Estimated number of people (adults and children) in each group based on their mental health over the 12 months up to 30 September 2019. People were categorised as having a mental illness (mild, moderate or severe) if they had an episode of mental illness within the 12-month period. They were categorised as being at-risk if they had emerging symptoms of a mental illness within the 12-month period, or an episode of mental illness before the 12-month period, or were children of parents with mental illness. Calculations are based on population estimates.

Source: Productivity Commission estimates using prevalence rates published in the Fifth National Mental Health and Suicide Prevention Plan (COAG Health Council 2017a) and NMHC (2014c); and population statistics published by the ABS (*Australian Demographic Statistics, Australia, September 2019*, Cat. no. 3101.0).

¹ This 17% estimate differs from the 20% cited earlier as it includes both children and adults.

There are many interconnected factors that determine a person’s mental health both positively and negatively (figure 1.2). Communities and governments can enhance mental health in many ways. Social participation and contribution to the community through education, employment and social activities improve wellbeing, particularly if these environments are supportive and inclusive. For people with mental ill-health who need targeted support, effective mental healthcare and social services (such as housing, employment or psychosocial support) can alleviate mental illness or some of the contributing factors. However, an individual’s personal history, which encapsulates their exposure to risk factors throughout their lifetime (such as physical illness, trauma and substance misuse) can undermine their mental health. These risk factors have complex and dynamic interactions with a person’s mental health across different life stages.²

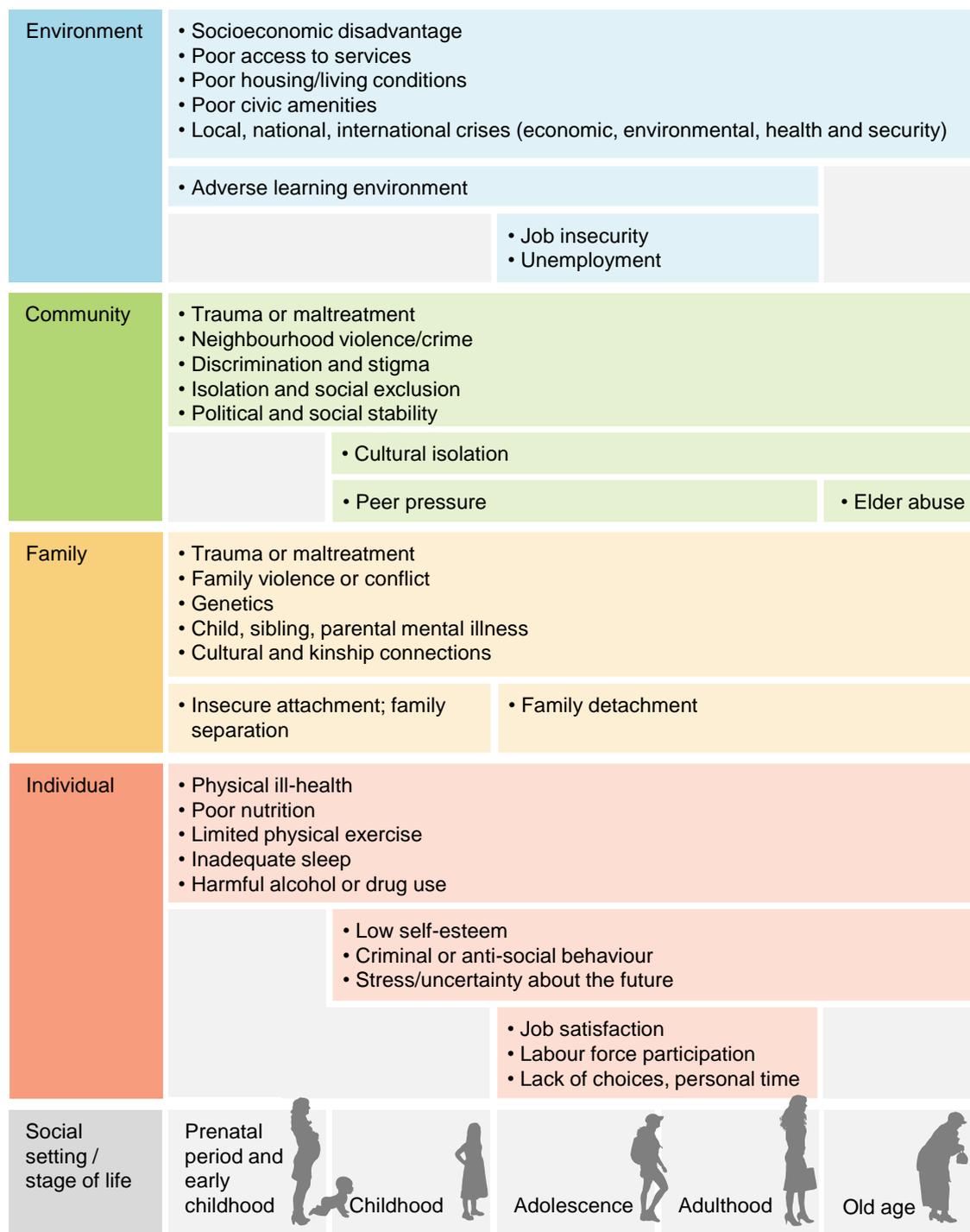
The risks to an individual’s mental health are influenced by their stage in life and their social setting. Some risk factors are specific to particular life stages (such as job insecurity or elder abuse), while others can manifest at any time (such as socioeconomic disadvantage or trauma). A person’s social setting — their family, community and broader environment and individual lifestyle — can both protect and put at risk their mental health. Having positive engagements with family, friends and the broader community within favourable environmental conditions (characterised by access to healthcare and social services and job security) are all protective factors for a person’s mental wellbeing.

Environmental, community and family risk factors affect mental health

Some people are more prone to mental ill-health than others due to exposure to environmental, community and family factors that are beyond any individual’s control. In some cases, exposure to multiple factors can compound the risk of mental ill-health. Submissions to this Inquiry, including by a number of people who appeared at our hearings, and extensive academic research point to several major factors that contribute to increased risk of mental illness among vulnerable populations — isolation, trauma, socioeconomic disadvantage, local, national and international crises, and genetics.

² Many of these risk factors (for example, physical ill-health or unemployment) can also be influenced by mental illness. The causal links are important, and are investigated throughout this report.

Figure 1.2 Risks to mental health over the course of life



Source: Adapted from Arango et al. (2018) and WHO (2012).

Isolation

Isolation comes in a range of forms. It can be geographic or social isolation, people can be isolated from services, or loneliness and discrimination can create feelings of isolation.

Geographic isolation can (but does not necessarily) affect people who live in rural, regional and remote areas — it is about how far away you are from the things that you value and from community supports. People living in these areas may also be at higher risk of mental illness due to occupational risks associated with farming, fishing and mining, or because they are more likely to experience adverse consequences from extreme weather events or natural disasters (CRRMH, sub. 465; QAMH, sub. 247; RDAA, sub. 475; RRMH, sub. 97). Poor access to services (including mental healthcare) can compound other consequences of geographic isolation.

But you can be nearby to people and services that you value and still be socially isolated from friends, family and community. Older people and those without access to transport can easily become isolated in their own homes, as can people housebound during the COVID-19 pandemic (discussed below).

Language barriers can contribute to isolation for some people in culturally and linguistically diverse (CALD) communities (FECCA and NECA, sub. 524) and for some Aboriginal and Torres Strait Islander people.

People can have a range of social connections yet still feel isolated if a disconnect between their desired and actual social relationships causes loneliness (chapter 8). Like other types of isolation, feeling lonely can increase psychological distress (Hare Duke 2017; Pippa Ross, Launceston transcript, p. 30). Cultural norms or taboos about mental illness in some communities or in some ethnic or cultural groups can act as barriers to seeking help (FECCA and NECA, sub. 524).

Discrimination — either about mental illness or some other characteristic of an individual or group — can also create a sense of isolation. Exclusion, harassment and more subtle forms of discrimination such as being ‘left out’ or avoided can both harm mental health and lead to delay or avoidance in seeking treatment. It particularly affects some population subgroups. Almost half of Aboriginal and Torres Strait Islander people who have experienced discrimination also reported high or very high levels of psychological distress (AIHW 2017a).

People who identify with the LGBTIQ community typically have poorer mental health outcomes than the general population. This may be affected by actions (such as changing identity) that sever connections with family or friends, but also by a higher likelihood of facing stigma, discrimination, social exclusion, homophobia, transphobia, stereotyping, ostracising and harassment (ACON, sub. 381; National LGBTI Health Alliance, sub. 494; PHAA, sub. 272; Queensland Council for LGBTI Health, Brisbane transcript, p. 67; Thorne Harbour Health and Rainbow Health Victoria, sub. 265). Chapter 8 discusses issues of isolation and social exclusion in detail.

Trauma

Trauma can have lifetime and intergenerational consequences on a person's mental wellbeing, regardless of the source of trauma (including childhood trauma, intergenerational trauma, exposure to violence, or trauma caused by extreme weather events or natural disasters). Some people may be at a higher risk of experiencing trauma than others. For instance, trauma is an occupational hazard for emergency service workers (police, ambulance, firefighters) and military personnel (chapter 7). Some refugees experience trauma caused by exposure to armed conflict, torture and/or life in a refugee or displaced person camp (Cabrini Outreach, sub. 464; FASSTT, sub. 293).

Childhood trauma (physical, emotional and sexual abuse, and physical and emotional neglect) can cause mental ill-health in childhood, which can carry through into adulthood. Experiencing trauma negatively affects the cognitive development of children and has ongoing ramifications for their capacity to form and maintain social relationships and to trust in possible sources of help (Springer et al. 2003). Mental health disorders can be more severe for people who have experienced childhood trauma as they report increased symptoms of depression, anxiety and stress (Duhig et al. 2015). And different types of trauma can affect children in different ways. Children who have experienced sexual assault are more likely to report suicidal ideation and suicidal behaviour than children who have experienced other types of trauma (Bravehearts Foundation, sub. 823).

Aboriginal and Torres Strait Islander people have a high risk of being exposed to trauma, including intergenerational trauma (chapter 8), which contributes to high rates of mental illness. Several submissions highlighted how trauma caused by loss of land, colonisation, suppression of languages and culture, the breakdown of traditional roles within communities, the forced removal of children from families, high levels of incarceration, and the ongoing experience of racism have negatively impacted the mental health and wellbeing of Aboriginal and Torres Strait Islander people over generations (AMSANT sub. 434; CBPATSSIP and NATSILMH, sub. 1217; Healing Foundation, sub. 193; VACSAL, sub. 225).

Exposure to trauma during extreme weather events or natural disasters can have lasting effects for both emergency service workers and people in affected communities. The prevalence of mental illness in communities connected to the Black Saturday and related fires of 2009 was roughly twice that of unaffected areas three to four years later (and was influenced by community response and whether people remained with their affected community or not in the aftermath of the fire) (Gibbs et al. 2016). The 2019-20 summer bushfires are likely to have a similar effect on connected communities. As climate change continues, the number of natural disasters and extreme weather events are likely to increase, placing more Australians at risk of trauma (Berlemann and Steinhardt 2017; Fritze et al. 2008).

Exposure to trauma can also reduce a person's capacity and willingness to engage with mental healthcare services (ADACAS, Canberra transcript, p. 60; MHCC ACT, Canberra transcript, pp. 74–75; RAV, sub. 1197). For example, people with a trauma experience may have a history of betrayal and as such may struggle to trust service providers (Blue Knot Foundation, sub. 613).

Socioeconomic disadvantage

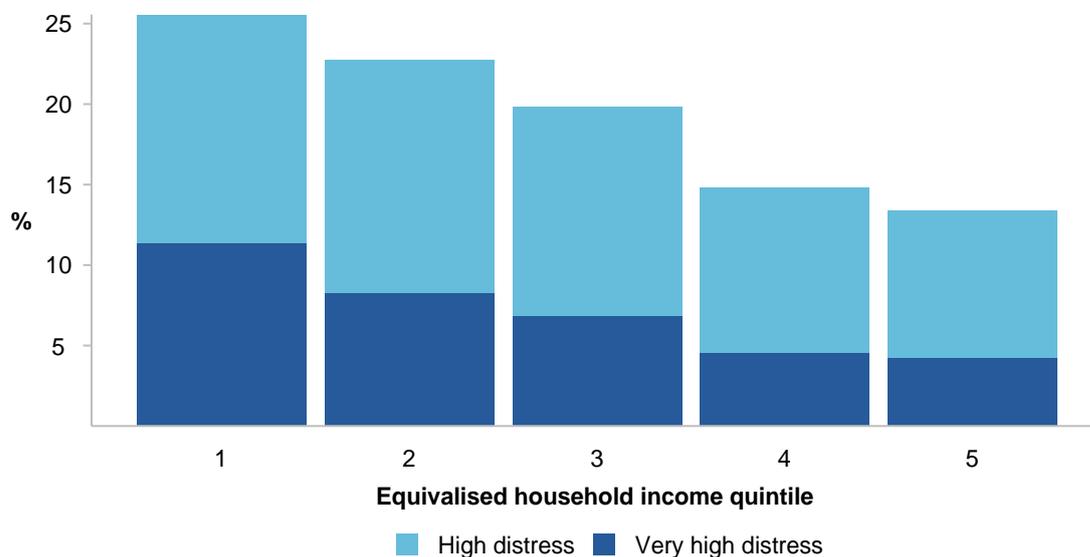
Socioeconomic disadvantage has strong links to mental ill-health. Some population groups are at a higher risk of income poverty and deprivation than the broader population, including people experiencing financial distress, unemployed people and Aboriginal and Torres Strait Islander people (PC 2018b). For example, the most disadvantaged fifth of the population are almost twice as likely to have high or very high levels of psychological distress than the least disadvantaged fifth (figure 1.3).

Financial stressors and/or compromised financial security (such as being unemployed or having excessive debt) increase the risk of developing mental illness (ACOSS, sub. 1208). As the COVID-19 pandemic continues to disrupt the economy, the number of Australians experiencing some form of financial distress will increase. While income support payments would be expected to reduce this distress, people who rely on income support payments have nevertheless, in the past, been more likely to experience income poverty than people in employment (PC 2018b) and experience mental ill-health (with Newstart Allowance³ and Disability Support Pension recipients being three and six times more likely to experience depression than wage earners (Collie, Sheehan and Mcallister 2019)). As well as distress caused by financial insecurity, social stigma towards people receiving income support may also affect their mental health (Kiely and Butterworth 2013).

Socioeconomic disadvantage also affects children's mental health. Social, emotional and behavioral difficulties among children aged as young as three years have been associated with low household wealth (Kelly et al. 2011), and the prevalence of depression or anxiety among people aged 10 to 15 years of low socioeconomic status is 2.5 times higher than for those of high socioeconomic status (Lemstra et al. 2008).

³ The JobSeeker Payment replaced the Newstart Allowance and several other income support payments in March 2020.

Figure 1.3 People with lower incomes are more likely to experience higher psychological distress^{a,b}



^a Psychological distress is measured using the Kessler 10 scale. Data is for wave 17 as the Kessler 10 questions are not included in each year of the Housing, Income and Labour Dynamics in Australia survey.

^b Equivalised income adjusts for household size and composition, accounting for larger households needing more resources to achieve the same standard of living as a smaller household (PC 2018b).

Source: Productivity Commission estimates using Housing, Income and Labour Dynamics in Australia, wave 17.

The entrenched social disadvantage facing some Aboriginal and Torres Strait Islander communities places their members at an increased risk of developing mental illness. For example, the lack of adequate housing, educational opportunities and employment experienced by those living in some Aboriginal and Torres Strait Islander communities can be both a cause of mental illness and a barrier to recovery (Northern Territory Mental Health Coalition, Darwin transcript, p. 63; TeamHEALTH, sub. 155). Housing issues can have particularly significant consequences.

This worsening housing reality in many Aboriginal communities is interrelated with mental health in many ways — increasing urban drift from overcrowded and under-resourced communities, further contributes to rates of homelessness as well as disconnection from country, family and culture, and increases associated mental and emotional ill-health. (AMSANT, sub. 434, p. 8)

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

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

Crises

National and international crises, such as large-scale natural disasters, economic crises and health crises, can have immediate and ongoing effects on the mental wellbeing of broad populations.

The 2019-20 summer bushfires were a national crisis — 33 people died, more than 1 billion animals were lost, 17 million hectares of land was burned, and around 3000 homes and numerous businesses were destroyed (Richards and Brew 2020). Bushfires can traumatise affected communities and emergency service workers, worsening mental wellbeing both at the time and for years afterwards (Gibbs et al. 2016). People living in burned areas are at particular risk of mental ill-health as they may have lost family and friends, homes, workplaces, schools, businesses and other community infrastructure. Feeling a loss of control over life and the future increases risks of mental ill-health (RACGP 2013).

The global COVID-19 pandemic is an international crisis that poses many risks to mental wellbeing. Social isolation and quarantine measures have heavily restricted face-to-face contact and drastically altered daily routines. This, coupled with job insecurity, unemployment and uncertainty about the future, is bound to negatively affect the mental wellbeing of many Australians. Some people who are quarantined will experience a high prevalence of symptoms of psychological distress (Brooks et al. 2020), and those with pre-existing mental health disorders are expected to be more responsive to fear and anxiety than the broader population (Yao, Chen and Xu 2020). A range of factors could also adversely affect wellbeing during social isolation and quarantine, such as taking on extra caring or home schooling roles for children, job insecurity, increased drug or alcohol consumption, or domestic violence or disharmony (OECD 2020a). For some people though (particularly if they are healthy and have income security), the changes in lifestyle necessitated by the pandemic have been — at least partially — positive (Jarral 2020). The simplicity of life without daily commutes and juggling of social activities, and increased opportunities to connect with household members and with neighbours, have improved wellbeing.

While a number of projects underway to measure the impact of COVID-19 on mental wellbeing have found it to negatively impact mental wellbeing, the extent to which this has translated to increased mental illness or increased risk of suicide is not *yet* apparent.

- Almost twice as many surveyed adults reported feelings associated with anxiety (mostly being restless and fidgety) at least some of the time in mid-March to mid-April 2020 compared to the 2017-18 National Health Survey (ABS 2020a), although the more serious symptoms of psychological distress were not evident at that time (Jorm 2020). For example, depression was found to be lower than in the 2017-18 survey and the changes in other indicators were not statistically significant.
- Surveyed Australians have reported increased levels of psychological distress, with those who expressed more worry about COVID-19 showing higher levels of distress than others (Biddle et al. 2020).

-
- Almost 70% of surveyed Australians have reported feeling ‘concerned’ or ‘very concerned’ about their health due to COVID-19 and there has been increased demand for crisis organisations and suicide prevention services (Australian Government 2020c).
 - Almost half of young Australians surveyed reported that COVID-19 had increased their levels of stress and anxiety (Marlay, Attenborough and Kutcher 2020).

Some providers of mental health services reported a substantial increase in the number of people reaching out for assistance during the pandemic. For example, Perinatal Anxiety & Depression Australia (pers. comm., 7 April 2020), experienced a substantial increase in the number of calls to their phone helpline, with people reporting that their mental health had been negatively affected by the pandemic and its economic fallout.

Although the need for support increases during crises, an improvement in mental health of those adversely affected will rely on not just the mental health system, but broader community and government responses.

Genetic predisposition

Some people are genetically predisposed to mental illness, although the exact role that genes play in some mental disorders has not been definitively determined. People with a high genetic risk are more susceptible to risk factors triggering mental illness (Arango et al. 2018).

The compounding effect of risk factors

Risk factors compound. For example, an older person who lives alone, has a chronic physical illness, is from a migrant background with limited English, and has few social contacts would have a higher risk of mental illness than a person facing only one of these factors. People living in remote communities may also face compounding risk factors. They may have limited employment and educational opportunities, poor quality housing, access to few healthcare services, and for Aboriginal and Torres Strait Islander people, may experience intergenerational trauma and discrimination.

Lifestyle factors can help support mental health

Lifestyle factors can promote mental wellbeing. Regular exercise, eating a healthy diet and getting enough sleep can reduce the risk of mental ill-health and work in conjunction with clinical treatments. However, having a healthy lifestyle is not necessarily a replacement for clinical treatments. And mental illness (and other factors such as financial constraints or housing insecurity) can be an active barrier that prevents people from developing or maintaining a healthy lifestyle.

Regular exercise is beneficial to the mental wellbeing of people with and without mental ill-health. Exercise can work in conjunction with other mental health treatments to further improve wellbeing (ESSA, sub. 881; Richardson et al. 2005). There are several pathways for exercise to assist wellbeing: improved self-esteem, cognitive function, emotional regulation and physiological reactions to stress (Callaghan 2004; Sharma, Madaan and Petty 2006). However, barriers such as medication side effects, physical comorbidities (Glover, Ferron and Whitley 2013), low energy and motivation, stress and lack of support can prevent people from exercising regularly (Firth et al. 2016).

Eating a healthy diet positively affects mental health. Diet impacts mental health throughout a person's life, including a mother's diet during pregnancy (Food and Mood Centre, sub. 243). Improvements to a person's diet can reduce symptoms of depression and anxiety (Opie et al. 2014) and ongoing adherence to a healthy diet can reduce the likelihood of a person experiencing some mental health disorders (Lassale et al. 2018). Some diet changes improve mental health more than others. Reduced consumption of processed foods is especially beneficial to mental health compared to increased consumption of healthy foods only (Francis et al. 2019). However, well-balanced healthy diets can be hard to achieve for people with limited financial resources or capacity to grow their own vegetables or fruit, little time to shop for or prepare meals, or for those who live in communities that are distant from shops with fresh produce.

Sleep and mental health can be related to each other in multiple ways, and a range of evidence was presented to the Productivity Commission in relation to this topic. On the one hand, symptoms of anxiety disorders, such as stress and restlessness, can interfere with sleep cycles. On the other hand, poor sleep and sleep disorders can increase the risk of developing mental ill-health, exacerbate symptoms of mental illness and limit treatment efficacy (Meelo, Havekes and Steiger 2015; Sleep Health Foundation, sub. 767). Insomnia can contribute to depression and anxiety, among other mental disorders (Pigeon, Bishop and Krueger 2017). The effects of inadequate sleep can exacerbate the negative effects of mental illness, such as poor concentration and memory, emotional regulation and motivation and energy levels (ASA, sub. 672; David Hillman, sub. 586; Ron Grunstein and Rick Wassing, sub. 717). Treatment of sleep disorders can be beneficial in reducing some symptoms of mental illness, such as paranoia and hallucinations (Freeman et al. 2017).

FINDING 1.1 FACTORS AFFECTING MENTAL HEALTH AND WELLBEING

A person's mental health reflects the interaction of a lifetime of individual and lifestyle factors with a range of environmental, community and family risk factors. Regular exercise, eating a healthy diet and consistently getting enough sleep can reduce the risks of mental illness. But genetic vulnerability and experiences such as trauma, socioeconomic disadvantage, isolation, discrimination and environmental stressors can all harm people's mental health and wellbeing.

1.3 Defining the scope of the Inquiry

This is a whole-of-system and whole-of-life Inquiry into mental health. The objective is to consider reforms both within and beyond healthcare to improve the mental health and wellbeing of the Australian population. To do this, we focus on the individual — how person-centred services can support each individual across their life.

A broad range of actions have been recommended. If adopted, the recommended reforms would lead to a person-centred but flexible mental health system: one that could be ‘ramped up and down’ to meet changing community need, particularly in times of crisis. Reforms are extensive, comprising a mix of large-scale institutional changes and small but important adjustments to existing supports.

The Inquiry objective and scope was determined by its terms of reference (provided at the front of this report), which were developed by the Australian Government in consultation with State and Territory Governments. While the reference is broad, the report is bounded. We address mental health as a part of the existing health system. Broader issues of health reform lie beyond the scope of this Inquiry — although some have been the subject of previous Productivity Commission work (PC 2017c, 2017e). And we do not and cannot recommend reforms that would eliminate mental ill-health, were that possible. Among other things, there is a range of risk factors, such as those arising from deeply entrenched environmental, community and family challenges, that we acknowledge can be very important for people’s mental health and wellbeing. But the solutions for these lie well beyond the scope of this Inquiry.

Not advancing reform options directed at some underlying social and economic influences on mental ill-health (such as climate change, trauma or job insecurity) was a cause for some criticism of the Inquiry draft report (ACOSS, sub. 1208; CHF, sub. 646; cohealth, sub. 846; PHAA, sub. 1119; RANZCP, sub. 1200; VLA, sub. 818).

We have taken these broader influences into account in developing our recommended reforms (as we did at the draft report stage) — for example, by considering prevention and early intervention for those at risk. To go further than this would be counterproductive and would undermine the focus of this Inquiry on mental health. As our report makes clear, there is much work to be done to create a person-centred mental health system in Australia. And while we do not attempt in this Inquiry to eliminate the range of economic, social and environmental challenges that can undermine mental health, our suggested reforms would deliver a mental health system that is better prepared for the next crisis or other shock to our community.

Coverage of different mental health conditions

The range of conditions which clinicians define as a mental illness is extensive (APA 2013; WHO 2004b). For the purpose of determining reform options for governments, we took a slightly narrower view of conditions that should be in scope. Intellectual disabilities, autism spectrum disorders and neurocognitive disorders, such as dementia, were excluded,

except where a person has these in combination with other mental illnesses (table 1.1). Nonetheless, many of our recommended reforms would be relevant to people who live with these conditions.

Similarly, while substance use disorders are in scope, this Inquiry did not examine broader substance use policies, such as the use of alcohol taxes, availability of medically supervised injecting rooms or legality of illicit drugs.

Table 1.1 Coverage of mental disorders by this Inquiry

<i>In-scope^a</i>	<i>Out-of-scope^b</i>
<ul style="list-style-type: none"> • Psychosis (including schizophrenia) • Mood disorders (including depression and bipolar disorder) • Anxiety disorders (including panic and compulsive disorders) • Personality disorders • Child behavioural disorders • Eating disorders • Substance use disorder 	<ul style="list-style-type: none"> • Neurocognitive disorders (including dementia) • Intellectual disabilities • Autism spectrum disorders

^a This list is not exhaustive. ^b Out-of-scope only in cases where a person does not also have a mental disorder which is in-scope.

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

More than just healthcare

Part of this report is devoted to healthcare, both mental and physical, because the healthcare system is an important gateway to, and provider of, the care chosen by people with mental ill-health. Many people with mental illness also experience physical illness and interact with the health system for multiple purposes. Healthcare includes primary care delivered by GPs, nurses and allied health professionals; clinician-supported online treatment; community ambulatory mental healthcare services delivered by psychiatrists, psychologists and other allied mental health professionals; residential mental health services; and hospital services, including emergency and crisis services (chapters 10 to 14).

However, the mental health system is much more than healthcare. It also encompasses a range of community services, such as psychosocial, housing and employment services, that are critical to an individual’s recovery. It includes sectors, such as our workplaces, correctional facilities and education institutions, which can support or undermine a person’s mental wellbeing. A person-centred mental health system must be built outwards from the individual, to include community services and institutions (as well as their funding and governance). It also includes an individual’s family, kinship group, friends and community, who can provide crucial mental health support. As such, healthcare is only one — albeit important — component of the mental health system.

Emphasising the critical role of community services and institutions, and focussing on value for individuals receiving services (rather than on service providers), makes this Inquiry different to most previous mental health reviews. The scope for reforms in sectors outside of healthcare has been considered in depth. Indeed, social services, social inclusion and community participation, together with prevention and early intervention make up the majority of this report. Some particularly important policy areas include:

- Education (chapters 5 and 6) — Most mental illnesses are first experienced during childhood or adolescence (chapter 2). Early childhood education centres, schools, colleges and universities therefore represent an initial point to identify risk factors for mental illness (and to offer direction towards any necessary services), as well as an avenue through which mental health and wellbeing can be regularly promoted.
- Workplaces and employment supports (chapters 7 and 19) — Workplaces can be both a cause of mental stress and an enabler of economic and social inclusion that improves mental wellbeing. Measures that improve participation of those with mental illness (and their carers), and reduce the mental stress of workplaces in general, are likely to be beneficial to both the individual workers and the broader community. Currently, the rate of workforce participation among people with diagnosed mental illness is well below the participation rate of those without mental illness.
- Housing and homelessness services (chapter 20) — Mental ill-health has a two-way relationship with accommodation stability. Stress about the cost, quality and accessibility of stable accommodation can contribute to mental ill-health. However, mental ill-health can make it difficult to find or maintain stable housing. About one-third of people who access homelessness services also experience mental ill-health.
- The justice system and correctional services (chapter 21) — People with mental illness are more likely to be a victim of crime or require resolution of legal issues than the general population. Further, the share of people with mental illness is much higher in prisons than in the general population, with mental illness compounding the likelihood of people repeat offending and ‘cycling in and out’ of correctional facilities over an extended period of time. Among other issues, this Inquiry has explored how to improve mental health services for those within the justice system and the reintegration of people with mental illness back into the community.
- Social inclusion and psychosocial supports (chapters 8 and 17) — Individuals whose mental ill-health significantly affects their capacity to undertake everyday activities (such as grocery shopping and paying bills) may choose to access psychosocial support services. Psychosocial supports can assist people with mental ill-health to recover in their community by helping them to manage daily tasks, increase independence and improve connections with friends, family and the broader community. As such, these supports serve a relational role in a person’s recovery (where recovery is framed as a social process within the community, rather than a solely clinical process) as they expand the social interaction and inclusion of people who might otherwise have limited opportunities for community participation. These supports can also provide relief to carers.

Learning from past reviews — and examining progress so far

This Inquiry has examined the many past reviews that have contributed to the evidence base on mental health in Australia.⁴ The most significant recent review is the 2014 National Review of Mental Health Programmes and Services conducted by the National Mental Health Commission (NMHC 2014a), which was referenced in this Inquiry's terms of reference. It proposed reforms for aspects of the mental healthcare system funded by the Australian Government, and discussed the role of employment, housing and social participation in determining mental wellbeing.

We have also engaged with those reviews of aspects of Australia's mental health system that have been running concurrently with our Inquiry. The Royal Commission into Victoria's Mental Health System, for example, is focused on the prevention and treatment of mental illness and service accessibility, and will submit its final report in February 2021 (Royal Commission into Victoria's Mental Health System 2020; State of Victoria 2019). In addition, we consulted with the two Australian Government reviews: the Medicare Benefits Schedule Review (an ongoing review evaluating the clinical relevance of all Medicare Benefits Schedule items and their payment values (DoH 2019i)) and the National Mental Health Workforce Strategy (a ten-year strategy to establish an appropriately sized mental health workforce for Australia (Hunt 2018)).

In refining the scope of our Inquiry, we took account of potential overlap with recently published reports that assessed specific aspects of the mental health system in Australia. On this basis, we decided not to examine:

- the National Disability Insurance Scheme (NDIS), because the Productivity Commission had previously examined it (2011, 2017d, 2019b) — however, this Inquiry has examined the interface between the NDIS and other services for those with mental illness, and any new developments that have significant implications for population mental health, participation and productivity
- support specific to military personnel and veterans, because we recently conducted a separate inquiry on compensation and rehabilitation for veterans (PC 2019a)
- mental illness associated with a terminal condition, because we examined end-of-life care in our inquiry on human services (PC 2017c)
- aged care accommodation choices, because the Australian Government has established a royal commission into the aged care sector (Royal Commission into Aged Care Quality and Safety 2019) — although the mental health of older people was not a particular focus in the interim report for that inquiry.

⁴ For example, CARC (2018), HREOC (1993), KPMG and Mental Health Australia (2018), Medibank and Nous Group (2013), Mendoza et al. (2013) and Richmond Sainsbury and Conoulty (1983). To illustrate the extent to which some aspects of mental health have been covered in previous reviews, WentWest (sub. 445) identified at least 12 major national reviews from 2006 to 2017 (equivalent to one every 12 months), 15 Commonwealth Parliament inquiries from 2006 to 2018 (one every 10 months) and many more reports by State and Territory Government agencies. ConNetica Consulting (sub. 450) stated that there were no fewer than 14 inquiries or independent reviews in 2018 alone (more than one a month).

We have, however, considered all relevant recommendations of past reviews, and the extent to which they have been implemented and achieved their intended outcomes (for example, AHMC 2009a; COAG Health Council 2017a; DoH 2019k, 2019b; NMHC 2020b).

Reforming Australia's mental health system has proved a challenge for a number of decades. Many previously identified problems have yet to be fully addressed, despite a long history of efforts by governments to improve outcomes (Doggett 2018). In some cases, recommended reforms have been accepted but implementation has fallen short of realising the envisaged benefits. In other cases, necessary changes to policy have not occurred and service gaps have not been addressed. And across the community, while there is an increased awareness of the prevalence (but possibly not the consequences) of more common mental disorders (anxiety and depression), stigma and discrimination still prevent people from accessing the support and treatment they need.

1.4 Input from the community

Following receipt of the Inquiry's terms of reference in November 2018, the Productivity Commission undertook extensive consultation, at levels unprecedented for the Productivity Commission (appendixes A and B). We received 1244 written submissions and 488 comments. We heard from over 200 participants in the public hearings that were held in all jurisdictions and had similar numbers of people participating in roundtables. This extensive community input has given the Productivity Commission important insights into people's experiences of the current mental health system and what needs to change to support better pathways to recovery and prevention.

Who provided input to the Inquiry

The wide range of participants who contributed to this Inquiry included:

- people who use mental health services and their families and carers — including young people, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, people who identify with the LGBTIQ communities, working age people and elderly people
- healthcare providers across the spectrum from primary care to community services, online services, acute care services, emergency departments and crisis support services; psychosocial support services in the community; employment support service providers; teachers, school psychologists, counsellors and principals; tertiary education representatives; housing and homelessness service providers; forensic mental health services; police; justice advocates; and other community and psychosocial support services
- unions, professional associations and employee representatives; employer and industry groups; workplace safety organisations; and employee assistance program representatives

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- private insurers; health service price setting bodies; anti-discrimination and human rights advocates; academics; international experts; retired service providers; and other members of the community
 - departments and agencies within the Australian, State and Territory Governments.

What we heard

We heard clear messages about the type of mental health system that people want — one that provides person-centred services, enables early intervention to prevent symptoms from escalating and is recovery oriented. Participants highlighted persistent problems that have long-exacerbated mental ill-health in Australia.

- Failing to assess what help an individual needs for their recovery and who is best placed to help them — both clinical and community support services are often based on an incomplete picture of what people need and inadequate evidence of what interventions work in the real world, with little evaluation of long-term outcomes for consumers (chapters 5, 8 and 9).
- Under-investment in prevention and early intervention — the result is that too many people live with mental ill-health for too long (chapters 5, 7, 8, 10, and 20).
- Disproportionate focus on clinical services — overlooking other determinants of, and contributors to, mental health, including the important role played by carers, family and kinship groups, and providers of social support services, in bringing about a person's functional recovery within their community (chapters 17 and 18).
- Difficulties in finding and accessing suitable support — sometimes because the relevant and culturally appropriate services do not exist in the regions where the people who need them live, the services have a very long wait list or little information about their availability and outcomes, or services are not sustained or do not adapt as people's conditions evolve and circumstances change (chapters 10, 12 and 13).
- Supports that are below best practice in delivery and resourcing — in part due to a culture of superiority that places clinicians and clinical interventions above other service providers, consumers and their families and carers (chapters 12 and 13).
- Stigma and discrimination — in how people feel about themselves (self-stigma) and from within the community and service providers, directed both at people with mental illness and those who support them (chapter 8).
- Dysfunctional approaches to the funding of services and supports — such that people cannot access the care they need. Funding arrangements motivate some providers to churn through the number of people they treat or support in a period (and minimise time with each person), some to provide services that could be more efficiently and effectively provided by lower cost providers, some placing greater weight on delivery of their particular model than on outcomes for people, and some to be perpetually seeking funding for their organisation's continuity beyond the current (very short) funding cycles (chapters 22 and 23).

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- A lack of clarity across the tiers of government about roles, responsibilities and funding — leading to both persistent wasteful overlaps and yawning gaps in service provision for people, with limited accountability for mental health outcomes that are valued by consumers (chapters 22, 23 and 24).

The Inquiry recommends reforms to address these persistent problems identified in Australia’s mental health system. The objective is a person-centred but flexible mental health system: one that can be ‘ramped up and down’ to meet changing individual and community need, particularly in times of crisis. Reforms are extensive, comprising a mix of large-scale institutional changes, cultural change and small but important adjustments to existing supports.

1.5 How we developed reform options

In formulating reform options, we have considered a large range of individual consumer needs, social contexts and service gaps and barriers faced in accessing treatment and support.

Each recommended reform resolves a specific issue and contributes towards a more coherent and efficient system. For example, reforms to healthcare (chapters 10 to 14) were considered in the context of supporting changes to the health workforce (chapter 16), care coordination (chapter 15) and creating a flexible mental healthcare system that can ‘ramp up and ramp down’ when necessary (chapters 10 to 13). Some of the reforms can be implemented independently, but the most substantial improvements to population mental health and wellbeing would come from taking a holistic approach.

We examined the overarching institutional arrangements and cultural settings that affect how consumers and providers interact. Actions that address complex issues of governance (chapter 22) and funding (chapter 23) also serve to improve consumer experiences. They align the incentives of funding bodies, service providers, employers and consumers to overcome the fragmented nature of service provision (chapters 23) and strengthen accountability through enhanced monitoring and reporting of system outcomes (chapter 24).

Incentives matter in the provision of mental health services as much as they do in any other part of the economy. The Productivity Commission came across many examples of dedicated individuals achieving substantial improvements in their area of responsibility, despite barriers to success. However, system-wide changes require more than the goodwill of individuals. These depend on designing funding structures that incentivise all agents to pursue person-centred care. For example, in the current system, there are limited incentives to minimise avoidable hospitalisations and provide resources to support people with mental illness to live in their communities.

Commentators and stakeholders have argued that one reform barrier has been the difficulty for organisations that fund reforms to see the benefits (Knapp and Iemmi 2016). They point to investments by one organisation (such as a health department) generating benefits that are largely realised by other agencies (such as reduced demands on housing support, justice and

education). It may also be the case that the benefits to individuals arise in the future, making them hard to identify. We sought to design governance and accountability mechanisms that help to overcome these problems (chapters 22 and 24).

Estimating the costs and benefit of recommendations and actions

The Productivity Commission conducted extensive quantitative analysis to identify and quantify gaps in the system, and to estimate the costs and benefits of recommended reforms. We analysed data from a wide range of sources to better understand the complex relationships between mental health and economic and social participation. This included data from the Australian Institute of Health and Welfare (AIHW); Household, Income and Labour Dynamics in Australia survey (HILDA); and the Australian Government's Multi-Agency Data Integration Project (MADIP), which links administrative data on Medicare, income support payments and other Commonwealth programs. Further, we used the National Mental Health Service Planning Framework (NMHSPF) to estimate the demand for ambulatory and bed-based services. The NMHSPF is a service planning tool jointly funded by the Australian, State and Territory Governments.

In the first instance, we determined current expenditure levels and mental health outcomes as a baseline from which to compare reforms. This involved:

- quantifying the nature and extent of mental ill-health in Australia, including the way prevalence and severity vary across the population (chapter 2)
- estimating the many different costs that mental ill-health imposes on individuals, carers and the wider community, including through lower participation (chapter 3).

Since the Inquiry draft report, we have estimated the costs and cost-savings for a range of recommended actions, as well as the expected benefits that would be realised through: greater economic participation and increased productivity associated with that participation; and the benefits of reforms in terms of improved quality of life (appendix I). The expected costs or benefits could not be quantified for all reform options. For example, the benefits of recommended reforms to change governance structures or to review existing policies or programs were not quantitatively estimated.

Determining reform priorities

This report contains 22 recommended reforms encompassing about 100 actions, across the wide range of mental health services and supports. Taken in its entirety, the package of reforms presents a whole-of-government roadmap to a person-centred mental health system. Achieving the full scale of reform would require significant time, government resources and changes to culture — both within the mental health system and in the broader community. However, it offers substantial benefits to individuals and the broader community that go beyond economic measures of increased productivity and income across the economy.

Given inevitable resource constraints, governments could be expected to need to prioritise and implement reforms in stages. The Productivity Commission developed criteria by which to prioritise reform options and identified reforms that would be priorities, as distinct from other reforms that should be undertaken to improve mental health, provided any necessary underpinning reforms have been implemented and sufficient resources are available after priority reforms have been adopted. For each set of reforms, we have specified the expected timeframes for implementation.

Recommended reforms in each part of the mental health system are described in detail across the report:

- Part I presents the current state of mental health in Australia and describes the Productivity Commission’s framework for developing a system to improve mental health and wellbeing for individuals and the community.
- Part II examines the broader systems that support people’s mental health and wellbeing, including through prevention and early intervention, and in education (from early childhood through to tertiary institutions), workplaces and the community. It also considers the complex questions around suicide prevention.
- Part III focuses on the healthcare system, including primary, acute and online supported healthcare as well as improving services in the ‘missing middle’. It also considers the implications of reform for the mental healthcare workforce.
- Part IV considers the range of other government services that support people with mental illness and their carers, and how to improve their effectiveness in supporting mental health and wellbeing. This includes psychosocial supports, income and employment support, housing and homelessness and the justice system.
- Part V sets out our recommended actions in the areas of governance, funding, monitoring and evaluation across the mental health system. These are the foundations of a person-centred system, the benefits of which it also summarises.

2 The state of Australia's mental health

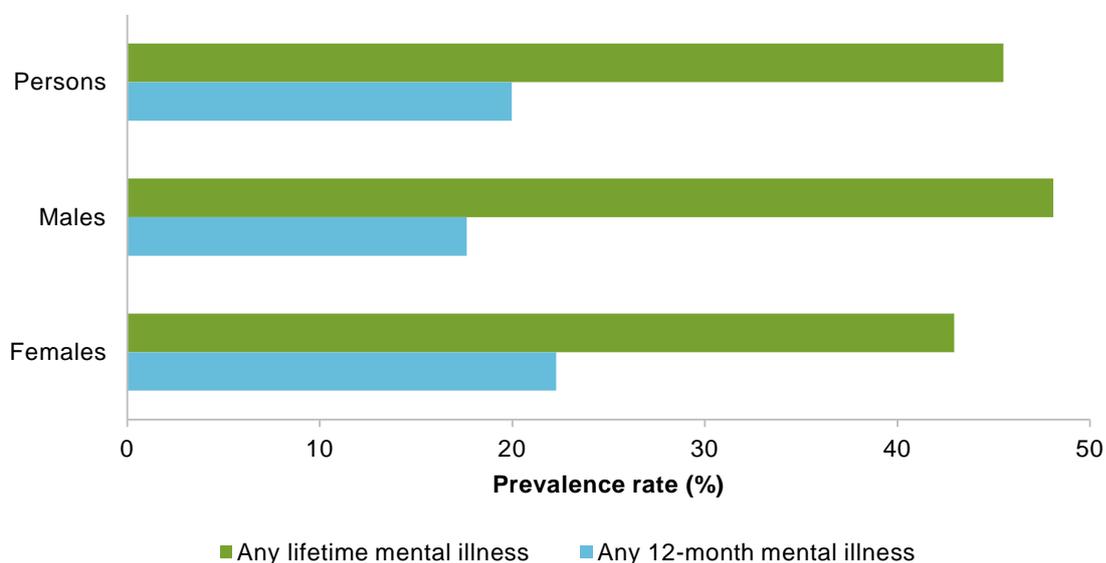
Why reform is needed ...

- Mental illness affects almost one-half of the population at some point during their lives and is the second largest cause of health-related disability in Australia.
- About half of the effect of mental illness on total years of life lost to disability is attributed to anxiety and depressive disorders, stemming from their high prevalence and the many years people typically live with these illnesses.
- Mental illness often emerges when people are young.
- About 60% of people with mental illness report also having a physical illness. Comorbidity is associated with worse health outcomes, increased healthcare costs, and a diminished length and quality of life.
- There are unique mental health challenges facing some groups, including: young people, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, people living in social isolation (including in remote parts of Australia), and those in the LGBTIQ community.

2.1 The prevalence of mental ill-health in Australia

Many Australians experience difficulties with their mental health. Mental illness is the second largest contributor to years lived in ill-health and is the fourth largest contributor (after cancer, cardiovascular disease, and musculoskeletal conditions) to a reduction in the total years of healthy life for Australians (AIHW 2019c). Almost half of all Australian adults have had a mental illness, and one-in-five Australians will meet the criteria in a given year (ABS 2008; figure 2.1).⁵

Figure 2.1 **Almost half of all adults have experienced mental illness^{a,b,c}**
Adults aged 16–85 years in 2007



a While very dated, this survey remains the most recent source of data for mental illness prevalence in Australia. **b** An individual is counted as having a lifetime mental illness if they have experienced mental illness at some point during their life, and is counted as having a 12-month mental illness if they have experienced mental illness in the previous 12 months. These categories are not mutually exclusive. **c** Includes substance use disorders.

Source: Productivity Commission estimates using ABS (*Microdata: National Survey of Mental Health and Wellbeing, Basic and Expanded CURF, 2007*, Cat. no. 4326.0.30.001).

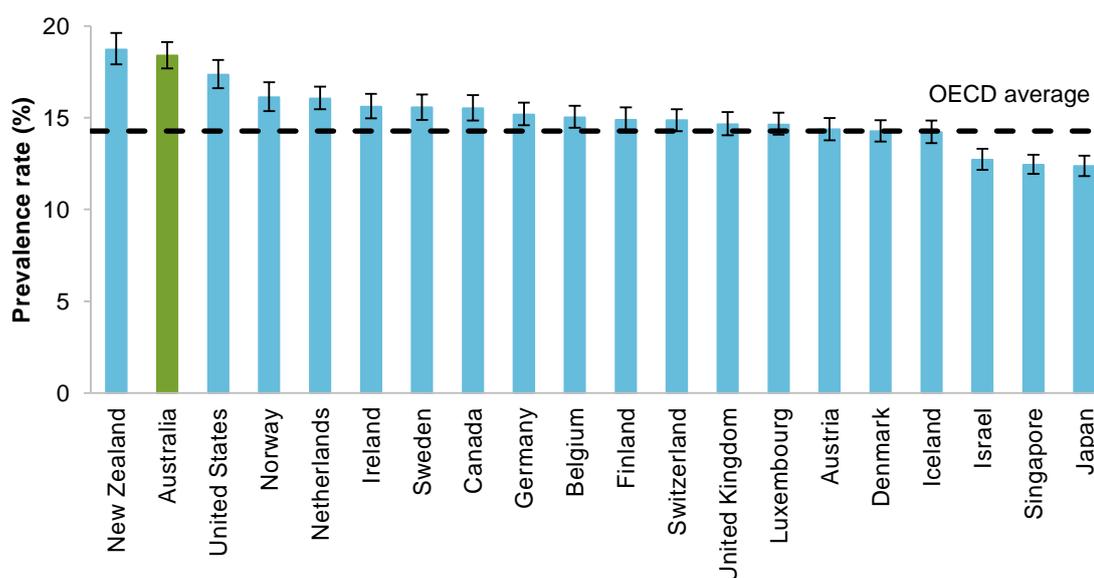
Reported prevalence rates are likely to be underestimates as parts of the population are not included in the main population surveys (for example, people who are homeless or in aged care facilities), and some who are surveyed may be reluctant to disclose a condition (Takayanagi et al. 2014). Among people with mental illness, not all will seek treatment for

⁵ While the data on prevalence rates is comprehensive, it is over a decade old which supports a need to collect mental health data more regularly and to evaluate how outcomes have changed over time (chapter 24). In August 2019, the Australian Government announced the Intergenerational Health and Mental Health Study, which aims to collect new data on the prevalence of mental illness in 2021.

their condition, which could also lead to under estimation of mental illness and the demand for treatment (Our World in Data 2018). There are also people who experience mental ill-health who do not meet the diagnostic criteria for a mental illness, but whose condition may still have a substantial negative effect on their life.

Among developed countries, the prevalence of mental illness in Australia is comparable to the United States and New Zealand (figure 2.2). Cross-country differences in reported prevalence likely reflect a number of factors other than differences in actual rates of mental illness — for example, data collection standards (box 2.1), the effectiveness of the healthcare systems in identifying and treating mental illness, the awareness of mental illness in the broader population and the degree of stigmatisation. Although some of the factors associated with mental illness will be systemic and unique to a country, cross-country differences can nevertheless help, to some extent, to identify effective measures taken by countries to reduce the prevalence of mental illness.

Figure 2.2 Prevalence of mental illness in developed countries^{a,b,c,d}
Age-standardised point prevalence rates in 2017



^a The developed countries shown here are those with the highest Human Development Index with data available on prevalence rates. ^b Does not include substance use disorders. ^c Some rates are modelled rather than being collected from a nationally representative survey and have confidence intervals. ^d Differences in survey methods and reporting between countries can influence the results.

Source: Institute for Health Metrics and Evaluation (2019).

Box 2.1 Sources of prevalence rate estimates

The estimated prevalence rate for mental illness in Australia varies according to the data source. This means rates can differ depending on how data is collected and interpreted, whether conditions are self-reported or from structured interview, and the diagnostic criteria used.

National Survey of Mental Health and Wellbeing 2007

The National Survey of Mental Health and Wellbeing surveyed households in Australia in 2007. The survey used interviewers trained to use the World Health Organization's Composite International Diagnostic Interview, version 3.0 (WMH-CIDI 3.0), which provides an assessment of mental illness based on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV); and the World Health Organization International Classification of Diseases, Tenth Revision (ICD-10). Based on responses to the questions, survey respondents are then assessed if they have met the criteria for a particular mental illness, the severity level, and whether it was a 12-month or lifetime mental illness. The survey focused on collecting data on high prevalence mental illnesses (anxiety disorders, mood disorders, and substance use disorders), and therefore, it did not cover, for example, eating disorders and psychotic disorders.

National Health Survey

The National Health Survey is an Australian household survey which collects data on a broad range of health conditions, including mental illness. The mental illnesses covered by the National Health Survey are broader in scope compared with the National Survey of Mental Health and Wellbeing, covering additional mental illnesses such as behavioural disorders, attention-deficit hyperactivity disorder and conduct disorder and schizophrenia. However the survey relied on respondents to identify whether they had a particular condition, rather than assessing against diagnostic criteria.

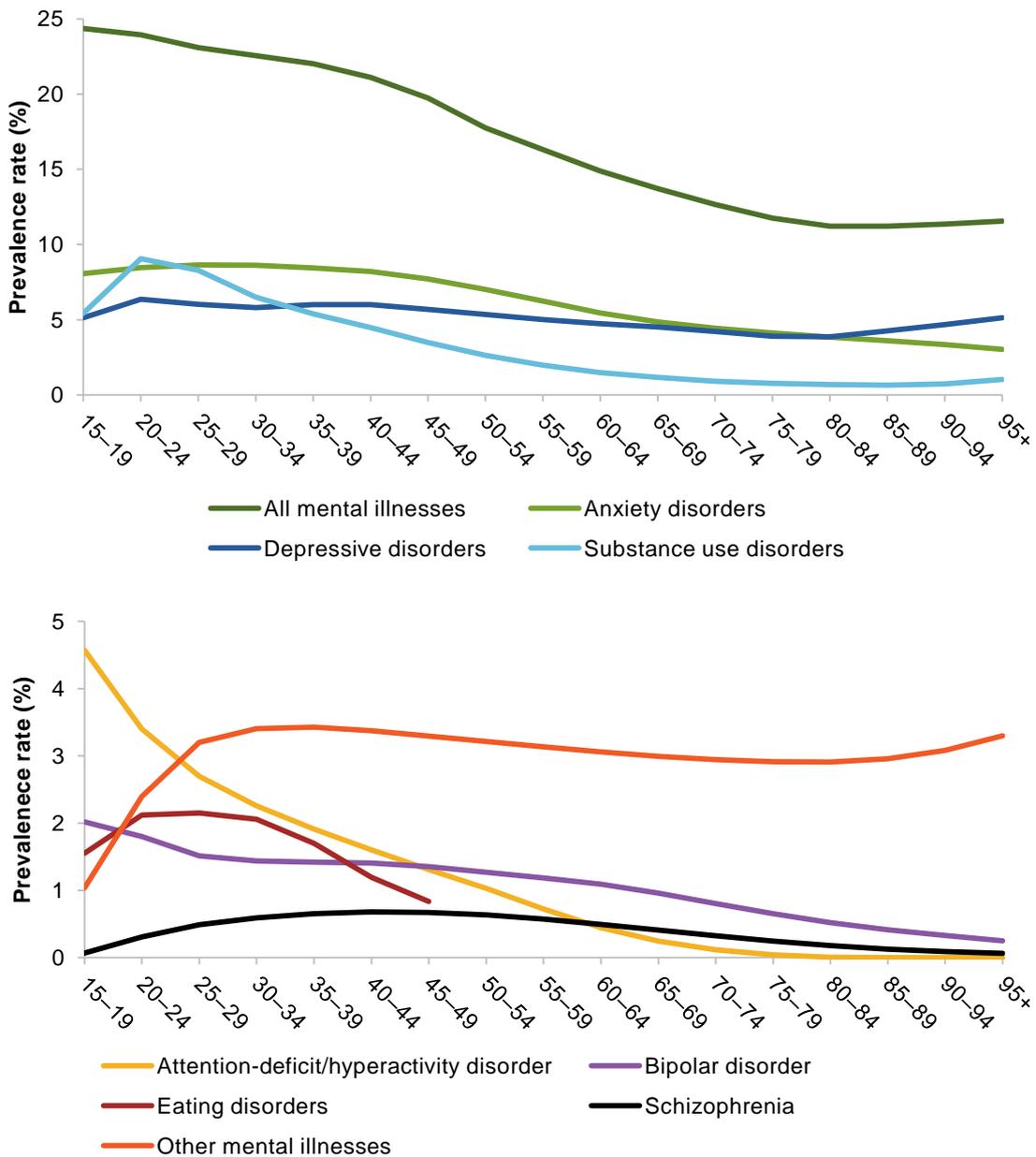
Global Burden of Disease Study

The Global Burden of Disease Study is an international epidemiological study, estimating the mortality and morbidity for most major health conditions at global, national, and regional levels. The Global Burden of Disease Study synthesises a large number of input sources to create these estimates — as such, the mental disorder prevalence rates for some countries, including Australia, are derived from multiple survey sources collected within the country, while the rates for countries for which there is no survey data is imputed using modelling techniques.

Source: ABS (2008, 2018e); Institute for Health Metrics and Evaluation (2019).

Mental illness can affect people during all stages of life (figure 2.3). Young people (aged 16–25 years) have the highest prevalence rate of mental illness and the effects of mental illness on this group can be devastating. Poor educational and social outcomes early in life can affect an individual (with flow-on effects to broader society) over their entire lifetime. However, the prevalence of mental illness tends to decline with age, although there is a rise in some disorders in the oldest ages.

Figure 2.3 **Mental illness remains prevalent across all life stages^{a,b,c,d}**
Point prevalence rates in 2017



^a The scales in the two figures are different — the top figure contains mental illnesses with higher prevalence rates. ^b The rates for some disorders are modelled rather than being collected from a survey. ^c The modelled rates for eating disorders are not available for ages 50 years and above. ^d Substance use disorders are not included in 'All mental illnesses'.

Source: Institute for Health Metrics and Evaluation (2019).

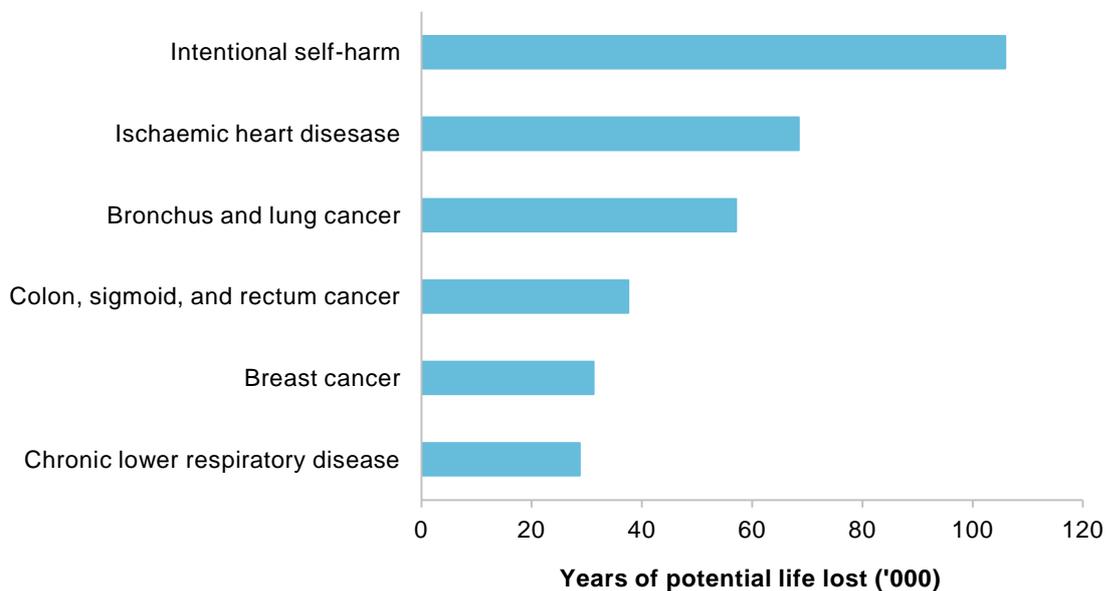
Suicidality and mental illness

Mental ill-health can also be associated with suicidality — the collective term for suicidal ideation, suicide plans, and suicide attempts (chapter 9). While suicidality is more common in people with mental illness, it is not confined solely to this group. Mental illnesses such as anxiety, mood, impulse-control disorders, and substance use disorders have been found to be strong predictors of suicide attempts (Nock et al. 2010). In the first few months after being discharged from a psychiatric facility, the suicide rate can be 100 times the global suicide rate (Chung et al. 2017).

While suicide accounts for a relatively small proportion of all deaths in Australia, it is the leading cause of years of potential life lost (figure 2.4), with each instance resulting in an average of 37 years of life lost (ABS 2019b). More than one-third of deaths among people aged 15–24 years are due to suicide and it is the leading cause of death for Australians aged 15–44 years (ABS 2019b).

Figure 2.4 Intentional self-harm accounts for the highest number of years of potential life lost^a

Causes of deaths in 2018



^a Years of potential life lost are calculated as the difference between the age at time of death and the life expectancy at that age.

Source: ABS (*Causes of Death, Australia, 2018*, Cat. no. 3303.0).

Mental illness affects everyone differently

Mental illness is a broad term that covers a wide range of health conditions. These are discussed in detail below. However, broadly, mental illness is:

... characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. (APA 2013, p. 20)

Mental illness is not homogeneous between individuals — no two people will have the same underlying factors or experience. To be effective, the treatment of a mental illness should be person-centred and tailored to an individual's needs, acknowledging the interdependence of the family, community, and the environment surrounding the individual in contributing to their recovery — in this report, we refer to this as person-centred care.

While heterogeneity is evident in different mental illnesses, it is sometimes more useful to break down reports by the severity of the illness and the effect this has on a person's life (box 2.2). Two people experiencing the same type of mental illness can have their daily functioning affected in different ways — the impairment to their everyday life may be small for one person, and large for another. While the severity and functional impairment of a person's mental illness is critical in understanding the effect on individuals and families, it is also not the whole story, as two people faced with a similar impairment can react in very different ways and have quite distinct needs.

In Australia, over a 12-month period, an estimated 3% of the population (800 000 people) have a severe mental illness, 5% (1.2 million people) have a moderate mental illness, and 9% (2.3 million people) have a mild mental illness (chapter 1).⁶ One-third of adults in the severe group are estimated to have a persistent mental illness, requiring ongoing services to address their residual disability (Whiteford et al. 2017).

There is also a large proportion of the population (23%) who are at-risk of mental ill-health (chapter 1). About half of these people will have had a previous mental illness and may require help to prevent relapse, while the remainder may require early intervention to prevent symptoms developing to a diagnosable illness. The Contributing Lives Review (NMHC 2014c) found that the greatest inefficiencies in the mental health system come from a lack of prevention and early intervention, which could reduce the future need for more complex and costly interventions. It also found that early intervention and intervening at the right time could lead to significant cost savings throughout a person's lifetime, highlighting the importance of a life course approach to prevention, early intervention, and recovery.

⁶ Prevalence rates are based on the National Mental Health Service Planning Framework severity definitions.

Box 2.2 **Classifying mental illness in terms of severity**

National Survey of Mental Health and Wellbeing, 2007

The National Survey of Mental Health and Wellbeing categorises the severity of mental illnesses into three categories: severe, moderate and mild. The measure of severity is a summary of the effect of mental illnesses experienced in a 12-month period on a person's daily life. Only individuals who had an episode of mental illness within the 12 months are considered.

The Sheehan Disability Scale is used to help determine the severity distribution in the population. Participants are asked about the level of interference during the worst period of symptoms in the preceding 12 months on four life domains: home management, ability to work, ability to form and maintain close relationships with other people, and social life. The responses are then transformed into a scale of mild, moderate and severe for each domain.

National Mental Health Service Planning Framework

The National Mental Health Service Planning Framework uses an alternative categorisation of severity levels. Severity levels differ by the amount and type of care required for an individual, which is estimated from the level of symptoms and impairment. The five levels are severe, moderate, mild, early intervention, and relapse prevention.

- *Severe*: diagnosed illness in a 12-month period, and severe impairment, including those where the diagnosis itself requires significant impairment or other diagnoses combined with severe impairment or risk. It includes all those admitted to specialist mental health units, general hospitals or residential aged care facilities with primary mental illness diagnoses, and all those receiving care from specialist community mental health teams.
- *Moderate*: diagnosed illness and service demand in a 12-month period, where the illness is chronic and/or causes moderate disability but does not fall into the severe group, whose illness can be adequately managed in enhanced primary care with some specialist support, including a small minority who also need community support services.
- *Mild*: diagnosed illness and service demand in a 12-month period, whose illness can be adequately managed within primary care; including clinician-led e-therapies.
- *Early intervention*: clinical indications not reaching the diagnostic criteria for a diagnosed disorder, who have a service demand in a 12-month period.
- *Relapse prevention*: those with a lifetime but not 12-month diagnosis, who have a service demand in a 12-month period.

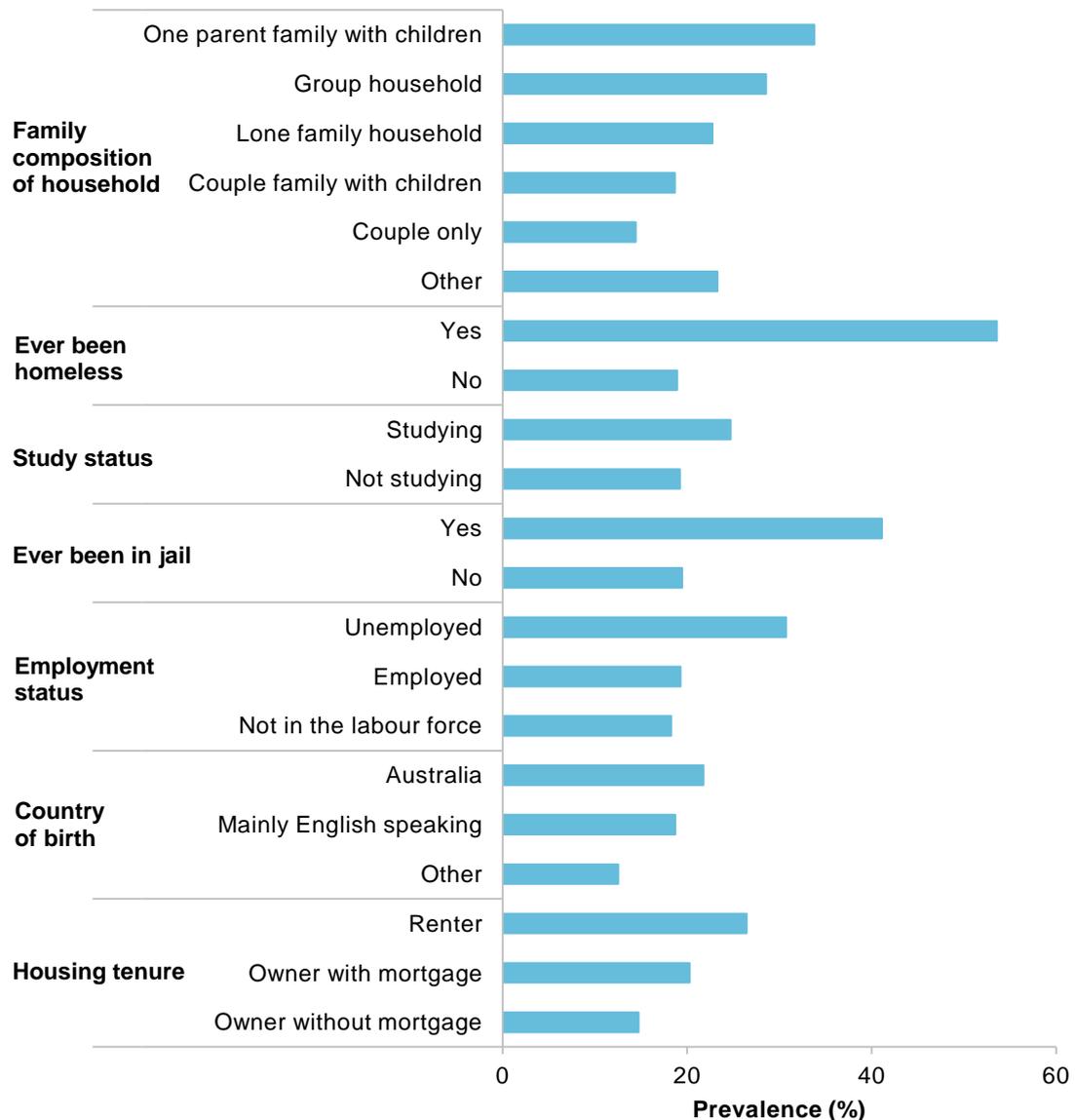
Source: Slade et al. (2009); University of Queensland (2016b).

There are individual characteristics other than age which are correlated with the prevalence of mental illness (figure 2.5). People who:

- live in couple-only households have the lowest prevalence rate among different household structures, while single parents have the highest prevalence rate
- are studying (post-high school) or unemployed have higher prevalence rates
- have been homeless or in jail at some point during their life have prevalence rates twice that of the rest of the population

- are renters tend to have higher prevalence rates compared with those who own their house, with prevalence rates lower still if the mortgage has been paid off
- are born in Australia have higher prevalence rates compared with those who live in Australia but were born overseas.

Figure 2.5 Prevalence differs by characteristics^a
12-month prevalence rates for adults aged 16–85 years in 2007



^a Studying refers to post-high school studies.

Source: Productivity Commission estimates using ABS (*Microdata: National Survey of Mental Health and Wellbeing, Basic and Expanded CURF, 2007*, Cat. no. 4326.0.30.001).

Within the population who were born overseas, there is a clear difference in prevalence rates — people who were born in a non-main English speaking country have a prevalence

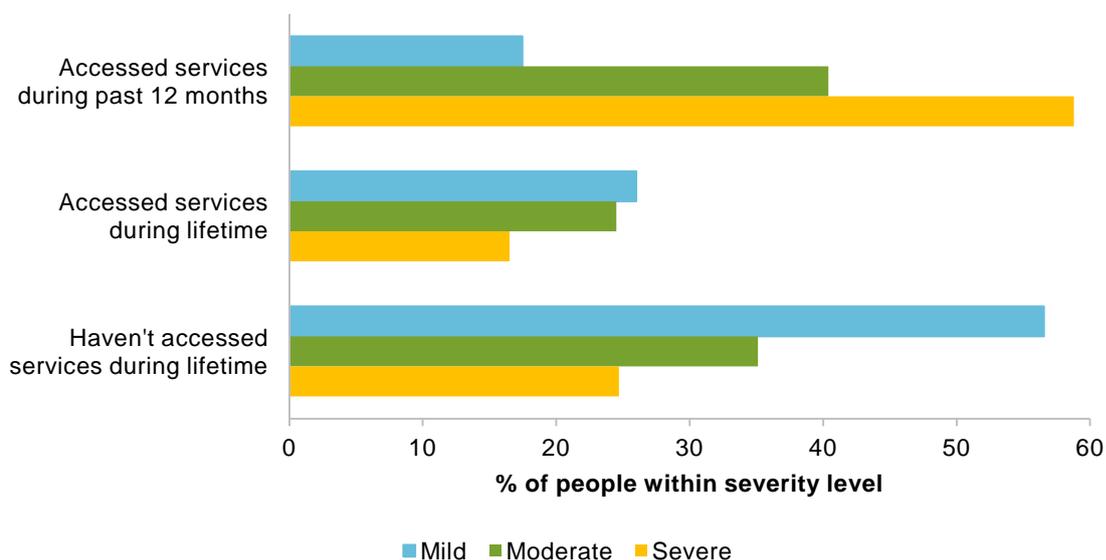
rate about 5% lower compared with people born in English speaking countries.⁷ This may reflect some cultural differences and views towards acknowledgment and reporting of mental illness between English and non-English speaking countries.

The Productivity Commission recognises that the data behind these statistics is over a decade old and does not necessarily reflect the current situation. But it nevertheless highlights that, at least in the past, exposure to different environmental factors has been correlated with the prevalence of mental illness.

Individuals who have experienced a severe mental illness in the past 12 months are more likely to have accessed mental health services compared with those with a mild or moderate mental illness (figure 2.6), but there is still a substantial proportion of people with a severe mental illness who do not access treatment — about 40% have not accessed services in the past 12 months, and 25% have not accessed any services during their life. However, this data is also over a decade old and was collected only shortly after the introduction of MBS-rebated psychological therapy, which has assisted in raising treatment coverage (Whiteford et al. 2014a). Between 2007-08 and 2017-18, the proportion of the population receiving clinical mental healthcare increased from 1.6% to 1.9% (AIHW 2020e).

Figure 2.6 Mental health service use differs by severity levels^{a,b,c}

Adults aged 16–85 years in 2007



a Includes substance use disorders. **b** People who have had a mental illness in the past 12 months. **c** Services are for mental health and include consultations and hospitalisations. This could include seeing a GP, psychiatrist, psychologist or mental health nurse.

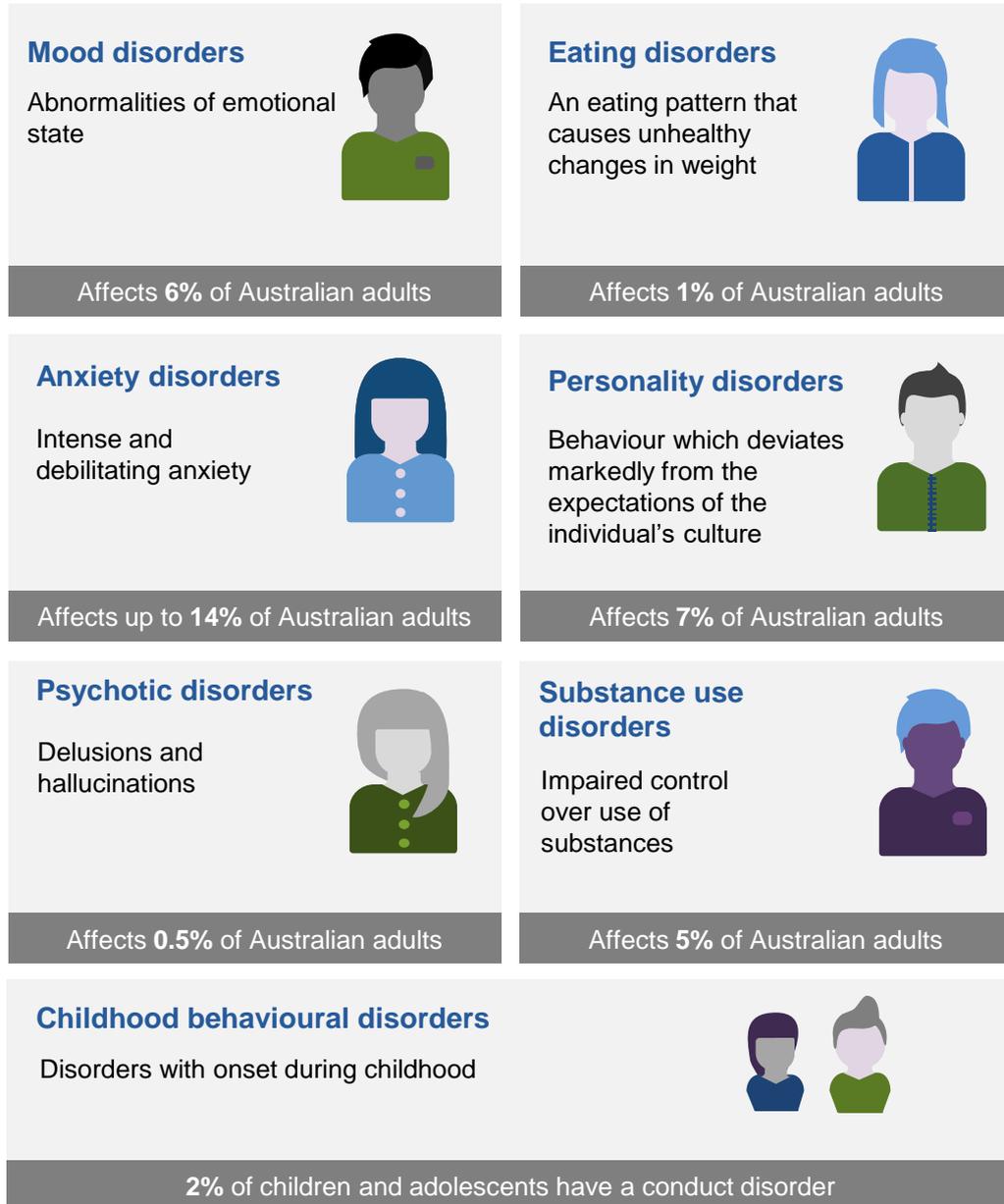
Source: Productivity Commission estimates using ABS (*Microdata: National Survey of Mental Health and Wellbeing, Basic and Expanded CURF, 2007*, Cat. no. 4326.0.30.001).

⁷ Main English speaking countries include the United Kingdom, Republic of Ireland, New Zealand, Canada, United States of America and South Africa.

Types of mental illnesses

Although different types of mental illnesses can affect people differently, they are usually grouped based on their symptoms and the effect they have on people's lives (figure 2.7).

Figure 2.7 **Mental illness can affect people in many ways^a**



^a 12-month prevalence rates for mood, anxiety, substance use disorders, psychotic disorders, and childhood behavioural disorders. Lifetime prevalence rates for personality disorders. 3-month prevalence rate for eating disorders, and includes only anorexia nervosa and bulimia nervosa.

Source: ABS (2008); Hay, Girosi and Mond (2015); Jackson and Burgess (2000); Lawrence et al. (2015); Morgan et al. (2011).

Mood disorders

Mood disorders (also known as affective disorders) are conditions in which a person's mood is distorted, interfering with everyday functioning. Some examples of common mood disorders are depression and bipolar disorder. Depression (and related disorders) are characterised by the 'presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's ability to function', while bipolar disorders are where individuals experience both periods of depression and hypomania (APA 2013).

The effects of these mood disorders on people's lives can be quite variable and extensive. For example, depression can deprive a person of their ability to enjoy life, and cause them to view life through a negative lens — this can go on to affect a person's responsibilities, work or study, close relationships and their social life.

Anxiety disorders

Anxiety disorders 'share features of excessive fear and anxiety and related behavioural disturbances' (APA 2013). Some examples of anxiety disorders are panic disorder, agoraphobia, social phobia, and post-traumatic stress disorder. Anxiety is not necessarily a bad thing — for example, it can increase levels of alertness and performance before an important event. But high anxiety can have the opposite effect, reducing the level of performance and a person's ability to rationally think and plan, and potentially lead to distress and disability (Andrews et al. 2018b).

Schizophrenia and other psychotic disorders

Schizophrenia and other psychotic disorders are a group of mental illnesses defined by abnormalities in one or more of the following: delusions, hallucinations, disorganised thinking, grossly disorganised or abnormal behaviour, and negative symptoms (APA 2013).⁸ Hallucinations can lead to a person seeing or hearing voices of a non-existent person, and delusions are fixed beliefs that are not amenable to change in light of conflicting evidence.

Schizophrenia has been the most common psychotic disorder, accounting for 47% of diagnoses (Morgan et al. 2011). Of the mental illnesses in scope for this Inquiry, schizophrenia has the highest disability weight (AIHW 2019d), reflecting an assessment by Salomon et al. (2015) that it potentially has the most devastating effects on life outcomes.

⁸ Some negative symptoms associated with schizophrenia include diminished emotional expression, a decrease in self-initiated purposeful activity, and diminished speech output (APA 2013).

Eating disorders

Eating disorders are mental illnesses, characterised by eating or eating-related behaviour becoming an unhealthy preoccupation of someone's life, impairing their physical health or psychosocial functioning (APA 2013). Some examples of eating disorders include anorexia nervosa, bulimia nervosa and binge-eating disorder. Many people with an eating disorder do not realise they have a problem, or if they do, they may go to extraordinary lengths to hide the signs of their behaviour or deny that they have a problem. Eating disorders tend to have a high rate of comorbidity with mood and anxiety disorders, are more prevalent in young females (APA 2013), and one of the eating disorders, anorexia nervosa, is estimated to have the highest mortality rates among non-substance use mental illnesses (Chesney, Goodwin and Fazel 2014).

There are psychological, physiological, and social risk factors which may increase the likelihood of an eating disorder developing, as well as behaviours and traits. Some risk factors include dieting, weight and shape concerns, self-esteem issues, sociocultural norms, media exposure and weight discrimination (APA 2013).

Personality disorders

Personality disorders are an enduring pattern of inner experience and behaviour that deviate markedly from the expectations of the individual's culture, are pervasive and inflexible, have an onset in adolescence or early adulthood, and lead to distress or impairment (APA 2013). Some examples of personality disorders are antisocial personality disorder, borderline personality disorder, narcissistic personality disorder, and obsessive-compulsive personality disorder. Unlike mood disorders, personality disorders tend to be stable over time, whereas mood disorders are transient and involve changes in behaviour that arise as a response to specific additional stressors.

Childhood behaviour disorders

Childhood behavioural disorders are a group of disorders which typically have their onset early in life, and often before a child begins going to school. Some examples of childhood behavioural disorders include attention-deficit hyperactivity disorder, conduct disorder and oppositional defiant disorder. These disorders are usually characterised by developmental deficits which can affect personal, social, academic or workplace functioning. People with these disorders typically have problems with self-control of emotions and behaviours, which can manifest as inattention, impulsivity and a lack of concern for the rights of others (APA 2013).

Substance use disorders

Substance use disorders are a group of conditions in which the use of substances (for example, alcohol or drugs) lead to significant impairment. They are characterised by cognitive, behavioural, and physiological symptoms indicating that a person continues to use a substance despite substance-related problems (APA 2013). Some of the behaviours that arise due to a substance use disorder include:

- impaired control — taking the substance for longer than intended, spending a lot of time obtaining and using the substance, and cravings for the substance
- social impairment — a failure to meet work, school, and home obligations, and a reduction in social and recreational activities
- risky use — the recurrent use of substances in situations where it can be physically hazardous.

There are environmental factors which can increase the likelihood of developing a substance use disorder. Some of these factors include ease and exposure to substances, neighbourhood disadvantage and disorder, barriers to treatment, and racial and socioeconomic inequities (Mennis, Stahler and Mason 2016).

Comorbidities

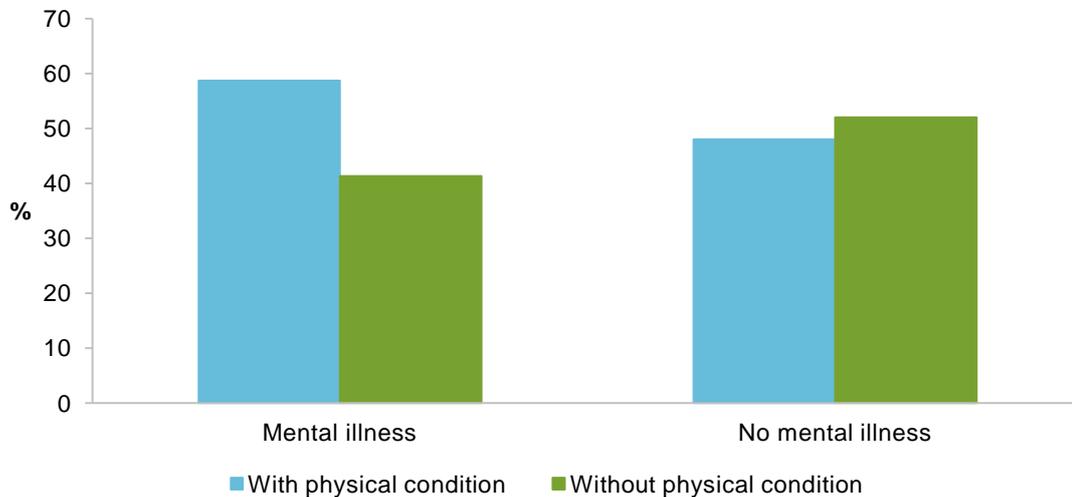
Comorbidity is the presence of two or more health conditions existing simultaneously in a person at a point in time. Comorbidity may involve more than one mental illness, which may be, for example, a substance use disorder, or a mental illness and one or more physical conditions (chapter 14).

People with mental illness have a relatively high rate of physical illnesses (SCRGSP 2020b). Almost 60% of people with mental illness report having a co-existing physical illness (figure 2.8) and this is elevated compared with the rest of the population. For those without mental illness, 48% have a physical illness (ABS 2008).

Physical comorbidities are accompanied by increased psychological distress, which is greater for males compared with females. For females, a physical comorbidity marginally increases the prevalence of high psychological distress (from 12.3% to 13.2%), but for males, the prevalence more than doubles (from 5.1% to 11.7%) (AIHW 2012a).

Comorbidities are associated with worse health outcomes, complex clinical management, increased healthcare costs and a diminished quality of life (Valderas et al. 2009). People with a greater number of comorbid health conditions tend to be more disabled, distressed and require more service utilisation for their mental illness (AIHW 2012a; Andrews, Slade and Issakidis 2002). Aside from the additional health problems, comorbidities can affect or be influenced by other aspects of life. Compared with people with only physical conditions, people with both mental and physical conditions are more likely to be unemployed, have lower levels of educational attainment, and be living by themselves (ABS 2015).

Figure 2.8 More people with mental illness also have a physical illness^a
Adults aged 16–85 years in 2007



^a A physical condition is defined as a medical condition, illness, injury or disability that the person had or received treatment for in the 12 months prior to the survey.

Source: ABS (2008).

Comorbidities between mental and physical conditions are associated with a lower life expectancy compared with the rest of the population (RANZCP 2016b). A study of psychiatric patients in Australia found that almost 80% of excess deaths were due to deaths from physical conditions (rather than from other causes) — this compares to about 14% caused by suicide (Lawrence, Hancock and Kisely 2013). While there have been advancements in research and healthcare, physical health outcomes have not changed for those with mental illness, and the years of life lost due to physical conditions for people with mental illness may be increasing (Firth et al. 2019).

Trauma and mental illness

Exposure to traumatic or stressful events can act as a risk factor for developing mental illness (APA 2013). A well-known trauma-related disorder is post-traumatic stress disorder (PTSD). Traumatic events can be:

- single events, such as natural disasters, community disasters, or the death of a family member
- ongoing events, such as domestic violence or childhood neglect
- intergenerational, such as the loss of land and culture for Aboriginal and Torres Strait Islander people.

It is estimated that 75% of adult Australians have experienced a traumatic event at some point in their life (Productivity Commission estimates using ABS 2009). One-in-six of these people go on to be diagnosed with PTSD at some point in their life (with a lifetime prevalence rate of about 12%). Half of these people experience an onset of PTSD before age 21 years, and the effects can be long-lasting — for about 25% of people with PTSD, the effects persist for over a decade. The lifetime prevalence rate of PTSD for females is almost twice that of males (15.8% compared with 8.6%) — this may be because males and females experience different types of trauma and cope with stress in different ways (Olf 2017).

Trauma informed care is a framework based on an awareness and sensitivity as to how trauma affects people and for care to be delivered in a broader context, extending past more than just the immediate symptoms. At the minimum, trauma informed care should help a person experiencing trauma to feel safe in seeking out services and avoid re-traumatisation. While there is no unified set of principles underlying trauma informed care, guidelines from the Substance Abuse and Mental Health Services Administration suggest that elements of trauma-informed care should include:

- realising and understanding the effects of trauma on not just the individual, but also families, groups, organisations and communities
- recognising the signs of trauma, which may be gender-, age-, or setting-specific
- responding by fully integrating knowledge about trauma into policies, procedures, and practices
- seeking to actively resist re-traumatisation of clients (SAMHSA 2014).

Childhood trauma

Trauma experienced early on in life can be a risk factor for mental illness later on in life. A study in the United States found that more than two-thirds of children had reported experiencing a traumatic event by age 16 years, with 13% developing post-traumatic stress symptoms (Copeland et al. 2007).

A study in the Netherlands found an association between childhood trauma (rather than childhood life events) and anxiety and depressive disorders later in life (Hovens et al. 2010). The link between childhood trauma and psychosis appears to be weaker — a systematic review of the evidence linking childhood trauma and psychotic disorders found only a few studies which could identify a possible association between the two (Bendall et al. 2008).

In Australia, the number of notifications, investigations, and substantiations for child protection services has risen over time (AIHW 2020b).⁹ However, it is unclear whether these trends reflect an increasing number of cases of child abuse or changes in legislation and public awareness (AIFS 2017). The most common type of harm was emotional abuse,

⁹ There are three steps involved in determining child abuse. A notification is first made to a child protection department alleging child abuse. An investigation is undertaken if a notification meets a threshold for further action. Finally, a substantiation is the result of an investigation where it has been determined that a child has been, is being, or is likely to be abused (AIHW 2020b).

followed by neglect, physical abuse, and sexual abuse. Children living in remote areas were more than twice as likely to be the subject of a substantiation compared with those living in major cities. And children living in the lowest socio-economic areas were more than four times as likely to have a substantiation compared with those in living in the highest socio-economic areas.

In Australia, Aboriginal and Torres Strait Islander children may experience intergenerational trauma, where trauma is transferred from one generation to the next. They may also have an increased likelihood of developing trauma through exposure to environmental risk factors such as poor family functioning, exposure to racism and discrimination, and domestic violence. Compared with non-Indigenous Australian children, Aboriginal and Torres Strait Islander children were more than five times as likely to be hospitalised from assault, eight times as likely to be subjected to child abuse/neglect, and more than seven times as likely to be in child protection care (AIHW 2011a, 2020b).

Prescriptions for mental health medication

In 2018-19, there were 39 million mental health-related prescriptions (subsidised and under co-payment) provided to 4.3 million people, with an average of 9 prescriptions per person (AIHW 2020i).¹⁰ Between 2014-15 and 2018-19, the number of prescriptions increased by an average of 3% per year.¹¹ This has been predominantly driven by the growth of ‘under co-payment’ prescriptions.¹² Similarly, the share of the population who have received a prescription has risen slightly from 16% to 17%. Across the states and territories, Tasmania has the highest proportion of people with a mental health-related prescription, while the Northern Territory has the lowest (figure 2.9). However, medications that are funded through the Aboriginal Health Services program are not included in the data and would be reflected as an underestimate of prescriptions in the Northern Territory.

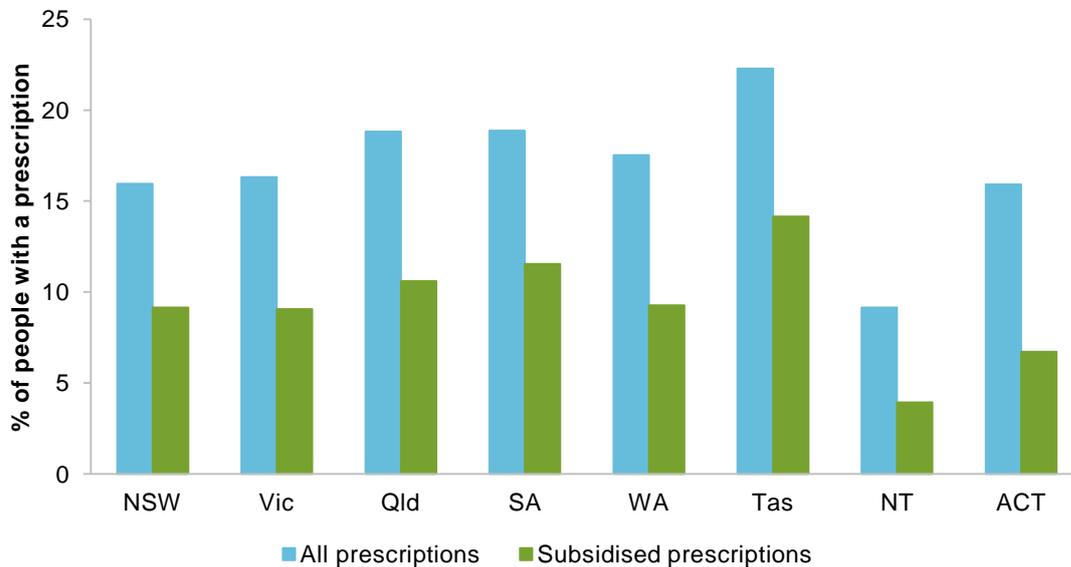
People aged between 45–64 years were most likely to have received a prescription, constituting about one-third of all people receiving a prescription. However, *within* age groups, people aged 85 years or older were the most likely to have a prescription (43%), with an average of 10 prescriptions per person (figure 2.10). Females were also more likely to have received a prescription compared with males, with about 60% of prescriptions for females. The rate of prescriptions tends to fall as remoteness increases, with only 7% of people in remote areas receiving a prescription, compared with 16% in major cities and 21% in inner regional areas.

¹⁰ The data on prescriptions does not include private prescriptions, over the counter medicines, and medicines supplied to public hospital inpatients (AIHW 2020i).

¹¹ While there is data available for earlier years, the AIHW caution that data published from 2013-14 onwards uses a different derived prescribing medical practitioner methodology and so are not comparable with data from earlier years.

¹² A PBS prescription is classified as ‘under co-payment’ when there is no government subsidy, i.e., when the dispensed price of the prescription does not exceed the maximum patient co-payment, and so the patient pays the full dispensed price of the medication.

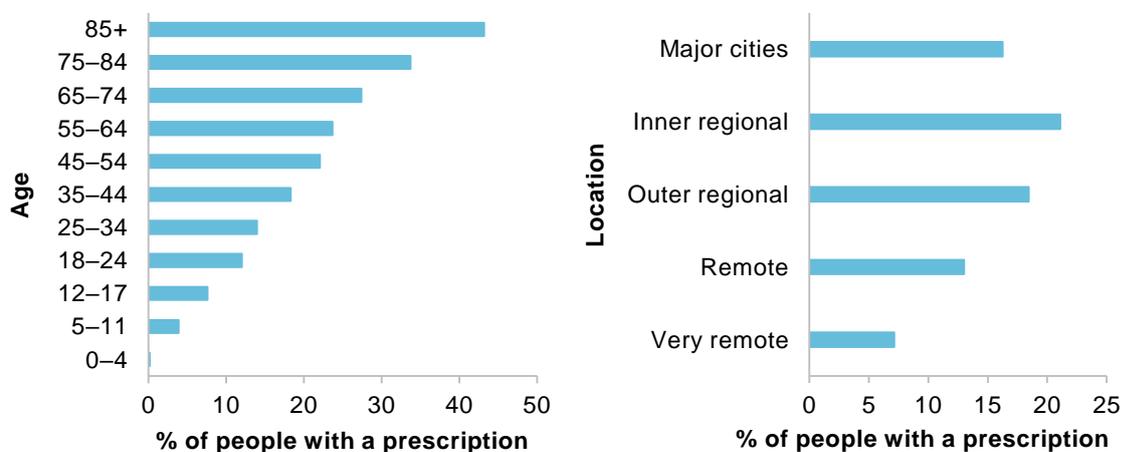
Figure 2.9 People with a mental health-related prescription^{a,b}
2018-19



^a All prescriptions include subsidised prescriptions and under co-payment prescriptions. ^b A proportion of the Australian Government subsidy of pharmaceuticals in remote communities (primarily the Northern Territory) is funded through the Aboriginal Health Services program, where drugs are supplied directly to patients and hence are not included in this data. Therefore, figures presented for the Northern Territory are considered to be an underestimate.

Source: AIHW (2020i).

Figure 2.10 People with a mental health-related prescription, by age and location
2018-19



Source: AIHW (2020i).

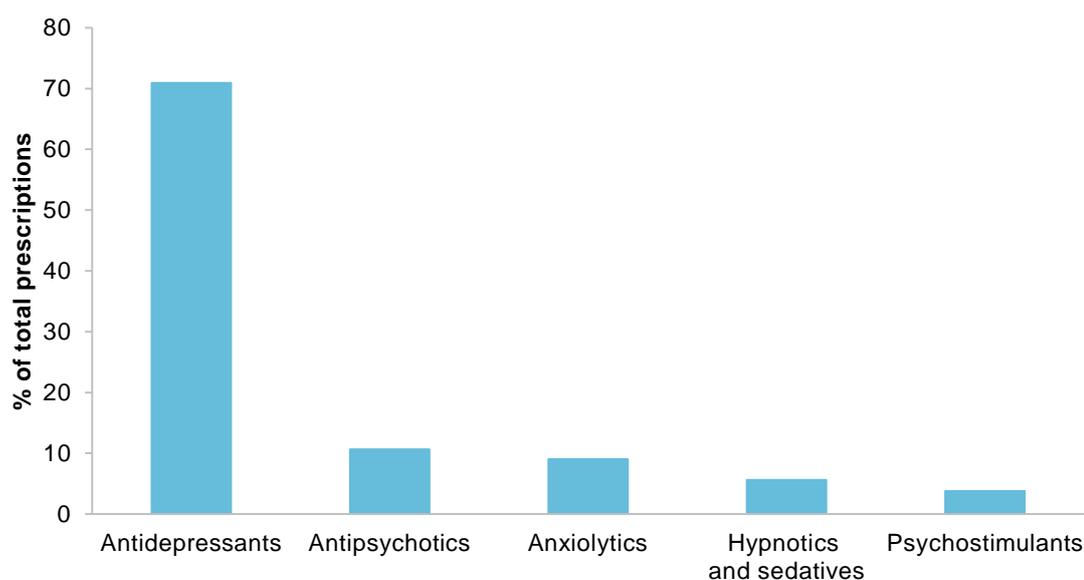
There are many types of medication which are used to treat different mental illnesses (table 2.1). Antidepressants make up the majority of mental health-related prescriptions, constituting more than two-thirds of prescriptions in 2018-19 (71%) (figure 2.11). Between 2014-15 and 2018-19, psychostimulants, agents used for attention-deficit hyperactivity disorder, and other nootropics recorded the largest average annual increase (12%), while hypnotics and sedatives recorded the largest average annual decrease (4%) in number of prescriptions.

Table 2.1 Types of mental health medication

<i>Drug group</i>	<i>Effects and indications</i>
Antidepressants	Drugs used to treat the symptoms of clinical depression.
Antipsychotics	Drugs used to treat symptoms of psychosis (a severe mental disorder characterised by loss of contact with reality, delusions and hallucinations), common in conditions such as schizophrenia, mania and delusional disorder.
Anxiolytics	Drugs prescribed to treat symptoms of anxiety.
Hypnotics and sedatives	Hypnotic drugs are used to induce sleep and treat severe insomnia. Sedative drugs are prescribed to reduce excitability or anxiety.
Psychostimulants and other nootropics	Agents used for attention-deficit hyperactivity disorder and to improve impaired cognitive abilities (nootropics).

Source: AIHW (2020i).

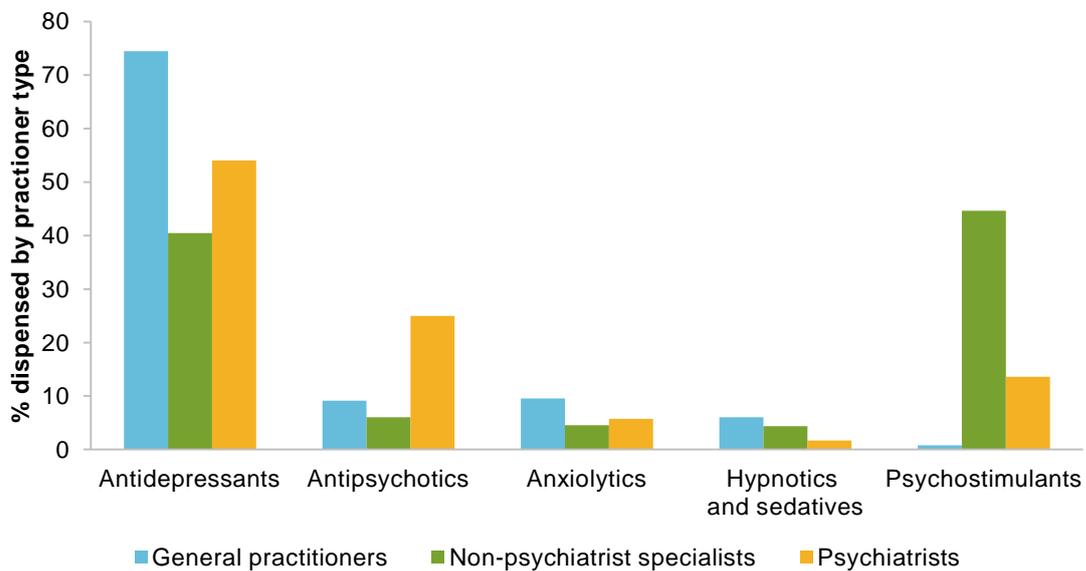
Figure 2.11 Antidepressants are the most common prescription
2018-19



Source: AIHW (2020i).

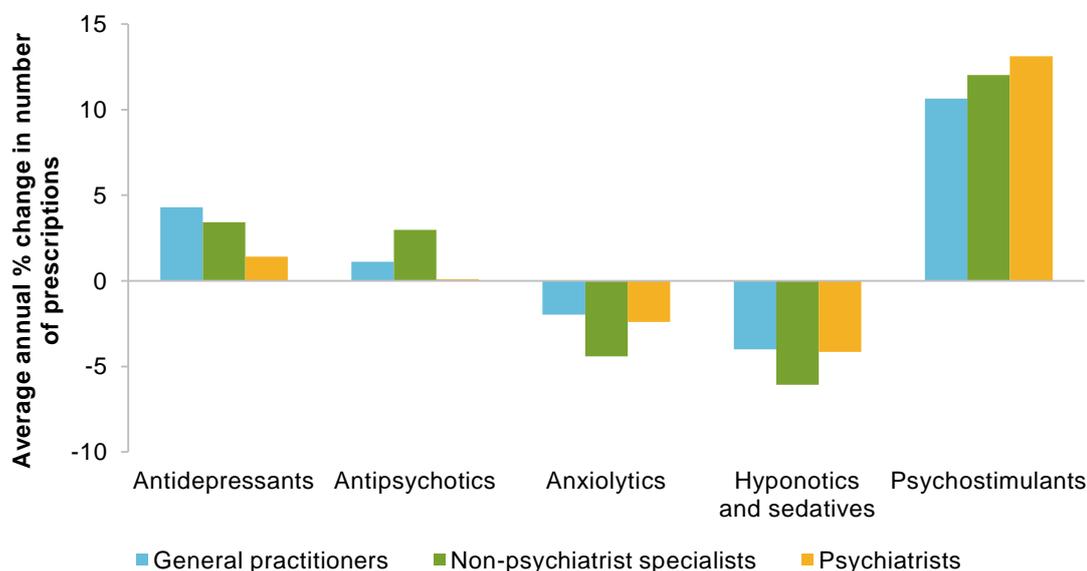
In 2018-19, the majority of mental health-related prescriptions were provided by GPs (86%), followed by psychiatrists (8%), and non-psychiatric specialists (5%). The most frequent prescription dispensed by a GP and psychiatrists were antidepressants (74% and 54% respectively), while non-psychiatric specialists were more likely to dispense psychostimulants (45%) (figure 2.12). Between 2014-15 and 2018-19, GPs had the highest growth rate in prescribing antidepressants, while psychiatrists had the highest growth rate in prescribing psychostimulants (figure 2.13).

Figure 2.12 Who is prescribing which medications
2018-19



Source: AIHW (2020i).

Figure 2.13 The mix of medication dispensed has changed over time^a



^a The data captures the average annual percentage change in the number of prescriptions dispensed by a particular practitioner type from 2014-15 to 2018-19.

Source: AIHW (2020i).

2.2 What is the reduction in years of healthy life lived due to mental illness?

Health conditions come in a range of forms — physical, mental, a combination of both — but all lead to the loss of healthy years of life. Some conditions have a larger effect than others. One way to measure the effect of different health conditions is by considering:

- how many years of healthy life a person may expect to lose due to the condition (*years lived with disability*)
- how many years of life are prematurely lost due to the condition (*years of life lost*).

Together, the years lived with disability and the years of life lost make up what has been termed the ‘burden of disease’ (box 2.3). We have used this terminology as it is the standard technical term describing the effect (burden) caused to the life of an individual by a disease, but appreciate that for some stakeholders the term may be stigmatising.

This health loss represents the difference between the current health status of the population and the ideal situation where everyone lived a long healthy life. This approach captures both the quantity and quality of life affected by illness, and reflects the magnitude, severity and effect of disease and injury within a population. With fewer years lived in disability, people have more opportunities to engage with society, whether it be through family and friends, the community, educational settings, or workplaces.

Box 2.3 Burden of disease — what are DALYs, YLDs and YLLs?

A disability-adjusted life year (DALY) is a measure of the effect of a disease. One disability-adjusted life year corresponds to a loss of one year of healthy life. The loss of healthy life can come in two forms.

First, people can experience illnesses, and in most cases, they eventually recover. But the time spent living with the illness can be thought of as years lived with disability (YLD). This is calculated using $YLD = P \times DW$, where P is the number of prevalent cases, and DW is the disability weight of the illness. The disability weight of a disease is a number between 0 and 1 which reflects the severity of a disease.

Second, illnesses can lead to a person dying earlier than expected. The additional years that the person would have lived is the years of life lost (YLL) due to premature mortality. This is calculated using $YLL = N \times L$, where N is the number of deaths due to the illness, and L is the remaining life expectancy at the time of death.

Together, years lived with disability and years of life lost sum to make up disability-adjusted life years.



Potential adjustments to the standard calculation

The Australian Burden of Disease Study 2015 (AIHW 2019c) included additional adjustments for comorbidity of diseases, as the available data on prevalence rates and disability weights do not consider comorbidities. If each disease were to be considered in isolation, the years lived in disability would tend to be overestimated due to double counting people with multiple illnesses.

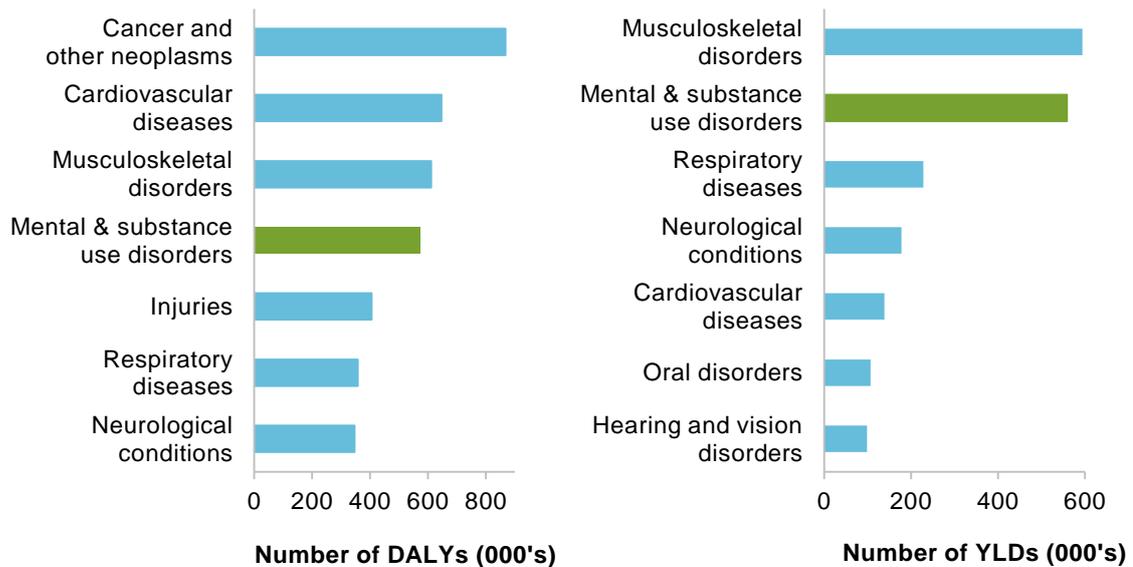
Source: AIHW (2019c); World Health Organization (2019c).

As a whole, mental and substance use disorders make up 12% of the total health loss in Australia, behind cancer, cardiovascular diseases, and musculoskeletal conditions (AIHW 2019c). However, mental and substance use disorders represent the second highest proportion of years lived with disability in Australia (figure 2.14).

Anxiety and depressive disorders are the most common form of mental illness, accounting for approximately half of the health loss due to mental illness. The health loss is distributed almost evenly between males and females, but the types of mental illness contributing to health loss differ between males and females. Females have a greater health loss due to anxiety, depressive, and eating disorders, whereas males have a greater health loss due to

substance use disorders and schizophrenia (figure 2.15). Across age groups, the health loss from mental and substance use disorders peaks during early adulthood (between ages 20-35 years), averaging about 30% of the total health loss (AIHW 2019c).

Figure 2.14 Mental illness is the fourth largest cause of overall health loss and the second highest cause of disability^{a,b}



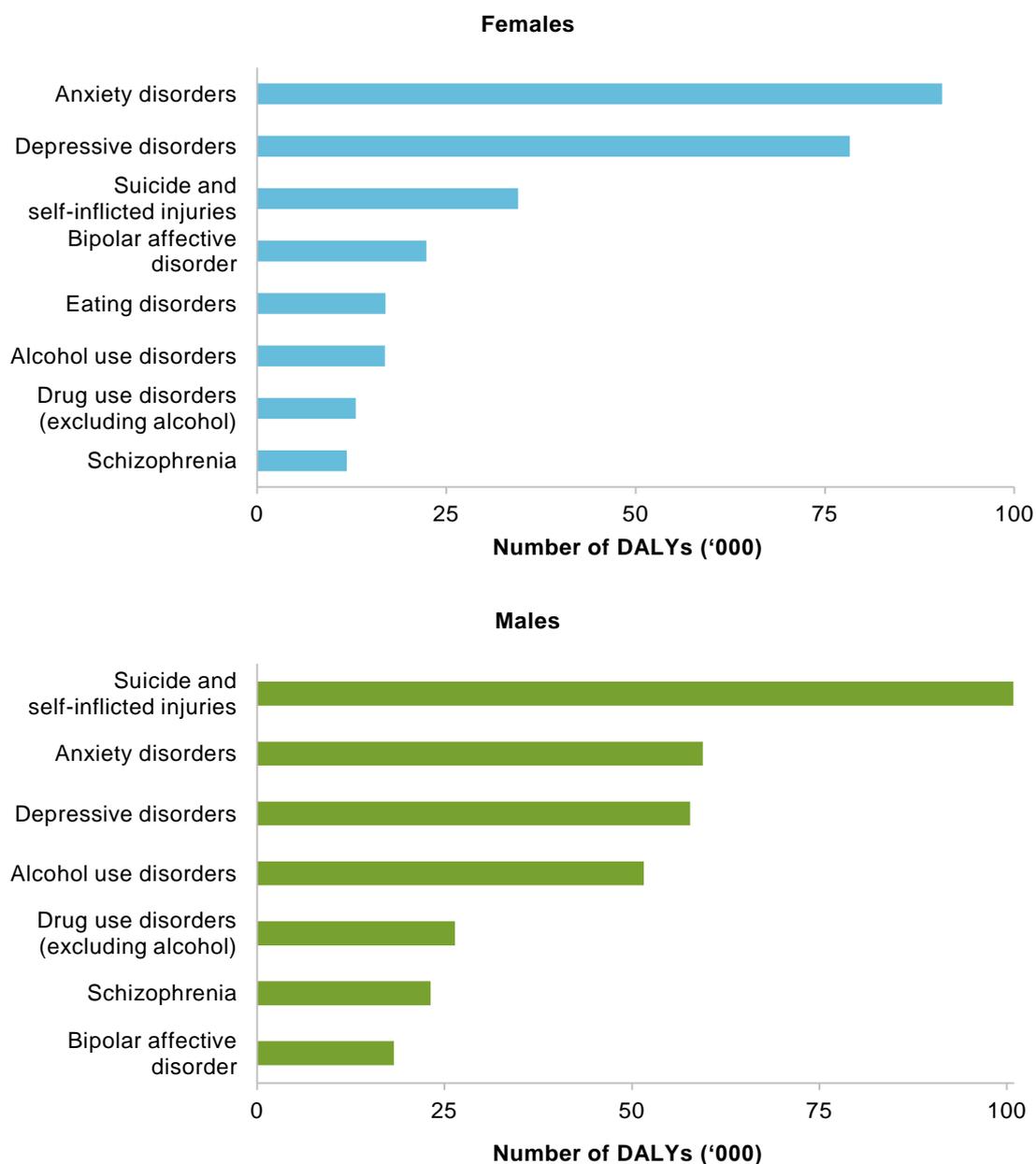
^a The illnesses on these two figures are those with the highest disability-adjusted life years (DALYs) and years lived in disability (YLDs) respectively. ^b Suicide is not included within mental and substance use disorders — it is included within injuries.

Source: AIHW (2019c).

Suicide is not counted as a cause of death from mental illness in usual burden of disease method — it is counted under injuries. However, about two-thirds of the health loss attributed to suicide is due to mental illness (Ferrari et al. 2014). When deaths from suicide is included in the picture alongside the other burden mental illnesses, it is the biggest contributor to the health loss for males (figure 2.15).

The health loss from mental illness also varies across the country and population. People living in major cities tend to lose more years of healthy life to anxiety and depressive disorders than those living in remote areas, but the years of healthy life lost due to suicide can be more than twice as large in very remote areas (AIHW 2019c). There are large differences across socioeconomic groups — of all illness groups, mental illnesses had the second largest difference in years of healthy life lost between people in the bottom income quintile and those in the top income quintile (an age-standardised rate of 27.7 compared with 17.4), suggesting that income disparities could be correlated with mental health.

Figure 2.15 The health loss varies by mental illness and gender^{a,b,c}

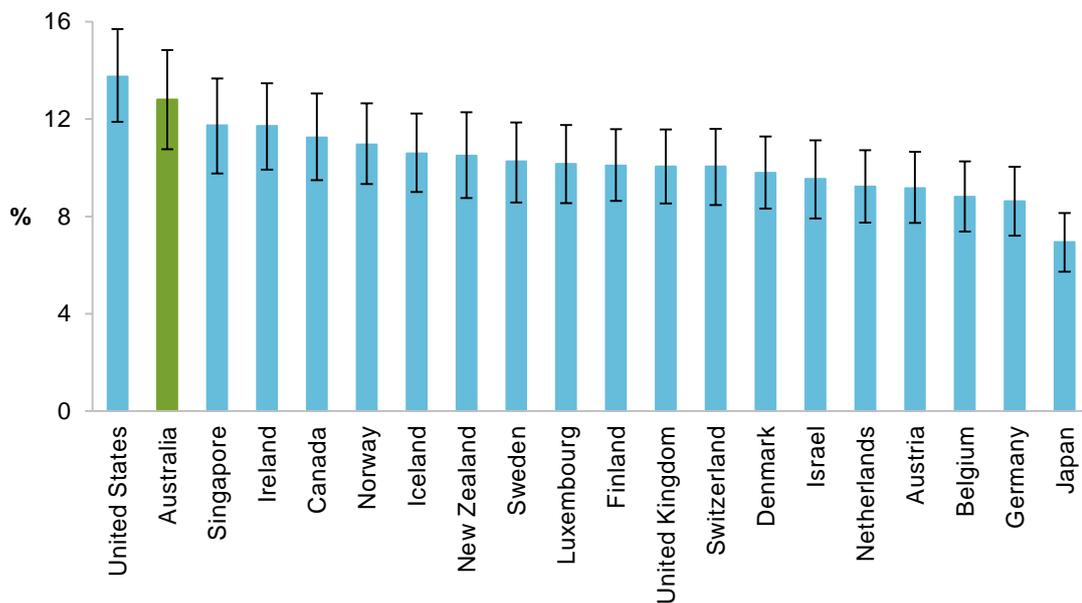


^a When breaking down DALYs into YLDs and YLLs, YLDs make up 95%, while YLLs constitute about only 5% (except in the case of suicide and self-inflicted injuries). ^b Suicide is not included within mental and substance use disorders — but it is included in this figure as there is evidence that two-thirds of the DALYs for suicide can be attributed to mental illness. ^c The mental illnesses here are not exhaustive — they are ones which have the highest DALYs.

Source: AIHW (2019c).

Over time, the overall rate of years of healthy life lost in Australia has fallen (between 2003 and 2015), but mental illness is one of the illness groups where the rate has risen over time, only behind neurological diseases (AIHW 2019c). Compared with other developed countries, Australia has the second highest proportion of the total health loss attributed to mental illness (figure 2.16).

Figure 2.16 **Mental illness as a proportion of the total health loss^{a,b,c,d}**
2017



^a The developed countries shown here are those with the highest Human Development Index with data available on prevalence rates. ^b Include substance use disorders. ^c The rates are modelled and have confidence intervals. ^d Differences in survey methods and reporting between countries can influence the results. It is worth noting that the confidence interval for Australia is within the range of most of the countries shown in the figure.

Source: Institute for Health Metrics and Evaluation (2019).

2.3 Needs and outcomes are diverse

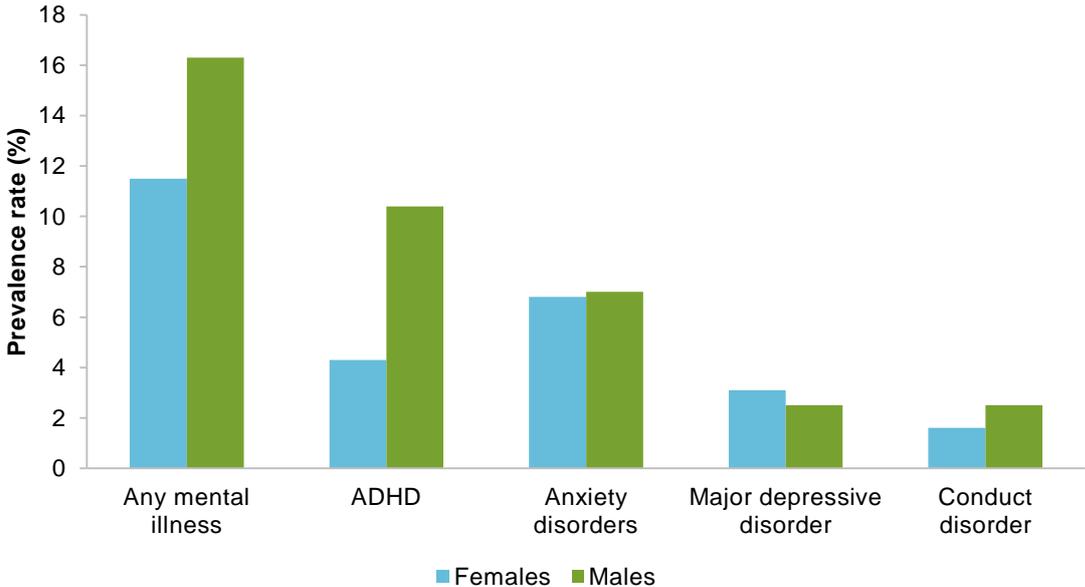
Young people

The effects of mental ill-health can persist over an individual’s entire lifetime, and so intervention at a young age is crucial (chapter 5). Most mental illnesses experienced in adult life begin during childhood or adolescence, with 64% of people with mood and anxiety disorders and half of those with psychosis having their onset before the age of 21 years (AHMC 2009b; Morgan et al. 2012).

Mental ill-health can result in absences from school, which could lead to lower levels of connectedness with peers and poorer educational outcomes (Goodsell et al. 2017). In turn, this can result in reduced opportunities for employment in the future and worse socioeconomic outcomes, with the associated negative externalities spilling-over to the rest of the community.

While the majority of Australian children and adolescents have good mental health, it is estimated that 14% of Australians aged 4–17 years had a mental illness in the previous 12 months (Lawrence et al. 2015). The prevalence rate was higher for males than females across all mental illnesses except for major depressive disorders (figure 2.17). Attention-deficit hyperactivity disorder is the most common mental illness for young males with a prevalence rate of 10%, while anxiety was the most common for females with a prevalence rate of 7%.

Figure 2.17 Mental illnesses begin early in life
12-month prevalence rates for people aged 4–17 years in 2013-14



Source: Lawrence et al. (2015).

Mental health problems in children can go unnoticed as they may not be able to identify their own problems, and adolescents are less likely to seek help, leading to a tendency to ‘suffer in silence’ (WHO 2018a). Additionally, parents are generally not good at identifying signs and symptoms of mental illness in their children — for example, the parent reported rate of major depressive disorders can be underestimated by up to half of the adolescent reported rate (Lawrence et al. 2015). This means that the true prevalence of mental illness among young people is likely to be higher than what the data collected from surveys would suggest.

Household demographics potentially play a role in determining mental health for young people. Family composition, income bracket, parent/carer employment, and location are correlated with the prevalence of mental illnesses, but whether these relationships are causal remains a question (Lawrence et al. 2015). Children and adolescents living with their original family have a lower prevalence rate compared with those who are not, and the prevalence rates of children and adolescents living in a household within the highest income bracket are about half of those in the lowest income bracket.

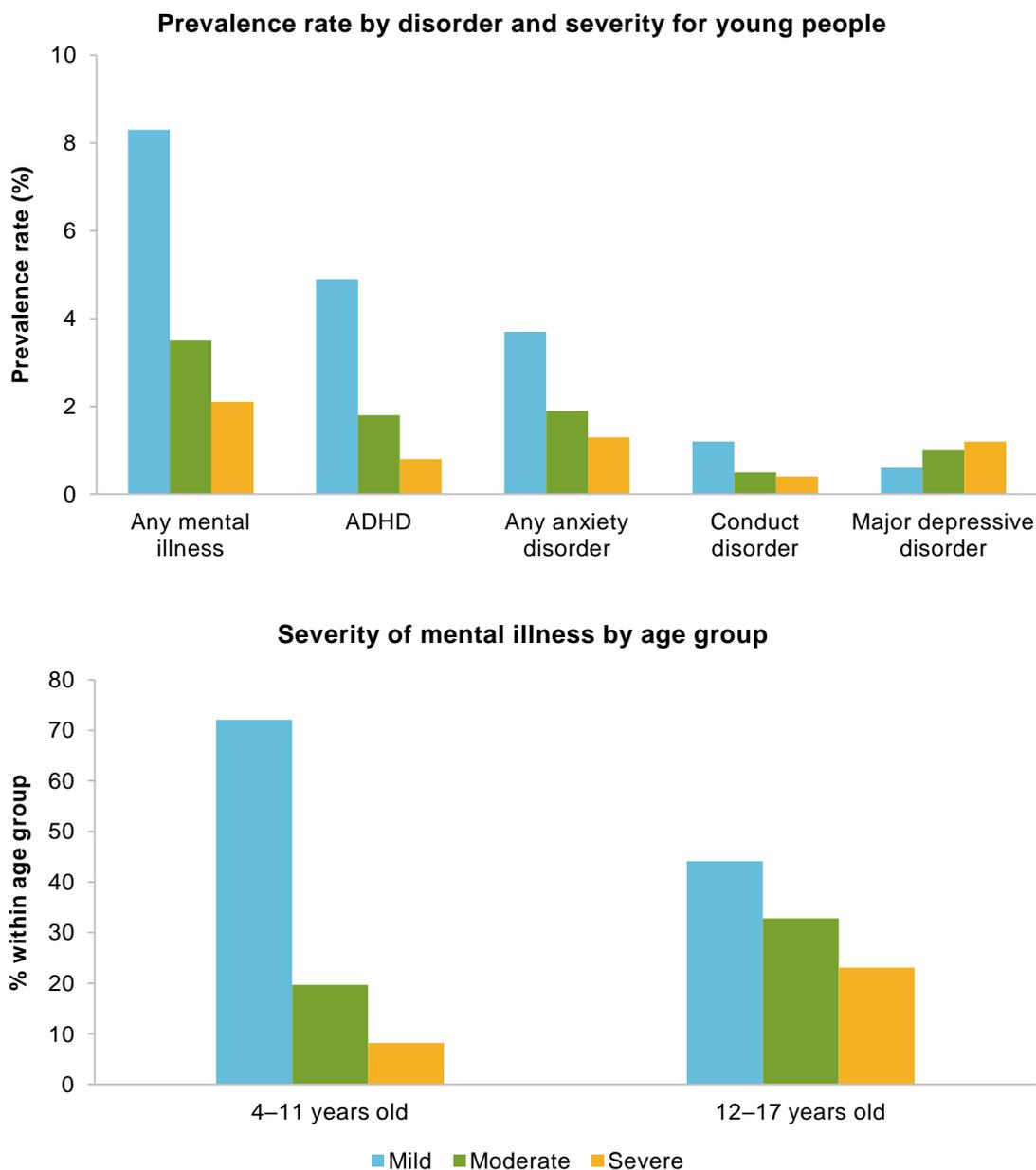
Similar to what is observed in the general population, the prevalence rate of mental illness in young people tends to fall as the severity of the mental illness rises — with one exception, the prevalence rate of a severe major depressive disorder is higher than one which is mild or moderate (Lawrence et al. 2015). Severe mental illnesses are more likely to be present (or at least diagnosed) in 12–17 year olds compared with 4–11 year olds (figure 2.18). These two features can stem from the identification problem — major depressive disorders are less transparent compared with other mental illnesses, such as attention-deficit hyperactivity disorder or conduct disorders. Additionally, children may not understand their symptoms and problems they are experiencing, and parents and clinicians may be wary of making these diagnoses in children.

Eating disorders can develop at any age, but the onset typically is during the adolescent years, and they are the second leading cause of mental illness for young females (NEDC 2012). Extreme dieting can make it 18 times more likely for young females to develop an eating disorder within 6 months, with an estimated 20% prevalence rate within 12 months (NEDC 2016).

Self-harm is twice as common for young females compared with males, with about 15% of females having self-harmed at some point in their life (figure 2.19). In particular, major depressive disorders appear to be correlated with self-harm — almost 50% of females with a major depressive disorder had self-harmed in the past (Lawrence et al. 2015).

Suicide is the leading cause of death for young people aged between 15–24 years (ABS 2019b). While suicidal ideation is more common among young females, young males are more than twice as likely to have taken their own lives, which is similar to what is observed in the general population, where males are more likely to choose deadly means.

Figure 2.18 Adolescents are more likely to have a severe mental illness^a
 12-month prevalence rates in 2013-14

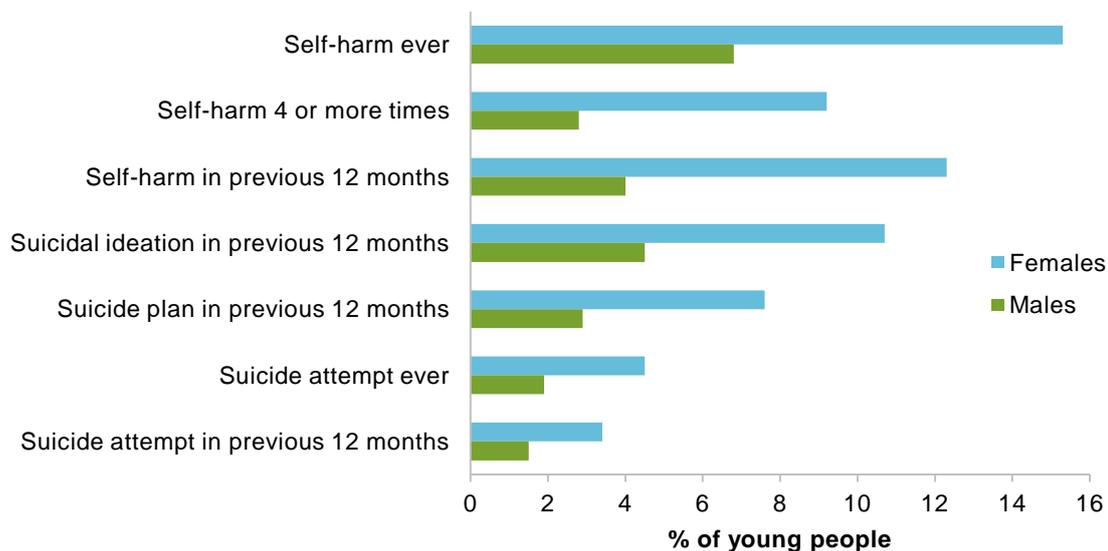


^a The population in the top figure were aged 4-17 years.

Source: Lawrence et al. (2015).

Figure 2.19 **Self-harm and suicidal ideation is more common among young females**

People aged 12–17 years in 2013-14



Source: Lawrence et al. (2015).

Aboriginal and Torres Strait Islander people

For Aboriginal and Torres Strait Islander people, more so than for many other demographic groups, mental health and mental illness are considered to be only one part of social and emotional wellbeing (chapter 8). The broader concept of social and emotional wellbeing recognises the importance of connection to land, culture, spirituality, family and community to people’s wellbeing.

Widespread disadvantage and health inequity have contributed to comparatively poor social and emotional wellbeing outcomes for many Aboriginal and Torres Strait Islanders (AIHW 2018b). There are also unique risk factors faced by Aboriginal and Torres Strait Islander people — including intergenerational trauma, racism, and discrimination — which can increase the likelihood of mental ill-health and worse outcomes for social and emotional wellbeing.

The prevalence rate of a long-term mental illness among Aboriginal and Torres Strait Islander people is about 24%, but this disguises significant heterogeneity within the population (ABS 2019g). Aboriginal and Torres Strait Islander people living in remote areas have a substantially lower prevalence rate (10%) compared with their counterparts living in non-remote areas (28%).

Aboriginal and Torres Strait Islander people are more than twice as likely to experience high or very high levels of psychological distress compared with non-Indigenous Australians, with nearly one-third of Aboriginal and Torres Strait Islander people reporting having high to very high levels of psychological distress (figure 2.20). This increases to 60% if the person has been diagnosed with a long-term mental health condition (ABS 2016). Aboriginal and Torres Strait Islander people with mental ill-health can find it more difficult to access culturally capable health services and find full-time employment.

Figure 2.20 Psychological distress is experienced more commonly by Aboriginal and Torres Strait Islander people^{a,b}
 People aged 18 years and above during 2017-19



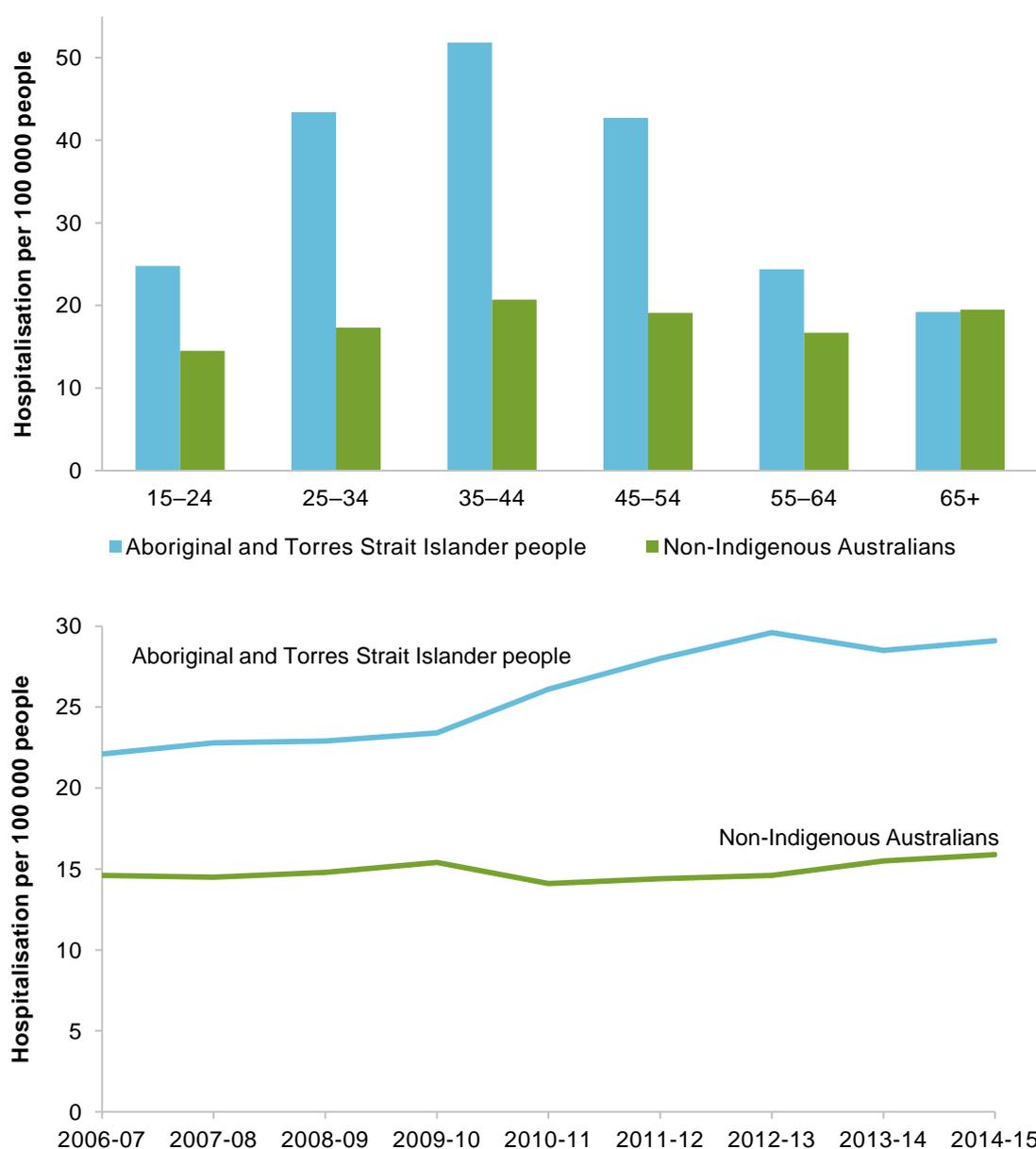
^a Levels of psychological distress are derived from the Kessler Psychological Distress Scale (K5), where scores between 12–25 are categorised as high/very high psychological distress. ^b Rates are age standardised.

Source: SCRGSP (2020b).

Although Aboriginal and Torres Strait Islander people are less likely to consume alcohol compared with non-Indigenous Australians, those who do consume alcohol are more likely to drink at high-risk levels (AIHW 2011c). High rates of alcohol use during pregnancy can lead to foetal alcohol spectrum disorder, with prevalence rates up to 12% in high risk Indigenous communities (Fitzpatrick et al. 2015). Substance use, alongside mental ill-health and poor physical health, can increase the likelihood of domestic violence (AIHW 2016). Aboriginal and Torres Strait Islander women are more likely to be victims of domestic violence compared with non-Indigenous women, with hospitalisation rates up to 32 times higher (AIHW 2018c).

Aboriginal and Torres Strait Islander people of working age are twice as likely to be hospitalised for mental health-related problems compared with non-Indigenous Australians (AIHW 2015), and between 2006–2015, hospitalisation rates for mental health-related conditions increased for Aboriginal and Torres Strait Islander people, while remaining stable for non-Indigenous Australians (figure 2.21).

Figure 2.21 Hospitalisation rates for mental health-related conditions^{a,b}

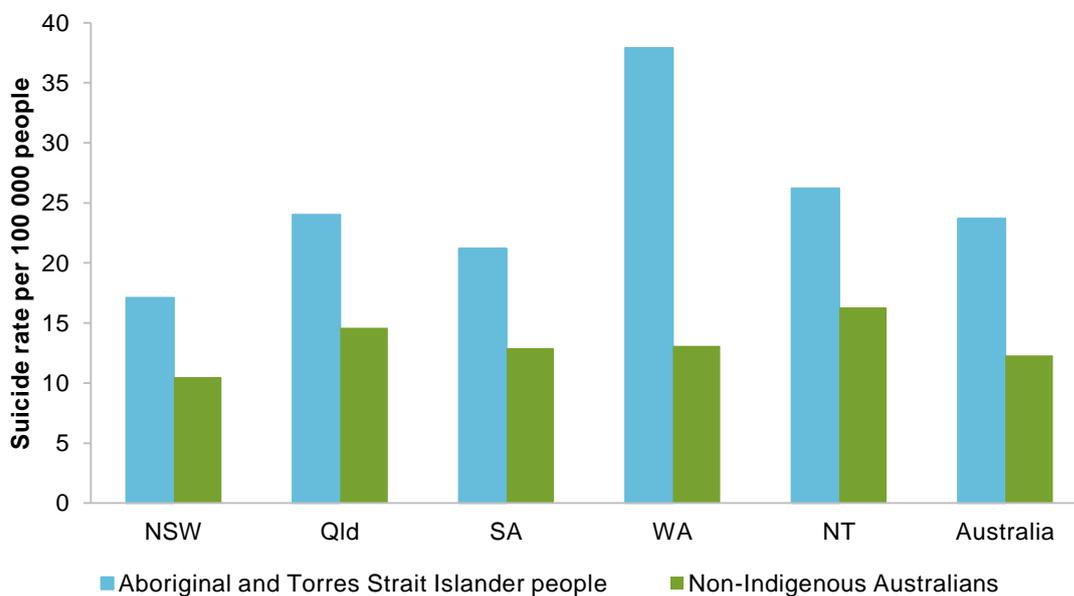


^a Based on principal diagnosis. ^b The top figure is for 2012-13.

Source: AHMAC (2017a); AIHW (2015).

Aboriginal and Torres Strait Islander people are over-represented in suicide statistics and face unique factors which can increase the risk of suicide (chapter 9). Suicide rates for Aboriginal and Torres Strait Islander people increased by 44% between 2009–2018, and in Western Australia are almost three times as high as suicide rates for non-Indigenous Australians in that state (ABS 2019b; figure 2.22).

Figure 2.22 Suicide rates for Aboriginal and Torres Strait Islander people are higher compared with non-Indigenous Australians^{a,b}
2018



^a Data for Victoria, Tasmania and the ACT have been excluded, in line with national reporting guidelines.
^b Suicide rates are age-standardised.

Source: ABS (*Causes of Death, Australia, 2018*, Cat. no. 3303.0).

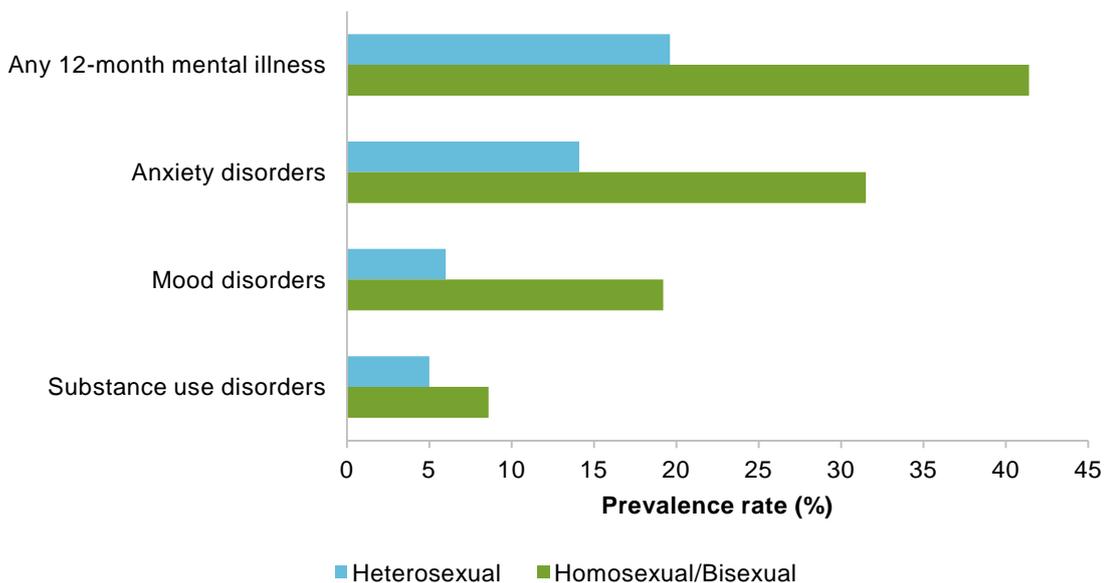
Unlike the general population, suicide rates for Aboriginal and Torres Strait Islander people are highest during early to mid-life, and then fall among the older age groups. Suicide is the leading cause of death for young Aboriginal and Torres Strait Islander people (aged between 15–34 years) and suicides in this age group account for more than two-thirds of deaths by suicide by Aboriginal and Torres Strait Islander people. For Aboriginal and Torres Strait Islander people, the median age at death by suicide is 29.5 years, compared with 45.4 years for non-Indigenous Australians (ABS 2018b).

Lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) Australians

While many LGBTIQ people do not experience depression or any other mental health problem, some LGBTIQ people have additional social difficulties and isolation and can face stigma, discrimination, harassment, and abuse which elevates the prevalence of mental illness. LGBTIQ people experience anxiety and mood disorders at higher rates than heterosexual people (ABS 2008) and are at greater risk of suicide and self-harm (Rosenstreich 2013). More than twice as many homosexual/bisexual Australians experience anxiety disorders compared with heterosexual people, over three times as many experience mood disorders, and almost twice as many experience substance use disorders (ABS 2008; figure 2.23). Transgender people have even higher prevalence rates, with about 56% of survey respondents indicating they had been diagnosed or treated for a mental illness in the past three years (Leonard, Lyons and Bariola 2015). LGBTIQ Australians are also more than twice as likely to have high or very high level of psychological distress compared with heterosexual people (11% compared with 23–28%) (AIHW 2018b).

Figure 2.23 **Homosexual and bisexual people are more likely to experience mental illness**

12-month prevalence rates for adults aged 16–85 years in 2007



Source: Productivity Commission estimates using ABS (*Microdata: National Survey of Mental Health and Wellbeing, Basic and Expanded CURF, 2007*, Cat. no. 4326.0.30.001).

Compared with heterosexual people, homosexual and bisexual people are more likely to drink alcohol in excess and are more likely to have used an illicit drug (AIHW 2018a), with findings suggesting that illicit drug use is three times as common and risky drinking is about one and a half times more common (AIHW 2017b).

LGBTIQ people have a higher risk for suicidal behaviour compared with the general population (Skerrett, Kolves and De Leo 2015), with studies finding 20% of transgender Australians and 16% of lesbian, gay and bisexual Australians report suicidal ideation (Rosenstreich 2013).¹³ However, data collected on suicides about the LGBTIQ population is poor because characteristics such as gender identity and sexuality are not typically present in death records (National LGBTI Health Alliance, sub. 494). Additionally, there may also be people who have not ‘come out’ before taking their own lives, which would further underestimate the already elevated suicide rate for LGBTIQ people.

Young LGBTIQ people are especially at risk — in particular, same-sex attracted young people are six times as likely to have attempted suicide compared with their heterosexual peers (Rosenstreich 2013). Almost half of young trans people had attempted suicide and 80% had self-harmed (Strauss et al. 2017). Homophobic abuse experienced by young people has been linked to substance-use, self-harm, and suicide attempts. Those who had experienced both verbal and physical abuse had suicidality rates between 20–40% higher than an LGBTIQ person who had never experienced abuse (Hillier et al. 2010).

Due to ongoing perceptions and experiences of stigma and discrimination, LGBTIQ Australians can also face access barriers to mental health services. Thorne Harbour Health and Rainbow Health Victoria (sub. 265) reported that about one-third of LGBTIQ Australians surveyed reported usually or occasionally hiding their sexual orientation or gender identity when accessing services.

Living in regional and remote areas

Living in regional and remote areas carries along a set of unique risk factors for mental illness, including isolation and environmental events such as droughts and bushfires. The prevalence rate of mental illness in regional areas is similar to those in urban areas, but males in regional and remote areas experience higher levels of psychological distress than those living in major cities (AIHW 2008).

A stark difference between urban and regional living becomes apparent when comparing suicide rates. The suicide rate in regional areas has been consistently higher over time compared with those in major cities (ABS 2019b), and suicide rates tend to increase with remoteness (AIHW 2019f; figure 2.24), with suicide rates in very remote regions almost twice that of the national average. There is likely to be some correlation with the higher

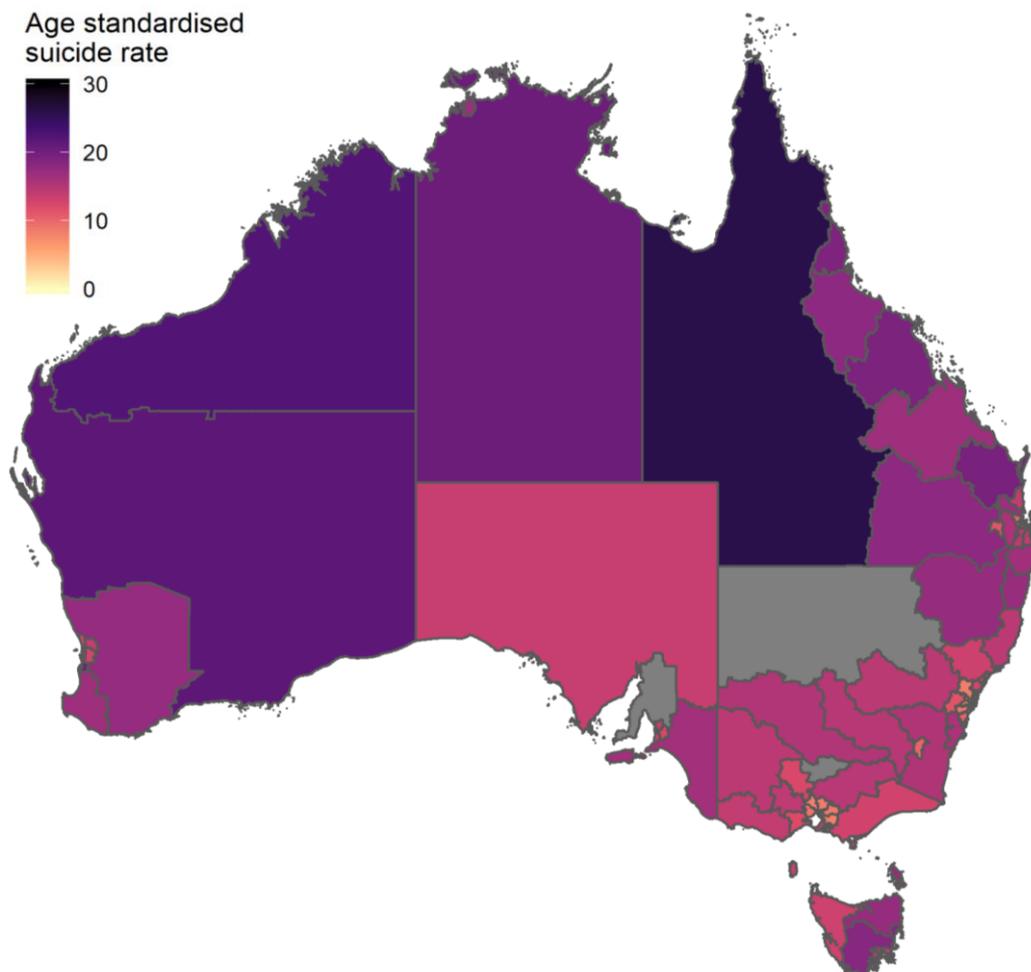
¹³ This compares with estimates of 13% in the broader population who had ‘serious thoughts’ about suicide at some time (Slade et al. 2009).

suicide rate for Aboriginal and Torres Strait Islander people, given this group makes up a large proportion of people residing in remote areas of Australia.

Those living in regional and remote areas may have access to a very small number of services, if any (RFDS, sub. 361). This can lead to waiting lists, unsuitability of services, no services on offer in a town, or people needing to travel long distances to access mental health services, which incurs additional costs and takes time. Sometimes travel is not an option as there are no services in neighbouring regions.

Figure 2.24 **Suicide rates tend to be higher in remote areas^a**

Age-standardised suicide rate per 100 000 people, 2013-17



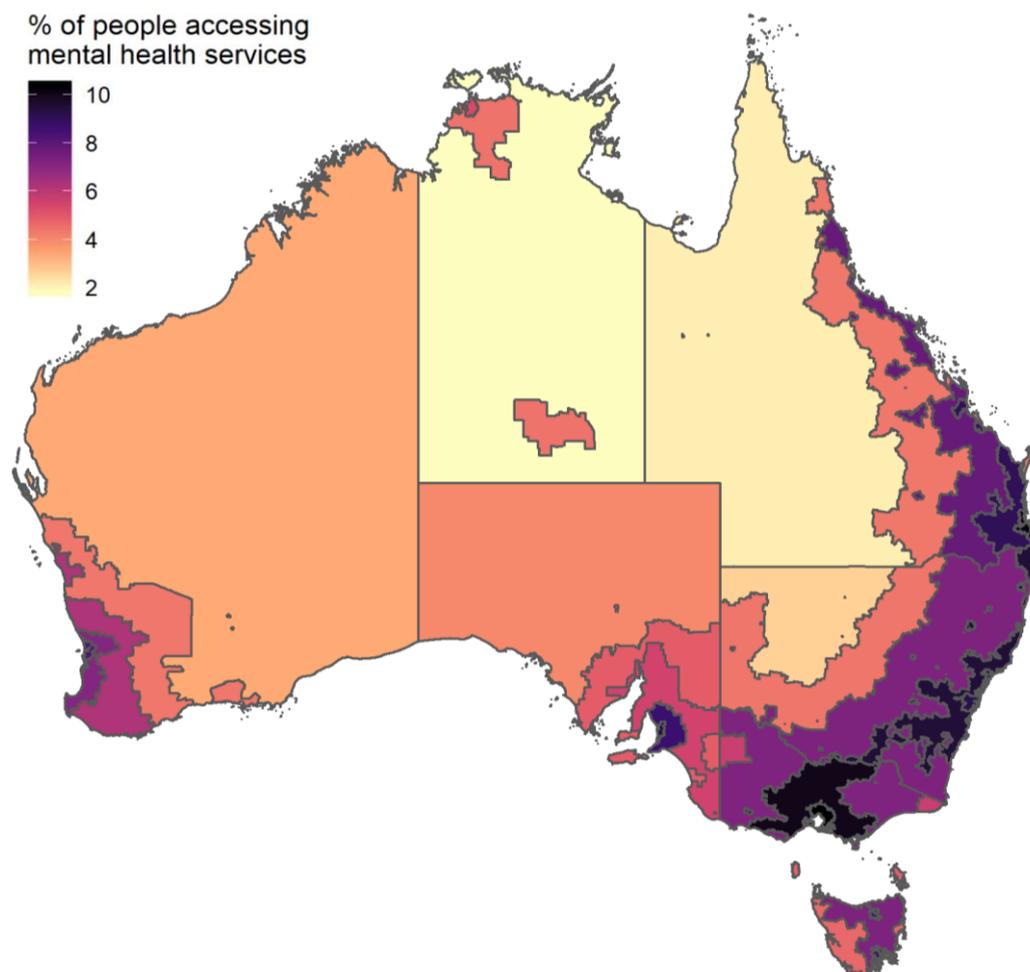
^a Regions are Australian Statistical Geography Standard 2016 SA4. Grey regions are where data is not available.

Source: AIHW (2019f).

These factors combined have resulted in a lower rate of use of mental health services in remote areas (figure 2.25). The small number of services available is in part driven by the small mental health workforce in these areas (in both absolute and relative terms) (AIHW 2019i), with substantial differences across different types of providers (figure 2.26). In smaller communities, issues of stigma and privacy may be heightened given the increased visibility in the community when accessing services or the possibility people will know health professionals in a personal capacity (QAMH, sub. 247; RRMH, sub. 97; Volunteering Australia, sub. 412), leading to fewer people accessing services.

Figure 2.25 Use of mental health services is lower in regional and remote areas^a

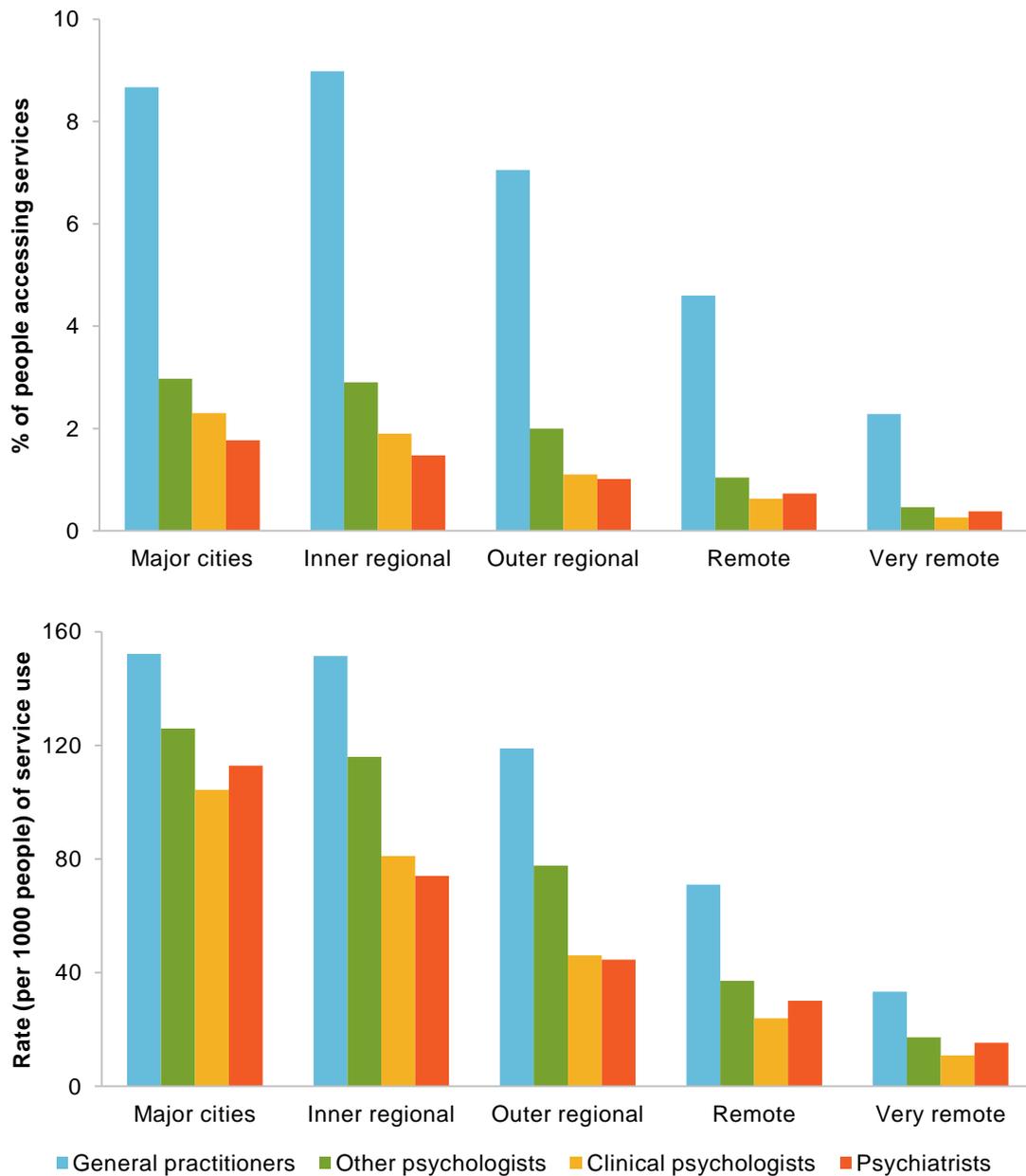
2016 Medicare Benefits Schedule services data



^a Regions are Australian Statistical Geography Standard 2016 Remoteness categories.

Source: Productivity Commission estimates using ABS (*Microdata: Multi-Agency Data Integration Project, Australia, Cat. no. 1700.0*).

Figure 2.26 **MBS-rebated mental health services by provider type^a**
2017-18



^a Regions are Australian Statistical Geography Standard 2016 Remoteness categories.

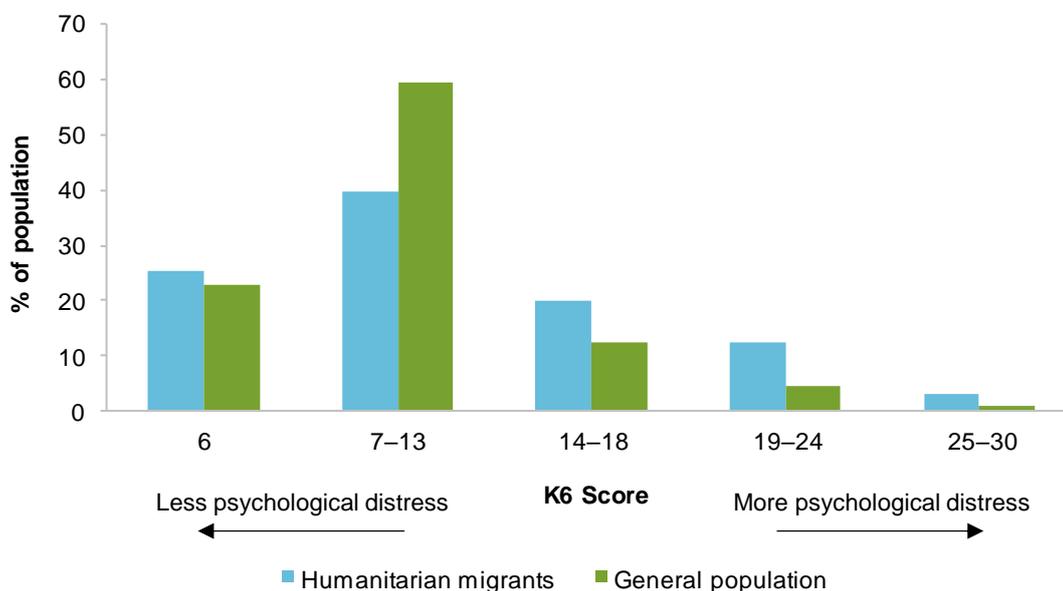
Source: AIHW (2019k).

Culturally and linguistically diverse people

The culturally and linguistically diverse (CALD) population represents Australians who are born overseas, have a parent born overseas, or speak a variety of languages. CALD people constitute almost half of the Australian population — 26% of Australians were born overseas and a further 19% have at least one parent who was born overseas (AIHW 2018b). Cultural aspects have been suggested to play a role in determining mental health, which can act as both risk factors and protective factors. In some CALD communities, there is significant stigma and taboo associated with mental illness. This can result in people not wanting to admit they have a mental illness due to shame from family and others around them, which can prevent them from seeking help (Western Australian Department of Local Government, Sport and Cultural Industries, sub. 78; Mental Health Australia, FECCA and NEDA, sub. 524). A lack of information due to language barriers and culturally capable services can also be a deterrent to access of mental health services (Victorian Government, sub. 483).

There is limited data on mental health within the CALD population (Minas et al. 2013), but the 2007 National Mental Health Survey (ABS 2008) suggests that at an aggregate level, the prevalence of mental illness in the CALD population is lower than that of the general population. However, immigrants and refugees are likely to experience higher rates of mental illness if exposed to trauma in their country of origin. For example, studies have found that Tamil asylum seekers and Burmese refugees in Australia had higher rates of mental illnesses, in particular PTSD, while Vietnamese refugees had lower rates of mental illness, compared with Australian-born people (Schweitzer et al. 2011; Shawyer et al. 2017; Silove et al. 1998, 2007). There is evidence that high levels of psychological distress is more common among humanitarian migrants (figure 2.27). It has been suggested that young CALD people are particularly vulnerable to environmental risk factors which can negatively affect their mental health (AHRC, sub. 491).

Figure 2.27 **Humanitarian migrants are more likely to have high psychological distress compared with the general population^{a,b}**



^a Data presented are the latest waves of Building a New Life in Australia (wave 5, conducted in 2017-18) and the Housing, Income and Labour Dynamics in Australia survey (wave 17, conducted in 2017-18). Building a New Life in Australia is a survey on humanitarian migrants, whereas the Housing, Income and Labour Dynamics in Australia survey is representative of the whole population. ^b A higher K6 score corresponds to higher levels of psychological distress, where a score of 19 or higher suggests the presence of a probable serious mental illness.

Source: Productivity Commission estimates using Building a New Life in Australia: The longitudinal study of humanitarian migrants, wave 5; Housing, Income and Labour Dynamics in Australia, wave 17.

FINDING 2.1 — THE STATE OF MENTAL HEALTH IN AUSTRALIA

Mental illness is the second largest contributor to years lived in ill-health, and almost half of all Australians will experience mental illness at some point in their life. The most common mental illnesses are anxiety disorders and depressive disorders.

Most cases of mental illness have their onset before the age of 21 years, highlighting the need for intervention early in life. Suicide is the leading cause of death for Australians aged 15 to 44 years, and suicide rates are higher in regional areas.

3 The cost of mental ill-health and suicide

The cost of mental ill-health and suicide is large and pervasive ...

- It is not necessary to quantify the cost of mental ill-health and suicide to know that it results in damaging and costly effects on the lives of individuals, their families and friends, business, and the community.
- Nevertheless, our aggregate community-wide estimate of the costs of mental ill-health and suicide, based on the data available, provide valuable insights. In particular, it is a motivating force to develop a person-centred vision for Australia's mental health system, to improve the lives of those with mental ill-health and their families and carers.
- In 2018-19, the annual cost to the economy of mental ill-health and suicide in Australia was estimated to be up to \$70 billion.
 - Direct expenditure on mental healthcare and support services is in the order of \$16 billion.
 - The annual cost of lower economic participation and lost productivity was up to \$39 billion.
 - The total annual cost of replacing the support provided by carers of those with mental illness was about \$15 billion.
- The cost of disability and premature death due to mental illness, suicide and self-inflicted injury was equivalent to a further \$151 billion per year.
 - The social and emotional costs of lower social participation or stigma associated with mental ill-health are considered qualitatively.

This chapter examines the aggregated costs of mental ill-health and suicide. These costs are large but much can be done to improve this situation over time, as outlined in this report.

The costs — and the potential solutions that are recommended by this report — provide an opportunity to galvanise government, business, communities and individuals to work together to improve the outcomes for people with mental ill-health and their families and carers. The needs of consumers and carers should be at the centre of these reforms, along with their voice.

Understanding these costs is also important for prioritising reforms in mental health. In setting our reform priorities, the Productivity Commission has, among other things, considered how reforms can reduce these costs — including the high social and emotional costs of mental illness that are highlighted by this chapter.

3.1 Effects of mental ill-health and suicide

Mental health determines people’s capacity to lead fulfilling lives — to develop and use their skills and talents, work productively and fruitfully, maintain a secure place to live, cope with the normal stresses of life, and have strong and supportive social connections. A person with mental ill-health may be unable to achieve some, or all, of these important elements of life. This results in lost opportunities and costs (figure 3.1).

Most, if not all, in the community bear at least some of these costs to an extent, especially people with lived experience of mental ill-health and their carers, families and friends, along with governments (through current and future taxpayers), employers and insurers. The consequences of mental ill-health can be experienced quite differently and the nature of these costs varies considerably.

- Direct expenditure on mental healthcare and other services and supports are well known and relatively more observable than some other types of costs. While governments are the main funders of mental healthcare, consumers can incur sizable out of pocket costs when accessing treatment.
- The time and effort spent by family members and friends in caring and supporting people with mental illness, while not ‘paid’ for in dollars, has considerable value. But this care can lead to some carers experiencing a deterioration in their own health.
- Lost career opportunities and lower living standards are a significant cost. Young people facing mental health problems may spend less time in education, which inhibits the development of their skills and talents. People’s work outcomes may also be affected through reduced hours, not being able to work, or being less productive when at work. As a result, people with mental illness often have lower incomes (chapters 1 and 8). The education and labour market outcomes of carers are also affected (chapter 18).
- The social and emotional costs can take a great toll on people with mental illness. They miss out on some life experiences and the enjoyment of doing activities with family and

friends. People with mental illness can experience added tension and stress to relationships, and in some cases, they die before their peers.

These costs are influenced by a wide range of interlinking factors (chapter 1). These factors include a person’s history of events (past mental illness, physical illness, trauma, substance use and stressful life events) and whether they have supportive environments and feel socially included. Businesses influence costs as their decisions shape people’s working environments. Governments affect these costs in setting budgets and determining the mix of services offered.

Figure 3.1 **Costs of mental ill-health to the community^a**

Resources expended on human services	Reduction in incomes and living standards	Social and emotional costs
Healthcare  Expenditure on diagnosis, treatment and recovery	Lower economic participation  Individuals and carers spend less time working or in education	Pain and suffering  Diminished health, and premature death
Other services & supports  Expenditure on education, employment, housing, justice & social services	Lost productivity  Absent from work, or less productive while at work	Stigma  Reluctance to seek treatment, discrimination & social exclusion
Informal care  Time and effort provided by family & friends to support individuals		Lower social participation  Less contact with family & friends, reduced community involvement

^a Income support payments (such as the Disability Support Pension and carer payments) are not included because they are a transfer between different members of the community, rather than a cost to the community as a whole.

Measuring the cost of mental ill-health and suicide

It is not necessary to quantify the cost of mental ill-health and suicide to know that it results in damaging and costly effects on the lives of individuals, their families and friends, governments, business, and the community. This Inquiry has heard from those with lived experience and their families and carers in submissions, brief comments, our public hearings, and in roundtables and meetings. We have also heard from those who work in the sector,

who are committed to achieving better outcomes for people with mental ill-health, their families and friends, and the community.

Estimating the cost of mental ill-health and suicide is challenging, particularly when the aim is to measure it in monetary terms. This is true even for costs such as government expenditure on healthcare and other support services, due to a fragmented system that makes gathering data difficult. Where we have limited data, costs need to be estimated and a range of assumptions made. There are some costs that are particularly difficult to measure, such as pain and suffering. Converting these to monetary values is to some people incomprehensible or objectionable. Other costs cannot be measured. Nevertheless, insights can be gained from trying to quantify the measurable costs of mental ill-health and suicide (box 3.1).

Box 3.1 Why measuring costs is important

Quantifying the cost of mental ill-health and suicide in monetary terms is a useful tool.

- It provides a universal measure of the ‘significance’ or ‘importance’ of the problem. Knowing the estimated costs can be a motivating force to unify all stakeholders to work together to deliver the necessary solutions.
- Estimating costs helps shed light on the nature of costs. In the process of calculating costs, it is important to consider the way these costs come about (figure 3.1). Understanding this helps to identify the types of solutions and interventions that may be needed.
- It ensures all types of costs are considered so that sufficient resources are invested to avoid these costs as much as possible.
- Quantifying costs identifies the relative sources of the costs. Knowing that one type of cost is larger than another can help identify where reform efforts should be focused.
- It provides a benchmark for comparison to assess the relative benefit associated with interventions.

Knowing the cost of mental ill-health and suicide may be a great motivator for reform but it provides no indication of what people want and need to maintain good mental health. A person-centred approach needs to be taken when designing specific programs and practices. This will ensure that the focus is on what matters to people receiving care, and their families and carers, and they are offered a combination of care and community support for their needs and empowered to choose the services that are right for them (chapter 4). The care and support offered needs to be effective and evidenced based to support a person’s recovery.

Quantifying the cost of mental ill-health and suicide can be approached from several different perspectives, and depending on the perspective, will include slightly different data. While consumers are at the heart of the mental health system, our approach to quantifying costs must be broader, using a community perspective, including various costs for all members of society. But these are the aggregate of the costs to various parties, such as consumers and carers. Our analysis highlights costs to various groups in our community where possible. For example, income support are a cost to government (or taxpayers) and out-of-pocket costs are important costs to consumers. Where possible, we have quantified

each category using Australian, State and Territory Government data, estimates from research literature and our own assessments. The cost estimates presented are for one year. Details of the cost calculations can be found in appendix H.

3.2 Examining the cost of mental ill-health and suicide

The cost of mental ill-health and suicide is large and pervasive, reflecting costs incurred in healthcare, education, housing, justice, employment, and the effect on the quality of life of consumers and their families and carers.

The quantifiable economic cost of mental ill-health and suicide ranged from \$43 billion to \$70 billion:

- the direct cost of healthcare expenditure and other services and supports was \$16 billion
- the cost of lost productivity due to lower employment, absenteeism and presenteeism range from \$12 billion to 39 billion
- the informal care provided by family and friends was valued at \$15 billion (finding 3.1 and table 3.1).

These costs have been estimated for 2018-19, but costs can fluctuate over time. The COVID-19 pandemic and the bushfires in preceding months are expected to have widespread implications for the mental health of Australians (Liu et al. 2020; Newnham, Titov and McEvoy 2020; Wind et al. 2020). Mental health costs are likely to be higher in the years immediately following these events, and may persist well into the future, as the mental health system responds to potential changes in the level of mental illness in the community.

While the primary intervention of isolation may well achieve its goals, it leads to reduced access to support from family and friends, and degrades normal social support systems and causes loneliness, and is a risk for worsening anxiety and depressive symptoms. If left untreated, these psychological symptoms may have long-term health effects on patients and require treatment adding to the cost burden of managing the illness (Zhou et al. 2020, p. 1)

In addition to these economic costs, there are a range of social and emotional costs.

The cost of diminished health and reduced life expectancy for those with mental ill-health, self-inflicted injury and death by suicide total approximately \$151 billion. About 80% is attributable to mental illnesses (\$122 billion) and the remainder attributable to death by suicide (\$29 billion).

The social and emotional costs of lower social participation or stigma associated with mental ill-health are not quantified (figure 3.1). These emotional costs may include people's feelings of self-doubt, hopelessness and a sense of isolation. These costs are difficult to value in monetary terms and consequently, we have not estimated them. Nevertheless, reducing people's emotional distress due to social isolation and lack of inclusion is extremely important and are addressed in our reforms in chapter 8. One person with lived experience

expressed the view that reducing these costs is necessary to make gains in the reduction in prevalence of mental ill-health:

I think the reality is ... the stigma of mental illness is, in some ways, worse than the illness itself. Unless the stigma can be removed to such a degree that it does not become a barrier to acknowledgement, treatment and hope for the future, the reduction of some mental illnesses will be nothing but a pipe dream. blueVoices member in (Beyond Blue 2015, p. 11)

From a government fiscal perspective, income support payments represent a substantial outlay that must be funded (box 3.2). The capacity to improve the outcomes for people with mental ill-health and their families through prevention, early intervention and better investment in evidence-based treatments and services will have flow on effects to the size of future government income support payments.

Box 3.2 Income support represents significant outlays

The Australian Government provides a range of income support payments to assist people with mental illness and their carers. These include the Disability Support Pension (DSP), Newstart Allowance, Youth Allowance, Carer payments, and Carer Allowance (chapters 18 and 19). In 2018-19, \$10.9 billion in income support payments were estimated to be related to mental illness (appendix H). The DSP accounts for over 50% of mental health related income support payments.

The level of these support payments is likely to be higher in the years immediately following the COVID-19 pandemic and the 2019-20 bushfires. There is also potential for a long-term effect with costs being incurred for a number of years into the future.

Income support is an important safety net for people with mental illness. Nevertheless, there is scope to improve the incentives for DSP recipients to return to work (chapter 19), given it is predicted that people with mental illness will receive some form of income support for about 47 years (appendix H). The Australian Government has been trialling innovative methods to help build people's self-reliance (DSS 2019), based on recommendations from the McClure review (2015).

Government expenditure concentrates on more acute services

Mental healthcare and related expenditure covers a broad range of activities. It encompasses the healthcare that some people with mental illness access, programs that are designed to promote and support people's mental health, and a range of prevention initiatives. It also includes activities that support the strategic direction of the system, including mental health research and organisations such as the National Mental Health Commission.

Total Australian, State and Territory Government expenditure on mental health-related services was estimated to be about \$10 billion in 2018-19 (table 3.1).¹⁴ While both tiers of government share responsibility for mental healthcare and related services, State and Territory Government outlays on mental healthcare account for about two-thirds of total

¹⁴ This estimate should be considered conservative as not all services that relate to mental health are included due to the way health service information is collected at the source (appendix H).

government expenditure, primarily on public hospital and community healthcare (appendix H). This expenditure is concentrated on acute care services for people with relatively more severe functional impairment as a result of mental illness (chapter 13).

When consumers are not able to access the appropriate combination of care and support at the right time, this can lead to preventable psychological distress and mental illness. When some do eventually access treatment, on average 8 years after the onset of symptoms, it is more likely to be for mental illness that has become more severe and tend to be more costly to treat (ReachOut and EY 2015).

Table 3.1 Estimated cost of mental ill-health and suicide
2018-19

<i>Cost category</i>	<i>\$ billion per year</i>	
	Lower	Upper
Mental healthcare & related services	15.5	
Government healthcare & related expenditure (includes prevention)	9.7	
Related services & supports ^a	4.1	
Individual out-of-pocket expenses	0.7	
Insurer payments for healthcare	0.9	
Loss of productivity	12.2	39.1
Lower participation and productivity ^b	12.2	22.5
Absenteeism	—	9.6
Presenteeism	—	7.0
Informal care provided by family and friends	15.3	
Cost to economy	42.9	69.8
Cost of disability and premature death	150.8	

^a This includes housing, justice, employment services and psychosocial supports. ^b The lower bound estimate of lower participation and productivity is based on assumptions that the costs captured include not working, working fewer hours, and lower productivity for those in employment associated with absenteeism and presenteeism. Separate estimates for presenteeism and absenteeism are therefore not included in the overall total. The upper bound estimate of lower participation and productivity assumes the costs captured are attributed to not working or working fewer hours. Separate estimates for absenteeism and presenteeism are, therefore, included in the overall total.

Source: Appendix H.

People with mental illness and psychological distress, at times, need more than healthcare to support their recovery, such as housing and employment services, along with other services they may come in contact with, including within the education system. Expenditure on these services attributable to mental illness is about \$4 billion. This is an under representation as not all expenditure can be captured, for example, mental health and wellbeing activities in education cannot be quantified due to the lack of data (appendix H). The follow-on effects of the COVID-19 pandemic are likely to increase the cost of these support services, particularly employment services.

There is merit in examining whether expenditure on healthcare and supports could be changed to improve the lives of people with mental ill-health. The following chapters demonstrate that changes to government expenditure on mental health and support services could yield improved benefits for people, their families and the community. What is needed is a stronger focus on prevention, people receiving the care that matters to their recovery, and a more coordinated system.

Consumers can face sizable out-of-pocket costs

Consumers accessing treatment for mental ill-health can face sizable out-of-pocket costs. To access services they may need to pay the full cost of a service or a shared payment, over and above any amount paid by the Australian Government or their private health insurance provider.

For many people, even a small out-of-pocket cost can have a direct effect on their access to healthcare (chapter 12). An estimated 44% of Australians with mental ill-health stated that they do not see a doctor and/or did not get the recommended care because of the cost. Compared with other chronic health conditions, people with mental illness were almost 8 times more likely to skip treatment (Callander, Corscadden and Levesque 2016).

However, data on the out-of-pocket costs of consumers of mental healthcare is limited. Based on administrative data, out-of-pocket costs for consultations and medication (which had an associated government subsidy) for people with mental ill-health was \$700 million in 2018-19 (table 3.1). There are many reasons why consumers could incur out-of-pocket costs for mental healthcare, including but not limited to co-payments relating to the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme (box 3.3). The Consumer Health Forum of Australia (sub. 496, p. 15) emphasised the 'need for much improved and apolitical measurement and reporting of out of pocket costs' to help inform policy discussion.

To improve access to affordable and effective mental healthcare, the Productivity Commission is recommending expanding access to low-cost care, such as supported online treatment (chapter 11).

Box 3.3 **Examples of out-of-pocket cost consumers pay**

Potential examples of out-of-pocket costs include:

- the gap between the fee for a GP consultation (such as to prepare a mental health plan) and the amount rebated by Medicare
- the cost of prescription medicines to consumers after the subsidy under the Pharmaceutical Benefits Scheme has been applied
- the gap between the fee for a psychologist or psychiatrist consultation and the amount rebated by Medicare or the person's private health insurance (if they have cover)
- the gap between the fee for private hospital in-patient treatment and the amount rebated by Medicare and the person's health insurance (if they have cover)
- the cost of private prescription medicines (those not under the Pharmaceutical Benefits Scheme)
- the full cost of a psychologist consultation not covered by Medicare, for example, after a consumer has exhausted their Medicare entitlement
- fees for online mental health services, such as some online treatment courses
- the cost of traveling to and from appointments
- the cost of accommodation when travelling for treatment.

Much scope to improve employment outcomes

Being employed can improve people's mental health (chapter 8) and mentally healthy workplaces are important to maintain the mental health of those who work there (chapter 7). In addition to an income, employment provides opportunities to socialise, a source of self-esteem and a sense of purpose. This broader purpose for work is highlighted in a number of submissions, including Friends of Callan Park (sub. 198, p. 3):

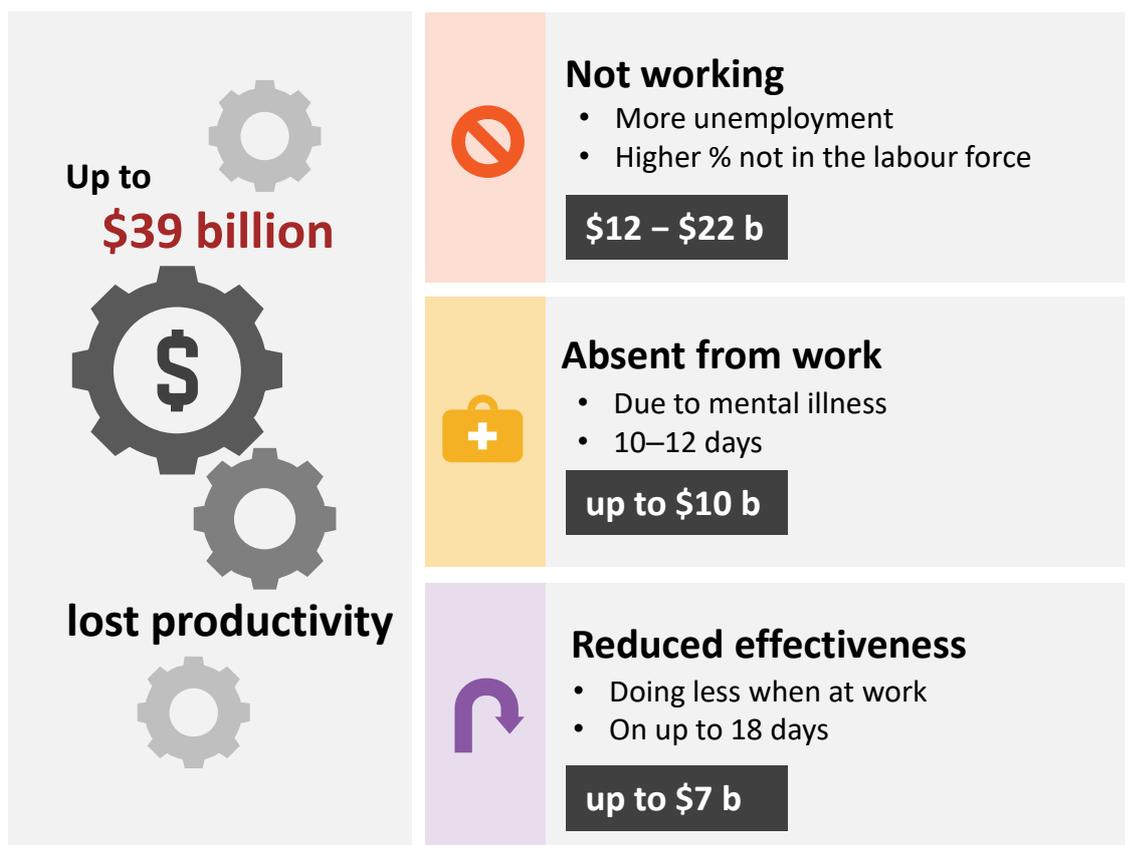
The value of meaningful work to people experiencing mental illness goes beyond financial gain and independence. The ability to lead a productive life contributes manifestly to a person's self-esteem, feelings of worth and ability to sustain relationships.

When people with mental ill-health alter their work patterns as a result of reduced mental health, temporarily or permanently, the consequence can be significant. The Productivity Commission estimates that the economic loss due to the effects of mental ill-health on participation, absenteeism and presenteeism is up to \$39 billion (figure 3.2).

- **Participation:** people may work less than they otherwise would, either being employed for fewer hours or not at all. The lost income of not working is estimated to be up to \$22 billion per year.
- **Absenteeism:** when people are unwell, they may need to take time off work. On average, people with mental ill-health are estimated to be absent from work for an *additional* 10 to 12 days a year because of their mental ill-health. This results in forgone output of up to \$10 billion per year.

- Presenteeism: people may be able to attend work but they may not always be able to function effectively while at work. On average, people with mental ill-health reported that they reduced the amount of work they did on 14 to 18 days a year because of their psychological distress. As a result, forgone output is estimated to be up to \$7 billion per year.

Figure 3.2 **Lost productivity due to mental ill-health**



Source: Appendix H.

In addition to these costs, the high prevalence of physical health problems that coexist with mental ill-health (either contributing to it or as a consequence of it) can further affect the work capacity of people with mental ill-health (chapter 7). People may also retire early. Broken work patterns or less time working mean that people with mental ill-health have fewer opportunities to save for retirement through the superannuation system, and therefore, are more often substantially dependent on the age pension.

People can also miss out on the social and emotional value of work. By not working or working less, people have fewer opportunities to interact socially and, with a reduced income, people may not be able to socialise as much. These emotional costs of reduced social interaction are acknowledged and considered in our analysis of reform options (chapter 8), but are not quantitatively estimated (as discussed above).

These costs highlight the depth of the potential gains from collective action by governments, employers and individuals to prevent and better manage mental ill-health. The Productivity Commission has recommended a range of actions to improve employment outcomes for people with mental illness (chapter 19), and to have mentally healthy workplaces for those people who are working (chapter 7).

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

The costs of mental ill-health and suicide are substantial. They are incurred across the healthcare, education, housing and justice sectors; by workplaces; and by consumers and their families and carers.

The direct economic costs of mental ill-health and suicide in Australia are estimated at \$43–70 billion in 2018-19. These estimates include:

- direct expenditure on healthcare and other supports and services (\$16 billion)
- lower economic participation and lost productivity (\$12–39 billion)
- informal care provided by family and friends (\$15 billion).

The cost of disability and premature death due to mental ill-health, suicide and self-inflicted injury is equivalent to a further \$151 billion. The social and emotional costs of lower social inclusion associated with mental ill-health, if quantified, would add to this.

Lifetime effects of early setbacks

The nature and size of the costs described above clearly illustrate in numerical terms how mental ill-health can have detrimental effects on people's lives, and the lives of their families and friends. But these costs are a snapshot for one year and they do not convey the full picture of how mental illness and psychological distress can change a person's life trajectory, in particular a young person's.

The lifetime benefits of solid education and training in the formative years is well-known with people having better employment outcomes, improved health and wellbeing, and higher levels of social participation as a result (chapter 6).

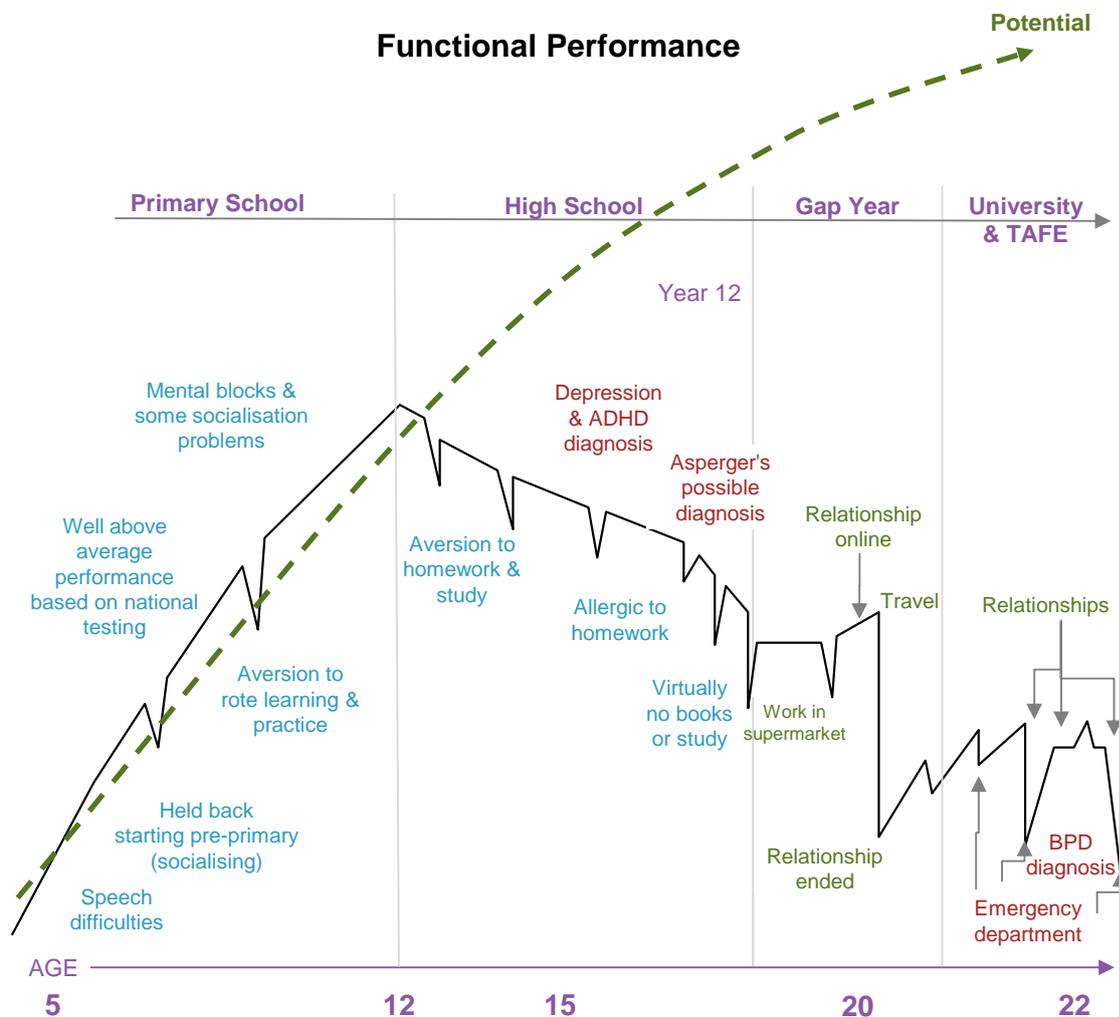
A young person's life path can be changed by mental illness and psychological distress. In particular, a young person whose mental ill-health results in them missing opportunities to fully develop their skills and talents while at school or in post-school education, may miss out on the lifetime benefits in health, relationships and employment. A person misses opportunities when their mental illness or emotional problems results in them attending school less regularly, performing at a lower level in a school learning environment, and leaving formal education early. In his submission, Robert Davis (sub. 133, p. 5) powerfully expressed how mental illness affected his daughter's learning path (figure 3.3):

Our daughter was intellectually bright (across Science, Maths and English) ... She had an inquiring mind and an innate aptitude to learn things ... She was also creative. A very competent

writer, developing stories well beyond her years. Based on the performance of our other children and our daughter's early performance, we would have expected an ATAR [Australian Tertiary Admission Rank] in the high 90s. However, BPD [borderline personality disorder] gradually eroded and stole her functionality and capability as she progressed through adolescence, high school and onto tertiary study ... In short — she should have been able to grow into a positively contributing member of society, not just in an economic sense — but in a creative and intellectual sense, rather than having an outlook of significant welfare and health system dependency.

While this analysis sits outside our quantified cost estimate, it is another important piece of evidence used to inform our reform agenda.

Figure 3.3 Life's trajectory: a stylised example of the lived experience of one young person^a



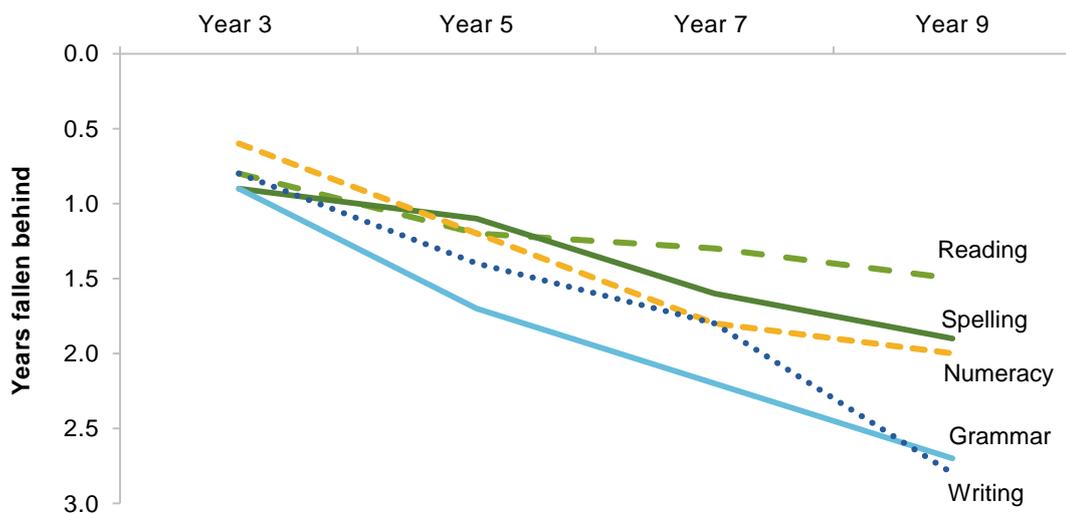
^a Horizontal axis is not to scale.

Source: Adapted from Robert Davis (sub. 133).

The years between 18 to 24 are an important transition point in a person’s life, typically from school to tertiary education and/or work. But it is also a time when mental health problems can first emerge, potentially disrupting this transition process (chapters 2 and 6). Those affected may fail to complete high school, find employment or enrol in and complete further education or training (chapter 6).

The origin of these poor transitions is sometimes rooted in missed opportunities to develop skills while in the earlier years of learning. Students with mental ill-health are less connected and engaged with their schooling, attend school less often and have poorer academic outcomes than their peers. Over time, students with mental disorders fall further behind such that by Year 9 they are, on average, 1.5 to 2.8 years behind their peers (figure 3.4). Furthermore, in Years 7 to 12, students with a mental disorder missed an average of 24 days per year compared with 11 days for students without a mental disorder (Goodsell et al. 2017).

Figure 3.4 Students with mental ill-health fall behind in school
Average years fallen behind in schooling, by test domain and year level^a



^a For students with a mental disorder, the average number of years of schooling which they are behind when compared with those with no mental disorder.

Source: Goodsell et al. (2017).

For those young people with mental ill-health who manage to transition to further education, they are more likely to be absent from their classes, have lower academic achievement or not complete their qualifications (chapter 6).

- Renner et al. (2015) found that in students at an Australian university, higher levels of psychological distress and a history of mental health problems were associated with more ‘days out of role’ in the past month (that is, days that students were unable to work, study, or manage daily activities specifically because of psychological distress).
- Australian and international research has found that increased mental health problems and higher levels of psychological distress are associated with lower grade point averages (Stallman 2010).
- Karmel and Nguyen (2008) found that mental illness had a relatively larger effect on completion rates than other disability types. Polidano and Mavromaras (2010) found that students with mental illness drop out of vocational education and training at a greater rate if they are unable to access help.

Starting tertiary studies and not completing a qualification can also be undesirable. It can create or reinforce a sense of failure, bring an end to otherwise positive social interactions, and result in students wasting their own resources (in time and effort, as well as money). Students who do not complete their tertiary studies receive minimal financial benefit from units that they have completed. Instead they may leave with ‘debt and regret’ (PC 2019c, p. 39).

The majority of young people have good mental health (chapter 2). But young people have the highest prevalence rate of mental illness and the effects of mental illness on this group can be devastating on young people’s life trajectory. Given that onset is often experienced at this time, it is important that interventions in early childhood, during the school years and through the transition to adulthood are effective and accessible. Reform in this area is paramount and the reassuring outlook is that reform and the subsequent benefit are possible (chapters 5 and 6).

4 The way forward

Towards a person-centred system

- Australia's mental health system has many dedicated and skilled workers, helping people across a large range of services. But as a system, it is failing to recognise and achieve the outcomes that matter for the people who need its services and supports. It is a system that is geared to the needs of service providers, who often respond to symptoms rather than the people who seek assistance. It is also a system that misses many opportunities to prevent mental ill-health or intervene early when mental illness develops.
- Australia needs a mental health system that places people at its centre. In a person-centred system, people would be empowered to choose the services that are right for them across a full spectrum of clinical and non-clinical needs. Such a system would focus on the outcomes that matter to people, delivering better quality, more efficient services, that integrate clinical treatment and community supports.
- Achieving this would require time and additional expenditure, but the reforms described in this report constitute a road map to change that would improve the wellbeing of all Australians, now and into the future.

RECOMMENDATION 4 — CREATE A PERSON-CENTRED MENTAL HEALTH SYSTEM

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

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

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

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

As a priority, governments should:

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

In many submissions, comments, public hearings and roundtables, the people who use the services and supports in our mental health system have told the Productivity Commission they are looking for meaningful change in the way the system works to support their recovery. They are looking for a system that listens to their needs and respects their preferences.

In response to what helps people with mental health issues one survey respondent provided this summation, *for people to encourage, support and 'see' the person beyond their illness. Inclusion (true inclusion) in all areas of life regardless of 'disability', but based on ability. Consultation on interests, aspirations and 'real options'*. (LELAN, sub. 771, p. 5, emphasis in original)

In this Inquiry report, the Productivity Commission presents its vision for *a mental health system that places people at its centre*.

The mental health system that the Commission envisions would put a concerted effort into preventing mental ill-health, from the earliest ages and throughout life, across all key domains — including education, housing, workplaces and employment support, and social inclusion. It is a system that would put an emphasis on intervening early — either early in life, to support social and emotional development, or early when illness emerges, to facilitate recovery and minimise the risks of a deterioration in mental health that would necessitate more intensive care.

For the people who need support and services — many of whom are currently missing out — it is a system that would pursue the outcomes that matter to them, empowering people to choose the services that are best suited to their needs and preferences.

A person-centred mental health system would aim to offer holistic services and supports, both clinical and non-clinical, to help people to live well within their communities, self-managing their mental health where possible. Services would be designed to be timely, affordable and accessible to people, irrespective of where they live or their cultural background, and effective in supporting their recovery. Regardless of the gateway through which they enter the mental health system, people should experience seamless care, with no service gaps as their circumstances change.

It is a system where the consumer — rather than the provider — is the focus of service delivery. This requires service providers to understand people's preferences and what recovery means to them, their family, kinship group, or carers, and act consistently to make progress towards those outcomes. All providers would adopt a culture of service delivery that is person-centred.

The interventions, services and supports that comprise the mental health system should be evidence-based and supported by both technology and a skilled workforce. This would enable the system to have the flexibility to respond to new challenges the community is facing, such as the COVID-19 pandemic and its aftermath.

Creating such a person-centred mental health system requires significant change in organisations' culture, as well as comprehensive governance, funding and evaluation mechanisms. These operate behind the scenes, and should work together to support seamless

pathways for people to access the services they need — regardless of how they are funded. The system would be underpinned by a monitoring and evaluation framework that enables continuous improvement in service provision and gives people the ability to make informed choices about their own recovery. Evaluation would encompass the system’s ability to progress outcomes as perceived by the people who use its services, as well as its efficient use of resources and best practice processes.

FINDING 4.1 — A PERSON-CENTRED MENTAL HEALTH SYSTEM

The Australian mental health system should be person-centred, supporting prevention by reducing the risk of an individual developing mental ill-health and enabling early intervention if mental illness develops.

A person-centred mental health system would comprise the full spectrum of community support and clinical services people may need to recover from mental ill-health and live healthy, productive lives. Consumers and carers should be able to access the services they need when they need them, regardless of administrative or funding structures underpinning them. Wherever possible, such services would reflect the cultural, social and clinical preferences of the consumer.

Services should be delivered by a skilled workforce, supported by technology and comprehensive governance arrangements, to ensure that they are responsive to local needs and can be readily ramped up and down as needs change.

4.1 Steps towards a person-centred mental health system

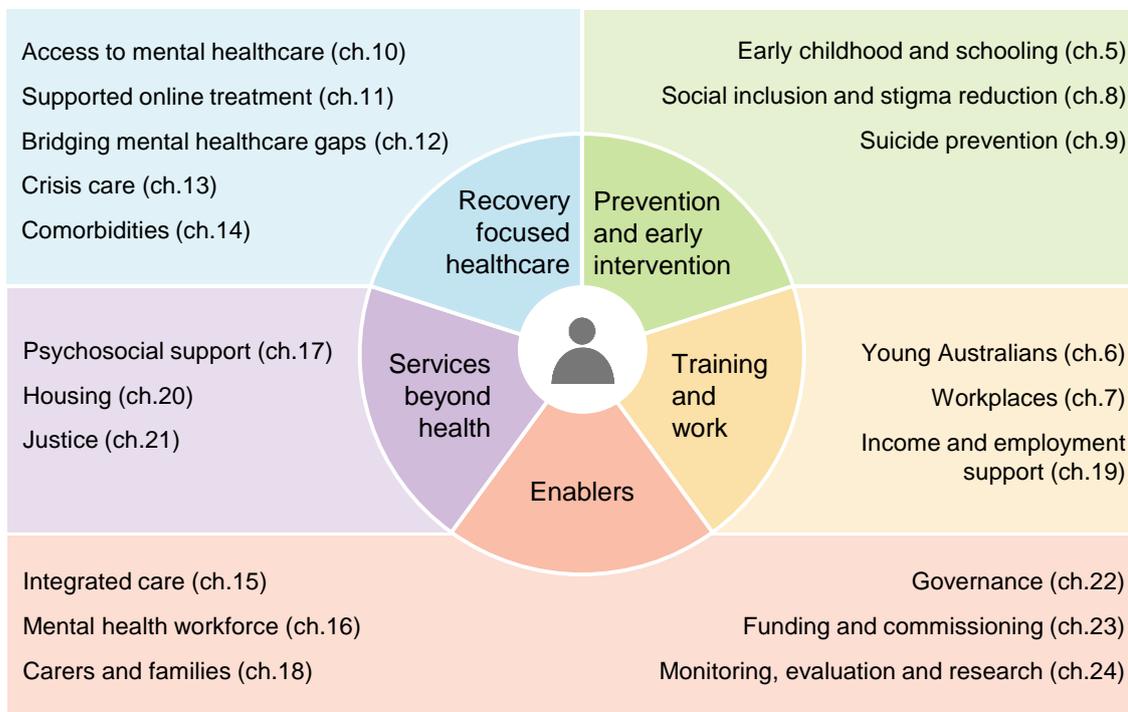
This Inquiry’s recommended reforms focus on five areas:

- prevention and early intervention, including reforms that would improve the prevention, early detection and intervention for mental ill-health across the life span
- recovery-focused healthcare that places people and their needs at its core. This includes addressing key gaps in the mental healthcare system, and creating meaningful gateways and pathways that enable people to find the treatment and support they need
- beyond healthcare, improving the provision of a range of services that can make a difference to the experience of people with mental ill-health, including psychosocial services, housing and homelessness services, as well as first responders, police and the justice system
- supporting people with mental ill-health to remain engaged in further education and work, through more supportive workplaces and better assistance for people with mental illness to gain and maintain employment
- key enablers of change, including improved supports for carers, who make an invaluable contribution to the lives of people with mental illness and the mental health system as a

whole; technology and workforce that enable the delivery of flexible, scalable services; and governance, evaluation and funding mechanisms that support organisational and cultural change across the mental health system. These arrangements would promote services that are evidence-based, locally responsive and accountable for delivering positive outcomes that consumers value.

Each of the chapters in this report examines a different part of the mental health system and proposes recommendations in these key areas. Recommended reforms reinforce each other to move Australia towards a person-centred system (figure 4.1).

Figure 4.1 Building a person-centred mental health system



In the short and medium term, the mental health system — along with the entire Australian community — is facing a substantial challenge in responding to the consequences of the 2019-20 bushfires and the COVID-19 pandemic. The importance of mental health has come to the fore during this time, with governments recognising the substantial mental health implications of the stress and uncertainty created by these large scale crises.

The Australian Government has put in place a range of interventions to respond to the immediate mental health implications of both events. The response to the COVID-19 pandemic in particular emphasised the need to deliver flexible services, such as telehealth (chapter 12). These measures are time limited, but the need for mental health supports is likely to remain high as the community deals with the long-term implications of a period of isolation and its economic consequences. Implementing the Commission’s

recommendations would enable the mental health system to respond to these needs, by moving to more flexible, person-centred service delivery. Expanding access to telehealth sessions for mental healthcare that are rebated through the Medicare Benefits Schedule and investing in supported online treatment would contribute to progress towards this goal (chapters 11, 12). The new governance arrangements recommended by the Commission would enable more flexible services that are responsive to local needs (chapters 22, 23).

Where should governments start — identifying priority reforms

There are many changes required to achieve a person-centred mental health system. While this Inquiry presents a comprehensive reform agenda, change would take time and it is for governments to make decisions about where to prioritise their efforts and expenditure. However, the Commission recognises that providing a road map to a person-centred mental health system is a very important part of our task. To assist governments, the Commission identified a number of priority reforms to be started as soon as possible. The roll out of other recommended reforms, while not priorities, is nevertheless likely to significantly improve mental health outcomes. Implementation of these should be planned, taking into account any necessary underpinning reforms and resources available after priority reforms have been adopted.

Priority reforms were identified in each one of the key areas required to achieve a person-centred mental health system, using a comprehensive set of criteria (table 4.1). This prioritisation process looked at economic measures, such as increased labour force participation and productivity, but also placed equal emphasis on the quality of life experienced by people affected by mental ill-health and the potential for governments to do things better without necessarily increasing expenditure. The Commission developed four criteria to prioritise reforms.

Potential to improve lives at the individual and/or community level — Some reforms can be expected to improve the quality of life and the life expectancy of a small number of people in a substantial way. Other reforms can be expected to improve quality of life in a small way but for a large portion of the community. The Commission has estimated the extent of this increase in each reform area, and has prioritised those reforms that are likely to lead to the most substantial overall improvements in the short term.

Benefits to the economy and expenditure required to achieve these — The benefits to the economy that have been estimated by the Commission are the increase in labour force participation for consumers benefiting from each reform area, and the higher wages possible through increased productivity of those people who are working. Additional benefits to the economy that were not measured include reducing the need for costly services in the longer term, including a reduction in insurer payments for healthcare, lower out-of-pocket costs for individuals and less informal care provided by family and friends. The Commission has also not quantified the long-term benefits of interventions that support better educational and developmental trajectories for children, given the significant uncertainty involved in estimating such benefits over long periods.

Table 4.1 Priority reforms

<i>Priority action</i>	<i>Improves lives</i>	<i>Economic benefits</i>	<i>Ease of implementation</i>	<i>Sequencing</i>	
Prevention and early help for people	Support the mental health of new parents	•	•	•	
	Make the social and emotional development of school children a national priority	•			
	National stigma reduction strategy	•	•	•	
	Follow-up care for people after suicide attempts	•	•	•	
	Empower Indigenous communities to prevent suicide	•			
Improve people's experiences with healthcare	Evidence-based mental health assessment and referral processes	•		•	
	Alternatives to emergency departments	•			
	Expanded supported online treatment and group therapy	•	•	•	
	Review limits on psychological treatment funded through Medicare and trial variations			•	•
	Telehealth with psychologists and psychiatrists	•	•	•	
	Expand community-based mental healthcare (outpatient clinics and outreach services)	•	•		
	Identify, support and include families and carers as part of mental healthcare	•	•		
	Address adverse outcomes from prescribing practices of mental health medication	•			
	Reduce the gap in life expectancy for people with severe mental and physical illness	•			
	Care continuity and coordination	•			
Improve people's experiences with services beyond the health system	Meet demand for community services that support people's recovery	•			
	Commit to no discharge from care into homelessness	•	•	•	
	Increased assistance for police responding to mental illness-related incidents	•			
	Legal representation for people facing mental health tribunals	•			
Equip workplaces to be mentally healthy	Elevate importance of psychological health and safety in workplaces	•	•	•	•
	No-liability clinical treatment for mental health-related workers compensation claims	•	•		
	Expansion of individual placement and support programs	•	•		
Instil incentives and accountability for improved outcomes	Integrated implementation plans for national strategies				•
	Commit to regional planning, decision making and commissioning				•
	Expand the remit and independence of the National Mental Health Commission			•	•
	Consumer and carer participation and advocacy in the mental health system	•			
	Strengthen evaluation culture, focusing on outcomes that matter to people and reporting at service provider level	•			•

Ease of implementation — Reforms that involve the redeployment of existing resources, focus on a specific type of services or supports, and require action from just one government or government agency, were considered easier to implement than reforms requiring the redirection of resources from other programs, or the cooperation of multiple agencies.

Sequencing — Many reforms would need to be implemented in stages, and therefore some actions should be taken in the short term to build towards systemic change.

Many of the priority reforms are expected to improve people's lives; some are likely to save lives. For example, providing appropriate care and follow up to anyone who presents to a hospital, GP or community mental health service after a suicide attempt has been identified as a priority, as it has the potential to make a very large difference to the people it affects. Not all people who are discharged from hospital after a suicide attempt receive support. Where follow up care is offered, only half of the people discharged attend. Follow up care could save 35 lives each year and prevent over 6150 suicide attempts, reducing the number of suicide attempts by up to 20% (chapter 9).

Other reforms have been identified as priorities as they are likely to generate an economic benefit, in addition to having a positive effect on people's lives. Providing no-liability clinical treatment for mental health-related workers compensation claims is one such priority reform. It is expected to result in about 8000 people returning to work earlier than otherwise would have been the case in 2018-19, which increases their income and economic output (chapter 7). Similarly, improving supports specifically for new fathers affected by mental ill-health is expected to lead to economic benefits, through increasing labour market participation, as well as improving the quality of life for families (chapter 5).

There are also priority reforms that are expected to affect a very large number of people; helping schools to support the mental health of their students is one reform that has the potential to affect 3.9 million children and young people who attend school. The Commission recommends recognising wellbeing as one of the outcomes of the education system through the National School Reform Agreement. This is expected to enable a range of improvements, from better preparation for teachers to help their students who may face mental health challenges to improved collection of data on the wellbeing of young Australians. The implementation of this priority reform is also expected to require relatively limited new expenditure, as it focusses on improving the effectiveness of existing programs (chapter 5).

Some priority recommendations are stepping stones towards reform. For example, a rigorous evaluation of the Better Access program, which enables people to access MBS-rebated psychology sessions, is urgently needed. As part of this evaluation, the Australian Government should trial alternative approaches, such as funding more psychology sessions for those who need them (chapter 12). Both the evaluation and the trials would be vital to informing future decisions about MBS-rebated psychological care, which plays a central role

in the mental health system and costs about \$860 million a year.¹⁵ Another important step on the way to a person-centred mental health system tackles a very different issue — measuring the outcomes that matter to consumers. Making the National Mental Health Commission a statutory body would give it the ability to closely monitor and evaluate the progress made towards reform, and promote continuous improvement. This is an example of where structural reform can lead to better experiences for people in the mental health system (chapters 22 and 24).

Some of the reforms identified as priorities are intended to address the shortcomings of the mental healthcare system. Most priorities, however, sit outside health, and are aimed at improving non-clinical supports, including employment supports and services in the justice and education systems, making workplaces more supportive and addressing stigma in the community. The focus of reform should not be confined to the health system alone, as this would overlook important opportunities to both support vulnerable people and extend the benefits of intervention across the community.

Other reforms to build the person-centred mental health system

The priority reforms are a subset of more than 100 recommended actions included in this Inquiry report. The Commission's priority list is intended to help governments plan their efforts, but all actions included in this report are worthwhile reforms that would make a positive difference to the people using the mental health system.

For example, the Commission recommends a comprehensive set of changes intended to further develop the mental health workforce. These actions would take a relatively long time to complete, but governments should consider them as part of planning for a person-centred mental health system (chapter 16). Other actions, such as addressing some housing shortfalls, may require large expenditure, while some actions may only affect a small subset of the population, such as young people with severe mental illness, but they would make a very large difference to their wellbeing and the wellbeing of their families.

As priority reforms are implemented, the potential gains from further reforms would become clearer. For example, the Commission recognises that there is an existing shortfall in mental health bed-based services (chapter 13). Rectifying this shortfall today would be both expensive and limited by the lack of information that currently exists about the size of the shortfall and the degree of substitution between different types of bed-based services and alternative community-based services. Priority reforms that improve data collection and planning would clarify the situation and assist governments to rectify shortfalls over time in a way that is both cost-effective and benefits consumers.

The Commission's recommended reforms are substantial and likely to result in a range of benefits, both in terms of economic gains and better quality of life for many people.

¹⁵ In 2019, this program cost the Australian Government \$630 million and people accessing services spent more than \$230 million in co-payments (chapter 12).

Nonetheless, they will not eliminate all the risk factors that lead to mental ill-health. Some risk factors, such as those arising from deeply entrenched social, economic and environmental challenges, lie beyond the scope of this Inquiry (chapter 1).

4.2 Estimating the benefits from a person-centred system: additional productivity and better quality of life

A person-centred mental health system has the potential to deliver substantial benefits to the community, in terms of improved quality of life and economic benefits (increased income, cost savings, or both). The Commission has estimated the expected effects of some of its key reform recommendations, including some of the priority reforms identified above, for which benefits could be quantified.

Implementation of the priority reforms (where benefits were quantified) requires expenditure of up to \$2.4 billion per year. These reforms are expected to generate savings of up to \$1.2 billion per year and increase aggregate incomes by up to \$1.1 billion.

Full implementation of all recommended reforms that have been costed by the Commission is expected to require expenditure of \$3.5–\$4.2 billion, which represents the total cost of reform for Australian, State and Territory Governments. Reforms are expected to lead to cost savings of up to \$1.7 billion and increases in aggregate income of up to \$1.3 billion per year.

The main benefits of this Inquiry's recommended reforms would be a substantial improvement in quality of life for a large number of Australians, which could reach up to the equivalent of nearly \$18 billion per year (an improvement of up to 84 000 quality-adjusted life years) (table 4.2) (chapter 25, appendix I).

These numbers tell only part of the story, as they do not include the lifetime benefits of improved mental health. The Commission has taken a conservative approach to estimating the economic benefits of reforms, focussing on a one-year post-reform period. This avoids including speculative returns that cannot be verified. There is also a range of other benefits that cannot be readily quantified. For example, the Commission did not quantify the possible effects of improving referral processes in the mental health system, which are likely to result in improved health outcomes and economic benefits, as people are matched to the services best suited to them. The same can be said about the Commission's recommended actions in the justice system, supports for vulnerable children and young people, and many others.

In addition, the Commission's modelling took a national view of costs and benefits. However, there are substantial differences between States and Territories, which would affect the implementation of reforms, including the additional expenditure required and the expected benefits. For example, there are only two jurisdictions — Tasmania and the ACT — that do not have mental health beds specifically for younger people in their hospitals. Investing in these beds would make a big difference to the recovery of young people with mental illness in these jurisdictions (chapter 13).

Table 4.2 Estimated benefits of select key reforms^a

All benefits are estimated for the year following reform implementation

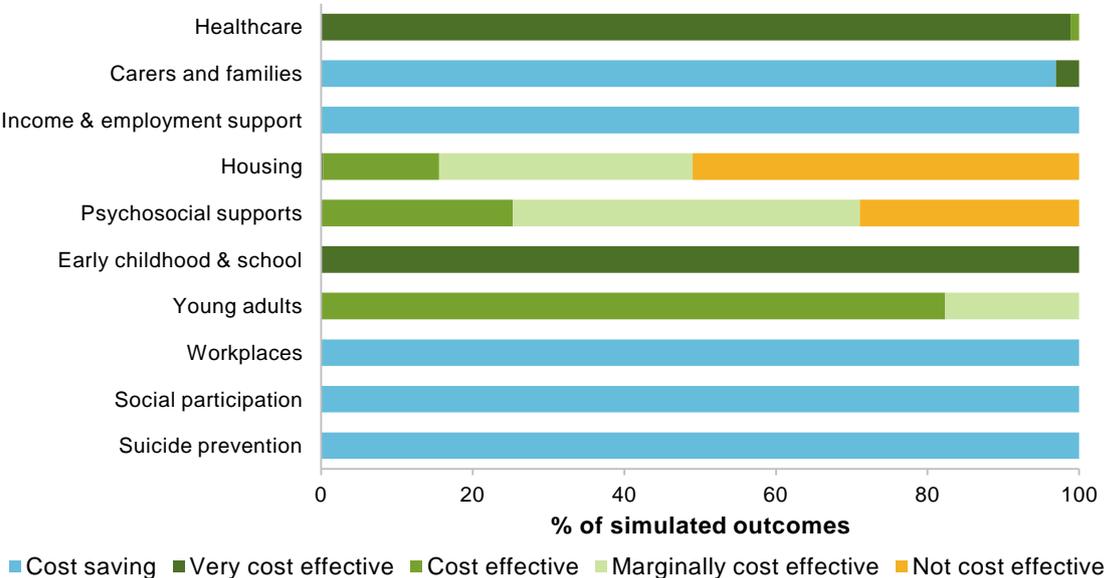
		<i>Additional labour income</i>	<i>Net economic benefit^b</i>	<i>Additional QALYs^c</i>
		\$ million	\$ million	
Prevention and early help for people	Support the mental health of new parents	46 – 86	25 – 65	500 – 920
	Make the social and emotional development of school children a national priority	–	-230	28 620 – 52 110
	Select reforms affecting children	46 – 86	-210 – -169	29 300 – 52 860
	Select reforms affecting young people	–	-83 – -65	980 – 1790
	National stigma reduction strategy	22 – 44	17 – 39	420 – 760
	Follow-up care of people after suicide attempts	3	124 – 213	50
Improve people’s experiences with healthcare	Alternatives to emergency departments	–	0 – 2	–
	Expand supported online treatment	108 – 211	64 – 168	1310 – 2390
	Telehealth with psychologists and psychiatrists	4 – 8	15 – 29	50 – 90
	Expand access to group therapy	3 – 5	4 – 6	30 – 60
	Select reforms affecting healthcare	501 – 718	-362 – -143	10 280 – 15 280
	Select reforms affecting carers	124 – 245	4 – 128	4390 – 6390
Improve people’s experiences with services beyond the health system	Meet demand for community services that support people’s recovery	79 – 177	-830 – -332	4910 – 8900
	Select reforms affecting housing	8 – 21	-406 – -146	920 – 4780
	Elevate importance of psychological health and safety in workplaces	–	18	170 – 310
Equip workplaces to be mentally healthy	No-liability clinical treatment for mental health-related workers compensation claims	12	3	–
	Select reforms affecting workplaces	12	21	170 – 310
	Expand of individual placement and support programs	42 – 90	113 – 437	240 – 430

^a The Productivity Commission has modelled the effects of key select reforms, where sufficient information was available to quantify likely effects. Data was not available for all priority reforms listed in table 4.1. Benefits and net cost per quality-adjusted life years are ranges drawn from the simulations described above with 90% intervals unless otherwise specified. ^b Net economic benefits were calculated as additional income and cost savings minus additional costs required to implement the reform. Negative benefits represent a net cost. ^c Quality-adjusted life years (QALYs) provide a measure of the impact that illness — including mental illness — has on the quality of life experienced by people affected. ‘–’ denotes ‘not estimated’.

Source: Appendixes I and K.

Some recommended actions lead to greater benefits, relative to the expenditure required to implement them. The Commission has estimated the cost effectiveness of groups of actions by looking at the extra years of improved health generated by the group (in terms of quality-adjusted life years (QALYs)) relative to the monetary cost required to implement them. Some groups of actions would lead to net cost savings, as they are likely to not only improve lives but also to increase income and/or reduce government expenditure. These groups of actions, including income support and employment services, carers and families, social participation and suicide prevention, are classified as ‘cost saving’. Others were found to be cost effective to various degrees (figure 4.2, appendix I).

Figure 4.2 Cost effectiveness of recommendation groupings^a



^a Recommended actions are cost saving if the net cost per QALY is negative, very cost effective if the net cost per QALY is less than \$33 000, cost effective if net cost per QALY is less than \$64 000; marginally cost effective if the net cost per QALY is less than \$96 000; and not cost effective if the net cost per QALY is greater than \$96 000 (appendix I). The dollar cut off points used are based on different estimates of the value of a QALY that are provided in the literature (appendix K).

Source: Appendixes I and K.

Recommended actions in healthcare, early childhood services, schools and workplaces are likely to be very cost-effective, demonstrating opportunities for governments to achieve relatively low cost improvements in both population and individual mental health. Actions relating to housing and psychosocial supports are less cost effective, but may still provide value for money. One limitation of this analysis is that it includes only the direct effects on mental health, and does not take into account substantial indirect benefits. For example, access to housing provides more than just shelter — it is likely to facilitate access to a range of existing services that would result in further improvements in mental health and quality of life. Improved psychosocial support is also expected to result in large health benefits, but the population that is expected to benefit is relatively small.

There is a range of reforms where robust quantitative data was not available to quantify expected benefits. This was the case for mental health reforms-related to the justice system, where the evidence base is still emerging (chapter 21). The case for these reforms, although not quantified, is still compelling. For example, access to legal advocacy for people attending a mental health tribunal and non-legal advocacy for people at risk of involuntary treatment help protect the human rights of vulnerable members of the community. Reforms focused on the mental health of those in correctional facilities may help break repeated cycles of arrest and imprisonment.

Other reforms where benefits could not be modelled include those that aim to empower consumers and carers to better navigate the complex mental health system and be more involved in decisions relating to their care. These reforms include the national digital mental health platform, care coordination and single care plans and better information about service options and treatment side effects from GPs (Recommendations 10 and 15). Among other benefits, these reforms reduce the significant amount of time that consumers, carers and clinicians spend seeking the right supports.

FINDING 4.2 — MODELLED BENEFITS OF KEY RECOMMENDED REFORMS

Improvements to people's mental health increase their likelihood of employment and their expected income, while also improving their health-related quality of life. The benefits from the recommended reforms are substantial and are mainly derived from improvements in people's quality of life — up to \$18 billion per year (corresponding to an improvement in quality-adjusted life years of up to 84 000 annually). There would be additional annual benefits of up to \$1.3 billion per year as a result of increased economic participation and productivity. These benefits would require expenditure of up to \$4.2 billion per year and generate savings of up to \$1.7 billion per year.

4.3 How consumers would benefit from a person-centred mental health system

As reforms are implemented, people's experiences in the mental health system would change for the better. We expect that these changes would be felt widely, as services improve their ability to respond to the needs of individuals and communities. The expansion of prevention and early intervention activities would help maintain mental health for many in the community. Those who do experience mental ill-health would be empowered to access the combination of healthcare and community supports that is right for them; and supports for people whose mental illness deteriorates would be better suited to their needs.

A person-centred mental health system would respect and respond to diversity

The person-centred approach taken in this Inquiry would benefit all Australians, recognising and respecting differences that exist between individuals. In the existing system, which often takes a ‘one-size fits all’ approach, geographical, cultural and language barriers can create substantial difficulties for people who are seeking to access the support and care they need for their mental health.

People in regional and remote Australia have long faced unequal access to mental healthcare compared to those in capital cities. The person-centred system envisioned by this Inquiry includes better regional planning and funding allocation to address this inequity (chapter 23). Those in regional and remote areas of Australia would also benefit from workforce development reforms that would reduce mental health workforce shortages, which are often stark outside of capital cities (chapter 16).

For some people, access to mental healthcare is not constrained by distance, but rather by stigma or the symptoms of their mental illness. Expanding access to supported online treatment would enable people to find the services that are best suited to their circumstances, rather than go without (chapter 11).

Culture and language barriers affect many people, including those from culturally and linguistically diverse (CALD) backgrounds. Peer workers can play a major role in overcoming these barriers, and the Commission makes recommendations intended to enable people using mental health services to benefit from the presence of peer workers (chapter 16). Nonetheless, all mental health service providers should be cognisant of people’s cultural needs, providing services that align with people’s preferences. Developing the capacity to respond to people’s needs, regardless of cultural background or other individual circumstances, is an important part of creating a person-centred system. This capacity should be evident in the work of individual service providers, and in the co-design and consultation practices of policy makers (chapters 16, 22).

These issues are particularly relevant to improving mental health services offered to Aboriginal and Torres Strait Islander people, who experience mental ill-health at far higher rates than other population groups (chapter 2). Aboriginal and Torres Strait Islander people’s understanding and experience of mental health can be different to that of non-Indigenous people (AMSANT, sub. 434). There are a number of recommended reforms across this report that aim to improve the experience of Aboriginal and Torres Strait Islander people in the mental health system, and help close the significant gap in mental health outcomes (box 4.1)

Box 4.1 Aligning the mental health system to the needs of Aboriginal and Torres Strait Islander people and communities

Aboriginal and Torres Strait Islander people experience mental ill-health at far higher rates than other population groups, and despite significant efforts, the mental health system has not managed to improve outcomes. Healthcare for Aboriginal and Torres Strait Islander people is often designed for people from non-Indigenous communities and their understanding and experiences of treating mental illness. For example, it can be difficult to diagnose mental illness where testing is based on the experiences of non-Indigenous people. For those Aboriginal and Torres Strait Islander people living in remote communities, the need to relocate to larger towns and centres for treatment away from their community can result in further deterioration in their mental health (HREOC 1993).

There have been some initiatives to develop tools that address the specific needs of Aboriginal and Torres Strait Islander people. For example, working in conjunction with Aboriginal and Torres Strait Islander people and health services, researchers have developed a screening tool that contains culturally appropriate questions asking about mood, appetite, sleep patterns, energy and concentration levels that can better determine mental health problems that may have previously been overlooked or dismissed (The George Institute for Global Health 2019). Another example is 'words for feelings', illustrated posters and conversation cards printed in both Pitjantjatjara and Ngaanyatjarra to assist Aboriginal and Torres Strait Islander people from these language groups to find the right word to express their feelings. These are used as tools by health professionals and families to assist people with talking about their feelings, thoughts and wellbeing (NPY Women's Council 2019).

The improvements in mental health services discussed in this report are likely to address some of the service gaps affecting Aboriginal and Torres Strait Islander people. Examples of specific initiatives include:

- recognising the conceptual underpinnings of social and emotional wellbeing for Aboriginal and Torres Strait Islanders, which extend to connections to culture, country, spirituality and ancestors, body, mind and emotions, family and kinship as well as community (chapter 8)
- increasing the numbers of Aboriginal and Torres Strait Islander health workers and improving their career pathways (chapter 16)
- ensuring that culturally capable mental healthcare is available in correctional facilities for Aboriginal and Torres Strait Islander people (chapter 21)
- expanding the role of Aboriginal controlled organisations in the planning and delivery of mental health services (chapters 22, 23)
- expediting and resourcing the development of an implementation plan for the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023 (chapter 22)
- improving the social participation of Aboriginal and Torres Strait Islander people (chapter 8).

Prevention and early intervention would become a key focus of the mental health system

A key conclusion of this Inquiry is that the mental health system should move beyond a primary focus on interventions once a person has developed mental illness, toward

prevention and early intervention, including for those people who have experienced mental illness previously. To achieve better mental health across the community, people need to be empowered to maintain and improve their mental health — either by taking up some of the many self-help resources available; or by reaching out to mental health services, which can address the needs of those at risk of mental illness before their condition deteriorates (box 4.2). In a person-centred mental health system, people would benefit from better promotion, prevention and early intervention initiatives across many sectors, to support better mental health.

Box 4.2 What do we mean by promotion, prevention and early intervention?

Promotion, prevention and early intervention are complementary sets of actions intended to improve mental health across the population.

The focus of mental health promotion is on strengthening protective factors that support psychological wellbeing. For children, this can include life skills programs and programs that create positive environments both in the home and at school (WHO 2018c).

Prevention programs build on these protective factors and focus on reducing risk factors associated with an increased risk of mental illness. There is a wide range of programs that fall in this category, such as removing or minimising exposure to risks present in the community, public awareness campaigns about mental symptoms, and screening at-risk groups and individuals (WHO 2004a).

Early intervention can be considered from three perspectives: treatment and support that is offered early in life; early in illness; and early in episode. Early intervention programs assist a child, young person or adult through the early identification of risk factors and/or the provision of timely treatment for problems that can alleviate potential harms caused by mental illness (DoH 2015a).

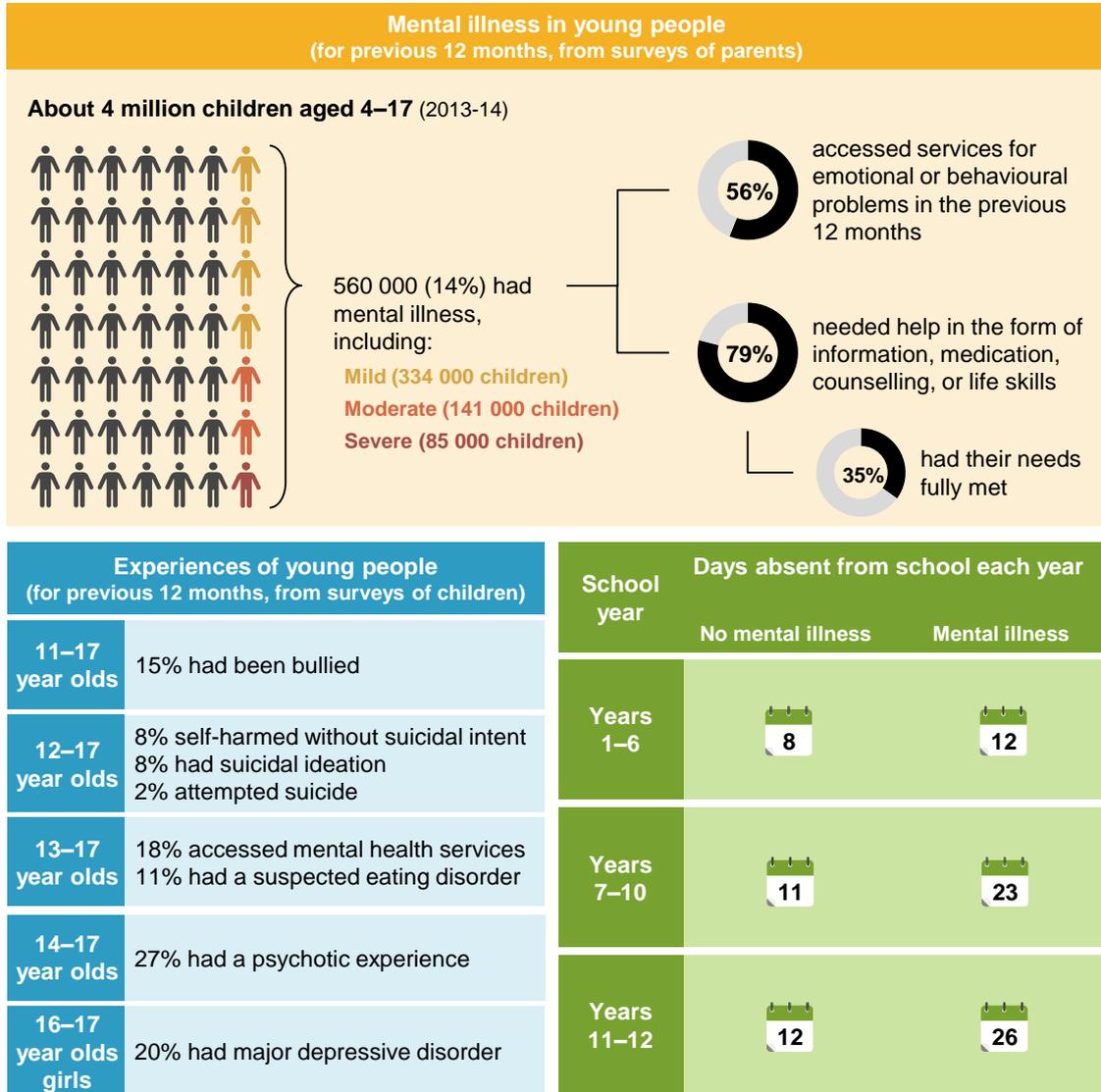
An opportunity for generational reform

Much of mental health promotion and prevention focuses on children and young people, equipping them and their families with tools to manage their own mental health. But the full benefits would be realised over a generation, once today's young people are adults who are able to lead contributing lives in their communities and cope better with life's ups and downs.

Investing in youth mental health has lifetime benefits and represents significant value for money – supporting young people to achieve mental health and wellbeing ensures they can participate fully in work and study and avoids future health system costs. (Orygen, sub. 947)

There is substantial potential to improve the mental health and wellbeing of children and young people (figure 4.3). According to the Royal Australian and New Zealand College of Psychiatrists (sub. 1200, p. 22) 'early intervention and prevention strategies for mental illness in infants, children and adolescents is imperative to addressing adverse outcomes and to prevent or reduce mental disorders in adulthood'.

Figure 4.3 Opportunities to improve lifetime mental health
Results from the Young Minds Matter survey



Source: Hielscher et al. (2018), Johnson et al. (2016, 2018), Lawrence et al. (2016), Lawrence et al. (2019), Sparti et al. (2019), Thomas et al. (2017), Zubrick et al. (2016a), Zubrick et al. (2016b).

This Inquiry has made a number of recommendations to improve prevention and early intervention efforts that focus on the wellbeing of children and young people. These reforms are likely to deliver substantial benefits, both in terms of improved mental health and improved income for parents as they will be able to participate more actively in the labour market. Reforms are estimated to result in an increase of 29 300 to 52 860 quality-adjusted life years per year (QALYs), \$46 million to \$86 million in additional income per year, and an improvement in educational attainment (chapter 5, appendix I, K). These are the largest benefits that were estimated by the Commission for any of our groups of recommendations.

These benefits can start from birth, as the mental health of parents can have substantial effects on the social and emotional development of their children. The birth of a child is a key transition point in a person's life, when the risks of mental ill-health are higher, and it is also a period of time when people come into frequent contact with the health system. Screening new parents to identify those who may benefit from mental health support requires relatively little new expenditure but is expected to yield significant economic and health benefit. Therefore, it should be a priority for State and Territory Governments (chapter 5).

Parents continue to engage with the health system as their children grow, and many families continue to attend optional child development checks. Consistently incorporating discussions on social and emotional wellbeing into these checks offers an opportunity for parents to raise any concerns they may have about their child's development. Identifying areas of concern early and taking action can greatly benefit children and their families (chapter 5).

For children and parents, identifying issues would be just the first step. Developing a person-centred mental health system would also mean creating comprehensive referral pathways, relying on accessible, effective services that are sensitive to people's preferences and work to support the outcomes that people value (discussed further below).

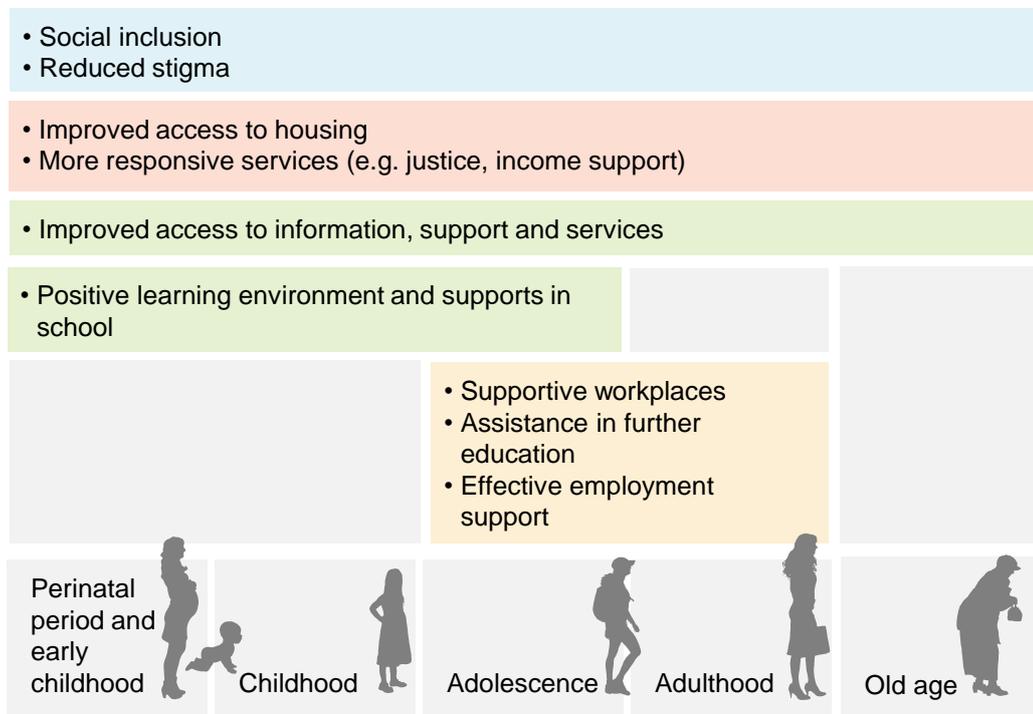
Many benefits can be realised through the education system, starting from early childhood and continuing on to higher education. In an education system that has a focus on wellbeing, in addition to teaching academic subjects, students experiencing mental ill-health would be able to find clear pathways to support, both within and beyond the school gates. Many dedicated teachers and principals already strive to help their students, but in the current system, schools are often limited in what they can achieve (chapter 5).

Some young people experiencing mental ill-health miss numerous days at school and they may be at risk of disengaging from their education. For these young people, effective outreach is essential in preventing very poor outcomes as they transition to adulthood (Watterston and O'Connell 2019). In a person-centred mental health system, schools and mental health services would work together to support these young people. For some, more supportive schools and tertiary education providers would enable them to continue their studies while recovering from mental illness (chapters 5, 6). For others, Individual Placement and Support programs could create significant benefits, by placing young people into employment (chapter 19). With appropriate support, these young people can change their life trajectories, away from deteriorating mental ill-health and towards recovery. This would benefit them, their families and communities, as well as governments.

Considering prevention and early intervention across life stages

The goal of early intervention and prevention extends beyond childhood, and this Inquiry makes recommendations that extend across the lifespan and across numerous sectors (figure 4.4).

Figure 4.4 People of all age groups would benefit from prevention and early intervention to support mental health



Some of these recommendations seek to rectify specific policy issues that can have very substantial impacts on people’s lives. Social housing policies are an example. Currently, people with mental illness living in social housing who are admitted to hospital may be evicted from their homes under state and territory regulations on temporary absences. Reviewing such policies, and ensuring they cater for the needs of people with mental illness, can prevent a further deterioration in people’s mental health and ensure they maintain their housing (chapter 20).

Other recommendations are much broader in scope, and likely to benefit many more people in the community. One in four working Australians have mental ill-health or are caring for someone with mental ill-health. This has substantial implications for all employers, as people with mental ill-health are more likely to be away from work due to their condition, and while at work, their productivity is likely to be negatively affected by their health condition.

Making workplaces more involved in preventing mental ill-health has benefits for employees, who would be able to work in a better environment, and employers, who would gain from increased productivity and lower absenteeism. It is also beneficial for governments, as keeping people in employment would reduce their need for income support and other government services.

Workplaces can contribute both to preventing mental ill-health and supporting early intervention. To promote prevention, psychological health and safety should be treated in the

same way as physical health and safety in the workplace. State and Territory Governments should task workplace health and safety authorities with assisting employers, and in particular small businesses, to fulfil their obligations, by developing codes of practice and assessing the effectiveness of workplace prevention programs. To support early intervention, workers compensation schemes should provide and fund clinical treatment for mental health-related workers compensation claims. This would allow people affected by mental ill-health to have better access to early intervention and treatment, enabling them to recover faster, rather than spend many months away from work (chapter 7). Given the potential for substantial benefits, the Commission considers both actions should be implemented as a priority.

Suicide prevention programs have been operating across Australia for many years, but despite substantial community interventions, the suicide rate in Australia has not declined noticeably (chapter 9). Current suicide prevention trials hold promise, and the Commission recommends evaluating and expediting the roll out of programs that have been successfully trialled. Such programs take a place-based view of the various activities that can contribute to suicide prevention. This is particularly important in Aboriginal and Torres Strait Islander communities, where suicide rates are unacceptably high. People in these communities should be empowered to design and implement suicide prevention programs that address the specific needs of their local community and are grounded in its culture and concepts of social and emotional wellbeing (chapter 9).

Many people do not benefit from mental health supports simply because they do not reach out. Seeking help early — and finding supports that are accessible and effective — is a key factor in preventing mental ill-health and enabling early intervention. But stigma (including self-stigma and stigma in the community) remains a major barrier for people, despite the progress made over many decades in opening up community conversations about mental health.

Reducing stigma is likely to benefit many people, through improved social inclusion, which would also result in increases in labour market participation and productivity. The National Mental Health Commission should prioritise the development of a national stigma reduction strategy. This strategy should not only encourage people to seek help; it should also tackle the stigma that can plague the health system, which can sometimes be too quick to dismiss the symptoms of people experiencing mental illness (chapter 8).

Prevention and early intervention reduce the number of people who experience mental ill-health or a deterioration in their mental illness. The recommended reforms in this area are expected to increase income and improve lives (table 4.2). They are also expected to lead to net economic benefits, as some of the additional government expenditure required to implement them is likely to be offset by cost savings and increased incomes. With effective prevention and early intervention, the mental health supports people would need are likely to be less intensive, and therefore cost less. A significant proportion of current healthcare costs are associated with treatment for people with severe mental illness (chapter 3), and people with complex mental illness are over-represented in the justice system and homelessness services. Lower intensity services for people who can seek help early would cost government much less than hospitalisations or intensive supports for vulnerable people with severe mental illness.

Empowering people to access the healthcare that is right for them

A focus on early intervention and prevention would reduce, but not eliminate, mental illness. Many people, at some point in their lives, would seek support from mental healthcare services. However, in the current system, people with mental ill-health often cannot access the services that are right for them — either because they are not available, or because there are a range of barriers that prevent access. To achieve a person-centred mental health system, governments would need to work towards expanding the availability of some services (such as supported online treatment and community ambulatory services) and improving the accessibility of others (chapter 12). The main goal of these reforms is to address the substantial gaps in the mental health system.

A person-centred mental health system should empower people to choose the services that are suitable to them, and focus on their recovery. What recovery means in practice depends on the individual circumstances of each person. Recovery also needs to be considered in the context of a person's family, carers and community (relational recovery is discussed in detail in chapter 18).

As the mental health system progresses towards a person-centred model, people would benefit from increased access to a range of services and simpler ways to find the support they need. There are numerous gateways into the mental health system, and this Inquiry's recommendations aim to make them easier for people to use, as well as more effective in linking people to the services that are most suitable to their needs. And for people with severe mental illness or those who are affected by physical as well as mental illness, a person-centred healthcare system would ensure that both health and community services are linked seamlessly from the consumer's perspective.

Creating a national digital mental health platform, that gives people more choices in accessing mental health support, is one of the priority reforms of this Inquiry (chapter 10). For many Australians, access would start with a visit to their GP. However, people would also have the option of using the national digital mental health platform directly, to assess their needs and find services that can help. Some of these services would be online; clinician-supported online treatment can have very positive outcomes, as well as enabling people to go through treatment at a time and place that suits them. Expanding supported online treatment, so that it can reach 150 000 people (rather than the current 4 000 people who access it), is expected to generate a net benefit of \$64–168 million (table 4.2). Other treatment options that would be expanded so more people can benefit from them are group therapies and telehealth (chapter 12).

For those people who choose to visit a GP, there are a number of recommendations across this report that would improve GPs' ability to help. These include, for example, information portals that a GP can use to find best practice clinical guidelines and local services (chapter 15), access to advice from psychiatrists (chapter 10), and training on prescribing practices, including helping people to stop taking mental health medication once it is no longer clinically required (chapter 16). To give people more choices in their treatment and

improve referral processes, GPs would use the recommended assessment and referral tool that would be incorporated into the national digital mental health platform (chapter 10).

A system that people can navigate easily

Beyond the initial gateway into the mental health system, there are many services to which people can be referred. For example, each child mental health catchment area in metropolitan Melbourne has over 140 separate product, program and service types that can be engaged to support child mental health across the health, education and social service sectors. However, it is not always the case that these services are available and accessible when and where required (Paraskakis 2019). In the current mental health system, pathways for people who need care are often extremely complex and there are still substantial gaps in services, leaving people without the support they need (chapters 10, 12, 15). People affected by mental and physical illness have particularly poor outcomes, which lead to shorter life expectancies (chapter 14).

People who use mental health services, their families and carers, would have substantially better experiences in a person-centred system. Implementing the Productivity Commission's priority recommendations would result in an expansion in clinical services, including community ambulatory services. Within hospitals, emergency departments would work towards treating people with mental illness in environments that are more suited to their needs (chapter 12, 13). People with mental and physical illness would benefit from better integrated care, as a result of the wider use of single care plans for people with moderate to severe mental illness who receive services from multiple providers, and additional funding for care coordinators to assist people with severe mental illness and complex needs (chapter 15).

Collaboration and coordination are key features of a person-centred system, and should permeate all levels of the system. Services providers would be expected to work collaboratively and will be better supported to do so, especially where a person uses more than one service. Collaboration would extend across clinical and non-clinical services, so that people experience seamless care and do not have to repeat their story or go through unnecessary repetitious assessments.

Carers are an important, but too often forgotten, part of the mental health system. They play a vital role in the recovery of people with mental illness, but their own needs are not always considered by the mental health system. They are often excluded from discussions on their care recipient's needs — regardless of the consumer's preferences — and not made aware of services that can assist them. Embedding family- and carer- inclusive practices across the mental health system would enable more effective support to people accessing services and their carers (chapter 18).

Implementing these recommendations would build on existing mental healthcare and psychosocial services, to work towards a system that can offer a continuum of care across the range of individual needs. It would give people the choice to access mental healthcare online or face-to-face, and individually or in group settings (chapters 10, 11 and 12). People

who require more complex care would be able to more easily access it in the community, rather than cycle through repeated hospital admissions (chapter 12).

Overall, improved access to mental healthcare is expected to lead to substantial benefits (table 4.2). The improvements to the health-related quality of life from all healthcare reforms that were modelled total between 10 280–15 280 additional years of healthy life annually. The additional income from increased employment and productivity that results from improved mental health for those receiving these services is estimated to be \$501–718 million annually. While these benefits would require some additional expenditure, there is considerable scope for governments to use existing mental health funding to deliver better outcomes for people, primarily through increased access and use of lower intensity services, such as supported online treatment and group therapy (chapters 10, 11 and 12, appendix K).

Recognising the role of community support services in a person-centred system

For many people, recovering from mental ill-health is about so much more than clinical care. It means rebuilding relationships, strengthening skills, finding and maintaining secure housing and employment. A person-centred system is built on the understanding that clinical services need to work in partnership with a broad range of community supports in order to help people experiencing mental ill-health to achieve the outcomes they value. For consumers, this would mean accessing the combination of supports that is right for them, where service providers work in collaboration, share information routinely (with consent from the person they are supporting) and respect each other's expertise.

This Inquiry takes a holistic approach to mental health, building on the clinical stepped care model, which matches people to the level of care most suited to them and allows services to change in intensity as needs change over time (figure 4.3).¹⁶ The Commission's vision extends this model, by considering clinical care alongside the provision of community support services. Some people's experience of mental illness may require little clinical intervention, but they may need more extensive support due to issues related to housing, employment, social inclusion or other factors. Without such support, symptoms of mental illness may worsen significantly, and the opportunity for early intervention is lost.

Achieving these benefits requires reforms to healthcare (discussed above) and cultural change that promotes collaboration in the mental health system (discussed in detail in chapters 22 and 25). In addition, there are also practical barriers that would need to be overcome to improve the capacity of community support services to help the people who need them.

¹⁶ The Australian Government's Department of Health (2019n, p.8) defines stepped care as 'an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs. ... While there are multiple levels within a stepped care approach, they do not operate in silos or as one directional steps, but rather offer a spectrum of service interventions.'

Figure 4.5 **Clinical care and community support services should work together to support recovery**

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

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

For example, over 150 000 people with severe and persistent mental illness who require psychosocial supports are unable to access them, due to insufficient funding for service provision and regulatory inefficiencies. These supports make a big difference to the lives of the people who use them. Services can encompass assistance with managing daily activities, rebuilding and maintaining connections, building social skills and participating in education and employment.

Closing this service gap is expected to generate benefits, as more people access support and recover from mental ill-health or manage their illness better. Ensuring that people who have psychosocial needs arising from mental illness can access the psychosocial supports they require would provide them with 4900–8900 additional years of better health (chapter 17, appendix K). Achieving this, however, will take time, as governments first work to identify needs, and then, over time, increase the funding allocated to psychosocial supports to meet the service shortfall (chapter 17).

Employment is a goal for many people with mental illness. For some with severe mental illness, expansion of the Individual Placement and Support model of employment support could create significant benefits by helping people to find work. Wider benefits include improved mental health and savings to the healthcare system (mostly from reduced hospital admissions) of \$137–575 million; \$42–90 million from income associated with employment outcomes; and savings on Disability Employment Services of up to \$49 million (chapter 19).

Many people with mental illness receive an income support payment. The existing structure of some payments is a disincentive to employment and does not recognise the episodic nature of mental illness. This situation also affects carers of people with mental illness. For both people with mental ill-health and carers, amending eligibility criteria would encourage more people to seek employment and education opportunities (chapters 18 and 19).

Access to appropriate housing is a key factor in the recovery of people experiencing mental ill-health. For some, it would mean being able to leave hospital and live in the community — about 30% of people in hospital with mental illness could be discharged if suitable accommodation, clinical and community supports were available (chapter 13). This would support their recovery, as well as freeing up capacity in hospitals for other people who need to be admitted.

Sometimes people are being discharged from hospital, correctional facilities or other institutional care into homelessness. Their ability to recover from mental illness is substantially compromised by a lack of secure housing. Addressing this would not only greatly benefit the people directly affected, but it is also expected to lead to lower healthcare expenditure. As a priority, people with mental illness who are discharged from hospital, correctional facilities or other institutional care should receive a comprehensive mental health discharge plan, and have ready access to transitional housing if they require it (chapter 20).

Supporting people in crisis – and the first responders who help them

There are many points at which the mental health system and the justice system interact. This starts with police, the first line of the justice system, who are spending increasing amounts of time responding to people in mental health crisis. These situations can be extremely difficult for the person in crisis and for the police who attend. Mental health professionals should be available to support frontline police. There are multiple ways in which their expertise can be incorporated, including placing mental health professionals in emergency communication centres and embedding them as part of response teams. This reform should be a priority for State and Territory Governments, given the large numbers of people it is likely to benefit (chapter 21).

Some people in mental health crisis would go on to face mental health tribunals, which have the legal powers to impose orders of involuntary detention and treatment. These people do not always have access to legal representation due inadequate resourcing of State and Territory legal assistance services. This issue should be a priority for governments, as it

seeks to protect the human rights of highly vulnerable people who face the possibility of being detained against their will.

People with mental illness are over-represented in all parts of the justice system, but the supports they are offered have severe shortcomings. Improving the services provided to people in correctional facilities and those transitioning out of these facilities and into the community, as well as early intervention approaches to keep people with mental illness out of prison, are likely to be beneficial for many people and the broader community (chapter 21).

4.4 Enablers of a person-centred mental health system

Transforming the mental health system requires changes to the way services interact with people, the tools they use and the policies and governance structures that guide them. Some of these changes, such as better use of information sharing tools or expanding the mental health workforce in regional and remote areas, would benefit people directly. Others, such as improving planning and evaluation, are structural reforms that would support change in the mental health system.

Workforce and technology are key to reform

The mental health system has a very diverse workforce, with a wide range of skills. Not all occupations have sufficient numbers of qualified workers, and some parts of the country, in particular regional and remote areas, are experiencing substantial shortages. Inefficient or absent planning has also seen inefficient allocation of skills across the mental health system, leading to long waiting times for people who need support. Compounding these issues have been a negative workplace culture within the health system that stigmatises people with mental illness; insufficient numbers of peer workers; and the technological challenges of data linkages and information sharing between service providers (chapter 15 and 16).

Addressing workforce shortages, including through peer workers, is an important step on the way to a person-centred system. The mental health system is increasingly recognising the substantial contribution of peer workers to the delivery of recovery-focused mental health services. Peer workers can provide a shared perspective in the provision of treatment, which is particularly useful for those people who find it difficult to engage with mainstream mental health services. For example, peer workers can enable the mental health system to better meet the needs of people from CALD backgrounds or the LGBTIQ community (Mental Health Australia, Federation of Ethnic Communities' Councils of Australia (FECCA) and National Ethnic Disability Alliance (NECA), sub. 524; Thorne Harbour Health and Rainbow Health Victoria, sub. 265).

Improvements in information sharing between service providers (with consumers' consent), using existing technology, has the potential to improve people's experience of the mental health system. Greater use of technology is likely to mean that people do not have to

constantly repeat their story, or act as conduits of information between their various service providers (chapter 15).

Such investments in technology and workforce development would create a mental health system that is flexible and scalable. This would allow it to respond quickly to current and emerging challenges that the community faces. This was evident in the early responses to the mental health issues emerging during the COVID-19 pandemic, which focused on expanding access to online and phone support (DoH 2020n).

Governance and funding mechanisms to create a person-centred system

The lack of coherent governance structures is one of the key reasons for the disjointed service delivery that people experience in the mental health system — there is no clear delineation between the responsibilities of governments in different parts of the system, and as a result, there is limited accountability.

For a person looking for help, it is immaterial whether a doctor is employed by a State-funded hospital or paid by the Commonwealth via Medicare; regardless of funding structures and institutional arrangements, people have an expectation of timely, affordable, respectful quality care. Nonetheless, to change the way people experience the mental health system requires reform to the institutional arrangements that underpin the system. The National Mental Health and Suicide Prevention Agreement, described in detail in chapter 23, would clarify the roles, responsibilities, and funding commitments of the Australian Government and State and Territory Governments to mental health services. In addition, the Australian, State and Territory Governments should develop a new whole-of-government National Mental Health Strategy that aligns the collective efforts of health and non-health sectors (chapter 22).

To improve the ability of the mental health system to respond to people's needs, governments have placed increased emphasis on regional planning and funding arrangements, rather than taking a top-down approach. However, these arrangements have not always delivered benefits for people. Current funding mechanisms in the mental health system contribute to poor consumer outcomes. In the health system, they create disincentives to the provision of community-based care; there are also weak incentives to minimise hospitalisations and avoid repeated presentations to emergency departments. Beyond the health system, funding for other supports such as psychosocial services is extremely fragmented and based on very short funding cycles, which make it harder to deliver quality services. Reforming funding arrangements in the mental health system, to create the incentives that will underpin person-centred services, should be a priority for governments (chapter 23).

When regional planning is effective, it presents an opportunity for individuals and communities to be involved in the design of the services they require and in their delivery. This co-design approach, at all levels of system planning, should be an integral part of mental health system governance. Further, the Commission sees a need for strengthening systemic advocacy, through organisations that represent the needs of people with lived experience of

mental illness, their families and carers. These organisations can often give a voice to people who are most disadvantaged, and therefore less likely to participate in formal consultation and co-design processes — but they could benefit significantly from a person-centred mental health system (chapter 22).

Implementing the reform agenda outlined in this report brings into closer alignment the incentives of governments, as funders, planners and service delivery organisations, and people who are seeking to recover from mental ill-health. Creating a person-centred system would ultimately mean that people can find the services that are best suited to support their recovery on their terms, and governments can direct their resources better through a funding and governance model that responds to local needs.

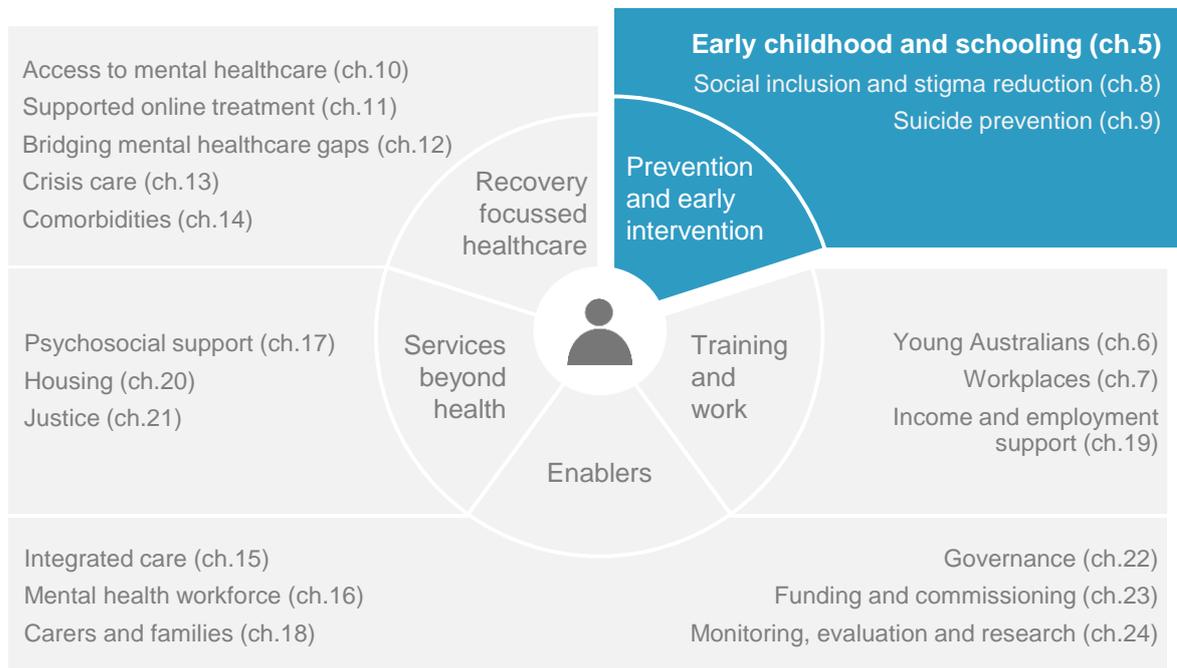
Using data to improve services and outcomes for people

Accountability for outcomes should be a core principle for the mental health system. This can only be achieved through a transparent, comprehensive and nationally-consistent monitoring and reporting framework. Currently, vast amounts of data are collected throughout the mental health system, but key indicators are out of date, there is limited use of data to improve outcomes, and some important data items are rarely collected. This Inquiry recommends updating and expanding key data collections, as well as setting out priorities for improving the use of the data being collected. Further, evaluation should be embedded into program design, not only to ensure that public funds are spent efficiently but also to support continuous improvement in service delivery (chapter 24).

Data is not just a tool for policy makers. Access to data empowers people to make informed decisions about their own treatment. The Commission's recommended monitoring and evaluation framework places a substantial emphasis on reporting consumer outcomes, and ensuring the mental health system focuses on improving outcomes for all types of consumers, regardless of age, location, and their unique combination of risk and social factors that may affect mental health. This framework also recognises different concepts of wellbeing, such as Aboriginal and Torres Strait Islander approaches to mental health and wellbeing, to ensure governments and service providers measure and report on outcomes that matter to people (chapter 24).

PART II – PREVENTION AND EARLY INTERVENTION

5 Social and emotional wellbeing of children: early childhood and schooling



Interventions in early childhood and school education matter because ...

- Mental illness often emerges in childhood and adolescence, but children and young people face substantial barriers to accessing treatment and support.
- Addressing risk factors and symptoms early not only improves children's wellbeing but is a cost-effective approach to improving life-long outcomes for people.
- Educational institutions are already investing significant efforts in students' wellbeing — but their role in promoting wellbeing and preventing mental ill-health has never been clearly articulated by governments. Schools need to support their students while also navigating a complex landscape of policies, frameworks, uncoordinated service delivery, inconsistent data collections and conflicting advice.

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

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

As a priority:

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

Additional reforms within the education system that should be considered:

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

Additional reforms within the health system that should be considered:

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

Mental health is a cornerstone of healthy childhood development; it underpins children's and young people's social and emotional development and their sense of wellbeing, and it enables them to thrive and grow. Investing in the mental health of children delivers significant returns, for the children themselves, their family, their community — and ultimately, the economy, when children become adults who contribute to productivity, consumption and innovation.

Giving families the tools to support the development of their young children, and ensuring schools better support the social and emotional development of their students, would help children to cope better with challenges arising from the environment they live in, external stressors and the difficulties of growing up. Nonetheless, children and young people — from infants to adolescents — may, at some point in their life, face mental health challenges. When these challenges persist, the child and their family are likely to need support from school teachers, GPs, other health or social services, and in some cases, community mental health services or hospitals. Early identification is key to helping children who experience mental health challenges, and their families.

From a policy point of view, there is a clear case for investment in child mental health and wellbeing. Such investment would not only improve the wellbeing of children and their families, both immediately and in the future; it would also save significant future government expenditure by lowering the risk of children disengaging from their education and could reduce the need for more intensive medical care and other supports.

This clear case for action has led to numerous policy interventions over time, but there is still no overarching national framework that articulates the roles of the education and health systems in helping children thrive. The many interventions funded by governments operate independently of each other, and there is limited monitoring of the outcomes that these initiatives are intended to achieve.

This chapter recommends reforms to improve early identification of risk factors that may jeopardise young children's social and emotional wellbeing, and enhance the efficacy of the education system in supporting children and young people's wellbeing. Community mental health services and acute services that are intended to cater for the needs of children and young people are discussed in chapters 12 and 13.

Some of these recommendations are not new. Most recently, these issues were raised by the 2014 National Mental Health Commission review, but the reforms implemented in response have addressed only a small part of the problem (box 5.1). Workforce training is one area where only minor improvements can be identified. The effects of reforms and other interventions would be short-lived if those working with children and young people are not equipped with skill sets that enable them to continue to support better mental health and wellbeing in their ongoing work.

Box 5.1 Key recommendations of the 2014 review relating to children and young people — and the Australian Government’s response

One of the strategic directions of the National Review of Mental Health and Programmes and Services in 2014 was promoting the ‘wellbeing and mental health of the Australian Community, beginning with a healthy start to life’ (NMHC 2014c, p. 100). Of the 31 recommendations made to achieve this goal, many are directly relevant to children and young people, including to:

- strengthen school-based programs and the broader mental wellbeing agenda in schools, including resilience and targeted interventions in curricula and pedagogical frameworks
- include evidence-based approaches to mental health and wellbeing in the training and continuing professional development of teachers and early childhood educators
- expand measurement of wellbeing in the early years to middle childhood
- consider expanding parenting programs.

The Australian Government responded to these recommendations through broader reforms to improve mental health services delivered to children and young people and focus on better coordination and availability of clinical services (DoH 2015a). In addition, the Government committed to:

- creating a single integrated end-to-end school based mental health program. This has led to the development of the Be You initiative (box 5.3)
- a national workforce support initiative for clinical and non-clinical professionals and services that work with children. The National Workforce Centre for Child Mental Health was funded by the Department of Health to provide this assistance, via online professional development materials and a national network of consultants (Emerging Minds 2019; subs. 455, 944).

More recently, in 2019, the Australian Government announced its plan to develop a national children’s mental health and wellbeing strategy, focusing on preventing mental illness and reducing its impact on children and families (Hunt 2019b).

Much of the policy infrastructure required to achieve substantial improvement in early intervention, prevention and promotion of mental health and wellbeing is in place. There is a large and dedicated workforce that can deliver effective interventions. But:

- qualifications often do not give staff the skills to be fully effective in implementing ongoing initiatives
- there is an array of overlapping policy documents and frameworks and a very large number of programs that can be delivered internally or outsourced; schools find it difficult to navigate this crowded space
- schools have many competing priorities that mean mental health and wellbeing does not always receive sufficient attention
- there is limited tracking of outcomes, and where outcomes are tracked, data is not always used effectively.

To address these issues, the Productivity Commission has made recommendations to:

- improve perinatal mental health services, through increased screening and better parenting support (section 5.1)
- expand the social and emotional aspects of the voluntary early childhood checks provided by State and Territory Governments, so that problems can be identified and addressed early (section 5.2)
- make wellbeing a national priority for the education system, by updating the National School Reform Agreement to include wellbeing outcomes, and clearly defining the roles and responsibilities of all those involved in student wellbeing, including school principals, teachers, counsellors and psychologists (sections 5.3 and 5.5)
- strengthen the ability of early childhood education and care (ECEC) centres and schools to support children’s social and emotional development by improving educator and teacher training and professional development, and by accrediting all wellbeing programs offered by external providers (sections 5.2 and 5.4)
- collect nationally consistent data on student wellbeing, and use it to report on progress against the outcomes in the national agreement, inform policy planning and improve schools’ implementation of a social and emotional wellbeing curriculum (section 5.6).
- improve outreach and support services to students with mental illness and other vulnerable children (section 5.7).

5.1 Mental health and wellbeing in the first three years of life

In recent years, the mental health of infants and young children and their social and emotional development have emerged as areas that attract increasing interest from practitioners and policy makers, based on an understanding of the important role they play in lifelong wellbeing (RACP, sub. 488). Infant mental health refers to:

the developing capacity of the infant and young child (from pregnancy to 3 years old) to experience, express and regulate emotions; form close and secure relationships; and explore the environment and learn, all in the context of the caregiving environment that includes family, community, and cultural expectations. (Osofsky and Thomas 2012 quoted in AAIMH 2020)

The health system closely monitors the physical development of infants and young children. Australia’s maternal and child health system is well-established and attendance rates are relatively high.¹⁷ Periodic checks primarily assess the physical development of the child,

¹⁷ The maternal and child health system comprises public health centres that offer services to families with young children, including periodic development checks for infant and toddlers conducted by specialised nurses. These centres have various names in different jurisdictions, such as child and parent centres in Western Australia; maternal and child health centres in Victoria; and child and family health centres in New South Wales and Tasmania. In all cases, however, the range of services provided includes routine health checks in the first years of children’s lives.

though their scope has been expanded to include psychosocial screening for caregivers (Schmied et al. 2015). Jurisdictions have also increased their focus on the social and emotional development of infants by developing a range of different programs to support families. Examples include:

- specific models of care and practice guidelines (for example, Queensland Centre for Perinatal and Infant Mental Health 2017; WA DoH nd; Women’s and Children’s Health Network 2019)¹⁸
- special programs that families can be referred to, such as Start Talking in New South Wales and a Perinatal and Infant Mental Health Clinic in Tasmania (NSW Government 2018a; Tasmanian Health Service nd)
- early parenting centres and enhanced maternal and child health programs, such as those working in Victoria and South Australia with families at risk (Centre for Excellence in Child and Family Welfare, sub. 211; Karl Brettig, Adelaide transcript, pp. 115–7)
- strategies intended to tackle specific risks to infant mental health and wellbeing, such as fetal alcohol spectrum disorder (NT DoH 2018).

These programs do not reach all the families who need support (Legislative Assembly of New South Wales 2018). Therefore, Inquiry participants suggested that all health service providers who come in contact with families before and after the birth of a child be trained in identifying risks to social and emotional development (Gally McKenzie, Darwin transcript, p. 99).

Further, stakeholders pointed to the need to expand the delivery of mental health services that can support infants and their families (Child and Adolescent Health Service, sub. 255; Perinatal Wellbeing Centre, sub. 752; Tasmanian Branch Australian Association of Infant Mental Health, sub. 677). Expanding child and adolescent community mental health services (CAMHS), to support the development of all children — including infants and their families — is discussed in chapter 12.

Improving infant wellbeing by supporting parents and families

The mental health of parents has a strong influence on the wellbeing of infants and young children. This suggests a strong case for supporting parents, particularly at times of major life transitions, such as the perinatal period (pregnancy and the weeks following birth).

Mental ill-health is not uncommon among pregnant women and new mothers and fathers. One in ten women experience depression during pregnancy, one in five women are affected by anxiety and one in seven women experience depression in the year following the birth of a baby (COPE 2017). One in ten new fathers or partners of new mothers experience perinatal

¹⁸ Nonetheless, stakeholders have pointed to gaps in service delivery. For example, according to the Child and Adolescent Health Service in WA (sub. 255, p. 2), there is no ‘comprehensive, specialist, multidisciplinary service providing infant and early childhood mental health assessment and intervention to Western Australian (WA) families’.

depression and/or anxiety (Gidget Foundation Australia, sub. 709; Perinatal Wellbeing Centre, sub. 752; Richard Fletcher, sub. 674).

This has substantial implications not only for the parents, but also the child, including detrimental effects on their emotional, social, physical and cognitive development (Beyond Blue 2008; Safe Motherhood for All, sub. 165). It also imposes significant costs on families, and the broader community — the annual costs of perinatal depression and anxiety have been estimated at \$877 million. This includes healthcare costs to parents and children, who are at higher risk of developing mental illness, lower productivity for parents and lower wellbeing for children (PwC 2019).

The frequent interactions of families with healthcare providers in the perinatal period afford a valuable opportunity to improve detection of mental illness and offer early intervention. Clinical guidelines and government policy — at the Australian, State and Territory Government levels — have been explicit about the expectation that screening of pregnant women and new mothers occurs routinely. However, implementation of screening policies is patchy:

Despite clear policy guidelines, screening has been inconsistently implemented ... the issue is not one of policy, but of implementation at a service delivery level. Much faith is held in the ‘best practice’ administration of screening tools both antenatally and postnatally, yet insufficient consideration is given to workforce development to ensure health professionals are ready to have difficult conversations, know how to explore sensitive and complex issues and feel confident responding when concerns are raised. This gap in confidence and skill set might be one explanation as to why most parents experiencing perinatal anxiety and depression are not identified by care providers. (PANDA, sub. 344, p. 15)

There is no consistent data collection on the proportion of women who are screened for perinatal mental illness. The Perinatal National Minimum Data Set, collected by the Australian Institute of Health and Welfare (AIHW), does not include indicators relating to parental mental health (AIHW 2018e). Survey estimates of the proportion of women screened for perinatal mental illness vary from 50% to 75% (AIHW 2012b; Reilly et al. 2013). Screening rates are estimated to be substantially lower for Aboriginal and Torres Strait Islander women, those born overseas, single mothers and those who use the private healthcare system (Australian Longitudinal Study on Women’s Health, sub. 218; San Martin Porter et al. 2019). Fathers or partners are ‘far less likely to be screened or offered appropriate interventions’ (Perinatal Wellbeing Centre, sub. 752, p. 3).

There have been efforts to tackle this issue in the past. The National Perinatal Depression Initiative was funded by the Australian Government with the aim of reaching universal screening and expanding support services for pregnant women (DoH 2013a). It appears to have increased access to mental health services and reduced psychiatric hospitalisation (Chambers et al. 2016; Lee et al. 2019). The initiative was defunded in 2013, and according to the Australian Nursing & Midwifery Federation (sub. 317), the lack of funding since then has limited the ability to build additional capacity in the workforce to address perinatal mental health concerns.

Healthcare providers report other difficulties in implementing universal screening, including lack of time and insufficient referral pathways. The available screening tools can also be unsuitable for parents from culturally and linguistically diverse backgrounds or Aboriginal and Torres Strait Islander parents (Perinatal Wellbeing Centre, sub. 752). Research has found that even where screening does occur and risk factors for mental illness are detected, many women either do not access mental health services or do not engage in treatment (COPE 2017). This is likely due to a complex combination of factors, including a lack of accessible mental health services and stigma (PANDA, sub. 344).

Realising the benefit of screening opportunities

The way screening policies are implemented appears to miss opportunities to improve population mental health and provide early intervention to new parents who are at risk of developing mental illness. Therefore, governments should step up their efforts to achieve universal screening. Rather than mandate a specific screening tool or point in time at which new parents should be screened, governments should aim to embed mental health screening into the routine practices of healthcare providers (Action 5.1). They should also explicitly include fathers and partners in any policies to support perinatal mental health screening.

As a first step, reliable data should be collected to establish the overall screening rates for perinatal mental illness. The Perinatal National Minimum Data Set, which is managed by the Australian Institute of Health and Welfare, should be expanded to include indicators of mental health screening conducted in the weeks following birth. Data on screening completed as part of maternal and child health visits should be collected by State and Territory Governments, and reported to the National Mental Health Commission, as part of its future monitoring role (chapter 24).

State and Territory departments of health should develop strategies to achieve universal screening rates for new parents, through their existing maternal and child health system. Strategies can include: using online screening tools, such as the iCOPE digital platform, which is being implemented in public hospitals as part of the Maternity to Home and Wellbeing program (COPE 2019); increasing the use of home visiting and outreach services that seek to engage as many families as possible; employing peer workers to support new parents and guide them through screening surveys; ensuring that the screening tools used are culturally appropriate and suited to the needs of the community; and raising awareness in the community of the benefits of screening new fathers and partners of new mothers. In addition, screening for perinatal mental illness should be part of mental health training of GPs and other health service providers (chapter 16).

Broadening the focus to fathers and partners

Special consideration should be given to increasing screening rates for fathers and partners of new mothers. This would require the development of dedicated screening tools for fathers and partners as well as a public awareness campaign, about the supports available and the

importance of screening. Using data about similar efforts undertaken in the past to raise the screening rates of mothers, and including costs of care for those fathers and new partners identified in the screening process, the Productivity Commission estimates that an intervention to expand screening for fathers would cost \$18–23 million. This intervention is expected to lead to increased income of about \$46–86 million, as more new parents access support for their mental health and are able to remain in the labour market (appendix K).¹⁹

However, as pointed out by Perinatal Anxiety & Depression Australia (PANDA, sub. 344, p. 14), ‘only screening programs which are properly embedded within a system of referral and support have any chance of improving outcomes’. Addressing the structural weakness of the healthcare system (as outlined in chapters 10, 12 and 13), including ensuring there are sufficient numbers of beds in mother and baby inpatient units, would improve referral pathways and the accessibility of treatment and support options. This in itself is likely to raise screening rates, as it would build confidence among providers and consumers that timely support and assistance are readily available. Similarly, tackling stigma across the community would likely mean more new parents would seek help when they need it (chapter 8 discusses stigma in detail).

The Gidget Foundation (sub. 709) suggested that the Australian Government change the Medicare Benefits Schedule funding rules so that people diagnosed with perinatal mental illness could access up to 20 psychology sessions (this is similar to the approach taken in funding treatment for eating disorders (box 5.8)), as well as expanding telehealth services, which might be more accessible for new parents. This Inquiry’s recommendations to review Medicare Benefits Schedule funding guidelines, as well as fund services that would be more suited to consumer need (chapters 10 and 11), are likely to be a step in this direction.

Information and guidance for new parents

The perinatal period offers an opportunity to provide parents with education and guidance to support them in building strong, positive relationships with their children in infancy and in later years (Becoming Us, sub. 132). According to a review conducted by the National Health and Medical Research Council (2017), the costs of providing antenatal and postnatal education and support to parents are outweighed by substantial benefits, including improved mental health for parents and children. There are benefits from programs that are offered to all parents, as well as interventions that target vulnerable groups. In particular, support programs provided by peer workers have been shown to be highly cost effective (Queensland Centre for Perinatal and Infant Mental Health 2017). There is a wide range of initiatives intended to educate parents about child development, including social and emotional development. Information is available from government and non-government sources,

¹⁹ Costs were assumed to include expenditure required for a campaign to raise awareness about screening and costs associated with implementing screening. These were calculated based on funding allocations for the National Perinatal Mental Health Initiative in 2008. In addition, costs included expenditure required to provide care for people with mental ill-health identified through screening, assuming that a mix of online supported and face-to-face treatments would be used (appendix K).

delivered through antenatal classes, individual and group therapy sessions, maternal and child health centres, online tools and other programs (Gidget Foundation Australia, sub. 709; Perinatal Wellbeing Centre, sub. 752). Only a small number of these services are offered specifically for fathers.²⁰ However, services for new parents are often disconnected and there is a lack of cohesion in their approaches (NHMRC 2017). They may also not be reaching those families most in need of support (VicHealth and partners, sub. 131).

Governments should make better use of existing channels to increase the provision of evidence-based support and education programs for parents with children of all ages (Action 5.2). The most useful channels for engaging parents have changed over time — online resources are some of the most common sources of information for parents, alongside talking with friends and family (Legislative Assembly of New South Wales 2018). Developing a trusted national online brand for evidence-based information on early childhood social and emotional development should form part of the national digital mental health platform (chapter 10). There are existing resources of information that can be used for this purpose, such as the Raising Children Network, which is supported by the Australian Government.

ACTION 5.1 — PERINATAL MENTAL HEALTH

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

Start now

In order to determine current screening rates and prioritise interventions, better data is required.

- The Australian Institute of Health and Welfare (AIHW) should expand the Perinatal National Minimum Data Set, to include indicators of mental health screening in the weeks before and immediately after birth.
- State and Territory Governments should collect data on screening undertaken by maternal and child health nurses and provide this data to the AIHW.
- Using the data from the AIHW, the National Mental Health Commission should commence monitoring and reporting on progress towards universal screening.

Start later

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

²⁰ For example, SMS4dads is a program that sends text messages to fathers both before and after the birth of a baby, which include information and links to resources for fathers as well as a mood tracker to assist those who are struggling with their mental health (Richard Fletcher, sub. 674, att. 1). Stayin on Track is a service tailored to the needs of young Aboriginal fathers (Perinatal Wellbeing Centre, sub. 752).

5.2 Mental health and wellbeing for preschool-aged children

Up to one in five children starting school experience emotional difficulties, which are likely to get worse as they get older and make it harder for children to learn (O'Connor, Quach and Goldfield 2020; Shay and Wang 2018). Early identification of emerging emotional problems in the preschool years offers an opportunity to help children start school ready to learn, and avoids an escalation of issues that families must cope with in years to come.

Many preschool children attend their final maternal and child health check between their third and fourth birthdays.²¹ Concerns about child behaviour, which may indicate emerging issues that can affect social and emotional development, are common topics for discussion at maternal and child health checks (MHYF Vic, sub. 628). In some jurisdictions, guidelines for maternal and child health checks already include questions on social and emotional development (for example, BetterHealth Channel 2019). Rolling out such guidelines for all child health checks would assist in early identification of emerging emotional difficulties and help families get advice and help.

Relevant guidelines were developed in the past, when the Australian Government attempted to introduce an Enhanced Healthy Kids Check, designed for 3 year olds. The check was never fully rolled out, partly due to public criticism around any possible mental health aspects of these checks (Oberklaid 2014). Nonetheless, the guidelines that have been developed could form the basis for improving current processes, and identifying families who miss out on services. Further consultation is likely to be required prior to implementation, to determine the scope and processes best suited to expanding early childhood checks. For example, Emerging Minds (sub. 944, p. 12) called for:

... establishing a governance structure inclusive of different professional groups to oversee the development and implementation of the check, and to collectively respond to potential scare mongering.

A recommendation to extend existing physical health checks to include a voluntary social and emotional wellbeing check was included in the draft report of this Inquiry. In response, the Commission received a very large number of submissions, voicing objection to the idea (for example, submissions 951 – 1105). These issues were also raised at the Inquiry's public hearings (for example, Tom Benjamin, Adelaide transcript, pp. 32–3; Shelley Wilkins, Sydney transcript, pp. 208–9).

Inquiry participants were concerned that such checks could lead to a large number of children being prescribed mental health medications, which carry significant risk of side effects:

[W]ith more screening there is likely to be an even greater increase of children on psychiatric drugs, of which many cause or have been linked to suicidal behaviour. This is a huge concern for me as a parent and member of our community. (Adam Clarke, sub. 973, p. 1)

²¹ In Victoria for example, 64% of children attend a check at 3.5 years of age (Vic DHHS 2019, p.9).

Once this screening takes place more often than not leads to referrals to a Psychiatrist or GP who then potentially prescribes psychotropic drugs (and often do). I have met numerous young children who have been affected adversely by these dangerous mind altering drugs (Rebecca Sferco, sub. 1111, p. 1)

What the screening of one to 3 years old for mental illness will lead to? [...]. If this means down the track the drugging of younger generations on mind altering drugs; it is not the answer and is not based in science. (comment no. 32, early childhood development)

I would like to express my strong disagreement with the proposal to screen children from 0 to 3 years old for signs of mental illness. The current criteria for evaluating early onset of mental disorder is wholly subjective and there is no science behind early intervention whatsoever. Screening children particularly as young as 3 years old is very dangerous. It leads to treatment and stigma. The treatment available in terms of medication are extremely harmful. (comment no. 96, early childhood development)

The Australian Association of Infant Mental Health (Gally McKenzie, Darwin transcript, p. 101) explained that such concerns are likely to be unfounded:

The main thrust of infant mental health work is around relational work. It's around the attachment between the little one and his or her primary carers as a vehicle for treatment. So in other words, AAIMH's preference and its main modality for working is actually in a relational way, rather than [...] pharmacology or even behaviourally-oriented interventions.

Clinical guidelines produced in Australia and overseas include numerous options to help children who are at risk of mental illness or have been diagnosed with mental illness. Medication is only one of these options, and it is only recommended for use in the rare cases where children experience severe or complex symptoms. For the vast majority of children, clinical recommendations include a range of psychological therapies, emphasising support and education for parents to assist their children, as well as creating supportive ECEC environments (Barrett 2014; Charles and Fazeli 2017; Gleason, Goldson and Yogman 2016; NICE 2019b). These clinical recommendations are echoed in Australian data available on children's use of mental healthcare services and medication. Of the children aged 4–11 years who were diagnosed with mental illness in 2014, 90% were not on medication (Lawrence et al. 2015). Medication was most commonly prescribed for children whose symptoms were very significant and continued to deteriorate over time (Mulraney et al. 2019).

Expanding the scope of early childhood checks, as envisioned by the Productivity Commission, is intended to give parents an opportunity to raise concerns about their children's social and emotional development; and it would give child health nurses the tools and the time to discuss these concerns with the parents, and refer the family on to other services where needed. While the Commission's recommendations are likely to lead to increased identification of families who are currently not accessing support services, the substantial majority would be offered a range of parenting supports or psychological therapies, rather than medication. Nonetheless, for all children, supporting early identification of emerging social and emotional difficulties is likely to improve outcomes and assist families to access support when they require it.

Many Inquiry participants expressed support for early childhood checks but also strongly advocated for additional services, from parenting supports to specialist child mental services (for example, Brigid Jordan, sub. 830; Centre for Excellence in Child and Family Welfare, sub. 862; Emerging Minds, sub. 944; NMHC, sub. 949; Triple P, sub. 859). Other submissions raised questions about the specific tools used to identify emerging issues, the availability of early intervention services that would be required if early identification were to become more widespread, and the possible risks of the checks leading to misdiagnosis of children (for example, Jon Jureidini and Melissa Raven, sub. 945; Prevention United, sub. 768).

The Commission recognises the need for additional services (chapter 12 discusses the expansion of child and adolescent mental health services). In addition to implementing specific guidelines for early childhood checks of social and emotional development, State and Territory Governments would need to develop referral pathways for families requiring support and ensure that services, in the form of parenting advice or family therapy, are available and accessible. What is also needed is a funding commitment from State and Territory Governments, to allow for any additional time required both to train nurses to administer the checks and extend consultation times with families. Further investment may also be required to achieve higher attendance rates.

In addition, community education and evaluation of outcomes (addressed in chapters 8 and 24, respectively, of this report) would be required if early detection of emerging social and emotional development problems is to be successful:

[T]here remains considerable disquiet in the community about programs designed to detect emerging mental health issues at an early age. Overcoming these concerns by implementing stigma reduction strategies, improving parental and community mental health literacy, and undertaking rigorous research on the effectiveness and outcomes of such programs may improve their reach and uptake. (Melbourne Children’s Campus Council, sub. 191, p. 3)

The role of early childhood education and care

The majority of children attend ECEC services before they start school. About 62% of 3 year olds attend some form of ECEC, and 86% of 4 year olds participate in a preschool program (either standalone or in a long day care service) (SCRGSP 2020a, tables 3A.15, 3A.19).

The high levels of attendance at ECEC — bolstered by a commitment from the Australian and State and Territory Governments to provide universal access to preschool — create another opportunity to support children’s social and emotional development and identify risk factors early. In this context, ECEC services can fulfil three important roles.

- High quality ECEC services provide healthy environments for children that can promote their social and emotional wellbeing.
- Trained staff can focus on child development, identify early signs of concern and communicate these to parents.

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- ECEC services can act as a gateway into the broader mental health system, or provide parents with information and education on social and emotional development and the support services available in the community (Oberklaid et al. 2013).

The national Early Years Learning Framework and the National Quality Framework (NQF) support ECEC services in fulfilling these roles. The Early Years Learning Framework includes strong social and emotional wellbeing for children as one of its outcomes (DoE 2009). The NQF's seven quality areas cover numerous aspects of children's wellbeing and the way it is supported through the curriculum used, the relationships between educators and children, and interactions with families (ACECQA 2020b). All ECEC services are assessed against these standards, and 80% comply with or exceed the national standards (ACECQA 2019). Services are also required to complete and update a Quality Improvement Plan (ACECQA 2020a).

Each service can design its own approach to implementing the wellbeing standards of the NQF. Services may choose to implement one of numerous wellbeing frameworks, some of which were developed with support from the Australian Government — for example, the Connections framework developed in 2014 by the Everymind institute (2014), and the current national mental health initiative for the education system, Be You (box 5.3). Over 3300 early learning centres have signed up to Be You since it was launched in late 2018 (Beyond Blue, pers. comm., 27 April 2020), representing about 40% of services. However, the uptake and implementation of any framework is subject to the decisions of individual centre (Mental Health Australia, sub. 407). Implementation costs are likely to pose a substantial challenge for the ECEC sector.

Whilst the access to the [Be You] program itself is free, the implementation of the program comes at a cost, with additional administration and activities required. Some services have struggled to implement the program due to the additional time and resources required. (ACA, sub. 867, p. 3)

Improving ECEC workforce capacity to support children's social and emotional development has the potential to deliver substantial benefits (Triple P, sub. 859). To ensure ECEC staff have suitable skills, the NQF mandates minimum qualifications for all staff in ECEC, and requires the presence of qualified teachers in all long day care services (ACECQA 2020b). Training courses are highly regulated, and graduates are expected to achieve core competencies that, among other skills, relate to supporting social and emotional development (SkillsIQ 2015). In its submission to this Inquiry, the Australian Children's Education and Care Quality Authority (ACECQA, sub. 673, p. 3) stated that the mandated training content 'appropriately addresses the need for vocational educator training on social and emotional development of children'. However, the authority also stated that 'while registered training organisations provide vocational training packages as a standard, they are ultimately responsible for their curriculum development'.

Past reviews have found a number of shortcomings in the delivery of ECEC training, including training course timeframes that are too short to enable the development of sufficient skills and knowledge (ASQA 2015).

This creates substantial challenges for ECEC providers:

The vocational training framework that services the early learning sector is failing in its role to deliver an adequate pool of highly skilled graduates. Early learning services are struggling to find suitable, highly-skilled employees, and there is very little consultation between training providers (Registered Training Organisations (RTOs) and TAFE institutions) and the sector. The result is a monumental gap between professional development outcomes and employer expectations. (Australian Childcare Alliance 2019, pp. 1–2)

A lack of adequate training in child development, and in particular social and emotional development, makes identifying risk factors in children’s behaviour, and supporting their development, a challenging task. The extent of training should be commensurate with the level of qualification (given that ECEC staff hold a mix of qualification levels, from certificate III to 4-year university degrees); however, such training is important for all types of educators working in ECEC, so that they are able to identify risk factors and other concerns in their daily interactions with children.

Beyond pre-service training, there are no regulated professional development requirements for ECEC educators. However, many participate in a range of learning activities. Teachers are required to undertake professional development to maintain their registration (section 5.4). Many public and private training providers offer professional development courses to ECEC staff, but there is limited monitoring of their quality (Siraj et al. 2018). For services struggling to attract staff and comply with legislated child-to-educator ratios, it can be challenging to allow staff sufficient time to participate in professional development. This was reflected in the evaluation of KidsMatter Early Childhood, the national early childhood mental health promotion, prevention and early intervention initiative (which has recently been rolled into Be You).

[E]xpectations and opportunities for ongoing professional learning in many early childhood settings, such as long day care services, have traditionally not been regarded as fundamental aspects of child-care educators’ roles. Thus, the structures of many early childhood services do not have timetabled spaces for formal professional development.

Therefore, during the period of the [KidsMatter Early Childhood] initiative, professional learning was undertaken by most early childhood educators in their unpaid time, and as such, depended on their personal commitment and availability to participate. In other words, [KidsMatter Early Childhood] professional learning was an additional undertaking, unlike the situation in the school sector where professional learning is structured into the work life of the educator; to occur on ‘student-free’ days, or combined with staff meetings, or undertaken in personal time with time-off in lieu, and being recognised and documented in formal ways. (Slee et al. 2012, p. 42)

Such concerns are not only relevant to centres providing long day care; the lack of time and the need to arrange alternative care for children were barriers to family day care educators improving their knowledge of social and emotional development (Davis et al. 2015).

Improving ECEC capacity requires coordinated action from governments

Building the capacity of ECEC services and equipping educators with the necessary skills would require action from several parts of government.

First, strengthening the pre-service training of vocationally trained ECEC staff would require stronger regulatory oversight of the way courses are delivered. According to the Australian Childcare Alliance (2019, p. 14), ‘it remains unclear to the early learning sector which agency is ultimately responsible for ensuring that the course content and the course outcomes adequately meet the needs of the sector’. These broader issues are being addressed by the Productivity Commission’s review of the National Agreement for Skills and Workforce Development, with the final report due to government in late 2020.

Pre-service training for early childhood teachers should be in line with the national guidelines for teacher qualifications, to be developed by the Australian Institute for Teaching and School Leadership, and promote a better understanding of child social and emotional development (section 5.4 and Action 5.4 address the need to improve pre-service training for teachers).

Second, where this is not already occurring, State and Territory Governments should allocate funding to assist ECEC services to improve their ability to support the social and emotional wellbeing of young children. This includes professional development for staff and access to advice from mental health professionals.

As part of their NQF quality improvement plans, regulators have an expectation that ECEC services implement a range of professional development strategies, including those that ‘support educators’ responsiveness to each child’s specific requirements’ (ACECQA, sub. 673, p. 4). However, as outlined above, professional development in ECEC can be inconsistent.

Further, unlike teachers in schools, ECEC staff do not always have access to external qualified mental health staff, such as psychologists, to offer advice or respond to concerns. Some services have established their own networks, but these are ‘ad hoc’ (ACA, sub. 867), and in some jurisdictions, they can access advice from nurses or other professionals.²² However, not all services can access these supports.

Access to professional development and expert advice are particularly challenging for ECEC services, given their regulatory requirements and funding mechanisms. The Australian Childcare Alliance (sub. 867) argued that costs of such ‘additional responsibilities’ are likely to be passed onto families in the form of higher fees.

²² In South Australia, for example, nurses visit kindergartens and preschools to provide development checks (SA Health 2016). In Victoria, preschool field officers from the Department of Education are able to assist services providing funded kindergarten programs (VIC DET 2019a).

Some jurisdictions have already put in place funding packages to assist preschool²³ services in enhancing children’s social and emotional development prior to school (box 5.2 presents a Victorian example). All types of ECEC services should be able to apply for similar funding, which should be allocated on the basis of need. Such funding should be used to enable ECEC services that do not currently have access to advice from specialist mental health advice, to receive such advice when they need it.

In addition, ECEC services should be able to apply for funding to backfill staff who attend professional development on the social and emotional wellbeing of children (Action 5.5).

Box 5.2 Victoria’s school readiness funding initiative

The Victorian school readiness funding initiative commenced in 2019, with \$160 million allocated over 4 years. The funding is being rolled out to all kindergarten services (as preschools are known in Victoria) for three and four-year old children, including those delivered in long day care centres.

Funding is intended to support three priority areas: social and emotional wellbeing; language development; and access and inclusion. Kindergartens can get between \$1000 and \$200 000, depending on the number of children and their level of educational disadvantage (as reflected by parents’ education level and occupation) (VIC DET 2019c).

Kindergartens need to spend most of their funding on programs and services that have been pre-approved by the Department of Education and Training. These programs and services include, among others, allied health support (speech pathologists, psychologists and occupational therapists); programs to educate kindergarten staff and families about mental health and resources to improve the social and emotional wellbeing of children. The Department has also engaged allied health providers, to deliver support for children while they attend kindergarten or offer advice to services over the phone (VIC DET 2019b).

While these programs can promote the use of evidence-based tools, some stakeholders argue that kindergarten providers are not being given enough information to deliver improved outcomes (Triple P, sub. 859).

Early childhood interventions for vulnerable groups

One in ten preschool-aged children in Australia are exposed to multiple factors that put them at increased risk of mental illness in adulthood (Guy et al. 2016). Examples of risk factors include:

- poor physical health, particularly among children who spend a long time in hospitals (Brigid Jordan, sub. 830)
- personal trauma, experienced either by the child or by a family member (Mental Health Australia, sub. 407)

²³ The educational program in the year before children start school is known as preschool in New South Wales, South Australia, the Northern Territory and the ACT. In Victoria, Queensland, Western Australia and Tasmania, it is referred to as kindergarten.

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- socio-economic disadvantage (Centre for Excellence in Child and Family Welfare, sub. 211)
 - lack of access to services, for example, for children living in remote areas (RFW, sub. 323)
 - being in out of home care or in the child protection system, and in particular Aboriginal and Torres Strait Islander children in out of home care (PACYPC, sub. 291; SNAICC, sub. 123; Victorian Aboriginal Children and Young People's Alliance, sub. 240).

For some children, these factors compound to put them at risk of severe mental illness. For example, Aboriginal and Torres Strait Islander children in remote communities are often affected by entrenched disadvantage, exposure to trauma and poor physical health. By the age of 3, Aboriginal and Torres Strait Islander children tend to have higher rates of social and emotional difficulties, compared with other children, and the gap continues to expand as children grow (Baxter 2013). The Productivity Commission's roundtable on Indigenous mental health in urban areas was strongly of the view that supporting the social and emotional development of Aboriginal and Torres Strait Islander children in both urban and regional areas can contribute to better mental health outcomes into adulthood. Governments and communities have put in place a range of interventions, which have achieved some progress, but Aboriginal and Torres Strait Islander children are still more likely to be developmentally vulnerable than other children (NSW Government 2018b).

Some of these risk factors can be ameliorated through early intervention. Numerous studies and trials have shown that early intervention for vulnerable children can significantly improve outcomes (Sandler et al. 2014). Early intervention usually takes the form of integrated education and therapeutic services, delivered by skilled staff. For example, one such program in Victoria for highly vulnerable preschool children employs experienced educators, an infant mental health consultant and family support workers (Jordan et al. 2014). An evaluation of the program has shown positive outcomes for both child and parental mental health (Tseng et al. 2019). The research team running the program is developing ways to scale up delivery, so that the program's reach can be expanded (Brigid Jordan, sub. 830).

Nonetheless, such programs are not widely available, due to funding shortages, a lack of services, limited coordination, poor tailoring of service provision to local circumstances and other problems. As a result, some children and families receive services that are much less intensive than what is needed (Emerging Minds, sub. 455). More commonly, however, vulnerable children, and in particular infants and young children, access no health services at all (Guy et al. 2016).

Vulnerable children are increasingly attending ECEC services and preschools (SCRGSP 2020a). While this makes ECEC a potential avenue for supporting the social and emotional development of these children, those who experience extreme adversity would require extensive specialised support from a range of services, and access to trauma-informed teaching practices (Berry Street, sub. 366; Brigid Jordan, sub. 830; Jeff Borland and Yi-Ping Tseng, sub. 792; Leonie Segal and Jackie Amos, sub. 468). For some vulnerable children, strengthening the skill sets of all ECEC

staff as well as offering additional support to all ECEC services (Actions 5.2 and 5.4) may aid an improvement in social and emotional wellbeing.

Beyond ECEC services, a holistic response, across multiple departments and agencies, is required to support the mental health and wellbeing of vulnerable children. Governments can address barriers to treatment by establishing accessible support services in the community and effective gateways and pathways within the mental healthcare system (chapters 10 and 12). Children facing multiple risk factors associated with a family member having a severe mental illness would benefit from coordinated interventions — the Productivity Commission’s recommended care coordinator model is described in chapter 15 and family therapies are discussed in chapter 18.

ACTION 5.2 — SOCIAL AND EMOTIONAL DEVELOPMENT IN PRESCHOOL CHILDREN

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

Start now

- State and Territory Governments should use existing guidelines to expand the scope of voluntary early childhood health checks, such that they assess children’s social and emotional development before they enter preschool.
- State and Territory Governments should provide funding to enhance the ability of early childhood education and care services to support the social and emotional development of children. This funding should be allocated based on demonstrated need, and services should be required to demonstrate better practices through their quality improvement plan. Services should be able to use funds to:
 - enable staff to attend accredited professional development (including paying for backfilling)
 - access support and advice from qualified mental health professionals.

Start later

- State and Territory Governments should expand the provision of parent education programs through a range of channels, including online platforms and child and family health centres.

5.3 Supporting children and young people during their school years

For many people, the signs of mental illness first emerge during their school years, but their symptoms can go untreated for long periods of time. Parents, and the community as a whole, are often poorly informed about mental health and this can contribute to delays in seeking help for their children and family.

[O]nly a third of Australian parents are confident they could recognise the signs of a mental health problem in their child, with a further third of parents believing a child's mental health problems might be best left alone to work themselves out over time. Less than half of parents (44%) reported being confident they would know where to go for help if their child was experiencing social, emotional or behavioural difficulties. (David Coghill, Jemimah Ride and Kim Dalziel, sub. 236, p. 8)

Submissions to this Inquiry emphasised the need to provide support and education to parents of children of all ages, from birth through to early adulthood (for example, Connect Health & Community, sub. 94; QFCC, sub. 85). Beyond teaching parents practical strategies to deal with unexpected challenges they may face, education programs can raise their awareness of the early symptoms of mental illness.

Parenting support is a highly complex question for policy makers, and one where government intervention has only a very short history. Nonetheless, there is strong evidence to suggest that well-designed programs can help parents in understanding and guiding their children's behaviour, and supporting their social and emotional development (Parenting Research Centre 2017). Particularly for mental health, the ability of parents to identify emerging issues, seek help and access it easily when it is needed, can make a substantial difference for children's wellbeing. This can lead to quantifiable cost savings, through lower healthcare costs for children and higher productivity for parents. These cost savings, as they apply to a parenting intervention for the prevention of anxiety disorders in children, have been quantified recently, in a research project commissioned by the NMHC (2019c).²⁴ Using this approach, the Productivity Commission estimated that a similar intervention could result in 385-703 disability-adjusted life years (DALYs) averted (appendix K).

Support programs for parents, partly or fully subsidised by governments, is offered by:

- healthcare providers (doctors, nurses, Aboriginal Health Workers and peer workers employed in the health system – family interventions are discussed in more detail in chapter 18)
- non-healthcare services, including community organisations, ECEC services and schools. For example, the New South Wales Departments of Health and Education cooperate to deliver early intervention for emerging conduct problems in young children through their school, including offering support to parents (NSW Government, sub. 551)
- phone lines such as parentline (although their availability differs by jurisdiction (eMHprac 2019b)) and online support (ReachOut, sub. 804)
- parenting classes such as the Positive Parenting Program (Triple P, sub. 859) and many others.

²⁴ The study for the National Mental Health Commission analysed the expected costs incurred in delivering a parenting intervention for the prevention of anxiety disorders in children. The intervention included screening for anxiety disorders in preschool children, and group-based education sessions for parents whose children were identified as being at risk. The program was found to cost \$3.7 million, but save \$8.3 million, as it reduced children's use of health services and the number of working days missed by parents as a result of their children's disorder (NMHC 2019c).

Parenting support services often find it difficult to engage the families who need them most. Past evaluations have pointed to various strategies that can increase the engagement of highly vulnerable families, such as outreach and service collaboration. The success of these strategies can be hampered by poor policy design, including short funding cycles that contribute to staffing shortages (Cortis, Katz and Patulny 2009). There are also gaps in services available, for example for parents of children with conduct disorders and those with an intellectual disability and mental illness (Mark Porter, sub. 331; Name withheld, sub. 81).

Governments should make better use of existing channels to increase the provision of evidence-based support and education programs for parents. State and Territory Governments should expand the provision of evidence-based group parenting programs for parents of school-aged children, delivered through schools and community centres. The Australian Government should expand the provision of evidence-based online parenting programs, and increase community and health professionals' awareness of such resources.

The role of schools is changing in line with community expectations

As children grow, the role of the education system in their lives becomes paramount. But this role has evolved over time.

There is a community expectation that early childhood and child care institutions, schools, universities and vocational education and training providers play a role in responding to social issues, including student mental health. (Australian Government Department of Education, pers. comm., 21 August 2019)

Schools are well placed to respond to community expectations, given that:

- nearly all children and young people attend school, meaning that interventions delivered through the education system have significant reach (ReachOut, sub. 220)
- implementing interventions through schools to support mental health and wellbeing improves student outcomes (Durlak et al. 2011)
- the mental health and wellbeing of students has a substantial effect on their academic learning outcomes and the classroom environment (Goodsell et al. 2017)
- schools can act as community hubs, bringing together families and services (NCOSS, sub. 143; Relationships Australia (National), sub. 103).

Schools contribute to the mental health of their students in four key ways. First, schools have long-established policies and practices to support the wellbeing of their students, in order to promote their learning and foster a positive school environment. These policies and practices can be implemented by school counsellors or psychologists, who have been working in Australian schools for many decades (Campbell and Glasheen 2017). Over time, many schools have adopted wellbeing policies that involve all teaching staff and other professionals beyond the school gates.

Second, schools are required to deliver a mental health and wellbeing curriculum to all their students, and support them through their schooling years. The Australian curriculum includes topics in personal, social and community health, from entry into school up to year 10, many of which are relevant to mental health and wellbeing.²⁵ While the topics covered are comprehensive and likely to support mental health and wellbeing, a major challenge for schools is the breadth of the curriculum and the extent of topics covered — this is discussed in detail in section 5.5.

Third, schools function as a gateway into the mental health system, as teachers or other school staff are often the first to raise concerns about children’s wellbeing (Lawrence et al. 2015). This gateway role is a difficult one, given the complexities of the mental health system and the gaps in services for young people. For example, according to the ACT Government (sub. 210, p. 21), ‘[w]hile there are significant supports in place for students in schools, it is often the referral pathways and linkages to clinical services that require further support’.

Finally, teachers and schools have a role to play in the recovery of children with mental illness — discussed in section 5.7.

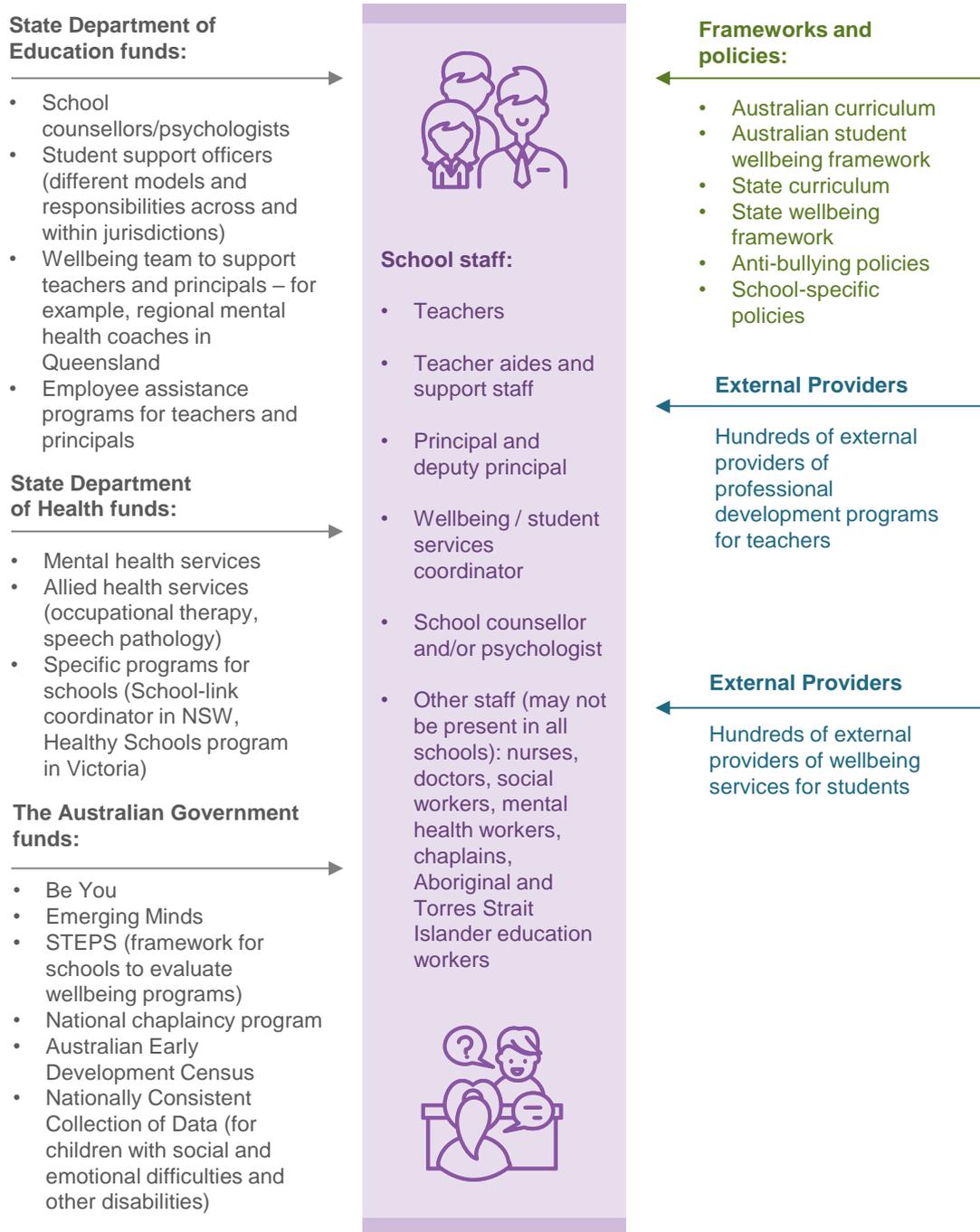
As the attention paid to mental health and wellbeing in the education system has increased, so too has the number of government policies and frameworks for the delivery of social and emotional wellbeing programs in schools (figure 5.1). The basic philosophy behind all policies is the same — intervening early to build capacity and prevent mental ill-health — but there is often limited coordination between them.

Mental health promotion programs contained within school settings are not consistent and planned at a State level, leaving schools and local services to plan and implement much of this without larger direction and support from the government. This results in unequal and unfair distribution of support and information for students, parents and teachers, and is based on the individual schools resources and capacity, not their need. ...

Currently, schools’ resourcing of mental wellbeing appears to be largely reactionary, without a lot of work being put in place for well-planned and structured prevention and early intervention models. (Connect Health & Community, sub. 94, pp. 14–5)

²⁵ For example, while children in years 1 and 2 are taught to ‘identify and practise emotional responses that account for own and others’ feelings’, those in years 9 and 10 ‘investigate how empathy and ethical decision making contribute to respectful relationships’ (ACARA 2015).

Figure 5.1 A crowded space — roles, responsibilities and policies in school wellbeing^a



^a The lists of programs and roles are not exhaustive.

In practice, schools need to navigate what has been described by stakeholders as a ‘crowded space’ of curricula, government programs, frameworks, service providers, community organisations and specialists of many kinds, and weave together an effective support system for their students (Bowles et al. 2017). This creates challenges for teachers and principals:

[E]ducators are overwhelmed by an explosion of new and existing mental health initiatives targeted at schools, ranging from meditation and mindfulness apps, peer and lived experience speakers and other wellbeing and mental health promotion programs. They are seeking simple, flexible resources that align with the curriculum and clearly fit within other mandated mental health and wellbeing strategies. (ReachOut Australia, sub. 220, p. 10)

In terms of challenges, teachers spoke of the time involved in reading and implementing policies and engaging with them in a meaningful way. They indicated how aspects of some policies can’t be taken up because they’re not practical or are vague in their instructions, and how difficulties are experienced when changes are continually made to policy or there are evident and persistent gaps. (Graham et al. 2014, p. 27)

Governments have put in place different initiatives over the years to support teachers in delivering mental health and wellbeing programs. The Australian Government’s current national initiatives are Be You (Beyond Blue, subs. 275, 877, box 5.3), which has various resources, from a directory of external programs to whole-of-school interventions; and Emerging Minds, aimed primarily at enhancing the skill sets of educators (subs. 455, 944, box 5.1). However, these initiatives do not address the fundamental issues that impede schools from making a measurable difference to mental health and wellbeing, including:

- the highly complex and overlapping set of policies and frameworks, at the Australian and State and Territory levels, with little articulation of clear goals or monitoring of outcomes
- inconsistent approaches to teacher pre-service training and professional development in mental health and wellbeing, coupled with numerous programs that schools can have difficulty choosing between
- incoherent pathways for children and families looking to access support in schools. There is a multitude of roles funded within schools to support students’ mental health and wellbeing — and yet, in some cases there are insufficient numbers of counsellors and psychologists, and their workload is at times unsustainable
- children with severe and complex mental illness and their families can find it very difficult to engage with the education system and find the right support. And there is insufficient support for children who have disengaged from education due to mental ill-health.

Our recommended reforms below aim to address each of these gaps — by creating a national commitment at the highest level to support students’ wellbeing, and putting in place practical policies to address the needs of students, teachers and principals.

Box 5.3 **Be You — the national mental health initiative for education providers**

Be You is the national mental health initiative for early childhood education and care (ECEC) centres and schools. Its establishment was part of the Australian Government's commitments following the 2014 National Mental Health Commission review, which identified duplication in prevention and promotion programs for children and young people.

Launched in 2018, Be You brings together professional development materials and other resources developed as part of previous initiatives dealing with various aspects of child mental health. Its online platform offers support to ECEC centres and schools in developing their own strategies and choosing suitable providers of wellbeing programs. It also employs consultants that assist ECEC centres and schools in creating and implementing wellbeing strategies, and following crises that affect the school community. An early evaluation of Be You found that feedback from users has generally been positive (Beyond Blue, pers. comm., 27 April 2020).

Participation in Be You is free and optional. About 3300 ECEC centres, 6400 schools and over 100 000 individual participants have joined the initiative (as at March 2020) (Beyond Blue, pers. comm., 27 April 2020). Be You remains one of 70 different programs that schools can choose from when looking to implement a mental health strategy (Mentally Healthy Workplace Alliance, sub. 209). For example, while the Department of Health funds Be You, the Department of Education has invested in the development of an online student wellbeing hub and the Australian Student Wellbeing Framework, which includes similar materials for educators, schools, parents and students (ESA 2019).

Beyond Blue (sub. 275, 877), which led the development of Be You, has argued that governments should extend its funding and adopt Be You as the overarching national mental health in education framework:

... having 'unscrambled the egg', it is now critical that governments invest in Be You for the long haul, avoiding unnecessary duplication and focussing investments on complementary initiatives. (sub. 275, p. 10)

Submissions to this Inquiry welcomed the development of Be You, but some stakeholders were cautious about challenges in rolling out the program across all schools.

The rollout of [Be You] may also present challenges for state and territory governments which have developed their own initiatives that aim to build the capacity of schools to respond to mental health issues. There needs to be careful consideration from this point forward to understand how jurisdictional governments can leverage from the Be You infrastructure, rather than compete or duplicate. (Orygen and headspace, sub. 204, p. 46)

Be You is a relatively new initiative and is yet to be evaluated. However, Be You acknowledge that the school mental health prevention space is crowded and often overwhelming for educators.

There is a growing evidence base that supports a more comprehensive approach to the prevention of mental illness in children and young people that should be used to build upon Be You. The school environment is essential but educators need to be supported to work collaboratively with psychologists within the school environment in order to better identify and target vulnerable young people and drive early intervention with students who have emerging mental health conditions. School-based strategies must be complemented by better support for parents and a focus on reducing the adverse childhood experiences that are strongly related to subsequent mental illness. (APS, sub. 543, p. 15)

The National School Reform Agreement should be updated to include wellbeing outcomes

Schools have a well-established role in teaching numeracy and literacy, with a relatively clear set of expectations and measurable outcomes. This is not always the case for wellbeing — while there is an increasing expectation that schools respond to mental health and wellbeing issues, there is limited clarity about the responsibilities of schools and the services they need to deliver or facilitate. Many surveys of wellbeing are run, but there is very little monitoring of the outcomes that wellbeing policies in schools achieve.

The need to support mental health and wellbeing is yet to be reflected in the high-level agreements between governments that determine the strategic direction of the education system. Wellbeing is not included in the outcomes, targets and measures of the National School Reform Agreement (box 5.4).

Box 5.4 National School Reform Agreement

The National School Reform Agreement is the most recent agreement between the Australian and State and Territory Governments that amends school funding arrangements and sets reform directions for the education system. These reform directions apply to both government and non-government schools. The Agreement commenced in 2019 and will expire in 2023.

The Agreement includes outcomes, targets and national measures to track the progress of the education system. The outcomes that governments have committed to include:

- academic achievement improves for all students;
- all students are engaged in their schooling; and
- students gain the skills they need to transition to further study and/or work and life success.

The Agreement also includes quantifiable targets, based on a range of national measures. For example, the target for engagement in schooling is to lift the Year 12 (or equivalent) or Certificate III attainment rate to 90% by 2020. Academic improvement is measured through various aspects of NAPLAN and the Programme for International Student Assessment.

Australian, State and Territory Government education ministers are responsible for overseeing the implementation of the Agreement. This includes reviewing various aspects of the education system and establishing a National Evidence Institute. The Agreement also includes reporting requirements, such as annual reports from State and Territories on progress towards targets, and a report from the Education Council on national policy initiatives.

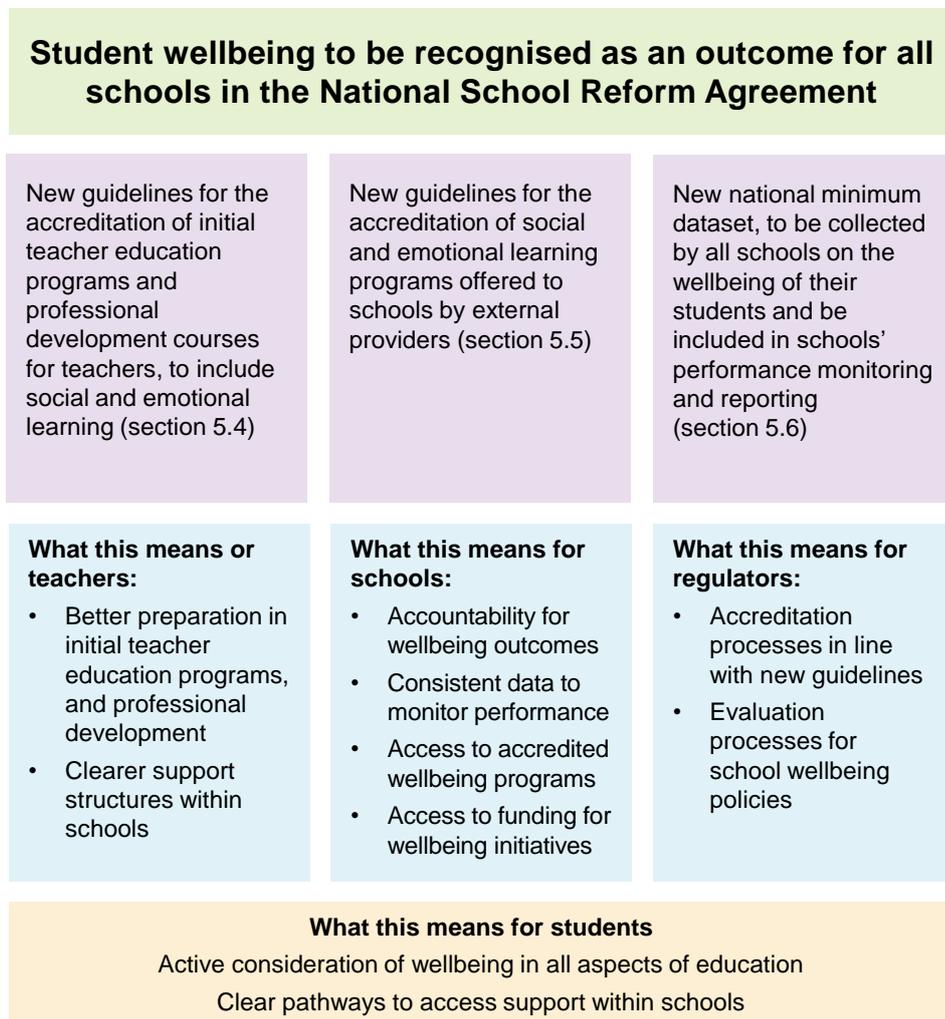
The National School Reform Agreement is underpinned by bilateral agreements between the Australian Government and each of the jurisdictions. These agreements detail specific funding arrangements and reform action undertaken in each jurisdiction to achieve agreed student outcomes.

Wellbeing does not form part of the Agreement's outcomes or reporting requirements. It states that 'the wellbeing of all students is fundamental to successful education outcomes' but does not include any other specific detail or direction.

Source: COAG 2018.

The Australian, State and Territory Governments should update the National School Reform Agreement, to include student wellbeing as an outcome of the education system (Action 5.3). The updated Agreement should include specific targets and measures that schools are expected to achieve — in line with the approach taken to other outcomes set for the education system. It should also mandate the collection of a national dataset to monitor changes in the wellbeing of students, as well as enable ongoing allocation of funding (figure 5.2). These changes should be reflected in the bilateral agreements that underpin the national agreement (box 5.4).

Figure 5.2 **A national agreement can facilitate better wellbeing outcomes**



To define a wellbeing outcome, an updated Agreement could build on the Alice Springs (Mparntwe) Education Declaration, which was developed by the COAG Education Council and sets out governments' vision for education in Australia. This vision includes an education system that would support all young Australians to become 'confident and creative individuals who ... have a sense of self-worth, self-awareness and personal identity that

enables them to manage their emotional, mental, cultural, spiritual and physical wellbeing' (Education Council 2019, p. 6).

In the National School Reform Agreement, this vision would need to be interpreted in the context of outcomes, targets and measures. One possible outcome for the agreement could be that all students gain the skills required to support their own wellbeing and are able to seek support when required. The target of such an outcome would be for all schools to implement evidence-based wellbeing policies and pathways, such that they can demonstrate improvements in wellbeing. Measures could include:

- nationally consistent indicators reflecting the wellbeing of students in all schools, including the proportion of students who access or who are offered assistance through their school and the outcomes of this support
- workforce skills, such as the proportion of teachers who undergo mental health and wellbeing training and the presence of mental health professionals in schools
- the proportion of schools evaluated by jurisdictions to have effective wellbeing policies.

Achieving improvements in student wellbeing within Australian schools depends on two main factors: teaching practice, which is supported by professional development and collaboration, and school leadership that promotes continuous improvement and a positive school culture. At the system level, accountability and evaluation based on national data collections can contribute to improvements across all school outcomes (Deloitte Access Economics 2017). Therefore, any policy gaps that affect these factors need to be addressed in order to achieve future wellbeing outcomes in an updated National School Reform Agreement.

Such policy gaps should be addressed through new national guidelines and policies, including:

- guidelines for the accreditation of initial teacher education programs and professional development courses for teachers, which must include social and emotional learning (section 5.4)
- similar guidelines for the accreditation of social and emotional learning programs offered to schools by external providers (section 5.5)
- a nationally consistent minimum dataset, to be collected by all schools on the wellbeing of their students. Data collected should also be included in schools' performance monitoring and reporting (the development of a nationally consistent minimum dataset is discussed in detail in section 5.6).

Education ministers should also take an active part in the recommended new Special Purpose Mental Health Council, to develop clear boundaries around the roles of schools in promoting mental health, and to coordinate the implementation of mental ill-health prevention policy (chapter 22, Action 22.2).

Funding mechanisms to support wellbeing initiatives

Under an updated Agreement, all schools would need to undertake additional data collection and evaluation processes, to monitor and report performance against outcomes; departments of education in all jurisdictions would work with schools to identify best practice and support those schools that are facing challenges. These processes are discussed in more detail in section 5.5.

Additional funding is likely to be required for schools to implement these new processes. This should take the form of a grant program that schools can apply for. The specific size of the grants program depends on existing expenditure.

Understanding current expenditure, as well as the outcomes that this expenditure achieves, should be the first step towards determining the size of any funding gap. The Australian, State and Territory Governments all dedicate substantial funding to wellbeing programs, mostly through grants programs, which have different eligibility criteria and can be used in different ways. For example, the NSW Government has allocated more than \$290 million since 2015 to support mental health and wellbeing in schools (State and Territory Governments Survey). Some jurisdictions do not account separately for their wellbeing interventions, and as such, have been unable to provide this Inquiry with overall expenditure figures.

Departments of education also fund the employment of a range of mental health professionals — in Victoria, for example, over 1500 mental health professionals work in government schools. Schools also use their own budgets to invest in wellbeing interventions and to employ additional staff if required (State and Territory Governments Survey).

All these resources would continue to be used to achieve the wellbeing outcomes that would be included in the National School Reform Agreement. In addition, using the limited data available on existing expenditure, the Productivity Commission estimates that additional funding of up to \$150 million a year may be required to support schools. Total funding (including existing budget allocations, where these can be identified) is estimated at \$230 million per year (appendix K). The improved monitoring and evaluation of school processes should lead to better allocation of funding to the schools that would benefit from it most.

To streamline funding processes, and address some of the difficulties that schools are experiencing in the current system, any new and existing grants intended to support wellbeing outcomes should be amalgamated to form one fund in each jurisdiction. Similarly, all Australian Government grants programs that support wellbeing could be amalgamated into one, to give better visibility and accountability over the money invested. All schools — both in the government and non-government sector — would be able to apply to receive funding for their wellbeing initiatives, which would be granted based on need and the ability of the school community to contribute. Data collected by the school should form part of this process, to demonstrate the need for specific interventions or additional staff members. The fund should also require schools to continue to report on how money is spent and what outcomes are achieved.

Other recommended reforms detailed below would carry their own specific costs, although most are likely to require governments to shift their focus to improving current efforts, rather than invest in additional functions. For example, the costs required to improve teachers' knowledge of child social and emotional development (Action 5.4) are likely to be relatively low. These improvements would require some change to regulators' activities, but can be achieved through existing legislated standards for initial teacher education and requirements for ongoing professional development.

Quantifying the benefits of recommended reforms

Updating the National School Reform Agreement, and subsequent actions to achieve improved wellbeing outcomes across the education system, are likely to lead to substantial benefits.

The most immediate benefit for children and young people is likely to be improved educational attainment, as students come to schools ready to learn and teachers have more tools for effective practice. There is a substantial body of evidence showing that school-based programs to improve mental health and wellbeing lead to a range of positive outcomes, including better academic achievements (Durlak et al. 2011). These positive effects are likely to persist for up to four years after the programs have been delivered (Taylor et al. 2017). Better mental health is also likely to reduce the risk of children disengaging from their education, given the strong link between mental ill-health and disengagement from school (Watterston and O'Connell 2019). Improved educational achievement and engagement will have long-term effects on the labour market outcomes of children and young people, when they eventually start working.

Using past research done in Australia and overseas, the Productivity Commission has estimated the possible effects of this Inquiry's recommendations on educational achievement, as measured by NAPLAN results. Improving the capacity of the education system to support students' mental health and wellbeing is likely to result in an average improvement in NAPLAN results of around 0.01 standard deviations for reading and writing and 0.005 standard deviations for spelling and numeracy (appendix K). In practice, this would result in an improvement of about one point in the average NAPLAN results across the population.²⁶ This may seem like a small number, but mean NAPLAN results tend to vary by only one to five points year on year (ACARA 2019).²⁷ In other words, a small average improvement in wellbeing across all children could result in a significant improvement in educational achievement for the population.

²⁶ Khanam and Nghiem (2018) report standard deviations of 95.09 points in NAPLAN reading results. Therefore, a 0.01 change would equal 0.95 points.

²⁷ For example, between 2018 and 2019, mean NAPLAN scores declined by 1.6, 3.2 and 2.8 points respectively for students in year 3, 5, and 9, and improved by 4.1 points for students in year 7 (ACARA 2019).

Improving the ability of the education system to support the wellbeing of children and young people is also very likely to reduce mental ill-health (Sandler et al. 2014). The Productivity Commission has modelled the expected increase in quality-adjusted life years (QALYs), which would result from better mental health across the student population. Results show an expected increase of 28 620 to 52 110 in the number of QALYs across the population, the largest expected benefit of all recommendations modelled. This implies a very significant reduction in the amount of time children and young people are affected by mental illness and the severity of that illness, and an increase in wellbeing across the population. This reduction in mental illness and improvement in wellbeing comes at a relatively low cost to governments — meaning that the recommendations pertaining to the education system are likely to be cost effective (appendix K).

ACTION 5.3 — WELLBEING IN THE EDUCATION SYSTEM

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

Start now

The Australian, State and Territory Governments should update the National School Reform Agreement, to include improvements in student wellbeing as one of its outcomes.

In line with other outcomes, the Agreement should include specific targets and measures of student wellbeing that the education system should work towards.

To support the implementation of a national student wellbeing outcome, Governments should develop or commission the development of:

- a nationally consistent minimum dataset, to be collected by all schools on the wellbeing of their students and be included in schools' performance monitoring and reporting (Action 5.7)
- guidelines for the accreditation of initial teacher education programs and professional development courses for teachers, which must include social and emotional learning (Action 5.4)
- guidelines for the accreditation of social and emotional learning programs offered to schools by external providers. (Action 5.5)

5.4 Building the skill sets of all teachers

The expectation that schools play an increasingly large role in supporting the social and emotional wellbeing of students has imposed new demands on teachers.

[T]here is a growing body of evidence that teachers feel overloaded with the demands of the curriculum, and the expectation they solve and manage social and emotional issues of students in partnership with families. (Australin Government Department of Education, pers. comm., 21 August 2019)

Even for those not directly involved in teaching social and emotional learning (SEL) programs, the whole-of-school approaches to student wellbeing require them to be equipped with potentially new skills to identify and respond to students' mental health needs.

The need to improve teacher training in student mental health was raised by numerous participants in this Inquiry.²⁸ This relatively new aspect of teachers' professional practice has required adjustments to what pre-service teachers learn in their degrees, as well as to the ongoing professional development programs undertaken by qualified teachers. The extent to which this has succeeded in giving teachers the tools they need is variable — and this can have very serious implications for the mental health of students:

[W]hile there is currently a strong desire for [teaching] staff to be able to identify and respond to students' mental health and wellbeing needs in the school setting, in practice most staff are not adequately skilled or trained to do this work, nor do they have adequate time. (Centre for Multicultural Youth (CMY) & the Multicultural Youth Advocacy Network (MYAN) Australia, sub. 446, p. 21)

The teachers' lack of understanding of mental health and their inability to recognise that something was wrong significantly set me back educationally. The scarcity of people that I could talk to about this issue, especially when I was transitioning to high school, made me feel like nobody cared. Essentially, I felt like nobody gave a sh#*.

I believe it is important that teachers are trained to recognise kids with mental health and also to actually be able to talk to them and be helpful. To give kids a platform where they can communicate is important because they feel like nobody cares about their issues. When teachers shame you, whether intentionally or unintentionally, by picking you out of the crowd, it makes you feel worthless. – Anon, 16 years (Youth Mental Health – North Metropolitan Health Service, sub. 99, p. 15)

²⁸ Centre for Multicultural Youth (CMY) & the Multicultural Youth Advocacy Network (MYAN) Australia, sub. 446; CHF, sub. 496; KYDS Youth development Service, sub. 166; Mental Health Coalition of South Australia (MHCSA) and the Lived Experience Leadership & Advocacy Network (LELAN), sub. 360; Mental Health First Aid Australia, sub. 224; MHCC ACT, sub. 517; Merri Health, sub. 120; Name withheld, subs. 16, 98; RRMH, sub. 97; Samaritans Foundation, sub. 121; VCOSS, sub. 478; Victorian Government, sub. 483; Wesley Mission, sub. 840; Youth Mental Health – North Metropolitan Health Services, sub. 99.

Pre-service teachers

In all jurisdictions, teachers must complete an accredited initial teacher education (ITE) program, and then gain and maintain their registration in order to work in schools (AITSL 2018).

Since 2011, all jurisdictions have been working towards the implementation of a nationally consistent approach to teacher registration. This has seen the introduction of the Australian Professional Standards for Teachers, as well as national standards for the accreditation of ITE programs, both developed by the Australian Institute for Teaching and School Leadership (AITSL), and agreed to by the COAG Education Council (AITSL 2018, 2019). The standards are broad, and include requirements that can form the basis of specific learning on social and emotional wellbeing. For example, ITE programs must ensure that graduates ‘demonstrate knowledge and understanding of physical, social and intellectual development and characteristics of students and how these may affect learning’ and ‘demonstrate knowledge and understanding of strategies for differentiating teaching to meet the specific learning needs of students across the full range of abilities’ (AITSL 2011, pp. 10–11).

The accreditation of courses remains a State and Territory responsibility, carried out by the teacher regulatory authority in each jurisdiction. In addition to the national standards, some jurisdictional teacher regulatory bodies have other requirements that providers must fulfil. For example, in New South Wales, the Education Standards Authority explicitly requires that pre-service teachers complete studies in child and adolescent mental health (NSW Education Standards Authority 2018).

A recent evaluation of the transition towards national teacher registration has found that there remain variations in how standards are interpreted in different jurisdictions (AITSL 2018). The national standards are open for interpretation in the way they are applied to educating pre-service teachers on mental health, and, as a result, course quality can differ across institutions.

The particular interest of one university lecturer seemed to determine what was provided in terms of MH [mental health], which was delivered in the margins of the main programme of study and varied widely in its form (what and how much specific education about child and adolescent MH pre-service teachers received). The identified lack of resourcing and institutional status given to MH provision ... implies an urgent need for change. Given the increasing policy emphasis on school-based identification and support of children and young people with MH issues, it is essential that teachers entering the profession have the skills, knowledge and confidence for effective practice with all students. (Armstrong, Macleod and Brough 2019, p. 7)

Teachers’ professional development

In order to maintain their registration, teachers must complete 20 hours of professional development activities each year (AITSL 2018). For registered teachers, these hours of professional development offer an opportunity to expand their knowledge of mental health.

The specific choices of professional development activities are up to the individual teacher, in consultation with their employer. Given the increasing attention paid to mental health issues in the education system, many teachers undertake professional development in this area, but it is not available to all (AEU NSW Teachers Federation, sub. 305).

There are many professional development programs to choose from, some developed with government funding and available freely online (such as those developed by Be You, box 5.3) and others offered by private providers. School principals and teachers may find choosing the most suitable, evidence-based program a significant challenge. Many rely on word-of-mouth recommendations or independent research. There is a risk that some program choices are influenced by ‘fashions and fads’ (Healthy Minds Education and Training, sub. 298, p. 11).

In some jurisdictions, such as the ACT, teacher regulatory bodies accredit professional development programs for teachers that include content in line with the school curriculum.²⁹ In some States and Territories, departments review programs that are offered to teachers in government schools (for example, NSW Auditor-General 2019). In addition, Be You (2019a) has developed an online directory for professional development as well as programs for students, which it has assessed as being evidence-based.

A national policy to support better teacher training and professional development

All teachers need a clear understanding of child and adolescent social and emotional development to allow them to respond effectively to the needs of children who are at risk of mental illness, as well as the daily challenges of the classroom, such as addressing bullying behaviour (Whitley, Smith and Vaillancourt 2012).

Improving pre-service teachers’ skills in this area can be achieved through the existing national standards for accreditation of ITE programs, by developing specific guidelines on social and emotional development and mental health. Guidelines should require that all programs include explicit instruction in child and adolescent social and emotional development, practical tools to support students’ mental health (including understanding the needs of children affected by trauma) and referral pathways to services when required. These requirements should apply to all ITE programs, including early childhood education.

There are different possible approaches to developing these guidelines. Governments can choose to adopt the guidelines used in a specific jurisdiction (for example, the NSW requirement that ITE programs include a mental health component) and implement those on a national scale. Or, it can task the AITSL with developing these guidelines, which would be closely aligned to the teaching standards that are the responsibility of the AITSL.

²⁹ In the ACT, teachers must undertake at least 5 hours of professional development programs accredited by the Teacher Quality Institute, as part of their required 20 hours of professional development per year (ACT Teacher Quality Institute 2017).

Alternatively, governments may choose to establish a new advisory body that would specialise in social and emotional learning.

Given the AITSL's existing role as the body responsible for setting the national standards for the teaching profession, there is benefit in tasking it with the development of the guidelines for accrediting ITE programs, provided they are clear and unambiguous. This process mirrors current approaches to quality improvements in the teaching profession, where AITSL develops the national standards, and these are implemented by the jurisdictional teacher regulatory authorities. The AITSL should also evaluate the way jurisdictional authorities implement its guidelines (similarly to past evaluations of the implementation of teaching standards) to promote national consistency.

A more structured approach to professional development is also required, to ensure teachers continue to develop the skills to support student mental health and wellbeing. First, teacher regulatory authorities should require that teachers devote time each year to building their skills and knowledge in mental health. Second, where this does not already occur, wellbeing professional development programs should be required to gain accreditation from the jurisdictional teacher regulatory authority; accreditation would only be available for programs that demonstrate their evidence base and their compatibility with the curriculum.

Similarly to ITE, accreditation processes should be based on national guidelines, to promote consistency across education systems. Such guidelines could be based on the approach taken by the ACT, or developed by an independent panel of experts. Only professional development undertaken with accredited providers should be recognised for the purposes of teacher registration. The costs of the accreditation system can be recouped through fees paid by applicants (where these are private providers). As the guidelines would apply nationally, this should allow for mutual recognition of accreditation, and remove the need for national programs to be accredited separately in different jurisdictions.

Improving teachers' skills, through ITE and professional development, is likely to have benefits for students' wellbeing. However, it is not intended to negate the need for specialised mental health workers within the education system (section 5.5).

Teachers' own mental health can be affected when they find themselves in complex situations arising from their students' mental health challenges (KYDS Youth Development Services, sub. 166). Teachers, principals and other staff in the education system often face substantial difficulties and time pressures in their roles (APACS, sub. 419; AEU NSW Teachers Federation, sub. 305). Their own wellbeing can be compromised as a result, and it is the responsibility of employers to support them. Some of this support can come from additional professional development in areas such as self-care, or offering debriefing sessions. The issue of mental health in the workplace is discussed in detail in chapter 7.

ACTION 5.4 — IMPROVING TEACHERS' SKILL SETS

Start later

State and Territory teacher regulatory authorities should accredit initial teacher education programs and professional development programs for teachers, using national guidelines (Action 5.3). Ongoing learning on child social and emotional development and wellbeing should form part of professional development requirements for all teachers. This should include the social and emotional wellbeing of Aboriginal and Torres Strait Islander children.

5.5 Supporting schools to promote wellbeing

Addressing the curriculum requirements and responding to the needs of students and families has prompted many schools to create detailed programs for SEL, and build wellbeing teams, which comprise teachers and other staff, charged with implementing a whole-of-school approach (VAGO 2010). Some have developed wellbeing hubs, offering students a range of services (NCOSS, sub. 143). Many others have written specific policies to deal with issues such as bullying (although stakeholders have suggested that a broader, community-based approach is needed (AUARA, sub. 431) — bullying is discussed in more detail in appendix E). Some schools also engage with external providers to deliver a range of mental health programs, including suicide prevention (chapter 9).

Whole-of-school approaches to mental health and wellbeing can be very effective when they become an integral part of the way the school operates. However, submissions indicate there are many barriers to success (box 5.5).

This is partly because there is currently no consistent assessment of the quality or effectiveness of the multitude of programs offered to or delivered in schools (CMHR, sub. 148). School principals and wellbeing staff have no source of reliable advice and information when designing their policies. While there have been some examples of jurisdictional departments of education reviewing the quality of programs offered (for example, NSW Auditor-General 2019), there is no consistent approach to accreditation of SEL programs.

State or Territory departments of education should accredit all SEL programs offered by external providers for delivery in schools. To be accredited, providers must demonstrate their programs are based on evidence. To ensure consistent implementation of accreditation processes, they should follow national guidelines. Such guidelines could be developed by an expert advisory panel commissioned by governments; alternatively, governments may choose to endorse one of several existing frameworks — one example is the STEPS framework that assists schools to select evidence-based anti-bullying programs. The STEPS framework was developed by the Safe and Supportive School Communities Working Group, which includes representatives from all Australian educational authorities (SSSC 2019).

Box 5.5 Poor uptake, ineffective implementation — Inquiry participants' views on whole-of-school wellbeing programs

VicHealth and partners (sub. 131, pp. 23–4):

While Australia is making reasonable use of schools as a setting for prevention there is scope for improvement with respect to reach, adoption, program fidelity (for classroom-based programs), parent engagement, and monitoring and evaluation. Not all schools use available programs or use them in ways that maximise their benefits. This in part reflects varying levels of engagement/commitment to health/mental health promotion within schools, the confidence of teachers to deliver the initiatives, particularly some of the more specialised classroom-based programs, and more importantly, time and resource constraints. Schools and their staff are doing an excellent job of promoting student wellbeing within the limited time and resources they have available. Additional resourcing coupled with dedicated health promotion/mental health promotion personnel in schools would substantially increase the likelihood that these initiatives are adopted fully, with greater fidelity and in a more integrated fashion. Insufficient monitoring and evaluation of programs, in particular tracking of their impact on risk and protective factors and on student-level outcomes, is also a major problem. Improved tracking of these metrics would enable funders to better assess whether these investments are producing the desired results, or whether they need to be strengthened, and how.

Office of the Commissioner for Children and Young People WA (sub. 311, p. 21):

The most effective mental health interventions and supports occur as part of a whole-of-school approach to mental health and wellbeing, which includes support for individual students, whole-of-school programs, staff training and capacity building, and student-specific programs developed to establish peer support. There are a range of mental health programs in place in schools across Western Australia, many of which have a strong evidence base behind them. However, there is often poor and ad hoc uptake, inconsistent messaging about benefits of programs and need, and a huge number of initiatives for schools to choose from. Often programs and activities are delivered once-off to teachers or students, rather than being embedded as part of the principles and functions of our education system. Many of these initiatives also lack any comprehensive longitudinal evaluation, either because the measurement of outcomes is not established or because the initiatives are not sustained over time, making it difficult to determine which of these are most effective in improving outcomes.

Black Dog Institute (sub. 306, p. 7):

Our current approaches to school-based prevention have focussed on making schools mentally healthy rather than focussing a set of programs across primary and secondary school which are directed at the individual child. We also see that our current school prevention programs are directed through school counsellors, who struggle with demand, and who essentially offer reactive rather than proactive approaches.

Associated problems include:

- Schools struggle with lack of clarity about which individual programs to use;
- There is lack of information about which programs work best in the Australian environment;
- Often programs which might be effective in high schools are expensive (or considered expensive). There are difficulties timetabling prevention programs; very little training available to teachers or others to implement programs; poor fidelity to potentially useful programs and teaching training may not be sustainable because of high staff turnover;
- Increasing demand on school counselling services (where they exist) are high, once issues have been identified; and
- Over-reliance on school wide approaches which do not target individual mental health prevention. It is known that specific programs that target individual mental health for anxiety, depression, acting out, suicide, stigma reduction managed across Kindergarten to Year 12 are effective ... but not put into practice.

In addition, departments should use wellbeing outcome measures (section 5.6) to evaluate all external programs, and only continue to accredit those that deliver measureable improvements. To minimise additional costs to government budgets, accreditation processes should be funded through fees imposed on program providers who choose to apply.

ACTION 5.5 — ACCREDITING SOCIAL AND EMOTIONAL PROGRAMS IN SCHOOLS

Social and emotional wellbeing programs delivered in schools should be based on rigorous evidence and have the ability to demonstrate improvement in student wellbeing outcomes.

Start now

To support the implementation of a national student wellbeing outcome, Governments should develop guidelines for the accreditation of social and emotional learning programs offered to schools by external providers.

Start later

State and Territory Government departments of education should accredit social and emotional learning programs delivered in schools, using national guidelines (Action 5.3).

Blurred responsibilities, insufficient resources — the challenges for schools implementing wellbeing policies

While all teachers need a broad understanding of social and emotional development and tools to support their students, this does not replace the need for specialised wellbeing and mental health staff in the education system.

Schools need properly qualified mental health professionals (psychologists, social workers and mental health nurses) to work with students and families. Teachers need more education and support in identifying and supporting students with mental health issues – but they should not be expected to take the place of a mental health professional. (MHCC ACT, sub. 517, p. 24)

Depending on the jurisdiction, school-based mental health and wellbeing staff can include school counsellors and/or psychologists, social workers, wellbeing officers, mental health workers, youth workers, peer workers, chaplains, wellbeing coordinators, school nurses and others (for example, Tasmanian Government, sub. 498) (figure 5.1). However, in all jurisdictions, various factors limit the ability of staff to improve student outcomes, including:

- blurred responsibilities and a lack of coordinated service delivery within schools
- insufficient services to respond to need
- overlapping responsibilities for policy and funding.

Unclear roles and responsibilities complicate service delivery

The range of professions involved in supporting children and young people's wellbeing in schools, their skill sets, responsibilities and titles vary considerably between institutions — for example, a school psychologist can also be known as a guidance officer or a school counsellor (APACS, sub. 419). Each jurisdiction has different definitions of the role and different qualification requirements for school psychologists working in government schools. In New South Wales, Queensland and Western Australia, they require both teaching and psychology qualifications, while in other jurisdictions, a psychology degree is sufficient (Faulkner and Jimerson 2017).

The model of service delivery also differs between jurisdictions and education sectors, with some psychologists being school-based and servicing single government schools while others work from regional offices. Non-government (independent or catholic) schools may employ psychologists or allow them to see clients on school grounds. Jurisdictions also have different approaches to the employment of school nurses, and their role in supporting students' mental health (ANMF, sub. 317; NSWNMA, sub. 246; QNMU, sub. 229).

A recent audit of the wellbeing services offered in NSW government secondary schools found a lack of clarity about the roles of the various professionals contributing to these services and the overall service model that schools should use. In one case, a school worked with more than 13 separate programs and 31 agencies to coordinate the delivery of their wellbeing services (NSW Auditor-General 2019). The possible overlap in responsibilities, as well as the sheer number of different staff involved, can lead to unclear pathways for students and families who need support, weaker accountability and poorer outcomes. Coordination between service providers, particularly when it involves school-based education professionals and community-based healthcare providers, can be challenging (Weist and Mellin 2012).

Insufficient professional services to respond to need

Depending on students' individual needs, in-school support services can initially be delivered by a range of professions — counsellors, social workers, school nurses. A school psychologist (who may work across more than one school) can be the next step in a student's pathway, once counselling provided by other professions has established the need for psychology services or more comprehensive assessment. School psychologists have extensive skills and are able to provide services to students, support teachers and assist with the implementation of whole-of-school prevention programs. The focus of their role, however, tends to be psychological and educational assessments (APS 2018b).

There are substantial differences in the ratios of psychologists to students in government schools. Information provided to the Productivity Commission on ratios ranged from 1:885 in Western Australia to 1:3090 in the Northern Territory. All fall short of the recommendation of the Australian Psychological Society, of 1:500 (APS, sub. 543).

A number of submissions described shortages of services, and their implications for service quality and accessibility.

Whilst many schools have psychologists and student wellbeing workers, these positions are often small in number, and do not have adequate resources to be able to provide an individualised response or support to each child or young person experiencing challenges within the school. (Office of the Commissioner for Children and Young People WA, sub. 311, p. 21)

[D]ue to heavy workloads and time constraints [school psychologists'] work is often reactive rather than proactive. Similarly, the demand for assessment services within schools (often linked to funding) tends to override the development of systemic and preventative practices. (APS, sub. 543, p. 16)

Where services do exist, submissions pointed to substantial barriers to access for students.

The Victorian Government has already proposed to place more mental health practitioners in schools. MHYF Vic does not think this will be efficient because the counsellor's office door is a threshold of stigma. ... [The] counsellor is in a position of structural conflict of interest within the school and within the family of the student. We are sure that some school counsellors manage the problems of conflict of interest well, but this probably has much to do with the service consumer as the counsellor. Structural conflicts of interest make for inefficiency. Being on campus addresses apparent problems of access, but creates other access problems that have always been the more important problems of access: stigma and confidentiality (MHYF Vic, sub. 628, p. 3).

Funding and policy overlap create confusion

State and Territory Governments have made numerous attempts to address these issues, by offering schools funding for specific wellbeing roles and supporting the employment of additional staff. However, the funding structures for these initiatives are inconsistent and they often lack planning.

For example, the NSW Auditor-General (2019) found that there is no workforce planning undertaken by the NSW Department of Education to estimate future need for counsellors and psychologists. In Victoria, funding for medical practitioners and mental health workers in schools has been sourced from the Department of Education and Training but the initiatives are implemented by primary health networks, which are funded by the Australian Government:

The service model design of both programs does not have strong provision to strengthen linkage and integration with the broader health and education sector environment resulting in implementation delays and the dilution of the programs' impact (Primary Health Networks, sub. 377, p. 18)

According to Australian Psychologists and Counsellors in Schools (APACS, sub. 419, p. 3), this uncoordinated approach may have implications for longer term improvements in mental health:

Shortfalls in school resourcing and the vast need within schools has led to a 'patching up' approach. This type of provision and uptake may be more cost-effective in the short term, but

may under-utilise the opportunities inherent in school spaces for creating better futures and longer-term positive outcomes for societal mental health.

Some schools can find it difficult to keep up with the range of initiatives, while others find themselves bound by rigid administrative requirements:

Some of the schools we visited were not aware of all of the [NSW Department of Education]'s funded programs for wellbeing, and the basis of the funding allocations was not widely understood.

The Core School Counselling Allocation and Flexible Funding for Wellbeing Services Allocation include 'hard' entitlement cut offs. For example, a school is not entitled to greater than 1.0 FTE school counsellor if enrolments exceed 850 students. This affects more than a quarter of secondary/central schools in NSW, and creates the risk of inequitable outcomes. (NSW Auditor-General 2019, p. 15)

What contributes to successful school mental health and wellbeing practices?

The implementation of wellbeing policies is managed in many different ways across different schools. Some have established wellbeing teams to coordinate their efforts and support staff; many others have appointed a staff member with responsibility for student wellbeing, which in some cases is part of the school leadership team (AHISA, sub. 734; QCEC, sub. 711). In some jurisdictions, government schools can receive funding to create a leadership position that oversees wellbeing programs. For example, the NSW Department of Education allocates funding for secondary schools to employ a Head Teacher Wellbeing, Victorian schools receive funding for school welfare coordinators or officers and South Australian schools can employ school wellbeing leaders (NSW Auditor-General 2019; VIC DET 2019d; State and Territory Governments Survey).

What determines the success of wellbeing policies in schools is often the commitment and shared understanding among principals, wellbeing staff and teachers. In its 2010 evaluation of student wellbeing programs, the Victorian Auditor-General used data from a student wellbeing survey to explore differences between two secondary schools. The schools reported similar results in the survey conducted in 2006, yet by 2009 one school's student wellbeing scores improved substantially while the other's declined. According to the Victorian Auditor-General's Office (2010, p. 20):

School one [where scores improved] had a strong cohesive student wellbeing team with a clear plan and objective, which has allowed it to integrate student wellbeing into the everyday life of everyone in the school. The student wellbeing team in School two [where scores deteriorated] is more disjointed and does not have a clear, shared vision for student wellbeing. This has prevented the school from delivering its student wellbeing services in an efficient and effective way.

These findings are important, not only because of the paucity of evaluations in this space (section 5.6), but because they highlight some of the key principles that are vital to the success of school-based wellbeing teams. These include:

- a joint vision and a clear plan for mental health and wellbeing initiatives in the school
- clear understanding of the roles of different staff members on the team, as well as clear leadership and accountability structures
- well-established student support pathways within the school. These pathways should recognise the contribution of different professional skill sets, such that the services offered are matched with need. Such pathways would also determine the staffing requirements on the team.

These principles can be interpreted in different ways, depending on the context of the school community. For example, community elders can play a pivotal role in schools with a large proportion of Aboriginal and Torres Strait Islander students. One principal of such a school explained that:

... while ‘formal western agencies’ were not used for program delivery, Indigenous Elders and Authorities who are in kin relationships or custodial relationships with students and their countries are engaged by the school to help build the depth and strength of students’ identity: ‘Over nine years we have not had one student commit suicide or self harm. I believe it is because we invest authentic and reinforced authority and leadership in our Elders.’ (AHISA, sub. 734, p. 9)

In other cases, youth workers and peer workers play a very important role in supporting the mental health and wellbeing of students (for example, VCOSS, sub. 478). The voices of young people with lived experience should be incorporated in school-based mental health and wellbeing programs.

Sharing lived experiences in a safe and effective way can help young people feel not so alone, and through hearing of real experiences navigating the health system, it educates people on what support is available and how to find the right fit and persevere. Stories of hope and resilience can model to others that it is possible to get through tough times and find ways to manage one’s wellbeing and that people care. (batyr, sub. 334, p. 4)

The Productivity Commission has spoken to schools in very different communities, each with different approaches to wellbeing, that all contribute to strong student outcomes (box 5.6).

Box 5.6 What success looks like in school wellbeing

St Charles Borromeo Catholic Primary School

St Charles Borromeo is a Catholic primary school in the Melbourne suburb of Templestowe, with about 220 students. It has a wellbeing leader, who works in collaboration with other wellbeing leaders in the cluster of schools in the area. The network keeps in close contact, sharing information and advice about social and emotional learning programs, incorporating wellbeing in each school's curriculum and getting principals to recognise the need for investment in wellbeing.

The school uses a range of programs to support wellbeing, and all teachers undertake professional development activities to implement these programs. The wellbeing leader has also established pathways for student referrals, both within the school and beyond the school gates. The school sets itself specific wellbeing targets as part of its improvement plan, and these are incorporated into annual action plans. The school collects a variety of data on its students' wellbeing, through surveys and focus groups with students. This collection of both qualitative and quantitative data allows the school to monitor its progress against targets and identify priority areas for action.

Rosebud Secondary College

About 900 students attend Rosebud Secondary College south of Melbourne. The government school has a wellbeing team, comprising a wellbeing leader, counsellors, a mindfulness coach and a family engagement worker, who works with the school but is employed by Anglicare. A GP and a mental health professional also visit the school. Over time, much of the work of the team has transitioned to addressing the entire range of needs that students have, within and outside school.

The school implemented a wellbeing focus across the curriculum, delivered by all teachers. The school's wellbeing framework permeates all areas of practice. It is used as a baseline to measure wellbeing of students; specific classes use it in different ways, including numeracy and literacy subjects that examine wellbeing through data or literature; and it informs whole-of-school initiatives. To support open discussions about mental health, all year 10 students undergo mental health first aid training. This has seen an increase in students' awareness of their state of mind, as well as their peers.

Glenunga International School

Ten years ago, Glenunga International High School, a government secondary school in Adelaide, decided to improve its academic achievement by improving pedagogy while also helping teachers understand the importance of wellbeing as the basis for improved academics.

The school established a wellbeing team, comprising an assistant principal, two counsellors and a psychologist. As well as case work, the school's psychologist leads proactive programs and advises on evidence-based interventions for the entire school or groups of students. Extensive pedagogical development occurred based on consultation with students, peer-led learning and professional development for all staff to understand 21st century students' social and emotional development. All teachers became mentors. The school highly values student agency so a wellbeing council was established, led by year 12 students, who use data to identify areas of concern and discuss solutions with both students and staff. As a result of these initiatives, the school has seen substantial improvement in academics and wellbeing. At the same time, it grew from 1200 to 1800 students, who come from 80 different countries of birth.

Source: Glenunga International School, Rosebud Secondary College, St Charles Borromeo Catholic Primary School, pers. comm., 28 May 2020.

Finding the missing piece of the puzzle

While many schools have in place management structures and wellbeing policies that are able to achieve strong outcomes for students and teachers, this is not the case everywhere. Our draft report raised the prospect of appointing a wellbeing leader in every school, to provide overarching coordination and direction to the various wellbeing initiatives that are rolled out in schools, support staff and assist students who may require external referrals or additional help. This approach would be similar to the one being rolled out in UK schools.³⁰

Many stakeholders voiced their support for this idea.³¹ The Victorian, South Australian and Western Australian Governments (subs. 1228, 692, 1227) supported the direction of the draft report, while noting existing policies that aim to achieve similar goals as well as funding pressures that may arise from changes to wellbeing practices in schools. The NSW, Tasmanian, Northern Territory and ACT Governments (subs. 1243, 1242, 1220, 1241) also noted the various policies they already have in place to support wellbeing.

Submissions emphasised the potential of the wellbeing leader to improve the implementation of effective interventions within schools and create pathways for students requiring additional services. At the same time, they raised many questions regarding the type of training that potential wellbeing leaders would require, as well as the most appropriate professions to carry out this role. Suggestions included school psychologists (APACS, sub. 906), school nurses (Australian Nursing and Midwifery Federation, Melbourne transcript, p. 17), social workers (AASW, sub. 848) and community mental health workers (HelpingMinds, Geraldton transcript, p. 8). Others raised concerns about the unsustainable demands of the wellbeing leader role (Elucidate, sub. 755), as well as the funding implications for the education system (MHCT, sub. 869).

On the other hand, stakeholders within the education sector pointed to the fact that schools already use a wide range of approaches to wellbeing, reflecting the unique needs of each school community (AHISA, sub. 734; Danielle Malone, Adelaide transcript, pp. 73–75; QCEC, sub. 711). The NSW Government (sub. 1243, p. 26) noted its concern that ‘mandating a specific position (that must also be funded from existing budgets) could reduce schools’ flexibility to address the need profiles of their students and ensure the best outcomes’. At its education roundtable, the Productivity Commission heard about the challenges in creating a new position within schools and the need to focus on *outcomes* —

³⁰ The United Kingdom is implementing large scale reforms intended to improve mental health and wellbeing among children and young people. These reforms encompass both the education and health systems, and include three core policies: all schools and colleges will be incentivised to identify and train a Designated Senior Lead for mental health; new Mental Health Support Teams, which will be supervised by the National Health Service (NHS) children and young people’s mental health staff, and focus on delivering prevention and early intervention; and piloting a four week waiting time for access to specialist NHS children and young people’s mental health services (UK Department of Health and Department for Education 2017).

³¹ For example: APS, sub. 853; batyr, sub. 907; Commissioner for Children and Young People Western Australia, Perth transcript, p. 65; Joe Calleja, Perth transcript, p. 26; CYSA, sub. 779; headspace, sub. 947; Healthy Minds, sub. 619; NMHC, sub. 949; Prevention United, sub. 768; SAMHC, sub. 691, att. B; Stronger Brains, sub. 591; yourtown, sub. 917.

rather than the specific processes adopted within a school, which vary based on the needs of its community, and the resources available both within and outside the school.

As discussed in section 5.3, wellbeing outcomes expected of schools should be incorporated in the National School Reform Agreement. In practice, this would mean schools would be required to monitor and evaluate wellbeing similarly to academic progress and attendance. Nationally consistent data on wellbeing would be routinely collected and reported and school principals would be accountable for improvements in school performance.

Commencing within two years of this Inquiry's conclusion, all schools should be required to collect and report data on student wellbeing, in line with the national minimum dataset, and evaluate their internal processes and structures against expected national outcomes (Action 5.6). These evaluations should be included by principals in school improvement plans and performance reporting to the relevant education regulator, board, governing body, or education office, in the same way as they monitor progress in numeracy, literacy and other academic subjects.³² Schools would also be expected to use the data to identify areas for improvement and develop plans to address these.

Since wellbeing is affected by many factors that are outside the control of the school, data collected from students should form only one part of reporting requirements. Other information that could be reported includes staff and parent surveys; professional development undertaken, and reflections on its impact in the school; evidence of effective pathways within and outside the school gates; and processes for improvement, including an open dialogue between school leadership, staff, students and the broader school community.

Each school is likely to seek to improve different aspects of wellbeing, and therefore may monitor a variety of outcomes, beyond those defined in the national minimum dataset. However, there would be aspects of wellbeing that all schools should be required to address, including:

- implementing whole-of-school wellbeing programs, including identifying the most suitable programs for the school community, developing the skill sets of teachers who would be delivering the programs, monitoring outcomes and supporting school staff to incorporate wellbeing practices in their day-to-day work
- appointing a first point of contact for teachers concerned about students' mental health and wellbeing, and supporting students in accessing services, both within and outside of the school
- evaluating the work of the school wellbeing team, which can include a school psychologist, counsellor, social worker, school nurse, chaplain, community elder or Aboriginal health worker, peer workers and others. This should include clear definitions

³² About 70% of Australian schools are government schools, which means they are owned and managed by State and Territory Governments and report to education departments. Catholic and independent schools have a range of governance structures, and while some are part of central or regional-based authorities, others are run by boards, councils or other bodies (PC 2012).

of the roles and responsibilities of wellbeing staff and pathways for student referrals within the school

- establishing the needs of the school community, in terms of additional programs or staff members required, and securing funding for implementation
- ensuring plans to support students with mental illness are implemented, and there is appropriate consultation with their family and mental healthcare providers
- developing and maintaining referral pathways to local community services, including community mental health services, parenting programs and support services for young carers
- using a range of sources, including the data collected as part of the national minimum dataset, to monitor and evaluate progress in student wellbeing, and the effects of any specific interventions.

Each school is also likely to approach the implementation of wellbeing interventions differently, based on the needs of its community, its educational philosophy, resource constraints and other factors. Nonetheless, evidence points to the importance of leadership in ensuring wellbeing policies are implemented effectively (Deloitte Access Economics 2017). All schools require effective leadership and accountability structures to implement their wellbeing policies — and principals should be held accountable for their school’s performance, as they are in all aspects of the education system. Where a school does not demonstrate improvement against wellbeing outcomes, the relevant regulator should work with the school principal to change necessary systems and processes, which can include appointing a wellbeing leader within the school to facilitate better outcomes for students.

Working towards best practice in school mental health services

Departments of education should work with schools to determine where more resources are needed, and address these gaps. Depending on the service models developed by schools and the needs of the school community, this may require additional staff, such as school psychologists.

Stakeholders suggested that resources available currently are insufficient (Merri Health, sub. 120; APS, sub. 543). It is difficult to identify best practice for the number of counsellors or psychologists required to improve student outcomes. The Australian Psychological Society (sub. 853) recommends a ratio of one school psychologist for every 500 students. However, it can also be argued that the specific ratio for each school ‘should be determined by the level of staffing needed to provide comprehensive school psychological services in accordance with the system’s needs assessment’ (NASP 2010, p. 10).

Departments of education should aim to work towards staffing levels that provide the best outcomes for students. However, it should be emphasised that the education system is not a suitable setting for managing acute mental health crises or the long-term treatment of mental

illness. Schools are responsible for identifying concerns and working with students and families to improve educational outcomes; they are a gateway into the mental healthcare system for those who need more intensive services and they need to work with mental healthcare professionals to support their students, but their role is not one of mental healthcare provision.

ACTION 5.6 — WELLBEING STRATEGIES IN SCHOOLS

All schools should be required to report on their progress against wellbeing outcomes, as set out by in an updated National School Reform Agreement (Action 5.3).

In addition to outcomes, all schools should report to regulators on their dedicated strategies, including leadership and accountability structures, to deliver wellbeing outcomes for students and teachers.

Each school principal should be accountable for the development and monitoring of wellbeing strategies, and progress against national targets.

Start now

State and Territory Government departments of education should roll out nationally consistent wellbeing measures to monitor school performance in improving wellbeing. These measures should be incorporated in school performance processes and annual reports, similar to measures of progress in numeracy and literacy.

Start later

State and Territory Government departments of education should:

- review the wellbeing policies and structures put in place by all schools to ensure they are effective in delivering wellbeing outcomes. Policies should be reviewed annually.
- develop policies to support schools that identify gaps in their wellbeing strategies and supports, as well as schools where wellbeing measures do not improve over time. This should include dedicated funding through a flexible funding pool.

5.6 Measuring children’s wellbeing — addressing the data gaps

The mental health and wellbeing of children — both within schools and in the community — is a topic where Australia is data rich but information poor (chapter 24). Beyond the headline indicators about mental illness among children and young people, which are often based on surveys that have been carried out many years ago, there is very little information to allow us to determine whether investments in mental health and wellbeing are delivering improvements and what policy initiatives have been effective.

Schools collect a lot of data, but its use is limited

Many data collections include metrics relevant to child social and emotional wellbeing in schools. The most extensive is the Australian Early Development Census, which includes information about each child when they start school, around the age of five years. Teachers fill in this census every three years (most recently in 2018), by assessing each child's development across five domains, including their social competence and emotional maturity (DoE 2019b).

In addition, State and Territory departments of education as well as individual schools collect vast amounts of data on students. Collections can be part of standardised testing, such as the Programme for International Student Assessment wellbeing collection (OECD 2017b), but more commonly occur through surveys that are either developed by jurisdictional departments of education or purchased by schools from private providers. In South Australia, for example, more than 90% of government schools participate in the Wellbeing and Engagement Collection survey, which offers a very detailed view of children and adolescents' wellbeing (box 5.7). Other jurisdictions run state-wide surveys, such as the Attitudes To School Survey in Victoria, student engagement data collections in NSW and Tasmania and the Australian School Climate and School Identification Measurement Tool in the ACT (SCRGSP 2020a, table 4A.27)

Box 5.7 The SA Wellbeing and Engagement Collection

The South Australian Wellbeing and Engagement Collection is one of the largest surveys of its kind in Australia; it differs from surveys run in other jurisdictions in that it specifically asks students questions about their mental health. It is based on the Middle Years Development Instrument, an extension of the Early Development Instrument from which the Australian Early Development Census was developed (Gregory et al. 2019).

In 2019, more than 96 000 students from year 4 to year 9 took part in the survey, enabling comparisons between students in their primary and secondary school years (South Australian Government, sub. 692). Past results have shown that older students tend to worry more, and feel less connected with their school teachers. The proportion of students who reported being bullied was somewhat higher in primary schools, with the exception of cyberbullying, which was more common among older students (SA DoE 2019).

The Middle Development Instrument was initially trialled in Victoria and South Australia in 2013, and according to the National Mental Health Commission (2014c), cost \$2 per student to administer. The National Mental Health Commission recommended introducing the index as a national measure 'as the next stage in measuring, identifying and responding to child development issues' (NMHC 2014c, p. 101).

However, state-wide results are not always available and data cannot be compared across jurisdictions. Surveys are not compulsory, and schools can choose to use commercial surveys or not measure wellbeing at all. For example, student participation rates in the survey offered to government schools by the NSW Department of Education vary between 41% and 91% (NSW Auditor-General 2019). Results of school surveys are not always transparent —

not all schools inform the community of their wellbeing surveys and their outcomes. It is unclear to what extent data is used to inform policy, evaluate programs or to improve the performance of individual schools.³³ Despite the large volumes of data collected, it is still very difficult to compile a clear picture of children's and young people's mental health and wellbeing in schools. According to the Australian Government Department of Education (pers. comm., 21 August 2019):

There are a range of issues that need to be addressed to ensure there is a solid evidence base to improve the mental health and wellbeing of students in education:

- there are currently no national measures to track student wellbeing,
- it is difficult to measure effectiveness of interventions, and consequently
- there is limited evaluation of school based approaches.

The updated National School Reform Agreement recommended by this Inquiry (section 5.3) should include measures to demonstrate progress against wellbeing outcomes. Such measures would have to rely on nationally consistent data on students' mental health and wellbeing. This data collection should be developed by the data strategy group that operated under the COAG Education Council, which has representatives from all jurisdictions. It should be designated as a national minimum dataset, similar to datasets collected under other national agreements. This would enable data to be collected from government and non-government schools, and reported on a consistent basis.

The national minimum dataset can include a small number of questions, which would be collected from all students. The data strategy group can develop this set of questions and corresponding data items, which would need to use a common set of definitions and metadata. Data should be collected every year to paint a picture of wellbeing and development of children over time.

There are several existing data collections that could be built upon to create a national dataset. For example, the SA Wellbeing and Engagement collection has been rolled out in Tasmania (Tas DoE nd) – a subset of questions could be rolled out across other jurisdictions by adding them to existing surveys that are run in government schools. Other options include surveys such as the Australian Council for Educational Research social and emotional wellbeing survey, which is used in a large number of schools. Education Services Australia, which operates under the Education Council, has developed tools to enable national rollout of any new data collections.

³³ The Productivity Commission reviewed a selection of annual reports completed by government schools in all jurisdictions and found that wellbeing measures were not reported consistently. All reports included results of various satisfaction surveys (usually administered to staff, students and parents), from which it is possible to get an indirect indication of wellbeing in the school. In the NT, survey results were reported alongside national benchmarks. Annual reports from Victorian government schools were the only ones to compare school results to other schools directly, based on the responses to the 'Attitudes To School' survey run by the Department of Education and Training.

This work should be completed within 18 months and the questions should be rolled out in schools within two years. The development of the minimum dataset would also have to consider issues such as the organisations that should be appointed as data custodians, as well as the public reporting requirements that would apply to this data. Australian Early Development Census data, for example, is reported at the state level, but is available to schools and communities to assess their needs.

A national indicator of children’s social and emotional wellbeing

Data gaps are also apparent in information collected about children’s mental health and use of mental health services. The national indicator for children’s social and emotional wellbeing, published by the AIHW, uses data that was collected in the last children’s mental health survey, *Young Minds Matter*, which was run in 2013-14 (AIHW 2020a; Telethon Kids Institute 2019). There are currently no plans to repeat the national survey. Some states collect data as part of their population health survey, but inconsistent definitions mean it cannot be used to construct a national indicator.

Efforts to develop a national indicator for children’s social and emotional wellbeing have been in train since 2006. It was included in the Children’s Headline Indicators, a set of key data items on children’s health, development and wellbeing that were endorsed by health, community and disability services ministers and education systems officials in 2006. Research undertaken by the AIHW concluded that the Strengths and Difficulties Questionnaire — a survey tool that has been validated and used extensively in Australia and overseas — would be the most suitable instrument to create an indicator of children’s social and emotional wellbeing. The AIHW suggested that the questionnaire, which takes about five minutes to complete, could be added to jurisdictional population health surveys, to produce a consistent national measure, which would be comparable over time (AIHW 2012c). However, apart from the data collected in the *Young Minds Matter* survey, there has been no further progress towards a current national indicator.

Given that the AIHW has laid the groundwork for a national indicator to assess children’s wellbeing, the Australian Government should fund the AIHW to complete its work and roll out a national wellbeing indicator. The AIHW should work with State and Territory departments of health to determine the most appropriate measurement approach, and add the necessary questions to their population health surveys. Data should be collected and published annually.

Apart from the Strengths and Difficulties Questionnaire, there are other approaches to measuring children’s mental health that could be considered, such as a mental health competence approach looking at healthy psychosocial functioning, rather than focusing on difficulties (AIHW 2020a). Particular consideration should be given to the measurement tools used to assess the social and emotional wellbeing of Aboriginal and Torres Strait Islander children. The Strengths and Difficulties Questionnaire is likely to have limitations as an indicator for Aboriginal and Torres Strait Islander children; a specific tool, developed

in consultation with Aboriginal and Torres Strait Islander communities, may be more appropriate (Marmor and Harley 2018).

A number of longitudinal studies follow groups of children as they grow, and collect detailed data on their health (including mental health) and wellbeing.³⁴ Data from these surveys has been used in many publications, describing the mental health of Australian children, and the effects it has on their education and other outcomes (for example, AIFS, sub. 753). However, the information collected varies widely between surveys, making it difficult to compare the effects of various government policies and produce up-to-date national indicators of mental health and wellbeing among children and young people.

As recommended by the Productivity Commission in its Education Evidence Base inquiry (2016a), the Australian Government should fund the establishment of new cohorts in the Longitudinal Study of Australian Children (LSAC) at regular intervals. The LSAC uses different measures of mental health and wellbeing, which can paint a comprehensive picture of children and young people mental health, and the factors affecting it. It can also be used in the calculation of a wellbeing index (Sanson et al. 2005). In order to inform policy initiatives that assist young carers, new waves of the LSAC should include questions about informal care provided by children and young people (chapter 18). There are other longitudinal surveys, such as Footprints in Time, the Longitudinal Study of Indigenous Children, which would also greatly benefit from having new cohorts added every 12–15 years.

The collection of data is important, but what matters most is the use of this data to improve policy development and implementation, including through increased data linkages. At a national level, a first step towards achieving this would be developing an evidence base for the education system, as recommended previously by the Productivity Commission (2016a). The new National Evidence Institute, being established as part of the National School Reform Agreement, should be tasked with expanding this knowledge, by building upon existing collections and commissioning additional research to address gaps and provide up-to-date data on children’s wellbeing. Such an evidence base would assist schools in choosing programs that have proven to support students and teachers in improving mental health and wellbeing outcomes. Evaluations of trials should form part of this evidence base; to this end, the Australian Government should fund the creation of school networks that run trials of wellbeing interventions, to inform the development of future policy.

³⁴ Examples include the LSAC, the Childhood to Adolescence Transition Study and the NSW Child Development Study (AIFS 2019; Murdoch Children’s Research Institute nd; UNSW 2018).

ACTION 5.7 — DATA ON CHILD SOCIAL AND EMOTIONAL WELLBEING

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

Start now

Governments should develop, or commission the development of, a national minimum dataset on student wellbeing.

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

Start later

The National Evidence Institute — which is being established as part of the National School Reform Agreement — should create an evidence base on social and emotional wellbeing. This should include funding networks of schools to trial and evaluate innovative approaches. The Institute should also promote the use of existing datasets to inform policy and fund additional research.

The Australian Government should fund new cohorts of the Longitudinal Study of Australian Children at regular intervals.

5.7 School-based support for vulnerable children

All children and young people would benefit from an education system that prioritises wellbeing. But there are specific groups — including those diagnosed with mental illness and other health and development concerns or children from highly disadvantaged backgrounds — for whom school-based support is vital. For example, ADHD Australia (sub. 295, p. 6) states that ‘school is the place where the most damage can be done, but also where the greatest difference can be made’.

All children have a legal right to education. Specifically for those with mental illness, the *Disability Standards for Education 2005*, discussed further below, impose a legal requirement on all schools to cater for their needs (DoE 2005). In addition to children with mental illness, this chapter discusses issues affecting children who are at risk of disengagement or who have disengaged from school, and those in the child protection system. The needs of children whose parents have mental illness or who are young carers are discussed in chapter 18. More broadly, however, schools should also be cognisant of the needs of vulnerable children, including those from Aboriginal and Torres Strait Islander families, those from culturally and linguistically diverse and refugee backgrounds, and young people who identify as LGBTIQ.

Children diagnosed with mental illness

One in seven children and young people are reported to have mental illness, though the true prevalence is likely to be higher (chapter 2). Many mental illnesses emerge in childhood and adolescence, and some, such as eating disorders, tend to affect young people more than adults (box 5.8). Mental illness can have substantial effects on the life trajectories of children and young people. For example, in year 3, children with mental illness were found to be lagging in their learning outcomes by about 7 to 11 months compared with children who were not affected by mental illness, and this gap expanded to 1.5–2.8 years by the time children reach year 9. Accessing support services, either within or outside the school, can help but does not completely close the achievement gap (Goodsell et al. 2017, p. 11).

A formal diagnosis is not required to receive some classroom supports, as this is usually determined by teachers and other school staff, in consultation with parents. In 2017, about 188 000 school-aged children required some adjustment to their education due to social/emotional disability (representing 26% of all children requiring adjustment due to disability, and nearly 5% of all children attending school) (Education Council 2017, pp. 4-5).³⁵ This can take the form of adjustments to teaching methods made by teachers within the classroom, through to more extensive forms of support provided by specialist staff (NCCD 2019). There can be substantial differences in how well schools implement these adjustments, depending on the resources available to them and the skill sets of staff (OTA, sub. 141; QAI, sub. 116).

The Australian Government provides additional funding for schools catering for students with disability (including mental illness). Government schools can also apply to their jurisdictional department of education for funding to employ aides or purchase materials that would assist students.³⁶ In some jurisdictions, there are services to assist schools in coordinating complex cases, but demand can be substantially higher than the support available (for example, NSW Auditor-General 2019).

Applying for additional funding can impose significant difficulties on parents.

Parents at all schooling levels highlighted the need for numerous assessments in order to ‘prove’ that their child had disability which required reasonable adjustment. Parents reported funding high numbers of these assessments, such as tests for dyslexia and psychological consultations, which left them considerably out of pocket. These assessments also take a long time. As a result, it appears that children from wealthier backgrounds and those with a committed parent or guardian advocate were more likely to be able to secure adjustments. Similarly, several parents and peak groups noted that, despite the Standards, they had to work as advocates for students to ensure reasonable adjustments were made in the classroom. (Urbis 2015a, p. 34)

³⁵ A social/emotional disability is defined by the Department of Education as ‘a disorder, illness or disease that affects the person's thought processes, perception of reality, emotions or judgement, or that results in disturbed behaviour’ (DoE 2019c).

³⁶ In some cases, further support is available from other departments. In New South Wales, for example, the School-Link program, based on a memorandum of understanding between the Departments of Education and Health, aims to support teachers and school counsellors in finding the most suitable assistance for individual students (NSW Health 2017a).

Box 5.8 Eating disorders — funding focuses on treatment while prevention remains ad hoc

About one million people in Australia are thought to experience an eating disorder (figures are estimates as there is no national data collection on prevalence (EDV, subs. 329, 892)). Although eating disorders can affect people of all ages, their prevalence is highest among teenagers. Early risk factors and symptoms often appear during the school years, with the highest prevalence of eating disorders found among females aged 15–19 years (although in rare cases, disorders have been diagnosed in children younger than 13 years) (Smink, van Hoeken and Hoek 2012). The education system can contribute to prevention efforts, and issues relating to body image are included in the Australian curriculum. However, according to the Butterfly Foundation for Eating Disorders (sub. 424, part 2, p. 2):

The HPE [health and physical education] curriculum is designed to be high level focusing on knowledge, skills and understanding, with each state and territory providing support to schools on implementing the curriculum; they exercise freedom in relation to implementation timeframes, classroom practices and resources to complement teaching. Mental health is one of the focus areas within HPE and appropriate intervals students are expected to learn about 'body image and self-worth and their impact on mental health and wellbeing'. We believe this is significantly insufficient focus on this critical area of health and wellbeing.

Overall, HPE may not account for more than 10% of teaching hours (in NSW for example); not only is there limited time for education relating to body esteem and other risk and protective factors for eating disorders; they must also compete with other important health content.

Further, there has been no government funding for eating disorder prevention programs since 2011. Lack of funding is not the only challenge faced by schools:

Other perceived barriers to schools addressing this issue effectively include:

- Lack of confidence, in part because many adults struggling with their own body issues and feel unable to 'walk the talk' or provide an authentic voice
- Limited up-to-date evidence based and age appropriate accessible resources
- Insufficient professional development and support on the ground to deliver, particularly around the sensitive areas of eating disorders.

Currently, the national picture of how these issues are being addressed within our schools is incomplete and largely anecdotal. (Butterfly Foundation for Eating Disorders, sub. 424, part 2, p. 3).

The Australian Government announced an increase in Medicare funding for treating eating disorders from November 2019 and additional investment in research and workforce development (DoH., sub. 556). However, stakeholders in the sector remain concerned about the lack of available specialist services and insufficient data on prevalence and consumer pathways (Butterfly Foundation for Eating Disorders, sub. 424).

Given that all students have a legal right to education, governments should ensure that students with mental illness (and indeed, all students with disability) have timely access to the support they require. The effectiveness of the Disability Standards is due to be reviewed again in 2020 (DoE 2005). The review should include specific consideration of the way the standards affect children with mental illness, and the effect of any adjustments made on their educational outcomes. It should also examine application processes for additional funding, and consider any necessary improvements (for example, by increasing access to publicly funded psychological assessment). Further, the Australian Government should use the data collected through the Nationally Consistent Collection of Data on Schools Students with

Disability to evaluate the effectiveness of its disability funding structures for children with social/emotional disability.

The Disability Standards for Education require schools to consult regularly with the student, their family and other relevant professionals (such as therapists and other community service providers) on the adjustments they require in the classroom (ACARA nd). The review of the Standards conducted in 2015 found a lack of clarity among schools regarding ways to conduct such consultation, and the development of individualised learning plans for students. The review called for the creation of clear policies on how consultations should be conducted and documented (Urbis 2015a).

Submissions to this Inquiry referred to the difficulty of bringing together schools and mental health service providers, to build a comprehensive treatment plan for children with mental illness. For example, the Australian Psychological Society (APS, sub. 543, p. 17) stated:

[External mental health service providers] are unlikely to be able to assist a child or young person to re-engage with their education because external providers are not able to work collaboratively with teachers to meet students' holistic needs in relation to their learning.

This situation is at least partly due to funding. While schools receive specific funding for students with disability, which can be used to allow teachers and other staff to attend meetings with mental healthcare providers, there is no such funding available for allied health professionals. Currently, case conferencing is rebated under the Medicare Benefits Schedule only for GPs and psychiatrists in some cases (chapter 15). This means, for example, that psychologists who treat children may need to forgo payment or bill their clients privately to attend consultations with schools.

There are various ways to support better communication between schools and clinicians treating children with mental illness. For example, psychologists treating children under the Better Access program are currently required to provide a written report to the referring medical practitioner (chapter 10). This report must include recommendations for future management or treatment, but there are no specific guidelines around providing recommendations for third parties, such as family members or schools. Such guidelines have been added to the reporting requirements for psychologists and other allied health professionals treating children with autism (DoH nd); a similar approach could apply to the reporting requirements for allied health professionals treating children with mental illness. In other cases, children with severe mental illness would have a care coordinator (chapter 15), who would work with all service providers, including the child's school, to coordinate care and support. Such care coordination needs to include the child's school, and be part of the consultation process required under the Disability Standards.

Children and young people who have disengaged from schooling

In some complex cases, children with mental illness or young carers of people with mental illness disengage from school to the point that they no longer attend regularly. Across

Australia, an estimated 50 000 children and young people of school age are not in school or another education program. For many, mental ill-health is a major reason for their disengagement and often a significant barrier for their return to school (Watterston and O’Connell 2019).

The Productivity Commission has heard from carers and parents about the substantial difficulties in finding help for their children who were at risk of disengaging from school:

[W]e really didn’t get the level of support, help or advice we needed from the school. It was never flagged to me that her behaviour could be anxiety or depression. The situation was exacerbated by the lack of school support for my daughter to catch up on her missed school work, which meant she fell further and further behind in her school work and felt increasingly unable to go to school for this reason. (Anonymous parent, sub. 399, p. 2)

Reintegration with my child’s school failed soon after she commenced ... I spent many hours sourcing information/advise from educational authorities. (Name withheld, sub. 392, pp. 18–9)

Parents and carers spoke about the need for more flexible approaches within the education system to assist children with complex needs:

The lack of flexibility on curriculum results in students like my son, not being able to participate in accordance with their capacity to learn. ... lack of part-time study options means that if a student is unable to cope with a full-time load due to mental or physical illness there is this continual sense of failing plus additional stress on the family, which embeds a lack of hope, causes tension and stress in the family dynamics and damages the self-worth of the young person. (Carer’s story quoted in Youth Mental Health - North Metropolitan Health Service, sub. 99, p. 7)

Such flexibility is particularly important for young people who may disengage from school due to caring responsibilities:

Many young carers have trouble balancing school work with their caring role and research indicates that young carers have higher rates of absenteeism and may have difficulties in completing assignments or homework due to their caring responsibilities. ... Unfortunately schools often fail to recognise young carers and address their needs. (Carers NSW, sub. 808, p. 8)

There are examples of schools that use approaches designed specifically to support such children and young people to return to education. There are also outreach programs run or funded by State and Territory Governments that work with schools, students and families to find solutions that enable children to return to the classroom (for example, Centre for Excellence in Child and Family Welfare, sub. 211; Marathon Health, sub. 88; Mission Australia, sub. 487). Other organisations, such as headspace, are trialling approaches to support young people returning to education (chapter 6). In some regions, demand for services supporting re-engagement in school outstrips supply (Merri Health, sub. 120). The success of these initiatives hinges on effective communication and coordination between the parties involved in supporting the child and their family, but this does not occur in all cases (for example, Australian Clinical Psychology Association, sub. 359; Robert Davis, sub. 133). Ways to promote effective care coordination for those requiring care from a larger team of professionals are discussed in chapter 15.

State and Territory departments of education should review the funding of outreach services offered and the extent to which it should be expanded such that all students who are at risk of disengagement or have disengaged from their schooling are supported. Departments should put in place clear policies for referrals of students and families to proactive outreach services once the student's attendance declines significantly, and monitor their implementation. These policies may be particularly important as the students go back to school after a period of remote learning during the COVID-19 pandemic. Remote learning may put vulnerable children at higher risk of disengaging (Baker 2020).

Children and young people in the child protection system

In 2019, more than 63 000 children and young people (aged 0–17 years) were in out-of-home care or other supported placements, which are part of the child protection system; nearly 270 000 children were the subject of notification to child protection services due to serious concerns about their safety and wellbeing (SCRGSP 2020c, tables 16A.1, 16A.2).

These are some of the most vulnerable children in the community. Many submissions raised grave concerns about the mental health of these children and their ability to access support services — in particular Aboriginal and Torres Strait Islander children and children who are in out-of-home care.

The prevalence of mental health problems for young people in out of home care is much higher than for the general population. These young people often have multiple and complex needs, particularly poor mental health and social functioning, both during and after care. They are also less likely to have timely access to mental health care.

It is now understood that the out of home care system needs to be based on therapeutic principles. Cross-service practice models that offer integrated and trauma-informed mental health support are required, but these are rarely available. (Orygen and headspace, sub. 204, p. 32)

In 2017-18 more than 19,000 children and young people were in out-of-home care (OOHC) in NSW. It is well recognised that these children and young people are a highly vulnerable group with increased physical, mental and social health needs and often limited access to services and support. ... Significant investment needs to be made to support increasing mental health needs of children and their families in the OOHC system.

It is also critical that other systems in which children and people interact (eg schools and higher education) are less rigid in their approach to supporting young people experiencing mental health issues. For example, schooling is often not a high priority for people experiencing mental illness (especially if they experience anxiety and depression), yet there is often family, societal and systemic pressure to attend regularly, achieve and socialise. Education settings could provide a safe and more supportive environment through delivery of alternative classes, such as life skills, learning and scaffolding that builds on the present and real experiences being faced by the individual and offering greater flexibility during assessment stages. (Anglicare Sydney, sub. 190, p. 12)

There is ... little specific research into the short and long-term impact of removal on Aboriginal children and young people's mental health and wellbeing. Anecdotal evidence drawing together the lifetime economic and social costs of child maltreatment and the impact of removal on

long-term life outcomes suggest that Aboriginal children and young people are at a significantly higher risk of poor mental health outcomes and self-harm than their peers. (Victorian Aboriginal Children and Young People's Alliance, sub. 240, p. 3)

In 2009, COAG endorsed the National Framework for Protecting Australia's Children, which includes national standards and indicators for out-of-home care (FAHCSIA 2011). The standards require jurisdictions to monitor and report on the number and proportion of children and young people who have an initial health check of their physical, developmental, psychosocial and mental health needs within a specified period of entering out-of-home care. However, no national data is available to monitor adherence to this standard (Centre for Excellence in Child and Family Welfare, subs. 211). Research undertaken in Victoria has shown that of the children who entered the child protection system between 2010 and 2015 and stayed at least three months, only 20% accessed any type of mental health consultations (Karen McLean, pers. comm., 29 April 2020).

All State and Territory Governments included a wellbeing indicator in the reporting framework for the child protection system. No data is available to track performance against this indicator. Measures relating to schooling included in the reporting framework show that children in the child protection system are less likely to participate in NAPLAN and have a lower achievement levels. Data is only reported for some jurisdictions, and only for children in year 5 (SCRGSP 2020c).

As a minimum first step, State and Territory Governments should collect the required data to monitor their compliance with agreed standards and the reporting framework. Such data would enable jurisdictions to identify gaps in service delivery and increase the availability of supports to vulnerable children.

ACTION 5.8 — EDUCATIONAL SUPPORT FOR VULNERABLE CHILDREN

The education system should review the effectiveness of disability funding structures for children with social-emotional disability, including a review of outreach programs for children who have disengaged from their schooling due to mental illness.

Start now

The Disability Standards for Education are due to be reviewed in 2020. The upcoming review should be independent and:

- include specific consideration of the way the standards support students with mental illness and their educational outcomes.
- examine application processes for adjustments and consider if improvements are required.

Mental health professionals (including those working in private practice and community mental health settings) who treat children should be required to include recommendations for parents/carers and teachers in their report to the referring medical practitioner, wherever relevant.

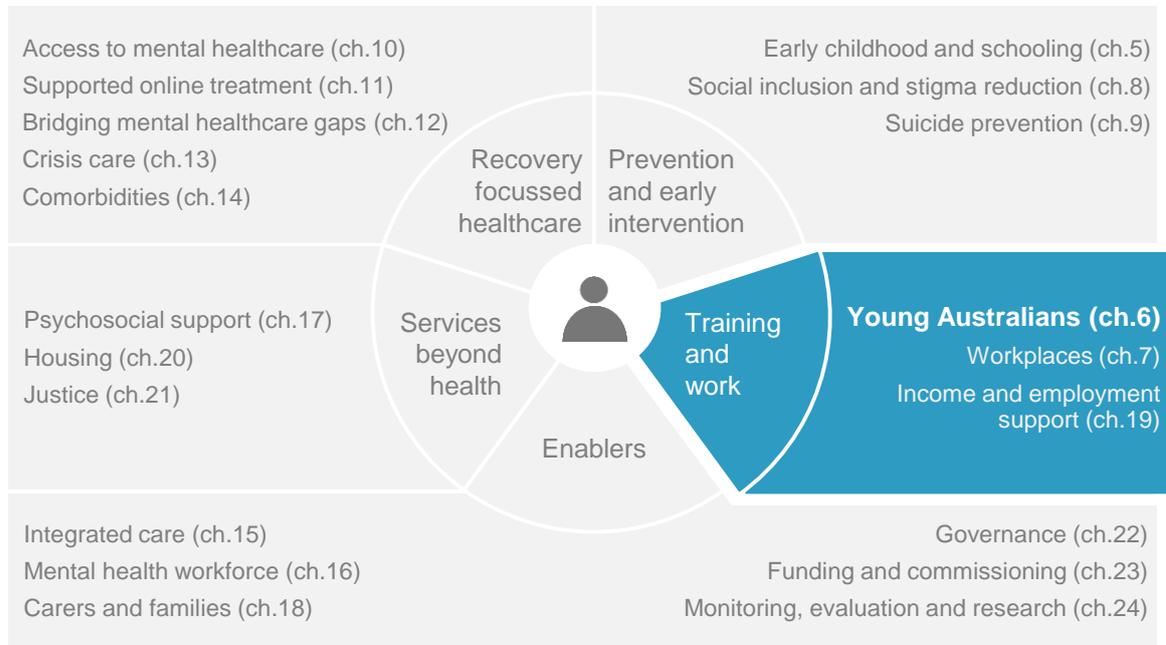
State and Territory Governments should collect data to monitor their progress against agreed measures of social and emotional wellbeing for children in out-of-home care and the child protection system. Data should be used to direct additional investment in support services.

Start later

The Australian Government should use data collected by schools as part of the Nationally Consistent Collection of Data on School Students with Disability to evaluate the effectiveness of its disability funding structures for children with social-emotional disability.

State and Territory Government departments of education should review the funding for outreach services supporting students who have disengaged from education due to mental illness to return to school. Services should be expanded such that they are able to support all students who are at risk of disengagement or have disengaged from their schooling. Departments should put in place clear policies for outreach services to proactively engage with students and families who are referred to them once the student's attendance declines below a determined level, and monitor their implementation.

6 Youth economic participation



Interventions for youth matter because ...

- The years of 16–24 are an important transition point in a person's life and participation and outcomes during this period can significantly affect economic and social participation in later life.
- Young adults experience higher rates of mental illness than the rest of the adult population and around three-quarters of adult mental health disorders emerge by 25 years of age.
- Many 18–24 year olds participate in tertiary education and there is evidence that tertiary students are more likely to experience mental ill-health than the general population.
- The level and types of mental health-related support provided by tertiary institutions to students varies between education providers.
- Some students do not feel comfortable disclosing mental ill-health and seeking support due to stigma, yet demand for services, such as counselling, exceeds supply at many institutions.
- Many youth experiencing mental ill-health are disengaged from education, training or work — and this group is at greater risk of potentially losing their jobs and/or having their skills development disrupted by external economic shocks.

RECOMMENDATION 6 — SUPPORT THE MENTAL HEALTH OF TERTIARY STUDENTS

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

Reforms that should be considered:

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

The years between 16 and 24 are an important transition point in a person's life. Many people in this age group are leaving school and moving on to tertiary education and/or work. Their economic participation during this period can affect their outcomes in later life. Many people also experience mental ill-health during this period. About three-quarters of adult mental health disorders emerge by the time people are 25 years old. Mental ill-health can negatively affect a person's ability to participate economically and socially and disrupt their transition from education to work.

This chapter discusses improving youth economic participation, and in particular, participation in education and training, and whether youth in education and training receive sufficient mental health-related support. It also looks at supporting disengaged youth to re-engage with education and training.

6.1 Youth mental health and economic participation

Young adults experience higher rates of mental ill-health

Many people first experience mental ill-health in their youth. Half of all mental ill-health onsets before the age of 14 years, three-quarters by 24 years of age (Orygen, sub. 204, p. 3). The 2007 *National Survey of Mental Health and Wellbeing* found that for those experiencing an anxiety or affective disorder, two-thirds would have experienced their first episode by age 21 years (ABS 2008).

Young adults experience higher rates of mental illness than the rest of the adult population and tragically, suicide remains the leading cause of death of young people aged between 15 and 24 years (sub. 204). According to the 2007 *National Survey of Mental Health and Wellbeing*, 26% of people aged 16–24 years had an anxiety, mood or substance use disorder in a given year, compared with 19% of people aged 25–85 years (ABS 2008). Young people also experience relatively high rates of psychological distress (figure 6.1).

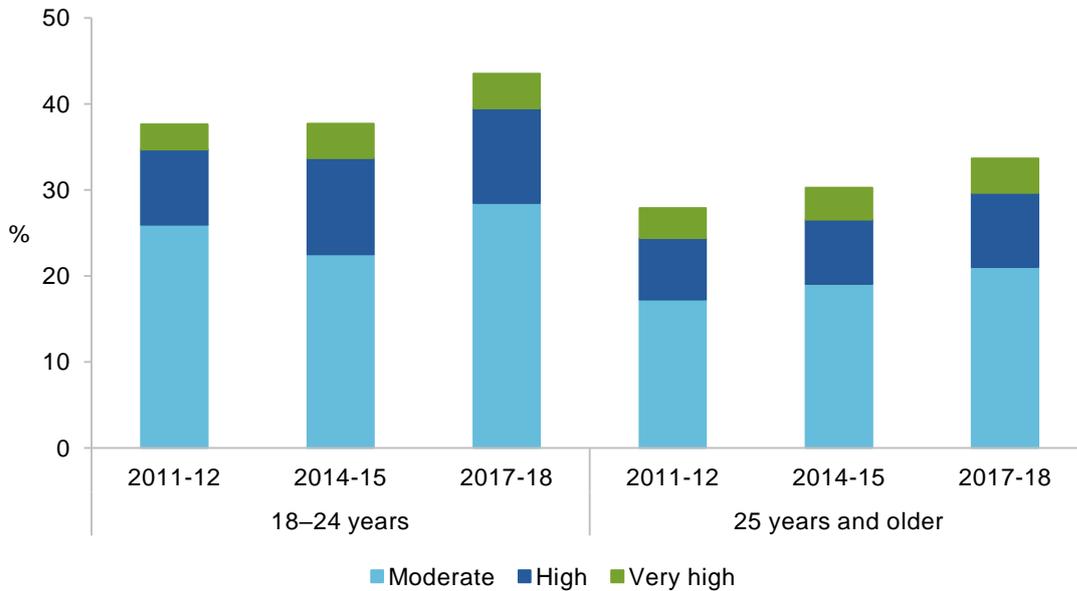
Similar to the general population, the proportion of young adults experiencing moderate or greater psychological distress increased between 2011–12 and 2017–18 — from 38% to 44% (figure 6.1). However, at least part of this increase could be due to increased awareness about mental health possibly leading to people being more likely to report feelings of distress.

The types of mental illnesses young people experience differ from the general adult population. Young adults have a much higher rate of substance use disorders (13% of 16–24 year olds compared with 5% of 16–85 year olds), but their rate of mood and anxiety disorders is similar to the remainder of the adult population (ABS 2008). Young adults also have lower rates of psychotic illness than the general population (Morgan et al. 2011).

Mental ill-health is a significant contributor to disability and the overall costs of ill-health for young people relative to the rest of the population. Mental health is the leading cause of disability in people aged 10–24 years (McGorry et al. 2014) and accounts for almost 50% of the burden

of disease in people aged 16–24 years (AIHW 2011d). As well, in 2018, 436 people aged 15–24 years died by suicide, making it the leading cause of death in this age group (ABS 2019b).

Figure 6.1 Psychological distress in young adults over time^a



^a Graph excludes not asked and unable to be determined.

Source: ABS (Microdata: Australian Health Survey, National Health Survey, 2011–12, Cat. no. 4324.0.55.001; Microdata: National Health Survey, 2014–15 and 2017–18, Cat. no. 4324.0.55.001).

Among young people, those leaving out-of-home-care at the age of 18 years are particularly vulnerable. A Senate inquiry considered them to be some of the most disadvantaged groups of young people and who were at greater risk of negative outcomes in terms of social outcomes, psychological functioning, financial status and educational and vocational achievements (SCARC 2015).

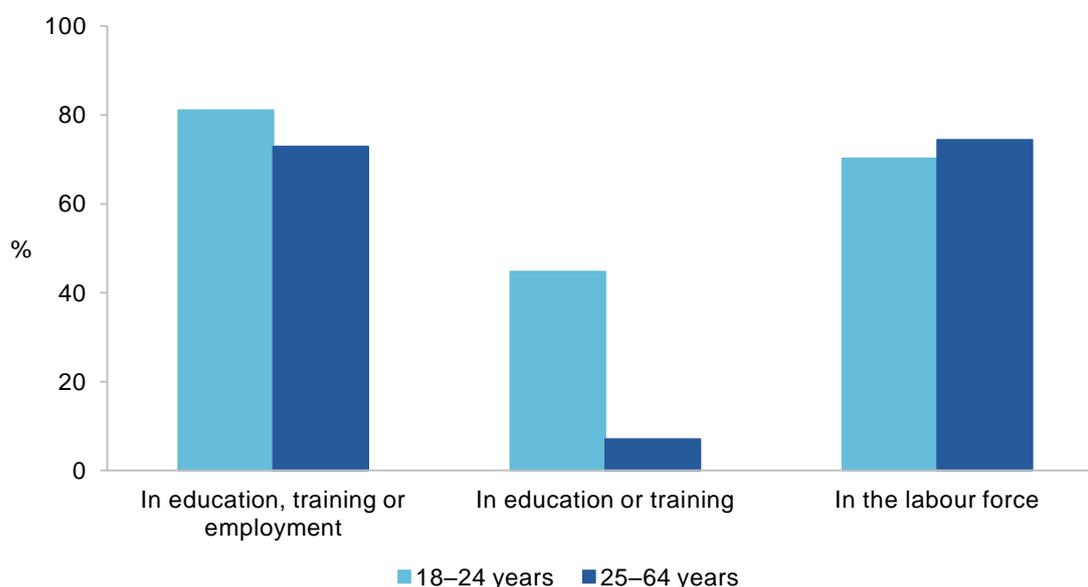
Young carers are another highly vulnerable group. About 12% of mental health carers in Australia are aged between 15 and 25 years (chapter 18).

Economic participation of young people

At the same time that many young adults are experiencing mental ill-health problems for the first time, they are also undertaking an important transition — moving from secondary school into further studies, employment or other activities.

Because many young people are studying, young adults have higher economic participation rates than the rest of the adult population. About 81% of Australia’s 2.1 million 18–24 year olds were engaged in education, training or employment in 2016, compared with about 73% of 25–64 year olds (figure 6.2).

Figure 6.2 **Adult economic participation^a**



^a Excludes not stated and unable to be determined.

Source: ABS (*Microdata: Census of Population and Housing, 2016*, Cat. no. 2037.0.30.001).

But there is a large group who struggle with the transition from secondary school into further studies or employment. For example, one study found 19% of 15–24 years olds seeking help for mental ill-health were not engaged in employment, education or training. Those not engaged are more likely to be male, older, and have a history of criminal charges, risky cannabis use, poorer social functioning, greater disability and economic hardship, higher levels of depression and a more advanced stage of mental illness than those who are engaged (O’Dea et al. 2014).

The high overall engagement rate of Australia’s young adults disguises the fact that they are much more likely to be unemployed than the general population. In August 2019, the unemployment rate for 15–24 years olds was more than double the unemployment rate of the working age population (ABS 2019d).

Participating in education, training and work have important benefits both for the individuals themselves and for the wider community, including:

- increased employment rates and incomes — for example, employment projections suggest that over 90% of new jobs over the next five years will require a VET qualification or higher (DJSB 2018)
- improved health and wellbeing — for example, a meta-analysis examining the relationship between socioeconomic status and depression found that each additional year of education was associated with a 3% reduction in the odds of being depressed (Lorant et al. 2003)

-
- increased social participation (OECD 2017a, 2018; Renner et al. 2015).

As noted by New South Wales Mental Health Commission (2014, p. 16):

Participation in education is critical to maintaining a young person's trajectory towards a fulfilling life, building skills and improving employment prospects.

Mental ill-health can negatively affect economic participation

Young people experiencing mental ill-health are at higher risk of disengaging from education or employment. For example, an evaluation of headspace (whose clients are aged 12–25 years) found that 20% of clients were disengaged from employment, education and training, compared with 11% of the comparable general population (Hilferty et al. 2015, cited in Orygen 2018b). This can have substantial negative consequences for their future wellbeing.

The broader impacts of mental health on workforce participation are discussed in chapter 19 and appendix D. Given that mental ill-health has been linked with lower economic participation, young people with mental ill-health might miss many of the important benefits of participating in education, training and employment. As Orygen and headspace noted:

The onset of mental illness peaks in adolescence and early adulthood, which is a critical developmental period for education, employment and interpersonal or relational outcomes. The experience and impact of mental ill-health during this life stage can interfere with the development of skills needed to successfully navigate these social and economic milestones. The persistence of mental ill-health through the prime years of productivity and economic participation can significantly increase the lifetime risk of poor health, social, education and employment outcomes. Therefore, the economic impacts of mental disorders in youth can endure well into life-stages at which mental ill-health represents relatively lower proportions of the prevalent health burden. (sub. 204, p. 16)

Transitioning from secondary education can be problematic

The transition from secondary to tertiary education and/or employment can affect a person's mental health. Transition points are known to place additional stress on a person's mental health (Orygen 2017a; ReachOut 2019). This particular transition can be accompanied by 'experiences of loneliness, self-doubt, anxiety and feelings of pressure' and it is also associated with other life changes and challenges, including having increased autonomy, balancing work and study, relocating from home and being financially responsible for the first time (Orygen 2017a, p. 14).

This transition is likely to have been made even more difficult for young people during the COVID-19 pandemic as a result of the pressures of social isolation and disruption to education and training. Having to engage remotely with their classes as well as the uncertainty around assessment can increase the sense of isolation and may increase levels of anxiety for continuing students and even more so for those commencing their tertiary studies.

Studies of the economic impact of youth mental health show the significant impact mental ill-health in young people can have on later outcomes. For example, a 2009 study of the economic impact of mental illness in people aged 12–25 years estimated that the annual financial cost in 2009 was over \$10.6 billion. This included \$7.5 billion in productivity lost due to lower employment, absenteeism and premature death of young people with mental illness (Access Economics 2009). A 2012 study of the cost of mental illness in young men aged 12–25 years concluded that it costs the Australian economy \$3.27 billion per annum. Of this, 24% were employment costs, including reduced earnings due to lower education, and 7% were unemployment costs (Degney et al. 2012). The costs associated with mental ill-health are discussed further in chapter 3 and appendix H.

Given the significant costs of mental ill-health, and the benefits of education, training and employment, it is important that young people, and particularly those experiencing mental ill-health, are provided with adequate support to complete their education and training and participate in employment.

6.2 Supporting people in tertiary education

Many young adults are studying at higher education or vocational education and training (VET) institutions (box 6.1).

While the focus of this chapter is on youth economic participation, it recognises that many people who undertake tertiary education are aged 25 years and older (ABS 2019e). As the data and research in this area generally covers students regardless of age, and that the benefits of education, and the rationale for supporting students to complete education, are not limited to the 18–24 year old age group, the following discussion encompasses all students undertaking tertiary education. ‘Support’ for this group is about arrangements that prevent the development of mental ill-health and helping those who have mental ill-health to remain engaged with their studies.

Who is undertaking tertiary education?

In 2018, there were just over 1.5 million university students in Australia and about 4.1 million undertaking VET studies (DoE 2018a; NCVER 2019b). In addition, there were about 276 000 apprentices and trainees in-training, as at 31 March 2019 (NCVER 2019a). Students in the higher education sector are more likely to be female, studying full-time, and from overseas (table 6.1).

Box 6.1 **The tertiary education sectors**

Tertiary education in Australia is made up of two sectors: higher education and Vocational Education and Training (VET). These sectors often overlap, with some universities, particularly in Victoria, providing VET-level qualifications and some public and private VET providers also offering higher education qualifications (Norton, Cherastidham and Mackey 2018; Orygen 2017a).

Higher education

The higher education sector confers awards that span levels 5–10 of the Australian Qualifications Framework, which include diplomas, advanced diplomas, associate degrees, bachelor degrees, graduate certificates, graduate diplomas, masters degrees, doctoral degrees, and higher doctoral degrees (TEQSA 2019c). As of October 2019, there were 178 higher education providers operating in Australia, including 40 Australian universities, 1 Australian university of specialisation, 1 Australian university college, 2 overseas universities and 134 non-university higher education providers (TEQSA 2019a). The non-university higher education providers are a mix of for-profit and not-for-profit providers, generally specialising in one field of education, occupation, qualification level or type of student (Norton, Cherastidham and Mackey 2018).

The Australian Government is predominantly responsible for policy and regulation of the higher education sector. Higher education providers are regulated under the Higher Education Standards Framework. The Tertiary Education Quality and Standards Agency was established in 2011 as the higher education sector regulator. It registers providers and evaluates their performance against the Higher Education Standards Framework (DoE 2018b).

VET

The VET sector includes a broad range of award courses that span levels 1–8 of the Australian Qualifications Framework and non-award courses. Courses include, for example, certificates, diplomas, apprenticeships, general use courses such as first aid training and part-day employer-specific training (Ey 2018; Orygen 2018b). As of 2017, there were 4193 VET providers, including 3156 private training providers, 442 community education providers, 398 schools, 143 enterprise providers, 41 TAFE institutes and 13 universities (NCVER 2018). Of these, 3193 were Registered Training Organisations. In 2018, private providers accounted for 71% and TAFE institutions for just over 19% of VET student enrolments (NCVER 2019c). Providers must be registered to deliver award courses (Ey 2018).

The VET sector is jointly funded and regulated by the Australian, State and Territory Governments. The National Agreement for Skills and Workforce Development and the National Partnership Agreement on Skills Reform set out the governments' roles and responsibilities (SCRGSP 2019a). The Australian Skills Quality Authority is the national regulator for the VET sector and accredits courses, regulates registered training organisations, and manages the registration of providers who wish to offer courses to overseas students studying in Australia. Victoria and Western Australia also have state-based regulators (the Victoria Registration and Qualifications Authority and the Training Accreditation Council). Providers who only offer courses in these states and do not enrol overseas students can register with these regulators (Ey 2018).

Table 6.1 Characteristics of tertiary students

Proportion of all students in sector, 2018^a

<i>Characteristic</i>	<i>Higher education</i>	<i>VET</i>
	%	%
Sex		
Male	42.9	50.8
Female	57.0 ^b	45.1
Located in: ^c		
Major cities	79.6 ^d	59.2
Regional	19.3 ^d	26.7
Remote	0.8 ^d	2.5
Full-time	71.3	10.7 ^e
Aboriginal or Torres Strait Islander	1.5	3.4
With disability	6.4 ^d	4.1
At school	na	8.4
Apprentice or trainee undertaking off-the-job training	..	7.7
Socio-economic indexes for areas (SEIFA) quintile: ^e		
1 (most disadvantaged)	na	17.3
2	na	18.3
3	na	19.6
4	na	17.4
5 (most advantaged)	na	14.9
Low socioeconomic status ^d	18.3	na
International student	26.9	4.4 ^e

^a For VET data, each category includes a proportion of students of which their status is not known.

^b According to the data notes, students who have requested their gender to be recorded as neither male nor female are counted as female. ^c Does not include students who are located overseas. ^d Excludes international students. ^e Data are for 2017. ^f Quintile 1 is the most disadvantaged. **na** Not available .. not applicable.

Source: DoE (2019a); NCVET (2019c).

The VET and higher education sectors have experienced quite different trends in enrolments in recent years. While the proportion of 15–64 year olds who undertake higher education has increased since 2001, the proportion undertaking VET has declined (Atkinson and Stanwick 2016). The introduction of the demand driven system has led to a significant increase in people undertaking higher education since 2008 (Atkinson and Stanwick 2016; PC 2019c). In addition, these changes, and other specific efforts by the Australian Government, have also led to increases in the participation rate of particular demographic groups including international students, students from regional and remote areas, students from lower socioeconomic backgrounds, students with disabilities and Aboriginal and Torres Strait Islander students. The proportion of overseas students enrolled in the higher education sector has increased in recent years from 18.7% of all enrolments in 2001 to 30.7% in 2018 (DESE 2019; DoE 2018a).

Mental health outcomes of university and VET participants

Many students experience mental ill-health

There is some evidence that tertiary students experience poorer mental health than the general population. For example:

- the National Union of Students survey of 3303 students across 40 universities and 30 TAFEs in 2016 found that 67% of 16–25 year olds and 59% of students over 25 years rated their mental health as poor or fair
- this same group also had high rates of psychological distress — 65% of 16–25 year olds and 53% of students over 25 years reported experiencing high or very high psychological distress (National Union of Students and headspace 2016)
- other Australian studies have also found that tertiary students experience relatively high rates of psychological distress (Renner et al. 2015; Stallman 2008, 2010; Stallman and Shochet 2009).

These findings are not unique to Australia, international studies have reported similar experiences (Eskin et al. 2016; Kramer et al. 2004; Said, Kypri and Bowman 2013; Steptoe, Tsuda and Tanaka 2007).

According to data from the Multi-Agency Data Integration Project (ABS 2019f), VET students appear to experience higher levels of psychological distress than university students. Both VET students and university students experience higher levels of distress than those in employment, but not as high as those who are unemployed (figure 6.3).

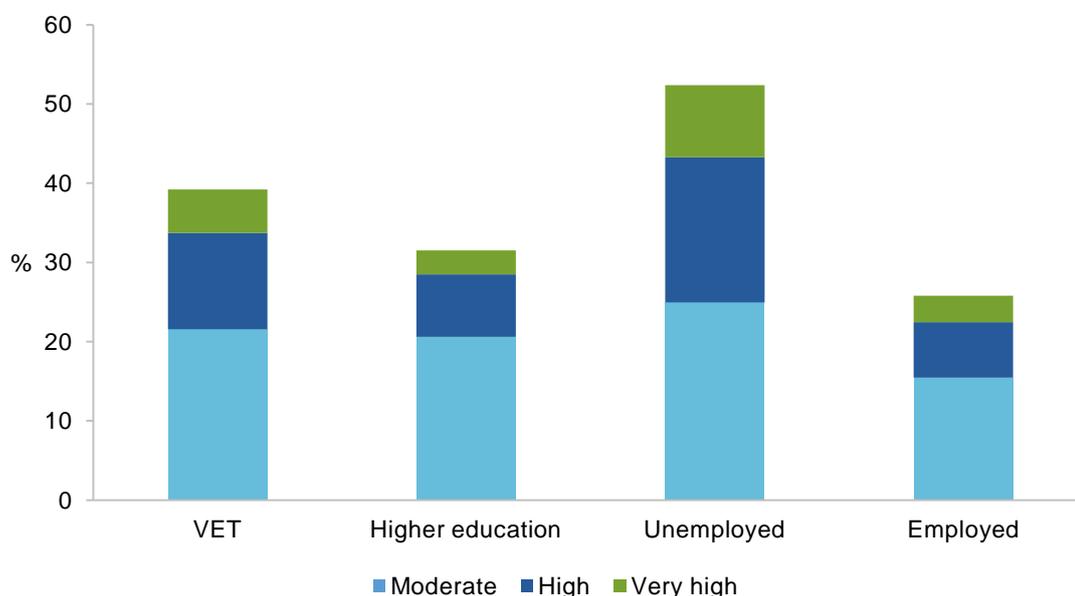
The prevalence of mental ill-health in university students could have increased in recent years. Also, a participant to this Inquiry who is a TAFE teacher advised that they were encountering more students with anxiety (Name withheld, sub. 41). Monash University Counselling Services experienced a 17% increase in clients and a 11% increase in consultations between 2017 and 2018 (sub. 698). However, an increase could also be driven by increased student awareness of problems and services, and/or an increased willingness to seek help.

There is no regular national data collection on the mental health of tertiary students in Australia that allows a comparison over time or a periodic assessment across institutions at a point in time. Other than Cvetkovski, Reavley and Jorm (2012), most of the research into student mental health has been in the form of optional self-reported surveys, mostly of university students.³⁷

³⁷ Given participation in these surveys has been optional and they generally have low response rates, the results should be treated with caution.

Figure 6.3 **Psychological distress by type of economic participation^a**

People aged 16–65 years



^a Psychological distress is measured using the Kessler Psychological Distress Scale (K10) assessment.

Source: Productivity Commission estimates using ABS (*Microdata: Multi-Agency Data Integration Project, Australia*, Cat. no. 1700.0).

Are international students at particular risk?

The prevalence of mental ill-health in tertiary students varies between different groups. However, the evidence, at best, is mixed, with a variety of studies each claiming to identify different groups that, in total, covers almost all students.³⁸

For example, international students have also been identified as a group that may experience higher rates of psychological distress, with some Australian studies finding that international students presenting at a university counselling service and Chinese students at a major Australian university had higher rates of distress than domestic students (Redfern 2016; Vivekananda, Telley and Trethowan 2011). As well, a study of international and domestic students at RMIT found that international students experienced higher rates of depression, suicide ideation and physical symptoms of psychological distress than domestic students (Summers et al. 2005, cited in Vivekananda, Telley and Trethowan 2011). However, other studies have found that international students do not have worse mental health outcomes (Said, Kypri and Bowman 2013; Skromanis et al. 2018; Stallman 2010).

³⁸ For example, Andrews and Chong (2011), Cvetkovski, Reavley and Jorm (2012), Mulder and Cashin (2015), Said, Kypri and Bowman (2013), Stallman and Shochet (2009) and Vivekananda, Telley and Trethowan (2011).

At least part of the mixed results relating to international students may be due to cultural factors. International students might under-report mental health illness as they may be less willing to disclose illness, even in an anonymous survey (Said, Kypri and Bowman 2013). As noted by Vivekananda, Telley and Trethowan (2011, p. 40), ‘international students may be a vulnerable group due to the many psychosocial and cultural transition stressors they experience’. There has been increased awareness of the pressures faced by some international student cohorts in recent years, with at least 27 international students dying by suicide between 2009 and 2015 in Victoria alone (box 6.2).

What factors worsen student mental health outcomes?

Being a student is associated with a number of stressors that can affect mental health. These include study-specific stressors and other factors associated with being a student.

Study-specific stress

For many students, beginning tertiary education is associated with increased workloads and academic demands, which can cause stress (Wynaden, Wichmann and Murray 2013). For example, 64% of those responding to the 2016 National Tertiary Student Wellbeing Survey said they found their academic experience to be very or extremely stressful (National Union of Students and headspace 2016). In comparison, a survey of year 12 students undertaking the Higher School Certificate in New South Wales found that 37% reported above average stress levels and 16% reported severe levels of anxiety (North, Gross and Smith 2015).

Separation from familiar support networks

For many people, beginning tertiary studies is associated with living away from home, and being away from support networks for the first time (Said, Kypri and Bowman 2013). And for many students — in particular, international students and students from regional and remote areas — beginning tertiary studies can involve moving long distances away from family and support networks (Forbes-Mewett and Sawyer 2011).

International students are often not just experiencing living away from their families and support networks, they are also adapting to a different culture, language and way of doing things (Forbes-Mewett and Sawyer 2011; Wynaden, Wichmann and Murray 2013).

Box 6.2 Suicide among international students

Suicides among international students have received significant attention in recent years. In 2019, a Victorian Coroner investigated the death of Zhikai Lui, an international student studying at the University of Melbourne in Victoria. The Victorian Coroner found that Zhikai Liu was likely depressed due to relationship issues, the difficulties he had understanding what was happening in his university classes and the language barriers he faced.

As part of the investigation, the Coroners Prevention Unit found that at least 27 international students had died by suicide in Victoria between 2009 and 2015. However, this is likely to be an underestimate as the Coroners Prevention Unit found, when reviewing the Victorian Suicide Register, in some cases they were unable to determine if the person was in Australia on a student visa or another type of visa. The Unit compared these students to a cohort of domestic students who had died by suicide and found that a lower proportion of international students had a diagnosed or suspected mental health disorder, and a higher proportion had experienced educational and financial stressors. The international students were also much less likely to have attended a health service for a mental health-related issue within six weeks prior to death (22.2% compared with 57.1%).

The Coroners Prevention Unit expressed concerns that the lower rate of diagnosed mental illness and lower engagement with mental health services could reflect increased barriers to international students accessing mental health treatment, rather than a lower underlying prevalence of mental illness.

The Victorian Coroner noted that while they were unable to conclude the student would still be alive if they had engaged with a mental health service, it at the least would have created prevention opportunities that did not exist otherwise.

The Victorian Coroner made a number of recommendations including that the Australian Government Department of Education should:

- consult with Victorian international student education providers as well as other relevant organisations to identify strategies to engage vulnerable international students with mental health support
- draw together critical incident reports maintained by education providers to inform interventions to reduce suicides among international students
- amend Standard 6 of the National Code of Practice for Providers of Education and Training to Overseas Students to include a requirement that education providers must forward a copy of the critical incident report and any remedial action taken to the Coroner in that jurisdiction within four weeks of the death of an international student.

The Australian Government Minister for Education agreed in principle to the Victorian Coroner's recommendations and noted that they were relevant at a national level, not just Victoria. The minister tasked the Australian Government Department of Education to consult with the education sector to further develop strategies to support international student mental health.

Source: Hunter (2019); Tehan (2019); Victorian Coroner (2019).

Financial stress

Many students also experience financial stress. While some are financially supported by their families, other students are responsible for their own finances and living costs for the first time. This can cause significant stress for these students. Stallman (2010) found that students with financial stress were twice as likely to report mental illness. As noted by the Curtin Student Guild (sub. 234, p. 2):

More than ever, students are experiencing high levels of stress associated with lifestyle factors related to financial strain, unemployment, graduate employability, and work or study pressures. A Universities Australia report found that most domestic undergraduate students (58%) are worried about their financial situation and students of low socioeconomic status are more likely (63%) to be worried. ... Accordingly, a significant number of students are now living below the poverty line and have been found to carry 30% more debt in 2012 than in 2006.

Balancing work and study

While some financial stress associated with study may be alleviated for those working at the same time, balancing study and work brings its own additional stresses (Orygen 2017a). The Curtin Student Guild (sub. 234, p. 6) noted that ‘nearly a third (30%) of full-time domestic undergraduate students are also working more than 20 hours a week’.

The administrative processes of tertiary education providers

The way certain processes are implemented by a tertiary education providers can also have impacts on the mental health of students. For example, the Productivity Commission was told that a university that had previously released the semester’s academic results on a Friday afternoon although the university counselling services were closed over the weekend addressed this potential risk to students’ wellbeing by simply changing the release date of results to a Monday morning. A simple awareness of the potential mental health implications of various administrative processes could avoid adding additional stressors to student mental health (Melbourne trans, p. 87).

What does mental ill-health mean for students’ education outcomes?

Mental ill-health can negatively affect tertiary students’ participation and academic performance. Curtin Student Guild (sub. 234, p. 4) stated:

A lack of response to mental health difficulties can result in poor academic performance or complete academic failure, relationship issues, and compounding problems such as drug or alcohol abuse, stigma, isolation, discrimination and the continued decline of physical and mental health.

There is evidence that mental ill-health is related to lower academic achievement. For example, Australian and international research have found that increased mental ill-health

and higher levels of psychological distress are associated with lower grade point averages (Stallman 2010).

Many tertiary students not completing their studies are also affected by mental ill-health. Cavallaro et al. (2005) found that VET students with mental illness had a subject completion rate of 67%, compared with 75% for all VET students with a disability and 82% for all VET students. Karmel and Nguyen (2008) found a similar result and that, once other student characteristics were controlled for, mental illness had a relatively larger impact on completion rates than other disability types. Mental ill-health also appears to affect higher education students' completion of their studies. For example, 45% of higher education students in 2018 who were considering exiting their course early were doing so for health or stress reasons (Social Research Centre 2019).

There are several channels through which mental ill-health affects students' outcomes, including:

- it can lead to difficulties with concentrating and studying, missing classes and disruptions to participation
- perceived and actual stigma, discrimination and fear of failure
- the effect of other issues associated with mental ill-health such as financial pressures and physical ill-health (Hartley 2010; Miller and Nguyen 2008; Orygen 2018b).

Many tertiary students with mental ill-health do not seek help

Many students do not seek help for their mental ill-health. Surveys of Australian university students have found that only about one-third of students with elevated levels of psychological distress had consulted a health professional regarding their stress (Stallman 2008, 2010). These rates are similar to the general population (Stallman 2008). However, according to Stallman (2010), a higher proportion of students compared to the general population reported seeing counsellors, which may reflect the availability of counselling services on university campuses.

Students with struggling with their mental health may also not know where to go for help. For example, the Productivity Commission was told that some students struggling mentally were not even aware that support services were available on campus (Mike Anderson, Perth transcript, p. 56).

Data from a VET provider survey indicated that only 12% of VET students who reported a disability also disclosed having a mental illness (NCVER 2011, cited in Orygen 2018b). This translates to only about 1% of VET students, which is much lower than the prevalence of mental illness in young people more generally (Orygen 2018b). This discrepancy indicates that either many VET students may choose not to disclose their mental illness and avoid seeking support and reasonable adjustments, or alternatively, young people with mental illness do not engage with VET. In addition, while the proportion of students with disability enrolled

in higher education has increased, only 6% of higher education students report having a disability (table 6.1) and only a portion of these would have a psychosocial disability.

Help-seeking behaviour appears to vary by type of student. For example, Skromanis (2018) found that international students at the University of Tasmania were less likely than domestic students to report seeking help for a mental health, relationship, or alcohol or substance use issues.

There are several reasons why students do not seek help. A key reason is stigma. A 2016 survey of university and VET students found that about 20% of 16–25 year old participants said they were too embarrassed to ask for help for their mental health and almost 20% said they were worried about what other people might think (National Union of Students and headspace 2016). McAuliffe et al. (2012, p. 117) stated:

... students often do not know who they should disclose to, what will happen to disclosed information, and who has access to this information. Student's often fear embarrassment, stigma, and shame about disclosing mental illness, which is compounded by the diverse attitudes, experiences, and beliefs of educators.

Another Australian study found that many students go to considerable lengths to conceal mental ill-health and, as a result, found it difficult to meet their academic requirements (Martin 2010; Orygen 2017a).

Similar to the general population, students may be unsure as to whether their problems are serious enough to seek help or may consider that they can deal with their problems on their own. Other reasons reported as to why students do not seek help include a lack of time and the cost (Wynaden, Wichmann and Murray 2013). However, given student counselling services are typically free (as are headspace centres), cost is likely to be less of an issue in practice, than is time or the perceived capacity of services to be helpful.

Mental health and wellbeing support for students

In addition to the supports available to the general community, there is a range of specific supports that are provided to tertiary students to help them with their mental health and wellbeing and to access and participate in education and training if they are experiencing mental ill-health. The education institutions themselves mostly provide these supports, but governments and other organisations also provide support.

Some of the institution-provided support is required by legislation or government policy. Nevertheless, the amount and types of support provided varies by institution, including by institution size (larger institutions with more resources typically provide more support) (for example, IHEA, sub. 555) and sector (different requirements are imposed on higher education and VET sector providers).

Similar to mental health more broadly, there has been increasing awareness of student mental health and wellbeing needs in recent years, which has driven significant activity in the sector.

Mental health-related support requirements

Requirements on both the higher education and VET sectors

Under the *Disability Discrimination Act 1992* (Cth) and the Disability Standards for Education 2005, all education providers regardless of sector are obligated to make ‘reasonable adjustments’ to ensure that students with disability (including psychosocial disability) are able to access and participate in education and training on the same basis as other students (DoE 2005) (box 6.3).

Box 6.3 Disability Discrimination Act and Disability Standards for Education

The *Disability Discrimination Act 1992* (Cth) makes it unlawful to discriminate on the basis of disability (including mental illness) in areas such as education, employment, the provision of goods and services, and access to public buildings.

The Disability Standards for Education 2005 were created under the Disability Discrimination Act to clarify education providers’ obligations and the rights of students with disability under the Act. The objectives of the standards are to:

- (a) to eliminate, as far as possible, discrimination against persons on the ground of disability in the area of education and training; and
- (b) to ensure, as far as practicable, that persons with disabilities have the same rights to equality before the law in the area of education and training as the rest of the community; and
- (c) to promote recognition and acceptance within the community of the principle that persons with disabilities have the same fundamental rights as the rest of the community.

The Standards are to be reviewed every five years, with the next review expected to take place in late 2020.

Source: Disability Discrimination Act 1992 (Cth); Disability Standards for Education 2005.

In addition, all higher education and VET sector providers that are registered to educate overseas students must provide certain supports (that include mental wellbeing supports) to these students under the *National Code of Practice for Providers of Education and Training to Overseas Students* (box 6.4).

Requirements for the higher education sector

The Higher Education Standards Framework 2015 and the National Access to Service Benchmarks include mental health-related requirements for higher education providers. Section 2.3 of the Higher Education Standards Framework includes wellbeing and safety standards that all higher education providers must meet, including:

- all students are advised of the actions they can take, the staff they may contact and the support services that are accessible if their personal circumstances are having an adverse effect on their education

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- timely, accurate advice on access to personal support services is available, including for access to emergency services, health services, counselling, legal advice, advocacy, and accommodation and welfare services
 - the nature and extent of support services that are available for students are informed by the needs of student cohorts, including mental health, disability and wellbeing needs
 - a safe environment is promoted and fostered, including by advising students and staff on actions they can take to enhance safety and security on campus and online
 - there is a critical-incident policy together with readily accessible procedures that cover the immediate actions to be taken in the event of a critical incident and any follow up required.

Box 6.4 Requirements of providers who educate overseas students

Under Standard 6 in the National Code of Practice for Providers of Education and Training to Overseas Students, education providers are required to provide a number of mental health-related supports including:

- giving overseas students an age and culturally appropriate orientation program that provides information about:
 - student support services available to assist overseas students to adjust to study and life in Australia and to assist with general or personal circumstances that are adversely affecting their education
 - emergency and health services
 - the provider’s facilities and resources
- either directly providing, or referring overseas students to, services and programs, including counselling and mental health, general health, and disability support, at no additional cost to the student
- having a designated contact officer for overseas students, who must have access to up-to-date details of the registered provider’s support services
- having a critical incident management policy.

Source: DoE (2018c).

Higher education providers under the National Access to Services Benchmarks (established under the *Higher Education Support Act 2003* (Cth)) are required to provide information about the support services available to students, including health, mental health, counselling and welfare services. Where higher education institutions provide these services directly, the benchmarks state that the services must be delivered by trained and qualified staff. Where higher education providers refer students to external services, they cannot charge students for these referrals.

VET sector requirements

Under the Commonwealth *Standards for Registered Training Organisations 2015*, Registered Training Organisations are required to provide educational and support services that meet the needs of learners. Standard 1.7 in regard to learner support states:

The RTO determines the support needs of individual learners and provides access to the educational and support services necessary for the individual learner to meet the requirements of the training product as specified in training packages or VET accredited courses.

The Australian Skills Quality Authority (ASQA 2019) notes that while there is no defined approach as to how support will be evaluated or provided, there is an assumption that the purpose of the support is to maximise the outcomes for the learner. This may include providing Learning, Literacy and Numeracy support, assistive technology including equipment, resources and/or programs, flexible scheduling and delivery of training and assessment, counselling services and referral to those services.

Individualised support provided to students experiencing mental illness

As discussed above, institutions are required to provide a range of supports to help students with mental illness engage with their studies.

While the exact process students need to go through to access these supports varies by institution, generally students need to apply for support and have their condition verified (such as by supplying evidence of a diagnosis) (IHEA, sub. 555). The supports provided vary depending on the student's diagnosis, their needs and preferred supports. Education providers are not required to provide any and all supports the student requests. Any support or adjustments need to be considered 'reasonable'. Examples of support that may be provided include: pre-enrolment information and advice; counselling and advocacy; extra tuition; and alternative learning and assessment arrangements.

Higher Education Disability Support Program

The Higher Education Disability Support Program was established by the Australian Government to help support higher education students with a disability. It provides funding to assist in removing barriers to access for students with disability. These funds are aimed at assisting higher education providers with the additional costs incurred in providing support and equipment to students with disability, implementing strategies to support these students and funding to maintain the Australian Disability Clearing House on Education and Training website that provides information and resources to promote inclusive practices for people with disability (DoE 2019d).

Counselling services

As discussed above, all higher education and VET providers are required to provide access to mental health-related support services. As part of meeting these requirements, some provide in-house counselling services, while others (often smaller institutions) refer students to external counselling services.

Whether institutions have counselling services generally varies by sector and the size of the institution. While there is no complete information on which institutions have counselling services:

- all Australian universities have counselling services (TEQSA 2019b).
- of the non-university higher education institutions (including independent and TAFE higher education providers)
 - 46% reported offering internal counselling services
 - 35% offered access to external counselling
 - about 25% of institutions reported that they do not offer any counselling at all (TEQSA 2019b).

The characteristics of internal counselling services also vary by institution, but they are usually free, low-intensity services and there is often a limit on how many sessions students can access (IHEA, sub. 555; Orygen 2017a; Universities Australia, sub. 251).

Most students who access counselling services do so for common mental disorders, including depression, mood disorders and anxiety disorders. Students also often want help for interpersonal issues such as family issues (Vivekananda, Telley and Trethowan 2011).

Other mental health and wellbeing support

Tertiary education institutions provide a range of other mental health-related supports that, similarly to counselling services, vary by institution. These include, for example:

- campaigns and activities aimed at increased mental health awareness and reducing stigma, such as the batyr@uni program, which aims to reduce stigma and encourage help seeking by getting people with lived experience to share their stories (batyr 2019)
- peer mentoring services, such as Monash University's Peer Mentoring Program, which pairs students registered with Disability Support Services with a student mentor (Monash University 2019)
- online support, such as thedesk, which support tertiary student mental health by providing free access to online modules, tools, quizzes and advice (thedesk 2018)
- training for educators, such as providing Mental Health First Aid Training (Andrews 2019)

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- psychology clinics, which are usually set up to provide postgraduate students in psychology and psychiatry with practical opportunities (Orygen 2017a).

Whole-of-institution mental health and wellbeing strategies and frameworks

There is increasing recognition that mental health and wellbeing should be embedded in all activities and processes at tertiary education institutions. Almost half of universities have developed whole-of-institution mental health and or wellbeing strategies or frameworks to guide their response to these issues and the support they provide (Andrews 2019). Each institution's strategy differs, but they generally include similar core elements. For example, the Australian National University's Mental Health Strategy (ANU 2016) includes seven components:

- institutional structure: organisation, planning and policy
- supportive, inclusive campus climate and environment
- mental health awareness and literacy
- community capacity to response to early indicators of concern
- self-management competencies and coping skills
- accessible mental health services
- crisis management.

In September 2018, the Australian Government announced it was providing Orygen, the National Centre in Youth Mental Health, with \$660 000 to develop a National University Mental Health Framework. The framework is intended to include guidelines and standards for all Australian universities to create learning environments that prevents mental ill-health and poor mental health outcomes and that strengthen connections between universities and community mental health services. The framework is intended to be voluntary at this stage and is expected to be completed by late 2020 (Minister for Health and Hunt 2018; Orygen and headspace, sub. 204).

What needs to be done to provide better support to tertiary students?

Given the high proportion of tertiary students who experience mental ill-health and the effect that ill-health can have on shorter- and longer-term economic participation, it is important that students experiencing mental ill-health are supported to remain in and complete their studies. Higher education and VET settings provide an opportunity to deliver support to a significant proportion of people aged 18–24 years.

Indeed, there is evidence that supporting tertiary students' mental health can yield substantial benefits. For example, the RAND Corporation evaluated prevention and early intervention programs delivered across universities and community colleges in California and their impact on accessing support services, retention and lifetime earnings. It found a

net societal benefit of \$6.49 for every dollar invested and a net societal benefit of \$11.39 for every dollar invested when the results were restricted to just community colleges (which tend to have a higher proportion of students in lower socioeconomic groups, than universities) (Ashwood et al. 2015).

While tertiary education institutions provide a range of supports, the level and type of support provided varies between institutions. Given that problems remain, even for people studying at institutions with greater levels of support, governments and tertiary education institutions need to do more to enable young people with mental ill-health to remain engaged in their education.

Encouraging students to seek help

The low rates of disclosure by students with mental illness and their reluctance to seek help (as discussed earlier), likely means that many do not receive the supports that they are entitled to receive under the *Disability Discrimination Act 1992* and Disability Standards for Education.

There have been concerns that tertiary education institutions are not doing enough to address the low rate of students seeking help for mental ill-health. For example, Miller and Nguyen (2008) argued that TAFE institutes needed to use mental health promotion to address the lack of disclosure. In addition, the Curtin Student Guild (sub. 234, p. 5) recommended:

An increase in mental health promotion campaigns and awareness raising strategies to direct students to resources and online interventions that are accessible through university channels targeted to their needs, schedules, and preferences.

There is limited evidence on how institutions can reduce stigma and encourage disclosure and help seeking in students. However, a study into non-disclosure of university students with disabilities made a number of recommendations, which could encourage disclosure or reduce the negative impact of non-disclosure, including:

- offering different disclosure channels (including online options and times) and ensuring that students retain control over their information
- explaining equity programs and services to students at university, with clear information on benefits, confidentiality and the disclosure process
- adopting clear, consistent and easily understood definitions of equity groups
- adopting inclusive practices and procedures across educational content, such as accessible online materials, so that students who choose not to disclose are less likely to reach a ‘crisis’ point (Clark, Kusevskis-Hayes and Wilkinson 2019).

Addressing the reasons why students do not disclose or seek help would likely increase the number of students seeking and receiving support for their mental ill-health.

Counselling services are important and need to be adequately resourced

Tertiary education institutions should support the mental health and wellbeing of their students, but they are primarily an education service. Accordingly, counselling services at educational institutions should play an important role in triaging students with mental ill-health and make available short-term counselling for those requiring it. Those students with more complex and severe needs that cannot be met by counselling services should be directed to the appropriate service providers in the wider mental health system.

Effectiveness and resourcing of these services

While there is limited evidence on the effectiveness of tertiary education institution counselling services in Australia, international evidence suggests that counselling provided by tertiary education providers can be effective in improving mental health outcomes.

For example, Connell et al. (2008) studied data from seven UK university counselling services and found that 70% of clients saw improvements in their level of psychological distress from pre- to post-counselling. Murray et al. (2016) examined the effectiveness of a UK counselling service and found that 63% of clients saw a reliable improvement in their psychological distress levels.

There is also evidence that university counselling can improve academic outcomes, even where academic issues are not the reason a student attends counselling in the first place (Biasi et al. 2017; McKenzie et al. 2015; Monti, Tonetti and Ricci Bitti 2014, 2016).

However, education counselling services are currently facing a range of challenges. There has been an increase in demand for counselling services, with many counselling services struggling to meet this demand (Andrews 2019; Orygen 2018b; Vivekananda, Telley and Trethowan 2011). There are a few reasons for this including:

- an increasing willingness of students to approach counselling services
- each student requiring more time with counselling services as they are more likely to have severe and complex needs than previously and the student population is becoming more diverse (Andrews et al. 2011).

The Australian and New Zealand Student Services Association has developed guidelines for the provision of counselling services in the post-school education sectors in both countries, based on international best practice guidelines for the provision of services to higher education students (Andrews et al. 2011). These guidelines cover a range of topics including the role, function and responsibilities of services, the typical activities and types of services provided, services standards, staffing — including staff levels, qualification and workloads — and risk management and occupational health and safety.

These guidelines also include a recommended staff-to-student ratio for counselling services of either one counsellor to 1000 or 3000 student population per campus, depending on the

types of services the counselling service is expected to provide (Andrews et al. 2011). Many universities do not appear to be meeting these recommended ratios (Andrews 2019).

There have been calls from student bodies for increased resources for counselling services. The Curtin Student Guild (sub. 234, p. 5) recommended:

An increase in funding to Australian university counselling services, with the aim of increasing numbers of professional staff to meet the demands of a student population who are demonstrating an increasing complexity and severity of mental health conditions.

Tertiary education institutions that provide on-site counselling services need to adequately resource these services so that they can meet the needs of students who require them. This includes ensuring that these services can meet the needs of a diverse cohort of students, including those who are Aboriginal or Torres Strait Islander peoples, from overseas, from culturally and linguistically diverse backgrounds and who are studying off-campus.

There have been calls for tertiary education providers to develop partnerships with external service providers. Orygen (2017a) called for counselling services to develop ‘pathways to appropriate and specialised mental healthcare within (such as psychology clinics) and outside of universities’. And the Curtin Student Guild (sub. 234, p. 5) argued for:

... improved collaboration between university campuses and external service providers who can assist students in specialised areas which are outside the scope of university counselling services.

While many institutions provide some mental health support services online (IHEA sub. 555) (Inglis and Cathcart 2018), there may be greater scope for counselling services to utilise online services for the diagnosis, triaging, and/or treatment of mental ill-health. This may enable improved access to counselling services for a demographic familiar with the use of online services (chapter 11). For example, Macquarie University provides an online delivered treatment course over five weeks for its students to provide practical skills for managing symptoms of stress, anxiety, worry, low mood and depression (Macquarie University 2018). Monash University (sub. 698) has provided online services since 2013 and noted that between 2014 and 2018 the growth in students accessing services online far exceeded face-to-face counselling.

Online services are increasingly being used as a means of triaging students or providing options for low-intensity, self-directed mental healthcare. While this can assist in reducing waiting times for accessing face-to-face services and as a means of stepped care, Orygen (sub. 1110) commented that some students still prefer face-to-face support. It concluded that online services should be integrated with face-to-face supports on campus and only utilised as a low intensity substitute where there was good evidence as to the efficacy of the online intervention.

The use of online services operating in conjunction with other mental health services, such as on-campus counselling services and access to external services, provide an additional means for tertiary education providers to better meet the mental health needs of the student population.

The use of online services could also improve (de-identified) data collection on the mental health of students and the effectiveness of different services for that institution. This may also create the opportunity to aggregate this data across institutions to develop a larger database on the mental health of the student population.

ACTION 6.1 — ONLINE MENTAL HEALTH SERVICES FOR TERTIARY STUDENTS

Online support provided by tertiary education institutions can help maintain students' mental health.

Start now

Tertiary education institutions should continue to expand online mental health services to meet student needs. These services should incorporate de-identified data collection on the mental health of students to enable ongoing improvements in the effectiveness and relevance of mental health support services.

Staff in contact with students need more training and guidance

Teaching staff at tertiary education institutions play an important role in supporting students' mental health and wellbeing. The curriculum that educators set and the teaching strategies used can affect a student's wellbeing (Baik et al. 2017). In addition, some students will approach teaching staff with mental health-related issues and how educators respond to this can affect the student's mental health and an ongoing approach to support. For example, if the staff member does not respond in an appropriate manner, this could result in further stigmatising of the student or the student not receiving the appropriate support or referrals (AMSA Student Mental Health and Wellbeing Committee 2013).

Anecdotal evidence suggests teaching staff generally receive limited guidance and training on how to effectively and appropriately respond to students' mental ill-health. There are currently no legislated requirements for teaching staff to undertake any sort of training on student mental health and wellbeing.

In a survey of teaching staff at an Australian university, about 60% stated they felt under-equipped to deal with student mental ill-health and about 50% stated they did not have access to formal training (Gulliver et al. 2018). TAFE staff have reported that they felt there was a lack of clarity about the extent of their roles in supporting mental health and that they require appropriate skills and collegiate support to respond confidently to the need of students with mental illness (Miller and Nguyen 2008). In addition, McAuliffe et al. (2012) reported that academics are often unsure of how to respond to students who disclose a mental illness and there is a need for clearer policies and procedures in this area.

Some institutions do provide optional training courses for educators; for example, some universities provide Mental Health First Aid or other training to help equip staff to respond

to students who are in distress (Andrews 2019; IHEA, sub. 555). In addition, there has been some guidance developed for teaching staff. For example, the *Enhancing Student Wellbeing* project was developed with the aim of building the capacity of university educators to design curriculum and create teaching and learning environments that enhance student mental wellbeing. It is an online resource that includes five modules for educators to work through on student wellbeing, curriculum design, teaching strategies, difficult conversations and educator wellbeing (Enhancing Student Wellbeing Project 2016). The University of Melbourne provides a 40 minute online course to enable staff to support student mental health (University of Melbourne 2020).

Stakeholders, including staff and students have called for more training and guidance for teaching staff to improve their mental health literacy, reduce stigma and help them appropriately and effectively respond to students who come to them with mental health concerns (AMSA Student Mental Health and Wellbeing Committee 2013; Miller and Nguyen 2008; Orygen 2018b).

In responding to the draft report, Monash University (sub. 698) agreed that there needed to be a significant increase in teaching staff trained in mental health and wellbeing, but was concerned that requiring all teaching staff to undertake this training would place too large a financial demand on tertiary education institutions for this training to be delivered free of charge. Nevertheless, it called for all ‘student facing staff’ both professional and academic staff to receive the necessary training.

Given the objective is to support the mental health of the student population and encourage early detection and treatment of any mental health problems, as a general principle all staff who have direct interaction with students should undertake this training. A number of non-teaching staff in a university setting are likely to have dealings with students facing stressful events, such as dealing with those students failing courses, facing possible exclusion and enrolment difficulties.

In providing this training, tertiary education providers should also be aware that academic staff providing lectures to hundreds of undergraduate students in crowded lecture theatres are less likely to have face-to-face dealings with students than those post-graduate students and other casual staff providing tutorials to smaller groups of students.

Tertiary education providers need to clarify the roles and responsibilities of teaching and other staff in supporting students’ mental health and provide information and guidance to teaching staff to help them meet their responsibilities. This could include promoting already available information including the *Enhancing Student Wellbeing* project and guides such as the Western Australian Department of Training and Workforce Development’s guidelines (WA TWD 2012).

Universities Australia raised concerns that this training would create an additional and unnecessary compliance burden for universities and that this would impose a prescriptive requirement and undermine the flexibility of the tertiary education providers to meet the standards through a different variety of approaches (sub. 943). However, how and when this

training is provided — such as online or face-to-face and the frequency and the duration — will remain a matter for each tertiary education provider. Indeed, as noted above a number of institutions already have courses and modules in place to train staff and including such a requirement in the Higher Education Standards Framework (Threshold Standards) would provide further impetus to raise the standard across the sector.

International students need additional support

While international students can benefit from many of the services provided to all students, as discussed earlier, they are often subject to additional stressors, such as language and cultural differences, and they are less likely to seek help for mental ill-health. This is likely due to cultural barriers and issues accessing support including not wanting to pay to access to services, uncertainty about any consequences associated with accessing services, waiting to access services in their home country and being unfamiliar with Australian services (Orygen, sub. 1110). Institutions need to provide services that meet the diverse and different needs of international students. This may require alternative approaches to those used for domestic students.

As discussed earlier, the Australian Government Department of Education have been tasked with consulting with the education sector to develop strategies to address international student mental ill-health, following increased attention on suicide deaths by international students (box 6.2).

More generally, if there are barriers to international students accessing mental health services, these need to be addressed. For example, Monash University (sub. 698) noted that it had seen a significant year on year increase in the share of international students using its counselling services — due to the growth in online counselling services, an increase in available appointments and increasing cultural diversity and languages spoken by the clinical team.

Ensuring that counselling services can meet the cultural and language needs of their international students is critical for these students to be comfortable in seeking out these services to address any mental health issues.

Students from most countries³⁹ are required to purchase Overseas Student Health Cover (OSHC) as a condition of their student visa. OSHC is offered under a Deed of Agreement between the Australian Government and certain insurers. The insurance covers the Medicare Benefits Schedule fee component of international students' (and their dependents) medical and hospital care and ambulance services and limited pharmaceutical benefits. It does not cover physiotherapy, dental, optical and other ancillary costs or any fees charged above the Medicare Benefits Schedule fees. However, insurers are able to offer a higher level of

³⁹ Students from some countries (Sweden, Norway and Belgium) may have access to special arrangements under their own national schemes and maybe exempted from the requirement to have OSHC. Those from countries that have reciprocal health care agreements (United Kingdom, Netherlands, New Zealand) with Australia can access Medicare, but are still required to have OSHC (Australian Government 2019d).

benefits as an OSHC product. Under the Deed of Agreement, treatment for pre-existing conditions in the first 12 months after arrival is not covered. An exception to this is pre-existing psychiatric conditions, for which treatment provided within the first two months following arrival is not covered, unless a medical practitioner certifies and the insurer agrees that the international student required emergency treatment in Australia (Australian Government 2019d).

The Department of Home Affairs, in granting a student visa, requires the visa holder to have acquired and maintain adequate health insurance for their stay. But it would appear to fall to hospitals and other medical service providers to recover unpaid mental healthcare expenses of international students (and indeed other unpaid health expenses of international visitors) (Parnell 2018).

For example, the Royal Melbourne Hospital requires those without a Medicare card (or those without reciprocal rights) to pay for all treatment prior to admission or for unplanned services on or immediately after discharge. Overseas visitors, including international students, seeking treatment at the hospital are required to provide their passport, visa status and contact information in Australia. Where visa holders do not meet the health insurance conditions of their visa, the hospital is obligated to notify the Department of Home Affairs (The Royal Melbourne Hospital 2019)

Of the \$100 million NSW public hospitals invoiced to ineligible patients or their insurers in 2018 (mainly for hospital accommodation charges), around \$70 million was paid, leaving a \$30 million gap for taxpayers (NSW Minister for Health and Minister for Medical Research and Hazzard 2019). Only a fraction of this would be related to mental healthcare, so consequently, the amount of taxpayer funds involved with respect to covering any mental healthcare costs incurred by uninsured international students is likely to be comparatively small.

Nevertheless, Orygen (sub. 1110) submitted that many international students with OSHC were unsure as to the extent of the coverage and how to use the OSHC cover when accessing services, creating confusion and anxiety for some international students.

Tertiary education institutions that choose to accept international students need to provide services to students that meet their varied and diverse needs and adequate information as to how they should access these services. At present, some of the private health insurers approved to offer OSHC have negotiated with the larger tertiary education institutions to be preferred OSHC providers (some of which are promoted by the tertiary education institute as providing their international students with additional benefits above the minimum required by the Australian Government). There is scope for tertiary education institutions (or groups of institutions and their representatives to allow smaller institutions to join together) to negotiate with those insurers providing OSHC, to secure group cover for their international students. Ideally, such cover would be of a level that met both the scheduled fees for treatment and some portion of the student's out-of-pocket expenses for treatment, to ensure that their mental health needs were adequately covered.

ACTION 6.2 — IMPROVING ACCESS TO MENTAL HEALTH SERVICES FOR INTERNATIONAL STUDENTS

International students need adequate insurance coverage and access to culturally appropriate services to maintain their mental health.

Start now

To improve the treatment and support provided to international students, tertiary education institutions (or their representatives) should make arrangements with insurers providing Overseas Student Health Cover to their international students to ensure there is adequate coverage for any required mental health treatment (including the scheduled fees for treatment and some portion of the student's out-of-pocket expenses).

They should also ensure their counselling services are able to meet the language and cultural diversity needs of their international students.

Alternatively, the Deed of Agreement between the Australian Government and the health insurers could be revisited to provide a higher level and range of services to international students as a condition of their visa. While this may provide a higher level of coverage, it would increase costs for international students and could make Australia a relatively less attractive destination for these students.

A whole-of-institution approach is required

There is an increasing awareness that whole-of-institutions responses are required by tertiary education providers to manage their students' wellbeing and mental health (discussed above).

Tertiary education institutions need to undertake a range of activities to support student mental health and wellbeing including providing accessible services, referring students to appropriate external services, developing connections to community based mental health services, training staff about mental health and providing wellbeing and resilience initiatives.

These approaches should be included in a student mental health and wellbeing strategy that would set out how tertiary education institutions will meet their obligations to their students in respect of mental health in relation to the *Disability Discrimination Act 1992* (Cth) and the Disability Standards for Education 2005 (Cth) and their requirements under the other Australian government standards placed on tertiary education providers. These include the Higher Education Standards Framework (Threshold Standards) 2015, Standards for Registered Training Organisations (RTOs) 2015 and the National Code of Practice for Providers of Education and Training to Overseas Students. In addition, tertiary education providers would be required to include information on their internal and external support and the partnerships with providers of external supports, their training and guidance for staff and any relevant dispute resolution processes in their mental health and wellbeing strategy.

Having a student mental health and wellbeing strategy in place would be a requirement of registration for each institution and would be assessed by the Tertiary Education Quality and Standards Agency or the Australian Skills Quality Authority as part of the registration process. That is, providing and maintaining an effective student mental health strategy would be a regulatory requirement, with oversight provided by the relevant regulatory agency. Such an approach is not that radical given that some tertiary education providers, for example Monash University (sub. 698), already have quite detailed mental health and wellbeing strategies in place.

Similar to workplaces in general, tertiary education providers, particularly the larger institutions, have undertaken interventions to develop and improve mental wellbeing and resilience for both students and staff. Effective evaluation of these interventions and the subsequent sharing of the outcomes across the higher education sector would enable tertiary education providers to select and implement initiatives and programs that are more likely to deliver improved outcomes for their staff and students.

Some tertiary institutions will require more guidance

The level and types of support non-university higher education and VET sector institutions provide varies. As discussed above, many of these have limited resources and infrastructure relative to the universities and the range of support and consequently the services they provide can be markedly different from those provided by the universities. For example, Independent Higher Education Australia (sub. 555) noted that its members had a variety of approaches and actions in place to assist with student mental health and wellbeing with larger providers having quite developed policies and frameworks in place with the smaller providers tending to have less developed structures in place.

However, teaching staff have indicated that they would like to do more, but in many cases do not know what the best approach is, or have found they do not have the resources to provide more support. In these cases effective links with external providers, both counselling services and community based mental health services, are critical.

The Australian Government has recognised the need to provide universities with guidance on how to address student mental health, with its funding of the development of the National University Mental Health Framework, which Orygen is currently developing (discussed above). Similar guidance is needed for non-university higher education providers and VET providers that reflects their circumstances to enable them to meet their regulatory obligations and provide the necessary programs and initiatives to support their students' mental health.

ACTION 6.3 — STUDENT MENTAL HEALTH AND WELLBEING STRATEGY IN TERTIARY EDUCATION INSTITUTIONS

To support students' mental health, tertiary education institutions should have comprehensive mental health and wellbeing strategies. The implementation of these strategies should be rigorously evaluated to enable continuous improvement.

Start now

The Australian Government should amend the *Higher Education Standards Framework (Threshold Standards) 2015* and the *Standards for Registered Training Organisations (RTOs) 2015* to require all tertiary education institutions to have a student mental health and wellbeing strategy. This strategy would be a requirement for registration and would be assessed by the Tertiary Education Quality and Standards Agency or Australian Skills Quality Authority as part of the registration process.

This strategy should cover:

- how they will meet their requirements under the *Disability Discrimination Act 1992 (Cth)* and *Disability Standards for Education 2005 (Cth)*
- how they will meet their requirements under the Higher Education Standards Framework (Threshold Standards) 2015, Standards for Registered Training Organisations (RTOs) 2015 and National Code of Practice for Providers of Education and Training to Overseas Students. This should encompass information on their internal and external support, including partnerships with providers of external supports
- a requirement that onsite counselling services, where available, provide appropriate links into the broader health system and are adequately resourced to meet the needs of students who require these services
- the prevention and early intervention support institutions provide
- training and guidance for staff, including:
 - that all staff who have direct interaction with students would undertake training on student mental health and wellbeing
 - guidance for staff on what they should do if a student approaches them with a mental health concern and how they can support student mental health.

Start later

The Tertiary Education Quality and Standards Agency and the Australian Skills Quality Authority should monitor and collect evidence from interventions initiated by tertiary education providers to improve mental wellbeing and mental health of students and staff. They should disseminate information on best practice interventions to tertiary education providers.

ACTION 6.4 — GUIDANCE FOR TERTIARY EDUCATION PROVIDERS

All tertiary education providers — including non-university higher education and Vocational Education and Training — would benefit from guidance on how to best support their students' mental health.

Start now

To supplement guidance being developed for universities to address student mental health, the Australian Government should develop or commission guidance for non-university higher education providers and Vocational Education and Training providers on how they can best meet students' mental health needs. This should include best-practice interventions that institutions could adopt to build students' resilience and support their mental health.

Apprentices and trainees' mental health

Apprentices and trainees combine on-the-job training with VET-level training. Typically, about 80% of their time is spent on-the-job with the remainder in college or TAFE (Knight 2012). For example, trade apprentices spend about 6 to 8 weeks a year at formal training or 'block training' while some trades may do one day a week at college (box 6.5).

Apprentices and trainees face unique pressures that may affect their mental health. They are often new to the workforce and young, and are in workplaces that pose special challenges.

There is evidence that many apprentices have experienced bullying, particularly in blue-collar industries (AISRAP 2006; ACTU, sub. 452; Evins 2019). Based on surveys of apprentices and trainees who did not complete their training, over 25% of apprentices and about 20% of trainees reported that bullying was a factor in deciding to withdraw from their training (Cully and Curtain 2001, p. 24). A survey of Queensland construction industry apprentices found that just over 27% experienced bullying in the past 6 months (Ross, Wardhani and Kolves 2020, p. 12).

In some workplaces, apprentices and trainees are 'soft targets' with an imbalance of power and status experienced by apprentices and trainees and limited potential to defend themselves. The bullying that sometimes results may be seen as a way of 'trailing' or 'testing' the recent arrival to the workplace — particularly by the more senior apprentices who experienced the same treatment as first year apprentices themselves (McCormack et al. 2011).

There have been a number of prosecutions under the relevant workplace health and safety legislation involving initiation rituals and hazing of apprentices in blue-collar industries. For example, a number of more senior apprentices were prosecuted in the Victorian Magistrate's Court for spraying brake cleaning fluid on a new apprentice, while a construction site supervisor was prosecuted in South Australia for dousing the clothes of an apprentice in

flammable liquid and then igniting the clothing (Jones 2010; Opie 2019). Workplace bullying and the role of workplace health and safety legislation is discussed in appendix E.

Box 6.5 Apprentices and trainees

The apprenticeship model is based on a combination of paid employment, on the job training and institutional training and has a long history in Australia. While the system has evolved in some areas, it retains many features of the apprenticeship model inherited from the United Kingdom. A contract (or indenture) is undertaken between the employer and the apprentice with the apprentice receiving on-the-job training and formal off-the-job training (at a Vocational Education and Training institution) with the indentures or training contract held by the relevant State or Territory Government training agency or department. On completion of the training contract, the relevant training agency or department provides a completion or trade certificate (or indenture papers) and the apprentice is then recognised as a tradesperson.

Traineeships were conceived and implemented by the Australian Government in the mid-1980s primarily to address growing youth unemployment by providing training opportunities for mostly young people. They cover a wide range of occupations, mainly in the services sector (retail and hospitality) and personal care (childcare and aged care), but have also been used in general administration and business services. Traineeships typically involve a one year or less training contract between the employer and the employee, compared with four years to complete an apprenticeship in one of the traditional trades.

By the mid-1990s, the Australian Government commenced paying incentives to employers to offset the costs of employing apprentices and trainees, resulting in a large growth in trainee numbers, but lesser growth in apprentices. Over the past 30 years, the system in Australia has evolved from providing trade training to mainly young males to providing training to people of all ages and genders and in a wider range of occupations.

Both apprenticeships and traineeships involve a contract between an employer and employee to learn the required skills for a particular occupation. However, there are differences in the level of commitment that both the apprentice or trainee and the employer make — with an apprenticeship requiring a greater level of commitment. In the case of an apprenticeship, there is a legally binding contract between the employer and the apprentice and the employer cannot cancel the apprenticeship if the business is sold or the employer is experiencing poor business conditions. For example, where the employer sells the business the new employer in most jurisdictions has to continue with the training contract and continue to employ the apprentice, whereas for trainees the new owner has no obligation to complete the training contract and continue to employ the trainee. State training agencies also put considerable effort into finding a new placement for an apprentice when they face the loss of an employer. For an apprentice, following the probation period, all parties must agree for the contract or apprenticeship to be cancelled whereas for a traineeship, either party can unilaterally cancel the training contract or traineeship. Consequently, completion rates for apprenticeships are significantly higher than for traineeships.

Source: Knight (2012); NCVET (2001); Noonan and Pilcher (2017).

A further pressure for trainees involves their contractual arrangements relating to their employment and training (box 6.5) — for example, the need to find another employer to continue and complete their training if their employer’s business fails. While no different in this sense to other employees in a failing business, apprentices lack the qualifications needed to enable a ready transition to a position in another business. Apprentices may also feel obliged to continue in a work environment where they are experiencing problems given that terminating the contract requires the mutual agreement of all parties and even with agreement from their employer, there may be concerns as to finding another employer to complete their apprenticeship.

In addition to the mental health-related support provided to tertiary students (discussed above), apprentices and trainees have access to the mental health support that is provided to other employees in their workplace (chapter 7). However, the unique circumstances of apprentices and trainees has been acknowledged by governments, particularly given their age and usually recent entry into the workforce. Accordingly, there is a range of targeted support provided, including:

- the Australian Apprenticeship Support Network, which provides universal generic support for all apprentices and trainees, and targeted services, including mental health-related support, for individuals who need additional help to complete their apprenticeship (Australian Government 2019f)
- the Industry Specialist Mentoring for Australian Apprentices program, which aims to improve retention and completion rates and aid the supply of skilled workers in industries undergoing structural change. Mentors provide support to apprentices who face additional barriers to finishing their training, for the first two years of their training. Apprentices and mentors develop a plan outlining the support required (Australian Government 2019c)
- the Disabled Australian Apprentice Wage Support Program, which provides funding to employers who employ apprentices and trainees who require tutorial, interpreter and mentor services (DHS 2019)
- supports provided by Group Training Organisations⁴⁰, which can include, for example, regular on-site visits, education for host employers, induction programs that include mental health training, and mentoring from former apprentices (box 6.6)
- OzHelp Foundation’s Life Skills Tool Box, which is a workshop focused on improving mental health and life coping skills in apprentices (OzHelp Foundation, sub. 294).

⁴⁰ Group Training Organisations hire apprentices and trainees and place them with host employers. The Group Training Organisation is responsible for meeting employer obligations, such as remuneration and other employment benefits (Australian Government 2019e).

Box 6.6 Mental health support provided by the Victorian Automobile Chamber of Commerce

The Victorian Automobile Chamber of Commerce is an employer group representing the automotive industry in Victoria. It also operates as a group training organisation employing automotive apprentices and placing them with host employers (typically small to medium sized enterprises). It currently employs over 540 apprentices and provides a life skills course to the apprentices during their induction covering mental health, alcohol and drugs, financial skills and communication skills with regular follow up training. The mental health component focuses on looking after themselves, family and friends.

Field managers work with Employee Assistance Program services to deal with any mental health concerns affecting apprentices. Work plans can be implemented and adjusted to deal with any mental health difficulties and keep the apprentices engaged with their work and training and typically operate similarly to a return to work program.

Prior to implementing the life skills programs, apprentices were dropping out of employment and training often due to alcohol and drug, and mental health concerns. The program is credited with improving the retention rates of their apprentices from 70% to 90%.

Source: Victorian Automobile Chamber of Commerce (pers. comm., 3 July and 12 August 2019).

There are also additional supports available in industries that employ a relatively high number of apprentices. For example, MATES in Construction is a charity established to reduce the higher level of suicide among construction workers. It implements community development programs, provides care coordination support to workers in need and has a 24/7 help line (MATES in Construction 2016).

Documented evidence on the effectiveness of supports provided to apprentices is limited. However, Buchanan et al. (2016) looked at social support structures for carpentry apprentices and found that informal and peer-based mentoring services are often more effective than formal mentoring arrangements. Support from industry mentors is also believed to have been effective in helping apprentices to complete their training. The Australian Industry Group (sub. 208, p. 31) stated that one employer has found that engaging families is an effective strategy in managing mental health of young workers:

One small employer, with a relatively high number of apprentices over many years, has found that directly engaging with parents in the recruitment and management of the apprenticeship relationship through the full four years of the apprenticeship greatly helps in managing mental health and broader behaviour issues for this group of young workers.

A longitudinal survey of apprentices and trainees with disability (11% had a mental illness) found that the most important factor in facilitating course completion was support, including support from disability employment services providers, group training organisations, TAFE, employers, and informal support from family and friends (Cocks and Thoresen 2013).

Apprentices and trainees spend the majority of their time in the workplace and the remainder in formal training in VET institutions. The draft recommendations in this chapter in regard to students in higher education and the draft recommendations to improve mental health in the workplace (chapter 7) will benefit apprentices and trainees and their mental health.

6.3 Support for youth to re-engage with employment, education and training

Youth who are not in employment, education or training face a higher risk of mental illness, but often do not seek support. For instance, young people are the least likely sub-population to seek help or access professional care for mental ill-health, and once a young person is disengaged from the system, it can take up to four years for them to access mental health services (Burns and Birrell 2014; Scott et al. 2013). Further, poor treatment of mental illness is associated with comorbidities, including drug and alcohol problems, which can complicate re-engagement (Burns and Birrell 2014). This group has an increased risk of lifelong social exclusion and economic marginalisation.

This group is also relatively large — 11.8% of 15–29 year olds in 2016 were not in employment, education or training (OECD 2016). Across Australia, rates of disengaged youth are highest in the Northern Territory, Tasmania and Queensland and lowest in the ACT (OECD 2016).

Re-engagement can be difficult

Re-engaging young people experiencing mental ill-health with employment, education and training can be difficult because they often have complex needs. Their engagement with learning can also be disrupted by fluctuations in thinking and concentration, lower levels of academic confidence, mood variability, motivation spikes and troughs, negative effects of medication and difficulty with creating and maintaining social relationships (Venville et al. 2016). Further, young people report that they are unsure whether reporting their mental illness, and therefore becoming eligible for support services, is in their best interest (Venville and Street 2012). Young people have reported discrimination, unstable housing, financial stress and not knowing how, when or where to access available support as key issues (Carter et al. 2017).

People experiencing mental ill-health have worse employment outcomes than the wider workforce (appendix D) and young people typically experience higher rates of unemployment than the wider workforce meaning that those young people experiencing a mental illness face additional difficulties engaging in employment. Employment outcomes for people with mental ill-health are discussed in chapter 19.

Young people, particularly those studying, are often employed on a non-permanent basis (57% of 15 to 24 year olds in paid employment in 2019 were part-time workers) (ABS 2019c). They are also concentrated in particular sectors of the economy such as the retail sector (32% of the workforce are aged between 15 and 24 years) and the accommodation and food services sector (45% of the workforce are aged between 15 and 24 years) (DJSB 2019). So not only are youth generally in more ‘precarious’ employment, but in the case of the COVID-19 pandemic at least, the sectors of the economy most susceptible to the economic impacts of the pandemic are significant employers of young people.

There is a strong case for prioritised intervention for young people experiencing mental ill-health given their risk factors and their numbers. Strategies to re-engage with them include specialised support and intervention and approaches that build self-esteem and confidence (FCDC 2012). Programs tend to take one of two broad forms. The first uses specialists to link young people with educational institutions and available support services. The second provides education, tailoring the experience to the student’s needs to reduce the risk of dropping out. Additional support structures, such as mentoring and work-plan development, are utilised by both program types. The Productivity Commission considers that both of these program types are needed for improved educational outcomes and that each State and Territory should have clear, well-funded policy and interventions that support the roll-out of such programs.

Education support for young people experiencing mental ill-health

Australia has no structure for addressing incompleteness of school education in a consistent way. Schools are able to register frequent or long-term absences, but cannot track a student who changes schools and do not have powers to intervene if a student chooses to leave school early (OECD 2015b). This limits the ability for States to track and identify disengaged youth and provide them with educational opportunities, leaving certain groups more at-risk than they would be otherwise.

The lack of a consistent policy framework also means that programs can be rolled out in uncertain funding environments. Programs have been de-funded despite showing early signs of success, such as Youth Connections (SSCOAGBC 2015). On the other hand, the diversity of programs can make it hard to rigorously evaluate outcomes, which means governments might struggle to justify the expenditure among competing priorities. Inconsistency can also hinder the formation of a cohesive sector, reducing the ability of providers to advocate and raise awareness (FCDC 2012, p. 84).

Although the programs in this space include pathways into higher education, their focus is usually vocational training leading into employment. For instance, headspace developed the Digital Work and Study Service in response to difficulties in funding their traditional vocational services (Orygen and headspace, sub. 204) (box 6.7).

Box 6.7 headspace Digital Work and Study Services

The Digital Work and Study Service is a vocational program delivered via email, web chat or phone that helps young people access employment and education. The program involves connecting the young person with an expert Work and Study Specialist, who helps the young person with a range of employment and education-related tasks, including identifying and tailoring individual career plans, exploring suitable education options and sourcing financial support for education, and skills to manage mental health challenges in a work or study environment (headspace 2019d).

The Digital Work and Study Service has been relatively effective at achieving its major outcomes and has strong support from its participants. For instance, over half of the young people participating in the service reported a work or study outcome, which increased to 72% for people who completed at least 10 sessions. A survey of participants found that 90% felt the program supported them to achieve their work and study goals and 77% believed they gained skills (Orygen and headspace, sub. 204, p. 44).

Youth focused Individual Placement and Support

Individual Placement and Support (IPS) is an intensive model of employment support, which involves a rapid job search, followed by on-the-job training and ongoing support from employment support specialists (chapter 19).

A youth IPS trial was conducted in headspace centres across Australia in 2018 and included the option of participating in education, as well as employment. The Department of Social Services initially funded 14 headspace centres to provide youth IPS employment and education support. The evaluation of the trial published in June 2019 found that 33% of the 1558 participants had been placed in employment and 9% in education. The evaluation was unable to assess the outcomes achieved by those taking part in the trial compared to young people participating in the existing disability employment services (DES) and Jobactive programs, although differences were noted in the increased engagement of those taking part in the IPS trial (KPMG 2019).

In January 2019, the trial was extended until June 2021, with additional funding to extend the trial to 10 more headspace centres (chapter 19).

Another evaluation was undertaken to examine the effectiveness of using IPS to assist young people (15–25 years) with first episode psychosis gain employment. This involved a randomised control trial using 146 young people who were clients of the Early Psychosis Prevention and Intervention Centre in Melbourne. The IPS treated group achieved a very high employment rate at the end of the 6 month intervention (71% compared to 48% for the treatment as normal group). However, the advantage of the IPS in employment outcomes was not seen at the post-intervention 12 and 18 month follow up. This was considered by the study to be related to the unusually high employment rate achieved by the control group rather than a failure of the IPS to provide long-term benefits to those young people who took part in the trial. The evaluation also noted that a general approach to IPS did not lead to

superior educational outcomes and a more targeted and specific approach to improving education outcomes may be needed (Killackey et al. 2019).

Vocational programs delivered in community mental health services

There are also programs that have educational and training elements, although these programs are not focused on the education of young people specifically. For example, the New South Wales Department of Health has funded programs that have educational and training elements such as the Vocational Education, Training and Employment program, which is similar to a youth IPS program. The program used local partnerships and in-house vocational rehabilitation services to promote vocational and educational outcomes for consumers with persistent mental illness. The Vocational Education, Training and Employment program had a similar level of success when compared with youth IPS (Private Mental Health Consumer Carer Network (Australia), sub. 49, p. 19).

In addition, there are the national, state-based and local programs that exist to re-engage youth with education that are not focused on youth with mental health needs. Programs can be targeted at groups that face employment barriers, such as early school leavers or those at risk of homelessness. They typically cater to 15–18 year olds but can extend to cohorts several years older.

Better supporting these youth

Although there are many programs and services available providing general support to assist young people re-engage with education and training, there is no coordinated or consistent approach across governments. Much of the activity in this area appears to be ad hoc.

Early intervention to re-engage young people in education and employment is crucial for their longer-term outcomes. It is estimated that the majority of 24 year olds not in education and training would likely remain disengaged for the rest of their adult life (Lamb and Huo 2017).

As a first step, being able to capture data on those who left school early and an understanding of why they did so would enable a more targeted and responsive approach to better support these young people. The next step would be to access and identify those youth not in education or employment to be able to direct them to support. The only point of contact with government for these youth is likely to be Centrelink and this may provide the best opportunity to reach out and direct them to appropriate programs. More detail on supporting disengaged school students is provided in chapter 5.

A better understanding of what type of programs deliver the best outcomes is also required. Reviews of program models for disengaged learners across all ages undertaken for the Victorian Government (Davies, Lamb and Doecke 2011) found that effective approaches to re-engagement required these features:

- outreach — being able to connect with the disengaged, who often are also socially and economically marginalised, through accessible information, bringing learning to the learners, targeting high needs groups and establishing lasting relationships with the learner
- wellbeing — identifying and addressing the welfare needs of disengaged people by identifying the structural or situational obstacles that affect their capacity to learn
- pedagogy — being able to take an approach to learning for disengaged people that takes account of their previous learning, failure at high school and avoidance of formal teaching and learning
- pathways — including and creating pathways for learners from the program to further study and employment through establishing connections with community and other institutions and other educational and labour market programs.

The review concluded that where programs do contain these features and are resourced adequately there is likely to be improvements in participation of disengaged learners in achievement (as measured by completion or improvement in skill levels) and progress to other types of study. However, these conclusions were for all disengaged learners across all age groups.

From the limited trials conducted in Australia to date, the evidence for the effectiveness of youth based IPS is mixed. However, the IPS services model in general is considered to be effective in improving the employment outcomes of people with mental illness. The relative effectiveness of the IPS services model is discussed further in chapter 19.

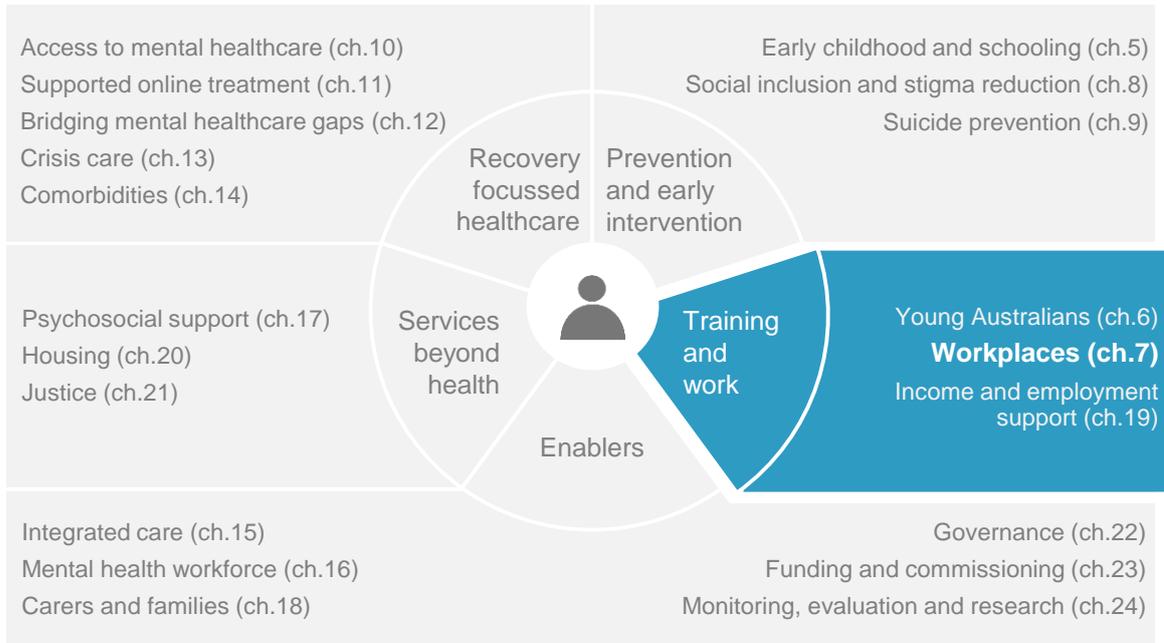
The evaluation of the IPS trial focusing on youth conducted in 14 headspace centres between late 2016 and early 2019 found that some of the IPS principles (such as rapid job search and competitive employment) designed for adults did not necessarily reflect some of the challenges young people faced in gaining employment — particularly the focus on rapid job searching and competitive employment for many young people who had little or no history of employment.

Further, IPS services have typically been provided to those with more severe mental illness and although the level of mental illness experienced by those taking part in the trial was not identified, headspace centres typically focus on those at the less severe end of the spectrum. Finally, the evaluation noted that in the absence of a control group, the trial could not determine what the outcomes would have been in the absence of intervention. The trial has been extended to further sites until June 2021 (KPMG 2019).

While the general IPS model is effective in improving employment outcomes, the current trials have identified that some of the difficulties faced by youth with mental illness to gain employment differ from those of adults. A youth focused IPS would need to address the different needs of young people and in particular their education needs.

Depending on the final outcomes of the trial being conducted by headspace and funded by the Department of Social Services, State and Territory Governments should include youth-focused services in their staged rollout of IPS services more generally (Recommendation 19).

7 Mentally healthy workplaces



Mentally healthy workplaces matter because...

- There are strong two-way links between employment and mental health — being employed can improve mental health and mentally healthy workplaces are important to maintain the mental health of those who work there.
- There are potential high returns to employers — in terms of lower absenteeism, increased productivity and reduced compensation claims — from investing in strategies and programs to create mentally healthy workplaces.
- But employers often don't know which strategies and programs will work for their businesses.
- A number of recognised workplace risk factors — such as high job demands with little control, imbalance between effort and reward and the level of organisational justice in the workplace — can create a poor psychosocial work environment.
- Hazards such as workplace bullying are increasingly common issues raised in workers compensation claims.
- The cost of workers compensation claims for work-related mental health conditions are about two and a half times the cost of other workers compensations claims and involve significantly more time off work.

RECOMMENDATION 7 — EQUIP WORKPLACES TO BE MENTALLY HEALTHY

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

As a priority:

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

Additional reforms that should be considered:

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

There are strong links between employment and mental health. Being employed can improve mental health and mentally healthy workplaces are important to maintain the good mental health of those who work there.

There are also strong economic reasons to encourage those with mental illness to participate in employment (including reduced income support, greater workforce participation and social engagement) and to ensure workplaces and those who work in them are mentally healthy (lower risk of developing mental health problems, improved productivity and lower compensation claims).

7.1 Mentally healthy workplaces

Although employment provides a range of mental health and broader economic benefits to the individual and the wider community, some workplaces can undermine the good mental health of employees and exacerbate existing mental health problems. Most studies have found that being employed supports good mental health and work, on balance, acts as a protective force, while unemployment can be psychologically damaging. However, poorly designed workplaces can also exacerbate mental health symptoms (Harvey et al. 2014; RACP and AFO&EM 2011). In this chapter we focus on mentally healthy workplaces. The benefits of employment on mental health are discussed in detail in chapter 19.

There are a number of costs associated with a mentally unhealthy workplace. They include absenteeism, presenteeism (where an employee remains at work despite experiencing symptoms that result in reduced levels of productivity) and the cost of workers compensation claims. Some studies have estimated that the cost of unhealthy workplaces to businesses in Australia is in the order of \$11 billion (PwC 2014) to \$12.8 billion each year (KPMG and Mental Health Australia 2018). The Productivity Commission estimated that absenteeism and presenteeism in the workforce costs up to \$17 billion per year (appendix H).

What is a mentally healthy workplace?

There is limited evidence of what constitutes a ‘good’ workplace or a ‘good’ job in terms of mental health, but there are a number of recognised risk factors or stressors that are specific to the workplace that can undermine the mental health of those in the workplace (box 7.1).

A mentally healthy workplace is most likely to be one that is able to recognise and manage these workplace-related risks. In research undertaken by the Black Dog Institute and the University of NSW, a mentally healthy workplace was conceptualised as one in which psychosocial risks are recognised and suitable action is taken to prevent or minimise their potential negative impact on the mental health of workers. At the same time, protective or resilience factors are encouraged and promoted (Harvey et al. 2014).

Box 7.1 Risk factors to workplace mental health

The risk factors pertaining to a mentally healthy workplace are generally grouped in the literature as the individual risk factors associated with work, workplace support and organisational factors.

In brief, these individual psychosocial risks include:

- *job demand and control* — jobs with high emotional and cognitive demands, but with little control or autonomy in decision making
- *effort-reward imbalance* — the perception and experience of the employee that their effort is inadequately rewarded both financially and non-financially
- *exposure to trauma* — regular exposure to traumatic events and/or potential threats as well as exposure to bullying or intimidatory behaviour
- *job insecurity* — the perception of employees as to how secure they consider their employment to be and the degree to which they feel powerless to do anything about it.

How jobs are designed plays a major role in creating individual risk factors. Job demand and control focuses on the demands placed on an individual in terms of workload, time pressure and physical and emotional demands and the control an individual has to manage their tasks and general work activity. There is also the risk created by exposure to trauma. Those employed as police, emergency service workers, medical staff and military personnel and exposed to regular trauma face an increased risk of developing mental health problems such as depression and post-traumatic stress disorder (PTSD). A Beyond Blue survey found 8% of ambulance, 9% of fire and rescue and 11% of police employees had probable PTSD compared to 4% of Australian adults.

Workplace support includes the level of social support from colleagues — the perceived support from colleagues and/or supervisors with higher levels of support mitigating psychosocial risks. The quality of the interpersonal relationships in the workplace and the leadership exhibited by supervisors and management also matters.

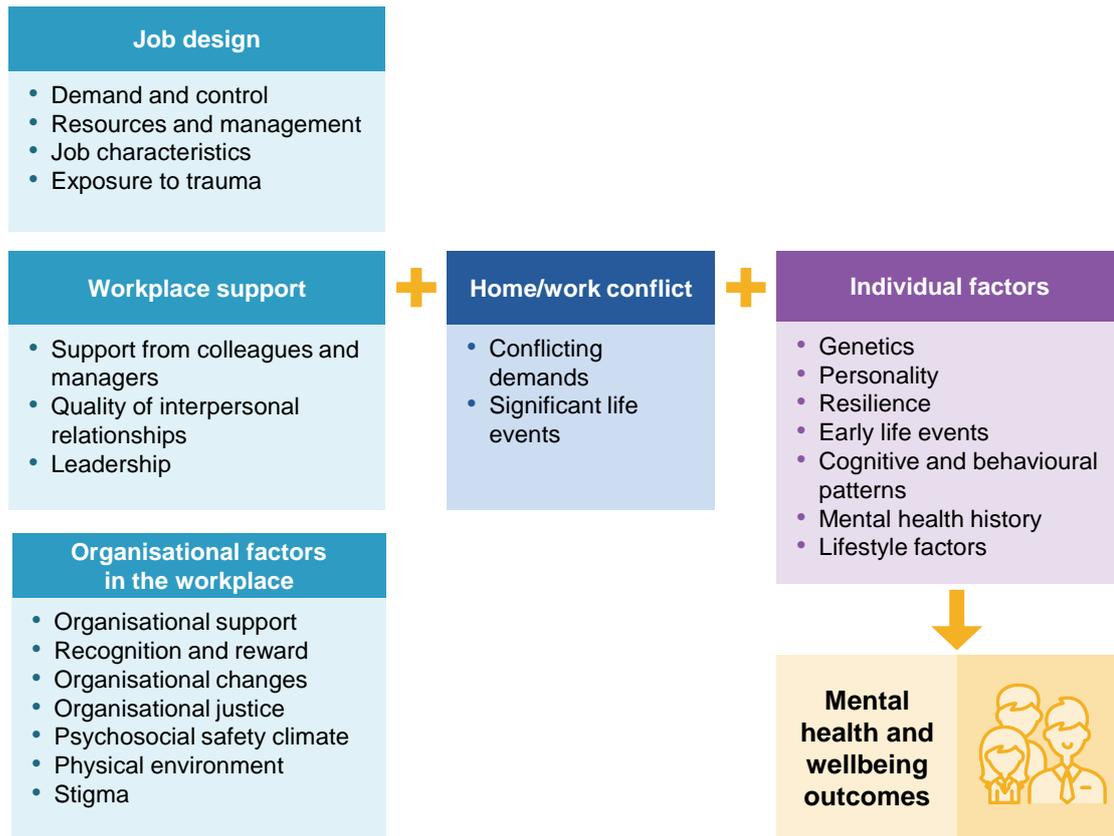
Research into organisational justice (the perceived fairness of rules and norms within an organisation in terms of the distribution of benefits and rewards and the methods and processes of how these rewards are distributed) has indicated that organisational factors relating to fairness and justice can influence employee mental health. This can involve relative remuneration, but also the provision of car parking, allocation of seating, distribution of information and the level of respect received from management. These organisation factors include:

- *organisational justice* — the fairness, rules or social norms in the organisation in terms of distributing resources and benefits across the organisation and the processes for governing the fairness or equity of decision
- *organisation culture or climate* — the perception of the individual as to the culture or climate in their workplace based on their experiences and beliefs as to the organisation's policies, procedures and practices
- *psychosocial safety climate (PSC)* — the balance of concern by management as to their employees' mental health versus productivity goals that is reflected in management values, philosophy and priorities
- *physical environment* — the physical environment in the workplace such as exposure to noise, low and high temperatures and chemicals or other agents can also impact on mental health
- *stigma* — the stigma that continues to be attached to mental illness in the community, including the workforce, can make it difficult for workers to seek help or discuss any symptoms with their employers which in turn can delay treatment or access to care.

Source: Beyond Blue (2018a); Harvey et al.(2012, 2014); Safe Work NSW (2017).

Although providing a mentally healthy workplace is important, it is only one component underpinning the mental health of an individual. The specific workplace-related risks or stressors are part of a much larger group of risk factors to mental health that are outside the workplace (figure 7.1).

Figure 7.1 **Factors contributing to a mentally healthy workplace**



Source: Harvey et al (2014).

These outside risk factors include home/work conflict or pressures at home, such as marital distress, domestic violence and caring for dependent children and older persons, all of which can impact on levels of depression and anxiety as well as an individual's performance at work. Stressful life events such as the death of a partner or the diagnosis of serious physical disease can have similar impacts. Importantly, there are also the individual determinants of mental health and there are a range of biological, psychological and social factors that determine each person's risk of developing a mental health problem. These individual determinants include genetic factors, early life events, personality, cognitive and behaviour patterns and prior mental health problems (Harvey et al. 2014).

Given the importance of a mentally healthy workplace to the mental health of an individual and the costs resulting from mentally unhealthy workplaces, governments, unions and many employers have sought to address this through the:

- requirements placed on employers to protect the mental health of their employees through the relevant workplace health and safety laws and through the workers compensation schemes
- initiatives undertaken by business to improve the mental health of their workplace and address the potential costs of ill-health.

7.2 Workplace health and safety and workplace mental health

Employers face a number of requirements under Workplace Health and Safety (WHS) legislation to ensure not only the physical health and safety, but also the psychological health and safety of their employees.

WHS legislation (both the Commonwealth and State and Territory) requires persons conducting a business or undertaking to ensure the health and safety of workers at work, so far as reasonably practical. This requires employers to eliminate risks to health and safety and where not able to do so, to reduce those risks as far as reasonably practical. ‘Health’ is defined in legislation to mean both physical and psychological health.

Model WHS legislation has been enacted by the Commonwealth and most states and territories.⁴¹ Victoria and Western Australia have not enacted the model laws, but place similar obligations on employers to ensure both the physical and psychological health of their employees.

All WHS regulators across Australia make it clear that there is a legal requirement on the employer to provide a workplace that protects the psychological health and wellbeing of their workforce.

Is the attention paid to WHS psychological health and safety equivalent to physical health and safety?

Although psychological health and safety in the workplace is now attracting increased attention (along with mental ill-health more generally in the community) it does not receive the same focus in a workplace as physical health and safety. For example, all workplaces have first aid officers in place to deal with physical injuries and illness, as required under

⁴¹ In 2011, Safe Work Australia developed a single set of model WHS laws along with supporting regulation and model codes of practice as practical guidelines to provide a nationally consistent framework for WHS. To become legally binding each jurisdiction has to separately implement the model laws as their own laws.

WHS regulations, but the appointment of the equivalent ‘mental first aid officer’ in the workplace is rare.

In previous work, the Productivity Commission highlighted that less attention was given in WHS legislation and by WHS regulators and inspectors to psychological health and safety compared to physical health and safety (PC 2010). In part, this is because psychological risks and hazards are harder to define and investigate compared with physical risks and hazards — a trip hazard or a piece of machinery without a safety guard is easier to identify and rectify than workplace stress or workplace bullying.

Some participants were of the view that the WHS system tended not to take mental health and safety as seriously as physical health and safety (ACTU, sub. 452; Maurice Blackburn sub. 239; Mental Health at Work, sub. 171). The independent review of the model workplace health and safety laws highlighted that unlike serious physical injuries in the workplace, psychological injuries were not subject to the same reporting requirements (for example, notification of these incidents to the relevant WHS regulator (Boland 2018)).

Also, there are a range of factors outside the workplace that can have negative impacts on an individual’s mental wellbeing (figure 7.1). Consequently, the detection, management and regulation of psychological hazards in the workplace presents challenges to employers and regulators alike.

Nevertheless, regulators have begun steps to better deal with psychological health and safety in the workplace. For example, WorkSafe Victoria has established a Psychosocial Operations Inspectorate to monitor and enforce compliance with psychological health and safety in the workplace, in accordance with the Victorian WHS legislation (sub. 483). Research is being undertaken to monitor and identify psychosocial risks in the workplace, such as the Australian Workplace Barometer project. Other work is being done on measuring the workplace psychosocial safety climate as a measure of risk levels of poor psychological health and safety in the workplace (box 7.2).

While the focus on workplace psychological health and safety lags behind that on physical health and safety, certain areas of psychological risk in the workplace have received growing attention in recent years. One aspect of workplace psychological health and safety that has received considerable attention is bullying in the workplace and is discussed in detail in appendix E.

The potential psychological harm from excessive working hours has also gained recent attention — for example the high rates of suicide and stress experienced by Australian doctors in their junior medical years and early stages of training (Hoffman and Bonney 2018). Long working hours experienced by new entrants to other occupations, such as law and finance, have also been highlighted as a risk to the mental health of these employees. While long working hours may be an individual choice to enhance career prospects, this is not always the case. Rather long working hours may reflect a poor culture in the workplace, excessive work expectations or bullying. Further, the Productivity

Commission has heard from consumers about how long working hours have impacted adversely on mental health (Godwin Grech, sub. 534).

Box 7.2 Psychosocial safety climate in the workplace

Psychosocial Safety Climate (PSC) refers to a workplace or organisation's priorities for the protection of its employees' psychological health defined in the policies, practices and procedures in place. It reflects senior management commitment, participation and consultation in relation to stress prevention and a communicated position from management about the value of human psychological health and safety at work.

PSC is measured using a 12-item questionnaire covering management commitment, management priority, organisational communication and organisation participation to build a scale from 12 to 60. Benchmarks used with the scale indicate that workplaces with scores of 41 and above places workers at a low risk of poor psychological health, those with scores between 38 and 40 at a moderate risk and those with scores below 37 at high risk.

In a workplace with low PSC, there are typically high work demands on employees with few resources available to help them cope with these demands. With high job demands and low job control, workplace stress is exacerbated. Where demands are intense and there is a lack of adequate job control to enable employees to develop a coping response, the residual stress can create harmful effects on both physical and mental health.

In a workplace with a high PSC score there will be policy and procedures that actively manage psychosocial risk factors to shape jobs where demands are manageable and resources are adequate. Human resource divisions, health and safety representatives and managers will have clear methods for promotion and protection of worker mental health. Employees will feel encouraged to utilise mechanisms for wellbeing such as flexible working arrangement and reporting bullying and harassment. Communication about stress prevention will be clear and psychosocial risks will be regularly discussed at safety meetings. Participation of policy, procedure, practices, and communication relating to psychological health and wellbeing will exist at all levels of the organisation (executive, management and worker).

Research around PSC implies that attempting to improve productivity by increasing work pressure or by reducing job control and the level of rewards (an imbalance of the effort and reward) will in all likelihood lead to psychological and physical health problems and ultimately a decline in productivity.

Source: Becher and Dollard (2016); Dollard and Bakker (2010); Dollard et al. (2012); McTernan, Dollard and LaMontagne (2013).

Improving workplace mental health through the WHS arrangements

Psychological health and safety needs to be treated with the same importance as physical health and safety to improve workplace mental health. Indeed, employers under the existing arrangements have a duty of care to both the physical health and safety and psychological health and safety of their employees.

At present, identifying physical risks to health and safety and managing these risks is widely done in the workplace and while psychological risks are obviously more difficult to identify and even address, both employers and employees are familiar with the approach to risk management that underpins WHS arrangements. Moreover, there is growing awareness and recognition across the community as to the importance of mentally healthy workplaces and a willingness to discuss mental health problems.

Is there is a lack of focus in the WHS legislation and regulation?

Although there is a duty of care to the health and safety of employees under WHS legislation (including their mental health), specific reference to psychological health and safety is limited. The recent independent review of the model WHS laws in Australia noted the widespread view that psychological health was neglected in WHS codes and regulations (Boland 2018). This has resulted in some uncertainty and confusion for employers as to how they should meet their duty of care in regard to psychological health. It has also presented challenges for the broader interpretation and implementation of the legislation as well as for WHS regulators in dealing with enforcement or breaches associated with mental health (Safe Work NSW 2017).

The review of the model WHS laws in December 2018 recommended that new WHS regulations be developed that set out how to identify the psychosocial risks associated with psychological injuries and appropriate control measures to manage those risks (Boland 2018).

A way forward

At present, the objectives of the model WHS legislation do not clearly specify the protection of workers from psychological harm, although a key objective is to protect workers and others against harm to their health, safety and welfare through the elimination of, or minimisation of risks. Psychological health is only mentioned in the definitions of health. Including psychological health alongside physical health up front in the objectives of the model WHS legislation would send a clear signal as to the importance of a psychological health and safety in the workplace.

Importantly, psychological risks and injuries should be treated similarly to physical risks and injuries within the legislation and regulation (unless there are clear reasons not to do so). For example, serious psychological injuries should be notifiable (as serious physical injuries are notifiable). As recommended by the recent review of the model WHS laws, the incident notification provisions in the model WHS Act should be reviewed to ensure they provide a notification trigger for psychological injuries (Boland 2018).

ACTION 7.1 — PSYCHOLOGICAL HEALTH AND SAFETY IN WORKPLACE HEALTH AND SAFETY LAWS

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

Start now

- All WHS legislation should clearly specify the protection of psychological health and safety as a key objective.
- Necessary amendments should be made to ensure that the relevant legislation and regulation addresses psychological health and safety in a similar way to physical health and safety.

Assisting employers to meet their obligations

A more significant challenge for WHS is the uncertainty and confusion many employers face as to how they should meet their duty of care in regard to the psychological health of their employees. Many commented that there are no specific requirements for dealing with psychological risks or hazards in the workplace or practical examples of how to comply with WHS legislation. This was particularly problematic for smaller businesses without the resources or expertise or for those employers in higher risk industries (for example, construction, emergency services and transport).

Various approaches both in Australia and overseas have been taken to assist employers in meeting their duty of care in regard to the psychological health of their employees. In Canada there is a national standard, *Psychological Health and Safety in the Workplace*, to provide guidance to employers on how to prevent psychological harm and promote psychological health and safety in the workplace. This standard is voluntary and is a guide only (Mental Health Commission of Canada 2018).

In Ireland, WHS laws require workplaces to have an Operational Safety Statement outlining the hazards and risks in that workplace and control measures in place to eliminate or reduce them. To deal with psychological risk, the Health and Safety Authority in Ireland provides guidance and feedback to workplaces on workplace stress, employee psychological wellbeing and critical incident exposure in the workplace. It also delivers structured guidance enabling organisations to develop an action plan to mitigate against these stressors (Health and Safety Authority, Ireland 2018).

The Danish Working Environment Authority (WEA) provides guidelines and checklists for employers including checklists designed for specific workplaces, such as building construction, agriculture and forestry and cleaning. However, while these guidelines are not a legal requirement for employers, the WEA will not take action for a breach of health and safety regulations against a business that has acted in accordance with the guidelines (Danish Working Environment Authority 2018).

Most WHS regulators in Australia as well as Safe Work Australia provide some type of guidance to employers to assist them in meeting their duty of care for the psychological health of their employees. For example, WorkCover Queensland provides guidelines and toolkits for employers, New South Wales provides tip sheets for employers, Victoria uses an online toolkit and survey for employers and South Australia provides guidelines and checklists for employers. Safe Work Australia has produced a Psychological Health Guide (*Work-related psychological health and safety: A systematic approach to meeting your duties*) to assist employers with meeting their duty of care under the model WHS laws (Safe Work Australia, sub. 256). However, overall many employers consider that this guidance falls short of what they need.

Guidance or regulation?

Some employers are seeking more than guidance in meeting their duty of care in regard to psychological health. Unlike with physical health and safety, there are no specific regulatory requirements or practical examples of how to comply in the WHS laws.

To address this issue, the independent review of the Model WHS laws recommended that the WHS regulations be amended to specify how to identify the psychosocial risk associated with psychological injuries and the appropriate control measures (Boland 2018).

Given that employers are legally required to protect their workers' psychological health and safety and there is greater complexity involved in identifying, eliminating and reducing psychological risks in the workforce compared to physical risks, WHS arrangements should provide more than just guidance to employers.

Those representing employees expressed a strong preference to introduce specific regulatory requirements to ensure employers met their duty of care. Unions NSW (sub. 382) endorsed the recommendations of the review of the Model WHS laws (Boland 2018) to introduce regulation to provide for identification and control measures relating to psychological risks in the workplace and also called for current legislation to define safe systems of work including adequate staffing, safe working hours and manageable workloads. The AEU and NSW Teachers Federation (sub. 305) pointed out that as employers did not have any regulation to follow, they often failed in the duty of care to provide a workplace that was psychologically safe for their employees.

Setting out in regulation the requirements necessary for an employer to comply with their duty of care would provide certainty. However, this certainty would come at the expense of flexibility for those employers, particularly larger employers, who may have in place certain processes to manage and deal with these risks. It would provide a prescriptive 'one size fits all' approach that may not suit the needs of all workplaces.

In contrast, employers groups, such as The Australian Chamber of Commerce and Industry (ACCI) (sub. 1202), typically favoured the use of guidelines rather than prescriptive regulation to enable individuals and organisations to meet their duty of care and were

supportive of the national guide produced by Safe Work Australia (*Work-related psychological health and safety: A systematic approach to meeting your duties*). ACCI said:

Blanket ‘one-size-fits-all’ approaches to psychological risk in workplaces are not effective and the emphasis should be on empowering and assisting workplaces to effectively manage psychological risk relevant to their individual work contexts (sub. 365, p. 30).

Nevertheless, ACCI noted that despite various promotions through the media and by Safe Work Australia the national guide was still relatively unheard of across industry — only 30% of ACCI members responded that they were familiar with the guide when surveyed (sub. 1202).

Alternatively, codes of practice could provide both certainty and flexibility for employers in meeting their duty of care in regard to psychological health. For those employers requiring greater certainty, a code of practice would provide practical guidance on how to comply with their legal obligations and having adopted and implemented the code would be important in a defence against any action taken by the relevant WHS authority. Where the employer had an alternative policy or process in place that delivered better or similar outcomes, the code of practice would not need to be implemented. This would also avoid placing additional regulatory obligations on employers that could create further barriers to the employment of those with mental health problems (appendix D).

The current WHS arrangements do provide for a code of practice to be used in this way. Under WHS legislation approved codes of practice are admissible in Court processes and while there is no requirement for a code of practice to be complied with, the Courts may regard a code of practice as evidence of what is known about a hazard risk or control and may rely on the relevant code to determine what is reasonably practicable in the circumstances (Safe Work Australia 2019).

Importantly, codes of practice could be developed to meet the different risk profiles of different workplaces and occupations. For example, separate codes of practice could be developed for those occupations exposed to greater risks of psychological harm such as for first responders, FIFO workers and/or by sector such as construction and hospitality. For example, the Western Australian Government recently introduced a code of practice for mentally healthy workplaces for FIFO workers in the resources and construction sector (DMIRS 2019). Codes of practice developed for small and/or medium sized businesses could provide the practical tools these employers need to meet their duty of care. Other employers such as larger businesses would continue to be able to implement their own processes and procedures to meet their duty of care.

Using industry based codes would differ from hazard based codes that have been commonly used in WHS. Moreover, as some participants pointed out there is considerable work required to develop a code of practice (AiG, sub. 819). However, the Safe Work Australia Psychological Health guide for employers provides a starting point to develop necessary codes of practice. Employee representatives called for both codes of practice and regulation to be introduced. The ACTU, while supportive of codes of practice for industry specific

guidance, called for these to be supported by overarching enforceable regulation to ensure worker safety (sub. 1214).

The use of codes of practice provide the means to offer both greater certainty and flexibility to employers in meeting their duty of care in respect of psychological health and safety in the workplace. Moving immediately from the current situation based simply on guidelines to the implementation of prescriptive regulation may prove difficult to amend or reverse in the future if it was found to be unable to meet the needs of all workplaces. However, should the development of codes of practice prove unduly difficult or, where developed, fail to gain traction to assist employers in meeting their duty of care, regulation as recommended by the independent review of the Model WHS legislation (Boland 2018) should be implemented.

ACTION 7.2 — CODES OF PRACTICE ON EMPLOYER DUTY OF CARE

Codes of Practice can play an important role in supporting mental health in the workplace.

Start now

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

The role of leadership in workplace mental health

Over the course of the Inquiry and in discussions with those involved in workplace mental health at the Inquiry roundtable hosted by the Productivity Commission, the role of leadership was often raised in ensuring a mentally healthy workplace. There is a view that improving and maintaining workplace mental health — beyond what that required through the duty of care — is linked to how interested senior management are in these issues and their willingness to take a leadership role to make improvements and increase attention on mental health in the workplace. Recent research as to the factors that triggered the introduction of initiatives to improve mental health in the workplace noted that the interest of senior leaders in mental health and their support for these initiatives was a key factor (figure 7.9; Rafferty, Troth and Jordan 2019). Further, a survey of workplace mental health identified the most significant perceived hurdle to achieving a thriving workplace was a lack of appropriate skills among managers and that education and training as well as a commitment by managers was required to improve mental health in the workplace (SuperFriend 2019).

A number of Inquiry participants suggested that workplace leaders should be trained to have a greater awareness and understanding of mental health. To this end, participants at this Inquiry’s business roundtable suggested that ‘mental health in the workplace should be

elevated from the human resources area to the boardroom'. Clearly it is difficult to regulate for, or impose the necessary leadership in an organisation to improve mental health in the workplace. However, there is scope for the Mentally Healthy Workplace Alliance as an organisation comprising various business groups, employer and employee organisations and committed to improving workplace mental health, to develop suitable programs for senior management. The increasing focus on workplace mental health across the community, along with elevating the importance of psychological health and safety to the same level as physical health and safety should encourage senior management, not already doing so, to take a greater interest in the mental health of their workplace.

7.3 Workers compensation arrangements and workplace mental health

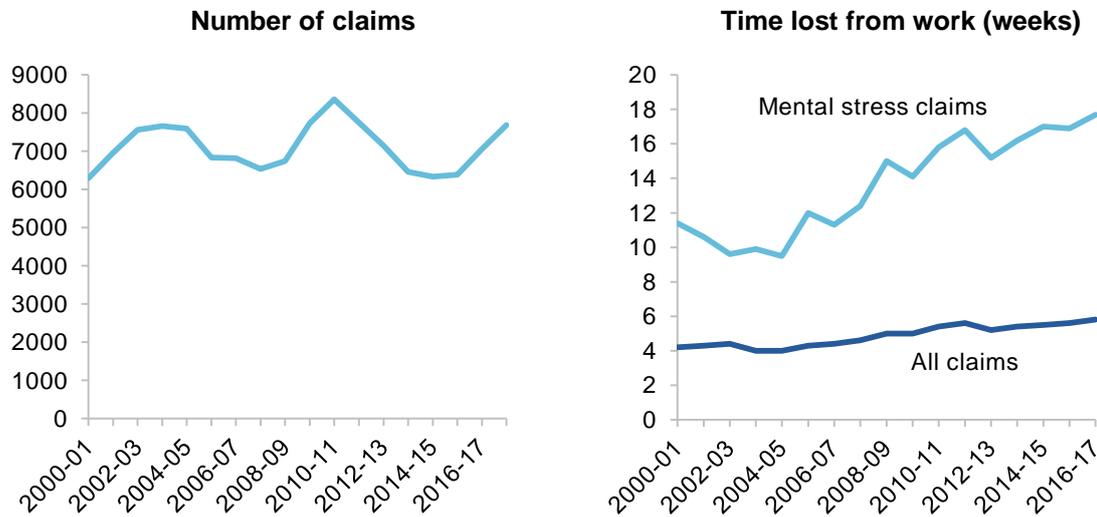
Workplace-related mental health compensation claims — how significant are they?

Although compensation claims for serious workplace-related mental health conditions account for about 6% of all serious workers compensations claims, these claims are typically more costly, involve more time off work and are much less likely to be accepted. (Serious claims are those accepted claims that resulted in at least a week's absence from work.)

- In Australia the number of serious workers compensation claims caused by workplace mental stress has fluctuated over the past 15 years between roughly 6000 and 8000 claims per year (figure 7.2). However, the number of serious work-related mental health claims as a proportion of all claims on a national basis has remained fairly stable at about 5 to 7% of all claims over the past 15 years.⁴²
- There has been considerable variability in accepted claims at the State and Territory level. New South Wales, Victoria and Tasmania have had increases in the proportion of accepted claims due to mental stress. In contrast, Queensland, Western Australia and the Northern Territory recorded the lowest proportion of accepted mental stress claims over this period. The Australian Government had the highest proportion of accepted workers compensation claims due to mental stress over the same period (figure 7.3).
- Mental health-related claims were around 12% of national payments for serious workers compensation claims each year between 2013-14 and 2017-18 (Safe Work Australia's National Data-Set for Compensation-based Statistics). There is considerable variation in this share between workers compensation schemes: mental health-related claims were 27% of all workers compensation payments in the Comcare scheme, but only 6% in Queensland's scheme in 2018-19 (Comcare 2019; WorkCover Queensland 2019a).

⁴² These numbers on claims relate to workers compensation claims that were both lodged and accepted. Others may simply have not lodged a claim or had their claim rejected.

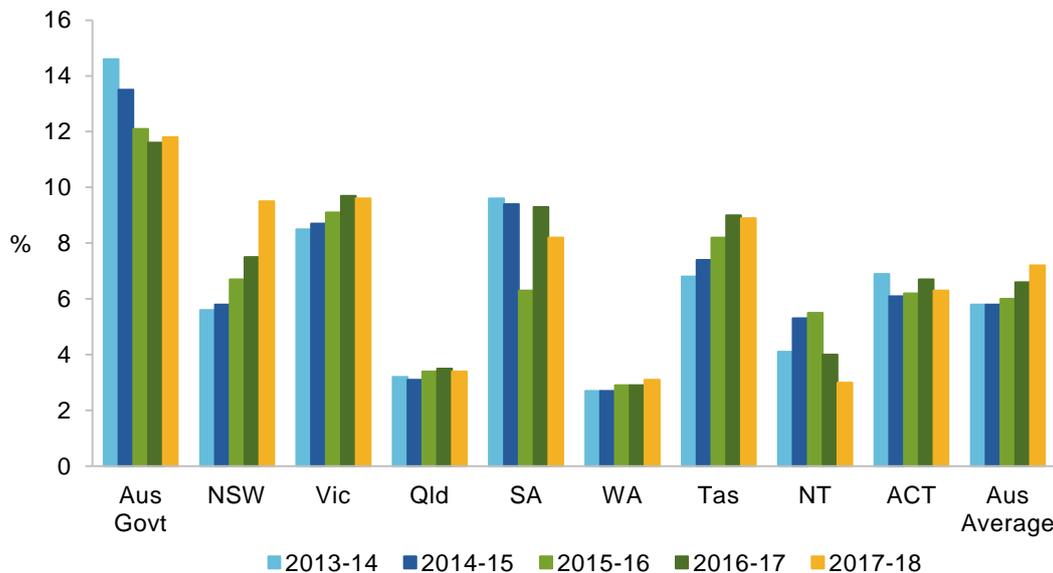
Figure 7.2 Serious accepted workers compensation claims caused by mental stress^a



^a Serious claims are those that resulted in at least a week's absence from work. Data for 2017-18 is provisional.

Source: Safe Work Australia's National Data-Set for Compensation-based Statistics.

Figure 7.3 Mental stress claims as a share of all serious accepted workers compensation claims, by jurisdiction^{a,b}



^a Serious claims are those that resulted in a least a week's absence from work. Data for 2017-18 is provisional. ^b Australian Government employees working in each jurisdiction have been included in Australian Government figures rather than state or territory results. The ACT Public Service employees are covered by the Australian Government's Comcare scheme, but operate under the work health and safety provisions of the Australian Capital Territory.

Source: Safe Work Australia (2020a).

- The typical (median) payment for a workplace-related mental health claim was \$25 650 (over the period 2012-13 to 2016-17) compared with \$10 600 for all other claims.
- Although the number of claims caused by work place mental stress as a share of all claims has remained fairly stable over time at the national level, the time lost from work from these claims has been increasing (figure 7.2). The typical time off work was 16.2 weeks compared with 5.7 weeks for all other claims (2018b); (Safe Work Australia, sub. 256).
- Mental health-related workers compensation claims are much more likely to be rejected than non-mental health claims (figure 7.4). In the State and Territory workers compensation schemes, 24 to 60% of workers compensation claims-related to mental health are rejected compared with only 6 to 10% of non-mental health claims. Similarly, in the Australian Government’s workers compensation scheme, Comcare, rejection rates average around 60% for mental health-related claims compared with 18% for non-mental health-related claims.⁴³

Figure 7.4 Rejection rates for mental health-related workers compensation claims^{a,b,c}
5 year average 2014-15 to 2018-19



^a Rejection rates are calculated by dividing total rejected mental health claims by the sum of total accepted and rejected mental health claims and multiplying by 100. Pending claims are not included. ^b Rejected claims only includes claims that were initially rejected, and does not include those rejected claims which may later have been overturned. ^c Data for NSW includes Nominal Insurer and Treasury Managed Fund.

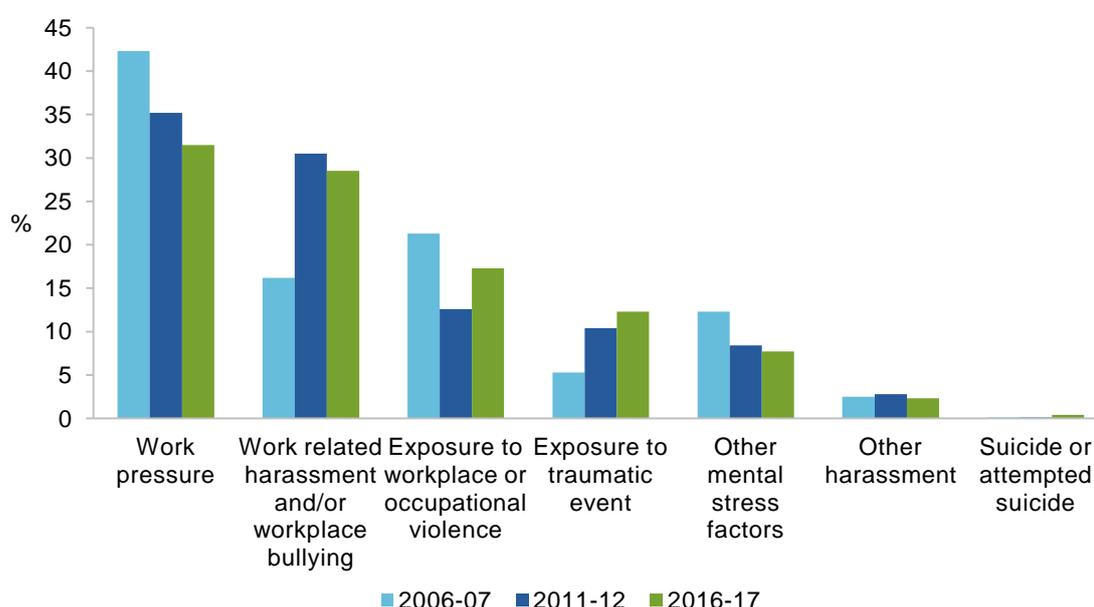
Source: Data provided by State and Territory workers compensation agencies and Comcare.

⁴³ Workers compensation arrangements and mental health along with the various requirements for a claim to be accepted are discussed below.

The most common cause of accepted mental health-related workers compensation claims is work pressure, followed by work-related harassment or bullying and exposure to workplace or occupational violence (figure 7.5). Work pressure as a cause of accepted mental health claims has been declining over the past decade whereas work-related bullying and/or harassment has been increasing. Appendix E discusses workplace bullying in further detail.

Figure 7.5 Accepted workers compensation claims caused by type of mental stress

Share of total accepted serious mental health-related claims in Australia for selected years^a



^a Serious claims are those accepted claims that resulted in absence from work of a single working week or more. Data does not include Victoria.

Source: Safe Work Australia's National Data-Set for Compensation-based Statistics.

Mental health-related workers compensation claims vary by gender, occupation and industry.

- By gender, females accounted for about 58% of work-related mental health claims in comparison with 42% for males on average between 2012-13 and 2016-17.
- By occupation, defence force members, police and fire fighters accounted for 9% of serious work-related mental health claims, school teachers accounted for 8%, followed by health and welfare support workers (6%) over the same period (Safe Work Australia 2018b).
- By industry, the incident rate for work-related mental health claims between 2012-13 and 2016-17 was highest for public administration and safety, followed by healthcare and social assistance and then education and training — reflecting the occupational share of

claims (figure 7.6). The relatively high level of work-related claims for public administration and safety reflect that this category includes police services and other emergency services workers, prison officers and border control officers.

Figure 7.6 Incident rate of serious accepted claims caused by mental stress, by industry^{a,b}

Claims per 1000 employees, 5 year average 2013-14 to 2017-18



^a Serious claims are those that resulted in a least a week's absence from work. Data for 2017-18 is provisional. ^b Public administration and safety includes police services, investigation and security, fire protection and other emergency services, correctional and detention services, regulatory services, border control and other public order and safety services.

Source: Safe Work Australia's National Data-Set for Compensation-based Statistics.

Workers compensation arrangements and workplace mental health

All employers are required to have workers compensation insurance. Workers compensation provides those workers experiencing a work-related injury or illness with weekly benefits, medical and hospital expenses, rehabilitation and a lump sum for permanent impairment on the basis set by the particular scheme. There are a number of different workers compensation schemes operating across Australia ranging from entirely government operated schemes to privately provided schemes.

In Queensland, the scheme is operated and underwritten by the state government and in New South Wales, Victoria and South Australia 'hybrid' schemes operate where private insurers operate as scheme agents on behalf of the relevant government. In Western Australia, Tasmania, Northern Territory and the ACT, workers compensation is provided by private

insurers underwriting the scheme (table 7.1). There are also the Australian Government schemes for Australian Government employees administered by Comcare, seafarers administered by the Seacare Authority and for Australian Defence Force personnel a scheme administered by the Military Rehabilitation and Compensation Commission. The Productivity Commission's inquiry into the compensation and rehabilitation system for veterans examined the arrangements for serving and ex-Defence personnel in detail (PC 2019a).

There are also those businesses, typically larger businesses, that the various schemes allow to self-insure. These self-insurers have to meet certain requirements in relation to financial viability, injury management and case management to be granted self-insurance status.

Incentives in the workers compensation system

As the price of an insurance premium reflects the previous claims experience or history of the policy holder, there is a strong incentive for the policy holder to avoid triggering a claim. Similarly, the pricing of workers compensation premiums creates an incentive for employers to minimise the risk to their workforce to avoid having to make a claim (including for psychological injury and mental illness) and paying higher premiums. As the South Australian workers compensation agency makes it clear to employers:

You can directly influence the amount of insurance premium you pay. This can be achieved by preventing injuries from happening, and if they do, assisting the injured worker to recover and return to work as quickly as possible. This helps to minimise the income support costs for a work injury claim, and therefore the premium you pay. (ReturnToWorkSA 2019)

There are also incentives for insurers to limit or delay compensation claims and for governments in designing these schemes to restrict overall eligibility and payments to manage the cost of premiums paid by employers.

However, some features of the existing arrangements can delay early intervention and treatment that are critical to improve the chances of a timely and successful return to work for the worker experiencing a psychological injury or illness.

Proving a psychological injury or mental illness is work related

Workers compensation arrangements require the illness or injury to be work related ('arises out of' or 'in the course of employment') to be eligible for compensation. This requires employment to have been the 'major contributing factor' or a 'significant' or 'material' factor — and this can be difficult to prove in the case of mental illness and psychological injuries.

In some sectors, such as first responders, mental health claims typically reflect the nature of the work. But in many sectors, mental health claims are often a result of workplace conflict and relate to interpersonal relationships. From the employer's perspective, mental health- or stress-related workers compensation claims are often seen as a response by the employee to management's assessment of and response to workplace performance issues. From the

employee's perspective, lodging a workers compensation claim may be the only way in which to draw attention to chronic overwork, poor supervision, bullying or other workplace dysfunction. Workplace bullying is discussed in detail in appendix E.

Proving that a mental illness or injury was related to employment is inherently difficult given the range of environmental and individual factors impacting on an individual's mental health (figure 7.1). Guidelines for GPs in diagnosing, managing and supporting patients with work-related mental health conditions recognise that making the determination of whether or not the psychological injury is work related is a 'challenge' as the triggers of mental health conditions are often multi-factorial and difficult to authenticate (Nelson 2019).

The process of proving that the injury is work related can create problems with the treatment of the mental illness. For example, in the case of workplace trauma being dealt with under a workers compensation claim, the treating clinician can only focus on the work-related trauma, even though the mental illness may be related to both the work-related trauma and other factors, such as past trauma experienced by the individual unrelated to the workplace.

Psychological injuries can also develop as a result of a worker's physical injury, particularly if the worker is off work for a significant period of time and/or there were difficulties in accessing compensation for the original physical injury.

For those claims where the link to employment may be tenuous and with relatively large future costs attached, such as mental health-related claims, there can be an incentive to deny liability to avoid these claims being reflected in future premiums, which in turn delays treatment for the injured or ill worker.

The difficulty of linking a mental health disorder to employment and the often lengthy process arising from medical examinations required by the insurer to prove this relationship can be a disincentive for those with mental health problems to seek help and in turn delaying their recovery and their return to work. These delays are likely to be exacerbated where the injured or ill worker pursues a common law claim for damages and can subject the worker to further medical examinations and the adversarial processes of the court system.⁴⁴

The Police Federation of Australia commented:

Our own research indicates that one of the biggest issues faced by police is the adversarial worker's compensation process; with the arduous and unhelpful process of making a claim, often standing in the way of many members getting quick access to effective treatment (sub. 248, p. 8)

⁴⁴ Unlike workers compensation which is based on a 'no fault' system, a common law claim is a claim for damages (medical expenses, future earnings and pain and suffering) whereby the injured or ill worker is required to prove 'fault' in the form of negligence or breach of statutory duty on the part of the employer. A workers compensation policy often covers the employer for any work-related common law claims made by employees. Most workers compensation schemes in Australia have limits on access to common law claims.

Return to work following a psychological injury or mental illness

Time away from work can be detrimental to recovery from psychological injury or mental illness. Research shows that those who return to work after illness or injury have better long-term health outcomes and extended time off work often sees a worsening rather than an improvement in symptoms. Returning to work as soon as possible facilitates income and health benefits to the employee and minimises costs for the employer in terms of lost productivity and lower workers compensation premiums.

However, return to work for those with a mental health condition (whether or not the condition was a result of their employment) is likely to be more difficult than for those with a physical illness or injury. Contributing to this is the stigma associated with mental ill-health and the employee's concerns about how they will be treated by their colleagues and managers — and if their condition was related to their work (such as due to interpersonal conflict or workplace bullying), there are likely to be even greater concerns as to how they will be treated.

Return to work may be extremely difficult if not impossible if the psychological injury or mental illness was due to wider cultural issues within the workplace that have not been addressed prior to the return to work. In these cases, there may be little prospect of a successful return to work with the same employer. This is particularly the case for smaller or medium sized businesses operating from a single site, who unlike larger employers with multiple sites, are unable to provide return to work at a different location. In regard to returning to work at a different location, the Australian Education Union (AEU) and NSW Teachers Federation noted that:

Psychological injuries in the workplace are often based in interpersonal conflict and perceived bullying. It is not unusual for medical advice to be that the teacher is well enough to begin a return to work, but at a different school. The improvement was a change in policy which allows for an injured worker to be placed at another school for the short to medium term as part of their recovery. The provision of same job same employer, but at a different workplace provides a mentally safe workplace for the injured worker to recover at work (sub. 305, pp. 7–8).

One possible approach that was raised at this Inquiry's roundtable on workplace mental health was for other businesses in a similar industry to 'host' the injured worker to enable a return to work at a different location. For small to medium sized businesses, industry and employer associations could assist placing the returning worker with a suitable similar employer, not unlike how group apprenticeship schemes place apprentices. However, many businesses are likely to be reluctant to employ a person they perceive as 'someone else's problem' so it is difficult to see this as a viable option. The difficulties around return to work are discussed further in box 7.3.

Box 7.3 **Return to work from mental health-related condition or injury**

Return to work is more problematic for those with a work-related mental health condition or psychological injury than for other injuries. Safe Work Australia (sub. 256) noted that in their national return to work survey, workers with a mental health condition:

- were less likely to have returned to work
- generally reported a lower perception of their ability to work
- generally worked fewer hours on their return to work
- were significantly more likely to report negative perceptions of their employers' and colleagues' attitudes and behaviour related to their injury/illness
- were significantly less likely to report receiving positive support from their employer.

Studies of return to work for those with compensated work-related mental health conditions indicate that delays in return to work and multiple attempts to return to work are associated with particular groups of workers — for example, older workers, females, those with high skill levels, those with previous claims and those working in small organisations. Increased age can lower the ability to cope with stressors and with dealing with work-life balance. For females, the delay in return to work is believed to be due to a fear of relapsing or returning to an unfavourable work environment. Small organisations have fewer resources to assist the worker and limited options for employment in a different location and for those from higher-status positions (a proxy for higher skill levels) the increased responsibilities and obligations make return to work more difficult. Delays in return to work for those with previous claims most likely reflect increased worry about re-injury and residual impacts of the previous condition (Prang et al. 2016).

Survey-based research focusing on those who had been off work with a psychological injury or mental illness had found that the timeliness and supportiveness of the employer, the injured worker's perceptions of employer support and fairness, the levels of work demands and the quality of the people management environment (or organisational climate) significantly facilitated or hindered their return to work. Furthermore, strong pre-existing levels of individual resilience contribute to earlier return to work outcomes (Wyatt, Cotton and Lane 2018).

The lodgement of a workers compensation claim for psychological injury or mental illness can create tensions between the employer and the worker. Although, workers compensation schemes are 'no-fault' schemes many claims relating to bullying or workplace stress are often seen as a failure of management and/or the behaviour of colleagues further increasing tensions in the workplace (AiG, sub. 208).

FINDING 7.1 — RETURN TO WORK CAN BE MORE DIFFICULT IN SMALLER BUSINESSES

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

Employers can play a critical role in return to work outcomes for those with a work-related mental health condition. Safe Work Australia, drawing on the 2013 and 2014 national return to work surveys, found that employer support (such as finding alternative duties or providing employees with information on their rights and responsibilities), early contact by the employer with the employee as soon as possible after being injured, responding when an injury occurs and assisting the employee to lodge claims were positive influences on return to work outcomes (Safe Work Australia 2018c).

Claims for psychological injuries and mental illness are treated differently

Workers compensation schemes do treat the claims made by a worker with a psychological injury differently to that of a worker making a claim for a physical injury. Workers compensation legislation provides a defence or an exception for psychological injuries resulting from reasonable management action carried out in a reasonable manner or reasonable way.

Reasonable management action relates to performance appraisals, ongoing meetings to deal with underperformance, counselling or disciplining an employee for misconduct, modifying an employee's duties, promotion, dismissal and denying an employee a benefit in relation to their employment. Whether these actions have been undertaken in a reasonable manner or way will depend on the action, the facts and the circumstances, the impact on the worker and any other relevant matters. This is typically determined on whether or not the established policies and procedures of the employer were followed, the employer breached any of its own guidelines, the employer adopted procedural fairness in dealing with the matter and any investigations were carried out in a timely manner. Consequently, employers are frequently advised to follow their policies and guidelines and to be consistent when managing employee underperformance and in conducting disciplinary matters (Portner Press 2019). Similarly, the Fair Work Act points out that reasonable management action carried out in a reasonable manner provides a qualification as to the definition of workplace bullying (appendix E; Fair Work Commission 2018; Reilly 2010; Workplace Law 2017). This is an important link with workplace and employment law that has been strongly supported by employers and in the numerous reviews of the various workers compensations schemes.

Some jurisdictions set a higher standard of contribution from employment for psychological injuries to be compensable than for physical injuries. For example, in South Australia, for workplace injuries, employment is required to be 'a significant contributing cause', but for psychiatric injuries employment must be the 'the significant contributing cause' (*Return to Work Act 2014 SA s7 (2)*). Comcare requires employment with the Commonwealth to have contributed to a significant degree to the injury or disease with the legislation specifying that, '**significant degree** means a degree that is substantially more than material' (*Safety, Rehabilitation and Compensation Act 1988 (Cth), 5B (1) (3)*).

Also, the insurer or compensating authority has a range of powers to investigate a claim — including obtaining reports or medical notes from the injured worker's doctors, referring the worker to an independent medical expert for examination, or engaging an

investigator to interview the worker and other witnesses. While these powers are not unique to investigation of psychological injuries, they do contribute to a claims process for psychological injuries and mental illness that tends to be slower than for physical injuries.

Claims for psychological injury or mental illness are more likely to be rejected than claims for physical injuries. As noted earlier, data provided by the State and Territory workers compensation schemes indicate that between 30 and 60% of workers compensation claims related to mental health are rejected in comparison to between 6 to 10% of non-mental health claims. Data provided by the Australian Government's Comcare scheme indicate higher rates of rejections of all workers compensation claims with nearly 60% of mental health-related claims and 18% of non-mental health-related claims rejected on average over the past 5 years (Comcare, pers. comm., 8 October 2019).

Weakening the incentives for some employers

Some workers compensation schemes in Australia have weakened the price signal provided through premiums paid for certain businesses by removing or limiting claims experience as an input into setting workers compensation premiums.

In the privately underwritten schemes, claims experience applies to all businesses in setting premiums whereas in the hybrid and government schemes, smaller businesses are often exempt from previous claims experience affecting the premium they pay for workers compensation (table 7.1). For example, in New South Wales businesses with annual premiums less than \$30 000 per year are classified as a 'small employer' and workers compensation premiums are based on the industry the business is in and the wages bill (although small employers without any claim and employers with an injured worker who returns to work within a certain time frame, receive a 10% discount on their premium). Only businesses with annual premiums over \$30 000 per year have claims experience taken into account when premiums are set.

In Victoria, the premiums paid by businesses with total payroll less than \$200 000 per year are not affected by their claims performance. In Queensland, claims experience applies to a limited extent to businesses with payroll less than \$1.5 million — premiums can vary between five rating categories ranging from 80% of the industry rate to 120% of the industry rate based on their previous claims experience and premiums and can only move one category (up or down) each year regardless of their claims experience. In South Australia, some sole business operators and very small businesses pay a flat premium (\$200 in 2018-19).

In those jurisdictions with privately underwritten schemes, premiums are based on remuneration, the industry in which the business operates and previous claims experience. In some of these privately underwritten schemes governments have some influence on the price of workers compensation premiums — the Western Australian scheme puts caps on the loadings and discounts that can be applied and the ACT publishes suggested reasonable rates to guide insurers.

Table 7.1 Workers compensation schemes

	<i>Scheme type</i>	<i>How premiums are set</i>	<i>Exemptions from claims history</i>
NSW	Hybrid (Private insurers operate as scheme agents on behalf of Icare)	Claims performance rate is calculated by comparing the employers claims performance with other similar NSW businesses	Previous claims do not affect premiums for those employers with an average premium less than \$30 000
Vic	Hybrid (Private insurers operate as scheme agents on behalf of WorkSafe Victoria)	Premiums are primarily set by the size of the remuneration, the industry and claims experience against the industry average. The larger an employer the more its experience impact on its premium	Previous claims do not affect premiums for employers with rateable remuneration less than \$200 000. Premiums are set on an industry average
Qld	Government scheme (WorkCover operates the scheme and no private insurers are involved)	For employers with payrolls <\$1.5 million premiums are based on claims performance, industry claims performance and size relative to industry. Below \$1.5 million a simplified model using categories relative to industry rate is used to set premiums	For those with payrolls less than \$1.5 million rating categories protects from large variances in premiums shifts due to expensive one-off claims For those over \$1.5 million claims history is taken into account
SA	Hybrid (Private insurers operate as scheme agents on behalf of ReturnToWork SA)	Based on remuneration, industry and claims experience in the previous year	Sole business operators and some small business pay a flat premium of \$200 in 2018-19
WA	Private^a	Based on remuneration, industry and claims experience in the previous year (discount and loading of up to 75% can apply depending on the risk profile)	There are no exemptions from claims history, but loadings are limited by the regulator
Tas	Private^b	Based on remuneration, industry and claims experience	No exemptions from claims history
NT	Private^c	Based on the industry type, claims history, payroll and number of employees	No exemptions from claims history
ACT	Private^d	Based on the industry type, claims history, payroll and number of employees	No exemptions from claims history
Cth	Government scheme (Comcare)	Based on the industry type, claims history, payroll and number of employees	Claims history is relevant

^a WorkCover WA sets recommended premium rates with the private insurers able to use their underwriting models to take into account claims experience. Insurers are able to apply a loading above 75% of the recommended premium and loading above that require WorkCover approval. ^b The Tasmanian WorkCover Board monitors premium rates at the scheme level, but is not able to influence the premiums charged by the licensed insurers. ^c The NT legislation does not regulate minimum or maximum premiums or establish advisory premiums and insurers operate with commercial independence. ^d The ACT Government annually publishes suggested reasonable rates to guide private insurers.

Source: Safe Work Australia (2018a); State-based workers compensation schemes.

As to the effectiveness of claims experience or ‘experience rating’ as an incentive to change employer behaviour, the Institute of Actuaries Australia made the following summary:

- (i) Experience rating makes sense — having a mechanism is better than not, at least for large employers.
- (ii) For smaller employers the incentives are not effective, because the likelihood of having a claim is very low and the impact on premium is small. A larger premium impact becomes punitive and unsustainable.
- (iii) Experience rating cannot be expected to change employer behaviour on its own — it must be only part of a broader tool kit to influence workplaces. (sub. 938, p. 7)

Why exempt smaller businesses from claims experience in setting premiums?

The reason put forward to exempt small businesses⁴⁵ from claims experience is to ensure that premiums for small businesses remain affordable by removing year to year volatility. For example, the NSW guidelines require licensed insurers to demonstrate that employer premiums are fair and reflective of risks and that premiums are not unreasonably volatile or excessive, particularly for small employers. The guidelines note that:

A small employer’s individual claims experience should not have an unreasonable impact on their premium ...

Large employers have a greater capacity to influence their own claims experience. The fairness of the system is more clearly served if the premiums of larger employers are more directly reflective of their claims experience. (NSW Government 2018c)

The Queensland scheme does provide for premiums for small business to increase or decrease depending on claims experience, although these changes to annual premiums are subjected to caps by using rating categories to avoid significant price changes in annual premiums for small businesses.

In some jurisdictions, workers compensation schemes seek to limit or weaken the price signal facing smaller businesses to minimise the risk to their employees in order to remove any price volatility in workers compensation premiums paid by these businesses. Other jurisdictions, such as Queensland, have attempted to balance these competing objectives by placing limits on annual premiums increases.

The trade-off between protecting small business from increases in premiums and ensuring employers have an adequate financial incentive provided by their workers annual compensation premium to improve workplace health and safety is a matter for each workers compensation scheme. However, setting premiums for these businesses without taking into account their claims experience reduces the financial incentive for employers to improve workplace health and safety and create a more mentally healthy workplace —

⁴⁵ The definition of a ‘small business’ for this purpose varies between schemes, but it is typically a business with a payroll or premium below a certain threshold level (as set out in table 7.1).

and means that safer workplaces subsidise the workers compensation premiums paid by the less safe workplaces.

Employer initiatives and lower premiums

There is potential for WHS agencies and workers compensation schemes and their insurers to work together to incentivise employers to identify and mitigate risks to psychological health and safety in the workplace.

Workers compensation schemes collect a considerable amount of claims data through their insurers. As discussed below, WHS agencies should have a role in monitoring and collecting evidence as to the outcomes from employer initiated interventions and programs to create mentally healthy workplaces and improve and protect the mental health of their employees. This should be used to assist in determining the outcomes of various interventions, including by business size and by industry to ensure that the interventions are appropriate for different businesses.

Employers who implemented the interventions considered to be appropriate and highly likely to produce positive outcomes for their workplace by the relevant WHS agency could pay a lower workers compensation premium. Such an arrangement would be of financial benefit to both employers and the insurers underwriting workers compensation policies.

Other insurance markets provide for lower premiums where policy holders undertake certain actions to reduce the risk of a claim (for example, burglar alarms and deadlocks on home contents insurance).

Some employer groups opposed this. Australian Industry Group (AiG) (sub. 819) were of the view that such an approach may not reduce the risk of a claim. It noted that schemes in certain jurisdictions that had previously offered reduced premiums based on the implementation of an external OHS audit of their management system had been discontinued as overall claims cost had not been reduced. ACCI (sub. 1202) supported linking lower premiums to the implementation of specific initiatives in principle, but were of the view that such measures would typically already be included in premium setting and those that did not implement such initiatives could end up being penalised. It also expressed concern that WHS authorities would be able to prescribe or consider which initiatives are acceptable for premiums to be adjusted as chosen programs may not be evidence based or be simply a result of a tick and flick response (ACCI, sub. 1202).

The introduction of such initiatives may not significantly reduce risks, overall claims costs and ultimately premiums for every workplace. However, greater flexibility around premium rates should act as a signal to employers to implement relevant initiatives that have been found to reduce the risks for similar workplaces. The need to collect information and provide wider exposure as to what initiatives work to assist employers, regulators and workers compensation agencies is discussed below in section 7.6.

ACTION 7.3 — LOWER PREMIUMS AND WORKPLACE INITIATIVES

Incentives for employers to reduce the risks of workplace-related psychological injury and mental illness can be improved through workers compensation schemes.

Start later

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

Changing the burden of proof

There have been suggestions to change the burden of proof in workers compensation claims for psychological injuries. This would involve use of ‘presumptive legislation’ that provides the injured worker with access to compensation without having to prove the injury was work related — the injury is presumed to be work related unless proven otherwise. Presumptive legislation removes any adversarial processes and streamlines the claims handling and focuses on injured workers receiving prompt access to treatment and return to work.

Nearly all jurisdictions have a list of diseases and conditions linked to particular occupations that are deemed to be caused by that occupation. Examples include, asbestosis from mining, manufacturing or other process involving use of or contact with asbestos along with particular skin cancers involving the handling of tar, pitch, bitumen or mineral oils are included on deemed lists. It is up to the employer to show that the disease was not caused by employment in order to challenge the claim (Quin 2015).

Presumptive legislation has also been introduced for fire fighters in regard to certain cancers. Under this legislation if a firefighter has been employed in that occupation for a defined period of time and is diagnosed with a particular cancer, it is presumed to be a result of their employment. This presumption also applies to volunteer fire fighters in most jurisdictions except for the ACT.⁴⁶

Presumptive legislation has been used in workers compensation schemes to deal with post-traumatic stress disorder (PTSD) in certain occupations, mainly first responders. In Canada, some provinces have presumptive legislation in place that applies to first responders diagnosed with PTSD — this means that once the condition is diagnosed by a clinician it is assumed to be the result of employment unless the contrary is proven. Tasmania has recently

⁴⁶ The fire fighter provisions of the *Safety, Rehabilitation and Compensation Act 1988* (Cth) that covers fire fighters employed by Air Services Australia, the Department of Environment and Energy and the ACT Government (including Rural Fire Service volunteers) were being reviewed in 2019, including extending the presumption of liability for prescribed cancers to volunteers, and a final report has not yet been released (Attorney-General’s Department 2019).

introduced presumptive legislation for PTSD for all public sector workers including first responders and volunteer first responders (Courtney 2019; Skatsoo 2019). In response to the Senate Education and Employment References Committee report on the mental health of first responders, the Australian Government provided in principle support to convene a national approach to presumptive legislation covering first responder and emergency service agencies (Australian Government 2020a). Following this, the Attorney-General then announced the establishment of a working group of State and Territory work health and safety ministers to consider appropriate legislation (McCauley 2020).

Changing the burden of proof to have workers compensation schemes accept all workers compensation claims for mental health would not be feasible given that not all mental health problems are a result of employment. As discussed above, workplace-related risks or stressors are part of a much larger group of risk factors to mental health, such as the stressful life events outside the workplace and individual risk factors such as genetic influences, early life events, personality, cognitive and behaviour patterns and prior mental health problems. Providing presumptive legislation for all mental health conditions claimed as resulting from employment could lead to a flood of claims and increased premiums placing the integrity of workers compensation schemes under considerable pressure.

Where there is good evidence that employment in a certain occupation is a causative factor for a particular condition, the burden of proof could be shifted from the worker to the insurer. Recent legislative changes in the Tasmanian workers compensation scheme introducing presumptive legislation for claims relating to PTSD by public sector and emergency service workers provide an opportunity to evaluate their impact on the workers compensation scheme and the mental health of these workers after these arrangements have been in place for a reasonable period of time.

Provisional liability and interim payments

Some workers compensation schemes provide support for all workers compensation claims — not just mental health-related claims — prior to liability being determined: the New South Wales scheme refers to these arrangements as provisional liability, South Australia as interim payments and the Tasmanian scheme as ‘without prejudice’ payments (table 7.2).

Under these arrangements, the injured worker is assumed to be entitled to benefits (including for the loss of income), and is supported on the basis of this assumption, unless and until a decision on liability is made to the contrary. These arrangements provide for the payment of benefits (for a specified period) and medical expenses (typically to a specified amount) before a decision is made on liability under the relevant legislation. For example, the Tasmanian scheme makes ‘without prejudice payments’ for limited medical expenses up to the value of \$5000 and the New South Wales scheme meets medical expenses of up to \$10 000 under provisional liability. This can reduce delays for an injured worker in gaining access to the appropriate medical attention and income and reduce other potential stressors while the decision of liability is being determined. However, where a final determination is

made to deny the claim any payments made are recoverable as a debt in South Australia, whereas in New South Wales and Tasmania the insurer is not able to recoup these payments.

Victoria has recently flagged introducing a provisional acceptance model for mental health claims. The Victorian Premier announced in 2018 that Victoria would introduce provisional acceptance payments in relation to medical expenses and like expenses (but no income payments) related to mental health claims sustained by emergency service workers. It would then undertake a 12 month pilot program of the provisional acceptance model and introduce legislation for provisional acceptance payments for medical and like expenses for mental health claims for all Victorian workers within two years. The pilot program commenced in July 2019. For the pilot scheme there would be no monetary cap on medical expenses, with the only requirement that the expenses remain reasonable (sub. 483). However, it is not yet clear whether or not the costs of treatment will be recovered if liability is ultimately denied by the insurer (being Worksafe Victoria) or its agents.

Following a 2018 review of Queensland's workers compensation arrangements, legislation was amended in late 2019 to provide for reasonable support services (including medical treatments, counselling and hospital emergency services as an outpatient) from the time a claim for a psychiatric or psychological injury claim is lodged until liability is determined. Where a claim is subsequently denied, treatment costs would be met by the insurer (WorkCover Queensland 2019b)

Provisional acceptance of claims allows those employees with psychological injuries to receive support and treatment as soon as the claim is lodged and avoids having to wait until liability is determined. This early intervention overcomes possible delays in treatment and increases the chance of an earlier return to work improving outcomes for the injured worker, the employer and the insurer.

However, who would pay for the initial treatment and any other benefits (such as for loss of income) where the psychological injury or mental illness is determined not to have arisen as result of employment is an issue. Clearly, if the liability is denied and the payments received by the claimant have to be recovered, additional pressure would be placed on the claimant, likely to further damage their mental health. On the other hand, having the insurer meet the costs for which they were not liable undermines the intent of the insurance arrangements to provide compensation to those injured in the course of their employment.

A way forward for workers compensation?

A key role of workers compensation is to enable a return to work. Early intervention and access to treatment are critical in providing for an early return to work for those workers with a psychological injury or mental illness. However, the processes and time required to determine whether or not the injury or illness was work related to determine liability can delay the treatment that would improve the likelihood of recovery and a successful return to work.

Table 7.2 Time requirements on determination of workers compensation claims and provisional or interim payments

NSW	The worker is entitled to receive provisional liability of up to 12 weeks compensation (for loss of income) and \$10 000 in medical expenses. If the claim is likely to exceed this period of time, the agent must determine whether to accept or reject the claim.
Vic	Agent has 28 days to accept or reject a claim. If the worker has not been advised of the decision by the 39th day after the claim was lodged with the employer, the claim will be deemed to have been accepted.
Qld	WorkCover Queensland has 20 days to accept or reject a claim, or must write to the worker (within 5 days of the 20 days) advising of its reasons for not making a decision, and advising that the worker can seek a review.
SA	The agent is required to make reasonable efforts to make a decision on the claim within 10 days. If this is not achieved, interim payments will be made.
WA	The insurer must advise the worker within 14 days that the claim has been accepted or is in dispute. If the worker does not receive final notification that the claim has been accepted or rejected, within a further 10 days, the claim is deemed to be accepted.
Tas	Payments are payable 'without prejudice' on lodgement of the claim. The employer, or their insurer, must advise the worker of the status of claim within 28 days of claim being lodged with the employer. If an employer wishes to dispute a claim, they must do so within 84 days
ACT	The insurer has 28 days from the time they receive the claim to make a decision to accept or reject the claim, otherwise the claim is deemed to be accepted.
NT	If a decision is not made by the Agent within 10 days of the employer receiving the claim, the claim is deemed to be accepted.
Comcare	No legislated time frame for claims decisions. The only requirement to make determinations accurately and quickly.

Source: AIG (2019); Safe Work Australia (2017).

Remove the link to employment?

One option would be to remove the link between employment and liability in workers compensation arrangements. All employed workers, irrespective of whether or not the psychological injury or mental illness was work related would be eligible for treatment through the workers compensation arrangements. There would be no delay in receiving treatment as liability would not need to be determined.

There are downsides to such an approach. It would continue the current two-class health system — those in employment would be able to access private treatment without any co-payment and with reduced waiting times whereas those not employed and with a similar health condition would not have access to similar treatment and may be limited to treatment through the public system.

There could also be cost shifting on to employers and others. Removal of the employment related test would likely require employers to pay increased premiums to meet the ongoing costs of all health conditions affecting their employees, not just those that have arisen within the workplace or within their control — and mental health claims on average require more time off work than other claims. This could undermine a key principle of the workers compensation system or would require another source of funds (the government) to cover

the gap between actuarially fair premiums (in that the premium should reflect the risk) and insurance costs.

An alternative approach that removes the link between employment and liability would be to remove most psychological injuries and mental illness as compensable conditions from workers compensation arrangements. All mental health conditions, whether or not they are related to employment, would be treated through the general health system. In other words, a person who has mental illness would receive the same treatment and care regardless of the origin of their illness. The New Zealand workers compensation arrangements limit compensation for psychological injuries or mental illness to those resulting from one-off traumatic events related to employment, such as experiencing a workplace armed robbery or workplace violence.

This alternative approach would avoid having a ‘two-class health system’. However, it presents a number of problems. Injured workers would be denied a benefit (easier and timelier access to private treatment without co-payments), there would be issues around the compensation for lost income and it would shift costs onto the public health system and the welfare system more broadly. This option would also remove a significant incentive for an employer to maintain a mentally healthy workplace if psychological injuries and mental illness were no longer compensable conditions in workers compensation arrangements. Maintaining this incentive would require a type of lump sum employee tax to be levied that would vary according to whether or not various indicators showed that the workplace was ‘mentally healthy’ — not dissimilar to workers compensation premiums.

A role for provisional liability?

Given that removing the link between employment and liability would create as many problems as it solves, another approach to provide early intervention and treatment to promote recovery and return to work would be to have workers compensation schemes fund medical treatment on a provisional liability or without prejudice basis until liability is determined — within a specified period to avoid delay. A number of jurisdictions, as noted above, have utilised these types of arrangements.

This raises the issue of meeting the costs of treatment provided to those workers with claims that are not accepted. Recouping the costs from the injured worker would be detrimental to their mental health (regardless of the links of their injury or illness to employment), while having the insurer meet costs for which they were not liable could raise premiums above a level that was actuarially fair.

A set period for treatment to improve return to work outcomes

A problem with having the date of determination of liability as the ‘set date’ for clinical treatment is that this date may not align with an appropriate point in the employee’s treatment. If liability is denied, then the employee is likely to suffer a disruption of treatment unless they have their own funds or private health insurance that allows them to continue

current treatment. This disruption can slow the employee's recovery and may slow their ability to return to work.

To avoid this problem the relevant time for coverage of treatment could be separated from the date at which the liability decision is made. Treatment and rehabilitation to facilitate return to work would be provided until the employee returned to work or for a specified period following lodgement of the workers compensation claim regardless of any determination of liability within that period. This would ensure the treatment and any required rehabilitation that commenced upon lodgement of the claim would, if required, be available to continue for a specified period to provide the best chance of a successful return to work. After the specified period, those workers with claims where liability was denied would revert back to treatment under Medicare.

As to the exact time period required, treatment could be provided to a worker with a mental health claim until they returned to work or up to a period of six months, irrespective of liability. This six month time limit reflects that most employees who have a mental health claim under workers compensation are likely, with appropriate and undisrupted treatment, to be able to return to work within six months. The median time off work for mental health-related workers compensation claims was 16.2 weeks between 2012-13 and 2016-17 and 64% of workers on mental health-related workers compensation claims were off work for less than 28 weeks (figure 7.7).

The six month period limit for treatment (including the rehabilitation to enable return to work) indicated above (based on the historical time-off work experienced by workers on workers compensation with a mental health claim) could be adjusted if required to improve return to work outcomes. It could also be a variable period of time depending on the treatment or nature of the mental illness. However, making this a variable time raises the potential for gaming the system where both the employee and the treating clinicians will prefer to maximise the time.

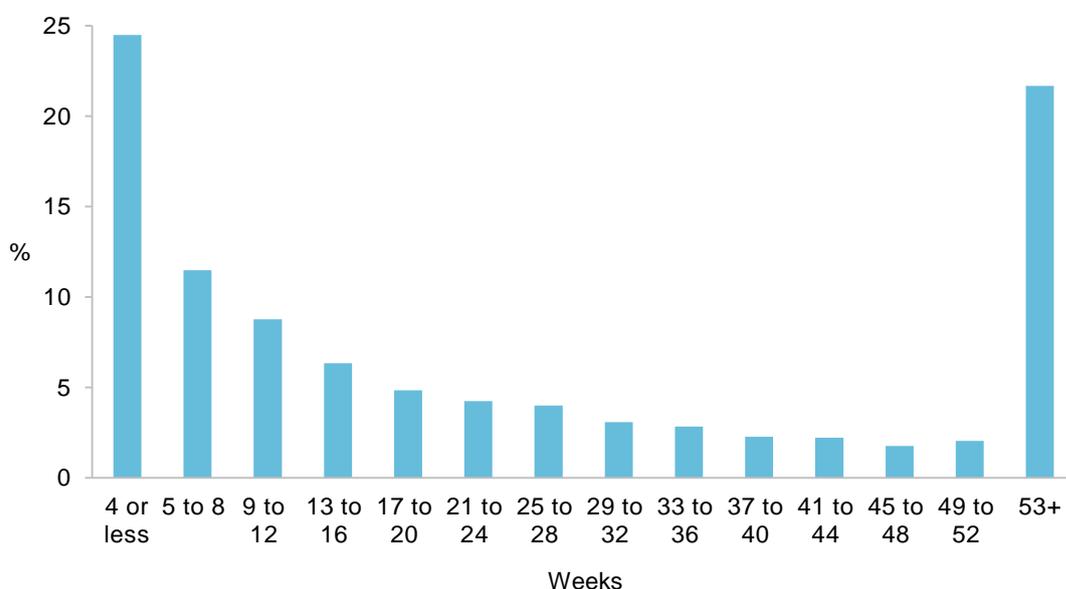
To ensure early intervention and the provision of treatment and rehabilitation to improve return to work outcomes, the relevant workers compensation scheme should provide clinical treatment for the psychological injury or illness, regardless of liability, until return to work or up to a period of six months following a mental health-related workers compensation claim being lodged.

To improve return to work outcomes, rehabilitation should also include discussion with the workplace to make any required changes in the workplace, where feasible, to facilitate the return to work. In some smaller workplaces, some changes to accommodate the return to work may not be possible.

In the Inquiry draft report, the Productivity Commission sought information as to how this should be funded. At first glance, funding this treatment through the workers compensation system could be expected to increase premiums as workers compensation would cover treatment for illness and injury that were not work related. Employer groups opposed employers having to pay for treatment where the claim was ultimately rejected (ACCI, sub. 1202; AiG, sub. 819).

Figure 7.7 Serious workers compensation claims for mental health-related claims, by work time lost^a

Share of all mental health claims, 2012-13 to 2016-17



^a Serious workers compensation claims are accepted workers compensation claims for an absence from work for one working week or more. Data for 2016-17 are preliminary.

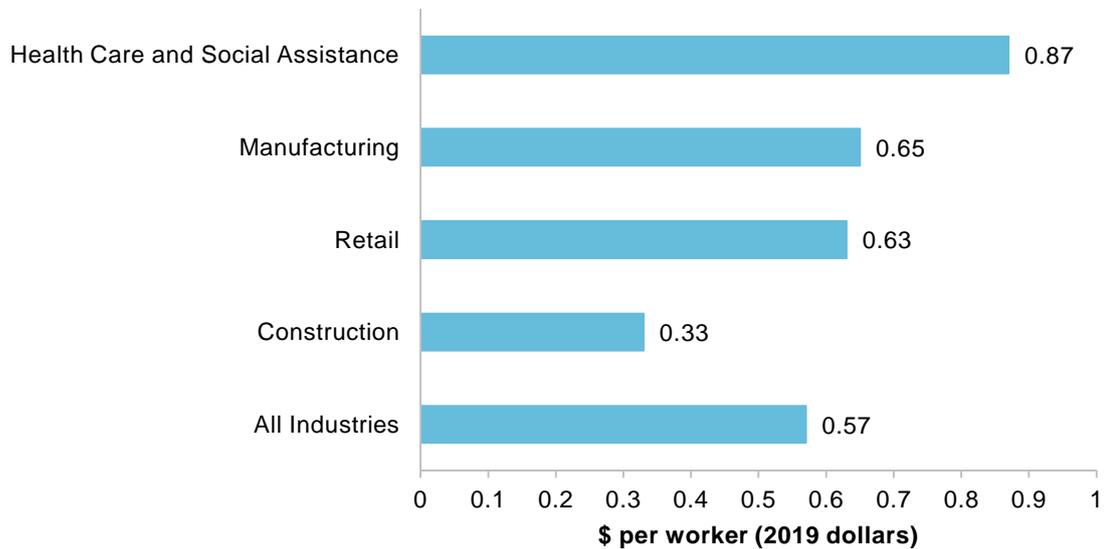
Source: Safe Work Australia’s National Data-Set for Compensation-based Statistics.

However, the Productivity Commission has analysed treatment and rehabilitation costs from accepted mental health-related workers compensation claims along with data on rejected claims to determine the additional cost that funding of mental health treatment through the workers compensation system would involve. In all jurisdictions (including the Comcare scheme), the estimated additional costs from providing unconditional treatment and the necessary rehabilitation for up to six months or until return work was determined to be a very small proportion of the annual premium cost to employers.⁴⁷

The maximum annual increase in premium revenue in order to cover the costs of mental health treatment for a limited period was estimated to be in the order of 0.6%. Based on 2017-18 data, the estimated additional cost per worker ranges between and \$0.87 in the health care and social assistance sector and \$0.33 per worker in the construction sector (figure 7.8). Given the very small magnitude of these additional costs for most businesses, coupled with the significant benefits achievable through early intervention and early return to work, the Productivity Commission has concluded that workers compensation schemes should be well able to cover mental health treatment costs for employees.

⁴⁷ Mental health claims are a small fraction of total claims, and the claims which represent the additional medical costs under this recommendation are a fraction of those. The cost of these additional claims is dwarfed by the size of annual premium revenues.

Figure 7.8 Increase in costs per employee of providing mental health treatment for 6 months
Selected industries for 2017-18



Source: Productivity Commission estimates using data provided by State and Territory workers compensation agencies and Comcare; ABS (2018d).

There is a possibility this approach would result in an increase in workers compensation claims (and additional costs) related to mental health if ‘healthy’ workers were to take advantage of the unconditional payment of medical and rehabilitation costs. However, this is unlikely to occur as there are limited incentives for disingenuous claims to be made to access treatment provided on this basis. In particular, there would be no compensation of employment income available (unless the claim is accepted) and consequently little incentive for an employee to feign or exaggerate an illness or injury to take time off work and be paid through workers compensation. In the absence of income compensation, it would be unlikely that a healthy employee would lodge a workers compensation claim simply to access unnecessary treatment and rehabilitation. Finally, for those employees with an existing mental health problem who are currently receiving treatment, making a claim to receive treatment through workers compensation would require disclosure to their employer of their mental health condition — a situation most employees would seek to avoid given the associated stigma.

ACTION 7.4 — NO-LIABILITY TREATMENT FOR MENTAL HEALTH RELATED WORKERS COMPENSATION CLAIMS

In dealing with mental health claims, workers compensation schemes can improve outcomes for employers and employees by providing for early intervention, early treatment and rehabilitation and successful return to work.

Start now

Workers compensation schemes should be amended to provide and fund clinical treatment (including any required rehabilitation) for all mental health-related workers compensation claims, regardless of liability, until the injured worker returns to work, or up to a period of six months following lodgement of the claim. Similar provisions should be required of companies that self-insure.

Estimate of the benefits of earlier return to work

Time away from work due to mental ill-health is costly to the economy. Our estimates for the benefits achievable from an earlier return to work for people claiming workers compensation focused on the likely reduction in time away from work.

Employees receiving workers compensation for more than 6 months were considered unlikely to substantially benefit from earlier access to medical care, and so were not included in the estimation of benefits. For employees receiving less than 6 months of workers compensation, it was assumed that early intervention and treatment (based on treatment being provided through workers compensation until return to work or up to 6 months) would reduce the time off work for a person with a work-related mental illness or psychological injury by 21% (appendix K). Accordingly, the estimated benefit from the provision of early treatment for work-related mental illness or psychological injury is in the order of \$12 million per year (appendix K). Given that the only benefit considered is an earlier return to work and not, for example, an increase in productivity from an improvement in employee mental health, this number potentially understates the true benefits of this policy. Using 2018-19 data, the additional estimated costs of providing treatment and rehabilitation through the workers compensation arrangements were estimated to be \$9 million⁴⁸ — ensuring the cost effectiveness of this policy.

⁴⁸ This is a potential overestimate as it assumes workers with rejected claims take a similar time off work to those with accepted claims under the recommended policy. This is unlikely as workers with rejected claims will not receive income compensation during their time off work, and so will likely return to work sooner.

7.4 Employer initiatives to create mentally healthy workplaces

The increasing awareness in the community around mental health has been reflected in the workplace and the role that workplaces can play in maintaining the mental health and wellbeing of their workers.

Business-specific and industry-wide initiatives

Many workplaces — ranging from those in the banking and finance sector, to the construction sector, to professional sports such as the Australian Football League (AFL) and the National Rugby League (NRL) — have made commitments to promote the importance of mental health and the wellbeing of those in their workplaces, and implemented initiatives and programs to deliver on these commitments (box 7.4).

For example, Qantas has implemented a health and wellbeing program, ‘Healthier Places, Healthier Bodies, Healthier Minds, Healthier Culture’ along with, ‘Our Minds Matter’ a program to support employees with mental health problems and create a mentally healthy workplace. Along with the relevant unions, Qantas also supports an independent peer assistance network of active trained pilot volunteers who are a confidential go-to point for pilots with stress and mental health concerns.

Examples of industry-wide initiatives include ‘Mates in Construction’ and ‘Mates in Mining’ to address suicide by construction and mining workers, and the ‘Arts Wellbeing Collective’ to support mental health for workers in the arts sector in Victoria through information, workshops, peer support networks and access to professional support.

Industry associations are also involved in supporting their members to take initiatives to improve mental health in the workplace. For example, ACCI has provided a range of online tools and information on mental health; partnered with unions, community groups and government to promote mental health; and supported and promoted academic research into interventions and control for mental health hazards in the workplace (partnering with Griffith University and iCare NSW to assess preventative measures for occupational violence in the retail and fast food sectors) (sub. 365).

Government in other workplace areas, for example maternity leave, has tended to be a leader in workplace issues. In some areas, particularly, in regard to emergency service workers, government employers have undertaken mental health initiatives beyond their statutory obligations. For their wider workforce, government has tended to lag behind the private sector in developing, trialling and implementing initiatives to improve workplace mental health. The Department of Industry, Science, Energy and Resources is currently reviewing the mental health management in the Australian Public Service (APS) to identify barriers to improving mental health management in the APS, understand managers’ capability and confidence in managing and supporting people with mental health conditions and develop a best practice approach to mental health across the APS (DIIS 2019).

Box 7.4 **Mental health, elite athletes and professional sport**

Survey research into elite athletes in Australia has suggested they experience common mental disorders such as depression at a higher rate than the wider community. As there are strong links between exercise and good mental health, it has also been suggested that elite athletes should experience lower rates of mental disorders than the rest of the community (Gulliver et al. 2015).

There are a number of factors that could increase the susceptibility of these athletes to mental disorders. For example, these athletes are typically required to relocate for their sport often when they are young and then can spend long periods away from home and family when competing at an elite level. There are also the expectations to perform at a certain level and pressure to win. Injuries in particular have been identified as being associated with depression in elite athletes (Gulliver et al. 2015).

There are specific risk factors for certain types of mental disorders, such as eating disorders. The prevalence of eating disorders is higher among elite athletes than the general population, higher in female athletes than male and more common among those involved in aesthetic sports relying on a lean physique, such as gymnastics and those where weight is critical, such as boxing and wrestling (Sundogot-Borgen and Torstveit 2009). Retirement from a professional career raises — particularly if premature as a result of injuries — further risks to mental health as these athletes may not have the skills, qualifications or experience even at a relatively young age to transition into another occupation. For some, the loss of public profile may also raise additional risks.

In looking at the job stress experienced by players in the AFL, Noblett et al. (2003) found that the most widely reported football specific stressors included poor performance, injury, the possibility of being de-listed and uncertainty as to their post-football career.

A study of the mental health of NRL players conducted prior to and during the 2015 season found that the overall presence of depression was significantly lower than for the general community, but with a higher rate of general anxiety disorders than the wider community and with little difference in outcomes between the pre-season and during the season. Of concern to mental health were the higher reported rates of alcohol misuse for these players than for the wider community (Du Preez et al. 2017).

Professional sports bodies in Australia have begun to develop an increasing awareness of mental health for those involved in their sport and in promoting this to the wider community. For example, the AFL has a framework in place to promote the importance of mental health and wellbeing for those involved in the AFL, develop and implement initiatives to support this and raise awareness as to the impact and causes of mental illness across the wider community (AFL 2019). Similarly, the NRL has a State of Mind program to increase awareness of mental health problems, start discussion and reduce stigma and engages current and past players to promote this within the NRL and the wider community (NRL 2019). Cricket Australia and the Australian Cricketers Association have implemented programs to develop the resilience of male and female players (Australian Cricketers' Association 2018).

Initiatives may be broad-brush or targeted

Primary interventions are initiatives delivered to all employees regardless of their current mental health or exposure to risks. These include strategies to improve job design and control, and to build organisational resilience through manager and leadership training and personal resilience through workplace health promotions and cognitive behavioural therapy

(CBT). Secondary interventions target specific employees often at greater risk of mental ill-health, such as first responders, through resilience training and workplace activity programs. Tertiary interventions are aimed at those who are already unwell either currently at work or absent from work, and focus on their return to work (box 7.5).

Box 7.5 Workplace interventions

These programs or initiatives to improve mental health in the workplace are often referred to as interventions. They are often identified as primary interventions delivered to all employees regardless of their current mental health or exposure to risks, secondary interventions targeting specific employees or tertiary interventions aimed at those who are already unwell. Different workplaces involve different risks — some will have higher risks such as emergency first responders, prison officers, FIFO miners — and these interventions and programs should be aimed at addressing these risks.

Primary interventions

Primary interventions include those aimed at improving job design and job control such as:

- worker participation — strategies to improve employees' perceptions of control over their work through consultative workshops, problem solving committees and stress management committees
- employee flexibility — empowering workers to have more control over their work patterns through working from home and flexibility around work hours.

Other primary interventions are aimed at building organisation resilience through:

- manager and leadership training — developing managers' awareness of mental health, reducing stigmatising attitudes towards mental health and increasing their confidence in supporting those with mental health problems
- team work group support — developing awareness of mental ill-health and confidence in teams to support colleagues with mental health problems
- mental health education and anti-stigma programs — educating employees to reduce stigmatising attitudes and discriminatory attitudes among employees
- anti-bullying programs — using communication strategies with awareness and stress management.

Primary intervention also can also focus on building personal resilience through:

- workplace health promotion — programs include workplace posters, media campaigns, mental health champions and discussions in team meetings
- cognitive behavioural therapy (CBT) based stress management programs — to assist individuals to problem solve and change behaviours to mental health
- problem solving therapy — to teach effective problem solving skills which can be applied to specific problems at work or in life
- mindfulness based interventions — to enable individuals to build awareness and understanding of themselves.

(continued on next page)

Box 7.5 (continued)

Secondary interventions

Secondary interventions target specific employees or risks. These are often those employees such as first responders who face elevated psychosocial risks in the course of their work. They include:

- CBT based resilience training for high risk workers — provide strategies and coping mechanisms to better manage exposure to risks and trauma
- coaching — to focus on individual wellbeing and stress management
- workplace physical activity programs.

Other secondary interventions focus on promoting and facilitating employees to seek help early. They include:

- wellbeing checks and/or screening — these need to have follow up interventions to address identified issues
- mental health first aid — provides increased mental health literacy, improve attitudes to mental health, reduce stigma and increase helping behaviours
- peer support schemes — provide additional training to groups of employees to provide support to colleagues and help identify colleagues requiring professional assistance
- workplace counselling — these services typically known as Employee Assistance Programs (EAPs) have been widely used to provide counselling to employees.

Tertiary interventions

Tertiary interventions are aimed at workers who are already unwell either at work, or off sick. The programs aimed at return to work are often the focus of WHS agencies, insurers as well as employers.

- facilitating return to work through support — assists an employee's return to work by making adjustments to their work by managers and peers
- work focused psychological therapy — therapeutical interventions aimed specifically at returning an individual to work.

Source: Safe Work NSW (2017) Harvey et al.(2012); Harvey et al. (2014); Glozier (2017).

How are Australian workplaces progressing?

While there has been an increasing recognition and awareness of mental health in the workplace and more widely in the community, it would appear that this has not yet resulted in widespread effective action to improve workplace mental health.

One approach to determine progress is to look at changes to the number of work-related mental health compensation claims. These claims by number and as a share of all workers compensation claims have remained relatively stable over the past decade (section 7.3).

A further measure is the action taken by businesses to address mental health in the workplace. The NSW Government, using a survey of businesses in 2017 to develop a benchmarking tool, found that about 9% of businesses have taken an integrated and sustained approach to workplace mental health, a further 14% had taken effective action, but nearly 20% only had a basic awareness of workplace mental health. Larger businesses tended to be more effective than smaller businesses (table 7.3).

Table 7.3 Workplaces approach to mental health in NSW

	<i>All businesses</i>	<i>Large (>200 FTE employees)</i>	<i>Medium (20–199 FTE employees)</i>	<i>Small (5–19 FTE employees)</i>
	%	%	%	%
Integrated and sustained approach	9	15	10	8
Effective action	14	15	13	14
Limited action	29	31	33	28
Intention	29	31	31	29
Basic awareness	19	8	12	21

Integrated and sustained approach: Mental health is everyone’s responsibility. Mental health specific systems, policies and procedures are integrated and embedded in the organisation. interventions are tailored to each work group and improvement in the mental health of the workplace is visible and continuous.

Effective action: Ongoing leadership commitment (work design, culture, funding) with a prevention focus. Universal mental health systems, polices and processes support evidence-informed intervention at the organisational level targeted at identified risks.

Limited action: The organisation recognises its responsibility to manage workplace mental health risks and issues. Generic mental health systems, policies and processes with reactive, optional or unconnected interventions.

Intention: General work health and safety systems, policies and processes with limited, ad hoc or outsourced psychosocial support services.

Basic awareness: The organisation views mental health as an individual’s responsibility. Only general workplace health and safety systems, policies and processes in place.

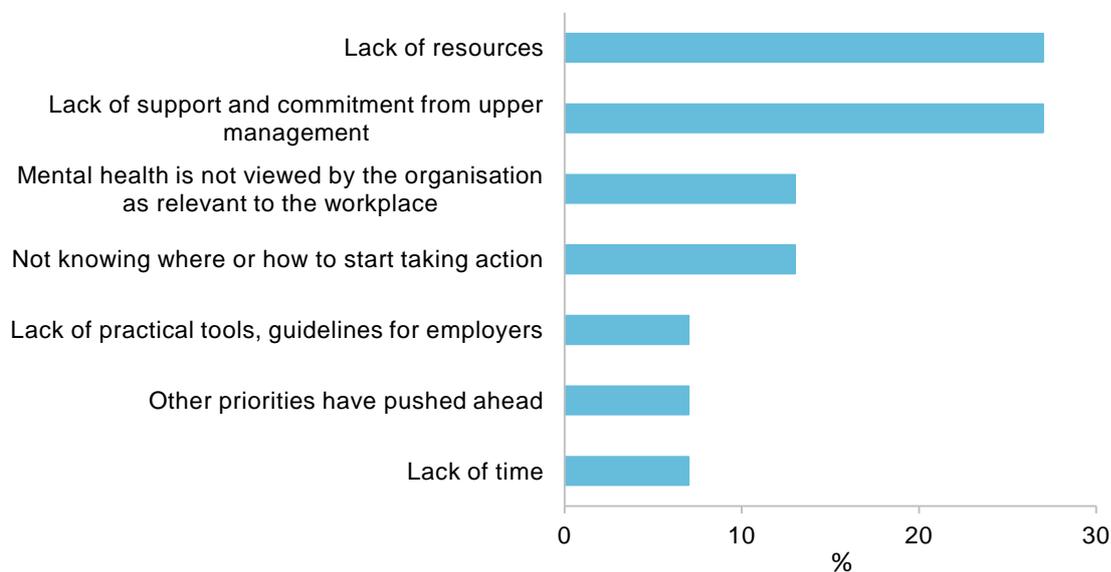
Note. totals may not add to 100% due to rounding.

Source: Donnelly and Lewis (2017).

The Diversity Council of Australia’s survey of 42 of its members across a range of industries in 2019, found that 61% of respondents had carried out initiatives in the last 2 years that focused on mental health in their workplace, 36% had not, and 3% had not yet, but intended to in the next 12 months (sub. 70, p 6). Of those who indicated that their workplace was not taking action, over a quarter cited a lack of resources and a further quarter cited a lack of support and commitment from upper management (figure 7.9).

An ACTU survey of employees reported that just over 70% of respondents said that their employer either never or only sometimes took mental health issues in the workplace seriously (ACTU 2019).

Figure 7.9 Why organisations are not taking action on mental health in the workplace



Source: Diversity Council of Australia (sub. 70).

Research for the AiG on the triggers, facilitators and barriers to implementing mental health initiatives in Australian businesses found that the major triggers included the strength of the business case for taking action on mental health in the workplace and the support of senior leadership (box 7.6).

Employee Assistance Programs

Employee Assistance Programs (EAPs) are one of the more widely used programs by employers to support good mental health. They provide support and counselling services to employees and often their immediate family members. These services are provided to employees on a confidential basis and are often the initial point of contact for an employee seeking assistance for a mental health problem (box 7.7).

Box 7.6 Triggers, facilitators and barriers to implementing mental health initiatives

Research was initiated by Australian Industry Group (AiG) and undertaken by Griffith University in 2019 to examine how Australian businesses were using mental health initiatives. In addition to a literature review, interviews were conducted with six Australian businesses from various industries including manufacturing, transport and logistics, professional services and energy services to gain insight into the Australian experience.

Types of initiatives used

In drawing on the interviews, the research report found that while there were more than 30 different initiatives in use, most businesses on average reported using 7 different mental health initiatives. The most widely used interventions were Employee Assistance Programs, mental health awareness days, mental health first-aid training and organisation wide meetings that included discussion of mental health. Other initiatives used included provision of information on mental health to staff, appointing a staff member to coordinate wellbeing and mental health, developing a supportive culture to support employee mental health and the introduction of social activities focussing on mental health and wellbeing.

Triggers and facilitators for business to implement mental health initiatives

From the interviews the triggers to introduce these initiatives included developing a clear business case for mental health activities and the existence of senior leader support for mental health initiatives. Other factors that facilitated implementing these initiatives included positive attitudes to mental health among senior leaders, an organisation culture that is aligned with or fits mental health activities, activities that assisted leaders to know their staff to allow them to identify issues as they develop and an appropriate budget to manage employee mental health.

Barriers to implementing mental health initiatives

The main issues that created barriers when implementing activities to manage employee mental health included:

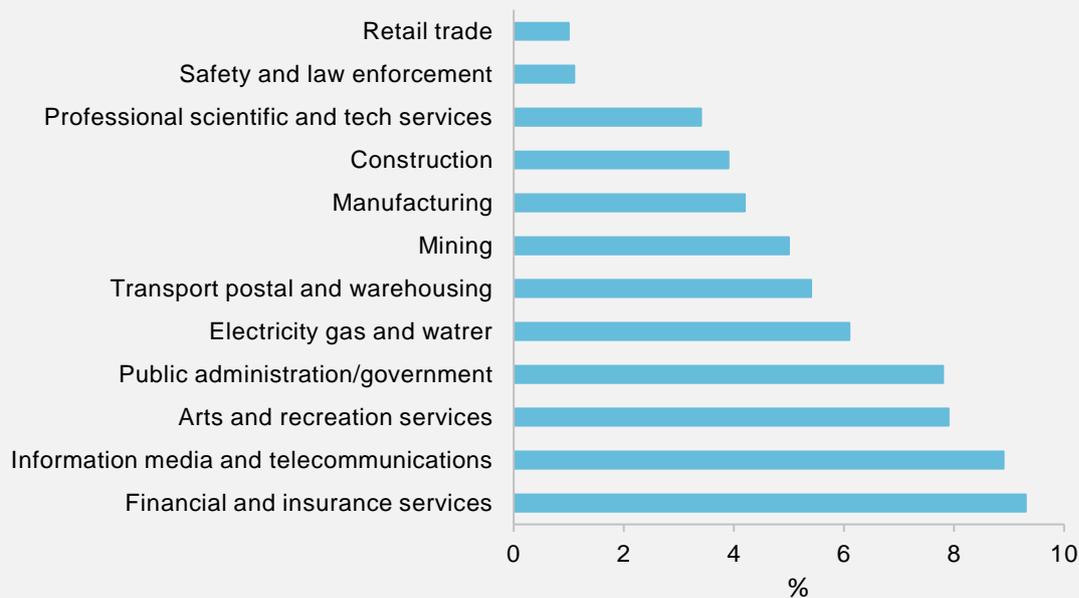
- stigma around mental health
- managerial resistance to dealing with employee mental health problems
- difficulties in accessing mental health assistance outside of an Employee Assistance Program
- unsupportive senior management attitudes to mental health
- a lack of engagement from employees with the organisation and/or mental health activities
- a lack of internal organisational knowledge and expertise in the mental health area.

Source: Rafferty, Troth and Jordan (2019).

Box 7.7 Usage of EAP services

In 2019, Converge International provided services to over 1 200 employers, with 130 000 hours of direct assistance to 65 000 employees. On average, these employees accessed just over two sessions of general EAP services, with the majority of clients able to access three sessions per employee.

The average utilisation rate was 5% for these services (excluding retail). There was considerable variation by industry groups with the financial and insurance services sector having a utilisation rate of 9%, compared to just 1% for those in the safety and law enforcement industries.



The low utilisation rate of the retail trade was due to the large number of non-permanent employees who did not have the same access to EAP services as permanent employees. Interestingly, those working in safety and law enforcement who typically have higher rates of workers compensation claims appear to have low rates of utilisation of EAP services.

Source: Information provided by Converge International.

There is considerable variation as to the actual services EAPs are contracted to provide. In contracting with a provider, an employer can opt for a basic type service, such as counselling provided by a call centre, to a more high level service with access to psychologists on a face-to-face basis. The number of sessions an employee is entitled to receive is usually also set out in the contractual arrangements, ranging from three sessions to an unlimited number of sessions. A further issue is that some employees may have doubts about contacting the EAP provider to address a workplace-related issue impacting on their mental health given that the employer is paying for the service.

As to the variability of EAP services provided, the industry body, Employee Assistance Professionals Association of Australasia (EAPAA) (sub. 411), noted that the increasing awareness of mental health in the workplace had created the opportunity for underqualified

and inexperienced clinicians and providers to enter the sector which to a degree had damaged the perception of reliability and tarnished the reputation of established providers.

For an employer, selecting an EAP can be complicated given that there are range of service levels available. This can lead to uncertainty as to what level of service and availability of service (24 hour availability, crisis response services) best meets the needs of the business and its workforce.

Based on interviews with management, most businesses considered EAPs important to manage risk and reduce costs associated with psychological injury, workers compensation, unfair dismissal claims, turnover, discrimination, conflict and formal complaints. Others considered engaging an EAP simply as a ‘tick the box’ exercise. Many businesses, in deciding which EAP provider to engage, make the decision based on what meets their own needs rather than by seeking out external evaluation or best practice (Joseph 2017).

In any case, there has been little external evaluation or benchmarking of best practice to guide employers. The OECD (2015a) found that although EAPs are widely used and appeared to be highly valued by employers and employees, there has been little evaluation of the outcomes of those using these programs. In the Australian context, Compton and McManus (2015) considered that the monitoring and evaluation of EAPs was at best patchy or perhaps even insufficient and inadequate. Others have noted that the studies on EAP outcomes have faced limitations due to difficulties in establishing a comparable control group (Joseph, Walker and Fuller-Tyszkiewicz 2017).

There are no set criteria as to what makes an ‘ideal’ EAP. Each business will make the decision as to what type and level of service to engage based on its own needs. Evaluation of the effectiveness of an EAP service at present is left to each individual business as the ‘purchaser’ of the EAP service.

There was some concern that many employers were unaware of the services they were purchasing and their effectiveness. For example, Jo Farmer Consulting said:

EAPs are poorly evaluated. Many employers do not know what they are purchasing and, once implemented, do not know the outcomes that are being achieved for their employees. Often the only metric supplied to employers is utilisation rate, which tells little about the effectiveness of the EAP and is often a broader indicator of EAP awareness and the organisation’s culture regarding mental health. Further, there is no ‘ideal’ utilisation rate so it is a largely meaningless benchmark. (sub. 715, p. 3)

EY commented that:

Overarching definitions of quality and service outcomes are required. Consideration may be given to an EAP quality index, against which EAP providers are independently measured and which is independently monitored and reported on. (sub. 1232, p. 4)

Surveys of organisations using EAPs found that most respondents (58%) had not established a method to evaluate the effectiveness of the service provided by their EAP. For those that did undertake evaluation, the main methods used were employee feedback and surveys.

Surprisingly, nearly a quarter of respondents (24%) did not even maintain records of their usage of EAP services (Compton and McManus 2015). Having paid for a service it would be considered prudent to assess the actual level of usage of that service.

The EAPAA (sub. 668) noted that it was involved with researchers at the University of South Australia to measure the efficacy of EAPs and the extent to which the workplace and safety culture in an organisation impacts on the efficacy of EAPs. This type of research and provision of summary information to employers would improve confidence as to the appropriateness of services they are purchasing and the likely outcomes from that service.

One approach to improve the effectiveness of EAP services would be for industry associations representing the EAPs to develop more formal mechanisms to enable individual businesses and their EAPs to evaluate outcomes for that business. There is also an opportunity for the EAP industry to further invest in research to develop reliable methods of external evaluation and benchmarking of best practice to assist more widely in the provision of EAP services — and provide greater confidence to a business when selecting an EAP provider and for the provider in determining the needs of a particular business.

There is also scope for the EAP industry and the employers using these services, through their respective industry association or other employer body, to develop a list of necessary features or minimum requirements for an EAP service. To provide input from the employee perspective who are ultimately the users of these services, employee representatives should also be involved.

The Productivity Commission notes that the EAPAA (sub. 668) has developed a list of standards its members are required to comply with that provide a base level of quality for those using these services. These 17 standards cover areas such as implementation, reporting, record keeping, confidentiality, staffing and training, service delivery, crisis management, availability of services, consultancy and services to managers and evaluation. The standards would provide a starting point for employers (many who value having these services available), and the EAP sector in consultation with employer and employee representatives to develop a set of minimum standards acceptable to both providers and employers, in particular around the evaluation of the services a business or organisation has purchased. These minimum standards would not be mandatory. The type and level of EAP services an individual business requires to meet its needs and those of its employees is best determined by the business itself.

However, having the EAP industry as well as those purchasing the services and users of the services develop these minimum standards may help to address the EAP industry's concerns around the reliability and level of services and its impact on the reputation of providers. It would also increase confidence for businesses when choosing a service provider and ensure that effective evaluation of these services is in place. It would also strengthen the important role EAP services can and do play in providing early intervention given they are often the initial point of contact for those with mental health problems in the workforce.

ACTION 7.5 — MINIMUM STANDARDS FOR EMPLOYEE ASSISTANCE PROVIDERS

Employee Assistance Programs can support workplace mental health. But employers need guidance as to which programs are likely to be most effective for their workplace.

Start later

Employee assistance program providers and their industry bodies, in conjunction with employers, and with employer and employee representatives, should develop minimum standards for employee assistance programs and for the evaluation of these programs.

Peer support networks

Peer support networks supported by employers have emerged in certain high risk jobs such as police, fire and rescue, paramedics, airline crew and the military. The peer support officers (PSOs) (employees provided with necessary training) typically provide support to their colleagues exposed to traumatic and high stress situations after such an event as well as monitoring the ongoing mental health of their colleagues. This provides for workers to seek assistance through a colleague operating as a peer support officer and lessens the stigma (and potential adverse consequences) attached to seeking help after a stressful event or situation. About half of all emergency service workers in a state ambulance and paramedic service have accessed a peer support officer at least once per year (Shakespeare-Finch et al. 2014).

In other types of workplaces where there is less exposure to stressful events and trauma, peer support officers have not been widely used. They do provide an initial point of assistance after which, where required, those seeking assistance can be directed on to counselling or medical services, such as those provided by the EAP. The effectiveness of a peer support network will depend on being able to select those individuals who are willing to become PSOs and have sufficient respect and confidence within the workplace so that their colleagues will be comfortable in seeking assistance from the PSOs if required.

Stay at work

The use of peer support networks and EAP services play an important role in supporting those with mental health problems to ‘stay at work’, as an alternative to taking time off work and then dealing with the difficulties involved in returning to work. The potential for such an approach to be successful would depend critically on the nature of the mental health problem, its impact on the individual’s functionality and the extent to which being at work is conducive to, or inhibits the individual’s recovery.

In addition to the programs and supports discussed above, Comcare has been trialling other early intervention programs in Australian Public Service agencies that would support stay at work. These have included a low intensity CBT program suitable for those experiencing

mild to moderate levels of depression and/or anxiety. Initial outcomes for those taking part in the trial indicate a significant clinical recovery in their psychological wellbeing as well as benefits in terms of reduced levels of absenteeism, presenteeism and mental health-related workers compensation claims. A further trial has been undertaken involving a nurse triaging service for both physical and psychological injuries that enable an injured or unwell worker to contact the service and be referred to the most appropriate treatment option (Comcare, pers. comm., 6 March 2020).

Which employer initiatives and programs are the most effective?

There is limited evidence on the effectiveness of these interventions. To date, there has been difficulty in establishing the effectiveness of different programs and initiatives.

A lack of good quality evidence as to what is effective

There have not been enough well conducted studies of workplace interventions to conclude with certainty what is and what is not effective in improving workers mental health (Harvey et al. 2014). In the past there has been a tendency to roll out interventions in the workplace without evaluating their effectiveness. And there are practical difficulties in conducting research in workplaces — randomised control trials of these types of interventions are relatively rare due to the practical difficulties in undertaking such an evaluation in a dynamically changing workplace. Nevertheless, the available research strongly suggested that there is a lot that workplaces can do to help the mental health of their employees (box 7.5; Harvey et al. 2014).

Other researchers in this area, such as Glozier (2017), have also found that systemic knowledge of the effects of these interventions on employee mental health and occupational outcomes is limited in many instances. In regard to particular types of interventions, Glozier (2017) concluded that there was limited evidence for those interventions targeting job demands placed on employees and assisting employees to cope with organisational change.

SafeWork NSW, in drawing on the work of Glozier, noted that the best evidence pointed to those interventions, ‘designed to enhance individual resilience, wellbeing, detection and early help-seeking or to manage those who are unwell’ (Safe Work NSW 2017, p. 15). Importantly, interventions that create mentally healthy workplaces may not be the same as those that reduce the symptoms and impacts of mental ill-health (Glozier 2017).

The KPMG study (KPMG and Mental Health Australia 2018) although finding positive outcomes from a range of workplace interventions, noted that the quality of the evidence base for these interventions was poor.

The OECD found that many of the campaigns and programs to acknowledge and support those with mental health problems including in the workplace, while highly valued and well-supported, had little firm evidence as to their effectiveness (OECD 2015a).

Given the range of programs and interventions on offer and the lack of clear evidence, many employers were often confused as to what action they should take (box 7.8).

Box 7.8 Participants' views on the use and effectiveness of these initiatives

The Mentally Healthy Workplace Alliance recognised that while workplace interventions could be effective, further research was required to identify those interventions that delivered unequivocal benefits to workplace mental health:

In addition to the foundations of good work design and the control of risks for an effective mental health strategy, there are numerous other interventions that can be implemented to strengthen the health and wellbeing of their workforce. The evidence suggests that there are effective workplace interventions to support mental health, although unequivocal direction about the most effective prevention activities is limited. This is an area for more real-world research and research translation. (sub. 209, p. 12)

SuperFriend noted that many employers were confused by the volume of information as to what actions they could take that would be effective in their workplace:

While there was a demonstrated appetite for action amongst Australian employers, many also reported feeling confused about exactly what action or actions they might usefully take. They described feeling overwhelmed by the sheer quantity of information available and daunted by the need to distinguish between evidence and anecdote. (sub. 216, p. 9)

While some employers recognised the benefits from investing in mental health, others simply took a short-term 'tick the box' approach to mental health. Rural & Remote Mental Health commented:

Some mining and resource companies have made significant investment in mental health in their workplace and, will over time, reap the rewards. However, there are other companies which recognise that it is a significant issue but take a short-term, limited investment approach that means they can 'tick the mental health compliance box'. (sub. 97, p. 24)

The use of some initiatives, while of short-term benefit could distract management from dealing with more serious issues:

... fruit boxes and yoga can be good for individuals and the culture of an organisation, but this can distract management and deflect actions and funding from more worthwhile and more efficacious actions on work-related factors and initiatives. Even resilience training can distract from more systemic issues. Some research show actions that can be effective, although many (even widely accepted programmes) have only short-term effect. (Carolyn Davis, sub. 192, p. 28)

In those workplaces where the risk of psychological injury was high (such as with first responders) programs were being developed, but in many workplaces senior managers 'have not received the requisite training or education to help them proficiently identify and manage mental health issues in their workplace' (EML, sub. 117, p. 11).

Others were concerned that such initiatives, including health promotion and general wellbeing, could be confused with legislative obligations. The Australian Chamber of Commerce and Industry said:

This distinction is critical as health promotion activities are optional whereas risk management duties are legal duties. (sub. 365, p. 10)

Is there an overemphasis on mental health in the workplace?

A differing view on workplace interventions questions how much mental illness symptoms should be discussed in the workplace. If mental health problems are over-discussed employees may doubt their own resilience and feel more vulnerable to illness. Also, workplace screening could risk labelling transient mental health problems as a more serious medical problem. There have been suggestions that the increase in back pain in workplaces during the 1970s and 1980s was partly a result of the interventions to make workers more aware of the risk of back pain (Harvey et al. 2014). Similarly, the outbreak of repetitive strain injury among office workers during the early 1980s in Australia (that did not occur in other countries with similar working practices and technology) coincided with an increase in awareness and simply later subsided without any significant change to work methods (Coggon 2005). The dangers of overemphasising the risks of mental health problems is countered by those who consider that mental health problems need to be discussed in the workplace to prevent stigma and ensure help is sought early on (Harvey et al. 2014).

There was also a concern that the use of these interventions had created an expectation that employers were able to safeguard the mental health of those who worked for them and address any mental health problems. Carolyn Davis commented:

Businesses alone are not the answer to everyone's happiness nor the answer for mental ill-health — health is a shared responsibility (sub. 192, p. 5)

Mental health is complex and there are a range of factors — such as stressful events outside the workplace, the individual's biological and genetic make-up and prior mental health problems — outside the control of the employer that impact on the mental health of an individual. A mentally healthy workplace, while important, is only one component underpinning the mental health of an individual.

7.5 The returns from investing in workplace initiatives

A recent focus has been on the benefits to employers from investing in mental health initiatives in terms of reduced absenteeism, workers compensation claims and increased productivity. For example, recent research and studies have found there are healthy returns to employers from such investments. The returns ranged from \$1 to \$4 for each \$1 invested, with the highest returns available from psychological return to work programs and minimal returns for interventions that focused on job control and job design. Returns may also be higher for larger businesses based on the study that focused on New South Wales (table 7.4).

These types of studies have triggered an interest by policy makers and some employers to invest in strategies and programs to improve productivity, lower costs for employers and improve the wider mental health of the workforce (Mattke et al. 2007).

Table 7.4 Return on investment by type of intervention

	<i>Job control/design</i>	<i>Cognitive Behavioural Stress management therapy</i>	<i>Workplace health promotion/physical activity</i>	<i>Health screening</i>	<i>Psychological return to work programs</i>
KPMG and Mental Health Australia	1.3	1.7	2.0	2.0	4.7
Yu and Glozier for SafeWork NSW	1.56 (SME) 0.96 (Large)	1.56 (SME) 2.39 (Large)	2.86 (SME) 4.01 (Large)	na	3.9 (SME) 3.74 (Large)
PwC ^a	2.3				

^a The PwC study estimated the return on investment was 2.3 for all interventions. This was based on the average of the individual return on investments resulting from implementing the appropriate actions in a combination of organisations, size and industry. Each action included in the analysis would achieve a positive return on investment at a different point in time depending on the size and industry of the business. *Source:* KPMG and Mental Health Australia (2018); Yu and Glozier (2017); PwC (2014).

Why are the returns so healthy?

A large proportion of the returns to employers from these initiatives and programs result from potential reductions in ‘presenteeism’ and the subsequent increase in productivity from the improved mental health and wellbeing of the workforce. Presenteeism refers to the reduced productivity of a worker with mental health problems when they attend work (as opposed to absenteeism).

For example:

- presenteeism accounted for 89% of the total annual cost to NSW employers from poor mental health in the workplace (nearly \$2.5 billion of the \$2.8 billion) (Yu and Glozier 2017)⁴⁹
- the KPMG study found that presenteeism accounted for 77% (\$9.9 billion of the \$12.8 billion) of the cost of workplace mental ill-health in Australia (KPMG and Mental Health Australia 2018)
- in PwC research, presenteeism comprised 55% of cost of mental health conditions in Australia (roughly \$6.1 billion of \$11 billion) (PwC 2014).

The Productivity Commission used data from the National Health Survey to estimate presenteeism arising from mental ill-health in the workplace. This produced an estimate in the range of \$5.3 billion to \$7.0 billion in reduced productivity due to mental ill-health in 2018-19 (appendix H). This estimate of reduced productivity arising from mental health is

⁴⁹ These estimates for NSW alone would, if simplistically scaled up to Australia, give a range of \$8.5 billion to \$8.8 billion for presenteeism.

in line with those produced by the PwC research (PwC 2014) and Yu and Glozier (2017), but below that produced by KPMG and Mental Health Australia (2018).

Measuring presenteeism or an individual's reduction in productivity over a period of time is more difficult than measuring workers compensation claims and absence from employment due to mental ill-health. Measuring presenteeism is complex for a number of reasons (Mattke et al. 2007). Unlike workers compensation claims and days absent from work, there is no direct measurable data available from which costs can be derived and assumptions have to be made as to how less productive per day or per month an individual has been due to poor mental health (box 7.9). Measurement has typically been based on self-reported survey data collected from employees, relying on an employee's perceptions and recollection of their effort and engagement in the workplace over a particular period to determine levels of presenteeism (Johnston et al. 2019).

The wider costs to the community of mental ill-health are discussed in detail in chapter 3 and appendix H.

Box 7.9 Estimating the cost of presenteeism

The recent studies on the return on investment for businesses investing in programs and initiatives to improve mental health and wellbeing in the workplace all used different methods to estimate the costs of presenteeism.

For example, the PwC study estimated that workers were 50% less productive due to presenteeism (this value was then multiplied by the amount of time the person is assumed to be working but not as productive – the hours lost depend on the severity of the individual's mental health) (PwC 2014).

In contrast, the work undertaken by KPMG (KPMG and Mental Health Australia 2018) estimated the impact of mild depression on labour productivity to be 3.9% and rising to 9.2 % for severe depression. These estimates drew on data from a telephone survey based on self-reporting by individuals on their work performance and level of depression. This was then deducted from the average performance of an employee with no reported depression to come up with a performance loss (McTernan, Dollard and LaMontagne 2013).

The research that focused on New South Wales assumed the loss of productivity per employee at 15.3%. This was taken from a meta study in the United States by Goetzel et al (2004) and was a mid-point between the high and low scores of other studies (8.1% (Kessler and Frank 1997) and 36.4% (Collins, Baase and Sharda 2005)).

The Productivity Commission used data from the ABS National Health Survey. From the survey, people with mental ill-health noted that they were less productive at work on an average of 14 to 18 days due to their psychological distress. This calculation was based on a survey question that asked people if they 'cut down' on work or study or day-to-day activities because of 'feelings' in the last 4 weeks. If people were employed at the time of the survey and indicated that they had 'cut down', it was assumed that they cut down at work (ABS 2019h). It was then assumed that workers with mental ill-health had a lower productivity of 50% *on days that they cut down*. Based on this, approximately 7 to 9 days per worker per year, on average, was lost because of presenteeism due to mental ill-health and monetised using average weekly earnings.

Because of the difficulties in establishing the actual loss in individual work performance, there is considerable variation across these studies as to the reduction in productivity (or presenteeism) due to mental health conditions in the workforce and the subsequent costs. However, while it is difficult to quantify with any precision the loss in productivity from those employees with mental health conditions, such losses are likely to be significant given the prevalence of mild to moderate mental ill-health across the community.

One way to check the estimates on the cost of presenteeism in the workplace would be to observe employer behaviour. If there were healthy financial returns available to employers from investing in these initiatives and programs it would be expected that employers would be making these investments. The lack of investment in mental health programs to reduce presenteeism in workplaces suggests that many of the studies that attribute high costs to presenteeism — and large benefits to its reduction — should be treated with caution. If the gains were as large as some studies claim, then programs to reduce presenteeism should have been widely adopted to raise business profits.

At the same time, the value of this ‘market test’ should not be overstated. It appears that while many employers are interested in investing in interventions and programs to improve mental health in the workplace, they are confused and uncertain as to the actual initiatives and/or programs that would be effective and suitable for their workplace. The Productivity Commission’s emphasis on evaluation is designed to assist employers in making these choices, but the difficult position employers find themselves in is discussed below.

7.6 Improving employer interventions

Employer initiatives can play an important role in creating mentally healthy workplaces and protecting the mental health of their employees, but as noted above to date there has been difficulty in establishing which interventions are effective across the board due to the limited evidence. Many employers want to undertake interventions to improve workplace mental health, but faced with a large amount of information on the various initiatives available to improve workplace mental health are confused and unsure as to what to do.

As the Australian Chamber of Commerce and Industry said:

Many employers feel that currently there is no sense of what workplace mental health ‘best practice’ comprises. There is a large amount of information available about approaches to workplace mental health but there is a lack of clarity around what is agreed best practice. This is partly attributed to the distinct lack of evaluative evidence on the impact of different approaches/interventions. (sub. 365, p, 17)

Similarly, the Mentally Healthy Workplace Alliance said:

... while many employers want to take action, they are confused about what to do, where to start, and are overwhelmed by the quantity and quality of available information. Information can be difficult to navigate, and not all applicable for an individual organisation’s needs and their stage of maturity embedding workplace mental health. (sub. 209, p, 16)

As workplaces and organisations are complex, interventions need to be developed, implemented and evaluated and then scaled up or tailored differently to meet the needs of the organisation (Glozier 2017). For example, workplace physical activity or CBT resilience training could be trialled and then adjusted for different workplaces. What works for larger employers may not work for smaller employers and similarly in different sectors across the economy.

There is a role for WHS agencies to advise workplaces on the likely effectiveness of various interventions and to monitor and collect evidence of the effect of these interventions that is then ultimately captured by Safe Work Australia on a national basis. This would enable these agencies to access and promote information from all jurisdictions as to what works for different workplaces. Employer groups and industry associations could also play a supporting role in collecting this information and feeding it back to WHS agencies to be collected by Safe Work Australia and then advising their members of the effectiveness of different interventions.

Further incentives for employers to improve mental health may be provided through greater use of data on workplace interventions, claims and insurance. As discussed above, workers compensation schemes collect considerable claims-related data that could be used to determine any association between different interventions and reductions in mental health-related claims. Data are also collected by life insurers providing income protection and total and permanent disability insurance through an employee's superannuation. Use of such data — outside of just the insurance business that is amassing it — would go some way to providing a better understanding of which workplace interventions are effective for different sized businesses and across different industries and allow employers to find the interventions that are likely to be the most effective for their business.

Employers could be ranked, for example, relative to similar sized businesses in the same industry and to all businesses as to how they performed in providing a mentally healthy workplace in the previous 12 months based on insurance claims data. This relative ranking could be attached to their annual premium notice (not unlike relative usage rates by household size on energy and water bills). Employers with relatively high rankings could use their ranking not only as an attraction to potential employees, but also to promote their business more widely as being a highly rated mentally healthy workplace whereas those with lower rankings (along with higher premiums) would have an incentive to improve their relative performance. Of course, such comparisons across different sized businesses based on claims per employee may disadvantage those businesses with very few employees.

Employers regardless of size, require information on how to effectively deal with mental health problems in the workplace and create mentally healthy workplaces. However, not all employers, particularly small and medium sized businesses, will have the ability to implement interventions to the same scale and scope as larger enterprises and such interventions may need to be adjusted and adapted accordingly.

As the Department of Jobs and Small Business (sub. 302) commented, most workplace mental health initiatives are designed for larger organisations that often require extensive infrastructure, such as access to human resources departments or occupational health services that may not be available in small businesses. AiG (sub. 208) also noted that while large organisations had the resources and staff to support such interventions, this was not necessarily the case with small and medium sized enterprises. It also pointed out that small business owners themselves experienced considerable mental stress as the family's livelihood and financial security were often bound up in the business (sub. 208). Small businesses will require interventions that recognise their specific needs and the resources available to these enterprises to implement initiatives to protect the mental health of the employees and the business owner.

In December 2018, the Australian Government announced specific funding for mental health assistance for small business — the majority of this funding will be to expand the trial of Everymind's 'Ahead for Business' program from New South Wales to a national level (Cash 2018a). The 'Ahead for Business' program provides a website and app for small business owners to connect them with information, self-assessment tools, programs and interventions to manage business stressors and assistance for mental health problems (Everymind 2018). A particular focus of the 'Ahead for Business' trial is the mental health of the small business owner. A previous survey of 442 small business owners by Everymind found that about 57% had levels of stress outside the normal range (Icare and Everymind 2017). The evaluation of the national trial will provide an opportunity for governments and small business organisations to disseminate information to small businesses on interventions and actions to support their mental health.

Further work is being undertaken by the Department of Education, Skills and Employment in conjunction with small business and mental health professionals to develop policy options to support small business owners to look after their mental health. Some of the options to better support small business developed at a Small Business Mental Health Roundtable held in late 2018 included providing those services that small business regularly deal with such as accountants, tax advisors, bankers and industry groups with the access to the necessary information and advice on mental health to enable them to recognise difficulties in their small business clients and provide direction to the appropriate services. Others included ensuring EAP services were more accessible to small business operators through voucher arrangements, bulk buys or subsidised access (Cash 2018b). A wellness campaign has been implemented with the provision of wellbeing and support pages on the Department's website and the development of a My Business Health Portal for the Australian Small Business and Family Enterprise Ombudsman's website (Department of Employment, Skills, Small and Family Business, pers. comm., 15 September 2019).

Importantly, employers are most likely to effectively implement interventions when they genuinely believe that the mental health of their employees is important and they will get a positive return on their investment in the mental health of their workforce. Otherwise, such interventions may simply result in tokenistic gestures (the fruit bowl in the lunch room) rather than in those that can make a difference.

ACTION 7.6 — DISSEMINATING INFORMATION ON WORKPLACE INTERVENTIONS

Creating an evidence base on employer-initiated mental health interventions in the workplace can help all employers choose the most appropriate intervention for their workplace.

Start later

Workplace health and safety (WHS) agencies should monitor and collect evidence from employer initiated interventions to create mentally healthy workplaces and improve and protect the mental health of their employees. This evidence should be captured by Safe Work Australia on a national basis, and provided back to WHS agencies in a timely manner and in a form that they can use to advise employers of effective interventions that would be appropriate for their workplace.

Additional insurance for high risk employees

Some employees take out additional income protection insurance, often through their superannuation, to provide income if they are unable to work due to injury or illness. Other employees in specific occupations may have insurance to cover the loss of a specific requirement related to their employment — for example, insurance to protect a pilot’s income in the event of loss of licence.

Employees in certain occupations, such as emergency service workers and construction workers — where there is a higher risk of developing a work-related psychological injury or mental illness — could benefit from access to additional income protection insurance that covers psychological injury or mental illness, on a group basis through their employer. This would potentially enable access to income protection insurance at a lower price than purchasing a policy as an individual.

In the Inquiry’s draft report the Productivity Commission sought further information as to any barriers to employers facilitating solutions for those employees who are at a particularly high risk of psychological injury or mental illness.

From the limited responses, most emphasised that this type of income protection was provided to employees through their superannuation. The Institute of Actuaries of Australia (sub. 938) noted that while an employer could as an alternative provide income protection insurance cover outside superannuation, there was a danger the insurance provided would end up as ‘junk’ insurance due to the double up of cover with multiple competing benefits for those employees with employer cover and their own superannuation cover.

The Police Federation (sub. 761) noted that while income protection was predominately provided through superannuation, there is often inadequate or poor coverage in certain jurisdictions for police officers and some schemes do not provide for automatic or default income protection insurance.

Overall, the Productivity Commission concluded that for most employees, income protection appears to be contained within superannuation arrangements (which were recently examined by the Commission in its superannuation inquiry (PC 2018c)). The need for any additional income protection is likely to be confined to a small number of employees in particular occupations, and does not warrant a broad-brush solution at this point in time.

The workforce of the future

There is no data on the mental health of Australia's current workforce. However, data from the 2007 National Survey of Health and Wellbeing (ABS 2008) covering the wider adult population aged 16 to 65 years is often referred to as a proxy for the workforce. This survey found almost half of adult Australians have had a mental illness at some point in their life and about 20% have experienced mental illness in a given year (chapter 2). Survey data collected for Beyond Blue indicated that about 1 in 5 Australians (21%) had taken time off work in the previous year because they felt stressed, anxious, depressed or mentally unhealthy (TNS Social Research 2014).

The mental health of the workforce in the future will reflect the mental health of those age groups who are yet to enter the workforce. It will depend on the current prevalence of mental ill-health in the younger population — now at school and in tertiary study — who will provide the workforce of the future and of course on the effectiveness of the overall mental health system in dealing with mental ill-health in these younger cohorts. However, younger people tend to experience poorer mental health than other age groups. The prevalence rates of mental ill-health are highest in young people aged 16 to 24 years although prevalence rates decline over time (chapter 2). For school children, an estimated 25 to 30% require psychological support and addressing risk factors and symptoms early is considered to be a cost effective way to improve longer-term outcomes (chapter 5). Those in tertiary study, university and VET students, experienced poorer mental health outcomes than the general population (chapter 6).

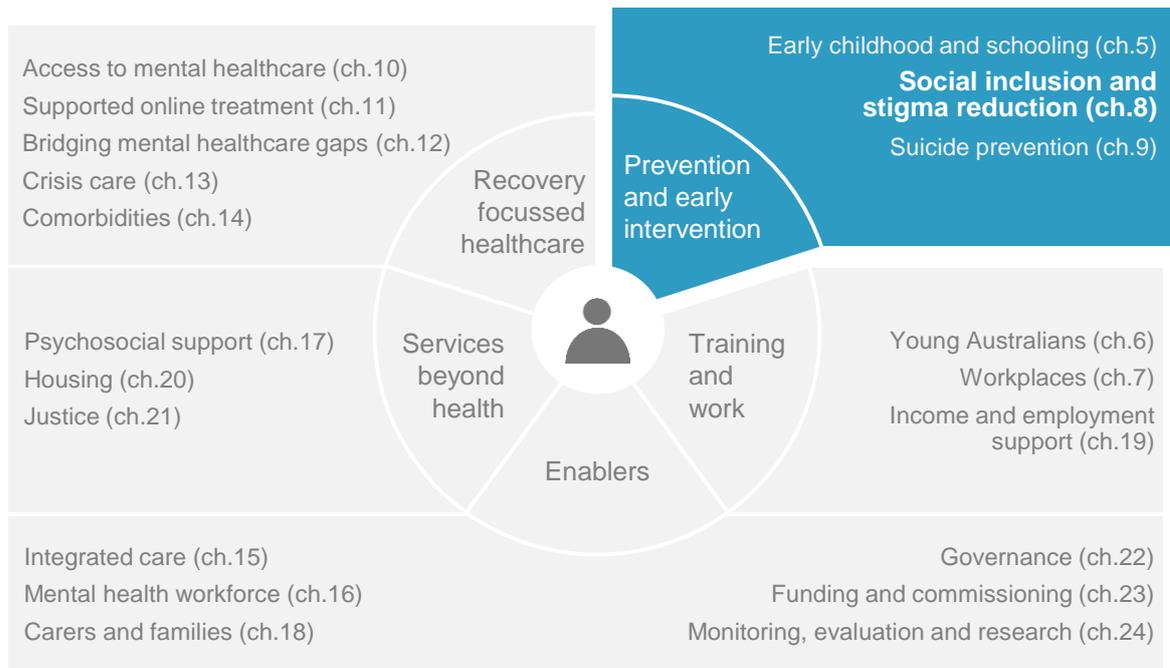
Given the relatively poor mental health and higher levels of stress and anxiety in those younger age groups who will be the workforce of the future, it would appear that (unless there are successful interventions to address mental ill-health in young people) the overall mental health of the workforce could decline in the future.

A further issue for the future workforce is that changes in employment arrangements (such as less secure employment), technological changes, the need to retrain to undertake different jobs over the course of a working life and the changed career aspirations and expectations of younger people from previous generations may also impact on levels of stress and anxiety for those in the workforce of the future.

Working from home for extended periods has become a necessity for many people in 2020 due to the COVID-19 pandemic and may have an adverse impact on an employee's mental health and present challenges to employers. For some employees, working from home could create a sense of isolation from the workplace, colleagues and supervisors, provide

additional pressures to balance work and family demands (such as caring for children) and present difficulties in being able to separate work and home life. Long periods at home may also increase the risk of relationship strain and domestic violence (Safe Work Australia 2020b). For an employer, meeting their duty of care to ensure psychological health and safety in a workplace that is also the employee's home may present particular difficulties. While risks associated with workload and isolation could be identified and managed, other risks to mental health from the home based work environment are likely to be difficult for the employer to identify and even more difficult to manage.

8 Social inclusion and stigma reduction



Interventions for social inclusion and stigma reduction matter because ...

- Social participation and inclusion can reduce the risk of developing mental illness; for people with mental illness, social participation and inclusion are important aspects of recovery and reduce the likelihood of relapse.
- People experiencing social isolation are more likely to have higher levels of distress and mental ill-health.
- Factors such as stigma, racism, persistent socioeconomic disadvantage, loneliness, and trauma can be major barriers to social participation, and are strongly associated with mental ill-health.
- Communities can actively encourage social participation and inclusion and reduce the risk of mental illness, by providing access to services and resources that facilitate social interactions.

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

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

As a priority:

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

Additional reforms that should be considered:

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

Our social interactions and feelings of inclusion are inextricably linked with our mental health and wellbeing.

Social inclusion, working and volunteering create purpose and human beings need purpose and social interaction to thrive. (Stefanie Roth, sub. 164, p. 14)

[t]he absence of meaningful relationships in a person's life will often make the notion that life is worth prolonging quite implausible. (Name withheld, sub. 482, p. 139)

For a person with mental illness, interacting with other people — family, friends, work colleagues or the broader community — can be an essential aspect of recovery, one that reduces the likelihood of a relapse in their illness.

[S]ocial interaction and friendships can be vital to emotional recovery ... (SleeplessNoMore – (Eyrie Pty Ltd), sub. 100, p. 55)

Those of us with mental illness need much more than weekly therapy to bring us back to health and stability. We need ... support, companionship, help connecting to community, help with friendships, support to study and work. (Pippa Ross, sub. 340, p. 2)

For those not experiencing mental illness, social participation can promote mental wellbeing and can protect against the risk of mental illness.

Positive peer social interactions can ... serve as a protective factor for children and young people as they grow. (ECA, sub. 221, p. 3)

Our social interactions and relationships at work — with coworkers, clients, managers, partners, and the community — have a profound impact on our own wellness and that of others. (OzHelp Foundation, sub. 294, p. 19)

Being at a family gathering, on country with family, at my grandmother's house with family. Times like that make my *liyan* [inner spirit] feel good, I resort to those things to make it better. (Yawuru woman, aged 28, in Yap and Yu (2016a, p. 48))

A person's involvement in activities with other people can be described as *social participation*, while *social inclusion* typically relates to feelings of belonging and being respected by others (box 8.1). When people experience mental ill-health, the extent to which they feel included can be an important marker of their recovery. People feel excluded when barriers — including mental ill-health and disadvantage — combine to stop them from participating socially or feeling included.

To improve social participation and inclusion, it is necessary to remove any barriers to participation so that everyone — with or without mental illness — has opportunities to engage socially. Accordingly, this chapter considers:

- the association between mental health and social inclusion
- how socioeconomic disadvantage, stigma and discrimination inhibit the social participation and inclusion of people with mental illness and their carers
- what can be done to improve the social participation and inclusion of people with mental illness.

Box 8.1 What are social participation, inclusion and exclusion?

While improvements in social participation are often recognised as key objectives for mental health programs, ‘a commonly accepted definition is still lacking’ (Piskur et al. 2014, p. 213). People use the term interchangeably with other terms such as social inclusion, social activity, social capital and social integration (Peace 2001; Wright and Stickley 2013).

Broadly, ‘social participation’ can be taken to refer to a person’s involvement in activities that allow interaction with others in society or the community (Levasseur et al. 2010). However, social participation may also refer to other concepts.

Social participation may be seen as a functional indication of a person’s involvement in various life situations — the product of the biopsychosocial interaction between their health condition, personal factors (such as age, personal history and cultural background), and the external physical and social environments in which they live (WHO 2013, p. 5).

The term may also describe the rights of people with mental illness to participate in decision-making about health, policy and planning, care and treatment and their own wellbeing as well as that of the community. This idea of social participation emphasises the rights of individuals ‘to experience self-determined modes of engagement in all aspects of society’ and the responsibility of the broader society to provide the conditions for this to happen (Bathgate and Romios 2011, p. 6).

‘Social participation’ can also refer to an individual’s access to ‘social capital’ — the ‘features of social organisation, such as civic participation, norms of reciprocity and trust in others that facilitate cooperation for mutual benefit’ (Kawachi et al. 1997, p. 1491). Social capital can protect individuals from isolation, provide social safety, improve schooling, education, community life and work outcomes. However, strong social capital can have negative effects — the same strong ties that enable people to act and work together in an inclusive and supportive way can exclude ‘non-members’ (Portes 1998).

‘Social inclusion’ can be considered a more *subjective* concept that relates to an individual’s feeling of belonging to and being valued and respected by a social network. Feelings of inclusion are likely to be affected by a range of individual factors, as well as the behaviour and attitudes of people in the community. Whether or not they have mental illness, people’s ability to participate socially is likely to affect their feelings of social inclusion.

Closely related is the idea of social exclusion — the processes whereby people are excluded from the social, political, economic and cultural systems that integrate a person into a community (Cappo 2002). Social exclusion is a multidimensional and complex idea; it includes traditional ideas of disadvantage (such as income) but also extends to a wider range of life domains, with a focus on social connection and participation (McLachlan, Gilfillan and Gordon 2013).

Social exclusion can be considered as the result of the *combination* of different barriers to social participation:

[a] shorthand term for what can happen when people or areas face a combination of linked problems such as unemployment, discrimination, poor skills, low incomes, poor housing, high crime, bad health and family breakdown. (SEU 2004, p. 3)

The causes of social exclusion span different areas of people’s lives, including access to material resources, employment, education and skills, health and disability, social connection, community and personal safety. Social exclusion is closely linked between these different areas, with exclusion in one area predisposing people to exclusion in other domains.

8.1 Social inclusion and mental health

The symptoms of mental illness can directly impede social participation. At the same time, access to material resources, employment, skills and education, health and disability status, social connections, community, and personal safety are factors that affect a person's risk of developing mental illness.

While mental illness does not discriminate, there are some people and communities who are disproportionately affected by mental ill-health. This includes [those] experiencing co-occurring and compounding problems that are socially determined in areas such as educational attainment; experiences of stigma and discrimination; quality and security of housing; and social interconnectedness and economic security. (Health Justice Australia, sub. 749, p. 2)

The multi-dimensional nature of social exclusion means that policies to reduce disadvantage need to act on multiple fronts. Many of these areas are discussed elsewhere in the report, such as housing (chapter 20), employment and income support (chapter 19), youth economic participation (chapter 6), interactions with the justice system (chapter 21), access to primary, specialist and emergency healthcare services (chapters 10, 12 and 13) and psychosocial supports (chapter 17).

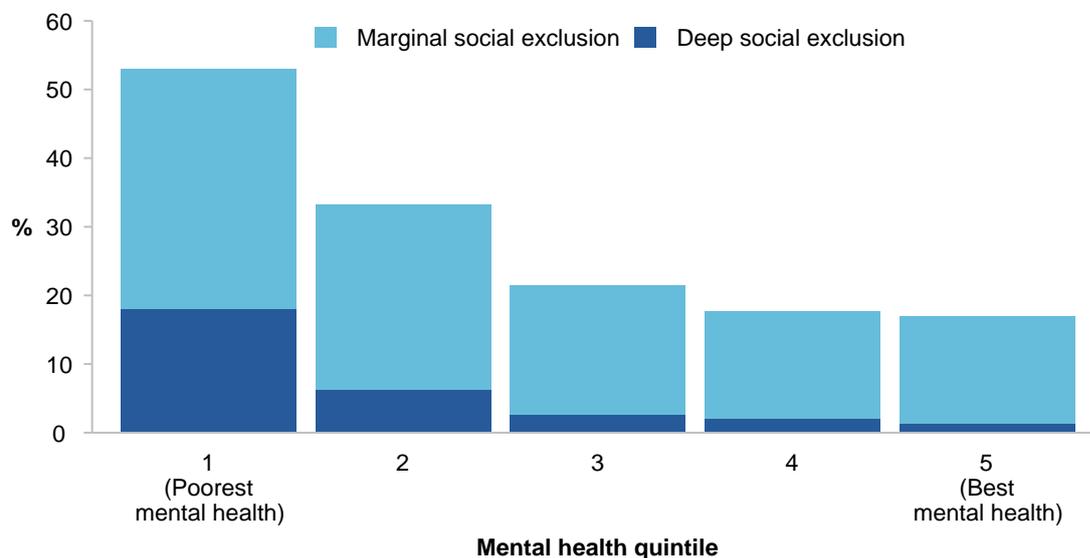
Who is socially excluded?

Social exclusion is strongly associated with mental ill-health.⁵⁰ More people, with poorer mental health, meet the criteria for social exclusion — with social exclusion decreasing as mental health increases (figure 8.1). Of the people considered deeply excluded, over 55% are in the bottom quintile for mental health.

⁵⁰ The Social Exclusion Monitor (SEM) is a method for estimating the extent of social exclusion in Australia, using population-representative Housing, Income and Labour Dynamics in Australia (HILDA) survey data (Scutella, Wilkins and Horn 2009; Scutella, Wilkins and Kostenko 2009). The SEM is based on 29 indicators across seven life domains (access to material resources; employment; skills and education; health and disability status; social connections; community; and personal safety) and can be used to identify people who are excluded and the extent of their disadvantage.

Figure 8.1 **Mental ill-health is associated with social exclusion^{a,b,c}**

Percentages of people deeply and marginally socially excluded



^a Social exclusion is measured using the Social Exclusion Monitor (Scutella, Wilkins and Horn 2009; Scutella, Wilkins and Kostenko 2009). People with a social exclusion score greater than one are regarded as marginally excluded, while those with a score greater than two are considered deeply excluded. ^b Mental health is measured by Mental Health Component summary score quintile, which is derived from the SF-36 survey instrument. ^c Responses are population weighted.

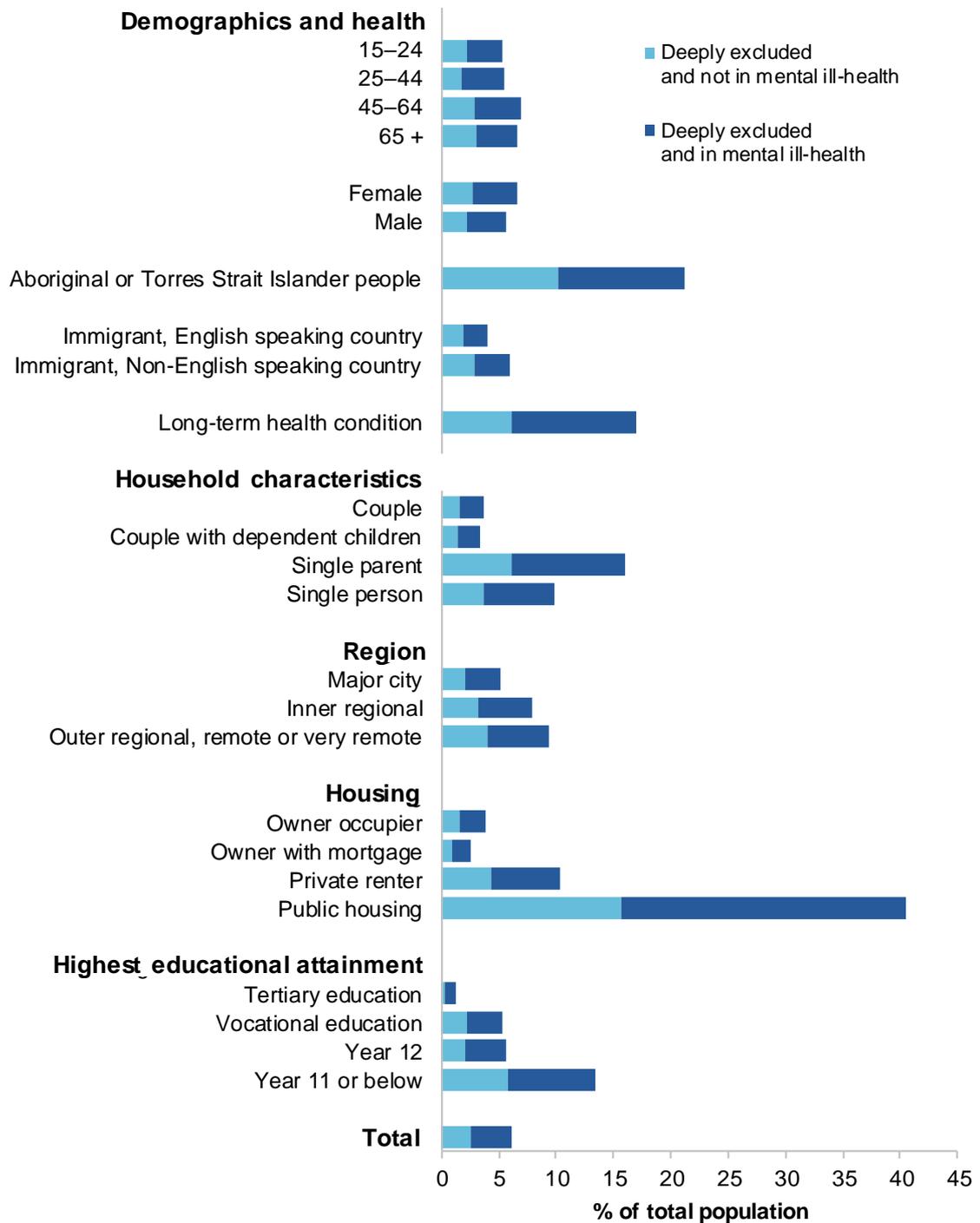
Source: Productivity Commission estimates using *Housing, Income and Labour Dynamics Australia*, wave 18.

Social exclusion is unevenly distributed across the population with:

- women experiencing slightly higher rates of exclusion than men
- people who did not complete year 12 (or equivalent) and those with a long-term health condition more likely to be deeply excluded and in mental ill-health
- Aboriginal and Torres Strait Islander people more excluded than non-Indigenous people
- people living in public or community housing having extremely high rates of exclusion
- single parents being more likely to experience social exclusion (Scutella, Wilkins and Kostenko 2009).

With the exception of people aged over 65 years, all of these groups also have disproportionately high rates of mental ill-health (figure 8.2).

Figure 8.2 Social exclusion and mental ill-health^{a,b,c}



^a Social exclusion is measured using the Social Exclusion Monitor. People with a social exclusion score greater than two are considered deeply excluded. ^b Mental health is measured by the Mental Health Component summary score, derived from the SF-36 survey instrument. People with a summary score in the lowest quintile are categorised as being in poor mental health. ^c Responses are population weighted.

Source: Productivity Commission estimates using *Housing, Income and Labour Dynamics Australia*, wave 18.

8.2 Limited access to material resources as a barrier to social inclusion

Poverty and persistent disadvantage limit people's ability to participate socially and economically — with people who have limited opportunities for employment and education also experiencing increased social isolation and a lack of inclusion (Wilkinson and Marmot 2003; cohealth, subs. 231 and 846).

Being poor is like money circling around you but you can't grab any of it. The money comes in and goes straight out. When something unexpected comes up, the pressure makes my mental health much worse, heightening my anxiety. (comment no. 34, consumers)

Economic participation through employment is likely to affect mental health directly, by providing opportunities for social interaction, and indirectly, by reducing financial stresses and increasing capacity for social interaction. Yet people with mental illness are less likely to be employed, and so have fewer opportunities for social interaction, while also facing greater stresses due to low income. The 2017-18 National Health Survey indicates that people with self-reported mental illness have a substantially lower employment rate (64%) than people who report no mental illness (82%) (ABS 2019h).

Access to material resources is an important determinant of social exclusion, with the relationship between socioeconomic status and mental ill-health well established (Murali and Oyebode 2004; Wilkinson and Marmot 2003). Material disadvantage can limit people's ability to meet their basic needs — such as accessing services, consumable goods and transport — leading to a lack of control over their individual circumstances and personal wellbeing, and an increased risk of mental ill-health. As Kiely and Butterworth (2013, p. 665) concluded, '[e]xclusion due to financial hardship may cause, maintain and reinforce mental illness'.

As described in chapter 1, Australians with the lowest household disposable income report the highest levels of psychological distress. Many of these people are not in stable employment, but rather receive some form of income support payment.

Income support is strongly associated with mental ill-health — not just because people with mental illness are more likely to be unemployed or not in the labour force (chapter 19), but also because welfare dependency and social stigma towards welfare recipients can be demoralising (Kiely and Butterworth 2013). Over time, dependency on income support payments and a lack of employment can lead to intergenerational mental ill-health. For example, young people are twice as likely to receive the Disability Support Pension for mental health reasons if their parents received single parent payments when they were growing up (Deborah Cobb-Clark, Sarah Dahmann, Nicolas Salamanca and Anna Zhu, sub. 57; Cobb-Clark et al. 2017). Income and employment support for people with mental illness is discussed in chapter 19.

It is beyond the scope of this Inquiry either to consider reforms that would address income and wealth inequality in Australia or to determine levels of income support payments that might alleviate psychological stress. But it is clear that:

- there is an association between socioeconomic disadvantage and mental illness that contributes to social exclusion
- social exclusion is not completely alleviated by the income support safety net (and in some situations may be exacerbated by aspects of the income support system).

FINDING 8.1 — SOCIAL EXCLUSION AND DISADVANTAGE ARE STRONGLY ASSOCIATED WITH MENTAL ILL-HEALTH

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

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

Recognition in all government policies, payments and programs, of the importance of social exclusion and disadvantage as ongoing risk factors for mental illness, could form a basis for improvement in mental health outcomes.

8.3 Stigma and discrimination exclude people with mental illness

People with mental illness regularly cite stigma as a concern (Corrigan et al. 2003; McNair, Hight and Hickie 2002). ‘Stigma’ refers to negative attitudes that lead to the exclusion of others on the basis of a particular characteristic. Discrimination is the behaviour people experience as a result of these attitudes (box 8.2).

In Australia, most people with mental illness report experiencing stigma, although the degree, nature and experience of stigma varies by type of mental illness, age, gender and cultural background (Harman and Heath 2017). About 29% of people with mental illness report experiencing discrimination or unfair treatment in the past year, compared with about 16% of people without a mental illness (SCRGSP 2020b, table 13A.64).

Box 8.2 What is stigma and what is discrimination?

Stigma is a social process that excludes, shames, rejects, and devalues groups of people on the basis of a particular characteristic (Livingston 2013). ‘Stigmatising attitudes’ refers to the beliefs held by a person towards someone else, whereas ‘discrimination’ refers to the behaviour toward that other person.

In terms of mental health, stigma exists on multiple interacting levels.

- *Self stigma* exists where individuals with negatively stereotyped characteristics — such as mental illness — are socialised into believing that they are devalued (Link and Phelan 2001). This belief can then have behavioural consequences, such as the avoidance of social interactions, reluctance to seek help, and unwillingness to pursue housing or employment opportunities (Corrigan and Watson 2002).
- *Social stigma* occurs at a community level; it exists when community members judge traits associated with mental illness to be contrary to community norms, and behave in ways that are harmful to people with mental illness. Social stigma may be expressed in an overt or a subtle way, and may be anticipated or perceived rather than experienced.
- *Structural stigma* refers to the rules, policies and practices of social institutions that restrict opportunities for people with mental illness (Corrigan 2004). Where policies disproportionately impact the lives of people with mental illness — even without having been intended to do so — this can be regarded as a form of structural stigma. Structural stigma can affect mental health through increased poverty resulting from discriminatory practices, systematic underfunding of mental health services and research, and coercive preventative measures.

All forms of stigma are associated with reduced quality of life, hopelessness, poor self-esteem and reduced ability to function socially (Livingston 2013; Zaska 2017). Stigma is associated with a reluctance to seek diagnosis and treatment. It affects the way symptoms are communicated, which symptoms are reported, and compliance with prescribed treatment (Corrigan 2004). In turn, this can harm recovery prospects, particularly for people with severe mental illness (Zaska 2017). People labelled as ‘mentally ill’ are also less likely to benefit from available healthcare for physical health problems (Corrigan 2004).

Discrimination is a consequence or effect of stigma. It is the unjust or prejudicial treatment of a person or group of people because of their background or a personal characteristic. Discrimination based, for example, on a person’s psychosocial disability can be unlawful (*Disability Discrimination Act 1992* (Cth)).

When do stigma and discrimination occur?

People living with severe mental illness face stereotypes and prejudice that result from misconceptions about mental illness:

Misconceptions commonly include that they are dangerous, violent or behave unpredictably; that they are incompetent and cannot look after themselves; and that their illness is a life sentence with little chance of recovery. (PHAA, sub. 272, p. 11)

While there is an absence of recent survey data about community attitudes towards mental illness, results from the 2011 National Survey of Mental Health Literacy and Stigma suggest that people with severe mental illness are likely to be subject to high levels of stigma,

although the nature of the stigma varies between illnesses. The survey found that perceptions of dangerousness, desire for social distance or separation, unpredictability, and a stated preference for not employing someone with a problem, were generally highest for those with chronic schizophrenia. In contrast, social phobia was more likely to be viewed as a ‘sign of personal weakness’ or ‘not a real illness’ compared with the other disorders considered. Perceptions of dangerousness and desire for social distance were generally higher for men than for women (Reavley and Jorm 2011).

Social stigma changes over time. Compared with previous surveys (in 1995 and 2003-04), mental health literacy has improved — people are more likely to know someone with mental illness and are more willing to disclose their own mental illness. Between 2003-04 and 2011 there was a decrease in the desire for social distance from people living with mental illness, although this did not apply to people with schizophrenia (Reavley and Jorm 2011). At the same time, however, there was an increase in perceptions of the dangerousness and unpredictability of people living with depression, depression with suicidal thoughts or schizophrenia.

People with mental illness also report experiencing stigma and discrimination in their interactions with the health sector. This can discourage people from seeking assistance, and can increase psychological distress. Stigmatisation by health professionals can also reduce adherence to treatment requirements and exacerbate symptoms (COAG Health Council 2017a). The stigmatisation of people with mental illness by health professionals as well as possible actions to target stigmatising behaviours are discussed in chapter 16.

Stigma often leads to exclusion and discrimination

The stigma associated with mental illness and suicide can limit people’s ability to engage socially and to feel included, and can lead to discrimination, social exclusion and a reluctance to seek care. The effects of stigma and consequent discrimination are reflected in many of the submissions to this Inquiry. For example:

I have endured extensive social isolation at times because of the stigma that my illness attracts. (comment no. 17, consumers)

Stigma is identified by people with mental illness and their carers as one of the greatest deterrents to their full citizenship within our society ... Stigma stops people asking for help and getting the support and treatment they need. (MIFA, sub. 343, pp. 27–28)

[A] depressing majority of employers do not comprehend mental health and disability as anything more than a potential liability, they want nothing to do with it, views are dated and backwards, talking about it is a career death sentence. (comment no. 2, consumers)

Stigma is especially likely to affect people with severe mental illness:

Many people with serious mental illness are challenged doubly. On one hand, they struggle with the symptoms and disabilities that result from the disease. On the other, they are challenged by the stereotypes and prejudice that result from misconceptions about mental illness. As a result of both, people with mental illness are robbed of the opportunities that define a quality life: good

jobs, safe housing, satisfactory health care, and affiliation with a diverse group of people. (Corrigan and Watson 2002, p. 16)

The extent and nature of stigma will also vary with cultural and social characteristics. For example, in some cultures mental illness is thought to reflect poorly on family lineage, diminishing the social and economic prospects of both the person with the mental illness and their family members. These perceptions can make people less willing to seek help or have it known that they are experiencing mental illness.

We try to refer someone to Headspace, and they won't go. There is stigma associated. Or the perception that 'Headspace is a place that white people go'. (CMY and MYAN, sub. 446, p. 10)

The issue of stigma was one that was constantly raised ... [r]ural communities have a culture of self-sufficiency and self-reliance which does not lend itself to openly seeking treatment when it might be required ... The lack of anonymity in small rural settings often creates barriers to access due to stigma and privacy. (QAMH, sub. 247, pp. 1–2)

[P]eople from [culturally and linguistically diverse] backgrounds face ... barriers ... in accessing mental health services ... including lack of knowledge or understanding about mental health services; stigma related to mental illness or seeking help; concerns about confidentiality; language barriers; cultural misunderstandings; previous unfavourable or negative experiences with health or other services; and concerns about being heard, understood or respected, especially in relation to their own explanation of their problem or issue. (DLGSC, sub. 78, p. 2)

Stigma is also likely to affect the mental health and wellbeing of children (chapter 5). Families may avoid or delay seeking help due to a lack of understanding of behavioural and emotional development or the perceived stigma and shame associated with mental illness at a young age (Mark Porter, sub. 331; Melbourne Children's Campus, sub. 191).

Throughout my child's struggle, I have found little understanding and support for myself and my other children — who have also suffered through this time. I have had to race around from one health professional to another at high cost, with often feelings of blame and shame ... [S]tigma around mental health is embedded in our culture. (Name withheld, sub. 66, pp. 2–3)

Social stigma and discrimination in the community

Not everyone with mental illness experiences stigma or discrimination — but when it does occur, it can limit their social participation and inclusion. A recent Australian survey asked people with mental illness about their personal experiences of social avoidance, discrimination and positive treatment (Reavley, Jorm and Morgan 2017). The survey results show a mixed picture: people with mental illness experience social avoidance and discriminatory behaviours, but they also report positive treatment.

- In social settings, more than one in five people with mental illness reported their friends and spouse or partner avoiding them, but half or more reported being treated more positively. Avoidance from family members was less common (16%).
- In the workplace, discrimination and positive treatment were both common (Reavley and Jorm 2015). Just under one in four people with mental illness reported positive treatment,

including increased flexibility, time off where necessary and the receipt of more support than usual. In contrast, about 11% of people reported being avoided or excluded, while about 14% reported that they suffered discrimination (including dismissive treatment or a lack of understanding, being denied opportunities or being forced to change responsibilities, being excluded from work events or being treated differently, or being judged as incompetent). Some respondents reported involuntary termination or suspension from work.

- In education settings, the experiences reported were much more positive. About 5% of people reported avoidance behaviours, and 7% reported discrimination, but nearly one in three reported being treated more positively.

Unlawful discrimination against people with mental illness

Stigmatising views of mental illness can lead to discriminatory and unfair treatment of people who experience mental illness.

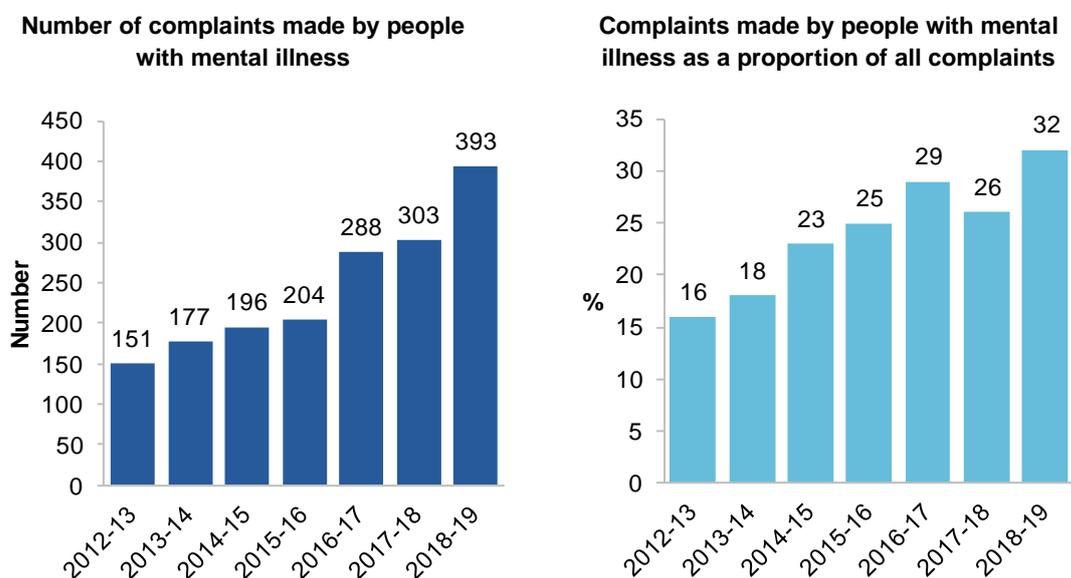
The *Disability Discrimination Act 1992* (Cth) (DDA) makes it unlawful to discriminate on the basis of disability (including mental illness) in areas such as education, employment, the provision of goods and services and access to public buildings. Nevertheless, hundreds of complaints by people with mental illness are made to the Australian Human Rights Commission each year, with the number of complaints increasing markedly over recent years (figure 8.3). It is likely that the number of people experiencing discrimination on the basis of mental illness greatly exceeds the number of complaints made, and that people with mental illness also experience discrimination that is not considered unlawful under the DDA (KLC, sub. 469).

It is usually up to individuals to seek to enforce their right to protection against discrimination (VLA, sub. 500). This can be particularly difficult for people living with mental illness, who often have limited access to material resources and legal supports. The limited availability of legal support for people with mental illness across a range of civil matters, including discrimination, was recognised in a number of submissions (KLC, sub. 469; MHLC, sub. 315; Paul Salsano, sub. 545; VLA, sub. 500).

The Productivity Commission has previously recommended that the Australian governments together provide additional annual funding to improve access to civil legal assistance services (PC 2014). The difficulties that people with mental illness face when engaging with the justice system, including ensuring legal representation, are discussed in chapter 21.

Figure 8.3 Complaints made by people with mental illness have increased in recent years

Complaints made under the Disability Discrimination Act



Source: Australian Human Rights Commission (2013, 2014, 2015, 2016a, 2017, 2018, 2019).

Plans to reduce stigma and discrimination have shown limited progress

The reduction of stigma and discrimination were prioritised in the Fifth National Mental Health and Suicide Prevention Plan (COAG Health Council 2017a). Under Priority 6 of this plan, governments from all jurisdictions committed to take action to reduce the stigma and discrimination towards people with mental illness that is poorly understood in the community, as well as reducing stigma and discrimination in the health workforce.

In the Implementation Plan (COAG Health Council 2017b), Australian and State and Territory Governments indicated that they would undertake a number of actions to reduce the stigma and discrimination experienced by people with mental illness. Agreed actions largely consist of further reviews, consultations and advice on potential future approaches, as well as developing and implementing training programs to build awareness and knowledge of the impact of stigma and discrimination within the health workforce.

While one review of existing initiatives and evidence has been completed (Reavley et al. 2018), there does not appear to have been any progress in terms of consultations on a nationally coordinated approach or directions for future government action. The Implementation Plan indicated that these were to be completed by early 2019 (COAG Health Council 2017b).

Similarly, some actions relating to the reduction of stigma and discrimination in the health workforce do not appear to have progressed as laid out in the Implementation Plan (COAG Health Council 2017b). This includes work that was to be completed by mid-2018 to identify:

- where national responses and leadership are needed to support stigma and discrimination reduction in the health workforce
- how consumers and carers can be empowered to speak about stigma and discrimination in order to reduce stigma and discrimination in the health workforce (COAG Health Council 2017b).

The recent replacement of COAG with alternative interjurisdictional structures may further delay progress in this area.

Importantly, the development and implementation of training programs to build awareness and knowledge of the effect of stigma and discrimination amongst the health workforce follows from these actions. The Mental Health Principal Committee was to seek advice from the Expert Advisory Group about the development and implementation of stigma reduction training programs for the health workforce, as well as engaging with consumers, carers, professional bodies, workforce accreditation bodies, mental health commissions, service providers and other stakeholders on these programs (COAG Health Council 2017b). This was to be completed by mid-2021.

The National Mental Health Commission was due to release a report on the progress of the Fifth National Mental Health Plan in February 2020. While the release of the progress report was delayed due to COVID-19-related matters, the NMHC advised the Productivity Commission that progress on reducing stigma and discrimination has been delayed, and that it ‘would welcome the opportunity to take a lead role in coordinating ... work to reduce the current high levels of stigma in Australia’ (NMHC, sub. 949, p. 28).

Anti-stigma interventions

Interventions intended to reduce stigma at the population level are likely to change attitudes and, to some extent, improve understanding of mental health. These benefits are likely to be short-term (Thorncroft et al. 2016).

‘Contact interventions’ are premised on the idea that contact between stigmatised and non-stigmatised people will increase understanding and reduce prejudice. Population studies show a negative relationship between stigma and the amount of contact with people with mental illness, where higher levels of contact are associated with lower levels of stigma (Jorm and Oh 2009). The nature of contact is important — contact that is successful in reducing stigma should be between individuals of similar social status, and interaction should be structured so as to disconfirm negative stereotypes. Contact interventions should emphasise the process of recovery (Corrigan et al. 2013; Knaak, Modgill and Patten 2014).

Education interventions seek to counter stigmatising beliefs by providing information that counters inaccurate stereotypes (such as the common misconception that people with schizophrenia are dangerous). They may also involve the provision of other information about the negative effects of stigma and discrimination on people with mental illness, and advice on how to engage with people with severe mental illness. It is important to address the recovery process, as well as the stability of the illness and the extent to which it can be controlled. Reavley et al. (2018) found that education programs targeted at family members of individuals with severe mental illnesses showed reductions in stigmatising attitudes. Education programs have also been found to be more effective than contact interventions in reducing stigma in younger people (Corrigan et al. 2012).

Differences in the attitudes towards people with different mental illnesses suggest that anti-stigma interventions are more likely to be effective if they focus on individual disorders rather than mental illness in general (Reavley and Jorm 2011). For example, ideas that people with schizophrenia are dangerous, and the misattribution of social phobia to personal weakness, require different approaches.

At the individual level, a number of actions centred around the idea of self-empowerment can assist in reducing the damaging effects self-stigma (Corrigan and Rao 2012). These include peer-assisted programs (SANE Australia, sub. 130). One example is the Being Herd program, which teaches young people with mental illness to share their stories in a safe environment that is empowering and leads to ‘greater self-confidence, self-acceptance and improvements in wellbeing’ (batyr, sub. 907, p. 12).

Public campaigns to reduce stigma

Anti-stigma campaigns can combine a range of interventions in an effort to counter the stigma and discrimination experienced by people with mental illness. Campaigns typically include marketing (such as TV, radio, print or social media advertisements) or activities requiring active participation (such as arts or sports events), and can be targeted towards either the general public or specific population groups (such as employers, youth or health professionals).

Reavley et al. (2018) found that public education campaigns were somewhat effective in reducing stigma, with almost all campaigns leading to some changes in knowledge, attitudes and intentions among the target audience. Successful campaigns were ‘more intensive, longer and ... involved both mass media and participation events’ (Reavley et al. 2018, p. 77). The authors identified two international campaigns that led to improvements overall and in experiences with family, friends and employment: *Time to Change* (United Kingdom) and *Hjärnkoll* (Sweden) (box 8.3). Both of these campaigns were well funded, included provision for both the campaign and the evaluation processes, and were long-running.

Box 8.3 **Examples of successful anti-stigma campaigns**

***Time to Change* (United Kingdom, 2007–present)**

Time to Change is an ongoing campaign aiming to ‘improve attitudes and behaviour towards people with mental health problems, so that they don’t have to live in shame, isolation and silence’ (Time to Change 2019). The campaign is led by mental health charities and funded by both government and charities.

Early stages of the campaign (2007–11) included a social marketing campaign; programs for target groups including trainee medical students, teachers, and employers; local initiatives; exercise programs designed to increase social contact; and social media. Subsequently, the campaign has sought to apply the experience gained and deliver an evidence-based approach to stigma reduction.

Evaluations showed that, between 2009 and 2015, there were improvements in attitudes towards people with mental illness and a reduction in the desire for social distance (Henderson, Lacko and Thornicroft 2017). There was some evidence of reduced discrimination reported by people with mental illness, particularly in informal relationships (such as with family and friends). However, there was little improvement in areas where stigma is structural, including mental and physical healthcare and employment (Corker et al. 2013).

Henderson, Evans-Lacko and Thornicroft (2017) found that the economic benefits of the campaign would exceed the costs, even if the campaign only resulted in a 1% increase in the number of people with depression accessing services and gaining employment due to improved mental health.

Hjärnkoll (Sweden, 2010–2014)

Hjärnkoll was a government-funded program, that aimed to increase mental health literacy and to change attitudes about mental health. It included a range of activities and events involving social contact with people with lived experience of mental illness, along with TV, print and internet media campaigns. The campaign was directed towards the general public, but also included targeted contact interventions that were intended to improve mental health literacy among police (Hansson and Markstrom 2014), as well as journalists, healthcare professionals and social workers (Beldie et al. 2017).

Hjärnkoll positively affected the attitudes, mental health literacy and intended behaviour of the general public during the campaign period, with social contact being regarded as an effective approach to reducing stigma (Hansson, Stjernswärd and Svensson 2016). The campaign also had a positive effect on the attitudes, mental health literacy and behaviour of police who had undergone training.

Effective stigma reduction has the potential to improve the lives of people with mental illness. However, this is a complex process that is likely to require a prolonged campaign that will have incremental successes. While relatively low cost in aggregate — the first phase of *Time to Change* cost a total of £21 million (about A\$38 million) over four years — stigma reduction campaigns are very difficult to assess in terms of their cost effectiveness, and literature in this area is slacking (Smith 2013). Nevertheless, there is a ‘consistent pattern of short-term benefits’ in terms of positive changes in attitudes towards people with mental illness, although the evidence for any longer-term benefits is weak (Thornicroft et al. 2016, p. 1123).

Given the magnitude of the challenges that result from stigma directed towards people with severe mental illness, there is a need to develop an evidence base for effective approaches to stigma reduction. A national stigma reduction strategy would support the development of a national campaign that targets stigmatising views of those with severe mental illness. The strategy should trial different approaches in different areas to identify effective means of stigma reduction, and should include measures of behaviour rather than relying solely on the evidence of stated intentions of survey participants. It is important that provision for ongoing evaluation and refinement be included in any campaign.

An essential element of stigma reduction campaigns that is not emphasised in the literature is the role of people with lived experience. Incorporating the views and recovery stories of people with lived experience is necessary for effective contact interventions, and is likely to benefit those involved in the campaign (batyr, sub. 334). Having an ‘ambassador’ for a stigma reduction campaign has been found to be empowering, increasing optimism about the future and improving self-esteem and the capacity to deal with stigma (Bratbo and Vedelsby 2017).

ACTION 8.1 — NATIONAL STIGMA REDUCTION STRATEGY

Much progress has been made over time in reducing the stigma that affects people with mental illness; however, more should be done to address the stigma that remains.

Start now

- The National Mental Health Commission should develop, and lead the implementation of, a National Stigma Reduction Strategy that builds on the work started under the Fifth National Mental Health and Suicide Prevention Plan and focuses on the experiences of people with mental illness that are poorly understood in the community. The National Stigma Reduction Strategy should:
 - rely on the leadership and direction of people with lived experience, including as national ambassadors for mental health
 - promote meaningful interactions between people with and without mental illness
 - focus on the experiences of people with mental illness that are poorly understood by the community, including those with schizophrenia and borderline personality disorder
 - target stigma reduction messages for different audiences, and address different aspects of stigma, including the desire for social separation, and perceptions of danger and unpredictability
 - develop an evidence base of effective anti-stigma activities, including through the trial and assessment of different interventions in different areas
 - recognise that effective stigma reduction requires a sustained commitment to ensure that reductions in stigma persist.

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

- All Australian governments should meet their previously agreed commitments to reducing stigma and discrimination made under the Fifth National Mental Health and Suicide Prevention Plan, and should adequately resource the National Mental Health Commission to develop and implement the National Stigma Reduction Strategy.

Stigma and discrimination in the insurance sector

Stigma by insurers toward people with mental ill-health has been raised as a concern during this Inquiry.⁵¹ Insurance gives people a way to financially protect themselves against a range

⁵¹ Similar concerns were also raised as part of the Parliamentary Joint Committee on Corporations and Financial Services Inquiry into the Life Insurance Industry (PJCCFS 2018), the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (FSRC 2019) and the Senate Economic References Committee Inquiry into the Regulatory Framework for the Protection of Consumers in the Banking, Insurance and Financial Services Sector (SERC 2018).

of unexpected events that can result in financial hardship and emotional stress. As well as ‘universal’ insurance protections provided by Medicare and social security, many people have additional insurance protections such as life insurance, income protection insurance, and temporary or permanent disability insurance as well as workers’ compensation, private health insurance and travel insurance.

Given the large number of people who experience mental illness, the negative impact that mental illness has on these individuals’ capacity to earn an income (appendix J), and the extent to which insurance is used to offset personal financial risk, it is not surprising that the insurance sector is particularly relied on by people with mental illness. For example, the life insurance industry paid over \$800 million to about 8500 people experiencing mental ill-health in the 12 months to June 2018 (FSC, sub. 535). As noted by Metlife Insurance Limited (sub. 443, p. 2), ‘the life insurance sector is arguably the largest non-Government supporter of mental health sufferers in Australia’.

However, stigma and poor understanding of mental illness within the insurance sector may cause problems for people with mental illness seeking to access different types of insurance:

[E]mpirical evidence and anecdotal reports demonstrate that many people with a mental health condition experience significant difficulties in obtaining and claiming on different types of insurance products ... These difficulties occur across the general and life insurance industries for products such as travel insurance, income protection, total and permanent disability (TPD) and life insurance. (Beyond Blue 2017, p. 3)

Discrimination — lawful or unlawful — is a relatively common experience among people with mental illness seeking insurance. About 22% of survey respondents who self-identified as being a ‘mental health consumer’ reported having an application for insurance declined for mental health reasons, with this number increasing to about 36% of those applying for life insurance and 45% of those applying income protection insurance (MHCA and Beyond Blue 2011).

The legal, regulatory and policy context relating to insurance provision, the conduct of insurance providers, and consumer protections is complex (PC 2018a). There are specific provisions to promote equitable access to insurance for people with a disability, including people with mental illness (box 8.4). However, these protections have exceptions that allow for the differential treatment of people with mental illness. Concerns about insurance raised in relation to mental illness include the:

- way in which insurers understand mental illness and use information about mental illness
- manner in which insurance claims and dispute resolutions are handled
- broad access of insurers to the medical records of people with mental illness.

Box 8.4 Ensuring people with mental illness have access to insurance

There are a number of protections in place to promote equitable access to insurance products for people with mental illness.

Legislation

The *Disability Discrimination Act 1992* (Cth) (DDA) — as well as state- and territory-based anti-discrimination legislation — establishes the rights of people with mental illness to participate equally in all areas of life. The DDA sets out that discrimination on the basis of disability is unlawful, subject to a number of exceptions. Under section 46 of the DDA, insurers can discriminate against a person on the grounds of disability by refusing to offer someone a product, or by varying the terms or conditions on which the product is offered, so long as the discrimination is based on actuarial or statistical data or other relevant factors. Insurers must prove that any discrimination is substantiated by data, where data is available.

The *Insurance Contracts Act 1984* (Cth) sets out the duty of an insurer to act in the utmost good faith and that insurers may not refuse to pay claims in certain circumstances. It also states that insurers must outline in writing, their reasons for refusing to enter into a contract of insurance, cancelling or not renewing a contract, or for offering insurance cover on less advantageous terms, if requested to do so in writing by the policy holder or applicant.

Legal remedies

The body which provides legal remedies varies with circumstances. The Australian Human Rights Commission investigates alleged breaches of the DDA. The Australian Securities and Investments Commission can bring action against insurers that breach the *Insurance Contracts Act 1984* (Cth). The Australian Financial Complaints Authority resolves disputes between consumers and financial service providers, including insurers. Complaints about policies or claims can be made to the Australian Financial Complaints Authority, but it does not deal with issues of discrimination relating to access to insurance.

The industry also provides guidelines for insurers. For instance, the Australian Human Rights Commission publishes the *Guidelines for Providers of Insurance and Superannuation*, which set out its views with respect to the DDA and relevant case law (AHRC 2016b). However, inconsistencies in consumer protections between the financial services sector and other sectors of the economy create barriers for consumers understanding and asserting their rights (PJCCFS 2018, p. 47), which are likely to reduce the use of these legal remedies.

Industry standards

There are also industry standards and codes of practice that guide the behaviour of insurance firms. For example, the Financial Services Council's Standard No. 21 (FSC 2013) requires that insurance staff and representatives of member firms receive an appropriate level of education and training in relation to mental health awareness. More generally, the General Insurance Code of Practice requires its signatories to be open, fair and honest, although it does not specifically address discrimination and is limited to where the product is offered by a life insurer.

Membership of industry bodies can also be limited. For example, many superannuation funds, which provide more than 70% of life insurance policies in Australia, are not members of the Financial Services Council. Revocation of membership is often the only way to enforce these standards.

Insurer understanding of mental health information

Insurers' understanding of mental health and use of mental health information has been questioned by a number of stakeholders. The Royal Australian College of General Practitioners (2017) and the Royal Australian and New Zealand College of Psychiatrists (2017b) argue that it is unclear how data is used in making underwriting decisions, whether or not the data is current, and whether the data reflects the fact that mental illness has many forms and affects people differently.

Practices such as the exclusion of all mental health-related conditions from policies illustrate the poor understanding of mental illness in the insurance sector. Beyond Blue suggest that policies are underwritten in ways that do not reflect current understanding of mental health, including:

... treat[ing] all mental health conditions as a single group, rather than treating each mental health condition ... as a unique diagnosis with relevant prevalence rates and prognostic characteristics ... cases of discrimination appear to be driven by an under-reliance on available statistical and actuarial data and an over-reliance on views of the nature of mental health conditions. (2016, p. 4)

Furthermore, some insurers conflate symptoms with diagnoses, impute illness from treatment information and confuse previous illness with current conditions (Beyond Blue 2017; Mental Health Australia 2018). The Public Interest Advocacy Centre (2017), noted that insurers had rejected claims by using medical records to impute illnesses that did not exist at the time of applying for insurance.

Some insurance policies — particularly travel insurance and injury/accident policies — refuse *any* cover associated with a mental health condition, meaning that any future claim based on a mental health condition would not be covered even if a client has no history of mental illness (Maurice Blackburn Lawyers, sub. 239, p. 9). Blanket exclusions of mental illness from travel insurance have been shown to be an unjustified form of discrimination⁵², although there is limited case law regarding discrimination against people with mental illness and no evidence that these exclusions are becoming less common.

A lack of understanding of mental illness by insurers and the denial of access to insurance due to mental illness has a number of possible negative effects. These can include: people avoiding necessary treatment in order to meet insurers' requirements⁵³; choosing or being forced to go without insurance where they would prefer to purchase cover; or not disclosing mental health conditions to their GPs so as not to affect access to insurance (Maurice Blackburn Lawyers, sub. 239; Beyond Blue 2018c).

However, there appear to have been some recent attempts to improve how insurance companies use information about mental illness and deal with mental health-related claims. The Financial Services Council (FSC) (sub. 535) has several initiatives that aim to create a more nuanced industry understanding of mental illness, including the development of a life

⁵² Ella Ingram v QBE Insurance (Australia) Ltd [2015] VCAT No. H107/2014 (18 December 2015).

⁵³ See, for example, Bainbridge, Selvaratnam and Clark (2018).

insurance data collection to improve industry understanding of variations in mental illness-related claims. While mental illness ranks third out of the top 10 sources of claims, there is no public information about the types of illness involved in those claims (MetLife, sub. 443). Increased awareness of how the industry resolves mental health-related claims is likely to improve their ability to effectively differentiate the risk associated with different mental illnesses. In addition, the FSC (sub. 535) expects that a review of the Life Insurance Code of Conduct will result in insurers being required to take into account the history and severity of claimants' mental illness rather than adopting a blanket approach.

Insurance claims and dispute resolution

Making a claim against insurance can be difficult for people with mental illness. The Australian Securities and Investments Commission's (ASIC) (2016, p. 62) review of life insurance claims in 2016 found that 'policyholders with a mental health condition face a challenging burden to establish that their condition entitles them to make a valid claim'.

Where claims are disputed, dispute resolution mechanisms for insurance claims that involve mental illness are often slow, opaque and can impart stress on claimants. A major source of disputes was about the evidence required to sustain a claim, with some policyholders required to attend 'psychiatric assessments, complete activity diaries, submit regular progress claim forms, provide medical reports and attend interviews with private investigators, as well as being the subject of surveillance' (ASIC 2016, pp. 62–63). About 5% of the disputes involved allegations that the insurer had engaged in investigation or surveillance practices that had exacerbated their condition.

The proportion of disputes about a claim being denied for non-disclosure of relevant information was much higher for mental health claims (15% of mental health claims, compared with 5% of all claims). ASIC noted that in some instances, insurers had reviewed policyholders' medical histories as far back as 20 years, as well as an instance where an insurer considered a visit to a counsellor — in the absence of a diagnosis — to be evidence of a pre-existing condition sufficient to deny a mental health-related claim many years later (ASIC 2016).

Difficulties with mental health-related claims and dispute resolution have been acknowledged by the insurance industry, and there have been recent efforts to reduce discrimination against people with mental illness by the insurance industry. The insurance industry adopted FSC Standard No. 21 in 2013 (FSC 2013), following the FSC's usual processes for adopting standards. The standard applies to FSC members that are (or have subsidiaries that are) a registered life insurance company, and is in the process of being rolled out to superannuation funds and financial advisory group members.

FSC Standard No. 21 seeks to ensure that 'customer facing employees of life insurers receive appropriate training in relation to mental health awareness' (FSC, sub. 535, p. 7). This training is in the form of a *Mental Health Education Program* that, among other things, intended to 'increase awareness and understanding of the causes, signs and symptoms of

common mental health conditions’ (FSC 2013, p. 5). Insurers that comply with the Standard are required to review the effectiveness of these programs, and identify the percentage of representatives who complete mental health training outlined in the Standard.

The Standard is a positive move towards mental health awareness in the life insurance industry. However, in the absence of published data on compliance with the Standard, it is difficult to assess its effectiveness.

The Life Insurance Industry (sub. 821, p. 7) told the Productivity Commission that the Standard is currently under review, and that the review is ‘well progressed’. This review provides an opportunity to increase awareness and understanding of the symptoms, treatments and prognosis associated with different types of mental illness among *all* employees of life insurers who influence coverage and claims decisions. While the exact nature of the knowledge that each employee requires will vary depending on their particular role, it is essential that *all* employees of life insurers have adequate training in, and understanding of, mental health.

The formal implementation of a Life Insurance Code of Practice in 2017 has already had some positive effects on the conduct of life insurers. The Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry recognised that the number of instances of life insurers undertaking surveillance on claimants with mental ill-health had fallen dramatically since the introduction of the Code of Practice (FSC, sub. 535).

The time required to resolve a claim is also a concern of insurance customers with mental illness. The Code of Practice includes maximum timeframes for assessing claims, and it appears that nearly 80% of the alleged breaches of the Code relate to time limits. There is no information available about the proportion of breaches that are mental health related.

Insurer access to clinical records

Insurer access to clinical records gives rise to a number of concerns. While it is clear that some access to clinical information may be necessary for insurers to categorise risk and identify pre-existing mental illness, there are legitimate concerns about insurance companies seeking broad access to clinical information when deciding whether to provide cover or when assessing a claim. The Parliamentary Joint Committee on Corporations and Financial Services noted that it is:

unclear ... why approximately half of life insurers ask for complete medical records considering the assertion made by the industry that only relevant information is used by the insurer. (PJCCFS 2018, p. 131)

Requests for complete medical records give rise to the concern that insurers are conducting ‘fishing expeditions’ for reasons to deny claims, as evidenced in the Royal Commission report (FSRC 2019, vol. 2, p. 333). Other concerns arising about insurers seeking access to complete clinical records include the:

- risk that GPs may not fully document a patient’s condition in their consultation notes because of concerns about how an insurer might use or misinterpret certain information
- risk that a patient may not fully disclose symptoms — or may avoid seeking treatment altogether — for fear of how an insurer might use that information (PJCCFS 2018)
- fact that, while consultation notes may include a diagnosis, they may not include a prognosis that takes into account treatment options and behaviour changes (Seidel 2017, p. 18).

These issues are particularly relevant to people with histories of mental ill-health who are seeking insurance coverage or to make an insurance claim. They have led to the development of a standardised consent form — FSC Standard No. 26 — for insurers to use when accessing the clinical records of people seeking insurance (FSC 2019). The explanatory notes to the form advise that insurers may ‘not be able to process’ an application for cover or claim if the consent is not signed (FSC 2019, p. 3). This standard authority form came into use on 1 July 2019, and all FSC members are expected to use it by 1 July 2020. The standardised form was developed by the FSC in agreement with the Royal Australian College of General Practitioners, and allows for GPs to release consultation notes if they are unable to provide a general report, or a report about a specific condition, within the specified timeframe of four weeks. As a matter of principle, when GPs provide information to insurers they should also notify the consumer and provide them with a copy of that same information (PC 2017a).

It is not clear at this point whether this new Standard will reassure people with mental illness sufficiently to offset potential disincentives to disclose or to seek assistance, or if it will result in insurers using targeted information requests that reduce the extent of unnecessary information being collected by insurance companies. Alternatively, it may simply lead to insurers receiving full consultation notes as they wait out the four week delay created by a busy GP. Nor do the protocols specifically address the concerns about more targeted information requests. The need to review the effectiveness of the Standard after it has been operating for some time has broad support amongst stakeholders (for example, FSC, sub. 863; Life Insurance Industry sub. 821; PIAC, sub. 801). The effectiveness of the Standard should be reviewed after it has been operating for two years.

ACTION 8.2 — AWARENESS OF MENTAL ILLNESS IN THE INSURANCE SECTOR

The insurance sector should improve the way it collects information about, and relating to, people with mental illness.

Start now

- The Financial Services Council (FSC) should update the mental health training requirements for insurers in FSC Standard No. 21, in consultation with a national consumer and carer organisation to reflect contemporary thinking about mental illness. The Financial Services Council should also:
 - expand the coverage of FSC Standard No. 21 to include all employees of covered insurers to ensure that the industry as a whole has a better understanding of mental illness
 - publish data it receives on industry compliance with the Standard.
- The Australian Securities and Investments Commission should review, within two years, the operation and effectiveness of the insurance industry Codes of Practice and industry standards that relate to the provision of services to people with mental illness. The review should consider whether the insurance industry:
 - has removed blanket exclusions relating to mental illness
 - differentiates between types of mental illness, takes into account the history, severity and prognosis of individual applicants or claimants and uses up-to-date prevalence, prognosis and pricing information to assess risk and make decisions about claims
 - meets maximum timeframes for the resolution of insurance claims consistently and whether these timeframes are adequate
 - has implemented industry guidelines that require claimants and applicants be provided with written advice when insurance coverage is declined or a claim refused on the basis of mental illness.

Where the review finds these changes have not been achieved, regulation should be used to require change.

- The Australian Law Reform Commission should review whether the protocols for insurer access to clinical records have resulted in more targeted requests for clinical information, and whether they give sufficient protections to people with histories that include seeking psychological treatment or counselling. The review should include consideration of whether the protocols are sufficient, whether there is a need for legislative change and whether insurance premiums are actuarially fair.

This review should be conducted in 2022, after the protocols have been operating for two years.

Other forms of stigma and discrimination can exclude people and affect mental health

Other forms of stigma and discrimination serve as barriers to social inclusion, and can have a profoundly negative effect on the mental health of those who experience them. The Fifth National Mental Health and Suicide Prevention Plan recognises the ‘specific experience’ of groups already at high risk of stigma, including Aboriginal and Torres Strait Islander people and people who identify as LGBTIQ (COAG Health Council 2017a).

Racism has a negative effect on both the mental and physical health of Aboriginal and Torres Strait Islander people and other people from culturally and linguistically diverse backgrounds.

[R]acism is a key determinant of the health of Aboriginal Australians and other minority groups ... racism is harmful to the health of those who are its victims. Moreover, racism is not just harmful to mental health, it is also harmful to physical health. (VIC DHHS 2017, p. iii)

The social and emotional wellbeing of Aboriginal and Torres Strait Islander people is discussed in section 8.6.

In Victoria, people who frequently experience racism are estimated to be almost five times more likely to have mental ill-health, and about two and a half times more likely to have poor physical health (VIC DHHS 2017). A 2012 survey found that nearly two in three Victorians who were from a culturally or linguistically diverse background had experienced some racism in the previous 12 months (VicHealth 2012).

Similarly, stigma associated with sexual preferences or gender identity can be profoundly harmful, and can be linked to the higher incidence of mental illness among people who identify as LGBTIQ (The National LGBTI Health Alliance, quoted in Mental Health Australia, sub. 407, p. 16). People who identify as LGBTIQ are more likely to experience mental illness than the rest of the population (chapter 2), are more likely (for stigma or other reasons) to isolate themselves from their family and community activities, and are twice as likely as others to be subject to violence or abuse, putting them at increased risk of depression, anxiety, substance use, self-harm and suicidal thoughts (Connect Health & Community, sub. 94; Queensland Council for LGBTI Health, sub. 681).

Exclusion on the grounds of sexual or gender preference is likely to increase social isolation and economic disadvantage, and can lead to decreased use of (but increased need for) mental health services. Conversely, a sense of connection and belonging to families and *both* LGBTIQ and mainstream communities is associated with improved mental health (Leonard, Lyons and Bariola 2015). The Fifth National Mental Health Plan recognises that reducing stigma and improving the appropriateness of mental healthcare is critical for the mental health of people who identify as LGBTIQ (COAG Health Council 2017a).

Stigma linked to involvement with the criminal justice system is also a barrier to social and economic participation. In particular, difficulties in obtaining and maintaining stable housing after exiting prison are recognised as an impediment to engagement with other services (Jesuit Social Services, sub. 441).

8.4 Loneliness and social isolation

Loneliness is simply when a person desires more or closer social relationships than they currently have. Loneliness is different from being alone — people can be with others and still feel lonely, or be alone and not feel lonely. Loneliness is a personal feeling of social isolation and associated distress, and is viewed as both a potential cause and a consequence of mental illness (Hare Duke 2017).

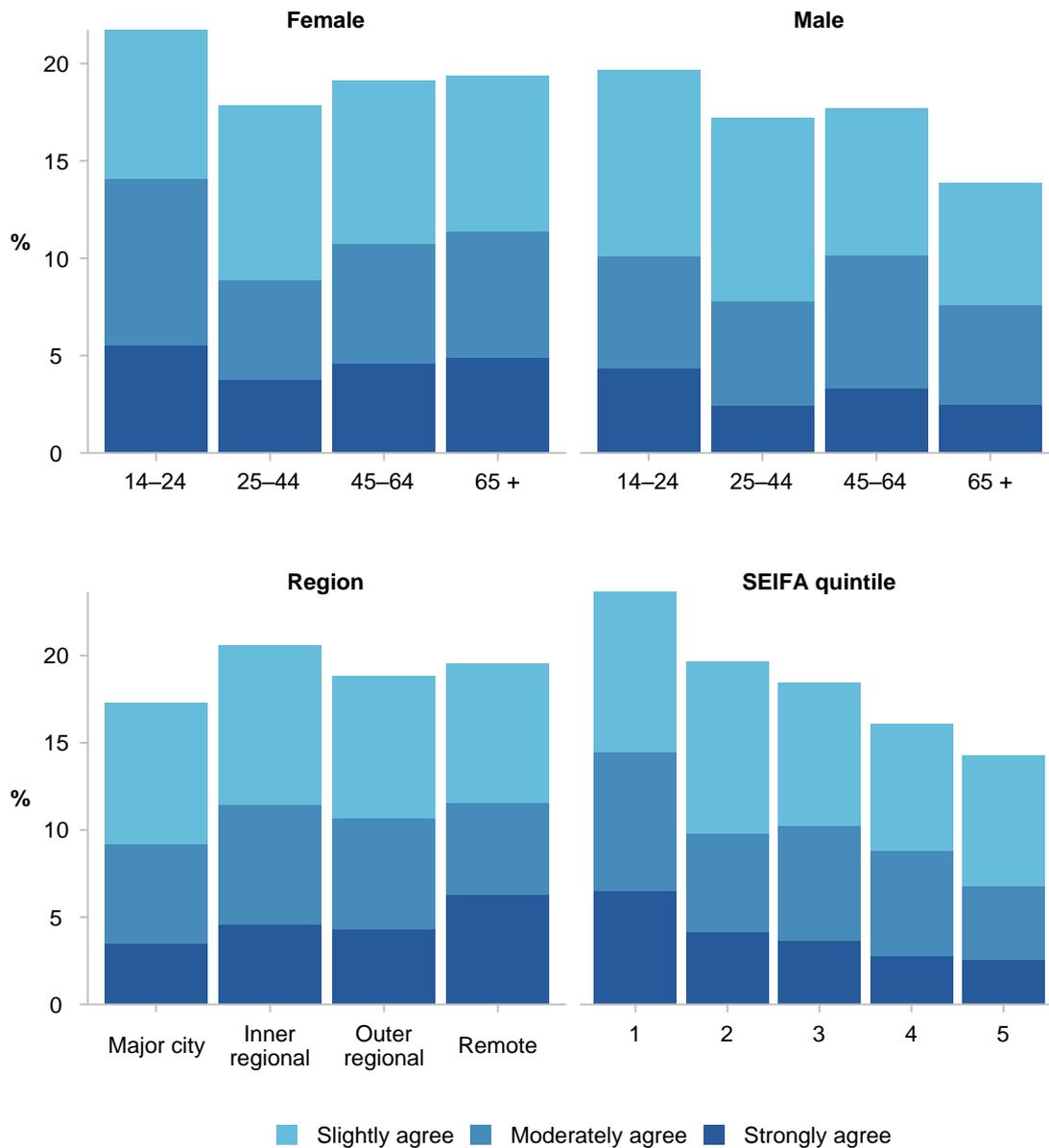
About one in four Australian adults consider themselves to be lonely, and as many as half of all Australians feel lonely for at least one day each week (APS 2018a). Young people, particularly women, report high levels of loneliness, as do people who live in more disadvantaged regions (figure 8.4).

Loneliness is an increasing health concern because of its association with both physical and mental ill-health (Beutel et al. 2017; Mushtaq et al. 2014) and an increased risk of mortality (Holt-Lunstad et al. 2015). Among older people, loneliness is also linked to dementia (Kuiper et al. 2015; Valtorta and Hanratty 2012), as well as to physical health conditions such as heart disease and stroke (Valtorta et al. 2016).

Loneliness and mental ill-health are mutually reinforcing — loneliness may increase an individual's likelihood of developing mental illness, but people with severe mental illness are particularly likely to be lonely. Part of the relationship between mental illness and the propensity to feeling lonely may be explained by social factors — people living in areas with low incomes, high unemployment, and poor access to transport and healthcare are likely to have higher levels of loneliness and are more likely to experience mental ill-health (Tong et al. 2019).

The *Housing, Income and Labour Dynamics in Australia* survey shows clearly the association between loneliness and mental ill-health — more than half of the people who strongly agree with the statement 'I often feel very lonely' score in the lowest quintile for mental health (figure 8.5). People with severe mental illness are particularly likely to report being lonely (Lim et al. 2018). In the 2015 Australian National Survey of Psychosis, around 75% of people with delusional disorders, and 94% of those with severe depression reported feeling lonely some or all of the time over the preceding 12 months (Badcock et al. 2015).

Figure 8.4 Loneliness in the Australian population^{a,b,c}
 % of people who agree with the statement 'I often feel very lonely'

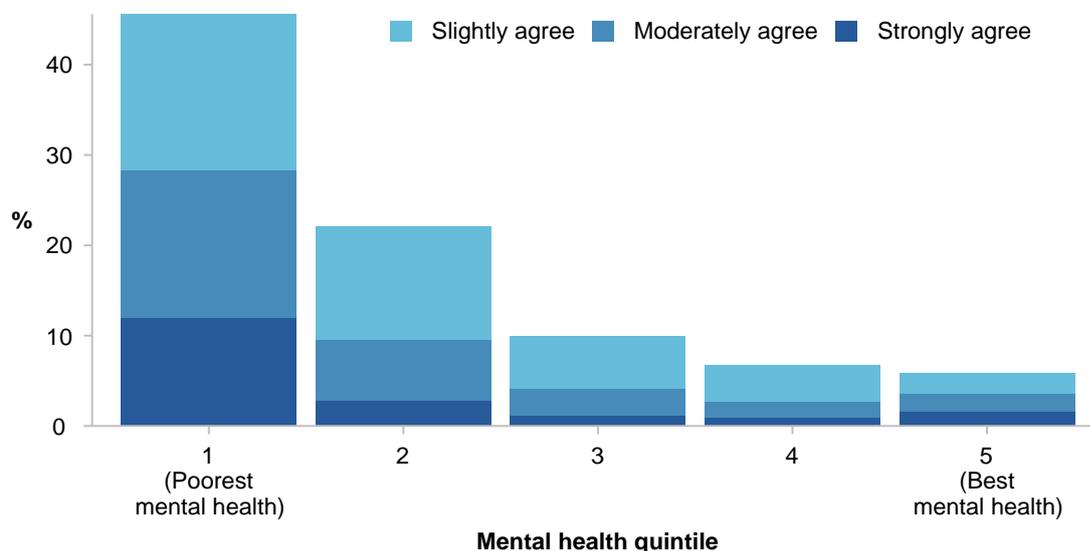


^a Survey respondents were asked to rate on a scale between 1 and 7 the extent to which they agree or disagree with the statement 'I often feel very lonely'. A score of 1 indicates strong disagreement with the statement and a score of 7 indicates strong agreement. ^b Responses are population weighted. ^c SEIFA (Socio-economic Indexes for Areas) quintile indicates the relative advantage of the region in which people live. People living in lower quintile areas are more disadvantaged.

Source: Productivity Commission estimates using *Housing, Income and Labour Dynamics Australia*, wave 18.

Figure 8.5 Feelings of loneliness are strongly associated with lower levels of mental health^{a,b,c}

% of people who agree with the statement 'I often feel very lonely'



^a Mental health is measured using the Mental Health Component summary score — a higher score indicates better mental health. ^b Survey respondents are asked to rate on a scale between 1 and 7 the extent to which they agree or disagree with the statement 'I often feel very lonely'. A score of 1 indicates strong disagreement with the statement and a score of 7 indicates strong agreement. ^c Responses are population weighted.

Source: Productivity Commission estimates using *Housing, Income and Labour Dynamics Australia*, wave 18.

The association between loneliness and mental health is also reflected in the responses to this Inquiry (for example, in College of Sport and Exercise Psychologists, sub. 273; Friends for Good Inc, sub. 115; Mission Australia, sub. 487; On the Line, sub. 258; WayAhead Mental Health Association NSW Ltd, sub. 310).

The experiences of poor mental health and loneliness are connected. A person can feel lonely as a result of their mental ill health (because they may be unable to participate in social activities), equally, feeling lonely can have a detrimental effect on mental health. (Australian Red Cross Society, sub. 490, p. 9)

[L]oneliness and isolation is a huge component of the distress that many mentally ill and people in crisis endure. What could be more lonely and isolating then living in a culture that refuses to listen to you when you want to speak about how you were terribly harmed when you reached out for help? (Name withheld, sub. 482, p. 95)

People who are systematically or geographically isolated are more likely to experience loneliness and may be at a greater risk of mental illness. This includes people living in rural or remote areas, elderly people, refugees and people with intellectual disabilities (Allianz Australia, sub. 213).

The risks of loneliness having a negative impact on health and wellbeing have increased in 2020, with social distancing measures implemented in response to the COVID-19 pandemic (box 8.5). This is likely to place certain groups within the community at increased risk of

mental ill-health, including people living by themselves and older people at greater risk from COVID-19. People living in aged care facilities are also at increased risk of social isolation throughout the pandemic, due to visitor restrictions and potential limitations on access to technologies that may offset isolation.

There is little evidence about what works to reduce loneliness

Although loneliness is regularly cited as an emerging mental health concern, there is limited evidence about how it should be addressed. Most of the literature focuses on older people (Cohen-Mansfield and Perach 2015; Gardiner, Geldenhuys and Gott 2018) rather than the general population and the quality of the evidence is generally low (NMHC 2017a, 2017b). There is also little evidence about effective interventions to reduce loneliness in other cohorts, particularly with respect to people with severe mental illness (Lim et al. 2018).

Jopling (2015) categorised loneliness interventions in the United Kingdom into three broad (but overlapping) types: foundation services; direct interventions; and gateway services.

Foundation services identify people who may be lonely or at risk of loneliness and their individual needs, and provide support when reconnecting with the wider world. This may involve the provision of individual and group cognitive therapies (Cacioppo et al. 2015), or for people with more serious mental illness, social skills training may be required (Webber and Fendt-Newlin 2017). Without access to these foundation services to identify people in need of support, and the types of support they need, other interventions are likely to be less effective at reducing loneliness in the general population (Friends for Good Inc, sub. 115).

Direct interventions provide people with opportunities for social engagement, either by supporting them in reconnecting or maintaining existing relationships or by providing opportunities for new social connections. Group-based interventions are likely to be most effective when they offer something in addition to opportunities for socialising, in that they are focused on a shared interest or have an educational focus and group members are involved in the running of the group (Cattan et al. 2005). Volunteering is a type of direct intervention that not only reduces the loneliness of those involved, but provides others with opportunities for social engagement. For example, Friend Line is a service staffed by volunteers who talk to people seeking to increase their social interaction (Friends for Good Inc, sub. 115, p. 2). The way in which these services are developed and delivered is also likely to affect their success, with initiatives developed and run at a local level more likely to be successful (Jopling 2015).

Gateway services such as transport and technology services can serve to facilitate social interactions while enabling other effective interventions. At the same time, the absence of these services can increase loneliness.

Not only do many people live with mental health symptoms or conditions that prevent them from leaving their home, for many access to transport is out of reach. (Australian Red Cross Society, sub. 490, p. 8)

Box 8.5 COVID-19, social distancing and loneliness

The COVID-19 pandemic is likely to affect population mental health in multiple ways (chapter 1). Government-imposed social distancing measures — instructing people to stay home and avoid close personal contact — increase social isolation and loneliness, and in turn may negatively affect mental health. The most commonly experienced stressor resulting from COVID-19 was loneliness, with more than in five people (22%) reporting feeling lonely (ABS 2020b).

Previous studies examining the consequences of mandatory isolation or quarantine (for example, during the SARs or Ebola virus outbreaks) have shown a clear negative impact on mental health, including through increased social isolation and feelings of loneliness (Brooks et al. 2020). However, due to the scale and severity of social distancing measures in Australia and the unknown duration for which such restrictions will remain, it is hard to predict what the overall effects on population mental health will be. Moreover, technological advancements since previous studies — facilitating improved methods of online communication — may lessen some of negative impacts of confinement or social isolation, both for the general population (staying in touch with friends and family) and for those accessing mental health services (such as, online psychological therapy) (OECD 2020a).

Previous research does, however, provide insights into the factors likely to influence the overall effect of social distancing. This includes the length of time that social distancing restrictions are in place, the clarity with which the risks of the virus and reasons for quarantine are communicated, the availability of resources (such as food and medical supplies), and the efforts of communities and individuals to adjust their behaviours to stay socially connected.

People with an existing mental illness and those already experiencing acute feelings of loneliness or social isolation are particularly vulnerable to the negative mental health effects of social distancing (Zaharieva 2020). An added concern is that social distancing measures make it increasingly hard for family, friends and mental health service providers to monitor and assist people with mental ill-health.

Recent research by the OECD (2020a) provides some policy advice focused on addressing the negative effects of social distancing measures and COVID-19 more broadly. This advice includes: increasing the provision of online mental health services (for example, telehealth in Australia); providing advice to general practitioners and frontline care workers about identifying individuals at risk of mental health problems or loneliness (as well as options for treatment and referrals); offering telemedicine consultations and allowing for the continuity of psychological and psychiatric treatment where possible. At a personal level, people are advised to use technology to stay 'socially connected while physically distant' and to make an extra effort to check-in and connect with those around them (WHO 2020). As indicated by previous studies, the efforts of communities and individuals to identify, monitor and support at risk-groups (such as elderly people, those with existing health issues and people living alone) are vital in ensuring that vulnerable people remain socially connected during times of crisis (Brooks et al. 2020; Druss 2020).

There is a lack of sound research on the effectiveness of targeted government interventions to address social isolation in different contexts and within populations. In the medium term, it would be instructive for governments to pay close attention to the different policy approaches and interventions implemented internationally (and their associated effects on mental health) to help guide best practise policy going forward.

Caring for people with mental illness can lead to social exclusion

Recovery from mental illness is aided by support from others in the community, including family, partners and friends. However, the emotional, financial and time costs associated with providing informal care can have broad-ranging effects on the lives of carers, including stress and financial burden, employment insecurity and social isolation (chapter 18). The increase in psychosocial stress associated with informal care provision can lead to poor mental health outcomes for carers, while also having negative effects on the people they care for.

The exclusionary effects of caring for people with mental illness are recognised in a number of submissions to this Inquiry (for example, LMMHCN, sub. 52; MHCA, sub. 489; Victorian Government, sub. 483). In particular, young carers can be disadvantaged in their ability to participate in education and employment (EACH, sub. 227; Mind Australia, sub. 380). In addition, the stigma associated with mental illness and a lack of understanding of the demands of caring can further isolate carers from their community (Carers Australia, sub. 372).

We care because we love the people who need us, but caring takes a massive toll on our mental health! We give up plans, dreams, relationships, careers and much, much more — to give them the best life possible. We become isolated from our friends, relatives and co-workers because our lives are ‘different’ and no longer ‘fit in’ to mainstream, ‘normal’ society. I am one such carer. I care for my son who I love dearly but I spend my days ‘on edge’. (Amy Wilson, sub. 467, p. 1)

The practical, physical, economic and emotional demands of supporting a loved one with a mental illness is draining. ... We are developing mental and physical health issues ourselves. We are isolated, neglected and often stigmatised by our own families. (Mental Health Carers Tasmania, sub. 391, p. 7)

Improved care for people with moderate to severe mental illness is likely to reduce the load on informal carers and increase their capacity to participate both socially and economically. In addition, there are a range of other actions governments can take in order to better support carers of people with mental illness. These are discussed in detail in chapter 18.

8.5 Promoting social participation and inclusion

Social participation and social engagement cannot be mandated by governments. Focus instead needs to be on increasing the public architecture which promotes opportunities for social inclusion in local communities and society at large. (NMHC, sub. 118, p. 18).

As well as minimising barriers to social participation and inclusion faced by people with mental illness, communities can actively encourage social participation and inclusion. For example, community associations can play an integral role in ensuring that members of particular cultural groups remain socially connected (box 8.6). Inclusive communities ensure that all individuals have an equal opportunity to participate in the community, and actively seek out and welcome the participation of everyone (Salzer and Baron 2016).

Box 8.6 Community organisations are crucial to the social participation and inclusion of migrants and refugees

People from culturally and linguistically diverse backgrounds make up a substantial proportion of the Australian population — nearly half of all Australians were either born overseas or had at least one parent born overseas, and over 20% speak a language other than English at home (ABS 2017). Settling in a new country is a major life transition, and can be accompanied by risks of social isolation and mental ill-health (particularly when people are exposed to trauma in their country of origin) (chapter 2). Challenges depend on a person's ethnic background, life experiences, English language proficiency, religion, sexuality, gender identity, age and socioeconomic status. Some new migrants and refugees also face problems such as poor housing, financial insecurity, and stigma and discrimination (Lau et al. 2018).

Improving social participation and strengthening the connectedness of people from culturally and linguistically diverse backgrounds can have a protective mental health effect. Community organisations — such as places of worship, schools, ethnic community organisations, community centres, refugee services and services for survivors of torture and trauma — can play a key role in supporting the social participation and inclusion of migrants and refugees (Eager and Steele 2016). These organisations also help migrants and refugees to navigate education and training, to find employment, and to understand and access healthcare.

Community organisations support migrants and refugees in ways that mirror the diversity of their backgrounds and experiences.

- Some organisations focus on the needs of older migrants. For instance, Indian Care supports older people by organising local English classes for Indian seniors, as well as producing podcasts in Punjabi (IndianCare 2019). Along with other services, Jewish Care runs various programs to help older people to maintain social connections, including linking older people with playgroups and school students to foster stronger connections in the community (Jewish Care Victoria 2019).
- Other organisations focus on children and young people. For example, the Centre for Multicultural Youth and the Multicultural Youth Advocacy Network (sub. 446, p. 18) said that: Accessible sport, arts and youth leadership opportunities provide an important context for the engagement of young people from migrant and refugee backgrounds. Recreational and youth-focussed activities allow young people to 'take a break' from the stresses of settlement or adolescence, while also providing opportunities to develop wider networks and develop friendships. They also have beneficial flow on effects, impacting on other areas of life such as overall wellbeing, education and employment.
- Similarly, the National Community Hub Program promotes the social participation of migrant women with preschool children. Predominantly based around schools, Community Hubs facilitate connections within local communities, as well as with organisations that provide health, education and settlement support. Hubs offer early childhood programs that meet the needs of culturally and linguistically diverse communities, provide opportunities for people to learn and practise English, and support emotional and social development of children. There are 74 Community Hubs operating around Australia — supported by a mix of government and philanthropic funding — with 32 more hubs planned to open in 2020 (Community Hubs Australia 2019).

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Box 8.6 (continued)

- Community organisations are often important in ensuring the wellbeing of people seeking asylum in the Australian community. In addition to the difficulties many migrants face with separation from family and adjusting to a new country, people seeking asylum can also have specific challenges due to their pre-migration experiences, visa status (often temporary protection visas) and the prospect of being sent back to a country where they fear persecution. All of these factors cause high levels of stress and risk to mental health (Higgins 2019; Momartin et al. 2006). People seeking asylum can have limited access to government-subsidised support services, in some cases including Medicare, meaning that they may be reliant on community groups to support their physical and mental health through direct assistance and referrals to services within the community (ASRC 2020).

Ensuring that communities are inclusive of people with mental illness can require government involvement, including:

- developing policies and supporting evidence to promote participation and inclusion
- providing assets and amenities
- supporting community organisations.

Mainstream community resources can be used to provide opportunities for social participation and inclusion for the community as a whole, including for people with mental illness. In addition, people with mental illness may require support to ensure that they are able to participate socially. They may also require support to build relationships.

Although it is incomprehensible to most people that a happy and fulfilling life could be devoid of healthy relationships with friends, family and community, too often people who seek help receive medication for their symptoms, strategies to address unhelpful patterns of thinking and yet no practical support to build healthy connections with others. (MHCN, sub. 1231, p. 2)

Family interventions can assist people with mental illness to build and maintain family relationships, and are considered in chapter 18.

Community resources promote social participation

Communities that actively seek to ensure that all people have an opportunity to participate can prevent social isolation and can reduce the risk of mental illness. Inclusive communities can aid in the recovery process and ensure that people with mental illness are provided with the support necessary to engage socially and to maintain relationships. As noted by Wilkinson and Marmot (2003, p. 13):

In schools, workplaces and other institutions, the quality of the social environment and material security are often as important to health as the physical environment. Institutions that can give people a sense of belonging, participating and being valued are likely to be healthier places than those where people feel excluded, disregarded and used.

Communities have a range of mainstream resources that are crucial to social inclusion for people across the community and are beneficial to individual health. These include, but are

not limited to, neighbourhood houses and community centres, public libraries, museums, galleries, religious institutions, sporting clubs and parks and community gardens (box 8.7). Importantly, social distancing restrictions during the COVID-19 pandemic have limited people's access to these resources, limiting people's abilities to engage socially, to feel included and realise the health benefits associated with them.

Box 8.7 Stakeholders recognise the importance of mainstream resources, activities and services

Submissions to this Inquiry recognised that mainstream community resources play an important role in community integration and the social inclusion of people with mental illness.

Sporting clubs often provide social focal points within a community, providing opportunities for social participation and inclusion, as well as offering the potential to promote positive health behaviours to the community.

Voluntary sporting clubs operate in most towns and suburbs across the country and bring together people of diverse backgrounds. They provide non-playing members, as well playing members, with regular social contact, and broader social connections which helps community bonding, reduces isolation and loneliness and promotes mental as well as physical health. Health promotion programs in these clubs reach many individuals in the community and effect social change. (VicHealth and Partners, sub. 131, p. 27)

Neighbourhood houses and **community centres** provide opportunities for different groups of people, including those with mental illness, to participate in a broad range of activities in the community. Examples of these activities include health and wellbeing programs such as yoga, adult education and training, art and craft groups, computer training, English classes, self-help groups, children's activities and community lunches (Neighbourhood Houses Victoria, sub. 203). As well as serving as 'soft entry points to mental health support':

[n]eighbourhood centres also provide a range of activities and supports for people who may not have a diagnosed mental health condition but are at risk of social isolation and other determinants of poor mental health. [They] offer programs and support groups to assist with health and wellbeing, community development, personal development, family support, employment support and financial counselling, as well as information on and referral to more intensive services such as housing. (NCOSS, sub. 143, p. 11)

Neighbourhood Houses offer a portal through which individuals grappling with their mental health can feel a sense of social inclusion and a way of connecting with ways of improving their mental health ... Men's Sheds are another model that works and should be further support[ed] ... (David Clark, sub. 809, p. 7)

Musical groups within the community also provide opportunities for all people to engage socially, while also experiencing the potentially therapeutic effects of music.

The act of creating music together is itself an act of connectedness, requiring cooperation, active listening, and unity. Audiences listening to performances can share similar feelings of participation through emotional response and enjoyment. This communal experience is a powerful catalyst for building belonging, self-worth, and a mutual feeling of achievement within the group. (SYO, sub. 327, p. 2)

As well as the social benefits of music, there is evidence about the effectiveness of music therapy, in conjunction with other modes of care, in treating a range of mental illnesses (AMTA, sub. 789) and helping people counter the effects of traumatic experiences (Lenette et al. 2016).

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Box 8.7 (continued)

Arts and cultural events are seen to improve social participation and have beneficial effects on participants' mental health.

[C]reative expression and cultural activities can improve quality of life, self-esteem, resilience, social engagement and confidence, as well as reduce stress and stimulate an interest in further learning. (Australian Government Department of Communications and the Arts, sub. 82, p. 4)

[M]useums can bring benefits to individual and community health and wellbeing in their role as public forums for debate and learning, their work with specific audiences through targeted programmes, and by contributing to positive wellbeing and resilience by helping people to make sense of the world and their place within it. (Dodd and Jones 2014, cited in AMaGA, sub. 113, p. 3)

[P]eople with disability indicated that going to arts events increases their wellbeing and happiness and makes for a richer and more meaningful life. (ACT Government, sub. 210, p. 22)

Informal community groups and activities can also aid social participation and be valuable sources of support.

Many South Australians stated that loneliness and isolation is a key driver to seeking support from services, and that this need may be better met not only by NGOs but also by other sustainable community models of support. This support is often provided by informal community groups such as **faith groups, choirs, art groups, sporting groups and other communities of interest**, but may also be provided by more formal community centres. (SAMHC, sub. 477, p. 8)

These community resources promote social participation among the community generally and also provide opportunities for people with mental illness to participate in broader society and develop social connections.

I manage depression and anxiety and have a history of complex post-traumatic stress ... My volunteering which started two years ago at the Neighbourhood House is still going, one thing I do there is that I'm part of a regular sewing group. I also help out at various local festivals, instead of just going to them I'm involved in running them ... What it all means is I know I can go down to the shops and run into someone I know and even if I don't see someone, I feel more part of the community. (cohealth, sub. 231, pp. 21–22)

... there should be art galleries and libraries and cafes and social ventures there so that people can go there and build community. Also indigenous safe spaces and actual community spaces. (Health and Community Services Union, Melbourne transcript, p. 104)

Public libraries are one example of a community resource that allows for social interaction through group activities, and provides contact points for health promotion, while also facilitating access to books, the internet and to other sources of information. They may also run a range of programs and activities specifically intended to encourage social participation. For example, the Lake Macquarie Libraries run a regular 'Small Talk Happenings' meeting, to enable people within a community to meet and interact with each other (ALIA, sub. 185).

Public libraries also provide a safe, common space for all members of the public, including those with mental illness, to interact with each other. For people with mental illness, libraries can be an important source of social contact and a way to be included in the community.

Mr Z is a regular visitor to the library, up to four times each week. Mr Z enjoys interaction with staff and often asks for assistance when using the internet services. Staff know Mr Z and spend time with him each visit as this is a key part of his library experience. Mr Z has very complex needs, and time and care is required during conversation to ensure his needs are understood and managed. Staff know Mr Z well and he is welcomed into the library on each visit. He is a familiar face to other regular library users and on occasion interacts with other members of the community. (ALIA, sub. 185, p. 4)

The important role that public libraries play with respect to people at risk of social exclusion is increasingly being recognised (Kelley et al. 2017; Luo et al. 2017; Pressley 2017).

[W]here there are gaps in services and support for people with mental health in the community, libraries provide a default, safe, neutral place. This library role is neither formally recognised nor funded by government but our open-door approach brings with it challenges; for example, requiring councils to invest in training programs for library staff so they can deliver services appropriately to people needing higher levels of support. (ALIA, sub. 185, p. 2)

For example, Melbourne City Council has recently employed a social worker to provide support for homeless clients, who make regular use of their library services (Topsfield 2019).

Physical environment

The physical environment in which people live can affect their social participation and mental wellbeing.

Access to well-designed public spaces that foster social interaction, [and] the ability to ... feel safe and secure, ... support better mental health and combat social fragmentation and isolation ... [W]ell-designed green spaces are key to encouraging social interaction, reduc[ing] chronic noise impacts, and provid[ing] restorative local environments. (Anglicare Australia, sub. 376, p. 11)

The physical neighbourhood and transport options are also recognised as important.

South Australians felt that ‘the way we plan our suburbs is critical to improving mental health outcomes’, and such plans may include community hubs, suitable public transport and green spaces to build stronger connections in the community. (SAMHC, sub. 477, p. 19)

As well as planning communities that foster connection, geography affects the accessibility of health services and people’s ability to access opportunities for social interaction.

[A]s much as we consider the role of clinical services, we need to understand how matters such as town planning practices influence health outcomes, whether people can use accessible public transport to get to where they need to be and whether people are able to find and keep somewhere safe to live, that meets their needs. (ACT Government, sub. 210, p. 3)

Public transport subsidies have been suggested as a way of reducing geographic isolation, and consequently facilitating social engagement for all people, including those with, or at risk of,

mental illness (ACT Government, sub. 210). There is some evidence supporting this idea: the provision of free public transport travel to people aged 60 years and over has been found to reduce depressive symptoms and feelings of loneliness, and to increase regular contact with children and friends (Reinhard et al. 2018). The Victorian Government has recognised the cost of public transport as an issue for carers, making holders of the Carer’s Card eligible for half price travel on public transport (Carers Victoria, sub. 461). Other participants have pointed out that, rather than just the cost, it is the lack of public transport altogether that affects social connectedness and access to healthcare (Northern Territory Mental Health Coalition, sub. 430; Anglicare Australia, sub. 376; Mission Australia, sub. 487).

Volunteering is beneficial to mental health

Social participation and inclusion, mental health and volunteering are interconnected. Across Australia, community organisations rely on the active involvement of volunteers to provide services to people in the community with, or at risk of, mental illness. In terms of mental health, the volunteer workforce ‘plays a vital role in the delivery of care, services and programs’ (Volunteering Australia, sub. 412, p. 2). Examples include the roles that volunteers play in:

- suicide prevention (Lifeline Australia, sub. 87)
- perinatal anxiety and depression (PANDA, sub. 344)
- peer support (cohealth, sub. 231; St Vincent de Paul Society National Council of Australia, sub. 1216)
- supporting new parents (Karitane, sub. 324)
- targeting loneliness and social isolation (Friends for Good Inc, sub. 115)
- identifying and responding to family violence (Family Life, sub. 316)
- providing a range of services through neighbourhood houses and community centres (Neighbourhood Houses Victoria, sub. 203; NCOSS, sub. 143).

Volunteers — with and without mental illness — are also likely to benefit from the process of volunteering. Volunteering is an important source of social capital: it can provide opportunities for diverse and genuine social relationships, while also serving as a possible pathway to employment (Volunteering Australia 2017). The act of volunteering may also have mental health benefits, although much of the evidence is observational (Jenkinson et al. 2013) or anecdotal.

People living with mental illness, social isolation or vulnerability experience a greater sense of social inclusion and improved mental health by volunteering their time to community organisations, by receiving support from community-based volunteer ... organisations, or by participating in community groups. (VCA, sub. 417, p. 3)

[T]he experience of helping others provides meaning, a sense of self-worth, a social role and health enhancement. (Volunteering Australia 2018, p. 4)

Peer workers who provide voluntary support for people with mental illness are likely to experience benefits in terms of their confidence, self-esteem and recovery (Kilpatrick, Keeney and McCauley 2017). However, literature regarding peer workers in paid employment cautions that care needs to be taken to ensure their own mental health and wellbeing is maintained (Holley, Gillard and Gibson 2015).

Assisting social participation for people with mental illness

As well as the general community resources described above, access to psychosocial supports can also be crucial in ensuring that people with mental illness are able to participate socially and have the opportunity to live a contributing life in the community. This includes centre-based services, where people can ‘drop in’ to access psychosocial supports when necessary, other group-based supports that provide opportunities for social activities, as well as access to supports for those who need to develop skills for social interaction. Psychosocial supports are discussed in detail in chapter 17.

Centre-based services

Centres where people can ‘drop-in’ to access psychosocial support services when necessary provide valuable opportunities for social participation and inclusion. They also can also allow people living with mental illness to guide their own activities, form a community with peers, gain employment skills and interact socially (One Door Mental Health, sub. 108). Beyond the services offered, they provide a valuable sense of social engagement and a counter to the isolation that can accompany mental illness.

We want drop in centre supports back. It’s a start to get us back in the community. When there was a drop in centre I never was on my own. When I was having a bad day I could go to the centre and be with people. (breakthru, sub. 112, p. 8)

While they differ in what services and supports they offer, examples of centre-based services include the Recovery Café, Recovery College and Clubhouse models (CMHA, sub. 449).

There are several Clubhouses in Australia (Samaritans Foundation, sub. 121). Clubhouses are ‘non-clinical, integrated therapeutic working communities’ composed of adults and young adults diagnosed with serious mental illness and staff who are involved in all Clubhouse activities (McKay et al. 2018). Membership is open to anyone with a history of mental illness. Membership is voluntary and without time limits. Being a member means that an individual is a critical part of the community and has both shared ownership and shared responsibility for the success of the Clubhouse. Clubhouses seek to help members participate in employment, pursue education, maintain housing, and participate in social and recreational activities (Samaritans Foundation, sub. 121; Stepping Stone Clubhouse Inc, sub. 647). They have low barriers to entry, and offer flexibility as members come and go according to their needs (MIFA, sub. 343). In Australia, they are typically funded by a mixture of government grants and private donations (Raeburn et al. 2016).

There is evidence that Clubhouses provide a number of benefits to their members, including increased employment, reduced contact with the criminal justice system, encouragement of recovery, better social, financial and educational outcomes, and improved quality of life (MIFA, sub. 343; McKay et al. 2018; Raeburn et al. 2016). Australian and Swedish studies have found that the peer support provided within the Clubhouse setting can contribute to improved self-esteem and promote recovery (Coniglio, Hancock and Ellis 2012; Schon 2010):

I have been hospitalised four times for Schizoaffective disorder living with episodes of psychosis at periodic times of my life ... Medication for me commenced at age twenty and after hospitalisation I accessed the service[s] of a Clubhouse ... [including] psychosocial rehabilitation alongside staff and consumers. This service worked as it exposed me to mental health conditions and developed insight and self-efficacy. There was mutual support amongst all the people with a mental illness attending and this would also improve the ability of the professional staff that learnt from us as well ... I became a bit of a peer advisor to others during those times. (Terry Deacon, sub. 35)

Stepping Stones Clubhouse ... offer[s] a great service to the mental health community in providing a place for you to go and feel a part of something meaningful. The staff are just so warm and welcoming and can assist you in a number of different facets of your life including employment, education and housing. You can mix and chat with fellow members who have shared a similar life experience. I am now getting enthusiastic about life again and I have Stepping Stones to thank for that. (Matt, quoted in Stepping Stone Clubhouse Inc, sub. 647, p. 5)

International evidence suggests that the Clubhouse model can be a cost-effective way of helping to ensure that people with mental illness are able to participate socially and access necessary psychosocial supports in the community. Regular attendance at a Clubhouse is associated with a reduction in total annual mental healthcare costs (Hwang, Woody and Eaton 2017). Access to centre-based supports varies across the country, with services typically piecing together funding from various government sources.

Historically we have had to have parts of the Clubhouses funded by different funding programs — Partners In Recovery, Day to Day Living, Disability Employment Services, Queensland Health Community Funding. This creates a massive amount of unnecessary administrative tasks as well as extra hoops for members wanting to access more than one service ... (Stepping Stone Clubhouse Inc, sub. 647, p. 4)

In addition to these compliance and administrative burdens, access to centre-based supports may also be affected by recent funding changes. Some centres were previously funded through the Australian Government's Day to Day Living (D2DL) program, which is in the process of transitioning to the individual-based NDIS funding model. As noted by One Door Mental Health (sub. 108, p. 16):

The NDIS model does not provide the financial stability for a provider to cover fixed costs such as rent, electricity and water that are necessary for a centre-based service, and the NDIS has removed the line item for centre-based services ... the NDIS model is still not fundamentally compatible with the concept of a low barrier to entry service.

The provision of psychosocial supports and the NDIS are discussed in chapter 17.

Social enterprises

People with severe mental illness place a high priority on employment. A national survey of Australians who live with psychotic illness found their three greatest challenges faced were employment, financial resources and loneliness and isolation (Morgan et al. 2012).

Having a job addresses all of these issues: it is a gateway to benefits such as social inclusion, the dignity of having a role and a place in society, better housing and other opportunities provided by a higher income. (WISE Employment, sub. 186, p. 5)

Employment outcomes for people with severe mental illness can potentially be improved through coordination between centre-based or other psychosocial supports and social enterprises. Social enterprises are businesses set up in order to address social problems, improve communities, or provide access to employment and or education. Most of their income is derived from trading and the majority of profits are reinvested in pursuit of their goal (CSI-S, sub. 509).

Work Integration Social Enterprises (WISE) provide employment opportunities to people experiencing social exclusion, including those with mental illness. They can positively affect the health and wellbeing of people through the provision of employment opportunities, which result in improved income and living standards, increased opportunities for social engagement and interaction, and improved mental health and wellbeing. An example of a successful social enterprise is Vanguard Laundry Services in Toowoomba (box 8.8). Vanguard Laundry Services is the result of a collaboration between the Toowoomba Clubhouse and St. Vincent's Private Hospital to provide opportunities for access to paid employment for clubhouse members. Over 50 clubhouse members have been employed in the laundry, and the Clubhouse continues to provide both clinical and social support to those in employment there (Vanguard Laundry Services, sub. 458). Other examples of WISE include a smash repair service in North Melbourne (Mission Australia, sub. 487), a commercial cleaning service (Mental Health at Work, sub. 171), cafés (FOCP, sub. 198), property and road maintenance, and traffic and grounds management services (WISE Employment, sub. 186).

Social enterprises can create opportunities for interaction between people with mental illness and the broader community. For example, coffee shops, catering businesses and project-based learning environments can create safe and supportive settings for interactions between services, clients and members of the public while supporting employment skills. The social enterprise model of employment for people with mental illness can help to break down stigma, prejudice and the enduring assumptions about mental health in the community (Anglicare Sydney, sub. 190, p. 21).

Box 8.8 Case study: Vanguard Laundry Services

Vanguard Laundry Services (VLS) is a commercial laundry based in Toowoomba, Queensland. It is a social enterprise providing transitional jobs and employment pathways for people with mental illness who have been long-term unemployed. Between 60% and 70% of staff have a lived experience of mental illness.

Staff are supported to build their skills and confidence through work experience pathways or employment under award wages with VLS. When they are ready to transition into other employment, an in-house career development team supports them to obtain work with other local employers.

VLS was initially developed through a local mental health support service, the Toowoomba Clubhouse, which identified that many Clubhouse participants were expressing a desire to work, but were experiencing barriers in gaining employment. St Vincent's Health Australia identified the need for a local commercial laundry service with a 'barrier-wall system' to provide the hygiene standard required for laundering hospital linens. St Vincent's Private Hospital Toowoomba agreed to provide VLS with a nine-year 'anchor contract' if start-up funding could be found to set up and operate the laundry.

The Australian Government invested \$1 million, with additional funds and support provided by several corporate and private philanthropic organisations and other entities, and VLS commenced operations in December 2016.

The flexible and supportive work environment of a WISE is particularly helpful in enabling staff to maintain both their health and their employment over time. VLS staff identified that supportive colleagues, flexibility with hours, tasks or stations, access to time off when needed, and job security were all particularly valued features of the WISE work environment at VLS.

Employment at VLS has reduced social isolation by providing staff with a reason to leave the house, opportunities for social contact, and a renewed sense of their own capability and self-worth. These findings reflect other research on WISEs and mental health (Akingbola, Phaetthayanan and Brown 2015; Wilton and Evans 2016). Staff without lived experience of mental illness expressed a view that working alongside people with lived experience had enabled them to see their commonalities and let go of fears or preconceptions they had previously held. These improvements in trust and social cohesion are supported by research on the impact of social contact on mental health stigma (Evans-Lacko et al. 2013).

Multiple staff members with a range of mental health diagnoses such as schizophrenia, depression or post-traumatic stress disorder have spoken of the benefits of work in providing a daily routine, a sense of purpose and hope, and a distraction from the symptoms they experienced.

The evaluation of the first year of the VLS found that while approximately half (52%) of VLS's target staff experienced high levels of psychological distress, the vast majority (96%) still reported being motivated to work, and 100% sustained their employment for at least six months or more. Notably, these rates of sustained employment are much higher than those currently being achieved through the Disability Employment Services system, where less than a third of people with psychiatric disability obtain employment, and less than a third of those who are employed sustain this for 26 weeks or more (DJSB 2017).

Source: CSI-S (sub. 509); Vanguard Laundry Services (sub. 458).

WISE are likely to be cost-effective approaches to improving the social participation of people with mental illness. Studies of the use of WISE to encourage employment among the long-term unemployed have indicated that for every dollar invested, four dollars of savings in government services are likely. Savings are most likely to be realised through reductions in income support payments and the use of health services (CSI-S, sub. 509). The effectiveness of social enterprises in providing skills and experience to people with mental illness will vary according to employees' diagnoses and levels of recovery, and the return on investment will also vary according to the type of business (WISE Employment, sub. 186).

There are several options for assisting the development of WISE in the community (CSI-S, sub. 509). First, tax incentives could be used to encourage initial investments in social enterprises. While philanthropic donations are tax-deductible, investments typically are not. A form of 'social investment tax relief' that provides for tax deductibility of a proportion of funds invested could encourage investment in new social enterprises.

Second, advisory services may provide a means of aiding the development of new WISE — the process of starting social enterprise can be complex, and may impede the development of new social enterprises.

One of the barriers to people starting social enterprises ... is that that simple process of just starting a business is actually quite complicated and having some better assistance through ... business advisory services specialising in the establishment of social enterprises would certainly go a long way (Julianne Christie, Canberra transcript, p. 104).

Third, governments could support WISE by signing long-term contracts, as ongoing support from customers is essential to their success. For example, in the case of VLS, a nine-year initial 'anchor contract' provided sufficient basis to commence trading. Social procurement policies could be used by different levels of government to prioritise the purchase of services from WISE in order to facilitate the employment of people with mental illness.

Social skills training

As well as ensuring that people with mental illness have opportunities for social participation and inclusion, it is important that they have the psychosocial supports necessary to develop the capability to participate socially and economically. These supports are typically delivered as individual or group-based social skills training that seeks to enhance people's social networks and social functioning (Anderson, Laxhman and Priebe 2015; Glynn et al. 2002; Roberts et al. 2014; Wang et al. 2013; Webber and Fendt-Newlin 2017). Peer support groups for people with psychosis have also been found to have a positive effect on social networks and social support (Castelein et al. 2008).

There is limited data available on the provision of individual or group-based support programs for people with severe and complex mental illnesses. However, the 2014 National Mental Health Commission Review (NMHC 2014b) considered that these programs have been underfunded. Funding of these programs has been further complicated with the rollout

of the NDIS. The interaction between the NDIS rollout and the provision of psychosocial support services is discussed in more detail in chapter 17.

Social prescription

Social prescription is a way that primary care services can link people with local, non-clinical services and supports within their community (Chatterjee et al. 2018). This is an approach to improving health and wellbeing that has experienced increased popularity in the United Kingdom over recent years. Referrals to non-clinical support services can complement clinical services for people with various social, emotional or practical needs, those at risk of social isolation or mental ill-health, and those with mild or moderate depression (AIAA, sub. 472; CHF, sub. 496; Latrobe Health Advocate, sub. 364). Chapter 10 discusses the need for gateways to mental health services, including GPs, to link with psychosocial supports. The need for low-intensity psychosocial supports is also discussed in chapter 12.

Social prescribing schemes can involve a variety of activities that are often provided by voluntary and community organisations. These activities include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports (Kings Fund 2017). People presenting at primary care are typically referred to these activities either directly by the source of primary care, or via a link worker who bears responsibility for assigning a suitable activity from those available in the local area.

Participation in social prescription has a number of possible benefits (Chatterjee et al. 2018; Kilgarriff-Foster and O’Cathain 2015). These include:

- increased self-esteem and confidence and a greater sense of control and empowerment
- improved mental wellbeing, including reduced symptoms of anxiety or depression
- improved physical health and lifestyle
- reduced usage of health services
- reduced social isolation and loneliness
- acquisition of new skills and personal interests.

There is some support for the idea that governments can encourage primary care services to refer patients to community-based activities that may involve social interaction (AIAA, sub. 472; Victorian Government, sub. 483).

Despite this, evidence about the effectiveness of social prescription is limited. This is because existing studies are typically small-scale and non-randomised, and many rely on qualitative evaluations only. While social prescribing may be seen as a reasonable approach to improving social participation and mental health while also reducing use of health services, there exists ‘limited quantitative evidence of its effectiveness’ (Kilgarriff-Foster and O’Cathain 2015, p. 11). In their systematic review of the social prescription literature, Chatterjee et al. (2018) identified just one randomised trial of social prescription. This trial

found that, while the social prescription intervention resulted in ‘clinically important’ benefits to the people with anxiety involved, the social prescription process was associated with a greater overall cost than usual GP-based treatments (Grant et al. 2000).

There is a need for further investigation about the cost-effectiveness of social prescription as a way of promoting social participation and improving mental health. Other potential issues associated with social prescribing include:

- GPs and other health workers may experience barriers to using social prescription either due to scepticism, consumer expectations or a lack of adequate referral services
- the take-up of social prescription will increase demand for community services. Any adoption of social prescription as a means of improving community mental health needs to include explicit provision for the funding of these services.

8.6 Improving social participation for Aboriginal and Torres Strait Islander people

Many Aboriginal and Torres Strait Islander people experience high levels of psychological distress — for example, one in three adults report having experienced high or very high distress in a recent four week period (figure 8.6).⁵⁴

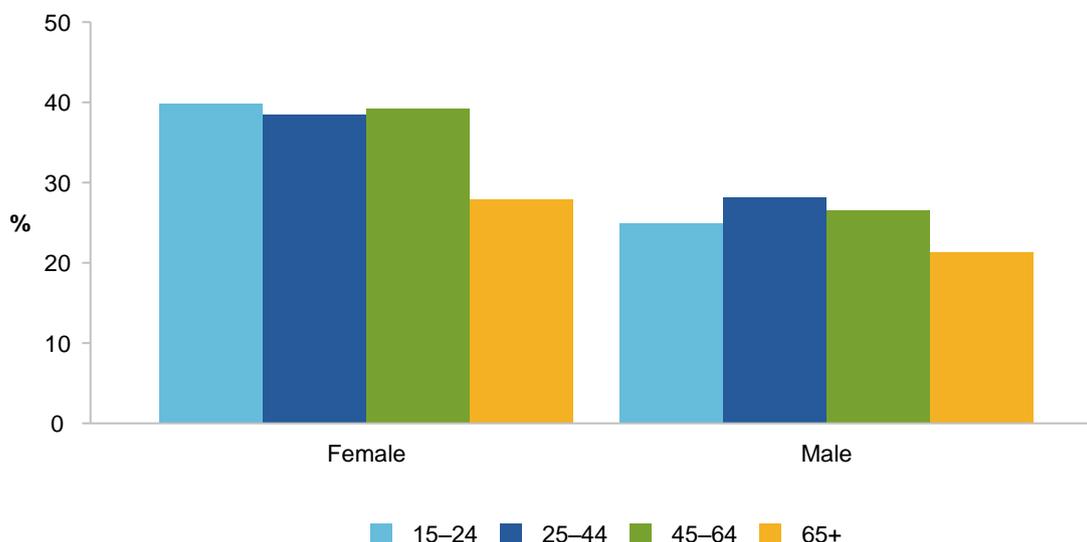
Social determinants of health — the ‘conditions of daily life’ and the broader structures of society that influence these conditions — play an important role in the health outcomes of Aboriginal and Torres Strait Islander people (WHO 2014b). Disadvantage and psychological distress often go hand in hand, and pose a concurrent risk to people’s health. Among other things, inadequate housing, high rates of incarceration and insufficient education and employment opportunities are sources of disadvantage for Aboriginal and Torres Strait Islander people that may lead to psychological distress (Zubrick et al. 2014). Entrenched poverty among Aboriginal and Torres Strait Islander people is recognised as a ‘significant underlying factor’ that contributes to self-destructive behaviour, intentional self-harm and suicide (chapter 1; Milroy et al. 2017).

The past 250 years of Australia’s history are replete with actions that have reduced social inclusion and wellbeing among Aboriginal and Torres Strait Islander people, and that continue to undermine progress in early intervention and treatment for those who have mental illness. Experiences of racism are consistently associated with mental ill-health (Paradies 2006; Paradies, Harris and Anderson 2008), as is reflected in the submissions to this Inquiry (AAL, sub. 151; AMSANT, sub. 434; Healing Foundation, sub. 193). Ongoing grief, loss and intergenerational trauma also contribute to the psychological distress of many Aboriginal and Torres Strait Islander people (Atkinson et al. 2014; HREOC 1997; Walker et al. 2014; Zubrick et al. 2014).

⁵⁴ In contrast, about 13% of non-Indigenous adults reported high or very high levels of distress (AIHW 2017a).

Figure 8.6 Many Aboriginal and Torres Strait Islander people have high levels of psychological distress^a

Proportion of people with high or very high levels of psychological distress



^a Psychological distress is measured using a set of questions about negative emotional states experienced in the past 30 days. This measure is a 5-item subset of the Kessler 10 Psychological Distress Scale, known as the K5. It is not a diagnostic tool, but an indicator of current psychological distress, where very high levels of distress may indicate a need for professional help.

Source: Productivity Commission estimates using ABS (*Microdata: National Aboriginal and Torres Strait Islander Social Survey, 2014-15, Cat. no. 4720.0.55.002*).

While individuals may be resilient to some of these factors in isolation, when combined and experienced over time they can have a substantial and negative effect on social and emotional wellbeing. Aboriginal and Torres Strait Islander people have been confronted with some of these risk factors over multiple generations, meaning that their health and wellbeing has been profoundly shaped by the circumstances of the past and is a ‘product of a history of dispossession, exclusion, discrimination, marginalisation and inequality’ (AH&MRC, sub. 206, p. 2).

The Royal Australasian College of Physicians (sub. 488, p. 6) concludes that the combined effects of these social risk factors are ‘particularly stark’ for Aboriginal and Torres Strait Islander people, and ‘have caused the higher rates of disease, mental ill-health, suicide and incarceration they face’.

Social and emotional wellbeing of Aboriginal and Torres Strait Islander people

Ideas of mental health and wellbeing are, to some extent, dependent on cultural perspectives, experiences and aspirations. This means that policy intended to support the mental health of

Aboriginal and Torres Strait Islander people must align with their concepts of wellbeing. But this does not always happen in practice. As Yap and Yu (2016b) pointed out, the ABS definition of wellbeing — a ‘state of health and sufficiency in all aspects of life’ — does not recognise that different aspects of life matter for different groups of people (box 8.9).

Box 8.9 The Yawuru Wellbeing Survey

Yawuru people are the traditional owners of the lands and waters in and around the town known as Broome, in the Kimberley region of Western Australia. *Mabu liyan* is a Yawuru concept that encompasses and extends on the Western idea of subjective wellbeing.

Mabu liyan reflects Yawuru’s sense of belonging and being, emotional strength, dignity and pride. Expressions of *liyan* are articulated based on collective structures: it is a model of living well in connection with country, culture, others and with oneself. Starting with *liyan* as the phenomenology of how Yawuru relate to, understand and define wellbeing provides a first step towards understanding and framing questions around wellbeing from Yawuru’s own way of knowing, being and living. (Yap and Yu 2016b)

In order to make well-informed decisions on matters affecting their community, country and wellbeing, Yawuru recognised that they needed to invest in data and knowledge development. This resulted in the development of the 2015 Yawuru Wellbeing Survey, a process that included:

- face to face semi-structured interviews to conceptualise Yawuru ideas of a good life and *mabu liyan*
- focus group activities to select the relevant indicators of wellbeing
- a final consultation process to present lists of indicators back to the community for discussion, refinement and validation.

For Yawuru, the purpose of developing indicators of wellbeing is to measure aspects of Yawuru culture, identity and life from a Yawuru perspective, alongside other information about people’s circumstances such as employment, health and education. This provides a baseline set of wellbeing information for Yawuru to use in making informed decisions about strengthening their wellbeing.

The survey development process identified a number of dimensions considered important to achieving and maintaining *mabu liyan* — family; community; country, culture and identity; self-determination, rights and autonomy; health and material wellbeing — and constructed a range of indicators to measure Yawuru wellbeing in these areas. For example, one indicator of connection to country was the frequency with which people were able to go fishing or hunting in the past twelve months.

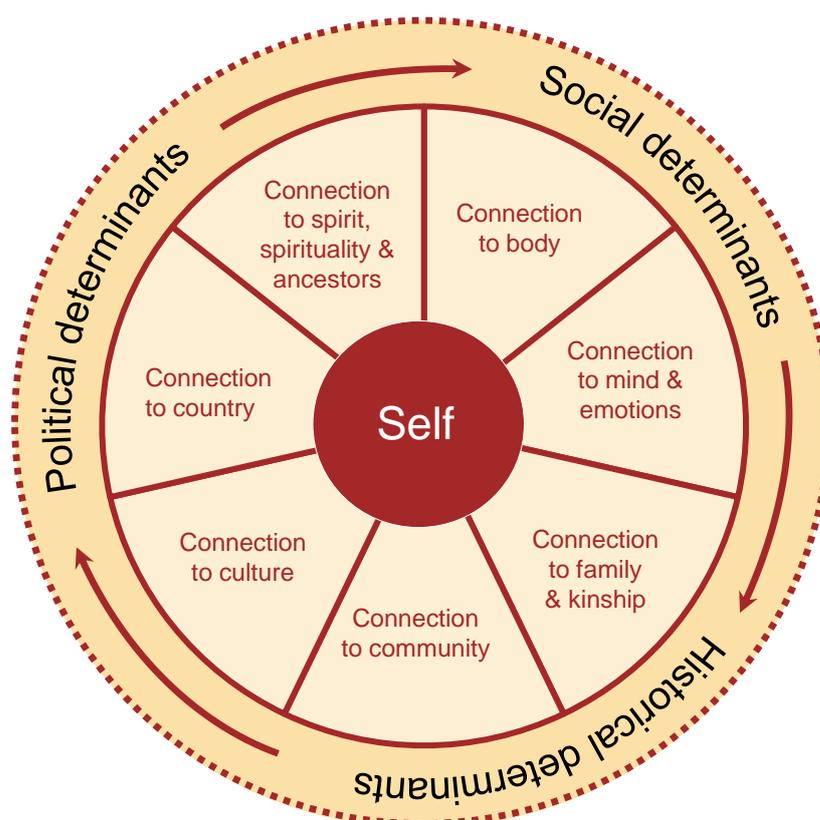
Source: Yap and Yu (2016a, 2016b).

Reflecting this, the individual social and emotional wellbeing of Aboriginal and Torres Strait Islander people is affected by overlapping connections to culture, country, spirituality and ancestors, body, mind and emotions, family and kinship as well as community (figure 8.7; Gee et al. 2014).

To us health is so much more than simply not being sick. It’s about getting a balance between physical, mental, emotional, cultural and spiritual health. Health and healing are interwoven, which means that one can’t be separated from the other. (Dr. Tamara Mackean in RACP, sub. 488, p. 6)

For Indigenous peoples ... social and emotional wellbeing ... carries a culturally distinct meaning: it connects the health of an Indigenous individual to the health of their family, kin, community, and their connection to country, culture, spirituality and ancestry. It is a deep-rooted, more collective and holistic concept of health than that used in Western medicine. (Dudgeon et al. 2016 in Thirrili Ltd, sub. 549, p. 2)

Figure 8.7 **A model of Aboriginal and Torres Strait Islander social and emotional wellbeing^a**



^a The concept of the individual in this model is viewed as being part of, and inseparable from, family and community (Gee et al. 2014).

Source: Australian Government (2017b); Gee et al. (2014).

The nature and importance of these connections, and the way in which people engage with each domain, can vary at a point in time and throughout their lives — people may experience health, connections and resilience in some domains while encountering difficulties and a need for healing in others (Gee et al. 2014). Loss of cultural connection has been identified as an important factor in youth self-harm and suicide in Aboriginal and Torres Strait Islander communities (Silburn et al. 2014).

The importance of culture and empowerment

Culture and cultural identity — including spirituality, connections to country and language, and relationships with family and kin — are recognised as fundamental to social and emotional wellbeing (Beyond Blue, sub. 275). Ongoing cultural engagements, such as living on or returning to country, learning or speaking an Aboriginal language and participating in cultural activities, are positively associated with subjective emotional wellbeing (Biddle and Swee 2012). For example:

When I'm on Country, or with my community, it reminds me of a time where colonisation didn't impact our culture and we weren't influenced by Western society. Being on Country is for me a form of self-preservation. It protects my mental health and puts things back into perspective ... It's because of my Country, my culture and my community, that I am able to be the proud Yuin/Kamilaroi woman I am today. (Jash 2019)

The importance of connections to culture and land was supported by a number of submissions.

A critical element of healing programs is an emphasis on restoring, reaffirming and renewing a sense of pride in cultural identity, connection to country, and participation in and contribution to community. (Healing Foundation, sub. 193, p. 16)

Aboriginal and Torres Strait Islander peoples with strong attachment to culture have better self-assessed health, and among those who speak an Indigenous language and participate in cultural activities, mental health is significantly better. (Beyond Blue, sub. 275, p. 28)

[P]ractising culture (including art, law and ceremony, caring for country, and hunting/food sources) builds empowerment and strengthens spirituality among Aboriginal and Torres Strait Islander people in remote Australia. These outcomes in turn improve wellbeing. (Australian Government Department of Communications and the Arts, sub. 82, p. 5)

The positive contribution that cultural identification and connection to land can make to social and emotional wellbeing may be tempered for those Aboriginal and Torres Strait Islander people who live in urban areas, where people tend to experience higher levels of psychological distress due to actual or perceived discrimination (Dockery 2011). Higher levels of stress and mental ill-health can, in turn, present an ongoing additional barrier to accessing services — including healthcare (IUIH, sub. 1108, p. 21).

Traditional healers

One aspect of connection to culture is the role of traditional healers, who protect and heal the physical, emotional and social wellbeing of Aboriginal and Torres Strait Islander individuals and communities (Oliver 2013; Panzironi 2013). Long held traditional healing practices remain most prevalent in more remote parts of Australia, including Central Australia (home to the Ngangkari) (box 8.10) and the Kimberley region of Western Australia (home to the Maparn).

Box 8.10 The Ngangkari of Central Australia

The Ngangkari are the traditional healers in the Anangu Pitjantjatjara Yankunytjatjara (APY) lands in Central Australia. The Ngangkari have nurtured the physical, emotional and social wellbeing of their people for thousands of years, helping them to cope and be resilient against life's problems. The basis for traditional healing is an understanding that the spirit is inextricably linked to the body and emotions, with a pathway to healing provided through cultural activity and connectedness to country. Some methods of healing and treatment used by Ngangkari healers include the blowing breath method, spiritual healing, the suction method, massage and wound healing, and bone manipulation (Panzironi 2013, p. 171). There are many parallels between traditional healing and methods employed in counselling such as developing trust, being held in mind (spirit), developing shared understanding, meaning and use of metaphors (Australian Indigenous HealthInfoNet 2019).

Ngangkari healers sometimes work alongside Western medicine practitioners in a complementary role. This has helped to encourage Aboriginal people to visit doctors when they otherwise would not have. Ngangkari and Western medical care are often provided in parallel and positive outcomes for patients reaffirms the importance of 'providing a holistic and culturally appropriate health care to Aboriginal patients' (Panzironi 2013, p. 134).

Qualitative research suggests that access to traditional healers is a mental health service that is prioritised by Aboriginal and Torres Strait Islander people (Lowitja Institute 2018a). The potential benefits are recognised in the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing* (discussed further in chapter 22) (AHMAC 2017b).

However, there is a need to develop further evidence about how traditional healing practices work best in partnership with mainstream mental health services to support the recovery of Aboriginal and Torres Strait Islander people with mental illness in their community (McKendrick et al. 2014). Assessment of the way in which traditional healing approaches work with mainstream services needs not only to consider conventional outcomes but also to incorporate the knowledge and views of Aboriginal and Torres Strait Islander people as to what are important outcomes. The Australian Government has asked the Productivity Commission to develop a strategy for evaluating policies affecting Indigenous Australians, and this strategy should be used as a basis for the assessment (PC 2020).

Inquiry participants (including AMSANT, sub. 1190; NACCHO, sub. 1226; MHV and VHA, sub. 1184) supported the draft recommendation that the Australian Government evaluate best practices for partnerships between traditional healers and mainstream mental health services for Aboriginal and Torres Strait Islander peoples. But the National Aboriginal Community Controlled Health Organisation (NACCHO, sub. 1226) cautioned that its support for traditional healers in mainstream practices is conditional on those practices having implemented Reconciliation Action Plans and Anti-Racism plans. And the Aboriginal Medical Services Alliance Northern Territory (AMSANT, sub. 1190) suggested that community-led healing programs such as creative, art and narrative therapy are more aligned with Indigenous models of healing and could play a role in addressing ongoing trauma and isolation.

ACTION 8.3 — TRADITIONAL HEALERS

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

Start later

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

The ability to continue to engage with culture is recognised as having protective effects for the social and emotional wellbeing of Aboriginal and Torres Strait Islander people, as is the ability to influence and control their daily lives (Chandler and Lalonde 1998; Marmot 2011), and ‘live lives they would choose to live’ (Marmot 2011, p. 3). Evidence from First Nations communities in British Columbia indicates that suicide rates are strongly correlated with measures of cultural continuity and local control (Chandler and Lalonde 1998).⁵⁵ ‘Self-determination and local leadership’ was one of five priorities identified from a series of suicide prevention roundtables held in six Aboriginal and Torres Strait Islander communities around the country (Milroy et al. 2017).⁵⁶ The need for local solutions to address suicide among Aboriginal and Torres Strait Islander people is discussed in chapter 9.

This is further emphasised in the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing*.

Individual and community control over their physical environment, dignity and self-esteem, respect for Aboriginal and Torres Strait Islander peoples’ rights and a perception of just and fair treatment is ... important to social and emotional wellbeing. (Australian Government 2017, pp. 3, 6)

‘This is the torment of our powerlessness’

The limited control that Aboriginal and Torres Strait Islander people have, and feel that they have, over the circumstances in which they live is seen by them as limiting both their social and emotional wellbeing and their own ability to do anything about it. In outlining their

⁵⁵ Local control was measured in terms of involvement in land claims and local government, along with control of education, health services, cultural facilities and police and fire services (Chandler and Lalonde 1998).

⁵⁶ As well as self-determination and the need for local leadership, other priorities were: social determinants of health, trauma, incarceration and justice, and culture and identity (Milroy et al. 2017).

objectives for reform in the 2017 Uluru Statement from the Heart, Aboriginal and Torres Strait Islander leaders described this situation as ‘the torment of our powerlessness’.⁵⁷

Proportionally, we are the most incarcerated people on the planet. We are not an innately criminal people. Our children are alienated from their families at unprecedented rates. This cannot be because we have no love for them. And our youth languish in detention in obscene numbers. They should be our hope for the future.

These dimensions of our crisis tell plainly the structural nature of our problem. This is the torment of our powerlessness. (Referendum Council 2017, p. i)

A truth and reconciliation process is one element considered likely to contribute to the social and emotional wellbeing of Aboriginal and Torres Strait Islander people, while also facilitating their broader social participation and inclusion (Lowitja Institute 2018b; RACP 2018). The Truth and Reconciliation Commission of Canada (2015, pp. 7, 12) described this process, for their people, as:

... establishing and maintaining a mutually respectful relationship between Aboriginal and non-Aboriginal peoples ... In order for that to happen, there has to be awareness of the past ... Without truth, justice, and healing, there can be no genuine reconciliation.

In Australia, such reconciliation is an ongoing process that is hindered by a lack of trust (AH&MRC, sub. 206, p. 2). For some, constitutional recognition is considered:

... a vital step towards making Aboriginal and Torres Strait Islander people feel historically and integrally part of the Australian nation, ... for the nation to connect with its past ... [and assisting] people to improve their chances for full participation in all Australia has to offer. (Lowitja Institute 2018b)

The Uluru Statement from the Heart outlines a path towards constitutional recognition and truth-telling that is acceptable to many Aboriginal and Torres Strait Islander people (Referendum Council 2017). A number of submissions to this Inquiry provide support for the changes proposed in the Uluru Statement from the Heart, recognising that these changes are likely to improve the social inclusion of Aboriginal and Torres Strait Islander people, and allow them to positively shape their own future.

[AMSANT] would like to see a further recommendation in the [Productivity] Commission’s report that acknowledges the importance of constitutional recognition and truth-telling in improving the [social and emotional wellbeing] of Aboriginal people; as well as the importance of supporting and growing the community controlled sector more generally. (AMSANT, sub. 1190, p. 25)

⁵⁷ A constitutional convention that brought together 250 Aboriginal and Torres Strait Islander leaders who met in May 2017 at Uluru, on the lands of the Anangu people in Central Australia. This convention was convened by the Referendum Council, and was the result of a process to determine an acceptable path towards constitutional recognition of Indigenous Australians (Referendum Council 2017). At the convention, a majority of delegates resolved to support the establishment of a ‘First Nations Voice’ in the Australian Constitution, and a ‘Makarrata Commission’ to supervise a process of truth, reconciliation and agreement-making between the Australian governments and the Aboriginal and Torres Strait Islander peoples. These resolutions are known as the ‘Uluru Statement from the Heart’.

The [Royal Australasian College of Physicians] urges the government to reduce the intergenerational effects of trauma, loss, racism and social disadvantage. Central to this is recognising self-determination and that the Indigenous concept of mental health encompasses social and emotional wellbeing and putting this at the core of Indigenous-led, evidence-based policy and program development. (RACP, sub. 488, p. 6)

Giving full effect to [the United Nations Declaration on the Rights of Indigenous Peoples] will necessitate an accommodation of Indigenous self-determination within the political system, and a space for truth-telling and healing, the need for which are expressed in the Uluru Statement from the Heart. (AHRC, sub. 491, p. 23)

Using the Uluru Statement from the Heart as guidance, there is an opportunity to promote truth-telling and healing as part of a national process on the establishment of a Voice to Parliament. As noted by community leaders this process can support healing and improve mental health outcomes for Aboriginal and Torres Strait Islander communities across Australia. (Victorian Government, sub. 483, p. 16)

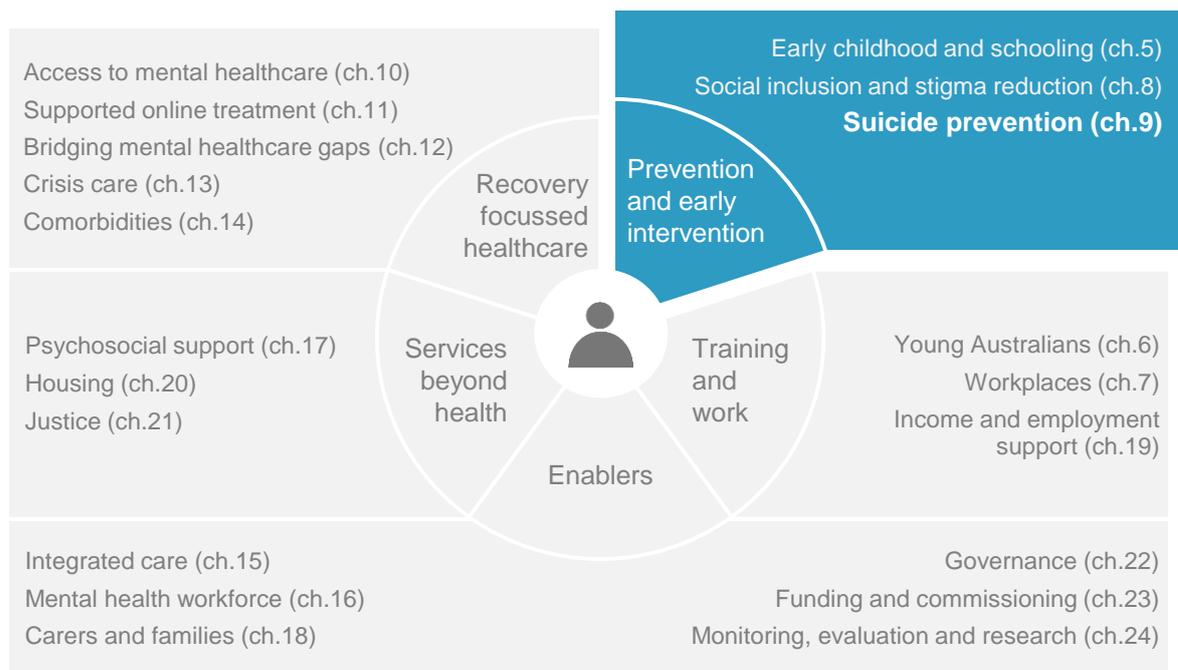
FINDING 8.2 — SOCIAL AND EMOTIONAL WELLBEING OF ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

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

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

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

9 Suicide prevention



Interventions for suicide prevention matter because ...

- The effects of suicide and suicide attempts, including hopelessness, pain, loss and grief, are felt deeply by individuals, families and communities across Australia.
- Suicide and suicide attempts are stark indicators of population mental health — the suicide rate in Australia has not declined noticeably, despite substantial community interventions.
- The quantifiable costs (medical costs and the value that the community places on lives lost) of suicides and non-fatal suicide attempts are estimated to be about \$30 billion each year.
- The social and emotional costs associated with suicide and suicide-related behaviour are beyond measure.

RECOMMENDATION 9 — TAKE ACTION TO PREVENT SUICIDE

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

As a priority:

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

Additional reforms that should be considered:

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

His suicide has been the most profound single event in my life ... Four years later there are no answers for me and the guilt and sadness are overwhelming. (Personal story, Lifeline Australia, sub. 87, p. 3)

Over the course of this Inquiry some of the most distressing evidence presented to us came from family members or carers who had lost a loved one to suicide. The effect of suicide and attempted suicide is profound and personal, affecting many individuals, families and communities across Australia.

While this chapter examines the statistical and policy-related aspects of suicide, it is difficult to adequately acknowledge the social and emotional costs of people losing their lives through suicide. Indeed, it is not necessary to quantify the cost of mental ill-health and suicide to understand the damage that they impose on the lives of individuals and the community as a whole. But quantifying these costs does help to identify where reform efforts should be focused. This does not in any way diminish or downplay the unmeasurable personal damage and distress associated with suicide.

This Inquiry recommends a range of reforms to improve the mental health of Australians, which will prevent some suicides. While there is a strong link between suicide and mental ill-health, many who die by suicide do not have diagnosed mental illness, and many people with mental illness do not have suicidal ideation. Specific efforts to address suicide are needed to complement broader reforms to the mental health system.

9.1 The ongoing impact of suicide in Australia

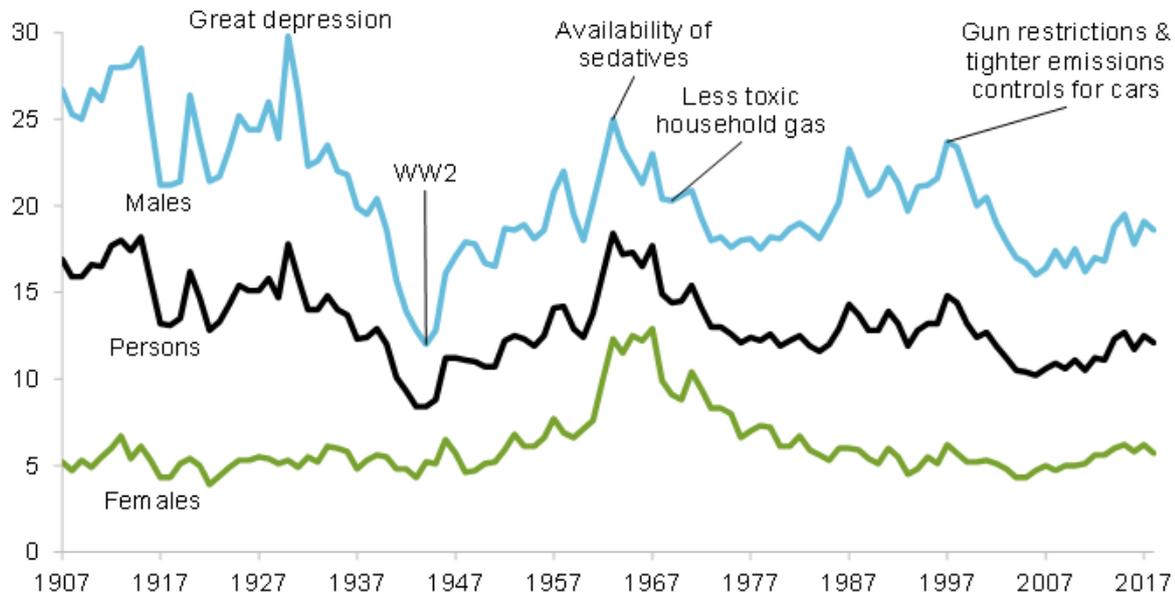
The suicide rate in Australia has varied considerably over time, but has been growing over the past decade (figure 9.1). In 2018, 3046 people died by suicide, an average of more than eight people per day. On current trend, the projected total would be about 3800 people each year by 2030 (Suicide Prevention Australia 2019).

Suicide rates in Australia are within the top one-third of developed countries (figure 9.2). The age-standardised suicide rate in Australia in 2016 was 11.6 suicides per 100 000 people.⁵⁸ This rate is comparable to that in New Zealand and Canada, and noticeably less than in the United States. However, it is substantially more than in the United Kingdom. If Australia was able to lower the suicide rate here to that of the United Kingdom, it would amount to a 35% reduction in deaths by suicide.

⁵⁸ Age-standardised rates are hypothetical rates of suicide that would have been observed if the age structure of the population was constant over time. Age-standardised rates presented here are calculated using the 'direct' method of age-standardisation (AIHW 2011b).

Figure 9.1 Suicide rates vary over time, but are rising again^a

Age-standardised suicide rate per 100 000 people, 1907–2018

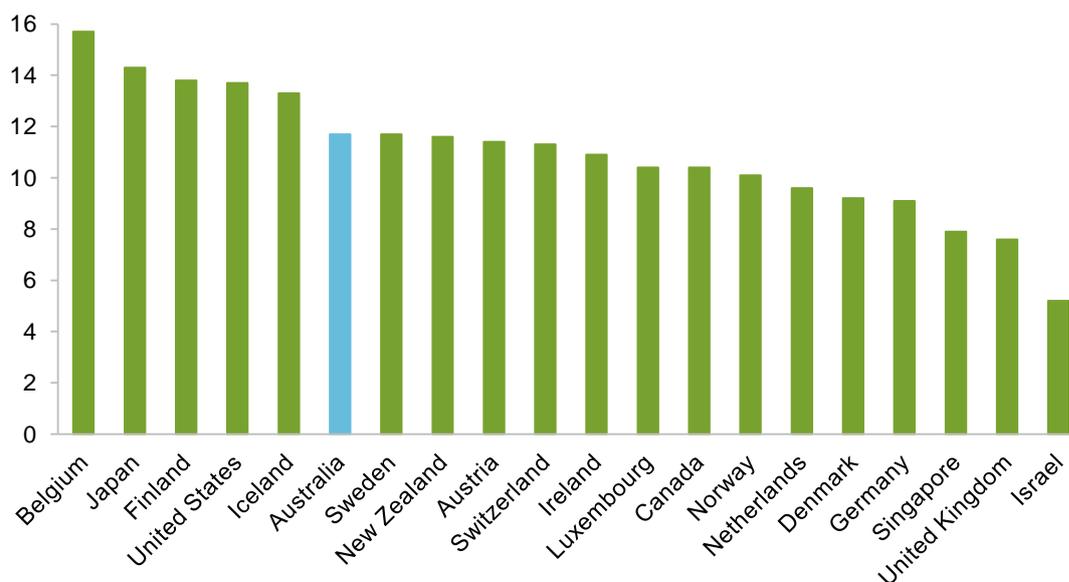


^a Descriptions show notable events that may be associated with changes in the rate of suicide deaths.

Source: ABS (*Causes of Death, Australia, 2018*, Cat. no. 3303.0); AIHW (2019f); Harrison and Henley (2014).

Figure 9.2 Suicide rates in developed countries^{a,b}

Age-standardised suicide rate per 100 000 people, 2016



^a Top 20 countries with available data ranked using the United Nations 2018 Human Development Index.

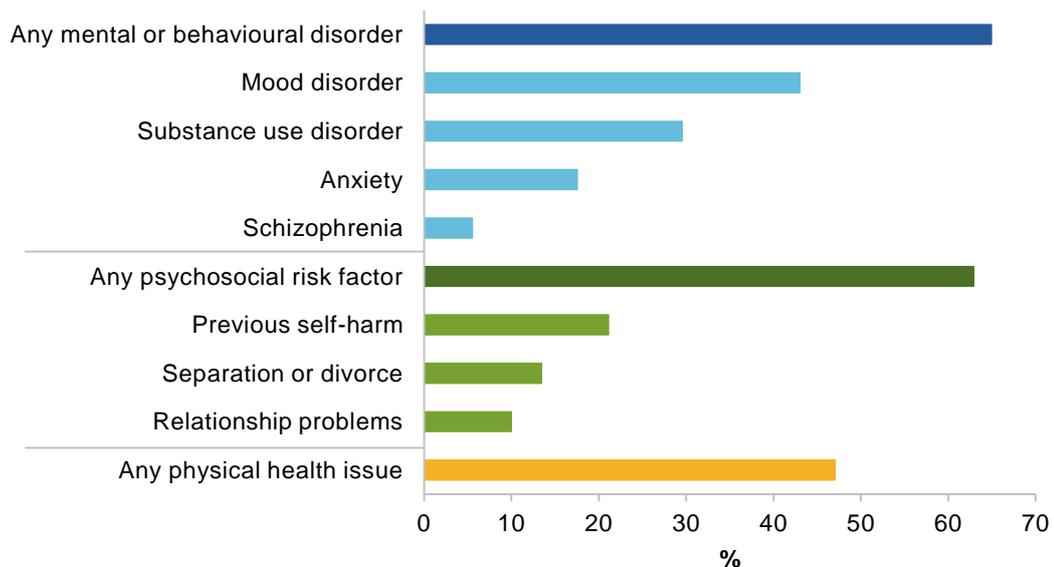
^b Estimates are adjusted for cross-country comparability and may differ from official national estimates.

Source: WHO (2019b).

Mental illness is a key risk factor for suicide (Ferrari et al. 2014). Almost two-thirds of people who die by suicide had a diagnosed mental illness, including depression, substance use disorders and anxiety (figure 9.3). Yet, most people with mental illness do not experience suicidal thoughts or behaviours.

Of the one-third of suicides not associated with mental illness, many occur when the individual is in a moment of crisis or is having difficulty dealing with some of the stresses in their life. Almost two-thirds of people who die by suicide had a ‘psychosocial risk factor’, such as personal history of self-harm, separation and divorce, or relationship problems (ABS 2019j). Further, almost half of all suicide deaths were associated with a physical health issue. Many people experienced more than one of these risk factors.

Figure 9.3 Proportion of suicide deaths associated with selected risk factors^{a,b}



^a Figures are for suicide deaths in 2017. ^b Death may be associated with more than one risk factor.

Source: ABS (2018c, 2019j).

Suicide is a major public health problem

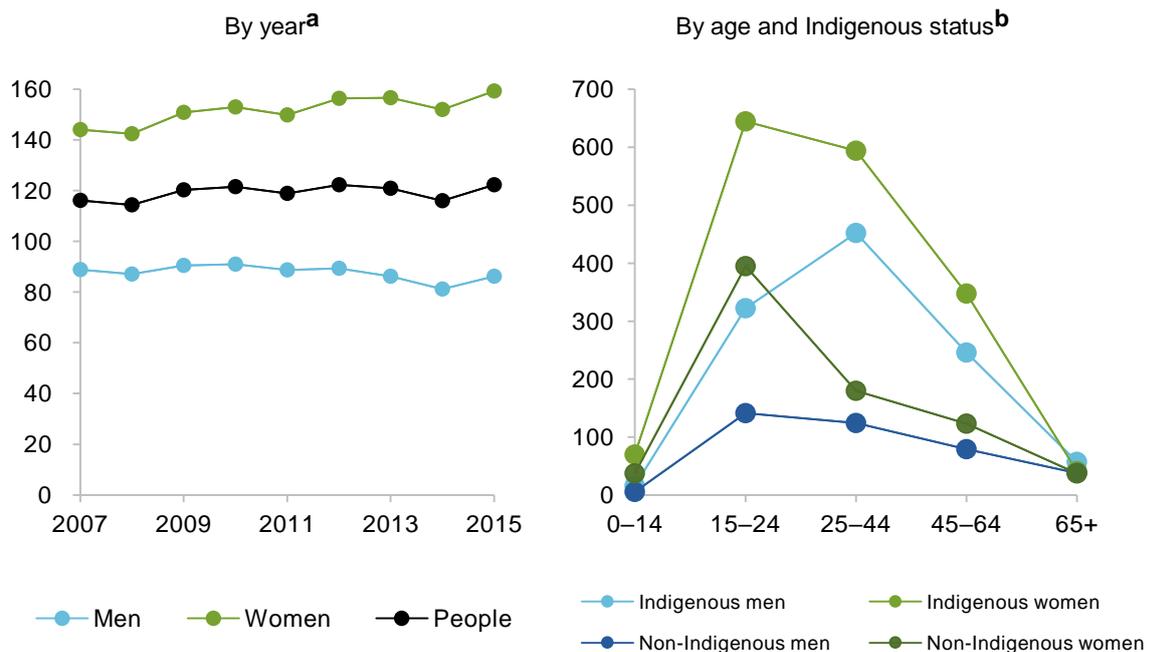
Suicide is a public health problem that extends well beyond the people who die by suicide — about 0.01% of the population. In 2007, survey data showed that many more people had attempted suicide (3%) or had made a suicide plan (4%), and even more (13%) had ‘serious thoughts’ about suicide at some time (Slade et al. 2009).

While not all people who intentionally self-harm are attempting suicide, the rate of hospitalisation due to intentional self-harm indicates that the rate of suicide attempts is likely to be significantly higher than that of suicide deaths (figure 9.4). In 2017-18, over 31 000 people were hospitalised for intentional self-harm (AIHW 2019b); although ambulance data suggests this number may substantially underestimate the scale of the problem (Turning Point 2019). For example, among men in Victoria, there are more than 10 ambulance attendances for every hospitalisation, and 60 ambulance attendances for each death by suicide (table 9.1).

As a result, estimates of the number of people who attempt suicide (a subset of the number of people who intentionally self-harm) vary widely. Most estimates suggest that for every death by suicide, there are a total of between 10 and 30 suicide attempts (COAG Health Council 2017a; Kinchin and Doran 2017; Slade et al. 2009).

Figure 9.4 People hospitalised due to intentional self-harm

Rate of intentional self-harm per 100 000 people



^a Age-standardised rate. Financial years. ^b Age-specific rate. 2011-12 to 2015-16.

Source: AIHW (2018f, 2019g).

**Table 9.1 Emergency attendances for self-harm, suicidal ideation
suicide attempts**
Men in Victoria

	Year	Number	Rate per 100 000 people
Death by suicide	2018	440	13.6
Number of hospitalisations for intentional self-harm	2016-17	2 067	82.8
Ambulance attendances for suicide attempt/suicidal ideation	2019	26 688	818.8
Ambulance attendances for self-harm behaviour	2019	29 677	910.5

^a Coded ambulance data is only available for men in Victoria. This figure counts hospitalisations and ambulance attendances not people. Individuals may experience multiple hospitalisations and attendances.

Source: Turning Point (unpublished); ABS (2019b, 2019a); AIHW (2018f).

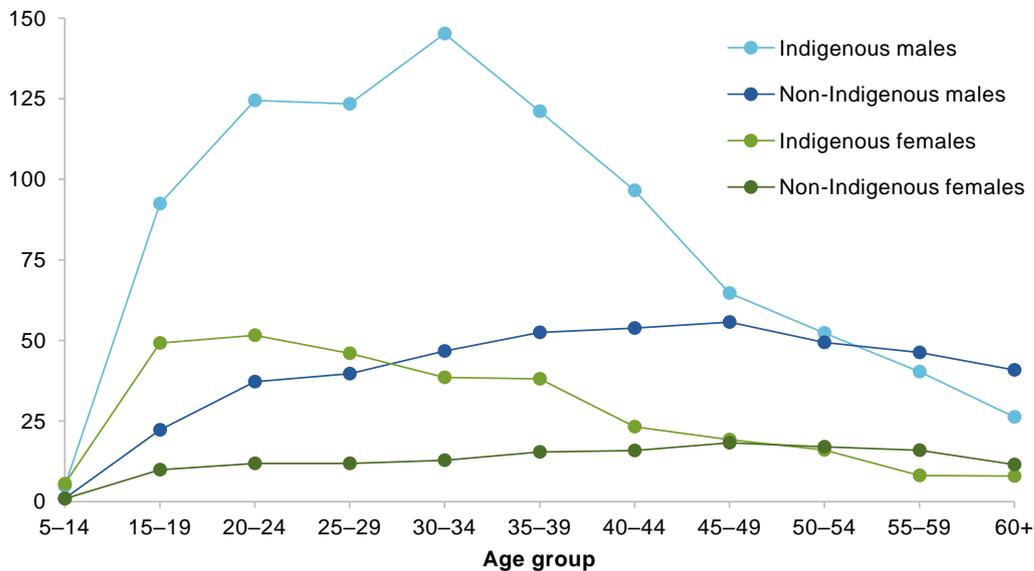
Some groups of people are at higher risk of suicide than others.

- About three-quarters of people who die by suicide are male (figure 9.1). This may be because males choose more deadly means when attempting to take their own life (Tsirigotis, Gruszczynski and Tsirigotis 2011).
- Suicide is more common among people who have served in the Australian Defence Force, with the overall age-adjusted suicide rate for male ex-service personnel being 18% higher than the rate for Australian men in general (AIHW 2019q).⁵⁹
- Over one-third of deaths among people aged 15–24 years are due to suicide and it is the leading cause of death for Australians aged 15–44 years (ABS 2019b).
- The suicide rate among Aboriginal and Torres Strait Islander people is double that of non-Indigenous people (ABS 2019b). This is largely attributable to young males who are at a much higher risk (figure 9.5). Suicide is the fifth leading cause of death for Aboriginal and Torres Strait Islander people, compared with the twelfth for non-Indigenous people.
- Regional communities have significantly higher rates of suicide (15.9 per 100 000 people) than capital cities (10.3 per 100 000 people) (figure 9.6) (chapter 2).
- While women are less likely to die by suicide, they tend to have far higher rates of hospitalisation due to intentional self-harm than men (figure 9.4). Aboriginal and Torres Strait Islander females have particularly high rates of intentional self-harm.

⁵⁹ In its inquiry into veterans rehabilitation and compensation, the Productivity Commission recommended Government urgently develop a new strategy for veterans' lifetime mental health, to be overseen by the NMHC (PC 2019a). The Government has not yet responded, but has since announced a permanent National Commissioner for Defence and Veteran Suicide Prevention (Morrison 2020).

Figure 9.5 Young Aboriginal and Torres Strait Islander males are at particularly high risk of suicide^a

Age-specific suicide rate per 100 000 people, 2009–2018

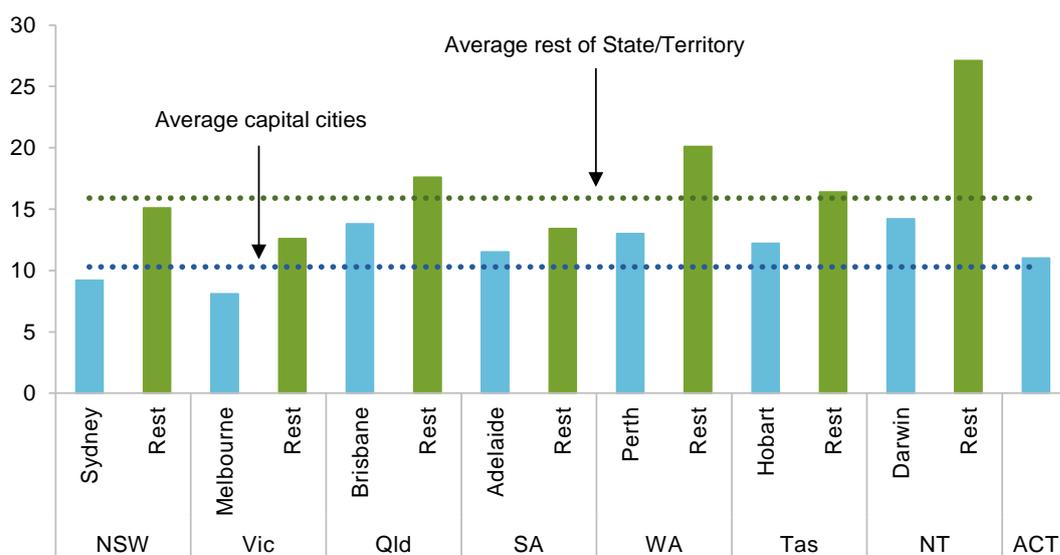


^a Data is for New South Wales, Queensland, South Australia, Western Australia and Northern Territory only.

Source: ABS (*Causes of Death, Australia, 2018*, unpublished data, Cat. no. 3303.0).

Figure 9.6 Suicide rates are higher in regional areas^a

Age-standardised suicide rate per 100 000 people, 2018



^a Greater capital cities and rest of the State or Territory.

Source: ABS (*Causes of Death, Australia, 2018*, Cat. no. 3303.0).

The cost of suicide is very high

Suicide has devastating effects on individuals, families and communities across Australia. It is said that there are about six ‘survivors’ whose lives are profoundly affected by each suicide (Andriessen 2009).⁶⁰ Further effects are felt across the community, with up to 135 people affected for each life lost (Cerel et al. 2019). The emotional costs to those left behind are profound and long-lasting:

The personal, social and emotional costs left after the suicide of someone close are immeasurable. In addition to grief, emotions of guilt, blame, anger and frustration are all felt by families, friends and work colleagues. (Private Mental Health Consumer Carer Network (Australia), sub. 49, p. 11).

A lady whose son had died by suicide told me that the light had gone out in her world. She felt she had failed him because she didn’t know how he felt and blamed herself. She was now considering suicide herself as she saw no reason to live. (Lifeline Australia, sub. 87, p. 10)

Since we lost Sabrina, we have been and continue to be in a daze, wondering what went wrong, how did this happen to our daughter, looking for answers that we will never get. (Lidia Di Lembo, sub. 354, p. 1)

Although three years have passed, the grief, pain and loss is still felt ... (Name withheld, sub. 1239, p. 1)

So, our lives consist of an almost annual trauma of dealing with the loss of a person well known to us by suicide. (Ken Barnard, sub. 924, p. 1)

While it is difficult to measure the social and emotional costs of people losing their lives through suicide, estimates of the economic costs of suicide allow policymakers to assess the potential benefits of policy actions to prevent suicide, relative to their costs. Estimates vary considerably depending on the method used, the target population and the extent to which non-fatal suicide behaviour is considered (box 9.1).

The Productivity Commission estimated the quantifiable economic costs of suicide and non-fatal suicide behaviour to be about \$30.5 billion each year (table 9.2) (appendix H). The costs of people’s suicidal behaviour can be split into three broad cost categories: direct, indirect and intangible. The Commission’s estimates included average costs of:

- suicide deaths, which includes average direct costs of about \$134 000 and average intangible costs of about \$9.2 million per person
- non-fatal suicide attempts that leave the person permanently incapacitated, which was between \$1.7 million to \$2.1 million per person
- suicide attempts resulting in a short absence from normal activity, which was between \$1200–5300 per person, depending on whether they were hospitalised (appendix H).

⁶⁰ Andriessen (2009) noted that there is no objective measure of the number of survivors associated with a death by suicide given the lack of a strategy for identifying and assessing survivors and a consensus definition of what it means to be a survivor.

Box 9.1 Estimates of the economic cost of suicide in Australia

ConNetica (2010) estimated the cost of suicide deaths and suicide attempts to Australia was \$13.6 billion to \$17.5 billion each year and \$6 million per suicide (2007 dollars). This was primarily determined using the Value of a Statistical Life measure, often used for evaluating the cost of lives lost in car accidents.

Kinchin and Doran (2017) estimated the cost of suicide deaths and non-fatal suicide attempts for employed people was \$6.7 billion each year (2014 dollars). Employed people accounted for about 37% of suicide deaths. The study estimated a cost of \$1.7 million per suicide and \$2.3 million per non-fatal suicide attempt where the individual was permanently unable to return to work. The vast majority of costs were attributable to the lost productivity of those permanently unable to return to work. This was primarily because many more people were estimated to attempt suicide and become incapable of resuming work, than die by suicide.

KPMG (2013) estimated the cost of suicide deaths (not attempts) was almost \$1.7 billion each year (2012 dollars). The vast majority of costs were attributed to lost productivity, measured as the value earnings an individual would have made had they lived. This estimate does not measure costs attributable to non-employed people.

Kinchin and Doran (2018) estimated the cost of suicide deaths (not attempts) of 15–24 year olds was about \$511 million each year and about \$2.9 million per person (2014 dollars).

Mindgardens Neuroscience Network (sub. 64, att. 1, p. 10) estimated the cost of suicide was \$5.9 billion each year (2017 dollars). This is based on the 'loss of productivity, decreased participation in the workforce, increased need for provision of treatment and support services and premature death and disability'.

Table 9.2 **Costs of suicide and non-fatal suicide behaviour**
2018 dollars

	<i>Suicide</i>	<i>Non-fatal suicide behaviour</i>	<i>Total</i>
Intangible costs	\$28.6b	\$0.3b	\$28.8b
Other indirect costs	\$51.4m	\$917.8m	\$1.0b
Direct costs	\$414.4m	\$237.9m	\$0.7b
Total	\$29.0b	\$1.4b	\$30.5b

^a Rows and columns may not add due to rounding.

Source: Appendix H.

These estimates are conservative. For example, they assume that a smaller proportion of the people who attempt suicide are permanently incapacitated than other estimates (Kinchin and Doran 2017), and they do not include the cost of providing mental health services for people who have survived a suicide attempt (estimated in section 9.2). They also exclude government expenditure directly on suicide prevention activities. The Australian Government spent almost \$50 million on suicide prevention under its National Suicide Prevention Program in 2017 (AIHW 2019j). State and Territory Governments also fund their own suicide prevention activities, designed to meet local needs. However, this expenditure is currently not publicly reported in a consolidated and consistent way (AIHW 2018b).

While the quantifiable cost of suicides is high, they do not account for all consequences of suicidal behaviour. In 2015, suicide was the second leading cause of the total years of life lost from disease and injury for men, behind coronary heart disease, and the 15th leading cause for women. Overall, suicide and self-inflicted injuries has remained the 8th leading cause of disease burden in Australia from at least 2003 (AIHW 2019c). On average, a person who dies by suicide loses almost 43 years of their expected life (Appendix H).

FINDING 9.1 — SUICIDAL BEHAVIOURS ARE COSTLY FOR EVERYONE

Suicide and suicide attempts have enormous social, emotional and economic effects on individuals, families and the broader Australian community. The quantifiable cost of suicide and suicide attempts in Australia is estimated to be about \$30 billion each year.

9.2 What works in suicide prevention?

Suicide prevention includes activities that seek to interrupt an individual's movement towards suicide, and to reduce suicidal thoughts, plans, attempts and deaths. However, the causes of suicide are complex, resulting from an inter-relationship between an array of biological, clinical, psychological, sociocultural and protective factors. Multiple factors are likely to be involved in decisions relating to suicide, with evidence suggesting that the more risk factors one is associated with, the greater the individual risk of suicide (O'Connor and Kirtley 2018).

A better understanding of how people are likely to move towards suicide allows for improvements in approaches to suicide prevention. Contemporary theories have sought to explain the development of suicidal thoughts (ideation), as well as factors that are associated with the progression from thinking to action, as well as the relationship between background factors and trigger events. One widely used model of suicidal behaviour emphasises the interactions between different types of risk factors, including:

- the biopsychosocial context that contributes to the development of suicidal ideation and behaviour, including individual vulnerabilities such as social disadvantage or personality traits combined with chronic life stresses

-
- the psychological factors associated with the formation of suicidal thoughts, including feelings of entrapment or defeat
 - factors that aid the transition from thinking about suicide to acting on those thoughts, including access to means and exposure to suicide and images of suicide behaviour (O'Connor 2011; O'Connor and Kirtley 2018).

There are many risk factors for suicide ...

Each person's risk of suicide is likely to be a different combination of risk factors. As well as mental illness, various social determinants (including trauma, abuse, discrimination, harmful use of alcohol and job or financial loss) can increase a person's risk of suicide (figure 9.7). For example, evidence shows that declining economic growth and increasing unemployment is associated with increases in the incidence of suicide (box 9.2). Among children and adolescents, mental illness and family conflict are the strongest indicators of risk of suicidal behaviour (Janiri et al. 2020). Inquiry participants provided examples of how these risk factors affected members of their family or community:

Each time [my husband] has been out of work, he has spiralled into depression. At times, he was exhibiting and verbalising suicidal tendencies. When I left for work each day, I was not 100% certain that he would be home when I got back and not dead somewhere (He told me he would not do it at home). (comment no. 23, carers and family members)

My brother in law developed severe depression and anxiety during his divorce, particularly as a result of parental alienation. He became very angry with the world, and he lost hope. He became suicidal on a number of occasions. (comment no. 30, carers and family members)

[A] significant minority of people who die by suicide have never come into contact with mental health services, and appear to have decided to take their own lives in response to life crises such as financial difficulties, the breakdown of an intimate relationship, or experiencing chronic illness. (Suicide Prevention Australia, sub. 1189, p. 4)

Many submissions to this Inquiry recognised groups within our community that are more vulnerable to suicide than others (for example, FASSTT, sub. 293; Justice Health Unit, sub. 339; OzHelp Foundation, sub. 294) (figure 9.7).

Farmers, young men, older people, and Aboriginal and Torres Strait Islanders in remote areas are at greatest risk of completing suicide ... due to the compounding social determinants of health of these demographics and geographic locations. (RRMH, sub. 97, p. 7)

LGBTIQ+ populations are more likely to experience a mental health disorder, attempt suicide and complete suicide than the rest of the population. The National LGBTI Health Alliance states these outcomes are 'directly related to experiences of stigma, prejudice, discrimination and abuse' (Mental Health Australia, sub. 407, p. 16)

Box 9.2 **Economic recessions and unemployment can increase suicide risk**

Economic recessions can increase suicide risk across the entire population. They are associated with a range of economic factors and other social determinants that can increase people's risk of suicide, such as job loss, difficulty finding employment, debt, mortgage default, house repossession, increased alcohol consumption and relationship stress (Haw et al. 2015). These factors can reach beyond those directly affected, including their families, and other groups within the community, such as those completing school or higher education and entering the workforce.

Unemployment is a key risk factor for suicide. Evidence suggests suicide rates are higher among people who are not employed. For example, following the Global Financial Crisis in 2007-08, suicide rates increased in Australia. Relative to 2006 levels, male deaths by suicide in 2008 increased by 22% among those unemployed, compared with a 7% increase among those in employment. For women, there was a greater difference: among those not employed there was a 19% increase, but suicide rates remained stable among women in employment (Milner, Morrell and LaMontagne 2014). This increased risk of suicide associated with unemployment persists after adjusting for mental illness (Milner, Page and LaMontagne 2014).

Further, increases in unemployment are associated with increases in deaths by suicide (Gunnell and Chang 2016). And for those who are employed, suicide rates tend to be higher among lower skill occupations (Milner, Niven and LaMontagne 2015).

Supporting people who are unemployed during recessions can limit the effects of unemployment on suicide (Norström and Grönqvist 2015). For example, Haw et al. (2015, p. 73) found that:

Countries with active labour market programmes and sustained welfare spending during recessions have less marked increases in suicide rates than those that cut spending on welfare and job-search initiatives for the unemployed.

In 2020, Australia's response to prevent the spread of COVID-19 involved significant shutdowns of several industries, such as hospitality and international tourism. This led to significant and rapid increases in unemployment and an expected economic recession (Biddle et al. 2020). This can be particularly detrimental to young people and is likely to be felt throughout their working life. There is also concern that this environment may lead to an increase in suicide. Estimates produced while unemployment was rising sharply in May 2020 suggest there could be an increase in the number of suicide deaths by up to 25% in years to come. This equates to an additional 750–1500 deaths every year — almost one third of whom will be young people (AMA, Brain and Mind Centre and Orygen 2020).

... but suicide remains difficult to predict

While risk factors are well documented, suicide remains difficult to predict. A meta-analysis of suicide risk factors found that 'prediction was only slightly better than chance' (Franklin et al. 2017, p. 201). This may be partly because past studies tended to examine risk factors in isolation, and did so in a static rather than dynamic fashion (Walsh, Ribeiro and Franklin 2017).

However, the growing availability of data and improvements to both technology and techniques show signs that prediction may improve in the future. For example, Walsh,

Ribeiro and Franklin (2017) used machine learning to improve prediction of suicide attempts in patients by incorporating combinations of potential risk factors using electronic health records. And Facebook (2019) has reportedly used machine learning to monitor user posts and identify those at greater risk of suicide from 2017, although there is a lack of published evidence as to the effect of this process.

Figure 9.7 Key suicide risk factors, vulnerable groups and interventions

	Risk factors	Vulnerable groups	Interventions		
Society	Access to means	Previous suicide attempt	Mental health policies	Universal	
	Inappropriate media reporting	Mental illness	Policies to reduce harmful use of alcohol		
	Stigma associated with help-seeking behavior	Aboriginal and Torres Strait Islander people	Access to health care		
Community	Disaster, war and conflict	Regional and remote Australians	Restrictions of access to means		
	Stresses of acculturation and dislocation	Fly-in Fly-out workers	Responsible media reporting		
	Discrimination	LGBTIQ	Raising awareness about mental health, substance use disorders and suicide		
	Trauma or abuse	CALD			
Relationships	Sense of isolation and lack of social support	Refugees			
	Relationship conflict, discord or loss	Emergency responders	Interventions for vulnerable groups		Selective
		Comorbid physical and mental illness	Gatekeeper training		
	Male-dominated industries	Crisis helplines			
Individual	Previous suicide attempt	Homeless		Indicated	
	Mental disorders	Prisoners	Follow-up and community support		
	Harmful use of alcohol		Assessment and management of suicidal behaviours		
	Job or financial loss		Assessment and management of mental and substance use disorders		
	Hopelessness				
	Chronic pain				
	Family history of suicide				
	Genetic or biological factors				

Source: Adapted from WHO (2014a).

Further investigation into the application of artificial intelligence to existing administrative datasets, such as health records may improve the predictive ability of suicide risk assessments. These data-driven approaches can be useful ways to augment existing clinical screening tools, such as clinician-rate instruments (Velupillai et al. 2019). If successful, there

may be scope in the future to link additional datasets to improve the predictive ability of screening tools. For example, health records can identify patients who have previously attempted suicide and legal records can identify individuals who have recently separated. However, the ethical and privacy concerns of linking data would need examination and extensive consultation, as well as a sensitive and appropriate method for responding to individuals identified as being at high risk.

This Inquiry has recommended that the National Mental Health Commission (NMHC) be tasked with sponsoring relevant research into mental health and suicide prevention (chapter 24). Research to improve the ability to identify individuals at imminent risk of suicide should be high on its list of priorities.

Evidence-based interventions

Interventions for suicide prevention are designed to reduce suicide risk factors. Given the many risk factors, there are various types of suicide prevention activities. They generally fall into three categories (figure 9.7).

- *Universal* interventions target an entire population. For example, they may involve improving access to health and mental healthcare, restricting access to the means of suicide, addressing the social determinants of health, improving social connectedness and raising awareness to reduce stigma (chapter 8).
- *Selective* interventions target vulnerable groups based on population characteristics, such as age, sex, culture or family history. They include, for example, ‘gatekeeper’ training for people in a position to identify whether someone may be contemplating suicide.
- *Indicated* interventions target vulnerable individuals at risk, such as those displaying early signs of suicide thoughts or who have made a suicide attempt. Interventions might include management of mental disorders or follow-up support after a suicide attempt.

A systematic review of suicide prevention strategies around the world identified certain interventions that are likely to be effective at reducing suicide, particularly:

- a broad range of mental health services, such as pharmacological and psychological treatments of depression
- support for people who have attempted suicide (‘aftercare’) to reduce further attempts or deaths
- school-based awareness programs to reduce attempts and ideation
- restricting access to the means of suicide to reduce deaths (box 9.3) (Zalsman et al. 2016).

Australia has been reasonably successful at progressing interventions in some areas. Means-restriction is clearly an effective approach and has been associated with reduced suicide rates in the past. However, it is difficult to take this intervention much further (box 9.3).

Nevertheless, there is room to improve Australia’s mental health services, support for people who have attempted suicide and school-based awareness programs. Many other potential interventions hold promise, but more research and evidence is needed to thoroughly determine their effectiveness.

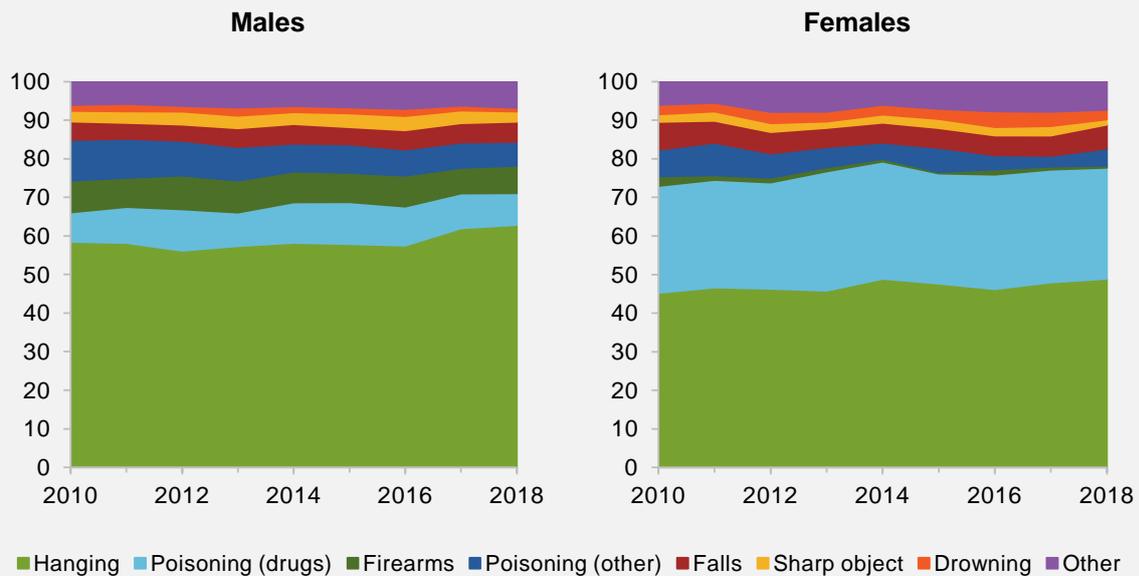
Box 9.3 Restricting access to the means of suicide

Difficulty in predicting suicide indicates that some interventions should include restricting access to the means of suicide (Large and Nielssen 2010). Evidence suggests this can significantly reduce suicide deaths and attempts, particularly when the method is highly lethal and common, and that substitution to other means appears to be limited (Yip et al. 2012; Zalsman et al. 2016). Means-restriction can be effective because some suicide attempts are impulsive, occurring in moments of crisis (Layard and Clark 2014; WHO 2014a). This gives individuals contemplating suicide time for the crisis to pass and to receive support.

A systematic review of international studies by Mann et al. (2005) found that restricting domestic gas use led to a 19–33% reduction in annual suicide rates, restricting guns led to a 1.5–9.5% decline and restricting barbiturates led to a 23% decline.

In Australia, means-restriction has been associated with a reduction in suicide rates in the past. For example, emissions controls, which greatly reduced the amount of carbon monoxide permitted in the exhaust gas of new motor vehicles, were associated with a significant decrease in poisoning by gas (Harrison and Henley 2014).

In recent years, the majority of suicide deaths in Australia have been caused by hanging and poisoning. It is not feasible to restrict the means of hanging due to the availability of different materials that can be used. Further, the vast majority of poisoning-related suicide deaths were caused by drugs that are either illegal or require a prescription (Henley and Harrison 2018). This makes it difficult to take means-restriction much further in Australia. Nevertheless, future interventions that can feasibly reduce access to means of suicide should be considered.



Source: ABS (*Causes of Death, Australia, 2018*, Cat. no. 3303.0).

Improving people's access to mental health services

Mental health services can effectively reduce suicidal behaviour (Ougrin et al. 2015; Zalsman et al. 2016). This includes medications and psychological treatment (such as Cognitive Behavioural Therapy). However, they can only be effective if services are available and people use them.

Many people in suicidal distress do not use mental health services. A systematic review of international studies (including some Australian data), found that in the three months prior to suicide, about 41% of people accessed primary healthcare and 35% accessed mental healthcare (Stene-Larsen and Reneflot 2017). In Australia, just 10% of Aboriginal and Torres Strait Islander people and 26% of non-Indigenous people were in contact with mental health services in the three months prior to suicide (Sveticic, Milner and De Leo 2012). This may be because of a lack of appropriate services or because they choose not to seek help.

In some parts of Australia, there is a significant lack of available mental health services (chapters 2, 10 and 12). A Senate inquiry found that people living in rural and remote Australia (where suicide rates are higher) access mental health services at a much lower rate, partly because the right care is not available and partly because stigma in these communities affects attitudes towards seeking help (SCARC 2018). Inquiry participants also noted these issues:

My daughter has attempted suicide and self-harm. Although the psychiatrist at Toowoomba Base hospital diagnosed depression and anxiety, we are constantly told she does not have mental health issues. I then [sought a] private psychiatrist and psychologist however have to travel to Brisbane 250km away. (comment no. 16, carers and family members)

My 26 year old son committed suicide in March 2019. He was high functioning and held down full time employment in regional NSW. Apart from the issue of not having enough resources for mental health treatment facilities we discovered on his journey that the services that are available are totally fragmented and difficult to access for working patients especially in regional areas. (comment no. 20, carers and family members)

It's clear the low rates of people accessing mental health services is a contributing factor to the high rates of suicide amongst these cohorts living in regional communities. To address issues in relation to rural suicide, the provision of adequate health services should be addressed. (QAMH, sub. 247, p. 6)

Aboriginal and Torres Strait Islander people who died by suicide were only half as likely as other Australians to receive professional help for mental health concerns (Sveticic, Milner and De Leo 2012). For example, the WA Coroner's inquiry into the suicide deaths of 13 young people in the Kimberley Region found that most had previously voiced suicidal ideation or intent, but had no contact with mental health services (Fogliani 2019).

While some people do not or cannot access mental health services, many people do access either these services or other health services prior to suicide. Therefore, mental health and other health services must not only be accessible, but be effective at treating an individual seeking help. This includes the need to refer people to the right service (chapter 10) and for care to be appropriately tailored to different cultures (chapter 4).

The lack of community-based mental health and suicide prevention services has led some people in severe suicidal distress to seek help at hospitals. However, many submissions expressed concern about the poor treatment of patients presenting to hospital in suicidal distress (box 9.4). Chapter 13 discusses the value of improving emergency departments for people with mental illness and in distress.

Box 9.4 Experiences of people going to hospital in suicidal distress

Many Inquiry participants expressed their experiences and concerns that people presenting to hospital in suicidal distress are turned away, wait a long time for treatment, are sent home without treatment, or experience stigma from hospital staff.

When 'G' was unwell and needed somewhere safe to go because they felt suicidal. The only place available was a Psych Ward in the nearby hospital, but they were given medication and 'thrown' out the next morning!! At that immediate time, when feeling so unwell, there was nowhere else to go! (Name withheld, sub. 31, p. 1)

A recent story from a carer was that she presented to [the Emergency Department] with her 18-year-old daughter who was very distressed. She was turned away from [the Emergency Department] and not even 24 hours later her daughter suicided. Sadly this story is becoming a common mental health story from families. (Mental Health Carers ARAFMI Illawara, sub. 161, p. 3)

Client A is a 23-year-old woman ... She has been referred to the public mental health system for psychiatric review on several occasions, and presented to the emergency department for suicidality and self-harm on another occasion, however the intake team at the hospital's mental health unit say she is not eligible for service (her symptoms are 'not severe enough') and refer her back into her GP and private psychologist's care each time. (Emma-Kate Muir, sub. 338, p. 3)

For a person in suicidal crisis, the experience of sitting for hours on end in the emergency department can be bewildering, triggering and ultimately a barrier to further help-seeking. Some experience stigma at the point of entry and many health professionals are not getting adequate support and training themselves. (Beyond Blue, sub. 275, p. 22)

A high proportion of these people will leave hospital without being admitted, so there is no discharge process to prompt a referral. People who have not been admitted are rarely given an onward referral ... (MHCT, sub. 314, p. 29)

Parents should not have to beg for their children, who are expressing suicide ideation, to be admitted to care because of a shortage of outpatient and inpatient treatment facilities. (NAPP, sub. 495, p. 2)

A doctor asked me if I was doing it for sympathy. A doctor! You'd think he would be someone who would know better. (Orygen, The National Centre for Excellence in Youth Mental Health and headspace, National Youth Mental Health Foundation, sub. 204, p. 51)

The patient explained that the emergency treatment staff suddenly announced that the patient had to go home, and they (literally) put the patient out on the street. The staff would not even let the patient wait inside. (Laurence West, sub. 541, p. 2)

And treatment in hospitals is not necessarily the most effective treatment for people in severe psychological distress.

My daughter committed suicide on 10 May 2018 after many years of un-treated mental illness. She had well over 20 hospitalisations over a period of 10 years and ongoing involvement with police. There was no consistency of care in any of these hospitals and despite suffering from suicidal depression, bi-polar disorder (Type 2), [Post-traumatic stress disorder] and Borderline Personality Disorder and despite the regular harm she came to and over-doses, she never received the specialist intensive treatment she needed for her to survive. ... The treatment she needed a

long time ago was [Dialectical behaviour therapy] — following detox and rehab and support with real housing. (comment no. 8, carers and family members)

The public hospital emergency department sometimes have areas set aside for mental health patients for observation. These areas do not distinguish between patients in an acute state of agitation because they are on recreational drugs and/or are suffering from an agitated psychosis, or from those who are in a state of despair and have attempted suicide or who are suicidal. The treatment area is frightening for those who are in despair and lacks containment for those who are agitated and psychotic. (Laurence West, sub. 541, p. 2)

There are several reasons why emergency departments are not suited for treating people in severe suicidal distress. They often have stressful environments and mental health patients tend to spend more time in emergency departments than other patients, although efforts are being undertaken to better accommodate patients in distress (chapter 13). There is also evidence of stigmatisation among some hospital workers towards patients in mental health or suicide distress (box 9.4).

The unpredictability of suicide means that individuals who make the effort to seek help for mental ill-health, or suicidal thoughts or behaviours should not be dismissed. Rather than waiting for things to get worse before they get better, mental health and suicide crisis services should act as preventative mechanisms to reduce suicidal distress.

Several submissions recommended the use of mental health and suicide crisis hubs that act as an alternative to emergency departments for people in severe distress (Beyond Blue, sub. 275; ConNetica Consulting, sub. 450; EMHS, sub. 152; Laurence West, sub. 541; Mindgardens Neuroscience Network, sub. 64; NMHC, sub. 118; NMHCCF, sub. 476; Tim Heffernan, sub. 552). These types of alternative services, such as the Safe Haven café located at St Vincent's Hospital in Melbourne, can be beneficial for those in suicide distress as well as avoiding emergency department presentations (chapter 13).

In addition to improving the effectiveness of mental health services received by those presenting at hospitals, this Inquiry makes several recommendations to improve access to community-based mental health services, including in regional Australia, and to online mental health treatment, in cases where this may be beneficial (for example, chapters 10, 11, 12 and 17).

Improving access to mental health services can prevent many suicide deaths and attempts, avoiding the associated social, emotional and economic costs. Krysinska et al. (2016) estimated that increasing the proportion of suicidal people who receive mental healthcare from 31% to 50% could prevent about 5.8% of suicide deaths and 8.0% of suicide attempts. This could prevent about 5200 people from attempting suicide resulting in short incapacity, 1065 people from attempting suicide resulting in full incapacity, and about 177 people from dying by suicide (appendix H). This could be expected to reduce the economic cost of suicide and suicide attempts by \$1.3 billion to \$2.6 billion each year. These costs do not include the significant social and emotional costs associated with suicidal behaviour.

Aftercare for people who have attempted suicide

A previous suicide attempt is considered one of the most reliable indicators of future suicide or suicide attempts (NMHC 2014c; Owens, Horrocks and Allan House 2002; WHO 2014a; Yoshimasu, Kiyohara and Miyashita 2008). For example, a recent meta-analysis found that patients discharged from inpatient psychiatric care who were admitted with suicidal thoughts or behaviours were nearly 200 times more likely to die by suicide than the global average (Chung et al. 2017). The risk of suicide is greatest in the days immediately following discharge and remains elevated for weeks, months and even years (Chung et al. 2017; Meehan et al. 2006).

Between 15 to 25 per cent of people who attempt suicide will re-attempt, with the risk being highest during the first three months following discharge from hospital after an attempt. Of these, 5 to 10 per cent will die by suicide. Half of the people discharged from hospital after a suicide attempt do not attend follow-up treatment. Two thirds of people who do attend follow up treatment cease treatment after three months. (Mental Health Australia, sub. 407, p. 24)

Adequate aftercare for people who have attempted suicide, including discharge planning and follow-up support, can prevent future suicide deaths and attempts (Luxton, June and Comtois 2013; Zalsman et al. 2016). For example, one study found that providing safety planning resources and follow-up intervention for suicide patients in emergency departments approximately halved the odds of suicidal behaviour over six months (Stanley et al. 2018). Ideally, aftercare should include support prior to leaving a service, as well as follow-up support within the first day, week and three months of discharge. There are several examples of improvements made to aftercare in Australia (box 9.5).

Preventing deaths and attempts through aftercare reduces the associated social, emotional and economic costs of suicide. Kryszynska et al. (2016) estimated that adequate aftercare could reduce the prevalence of suicide attempts that reach an emergency department by about 19.8% and all suicide deaths by 1.1%. This would be expected to prevent about 35 people from dying by suicide, as well as preventing about 6100 people from attempting suicide, including nearly 40 people who would be unable to return to work.⁶¹ Using the Productivity Commission's estimated costs of suicide, aftercare could be expected to reduce the economic cost of suicide and suicide attempts by more than \$294 million each year (appendix K).

⁶¹ The number of suicide attempts was derived using the assumption that, of the 31 083 cases of hospitalisation due to intentional self-harm in 2017-18 (AIHW 2019b), 0.6% resulted in full incapacity and 99.4% in a short absence from work (appendix H). Despite this being the best estimate available, it is unlikely to reflect the true number of suicide attempts. On one hand, it may be an underestimate because not all people who attempt suicide are admitted into hospital or accurately coded (section 9.1). On the other hand, it may be an overestimate because one individual may account for multiple cases and some individuals may not have intended to die by suicide. The number of suicide deaths was derived using total number of suicide deaths in 2018 (ABS 2019b).

Box 9.5 Efforts to improve aftercare in Australia

The proportion of patients leaving hospital mental health units who received post-discharge care within seven days increased from 48% to 64% for Aboriginal and Torres Strait Islander people and 57% to 69% for other Australians between 2011-12 to 2015-16 (NMHC 2018a). This is a move in the right direction. However, it is unclear whether this increase in care has effectively targeted people who previously attempted suicide, if the care provided is culturally capable, or if this has had any impact on suicide rates.

Suicide-focused aftercare programs are being trialled in Australia. In Victoria, 12 hospitals are trialling the Hospital Outreach Post-suicidal Engagement (HOPE) program which provides intensive support within 24 hours of hospital discharge, with support continuing for up to three months (VIC DHHS 2019d). More than 800 people have been assessed and received support. An outcomes evaluation of this program is expected to be completed by June 2021 (Victorian Government, pers. comm., 25 July 2019). In their interim report, the Royal Commission into Victoria's Mental Health System has recommended that the HOPE program be expanded into all mental health service areas within Victoria (State of Victoria 2019).

Beyond Blue's The Way Back Support Service program offers similar support, and has recently received funding to expand across many Primary Health Network regions (DoH, sub. 556). A limited evaluation of a Darwin trial found positive indications that supported the model, but could not robustly determine the effectiveness or cost-effectiveness of the program (ConNetica Consulting, sub. 450; EY 2016). Beyond Blue (2019) has initiated a more comprehensive outcomes-based evaluation of the program, expected to be completed by the end of 2022.

Some organisations, such as Roses in the Ocean, are also building a workforce of peer workers with lived experience of suicidal distress to deliver peer support programs (chapter 16).

This suggests that effective aftercare is likely to deliver a positive return on investment. The provision of aftercare for each person hospitalised due to intentional self-harm would cost between \$63 million to \$194 million each year (about \$2000 to \$6200 per person).⁶² Therefore, aftercare could provide a long-term return on investment of \$2.37 to \$6.90 per dollar invested. As a return on investment, this exceeds the return from investing in several high priority infrastructure projects.⁶³ Other studies have also estimated that the provision of aftercare is expected to lead to a positive return on investment (KPMG and Mental Health Australia 2018).

In 2014, the NMHC (2014c) recommended that Australian, State and Territory Governments establish a national protocol for providing aftercare to patients after a suicide attempt. In response, the Australian Government committed to 'working with State and Territory Governments to ensure effective post-discharge follow up for people who have self-harmed or attempted suicide, in the context of the Fifth National Mental Health Plan' (DoH 2015a, p. 17).

⁶² Productivity Commission estimates based on a range of average costs for aftercare from Beyond Blue (pers. comm., 24 September 2019), KPMG and Mental Health Australia (2018) and MHV (2018).

⁶³ For example, the Western Sydney Airport is estimated to deliver less than 2:1 for every dollar spent (Infrastructure Australia 2020).

However, gaps in aftercare remain. For example, some people may present to services other than hospitals following a suicide attempt, such as GPs or other government services, and will not receive aftercare. And anecdotes suggest that many people who do present or are admitted to hospitals are still being discharged without adequate aftercare:

Currently in Australia not everyone who attempts to take their own life and seeks help receives aftercare. When it is provided, while some people with lived experience of suicide report positive experiences, far too many report negative experiences. They report that care was not always intuitive or easy to access, not offered consistently and that the quality, length and amount varies. They report a lack of connection between services and clinicians, meaning that people need to tell their story again and again. (NSPPRG 2019, p. 21)

The Commission heard about situations where people had been discharged from hospital following admission for mental illness and/or suicide attempt with no scheduled follow-up, or where a follow-up had been scheduled but the person had not been contacted if they did not attend. We were told that responsibility and accountability for follow-up was unclear and inconsistent. (SAMHC, sub. 477, p. 31)

I was in a psychiatric ward for 5 days (for attempted suicide) ... I was not given the opportunity once to speak about why I was feeling the way I was, how they can help when I leave the ward and what we can do to prevent this from happening again. ... Once I had left the ward I was back to the beginning. I had no connections outside of the ward to help me on an ongoing basis, by changing this, people can feel like they are receiving the help they desire. (comment no. 21, consumers)

Many Inquiry participants identified the need for effective support for people who have attempted suicide.⁶⁴

There is a clear need to expand community based assertive outreach services to people who have attempted suicide. (Mental Health Australia, sub. 407, p. 24)

In addition to supporting people with suicide ideations, targeted after care and crisis care must be available to those who have previously attempted to end their life. (Mission Australia, sub. 487, p. 7)

While supporting the provision of universal access to aftercare, the NMHC (sub. 949, p. 20) recommends that access to aftercare be extended to people expressing suicidal ideation, pointing out that:

... by limiting access to this care to people who have already attempted suicide, people who present to services with suicidal ideation in the absence of an attempt would be excluded.

The value of expanded pathways into assertive outreach and aftercare programs is recognised by the Royal Commission into Victoria's Mental Health System. The Royal Commission noted that people who attempt suicide or experience major suicidal ideation often do not attend a hospital, and may attend a GP or a community mental health service instead. While it is important that these services are able to provide some support, people's

⁶⁴ APS (sub. 543); Beyond Blue (sub. 275); CATSINaM (sub. 75); Jesuit Social Services (sub. 441); Laurence West (sub. 541); Mental Health Victoria (sub. 479); Private Mental Health Consumer Carer Network (Australia) (sub. 49); Relationships Australia (National) (sub. 103); Suicide Prevention Australia (sub. 523); yourtown (sub. 511).

needs may extend beyond their capacity. As a consequence, the Royal Commission has recommended in its' interim report that the Hospital Outreach Post-Suicidal Engagement aftercare service be provided with sufficient recurrent funding so as to expand referral and entry pathways to the program. This expansion would allow all mental health services to be able to refer people for outreach and follow-up care after a 'suicide attempt, self-harm or suicidal ideation' (State of Victoria 2019, p. 454).

There is a clear net benefit to providing universal aftercare for people who present at a hospital following a suicide attempt. Aftercare should also be provided to people presenting to any health or government service following a suicide attempt in order to reach and support as many people as possible. Evaluations of the expanded use of aftercare services in Victoria should seek to establish efficacy for people expressing suicidal ideation and the use of expanded referral pathways into aftercare programs. Where it is supported by evidence, universal access to aftercare should also be provided to people expressing suicidal ideation, in the absence of a suicide attempt and without the requirement of attending hospital.

School-based awareness programs

Stigma and negative attitudes about mental illness and suicide can discourage people from seeking help (chapter 8). There is significant stigma towards suicide in Australia — a survey found that over one-third of Australians thought suicide was 'irresponsible' (Suicide Prevention Australia 2017). Stigma and a lack of awareness that suicide is preventable can be so strong that many individuals do not seek help at all. For example, a survey by yourtown (sub. 511) found young people may not seek help because of stigma, lack of parental support or fear of being labelled an attention seeker.

Awareness campaigns aim to reduce stigma, encourage help-seeking, and support the community's understanding that suicides are preventable. However, there is insufficient evidence linking whole-of-population awareness campaigns to a meaningful reduction in suicide deaths (Zalsman et al. 2016).

In contrast, awareness programs delivered in school settings appear more effective (Calear et al. 2016; Katz et al. 2013). A large European study found that the Youth Aware of Mental Health (YAM) program significantly reduced suicide attempts and ideation after one year (Wasserman et al. 2015). Yam is a universal, school-based program targeted at people aged 14–16 years that seeks to develop emotional intelligence as well as problem-solving skills and an understanding about mental health. The Black Dog Institute (2018; sub. 306, p. 29) has begun trialling the Yam program (evaluations underway), with '[m]ore than 5000 students across 46 schools [having] completed school-based suicide prevention programs'.

Krysinska et al. (2016) estimated that school-based programs such as Yam could reduce the prevalence of suicide attempts in Australia by 2.9%, assuming half of all schools participate. This could prevent about 2260 people from attempting suicide, including at least 10 suicide attempts that would result in full incapacity. Using the Productivity Commission's estimated

costs, school-based awareness programs could be expected to reduce the economic cost of suicide attempts by about \$42 million each year.⁶⁵

These savings are significantly greater than the estimated cost of implementing YAM. The cost of implementing YAM across half of all schools was estimated be \$9.5 million to \$18.6 million each year.⁶⁶ However, these costs are likely to be underestimated because they do not include the cost of training YAM instructors or their travel expenses. Nevertheless, school programs such as YAM provide a significant positive return on investment of between 1.8:1 to 4.4:1.

Other school-based programs show an increase in help-seeking behaviour. For example, an evaluation of ‘safeTALK’ — a three hour school-based workshop — showed increased suicide awareness and help-seeking for suicidal thoughts (Bailey et al. 2017). However, this study did not evaluate whether the program reduced rates of suicide attempts or deaths.

Governments should encourage the use of school-based suicide prevention awareness programs and make it easier for schools to choose and run these programs. This Inquiry has recommended accreditation of social and emotional learning programs offered to schools, such as those that can encourage help-seeking behaviour (action 5.5). At the same time, there is a need to build rigorous outcomes-based evaluations into these programs to continue to build the evidence base and confidently direct government funding.

FINDING 9.2 — SCHOOL-BASED AWARENESS PROGRAMS CAN BE COST-EFFECTIVE

Universal, school-based suicide prevention awareness programs can be effective at reducing suicide attempts and are likely to be cost-effective. Governments can encourage the use of these programs by accrediting evidence-based programs through the process outlined in Action 5.5.

Other interventions hold promise but more research is needed

Many other interventions to prevent suicide have been trialled in Australia and overseas. While these have been designed to reduce specific risk factors and many hold promise, further investigation is needed to confidently determine their effectiveness at reducing suicide deaths, attempts and ideation. Zalsman et al. (2016) found insufficient evidence to assess the benefits of several interventions, including screening in primary care, general

⁶⁵ Cost savings include both direct (\$34 million) and indirect costs (\$8 million), as described in appendix H.

⁶⁶ The cost of YAM was calculated based on the cost per student (\$10), cost of posters per school (\$120) and cost per YAM instructor (\$484) (Be You 2019b). It is assumed that YAM would be delivered to half of all 14–16 year olds (430 116 people as at June 2018) in half of all schools (4739 schools in 2018) (ABS 2018a, 2019k). It is also assumed that between 2 and 6 YAM instructors were needed for each school, yielding a range in the estimated costs and return on investment.

public education, media guidelines, and internet and helpline support. The Black Dog Institute (sub. 306, p. 13) noted that:

There remains a paucity of gold-standard [Randomised Controlled Trial] evidence in the field of suicide prevention, which is a major limitation in the evaluation of preventive interventions.

One example of emerging evidence is training for community, health and other frontline professionals (so-called ‘gatekeepers’ or ‘local go-to people’). These include anyone who is in a position to identify whether someone may be contemplating suicide, such as GPs, other health workers, teachers and police. This intervention can be useful because many people in suicidal distress do not necessarily access mental health services, but will interact with other health services or government services, such as police or Centrelink.

Inquiry participants supported improving suicide prevention training for community and other local health professionals.⁶⁷ And studies have estimated that such training programs (including related GP training) may be cost-effective (Knapp, McDaid and Parsonage 2011). For example, the Mates in Construction program in Australia delivers multi-level suicide prevention training to construction workers and has been estimated to reduce the number of suicide incidences and provide a return on investment of about 1.5:1 (Kinchin and Doran 2017). However, Beyond Blue (sub. 275, p. 24) stated that ‘[t]he evidence of gatekeeper training in reducing suicidality is still emerging ...’ and the Black Dog Institute (sub. 306) suggested that such training requires further investigation.

Mental health and suicide prevention training for community, health and other local frontline professionals is a logical approach to identifying people in distress and responding quickly and effectively. Training should be tailored to the role of the worker, for example health workers take on a much greater role in treatment and recovery than other community professionals, but are more likely to have some level of mental health and suicide prevention training. This Inquiry makes several recommendations to improve mental health and suicide prevention-related training and referral pathways for police (chapter 21), teachers (chapter 5) and housing workers (chapter 20).

Another form of intervention with promise is ‘postvention’ programs — these are interventions targeting people directly affected by suicide, such as families and friends, who are themselves at increased risk (Pitman et al. 2016). Postvention involves supporting those affected by suicide to grieve and reduce the risk of follow-on suicide. As an approach to suicide prevention it is widely supported (for example, Jesuit Social Services, sub. 441, sub. 1186; Wesley Mission, sub. 383, sub. 840; PLWSA, sub. 609).

⁶⁷ ARHEN Mental Health Academy Network (sub. 444); Hunter Rise Associates (sub. 439); Maria Lohan (sub. 515); MHCT (sub. 314); Name withheld (sub. 23); Ron Spielman (sub. 18); Suicide Prevention Australia (sub. 523); Wesley Mission (sub. 383); yourtown (sub. 511).

Australian studies of the StandBy Response Service support postvention program found that clients were significantly less likely to be at risk of suicidality or experience mental health concerns, were more likely to experience improved quality of life, and that the intervention was likely to cost less than treatment-as-usual (Comans, Visser and Scuffham 2013; Gehrmann et al. 2018). The Be You initiative also delivers postvention programs in schools to support the school communities after a suicide death (Be You 2020). And the National Indigenous Critical Response Service provides culturally responsive support to Aboriginal and Torres Strait Islander families and communities affected by suicide-related or other trauma (Thirili Ltd, sub. 549). While these programs are promising, more research is needed to determine their effectiveness and cost-effectiveness (Jesuit Social Services, sub. 441; Orygen, The National Centre for Excellence in Youth Mental Health and headspace, National Youth Mental Health Foundation, sub. 204).

Interventions such as suicide training for community, health and other local frontline professionals, and postvention programs are likely to be high on the list of research priorities for the NMHC (chapter 24).

Of the evidence-based interventions to prevent suicide, aftercare, mental health services and school-based awareness programs have potential to be most effective. As a matter of priority, Australian, State and Territory Governments should implement universal access to aftercare support for people who have attempted suicide. The Productivity Commission has made recommendations to improve mental health services and school-based programs elsewhere in this report. Suicide postvention is likely to be an effective approach to suicide prevention, and should continue to be trialled in order to develop the evidence as to its cost-effectiveness.

ACTION 9.1 — UNIVERSAL ACCESS TO AFTERCARE

The Australian, State and Territory Governments should offer effective aftercare to anyone who presents to a hospital, GP or community mental health service following a suicide attempt.

Start now

- Effective aftercare should be directly provided or the consumer referred to support.
- Effective aftercare should be provided before people are discharged or leave a service, with proactive follow-up support within the first day, week and three months of discharge.
- Aftercare should include culturally capable support.

9.3 Empowering Aboriginal and Torres Strait Islander people to prevent suicides

Aboriginal and Torres Strait Islander people are significantly more likely to die by suicide than non-Indigenous people and face unique risk factors (box 9.6). For example, Aboriginal and Torres Strait Islander youth (up to 24 years old) are up to 14 times more likely to die by suicide than other Australian youth (Dickson et al. 2019).

Box 9.6 Risk factors for suicide in Aboriginal and Torres Strait Islander communities

Suicide is believed to have been rare among Aboriginal and Torres Strait Islander people in pre-colonial times, but has become increasingly prevalent over recent decades. Research has identified risk factors that are disproportionately or exclusively experienced by Aboriginal and Torres Strait Islander people, including:

- lack of ‘cultural continuity’ — Indigenous self-determination over aspects of culture and community
- poor physical health and access to health services, family and relationship difficulties, stress associated with the death of family members, unemployment, homelessness, financial stress, violence and racism
- exposure to traumatic stressors and intergenerational trauma associated with cultural dislocation, and loss of identity and practices resulting from colonisation and the effects of the Stolen Generation
- alcohol use and Foetal Alcohol Spectrum Disorder — alcohol-attributable suicides were estimated to be 30% higher for Aboriginal and Torres Strait Islander males than for non-Indigenous males
- suicide ‘clustering’ — a series of suicides or self-harming acts that occur within a community over a period of weeks or months
- living in regional or remote areas where there are greater levels of social isolation and poorer access to services
- comparatively high rates of incarceration, although typically for relatively short periods of time
- a strong element of impulsivity to many suicide deaths.

Source: ATSIPEP (2016b); Dickson et al. (2019); Fogliani (2019); Thiririli Ltd, sub. 549; Pascal, Chikritzhs and Gray (2009).

Evidence indicates that suicide prevention interventions for Aboriginal and Torres Strait Islander people are most effective when the relevant Indigenous community is involved and has control over the intervention (ATSIPEP 2016a; Prince et al. 2018; WHO 2014a). For example, the Yarrabah community came together to respond to high rates of suicide through programs that empowered the community (box 9.7). In another example, Chandler and Lalonde (2008) found that Indigenous communities in Canada that exhibited many key markers of community control, such as control over health or education services, experienced significantly lower suicide rates.

Box 9.7 Suicide prevention in the Yarrabah community

In the 1980s and 1990s, the regional Aboriginal community of Yarrabah in far North Queensland experienced several waves of suicide. During the third wave in 1995, the community held a crisis meeting that included community Elders and service providers. The meeting recognised the historical and social determinants that lead to suicidal behaviour and identified a number of solutions to be implemented at the local level, such as closing the alcohol canteen. A key outcome of the meeting was the development of a feasibility study in 1997, which proposed a community-controlled primary healthcare service model as the best way to improve the health of the Yarrabah community. The feasibility study ultimately led to three important developments that were considered key to addressing the high number of suicides in the mid-1990s:

- Gurriny Yealamucka Health Service — one of the first community-controlled primary healthcare services in Queensland
- Family Wellbeing Project Partnership — a personal development course (developed by Aboriginal and Torres Strait Islander people) focusing on problem solving, conflict resolution and other life skills
- Yaba Bimbie Men's Group — a group that focuses on men's healing and restoring cultural pride, connection and responsibility.

These programs led to improved outcomes as they were led, controlled and empowered the local community, including:

- improved reflective skills, hope and confidence
- prevention and management of domestic conflict and more positive family relationships
- reduced levels of alcohol consumption and conflict.

Source: Healing Foundation (2018).

Over time, governments have recognised the need to develop a tailored approach to suicide prevention for Aboriginal and Torres Strait Islander people (box 9.8). In 2016, the Aboriginal and Torres Strait Islander Suicide Evaluation Project (ATSISPEP 2016a) evaluated what works for Aboriginal and Torres Strait Islander people. It made several recommendations to governments including:

- suicide prevention activity should be community-led
- the Australian Government should require Primary Health Networks (PHNs) to demonstrate cultural capabilities and standards, and include Indigenous representation
- a National Aboriginal and Torres Strait Islander Suicide Prevention Strategy Implementation Plan should be developed and funded
- Aboriginal Community Controlled Health Organisations (ACCHOs) should be preferred providers of suicide prevention programs for Aboriginal and Torres Strait Islander people.

Many submissions supported pursuing some or all of these recommendations,⁶⁸ but their implementation appears slow or non-existent.

**Box 9.8 Australia's evolving suicide prevention strategy for
Aboriginal and Torres Strait Islander people**

In 2010, the Senate Community Affairs References Committee (2010) undertook an inquiry into suicide in Australia. Given the significant impact of suicide on Indigenous communities, the inquiry recommended that the Australian Government develop a separate suicide prevention strategy for Indigenous communities.

In response, the Australian Government developed the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy in 2013 to complement the LIFE Framework (discussed in section 9.4) in acknowledgement of the disproportionately high rates of suicide and suicidal behaviour among Aboriginal and Torres Strait Islander people (DoHA 2013).

In 2016, the Australian Government funded the Aboriginal and Torres Strait Islander Suicide Evaluation Project to expand the evidence base for what works in Indigenous community-led suicide prevention and develop tools and resources to support suicide prevention activities (ATSISPEP 2016a).

In 2017, governments established the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee under the Fifth National Mental Health and Suicide Prevention Plan (COAG Health Council 2017a). This subcommittee was responsible for advising and supporting the inclusion of Aboriginal and Torres Strait Islander people in the National Suicide Prevention Implementation Strategy also under development (discussed in section 9.4).

In 2018, the second National Aboriginal and Torres Strait Islander Suicide Prevention Conference (2018) recommended revising the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and developing a related Implementation Plan, as well as allocating funding to Indigenous organisations to deliver component programs.

Australia is yet to revise its National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and develop an associated Implementation Plan (box 9.8). These actions are warranted given that relatively high rates of suicide persist in some Indigenous communities. The existing strategy was developed by the Australian Government. Further, a new strategy and plan should extend beyond the Australian Government and secure agreement from State and Territory Governments who are responsible for delivering some suicide prevention activities.

The Australian, State and Territory health ministers should develop a renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and associated Implementation Plan. This approach would mirror arrangements for the National Suicide Prevention Implementation Strategy under development (section 9.4).

⁶⁸ AHRC (sub. 491); AH&MRC (sub. 206); Healing Foundation (sub. 193); Jesuit Social Services (sub. 441); Mental Health Commission of New South Wales (sub. 486); Mission Australia (sub. 487); NACCHO (sub. 507); Northern Territory Mental Health Coalition (sub. 430); Orygen, The National Centre for Excellence in Youth Mental Health and headspace, National Youth Mental Health Foundation (sub. 204); Thirrili Ltd (sub. 549); VACSAL (sub. 225); WAAMH (sub. 416); WHV (sub. 318).

Some Inquiry participants expressed concern that PHNs are not adequately engaging with Indigenous communities.

The authors are also strongly concerned with the accountability of PHNs to the Aboriginal and Torres Strait Islander communities they serve ... There are 31 PHNs across the country. If the \$196 million allocated to them towards Aboriginal and Torres Strait Islander mental health and suicide prevention since 2015 (as discussed above) is averaged out, that means that each PHN has received \$6.32 million. But we are not clear how this money has been spent, on which organisations, by what processes and with what results. Further, PHN approaches to commissioning or otherwise establishing mental health services in rural and remote areas vary significantly throughout the networks. (NATSILMH, IAHA and AIPA, sub. 418, p. 10)

The national peak body for ACCHOs recommended that its agencies become the preferred providers of all mental health and social and emotional wellbeing programs for Aboriginal and Torres Strait Islander people, rather than PHNs, primarily because:

Some Primary Health Networks do not collaborate well with ACCHOs ... Funding of ACCHO mental health services through PHNs is unacceptable due to the imposition of inappropriate and unacceptable reporting requirements. PHNs also have discretion to allocate Aboriginal and Torres Strait Islander specific funds to non-community-controlled providers that are not necessarily culturally competent. (NACCHO, sub. 507, pp. 4–6)

The specific needs of consumers from particular communities or backgrounds are likely to be better met with services and supports that are sensitive to their experiences, culture and the specific issues they face (chapter 4). The Productivity Commission supports a greater role for Indigenous organisations in suicide prevention as they are often better placed to meet the needs of Aboriginal and Torres Strait Islander people.

This approach may not be feasible in all situations, such as areas where there is no appropriate Indigenous organisation. In these cases, there would still be a need for culturally appropriate suicide prevention activities and health workers in mainstream mental health services. One way to achieve this is to develop pathways for Aboriginal and Torres Strait Islander health workers to transition into mental health-related professions (chapter 16).

However, in many situations, capable Indigenous organisations exist and building their capacity would enable them to take on a suicide prevention role. For example, in its interim report, the Royal Commission into Victoria's Mental Health System (State of Victoria 2019) recommended that recurrent funding be provided to establish or expand the work of social and emotional wellbeing teams within ACCHOs across Victoria. The work of these teams includes, among other things, provision of after-hours support and outreach services to people at risk of suicide.

Indigenous organisations should be the preferred providers of local suicide prevention activities for Indigenous communities. For these activities, performance monitoring, reporting and evaluation requirements should be adapted to ensure they are consistent with the principles outlined in the Indigenous Evaluation Strategy that is being developed by the Productivity Commission, including that Aboriginal and Torres Strait Islander people, perspectives, priorities and knowledges are centred in the evaluation process (PC 2020).

ACTION 9.2 — EMPOWER INDIGENOUS COMMUNITIES TO PREVENT SUICIDE

Indigenous communities should be empowered to prevent suicide.

Start now

- The Australian, State and Territory Governments should support development of a renewed *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* and associated *Implementation Plan* to guide suicide prevention activities in Indigenous communities. The development of this strategy and its implementation plan should be led by Aboriginal and Torres Strait Islander people.
- Indigenous organisations should be the preferred providers of local suicide prevention activities for Aboriginal and Torres Strait Islander people.
- All organisations providing suicide prevention programs or activities in Indigenous communities should recognise the importance of building on existing capabilities within the Indigenous workforce.
- Performance monitoring, reporting and evaluation requirements for programs to prevent suicide among Aboriginal and Torres Strait Islander people should be adapted to ensure they are appropriate to the cultural context in which they are delivered and consistent with Indigenous evaluation principles.

9.4 Improving our approach to suicide prevention

Australia's early approach was not very effective

Australia was one of the first countries globally to take a national approach to suicide prevention, creating the National Youth Suicide Prevention Strategy in 1995 and expanding this into the National Suicide Prevention Strategy in 2000 (AHA 2014). In 2007, the Australian Government, in consultation with State and Territory Governments, developed the Living is For Everyone (LIFE) Framework — the strategic policy document that used an evidence-based approach to outline the key elements necessary for suicide prevention activities. In addition, State and Territory Governments have developed their own high-level suicide prevention frameworks and programs.

However, there have been issues with Australia's approach. For example, the LIFE Framework lacks clear governance arrangements outlining who is responsible for suicide prevention, accountability measures and formal mechanisms for different levels and portfolios of government and the community to work together. Further, the Australian Government Department of Health took a top-down approach to funding suicide prevention activities across the country through ad hoc grant rounds (AHA 2014). This process was not well coordinated with State and Territory Governments. As such, there has been scope for Australia to improve its approach to suicide prevention.

Australia's post-2015 move to a 'systems approach' holds promise

Mounting international evidence indicates that a *systems (or multi-component) approach* to suicide prevention is likely to be a more effective means of reducing suicide rates. A 2014 review by the NMHC (2014d, p. 116) said:

It is now time for a new strategy to be rolled out on a regional basis so that programmes reflect the needs of local communities instead of a one-size-fits-all approach to preventing suicide.

The Black Dog Institute estimated that a systems approach could prevent 20% of suicide deaths and 30% of suicide attempts (box 9.9).

A systems approach devolves decision making to the local community to develop tailored approaches for implementing multiple suicide prevention activities at the same time. For example, a community may consider it most effective to fund a combination of aftercare, school-based awareness programs and bereavement support in their region, given the needs of their area. Growing evidence indicates that a systems approach to suicide prevention can be particularly effective (van der Feltz-Cornelis et al. 2011; Kryszynska et al. 2016; Zalsman et al. 2016) (box 9.9). Several Inquiry participants favoured a systems approach to preventing suicide (Connect Health & Community, sub. 94; ConNetica Consulting, sub. 450; Jesuit Social Services, sub. 441).

A systems approach may be an effective way to prevent suicide given the many factors that contribute to suicide (section 9.2). Multiple strategies implemented at the same time are likely to work synergistically, generating bigger effects than the sum of each individual part. It may also promote collaboration across sectors, such as between hospital and community services (NMHC 2014d, p. 117).

In 2015, the Australian Government began moving towards a systems approach for suicide prevention by devolving responsibility for planning and funding local suicide prevention activities (ConNetica Consulting, sub. 450). The Australian Government now provides a flexible funding pool to PHNs to develop and implement suicide prevention activities in their region. PHNs are responsible for leading suicide prevention activities in partnership with Local Hospital Networks (LHNs) and other local organisations. At the same time, the Australian Government retained its role of funding national leadership and population-level suicide prevention activities, such as national communication strategies.

In 2017, all governments committed to supporting PHNs and LHNs in following a systems approach under the Fifth Plan. Since then, PHNs and LHNs have been developing joint regional plans for mental health and suicide prevention services and are required to publicly release these plans by mid-2020 (Integrated Regional Planning Working Group 2018).

Box 9.9 Examples of a systems approach to suicide prevention

International experience of a systems approach

The U.S. Air Force developed the Air Force Suicide-Prevention Program in 1996. This program implemented an integrated approach based on 11 interventions, such as training for commanders, education to reduce stigma and a suicide event surveillance system. An evaluation found a 33% reduction in suicide risk in the six years after the program was implemented, relative to the six years prior (Knox et al. 2003). The study also found significant reductions in homicide (51%) and in severe family violence (54%).

The European Alliance Against Depression was implemented in many European countries in 2004. This model involved four interventions: training for frontline workers; improved screening and treatment in primary and mental healthcare; targeted support of high-risk groups; and increasing community awareness about depression. Studies showed a 24% reduction in suicide attempts and deaths sustained two years post-intervention and significant reductions in the suicide rate over time (Baker et al. 2018).

A UK study examined the effect of nine components of mental health service reform on suicide outcomes of people in contact with mental health services (While et al. 2012). These components included reducing access to lethal means of suicide, assertive outreach, 24-hour crisis teams and training of front-line staff. The study found that areas that implemented at least seven components were associated with a significant reduction in suicide rates, compared with areas that implemented fewer strategies.

Australian trials of systems approaches

In Australia, 30 trials are being run that generally use a systems approach to suicide prevention (Black Dog Institute 2019). Many of these trials were established independently of each other.

5 LifeSpan trials — LifeSpan was developed by the Black Dog Institute and the National Health and Medical Research Council. The approach involves using up to nine evidence-based strategies operating simultaneously in a community, such as follow-up care for suicidal crisis, promoting help-seeking in schools and training the community to recognise and respond to suicidality. The Black Dog Institute estimated that a systems approach, such as LifeSpan, could prevent 20% of suicide deaths and 30% of suicide attempts (Ridani et al. 2016). LifeSpan is currently being trialled in four sites in New South Wales and one site in the ACT. An evaluation is expected to be completed by 2021 (Black Dog Institute, pers. comm., 26 September 2019).

12 National Suicide Prevention Trials — The Australian Government has funded 12 trials led by select Primary Health Networks (PHNs). Many of these trials have used or adapted the LifeSpan approach, while others have used similar approaches from overseas, including the European Alliance Against Depression. For example, Brisbane North PHN has implemented aftercare programs for Indigenous and LGBTIQ communities, delivered training for health practitioners and produced resources to develop the lived experience workforce. Evaluations are expected to be completed by the end of 2020 (University of Melbourne, pers. comm., 3 July 2019).

12 Victorian place-based trials — The Victorian Government has funded and partnered with PHNs to deliver 12 trials, which have typically used or adapted the LifeSpan approach. Evaluation of these trials is expected to be completed in 2021 (Victorian Government, pers. comm., 25 September 2019).

1 Queensland place-based pilot — The Queensland Mental Health Commission (2019b) and Western Queensland PHN have collaborated to deliver a suicide prevention pilot in the Maranoa.

The Australian, State and Territory Governments are trialling a systems approach to suicide prevention to support their wider use. Currently, there are 30 local suicide prevention trials that generally follow a systems approach in Australia (box 9.9). These trials are funded through PHNs, State and Territory Governments or charities. However, implementation of these trials has been slow and uncoordinated. And so far no evaluations have been completed to assess the trials' effectiveness at reducing suicide rates. Most evaluations are expected to be completed in 2020 or 2021.

Evaluations of local trials will be key to determining if the systems approach is effective in Australia. Once the majority of trial evaluations have been completed, the NMHC, in its new role as the national body for mental health and suicide prevention evaluation (chapters 22 and 24), will need to assess if these evaluations provide adequate evidence that a systems approach is likely to be successful at reducing suicide rates. The NMHC (sub. 949, p. 29) suggested that work on an evaluation framework need not wait until the trials are complete but should be undertaken as a priority to support a meta-analysis across all trial sites. All stakeholders involved in the suicide prevention trials should collaborate with the NMHC to develop the evaluation framework as a priority.

Setting up the new approach for success

The Australian Government's approach of devolving responsibility for most suicide prevention activities holds promise. But this process has been slow and it is still too early to tell if it will ultimately be effective at reducing suicide rates.

Regardless, some longstanding issues remain, such as a lack of clear responsibilities within and across governments, poor accountability mechanisms and a dearth of rigorous evaluations. Without resolving these issues, Australia's approach to suicide prevention is at risk of repeating past mistakes.

Clarifying responsibilities to coordinate activities

Even as governments devolve some of their responsibilities for suicide prevention, it remains unclear who is responsible for funding and delivering different activities. Undefined responsibilities have led different levels of government to work in isolation, delivering various programs in an uncoordinated and ad hoc way. This can lead to inconsistency and gaps in services in some areas and duplication of similar services in others.

Victoria is an example where a lack of clear responsibilities has led to duplication of similar services. The Victorian Government has funded some hospitals to trial the Hospital Outreach Post-suicidal Engagement initiative, which generally provides clinical follow up support for people who have attempted suicide (VIC DHHS 2019d). However, the Australian Government has also announced that it will increase coverage of The Way Back Support Service across Australia to deliver non-clinical support for people who have attempted

suicide (DoH, sub. 556). Ideally, these services would be planned and delivered in a coordinated way to avoid potentially costly duplication.

There are other examples of shortcomings. Many of the 30 regions trialling a systems approach to suicide prevention have been implemented separately from one another (box 9.9) making it difficult to compare experiences on a consistent basis. And Lifeline Australia (sub. 87) is concerned that PHNs are not required to fund suicide bereavement programs consistently, creating gaps in coverage.

Clarifying responsibilities for suicide prevention will require agreement and buy-in from different levels of government. This can be achieved using the framework outlined in this report to clarify responsibilities for funding and delivering mental health services more broadly. This Inquiry has recommended that the Australian, State and Territory Governments should develop a National Mental Health and Suicide Prevention Agreement between the Australian, State and Territory Governments that includes (among other things) precise detail about the responsibility of each tier of government to fund and deliver mental health services and suicide prevention activities (action 23.3).

The agreed set of responsibilities should be published clearly in the Agreement, balance flexibility and consistency in service provision across Australia, and be informed through consultation with the community, peak bodies, suicide experts and people with lived experience of suicide. Some underlying principles should guide allocation of responsibilities.

- A systems approach requires local communities to identify, plan and deliver the optimal mix of suicide prevention activities for their area. As such, commissioning agencies (PHNs, LHNs or Regional Commissioning Authorities (chapter 23)) in conjunction with local governments and non-government organisations are best placed to deliver local activities.
- The Australian Government should be responsible for national leadership and coordination across all suicide prevention activities.
- The Australian Government should be responsible for suicide prevention activities that are directed at the entire population and are more efficiently delivered at scale in a consistent way, such as national awareness campaigns, refining media guidelines, maintaining crisis telephone lines and coordinating nationally consistent data reporting.
- Some suicide prevention activities require coordination and co-operation between multiple parties. For example, providing aftercare to people admitted to hospital after attempting suicide will require hospitals and community mental health services to work together to plan for discharge and follow-up support in the community. These activities will need clear boundaries where care provided by one party ends and the other begins.

Responsibilities detailed in the recommended National Mental Health and Suicide Prevention Agreement (action 23.3) should be informed by, and consistent with, the *National Suicide Prevention Implementation Strategy* (the Strategy) under development. The Strategy will provide the high-level strategic direction for suicide prevention activities for governments and non-government organisations. It will focus health sector initiatives on a

number of priority actions, such as increasing access to mental health services and providing effective aftercare following a suicide attempt. The Agreement should also be consistent with a renewed *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and Implementation Plan* (section 9.3).

In addition to clarifying responsibilities between governments, there is also a need to clarify responsibilities *within* governments. Suicide prevention needs a whole-of-government approach that integrates a range of policies across multiple portfolios.

Some of the most challenging policy choices faced by government are those that cross the traditional boundaries between Cabinet ministers' portfolios and between the Commonwealth, State and Territory levels of government ... [T]asks that run well beyond the remits of individual ministers ... are whole-of-government problems and their resolution requires a long-term strategic focus, a willingness to develop policy through consultation with the community and a bias towards flexible delivery that meets local needs and conditions. (Howard 2002)

There is broad agreement regarding the need for a whole-of-government approach to suicide prevention. While the health sector has taken a leadership role in suicide prevention, other government portfolios have important roles to play within their direct scope of influence (Suicide Prevention Australia, sub. 523).

The Australian Government has appointed a National Suicide Prevention Adviser to the Prime Minister to drive a whole-of-government approach to suicide prevention (DoH, sub. 556, p. 4). By the end of 2020, the Adviser is expected to provide its final advice for practical recommendations to improve suicide prevention, including implementing a shift to a whole-of-government approach to suicide prevention. The Adviser's initial report discussed some of the challenges:

While Commonwealth and State policies have suggested that a range of approaches are funded and delivered, the policy has generally been focussed on responding to suicidal behaviour and developed through a health focus. There is a need to broaden the approach and harness opportunities across portfolios to address the factors contributing to distress. (National Suicide Prevention Adviser 2020, p. 17)

Following this initial advice, the Australian Government committed \$64 million for suicide prevention and mental health initiatives in January 2020 (Hunt 2020a). This included funding to expand aftercare and postvention services, as well as extending the National Suicide Prevention Trial sites for a further year and enhancing their evaluations.

There are several key changes required to realise a whole-of-government approach to suicide prevention. This Inquiry recommends that the Australian, State and Territory Governments should develop a new National Mental Health Strategy that covers the roles played by health and non-health portfolios in improving mental health outcomes across the population (action 22.1). Among other things, Australian, State and Territory Governments should commit to a Special Purpose Mental Health Council comprised of health and non-health Ministers to facilitate a whole-of-government approach to suicide prevention. Partnering

portfolios should be required to adequately fund their contributions to the work plan of the Special Purpose Mental Health Council (action 22.3).

Performance monitoring and reporting

Performance monitoring and reporting are essential to informing and improving policymaking and service delivery.

The performance of *governments* in contributing to suicide prevention efforts should be monitored. Currently, Australia has a basic performance monitoring framework for suicide prevention — the Fifth Plan lists four indicators specifically related to suicide prevention (presented in black in table 9.3). The NMHC currently reports on the progress of indicators detailed in the Fifth Plan.

However, this framework is little used in practice for several reasons. First, two of the four indicators have been under development since the Fifth Plan was released in 2017. Second, the indicator measuring post-discharge community care does not distinguish between people in suicidal distress or anyone else admitted to a mental health unit, and is thus too broad to be a meaningful measure of suicide prevention activities. Finally, the indicator measuring suicide rates does not include information about rates of suicide attempts or suicide ideation.

This Inquiry has recommended that the NMHC monitor and report on the performance of governments in meeting system-level outcomes for mental health and suicide prevention, as well as the performance of service providers (chapter 24). There is scope for the NMHC to improve the use of the existing suicide prevention performance framework by including additional indicators to measure performance of suicide prevention activities. This will require the NMHC to consult with Australian, State and Territory Governments to fill data gaps.

The NMHC should monitor and report five additional indicators that measure the rate of suicide attempts and suicide ideation (presented in blue in table 9.3). In Australia, data recording suicide deaths are relatively well reported, but data recording suicide attempts and ideation are incomplete. Efforts are underway to improve data use and availability, but improvements to reporting will rely on collaboration across governments and portfolios (box 9.10).

The performance of suicide prevention services should also be monitored. But existing performance frameworks for service delivery tend to lack measures related to suicide prevention. For example, the Australian Government Department of Health's (2018b) performance framework for PHNs includes just one indicator related to suicide prevention. The NMHC should also collect and report performance indicators at the service level (table 9.3). In particular, there is a need for the NMHC to develop a consistent monitoring and reporting mechanism for State and Territory Government expenditure on suicide prevention activity. Other measures can also be used to indicate the level of suicide ideation among service users and stigma or literacy across service providers (NHMRC Centre for Research Excellence in Suicide Prevention and Black Dog Institute 2015). These indicators

can measure how effective service providers are at identifying and responding to suicidal thoughts and behaviours, and guide the flow of resources to those service providers that are more likely to interact with individuals in distress.

Table 9.3 Existing and potential suicide prevention indicators^a

<i>Indicator</i>	<i>What does this measure?</i>	<i>Data source</i>	<i>Availability</i>
System-level outcomes indicators			
Rates of suicide	The number of suicides per 100 000 Australians	ABS Causes of Death	Available
Rates of suicide attempts	The number of suicide attempts per 100 000 Australians	AIHW Injury due to self-harm	Partial measure
Rates of suicide ideation	The number of people reporting suicide ideation per 100 000 Australians	ABS National Survey of Mental Health and Wellbeing	Available (decade-long intervals)
Service-level performance indicators			
Suicide of persons in inpatient mental health units	The number of suicides that occur in admitted patient specialised mental health services	State and Territory hospital data	Requires development
Rates of follow-up after suicide attempt/self-harm	Proportion of presentations to hospital for which there was a follow-up in the community within an appropriate period	Data linkage of State and Territory clinical mental health and patient administration systems	Requires development
Post-discharge community care	Proportion of discharges from an acute admitted specialised mental health unit for which there was a follow-up by a community mental health service within 7 days	State and Territory clinical mental health data systems	Available
Rates of suicide ideation in patients presenting to services	Level of suicidal ideation or behaviour experienced by patients presenting to services, before and after support	Suicidal Ideation Attributes Scale; Suicidal Behaviours Questionnaire-Revised	Requires development
Suicide stigma and literacy	Level of suicide-related stigma and literacy of service staff and the community, and proportion of service staff trained	Literacy of Suicide Scale; Stigma of Suicide Scale; Service admin data	Requires development
Expenditure on suicide prevention activities	Total expenditure on suicide prevention activities defined in a consistent way	State and Territory Governments	Requires development

^a Black text denotes existing indicators. Blue text denotes potential additional indicators.

Source: COAG Health Council (2017a); NHMRC Centre for Research Excellence in Suicide Prevention and Black Dog Institute (2015); NMHC (2018a).

Box 9.10 Improvements to suicide data collection

In Australia, data recording suicide deaths are reasonably well reported, but tend to lack more contextual information about individual characteristics, such as health and mental health experiences, employment and family circumstances. Data recording suicide attempts is much less reliable, in part due to the difficulty of accurately recording attempts. For example, some hospital presentations may not result in an admission and some may not visit a hospital or any other government service (Turning Point 2019). Further, data recording the prevalence of suicide ideation generally relies on ad hoc surveys, such as the National Survey of Mental Health and Wellbeing. Several Inquiry participants acknowledged some of these data gaps (AIHW, sub. 370; DLGSC, sub. 78; National LGBTI Health Alliance, sub. 494; Orygen, The National Centre for Excellence in Youth Mental Health and headspace, National Youth Mental Health Foundation, sub. 204).

However, there are efforts underway to improve data collection. Some State and Territory Governments have (or are considering implementing) suicide registers that report more comprehensive suicide death data. Further, in 2019, the Australian Government tasked the Australian Institute of Health and Welfare to establish a new collection of data reporting suicide deaths and attempts (DoH, sub. 556). This new collection is intended to link up State and Territory Government data for suicide and self-harm, provide near real-time monitoring capabilities, improve reporting of suicide attempts (by for example reporting ambulance callouts related to suicidal distress), and use data linkages to analyse contextual information about individual characteristics. These improvements to data collection show promise, but will require collaboration across government portfolios to report relevant information, for example police interactions.

Promoting better use of evaluations

A lack of outcomes-based evaluations was a clear failing of Australia's previous approach to suicide prevention. This was particularly relevant for Indigenous suicide prevention activities (ATSISPEP 2016a; Clifford, Doran and Tsey 2013). In 2014, the Australian Government Department of Health evaluated its suicide prevention activities from 2006 to 2013. The results were stark. The evaluation found that it was not possible to assess the effectiveness of its suicide prevention activities because *programs did not measure outcomes*.

Assessing the effectiveness of [National Suicide Prevention Program (NSPP)] activities was hampered by a general absence of quantifiable outcome measurement by NSPP-funded organisations ... Outcome measurement involving validated tools has been rare among NSPP-funded activities. Even in cases where independent external evaluations had been undertaken, most reported on the achievement of project objectives rather than on short, medium or long-term outcomes ... Although significant achievements have been identified, it should be noted that it is not possible to determine the extent to which the NSPP-funded activities have impacted on rates of suicide. (AHA 2014, pp. 10–11)

Several Inquiry participants recognised the need for proper independent and rigorous outcome evaluations of the effectiveness of suicide prevention activities.⁶⁹ Some also recognised the need to develop Indigenous-specific outcomes measures for evaluations of Indigenous-focused suicide prevention programs (CATSINaM, sub. 75; Northern Territory Mental Health Coalition, sub. 430).

There needs to be a shift in suicide prevention research from descriptive studies towards evaluating programs and establishing a knowledge base about effective interventions.

In the eight years, 2010 to 2017, a total of 36 grants and fellowships were awarded where suicide was the primary focus. These totalled \$10.7 million or just over \$1.3 million per year. The number of grants and fellowships had almost doubled when compared with the 8-year period, 1999–2006. However, the focus of the research tends to remain on descriptive epidemiological studies (34% over 2010–17 compared to 22% over 1999–2006). Significantly less attention has been given to evaluating the efficacy of interventions in 2010–17 (30%) compared with the previous period (52%). (ConNetica Consulting sub. 450, p. 17).

Well-designed evaluations are essential for generating evidence about what works, for whom and in what circumstances, and this Inquiry has recommended that the NMHC lead and coordinate a national approach to evaluation in mental health and suicide prevention (chapters 22 and 24). Australia has the potential to become a world leader in suicide prevention research if our mechanisms for adequately evaluating programs can be improved.

⁶⁹ Anthony Jorm (sub. 45); ConNetica Consulting (sub. 450); Mental Health Commission of New South Wales (sub. 486); Paul Vittles (sub. 262); RANZCP (sub. 385); RRMH (sub. 97); Suicide Prevention Australia (sub. 523); Western Australian Mental Health Commission (sub. 259); yourtown (sub. 511).

ACTION 9.3 — APPROACH TO SUICIDE PREVENTION

Australia's approach to suicide prevention holds promise, but there are opportunities for improvement. Governments should make changes to ensure a cross-portfolio approach to suicide prevention in Australia.

Start now

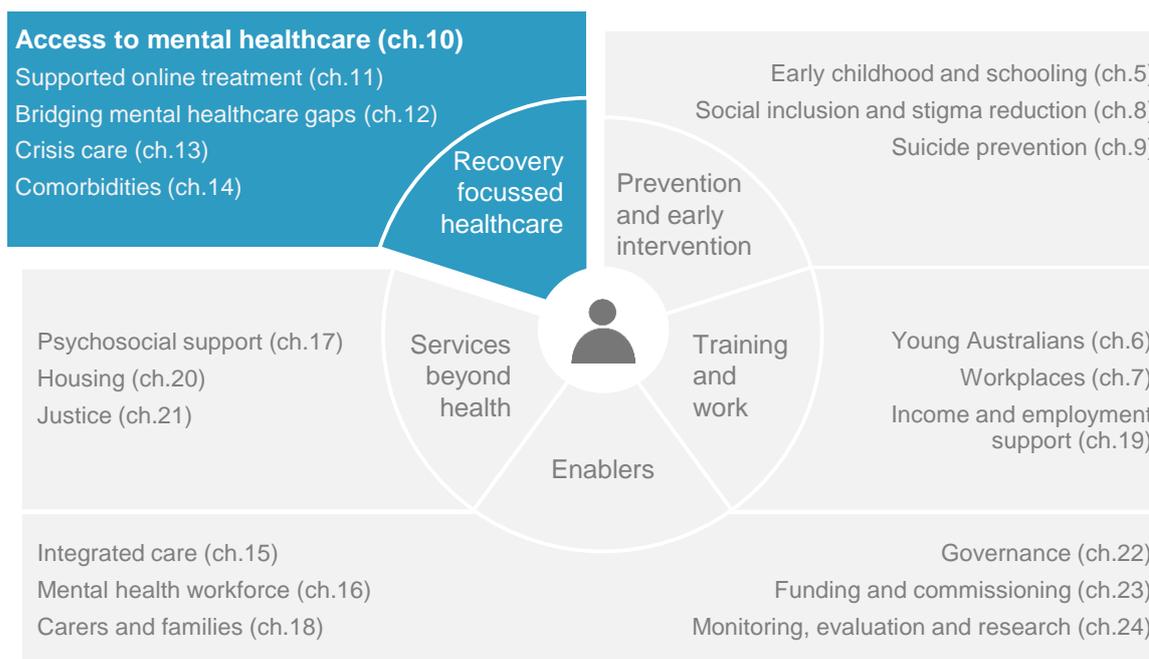
- The recommended National Mental Health and Suicide Prevention Agreement (Action 23.3) should identify responsibilities for suicide prevention activities across different levels of government and across portfolios to create a truly whole-of-government approach to suicide prevention. Responsibilities should be informed by, and consistent with, the *National Suicide Prevention Implementation Strategy* under development.
- The *National Suicide Prevention Implementation Strategy* should be extended to include strategic direction for non-health government portfolios that have influence over suicide prevention activities.

Start later

- The National Mental Health Commission should assess the results of the trials of a 'systems approach' to suicide prevention that are currently underway. It should consider whether they are likely to be successful at reducing suicide rates and behaviours in Australia. If this is found to be the case, a systems approach to suicide prevention should be implemented across all Australian regions.

PART III – RE-ORIENTING HEALTHCARE

10 Informed access to mental healthcare



Why access to healthcare needs reform ...

- People with mental illness are rarely offered the full range of service options and supported to choose between them.
- People are too often prescribed medication as a first-line treatment, without being informed of the side effects or being offered other non-pharmaceutical treatment options.
- Mental health assessments should encompass all dimensions of a person and their environment and not simply reflect the symptoms being presented to the clinician. Access to such holistic mental health assessments is patchy at best.

RECOMMENDATION 10 — INCREASE INFORMED ACCESS TO MENTAL HEALTHCARE SERVICES

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

As a priority:

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

Additional reforms that should be considered:

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

Disadvantaged people like me, who have been caught up in the mental health system for years, want to be able to have the freedom of choice to access what services we need. We are the experts. (Consumer quoted by Karen Hancock sub. 379, p. 3)

10.1 Person-centred gateways to mental healthcare

When people recognise they are becoming mentally unwell, there are a variety of gateways through which they typically seek help. Many are non-health gateways (such as workplace counselling services, churches or social groups), but most people eventually present to a health service of some kind. Gateways into mental health services include online resources, and health services in the community such as GPs, Aboriginal Medical Services, headspace centres and other services commissioned by Primary Health Networks (PHNs). People experiencing an acute mental health episode may go straight to a hospital emergency department (chapter 13).

As entry points into mental healthcare, these gateways will only be ‘person-centred’ — delivering improved outcomes for the people for whom the services exist — if they:

- are readily accessible (in a culturally appropriate form) as and when people need help (noting that this may mean providing people with a choice of gateways, including a self-referral path)
- are affordable (noting the broader community-wide benefits of ensuring people receive early treatment for mental ill-health)
- empower people to make informed choices between a range of service and provider options
- are connected to services that people value, with the assessment of a consumer’s needs (and the services that are recommended as most likely to meet those needs) independent of the gateway to care that the consumer has chosen.

The importance of choice

A key facet underlying each of these aspects of person-centred care is *consumer choice*. Numerous consumers, clinicians, and organisations have stressed to us the importance of consumer choice (for example, ARCAP, sub. 337, p. 6; CHF, sub. 496, p. 5; Mental Health Commission of New South Wales, sub. 948. pp. 4, 15; Psychotherapy and Counselling Federation of Australia, sub. 883, p. 16; Queensland University of Technology, sub. 826, p. 1; Wellways Australia, sub. 396, p. 7). The Victorian Mental Illness Awareness Council — a peak body run by and for consumers — told us that their work is premised on six beliefs.

- People’s experiences are respected and valued.
- People are experts in their own lives.
- People have a right to self-determination.

-
- People have capacity to make genuine choices, free from coercion.
 - People should be safe, respected, valued and informed.
 - People’s diversity is embraced (sub. 844, p. 2).

The importance of choice to consumers is not news to governments. The ACT Government told us that:

Mental health consumers have for a long time been advocating for their right to be able to make decisions regarding their health care, with support if necessary, according to their recovery goals. (sub. 1241, p. 3)

In its 2014 review, the National Mental Health Commission highlighted ‘limited choice’ as a key problem in the mental health system, and argued that the system should be aiming for ‘enhanced choice of providers’ (NMHC 2014b, pp. 8–9) — a goal that the Australian Government endorsed in its response (DoH 2015a, p. 7). And indeed, the right to choice is held up as a guiding principle for mental health systems, such as in the Victorian *Mental Health Act 2014*, which states that:

Persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected. (Victorian Government 2019, p. 11)

But consumer choice is still too often an aspiration rather than a reality.

People with mental ill-health should be able to choose among a variety of care options and providers. Choice is crucial, because the acceptability of a service to the consumer, and their willingness to engage with treatment, are key drivers of outcomes (Lindhiem et al. 2014). For example, in the context of psychological therapy, choice can help ‘promote a strong therapeutic alliance’ between the consumer and the psychological therapist (MBS Review Mental Health Reference Group 2018, p. 22) — a key ingredient in effective psychological therapy (Lambert 2013). Consumers who can make informed choices between care options and providers are more likely to find one that matches both their needs and preferences. Choice can even drive service improvements under certain circumstances (PC 2017c, p. 317).

There can be practical limitations on the choices available to people. For example, people in regional and remote areas have fewer local providers to choose between — there are many more psychiatrists and psychologists in the major cities than in regional and remote areas (chapter 16).

But choice is valuable even when it is limited. And we have proposed changes to increase the options available to people across Australia, including the establishment of a national digital mental health platform — to make low-intensity digital treatment options more widely available (section 10.4) — and the expansion of telehealth for psychological therapy and psychiatry (chapter 12).

Currently, gateways to mental healthcare are unclear and do little to inform and support consumers to choose among the range of available treatment and support options.

This chapter details how gateways to mental healthcare are not currently working as well as they should for consumers, with a focus on GPs and PHN-commissioned services. We recommend changes to empower consumers to choose the services that are ‘right for them’ (section 10.2). We also recommend the establishment of an online gateway — the national digital mental health platform — incorporating a new person-centred assessment and referral tool, which could be used across primary care gateways (section 10.4). The current online gateway is discussed in more detail in chapter 15. Chapter 13 discusses ways to improve the emergency department gateway for people with mental ill-health.

10.2 Improving the GP gateway for consumers

GPs are the ‘first port of call’ for many people when they begin to experience symptoms of mental ill-health. We estimate that in 2018-19 *at least* 5 million people (or 1 in 5 Australians) had a consultation with their GP about their mental health. About 1 in 8 GP consultations relates to a mental health problem, equating to about 20 million consultations a year.⁷⁰

GPs are generally a relatively accessible gateway to mental healthcare. For most people, neither location nor money are a barrier to accessing a GP. In 2017-18, nine out of ten people saw one of the 27 000 GPs in Australia (AIHW 2019h; DoH 2020l), although consumer access to GPs is generally more limited in rural and remote areas (chapter 16). Few GP consultations (about 15%) involve a co-payment, though about a third of people sometimes pay to see a GP (DoH 2020f, table 1.1; Productivity Commission estimate using Senate Community Affairs Committee 2019). In 2018-19, the average co-payment was about \$40 (DoH 2020f, table 1.1).

Additionally, GPs are widely trusted. Australians rate GPs as the fourth most ethical occupation, after ambulance services, nurses and fire services (Governance Institute of Australia 2019, p. 35).

GPs have a central role in the mental health system in assessing people’s mental health (and associated comorbid conditions) and, where relevant, providing an initial diagnosis about a mental illness. Accurate diagnosis and treatment can mitigate the risk of developing more severe and persistent illness. But inaccurate diagnosis can exacerbate mental health problems.

The skills and cultural capability of clinicians to listen to an individual’s story, and to draw on contextual information about the individual, is critical. Families, kinship groups and carers, for example, often hold a lifetime of information that would support recovery, which may be underutilised currently (chapter 18).

⁷⁰ Productivity Commission estimates using AIHW (2020j, table PBS.3, 2020h, table GP.4), Britt et al. (2016, p. 19), and DoH (2020f, table 2).

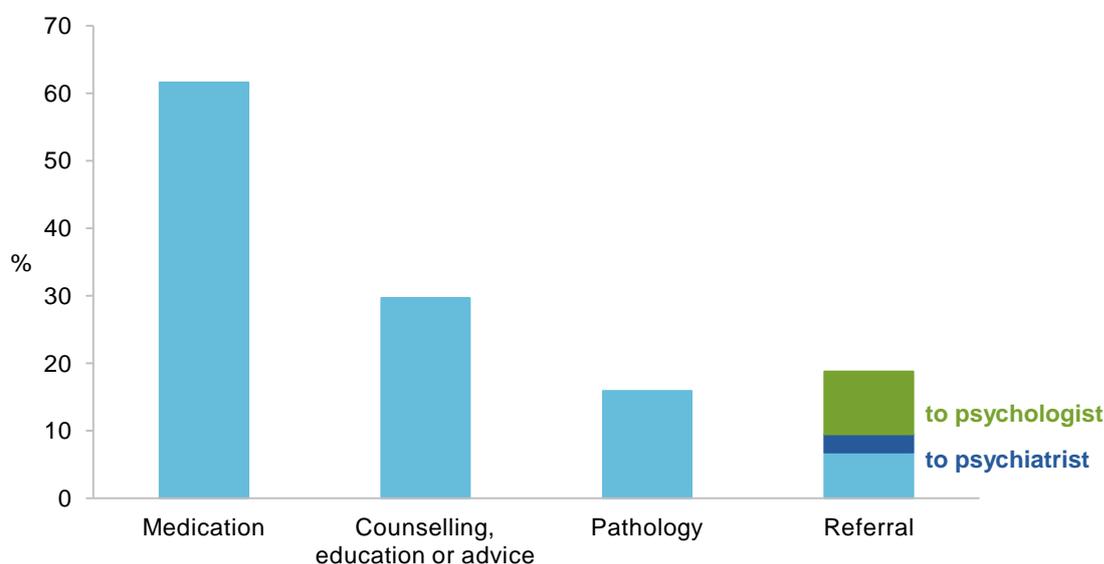
Once an individual's needs have been assessed, GPs have a role in either providing them with mental healthcare, or helping connect them with specialist mental health services or non-clinical supports in the community. Of people presenting to a GP with mental ill-health:

- 6 in 10 are prescribed medication
- 3 in 10 receive some counselling, education or advice from the GP
- 2 in 10 receive a referral, with about half of these referred to a psychologist, and 10–20% referred to a psychiatrist (figure 10.1).

Of those referred to mental health-specific services, only a handful are referred for low-intensity services (chapter 12). In 2016-17, for example, GPs were more than 20 times as likely to refer to a psychologist than to a support group (AIHW 2020h, table GP.4). Referrals to community support services may help improve social participation, among other benefits (chapter 8). Consumers do not benefit from being referred for more intensive care than they need (chapter 12). As well as recommending the provision of more low-intensity services (noted above), we are proposing a new assessment tool to encourage referrals to low-intensity services where appropriate — while promoting consumer choice and maintaining clinician autonomy (section 10.4).

Figure 10.1 GP management of mental ill-health

% of consumers presenting with mental ill-health receiving, 2016-17^a



^a Other referral destinations include sleep clinics (1.1%), paediatricians (0.8%), and patient support groups (0.4%).

Source: Productivity Commission estimates using AIHW (2020h, table GP.4).

As well as being a key gateway to other mental health services, GPs are themselves key providers of mental health services. More people receive mental health treatment (usually medication rather than psychological therapy) from their GP than from psychologists and

psychiatrists combined. This central role is even more important in rural areas, where there are fewer mental health clinicians — such as psychiatrists and psychological therapists (chapter 12, chapter 16) — to provide mental health services. The Australian Medical Association told us that:

Around 80% of all community-based mental health care in Australia is provided by GPs. In rural areas this number rises to 95%. (AMA, sub. 387, p. 14)

People with mental ill-health receive a range of treatments from GPs. As noted, GPs provide counselling, education or advice to about 3 in 10 people presenting with mental ill-health (figure 10.1). This includes teaching people simple techniques (such as relaxation and breathing exercises for anxiety), or providing information about how lifestyle changes can improve mental health (such as improved diet or more exercise). GPs also provide pregnancy support counselling (about 23 000 sessions in 2019) and family group therapy (about 9 000 sessions). And about 4% of GPs have done the training necessary to provide psychological therapy under the Better Access program — about 28 000 sessions of which were provided in 2019 (Productivity Commission estimates using DoH 2020l; Services Australia 2020a; GPMHSC, sub. 395, p. 6). GPs also — most commonly and too often — treat with medication (discussed below).

GPs also have an important role in managing and coordinating a consumer's mental and physical healthcare (chapter 15).

Consumers are mostly happy with the quality of mental healthcare provided by their GP. Roughly 4 out of 5 people with mental illness say that the service they receive from their GP is excellent or very good (NSW BHI 2019, p. 33).

However, most GPs have received limited training specific to mental health, and some GPs lack the knowledge and skills to provide the best possible care to people with mental ill-health. GPs could also be assisted in this front line role by more training in non-pharmacological interventions, managing the side effects of mental health medications, and recognising the importance of personal recovery (in addition to clinical improvement) (chapter 16).

The GP gateway could also be improved by ensuring that GPs support people with mental ill-health to choose the treatment option and service provider that are right for them. Currently, too many people who go to their GP for help with their mental health are being prescribed medication, or referred to a psychological therapist, without being given the opportunity to consider the full range of treatment and support options for their condition.

GPs should do more to support consumer choice

Person-centred referral means that, following assessment, the GP would advise the consumer of possible treatment options, and different providers, discuss these options with them and assist in helping them to decide which option is most suited to their needs.

Current Medicare Benefits Schedule (MBS) rules allow people to choose between providers whenever they are given a referral. For example, an individual can take a referral specifying one psychologist (named in the referral) to a different psychologist of their choosing. But many GPs and other clinicians who write or receive referrals do not know this (NT PHN, sub. 1213, p 7). And even fewer consumers understand this right when they are given a referral, or their right to go to a second, different psychological therapist with the same referral.

The Productivity Commission has previously made a suite of recommendations aimed at increasing consumer choice among private health providers, which the Australian Government has not implemented at this time (PC 2017c). These recommendations aimed to clarify — for both clinicians and consumers — the consumer’s right to choose their provider. For example, we recommended that all referrals to specialists and allied health professionals, and requests for pathology and radiology services, should include a prominent and easy to understand statement advising patients that they can use an alternative to any provide mentioned in the referral or request. We still support these recommendations being implemented across the health system. These recommendations — which we also proposed in our draft report in this Inquiry — were supported by a range of participants to this Inquiry.⁷¹

But these recommended changes are only part of the solution. Consumers need to be supported to choose the provider (and the services) that are right for them. As the ACT Government (sub. 1241, p. 19) put it: ‘knowing you can choose another provider may not assist you unless you have knowledge of how, and or support, to make that decision’.

GPs have two roles to play in facilitating choice.

- First, the GP should advise the consumer of the full range of possible treatment options. This requires that the GP knows (or can easily get information) about the relevant treatment options, including information about treatment efficacy, possible side effects, waiting times, and out-of-pocket costs.
- Second, the GP should support the consumer to choose the treatment option that is best for them.

At present, many GPs are falling short in performing these roles. Partly, this is because it is difficult for GPs to stay across the full range of mental health treatment options available to people in their area — not surprising, given that GPs often see dozens of patients in a day, presenting with a wide variety of (mostly physical) health problems.

For GPs to provide more complete information to consumers about the full range of services (including non-clinical support services) available in their area, this information needs to be made more accessible. The HealthPathways infrastructure is set up to do this, but HealthPathways is currently focused on clinical services and is not kept up to date.

⁷¹ This included the Australian Nursing and Midwifery Federation (sub. 1187, p. 19), Australian Psychological Society (sub. 853, p. 9), Consumers Health Forum of Australia (sub. 646, p. 5), PHN Cooperative (sub. 850, p. 23), Psychotherapy and Counselling Federation of Australia (sub. 883, p. 16), QUT Faculty of Health (sub. 826, p. 1), Stephanie Roth (sub. 841, p. 17), and Uniting Vic.Tas (sub. 931, p. 11).

Chapter 15 discusses ways in which information about mental health services, including information to assist GPs in making referrals, can be improved and made more accessible.

GPs, unsurprisingly, tend to refer to providers they know and trust. But many low-intensity services struggle to clear this barrier (chapter 12). Wind et al (2020, p. 1) have argued that digital mental health:

... has not been integrated as a normal part of routine care practice due to the lack of acceptance by health professionals themselves. Myths ... such as ‘the therapeutic alliance can only be established face-to-face’ have dominated the field, in spite of research showing the opposite.

We have recommended the establishment of a new national digital mental health platform, which would provide best-practice, digital, low-intensity services to people across Australia under a single brand, with the aim of becoming known and trusted by all GPs (chapter 10).

And while most GPs will know a handful of psychological therapists and psychiatrists that they can refer to, this knowledge is often limited to those with whom they have had professional experience, often with past referrals. They are unlikely to know the wider range of available clinicians, their expertise, waiting times or co-payments, for example.

Greater transparency in pricing information would help consumers and GPs to choose between providers. While treatment effectiveness may be a primary consideration for clinicians and for many consumers in service choice, the reality is that for many people, factors other than clinical effectiveness will feature in their decision making and even a small out-of-pocket cost can be a barrier to accessing the treatment they need.

The Australian Government recently launched the Medical Costs Finder website, which will eventually include information on the fees charged by individual medical specialists of all kinds (DoH 2019g).⁷² The fees of individual psychiatrists, paediatricians and allied health providers of MBS-rebated therapy should be included on this website. The Government should also consider including information about how long people must wait for an appointment and areas of practice for each clinician, to assist with consumer choice. Creating an ‘accessible and co-designed online directory’ with this information was what parents of children with mental illness said they would change about the mental health system ‘if they had a magic wand’, in a 2018 survey (Melbourne Children’s Campus, sub. 927, p. 11).

The Australian Psychological Society (APS) runs a ‘Find a Psychologist’ website which provides searchable information about its members — such as location, areas of practice, and whether they offer telehealth — but rarely provides fees (APS 2020). To help consumers choose a psychologist, the APS should recommend that their members include pricing information on their profiles.

⁷² At its launch in December 2019, the website only showed ‘typical’ out-of-pocket costs for 62 common in-hospital procedures, by PHN (Atlay 2020).

On GPs' second role in referral — supporting consumers to choose the treatment that is best for them — GPs' skills vary. Some GPs are adept at supporting consumer choice. But others tend towards a disempowering approach of making the decision for the consumer, rather than helping the consumer to decide for themselves.

Supporting and empowering people in making decisions about their treatment options should be considered a core skill for GPs, and all GPs should be trained in this skill. Chapter 16 discusses the issues of training for mental health professionals including GPs.

We are recommending that all referrals to psychiatrists and allied health professionals providing mental health services include a prominent and easy to understand statement advising people that they can use an alternative to any provider mentioned in the referral. The statement aims to prompt a conversation between the referring clinician (usually a GP) and the consumer about which provider the consumer would like to go to.

ACTION 10.1 — INCREASE CONSUMER CHOICE WITH REFERRALS

Australians have the right to choose their preferred mental health specialist, but the referral system masks these rights and, in effect, limits consumer choice.

Start now

The Australian Government should amend the Medicare Benefits Schedule (MBS) regulations to require that all referrals to psychiatrists and allied health professionals providing mental health services include a prominent and easy to understand statement advising people that they can use an alternative to any provider mentioned in the referral.

The Australian Government should include on the Medical Costs Finder website the fees and areas of specialty practice of all individual psychiatrists, paediatricians and allied health providers of MBS-rebated therapy. It should also consider including information about how long people must wait for an appointment with each clinician.

The Mental Health Treatment Plan does little to help consumers and should be replaced

Mental Health Treatment Plans (MHTPs) were designed to encourage GPs to better assess and manage the care of people with mental ill-health, which could include referring on to other providers. But in practice they are not promoting holistic mental health assessments, nor are they helping consumers access the care that is right for them. Instead, many GPs fill out an MHTP as a 'tick-box' exercise, to so that they can refer the consumer in front of them for MBS-rebated psychological therapy (issues pertaining to MBS-rebated psychological therapy are discussed in chapter 12).

To be eligible for MBS-rebated psychological therapy, a consumer must be: referred by a GP, a psychiatrist or a paediatrician; be diagnosed as having a mental disorder; and for GP referrals, have a MHTP completed by their GP (box 10.1; Services Australia 2018).⁷³

In 2019, 1.39 million consumers had an MHTP written for them by their GP (Productivity Commission estimate using Services Australia 2020a). About 60% of these consumers accessed MBS-rebated psychological therapy in the same year (Productivity Commission estimate based on unpublished MBS data). This indicates that *at least* 60% of the consultations in which a GP wrote an MHTP for a consumer, they also referred the consumer for psychological therapy — the true percentage is almost certainly higher, as some consumers would have had an MHTP written for them and been referred for psychological therapy, though they did not go on to undertake therapy (or at least not in 2019). This data, and anecdotal evidence provided to us, suggests that MHTPs are mostly being written by GPs who have already decided to refer consumers to MBS-rebated psychological therapy, rather than being used as a tool to inform the care GPs provide, or the referrals they make.

Of consumers who received an MHTP in 2019, about a third received an MHTP Review on a return visit to the GP (box 10.1).⁷⁴ After accessing up to six sessions of MBS-rebated psychological therapy, consumers *must* return to the referring clinician for a re-referral in order to access up to four additional sessions (at the same time, or at some other time, they *may* have their MHTP formally reviewed, but this is not needed to access the additional sessions). Whether consumers benefit from a requirement for re-referral should be evaluated in an effort to improve the effectiveness of MBS-rebated psychological therapy for consumers (chapter 12).

We found no evidence that consumers are benefitting from the use of MHTPs — such as through more holistic, person-centred assessments or supporting more informed choices by consumers about their treatment options. A recent consumer experience survey indicated that ‘care planning was often delivered in a perfunctory manner that satisfied requirements of government administrative [arrangements] but not those of the consumers, with comments that the process felt like a “tick box” exercise to satisfy bureaucracy’ (CMHR, sub. 148 att. 1, p. 11). Dr Bob Vickers (2018), a GP, wrote:

It’s not an irregular occurrence to see ‘care plans’, which apart from the practice software template, are absent of any detail apart from a few key words [T]hese poorly put-together plans become an impairment to patients in receiving the care they need.

⁷³ Until the end of 2021, there are no such requirements for people affected by the 2019-20 bushfires accessing MBS-rebated therapy (chapter 12). ‘Other Medical Practitioners’ may also write MHTPs — in 2019 they accounted for about 2% of MHTPs written (Productivity Commission estimate using Services Australia 2020a) — but for simplicity this section refers only to MHTPs written by GPs.

⁷⁴ 460 000 of 1.39 million (Productivity Commission estimate using unpublished MBS data).

Box 10.1 What is in a Mental Health Treatment Plan?

Medicare rules require that a **Mental Health Treatment Plan** (MHTP) incorporates an assessment of the patient, including:

- recording the patient's agreement for the GP MHTP service
- taking relevant history (biological, psychological, social) including the presenting complaint
- conducting a mental state examination
- assessing associated risk and any comorbidity
- making a diagnosis and/or formulation
- administering an outcome measurement tool, except where it is considered clinically inappropriate.

In addition to an assessment of the patient, preparation of the MHTP must include:

- discussing the assessment with the patient, including the mental health formulation and diagnosis or provisional diagnosis
- identifying and discussing referral and treatment options with the patient, including appropriate support services
- agreeing on goals with the patient — what should be achieved by the treatment — and any actions the patient will take
- provision of psycho-education
- a plan for crisis intervention and/or for relapse prevention, if appropriate at this stage
- making arrangements for required referrals, treatment, appropriate support services, review and follow-up
- documenting this (results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date) in the patient's GP MHTP.

An **MHTP Review** must include:

- recording the patient's agreement for this service
- a review of the patient's progress against the goals outlined in the GP MHTP
- modification of the documented GP MHTP if required
- checking, reinforcing and expanding education
- a plan for crisis intervention and/or for relapse prevention, if appropriate and if not previously provided
- re-administration of the outcome measurement tool used in the assessment stage, except where considered clinically inappropriate.

Source: DoH (2019h, pp. 103–105).

Several submitters proposed that a referral alone (without an MHTP) should be sufficient for consumers to access MBS-rebated therapy (including one member of the AMA (sub. 633, p. 3)). Reliance on a referral alone would be consistent with the approach taken for access to other clinical specialists. The APS (sub. 853, p. 26) proposed that:

A referral for therapy should be adequate and a MHTP is not necessary or helpful but increases the administrative burden to consumer, GP and treating mental health professional.

Similarly, the Institute of Clinical Psychologists (sub. 447, pp. 10–11) argued:

The MHTPs provided by GP's are of little assistance to Clinical Psychologists who have specific training in mental health diagnosis and are competent to develop and implement appropriate treatment. Omitting this requirement would redirect funding from administration to treatment and improve patient care.

The Royal Australian College of General Practitioners (RACGP), however, held a different view. It described MHTPs as 'an essential starting point for the delivery of mental health care', and emphasised that MHTPs were intended to aid the GP in assessing the patient and planning their care, while engaging the patient in their own mental healthcare (RACGP sub. 858, pp. 8–9). It also argued that:

The MHTP should ... not be regarded solely as a referral document to other psychological services. **GPs should be supported to appropriately refer patients to other psychological services, if necessary, with the right referral document.** [emphasis added] (RACGP, sub. 858, pp. 8–9)

While the RACGP is likely correct about the *intention* of MHTPs, few fulfil this aim, or provide benefit to consumers (in fact, we were advised that some consumers never even see their MHTP). In addition, while MHTPs were not *designed* as a tool for GPs to use when referring to psychological services, in practice, this is how they are mostly used.

The MHTP is not supporting best-practice assessment or informed consumer choice, and should be replaced with a tool that does.

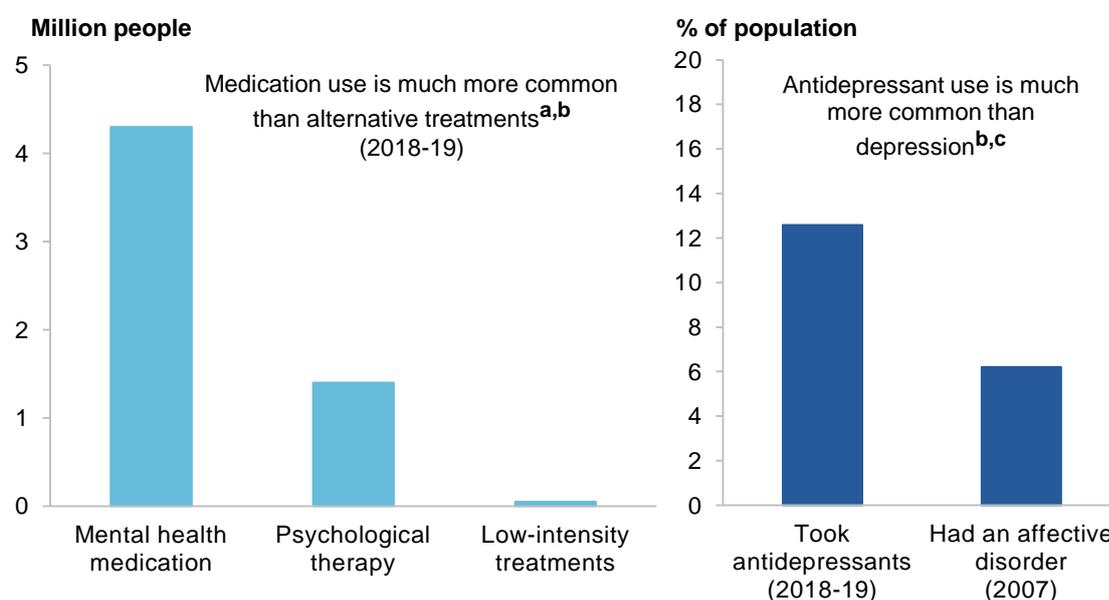
Ensuring consumers can make fully-informed choices about medication

The most common form of mental health treatment provided by GPs is medication — GPs prescribe a medication for about 6 out of 10 people who present with mental ill-health (figure 10.1). About 4 million people (almost 1 in 6 Australians) received a mental health-related prescription from their GP in 2018-19 (AIHW 2020j, table PBS.3). Chapter 2 describes who takes mental health medication, what type of mental health medication, and who is prescribing it.

Concerns have been raised about widespread prescribing of mental health medication, including how side effects are managed (ACSQHC 2017; Brijnath et al. 2017; Gardner 2014).

Use of antidepressants is particularly common — accounting for about three-quarters of mental health prescriptions in Australia (AIHW 2020j, table PBS.5) — although their clinical benefits appear modest at best (Cipriani et al. 2018; Davey and Chanen 2016; Munkholm, Paludan-Müller and Boesen 2019). In 2018-19, 1 in 8 Australians took antidepressants — roughly double the proportion of the population estimated to have had an affective disorder (such as depression) in the past 12 months (figure 10.2). Australians were the third most frequent users of antidepressants among OECD countries in 2017 (OECD 2020b).

Figure 10.2 Over-prescription of medication?



a Psychological therapy refers to both MBS-rebated and PHN-commissioned therapy. Low-intensity treatments are the clinical subset of low-intensity services (chapter 12). **b** Medication counts do not include medicines not listed on the Pharmaceutical Benefits Scheme, over-the-counter medicines, or medicines supplied to public hospital inpatients (AIHW 2019o, p. 8). **c** Someone is counted as having had an affective disorder in the past 12 months if they had had a diagnosis in their lifetime, and symptoms within the past 12 months. Data is from the 2007 Mental Health Survey, which is still the best estimate of prevalence today.

Source: *Mental health medication*: AIHW (2020j, table PBS.3). *Psychological therapy*: Productivity Commission estimate using AIHW (2020f, table MBS.8), DoH (2019, p. 19), and headspace (pers. comm., 16 October 2019 and 29 April 2020). *Low-intensity treatments*: Productivity Commission estimate using Beyond Blue (pers. comm., 19 July 2019), DHS (2020a), and Mindspot (sub. 666, p. 13). *Took antidepressants*: AIHW (2020j, table PBS.3). *Had an affective disorder*: ABS (National Survey of Mental Health and Wellbeing 2007: Summary of Results, October 2008, Cat. no. 4326.0).

Concerns have also been raised about the use and side-effects of other types of mental health medication. For example, numerous studies and the recent Aged Care Royal Commission have emphasised the over-medication in aged care facilities (including excessive prescribing of antipsychotics and benzodiazepines) (Cumming et al. 2019; Lind et al. 2019; Royal Commission into Aged Care Quality and Safety 2019; Westbury et al. 2019). In 2018-19, more than 40% of people aged 85 years and over received a mental health-related prescription (AIHW 2020i, table PBS.4). A number of participants raised concerns about the

long-term effects of mental health medications (such as psychostimulants) in young children (for example, Citizens Committee on Human Rights, Sydney transcript, pp. 207–213). The physical health outcomes of some mental health medications (such as atypical antipsychotics) remain uncertain (DUSC 2013; Nasrallah 2008). And the longer term mental health outcomes of common medical interventions for transgender people, who have a very high prevalence of mental illness and self harm (chapter 2), have not yet been robustly tested (Nobili, Glazebrook and Arcelus 2018; White Hughto and Reisner 2016).

There is evidence that medications are being prescribed:

- to people without mental illness (discussed above), who are unlikely to get benefit from them, but still contend with the side effects
- contrary to people's preferences — on average three times as many people prefer psychological treatment as prefer medication for treating depression and anxiety disorders (McHugh et al. 2013), and there is evidence that psychological therapy and medication are *on average* similarly effective in treating these disorders (Cuijpers et al. 2011; Roshanaei-Moghaddam et al. 2011); but in Australia, more than three times as many people use mental health medication as access psychological therapy (left panel, figure 10.2).
- before alternatives have been tried, and contrary to treatment guidelines — The National Institute for Health and Care Excellence (NICE) in the United Kingdom recommends self-help programs, computerised cognitive behavioural therapy (CBT), or physical activity programs (but neither antidepressants nor therapy) as initial treatments for mild to moderate depression in adults (NICE 2009); but in Australia, more than a hundred times as many people use mental health medication as access low-intensity treatments (left panel, figure 10.2)

Consumers should be offered evidence-based alternatives to medication wherever these are indicated by treatment guidelines — including non-clinical support services, low-intensity treatments, or individual or group psychological therapy. Where clinical evidence indicates that medication is the best treatment for a person (either by itself or in concert with therapy), it is essential for the clinician to explain the need for, and support the consumer to use, the medication, to achieve the best possible outcome. Ultimately, the choice to take medication as prescribed, remains with the consumer (unless they are being treated under a mental health treatment order).

Elsewhere in this report, we have recommended a range of reforms to encourage consumers and clinicians to consider alternatives to medication, including:

- improved training for GPs on non-pharmacological interventions and the appropriate prescribing of mental health medication (chapter 16)
- a new national digital mental health platform, which aims to establish a well-known trusted brand for digital services, to make low-intensity digital treatments more attractive to consumers and clinicians alike (section 10.4)

-
- as part of the platform, a new assessment tool, which clinicians could use to support holistic assessment and consumer choice among a range of recommended treatment options (section 10.4)
 - increasing the accessibility of other treatment options, such as group therapy or therapy by telehealth (chapter 12)
 - ensuring that HealthPathways contains a broader range of service options, including non-clinical options (chapter 15).

GPs should discuss side effects prior to the consumer choosing medication

Medications usually have side effects. We have heard distressing evidence about the adverse side effects of some mental health drugs, including dramatic weight gain, disabling lethargy, sexual dysfunction and suicidality (for example, Richard Burnell, sub. 504, sub. 1224). We have also heard examples where the people taking these medications are not told about their possible side effects. Dr Niall McLaren, a psychiatrist, asked:

Does it matter that psychiatric patients are almost never told the side effects of drugs? For example, that the drugs are both highly addictive and little better than placebos? That patients may double their weight, or lose their sexual function in the very long term? That they will die younger from taking them? I believe it does matter, and so does every patient I have ever spoken to. Psychiatrists, however, and on the authority of their governing board, clearly don't. (sub. 44, p. 26)

Emma Spinks shared her daughter's tragic story with us, explaining that neither the GP nor the pharmacist warned her daughter of the side effects of the drugs she was prescribed.

My daughter was a loving and caring wife and mother, she had many friends. She had no history of consultations for anxiety or depression. Before her death she had been very sick for over a month suffering from nausea, recurrent diarrhoea, chronic fatigue, significant weight loss and difficult sleeping. Pathology tests identified the case as hyperthyroidism and iron overload. ...

[A different GP] gave her a completely different diagnosis telling her that the chemical imbalance in her brain was causing her problems and anxiety. He prescribed ... an SSRI [selective serotonin reuptake inhibitor] antidepressant which he said would rebalance her system but would take two weeks to work. He made no mention of side effects instead telling her that this ... was 'as safe as houses'. ...

Both the GP and the pharmacist who dispensed her prescription failed to warn my daughter about the risks associated with [the medication], the possible side effects that include suicidal ideation and self-harm. ...

As a family we had absolutely no idea there was a prescription drug that could cause possible side effects of suicidal ideation and self-harm in anyone who hadn't even suffered from a mental illness. If a warning had been included in the packaging we would have been able to save my daughter's life. I know that if my daughter had been warned of the slightest risk of possible side effects of suicidal ideation and self-harm she would never even contemplate taking [the medication]. (Sydney transcript, pp. 130–132)

Person-centred care means not only that people are provided with the relevant information about any medications they are prescribed, but that they are provided with this information prior to deciding whether medication or some other form of treatment is right for them.

Prescribing clinicians should be responsible for providing consumers with the relevant information — on effectiveness, as well as on risks and side effects — at the time they decide on a treatment option. GPs prescribe most mental health medication (chapter 2), but psychiatrists and paediatricians should also have this responsibility when they prescribe mental health medications. While the dispensing pharmacist should always check that the consumer has the relevant information when dispensing a medicine, real choice means that the consumer has the relevant information before receiving a prescription.

To ensure this happens, the Australian Government should require that all mental health prescriptions include a clear and prominent statement that clinicians have discussed possible side effects and proposed evidence-based alternatives to medication, prior to prescribing (action 10.2). This statement must be easy to understand and prominent. The Productivity Commission has previously examined patient advisory statements on request forms for pathology and radiology services, and found that ‘the wording of these statements means they do little to support patient choice’, and that ‘the statement is often included on the form in a small font and is usually positioned where the patient could easily miss it’ (PC 2017c, p. 306). HealthPathways (chapter 15) should also include reminders to GPs (where relevant) that they have an onus to inform consumers about medication side effects.

Off-label prescribing

Australia’s very high prescribing rates for mental health medication may reflect so-called ‘off-label’ prescribing by GPs and other clinicians — where a drug is prescribed for a use other than that for which it has been approved. This is particularly the case for antidepressants, where use appears to be significantly higher than the rate of affective disorders in the population (discussed above).

The level and consequences of off-label prescribing are beyond the scope of this Inquiry. However, the increased use of antidepressants and other mental health medications (chapter 2) suggests that off-label prescribing should be separately considered by an independent review. This is consistent with the approach taken in the European Union, where a large study on the off-label use of medicinal products was completed in 2017 (Weda et al. 2017).

ACTION 10.2 — MENTAL HEALTH RELATED PRESCRIBING

The prescribing of mental health medications should be based on informed consumer choice and follow evidence-based guidelines.

Start now

The Australian Government should require that all mental health prescriptions include a clear and prominent statement saying that clinicians should have discussed possible side effects and proposed evidence-based alternatives to medication, prior to prescribing.

Start later

The Australian Government should commission a review into off-label prescribing of mental health medications in Australia.

GPs should have timely access to psychiatric advice

GPs sometimes need assistance from mental health specialists to provide the optimal care to consumers, whether regarding diagnosis and assessment, treatment (including medication) or referral. While GPs may seek this assistance through their own professional networks, consumers should not have to rely on *their* GP having these connections. All GPs should be able to get this assistance when they require it, so that all consumers are assured of optimal care.

The RACGP has called for a psychiatric advice service across Australia.

GP access to support and advice from relevant mental health specialists (e.g. psychiatrists) on the management of patients with mental health-related issues is valuable but largely missing from the current system. General practice registrars, early career GPs, and rural and remote GPs may find particular benefit in such consultation services. (sub. 386, p. 7)

Such a service has merit. It could improve care for consumers, help GPs fill the gaps in their knowledge (particularly around mental health medications), and could reduce the need for GPs to refer people to see a psychiatrist (who are relatively costly, and often have long waiting lists). However, these types of advice services have been tried in the past with mixed success. Any new service needs to draw on the lessons of previous attempts.

One previously-funded (and now terminated) national service, known as GP Psych Support, was seen as beneficial by GPs (box 10.2). However, each year the service cost about \$900 000, and fielded only about one thousand inquiries, equating to a cost per inquiry of \$900 (RACGP, pers. comm., 23 July 2019). This is much higher than the average fees charged by private psychiatrists for a face-to-face consultation. In 2019, the average fee (MBS rebate plus co-payment) was about \$69 for a consultation lasting less than 15 minutes, and about \$132 for a consultation lasting 15–30 minutes (Productivity Commission estimates using unpublished MBS data).

Since this service was discontinued, other services with limited geographical reach have sprung up, including a subscription service run by the Black Dog Institute. The largest such service is the GP Psychiatry Support Line, jointly commissioned by eight PHNs across New South Wales (GP Psychiatry Support Line 2020). The service is contracted until June 2022, at a fixed cost of \$500 000 per year. In 2019-20 (its second year of operation), the service is on track to receive a little over one thousand inquiries, implying a cost per service of about \$475 (Productivity Commission estimate using Coordinare, pers. comm., 27 May 2020). Increased service volumes over the course of the current contract would lead to a lower cost per service.

The very high cost per inquiry for both of these services can be attributed to the high fixed costs associated with a commissioned service, combined with low take-up. Any new scheme must be attractive to GPs, flexible in terms of its capacity, and cost-effective. National coverage would mean that all consumers could benefit.

Box 10.2 **GP Psych Support**

From 2004 to 2013, the Australian Government funded GP Psych Support, a free national advice service linking GPs to psychiatrists by phone, fax or email within 24 hours. It was managed by the RACGP, with the phone/fax arm of the service delivered privately by what is now Medibank Health Solutions.

About two thirds of inquiries to the service related to depression and anxiety. About three quarters of inquiries were related to medication (Bradstock et al. 2005, p. 90).

GPs providing feedback on the service said that it improved the quality of care they provided to consumers.

- 99% said they would consider using the service again.
- More than 85% rated the service better than other sources of advice on mental healthcare, in terms of accessibility, reliability and the appropriateness of the advice given.
- More than 70% said that contact with the service had increased their knowledge and confidence in managing 'mental health problems', and had improved the quality of care they provided to their patients.
- More than half reported an increased willingness to manage 'more complex mental health problems' (Bradstock et al. 2005, p. 90).

The introduction of a new MBS item for psychiatrists to provide advice over the phone to GPs could be designed to meet these criteria. A fee-for-service approach would have the flexibility to allow GPs to choose to either contact a psychiatrist that they know and trust, or go through an intermediary who would connect them with an available psychiatrist with the relevant skills (for example, child psychiatry) — similar intermediaries already exist to help people connect with psychiatrists for telehealth consultations (chapter 12). Providing this service through the MBS would enable funding of these services at a much lower per call rate than previous services.

As a further check on costs, the MBS item should only be available to a psychiatrist who is *not* treating the relevant consumer, and would only be available to a *consumer* who is *not* being treated by any psychiatrist (including in the public system). Clinicians who are part of a consumer's care team (including GPs and psychiatrists) would be expected to continue to communicate with each other as part of standard practice, and would not generally receive an MBS rebate for doing so.

Additionally, the item should always be bulk-billed, as the consumer would not necessarily be present for the call (the GP and the consumer should decide together whether the consumer would be present for the call or not).

We made this recommendation in our draft report (draft recommendation 5.1) and it was supported by a wide range of stakeholders, including two of the NSW PHNs that commission the GP Psychiatry Support Line — Hunter New England Central Coast PHN (sub. 641, p. 10) and Coordinare (sub. 1194, p. 13). It was also supported by the Consumers Health Forum of Australia (sub. 646, p. 14), headspace (sub. 947, p. 33), the National Rural Health Alliance (sub. 1192, p. 4), Queensland Advocacy Incorporated (sub. 889, p. 10), as well as, broadly, the Melbourne Children's Campus (sub. 927, p. 12), and One Door Mental Health (sub. 856, p. 9).

The RACGP (sub. 858, p. 4), the Royal Australian and New Zealand College of Psychiatrists (sub. 1200, p. 9), and GP Dr Victoria Hughes (sub. 571, p. 1) also supported the recommendation but considered that GPs as well as psychiatrists should receive an MBS rebate for using the service. The psychiatry advice service, however, would represent a clinical resource for GPs, and in our view GPs should no more receive an MBS payment for accessing *this* clinical resource than they should for accessing any other clinical resource (such as those found online). Accessing such resources in order to provide high quality care to a consumer should be considered an integral part of offering a quality service to people.

Some stakeholders questioned whether an MBS item was the best way to deliver the service (ACT Government, sub. 1241, p. 5; NT PHN, sub. 1213, p. 9). The Grattan Institute (sub. 816, p. 12) agreed that GPs should be able to get advice from psychiatrists without needing to refer the patient, but said that PHNs should ensure this. Both Procure Mental Health Services (sub. 1244) and the PHN Cooperative (sub. 850, p. 24) doubted whether an MBS item could deliver a timely service, and argued that the current GP Psychiatry Support Line (which Procure runs) is a better way to provide the service. This is not our view. We see no reason why the MBS item would not be able to incentivise a timely service, as well as providing more flexibility and a much lower cost per inquiry. However, if for any reason the MBS service was not attractive to GPs, then little would be lost — the MBS item would simply go unused.

Procure (sub. 1244) and Coordinare (sub. 1194, p. 13) also argued that an MBS service would not replace the Support Line, which does differ in some ways. For example, it allows pre-scheduled callback times and online bookings, and provides a written response to the GP 12–24 hours after the call. While the services are similar, the decision to continue funding the GP Psychiatry Support Line in parallel would remain with the eight New South Wales PHNs. An MBS item should be introduced regardless, so that all GPs have access to psychiatric advice, to the benefit of consumers across Australia.

The Melbourne Children’s Campus (sub. 927, p. 15) argued that any psychiatry advice service should be extended to paediatricians. We also see merit in extending the service to paediatricians who, like GPs, regularly provide mental healthcare but may not always have the skills or knowledge to provide the best care possible. Hiscock et al. (2017) found that in 2013 in Australia, close to two thirds of paediatricians’ consultations were to do with developmental or behavioural conditions, and that rates of medication prescribing were rising.

The Melbourne Children’s Campus (sub. 927, p. 15), along with the APS (sub. 853, p. 25), also suggested that psychologists should have access to the service. We do not agree. Psychologists are experts in non-medicine based psychological therapies and have existing case-management and supervision protocols that help ensure consumers receive the highest quality care. While the APS notes that the service may be beneficial when ‘consumers are working with psychologists who may recognise major medication concerns’ (sub. 853, p. 25), we consider that in such a situation, the psychologist and consumer should be discussing those concerns with the prescribing clinician.

Although it is not possible to quantify the potential benefits of this reform, we have estimated the costs. In a year, on the basis that the service receives between 4 000 and 10 000 calls, we estimate that it may cost between \$400 000 and \$1.1 million (appendix K). This cost includes the MBS rebates paid to psychiatrists,⁷⁵ and the (unreimbursed) cost of GPs’ and paediatricians’ time in using the service (although we have not accounted for the time they are likely to save in not looking for alternative sources of psychiatric advice).

⁷⁵ We assume a rebate of \$66, although the rebate could be set lower or higher. This was the average fee (MBS rebate plus co-payment) charged by private psychiatrists for a consultation lasting less than 15 minutes in 2018 (Productivity Commission estimates using unpublished MBS data).

ACTION 10.3 — PSYCHIATRIC ADVICE FOR GPs AND PAEDIATRICIANS

GPs and paediatricians should be able to access psychiatric advice when they need it, to assist with the care of people with mental illness.

Start now

The Australian Government should introduce an MBS item for psychiatrists to provide advice to a GP or a paediatrician over the phone on diagnosis and management issues for a person who is receiving care from the GP or paediatrician.

- The MBS item would be available only in relation to a consumer who is not receiving treatment from any psychiatrists.
- The person may or may not be present for the call. In either case, the person should not be charged a co-payment for the call.

Start later

The effectiveness and ongoing need for this MBS item should be evaluated after three years.

10.3 Improving other primary care gateways for consumers

PHNs have two distinct roles in assessment and referral. First, PHNs are tasked with supporting other gateways (such as GPs and Aboriginal Medical Centres) to help consumers find the services that are right for them. A big part of this is providing these gateways with information about services in their region, including services commissioned by the PHN. This includes, for example, maintaining HealthPathways (chapter 15).

Second, PHNs have a more direct role in assessment and referral, as PHNs (and the services they commission) are often gateways themselves. In this role, as providers and commissioners of *intake* services, PHNs are responsible for ensuring that consumers receive holistic assessment and are supported to find services that meet their needs (DoH 2019l, pp. 47–55). Consumers go through the PHN gateway if they are referred to (or refer themselves to) a PHN or to a PHN-commissioned service.

A framework for person-centred assessment and referral

To support PHNs in this second role, and to ensure that consumers can access consistent, person-centred assessment and referral in all PHNs, the Australian Government Department of Health has published guidance for PHNs on Initial Assessment and Referral (IAR).

The IAR provides a framework for person-centred assessment and referral. Assessment and referral should be undertaken in partnership with consumers, ‘to determine suitable and appropriate treatment choices/options’ (DoH 2019l, p. 10).

Assessment should consider the whole person, across four ‘primary assessment domains’, and four ‘contextual domains’.

- **Primary Assessment Domains** — Symptom Severity and Distress, Risk of Harm, Functioning, and Impact of Co-existing Conditions.
- **Contextual Domains** — Treatment and Recovery History, Social and Environmental Stressors, Family and Other Supports, and Engagement and Motivation (DoH 2019l, p. 32).

Based on the consumer’s assessment across these eight domains, the IAR framework suggests an appropriate level of care — ranging from ‘self-management’ to ‘low-intensity’, and all the way up to ‘acute and specialist community mental health services’. It encompasses clinical and non-clinical interventions (such as diet and exercise).

The IAR does not claim to be a substitute for professional knowledge and clinical judgement, but is intended as a guide to help clinicians assist consumers in finding the care that is right for them. For example, the IAR may indicate that one-on-one therapy or medication is suitable, based on a consumer’s assessment. The GP should discuss these and other options with the consumer, and the consumer should still be able to choose an alternative (for example, supported online treatment) if that is their preference.

However, while the IAR is a valuable framework, it needs further development. As it stands, the IAR is not calibrated for all population subgroups.

[It] includes information and advice about initial assessment and referral that is common across most population groups. However, the processes necessary for ensuring the Guidance is appropriate for some population groups has not yet been undertaken. These groups include:

- children and young people
- Aboriginal and Torres Strait Islander Peoples
- people from culturally and linguistically diverse backgrounds
- people with multi-morbidities (including development disorders and intellectual disability). (DoH 2019l, pp. 12–13)

The inclusion of these groups is critical, so that *all* people with mental ill-health can access person-centred gateways. The Department of Health should immediately begin the work needed to assess the suitability of the IAR for these groups, and if necessary to develop alternative guidance so that person-centred assessment and referral can be put into practice for all consumers.

With this work done, the IAR framework could underpin consistent, person-centred assessment and referral not only across PHN-commissioned services (discussed below), but across the primary mental healthcare system, including online (section 10.4).

Implementing the IAR across PHN-commissioned services

PHNs, and the Department of Health, are currently engaged in a range of work to incorporate the IAR into assessment and referral practices for all PHN-commissioned services. For example, the WA Primary Health Alliance, which runs all three PHNs in Western Australia, announced in December 2019 that it would establish a central digital assessment and referral service, consistent with the IAR, to be integrated with PHN-commissioned services, as well as being open to referrals from GPs (WAPHA 2019b). And the Hunter New England Central Coast PHN advised that:

In July 2019, [we] introduced a Central Access and Referral Service across [our] funded primary mental health services. The model is underpinned by Department of Health Guidance on Initial Assessment and Referral. [We are] also engaged in round two the Department of Health's Initial Access and Referral trial to commence in 2020. (sub. 641, pp. 8–9)

Over time, all PHN-commissioned services should adopt assessment and referral practices based on the IAR. For many services this could happen in the short term. Other services focused on consumer groups for whom the current IAR may not be appropriate will not yet have the appropriate framework available to them, but should move as soon as the relevant work has been done. For example, as soon as a version of the IAR has been developed for young people, headspace centres should be expected to put in place assessment and referral processes that are consistent with it.⁷⁶

We are concerned that some consumers who are accessing PHN-commissioned services are not currently being offered the full range of service options (box 10.3). This may be partly driven by existing relationships within or between service providers (for example, where co-located service providers tend to refer to each other). It may also be driven by funding rules — commissioned services may be able to ‘stretch their funding further’ by directing consumers to MBS-rebated services (box 10.3).

The Department of Health requires that — as well as implementing assessment and referral practices consistent with the IAR — PHNs establish mechanisms for monitoring the use of services to detect over-use or under-use, and take corrective action if required (DoH 2019l, pp. 54–55). While the IAR is flexible for individual consumers, it can assist a PHN to fulfil this monitoring role. The PHN can check whether the broader patterns of service use for a particular region or provider are consistent with the patterns indicated by the IAR. If they are not consistent then this may indicate that consumers are not being connected with the right services, perhaps because certain types of services are not being offered, or are being recommended too frequently.

⁷⁶ headspace centres are PHN-commissioned services, although the Australian Government (not PHNs) makes decisions about whether they will be commissioned (appendix G).

Box 10.3 Are headspace centres helping young people find the services that are right for them?

headspace centres are integrated service hubs for 12–25 year olds, focusing on mental health. In 2018-19, about 100 000 young people visited a headspace centre, with almost 9 in 10 presenting with mental ill-health (headspace, pers. comm., 29 April 2020). headspace centres also cover alcohol and other drugs, physical and sexual health and social and vocational participation. As of January 2020, there were 112 centres across Australia (headspace, sub. 947, p. v), with two more to be added in the near future (Hunt 2020b). The centres employ a range of personnel, including GPs, youth workers, vocational workers, and drug and alcohol workers, with most mental health services provided by psychologists and other allied health workers (Rickwood et al. 2015b, p. 536).

headspace has developed a holistic assessment for use by clinicians in headspace centres (headspace 2020b; Parker, Hetrick and Purcell 2013). And headspace head office appears to embrace a stepped-care approach — proposing, for example, that centres could use low-intensity options for the management of anxiety and depression — including self-help, psychoeducation and lifestyle advice, group therapy, and online guided self-help (such as MoodGYM and e-couch) (headspace 2019a, 2019b). But data on the services provided at headspace centres demonstrates a heavy reliance on individual therapy, and suggests that headspace centres may not be offering young people choice among the full range of care options.

About half of young people presenting at headspace centres have either mild, moderate or no *symptoms* of mental ill-health (headspace, pers. comm., 16 October 2019), and about half have low or moderate *distress* (Orygen and headspace, sub. 204, p. 28) — indicating that low-intensity services may well be suitable for a many of these young people (DoH 2019l, pp. 38–39).

headspace advised (pers. comm., 29 April 2020) that in 2018-19, 35% of young people with mental ill-health ‘received only low-intensity mental health services’, although ‘they may have also received other services such as assessment, physical health or vocational services’. However, among young people with mental ill-health who *received an assessment*, 4 out of 5 went on to receive individual therapy (which is not a low-intensity service) (Productivity Commission estimate using headspace, pers. comm., 16 October 2019).

The dominance of individual therapy within the headspace model is at least partly due to funding (appendix G). In their evaluation of headspace, Hilferty et al (2015, p. 107) found that more than 45% of services received at headspace centres attracted MBS funding, and concluded that the headspace model was ‘designed to leverage from the MBS.’

The PHNs also require ongoing support. Responding to our draft recommendation, the Australian Association of Social Workers (sub. 848, p. 7) stated:

The recommendation envisages a leadership role for PHN’s in reforming this aspect of the system. In this context, the [Australian Association of Social Workers] points to the unpublished report of the PHN Advisory Panel on Mental Health. This review found that PHNs’ varied widely in their understanding of the Stepped Care approach and its implications for commissioning mental health services. For that reason, the [Australian Association of Social Worker]s recommends that PHN’s themselves should be the targets of reform and capacity building to enable them to fulfill an expanded role in providing better mental health services.

The Department of Health should continue to work with PHNs to ensure that all have the capacity and resources to implement their agreed duties. In addition, there is a need for ongoing research to ensure that assessment and referral practices based on the IAR are connecting consumers ‘with the highest quality and safest services available’ (APS, sub. 853, p. 25).

Finally, below we recommend the development of a new assessment and referral tool that is consistent with the IAR. Once this tool is developed, it should be adopted by PHNs for inclusion in the services they commission.

10.4 A national digital mental health platform

A national digital mental health platform should be a key component of the mental health system. Such a platform could provide easy access to holistic mental health assessments and digital low-intensity services across Australia. It would also allow mental health services to respond quickly to any other challenges that the community may face in future, and contribute to the creation of an integrated, flexible, person-centred mental health system.

The platform would be accessible to consumers, GPs and other clinicians through a website, and would have three pillars:

- a tool for person-centred assessment and referral, which would be used by GPs, and by individuals who could access online assessment and referral, supported by an experienced mental health clinician
- evidence-based digital low-intensity services that are low cost and accessible to consumers
- a gateway to other digital and face-to-face treatment and support services, and in time, draw on the recommended navigation portals in each region as a source of local information on service availability and capacity (Action 15.2).

The success of the national digital mental health platform would hinge on its ability to build a prominent and trusted brand, to encourage people with mental ill-health to self-refer, and encourage referrals from GPs, other clinicians, and other service providers. In time, the platform should connect to the recommended navigation portals (chapter 15) to draw on links to other clinical treatment and non-clinical support services.

A new person-centred assessment and referral tool

The first pillar to the national digital mental health platform would be a new person-centred assessment and referral tool. The tool would:

- provide a holistic assessment, consistent with the IAR, and encompassing the IAR’s four primary domains and four contextual domains (discussed above)

-
- provide a structured and largely automated assessment, with the set of questions adapting based on the consumer's responses
 - aim not to diagnose mental illness, but to assess the person's service needs
 - provide clear guidance to clinicians and consumers about the services that are likely to best meet the person's needs and preferences
 - enhance consumer choice, by considering a broad range of services — including digital services and psychosocial support services such as exercise or community support groups — with the aim of supporting consumers to choose the service that is right for them
 - replace the MHTP as a requirement for accessing MBS-rebated psychological therapy (section 10.2).

As noted, the assessment tool could either feed into an assessment by a GP,⁷⁷ or be used by an individual independently accessing an assessment online, with support provided by a clinician through the platform. The assessment tool need not operate identically in both situations, but would produce a consistent assessment, that could provide access to a range of services.

GP-led assessment

The assessment and referral tool would be designed to assist GPs in undertaking holistic mental health assessments and suggesting appropriate referral options. Currently, some GPs find this difficult; for instance, they may not have specific mental health expertise, or they may be constrained by 10–15 minute scheduled appointments and are unable to give the individual the required time.

The tool would be designed so that most consumers could complete most of the assessment without a clinician present. People who identified their poor mental or emotional wellbeing prior to seeing the GP could complete most parts of the assessment online at home before their GP consultation, or on a confidential tablet in the GP's waiting room. A version of the tool that does not require internet access would be developed for places with poor internet.

Other consumers may not disclose their mental ill-health until they are in the GP's consulting room. Depending on their level of distress and need for immediate support, these consumers could either complete the assessment on the spot, or else make another appointment to complete the assessment with the GP later that day or later in the week, just as consumers currently often need to make another appointment to complete an MHTP.

Consumers would still require the GP (or possibly a practice nurse) to be present or to provide input for at least some questions asked of some consumers, but these questions

⁷⁷ Other clinicians who undertake mental health assessments, such as paediatricians, could also use the tool. But for simplicity we just refer to GPs.

should be minimised. And some consumers may still need (or prefer) a clinician to be present for the whole assessment.

Structured and adaptive questions would ensure that all consumers receive a rigorous, relevant and consistent assessment. But the GP could supplement the questions in the assessment tool by asking additional questions of the consumer, and could consider other information as part of their assessment, informed by their ongoing relationship.

Greater automation of the more routine question-and-answer part of the assessment process would also allow clinicians to spend more time helping consumers understand the outcome of the assessment, and supporting them to choose among treatment options. Based on the assessment, the tool would recommend clinical and/or psychosocial support services that would be most likely to meet the consumer's needs and preferences, including low-intensity options where suitable. The GP would be expected to talk through these (and possibly other) options with the consumer.

The recommendations made by the tool would not override the GP's clinical expertise or the person's preference. Services other than those suggested could still be chosen. GPs will remain responsible and accountable for their referral decisions, as they are currently. But GPs should be periodically provided with feedback from the tool that indicates how closely their treatment and referral practices align with the recommendations made by the tool. Whichever services the consumer goes on to access, the providers of those services would be expected to update the GP on the consumer's treatment and progress towards recovery.

GPs would have the option of using the new assessment tool for a mental health assessment of any consumer. The tool should be integrated with GP practice software, and co-designed with GPs, to make this as simple as possible. GPs would also be required to use the tool before referring a consumer for MBS-rebated psychological therapy (in place of completing an MHTP). As discussed in section 10.2, the MHTP is failing to ensure consumers receive holistic mental health assessments and are supported to choose between appropriate service options.

Online clinician-supported assessment

As well as being used by GPs as an aid to undertake assessments, individuals could independently access the assessment tool online, with support provided by an experienced mental health clinician through the platform. As with existing clinician-supported online assessments, the clinician could monitor the consumer's responses, and speak to them via online chat, phone or videoconference, for example. However, the online assessment is not intended to replace emergency phone triage or other phone-based support services such as Lifeline (although consumers could be referred on to emergency services when required).

There are important benefits from making available a free and easily accessible clinician-supported mental health assessment tool.

- It provides an alternative to the GP gateway. The GP is currently the default gateway to mental health services, and effectively the only gateway through which some services,

such as MBS-rebated psychological therapy, can be accessed. But people may not feel comfortable talking to their GP about their mental health, or stigma may prevent them from seeing their GP, or they may find it difficult to get a timely appointment. An alternative gateway would increase access and choice.

- It could encourage early intervention. Consumers could use the online assessment tool as a ‘self-check’, even when they did not have a level of concern that would lead to them see a GP or to access mental health treatment directly.
- It would help ensure that consumers access evidence-based tools rather than relying on internet searches or other self-assessments online, only some of which are evidence-based (chapter 11).

GPs could also choose to refer consumers to this service, instead of undertaking the assessment themselves using the tool (figure 10.3). The GP could ask the consumer to return to them after completing the assessment to discuss care options, or the consumer could go on directly to treatment following an online assessment, and consideration of the options suggested by the clinician-supported online tool. GPs may prefer this option if they are time-poor, or feel they don’t have the skills to respond to people’s mental health challenges. As noted earlier, the WA Primary Health Alliance is in the process of establishing a digital assessment and referral service in Western Australia in line with the IAR, which GPs could refer people to for a holistic mental health assessment and referral on to appropriate services (WAPHA 2019b).

Other service providers could also refer consumers for a clinician-supported assessment on the platform, if the consumer preferred this option to a GP (figure 10.3). A range of other service providers often find themselves unable to help people with mental ill-health to connect to services that meet their needs, whether clinical or psychosocial. These include people working in healthcare (such as nurses in hospitals or the community, Aboriginal health workers, other medical doctors) and in other service areas (such as teachers, youth workers or disability support workers). We have also recommended that an enhanced HealthPathways — which would provide information about best-practice referral pathways, and clinical and psychosocial services — should be accessible to a broader group of service providers (it is currently targeted at GPs) (chapter 10).

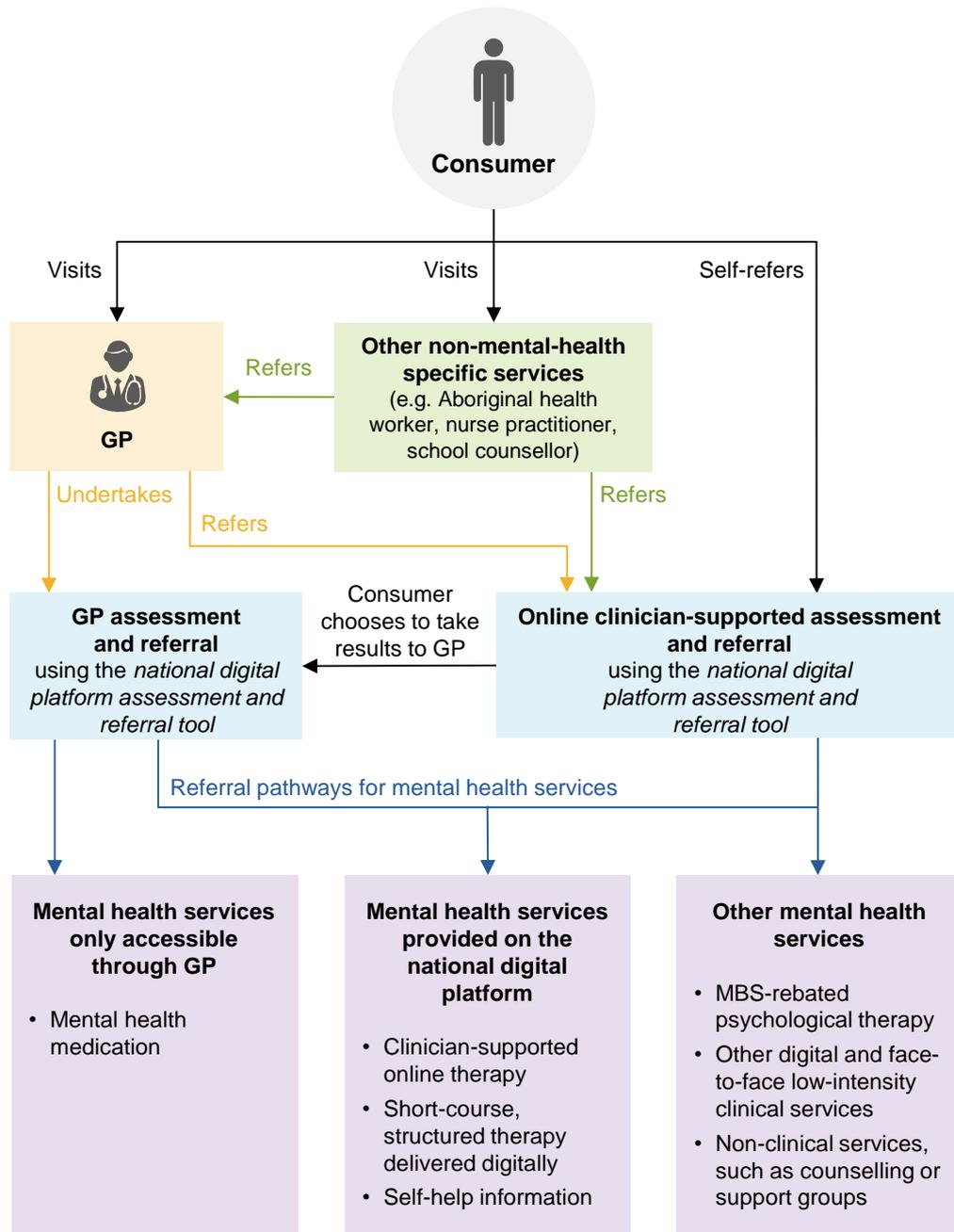
A consistent assessment across services

Whether the consumer accesses a GP-led assessment or an online clinician-supported assessment, consumers would be able to take these results to service providers of their choosing. In this way, the tool could facilitate ‘warm referrals’ between service providers, where people do not need to retell their story every time they are referred to a new service.

Having a consistent and transferable assessment used across multiple services would remove the need for consumers to undertake multiple repetitious assessments. Completing the new assessment tool once would be sufficient for consumers to access a range of primary care services, including (at launch) MBS-rebated psychological therapy and digital low-intensity

services provided through the national digital mental health platform. This would work towards the RACGP’s goal of ‘better integration between digital and face-to-face gateways to care’ (sub. 858, p. 4).

Figure 10.3 The new assessment tool will give consumers and GPs new options for assessment



Other services could adopt the assessment tool over time (or at least accept a consumer's results from the assessment tool in place of their own assessment). In particular, the assessment tool would be consistent with the IAR, and should over time be adopted by PHNs and PHN-commissioned services.

To store and share the assessment results, they could be added to the consumer's My Health Record. But this would be the consumer's decision, and they would also be able to choose who could view the results, and could remove the information at any time.

Specific consideration would have to be given to issues concerning the collection and sharing of personal information provided by people as part of the assessment process. It is likely that some of this information would be considered personal or sensitive information under the *Privacy Act 1998* (Cth), which would raise further legal requirements if the answers to any questions or identifying information were stored and shared (for example, with a GP or psychologist). Consumers would have to provide their consent for this to occur.

Finally, we have heard that some consumers have had MHTPs written for them without their knowledge. This is unacceptable. Regardless of whether the consumer accesses a GP-supported assessment (using the assessment tool) or an online clinician-supported assessment, the GP or clinician supporting the assessment should ensure the consumer understands the outcomes of the assessment, is supported to choose the service options that are right for them, *and receives a copy of the assessment results* (unless there are special circumstances and these results contain information that places the consumer or a third party at serious risk of harm). The APS supports a move to greater transparency in mental health assessment.

Increasing transparency is important and the [MHTP] report and subsequent review should be discussed with the consumer to increase transparency and enhance consumer autonomy and choice. (APS, sub. 853, p. 35)

A platform for low-intensity digital services

The second pillar of the national digital mental health platform would be provision for low-intensity digital services. As discussed in chapter 12, there is currently a very large gap between the number of people who are using low-intensity services, and the number of people who would likely benefit from them. This is especially true for low-intensity *treatments*, the clinical subset of low-intensity services.

There are two key digital low-intensity treatment types that have been shown to be both highly effective and cost effective at scale:

- supported online treatment (chapter 11)
- short-course, structured therapy delivered by videoconference or phone (box 10.4, chapter 12).

Both should be provided on the platform at launch. This should not require the design or development of new services. Rather, the idea is to provide a platform for existing digital services to reach many more people. Accessible self-help information should also be provided on the platform.

While there are additional costs of providing services as part of the platform — rather than simply linking to external services — we believe these costs are justified by the benefits.

First, providing these services as part of the platform ensures that as many Australians as possible can access them (an imperative discussed in chapter 12). Currently, access is restricted by funding and geographical restrictions. For example, the Practitioner Online Referral Treatment Service (PORTS) is only funded to provide services to West Australians who are also experiencing financial or geographical disadvantage (box 10.4). And Mindspot — by far the largest Australian Government-funded provider of supported online treatment — has its growth limited by a capped funding model. It receives 21 000 registrations a year (conducting ‘limited marketing and promotional activities’), but only about 4000 of these go on to receive treatment (MindSpot 2019b, p. 6; sub. 666, p. 16). Providing low-intensity digital services as part of the platform aims to expand access far beyond the current constraints. The importance of expanding digital mental health solutions was recognised in The National Mental Health and Wellbeing Pandemic Response plan (Australian Government 2020c).

Second, the platform aims to build GPs’ and consumers’ knowledge of and trust in low-intensity digital treatments. Currently, these treatments suffer from low visibility (many GPs and consumers don’t know they exist), and low acceptability (including that many GPs or consumers don’t trust that they work). Beyond Blue told us that a ‘key challenge for community members and clinicians is to know which low intensity supports to trust’ (sub. 877, p. 20). Providing a small number of the most effective low-intensity services on the platform — under a single well-known and trusted brand — aims to increase the visibility and acceptability of these services. To build GPs’ trust in these low-intensity services, all services provided on the platform should have strong clinical governance, and strong communication with GPs about consumers’ progress (as PORTS does — box 10.4).

Third, providing assessment and low-intensity services together allows for a more integrated service from the perspective of the consumer. This would include, for example, a single interface and a single assessment. In reducing the number of steps required of consumers, integration should reduce the likelihood that consumers drop out between assessment and treatment.

To maximise the benefit to consumers over time, the services provided on the platform should be dynamic. Monitoring of outcomes should make it possible to continue to experiment and improve the services. Different modules (focusing on sleep, alcohol use or a large-scale traumatic event, for example) could be added (or removed) as needed. And new digital services could be added to the platform, or could replace an existing service if shown to work better for consumers.

Box 10.4 Practitioner Online Referral Treatment Service (PORTS)

PORTS is commissioned by the WA Primary Health Alliance — which runs all three PHNs in Western Australia — and was co-designed with Mindspot (chapter 11). It provides psychological assessment, treatment, and consultation services across the state to adults (aged 16 years and older) referred by their GP with anxiety, depression or substance use problems. Since launching in 2017, more than 3000 consumers have received PORTS services (MindSpot, sub. 178, p. 13). PORTS is targeted at people experiencing financial and/or geographical disadvantage, or some other barrier to accessing care — in the first 18 months of operation almost half of people using PORTS were in the lower two quintiles of socioeconomic disadvantage (Titov et al. 2019a, pp. 3–4, 8).

PORTS offers two treatment options to people assessed as suitable:

- a brief telephone-delivered intervention called ‘Tele-CBT’, based on strengths-based cognitive behavioural therapy (CBT). Treatment is delivered by the same psychological therapist at a pre-scheduled time over 1 to 4 structured sessions, each lasting 20–40 minutes
- a supported online CBT intervention, involving a course that people work through online (or in a hardcopy workbook), with support throughout from the same psychological therapist, who provides brief weekly therapy using a combination of secure email and telephone.

PORTS Tele-CBT has been shown to be highly effective. For consumers who had 3 or more sessions, there was an average effect size of 1.0 (as a comparison, one study found an average effect size of 0.7 for young people receiving services — including psychology therapy — through a headspace centre). Consumers who completed the supported online CBT showed even larger improvements — an average effect size of 1.4 (based on the Kessler Psychological Distress Scale) (Bassilios et al. 2017; Titov et al. 2019a, pp. 10–12). For both treatment options, more than 60% of those who began treatment completed it (Titov et al. 2019a, p. 8).

These low-intensity services are free and easily accessible, and require less time (fewer sessions and shorter sessions) than standard psychological therapy. However (unlike NewAccess — chapter 12) all therapists are mental health professionals (primarily registered psychologists), and psychiatrists provide consultation, supervision, and training (Titov et al. 2019a, p. 5). People using the service, and GPs, can also contact therapists during business hours. Therapists work from the Mindspot Clinic at Macquarie University in Sydney, and will soon also work from a new clinic in Perth.

The two treatment options were co-designed with more than 6000 people from across Australia (PORTS 2020), while PORTS itself was co-designed with GPs. It is integrated into practice software to help GPs quickly refer consumers to care, and provides feedback back to GPs about their patients’ progress (MindSpot, sub. 178, p. 13). During PORTS first 18 months of operation, close to 20% of those referred to PORTS were referred on to other services, including crisis services, or for face-to-face therapy. The referrals to face-to-face services were due to consumer or GP preference, or were recommended because of symptom complexity, language spoken, cultural reasons, or cognitive impairment (Titov et al. 2019a, p. 8).

PORTS is cost-effective. While not perfectly comparable, it costs much less per service than NewAccess, MBS-rebated therapy, and PHN-commissioned therapy (chapter 12). In 2018-19, PORTS delivered almost 25 000 service contacts at an average cost of about \$87. This is down from an average cost of about \$243 per service contact in its first 18 months (ending June 2018), which included the costs of establishing the service (WA Primary Health Alliance, pers. comm., 3 October 2019). The cost per service contact should continue to fall if the number of contacts continues to rise.

A gateway to other mental health services

Complementing the small number of low-intensity services provided as part of the platform, the platform would, as a third pillar, provide a gateway to a wide variety of other mental health services.

As noted above, the assessment and referral tool would consider a wide range of services when suggesting options for each consumer, and would need to cater to consumers with a wide spectrum of clinical and psychosocial needs. The development of the tool would include consideration of which digital and non-digital services should be recommended to consumers based on their needs and preferences (with non-digital recommendations depending on the services available in each region).

Beyond the self-help resources, and digital low-intensity treatments provided on the platform, service options considered could include:

- automated digital therapies
- other low-intensity treatments — either digital treatments that offer something different to what is offered on the platform, or in-person low-intensity treatments, such as group therapy or short course, structured therapy (chapter 12)
- low-intensity supports (the non-clinical subset of low-intensity services), such as online peer support forums, in-person peer support groups, counselling, or social, sporting or activity groups (chapter 12)
- other psychosocial support services, such as housing services (chapters 17 and 20)
- individual MBS-rebated psychological therapy, provided face-to-face or via videoconference or telephone (chapter 12); individuals who complete the assessment tool online would be able to access MBS-rebated psychological therapy without getting a referral from their GP, if therapy was determined to be an appropriate treatment.

For some treatment options, including psychological therapy, the individual's GP could be informed of the referral (with the individual's consent), and receive updates from the service provider. For other treatment options, including medication, the individual would only be able to access the treatment from their GP. People who access an online clinician-supported assessment would also have the option of taking the results to their GP, to talk through treatment options.

A range of existing resources provide information on mental healthcare pathways. The platform should draw on these resources, and they could be incorporated into the platform in the future.

- HealthPathways — these are clinician-facing portals with information on local referral pathways and services, maintained by PHNs. We have recommended that HealthPathways should be established in all regions, should be expanded to include non-clinical services, and that a broader range of service providers should be able to access the resource (chapter 15).

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- Head to Health — an online directory of digital mental health services (such as apps, telephone support lines, online programs and digital information resources). However, Head to Health is far from its full potential (for example, it only lists services funded by the Australian Government — chapter 15 discusses Head to Health in detail).
 - The Carer Gateway — which provides a broad range of relevant information and referrals for carers (chapter 18).

In the future, additional functions could be added to the platform to make connecting to external services easier. For example, the platform could allow people to book a consultation with a psychological therapist, or could allow a GP to see the availability of local services or make a referral through the platform.

Building the national digital mental health platform

The Australian Government should fund the development and ongoing provision of the new assessment tool and the national digital mental health platform.

The development of the platform itself could be tendered to providers (or consortia of providers) with experience in this space. However, the Australian Government should retain the intellectual property created in this process, to maintain the platform as a publicly controlled resource that cannot be on-sold for profit. The Government should also retain the intellectual property related to the new assessment and referral tool.

The Government should also tender for a small number of digital low-intensity services to be delivered on the platform. To ensure the Government can select from a wide pool of services, it should not require control of these services' intellectual property. However, competition issues would need to be considered if a provider of mental health services also won the tender to develop the platform. In this case, the Government would need to ensure that this provider's services were not unfairly advantaged.

The platform should be funded such that the assessment tool and the low-intensity services offered on the platform are available at low cost to consumers and operate without waiting lists. This is crucial so that services are able to expand to meet consumer demand without the cost to consumers of services offered on the platform becoming a deterrent to its use. Mental health services that receive demand-driven government funding — particularly MBS-rebated therapy and medications subsidised under the Pharmaceutical Benefits Scheme — have been able to expand to meet consumer demand considerably more than low-intensity services, which mostly receive capped block funding (Beyond Blue, sub. 877, pp. 21–22). We estimate that up to two million people currently accessing mental health medication or individual psychological therapy each year would benefit from greater access to low-intensity services (chapter 12).

The success of the national digital mental health platform will hinge on its ability to become a trusted and prominent referral option for GPs, and a recognisable and appealing gateway for individuals seeking help. This will require a substantial investment in the design,

branding and marketing of the new platform (it may make sense to build the platform under an existing brand in the mental health space that is already well-known and trusted). Co-designing the platform with its end users — consumers and GPs — would be a vital part of this (potentially drawing on established co-design processes, such as those developed by Head to Health). Establishing the platform would also require information campaigns aimed at consumers and GPs, and could include face-to-face engagement with GPs to build trust in the assessment tool and the low-intensity services offered on the platform (chapter 11).

The full development of the national digital mental health platform would require significant time. For example, it would take time to expand the capacity of digital low-intensity services and to build links in different regions to in-person mental health services that can be referred to. A staged region-by-region rollout should be considered, as it would enable ongoing improvements to the system and minimise risks in implementation. Consideration should be given to rolling out the platform early in areas where access to mental health services is most restricted, such as regional and remote areas.

Through development, rollout and beyond, the platform should embrace the idea of continuous experimentation, evaluation and improvement. This is possible with digital services with built-in measurement of consumer outcomes and progress monitoring. Co-design with end users should not just be about consultation, but about testing of alternatives to see what users prefer (Hickie et al. 2019).

Transitioning to the new assessment tool

The Australian Government should appoint an expert panel to develop the assessment and referral tool. Its development should leverage previous work, including the Target-D and Link-me trials (for example, Anderson et al. 2019; Fletcher et al. 2019; Kurian et al. 2009). Consumers must be embedded in the process of designing the assessment tool, to ensure the tool is accessible for consumers — with clear and consumer-friendly language and design. And GPs and other clinicians should also be involved, to ensure the assessment tool provides them with the information they need, and fits with how they work in practice — including integrating with GP practice software. The tool may need to be adjusted and validated for groups with different needs, such as young people (including for use in headspace centres that provide MBS-rebated psychological therapy), Aboriginal and Torres Strait Islander people, and culturally and linguistically diverse groups.

As a condition for accessing MBS-rebated psychological therapy, consumers would no longer require an MHTP, but would be required to complete the assessment tool (either with a GP or independently). The MHTP and MHTP Review (section 10.2) should remain in place until the assessment tool has been developed, and should be phased out together when the tool is introduced, although they could continue to be used for groups with different needs until suitable versions of the assessment tool have been developed for these groups. After the assessment tool has been introduced, and an evaluation of MBS-rebated therapy has been completed (chapter 12), the Australian Government could consider encouraging or

requiring that a version of the assessment tool be completed as part of a formal review of the consumer's progress (similar to the MHTP Review now).

If the assessment tool demonstrates that it is effective in supporting holistic assessments and consumer choice, the Australian Government could also consider requiring that consumers complete an assessment using the tool before a GP would be able to prescribe mental health medication. This would help ensure that consumers receive a holistic assessment and are presented with the full range of suitable care options prior to choosing medication.

When the assessment tool is first introduced, a consumer would continue to require a mental illness diagnosis to be eligible for MBS-rebated psychological therapy. The MBS Review Mental Health Reference Group (2018, p. 25), and the APS (sub. 853, p. 26), among others, have recommended relaxing this requirement. But it would be preferable to keep it in place until the assessment tool has been shown to be effective in guiding referrals in line with the IAR. The assessment tool should *not* be designed to diagnose a mental illness. Rather, in cases where the assessment tool or the clinician supporting the assessment (who would sometimes be a GP) consider that psychological therapy would be an appropriate treatment, it would be the responsibility of the clinician to determine whether the consumer had a mental illness (which may require additional questions or investigation).

When it has been demonstrated that the assessment tool is effective in guiding referrals in line with the IAR, the requirement for a mental illness diagnosis to access MBS-rebated psychological therapy should be removed, in recognition that best-practice, person-centred assessment and referral (embodied in the IAR), deems individual psychological therapy most appropriate for some consumers who do *not* have a diagnosable mental illness. The decision to access individual psychological therapy should ultimately be up to the consumer.

The assessment tool should be expected to evolve over time, to ensure that it is helping consumers access the care that is right for them, and to incorporate new services and respond to changing evidence about what works. To allow this, the Australian Government Department of Health must be able to observe how the tool is employed by GPs in practice — including, for example, how GP treatment and referral practices align with the assessment tool's guidance. This information could also inform GP education and training programs.

Finally, while we have recommended the new assessment and referral tool as an integrated part of the national digital mental health platform, the assessment and referral tool should be developed for use by GPs (and as a replacement for the MHTP) regardless of whether the platform is built. As discussed in section 10.2, too many consumers are not receiving holistic mental health assessments and are not being supported to choose among the full range of mental health services.

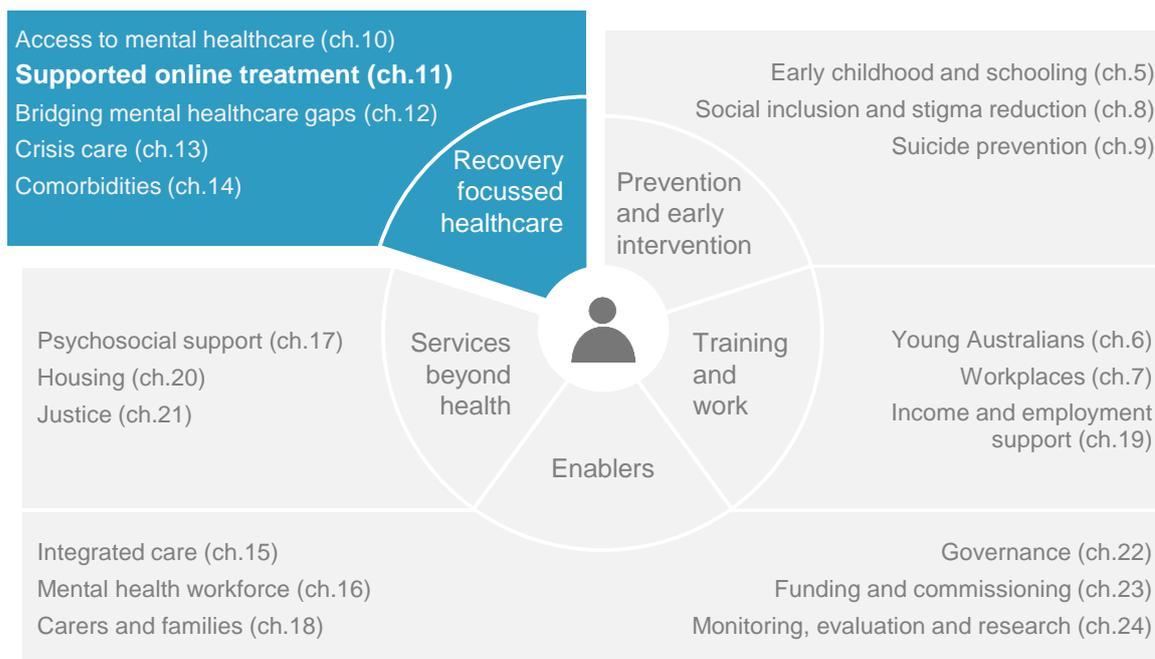
ACTION 10.4 — MENTAL HEALTH ASSESSMENT AND REFERRAL TOOL

A new assessment tool, that is consistent with the Australian Government Department of Health Guidance on Initial Assessment and Referral, should be developed and implemented across the mental health system, to ensure a robust and person-centred approach to assessment and referrals.

Start now

- The Australian Government should fund the development and ongoing provision of a national digital mental health platform. The platform should provide:
 - a tool for free person-centred assessment and referral, to be used by GPs and by individuals to access online assessment and referral, underpinned by a mental health clinician. The assessment and referral tool should:
 - ... provide clear guidance to referring clinicians and consumers about the evidence-based interventions and services that are likely to best meet the consumer's needs, as well as those that are not recommended, given the consumer's circumstances
 - ... enhance consumer choice, by recommending a broad range of services and modes of delivery, including clinical and non-clinical services delivered digitally and face-to-face.
 - ... be given to the consumer, to share with providers of their choice
 - ... replace the Mental Health Treatment Plan as a requirement for accessing MBS-rebated Psychological Therapy Services and Focused Psychological Strategies.
 - low-cost, accessible and evidence-based digital low-intensity services; at launch, this should include supported online treatment (Action 11.1) and short-course, structured therapy delivered by videoconference or phone
 - be capable of being connected to the recommended navigation portals to draw on links to other digital and face-to-face treatment and support services (Action 15.2)
 - provide data on assessment and referral practices to enable the Australian Government Department of Health to observe how GP treatment and referral practices align with the tool's recommendations, to inform ongoing improvements to the tool, and indicate where additional GP education and training is required.
- The Australian Government should appoint an expert panel to oversee the development of the new mental health assessment and referral tool, to be co-designed with consumers and clinicians. The Government should tender for the construction of the platform, and for a small number of digital low-intensity services to be provided on the platform.

11 Supported online treatment



Supported online treatment matters because ...

- Supported online treatment has features that are highly valued by some consumers. It supports self-management of mental health with a largely anonymous approach. It is also convenient, effective, low-cost and generally available at the time of need.
- Supported online treatment can be used either as a complement or as an alternative to face-to-face therapies.
- Supported online treatment strengthens the mental health system by using a comparatively small amount of clinician time without a reduction in consumer outcomes.
- It is a form of treatment that can potentially be expanded relatively quickly to manage the extensive increases in demand that can follow environmental, social and economic shocks.

RECOMMENDATION 11 — EXPAND SUPPORTED ONLINE TREATMENT

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

As a priority, the Australian Government should:

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

Additional reforms that should be considered:

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

11.1 Why focus on supported online treatment?

Supported online mental health treatments are a range of automated internet programs which provide treatment directly to consumers, with clinician support usually occurring after consumers complete each online module (box 11.1).

For many people, supported online treatment can be a convenient, effective, low-cost way to manage their mental ill-health. It has a range of features that are highly valued by some consumers. It is accessible from most parts of Australia, unlike traditional face-to-face treatments. It can be accessed reasonably anonymously, which can help consumers to avoid the stigma that may otherwise accompany mental ill-health. It can be tailored, so that consumers can choose the service that best meets their individual needs, in terms of age, culture, language and symptoms. It can allow consumers to access treatment when and where they need it, rather than waiting until they have reached the top of a waiting list and having to travel to the clinician's premises. It can be a low-cost option, particularly when compared with some face-to-face treatments. And, most importantly, it works.

Many people find that they can effectively manage their mental ill-health by engaging with supported online treatment. It should be available to people as a choice when there is a strong evidence base that it would meet their needs. But it is not necessarily going to be everyone's preferred approach; some people will prefer other treatment options and these preferences need to be respected.

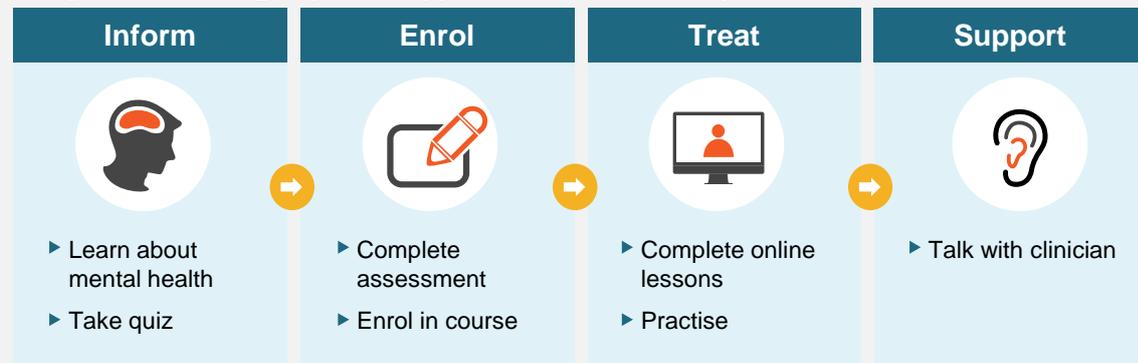
Supported online treatment expands consumer choice, complements other treatments people may choose to access, and makes the mental health system more person-centred.

The COVID-19 pandemic and the bushfires in preceding months are expected to have widespread implications for the mental health of Australians (Liu et al. 2020; Newnham, Titov and McEvoy 2020; Wind et al. 2020). For most people, the heightened level of distress that occurs with crises subsides over time with their own self-management. But others require support either immediately, to manage challenging events or later, after the events have concluded (Newnham, Titov and McEvoy 2020).

These events reinforce the importance of people having access to care that is right for them at the right time. For that, they need a system offering options that can respond to rapid changes in their needs, which may be geographically concentrated. Supported online treatment can be a flexible service that suits the needs of some people, that can be expanded with moderate demands on the workforce, and that empowers people with self-management skills. Nevertheless, the task of mitigating disaster risk and effects extends beyond one form of mental health treatment — and indeed beyond the health system alone (Department of Home Affairs 2018).

Box 11.1 What is supported online treatment?

Supported online mental health treatments are a range of automated internet programs which provide treatment directly to people, with clinician support. Clinicians providing support have similar qualifications to those providing face-to-face therapy. People could experience up to 4 steps when seeking help from supported online treatment providers.



Many people use online services to get information or to undertake an online assessment of their mental health. Access to information can help people to make informed decisions about managing their mental health, potentially reducing their need for further services (MindSpot, sub. 666). Once enrolled, people start treatment by undertaking interactive learning activities to help them understand their mental health problem or disorder and learn strategies to improve thoughts and behaviours. The programs can include real-life stories of recovery.

MindSpot: Wellbeing course

About Glenn and Jo

Most of the people in our Courses learn a lot from the experience of people who have recovered from anxiety and depression.

So, during each lesson we will include comments from Glenn and Jo. They have kindly offered to share their stories.

Glenn and Jo will help us to provide some of the information and teach some of the skills in the course. We do not expect your experience or story will be exactly the same as theirs. However, we hope that reading their stories will help you understand and manage your own wellbeing.

** Names and details have been changed. Pictures are of actual people.*



Let's meet them

THIS WAY UP: Post-traumatic stress course



Can you see from that example how your thoughts affected how you felt and what you did?

Yes, but what else could I?

In practice, the nature of supported online treatment programs can be quite diverse (Andrews et al. 2018a). People usually receive support via email or phone. A clinician may spend time talking with a person as well as reading and providing feedback on written tasks. For some treatment programs, support is embedded in the program while in other programs consumers are supported by their GP (CRUfAD 2019; Thomas, Seabrook and Foley 2019; MindSpot, sub.178). There are three major providers of supported online treatment for mental illness in Australia: Mental Health Online, MindSpot and THIS WAY UP — all received government funding in 2019-20.

Supported online treatment can also be integrated into a triage system and provide referral support and treatment information to GPs (for example, the Practitioner Online Referral Treatment Service (PORTS) (chapter 10).

It is time to integrate and expand consumer access

Over the past decade or so, the Australian Government has assisted the development of supported online treatment and e-mental health information and services more broadly (box 11.2). While these represent the first important steps in offering consumers access to an effective treatment option with appealing features, it is now time to integrate and expand consumer access to this treatment option (section 11.6).

Box 11.2 The Australian Government's e-mental health strategy

E-mental health refers to the use of the internet and other digital technologies to facilitate engagement in, and the delivery of, mental health information and services (including suicide prevention). These services are delivered primarily to consumers but also to carers and the broader public. E-mental health includes services delivered via phone, web chat, video, websites (including social media), applications and software, wearable devices, sensors and robots. These services may be self-guided or involve real time or delayed interaction with a person, including peer support. Consequently, e-mental health covers a wide assortment of information and services delivered in a multitude of forms.

The Australian Government has supported the use of e-mental health services as an accessible and cost-effective alternative or adjunct to face-to-face care.

- In 2006, the Australian Government invested in e-mental health through the development of a number of projects under the Telephone Counselling, Self Help and Web-based Support Programmes (now known as Teleweb). This early investment focused on expanding telephone counselling service centres as well as providing information, counselling and online self-help programs (DoHA 2006).
- In 2012, the Australian Government released the e-Mental Health Strategy for Australia. It highlighted the need for further expansion of e-mental health services, including expanded youth-focused telephone and online counselling services (via headspace), an online e-mental health portal to provide pathways to services (mindhealthconnect.org.au), and the establishment of a virtual clinic providing supported online treatment (MindSpot) (Australian Government 2012).

As a result of a commitment in the Australian Government's 2015 response to the National Mental Health Commission's review (DoH 2015a), Head to Health was developed. Head to Health is a digital mental health gateway, offering online access to navigate mental health services. Mindhealthconnect was decommissioned and replaced by Head to Health in October 2017 (ReachOut Australia, sub. 804).

In recent years, a number of organisations have also advocated for or recommended expanding access to e-mental health. For example, the National Mental Health Commission (2014c) recommended e-mental health solutions be more closely integrated with primary care. Similarly, ReachOut Australia (2015) noted that to make the most of e-mental health, it was time to integrate online services into the broader mental health system and promote their use to health professionals and the community. Many participants in this Inquiry emphasised that digital options offered a source of benefit to consumers and the operation of the sector (for example, Black Dog Institute, sub. 306; Mental Health Australia, sub. 407; Mindgardens Neuroscience Network, sub. 64; Queensland Mental Health

Commission, sub. 228). However, at present, people are not regularly being offered supported online treatment as part of a range of treatment options. What's more, the supporting structures needed for a successful, integrated and mature e-mental health system (such as consumer awareness and health professional understanding and support) are still developing (section 11.5). Without this integration, some people lose the ability to choose the treatment option that is most suitable for them.

Consumers should have choice

The Productivity Commission received support for the draft report recommendation to provide consumers with greater access to supported online treatment by increasing funding for these services and integrating the option into routine care.⁷⁸

Inquiry participants also emphasised that, with any increase in consumer access to online treatment, consumers should still have the choice of other treatment methods (such as face-to-face therapy) (box 11.3). We concur that supported online mental health treatment should be one choice among a range of treatment options. The choice of treatment should lie with the consumer, with information and advice provided so that they can make an informed decision about what would likely be effective (given their mental ill-health and recovery needs). This requires consumers and health professionals to be informed. The Productivity Commission recommends two separate information campaigns to help support and guide decision making when consumers are choosing treatment options (Action 11.1).

Community knowledge of the importance of mental health and the benefits of digital services is evident in the wake of the COVID-19 pandemic. The Australian Government, not-for-profit organisations and businesses have embraced and leveraged the advantages of digital options to provide information and additional services (Beyond Blue 2020a; DoH 2020n; headspace 2020a; THIS WAY UP 2020). Digital options have been used to raise awareness of the mental health implications of the spread of a serious physical illness and of the behavioural measures used to limit this spread (Australian Government 2020d). The apparent community openness to maintaining mental health via online resources provides further indications that it is time to expand and integrate supported online treatment into the mental healthcare system.

The remainder of this chapter explores the consumer value of supported online treatment (sections 11.2-11.3) and how it can benefit the broader mental health system (section 11.4). It also examines the key role of information in helping consumers to make choices about their mental healthcare, and the gaps in the information currently available (section 11.5).

⁷⁸ For example: Australian Clinical Psychology Association (sub. 727); Australian Nursing and Midwifery Federation (sub. 1187); Australian Psychological Society (sub. 853); BrainStorm Mid North Coast (sub. 803); Consumers Health Forum of Australia (sub. 646); Eating Disorders Victoria (sub. 892); eMental Health in Practice (sub. 602); headspace — National Youth Mental Health Foundation (sub. 947); Mental Health Victoria and Victorian Healthcare Association (sub. 1184); MindSpot (sub. 666); National Mental Health Commission (sub. 949); Priority Research Centre Brain and Mental Health Research and Society for Mental Health Research (sub. 759).

The benefits and costs of expanding supported online treatment are presented, along with some policy design considerations (section 11.6). Finally, the promising and emerging role of self-guided applications and programs is outlined (section 11.7).

Box 11.3 Supported online treatment is one option for consumers

Australian Psychological Society (APS) (sub. 853, p. 25): ... online treatment is not a substitution for face-to-face treatment in some cases and the role of online interventions is different across the stepped care model ... Further, the APS believes it should remain the consumer's choice about the type of service they receive and they should not be mandated to use online treatment services.

Centre for Mental Health Research (sub. 148, p. 7): The provision of online treatment programs, as well as face-to-face interventions, is important.

Mental Health Victoria and Victorian Healthcare Association (sub. 1184, p. 8): ... we note that digital consultations cannot be seen as the panacea for filling gaps in a stretched system, particularly in rural areas. We welcome the PC's requirement ... that online treatment programs have a strong evidence base, and suggest that online treatment programs should be available for consumers only as an alternative to direct consultations with a practitioner or counsellor, rather than as a substitute.

National Mental Health Commission (sub. 118, p. 24): Digital technology can also be useful for remote service provision and as an adjunct to the workforce in rural and remote areas, including as a method of providing distance education and training, and e-supervision to health professionals. However, these should not be a substitution for face-to-face care.

NSW Council of Social Services (sub. 143, p. 10): In addition, while telehealth and digital solutions certainly have a place in promoting and servicing mental health, they do not replace the need for people to be able to access face-to-face services.

Queensland Alliance for Mental Health (sub. 247, p. 7): In summary, digital therapies should supplement, but not make redundant, remote, practitioner-based services.

Rural and Remote Mental Health (sub. 97, p. 13): Although there are many ways of communicating with people living and working in rural and remote Australia, including various tele-health and internet-based platforms, there is and will continue to be a need for face-to-face communication.

11.2 A treatment option that consumers value

There are a range of reasons why people with mental ill-health do not access services.

Some people prefer to self-manage their condition without professional assistance, and may only need information to help them do this (Harris et al. 2014; MindSpot, sub. 666). For some, their heightened level of distress and symptoms subside over time, and they do not require treatment (Newnham, Titov and McEvoy 2020). As many as 50% of previously untreated individuals who meet the criteria for having mental illness may improve without treatment in a 12 month period (Harris et al. 2014, p. 839).

Other people have difficulties in engaging with and accessing face-to-face services and consequently do not gain the treatment they need (Whiteford et al. 2014a). This happens because the range of services currently offered do not suit the preferences and needs of some people with mental ill-health, placing barriers between consumers and the care they require.

Supported online treatment can help to break down some of these barriers by allowing consumers to undertake treatment at a place and time that is suitable and convenient for them, while still benefiting from professional guidance when required.

The most common barrier that online mental health services can overcome is a preference for anonymity and a self-management-based approach. Financial constraints, convenience and lack of other available services were also reasons endorsed by a significant minority. (Thomas, Seabrook and Foley 2019, p. 16)

Digital mental health services are particularly beneficial for people with, or at risk of, mild to moderate mental illness and may also be an important resource for some people with severe mental illness. They provide an opportunity to significantly increase access to care by transcending geographic, stigma, privacy and financial barriers. They can be used either as a complement or alternative to face-to-face therapies, and allow people to seek support in times of need or when it is most convenient for them. (Department of Health, sub. 556, p. 22)

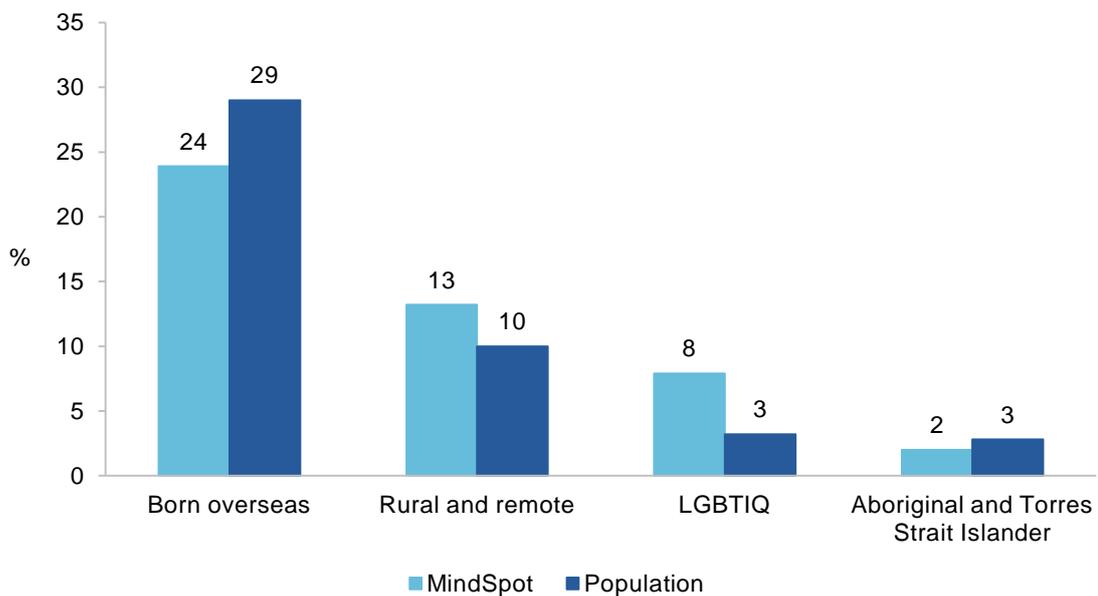
Embracing the anonymity of online services

Stigma and embarrassment about mental ill-health can prevent people from receiving help from professionals face-to-face (chapter 8). In submissions, Inquiry participants highlighted a range of examples of how stigma can stop people accessing services.

- In small communities, issues of stigma and privacy may be heightened given the increased visibility in the community when accessing services or the possibility that people will know health professionals in a personal capacity (Matilda Centre for Research in Mental Health and Substance Use, sub. 880; Murrumbidgee Primary Health Network, sub. 1199; Queensland Alliance for Mental Health, sub. 247; Rural and Remote Mental Health, sub. 97; Volunteering Australia, sub. 412).
- The understanding and experience of social and emotional wellbeing of many Aboriginal and Torres Strait Islander people is very different from that of many other Australians (chapter 4). Orygen and headspace (sub. 204) emphasised that stigma among young Aboriginal and Torres Strait Islander people is one of a number of access barriers for headspace services.
- Due to ongoing perceptions and experiences of stigma and discrimination, LGBTIQ Australians also encounter barriers to accessing face-to-face mental health services (National LGBTI Health Alliance, sub. 888). Thorne Harbour Health and Rainbow Health Victoria (sub. 265) submitted that about one-third of the LGBTIQ Australians surveyed reported usually or occasionally hiding their sexual orientation or gender identity when accessing face-to-face services.

Some of the consumer groups that have reported experiencing stigma in face-to-face services are using supported online treatment (figure 11.1). For example, approximately 8% of people participating in a MindSpot course identified as being LGBTIQ, which is higher than the percentage identifying in the population (3%). Similarly, about 13% of people participating in online treatment lived in rural and remote areas, yet this group makes up only 10% of the Australian population.

Figure 11.1 Selected demographic characteristics of users of online treatment^a



^a LGBTIQ - Lesbian, gay, bisexual, transgender, intersex and queer.

Source: ABS (*General Social Survey, 2014*, Cat. no. 4159.0); ABS (*Census of Population and Housing: Aboriginal and Torres Strait Islander Population, 2016*, Cat. no. 2017.0); ABS (*Migration Australia, 2017-18*, Cat. no. 3412.0); MindSpot (2019a); Wilson and Shalley(2018).

While not addressing the attitudes and behaviours that underlie stigma, some consumers value the level of anonymity offered by supported online treatment options, reducing the embarrassment or discrimination that individuals may experience in seeking face-to-face treatment. For example, about 32% of people who sought treatment from the MindSpot online clinic did so for reasons relating to privacy, anonymity, stigma, or that face-to-face treatment is too confronting (Titov et al. 2017, p. 1233). Furthermore, 28% of people who participated in a treatment program had not previously accessed mental health treatment. About 41% of people who sought online treatment from Mental Health Online stated they had a preference for anonymity, and 15% stated that they wanted minimal therapist contact (Thomas, Seabrook and Foley 2019, p. 8). Over 30% of Mental Health Online participants had never accessed other mental health services prior to seeking help online (Thomas, Seabrook and Foley 2019, p. 9).

In accessing supported online treatment, consumers can maintain a level of anonymity by specifying the preferred nature of their contact with a clinician. For example, while it is recommended that consumers of MindSpot services receive assessment results via phone and email, it is possible to receive these results via post or email only. About one-third of participants reported that they do not want to be contacted by phone (MindSpot 2019a, p. 11). THIS WAY UP also noted that consumers can choose their preferred level and mode of contact:

... in our clinician-guided programs, we advise users and clinicians to determine mutually appropriate levels of contact during program duration, in order to suit each users' unique circumstances and preferences. The nature of contact in our programs is flexible, and in our effectiveness studies (> 20 evaluations completed), we have found that email, online forum participation, text-messaging, phone and face-to-face contact are all effective methods of contact. (CRUFAD 2019, p. 14)

As many people with mental illness do not seek treatment from health professionals due to stigma, the ability to self-refer and undertake treatment online also provides consumers with greater choice (Andersson and Titov 2014; Titov et al. 2017). Self-referral is common. For example, about 60% of consumers who sought treatment with MindSpot self-referred (Productivity Commission estimates using MindSpot 2019a, p. 10). Similarly, 40% of people participating in a program with THIS WAY UP used self-referral methods such as internet searches, other websites or advertising (Productivity Commission estimates using CRUFAD 2019, p. 10). Mental Health Online noted that Google Analytics data showed that the main sources of web traffic to their site are web search and the Australian Government Head to Health website (Productivity Commission estimates using Thomas, Seabrook and Foley 2019, p. 9).

Reducing locational access barriers

Consumers living in regional and remote areas of Australia can face difficulties accessing mental health treatment due to a lack of availability or choice of services (chapter 12).

Supported online treatment can overcome locational barriers to access, with consumers in regional areas able to receive treatment based in another location (figure 11.2). The clinician-supported online treatment MindSpot, for example, is 'moderated' out of Macquarie University in Sydney, while 40% of users are from regional and remote areas (MindSpot, sub. 178, p. 5). Furthermore, about 10% of MindSpot consumers indicated that they use online services because of difficulty in accessing local face-to-face services or because none existed in the local area (MindSpot 2019a, p. 9). Over 45% of participants in the Mental Health Online program lived in regional and remote areas; this proportion increased by, 5% per year, on average, over the four financial years to 2018-19 (Thomas, Seabrook and Foley 2019, p. 11).

Figure 11.2 **Consumers can access supported online treatment from anywhere in Australia^a**

Postcode location of MindSpot consumers, 2018



^a The postcode location of MindSpot consumers is denoted by the dark blue dots. MindSpot is located in Sydney, denoted by a grey dot.

Source: MindSpot (sub. 178).

While internet connectivity is widespread and increasingly mobile across Australia, a number of participants noted that a lack of telecommunications infrastructure keeps consumers from accessing online services, particularly in regional and remote areas. Many participants described unreliable internet coverage or slow internet speeds. The NSW Council of Social Services (sub. 143, p. 10), for example, submitted that:

With a growing range of education, information, government, and community services moving online, internet access and connectivity is increasingly regarded as an essential service. Online and telehealth services have the potential to improve access to mental health services for people in regional and rural areas. However, telecommunications and internet connectivity remains an issue in many regional and remote areas, rendering telehealth services unavailable for many of these communities.

Having little or no internet access after a natural disaster can sometimes be a problem for people wanting to seek mental health support. In January 2020, about 150 mobile base stations across New South Wales, Victoria and South Australia were unavailable and over 20 000 national broadband services were down as a result of bushfires in these states (Fletcher 2020).

While intermittent and unreliable internet coverage is a real issue for people living in regional and remote Australia, it is still possible for them to undertake and benefit from supported online treatment with some adjustment. For example, online material can be made available via post for those with limited internet reliability, as is the current practice of MindSpot (Titov et al. 2018).

To provide real choice, people living in regional and remote areas (or areas with temporary internet access problems due to natural disasters) should still have access to a range of other treatment options (such as face-to-face and group therapy, and tele-CBT as delivered by the Practitioner Online Referral Treatment Service (PORTS)). Some of these alternative options have been designed based on the preferences and needs of consumers living in regional and remote areas. In some circumstances, supported online treatment may not be a practical treatment option.

Making treatment services more convenient

Consumers can find attending face-to-face treatment services inconvenient. Even those living in major cities can have difficulty finding a suitable mental health professional in a location and at a time convenient to them. THIS WAY UP noted that:

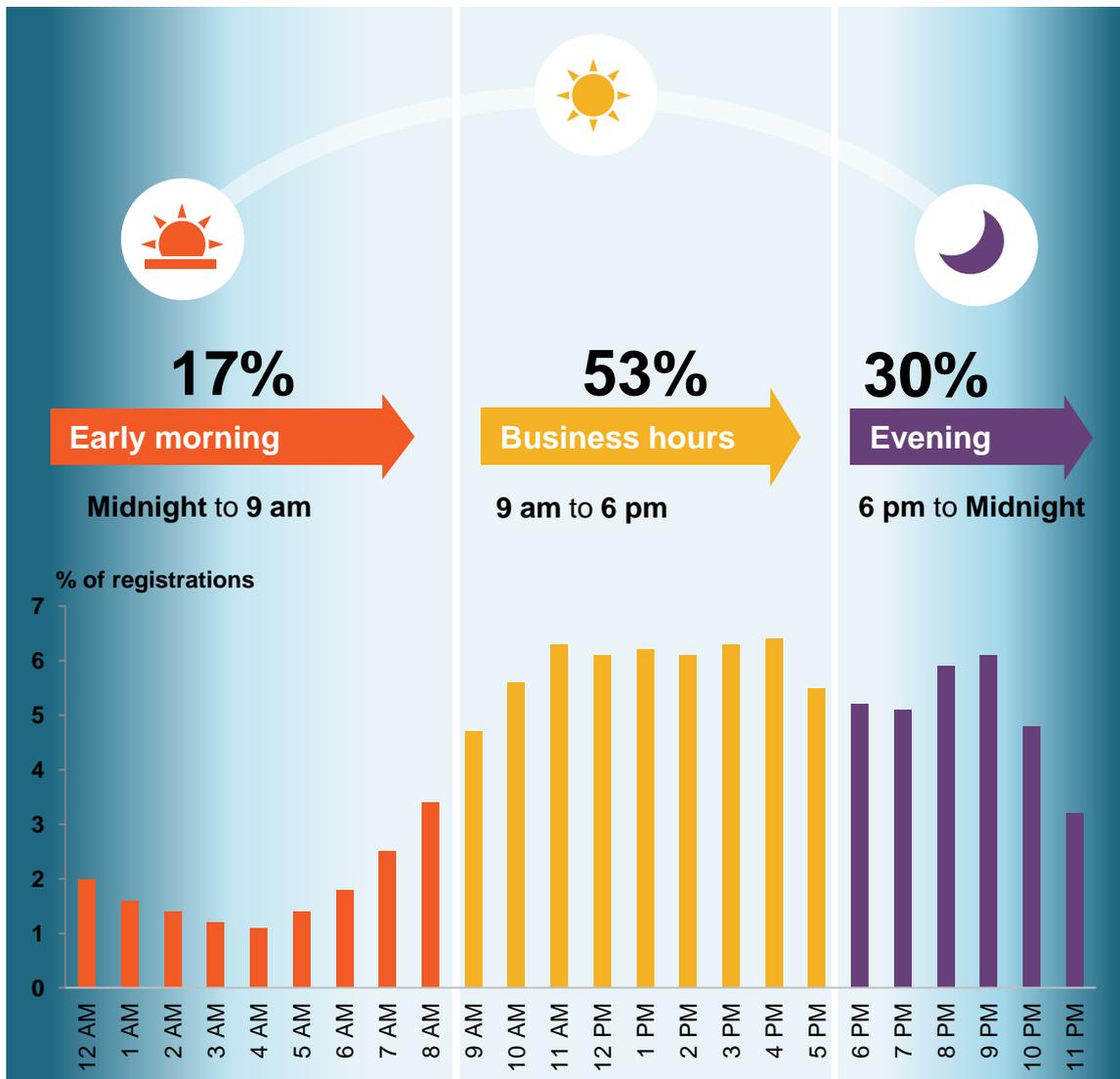
... our online programs also service a large number of Australians living in major cities where the population density means that the demand for mental health services far outweighs the supply, and where long waiting lists in both public and private health care facilities are common place, and the breadth and depth of services can vary across health networks. (CRUfAD 2019, p. 15)

Internet-based treatment offers consumers a choice of service at a place and time that is suitable and convenient to them. For example, online treatment options are generally available 24 hours and 7 days a week, and treatment can be accessed when and where it is safe and suitable to the consumer. By contrast, most clinicians only operate during daytime hours on weekdays, and/or charge higher service fees to consumers who need their services at other times. About one in five people who report needing to see a GP after hours do not end up seeing one at all (ABS 2019i).

THIS WAY UP noted that almost half of course registrations were made outside of normal business hours, with similar proportions for the times when subsequent lessons were completed (figure 11.3). They also noted that '[i]ndividuals access the website and courses at all days of the week, and more specifically 14% of registrations were done on a Saturday or a Sunday' (CRUfAD 2019, p. 15).

Figure 11.3 **Access to online treatment is not confined to business hours**

Time of registration for THIS WAY UP online courses



Source: Productivity Commission estimates using CRUfAD (2019).

The convenience of access to online treatment makes it an attractive option for some consumers, especially when compared with the dissatisfaction of accessing some face-to-face services. (For example, a quarter of people were not able to get an appointment with a GP for urgent medical care and almost 20% of people indicated that they had spent longer than they felt acceptable in a GP waiting room (ABS 2019i).) Almost one quarter of MindSpot participants stated that their main reason for seeking treatment with MindSpot was that ‘I can access online support immediately, at a time that suits me’ (MindSpot 2019a, p. 9). Similarly, THIS WAY UP stated:

Qualitative feedback from our users suggests that work and study commitments (including shift and seasonal work), carer duties, national and international travel, and transport and mobility

limitations (especially for our youngest and oldest users) make online CBT [cognitive behavioural therapy] options appealing. (CRUFAD 2019, p. 16)

Providing a low-cost treatment option

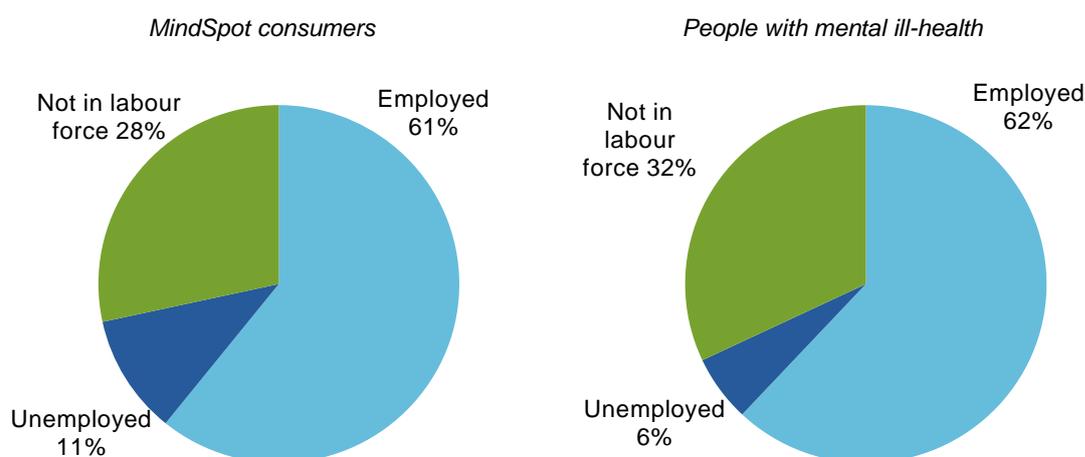
People accessing face-to-face treatment can pay out-of-pocket costs. These costs can affect the affordability of treatment (chapter 12).

A number of the supported online treatment programs have been developed by the university sector with various funding sources from the Australian Government. Consequently, these government-funded supported online treatment programs are either free or offered at a low cost to all participants.

Low-cost supported online treatment provides a real choice to those who may not be able to afford the out-of-pocket costs sometimes associated with face-to-face treatment.

- About 13% of MindSpot consumers indicated that their main reason for seeking treatment online was that they could not afford to pay to see someone, or that the costs of travel were too high (MindSpot 2019a, p. 9). A similar proportion of participants in Mental Health Online courses indicated that financial constraints were one of their reasons for using online treatment (Thomas, Seabrook and Foley 2019, p. 12).
- About 11% of those accessing treatment with MindSpot indicated that they were unemployed at the time of registration — a considerably higher proportion than in the general population of people with mental ill-health (figure 11.4). Mental Health Online also reported a disproportionate number of users not in paid employment (Thomas, Seabrook and Foley 2019).

Figure 11.4 **Supported online treatment: labour force status comparison**



Source: Productivity Commission estimates using ABS (*National Health Survey: First Results, 2017-18*, Cat. no. 4364.0.55.001); MindSpot (2019a).

Options that improve on past experience

This Inquiry heard from many people who were dissatisfied with their past experience as consumers of face-to-face mental health services. They described difficulty finding and accessing relevant services, being treated in ways that were demeaning and disempowering, and not receiving the necessary support to achieve a functional recovery in the community. The National LGBTI Health Alliance (sub. 888, p. 3), for example, submitted that:

In 2014, the From Blues to Rainbows report asked 188 trans and gender diverse young people their reasons for not seeing a health care professional. Among the reasons were fears that they wouldn't be understood (33%), the language used by health professionals made them feel uncomfortable or angry (23%), and negative past experiences (30%).

Some consumers who have disengaged from the mental health system value the treatment received from supported online providers. For example, 10% of MindSpot consumers stated that they sought online treatment because 'face-to-face treatment had not helped me, or I need additional support' (MindSpot 2019a, p. 9). That said, Mental Health Online noted that less than 2% of users indicated 'dissatisfaction with previous face-to-face services' as the reason for seeking help online with them (Thomas, Seabrook and Foley 2019, p. 12).

Opportunities to lower cultural and language barriers

People from culturally and linguistically diverse backgrounds (CALD) often have difficulty accessing services that meet their preferences and needs. People with no or limited English in need of mental health treatment cannot access services and interact with them if they are largely offered in English (Mental Health Australia, FECCA and NEDA, sub. 524). Cultural approaches can add to access barriers, particularly if mental health problems are not discussed or conceptualised in some cultures, or are understood in a way that is different from mainstream English-based services (FECCA and NEDA, sub. 524). The CALD community may also face the access barriers discussed above, including stigma and cost.

There is evidence that some people born overseas find supported online treatment accessible. For example, 24% of people using MindSpot's online courses were born overseas (although some of these people will be from other English-speaking countries) (figure 11.1). MindSpot (sub. 666, p. 10) also noted in their submission that some individuals are 'keen to practice their English language skills, and do not wish to be seen as different', and so opt to use the English version of the supported online treatment rather than seeking options in their native language.

While supported online treatment has the potential to reduce access barriers for the CALD community, the services currently available are unlikely to do this. Only a small number of services are currently offered in languages other than English due to the absence of strong demand for non-English supported online treatment. This is self-reinforcing. The limited exposure of supported online treatment in consumers' native languages or in ways that are culturally relevant means that they are not familiar with this type of treatment, potentially constraining the demand for such services. In turn, the lack of visible demand reduces the

immediate necessity to develop non-English supported online courses. MindSpot (sub. 666, p. 9) noted that the absence of strong demand combined with costs of translation and delivery have ‘prohibited the routine delivery of supported online treatment for non-English speaking Australians’. Options for reducing these barriers and providing greater choice of treatment for CALD consumers are discussed in section 11.6.

11.3 A high quality treatment option for consumers

To ensure that consumers can choose the best-quality care, any expansion of supported online treatment must only include effective services with a strong evidence base.

Supported online treatment is not new and has been proven to be effective in trials and routine care for more than two decades (Andrews et al. 2018a). Consequently, there is a large and growing body of evidence showing that supported online treatment can benefit many Australians, if they choose to use it. As many of these studies have focused on cognitive behavioural therapy (CBT), that is the main focus of this section. Other types of therapy have been less extensively delivered, such as interpersonal therapy, positive psychology, problem solving therapy and acceptance commitment therapy (Andersson and Titov 2014; Carlbring et al. 2018; Kladnitski et al. 2020). Consumers should be offered these services where there is a strong evidence base that it would meet their needs.

Effective for high prevalence mental illness

It is well-established that supported online treatment is an effective option for people with high prevalence mental illness (such as anxiety and depression) (Andrews et al. 2018a; Newby et al. 2016). For example, in a meta-study of supported online treatment, mental health improvements among consumers were moderate to large (Andrews et al. 2018a). The longer-term effects are somewhat smaller but nonetheless, consumers still benefited from the treatment.

The effectiveness of supported online treatment has, in certain situations, been found to translate from clinical trials to routine care (Titov et al. 2018).⁷⁹ A range of factors are considered important for a successful translation to routine care, including validating the program in trials, practising good governance and seeking consumer feedback (box 11.4).

⁷⁹ Trial studies more generally can lack ‘external validity’: outside the experimental setting, participants or other factors may differ. This can mean that the intervention does not have the same effect (if it even remains effective) when provided to a broader population.

Box 11.4 **Successful translation from trial to routine care**

From a study of five clinics^a, eight factors were identified as contributing to the successful delivery of supported online treatment in routine care:

1. developing strong clinical, information technology and organisational governance at the outset
2. having strong links with funding bodies, local health services and universities
3. being a specialised and centralised healthcare unit
4. offering programs that were validated in clinical trials before deployment in routine care
5. monitoring consumer satisfaction and using feedback to improve clinic procedures
6. developing systems to monitor quality care, in particular, the regular monitoring of progress in treatment and supervision of clinicians
7. accepting self-referrals as well as referrals from health professionals
8. developing efficient processes for conducting online and telephone assessments, and providing systems for training and supervising clinicians to manage large volumes of referrals.

These clinics provided treatment to large numbers of consumers, and have progressed from trial or pilot or project models to permanent services (routine care) with sustainable funding. They primarily treat depression and anxiety disorders using cognitive behavioural therapy, with ongoing monitoring of effectiveness.

A limitation of this analysis, as acknowledged by the authors, is that it is based on examples of supported online treatment and does not include other models of online treatment, including blended models of care.

^a The clinics include: Internet Psychiatry Clinic (Sweden), Internetpsykiatrien Clinic (Denmark), eMeistring clinic (Norway), Online Therapy Unit (Canada), and MindSpot (Australia).

Source: Titov et al. (2018).

Consumers should not consider supported online treatment as inferior or less effective compared to face-to-face treatment. A meta study of nine reviews (Andrews et al. 2018a), for example, indicated that supported online treatment is as effective as face-to-face therapy, and carries additional benefits such as fidelity of treatment. CBT delivered face-to-face, is difficult to standardise because factors unique to each clinician-consumer interaction can alter how and what treatment is delivered. Elements can be omitted, and each individual clinician can introduce ‘drift’ by administering their own personal version of the treatment. However, clinician variability for supported online treatment is less likely because courses can be distributed as they were designed (Andrews et al. 2018a).

Furthermore, consumer outcomes from supported online treatment are routinely measured, unlike for many face-to-face services. Participants regularly complete questionnaires, which allow a clinician to monitor progress, safety and outcomes (Andersson and Titov 2014). Some programs have the option for GPs and other health professionals to receive the results of these questionnaires, depending on the participant’s preference or the requirements of the program. Providing such information to the referring clinician can substantially improve a person’s care coordination and treatment outcomes (chapter 15).

A number of supported online treatment programs have been tailored so that consumers with specific needs, such as women with perinatal depression and anxiety, can choose the service that best meets those needs (box 11.5). Offering consumers tailored programs is important given the general lack of specialised treatment available. One participant noted her own difficulty in finding a professional suitably qualified in post-natal depression:

Many of the health professionals that I sought care from or was referred to simply did not have the education and skills to provide care specific to the perinatal period. My family and I had to spend many days and hours trying to find the right professionals that would be able to help, and this came at a cost as I had ended up having to pay for private care away from my home town. (comment no. 37, consumer)

A possible option for more complex mental illnesses

People with more complex mental illness can also benefit from supported online treatment. There is some evidence that specifically designed supported online therapy may be effective in complementing specialist mental health treatment for severe and less prevalent disorders, such as schizophrenia, bipolar disorder and bulimia nervosa (DoH, sub. 556; Eating Disorders Victoria, sub. 892; Thomas, Seabrook and Foley 2019).

Given the developing and fast moving nature of this field, evidence is paramount in policy development and to ensure that consumers are offered clinically effective treatment. Mental Health Online cautions against making assumptions about who can benefit from online treatment:

We have also, more anecdotally, noted that digital mental health is often automatically assumed to be just for younger people, and just for people with less severe mental health problems, rather than the full range of persons who might be able to benefit from digital resources. (Thomas, Seabrook and Foley 2019, p. 15)

Box 11.5 Evidence of supported online treatment program effectiveness for particular groups**Perinatal women**

A therapist-assisted six-session online cognitive behavioural therapy (CBT) intervention, MumMoodBooster, for women with a clinical diagnosis of post-natal depression was evaluated through a randomised control trial. Post treatment, depression symptom severity scores were significantly lower for the intervention group compared with the group treated as usual, with 79% of women in the intervention group no longer meeting diagnostic criteria for depression at 12 weeks (Milgrom et al. 2016). A trial of Canadian women with post-natal depression found that, following a course of therapist supported online CBT, symptoms of postpartum depression decreased more for participants than for those in the waitlist control group (Pugh, Hadjistavropoulos and Dirkse 2016).

Children and adolescents

Some online treatment programs have been shown to reduce anxiety in children and adolescents. A review of 27 studies of online CBT for young people aged 12 to 25 years reported a reduction in anxiety symptoms (Pennant et al. 2015) Programmes for children and adolescents that are available in Australia include the Brave Program and THIS WAY UP's TeenSTRONG.

Aboriginal and Torres Strait Islander people

MindSpot's supported online program has been found to be effective in treating anxiety and depression in Aboriginal and Torres Strait Islander people, with outcomes similar to those of non-Indigenous consumers (Titov et al. 2019b). The Indigenous Wellbeing Course is a version of the Wellbeing Course; it has the same core content, but has been modified by an Indigenous mental health worker in consultation with a range of other Aboriginal and Torres Strait Islander groups and individuals. In this study, Aboriginal and Torres Strait Islander participants had similar rates of treatment completion and similar reductions in symptoms to non-Indigenous participants.

Older people

Clinical evidence shows that older adults can obtain large and clinically-significant benefits from supported online treatment. MindSpot offers supported online treatment, under the name of Wellbeing Plus, which is tailored to adults aged 60 years and over to help them manage symptoms of depression and anxiety. (Titov et al. 2015b)

Culturally and linguistically diverse people

There are only a few supported online mental health treatments in languages other than English (MindSpot 2019a). The eCentreClinic at Macquarie University, in collaboration with overseas partners, have conducted several trials of programs that were translated from English into Chinese, Arabic, and French languages (MindSpot, sub. 666). Their evidence provides preliminary support for the efficacy of supported online treatment for these cultural groups (Choi et al. 2012; Kayrouz et al. 2016; Robichaud et al. 2019).

11.4 Strengthening the mental health system

Less intensive demand for mental health professionals

On average, online treatment uses a comparatively small amount of clinician time to provide treatment for participants without a reduction in consumer outcomes (box 11.6).

A flow-on benefit of requiring less mental health professional time is that it potentially eases the demand for these professionals, who are in short supply in some fields and locations. This means that more people can be treated, with the same number of health professionals. It also allows some health professionals to focus on individuals with complex, severe and potentially life threatening disorders (Hickie, Rosenberg and Davenport 2011). The National Mental Health Commission (2014d, p. 188) highlighted this benefit of online interventions:

... e-mental health increases reach and frees up time to use clinical treatment for those people with very complex needs, such as eating disorders, major depression and anxiety, drug and alcohol addictions and psychoses.

Box 11.6 Supported online treatment uses less clinician time

On average, online treatment uses a comparatively small amount of clinician time to provide treatment for participants.

- The average amount of clinician time per participant on a MindSpot course was between 2 to 3 hours, with an average of 25 minutes of clinician time for an assessment. This is about a quarter of the time required for equivalent face-to-face care (Titov et al. 2017, p. 1234).
- Supported online treatment provided by Mental Health Online has an average support time of about 2 hours over a 12 week course, which is considerably less than an estimated 8 hours required for 10 sessions of face-to-face therapy under Better Access (Thomas, Seabrook and Foley 2019, p. 13).
- THIS WAY UP found that clinicians only used 10 minutes per fortnight for supported online treatment compared with 1 to 2 hours for face-to-face treatment (CRUfAD 2019, p. 17).
- A meta study found that, on average, clinicians spent less than 13% of the time required for face-to-face therapy on supported online treatment (Productivity Commission estimates using Andrews et al. 2018a).
- The Centre for Rural and Remote Mental Health (2017) found that, compared with face-to-face treatment, supported online treatment reduced the amount of time the clinician was in contact with the consumer. There were fewer and/or shorter sessions, and individuals relied more on self-help materials.

Nevertheless, both consumers and the system would benefit from more research on the optimum frequency and form of clinician support (Andersson and Titov 2014). If further research demonstrated that a greater range of people (such as youth workers) could provide effective support, even if only for some consumer groups, then supported online treatment could be expanded quickly when responding to crises (such as the COVID-19 pandemic) — giving consumers greater choice in times of need.

Some evidence that it is a lower-cost option

Online treatment is often claimed to be cost-saving and there is some evidence to support this claim. A study found that MindSpot treatment for people with mild to moderate symptoms of depression and anxiety cost less than the comparison group (minimum adequate treatment in usual routine care) with an increase in quality-adjusted life years. The average cost of delivering MindSpot treatment was estimated to be \$392 (in 2014 dollars) for an 8-week treatment course supported by a clinician.⁸⁰ This compares with a delivery cost of \$410 (in 2014 dollars) for a person receiving minimum adequate treatment in usual routine care (Lee et al. 2017, p. 160).

While this study validates the expansion of supported online treatment from a government budget perspective, it would be preferable to have more high quality studies of cost-effectiveness to support this decision (chapter 24).⁸¹

11.5 Lack of information could reduce consumer choice

Consumers need information to support their decision making

Access to evidence-based information can help consumers to make informed decisions about managing their mental health. Many consumers value the information and assessment options available on online treatment websites, choosing only to access this information (MindSpot, sub. 666). Access to high quality self-directed information may reduce the need for further services for some consumers and, for others, may lead them to local services of their choice. An early evaluation of MindSpot found that the two main reasons why people visited the website were that they were seeking an assessment or seeking information about local mental health services (Titov et al. 2015a). It is important that consumers can access information that is culturally relevant and in their own language. Mental Health Australia, FECCA and NEDA (sub. 1113) highlighted the Embrace Project, which provides an online website with information, resources and self-assessment options in multiple languages.

Consumer willingness to use online options to seek *information* about mental health appears to be widespread. The Mission Australia and Black Dog Institute youth survey showed that the internet was a source of information, advice and support that most young people felt comfortable turning to (Ivancic et al. 2014). Another survey found that about one in five young people surveyed reported they would use the internet to access an online quiz or assessment tool (Reachout Australia, sub. 804).

⁸⁰ A more recent estimate has the average cost of supported online treatment at \$300 or less in 2019 (Titov 2020).

⁸¹ Cost-effectiveness analysis is an important tool, as it helps decision-makers to assess and potentially improve the performance of their health systems. It indicates which interventions provide the highest ‘value for money’, and helps them to choose the interventions and programmes which maximise health outcomes for the available resources (WHO 2019a).

Evidence of consumers' openness to receiving mental health *treatment* online, however, is limited — and what evidence is available is somewhat dated and sometimes based on small samples. Studies that examined consumer preference found a preference for face-to-face therapy over online treatment, but not an aversion to online treatment (Meurk et al. 2016). This makes it difficult to determine the broad consumer acceptability of online treatment and just how many consumers will value this type of service. However, the COVID-19 pandemic has provided some more recent evidence that consumers are open to accessing online services (Cox 2020; SBS News 2020a). MindSpot, for example, experienced a surge in demand during March 2020, following an increased number of cases of COVID-19 in Australia and the introduction of social distancing measures:

... in its eight years of operation, online mental health clinic MindSpot has never been busier. ... the clinical service has had a 100 per cent increase in web visits and up to 75 per cent more social interactions. More than a quarter of a million people are accessing the Instagram and Facebook advice every week and about 4000 are logging onto the website each day, on top of a large volume of phone calls. (Cox 2020, p. 1)

Having been exposed to mental health treatment services online, some people may be more willing to use them in the future (more so than past surveys have suggested) (box 11.7).

Supporting consumers to make informed choices

Consumers have raised concerns in the past about online mental health applications. These concerns include that they are overwhelmed by the variety of online options and have no real way to determine the quality and safety of the applications on the market, with privacy a key concern (ACSQHC 2019; Grundy et al. 2017). When some consumers are uncertain or overwhelmed by the information they have access to, they can default to the status quo (Samuelson and Zeckhauser 1988). In the case of mental health treatment, the status quo is usually either face-to-face services or no treatment at all.

Consumers need to be empowered with the necessary information for them to make informed choices for improving their mental health outcomes.

One way to do this is through a certification framework. MindSpot (sub. 666) submitted that a certification framework would provide minimum safety and quality standards for the sector. The Australian Government is currently in the process of developing safety and quality standards and a certification framework for e-mental health services. A draft certification framework was released in March 2020 (ACSQHC 2020b). We support the principle of a framework as its aim is to support consumers in their decision making. A strong certification framework will be vital to the development of the national digital mental health platform (chapter 10).

Another way consumers can obtain information about the safety and effectiveness of supported online treatment is through a consumer information campaign (Action 11.1). As this treatment will form part of the new national digital mental health platform, this campaign

would be positioned within a broader campaign, to create a recognisable and trusted gateway that is accepted by the community as a source of evidence-based advice and support.

One challenge for the effectiveness of information campaigns is reaching consumers in the target group. An understanding of the needs and preferences of consumers would assist a successful information campaign. This is particularly relevant for the CALD community. Developing this understanding and the associated information campaign will require co-design with people with lived experience and their carers (chapter 22).

Box 11.7 Preference for face-to-face mental health treatment has been strong in the past

All consumers

Klein and Cook (2010) found that 77% of respondents preferred face-to-face treatment services, although only 10% indicated that they would not use online mental health services (sample size = 218). They also found evidence that those who had previously accessed online counselling were more likely to prefer online services than other respondents.

In a Relationships Australia survey (2018), about one-third of people surveyed reported that they did not prefer online mental health services over in-person forms of support. Just over half of female respondents, and 45% of male respondents, stated that they would prefer to use more than one form of mental health support. People in urban and non-urban areas had similar preferences (Relationships Australia, sub. 831).

Young people

Mission Australia and ReachOut (2018) found that 53% of young people nominated face-to-face services as their preferred service type. Another 44% indicated a preference for online services, 21% suggested phone services, and 13% stated that they would not seek help from any of these sources.

Mission Australia and the Black Dog Institute (2014) found that 62% of young people with a probable serious mental illness would feel uncomfortable seeking support from online counselling.

Bradford and Rickwood (2014) found that, of the 231 adolescents surveyed (who were living in Canberra in 2011), 59% preferred face-to-face help, with 24% preferred not to seek help and 16% stated that online help was their first preference.

Ellis et al. (2014) conducted an online survey of about 1000 young people aged 16 to 24 years in 2010 to explore their attitudes and behaviours about mental health and technology use. Participants were asked to indicate their preference for receiving mental health information and support through technology. The top two responses were: (1) website with information and/or fact sheets (males: 48%; females: 60%) and (2) website with online clinic (males: 39%; females: 49%).

Health professionals need to be a gateway to information and choice

Consumers knowing about and choosing supported online treatment depends, in part, on the willingness of practitioners to offer and refer people to these treatment modes.

The Australian Government is raising health practitioner awareness of e-mental health services via eMHPrac (e-Mental Health in Practice). eMHPrac provides free training and support in its use to GPs, allied health professionals and service providers (eMHprac 2019a; eMental Health in Practice, sub. 602). While 20 to 40% of referrals to supported online treatment come from health professionals (CRUFAD 2019; MindSpot 2019a), there is some evidence that health professionals are not offering consumers the option of supported online treatment as often as they could. This appears to be due, in part, to lack of knowledge and to clinician misgivings about these options (Andersson and Titov 2014; Northern Territory Mental Health Coalition, sub. 430).

Some professionals, in particular GPs and their colleges and associations, have a range of reservations about online treatment. The General Practice Mental Health Standards Collaboration (sub. 395) and the Royal Australian College of General Practitioners (sub. 386) expressed concerns:

- that e-mental healthcare was, at times, excessively and persistently promoted as a solution to barriers in treatment that was not evidence based
- that lower quality treatment will primarily be offered to lower socio-economic groups, reinforcing inequality of access to treatment
- about the skills required to undertake online therapy, in particular the literacy and mental functioning needed for this therapy to be effective.

Some clinicians considered that technology would interfere with their ability to develop a rapport with their patient. For example, Mental Health Online found that community mental health clinicians thought technology would interfere with the way they were accustomed to working and with their ability to maintain the therapeutic relationship (Thomas, Seabrook and Foley 2019). These concerns, however, are not borne out in evidence.

Yet, despite two decades of evidence-based e-mental health services, numerous barriers have stalled the overall implementation in routine care thus far (Tuerk, Keller and Acierio 2018; Vis et al. 2018). One of the most important barriers highlighted, however, has been that e-mental health has not been integrated as a normal part of routine care practice due to the lack of acceptance by health professionals themselves (Topooco et al. 2017). Myths on telehealth [supported online treatment] such as ‘the therapeutic alliance can only be established face-to-face’ have dominated the field, in spite of research showing the opposite (Berger 2017). (Wind et al. 2020, p. 1)

The Black Dog Institute (sub. 306, p. 24) indicated that some reservations from health professionals are due to a lack of support provided to help guide referrals:

Despite programs to support health professionals e.g. eMental Health in Practice Program, there has been a failure to engage clinicians and give them something that helps guide e-health

selection and use. This results in mismatched expectations about what digital therapeutics can do in general practice.

Furthermore, as the notion of developing a relationship and having continuity of care is changing, with approximately 20% of consumers not having a regular GP and others not able to see their GP when they want, the ability to share information between a variety of providers may be of more importance to some consumers than having face-to-face treatment with one provider (Dubecki 2017).

Consumer gateways to supported online treatment as an option

Inquiry participants have indicated that clinicians are more likely to accept and offer people supported online treatment if they are aware of such services, they trust the efficacy of the treatment and it is easy to make a referral.

The Australian Government's proposed certification framework will go some way towards building confidence and acceptance of supported online treatment among professionals (as well as consumers) (ACSQHC 2020b). eMHPrac, as discussed above, should continue to promote awareness of services among health professionals.

GPs and other mental health professionals generally rely on a range of information sources to help support people with mental ill-health and to refer them to the most suitable service. Some digital resources are available; however, they are underutilised due to a lack of awareness, busy schedules, and technological barriers such as the inability to make electronic referrals from within online information platforms. To support consumer choice, the Productivity Commission is recommending improved access to better-quality information for GPs through online navigation platforms (chapter 15).

In addition, the Australian Government should deliver an information campaign to health professionals that outlines the effectiveness, quality and safety of online treatment (Action 11.1). This information campaign would form part of a wider campaign to promote the new national digital mental health platform. The platform would support consumers and health professionals in deciding on treatment options (chapter 10).

Following the draft report, Inquiry participants expressed support for an information campaign to promote supported online treatment (for example, BrainStorm Mid North Coast, sub. 803; eMental Health in Practice, sub. 602; Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212; MindSpot, sub. 666; Mission Australia, sub. 684; SA Mental Health Commission, sub. 691; Settlement Services International, sub. 795). Some participants offered suggestions in developing such a campaign, including being aware of language and its role in stigma, emphasising that consumers still had choice, and consulting with consumers in developing the campaign. Settlement Services International (sub. 795) questioned whether the government was best placed to develop a campaign as they were concerned that it would not reach marginalised populations.

11.6 Offering more choice with supported online treatment

Despite increased government expenditure on mental health services more broadly, many people with mental illness are not receiving the treatment they need (chapter 12).

Given that supported online treatment is an effective option with features that are valued by some consumers, the Productivity Commission recommends that funding be expanded and services be offered to consumers as part of a range of routine treatment options (Action 11.1). This expansion is part of the broader vision of a national digital mental health platform that offers an effective gateway to treatment, supporting consumers and health professionals to make decisions about treatment options (Action 10.4). Nevertheless, an expansion in supported online treatment should proceed regardless of the progress in developing the digital platform.

To inform both consumers and referring clinicians, the Australian Government should publish annual summary output on use of services, treatment provided, and any measurable outcomes (Action 11.1).

A small expansion to start

As noted above, many participants in this Inquiry emphasised that digital options benefit consumers. The group who benefit might include people who are:

- not currently accessing services but would like to
- currently receiving treatment but would prefer to change to a service that has features they value more
- seeking to complement their existing mental health treatments, such as face-to-face therapies
- at risk of developing mental illness and who are seeking information or treatment.

Given the size of these groups, it seems that several million people could potentially access supported online treatment options if that was their choice (chapter 12). As people have a wide range of needs and preferences, it is unlikely that all would choose supported online treatment. Some consumers could choose alternative treatment options such as face-to-face therapy, group therapy, tele-CBT or self-guided options, as those might best suit their needs and preferences. Nevertheless, it is clear that a large number of people could potentially benefit from supported online treatment.

In the short-term and as a first step, we estimate that supported online treatment services could be expanded to service another 150 000 places. This calculation is based, in part, on prevalence rates for mental illness and on treatment service use (Diminic 2017; Whiteford et al. 2014a; Productivity Commission estimates). An expansion of this size is estimated to require additional expenditure of up to \$69 million, although there are likely to be some cost

savings from instances where consumers currently receiving treatment change to supported online treatment. Mental health improvements associated with this change are estimated to result in between \$108–210 million in aggregate income, and between 1300 and 2400 additional quality-adjusted life years (appendix K). MindSpot (sub. 666, p. 10) highlighted that those consumers who previously did not access treatment would be the main beneficiaries of greater funding and integration:

... the true value proposition of this sector, which is that DMHS [digital mental health services] are not a replacement for existing services, but can greatly improve the reach of services and efficacy of the mental health system as a whole.

While 150 000 may seem a small number of additional treatment places for consumers, it recognises that it will take some time for both consumers and professionals to increase their knowledge of this form of treatment and decide if it is suitable. It also takes into consideration the sector's ability to expand while maintaining treatment quality for consumers. At present, about 21 000 people per year register to use the MindSpot assessment and treatment services, of whom approximately 4000 receive online treatment. MindSpot (sub. 666, p. 10) noted the system constraints that will make it difficult to expand quickly and the cost to the consumer if an expansion is not managed well.

... scaling up the capacity of this sector requires careful consideration, planning, and investment. In particular, we note that appropriate attention should be given to workforce development, integration with primary care, integration with health data systems, and quality assurance. Our concern is that poorly managed and poorly integrated expansion may not deliver the same level of benefit to consumers and carers achieved at the current scale.

In the short to medium term, supported online treatment should continue to be grant funded, with consideration given to funding having an activity component. This would allow funding to increase as a service treated more people, or to decrease if the expansion was slower than anticipated. When reviewing supported online treatment, consideration should be given to funding options beyond grant funding, including the Medicare Benefits Schedule. A Medicare-funded service could be expanded more easily in the event of widespread community need, although it would have budget implications.

To keep services affordable, it is recommended that, in the short to medium term, consumers receive supported online treatment at minimal cost (Action 11.1) (box 11.8).

The bushfires in late 2019 and early 2020, and the subsequent COVID-19 pandemic have highlighted the need to be able to expand service provision rapidly. Supported online treatment has the potential to expand to meet some of this consumer need in a timely way, subject to temporary funding increases. However, the current way of accommodating spikes in demand for services may be different from the systematic expansion and integration into the mental healthcare system described above. At a time in the future, when supported online treatment is integrated and matured, any rapid expansion pathway might be different — reflecting a greater number of evidence-based providers backed by a system of standards, a larger workforce pool to draw upon that is adept at providing services online, and more community and health professional confidence in these services.

Box 11.8 **Should consumers pay for supported online treatment?**

Arguments in favour of no payment

- A service free to the consumer is aligned with government healthcare objectives to provide timely access to quality health services based on need, not ability to pay, or where people live. It is also consistent with the Australian Government's objectives to commission psychological therapy for people in underserved groups, including those who may not be able to afford the co-payments associated with Medical Benefit Schedule rebated services.
- Offering a free service would also encourage consumer take-up of supported online treatment services. Consumers may be more willing to try what they would perceive as a relatively new form of treatment if there is no cost.

Arguments in favour of a payment

- A consumer payment may increase the engagement and overall effectiveness of the treatment. There is some evidence of greater engagement and adherence to completing the treatment program when the consumer pays a small fee (CRUfAD 2019). Engagement may be higher because the payment consumers make is symbolic of their commitment to the course.
- A lack of fee can signal to consumers that the treatment is not as valuable or effective as other treatment options. This may lead to waste: if consumers enrol in supported online treatment but do not complete the course.
- On equity grounds, those who have the capacity to pay should make a payment, while those who face financial constraints should receive the service free or at a reduced rate. Some consumers choosing to undertake supported online treatment do not face financial access barriers. For example, only 13% of MindSpot consumers indicated that financial constraints were their main reason for seeking treatment online (MindSpot, sub. 178).

If a payment were to be introduced, holders of Australian Government concession and health cards could be exempted from the payment. There is also scope for private health insurers to assist with the cost of supported online treatment, such as the recent partnership with THIS WAY UP and the health insurer, Bupa (Bupa 2019).

If some consumers were to make a payment, consideration would need to be given to where that revenue stream is directed (that is, back to general revenue or to the service provider), what incentives that may create, and whether caps on the proportion of paying consumers would be required.

Providing choice for culturally and linguistically diverse communities

Supported online treatment offers scope for consumers to access treatment that is culturally relevant in their preferred language. A staged approach should be taken to expanding the cultural diversity of online treatment. First, CALD communities should be consulted to discuss their preferences and whether there are any barriers to accessing online treatment. With ongoing consultation, if consumers from various CALD communities are interested in supported online services, then programs should be translated and adapted (Action 11.1).

A number of Inquiry participants supported the introduction, or at least greater exploration of, the suitability of supported online treatment options for people from CALD backgrounds (for example, Forum of Australian Services for Survivors of Torture and Trauma, sub. 838; Independent Private Psychiatrists Group, sub. 742; MindSpot, sub. 666; Multicultural Youth Advocacy Network, sub. 683; SA Mental Health Commission, sub. 691; Settlement Services International, sub. 795). Mental Health Australia, FECCA and NEDA (sub. 1113, p. 12) jointly submitted that:

For CALD communities, online services could support individuals in their first language and/or understand their cultural norms and values around mental health and wellbeing. This includes established migrant and refugee communities here in Australia, international students, and second-generation Australians who may not need someone who speaks a language other than English but do need someone who understands the nuances of their cultural background.

Nevertheless, many of the same submitters highlighted the importance of the implementation process in ensuring success of any such expansion (box 11.9). These insights need to be considered along with community views when developing CALD programs.

Box 11.9 Developing supported online treatment in other languages

The adaptation of supported online treatment into languages other than English, which are culturally relevant, faces a number of barriers that need to be considered.

First, there are upfront activities that take time, effort and have associated costs. A course needs to be translated and adjusted for cultural relevance. While this is a feasible task, the time and effort needed to adapt a course can be considerable. MindSpot (sub. 666) submitted that the translation costs for a 5-module program are approximately \$50 000. The Employee Assistance Professional Association of Australia (sub. 668) noted these high upfront costs and questioned the cost-effectiveness of such an initiative.

Second, bilingual professionals need to be employed. In providing supported online treatment therapists need to be available to provide support in the target language who also have the necessary clinical training and culturally capable practice as well as other staff, such as web developers. This may be a major constraint in rolling out effective non-English programs (MindSpot, sub. 666).

Finally, the lack of strong demand for supported online treatment often leads to low take-up rates. For example, in a trial of supported online treatment in Arabic, there were issues with recruiting participants, reflecting the relatively low levels of mental health literacy among culturally and linguistically diverse people (Kayrouz et al. 2016). Similarly, an online cognitive behavioural therapy program for depression that was culturally adapted for Chinese Australians had low uptake. This could be for a number of reasons, including that the THIS WAY UP front-end website and user interface are in English, or the minimal targeted promotion and marketing activities (CRUfAD 2020). The Multicultural Youth Advocacy Network (sub. 683, p. 8) highlighted that all aspects of online service sites need to be available in different languages.

Ensure that all aspects of online service sites are available in different languages rather than having a fact sheet written in different languages. This includes ensuring that it is easy and seamless to switch to one's preferred language when accessing the website/online platform.

ACTION 11.1 — SUPPORTED ONLINE TREATMENT OPTIONS SHOULD BE INTEGRATED AND EXPANDED

The Australian Government should facilitate greater integration of, and access to, supported online treatment.

Start now

The Australian Government should:

- increase the number of supported online treatment services available for people with high prevalence mental illness and distress
- collect and publish data on the use, type and outcomes of supported online treatment
- instigate two separate information campaigns for consumers and health professionals to raise awareness of the effectiveness, quality and safety of government funded supported online treatment.

It should require supported online treatment providers to offer treatment:

- only if it has demonstrated efficacy
- to children, youth and/or adults
- for people from culturally and linguistically diverse backgrounds, subject to demand
- at minimal cost to the consumer
- that includes the option for outcomes data to be forwarded to a nominated GP or other treating health professional.

Start later

The Australian Government should, within five years, commission an independent evaluation of online treatment services, examining performance of supported online services and technological developments in online treatment approaches.

11.7 The option of self-guided online treatment

In addition to supported online treatment, there are a range of other digital mental health services, such as portals, websites, and applications (apps) for smartphones and other mobile devices (box 11.2). While terminology is constantly changing and there is considerable diversity among the services offered, this section will refer to unguided self-help digital mental health services as ‘self-guided apps’ for simplicity.

Self-guided apps have many positive features

Self-guided apps can offer similar digital services to supported online treatment, with the key distinguishing feature that the consumer works through the app without the support of a mental health professional (table 11.1). People can access these self-guided programs via a website or by downloading an app on their smart device.

Consumers see many positive aspects to some of the self-guided apps. For example, they support consumer preference for anonymity and a self-management-based approach, as well as overcoming access barriers relating to lack of service availability, convenience, stigma and cost. Self-guided apps also offer considerable flexibility for rapidly scaling up and down mental health supports for communities. These are the same advantages outlined for supported online treatment above.

Importantly, some self-guided apps offer consumers recovery-focused treatment that works. A number of self-guided mental health apps have been demonstrated to improve outcomes for consumers with mental ill-health (CMHR 2018; Cuijpers et al. 2019; Karyotaki et al. 2019; Morgan et al. 2017; eMental Health in Practice, sub. 602). The Black Dog Institute (sub. 1207) highlighted that online school-based programs are effective at improving outcomes for people with substance use, depression and anxiety, and reducing suicide ideation. There is emerging evidence that some self-guided programs are just as effective as supported programs. The Clinical Research Unit for Anxiety and Depression, developers of THIS WAY UP, recently completed a randomised control trial which found that there were no significant differences in anxiety or depression reduction, or in adherence, between their unguided and supported online CBT programs (CRUFAD 2020).

However, despite this emerging evidence, consumers need to be made aware that outcomes may not always be as effective as other treatment options. *Self-guided* treatment apps are generally less effective than supported online treatment and face-to-face therapy (Andersson and Titov 2014; Cuijpers et al. 2019; Karyotaki et al. 2019). Lower effectiveness is related to low consumer adherence to completing self-guided app programs. eMHprac (sub. 602, p. 5) submitted that:

Differential retention may be a contributing factor to smaller effect sizes from self-guided treatments. For example, completion of more elements in the intervention is usually associated with more positive outcomes.

But consumer preference, choice and self-management of mental health are important. Mental Health Online and THIS WAY UP provide consumers with a choice of completing their programs with or without guidance, with a majority choosing self-guided. Furthermore, it would be better for a consumer to select a quality self-guided app than not receive treatment for mental illness at all. THIS WAY UP reported that:

... consumers have different treatment preferences and requirements for clinical care, and some may not require the support of a clinician. Therefore, **decisions about treatment modality should be made by the consumer and must also be clinically appropriate to the individual and their circumstances.** This increases consumer agency in determining their care. ... As a

significant proportion of consumers prefer self-help to supported online treatments, it is important to recognise the need to offer evidence-based, safe and effective self-help online treatments as a treatment option, in addition to the clinician-supported online treatment format. (CRUFAD 2020, p. 2) [emphasis in the original document]

eMHprac (sub. 602, p. 5) summarised the role of self-guided interventions:

Self-guided interventions have an important place in the promotion of wellbeing, management of sub-clinical distress and the prevention of mental disorders. Their modest average effect sizes may not make them the treatment of choice for established disorders, but for people who reject other alternatives (including supported treatments), they provide a way to increase access to evidence-based digital support for their self-management.

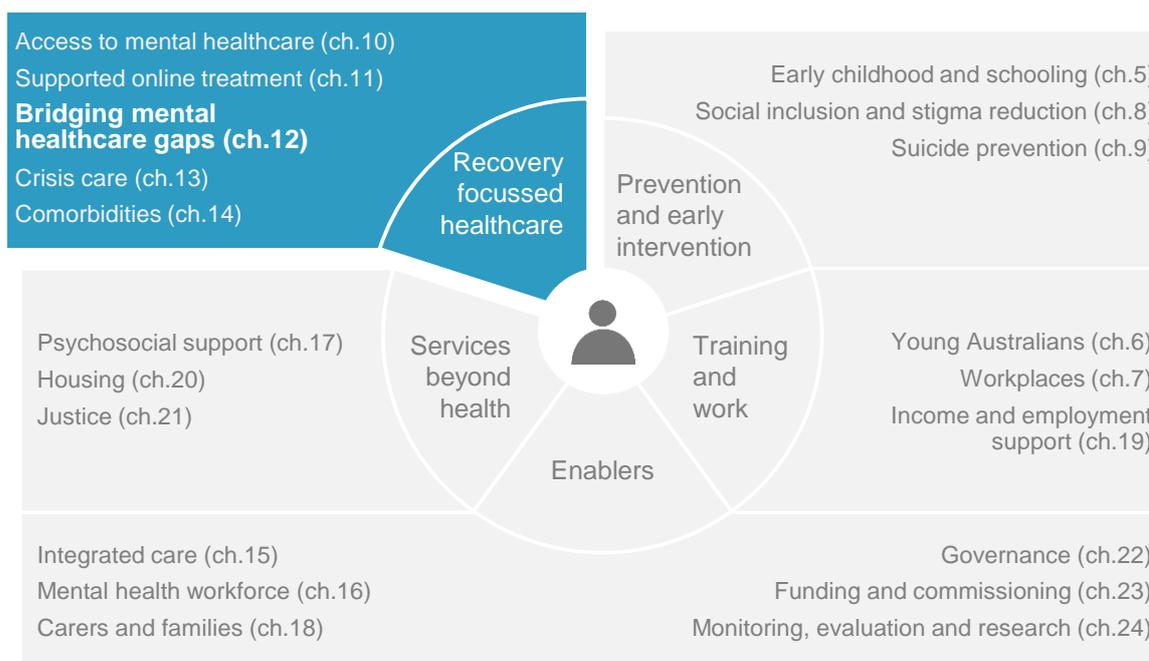
The Productivity Commission recognises the valuable role that self-guided apps can play in providing consumers with choice. In addition to self-management, consumers and health professionals may also choose to use self-guided apps as a complement to other forms of treatment or as a relapse prevention strategy.

Table 11.1 Selected online mental health treatment programs

<i>Program</i>	<i>Developer</i>	<i>Mental ill-health</i>	<i>Type</i>	<i>Population</i>	<i>Therapy</i>	<i>Cost</i>	<i>No. of courses</i>	<i>Course length</i>
Mental Health Online	Swinburne University	anxiety, depression	supported self-guided	adults	CBT	free	7	12 weeks
MindSpot	Macquarie University	stress, anxiety, worry, low mood, depression, post-traumatic stress, obsessive behaviour	supported	adults, Indigenous, young adults older people	CBT	free	7	8 weeks
THIS WAY UP	St Vincent Hospital	depression, anxiety	supported self-guided	adults ^a	CBT	free ^c	18	13 weeks
Brave	b	anxiety	supported self-guided	3–7, 8–12, 12–17 year olds (with parent involvement)	CBT	free	4	10 weeks (based on one session per week)
Cool Kids Chilled Out	Macquarie University	anxiety	supported	3–6, 7–12, 13–17 year olds	CBT	\$710	2	..
MyCompass	Black Dog	stress, anxiety, depression	self-guided	Adults	CBT, problem solving therapy, interpersonal psychotherapy & positive psychology	free	14	..
BITE BACK	Black Dog	wellbeing	self-guided	13–16 year olds	positive psychology	free	1	6 weeks
HeadGear	Black Dog	common mental disorders	self-guided	Employees male dominated industries	behavioural activation & mindfulness	free	1	..
MoodGym	ANU	depression, anxiety	self-guided	adults and youth	CBT	free	1	..
e-couch	ANU	depression, anxiety, relationship breakdown, and loss and grief	self-guided	adults and youth	CBT, interpersonal therapies, relaxation & physical activity	free	1	..

^a one program available for teenagers. ^b University of Queensland, Griffith University, the University of Southern Queensland, Griffith University and UniQuest. ^c In March 2020, following the announcement of the COVID-19 pandemic, fees were waived for services provided by THIS WAY UP. CBT – cognitive behavioural therapy. .. not applicable (as the online treatment is self-guided).

12 Bridging the mental healthcare gaps



Where are the gaps in mental healthcare?

- There are two key gaps in Australia’s clinical mental healthcare: a low intensity gap and a missing middle gap.
 - Up to 500 000 people who are not currently accessing any mental healthcare would benefit from greater access to low-intensity services. Up to two million people who currently take mental health medication or access individual psychological therapy (or both) each year could similarly benefit from greater access to low-intensity services — receiving treatment that is at least as effective for them as their current services but costs them less, takes less time, and has fewer adverse side effects.
 - Several hundred thousand people with more acute needs continue to miss out on the mental healthcare they require — affecting their quality of life and their ability to participate socially and economically.
- Key barriers to be addressed to bridge these gaps include: service underprovision, inadequate information, locational mismatches and high out-of-pocket costs.

RECOMMENDATION 12 — ADDRESS THE HEALTHCARE GAPS: COMMUNITY MENTAL HEALTHCARE

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

As a priority:

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

[After using up your ten subsidised sessions of psychological therapy for the year] it becomes very difficult to get care until you are in a bad enough place to be eligible for hospital. And for that, you need to be in a really, really bad place. Mental health professionals and politicians know all about this problem. In the sector it's called 'the missing middle'. I call it 'The Vast Wasteland'. (Consumer and writer Honor Eastly (2018))

12.1 Mental healthcare gaps and barriers to care

In a person-centred mental healthcare system, individuals would be able to access effective services that match their treatment and support needs and preferences. Currently, many Australians cannot do this, because there are significant gaps in the mental health system. Too often, preferred services are either not available or access is limited due to where the individual lives, what they can afford to pay, or because neither the individual nor their referring clinician know about the service.

While people in particular demographic or cultural groups, or in particular parts of Australia, can encounter barriers to care across the spectrum of mental health services, we have identified two key gaps in clinical mental health services — the low-intensity gap and the missing middle gap.

This chapter proposes ways to address these gaps. Other chapters propose complementary reforms to help fill other gaps in the broader mental health system — including psychosocial supports (chapter 17) and non-acute bed-based services (chapter 13).

Gap 1: The low-intensity gap

Low-intensity mental health services are those that are low-cost, low-risk and easy to access (usually without the need for a formal referral). But currently in Australia they are vastly underutilised.

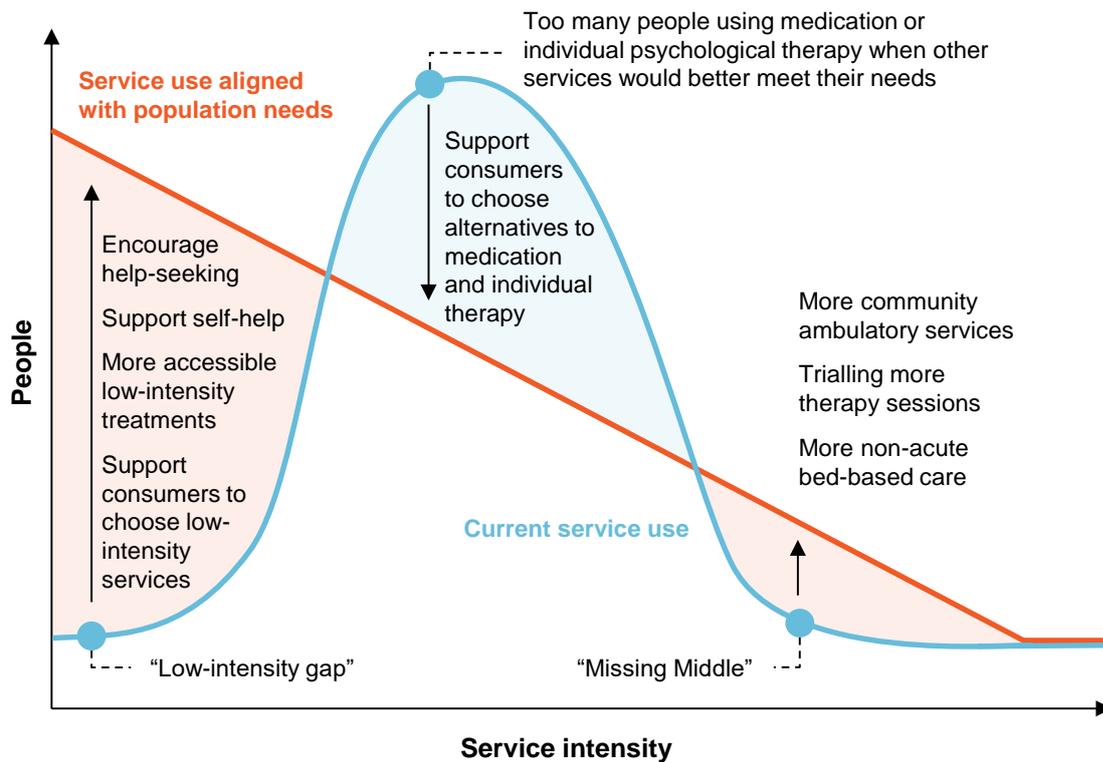
This low-intensity gap affects two groups of people:

- those who are not accessing any mental health services but could benefit from services matched to their needs and preferences — they may have a mental illness, or they may be at risk of developing one⁸²
- those who are taking mental health medication, or accessing individual psychological therapy, but would be better served by low-intensity options (figure 12.1).

⁸² People at risk of developing a mental illness include those who have previously had an illness and are at risk of relapse without ongoing care, and those who have early symptoms and are at risk of developing a diagnosable illness (DoH 2019l, p. 14).

Currently, up to one million Australians who have a mental illness, and millions more at risk of developing one, are not accessing any mental health services. Some of these people would prefer not to access any services — in one survey, close to 4 in 10 Australians experiencing emotional distress said they did not want to see a professional (NSW BHI 2019, p. 36). And many *are* able to manage their own mental health (Harris et al. 2014, p. 839), sometimes drawing on resources such as online information and automated digital supports (chapter 11).

Figure 12.1 The low-intensity gap and the missing middle



However, many of those not currently accessing services *would* benefit from clinical treatment and/or psychosocial supports. More needs to be done to reduce barriers that prevent them seeking help (chapters 5 and 7), including reducing the stigma associated with mental illness (chapter 8). And more needs to be done to ensure people have easy access to a range of services — including more low-intensity services — and that they are supported to choose between them (chapter 10). We estimate that up to 500 000 people who are not currently accessing any services would benefit from greater access to low-intensity options.

The same low-intensity options could also benefit many of the 5 million Australians who take mental health medication or access individual psychological therapy (or both) each year. These treatments dominate Australia’s community mental healthcare system (figure 12.2).

But we estimate that up to 40% of people who access these treatments — up to 2 million people each year — may be better served by low-intensity options.⁸³

The National Institute of Health and Care Excellence (NICE) in the United Kingdom recommends that adults with mild to moderate depression, generalised anxiety disorder or panic disorder should be offered low-intensity interventions in the first instance (prior to medication or individual psychological therapy) (NICE 2009, 2019a). In Australia, this is not happening.

Drop-out rates show that many people are not accessing the right services. Close to half of people accessing MBS-rebated individual therapy receive three or fewer sessions — rarely enough to get better (section 12.4). And international studies find that about half of people taking antidepressants do not complete the recommended course of treatment (Sansone and Sansone 2012). In contrast, completion rates for common low-intensity *treatments* (the clinical subset of low-intensity services) are significantly higher. About 60% of people complete low-intensity treatments through the Practitioner Online Referral Treatment Service (PORTS) (chapter 10), and NewAccess treatments (box 12.1).

The underutilisation of low-intensity *treatments* is particularly striking. Fewer than 30 000 people a year access any low-intensity treatment — despite their demonstrated effectiveness and accessibility (section 12.2). This is not even 1% of the number of people using mental health medication or individual therapy.

Others have recognised this gap. For example, Beyond Blue (sub. 275, p. 5) described the need to ‘put the missing steps in stepped care’.

Low intensity prevention and early intervention services — like coaching, digital and self-guided interventions — are cost effective and deliver what most people need. Yet this system is still in its infancy despite the evidence.

The MBS Review Mental Health Reference Group (2018, p. 52) noted ‘both the cost-effectiveness and the access advantages of digital mental health and other lower-intensity solutions’, and recognised the need to increase the uptake of these services.

The low-intensity gap means that many people whose needs and preferences would be best met by low-intensity services either do not access any services, or access services that are more costly, more time-consuming, or have more side effects. The result is unnecessary suffering, loss of productivity and a higher cost to the health system.

⁸³ We have estimated that there would be annual cost savings of \$7 million–\$22 million if 100 000 people accessed supported online treatment instead of receiving care-as-usual (appendix K).

Figure 12.2 Community mental healthcare services^a



^a Used most recent available data. Mindspot has about 21 000 people register per year, but only 4000 people receive treatment. It is by far the largest provider of supported online treatment (MindSpot 2019b, p. 6). 'Psychological therapy' refers to Psychological Therapy Services or Focused Psychological Strategies provided through Medicare, and psychological therapy commissioned by Primary Health Networks. Medications count does not include medications not listed on the Pharmaceutical Benefits Scheme (which were about 7% of mental health medications in 2011-12, the most recent year for which data is available (Commission estimate using AIHW 2013, table PBS.9)), over-the-counter medicines, or medicines supplied to public hospital inpatients (AIHW 2019o, p. 8). headspace number is for people attending centres in person and includes people accessing psychological therapy.

Source: *GPs (2018-19)*: Productivity Commission estimate using Britt et al. (2016, p. 19) and DoH (2020f, table 1.1). *headspace (2018-19)*: headspace (pers. comm., 29 April 2020). *Mindspot*: Mindspot (sub. 666, p. 13). *Medication (2018-19)*: AIHW (2020j, table PBS.3). *Psychological therapy (including with medication, 2018-19)*: Productivity Commission estimates using ABS (Microdata: Multi-Agency Data Integration Project, Australia, Cat. no. 1700.0, 2019f), headspace (pers. comm., 17 October 2019), and unpublished Department of Health and MBS data. *State and Territory community ambulatory*: AIHW (2019n, table CMHC.1). *Private psychiatry (2018-19)*: AIHW (2020f, table MBS.7).

Gap 2: The missing middle

There are several hundred thousand Australians whose illnesses are too complex, too severe or too enduring to be treated by primary care services alone, but are deemed ‘not sick enough’ to access specialist mental health services, or who access some care but not enough (figure 12.1).

The large shortfall in clinical, psychosocial and bed-based services⁸⁴ that affects this group — often described as the ‘missing middle’ — has been well established and is widely accepted (NCOSS 2016, p. 19; NSW Mental Health Commission, sub. 948, p. 7; NMHC 2014c, p. 33; Orygen and headspace (joint submission), sub. 204, p. 4; Rosenberg 2015; Victorian Government 2019, pp. 23–25; WentWest Limited, sub. 445, p. 28). It has been described as ‘a huge blind spot, a devastating chasm in care that successive governments have never addressed’ (McGorry 2019).

The missing middle gap means that many people who need significant care and support to manage their mental ill-health do not have their needs met. Often, help is only given to someone once their mental health has deteriorated to the point of crisis, and even then they may well be provided with enough care and support to see the crisis through, but not enough to get better. This can reduce the individual’s quality of life and limit the opportunities for them, and their family and carers, to participate in the social and economic activities that they consider necessary to give meaning to their life.

The missing middle gap encompasses a range of different services, including individual psychological therapy (sections 12.3 and 12.4), MBS-rebated psychiatric services (sections 12.3 and 12.4), State and Territory community ambulatory care (section 12.5), bed-based services (chapter 13) and psychosocial supports (chapter 17).

Barriers to be addressed in bridging the gaps

The low-intensity gap and the missing middle gap exist because a range of barriers prevent people from getting the help they need. We have identified four key barriers: service underprovision, lack of information, locational mismatches, and out-of-pocket costs.

Barrier 1: Service underprovision

The missing middle gap is chiefly due to service underprovision. Throughout our consultations, hearings and submissions, we heard stories of how service underprovision meant that people could not get the help they needed. In the context of a person-centred

⁸⁴ Chapter 13 discusses bed-based services, including the related issue of ‘delayed discharge’ — where people are kept in acute hospital beds because there are not adequate services for them to ‘step down’ to.

mental health system, this may include situations where services exist but are not, for example, culturally capable or age-appropriate.

We heard that people could not receive the services they needed as their condition deteriorated.

You only got to see the [visiting medical officer], who I might add was a psychiatrist, once every 3 months unless you contacted the office to request an extra visit. Sometimes we were told that he was too busy even after the school's deputy principal wrote letting them know of the erratic behaviours and the concerns they had in managing it and us providing evidence of him being transported to the mental health unit at Canberra hospital. (Name Withheld, sub. 81, p. 1)

We heard many stories about the long waits people face to get the services they need (for example, AMA, sub. 633, p. 1; BPD Community, sub. 622, p. 1; FND Australia Support Services, sub. 253, p. 17; Niall McLaren, sub. 44, pp. 37, 46; yourtown sub. 511, p. 2).

There's always a waitlist, like a six-month waitlist, for services these days. So when I was at CAMHS [Child and Adolescent Mental Health Services], they were trying to send me to the place I'm at now and I had to wait about four months even though it was a crisis problem. (young consumer quoted in Youth Mental Health sub. 895, att. 3, p. 21)

Tracey Martin-Cole (Launceston transcript, p. 22) from Psychology CAFFE, a multidisciplinary group private practice, told us that:

... we've had a wait list for eight years. We've reduced it down to two weeks at times, but generally, it's up to 4 to 6 months for children ...

Many participants explained how services are being rationed so that people only receive care if they are experiencing the most severe symptoms of mental illness (The Adult Psychiatry Imperative 2019, p. 36).

Public psychiatric services ... are almost exclusively directed to those people who are acutely suicidal, and those with acute psychoses ... The State and Territory (public) mental health services have drifted over the last thirty years, from being available to most Australians, to being available only to a minority of those suffering significant mental illness. Services in this sector tend to be provided on an episodic treatment basis, rather than a long-term treatment and follow up basis. This, despite the fact that most people using public mental health services will suffer ongoing or recurrent mental illnesses. (Independent Private Psychiatrists Group, sub. 473, p. 9)

Talking about community (psychosocial) support services, the Western Australian Association for Mental Health told us:

Consumers and families who are not connected to services currently report an almost complete inability to access support before mental health issues escalate to the point of crisis or after acute care experiences. Even then, the majority of consumers report that services are hard to access, are not available in their area, or that they do not meet the eligibility criteria. Mental health providers have the same concerns, with many reporting waiting lists from several months to 9-12 months ... (WAAMH, sub. 416, p. 9)

We heard that even if people do reach the high threshold for entry, they are often discharged from hospital before they are ready (The Adult Psychiatry Imperative 2019, p. 38; VIC DHHS 2015, p. 10).

When ‘G’ was unwell and needed somewhere safe to go because they felt suicidal. The only place available was a Psych Ward in the nearby hospital, but they were given medication and ‘thrown’ out the next morning!! At that immediate time, when feeling so unwell, there was nowhere else to go! A place to stay for a few days, to be listened to by a professional who cared (without drugging you up) and offering some realistic support would have been helpful. (Name withheld, sub. 31, p. 1)

And after being discharged from hospital, people are not provided with adequate services in the community.

Once discharged and thrust outside the walls that have managed her exclusion (detachment) and provided a sanctuary, the local Child and Adolescent Mental Health Service (CAMHS) begins outpatient family support: i.e. only one meeting per week for 1 hour: this just isn’t practical and fuels the adolescent’s vulnerability; it’s like quitting a crippling addiction, ‘cold turkey’. (Name withheld, sub. 392, p. 19)

The clinicians emphasised strongly, repeatedly and unanimously that my brother needed to be discharged to a transition program, such as a rehabilitation facility ‘when a bed became available’ and NOT directly to his flat. Despite this, less than 4 weeks later, my brother was discharged to his public housing flat. His only ongoing care comprised two short appointments per week which he was required to attend at the Koonung Community Mental Health services office for medications. Apparently, the potential transition services had refused to take him because he was deemed too high a risk (we believe based on violence displayed towards a doctor during a hospitalisation 7 years earlier). (Name withheld, sub. 58, p. 2)

In summary, service underprovision means that many people who need significant care and support to manage their mental illness do not have their needs met until they end up in an emergency department, or they cycle in and out of hospital instead of receiving the continuous support they need.

Underprovision of low-intensity services, and especially low-intensity treatments, is also a barrier to people accessing the care that is right for them. Provision of low-intensity treatments is limited by PHN budgets and commissioning decisions (section 12.2; chapter 23), restrictive MBS rules around group therapy (section 12.2), and funding arrangements for supported online treatment that are based on arbitrary caps rather than need (chapter 10).

Barrier 2: Inadequate information

Poor information about the availability, accessibility and effectiveness of low-intensity services is a key barrier preventing people from accessing them, even though these services may closely match an individual’s needs and preferences.

Medication and individual psychological therapy are widely known treatments for mental illness — and many people seek out these treatments if their mental health deteriorates. Low-intensity services are scarcely known, and much less likely to be sought out

(section 12.2; chapter 11). Indeed, people with mental illness may put off seeking help because they think that medication and individual therapy are the only options. Even those who know about low-intensity treatments may not trust that they are as effective as medication or individual therapy.

This information barrier affects professionals as well. When someone seeks help from a GP (or other clinician or service provider) they should expect to be offered the full range of service options. But these professionals are often unaware of, or do not trust, low-intensity services, and the person seeking help is much more likely to be pushed towards medication or individual psychological therapy (chapter 10). In 2016-17, for example, GPs were more than 20 times as likely to refer to a psychologist than to a support group (AIHW 2020h, table GP.4).

Chapter 10 proposes a national digital mental health platform, which would aim to build a prominent and trusted brand under which low-intensity digital treatments could be provided. It would aim to appeal to both GPs and individuals who may seek help. As part of the platform, a new assessment and referral tool would aim to ensure that people are always given the option of low-intensity services, where these are suitable (chapter 10).

Barrier 3: Locational mismatch

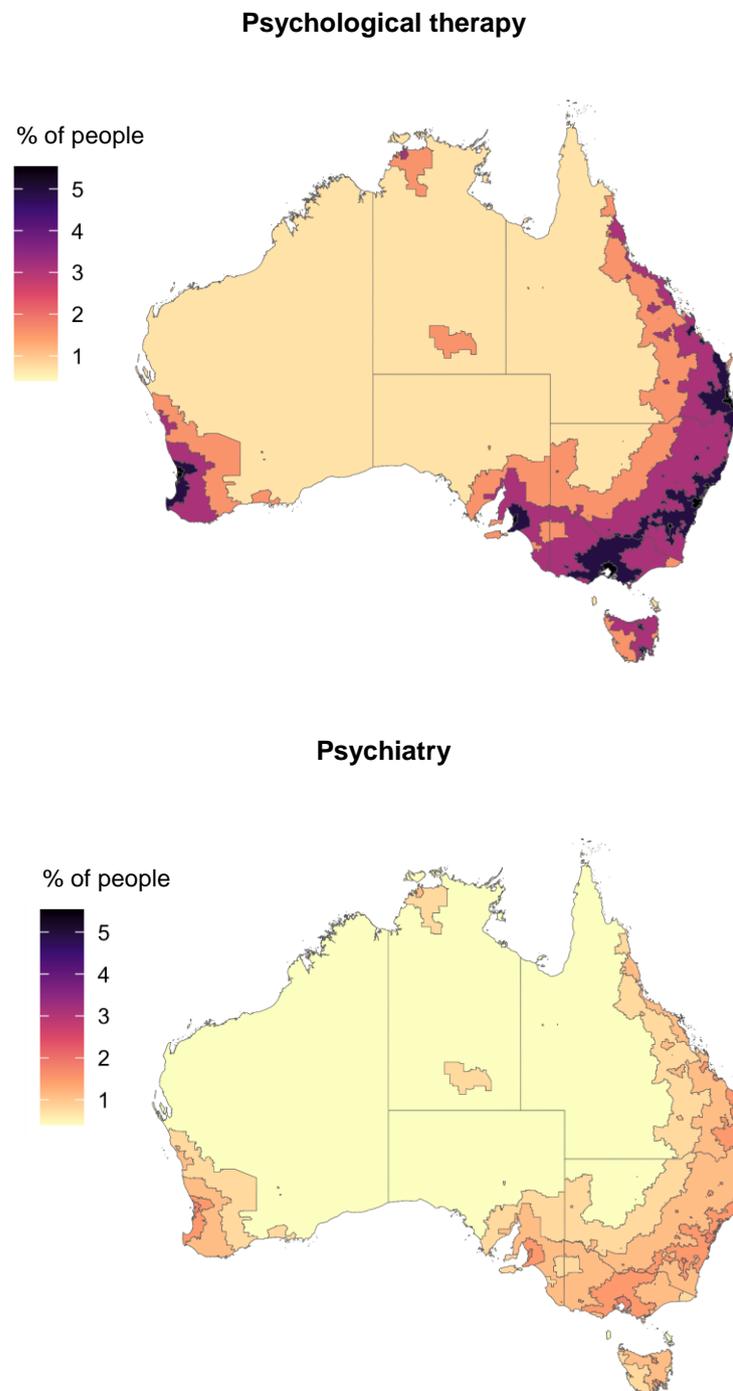
Under the 2012 *National Healthcare Agreement*, all governments have agreed to ‘provide all Australians with timely access to quality health services based on their needs, not ability to pay, regardless of where they live in the country’ (COAG 2012, p. A2). But for many people trying to access mental healthcare in regional, rural and remote areas, this commitment has not been met (Gateway Health, sub. 42, pp. 2–3; Office of the National Rural Health Commissioner, sub. 1185; Rural Doctors Association of Australia, sub. 475; Stuart Gamble, sub. 730).

Geographical differences in access to mental health services are starkest for MBS-rebated psychological therapy, and MBS-rebated psychiatry, due primarily to the location of the mental health specialists who deliver the services (figure 12.3). In 2018-19:

- for psychological therapy, roughly 5% of people in major cities and ‘inner regional’⁸⁵ areas had at least one session in a year, compared with less than 2% of people in remote and very remote areas
- for psychiatry, roughly 2% of people in major cities and inner regional areas had at least one session in a year, compared with less than 1% of people in remote and very remote areas.

⁸⁵ Parts of Australia classified as Inner Regional include Tamworth and Wagga Wagga in New South Wales, Ballarat and Bendigo in Victoria, Rockhampton, Bundaberg and Gladstone in Queensland, the Adelaide Hills region in South Australia, Bunbury in Western Australia and Hobart and Launceston in Tasmania. Darwin is classified as Outer Regional (ABS 2004).

Figure 12.3 **People in remote areas receive less MBS-rebated mental healthcare**
2018-19, by remoteness area



Source: *Psychiatry*: AIHW (2020f, table MBS.2). *Psychological therapy*: Productivity Commission estimates using AIHW (2020f, table MBS.10) and unpublished MBS data.

People with mental ill-health in many rural, regional and remote areas cannot access the same treatment as many other Australians. We have recommended a number of ways to address locational barriers to care, including:

- addressing the uneven distribution of the psychological therapy and psychiatry workforces (chapter 16)
- expanding telehealth as a way to increase access to these services across Australia (section 12.3)
- expanding supported online treatments as a further option for people who are not able to access a suitable clinician in the area where they live (chapter 11)
- creating a national digital mental health platform, which would provide low-intensity services — including short-course structured therapy (discussed below) — across Australia (chapter 10).

Barrier 4: Out-of-pocket costs

Many types of mental health services are provided free-of-charge to consumers. This includes most digital and low-intensity services, psychological therapy provided through headspace centres or commissioned directly by PHNs, and state and territory community and public hospital services. However, these services tend to have waiting lists or other means of rationing services, such as strict access criteria.

Consumers often pay to access other mental health services, including: private hospital services (chapter 23); some online treatments; private psychiatrists; psychological therapists; counsellors; and GPs. Some of these services attract an MBS rebate, but may also require the consumer to make a co-payment. Consumers typically have to pay for mental health medications, although they are often subsidised through the Pharmaceutical Benefits Scheme (PBS). Co-payments are a deliberate feature of both the MBS and the PBS, and are common across physical healthcare as well as mental healthcare.

Many participants emphasised that the co-payments associated with seeing a psychological therapist or psychiatrist were a barrier to accessing treatment.⁸⁶ For example, Danielle Gamble (sub. 797, p. 4), a consumer who lives in Wagga Wagga, told us:

We have two private psychiatrists ... who charge excessively. ... [one] charges \$610.20 for an initial appointment and \$472 for successive appointment. They are able to do this because there are two of them and they have been able to corner the market. ... They are only available to the wealthiest residents in our community.

⁸⁶ ACT Government, sub. 210; CHF, sub. 496; CMHR, sub. 148; Danielle Gamble, sub. 797, p. 4; ESSA, sub. 91; Healing Foundation, sub. 193; Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212, p. 6; NCOSS, sub. 143; RANZCP, sub. 385; ReachOut Australia, sub. 220; RFDS, sub. 361; and Victorian Government (2019, pp. 23–24).

Other participants stressed that they were unable to afford the full price of psychological treatment — and struggled to find affordable alternatives — after their ten sessions of MBS-rebated therapy ran out (comment no. 12, carers and family members) (section 12.4).

[The GP] wrote a mental health care plan and helped me find a psychologist. With access to sessions limited, I was not able to get the help needed. The care plan sessions concluded and I was still struggling, feeling lost and in a dark place. With no income I could not continue to access the services I needed. Fortunately for me, I stumbled upon a free counselling service run by the local council. (Clive Kempson, sub. 84, p. 1)

For MBS-rebated consultations in 2019:

- 57% of individual psychological therapy sessions had a co-payment, averaging \$68
- 66% of outpatient consultations with a psychiatrist had a co-payment, averaging \$93.⁸⁷

While many consumers do meet the cost of co-payments, they can create hardship, particularly for people with low incomes. In a 2012 survey, private psychiatrists said that 20% of their consumers were on a government pension and 45% were not working (Independent Private Psychiatrists, sub. 473, p. 12).

However, clinicians regularly waive co-payments for people they consider financially disadvantaged (Independent Private Psychiatrists, sub. 473, p. 20). This means that while average co-payments do not vary much between socioeconomic disadvantage groups for people who are charged co-payments, people are significantly more likely to pay nothing for a consultation if:

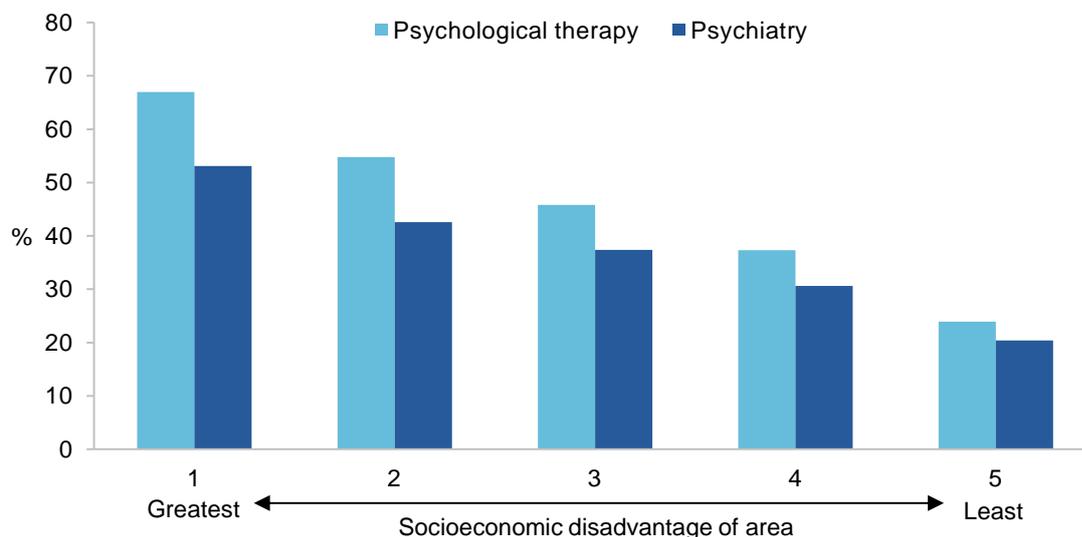
- they are aged over 65 years
- they live outside a capital city (Harris et al. 2010, pp. 79, 82, 85)
- they live in an area of greater socioeconomic disadvantage (figure 12.4).

Moreover, the Australian Government has put in place two ‘Medicare Safety Nets’ to limit any individual’s or family’s out-of-pocket expenses for out-of-hospital medical services in a year (table 12.1). Of the two Safety Nets, the *Extended* Medicare Safety Net provides substantial fee relief to more people. For concession card holders and families eligible for Family Tax Benefit Part A, once the individual or family has paid about \$690 in cumulative co-payments for medical services, including mental health services, for the year, the Government will cover 80% of any co-payments for the rest of that year.

⁸⁷ Productivity Commission estimates using unpublished MBS data. As is standard, we calculated average co-payments excluding services with no-payment.

Figure 12.4 People from more disadvantaged areas are more likely to pay nothing for a consultation

Percentage of MBS-rebated consultations with no co-payment, by quintile of socioeconomic disadvantage, 2019^a



^a Psychological therapy includes both Psychological Therapy Services and Focused Psychological Strategies. Socioeconomic disadvantage of area defined as the ABS Socio-Economic Index of Areas (SEIFA).

Source: Productivity Commission estimates using unpublished MBS data.

Table 12.1 Medicare Safety Nets

	2020 Thresholds ^a	What counts towards the threshold?	What benefit is paid above the threshold?
Original Medicare Safety Net	\$477.90	The individual's or family's cumulative 'gap amount' ^b for the calendar year	100% of the 'gap amount' ^b for out-of-hospital services
Extended Medicare Safety Net	\$692.20 (for concession card holders and families eligible for Family Tax Benefit Part A) \$2169.20 (for everyone else)	The individual's or family's cumulative co-payments for the calendar year	80% of co-payments for out-of-hospital services ^c

^a Thresholds are adjusted each year in line with inflation (DoH 2015b). ^b The 'gap amount' is the difference between the schedule fee and the MBS rebate (which is commonly set at 85% of the schedule fee). ^c Up to a maximum of 300% of the schedule fee for consultation items (DoH 2015b).

Source: DHS (2020b).

Even with the Medicare Safety Nets, healthcare cards, and clinicians waiving co-payments for some people, people with less capacity to pay access fewer mental health services though Medicare. In 2019, about 4.5% of people living in areas of greatest socioeconomic disadvantage accessed MBS-rebated psychological therapy (averaging 4.1 sessions), compared with about 6% of people in areas of least socioeconomic disadvantage (averaging 4.7 sessions). And about 1% of people living in areas of greatest socioeconomic disadvantage accessed MBS-rebated *psychiatry*, compared to about 2% of people in areas of least socioeconomic disadvantage.⁸⁸

Primary Health Networks (PHNs) are tasked with increasing access to treatment and support for underserved groups, including people who may not be able to afford co-payments associated with therapy funded through the MBS. But roughly 20 times as many therapy sessions are subsidised through the MBS as are funded through PHNs (section 12.4), meaning that PHN-commissioned therapy has minimal effect on overall usage patterns for psychological therapy.

Some stakeholders objected to the out-of-pocket costs of mental health medications (CHF, sub. 646, p. 30; Penelope Knoff, sub. 28, p. 1; Trinity Ryan, Darwin transcript, p. 76). Others objected specifically to the cost of medications that are not on the PBS, and receive no government subsidy (comment no. 57, carers and family members; SANE Australia, sub. 130, p. 12), which in 2011-12 accounted for about 7% of mental health prescriptions.⁸⁹ For medications that *are* on the PBS, consumers are only required to pay *up to* the set co-payment — \$6.60 for people with a concession card or \$41 for those without. An individual using mental health medication fills nine prescriptions in a year on average (AIHW 2020j, table PBS.4). For someone with a concession card, this would cost about \$60. For someone without a concession card, this might cost up to about \$370 — though it could cost much less, as roughly half of prescriptions for mental health medications on the PBS are priced below the set co-payment (Productivity Commission estimate using AIHW 2020j, table PBS.4). For those filling many more than the average number of prescriptions, the PBS Safety Net limits total co-payments to under \$320 a year for families with a concession card, and to roughly \$1500 for those without (DoH 2020m).⁹⁰

Out-of-pocket costs mean that Australians in lower income brackets— who have a higher prevalence of mental ill-health — are sometimes unable to afford the care they need. We are proposing a range of changes to improve access to affordable and effective mental health services.

- The creation of a national digital mental health platform, which aims to give all Australians access to free assessment of their treatment needs, supported online treatments and short-course, structured therapy delivered by videoconference or phone

⁸⁸ Productivity Commission estimates using unpublished MBS data. Socioeconomic disadvantage of area defined as the ABS Socio-Economic Index of Areas (SEIFA).

⁸⁹ Productivity Commission estimate using AIHW (2013, table PBS.9). While dated, this is the most recent data available.

⁹⁰ Beyond the cap, families without a concession card pay the concession co-payment (\$6.60).

(chapter 10). The platform would also provide a gateway to MBS-rebated therapy other than a GP (removing a barrier that prevents some from accessing therapy).

- A suite of changes to encourage the provision of group therapy, which is usually less expensive for the consumer (section 12.2).
- A trial and evaluation of an increase in the session limit for MBS-rebated therapy to 20 sessions per person per 12-month period.
- An expansion of access to psychological therapy and psychiatry via telehealth, which can help people access more affordable clinicians. Currently, telehealth services rarely require a co-payment (section 12.3).
- Finally, changes in funding rules to give PHNs more flexibility in providing therapy services to underserved groups (chapter 23).

12.2 Improving access to low-intensity services

As discussed above, up to 2.5 million people with mental ill-health could benefit from greater access to low-intensity services. This section proposes ways to improve access. But closing the low-intensity gap also requires actions to encourage people who aren't receiving care to seek help (chapters 5, 7 and 8), and actions to ensure that people are supported to choose between the full-range of treatment options, instead of being funnelled toward medication or individual psychological therapy (chapter 10).

Increasing access to low-intensity service options can also help address the barriers to care due to locational mismatches and out-of-pocket costs. Low-intensity services can provide low-cost and accessible alternatives to other services that consumers may have difficulty accessing because of location or cost (although we are not proposing them as a replacement).

We distinguish between low-intensity treatments (clinical), and low-intensity supports (non-clinical) — although they are equally important, and the line between the two is not always clear. Low-intensity *treatments* fit roughly into three categories.

- **Supported online treatment** — automated treatment programs that have a mental health clinician sitting behind them providing oversight and stepping in when necessary. The largest provider of supported online treatment is Mindspot, which provides assessment and education along with treatment. In 2019, 21 000 people registered with MindSpot, of whom 4000 received treatment (Mindspot, sub. 666, p. 13). Chapter 11 discusses supported online treatment in detail.
- **Short-course, structured therapy** — often involving up to 6 sessions of about 30 minutes each, with each session closely following a prescribed, evidence-based structure. It can be delivered face-to-face or via telehealth, and can be provided by a tertiary-qualified psychological therapist (as with PORTS — chapter 10), or by a vocationally certified 'coach' — as with NewAccess in Australia (box 12.1) and the IAPT (Improving Access to Psychological Therapies) program in the United Kingdom.

About 2000 people received therapy from a NewAccess coach in 2018 (Productivity Commission estimates using Beyond Blue, pers. comm., 19 July 2019).

- **Group therapy** — usually provided by a psychological therapist, and run in groups of six to ten people. Group therapy is no less intensive in content, and places a similar time burden on the consumer to individual therapy but is often provided at a lower cost or free to the consumer. And it can help overcome workforce constraints because a single clinician (sometimes with a helper) can provide therapy for up to 10 consumers at a time. Structured group sessions (‘group work’) may also be delivered by social workers, occupational therapists, peer workers or others. About 7000 people received MBS-rebated group therapy in 2019 (Productivity Commission estimates using unpublished MBS data).

Counted together, we estimate that fewer than 30 000 people across Australia receive these low-intensity treatments each year.⁹¹

Low-intensity *supports* are much more widely accessible, although they could still play a larger role in supporting people with mental ill-health (including many who do not have a diagnosable mental illness). Low-intensity (including psychosocial) supports include:

- **online peer support forums** — for example, Beyond Blue’s forums are accessed by over 1.2 million people a year (Beyond Blue sub. 275, p. 33)
- **in-person peer support groups** — for example, each week 1500 people attend in-person peer to peer support programs run by Grow Australia (Grow Australia, sub. 847, p. 5)
- **ehespace** — in 2019, about 37 000 young people used ehespace, which provides a range of services, including email, phone calls or one-on-one online chat with a clinician, online group chats, and information related to mental health (Orygen and ehespace (joint submission), sub. 204, p. 23)
- **consumer assistance phone lines** — including Lifeline, which provides 24-hour crisis support and suicide prevention services, and receives an average of 60 000 calls per month (DoH 2019l, p. 18); and Beyond Blue, which provides 24-hour support focusing on depression and anxiety, receives calls from about 170 000 people in a year (Beyond Blue sub. 275, p. 33) (discussed in chapter 15)
- **social and activity groups** — such as clubhouses, men’s sheds, and groups which meet around a sporting, musical or art activity, which may or may not be targeted at people with mental ill-health.

⁹¹ In 2018-19, PHNs commissioned about 20 000 separate episodes of low-intensity services, comprising about 90 000 service contacts (although the true figure may be higher due to under-reporting). Counts are based on the principal focus of treatment rather than provider type (unpublished Department of Health data).

Box 12.1 **NewAccess**

NewAccess was developed by Beyond Blue based on the IAPT model in the United Kingdom, and commenced in Australia in 2013. In NewAccess, consumers have an initial assessment (of up to 60 minutes) followed by up to five 30 minute sessions of cognitive behavioural therapy (CBT) with their NewAccess coach. Coaches receive 7 weeks initial intensive training and 12 months of on-the-job training (Beyond Blue, pers. comm., 19 July 2019), and are clinically supervised. The burden on consumers is relatively low — following an assessment, it can be delivered online or over the phone (as well as in person), it is free to consumers, and no referral is required. People can also be referred up to more intensive services if needed (Beyond Blue, sub. 877, p. 23). It is aimed at people with low to moderate needs, especially those who are not currently accessing mental health services, including ‘hard to reach groups’ such as men and people living in regional and remote communities (Cromarty et al. 2016).

NewAccess is currently commissioned by 14 of the 31 Primary Health Networks (PHNs), as well as other agencies such as Comcare and the Department of Defence (Beyond Blue sub. 877, p. 23).

Commissioning bodies engage local service providers, with Beyond Blue licencing the model to them ... Beyond Blue provides advice, quality assurance and model fidelity oversight, some data collection and coordination of a national community of practice network. (Beyond Blue sub. 877, p. 23)

A recent evaluation of NewAccess — including more than 3000 consumers — found strong positive effects on mental health outcomes. The results indicated large pre–post effect sizes of 1.23 (on the PHQ-9 depression measure) and 1.25 (on the GAD-7 anxiety measure) (Baigent et al. 2020, table 2). Of those who were assessed and treated, about 60% completed according to schedule (Baigent et al. 2020). Another study looked at young people receiving NewAccess through two regional headspace centres, and found similar improvements in mental health (Fox et al. 2020).

However, NewAccess has so far struggled with service volume — attracting few consumer self-referrals, and few referrals from GPs — and has failed to demonstrate cost-effectiveness. In the 12 months to March 2019, the highest number of sessions provided at *any* of the 9 sites was 1230, and the average number of sessions per site was just 763 (Beyond Blue, pers. comm., 19 July 2019). For comparison, Beyond Blue advised that a single full-time NewAccess coach has capacity to provide about 1125 sessions per year (Beyond Blue, pers. comm., 19 July 2019).

Beyond Blue provided information about two PHNs’ contracts for provision of NewAccess up to June 2020. The contracts are each for a fixed amount that does not depend on the number of sessions delivered (Beyond Blue, pers. comm., 13 August 2019). In 2019 dollars, the implied cost per session is \$141–\$161 (assuming the average number of sessions per person remains at 3.8 (EY 2015, p. 128)). However, the contracts assume significant increases from current service volumes. If the two PHNs instead were to have service volumes equal to the highest recorded for any site in the year to March 2019 (1230 sessions), the cost per session would be \$203–\$317.

Despite the name, low-intensity treatments and supports can help people across the spectrum of mental health needs.⁹² For example, Jones et al (2018) showed that consumers with bipolar disorder can benefit from group therapy. Grow Australia (sub. 847, p. 11) stated:

... People across the spectrum of mental ill-health – from low to moderate intensity, high intensity and acute and specialist community mental health services – need low intensity services such as Peer to Peer support (including face-to-face and online support): low intensity does not equal low levels of distress, illness, depression or anxiety nor does it mean minimal impact or outcome ... While Peer to Peer programs such as [Grow Australia’s] are low intensity and have low unit costs, they deal with people who have illnesses ranging from mild to moderate to severe episodic and severe and persistent.

Low-intensity treatments already exist in many parts of Australia, but they need to be more accessible — to ensure that all consumers can choose the services that are right for them. We are proposing changes to improve the availability of a number of face-to-face treatment options, but the biggest improvements in access are likely to come from better use of digital technologies (covering online, phone apps, videoconferencing and telephone).

Digital technologies have already improved access to low-intensity supports but digitally-delivered low-intensity treatments are yet to reach anywhere near their potential. Well-designed digital treatments are both clinically effective and cost-effective (chapters 10 and 11). Increasing their accessibility is vital to ensure that more people with mental ill-health can access services that work for them. The importance of expanding digital mental health solutions was recognised in The National Mental Health and Wellbeing Pandemic Response plan (Australian Government 2020c).

With this aim, we are proposing the establishment of a national digital mental health platform (chapter 10). The platform would offer consumers a range of support and treatment options to suit their individual circumstances, needs and preferences. The consumer would be assisted in that choice through a clinician-supported online assessment, which could connect consumers with digital services or local, in-person services.

To maximise consumer choice and access to services, the recommended national digital mental health platform would:

- provide evidence-based digital low-intensity services that are accessible and low-cost to consumers
- encourage individuals to self-refer, by establishing (or augmenting an existing) well-known, trusted brand
- encourage GP referrals through strong communication with GPs, integration with GP practice software, and establishing a well-known, trusted brand.

We are also recommending steps to improve Head to Health, Australia’s online mental health portal, which can help inform people about digital low-intensity treatments (chapter 15).

⁹² Chapter 17 discusses issues specific to psychosocial support, including some low-intensity supports. Chapter 10 recommends changes to the gateways to mental healthcare to ensure that consumers are given the choice to access low-intensity supports. Chapter 8 discusses the potential benefits of social prescription as a means to increase social participation.

And expanded use of digital technology could improve consumer access to higher-intensity services that are typically accessed face-to-face, such as individual psychological therapy and private psychiatric care (section 12.3).

Other low-intensity services, particularly those delivered face-to-face, would only be available to consumers if they were commissioned locally by a regional commissioning body — whether PHNs or other bodies (chapter 23). For example, 14 PHNs currently commission short-course structured therapy under the NewAccess banner. NewAccess has been shown to be effective in improving outcomes, but it has so far struggled with scale, and has *not* been cost-effective at its current usage levels (box 12.1). We discuss regional commissioning bodies, including the need for more consumer involvement in deciding which services are provided, in chapter 23.

Improving access to group therapy

Only about 7000 people access MBS-rebated group therapy in a year (box 12.2), with MBS rules severely limiting its availability. In 2019, there were close to 6 million sessions of individual therapy subsidised through the MBS, but only about 30 000 sessions of group therapy — or about 1 in every 200 sessions (Productivity Commission estimates using unpublished MBS data). For many people, group therapy is an appealing, effective and low-cost option, and should be made more accessible.

Group therapy is an appealing treatment option for many consumers, providing a different and more sociable experience than individual therapy. For example, Orygen (sub. 1110, p. 6) pointed out that group therapy and group programs are ‘highly acceptable to some young people’. And the NT Legal Aid Commission (sub. 410, p. 12) argued that group therapy for children with mental illnesses ‘can reduce feelings of isolation and provide effective counselling both from the counsellor/facilitator and the children amongst themselves’.

Group therapy is on average just as effective as individual therapy (Burlingame et al. 2016; Cuijpers et al. 2019). A recent meta-analysis by Burlingame et al. (2016, p. 457) — including multiple studies on depression, anxiety, eating disorders, substance use and childhood disorders — found that group therapy and individual therapy led to ‘statistically indistinguishable outcomes’. In a separate review, Burlingame et al. (2013, pp. 664–665) concluded that:

The ‘no difference conclusion’ is more or less confirmed for mood disorders, panic disorders, personality disorders, schizophrenia, and eating disorders ... Although there may be some disorders where the individual format seems more promising (e.g., specific trauma-related disorders), format equivalence [between individual therapy and group therapy] is convincingly supported, as are the economic advantages.

Group therapy tends to be more cost-effective than individual therapy. MBS-rebated group sessions are less likely to have a co-payment than individual sessions (47% compared with 57%), and where there is a co-payment, it tends to be lower for group sessions (averaging \$45 compared with \$68) (Productivity Commission estimates using unpublished 2019 MBS data).

Box 12.2 Psychological therapy under Medicare

Most talking therapy provided under Medicare is classed as either Psychological Therapy Services or Focused Psychological Strategies and was introduced as part of the Better Access program — we use the term ‘psychological therapy’ to cover both.

To be eligible for MBS-rebated psychological therapy, a person: must be referred by a GP, a psychiatrist or a paediatrician; be diagnosed as having a mental disorder; and for GP referrals, have a Mental Health Treatment Plan (MHTP) completed by their GP (Services Australia 2018).

In 2019, people that received some therapy averaged 4.5 subsidised sessions (of individual and/or group therapy) (Productivity Commission estimates using unpublished MBS data). In a calendar year, consumers can receive up to 10 subsidised sessions of individual psychological therapy as well as up to 10 subsidised sessions of group psychological therapy. However, consumers can only be referred for up to 6 subsidised sessions at a time. After this, the consumer must return to the referring doctor for a new referral. (though if a consumer is mid-way through a course of treatment at the end of a calendar year, they do not need to get a new referral to complete the course of treatment) (Services Australia 2018).

In 2018-19, women were about 70% more likely to receive MBS-rebated psychological therapy than men (Productivity Commission estimate using AIHW 2020f, table MBS.10). Younger people received more services than older people, reflecting higher rates of mental illness among the young (chapter 2). Young people aged 12–24 years accounted for 23% of services, and people aged 25–34 years accounted for 20% (Productivity Commission estimate using AIHW 2020f, table MBS.10).

Psychological therapy items can be provided by a clinical or registered psychologist, or by a social worker, occupational therapist or GP who has completed additional mental health training. In 2018-19, 92% of sessions were provided by a clinical or registered psychologists (Productivity Commission estimate using AIHW 2020f, table MBS.9).

The Australian Government has recently expanded MBS-rebated therapy for particular groups. In 2018, the Australian Health Minister announced that people with anorexia nervosa and other severe psychological eating disorders would be able to access up to 40 subsidised sessions per year (Hunt 2019a).

In January 2020, the Australian Government announced a mental health support package for Australians affected by the 2019-20 bushfires, which included new MBS therapy items (available until December 2021) (DoH 2020a).

To access the new Medicare rebated items you do not need to have a diagnosed mental health condition, GP referral or mental health treatment plan. ... Individuals who currently access services under the Better Access initiative and were directly affected by the bushfires, will be able to access the additional 10 sessions under the Bushfire Recovery items. (DoH 2020i, p. 3)

The support package allowed people affected by the bushfires who could not easily access mental health professionals in person to obtain MBS-rebated therapy via videoconference (DoH 2020i, p. 1). In the first three months of 2020, about 4000 sessions of therapy were provided as part of the package (Productivity Commission estimate using Services Australia 2020a). The package also contained a range of other measures, including distress and trauma counselling to be provided in the short term at bushfire recovery centres (DoH 2020a).

During the COVID-19 crisis, the Australian Government introduced new MBS items to support MBS-rebated therapy by either videoconference or phone. These services (discussed in more detail below) are available to any individual who would otherwise be eligible for MBS-rebated face-to-face therapy, and are available until 30 September 2020.

A psychological therapist providing group therapy can, by definition, treat more consumers than one providing individual therapy. This means that group therapy can increase consumer access to psychological therapy, particularly in communities where there is a shortage of clinicians.

Additionally, because of the MBS rebate structure, group therapy is also cost-effective from an Australian taxpayer perspective. The MBS rebate is provided on a per-person basis, so the total MBS rebate received by the psychological therapist running the group increases with the number of people in the group (to a maximum of 10). But the per-person MBS rebate is much lower than for individual therapy (\$32 instead of \$127, for a clinical psychologist) (DoH 2020h).

All up, the average fee per person for a group sessions (including both the MBS rebate and any co-payment) is about one-third the cost of an individual session — regardless of the number of people in the session or the type of clinician (Productivity Commission estimates using unpublished MBS data). This means that with a group of three (if allowed), the average clinician would receive about the same from a group session as an individual session; with a group of six, they would receive about double as much; and with a group of nine, they would receive about triple. However, running group sessions can involve additional administrative costs and overheads (APS, sub. 543 att. 1, p. 2).

So increased access to group therapy has benefits for consumers, clinicians and taxpayers. But as discussed, it is currently massively underutilised relative to individual therapy. The MBS Review Mental Health Reference Group (2018, p. 41) argued that ‘the uptake of group work items in the MBS should be higher, given the proven effectiveness of group therapy and the greater access to services it provides’.

Consumers can only access group therapy if clinicians provide it, and we have identified several barriers that deter clinicians from running group sessions. One barrier is the MBS restriction that group therapy must include at least six participants. The Australian Psychological Society highlighted the difficulty of getting six people to attend, particularly with high drop-out rates (APS, sub. 543, p. 2). This restriction does not appear to be based on evidence. The meta-analysis by Burlingame et al (2013) found ‘no significant differences’ in the ‘degree of improvement’ due to group size. And as MBS funding for group therapy is on a per-person basis, smaller groups are just as cost-effective from the taxpayer’s perspective as larger groups (as long as the per-person rebate remains at its current level, and we do not consider that an increase is necessary).

On these grounds, we are proposing a reduction in the lower limit for group therapy from six to four people. Both the MBS Review Mental Health Reference Group (2018, p. 40) and the Australian Psychological Society (2019b, p. 40) have recommended lowering the limit from six to four.⁹³ In addition, so that participant drop-out does not deter the creation or continuation of group therapy, groups with fewer than four people should be allowed, as long as the course of group therapy began with at least four in the group.

⁹³ For regional and remote areas, the APS recommended that the limit be lowered to three (APS 2019b, p. 40).

Another barrier to group therapy is the *perception* that individual therapy is the default for referrals. The APS (sub. 543, att. 1, p. 3) told us:

Eligibility for the Better Access group therapy services requires that the referring practitioner specify that the referral is for group (not individual) items. Individual therapy services is the default if not specified. This requires clients to return to their GP for a separate referral for group items.

This is a misconception. The Australian Government Department of Health (pers. comm., 17 October 2019) advised that if the referral does not specify individual therapy or group therapy, then the consumer can use that referral to access either.

A further barrier is that the MBS rebate for group therapy does not vary with session length. Currently, there is a standard MBS rebate for group therapy, which requires that the session length is at least 60 minutes. But many group sessions go for longer (APS, sub. 543, att. 1, p. 2) with clinical evidence supporting durations of up to 120 minutes (National Collaborating Centre for Mental Health (UK) 2010, p. 216). Introducing MBS item numbers for longer sessions has been proposed by the APS (2019b, p. 40), and is likely to increase both the quality and number of group sessions being provided.

The changes we proposed to encourage more group therapy received wide support.⁹⁴ We estimate that they may encourage an additional 3000–5000 people to access group therapy each year who would not otherwise access any psychological therapy, at an annual cost of \$900 000–\$1.5 million, with the annual benefit of this treatment estimated at 33–61 quality-adjusted life years (QALYs) and \$2.8 million–\$5.3 million in income. Additional to this, we estimate that the changes may encourage 5000–7000 people who are currently accessing MBS-rebated individual therapy, to access MBS-rebated group therapy instead (with a comparable mental health outcome), this would provide a cost *saving* of \$1.9 million–\$2.6 million per year (appendix K).

⁹⁴ ACT Government, sub. 1241, p. 5; ACPA, sub. 727, p. 10; ANMF, sub. 1187, p. 19; headspace, sub. 947, p. 34; National Rural Health Alliance, sub. 1192, p. 3; Orygen, sub. 1110, p. 6; PHN Cooperative, sub. 850, p. 24; QAIHC, sub. 1235, p. 7; RAV, sub. 1197, p. 13; RANZCP, sub. 1200, p. 9; Uniting Vic.Tas, sub. 931, p. 11.

ACTION 12.1 — ENCOURAGE MORE GROUP PSYCHOLOGICAL THERAPY

The Australian Government should change the Medicare Benefits Schedule (MBS) to encourage more group therapy.

Start now

- The Australian Government should change the MBS so that group therapy is allowed with a minimum of 4 people (instead of 6 people), and with fewer than 4 people, as long as the course of group therapy began with at least 4 in the group.
- The Australian Government should create new MBS items for group sessions that run for ‘at least 90 minutes’ and ‘at least 120 minutes’.
- The Australian Government should clarify that unless explicitly stated otherwise, referrals for MBS-rebated Psychological Therapy Services and Focused Psychological Strategies can be used for either group therapy or individual therapy — at the discretion of the consumer, after discussion with their referring clinician. The Government should communicate this to clinicians that refer to or provide these services.

12.3 Telehealth can help more people access the care they need

For many people with mental illness, psychiatry or psychological therapy delivered by videoconference or telephone (‘telehealth’ is used to refer to both) is just as effective as therapy delivered face-to-face (box 12.3). Allowing all consumers to access these services by telehealth will ensure that more people can access the services they need, as well as reducing the time, effort and cost involved.

While telehealth is already available in some regional and remote areas, expanded access to telehealth can help address the locational barrier to care. Telehealth can also improve access to psychiatry, which is part of the solution to the missing middle.

Telehealth has obvious value in places where there are few clinicians — including some regional and remote areas (chapter 16) — and in the period of social distancing during the COVID-19 pandemic. But there are a multitude of other reasons why it may be difficult for someone to attend therapy in person, including work or family commitments, poor access to transport, physical disability, or because their mental illness makes it hard for them to leave the house (PHN Cooperative sub. 850, p. 24). A consumer who joined a support group via videoconference shared: ‘I was feeling suicidal, I didn’t want to go travelling or do anything. Being able to go online, in my own home, was an option that was suitable for me’ (Grow Australia, sub. 194, p. 5). Other examples abound.

- The Gidget Foundation (sub. 709, p. 12) argued that remote access was ‘critical’ for new mothers, who may not be able to drive a car or travel. Women in late pregnancy may be similarly restricted.

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- A member of the Australian Association of Social Workers (AASW, sub. 848, p. 8) told us that they have ‘a number of clients’ who they see via videoconference who ‘previously lived near me and saw me face-to-face but then moved away and wanted to maintain a therapeutic relationship with a known clinician’.
 - yourtown (sub. 511, p. 7) told us that ‘face-to-face services are extremely hard to access in close-knit communities (e.g. remote and rural communities in particular), due to associated stigma or knowing practitioners’. The same point was made by Murrumbidgee PHN (sub. 1199, p. 11).

Box 12.3 **Telehealth works for many consumers**

Psychological therapy delivered by videoconference can be equally effective as face-to-face therapy (Backhaus et al. 2012; Berryhill et al. 2019; Gros et al. 2013). This holds for a wide range of mental illnesses, including eating disorders (Schlegl et al. 2015) and post-traumatic stress disorder (Morland et al. 2015; Yuen et al. 2015).

A large meta-analysis found that psychological therapy delivered by *telephone* was just as effective in the treatment of depression (Cuijpers et al. 2019). And there is evidence from the IAPT program in the United Kingdom (box 12.1) that therapy delivered by telephone is as effective as face-to-face for most people (Hammond et al. 2012; Turner 2015). Wider-ranging reviews have also supported the effectiveness of psychological therapy by telephone, while pointing to the need for more high-quality studies (Hailey, Roine and Ohinmaa 2008; Leach and Christensen 2006).

For psychiatry, the available evidence supports equivalence between videoconference and face-to-face, although several reviews have noted that many of the relevant studies have small sample sizes and/or methodological flaws (Chakrabarti 2015; De Las Cuevas et al. 2006; Drago, Winding and Antypa 2016; Frueh et al. 2000; García-Lizana and Munoz-Mayorga 2010; Hylar, Gangure and Batchelder 2005; Monnier, Knapp and Frueh 2003; O’Reilly et al. 2007; Richardson et al. 2009). Pakruey et al (2010) suggest that psychiatry by videoconference may be superior for some children and adolescents, partly because of the extra (psychological and physical) distance involved. The available evidence also supports the effectiveness of psychiatry by telephone, although the number of studies is limited (Hailey, Roine and Ohinmaa 2008; Kasckow et al. 2014). Finally, providing psychiatry by telehealth can improve links with primary care or psychosocial support services, where telehealth services are accessed from within their premises (as might be the case in regional or remote areas with poor internet) (RANZCP 2014, p. 23).

While some have worried that it can be harder to build rapport using telehealth (for example, AASW, sub. 848, p. 8), there is substantial evidence that consumers and clinicians *can* establish a strong therapeutic alliance via videoconference (Jenkins-Guarnieri et al. 2015; Simpson and Reid 2014). Telehealth will not work for every consumer or every clinician, but they are best placed to decide.

Even people who do *not* find it difficult to get to face-to-face sessions, may nonetheless benefit from improved access due to telehealth.

- Telehealth can help people access more affordable services. In 2019, more than 99% of psychological therapy provided by videoconference had no co-payment (Productivity Commission estimate using unpublished MBS data).
- Telehealth can help people access care more quickly (Murrumbidgee PHN, sub. 1199, p. 11). It can take six weeks or more to get a first consultation with a psychiatrist face-to-face (Melbourne Children’s Campus sub. 927, p. 9). But telehealth provider Call to Mind can usually set up a bulk-billed videoconference consultation within a week (Chan, Parish and Yellowlees 2015).
- Telehealth can minimise the travel and waiting time, and incidental costs (such as childcare, transport costs, and lost income) associated with attending an appointment. Anderson et al. (2016) estimated that these incidental costs averaged about \$60 per appointment for consumers attending an anxiety clinic in inner Sydney.
- Telehealth makes it easier to for consumers with specialised needs to link up with a clinician who can help them, such as a clinician who has the same cultural background⁹⁵ or speaks the same language (Murrumbidgee PHN, sub. 1199, p. 11), or a psychiatrist of the appropriate sub-speciality (Hilty et al. 2018; RANZCP, sub. 1200, p. 13; Ye et al. 2012). The parent of a child with autism, attention deficit hyperactivity disorder (ADHD) and mental illness told us:

... we tried desperately to access a private psychiatrist in Canberra but were turned away by all. Some stating that they didn’t specialise in disabilities/mental health while others just said flatly no we don’t have any vacancies. (Name withheld, sub. 81, p. 1)

- Finally, telehealth can be convenient for *clinicians*, can save on their office expenses, and may encourage them to provide more hours of care (including outside of standard weekday daytime hours). The RANZCP reported that telehealth can reduce travel time for psychiatrists, enabling them to provide more services (RANZCP 2014, p. 23). Call to Mind (sub. 499, p. 2) told us:

Telehealth allows for more efficient use of the current medical workforce. Since starting Call to Mind, we have received a lot of interest from psychiatrists and psychologists who are eager to work, but find the standard pathways of public mental health services or individual private work to be inflexible and limited. Many of our psychiatrists are either young parents on leave or returning to work or part-time employees in public services looking for additional clinical time.

⁹⁵ For example, there were fewer than 200 Aboriginal and Torres Strait Islander psychologists and only 15 Australian and Torres Strait Islander psychiatrists across Australia in 2018 (Productivity Commission estimate using DoH 2020l).

Telehealth has already improved consumer access in regional and remote areas

People living in some parts of the country already have access to psychological therapy and psychiatry by telehealth under the MBS.

- From 2003, people in rural and remote areas⁹⁶ have had access to MBS-rebated *psychiatric* consultations by *telephone*. They accounted for just 1–2% of psychiatric consultations in these areas in 2018-19.
- From 2011, people outside major cities⁹⁷ have had access to MBS-rebated *psychiatric* consultations by *videoconference*. They accounted for 15–20% of psychiatric consultations in these areas in 2018-19.
- From 2017, people in rural and remote areas⁹⁸ have been eligible for MBS-rebated *psychological therapy* sessions by *videoconference*. They accounted for 2–4% of psychological therapy delivered in these regions in 2018-19. (Productivity Commission estimates using AIHW 2020f, table MBS.10; Services Australia 2020a).

There has been strong growth in the use of both psychiatry and psychological therapy by videoconference (figure 12.5). For MBS-rebated psychological therapy, this can be partly explained by the removal (in September 2018) of a requirement that consumers access at least one of their first four sessions face-to-face (as well as at least three out of the ten) (DoH 2019c, p. 1). While the trend for MBS-rebated psychiatry by videoconference suggests that many clinicians and consumers took some time to adopt the new technology, COVID-19 has forced the rapid adoption of telehealth.

Consumers rarely pay a co-payment for a consultation with a psychiatrist by videoconference. In 2019, Call to Mind reported that 99% of videoconference sessions booked through its services were bulk-billed (they did not have a co-payment) (Whelan 2019). High rates of bulk-billing may be partly because, for psychiatry, video and phone consultation items receive a higher MBS rebate compared with standard consultations for people in regional and remote areas. Videoconference consultations attract an MBS rebate that is 50% higher and telephone consultations attract an MBS rebate that is about 30% higher (and varies between items). In 2019, the value of these *additional* rebates was about \$6.9 million for videoconference and about \$200 000 for telephone (DoH 2020h; Productivity Commission estimates using Services Australia 2020a).

⁹⁶ Rural Remote Metropolitan Areas 3–7.

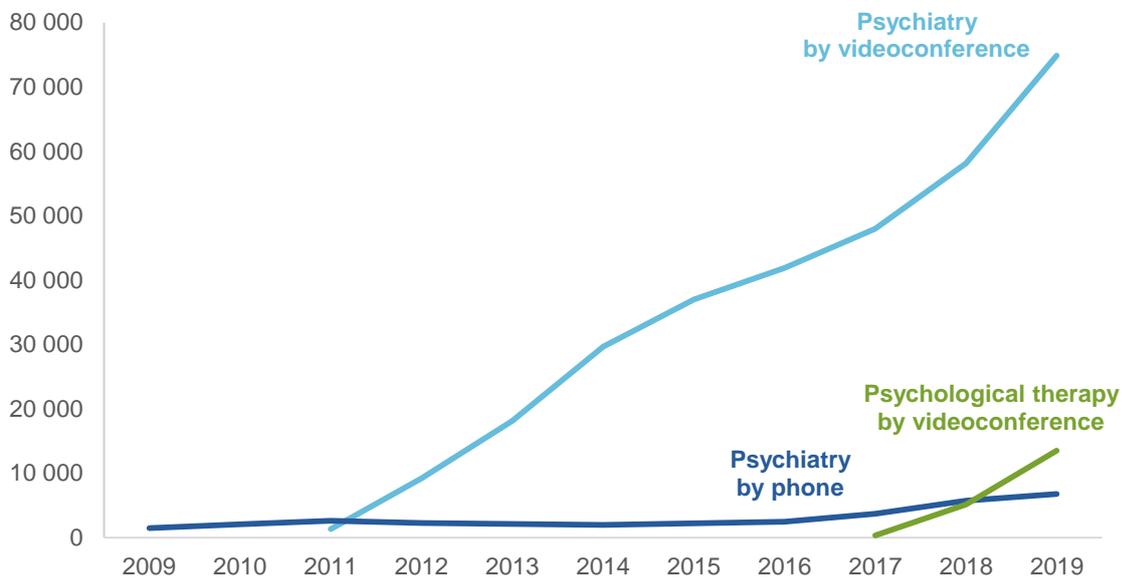
⁹⁷ Australian Standard Geographical Classification Remoteness Areas 2–5.

⁹⁸ Monash Modified Model Areas 4–7.

In March 2020, in response to the COVID-19 pandemic, the Australian Government introduced a suite of *temporary* MBS items that give people across Australia access to psychological therapy and psychiatry by videoconference (and by telephone if videoconference is not available). For psychological therapy, the MBS items mirror existing videoconference items, but with location restrictions removed (DoH 2020c, 2020d).⁹⁹ For psychiatry, the MBS items mirror a dozen or so existing items for face-to-face consultations, including the most common consultation items (DoH 2020b).

Figure 12.5 Videoconference has improved access in regional and remote areas

MBS consultations per year



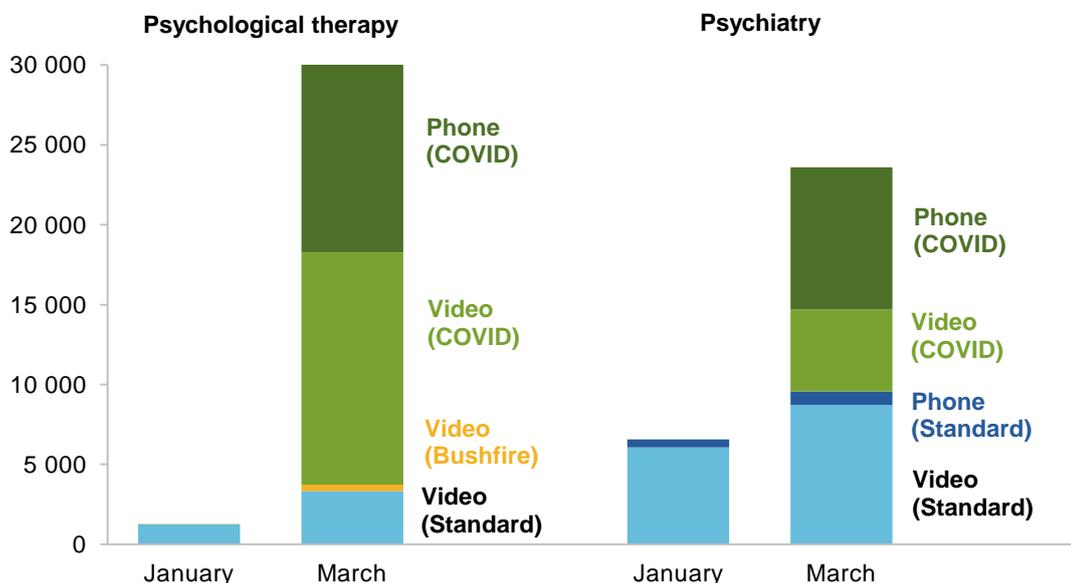
Source: Productivity Commission estimates using Services Australia (2020a).

As a result of the pandemic, and aided by the additional rebates and the new MBS items, use of telehealth for both psychological therapy and psychiatry has increased dramatically (figure 12.6). At 6 April 2020, half of all MBS-rebated services delivered by psychologists were delivered via telehealth (Australian Government 2020c, p. 10).

⁹⁹ The Australian Government also introduced a range of additional temporary mental health MBS items for use by GPs (and ‘Other Medical Practitioners’), including items related to Eating Disorder Management, Mental Health Treatment Plans (chapter 10), and pregnancy support counselling (DoH 2020c).

Figure 12.6 Telehealth use has increased dramatically since COVID-19

Use in January 2020 compared with March 2020



^a 'Standard' refers to MBS items existing prior to 2020. 'Bushfire' refers to MBS items announced as part of the bushfire support package (box 12.2). 'COVID' refers to MBS items introduced in March 2020 in response to COVID-19.

Source: Productivity Commission estimates using Services Australia (2020a).

All consumers should have ongoing access to telehealth

To help consumers access the services they need in the way that works best for them, the new COVID-19 telehealth items for consultations with a psychiatrist or psychological therapist¹⁰⁰ should be kept in place permanently, replacing existing telehealth items for psychiatry and psychological therapy.¹⁰¹

These new items make three important improvements over previously existing psychological therapy and psychiatry telehealth items.

- They open up access to people who live in metropolitan areas, and (for psychological therapy) regional centres and large regional towns. While these people are more likely to have a clinician close by, they may still face a range of other barriers to getting to a face-to-face session (discussed above).

¹⁰⁰ Psychological therapy refers to all services classed as Psychological Therapy Services or Focused Psychological Strategies, which can be provided by clinical psychologists, registered psychologists, social workers, occupational therapists, GPs and Other Medical Practitioners (DoH 2020c, 2020d).

¹⁰¹ This includes items 363–371, which relate to face-to-face psychiatric consultations following a consultation by phone. They are rarely used — they were billed a combined total of 175 times in 2019 (Productivity Commission estimate using Services Australia 2020a) — and serve no apparent purpose.

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- They effectively remove the current requirement that the consumer and the clinician providing the service are at least 15 km apart. We understand that this requirement was put in place to ensure that the consumer attends the clinician’s practice in person, where this is not too inconvenient. But it constructs an additional unnecessary barrier to people accessing services, and should be removed.
 - They provide all consumers with the option of accessing services by telephone where videoconference is not available. This ensures that consumers in regions with poor internet (chapter 11) can also access services, where currently they may miss out. A social worker related how providing psychological therapy in Far North Queensland is hampered by poor internet.

‘ ... [the] videoconference is not fluent. Too many interruptions prevent building sound relations and positive forward movement.’ (AASW, sub. 848, p. 8)

Once the need for social distancing has reduced, an annual cap should be placed on the number of *MBS-rebated* consultations that an individual can have with a psychiatrist via telehealth. Annual MBS caps are standard in psychiatry (and psychological therapy — section 12.4). The rebate for standard psychiatric consultations with a consumer halves after 50 MBS-rebated sessions in a calendar year (items 309–318).¹⁰² Telehealth items should count towards this limit, but a lower ‘telehealth cap’ should also apply.

While any cap on rebated consultations restricts access or choice for some consumers, it can also help ensure that psychiatrists allocate their time in a way that ensures a greater number of consumers can get the help they need in a timely fashion. It is not easy to strike the right balance between consumers that have ongoing consultations with a psychiatrist, and consumers that need an assessment or an initial consultation. But with this aim, we are recommending that a limit of 12 MBS-rebated telehealth sessions per consumer per year be applied across Australia. This would restrict choice for a relatively small group of people — only about 500 consumers (about 0.1% of people receiving private psychiatric care) accessed more than 12 MBS-rebated psychiatry consultations by telehealth in 2019, and only about 300 consumers accessed more than 15 (Productivity Commission estimate using unpublished MBS data). The MBS Review Psychiatry Clinical Committee also proposed a limit of 12 MBS-rebated videoconference sessions per year as an expansion of psychiatry by videoconference to people living in major cities (though it did not suggest that this limit apply to people living in regional and remote areas) (MBS Review Psychiatry Clinical Committee 2019, p. 24).

¹⁰² There is carve-out for consumers with certain diagnoses or severe functional impairment (item 319), for whom the rebate is unchanged. In 2019, more than three quarters of consultations with consumers that had had more than 50 consultations in that year qualified for the (higher) standard rebate (Productivity Commission estimate using Services Australia 2020a).

The Committee also recommended that in major cities the videoconference items should be restricted to consumers who:

... would benefit from telehealth for reasons of either severe physical disability, a mental health disorder that prevents them from attending a face-to-face consultation, or psychosocial stress (for instance if a patient cannot take time off from work). (MBS Review Psychiatry Clinical Committee 2019, p. 24)

We do not agree with this restriction. In a person-centred mental health system, it should be up to the individual to choose the method of delivery that works best for them. And as discussed above, telehealth may work better for a wide range of consumers.

We expect that making the new MBS telehealth items permanent would encourage some people who need psychological therapy to access it (when they otherwise would not have), and would make access easier for many people who already access therapy or psychiatric care. We estimate that (post-COVID-19) between 200 000 and 400 000 psychiatry consults and psychological therapy sessions could switch from face-to-face to telehealth, with time and incidental cost savings equal to anywhere from \$4 million to \$24 million per year. We assume that on average the telehealth consultations have the same fees (rebate plus co-payment) and provide the same benefit as face-to-face consultations. We also estimate that 5 000–10 000 *people* could access MBS-rebated psychological therapy who otherwise would not, costing \$3.3 million–\$6.5 million per year, but leading to a yearly benefit of 50–90 QALYs and \$4 million–\$8 million in income (appendix K).

Our recommendations here are bolder than those made in the Inquiry draft report. At that time, we envisaged the huge potential for telehealth to address consumer access needs but underestimated the scope of the health profession to accommodate such a change to their service delivery approach. Nonetheless, our draft report recommendations to expand MBS-rebated psychological therapy and psychiatry by videoconference received broad support. The Australian Nursing and Midwifery Association (ANMF sub. 1187, p. 19) and the APS (sub. 853, p. 26) supported draft recommendation 5.7, although the APS suggested that psychological therapists ‘will require financial support to establish secure software platforms’. A large number of stakeholders supported both draft recommendations.¹⁰³ The RANZCP (sub. 1200, p. 10) argued that our proposed expansion of psychological therapy by videoconference ‘could bring benefit’ but that there is ‘a need to ensure that increasing access to telehealth in non-rural areas does not lead to a reduction of services to those already accessing telehealth in rural areas, by drawing services away from these areas’. The RANZCP (sub. 1200, p. 13) also suggested that the expansion of psychiatry by telehealth should include a broader range of psychiatry consultations. The Inquiry final report recommendation does just this.

¹⁰³ Black Dog Institute, sub. 1207, p. 2; CHF, sub. 646, p. 13; headspace, sub. 947, pp. 33–34; NMHC, sub. 949, p. 11; NT PHN, sub. 1213, p. 8; Relationships Australia (National), sub. 831, p. 12; SAMHC, sub. 691, att. B, p. 2; Uniting Vic.Tas, sub. 931, p. 11; Wesley Mission, sub. 840, p. 8.

Psychiatrists should no longer receive higher rebates for telehealth

Finally, we see a strong case for removing existing additional MBS rebates associated with psychiatrists providing telehealth services in regional and remote areas. These additional rebates do not appear justified. On average, psychiatrists received an *additional* rebate of more than \$80 for each consultation they provide via videoconference instead of face-to-face (Productivity Commission estimate using DoH 2020h; Services Australia 2020a). As noted above, the cost of additional telehealth rebates to taxpayers was more than \$7 million in 2019 (or just under \$600 000 per month). Use of these items has been higher during the COVID-19 crisis — in March 2020, the additional telehealth rebates totalled about \$850 000 (Productivity Commission estimate using Services Australia 2020a).

The MBS Review Psychiatry Clinical Committee (2019, p. 22) also recommended the removal of these additional payments for videoconference. They argued that the payments were intended as a time-limited incentive to accelerate the adoption of videoconferencing, and that this purpose has been served.

However, the MBS Committee also set out some caveats. They recommended that an *initial* consultation via videoconference should continue to attract a higher rebate than an *initial* consultation provided face-to-face, ‘to recognise the extra time and complexity associated with delivering this service’ (MBS Review Psychiatry Clinical Committee 2019, p. 51). (An initial consultation provided face-to-face already attracts a higher rebate than a repeat consultation face-to-face.) They also recommended that the MBS Review Taskforce:

... should consider recommending an incentive payment, or another similar funding mechanism be instituted, to continue to stimulate services in regional and remote areas. If opting not to introduce an incentive payment or similar, item 288 should be gradually withdrawn rather than removed, as a means to avoid any sudden retreat from its use and allow the system time to adjust. (MBS Review Psychiatry Clinical Committee 2019, p. 23)

The RANCZP (sub. 1200, p. 13) argued that ‘any cut’ to current rebates for videoconference consultations ‘will severely disrupt services, as many psychiatrists will no longer be able to bulk-bill these services and will therefore stop doing so’. Similar arguments were put by the Independent Private Psychiatrists Group (sub. 742, pp. 9–10), Danielle Gamble (sub. 797, p. 1) and Stuart Gamble (sub. 730, p. 1).

Our position is that services provided by telehealth warrant neither higher rebates nor ‘incentive payments’, because the costs to the psychiatrist of providing services via telehealth are (if anything) lower than face-to-face. Given this, it is difficult to believe that the removal of additional rebates would lead to a ‘sudden retreat’ from psychiatrists offering telehealth, particularly following COVID-19.

ACTION 12.2 — PSYCHOLOGICAL THERAPY AND PSYCHIATRY BY TELEHEALTH

Widening access to psychological therapy and psychiatry by videoconference and telephone would offer significant benefits for consumers.

Start now

- The Australian Government should make permanent the MBS items introduced during the COVID-19 pandemic that allowed people in any part of Australia to access:
 - MBS-rebated Focused Psychological Therapies and Psychological Therapy Services by videoconference and by telephone from clinical and registered psychologists, and credentialed social workers, occupational therapists, GPs and other medical practitioners
 - certain MBS-rebated psychiatric services by videoconference (and by telephone where videoconference is unavailable).
- Standard psychiatry consultations by videoconference and phone should be limited to 12 MBS-rebated consultations per year.
- These new MBS items — which expand access to telehealth — should replace existing telehealth items, including those that provide higher rebates to psychiatrists for telehealth services than for face-to-face services.

12.4 Enabling psychological therapy to meet people’s needs

In 2019, about 1.4 million Australians with mental ill-health accessed individual psychological therapy, making it one of the dominant treatments in the mental health system (along with, and often combined with, medication — figure 12.2). This section considers expanding limits on MBS-rebated sessions of psychological therapy, to better align with the needs of the missing middle, and to reduce the out-of-pocket cost barrier to care. It also outlines actions needed to ensure that the psychological therapy people are accessing is as effective as possible.

How do consumers access individual psychological therapy?

Anyone can access psychological therapy in Australia if they are able to pay the fee charged, travel outside their local area and/or wait (often months) for an appointment. Most people instead choose to seek access to government-subsidised psychological therapy through one of three avenues: MBS-rebated psychological therapy (from psychologists, social workers, occupational therapists and GPs in private practice); through headspace centres (chapter 10); or through PHN-commissioned psychological therapy programs (box 12.4).

The creation and growth of these three avenues (mainly from the mid-2000s) has dramatically increased access to individual psychological therapy for consumers, with each avenue catering to a different group of consumers.

- MBS-rebated psychological therapy is the largest (catering to the general population), providing services to about 1.3 million people a year.
- PHN-commissioned psychological therapy (catering to hard-to-reach consumers) provides 70 000 separate episodes of psychological therapy in a year.
- headspace centres (catering to young people aged 12–25 years) provide therapy to about 60 000 people a year.¹⁰⁴

Box 12.4 PHN-commissioned psychological therapy

All PHNs must commission psychological therapy services for ‘underserved populations’ that face barriers to accessing mainstream treatment options. In 2018-19, PHNs reported that they commissioned about 70 000 separate episodes of psychological therapy, comprising about 350 000 service contacts (PHN counts are based on the principal focus of treatment rather than provider type) (unpublished Department of Health data). These services account for more than half of the mental health service contacts commissioned by PHNs.

Typically, clients must reside or work in the PHN catchment and be socioeconomically disadvantaged, usually in addition to having another contributing factor (such as living in a regional or remote area, or being homeless, Aboriginal and Torres Strait Islander, LGBTIQ, or an asylum seeker). The Australian Government recommends that PHNs cap the number of psychological sessions available under these programs at 12, except for in ‘exceptional circumstances’ (DoH 2019m, p. 3).

These services are intended to complement MBS-rebated psychological therapy. PHNs within which less MBS-rebated psychological therapy takes place receive more funding from the Australian Government with which to commission a range of mental health services, including psychological therapy (chapter 23).

PHNs have more flexibility when commissioning services compared with services provided under the MBS. They can allow self-referral. They can hire allied health professionals on a salary, or through subcontracting arrangements, meaning that if needed they can pay clinicians more to provide services in certain areas. They can also combine psychological therapy with services from other providers, such as mental health nurses and Aboriginal and Torres Strait Islander health workers. Finally, they have the opportunity for more oversight and accountability (and for tighter control of service providers) relative to MBS services.

PHNs have had responsibility for these services from 2016, replacing the Access to Allied Psychological Services (ATAPS) and Mental Health Services to Rural and Remote Areas programs) (DoH 2019l, p. 16).

¹⁰⁴ PHN-commissioned psychological therapy numbers are for 2018-19, based on unpublished Department of Health data (The PHN counts are based on the principal focus of treatment rather than provider type). headspace numbers are for 2018-19 from headspace (pers. comm., 17 October 2019). Estimates provided here for the number of people receiving MBS-rebated services and PHN-commissioned services estimates exclude services delivered through headspace centres. Some people may receive services through more than one program.

As well as catering to different consumers, the three avenues differ in their effectiveness, their cost to consumers, and their cost to taxpayers (table 12.2, figure 12.7). As shown, the effectiveness of MBS-rebated psychological therapy has not been established, though it has a substantially lower overall per-session cost than PHN-commissioned or headspace-provided therapy. This lower cost is driven by the administrative efficiency of Medicare, the flexibility built into the system that allows a scaling up and down of services to meet demand, and the minimal amount of service ‘infrastructure’ (such as administration and oversight). Given its lower cost and flexibility, the MBS should continue to be the delivery vehicle for most individual psychological therapy, pending a new, rigorous evaluation of its effectiveness (discussed below).

Table 12.2 Cost and effectiveness of psychological therapy programs

<i>Program</i>	<i>Target population</i>	<i>Total average cost per session (2019 dollars)</i>	<i>Average cost to consumers per session</i>	<i>Effect size (pre–post)</i>
MBS-rebated individual therapy (box 12.2)	General population	\$145 ^a	57% of sessions had a co-payment, averaging \$68 ^a	No rigorous evaluation of effectiveness
headspace centres (chapter 10)	Young people aged 12–25 years	\$275 ^b	Mostly free	0.7 (K-10) ^c
PHN-commissioned therapy (box 12.4)	Underserved groups	\$240–\$310 ^d	Mostly free	No rigorous evaluation of effectiveness
NewAccess (box 12.1)	Low–moderate needs, those not currently getting help	\$141–\$317 ^e	Free	1.23 (PHQ-9) 1.25 (GAD-7) ^f
PORTS Tele-CBT (chapter 10)	Financial hardship, geographical disadvantage	\$88 ^g	Free	1.0 (K-10) ^h

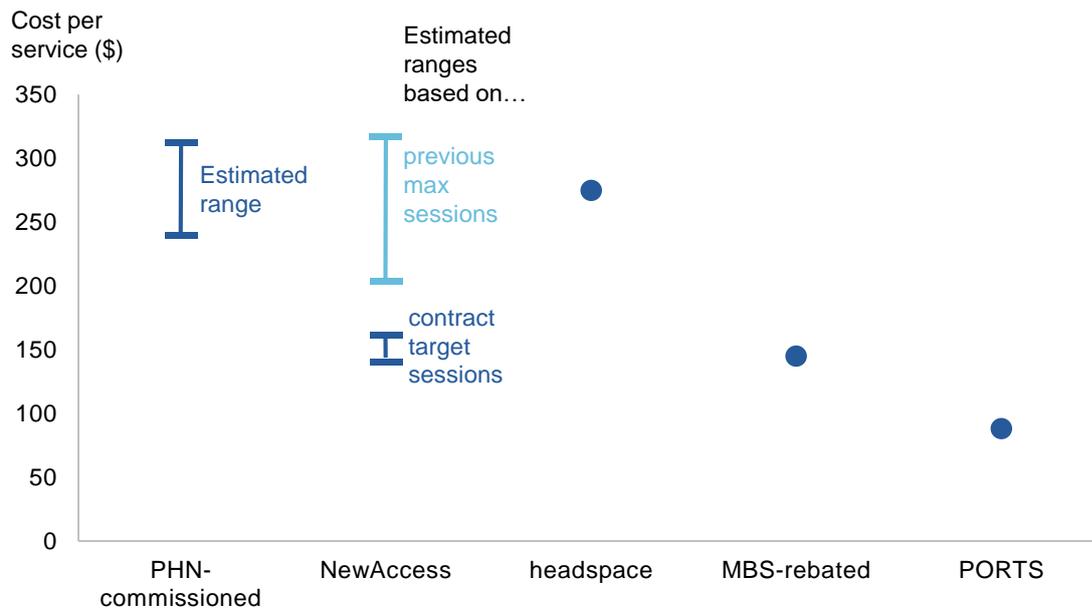
^a 2019, Productivity Commission estimates using unpublished MBS data. ^b 2017-18 cost per occasion of service, which includes some costs related to community awareness activities (Orygen and headspace, sub. 204, p. 18). ^c Productivity Commission estimate using Bassilios et al. (2017). ^d Productivity Commission estimate using unpublished Department of Health data (The PHN counts are based on the principal focus of treatment rather than provider type). ^e Range in average cost per session estimates is described in box 12.1. ^f Baigent et al. (2020, table 2). ^g Average cost is across all PORTS service contacts for 2018-19 (WA Primary Health Alliance, pers. comm., 3 October 2019). ^h Titov et al. (2019a, p. 12).

Table 12.2 and figure 12.7 also compare these three psychological therapy programs with two examples of short-course, structured therapy — PORTS Tele-CBT (chapter 10) and NewAccess (box 12.1). While these services are substantially different from the three psychological therapy programs, there is substantial overlap in the groups they serve — we estimate that up to 40% of people receiving individual psychological therapy may be better suited to a low-intensity services such as these (section 12.1). The comparison demonstrates the relative (and proven) effectiveness of both NewAccess and PORTS Tele-CBT, and the cost-effectiveness of PORTS in particular. Chapter 10 recommends the establishment of a

national digital mental health platform, which aims to give all Australians access to short-course, structured therapy.

Figure 12.7 Cost of psychological therapy programs^a

Total cost per service, including government and consumer out-of-pocket costs



^a For MBS-rebated therapy, calculated as the average rebate plus the average co-payment (table 12.2). For all other programs, calculated as total program cost divided by the number of services. Ranges in NewAccess session costs are described in box 12.1.

Source: Table 12.2.

A rigorous evaluation of MBS-rebated therapy is long overdue

Individual psychological therapy services are only person-centred if they are focused on the outcomes of the people using them. There is strong evidence demonstrating the efficacy of individual psychological therapy *in clinical trials* (Lambert 2013, pp. 176, 193). But there is currently insufficient evidence that any of the three avenues for taxpayer-subsidised psychological therapy are effective *as they are delivered*. In other words, it is not clear that they are substantially improving the outcomes of the people using them. This is concerning, given the dominant role of psychological therapy in Australia's mental health system.

Of the three avenues, only headspace centres routinely collect 'patient-reported outcomes measures' (PROMs). This data has been used to evaluate the effectiveness of headspace

(Bassilios et al. 2017; headspace 2019c; Hilferty et al. 2015; Rickwood et al. 2015a).¹⁰⁵ Individual psychological therapy is at the centre of the headspace model — about 60% of young people attending a headspace centre with a mental health problem receive at least one session (headspace, pers. comm., 16 October 2019) — but these studies evaluate the broader package of services provided by headspace (discussed in chapter 10). The most comprehensive evaluation, by Hilferty et al. (2015, p. 2), compared those receiving treatment at headspace centres with a matched control group receiving no treatment, and found that headspace had a ‘small program effect’ on consumer outcomes. In other words, the benefits to consumers of headspace are known but are small.

In contrast to headspace, the other two avenues for taxpayer-subsidised psychological therapy — the MBS and PHN commissioning — do not routinely collect PROMs, and have not been well evaluated. MBS-rebated therapy has been formally evaluated once (Pirkis et al. 2011), but that evaluation suffered from significant shortcomings in its ability to estimate program effects — including having a potentially biased sample of providers and consumers (Allen and Jackson 2011; Hickie, Rosenberg and Davenport 2011).

Given the size and cost of MBS-rebated psychological therapy, a new, well-funded and rigorous evaluation is warranted (including the collection of outcomes data from a sample of consumers). In 2019, about 1.3 million Australians accessed these services, spending more than \$230 million on co-payments — and millions of hours of their time — and with taxpayers footing a bill of more than \$630 million.¹⁰⁶ There is widespread support for a new, rigorous evaluation of MBS-rebated psychological therapy, including from prominent researchers (Berk 2019; Hickie, Rosenberg and Davenport 2011; Jorm 2018; Mihalopoulos 2019), and a host of other stakeholders.¹⁰⁷ For example, the Psychotherapy and Counselling Federation of Australia (sub. 883, p. 17) stated that they:

... strongly support an evaluation of MBS funded psychological therapies and recommend that the evaluation methodology take into account critiques of previous evaluations, which have highlighted methodological flaws in data collection and analysis, and suggested more rigorous evaluation that incorporates non-biased sampling, does not rely on self-reported data, focuses on patient outcomes and reduces the potential for practitioner bias.

¹⁰⁵ headspace (2019c) presents outcomes for a sample of headspace consumers at ‘follow up’ (on average, 12 months after completing care). However, because the survey method relied on self-selection, it is not possible to draw conclusions about the overall long-term effectiveness of headspace based on the outcomes for this sample.

¹⁰⁶ Productivity Commission estimates using unpublished MBS data. These estimates do not include the costs of consultations with referring clinicians, such as GPs writing Mental Health Treatment Plans, or other costs to the consumer (such as time off work or travel time).

¹⁰⁷ ACP, sub. 763, p. 12; ACPA, sub. 727, p. 3; ANMF, sub. 1187, p. 19; MHCC, sub. 920, p. 12; Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212, p. 6; National Rural Health Alliance, sub. 1192, p. 4; NovoPsych, sub. 645, p. 2; QAIHC, sub. 1235, p. 7; RANZCP, sub. 1200, p. 9; and Uniting Vic-Tas, sub. 931, p. 11.

Feedback-informed practice could improve outcomes for consumers

Feedback-informed practice — where consumer feedback is used to inform the care provided by clinicians — is a promising avenue for boosting the effectiveness of individual psychological therapy, although the evidence for its effectiveness is not conclusive (box 12.5). Feedback-informed practice involves routine outcomes monitoring using PROMs (and sometimes also ‘patient-reported experience measures’ — PREMs). This allows consumers to feedback information to the clinician about their progress — including if their condition is not improving, or even getting worse — to help the clinician determine whether a change in treatment is needed. Routine outcomes monitoring also allows clinicians to benchmark themselves against their peers, and work to improve their practice if their performance falls short.

Feedback-informed practice is already practiced in Australia. For example, it is part of the effective, structured, short-course therapy provided through NewAccess (box 12.1):

... outcomes data is available in real time to clinical supervisors, coaches and clients to track recovery and respond as necessary. Clients report seeing their progress as highly motivating’. (Beyond Blue, sub. 877, p. 24)

It is also used (although not widely) in private practice. NovoPsych — one of the largest Australian providers of outcomes monitoring services — told us that about 3000 clinicians (mostly psychologists in private practice) were signed up to their service (sub. 423, p. 1). The PROMs collected in headspace centres are accessible to psychological therapists working in these centres to inform the therapy they provide, but the extent to which this happens depends on each therapist and each centre’s management — it does not happen systematically.

Embedding feedback in psychological therapists’ practices involves some effort, but the ongoing time and costs are relatively small. The feedback is normally automated — with the consumer filling out a short questionnaire on a tablet — and the results are presented automatically to the clinician in a user-friendly format. Guidance to clinicians on how to respond to the results can also be automated. And minimal training is needed — feedback-informed practice is already a standard part of undergraduate psychology curricula, and a single day-long course would be sufficient to bring others up to speed.

Next to these relatively small costs, the potential benefits are substantial. We estimate that feedback-informed practice could boost the effectiveness of therapy by up to 25%.¹⁰⁸

Some participants advocated for wider use of feedback-informed practice. For example, the Association of Counselling Psychologists (sub. 763, p. 11) called for ‘integrated best practice feedback and outcome measurement tools throughout all service pathways and engagement’. Mental Health Australia (sub. 864, p. 45) proposed the introduction of ‘real time consumer and carer driven outcomes measurement’, and sought a commitment to

¹⁰⁸ Assumes that psychological therapy has an effect size of 0.8, and feedback-informed practice has an effect size of up to 0.2 (based on the evidence in box 12.5).

‘public reporting of these outcomes so consumers and carers have greater visibility over the outcomes achieved by the services they are using’.

Box 12.5 Evidence of the effectiveness of feedback-informed practice

There is a substantial body of literature estimating the effectiveness of feedback-informed practice, and routine outcomes monitoring more broadly. This literature suggests that feedback-informed practice could well be associated with an effect size of 0.1–0.2, but it is not conclusive (the effect size is a standardised measure of how much an intervention improves someone’s mental health). This may be partly due to what these studies try to measure — because any effect size is likely to be relatively small relative to the noise in the data, it is more difficult to establish a statistically significant effect, especially with small sample sizes (which are characteristic of many studies in psychology). Meta-analyses are more likely to draw conclusions.

- Knaup et al. (2009) reviewed 12 studies of feedback-informed treatment, and found an effect size of 0.1 associated with outcomes-informed treatment, although this did not persist in the long run.
- Shimokawa et al. (2010) conducted a meta-analysis including about 6200 patients, and found that feedback-informed practice interventions could be effective in both enhancing treatment outcome and preventing treatment failure.
- Carlier et al. (2012) reviewed more than 50 randomized control trials involving routine outcomes monitoring (including some not focused on mental health). They found that routine outcomes monitoring ‘appears especially effective for the monitoring of patients who are not doing well in therapy’.
- A 2016 Cochrane Review (Kendrick et al. 2016) included five studies undertaken in psychological therapy settings (with about 1800 participants combined). Kendrick et al. found no statistically significant effect, although their point estimate indicated an effect size of 0.1 (Kendrick et al. 2016, pp. 24, 79–80).
- A large, and more recent study containing about 2200 participants in an IAPT setting by Delgadillo et al. (2018), found that ‘supplementing psychological therapy with low-cost feedback technology can reduce symptom severity in patients at risk of poor response to treatment.’

Other peer-reviewed studies published since the Cochrane review have shown mixed results, although most have relatively small samples of a couple of hundred participants or less (Connolly Gibbons et al. 2015; de Jong et al. 2019; Metz et al. 2019; Rise et al. 2016).

A very large study with more than 14 000 participants (although not published in a peer-reviewed journal) concluded that ‘clinician engagement in receiving feedback on outcomes is associated with significantly larger effect sizes of clients’ (Brown and Cazauvieilh 2019). The study was undertaken by the ACORN Collaboration, which is a provider routine outcomes monitoring tools (Brown et al. 2015b). Therapists using the ACORN tools must login to see how their patients are doing. The study identified therapists as either High Engagement or Low Engagement, based on whether they had more or less than 24 logins in a year. It found that over a year, clinicians classified as High Engagement has an average effect size of 0.90, while those classified as Low Engagement had an average effect size of 0.71 (Brown and Cazauvieilh 2019). This difference was highly statistically significant.

While we support public reporting of health outcomes (PC 2017c; chapter 24), we are not in favour of publicly reporting outcomes from psychological therapy that would, at this stage, identify individual clinicians. We are concerned that public reporting may provide an incentive to some clinicians to encourage their patients to provide positive (rather than honest) feedback. It may also expose clinicians to unfair or biased feedback where the consumer did not form the necessary therapeutic rapport with the clinician. This could undermine the main benefits from collecting PROMs — informing practice in real-time, and allowing clinicians to benchmark themselves against their peers. Benchmarking requires that outcomes are publicly reported, but does not require that individual clinicians be identified. Chapter 24 discusses organisational-level benchmarking.

As part of the broader evaluation of MBS-rebated therapy that we are proposing, the Australian Government should commission a large-scale, randomized control trial of feedback-informed practice. As the broader evaluation would require the collection of PROMs anyway, it would not be huge extension to incorporate these into real-time feedback for some therapists. While the benefits are uncertain, the potential upside of such a trial is very large, given that feedback-informed practice could provide a relatively low-cost boost to the effectiveness of therapy for up to 1.3 million Australians each year. On the basis of this trial, the Australian Government should determine whether to encourage or mandate feedback-informed practice as part of MBS-rebated therapy. And the Australian Government and PHNs should consider the same for PHN-commissioned therapy and therapy provided through headspace centres.

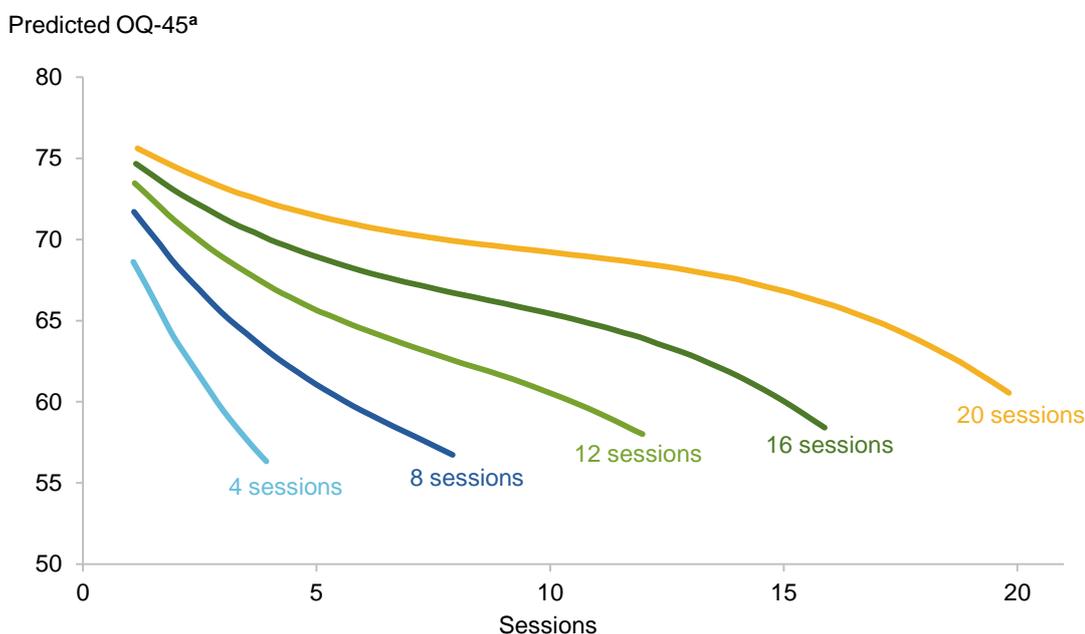
Are consumers getting enough sessions of psychological therapy?

Clinical evidence shows that consumers respond to individual psychological therapy differently, and recover at different rates — some quicker, some slower, some not at all. And consumers tend to stop therapy once they (along with their psychological therapist) feel they are well enough that they no longer need to continue, which may be before they have fully recovered. Baldwin et al. (2009, p. 209) found that consumers who have fewer sessions, and who get better at a faster rate, are on average less ill to begin with (figure 12.8).

After 3–5 sessions, only the consumers most responsive to psychological therapy have recovered. As the number of sessions increases, less-responsive consumers are also able to reach recovery, but the number recovering diminishes with each additional session. Different studies find that varying proportions of the client pool have recovered after 5, 10, 20 or 50 sessions, depending partly on how recovery is defined (Anderson and Lambert 2001; Harnett, O’Donovan and Lambert 2010; Howard et al. 1986; Kadera, Lambert and Andrews 1996; Lambert, Hansen and Finch 2001). But a constant finding is that a substantial proportion of clients recover between sessions 10 and 20.

It is worth noting that recovery is not the only aim of psychological therapy. In some cases, preventing deterioration of the person’s condition, or helping them live with the symptoms, may represent success.

Figure 12.8 People get better at different rates



^a Predicted rate of change in Outcome Questionnaire-45 (OQ-45) scores across sessions in treatment. A lower score implies better mental health.

Source: Baldwin et al. (2009, p. 207).

Consumers can currently access up to 10 MBS-rebated individual psychological therapy sessions a year (as well as up to 10 group sessions). While for PHN-commissioned therapy, the Australian Government recommends that PHNs cap individual therapy at 10 or 12 sessions per year, advising that ‘only in exceptional circumstances should the session cap be exceeded’ (DoH 2016c, p. 3). MBS-rebated therapy also requires a new referral after 6 sessions.

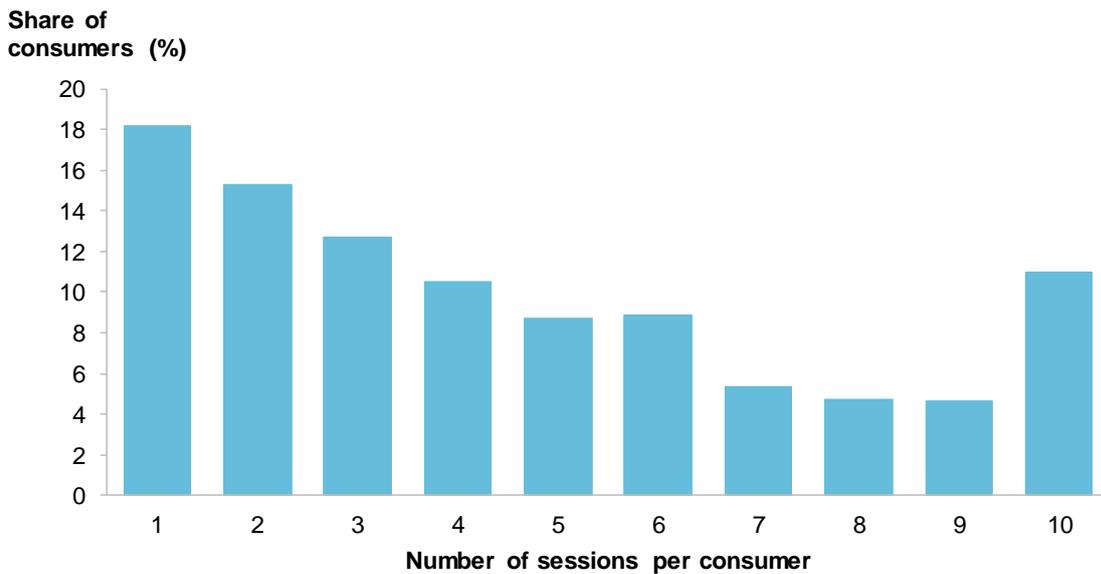
While these restrictions might be acting as barriers to effective treatment, they only affect a minority of consumers. Of consumers accessing MBS-rebated individual therapy, we estimate that only about 10% would get more than 10 sessions if more rebated sessions were available. And that about 2% of consumers are dropping out after six sessions because of the requirement for a new referral (Productivity Commission estimates using unpublished MBS data).

Most consumers are not constrained by the limit on rebated sessions, yet some who would benefit do not receive enough sessions to achieve a significant and sustained improvement in their condition (as indicated by the clinical evidence cited above). Consumers accessing MBS-rebated individual therapy received 4.5 sessions on average in 2019, with many getting just one or two sessions (figure 12.9). Usage patterns are similar for PHN-commissioned therapy.

Average session number do not seem to vary greatly between groups. People who spoke a language other than English at home, for example, while about half as likely to access any therapy, averaged the same number of sessions as the broader population if they did.

Aboriginal and Torres Strait Islander people, however, were in 2016 more likely than the broader population to have only one session (22% compared with 17%) and averaged 4.1-4.2 sessions, compared with the wider population average of 4.5 (Productivity Commission estimates using ABS 2019f).

Figure 12.9 **Many consumers have only a few individual sessions**
2019^a



^a MBS-rebated Psychological Therapy Services and Focused Psychological Strategies, including MBS-rebated therapy provided through headspace centres. MBS-rebated sessions of individual therapy are limited to 10 per consumer per calendar year.

Source: Productivity Commission estimates using unpublished MBS data.

There are several reasons why some people stop therapy before they receive the full benefits.

- Therapy can impose a significant burden on the consumer. In 2019, 57% of individual psychological therapy sessions had co-payments, averaging \$68.¹⁰⁹ Consumers also have to give up their time (with the therapist, getting there and back, and possibly waiting in the waiting room), and may incur incidental costs such as transport costs or lost income (Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212, p. 6). These costs would be reduced, were more consumers able to access therapy via telehealth (section 12.3) or access alternative lower-intensity options (section 12.2; chapter 10).
- Some consumers do not establish the necessary therapeutic rapport with the psychological therapist to which they are referred, and then drop out. Less than 3% of those who received MBS-rebated psychological therapy in 2018 tried more than one provider (Productivity Commission estimates using ABS 2019f). Increased consumer

¹⁰⁹ Productivity Commission estimates using unpublished MBS data. As is standard, we calculate average co-payments excluding services with no-payment.

choice of therapist — an imperative addressed in chapter 10 — would mean that more consumers find a therapist that works for them.

- Some consumers may feel they are not getting benefit from treatment. As discussed above, consumers should be able to regularly provide their feedback to psychological therapists and this information should then feedback into the care they receive, to ensure the consumer is benefitting.

Higher session limits for psychological therapy should be trialled

Many consumers, carers and clinicians argued that the current yearly limit of 10 MBS-rebated sessions of individual therapy was insufficient and should be raised (for example, comment no. 2, service providers and mental health workers; comment no. 19, interested persons; RACGP, sub. 386, pp. 12–13; ICP, sub. 447, p. 12). One carer told us:

My daughter ... was discharged from Headspace and we then found a fabulous psychologist who has really made a difference with her varied and many issues. The visits were initially weekly, then fortnightly and this frequent therapy has been a real stabilising influence to my daughter's quality of life. Now that NDIS have ceased the core funding for psychology therapy, we have been forced to utilise the 10 sessions allocated by Medicare in a Mental Healthcare Plan. This means that instead of seeing her therapist fortnightly, she has gone to every 4-5 weeks. I have seen how this has impacted on my daughter's mental health. Anybody can access the Medicare funded sessions, but why can't there be more funded sessions for those with a diagnosed mental illness when those sessions form the basis of their treatment? Once the ten sessions are used, it means \$150 out of pocket for each essential therapy session. This is a constant source of frustration, stress and angst. (comment no. 12, carers and family members)

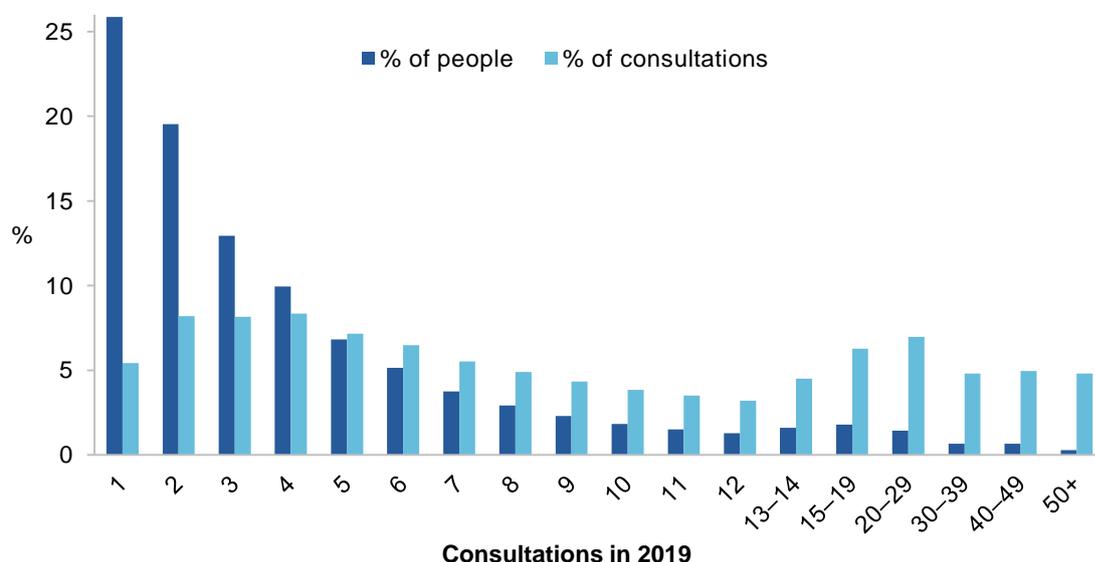
While the NSW Government (sub. 551, p. 15) told us that the limit on rebated sessions:

... results in patients rationing their sessions, or running out of sessions prior to the threshold for effective therapy being reached. It also results in patients inappropriately relying on pharmacotherapy alone (or with no other strategies) without adequate access to the necessary psychological therapies for recovery from mental illness.

The same arguments were heard by the 2014 National Mental Health Commission Review, who stated that the limit on rebated sessions was the number one complaint of both the public at large and clinicians (NMHC 2014b, vol. 3, pp. 11, 14).

The MBS Review Mental Health Reference Group (2018, p. 38) suggested that the limit on rebated sessions of *psychological therapy* means that some consumers instead have more rebated consultations with private *psychiatrists*. But psychiatrists are scarce (chapter 16) and consultations with psychiatrists cost the taxpayer more. People who are referred to a *psychiatrist* can access an unlimited number of sessions in a year, although for some consumers the rebate halves after 50 sessions (section 12.3). In 2019, the median number of psychiatric outpatient consultations was just three. But 9% of consumers had more than 10 outpatient consultations — accounting for close to 40% of total psychiatric outpatient consultations. And 3% of consumers had 20 or more outpatient consultations, accounting for 22% of the total (figure 12.10)

Figure 12.10 **A small number of consumers account for a large proportion of psychiatric outpatient consultations**



Source: Productivity Commission estimates using unpublished MBS data.

A higher limit for rebated sessions of *psychological therapy* — in line with the clinical evidence for treatment of mental disorders — could increase the scope for more people to access the services they need (partly addressing the missing middle). But there are divergent views on how this should be done.

The MBS Review Mental Health Reference Group (2018, pp. 34–36) recommended a three-tiered system: 10 rebated sessions available annually for the first tier, 20 for the second tier, 40 for the third tier, with a re-assessment and re-referral from the GP required to move up a tier. The Australian Psychological Society (2019b) and the Institute of Clinical Psychologists (ICP, sub. 447, p. 13) have made similar recommendations. The RACGP (sub. 858, p. 6) argued that the ‘patient, their GP and psychological services’ should have ‘flexibility to increase the number of sessions beyond an arbitrary maximum number’.

However, the proposed upper limit of 40 sessions was premised on the view that consumers with severe and complex mental illness did not receive adequate care through other mechanisms (MBS Review Mental Health Reference Group 2018, p. 36). It would be better to remedy that deficiency through increased funding for State and Territory community mental health services (section 12.5), as these team-based services are better able to facilitate the coordinated care among multiple providers that such consumers require. In this setting, longer courses of psychological therapy can be provided if required.

Several factors suggest that in practice a limit of 20 sessions per year would strike a reasonable balance between the desire to help more consumers recover with psychological

therapy, and the need to allocate limited resources to where they are likely to provide the most benefit (including the limited number of psychological therapists).

- The National Institute for Health and Care Excellence (NICE) in the United Kingdom, which uses rigorous processes and evidence to establish what healthcare provides good value for money, recommends up to 20 sessions for a range of common mental disorders (figure 12.11).
- When psychological therapy was introduced to the MBS, up to 18 MBS-rebated psychological therapy sessions were allowed in a year.¹¹⁰ The limit was reduced from 18 to the current level of 10 in 2012, apparently motivated by budgetary pressures (Littlefield 2017).
- Finally, the National Mental Health Commission's 2014 Review recommended that the number of available sessions under Better Access be increased to 16 in a calendar year, but that those consumers identified as likely to require the additional sessions be referred to clinical psychologists (Littlefield 2017).

The Australian Government should trial allowing consumers to choose to access up to 20 sessions total of individual or group therapy in a year, if their clinical condition has been assessed as requiring more than 10 sessions. A wide range of organisations supported trialling up to 20 sessions.¹¹¹ The National Mental Health Commission (sub. 949, p. 12) cautioned that:

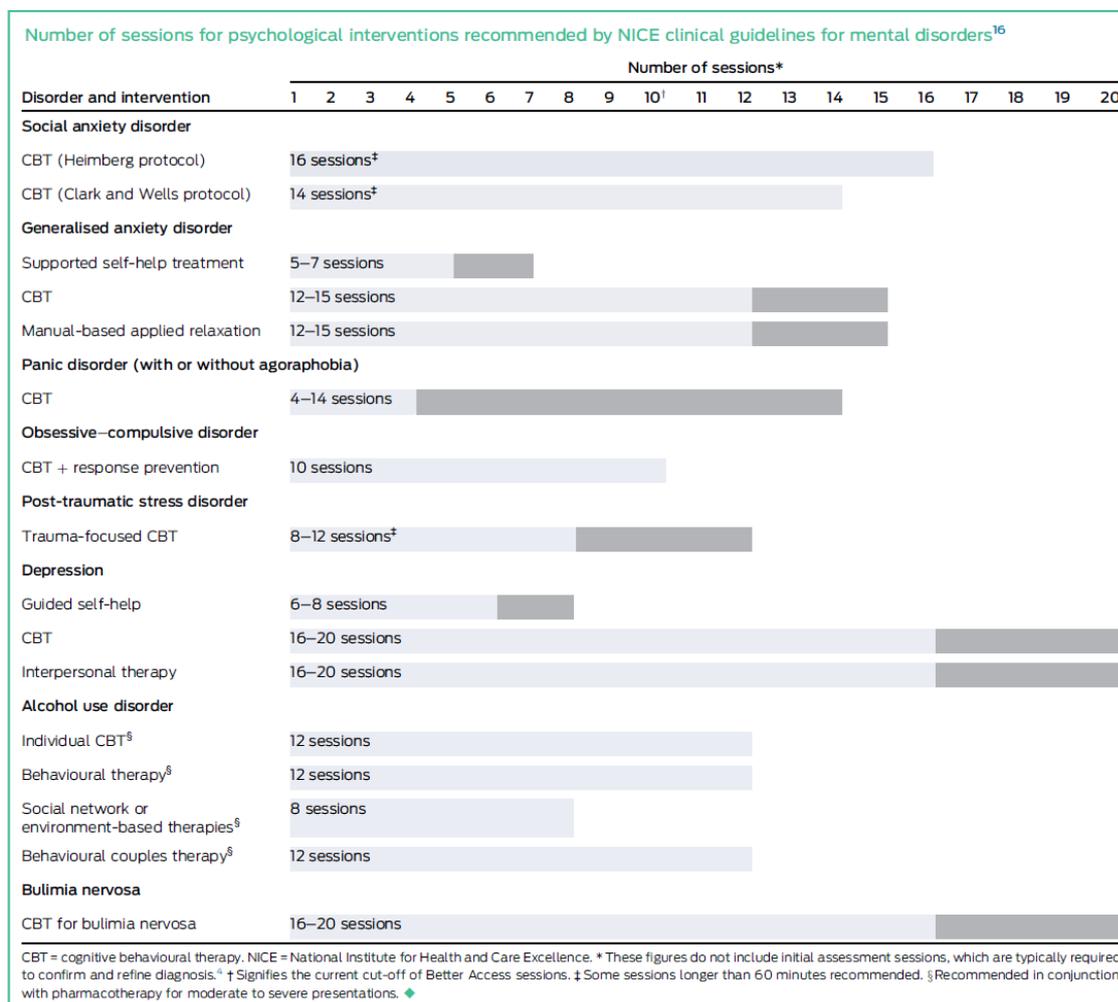
... it is important that the increase of MBS rebated sessions is not viewed as a general increase for any person experiencing a mental health illness undergoing treatment. The NMHC believes that more detailed analysis should be undertaken to ensure the evidence-based modalities of care appropriate for specific illness are the ones being delivered and rebated, and that there are outcome measures included in the assessment of the need to increase the number of sessions for a person.

The recommended trial should include the collection and analysis of relevant outcome data — including longer-term (such as 12-month) outcomes. The Australian Association of Social Workers (AASW, sub. 848, p. 6) told us that 'the benefits of treatment provided by Medicare rebated services continue to develop for some time after the person has finished treatment so that the evaluation would need to allow for this'. Given that the data requirements are likely to significantly overlap, and to avoid unnecessary delay, the trial should run simultaneously with the recommended evaluation of the Better Access program.

¹¹⁰ Consumers were allowed 12 sessions, and an additional six sessions under 'exceptional circumstances' (where 'exceptional circumstances' essentially meant that a person's GP thought their condition or care circumstances had changed enough that they needed more sessions). (Explanatory Statement, *Health Insurance Act 1973, Health Insurance (Allied Health Services) Amendment Determination 2012 (No. 1)* (Cth)).

¹¹¹ ACP, sub. 763, p. 12; ACPA, sub. 727, p. 3; ANMF, sub. 1187, p. 19; headspace, sub. 947, p. 34; Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212, p. 6; NovoPsych, sub. 645, p. 2; Orygen, sub. 1110, p. 18; PACFA, sub. 883, p. 17; PHN Cooperative, sub. 850, p. 24; QAIHC, sub. 1235, p. 7; RANZCP, sub. 1200, p. 9; and Uniting Vic.Tas, sub. 931, p. 11.

Figure 12.11 Psychological therapy sessions recommended by NICE



Source: Crome and Baillie (2016, p. 343).

Finally, consumers would also benefit from a move away from the current arbitrary system of allowing each consumer a limited number of sessions per calendar year, to allowing each consumer a limited number of sessions per 12-month period, beginning from the date of the initial referral. This would ensure a more equitable distribution of sessions. The MBS Review Mental Health Taskforce (2018, p. 74) made the same recommendation, and the recommendation has received support from the Australian Clinical Psychology Association (sub. 727, p. 3), the APS (sub. 853, p. 7), the PHN Cooperative (sub. 850, p. 24), the Psychotherapy and Counselling Federation of Australia (sub. 883, p. 17), and the RANZCP (sub. 1200, p. 9).

A higher number of sessions per referral should also be trialled

MBS rules specify that consumers must return to the referring clinician for a new referral after a maximum of six sessions of MBS-rebated psychological therapy (no such re-referral is required for PHN-commissioned therapy). When consumers return, GPs sometimes undertake an formal review of their Mental Health Treatment Plan (MHTP), although the need for a re-referral and the role of the MHTP Review can be considered separately (the MHTP and MHTP Review are discussed in chapter 10).

It is not at all clear that consumers benefit from such early re-referral. Requiring a re-referral aims to prevent consumers from getting care they do not need, but ignores the capacity of the consumer or the therapist to cease treatment where that is the case. Moreover, the additional barrier to continuing treatment is likely to deter some consumers from getting care they do need.

Some clinicians considered that the requirement for re-referral after six sessions was unnecessary and could disrupt treatment (ICP, sub. 447, p. 11; MBS Review Mental Health Reference Group 2018, p. 32), especially for group therapy, where a course regularly runs for 8 or 10 sessions (APS, sub. 543, att. 1, pp. 2–3).

Given the drawbacks of the current requirements and the recommended expansion of group therapy (section 12.2), the Australian Government should trial an increase in the maximum number of MBS-rebated sessions available with a single referral from 6 to 10— as proposed by both the MBS Review Mental Health Reference Group (2018, p. 28) and the Australian Psychological Society (2019b). This change would give psychological therapists more flexibility to deliver optimal care for consumers. Where they see the need, therapists could still advise a consumer to return to their GP for a consult, and GPs would still be able to request that the consumer returns for a consultation with them. And therapists should be required to communicate with the GP at the end of a course of treatment *and* where clinically indicated, as well as when the consumer requests it. Such a system, relying more on clinical judgement and communication, is closer to what is currently in place for GP referrals to psychiatrists.

Finally, we agree with the MBS Review Mental Health Reference Group (2018, p. 82) that ‘the referring practitioner should use their discretion, and discuss with the consumer, when setting the referred number of sessions for any course of treatment’. That is, in consultation with consumers, referring practitioners should still be able to refer consumers for fewer sessions than the maximum.

ACTION 12.3 — PSYCHOLOGICAL THERAPY TRIALS AND EVALUATION

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

Start now

The Australian Government should commission an evaluation of the effectiveness of MBS-rebated psychological therapy. The evaluation should consider the effectiveness of therapy delivered in different ways (including group therapy and telehealth), and should include a long-term follow-up.

As part of this evaluation, the Australian Government should trial:

- allowing consumers to choose to access up to 20 MBS-rebated sessions of individual or group therapy over a 12-month period, if their clinical condition has been assessed as requiring more than the current 10 MBS-rebated sessions
- allow referring clinicians to delay the need for re-referral of a consumer to be after the first 10 sessions rather than after 6 MBS-rebated sessions
- the use of feedback-informed practice

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

Start later

Based on the results of these trials and evaluation, the Australian Government should determine whether to roll out the above changes to the MBS more widely.

12.5 Expanding community ambulatory services to meet consumer needs

In 2017-18, about 435 000 Australians received State and Territory community ambulatory mental health services (AIHW 2019n, table CMHC.1). These are clinical services mostly provided in community or outpatient clinics, and include hospitals' outpatient services and day programs, and outreach services provided at a person's home or at an aged care facility. A range of clinical staff deliver these services, including psychiatrists, psychologists, mental health nurses, social workers, paediatricians and occupational therapists.

Community ambulatory services are generally government-funded (free or at low cost to consumers), and provided by Local Hospital Networks (LHNs).¹¹² In 2017-18, recurrent

¹¹² Some jurisdictions have their own local names for the areas and administrative units known nationally as Local Hospital Networks. For example, in New South Wales they are known as 'Local Health Districts', in Queensland they are known as 'Hospital and Health Services', in South Australia they are known as 'Local Health Networks', and in Tasmania they are known as 'Tasmanian Health Organisations' (AIHW 2019p).

expenditure on these services was about \$2.25 billion (AIHW 2020d, table EXP.1). (Funding is discussed in chapter 23.)

However, this funding is a long way short of the level required. The large shortfall in community ambulatory services means that several hundred thousand people are either receiving only a fraction of the care they need, or are missing out on community ambulatory care altogether. This shortfall represents a substantial part of the missing middle. Addressing this would also help address the barriers to care that are due to locational mismatch and out-of-pocket costs.

Other chapters address other aspects of the missing middle, including psychosocial support services (chapter 17) and bed-based services (chapter 13). Chapter 23 proposes the loosening of restrictions that prevent private health insurers from funding care in the community, which will encourage more private community mental healthcare.

Community ambulatory staff should be spending more time with consumers

Consumers benefit when clinical staff spend time *with* them — talking with them or providing treatment, for example — or when clinical staff spend time without them, but working on ‘consumers-related activities’, such as care coordination, clinical planning, and documenting or reviewing treatment.

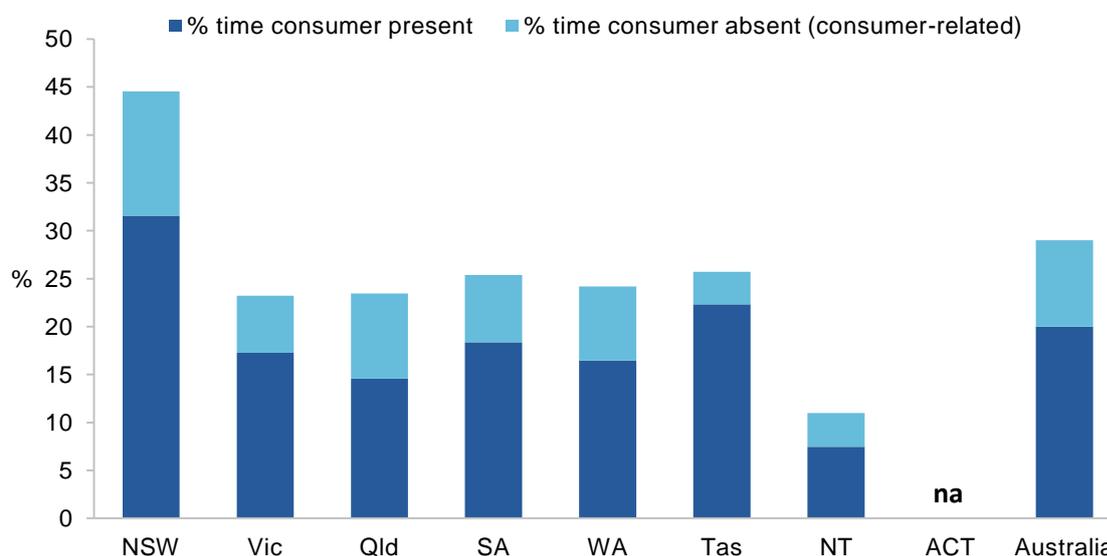
The benefit to consumers is less clear (which is not to say non-existent) when clinical staff spend time on non-consumer-related activities, which can include demonstrating compliance with regulatory requirements, program planning, and travel, in addition to professional activities such as staff supervision and evaluation.

But clinical staff in community ambulatory settings spend less than one-third of their time on consumer-related activities. Using unpublished data from AIHW, we estimated that, in 2017-18, only about 29% of clinical staff time in community ambulatory care services was spent on consumer-related activities — 20% with the consumer present and 9% without the consumer present. These estimates — and especially the amount of time clinicians spend with the consumer present — varied greatly between jurisdictions (figure 12.12).

Of particular concern, from 2013-14 to 2017-18 the percentage of time that clinical staff spent with patients fell by more than a quarter — from about 28% to about 20%. Overall consumer-related time also fell by about a quarter, from 38% to 29% (Productivity Commission estimates using AIHW (2020n, table FAC.42) and unpublished data provided by the AIHW).¹¹³

¹¹³ Tasmania transitioned to a new clinical information system in 2013-14, which impacted on activity data reporting. See also notes to figure 12.12.

Figure 12.12 Clinical staff spend only 20% of their time with consumers on average^a
2017-18



^a Derived by comparing the total duration of care (with patient present and with patient absent) provided in community mental health services (unpublished data supplied by AIHW) with the number of full-time equivalent healthcare providers working in community mental health services (AIHW 2020n, table FAC.42), assuming 44 productive working weeks per year. New South Wales data was affected by the introduction of a new system in the Justice Health Network in 2017-18; this resulted in reduced data coverage. (More detail is available in the data quality statement for the Community mental health care National Minimum Dataset.) Additional data quality issues are noted in AIHW (2020n, table FAC.42). **na** not available — the ACT collects this data, but did not give permission for it to be published.

Source: Productivity Commission estimates using AIHW (2020n, table FAC.42) and unpublished data provided by the AIHW.

In comparison, the National Mental Health Service Planning Framework (NMHSPF — chapter 24) assumes that 67% is the ‘optimal proportion’ of clinical staff time that should be spent on consumer-related activities (University of Queensland 2016a, p. 26).¹¹⁴ This disparity has (at least in part) been acknowledged by the South Australian Mental Health Commission and the Office of the Chief Psychiatrist of South Australia.

The Framework assumes that adult service clinicians spend more face-to-face time with clients than is currently the case in South Australia and other jurisdictions. (SAMHC 2019, p. 40)

An even higher ‘optimal proportion’ of 85% is assumed for individual private-sector clinicians, on the basis that clinicians in public community ambulatory settings should legitimately spend a bit more time on some non-consumer-related activities, including

¹¹⁴ This is ‘optimal proportion’ is based on expert opinion. The NMHSPF collated, over two years, expert input from over 100 service managers and planners, public and private sector clinicians, community sector professionals, consumers, carers, technical experts and academics.

research, training of undergraduate students on clinical placements, and supervision of clinicians in specialist training.

This assumption of 67% is important for two reasons. First, it points to a large ‘productivity gap’ between how much time mental health experts think clinical community ambulatory staff should be spending on consumer-related activities, and how much they actually are. Second, this assumption is baked into the NMHSPF, which is used widely for service planning and gap analysis. The NMHSPF is useful for estimating the ‘resource gap’, but a gap analysis using the NMHSPF *alone* would not account for the ‘productivity gap’, and would therefore understate the true extent of the gap in services received by consumers (discussed below).

One jurisdiction supplied us with a detailed (although also unpublished) time-use study of several community ambulatory mental healthcare services that indicated that 77% of clinical staff time was spent on consumer-related activity. However, only 21% of clinical staff time was spent with the consumer present, which is close to our Australia-wide estimate. While consumer-related activity with the consumer not present is important, clinical staff should be spending much more than a fifth of their time with consumers.

We have *no* reason to believe that the apparent misallocation of clinical staff time is due to staff *choosing* to spend their time in a way other than what would benefit patients most. Throughout this Inquiry, we have consistently heard stories of the dedication and hard work of clinicians, care-givers and front-line administrators working in a sector that is often very challenging. It is the systems that staff work within that determine how they spend their time — overloading them with reams of paperwork, for example (HSU, sub. 237, p. 12). We propose below steps that State and Territory Governments should take to ensure that staff are able to spend their time in the way that benefits consumers most.

To what extent are people missing out?

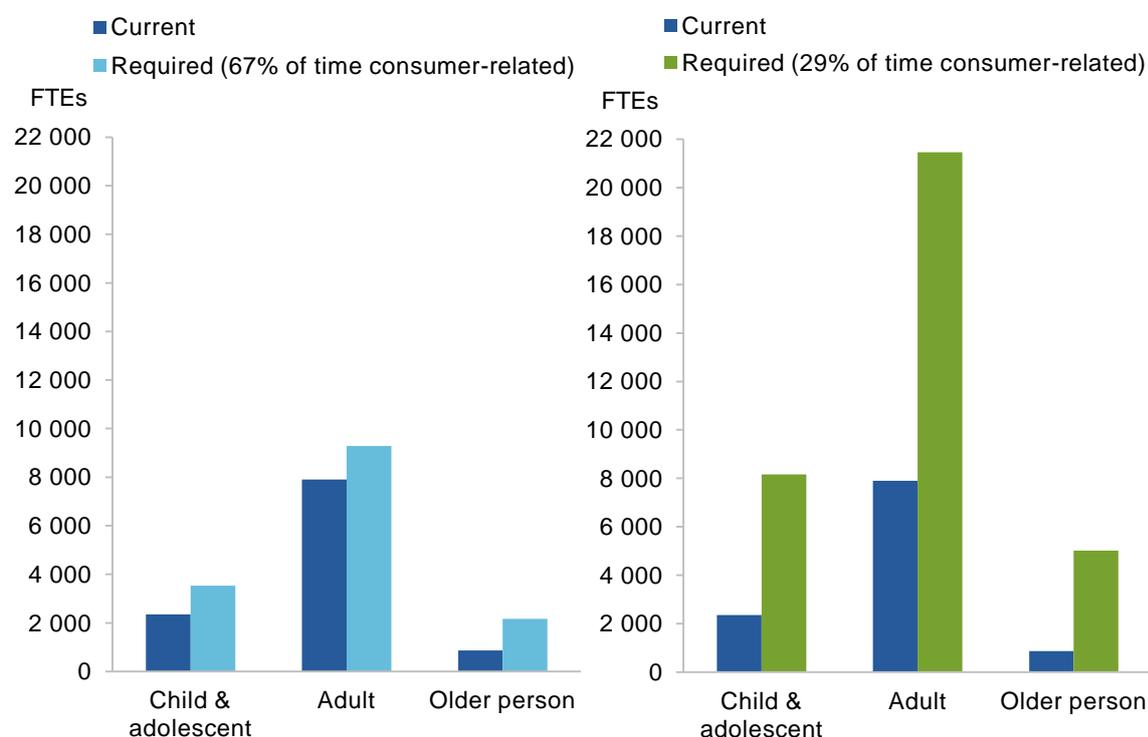
The gap in public community ambulatory services — between the services people are receiving and the services they require — can be expressed in terms of the number of staff providing these services. In 2017-18, the overall community ambulatory workforce was 20% below the benchmark level (figure 12.13, left panel). This represents a substantial resource gap that should be addressed.

But the number of staff required to provide an adequate level of service to consumers is much higher if they are spending less time on consumer-related activities than the NMHSPF’s best-practice assumption. If we replace the NMHSPF’s assumption (67%) with our estimate (29%), then we find that in 2017-18, the overall community ambulatory workforce was 65% below the benchmark level (figure 12.13, right panel). In other words, consumers were receiving only *one third* of the community ambulatory services that they required.

The point here is not that State and Territory Governments need to triple their community ambulatory workforces to address the gap in services. That is neither feasible nor desirable. Rather, the point is that *both* the number of clinicians *and* how much of their time they devote to consumer-related activities determine the care that consumers receive. And that deficiencies in both these areas must be addressed in order for consumers to have access to adequate services.

Figure 12.13 There is large shortfall in community ambulatory services

2017-18, assuming either 67% or 29% of clinical staff time spent on consumer-related activities^a



^a FTE = Full-time equivalent. Adult services refers to General (not age specific) services.

Source: Current: AIHW (2019m, table FAC.41). Required: Productivity Commission estimates using unpublished AIHW data and the National Mental Health Service Planning Framework (chapter 24).

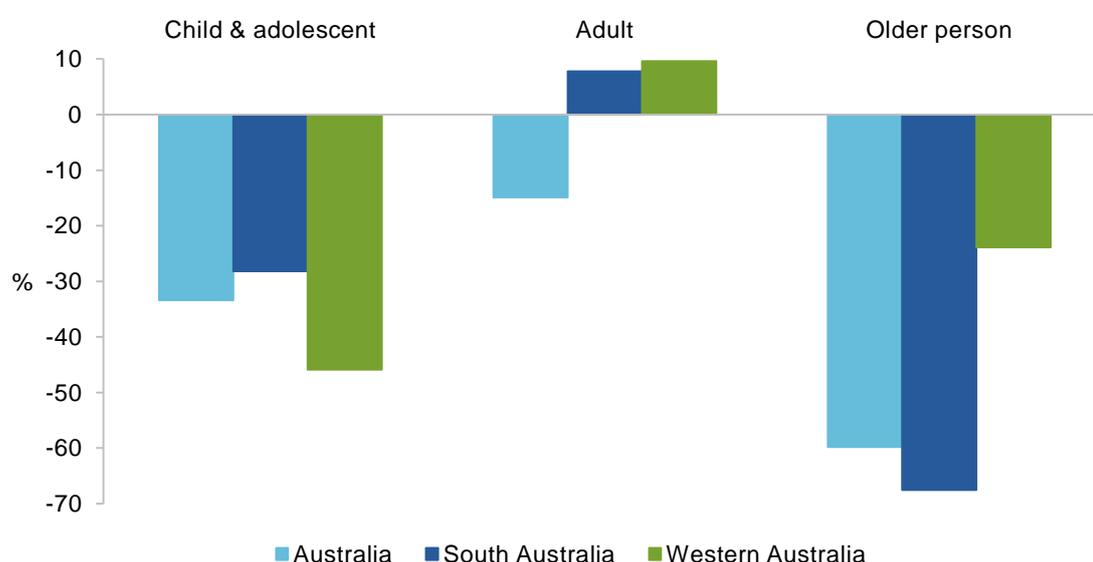
Consumer access to State and Territory community ambulatory services is not *uniformly* deficient across age groups or across the country. In percentage terms, the shortfall was greatest for child and adolescent services and older person services (figure 12.14).

Different jurisdictions (and regions within them) have different services currently being provided, and different service needs — which vary according to (for example) age demographics, the sub-populations of culturally and linguistically diverse (CALD) people, and the proportion of Aboriginal and Torres Strait Islander people.

Both Western Australia and South Australia have published strategic mental health plans based on the NMHSPF. Both States found that there were community ambulatory workforce shortfalls for child and adolescent services, and older person services. Both States also reported workforce *surpluses* for adult community ambulatory services (figure 12.14). However, neither State’s analysis took account of the disjoint between assumed and actual time spent on consumer-related activities.¹¹⁵

Figure 12.14 Shortfalls in community ambulatory staff vary between jurisdictions

Community ambulatory FTE compared with the benchmark level in a recent year. Assuming 67% of clinical staff time is spent on consumer-related activity^a



^a Western Australia also reports Youth services (16–24 years) for which provision is found to be about equal to the benchmark. The WA Plan counts both consumer-related and non-consumer-related activities as ‘hours of service’ (WAMHC 2019, p. 33). For Australia, analysis is for 2017-18; for Western Australia, analysis is for 2017; for South Australia, analysis compares services on the ground in 2016-17 with benchmarks for 2018-19.

Source: Productivity Commission estimates using AIHW (2019m, table FAC.41), the National Mental Health Service Planning Framework, SAMHC (2019, p. 39), WAMHC (2019, p. 54).

¹¹⁵ For community (ambulatory) treatment, the WA Plan measures ‘hours of service’ to include both consumer-related and non-consumer-related activities. In contrast, for community (psychosocial) support services, the WA Plan instead measures ‘hours of support’, which includes face-to-face time only (WAMHC 2019, p. 33).

What would be the benefit to consumers, and the cost, of more community ambulatory services?

As would be expected, people who access community ambulatory treatment see an improvement in their mental health. We have estimated that in 2017-18, adults receiving community ambulatory services had an average effect size¹¹⁶ of 0.91, and older people had an average effect size of 0.96 (it was not possible to estimate benefits of community ambulatory services to children and adolescents — appendix K). Roughly three-quarters of people receiving community ambulatory services report having a ‘positive experience of service’ (SCRGSP 2020d, table 13A.29).

The total benefit to consumers created by each clinical staff member, however, is greatly dependent on how much of their time is spent on consumer-related activities (figure 12.15). For adult consumers, these benefits include greater likelihood of employment, and higher average income. If 67% of clinical staff time is spent on consumer-related activities, then this increased income is likely to exceed the additional cost of providing the services (without including the broader benefits to health and wellbeing) (figure 12.15).

Using the NMHSPF, we estimate that if 67% of time is spent on consumer-related activities, then 3400 more clinical staff are needed in community ambulatory care across Australia, at a cost of about \$570 million per year. If, on the other hand, 29% of time is spent on consumer-related activities, then 21 300 more clinical staff are needed at a cost of about \$3.51 billion per year.¹¹⁷

These differences are stark. They reinforce the point made earlier that more resources alone are neither a feasible nor desirable way to address the shortfall in community ambulatory services. Rather, actions are needed both to increase the resourcing *and to improve the productivity* of community ambulatory services.

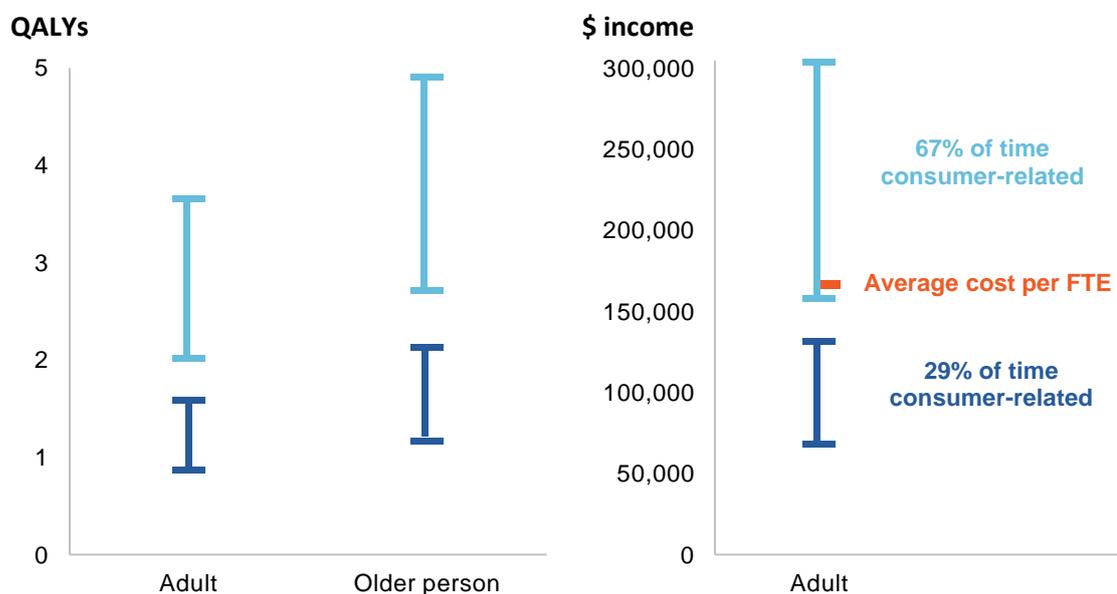
Even at current levels of staffing, there are huge gains to be made with productivity improvements. We estimate that increasing the percentage of time that currently-employed clinical staff spend on consumer-related activities from 29% to 67% would generate *each year* an additional 9500 to 17 300 quality-adjusted life years (QALYs — appendix I), and an additional \$650 million to \$1.25 billion in income. These estimates do not include the benefits to children and adolescents, which we have been unable to estimate (appendix K).

¹¹⁶ Effect size is a standardised measure of how much an intervention improves someone’s mental health, and our estimates are based on changes in Kessler Psychological Distress Scale (K10+LM) scores between admission and discharge (AMHOCN 2019).

¹¹⁷ These estimates include the cost of care coordination, which are discussed in more detail in chapter 15.

Figure 12.15 **More consumer-related time means larger benefits for consumers**

Annual benefits from one additional clinical staff member^a



^a Full-time equivalent. This is based on a weighted average of different types of clinical staff, with an average cost of about \$170 000 per year, including the cost of non-clinical support staff, overheads, on costs, penalty rates and capital costs. QALYs are quality-adjusted life years; one QALY is the value of one year of life with perfect health (appendix I). It was not possible to estimate the benefits of community ambulatory services to children and adolescents (appendix K).

Source: Appendix K.

Addressing gaps in community ambulatory services

Publishing data on service gaps

We propose that gaps in mental health services (including community ambulatory services) should be estimated using the NMHSPF and published annually:

- at a region-level, by PHN–LHN groupings, as part of the broader joint regional planning process
- at both a state and territory level, and a national level, by the AIHW (chapter 24).

In addition, all State and Territory Governments should permit the AIHW to annually publish data on the percentage of time that clinical community ambulatory staff are spending with consumers, and on consumer-related activities without the consumer present (chapter 24). This ‘productivity gap’ data should be published side-by-side with the ‘resource gap’ data, to make clear that both gaps need to be addressed for consumers to get adequate services.

Improving productivity

States and Territories should investigate and address the productivity gap in community ambulatory services.

One common complaint is that excessive paperwork is taking up too much staff time. Clinical Directors of community mental health services in several jurisdictions told us that excessive paperwork, often seen as an administrative response to risk management, is taking an increasing amount of staff time. The Health Services Union (sub. 237, p. 12) told us that:

HSU members report doing ‘hours of paperwork’ ... [with some having] a sense of the data ‘going nowhere’ and of ‘systems that do not talk to each other’ so the real benefits of that information ... are not realised.

The South Australian Mental Health Commission and the Office of the Chief Psychiatrist of South Australia promised in South Australia’s Mental Health Plan that:

Efforts will be made to increase the efficiency of adult services through reducing current time-consuming paperwork requirements, and through the provision of mobile technology to access information and make notes when providing home treatment. (SAMHC 2019, p. 40)

These steps are welcome, and all jurisdictions should make similar efforts. And the Australian Government should support these efforts by re-considering regulations or reporting requirements that the States and Territories identify as barriers to greater productivity.

More systematic changes are also needed. We are proposing that States and Territories adopt activity-based funding for community ambulatory services. Activity-based funding would incentivise services to spend more time with patients (chapter 23). We are also proposing the establishment of a Mental Health Innovation Fund, to encourage the trial and evaluation of new funding models, and promote the wide adoption of successful funding models (chapter 23).

Clarifying responsibilities for funding and service provision

Currently, it is not sufficiently clear which level of government is responsible for funding and delivering community ambulatory services up to the required level. State and Territory Governments and their LHNs provide the vast majority of what are called community ambulatory services (with funding from the Australian Government). But PHNs commission some similar services, such as Mental Health Integrated Complex Care (MHICC) services, which offer support for consumers with severe mental illness and complex needs who require coordination of their care over an extended period of time, including clinical nursing services, family support and liaison, and care coordination (South Eastern Melbourne PHN 2018). A small group of PHNs also fund the headspace Youth Early Psychosis Program, which provides intensive integrated services, including case management, to young people experiencing psychosis. And in the 2019-20 budget, the Australian Government announced that it would fund the trial of eight adult community mental health centres — although it is not yet clear what type of services they will provide (DoH 2019e).

Additional funding for community mental healthcare is clearly a pressing need, as is experimentation with new models of care. But we are concerned that encroachment of the Australian Government (and the PHNs) into the community ambulatory space complicates responsibilities — making it less likely that the States and Territories will provide some services their populations require. The National Mental Health Commission (NMHC 2014c, p. 33) identified the same issue.

While the Commonwealth has parachuted various siloed programmes into the mental health system, the states and territories have been pulling back their community-based mental health services, resulting in a growing gap between what GPs do and what services are provided in hospitals.

Under the existing National Health Reform Agreement, the Australian Government is already committed to supporting increased State and Territory expenditure on mental health. However, growth in funding via this stream is unlikely to be sufficient to fill the gaps identified (chapter 23).

Chapter 23 proposes that additional funding commitments could be made through a new National Mental Health and Suicide Prevention Agreement. This Agreement should also clarify which level of government is responsible for providing which types of community ambulatory services up to the required level. Clear responsibilities for providing certain types of services does not mean inflexibility in service provision at the local level. Indeed, in providing an agreed starting point, it should encourage collaboration and co-operation between PHNs and LHNs (chapter 23).

But even if a new agreement is not struck, States and Territories should fund community ambulatory services to the level required to meet population needs. Too often have States and Territories committed to provide more community ambulatory services, and failed to deliver (for example, OAGWA 2019, p. 8; VAGO 2019a, p. 8).

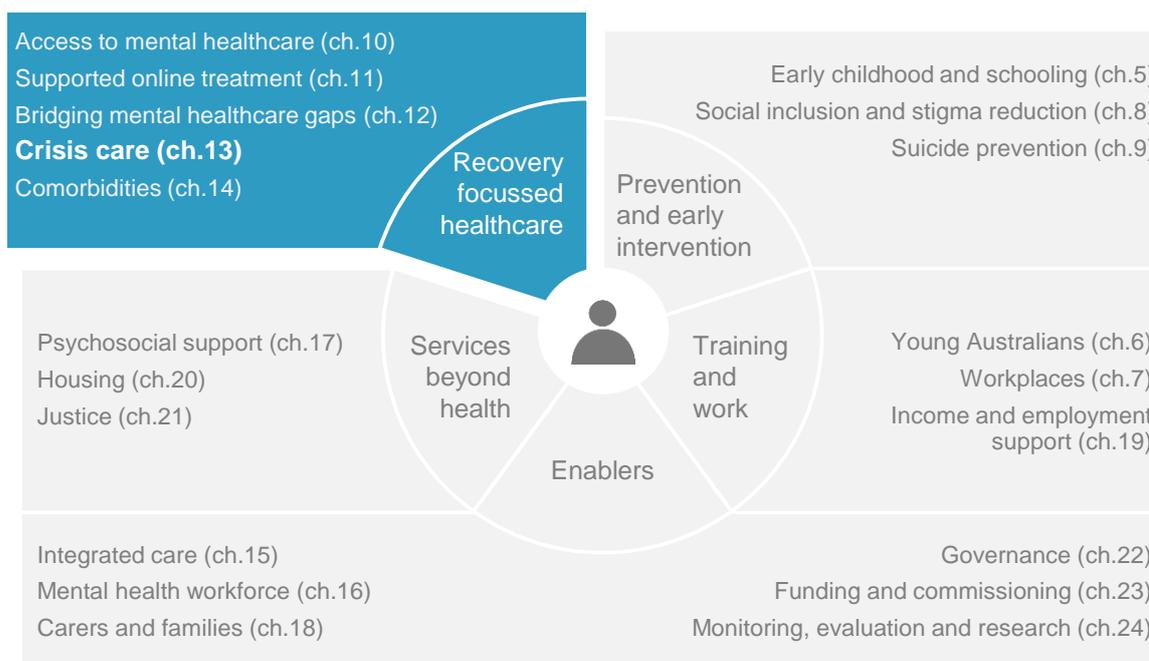
ACTION 12.4 — DELIVERING COMMUNITY AMBULATORY SERVICES

Across Australia, community ambulatory services fall well short of population needs. Addressing this shortfall requires both more resources and greater productivity.

Start now

- State and Territory Governments should investigate and address the reasons for the disparity between the amount of time that community ambulatory clinical staff in their jurisdiction actually spend on consumer-related activities, and what is considered optimal (assumed to be 67% in the National Mental Health Service Planning Framework).
- The Australian Institute of Health and Welfare should estimate and make public the shortfalls in specialist mental health community ambulatory services for each State and Territory, with the agreement of these jurisdictions.
- State and Territory Governments, with support from the Australian Government, should, over time, increase funding for these services to the level required to meet population needs.

13 Mental healthcare for people in crisis



Emergency and bed-based care matter because ...

- Emergency departments are not working effectively for people with mental illness — they are high stimulus environments, and people with mental illness often wait many hours before they receive treatment.
- Many people who present at emergency departments would be better served outside the hospital environment, although alternatives are available in few locations.
- Insufficient resources elsewhere in the mental health system mean that emergency presentations of people with mental illness have increased over recent years, leading to long wait times and pressures on hospitals to discharge patients to free up beds.
- There are hundreds of people in acute hospital beds who could be discharged if the non-acute services they need were available.
- Some jurisdictions do not have the dedicated mental health beds required to provide safe and high-quality acute treatment to younger people and women.

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

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

As a priority:

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

Additional reforms that should be considered:

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

13.1 Emergency and bed-based care — an important role, but there are problems

The recommendations included in previous chapters will go a long way towards intervening earlier to support people with mental illness and prevent unnecessary hospitalisation. However, public hospitals will continue to play a vital role in the continuum of care for people with severe mental illness — some will need to go to hospital, either for treatment in the emergency department (ED) or to be admitted for treatment and care.

Many people have shared with us their experiences of going to hospital as a person with mental illness or as a carer (for example, David Clark, sub. 205; Name withheld, sub. 16; Name withheld, sub. 392; Name withheld, sub. 587). Some of these experiences reflect the challenges of delivering mental healthcare through emergency and inpatient services:

I wasn't treated with the respect and dignity I deserved nor are many MENTALLY ILL patients in the Emergency Room. As it is not the place for us. It is designed for PHYSICAL ILLNESS. ... I have a MENTAL ILLNESS that I have managed since my diagnosis, I have learned to understand it. Hence why I KNEW EXACTLY WHAT I NEEDED FOR TREATMENT. TWO MEDICATIONS. TWO MEDICATIONS! I didn't even take up a bed, I slept on the couches in the "meeting room" with my mother being forced to "watch me" as the hospital was short staffed. (Jade Weary, sub. 436, p. 2)

... on that occasion I got lucky and we got her into a place where it was a quieter environment, less people screaming at her, abusing her, you know, she had one case where she'd been urinated on. It was so awful. And when I got her moved, all of that disappeared and so her trauma gradually lessened after a few weeks ... (Gita Irwin, Sydney transcript, p 200)

Addressing the unacceptable situation for mental health patients requires consideration not only of how to improve service delivery when patients arrive at a hospital, but also how to prevent patients deteriorating to the point where ED and bed-based services are needed.

For some people with mental illness, ED services are used because there is either a lack of alternative services in the community or, if they do exist, are not accessible outside of standard business hours when many mental health crises are experienced. The Royal Australian and New Zealand College of Psychiatrists (RANZCP, sub. 385, p. 10) noted that:

If the emergency department is overwhelmed by mental health presentations, as it is in many parts of Australia, it indicates upstream and/or downstream difficulties.

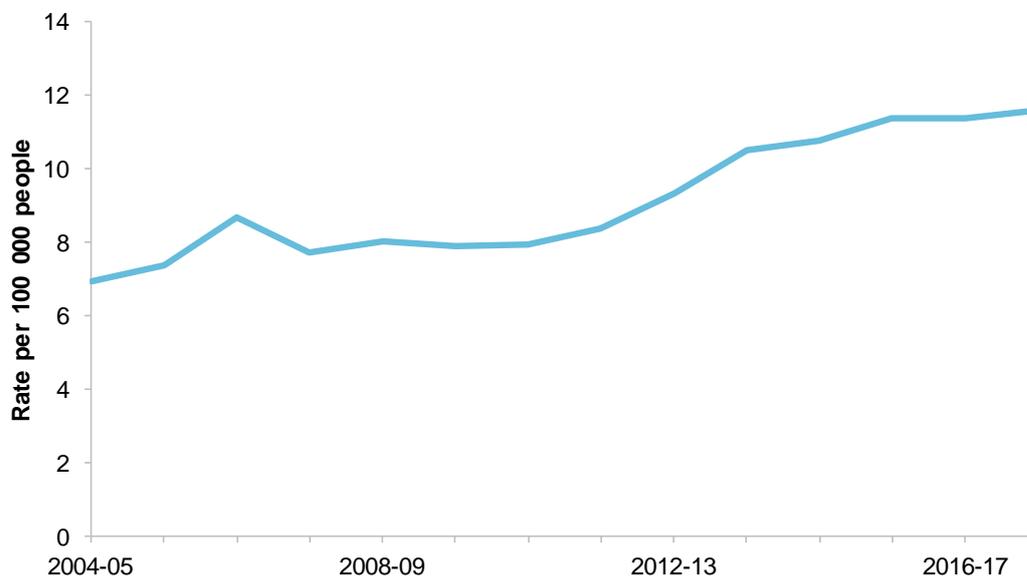
Actions in chapter 12 to improve mental health services available outside of hospitals (primary care and community ambulatory services) would enable more people to stay healthy and live in the community, and therefore should reduce the number of people needing to attend an ED or requiring a mental health bed.

Emergency departments

Consumer assistance phone lines, such as Lifeline, are often a first step taken by people experiencing acute mental illness or a crisis in seeking help. But sometimes this may not be enough for either the individual, or the carers or family who are seeking help on the unwell person's behalf. In this case, the person or their carers or family will have to engage with crisis and emergency services, to receive assessment, observation and clinical treatment. Most often this involves interactions with emergency departments (EDs), but it may also include after-hours and community-based crisis services.

Australians attended an ED almost 290 000 times due to mental illness, accounting for 3.6% of all presentations in 2017-18 (AIHW 2019l). More than half of these attendances were related to either anxiety disorders (26%) or substance use disorders (27%) (AIHW 2019l). This figure does not include all the people who attended the ED due to suicidality or self-harm. The attendance rate per person has risen over the past decade, with most of this increase having occurred over the 5-year period from 2010-11 to 2015-16 (figure 13.1). At a state and territory level, the Northern Territory is an outlier, with a rate of attendance twice as large as most jurisdictions and three times that of Victoria (AIHW 2019l).

Figure 13.1 **Mental health-related ED attendances at public hospitals**



Source: AIHW (2019l).

A range of factors have caused the growth in ED attendances. This includes insufficient investment in community ambulatory (outpatient) services to prevent people with mental illness needing emergency treatment for a crisis (chapter 12), and a lack of alternatives to EDs for people who are experiencing a crisis, particularly after-hours (Jenkins and Katz 2015; Sawyer and Patton 2018). Moreover, the AIHW (2019I) has reported that mental health-related ED attendances due to substance use accounted for about 30% of the increase in such attendances from 2008-09 to 2017-18.

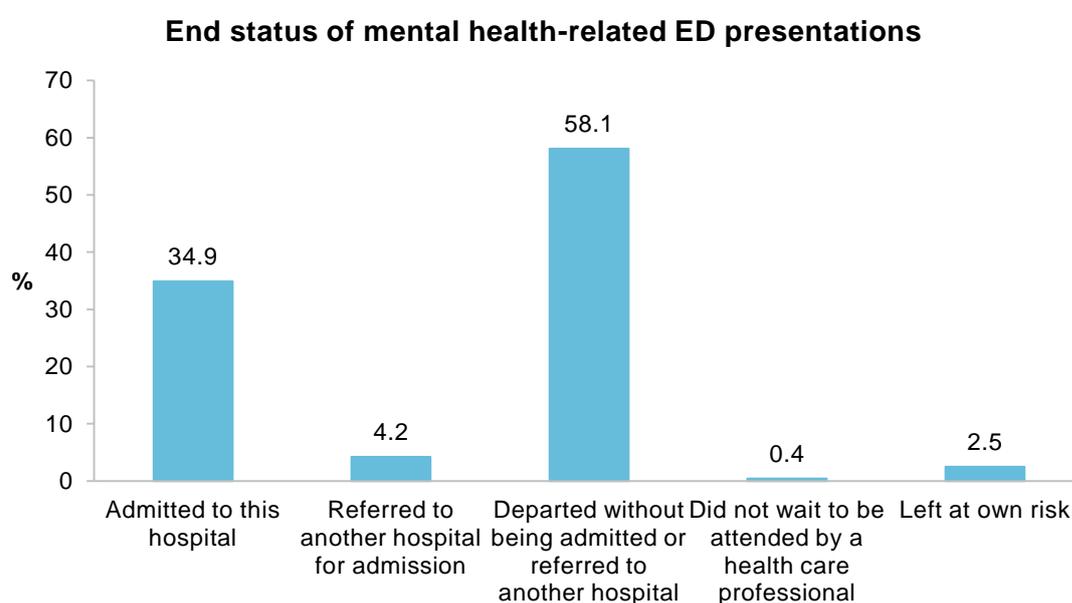
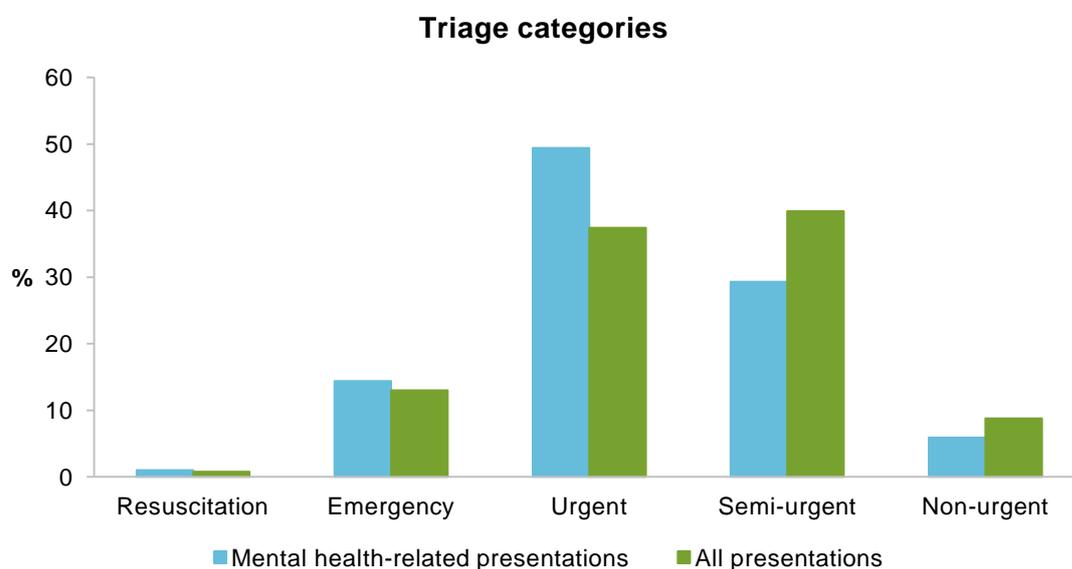
About 47% of all mental health-related presentations to an ED were via an ambulance and 7% were through a police/correctional services vehicle. This compares to about 25% and 0.7% respectively across all ED presentations (AIHW 2019I). Mental health-related presentations are also more likely to be classified as ‘urgent’ or ‘emergency’ compared with other ED presentations (figure 13.2), and about 3% of presentations ended with the person leaving at their own risk or not waiting to be treated by a healthcare professional (AIHW 2019I). About 40% of people attending an ED for a mental health-related reason are admitted to the hospital or referred to another hospital for admission. This suggests that a large proportion of people could potentially be assessed and provided with the treatment they require in the community.

Compared with other people attending an ED, people with mental illness were more likely to be adolescents or adults under the age of 55 years in 2017-18 (figure 13.3), and Aboriginal and Torres Strait Islander people were more than four times as likely to present at an ED for a mental health-related reason compared with non-Indigenous people (AIHW 2019I).

EDs could work better for people with mental illness

In a well-functioning and navigable mental healthcare system, the ED should be accessed for acute care rather than as a front door to mental healthcare (ACEM, sub. 926; RANZCP, sub. 1200). People who attend public EDs often report that they ‘are unsure about how and where to seek out alternative, and more appropriate support’ (State of Victoria 2019, p. 168). This can also be the case for Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds due to a lack of culturally appropriate services (Mental Health Commission of New South Wales, sub. 948; NSW Health 2015b).

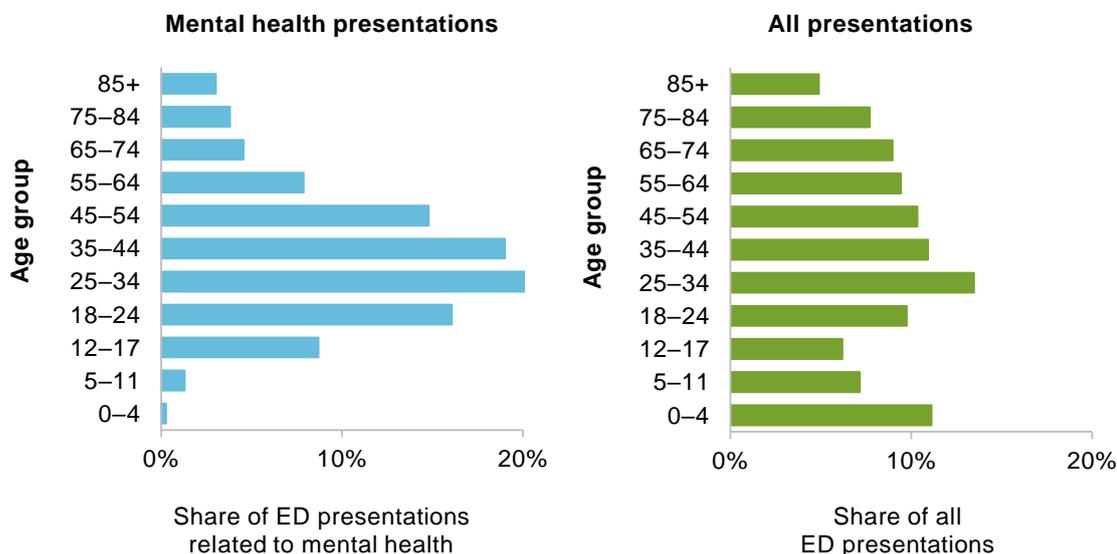
Figure 13.2 Mental health-related ED presentations can be urgent but only about one-third of people are admitted^a
2017-18



^a Presentations classified as 'Resuscitation' should be attended to immediately; emergency — within 10 minutes; urgent — within 30 minutes; semi-urgent — within an hour; non-urgent — within 2 hours.

Source: AIHW (2019e, 2019l).

Figure 13.3 **ED attendances at public hospitals by cause and age**
2017-18



Source: AIHW (2019).

People who access services through an ED can find the process lengthy, inefficient, and traumatising (HACSU, sub. 784), and some people may also become aggressive or violent, resulting in them being sedated, secluded, or restrained (ACEM, sub. 926). Other consumers have described the ED experience as ‘inadequate, stigmatising and distressing’ (SA Mental Health Commission, sub. 691, att. B, p. 2), and surveys from people with lived experience suggest that EDs are ‘often ill equipped to provide the best possible support’ (Being, sub. 918, p. 19).

Once at the hospital I was left in emergency overnight. Without having seen a doctor or other medical professional and cramped from trying to rest on the waiting room floor, I only wanted to be home with my cat. I eventually asked reception where I was, as I did not know what hospital I had been taken to. I was simply told that I was in hospital. (Trinity Ryan, sub. 159, p. 4)

... complaints to the MHCC [Mental Health Complaints Commissioner (Victoria)] have raised consistent themes about the experiences of mental health consumers in emergency departments, including concerns about the nature of responses, the negative impacts of the environment, wait times, use of restrictive practices and the often highly traumatic nature of people’s experiences. In complaints to the MHCC, consumers commonly speak about their fear and active avoidance of emergency departments. (Mental Health Complaints Commissioner (Victoria), sub. 916, p. 2)

People with acute mental illness require an environment which is calm, offers privacy and makes them feel safe. In contrast, EDs are typically high-stimulus environments with bright florescent lights, lots of noise, little privacy, and can be crowded and at times appear chaotic (QAMH, sub. 714). While most patients (including those with physical illnesses) would likely prefer a less stressful ED environment, for people with mental illness, the stimuli in EDs can exacerbate their distress and worsen the symptoms of mental illness.

People with mental illness are less likely to be assessed on time according to their triage status, and for those who do wait until their assessment is completed, they often have to endure more time in the ED than other patients. People with mental illness attending an ED:

- are seen on time 67% of the time, compared with 72% across all ED presentations (AIHW 2019l)
- spend a median time of about 3.5 hours in the ED, compared with a median of just under three hours for all patients (AIHW 2019e, 2019l)
- are twice as likely as other patients to stay for more than 8 hours (ACEM, sub. 516)
- regularly experience instances of three or more days in an ED (ACEM, sub. 516).

However, there are mental health-specific reasons which may explain the longer stay in an ED. For example, people who arrive at an ED intoxicated will require time to recover from the effects of intoxication before a proper assessment can be made, which can increase the amount of time spent in the ED before the person can be discharged.

Inpatient services currently struggle to meet demand, leading to a major problem of ‘access block’ in EDs. This is where patients have been admitted to an ED but are delayed from leaving the ED due to an inpatient bed not being available. The Australasian College for Emergency Medicine (sub. 516) recommended that, for patient safety, people who need admission should be admitted within 8 hours of being assessed.

A lack of mental health outreach services may force family and carers of people experiencing suicidality to have no other choice but to take the person to an ED (Parents Living with Suicide Australia, sub. 609). Studies have found that there are relatively low levels of satisfaction with ED care (compared with other services) after a suicide attempt (NHMRC Centre of Research Excellence in Suicide Prevention 2015), and young people have reported that EDs are not youth friendly and that staff lack training and empathy (Telethon Kids Institute, sub. 793, att.). Some of the reasons for low satisfaction include poor staff attitudes and knowledge, and not having their emotional distress addressed by staff (NHMRC Centre of Research Excellence in Suicide Prevention 2015).

In some cases, people with suicidal thoughts are sent home and told that someone will follow up — but this does not happen (State of Victoria 2019, pp. 304, 338). In another example, a person experiencing suicidality was turned away because they ‘didn’t have specific plans’ to die by suicide (State of Victoria 2019, p. 336). Some participants commented about their personal experiences, and of experiences in their communities:

When [the individual] was unwell and needed somewhere safe to go because they felt suicidal. The only place available was a Psych Ward in the nearby hospital, but they were given medication and “thrown” out the next morning! At that immediate time, when feeling so unwell, there was nowhere else to go! (Name withheld, sub. 31, p. 1)

[The individual] presented to the emergency department for suicidality and self harm on another occasion, however the intake team at the hospital’s mental health unit say she is not eligible for

service (her symptoms are “not severe enough”) and refer her back into her GP and private psychologist’s care each time. (Emma-Kate Muir, sub. 338, p. 3)

Repeatedly I have heard stories of people being turned away from Emergency Departments and later committing suicide or being discharged from Emergency Departments and later committing suicide. (Laurence West, sub. 541, p. 2)

People turning up to ED who are genuinely suicidal, or have even made an attempt on their life, are regularly (almost always) sent home with an appointment to see their GP or an appointment to attend the Community Health Centre. ... There are regular stories in our local paper of people who have been sent home from ED only to go home and commit suicide. I find this situation unconscionable. (Danielle Gamble, sub. 797, p. 5)

All the above factors can potentially exacerbate a person’s condition, leaving them feeling that the hospital is the wrong door (Roses in the Ocean, sub. 710) and discourage the person from accessing care in the future, which can lead to a further deterioration in mental health. The Australasian College for Emergency Medicine (ACEM 2018, sub. 516) stated that unsuitable ED environments make people experiencing mental illness more likely than other patients to leave before their treatment is completed and against medical advice, and other Inquiry participants have voiced similar experiences:

Anxiety and/or panic attacks often occurred but waiting in an Emergency Hospital waiting room or a 24 hour medical centre waiting room was not an ideal situation and [the individual] would often leave before help was given. (Name withheld, sub. 31, p. 1)

The patient explained that the emergency treatment staff suddenly announced that the patient had to go home, and they (literally) put the patient out on the street. The staff would not even let the patient wait inside ... This patient later told me they were adamant they would never return to an Emergency Department for help. (Laurence West, sub. 541, p. 2)

Acute inpatient mental health services

Acute inpatient mental health services involve an admission to hospital for short-term treatment of an acute episode of mental illness, characterised by a recent onset of severe clinical symptoms which have the potential for prolonged impairment or risk to self and/or others (AIHW 2020n). People who require an episode of care in a hospital can be voluntary or involuntary — where they receive treatment under an involuntary treatment order as part of a state or territory’s mental health legislation (AIHW 2020m).

This section focuses on a widely held concern that access to acute inpatient services is constrained by a lack of inpatient beds. Current demand for acute mental health beds has to some extent been affected by a lack of community ambulatory services (discussed in chapter 12) and non-acute bed-based care.¹¹⁸ The other key issue raised about acute inpatient services was the funding arrangements for private hospitals and patients, and

¹¹⁸ Non-acute bed-based care focuses on rehabilitation and improving the functioning of people with mental illness to live independently in the community. Acute care focuses on reducing the symptoms and impairment caused by an episode of severe mental illness.

associated role of private health insurance. The issue of funding arrangements is considered in chapter 23.

There were 165 000 separations¹¹⁹ for overnight admitted specialised psychiatric care, with 109 000 separations coming from public acute hospitals in 2017-18 (AIHW 2020k). In contrast to EDs, the most common principal diagnoses for these patients were a depressive episode or schizophrenia. At a national level, the proportion of involuntary patients in public acute hospitals is about 46%, but this disguises the heterogeneity between states and territories — for example in the Northern Territory, about 80% of separations are for involuntary patients, while the reverse is true for Western Australia (figure 13.4).

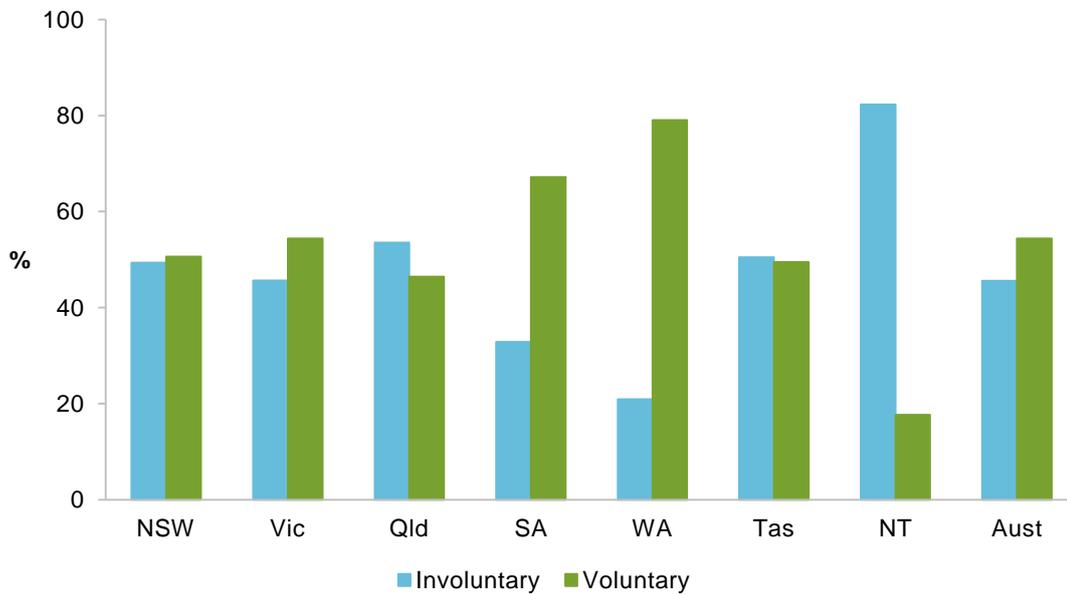
In Australia, there are about 10 100 specialised mental health beds in 2017-18, equating to 41 beds per 100 000 people (AIHW 2020n). About 70% of these were in the public sector (28 beds per 100 000 people), of which most were for acute care (21 beds per 100 000 people). The availability of public sector beds varies between jurisdictions (figure 13.5). Data on private sector beds are not reported at a state and territory level, or separately for acute versus non-acute bed-based care.

At a national level, over a quarter of all public sector mental health beds are reserved for particular groups: older person services (14% of beds in 2017-18), forensic services (10%), and youth, child and adolescent services (5%).

The per capita supply of public sector acute beds has been constant from the early 1990s (figure 13.6). In contrast, there was a significant decline in the per capita supply of public sector non-acute beds up until the end of the 1990s, when the last of the public mental healthcare facilities, referred to as ‘institutions’ or ‘asylums’, were being closed down and the process of deinstitutionalisation placed an increased emphasis on care provided in the community. The other notable trend in the public sector has been a shift of beds from stand-alone psychiatric hospitals to specialised psychiatric units or wards in general hospitals. The share of public sector mental health beds in general hospitals (as a proportion of all public sector mental health beds) grew from about one-quarter in 1992-93 to more than three-quarters by 2017-18.

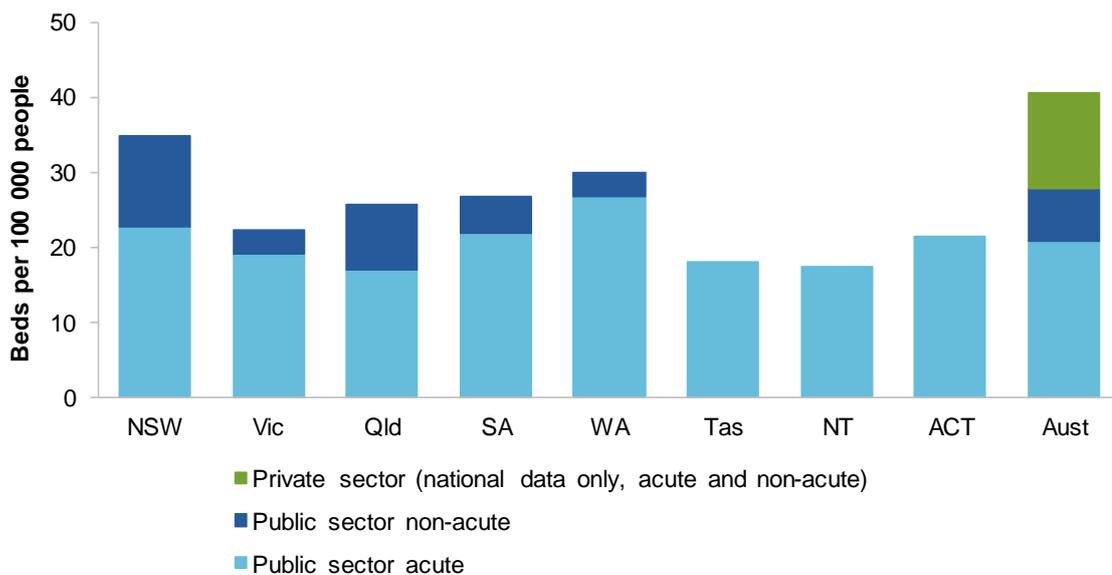
¹¹⁹ Separations refers to the process by which an admitted patient completes an episode of care, for example, being discharged, dying, transferred to another hospital, or a change in their type of care (AIHW 2020k).

Figure 13.4 Public acute hospital separations by mental health legal status^a
2017-18



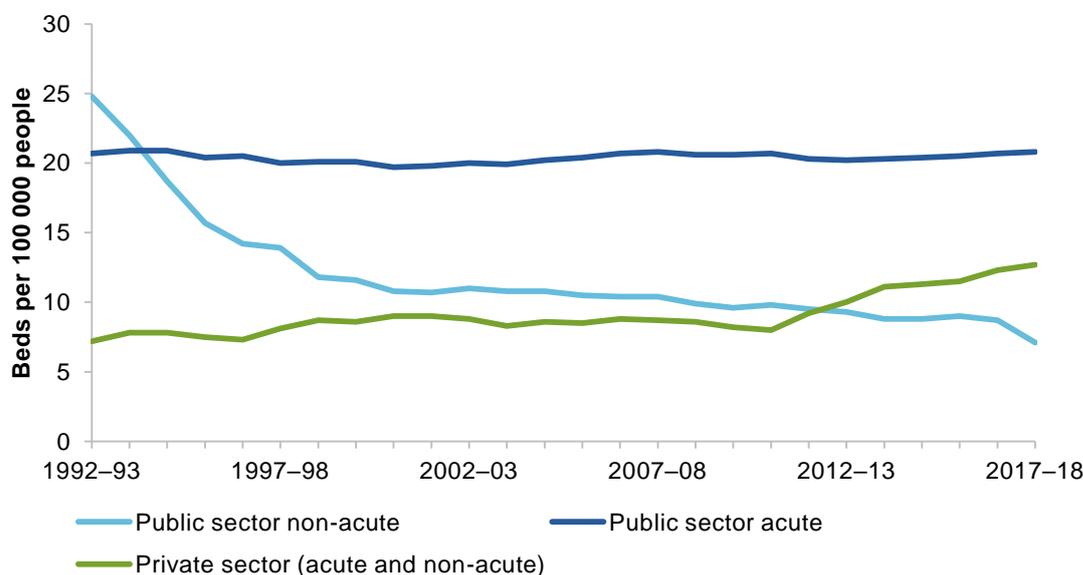
^a Data for the ACT is not presented here as a majority of separations were not reported as voluntary/involuntary.
Source: AIHW (2020k).

Figure 13.5 Specialised mental health hospital beds, 2017-18



Source: AIHW (2020n).

Figure 13.6 **Specialised mental health hospital beds**



Source: AIHW (2020n).

In the private sector, there has been a long-term upward trend in the number of specialised mental health beds, reaching a total of about 3100 beds by 2017-18. Most of the growth has occurred from 2010-11, with the per capita supply of private hospital mental health beds growing by an average annual rate of 7% per year up to 2017-18.

Views on bed shortages

Many Inquiry participants expressed the view that there are insufficient acute mental health beds (for example, AMA, sub. 387; ASMOF, sub. 233; CHF, sub. 496; David Guthrey, sub. 902; MHV, sub. 479). This was often linked to the problems in EDs discussed in section 13.1. Specifically, when patients attending an ED need to be admitted for acute care, too often they have to endure a long wait until an inpatient bed becomes available. Sometimes they may even be transferred to another hospital with an available bed (Connect Health & Community, sub. 94) or be offered a service which lacks the intensity of clinical treatment and supervision necessary.

The Australasian College of Emergency Medicine (sub. 516, p. 4) quantified the problem by submitting results from a survey of 65 EDs it conducted in December 2017, which revealed that:

- While only 4% of presentations were for mental health, this group comprised 19% of patients waiting for inpatient beds and 28% of those experiencing access block.
- The rate of access block varied from state to state, and was much higher in Western Australia (66.7%) than the national average.

-
- Two thirds of EDs had patients waiting in the ED [for an inpatient bed for] longer than 24 hours, with 23% of respondents reporting waits of longer than 72 hours.
 - The maximum length of stay for an ED patient with a mental health presentation was 145 hours, or six days.

The Royal Australian and New Zealand College of Psychiatrists (sub. 385, p. 10) noted the problems that a lack of inpatient beds had caused at the ED of one New South Wales public hospital:

... \$4 million in one year was spent on using security to provide one-to-one supervision of mental health patients waiting for beds. The same unit has days where up to 28 admitted patients wait in the emergency department for a psychiatric bed.

A number of Inquiry participants suggested that a shortage of beds has led to pressure on hospital staff to discharge patients prematurely to make beds available for new patients (for example, Consortium of Australian Psychiatrists and Psychologists, sub. 260; Olav Nielssen, sub. 37, att. 2). The NSW Nurses and Midwives' Association (sub. 246, p. 11) described the issue as follows:

... admitted patients are being discharged so their bed can be made available for those more acutely ill waiting in the Emergency Department (EDs) or in the community. The inpatient near discharge is often deemed less acutely ill and discharged early due to the urgency of a bed being required, but without the discharge planning required due to the emergency of the situation.

However, in some instances, the patient who was prematurely discharged may not have recovered sufficiently — consequently, their mental health continues to deteriorate and they are readmitted in the future. The ACT Human Rights Commission (2019) described this situation as a revolving door in inpatient facilities. This problem appears to be most prominent in the ACT, where only 41% of people who were discharged from hospital after receiving mental healthcare reported that they had a significant improvement in outcomes, compared with a national average of 72% (SCRGSP 2020b, chap. 13).

Non-acute bed-based services

Non-acute bed-based services are provided to people whose needs are more complex, and require higher levels of support, than can be provided through community ambulatory (non-bed-based) services (box 13.1). Non-acute bed-based care incorporates both specialist clinical and psychosocial services, with staff available on site 24 hours a day. Non-acute bed-based care can be provided:

- in the community ('community residential'), which includes short, medium and long-stay accommodation, and may be operated by government or non-government organisations
- on the grounds of public hospitals, separate from acute hospital beds.

Box 13.1 What is non-acute bed-based care?

For this report, the term ‘non-acute’ is used to refer to both sub-acute and non-acute care. When others draw a distinction between sub-acute and non-acute care, the key difference is that non-acute care is provided over an extended period, with an expected length of stay in excess of 6 months (QCMHR 2016, p. 204). Non-acute services aim for an improvement over the long term, or to maintain a certain level of functioning without deterioration over an extended period. Sub-acute care comprises:

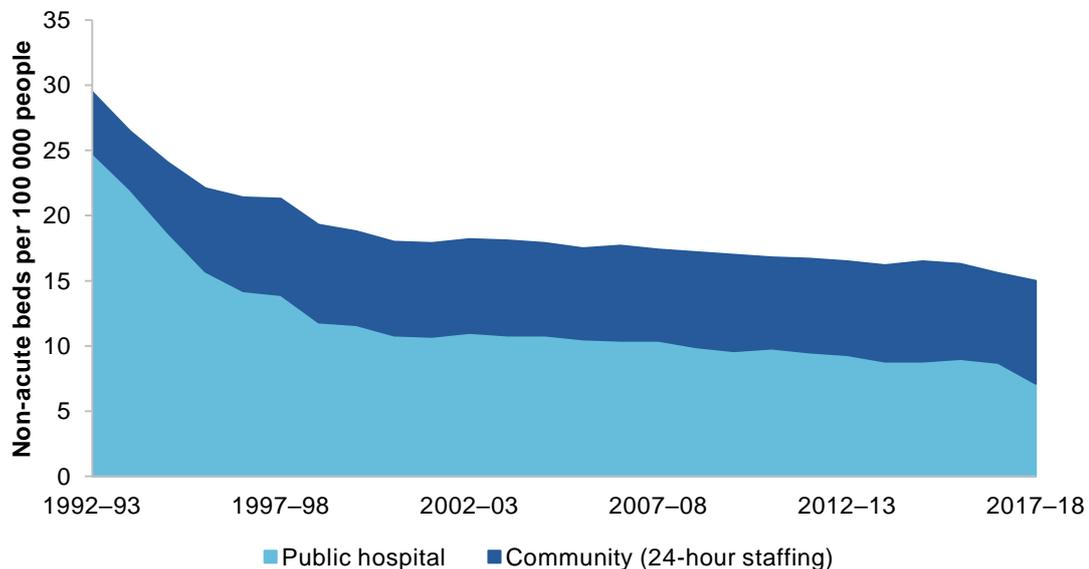
- **Step up/step down services** are provided to people who have recently experienced or who are at increasing risk of experiencing an acute episode of mental illness. The person usually requires higher intensity treatment and care to reduce symptoms and/or distress that cannot be adequately provided in the person’s home but does not require the treatment intensity provided by an acute inpatient unit. People may access these services by:
 - ‘stepping down’ from a period of treatment in an acute inpatient unit to allow continued treatment in a supportive environment aimed at achieving further symptom reduction and recovery from the acute episode
 - ‘stepping up’ from the community when experiencing an increase in symptoms/distress to receive treatment in a supportive environment designed to prevent further deterioration and avoiding a hospital admission.
- **Community residential rehabilitation services** are provided to improve functioning and help people live independently in the community. People admitted to rehabilitation services have complex needs associated with mental illness. Clinical symptoms, while severe, are usually relatively stable.
- **Intensive care services** are provided on hospital campuses, for medium-term recovery-oriented treatment and rehabilitation in a safe, secure, structured environment for people with unremitting and severe symptoms of mental illness and an associated significant disturbance in behaviour which precludes them receiving support safely in a less restrictive environment (QCMHR 2016, p. 195).

Supported housing — where the focus is on long-term housing and supporting the psychosocial and clinical needs of people with mental illness — is discussed in chapter 20.

In 2017-18, Australia had about 2000 community residential beds with 24-hour staffing, 15% of which were operated by non-government organisations, and about 1400 public non-acute hospital beds, not including about 350 non-acute forensic beds (AIHW 2020n).

There was a sharp decline in the number of non-acute hospital beds per 100 000 people in the 1990s, as part of the movement to mainstream mental health services and getting people out of stand-alone mental health institutions (figure 13.7). At the same time, there was an increase in the number of non-acute community beds with 24-hour staffing, but not enough to compensate for the decline in non-acute hospital beds. The total number of non-acute beds per 100 000 people fell from 30 in 1992-93 to about 19 at the end of that decade. In the past two decades, this has fallen further, with little growth in community non-acute beds.

Figure 13.7 Public non-acute beds per person has fallen over time^a



^a Community beds include non-acute and sub-acute beds.

Source: AIHW (2020n).

Delayed discharge hurts consumers and reduces the efficiency of the system

An important indirect consequence of a shortage in non-acute bed-based services, as well as supported housing and housing more generally (chapter 20) is ‘delayed discharge’. This is when people are kept in acute hospital care longer than they should be, because the services that are most suitable to their needs are not available. This means fewer acute beds are available for other people who need them — many of whom will miss out on the care they need as a result.

Delayed discharge hurts consumers. People who are kept in hospital for too long may find it difficult to seek employment, participate in community activities, and maintain meaningful social connections after being discharged. It has been estimated that ‘up to 70 per cent of a person’s day during an inpatient admission is “down time” or not purposely occupied by the development or practice of everyday living skills’ (Regional and Rural Area Mental Health Services of Victoria 2019, p. 6). The Consortium of Australian Psychiatrists and Psychologists (sub. 260, p. 6) said:

There is robust evidence to show that participation in community – be it in a workplace, volunteering or participation in community groups – is associated with greater well-being, reduced symptoms of mental illness, greater social contact, greater independence, improved self-esteem, lower relapse rates, and better quality of life.

Those who miss out on care are either people who do not get admitted when they need to be, as well as those who do get admitted, but are discharged early because of the pressure on beds. While this may seem paradoxical, early discharge and delayed discharge can co-exist. Where beds are being taken up by longer-stay patients due to delayed discharge, there are effectively fewer beds available for people who need acute care. When under pressure to accommodate the same number of acute patients with a fixed supply of beds, hospital staff may be forced to discharge some people early (as discussed above).

While the data is patchy, surveys conducted by states and territories suggest that roughly one-quarter to one-third of mental health inpatients could be discharged if appropriate community services and accommodation were available (box 13.2). This translates to almost 1800 people taking up hospital beds because more appropriate, and less intensive care services are not available to them.¹²⁰

The extent of delayed discharge can be observed in the excessive number of long stays in acute mental health hospital beds. Acute mental health hospital beds are intended to provide short-term, stabilising care to people in crisis or with acute mental health needs (OAGWA 2019, p. 9).

While ... some people will require a stay longer than the [Western Australian target of] 15 days in line with their support needs, groups of people who stay significantly longer than 15 days highlight where the use of services does not match the model of care. This pattern may also indicate difficulties in accessing more appropriate care settings. (OAGWA 2019, p. 25)

Yet, a substantial number of people are spending long periods in acute hospital beds.

- In Victoria in 2018-19, more than 10% of acute bed hours were used by patients who had already been in hospital for at least 35 days (State of Victoria 2019, p. 548).
- Across five Victorian child and youth mental health services over a 12-month period, 29 patient-stays accounted for a combined 1054 bed days (averaging more than 35 days each) without a clinical need:

Young people are routinely getting ‘stuck’ in [child and youth mental health services] inpatient beds when they should be discharged, because they cannot access family or carer support and/or services such as disability accommodation or child protection and out-of-home care. (VAGO 2019b, p. 10)

- In Western Australia between 2013 and 2017, 126 people spent more than 365 consecutive days in an acute hospital bed costing the public system \$115 million, and 10% of service users used 90% of hospital care. An additional 158 people had multiple stays in an acute hospital bed that totalled more than 365 days, and 41 people were either in State-managed hospital for the entire 5-year period or had completed a stay during that period that had lasted longer than 5 years (OAGWA 2019).

¹²⁰ Based on 6262 public mental health hospital beds (excluding forensic beds) (AIHW 2020n), an occupancy rate of 95% (in line with data for Victoria), and assuming 30% of patients could be discharged. If forensic beds are included (6920 beds in total), it would be 2000 people instead of 1800 people.

Box 13.2 **The extent of delayed discharge**

We asked the States and Territories: 'What proportion of mental health inpatients could be discharged from hospital/acute care if appropriate supported accommodation was available?' The ACT indicated that 'approximately 7%' of current inpatients could be discharged if appropriate accommodation was available. The Northern Territory told the Productivity Commission:

Anecdotally an estimate of 25% average of all inpatient clients could be discharged earlier if appropriate accommodation was made available. On current ward census today this figure is 35% (State and Territory Governments Survey).

Less recent published estimates were available for some other States:

- In Queensland in 2004, hospitals indicated that 30% of mental health consumers did not need hospitalisation if other supports were available. Difficulty accessing suitable support and accommodation was the key factor preventing discharge (SCMH 2006, p. 189).
- In South Australia, a 2004 Homeless and Housing Taskforce indicated that there were 505 patients in 10 mental health inpatient units on Census day in South Australia who could have been discharged immediately if more intermediate treatment, rehabilitation support and accommodation services were available in South Australia (SCMH 2006). At the time, South Australia had only about 640 public sector mental health beds (AIHW 2020n).
- In Western Australia, a 2009 survey found that 40% of individuals occupying mental health inpatient beds at any given time could be discharged if appropriate community services were available (WAMHC 2015, p. 21).
- In New South Wales, a 2012 New South Wales Ombudsman report found that 'long-term and highly supported accommodation are in short supply' and are contributing to people overstaying in hospital settings. The conservative estimate is that about one-third of people currently living in mental health facilities in New South Wales could be discharged to the community, if appropriate accommodation and supports were available (NSW Ombudsman 2012, pp. 3, 67).

Extended stays in an acute bed are contrary to their intended purpose, and restrict the capacity of a hospital to meet the needs of people in its region. It also reflects that consumers are not receiving the care that best meets their needs and preferences. Hospitals should actively be identifying these 'super frequent' consumers with the intention of guiding them towards services more suited to their needs and increasing the availability of acute beds (University of California, San Francisco 2019).

13.2 Improving crisis and emergency services

Offering improved alternatives to EDs

In addition to increasing the availability of, and access to, community mental health services for people in crisis (chapter 12), State and Territory Governments should aim to expand the range of alternatives to EDs for people experiencing mental illness. These alternatives would be places where people experiencing acute mental illness or an episode which is detrimental to their mental health could seek help or treatment in a timely and considered way.

Such alternative models — including after-hours services and community-based crisis services — can significantly improve the experience of people with mental illness. These alternatives should be co-designed, utilising lived experience to understand and identify what works (MHCC, sub. 920; VLA, sub. 818).

After-hours alternatives

There is a clear need for after-hours alternatives to EDs. Half of all mental health attendances at EDs, and the majority of ambulance attendances for men related to mental health, alcohol and other drugs, or self-harm in 2015-16, occurred after-hours (Doggett 2018; Turning Point 2019). Some of these people would not have needed acute hospital care and could instead have been treated in alternative services, if they were available.

One option would be more after-hours GP clinics. For example, the Australian Government announced \$28 million funding in June 2019 for four new ‘urgent care’ clinics (employing GPs and nurses) in Perth to provide timely alternative care pathways for unscheduled care, with extended opening hours (Minister for Health and Hunt 2019). Another primary care option for young people seeking help after-hours would be to extend the opening hours of headspace centres. Currently, headspace centres are typically closed on weekends and only open from 9 am to 5 pm during the week, although some stay open later on selected weeknights.

To reduce pressure on clinical staff needed during business hours and the operating costs of ED alternatives, after-hours services could also be supplemented by peer workers, rather than having only clinical staff (box 13.3).

In June 2019, the Queensland Government announced that it was allocating almost \$11 million over the following four years to fund safe haven cafés in some of its hospitals (Miles 2019). Similarly, in October 2018, as part of the Towards Zero Suicides initiative, the New South Wales Government announced that it will be investing \$25.1 million over the next three years into opening twenty new alternatives to emergency departments based on the Safe Haven café model and co-designed with people with lived experience (NSW Health 2019c). The South Australian Mental Health Plan has proposed the development of a Safe Haven Café in the central business district as a hospital avoidance initiative (SAMHC 2019), and there are plans for an urgent mental healthcare centre to be established close to the Royal Adelaide Hospital to divert people from the ED (Siebert 2020).

Box 13.3 Examples of peer run services as an alternative to EDs

St Vincent's Safe Haven Café

The Safe Haven Café operates near the emergency department (ED) in St Vincent's Hospital, Melbourne, after hours three days per week. It is staffed with peer workers and volunteer workers alongside mental health professionals. The café offers respite in a warm, caring and respectful environment to people needing mental health support, as well as social connection, but not necessarily acute care. It is based on a model successfully trialled in the United Kingdom, which was developed by and for consumers (St Vincent's Melbourne 2018).

Crisis Now

Crisis Now is a model of care in the United States, operated by RI International, which aim to provide 24-hour peer led psychosocial and clinical services, and has been shown to be a cost-effective alternative to an ED (SA Mental Health Commission, sub. 691, att. A, att. B; UnitingSA, sub. 807; Zero Suicide Institute of Australasia, sub. 671). The model includes a crisis stabilisation program which offers short-term sub-acute care for individuals who need support and observation, without the overhead of acute inpatient care.

These crisis stabilisation programs do not necessarily need to be located within a hospital, which can help to remove the stigma associated with attending an ED. The stabilisation unit would ideally be staffed by mental health workers who are linked to local community-based services, so that when a person leaves the facility, they are connected to community services that can support them (Zero Suicide Institute of Australasia, sub. 671). In June 2019, the Queensland Government announced that it has allocated \$11.3 million to trial a similar model to Crisis Now (Miles 2019).

Living EDge

At Redland hospital, Brook RED and Enlighted Consultants have collaborated in designing and trialling 'The Living EDge' (introduced in mid-2019), which is a peer-hosted space serving as an alternative to an ED for people experiencing suicidal distress. The Living EDge has been co-designed by consumers, families, carers, and clinicians (Lived Experience Leadership Roundtable (Queensland), sub. 799, att. 3) and is an example of utilising peer workers and lived experience to fill service gaps. The initial trial of The Living EDge has been successful, with the trial extended until April 2020.

Alternatives to EDs could — in addition to improving the wellbeing of people experiencing mental ill-health — save money and help EDs work better for other patients. An evaluation of the Safe Haven café at St Vincent's Hospital found that it reduced mental health-related ED presentations, with almost 40% of those attending the café saying they would have gone to the ED if the café did not exist. The evaluation reported that the reductions in ED presentations resulted in annual net cost savings of \$34 000 (PwC 2018). It was also found to improve patient experiences and social connections in the local community. While the café is well-regarded, it is currently only open for a limited number of hours, which could limit its effectiveness (Beyond Blue 2018b; MHLC, sub. 1222; St Vincent's Melbourne 2018). It is not open late on Friday and Saturday nights, which are peak times for mental health crises. In establishing future trials of ED alternatives, extended or alternative operating hours should be considered to understand how to best meet the demands for these services.

Current governance and funding arrangements dilute the incentives for governments to invest in after-hours services. In particular, State and Territory Governments (which fund public hospitals, and therefore, would be the main beneficiaries of any reduction in spending on ED services) are precluded from contributing to Medicare Benefits Schedule-rebated clinical services in the community, such as those which would help people to avoid needing to visit an ED (chapter 23). The Productivity Commission is recommending that Australian, State, and Territory regional commissioning bodies (PHNs or RCAs) be allowed to co-fund services which currently receive public funding exclusively from the Medicare Benefits Schedule (action 23.4). This would include allied health services and out-of-hours care from GPs.

Community-based crisis services

Community-based crisis services help connect people with the appropriate level of care to prevent a deterioration in mental health, whether it be within a hospital or outside a hospital. Broadly, there are two groups for whom these services are required:

- For people already known to mental health services, ideally assertive follow-up when they fail to attend appointments and step up services which can help them avoid a hospital presentation (section 13.4 and chapter 12). However, where a crisis does occur, urgent assessment and treatment services need to be available and accessible.
- For people not known to mental health services, their first contact with the system is often in crisis and can involve first responders. First responders often have little choice but to take someone to the ED for assessment and treatment, however in some cases, diverting the person to an alternative service may be appropriate.

Mobile crisis services differ from the traditional emergency service response by including specialised mental health staff as part of the team. By incorporating greater mental health expertise among first responders, and improving access to ED alternatives, this could help some people with mental illness to avoid EDs. Compared with increasing the availability of after-hours services, which could require a large fixed investment in additional infrastructure, utilising mental health staff in this way is relatively quick to implement.

There are several models of mobile crisis services in Australia.

People experiencing a crisis, or their carer, who are familiar with mental health services may call their local crisis assessment and treatment (CAT) service. CAT services are staffed by people with backgrounds in medicine, nursing, social work and psychology. CAT teams are able to provide support over the phone by working with the person, and potentially their family or carer, to determine the most appropriate avenue for treatment. CAT teams can also provide mobile assessment and treatment, including in people's homes where clinicians are sometimes accompanied by a peer worker, but in most cases do not require paramedics or police to attend. They are skilled at de-escalation, and can often help the person experiencing a mental health crisis avoid the need to attend the ED.

However, delivering CAT services has challenges. Occupational health and safety concerns have led to restrictions on CAT staff going alone to potentially unsafe or previously unvisited community locations and residences, especially at night (SCMH 2006). Most CAT services operate over extended business hours, rather than being a 24-hour service, which limits their effectiveness as an ED alternative.

For those who call triple zero, first responders attend to ensure the safety of the person. However, a survey of paramedics found that less than 14% felt that their training had provided them with adequate skills, and less than a third were highly confident in responding to people experiencing mental ill-health (Turning Point 2019). This can be alleviated by including specialised mental health staff as part of the response team, who are able to bridge the gap in skills and knowledge.

In 2015, the New South Wales Ambulance Service implemented the Mental Health Acute Assessment Team (MHAAT) program following the successful results of a trial, which involved specially trained paramedics and mental health nurses providing medical assessment at the scene before deciding on the best course of care (Faddy et al. 2017). This could be to contact a GP, follow-up with a community mental health team, or admit the patient to a mental health facility. Between 2015 and 2017, about 50% of mental health-related callouts resulted in patients bypassing EDs in favour of more appropriate care (WSLHD 2017).

Beginning in May 2019, Ambulance Victoria and Barwon Health are also trialling pairing up mental health staff with paramedics as part of the Prehospital Response of Mental Health and Paramedic Team (PROMPT) model. Similar to MHAAT, triage can begin sooner as the person does not need to wait in an ED (MHV and VHA, sub. 1184). The results of the initial trial resulted in about 75% of PROMPT callouts successfully diverting people away from an ED towards more appropriate care, and the trial being extended (Barwon Health 2019).

The presence of police as part of an emergency response could help ameliorate issues of safety, especially when the person in crisis is not known to mental health services. An available option which utilises police in this way is the Police, Ambulance and Clinical Early Response (PACER) model. This is a dedicated joint police and mental health secondary response activated by police, targeted to times of greatest demand, and offering on-site and telephone mental health assistance (Allen Consulting 2012).

The results from PACER have been positive in New South Wales — mental health-related presentations to EDs via police have fallen and there has been faster turnaround in the ED since the person can be assessed prior to arrival (NSW Health 2019b). Similarly in Victoria, PACER has been successful in de-escalating mental health crises, with people less likely to end up in an ED (Foley 2015).

Similar models are considered in chapter 21. The Productivity Commission is proposing all State and Territory Governments implement initiatives which enable police, mental health and ambulance services to collectively respond to mental health-related incidents (action 21.2).

The Productivity Commission has considered the cost-effectiveness of providing Safe Haven Cafés as an alternative to EDs and mobile crisis services as a method for averting unnecessary ED attendances (appendix I and appendix K). Both options were found to be potentially cost-effective, through avoiding the costs associated with an ED presentation (\$805 per ED presentation for severe mental illness). Not estimated, but also beneficial, are the potential quality-of-life benefits from people not having to wait in an ED for an extended period of time and exacerbating their condition.

An important consideration is where these services will be located, as they will only be cost-effective if there is sufficient demand for them. As a first step in choosing to deliver these services, States and Territories should identify the regions with the highest demand for mental health-related emergency services. Any additional services should first be trialled within an area to ensure that their operations are best suited to meet regional needs — for example, this could include skills tailored to treating particular demographics, and optimal operating hours. By incorporating co-design as part of the process, it would help to test the needs of people who require these services.

Improving the experience for people who attend EDs

While more alternatives are required, some people with mental illness will continue to need emergency clinical care in an ED. For these patients, the ED experience should be improved in both public and private hospitals.

The Royal Australian and New Zealand College of Psychiatrists (sub. 385, p. 10) argued that the design of EDs need to be significantly changed.

... emergency departments require significant structural redesign of specific spaces for mental health, to ensure that individuals with mental illness can seek help in a calm, safe and private environment.

This could involve a dedicated space in EDs for people experiencing mental illness, which:

- provides a calmer, low sensory environment with a sense of support for the person
- allows for longer periods of observation and assessment
- reduces the need for restraint because there is perimeter security
- creates a safer and calmer environment for other patients elsewhere in the ED.

Separate mental health units within EDs have recently been established in hospitals in Western Australia, with plans to open more (Western Australian Mental Health Commission, sub. 259). The Royal North Shore Hospital in New South Wales has a psychiatric emergency care centre, which is a specialist short-stay mental health unit co-located in the ED (NSLHD 2020). In May 2018, the Victorian Government announced that it would invest \$100 million to create six units in hospitals across the state, to be termed crisis hubs (Andrews 2018). Not only does the creation of separate units require substantial funding

(albeit potentially outweighed by the benefits), but some hospitals may not be able to add a new mental health unit within their existing building footprint.

A lower-cost alternative is to make the care and physical environment of existing EDs more suitable to the needs of people with mental illness. For example, there is evidence to support:

- sensory modification techniques (Adams-Leask et al. 2018)
- using staff skilled in de-escalating situations before security guards are needed (Kelley 2014)
- increasing natural light, surfaces and colours (Ampt, Harris and Maxwell 2008; Thomas et al. 2018).

Mental health advance directives allow people to express their preferences for treatment and care *prior* to engaging with emergency care. The Productivity Commission is recommending the expanded use of advance directives for people with severe mental illness (action 21.12). This would provide crisis or emergency staff with information which can help de-escalate and assist with identifying the appropriate support for the person (MHLC, sub. 1222).

Several participants have commented on the potential roles that mental health workers could play in hospitals in the future mental health system:

- mental health nurses could be used in emergency departments to assist with triage (QNMU, sub. 760)
- mental health support workers and peer workers could accompany crisis support teams, which could remove the need to attend an ED (Roses in the Ocean, sub. 710)
- peer/community mental health workers in EDs could help with de-escalation and liaising between consumers and staff (Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212).

For example, the Royal Prince Alfred Hospital in Sydney has successfully trialled an extended-hours mental health liaison nurse service based in its ED. The team of nurses see people presenting with mental health problems and begin the process of helping to manage and coordinate care. This has been shown to provide prompt and effective access to specialised mental health services by determining the cause and treatment needed for a mental health crisis, and removing a significant workload from ED nursing and medical staff (ACEM, sub. 516).

In Queensland, the Metro North Hospital and Health Service has established ED-based mental health nurse practitioners at The Prince Charles Hospital and Redcliffe Hospital, and is trialling a clinical nurse consultant and mental health peer support worker within the ED at The Prince Charles Hospital (MNHHS, Brisbane North PHN, MSHSS and Brisbane South PHN, sub. 874).

Participants suggested ways to improve the skills of ED staff to deal with presentations which involve suicidality. Telethon Kids Institute (sub. 793, att.) suggested that there may be a need for additional training for ED staff to adequately deal with cases which involve suicidality. Roses in the Ocean (sub. 710) promoted the use of suicide prevention peer workers, working alongside clinical and other ED staff, who can utilise their lived experience to support people experiencing suicidality.

For example, South Eastern New South Wales has a Next Steps Suicide Prevention Aftercare Service which is ‘based on the emerging evidence for peer work in helping people with suicidality’ (NSW MHC 2019). Outcomes for people presenting at the ED who participated in the program have been positive, with participants reporting a reduction in depression and anxiety.

There are a variety of options to improve ED experiences for people experiencing mental illness. Some can be implemented quickly and at relatively low cost, while others, such as redesigning the physical layout of EDs, are higher-cost options, which may have to be implemented over the longer term. Determining which approaches are implemented, and when, is a decision that should be made at a local level to reflect regional circumstances, including the available resources, space, personnel, and needs of people who access that service.

ACTION 13.1 — IMPROVE EMERGENCY MENTAL HEALTH SERVICE EXPERIENCES

Hospitals and crisis response services should be able to support a person’s recovery in a safe environment that meets their needs.

Start now

- State and Territory Governments should provide more and improved alternatives to hospital emergency departments for people with acute mental illness, including peer- and clinician-led after-hours services and mobile crisis services.
- State and Territory Governments should consider best practice approaches to improving the interactions of people with mental illness with paramedics, including providing paramedics with access to mental health resources when undertaking medical assessments in the field.
- Public and private hospitals should take steps to improve the emergency department experience they provide for people with mental illness. This could include providing separate spaces for people with mental illness, or otherwise creating environments that do not escalate the severity of their illness.

Start later

- State and Territory Governments should, when building or renovating emergency departments, design them to take account of the needs of people with mental illness by collaborating with and incorporating the lived experience of consumers and carers as part of the process.

13.3 Improving acute inpatient mental health services

Addressing concerns about mental health beds

There are reforms recommended in this Inquiry which aim to increase the provision of community mental health services and availability of non-acute mental health beds, which would potentially reduce the demand for acute beds. However, not all hospitalisations are avoidable and for some people, the intensity of treatment and support needed can only be provided in an acute inpatient bed.

The supply and demand for acute mental health beds in public hospitals

The University of Queensland provided this Inquiry with estimated benchmarks for the mental health services required to meet the needs of Australia's population. The benchmarks suggest that only a relatively small increase in acute beds would be required nationally if accompanied by the necessary level of community ambulatory services and non-acute bed-based services (box 13.4). The current under-provision of those services is large, and part of the rationale for increasing their capacity is to prevent relapse and manage acute episodes of mental illness early and to support recovery from such episodes, which should reduce the demand on acute inpatient services.

The Western Australian Mental Health Commission published an analysis of the gap in services needed in its jurisdiction (WAMHC 2015, 2019). The results suggest that Western Australia would, in 2025, need 8% *fewer* public sector acute beds than in 2017, provided it also implemented a significant planned increase in community ambulatory and non-acute hospital services. However, progress in implementing the plan has been limited — the Western Australian Auditor General reported that there has yet to be a rebalancing of the mix of mental health services, with people continuing to rely on acute care due to a lack of alternative services (OAGWA 2019). Furthermore, the Australasian College of Emergency Medicine (sub. 516) survey results suggested that Western Australia had the highest rate of access block in late 2017, which raises significant doubts about its ability to reduce acute beds over the short term and until the increased community ambulatory and non-acute hospital services are in place.

Similarly, the South Australian Mental Health Commission conducted a gap analysis using the National Mental Health Service Planning Framework (NMHSPF) (SAMHC 2019). The results of the gap analysis suggested that South Australia has an excess of public sector acute beds compared with what would be required in 2023-24 (372 actual beds in 2019-20 compared with the framework benchmark of 294 in 2023-24). However, the South Australian Mental Health Commission recommended not to close down these beds due to the current state of other services and system demand, as one of the core assumptions of the NMHSPF is that all other parts of the system are operating at their benchmark levels.

Box 13.4 **Benchmarking public sector mental health services**

The Queensland Centre for Mental Health Research at The University of Queensland is responsible for maintaining and updating the National Mental Health Service Planning Framework (NMHSPF) — a model which quantifies the mental health services needed to meet the needs of Australia's population. The model was initially developed by the New South Wales and Queensland Governments, and is funded by the Australian, State and Territory Governments with the approved version of the NMHSPF planning tool is hosted by the Australian Institute of Health and Welfare.

NMHSPF benchmarks indicated that to meet the mental health service needs of the Australian population in 2019-20 would have required the public sector to provide:

- 1% more acute beds than existed in 2017-18
- 85% more non-acute beds than in 2017-18
- 39% more community ambulatory (outpatient) services (measured in terms of full-time equivalent workers providing services) than in 2017-18.

The estimated number of acute beds needed in 2019-20 was calculated on the assumption that readmission rates remain at the average levels prevailing over the period 2015 to 2017.

The benchmarks generated by the current version of the NMHSPF planning tool are based on national averages, and do not take into account variations in prevalence rates or population characteristics which affect the demand for mental health services (such as Aboriginal and Torres Strait Islander populations). As these adjustments must be made locally, it was not possible to identify how any needed changes would vary between States and Territories.

Other states and territories have not published similar analyses but available data indicate that they have even fewer public sector acute beds per person than Western Australia or South Australia (figure 13.5). While such cross-jurisdiction comparisons may be distorted by differences in how jurisdictions define and classify beds, they suggest that other states and territories should also be cautious about considering a reduction in acute beds until the recommended level of community ambulatory and non-acute hospital services are established.

The Productivity Commission has also considered how Australian mental health bed numbers compare with those overseas. The per capita provision of (acute and non-acute) mental health beds in Australia of 41 per 100 000 people (figure 13.5) is significantly below the OECD average of 71 beds (OECD 2019). To match the OECD average, Australia would have to increase its per capita supply of mental health beds by 73%. However, such a simple calculation overlooks substantial cross-country differences in health systems and data definitions. As noted by AIHW (2003, p. vi), comparing expenditure on mental disorders in Australia with other countries was compromised by 'differences in what is included in the "mental disorders" categories, differences in institutional arrangements and what is considered health expenditure'. The OECD (2014a, p. 1) has previously praised Australia for 'leading the way in innovative approaches to delivering mental health services, including a decisive shift away from hospital care'. This is reflected in the fact that Australia's mental health share of hospital inpatient expenditure is low by OECD standards (Consortium of Psychiatrists and Psychologists, sub. 882).

There is merit in having a *minimum* inpatient bed per person target (ACEM, sub. 926; RANZCP, sub. 385, sub. 1200) that State and Territory Governments must meet. Minimum targets can help to foster change in the system and act as a source of accountability (chapter 22). The Consortium of Australian Psychiatrists and Psychologists (sub. 260, p. 11) called for a specific increase in public hospital inpatient beds to at least 50 per 100 000 people, which would be an increase of 80% from the 2017-18 level of 28 per 100 000 people.

Our groups have extensively analysed and reviewed KPIs [key performance indicators], and Australia is encountering major quality and safety issues on ED boarding, out-of-area admissions, high occupancy rates, high 28 day readmission rates, increasing rates of incarceration and an increased risk of suicide in community settings. These adverse effects worsen as total bed numbers fall below a critical range of 50-60 public sector beds per 100,000 for people with SMI [serious mental illness].

The precise number of beds required is a technical issue for clinical and planning experts and may vary between regions, so this Inquiry has opted not to recommend a specific level. The benchmarks generated by the NMHSPF suggest that, in 2019-20, a total of 11 075 public sector mental health beds would have been needed (4874 acute and 6201 non-acute). However, the NMHSPF does not account for potential substitution *between* services — the benchmarks implicitly assume that all other services are also being provided at their benchmark levels. In practice, some regions may have an excess of a particular service — for example, community ambulatory services — which could offset the demand for acute mental health beds by offering an alternative option to receive treatment, but would not be captured in the current version of the NMHSPF.

The exact number to provide is ultimately a matter best determined through integrated service planning at a regional level, taking account of the relevant population and what services exist to prevent avoidable hospital admissions. Which organisations should be responsible for such planning is an issue that is considered in chapter 23.

Can we improve the efficient use of existing beds?

More efficient use of existing mental health beds could increase the number of inpatients who could be cared for with current resources and reduce the need for more mental health beds.

A measure of efficiency is the average length of stay. Data on the average length of stay provides little evidence of unused capacity in the public hospital system, and in fact, the average length of stay for public mental health services in Australia has been falling — from 15 days in 2010-11 to 13 days in 2017-18 (AIHW 2020e). Victoria's chief psychiatrist, Neil Coventry, stated that the declining length of stay in his State was due to pressure to 'move people through before perhaps they're really ready to be able to be discharged' (Bennett 2019). While a lower average length of stay indicates that more people are able to be treated, it can involve an *inefficient* use of capacity if 'early' discharge leads to future readmissions.

Data from the AIHW (2019b) suggests that the average length of stay in private hospitals for specialised psychiatric care is higher than that for public acute hospitals. However, there are usually agreements in place between private hospitals with private health insurers for the maximum length of stay that the insurer will cover — whether or not this constraint is binding will dictate if a person is receiving the appropriate level of care.

The difference in the mix and severity of mental illnesses treated by public and private hospitals is another factor which can influence the average length of stay. Ramsay Health Care (sub. 548, p. 6) suggested that:

The dedicated specialist knowledge about the treatment of higher prevalence mood and anxiety illnesses is often less developed in public sector hospitals. ... Public hospitals are simply not equipped to manage non-psychotic, medium to higher prevalence disorders on an in-patient basis. Consequently, these conditions are the most common diagnoses in private psychiatric hospitals ...

Furthermore, clauses set by private health insurers which restrict a hospital from readmitting a person unless they have been out of care for a pre-specified period of time can mean that, by the time a patient has been re-admitted, their condition has deteriorated further, and may experience a longer average length of stay.

However, a declining length of stay in hospitals is not always associated with a higher need for readmission. For example, the rate of unplanned readmissions for mental health patients has remained stable at about 15% from the mid-2000s, with similar readmission rates observed in private hospitals (AIHW 2020e; APHA 2018). Readmission rates are much higher for mental illness admissions than for surgery admissions, but this may be explained by the episodic nature of mental illness.

Another measure of efficiency are bed occupancy rates — but these are only available for Victoria. It does not appear that there is much potential for existing beds to be used more intensively by Victoria's adult mental health services. It already has an average bed occupancy rate of about 95%, compared with the 85% rate often nominated as best practice in mental health to avoid many patients having access problems (Consortium of Australian Psychiatrists and Psychologists, sub. 260; NICE 2018; VIC DHHS 2019e).

Acute beds outside the hospital — hospital in the home

Acute mental health services are sometimes provided in a patient's home. Increased use of hospital in the home services may promote efficiencies in acute care, while also leading to improved care quality. Reviews of acute care in the home has found it to be a cost-effective alternative to an inpatient unit and lead to an increase in satisfaction for consumers, carers, and clinicians (OAGWA 2019; Singh et al. 2010; Vázquez-Bourgon, Salvador-Carulla and Vázquez-Barquero 2012). Some examples of hospital in the home around Australia include:

- the Tasmanian Government (sub. 498) has offered this option in southern Tasmania for people in an acute phase of mental illness, where appropriate

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- the Western Australian Government planned to have the equivalent of about 180 hospital in the home beds by 2025 (WAMHC 2019)
 - Victorian hospitals developing a hospital in the home model of care for mental illness (MHV and VHA, sub. 1184).

While hospital in the home services can help to improve patient flow and divert demand, such services are only appropriate for people who meet a given criteria. These patients include are those:

- whose acute episode is very likely to be short term
- who have a carer at home
- where required visits from health professionals are not so frequent as to be impractical and uneconomic compared with being treated in a hospital
- where any workplace health and safety concerns for professionals in visiting a patient's home are manageable.

There are also practical difficulties in implementing hospital in the home services. In Western Australia, hospital in the home beds have increased from 14 to 48 between 2014 to 2017, but occupancy rates have fallen to below 70% — far below the target occupancy rate of 85%, which reduces their cost-effectiveness (OAGWA 2019). It has been suggested that the eligibility criteria may have limited the number of people who could access the service, and this should be taken into account if States and Territories decide to ramp up hospital in the home services.

Improving the effectiveness of acute care

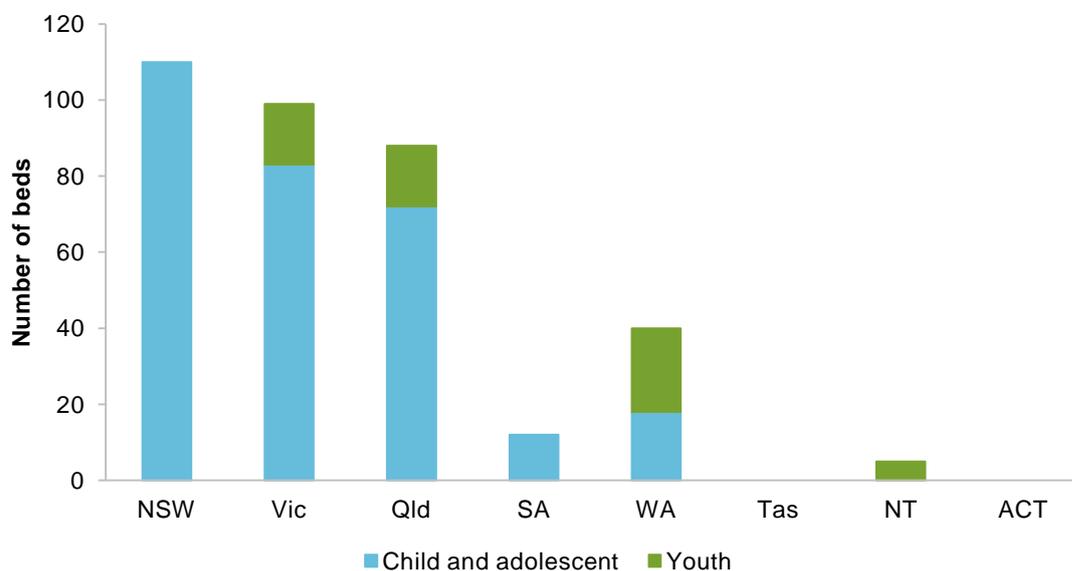
Mental health beds for young people

About 5% of mental health beds in the public sector were specifically for children, adolescents, and youth in 2017-18 (AIHW 2020n).¹²¹ This conceals significant differences between states and territories, with two jurisdictions — Tasmania and the ACT — having no mental health beds specifically for young people (figure 13.8).

The Northern Territory opened its first young persons' mental health facility in early 2016 with 5 beds, attached to the Royal Darwin Hospital (Sorensen 2016). In the ACT, there are plans for the first private adolescent mental health unit to open in 2020, and for a public adolescent mental health ward to open in 2022 (White 2019).

¹²¹ Child and adolescent beds are targeted at those aged under 18 years, and youth beds for those aged 18–24 years.

Figure 13.8 Mental health beds specifically for young people, 2017-18^{a,b}



^a Public sector specialised mental health hospital beds. No mental health beds for young people are provided in public hospitals in Tasmania or the ACT. ^b Child and adolescent beds are primarily targeted at people aged under 18 years, and youth beds at those aged 18-24 years.

Source: AIHW (2020n).

When there are no dedicated mental health beds available for children and adolescents, there is a risk that they will be placed in either:

- adult mental health wards, where their safety may be threatened by adult patients
- paediatric wards, where staff may have insufficient skills in mental health.

No children or adolescents should be placed in an adult mental health ward — it is important for treatment to be delivered in a safe and youth appropriate environment (headspace – National Young Mental Health Foundation, sub. 947). If it is not possible for a public hospital to provide child and adolescent mental health beds which are separate from adults, the relevant State or Territory Government should explore options for contracting services from private providers or have the capacity to provide an alternative form of care, such as hospital in the home for children and adolescents.

An alternative to overnight stays in hospital are day programs for children and adolescents. These programs are designed to provide children and adolescents with supported education and clinical treatment (Queensland Health 2020). For example, the Queensland Children’s Hospital runs a program in collaboration with Education Queensland for people aged 5–18 years, which allocates a primary therapist to each young person and involves the parent/carer as part of the recovery process (Queensland Government 2020).

Under these programs, parents/carers are able to drop off their children in the morning and pick them up after work, with their children staying home overnight. These day programs alleviate the problem of building a physical hospital unit specifically for a group of patients which may not always be fully utilised.

Gender-separated wards

People being treated in inpatient units are often already in a vulnerable state, and women have reported feeling unsafe and experiencing physical and sexual violence, which can lead to re-traumatisation and prevent recovery (QAMH, sub. 714). In Victoria, about 80% of complaints about sexual safety in acute inpatient care were reported by women, and 83% of perpetrators were men (WHV, sub. 773).

We were both very scared to go out of the woman's only section as some of the men terrified us. I was so glad that we could stay in a room doing puzzles and not be concerned about some of the aggressive patients. (Linda Fenton, sub. 629, p. 7)

... I'll say that my mum and I think that improvements need to be made to the prevention of inpatient sexual abuse. ... So there are practices that occur in inpatient mental health services where gender segregation doesn't happen and, you know, we all know that there'd be reasons for that; lack of beds and so on. But, you know, if someone gets raped in hospital this is re-traumatising them, it is going to prevent recovery. So that needs to be taken a lot more seriously and from a legal perspective as well, that duty of care is potentially being lapsed there. (Sjon Kraan, Perth transcript, p. 31)

People should not have to face this serious concern about their safety during their stay in care, and gender-separated wards can assist in preventing violence and improve safety for women (Kulkarni et al. 2014). This should be considered in the future when designing and renovating acute inpatient wards.

ACTION 13.2 — MENTAL HEALTH BEDS FOR PEOPLE WITH ACUTE CARE NEEDS

Inpatient services need to be safe spaces for children, adolescents, and women.

Start now

State and Territory Governments should provide child and adolescent mental health beds that are separate to adult mental health wards. If it is not possible to provide these beds in public hospitals, State and Territory Governments should create the capacity to offer alternative services for children and adolescents, such as hospital in the home or day programs, or explore options for contracting the services from private providers.

Start later

When designing and renovating acute inpatient wards, State and Territory Governments should establish wards that can be configured to allow for gender segregation.

The hospital workforce

Participants have suggested that poor experiences in acute and emergency care have been driven in part by the workforce. For example, Mental Health Carers NSW (sub. 1231, att. 1, p. 20) mentioned, in relation to acute mental health services:

- a stigmatising and discriminatory culture was pervasive across all levels of the workforce
- that there were staff with insufficient skills and mental health knowledge working with mental health consumers.

It has also been suggested that there could be an expanded role which peer workers could play in hospitals.

- People staying in hospital could be provided access to peer workers for support and advocacy (UnitingSA, sub. 807).
- Further utilising peer workers to assist people to navigate primary care, specialist, and hospital services (NMHCCF, sub. 708).

The Productivity Commission has made recommendations in chapter 16 and chapter 8 to address these views. Educating health professionals on the roles and values of peers workers (action 16.5) and training staff to appropriately deliver mental healthcare without stigma and discrimination (action 8.1) will go a long way in improving the experience for people in hospitals.

Culturally capable care for Aboriginal and Torres Strait Islander people

For hospital services to be effective, the care provided to Aboriginal and Torres Strait Islander people must be culturally capable. The Commission has been told that this remains an issue in the current system:

... limited access to culturally appropriate, hospital and mainstream services for Aboriginal people who are self-referred or referred by their local ACCHSs remains a significant issue. (AH&MRC, sub. 206, p. 3)

Most Aboriginal and Torres Strait Islander people want to be able to access services where the best possible mental health and social and emotional wellbeing strategies are integrated into a culturally capable model of health care. This approach needs an appropriate balance of clinical and culturally informed mental health system responses, including access to traditional and cultural healing. (IUIH, sub. 1108, p. 24)

Being Indigenous I would have liked to have been connected with the hospital's Indigenous support staff during my stay. (NSW Health 2019e, p. 23)

There are many ways in which cultural capability can be incorporated into the service delivery in hospitals. This could include employing Aboriginal and Torres Strait Islander mental health workers, training culturally capable staff, or funding specialist Aboriginal and Torres Strait Islander-led services.

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- The Wungen Kartup Mental Health Service in Western Australia is a provider of culturally capable mental health services for Aboriginal people, and collaborates with hospital inpatient units to ensure the person is receiving appropriate care (WA DoH 2019b).
 - In the Northern Adelaide Local Health Network, Aboriginal traditional healers (Ngangkari) work alongside doctors treating people in hospitals (NACCHO, sub. 1226).
 - At the Bloomfield Hospital in New South Wales, about one-third of hospital patients were Aboriginal and Torres Strait Islander people — in response, the peer support worker program recruited peer workers who identified as an Aboriginal and Torres Strait Islander person to help provide culturally capable services (Mission Australia, sub. 487).

13.4 Improving non-acute mental health services

Addressing the supply of non-acute beds

Non-acute beds are a necessary service in the mental health system, helping to improve people's mental wellbeing and avoiding deterioration of mental wellbeing over an extended period. However, as discussed in section 13.1, a mismatch between need and the limited resources in the system has resulted in delayed discharge — a symptom that points to a shortage of non-acute beds.

What have States and Territories said about the supply of non-acute beds?

For non-acute beds, the *Western Australia Mental Health, Alcohol and Other Drug Services Plan* distinguished between beds in hospital and in the community. In 2017, Western Australia had:

- 328 community mental health beds, which was about 80% of the benchmark
- 79 hospital non-acute beds, about 50% of the benchmark
- 48 hospital in the home beds, about 65% of the benchmark (WAMHC 2019, pp. 60, 69).

The *South Australia Mental Health Services Plan* indicated that in 2018-19, South Australia had about 180 non-acute beds (including sub-acute beds), while the NMHSPF benchmark said that about 490 were required — a shortfall of about 65% (SAMHC 2019, p. 43). However, South Australia was also found to have a *surplus* of acute beds — with about 370 beds provided in 2018-19, against the NMHSPF benchmark of about 280 beds (SAMHC 2019, p. 43). However, rather than pledging to close these beds, the South Australia Mental Health Commission (SAMHC 2019, p. 44) argued that:

Consensus opinion in the development of the Plan is that closing [the surplus] adult acute beds and replacing them with an approximately equivalent number of long term beds is not recommended based on the current state of services and system demands.

The South Australia Plan recommended that the acute inpatient beds remain, but ‘would be operated flexibly along the lines of beds in medicine and surgery that are open and closed as required, with full transparency of the number of beds opened on any particular day’ (SAMHC 2019, p. 44).

Such reasoning is completely appropriate. The NMHSPF is meant to provide a guide to what is appropriate in a particular region, but governments and regional commissioning bodies should use it as a tool, and be prepared take regional circumstances into account in planning services for the future.

The gaps in state and territory community residential services identified above have long been recognised by governments. And some efforts have been made to fill them. For example, Victoria, Queensland and Western Australia have made significant recent outlays on step up/step down units (MHCC 2018, p. 10; Victorian Government 2019, p. 12). And per capita expenditure on state and territory community ambulatory and community residential services has grown by more than 10% in real terms over the past decade (AIHW 2020d).

A national gap analysis

In 2017-18, Australia had about 1200 non-acute public hospital beds, and about 1400 non-acute community beds, totalling about 2600 beds (excluding older adults and forensic beds). This compares to the NMHSPF benchmark of about 4000 beds (figure 13.9), implying a shortfall of about 35%.

The NMHSPF categorises older adults (aged 65 years and over) separately. In 2017-18, there were about 200 non-acute hospital beds and 550 community residential beds with 24-hour staffing for this age group (AIHW 2020n). However, there are outstanding issues related to how jurisdictions classify non-acute beds for older adults, which mean it is not possible to accurately report the gap in older adult non-acute beds. Nonetheless, the imperfect data available indicates that there is also a very large gap in non-acute beds for older adults. In addition, the required number of non-acute beds for older adults is set to grow rapidly over the next decade, as the population ages — the number of Australians aged 65 years and over is projected to grow from about 4.1 million in June 2020, to about 5.5 million in June 2030 (ABS 2018f).

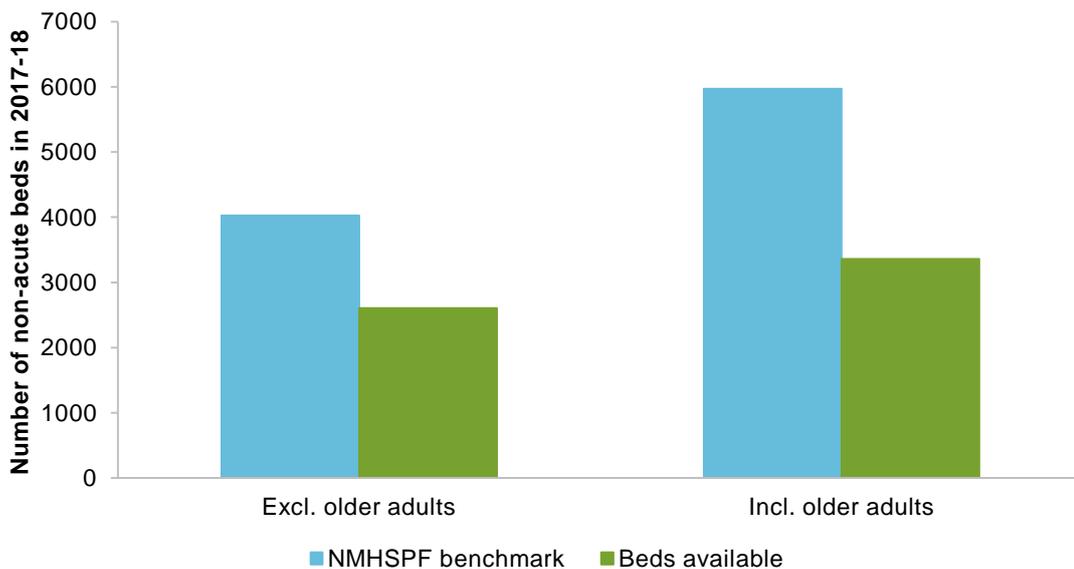
Expanding the supply of non-acute beds can reduce delayed discharge

The provision of additional non-acute beds can reduce demand for acute care by reducing the extent of delayed discharge. If there are 1800 acute beds being taken up by people who could be better treated in a non-acute bed, then this implies that up to 650 000 inpatient bed-days are being forgone per year that could be used to provide care to consumers that are currently missing out. With an average length of stay of 15 days for people in public acute

hospitals (AIHW 2020k), this would mean freeing about 43 000 episodes of acute inpatient care for people that are currently missing out.

Moving people requiring long-term clinical care into more appropriate alternative care settings would effectively increase acute bed capacity in hospitals without expanding bed numbers. It would also improve access to care for those who need short-term stabilisation. (OAGWA 2019, pp. 25–26)

Figure 13.9 The shortfall in public non-acute mental health beds^{a,b,c}



^a Includes sub-acute and non-acute beds as defined by the NMHSPF. ^b The estimates are based on 2017-18 data and benchmarks, adding together children, youth, and adult for the bars on the left, and including older adults on the right. ^c The estimates which include older adults may be inaccurate as some residential or nursing home-based services modelled in the NMHSPF may not be counted in the AIHW data. This means that the true gap is likely to be smaller.

Source: AIHW (2020n); Productivity Commission estimates using the National Mental Health Service Planning Framework.

While delayed discharge harms people by reducing the potential number of people who could be treated, there is also an indirect cost from matching people with non-acute needs with an acute bed — that is, the inefficiencies from matching a person with the wrong level of care. This difference represents wasted mental health resources, which could be spent providing other people with services they need. There are huge cost differences between providing different sorts of mental healthcare. On average, the daily cost for:

- an acute bed in a public hospital is about \$1240
- a non-acute bed in a public hospital is about \$970
- a community residential bed with 24-hour staffing is about \$580 (SCRGSP 2020d).

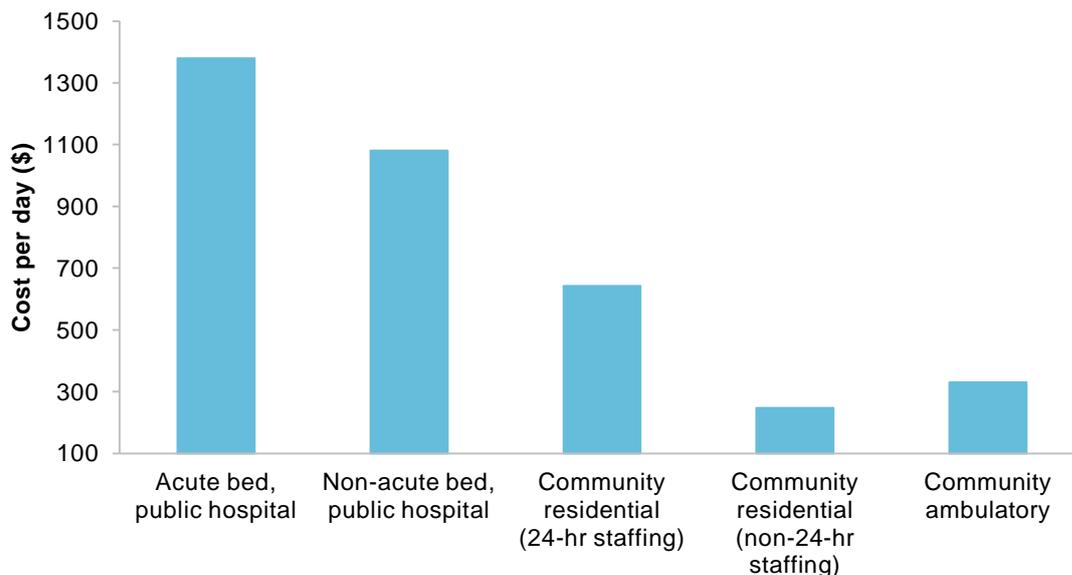
The average daily cost difference between an acute hospital bed and a community residential bed is about \$660. Of the 650 000 inpatient bed days identified above, if half were patients in acute care that could be accommodated in community residential care, it would represent a potential resource saving of over \$200 million annually.

The Western Australian Auditor General had made the same point:

Providing options for people needing long-term clinical care out of hospitals is more cost effective. The State currently has Jacaranda House, which provides long-stay mental health care for people with enduring, severe mental illness. ... [B]eds at Jacaranda House cost around \$435 a day, over \$1,000 less than a bed day in an acute hospital bed. (OAGWA 2019, p. 26)

The resource saving could be even larger for those consumers who are able to be accommodated in public housing or supported accommodation (without 24-hour staffing), along with receiving community ambulatory services (figure 13.10).

Figure 13.10 An acute hospital bed is the most expensive care option^{a,b}
2017-18 dollars



^a We take account of the fact that community ambulatory services often provide reach-in services for acute and community residential care. Based on information provided by States and Territories, it is estimated that reach-in services increases the cost of both acute inpatient care and community residential care by about 5%, and decreases the cost of community ambulatory care by about 5% (Productivity Commission estimate using AIHW, pers. comm., 17 March 2020). ^b Also included are capital costs equal to 6% of recurrent costs for bed-based care and 4% for community ambulatory care (Rosenheck, Frisman and Neale 1994).

Source: AIHW (2020e); SCRGSP (2020b, chapter 13).

Can additional non-acute beds be a cost effective option?

The Productivity Commission has considered two alternative approaches for estimating the benefits and costs of increasing the supply of beds, to match the benchmarks from the NMHSPF. The national gap analysis suggests that the supply of acute beds is close to sufficient, and so any additional beds should be non-acute beds provided either in hospitals or in the community. Supplying additional non-acute bed can result in either:

- treating a person who requires non-acute mental health services, but was not being treated previously — this means more people with non-acute needs can be treated
- moving a person with non-acute needs out of an acute hospital bed, thus reducing the extent of delayed discharge — this means more people with acute needs can be treated.

Of course, in practice, supplying additional non-acute beds is likely to result in a combination of these outcomes. However, for the purpose of modelling whether additional non-acute beds are cost effective, the Productivity Commission has separately considered these alternatives (appendix I and appendix K). The modelling assumes that, under either alternative, there are no cost savings on acute inpatient services as any additional bed days would be taken up.

Taking all costs and benefits modelled into account, the results suggest that if additional non-acute beds only resulted in more people being treated then this is unlikely to be cost effective. The number of additional people who can be treated using a non-acute bed per year is relatively small. And in the most severe, but not uncommon cases, the non-acute bed may be occupied by a single person for the entire year.

In contrast, if additional non-acute beds only lead to moving people with non-acute needs out of acute hospital beds, then additional non-acute beds may be marginally cost effective. It allows more people who require an acute bed to be treated. With a substantially lower average length of stay, each case of delayed discharge mitigated can, on average, result in an additional 22 people per year utilising the acute bed, allowing for more health-related quality of life benefits and labour force benefits. If the additional non-acute beds were to be provided in a community residential setting, the costs would also be lower than providing a combination of hospital and residential beds. However, even under this alternative, supplying additional non-acute beds remains marginally cost-effective.

Nevertheless, while acute and non-acute beds are one of the more costly options for treating people, in many cases they are the only option. Gaps in mental health services (including bed-based services) should be estimated and published at a national level, state and territory level, and regional (PHN or RCA) level (chapter 24). State and Territory Governments should, with support from the Australian Government, over time increase funding for mental health bed-based services to the level required to meet population needs.

ACTION 13.3 — DELIVERING BED-BASED MENTAL HEALTH SERVICES

People who require treatment provided by bed-based services should be able to access these services.

Start now

The shortfalls in sub-acute and non-acute mental health bed-based services should be estimated and published at both State and Territory and regional levels.

Start later

State and Territory Governments, with support from the Australian Government, should increase funding for these services, in line with agreed commitments to rectify service shortfalls over time.

Treatment in the community can be preferable to a hospital

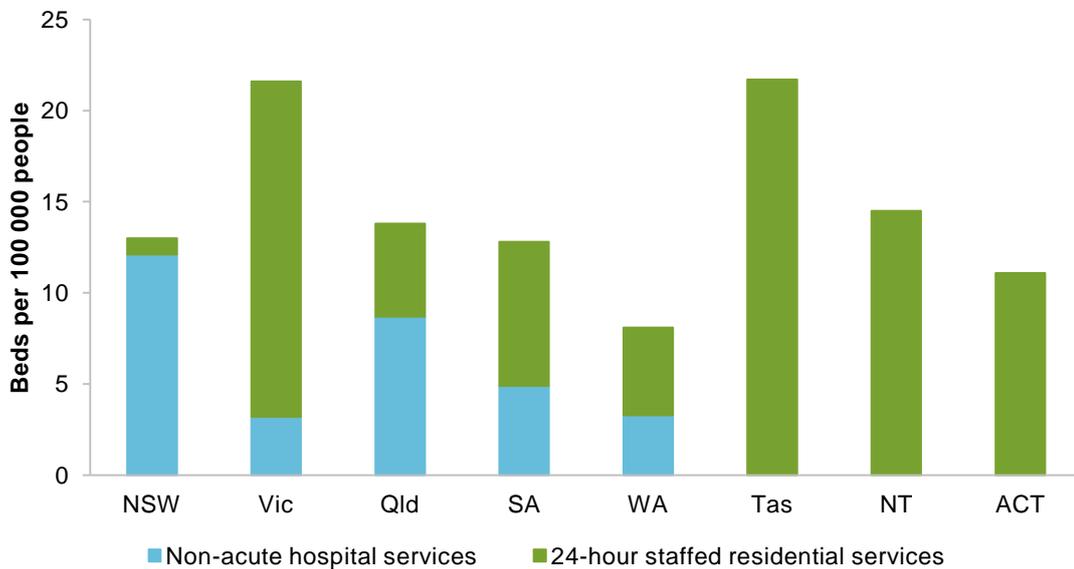
Most people experiencing delayed discharge need both accommodation and clinical treatment, either separately (community ambulatory services along with accommodation support), or together (non-acute community residential care). Community and hospital non-acute beds are to some extent substitutable, although there are important differences. Non-acute hospital beds, for example, tend to be able to accommodate consumers with greater risk of harm to themselves or others (QCMHR 2016), and consumers often prefer to receive services in the community. Different jurisdictions have very different mixes of public hospital and community non-acute beds (figure 13.11). These differences are partly historical, but also reflect an ongoing debate within the sector about which is best for different types of consumers.

Care in the community can often be preferred by people. The Royal Commission into Victoria's Mental Health System found that:

Many people living with mental illness and their families and carers prefer to be treated in their home or in a community residential facility because it is less disruptive, more familiar and less stigmatising. For many people, a hospital-based setting can be intimidating and upsetting. (State of Victoria 2019, p. 432)

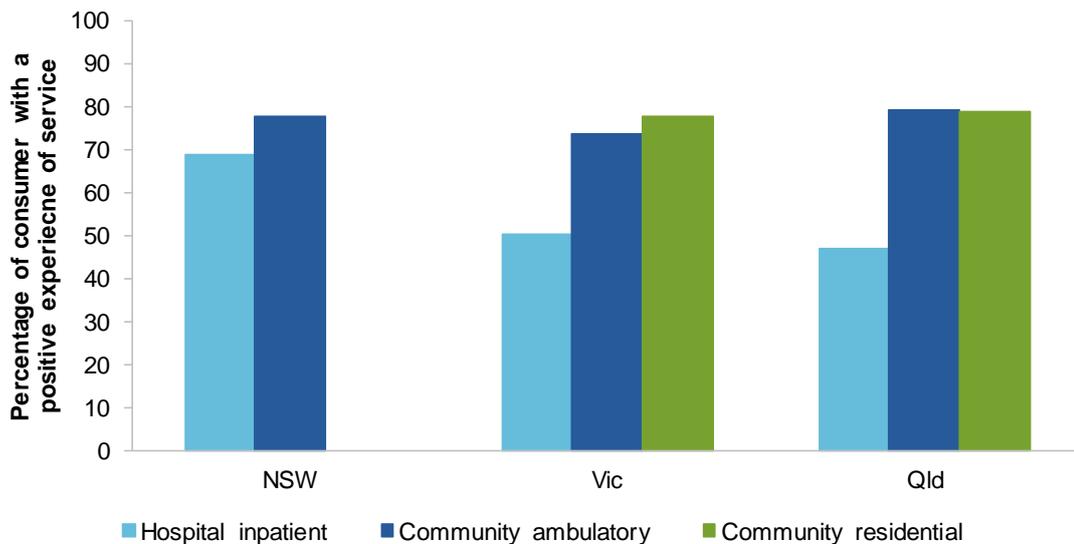
In addition, survey data from three States show that consumers are much more likely to have a positive experience of service in community ambulatory care or community residential care than in hospital admitted care (which includes both acute and non-acute) (figure 13.12). In New South Wales, the Your Experience of Service survey found people who had stayed in hospital for more than 6 months were less likely to report a positive experience compared with someone receiving treatment in the community (for more than 6 months) (NSW Health 2019e).

Figure 13.11 **States have different mixes of hospital and community non-acute beds^{a,b}**
2017-18



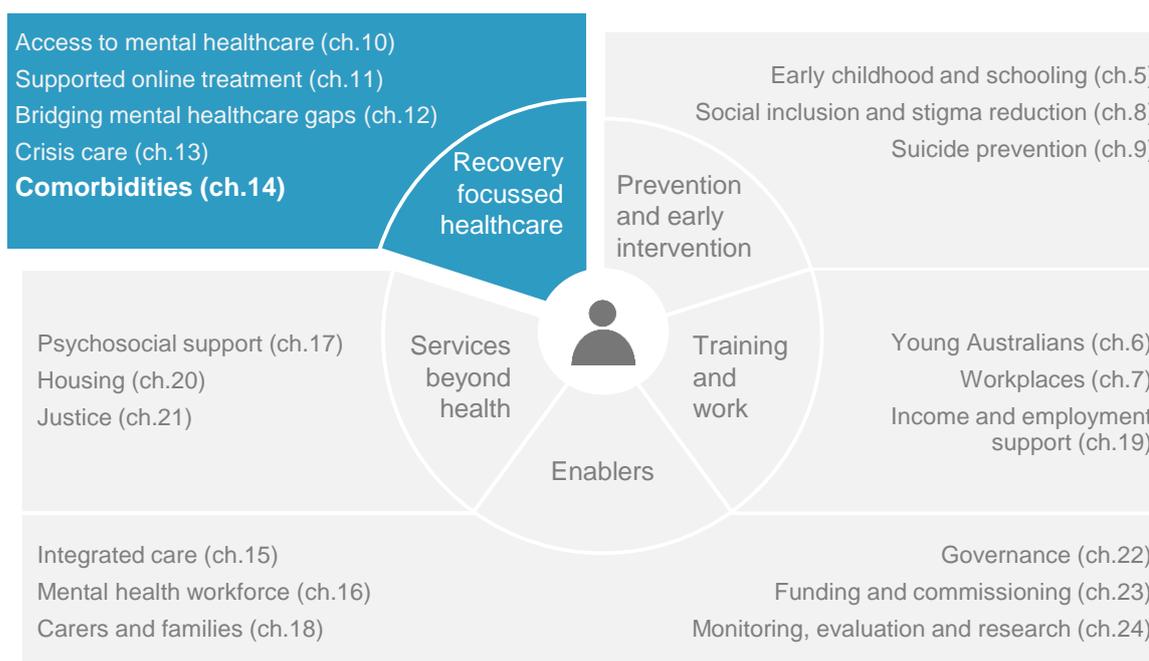
^a Public sector non-acute hospital beds. ^b Community sub-acute and non-acute beds with 24-hour staffing.
Source: AIHW (2020n).

Figure 13.12 **More consumers have a good experience in community care^a**
2017-18



^a Data are not comparable across jurisdictions.
Source: SCRGSP (2020b, chap. 13).

14 The life expectancy gap: physical and substance use comorbidities



Addressing mental health and physical health comorbidities matter because ...

- Many people with mental illness experience poor physical health and/or adverse health consequences from substance use, including reduced life expectancy.
- There is a two-way relationship between mental illness and comorbidities, with mental illness often leading to poor physical health and substance misuse, and vice versa.
- Intervening to provide integrated care that addresses both an individual's mental health and comorbidity needs would lead to improved outcomes for the individual and the wider community.

RECOMMENDATION 14 — IMPROVE OUTCOMES FOR PEOPLE WITH COMORBIDITIES

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

As a priority:

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

Additional reforms that should be considered:

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

People with mental ill-health often experience other health-related issues, including physical and substance use comorbidities, which lead to poor outcomes. Despite the acknowledgement of the importance of improving care and outcomes for people with comorbidities and the numerous initiatives aimed at achieving this, progress is frustratingly slow in some areas and outcomes remain poor. For example, physical comorbidities account for much of the average 10–15 year mortality gap between people with severe mental illness and the general population.

Reforms are required to ensure that people with comorbidities can get care for both their mental health needs and their comorbid conditions. To improve outcomes for people with physical comorbidities, governments need to agree to a target to reduce the gap in average life expectancy between people with severe mental illness and the general population. As well, governments need to implement all the initiatives in the Equally Well Consensus Statement, and release clear statements detailing how they will implement initiatives so that progress can be measured (Action 14.1).

To improve outcomes for people with substance use comorbidities, governments and regional commissioning bodies should integrate the planning and commissioning of substance use and mental health services. In addition, mental health services should be required to ensure that treatment is provided for both mental illness and comorbid substance use disorders, either through directly providing care, or ensuring adequate referral pathways are in place (Action 14.2). To help facilitate this, guidelines covering screening and treatment for comorbidities, and training and other resources for workers, will be required.

To ensure progress is made in improving care and outcomes for people with comorbidities, governments need to improve their monitoring and reporting in this area (Actions 14.1 and 14.2, chapter 24).

14.1 Physical comorbidities

People experiencing mental ill-health have a relatively high rate of physical illness compared with the rest of the population, which can lead to lower quality of life and premature death. However, many people with physical comorbidities do not receive effective and integrated treatment for both their physical and mental ill-health. There is significant scope for governments to improve care for people with mental and physical health comorbidities.

Many people with mental ill-health have physical comorbidities

According to the 2007 *National Survey of Mental Health and Wellbeing*, 59% of adults who experience mental illness in a given year also have at least one physical health problem,

compared with 48% of adults without a mental illness (chapter 2). The Royal Flying Doctor Service Tasmania (Launceston transcript, p. 85) stated:

... 90 per cent of our clients come to us with comorbidities. Mental health and physical health go hand in glove, and as Reverend John Flynn said 90 years ago, the mind and body are integrated yet inseparable, and we see that all the time and that's how we work with the program.

International and Australian evidence indicates that people with mental illness:

- are more likely to be diagnosed with a respiratory disease
- are two to three times more likely to be diagnosed with type 2 diabetes
- are six times more likely to die from cardiovascular disease
- have high rates of chronic pain
- have high rates of overweight/obesity
- are twice as likely to have osteoporosis
- are 50% more likely to have cancer
- are six times more likely to have a dental health issue (ACDPA and Quit Victoria, sub. 140, p. 2; Cancer Council Australia and the National Heart Foundation of Australia, sub. 702, p. 3; COAG Health Council 2017a, p. 36; Painaustralia, sub. 680; Restart Health Services, sub. 705, p. 2).

There is a two-way relationship between mental ill-health and physical health problems, with physical illness often leading to poor mental health as well as vice versa. People with chronic health conditions are more likely to experience anxiety and depression (APS, sub. 543, p. 26; Duggan 2015, p. 9; Michael Epstein, sub. 656, p. 5; VicHealth and Partners, sub. 131, p. 17). Particular chronic conditions noted to lead to a higher chance of mental ill-health include cardiovascular diseases, musculoskeletal disorders, obesity, pain and stroke (ACDPA and Quit Victoria, sub. 140, p. 3; AHPA, sub. 834, p. 2; Duggan 2015; Stroke Foundation, sub. 281, p. 1; VicHealth and Partners, sub. 131, p. 17). For example, a respondent to a survey on the impact of chronic pain stated:

It's impossible not to feel a certain level of depression, anxiety, fear and hopelessness when you deal with persistent pain. Addressing these issues would go a long way to helping people live with persistent pain. (Painaustralia, sub. 172, p. 1)

Common comorbidities are not just limited to physical illness. There is also a higher prevalence of intellectual and physical disabilities in people with mental ill-health (box 14.1).

Box 14.1 Other comorbidities

Intellectual disability

Intellectual disabilities or impairments affect a person's intellectual functioning (learning, problem solving, judgement) and adaptive functioning (work, leisure and activities of daily life such as communication and independent living) (APA 2020). Australians with intellectual disability experience mental ill-health at a far greater rate than the general population, with estimates that 57% have a mental illness (Dew et al. 2019).

Specific genetic conditions associated with intellectual disability can increase the risk of mental illness, as can developmental brain abnormalities and certain medications and their side effects. They also tend to receive less social support, a protective factor against developing mental ill-health (Lippold and Burns 2009). People with intellectual disability also risk more physical health conditions, which in turn increase the risk of mental illness. Additionally, for people with more severe intellectual disability or communication difficulties, mental illness may be interpreted by others as problem behaviours or overlooked as an issue relating to the person's intellectual disability (Achieve Australia 2019a; NSW MHC 2017b).

Autism spectrum disorder

Autism spectrum disorder is a neurodevelopmental disability that affects the way people communicate and interact with the world (Amaze 2020). Autism involves persistent deficits in social communication and interaction, as well as restricted, repetitive patterns of behaviour and interests (APA 2013).

Studies have found that people with autism are at higher risk of mental ill-health than the general population (Foley and Trollor 2015; Hofvander et al. 2009). Additionally, a recent Australian study found that having a comorbid mental health condition significantly increased mortality risk for people with autism (Hwang et al. 2019). People with autism experienced risk factors for mental ill-health at higher rates than the general population (AMAZE, sub. 825, p. 5; Autism Aspergers Advocacy Australia, sub. 561, p. 1), including difficulties at school, social isolation and stigma (Ashburner, Ziviani and Rodger 2010; Kinnear et al. 2015; Orsmond et al. 2013).

Physical disability

Physical disabilities affect a person's mobility, physical capacity, stamina, or dexterity. Examples include brain or spinal cord injuries, multiple sclerosis, cerebral palsy and epilepsy. The causes are varied and they usually fall into one of two categories: hereditary/congenital or acquired (Achieve Australia 2019b).

Studies have found that people with physical disabilities are more likely to experience mental ill-health due to greater social isolation, less social support, increased financial strain, and elevated risk of substance disorders (Tough, Siegrist and Fekete 2017; Turner, Lloyd and Taylor 2006; Turner and Noh 1988; Turner and Turner 2004).

Acquired brain injury

An acquired brain injury (ABI) refers to any type of brain damage that occurs after birth (AIHW 2007). It can be as a result of accidents or trauma, stroke, brain tumours, infection, poisoning, lack of oxygen to the brain and degenerative neurological disease (AIHW 2014).

(continued next page)

Box 14.1 (continued)

Mental illnesses, such as depression and anxiety, are prevalent after a brain injury (Jorge et al. 2004; Scholten et al. 2016). A number of factors may adversely influence the mental health of a person with ABI, such as the direct effects of the ABI (cognitive and motor disturbances), personality changes, changes in capabilities and competencies post-injury, and permanent changes in work status, role, income, family life, support networks and quality of life (Queensland Health 2017).

Additionally, there are high rates of comorbidity between ABI, substance use disorder and mental illness (NT Government, sub. 1220, p. 6). Higher rates of substance use disorder result in higher rates of ABI and substance use disorder is likely to adversely influence a person's mental health.

Dementia

Dementia is a collection of symptoms caused by disorders affecting the brain. It is characterised by gradual impairment of brain function and symptoms include impaired memory, speech, cognition, behaviour and mobility. It can also lead to a changes in personality, and is a terminal condition (AIHW 2020c; Dementia Australia 2017; DoH, sub. 556, p. 34).

Mood disorders are common in people with dementia. About 20–30% of people with dementia also experience depression. Because of the similarities in symptoms between dementia and depression, including impaired ability to think and concentrate and problems with memory, it can be difficult to separate the two conditions, sometimes leading to incorrect diagnoses in older people (Beyond Blue nd; DoH, sub. 556, p. 34).

Experiencing mental and physical ill-health together often involves poorer outcomes for individuals than if they experience mental illness or physical ill-health alone. It is associated with:

- higher psychological distress
- greater disadvantage — they are more likely to live in an area in the lowest quintile for socioeconomic status
- decreased ability to function — they are more likely to have been unable to work or carry out their normal activities for more than 7 out of the past 30 days
- reduced workforce participation — they are more likely to be unemployed or not in the labour force (AIHW 2012a).

The interaction between physical and mental ill-health also increases healthcare use and costs (Duggan 2015, p. 11; Mental Health Australia, sub. 864, p. 19). For example, people who have a physical health condition in addition to depression incurred increased costs of care (excluding direct mental healthcare costs) of between 33% to 169% (ACDPA and Quit Victoria, sub. 140, p. 4; Duggan 2015). In Victoria in 2016-17, the cost of mental health patients admitted to public hospitals was 39% higher than for the average inpatient stay and 77% higher for an emergency department attendance (VIC DHHS 2019a, p. 11). The Australian BPD Foundation (sub. 267, p. 2) noted:

The poorer physical health status of those with [Borderline Personality Disorder] lead[s] to more utilisation of general medical services, pharmaceutical services and to longevity less than a comparable age cohort.

Physical ill-health is not only more common in people with mental ill-health, but also tends to result in earlier death. People with severe mental illness are estimated to die 10–15 years earlier than the rest of the population. It is estimated that physical illnesses cause almost 80% of the gap in average life expectancy between people with severe mental illness and the general population, compared with 14% of the gap being due to suicides (Harris et al. 2018; Lawrence, Hancock and Kisely 2013). Moreover, many of the physical illnesses from which people with mental illness die — cardiovascular disease, respiratory disease and some cancers — have effective treatments that are commonly used by the rest of the population (Harris et al. 2018; NSW MHC 2018; RANZCP 2015). In addition, ‘people accessing mental health-related [Medicare Benefits Schedule] and [Pharmaceutical Benefits Scheme] services constitute over half of the all premature deaths in Australia due to physical health conditions’ (Equally Well Australia, sub. 833, p. 1).

Mental illness can also exacerbate the mortality rates of physical ill-health. Duggan (2015, p. 10) noted that cardiovascular patients and people with asthma have higher mortality rates if they also have depression.

The Victoria Institute of Strategic Economic Studies estimated the annual cost of comorbidities associated with premature death in people with serious mental illness in 2014 was about \$15 billion (ACDPA and Quit Victoria, sub. 140, p. 4; RANZCP 2016b). In addition, Medibank Private estimated the total direct cost of comorbid physical and mental health conditions at \$1.96 billion (Medibank and Nous Group 2013).¹²²

It is not just the people with mental ill-health who are more likely to experience physical ill-health — carers are also more likely to experience physical ill-health (Mental Health Commission of New South Wales, sub. 486, p. 27). Mental Health Carers NSW (sub. 245, p. 6) stated that carers are significantly more likely to experience poor physical health compared with the general population.

Why is physical health worse for people with mental ill-health?

The mechanisms underlying the relationship between mental and physical health are complex. There is a two-way relationship between mental and physical ill-health, and they share common risk factors, which can further exacerbate one or both conditions (CMHA, sub. 449, p. 19; Justin Kenardy, sub. 6, p. 1; VicHealth and Partners, sub. 131, p. 17). However, the literature points to multiple causes of physical comorbidities that are, to some extent, avoidable (Harris et al. 2018; NSW MHC 2018; RANZCP 2015).

- Many of the symptoms of mental ill-health are also known risk factors for physical ill-health, including being sedentary, lacking motivation, experiencing cognitive impairment, and poor diet (ACDPA and Quit Victoria, sub. 140, p. 2; Cancer Council

¹²² Equally Well Australia (sub. 833, p. 2) argued this is likely to be an underestimate as ‘it only includes the 12 main chronic conditions, and does not include paediatric, physician or GP services not recorded with a mental health item number’.

Australia and the National Heart Foundation of Australia, sub. 702, p. 3; Duggan 2015; RANZCP 2015).

- Mental illness is associated with higher rates of smoking and substance use, which can also lead to physical ill-health (ACDPA and Quit Victoria, sub. 140, p. 1; AIHW 2012a; RANZCP 2015). For example, people with mental illness are much more likely to smoke than the general population, which can then lead to a raft of physical health and other problems (box 14.2).
- Some treatments for mental and physical illness can exacerbate the other condition. Michael Epstein (sub. 656, p. 5) noted that some medication used to treat physical illness can adversely affect mental health. As well, some mental health medications can cause significant weight gain, increasing the risk of obesity, diabetes, cardiovascular disease and metabolic syndrome (Duggan 2015, p. 8; NSW MHC 2018; RANZCP 2015).

One of the things that's happened is that his physical weight has ballooned out. You'd be aware, of course, that the antipsychotic medication has clearly increased the appetite, and that's one of the factors in that. ... He was about 72 kilograms when he fell into psychosis. A fit, slim, young man. Now he's about 105 or 106. So his weight's gone up 50 per cent in 12 years, and that creeps up on you. I mean, it's three kilograms a year. ... He wants to bring his weight down. He's trying to do that; he struggles. (Restart Health Services, Melbourne transcript, p. 41)

- Many people with physical comorbidities do not receive treatment for all their needs, and the treatment they receive can be lower quality (discussed below).

Many people with physical comorbidities are not receiving effective care

Given the gap in life expectancy between people with severe mental illness and the rest of the population is predominantly driven by physical comorbidities, there are strong arguments for intervening to provide specialised and integrated care to people experiencing mental and physical ill-health.

While preventing mental health conditions will generate significant social and economic benefits, linking this with efforts to improve the prevention and management of closely related co-morbid conditions such as chronic disease, alcohol and substance misuse, and problem gambling, has the potential to generate even greater gains. (VicHealth and Partners, sub. 131, p. 4)

However, many people are not receiving effective and coordinated care (APS, sub. 543, p. 26; Mental Health Australia, sub. 864, p. 19; Michael Epstein, sub. 656, p. 5). People with comorbid physical and mental illness are 50% less likely to receive treatment for their physical ill-health than people with only a physical health condition (COAG Health Council 2017a, p. 36). In addition, the Consumers Health Forum of Australia (sub. 646, pp. 6–7) stated:

A major issue for our constituency is physical and mental health comorbidity and the management of multimorbidity, which is becoming increasingly commonplace and is not well managed in the current health system. Many consumers' experience of the system is one of fragmented, disconnected services and care, and CHF has long advocated for a shift to coordinated, multidisciplinary clinical and non-clinical care.

Box 14.2 **Mental ill-health and smoking**

While the prevalence of smoking has declined over time in the general community, it remains high among people with mental illness. Compared with the general population, women with mental illness are 69%, and men are 38%, more likely to be smokers (Harris et al. 2018, p. 9). Smoking prevalence also tends to increase with the severity of mental illness and can also vary by diagnosis (Mendelsohn, Kirby and Castle 2015), with approximately two-thirds of people with psychotic disorders being smokers (Cooper et al. 2012).

These high rates of smoking have led to poor outcomes for people with mental illness. Notably, the gap in life expectancy between those with and without mental illness has widened over time, attributable to a number of smoking-related illnesses such as cardiovascular disease, respiratory disease and cancer (Lawrence, Hancock and Kisely 2013; Telethon Kids Institute, sub. 793, p. 1). Smoking is also associated with increased psychiatric symptoms, increased hospitalisations, and higher required psychiatric medication dosages (Prochaska 2011). These higher dosages can, in turn, increase the risk of poor metabolic health. Evidence has also shown that smoking can increase the risk of anxiety, depression and psychotic disorders including schizophrenia (ACDPA and Quit Victoria, sub. 140, p. 3).

Furthermore, smoking exacerbates financial stress and can reinforce the cycle of poverty and disadvantage experienced by people with mental illness (Telethon Kids Institute, sub. 793). It was estimated that in Australia in 2000, people with psychotic illness who smoked and were in receipt of a disability support pension spent more than one-third of their pension on tobacco products (Greenhalgh et al. 2020).

Quitting smoking for at least six weeks has been found to improve mental health, mood, and quality of life (Taylor et al. 2014). However, people with mental illness who smoke often have limited access to services to help quit, have smoked for a longer duration, and have lower rates of quitting successfully (Greenhalgh et al. 2020).

There exists a common misperception that people with mental illness do not want to quit, which can lead to a lack of encouragement and support to do so (Siru, Hulse and Tait 2009). A study of mental health centres found that the most common barrier to staff implementing smoking cessation treatment was a perceived lack of patient interest in quitting (Brown et al. 2015a). Although the presence of mental illness can make quit attempts more challenging and less successful (Cook et al. 2014), some studies have shown that they are just as likely as the general population to want to quit smoking (Prochaska 2011).

There is a growing body of evidence that supports the beneficial role of quitting smoking with improved mental health (Secades-Villa et al. 2017; Taylor et al. 2014). Smoking cessation interventions developed for people with mental illness have been shown to be effective, and there is scope to implement them more widely (discussed in more detail below).

The SA Mental Health Commission (sub. 477, p. 14) said:

South Australians also advised that there needs to be greater recognition of the interplay between physical and mental health. People are concerned that there are insufficient mental health services for those with physical health problems, and also that there is insufficient focus on the physical health of people with mental health problems.

Many Inquiry participants argued that services for people with comorbidities are siloed and not integrated, with a lack of co-operation and coordination across providers (One Door Mental Health, sub. 108, p. 10).

There is a general lack of co-ordination between physical and mental health services, and health professionals outside mental health services do not generally engage with people's mental health conditions. Given the high levels of co-existing illnesses and the reduced life expectancy of people with severe mental illness, such poor practice is unacceptable and is a cost carried by people and services. (Mental Health Commission of New South Wales, sub. 486, p. 22)

Despite the presence of [World Health Organization] physical health treatment guidelines for the management of co-existing physical and mental health conditions, the implementation of these guidelines is limited by service fragmentation, a lack of role clarity, a lack of whole person focus, and poor consultation with consumers. Collaboration between different streams of health services is often limited by different treatment approaches, and health services tend to focus on the treatment of single conditions. (NMHC, sub. 118, p. 21)

The siloing of care for people can be explained by professionals either not being confident in managing conditions outside their area of expertise (Duggan 2015), or viewing areas outside their expertise as not being relevant to their services. But the lack of coordination with other experts and care givers is less readily justified and is indicative of professionals lacking the training and/or support in providing coordinated care for people and in recognising the importance of a recovery for people that extends beyond just their mental health to their broader wellbeing.

Compounding these siloing issues, many people with mental illness are not adequately screened, or screened at all, for physical health problems (Wellways Australia, sub. 396, p. 18). 'Diagnostic overshadowing' — whereby all symptoms are interpreted as related to mental illness — is a commonly cited problem (Canberra Mental Health Forum, sub. 62, p. 8; NMHC, sub. 118, p. 21; RANZCP 2015; VCOSS, sub. 478, p. 16).

Yes, just like it took so long to get action on my depression when I got symptoms that turned out to be Chronic Fatigue syndrome - my GP actually didn't believe me that I was not suffering from my symptoms of my depression. I knew it was different. It's just like knowing the difference between your usual hay fever (I also suffer from) and catching a cold - yes they are similar, but you quickly start to realise the difference. So as much as I love my couple of brilliant GP's I have, they still didn't always listen to and believe me early on. (consumer cited in CHF, sub. 496, p. 52)

And from my experience of using systems ... as soon as you present with a mental health, or agitation, or anything that makes people think, that's a mentally ill person, that all goes out the door. You know, the physical health checks are just rudimentary, and they really ... should be ... more pronounced. (Colin Hales, Canberra transcript, p. 58)

Inquiry participations also argued that many people with physical comorbidities do not receive coordinated care due to stigma and discrimination (Equally Well Australia, sub. 833). Duggan (2015, p. 8) stated that the discriminatory attitudes of healthcare staff in primary and secondary care and specialist settings are inhibitors to people with physical comorbidities seeking help. The Canberra Mental Health Forum (sub. 62, p. 7) said:

Stigma and discrimination are substantial barriers to people with serious mental illness accessing physical health care. Fear of this can inhibit people with mental illness from seeking physical health care, or have a negative impact on medical and health professionals' attitudes when physical health care is sought.

Another particular area of concern is the side effects of medication. As discussed above, many medications for mental illness can have physical side effects, such as weight gain and high blood pressure. The Canberra Mental Health Forum (sub. 62, pp. 4–5) stated that healthcare professionals are often not aware of the complex interactions between the different medications people with physical comorbidities are taking due to the siloing of medical services. Inner South Family and Friends (sub. 129, p. 5) argued:

Our mental health services need to be accountable for their lack of attention to the general health of their patients. If a medico knew that a drug for treating (for example) arthritis was closely associated with diabetes and the medico failed to investigate diabetes and to treat it, the medico would be professionally negligent. Yet in mental health, systemic side effects are routinely accepted without management until it is too late. This situation is all the more disgraceful because much of this suffering could be prevented by routinely including dietary and physical health personnel in mental health teams.

The Victorian Council of Social Service (sub. 478, p. 28) said that many consumers report they are often not informed about the side effects of their medication. There is evidence these issues may be particularly problematic where evident among Aboriginal and Torres Strait Islander people (de Crespigny et al. 2005; Emden et al. 2005).

Some stakeholders also raised funding as a reason people with comorbidities do not receive integrated care. Primary Health Networks (PHNs) have reported that the lack of a clear funding mechanism to address physical health issues, limitations on existing funding structures, and segmented funding arrangements are barriers to improving the physical health of people with mental illness (Canberra Mental Health Forum, sub. 687, p. 2; NMHC 2018a, p. 33). The issue of separate governance and funding arrangements for physical and mental health is discussed further in appendix G.

These issues are not just confined to consumers in the mental health sector. Inquiry participants also noted that many people with chronic health conditions who have mental ill-health do not receive any support, or referrals for support from the physical healthcare providers. The Stroke Foundation (sub. 281, p. 7) stated that while 50% of stroke patients had some degree of mood impairment, mental health is ignored by many rehabilitation services. The Australian Psychological Society (sub. 543, p. 26) also raised concerns about the accessibility of psychological treatment for people with chronic conditions who are at risk of developing mental illness:

... access to psychological interventions to avert the development of mental illness is limited. Individuals at risk of mental illness and individuals whose symptoms do not yet meet formal criteria for a diagnosis, must rely on the Medicare Chronic Disease Management items to access psychological interventions. This initiative allows for five short treatment sessions per year shared among the multidisciplinary allied health team supporting the client.

What has been done so far to address physical comorbidities?

Despite the significant negative outcomes of physical comorbidities, including reduced life expectancy, until recently this issue received relatively little attention from policy makers. However, efforts to address the issue recently gained momentum through two interrelated national initiatives. The *Fifth National Mental Health and Suicide Prevention Plan* (the Fifth Plan) identified improving the physical health of people with mental illness and reducing early mortality as one of the eight priority areas. The actions governments agreed to take to achieve this included committing to the *Equally Well Consensus Statement*, developing guidelines for health services on how to improve the physical health of people with mental illness, working with PHNs and Local Hospital Networks to ensure that they jointly plan and commission services for people with physical comorbidities and regularly report on the physical health of people with mental illness (box 14.3).

Governments have reported mixed progress against each of these actions, with each action having at least one government reporting they were ‘behind schedule’ (NMHC 2018a). Government initiatives to improve the physical health of people with mental illness as part of these actions include:

- multiple PHNs reported introducing education and training for GPs on the management of physical health issues for people with mental illness
- the Country Western Australia PHN reported trialling telehealth services to assist people with chronic physical conditions manage their mental ill-health
- the Western Australian Department of Health reported launching My Medicines and Me, which is a tool aimed at helping consumers to understand and track the side effects of medication and communicate this to their healthcare professionals (NMHC 2018a, p. 32).

At a national level, the Equally Well initiative and the *Equally Well Consensus Statement* have been developed by the National Mental Health Commission. Equally Well aims to bridge the life expectancy gap between people with mental illness and the general population, and improve the quality of life of people with mental illness by providing equal access to healthcare. It includes 48 actions aimed at delivering person-centred, effective, equitable, and coordinated healthcare (box 14.4; *Equally Well Australia*, sub. 833, p. 5; NMHC 2016). The National Mental Health Commission is responsible for monitoring and reporting on the implementation of Equally Well across jurisdictions (NMHC, sub. 118, p. 22).

Box 14.3 **Physical health-related actions in the Fifth Plan**

Priority Area 5 in the Fifth Plan covers ‘Improving the physical health of people living with mental illness and reducing early mortality’. Under this priority area, governments have committed to a range of actions:

- the principles of Equally Well — The National Consensus Statement
- developing or updating guidelines and other resources for use by health services and health professionals to improve the physical health of people with mental illness. Implementation of the guidelines and resources will be monitored and reported. These guidelines and resources will:
 - provide advice on how to ensure physical health checks are part of the routine care of people with mental illness
 - provide advice on screening, detection, treatment and early medical intervention for people known to be at high risk of physical ill-health
 - define the roles of GPs, other primary care providers and specialist health providers in supporting integrated physical and mental healthcare.
- working with Primary Health Networks and Local Hospital Networks to build into local treatment planning and clinical governance the treatment of physical illness in people with mental illness by:
 - including it as part of joint service planning activity between Primary Health Networks and Local Hospital Networks
 - including it as part of joint clinical governance activity
 - requiring roles and responsibilities to be documented as part of local service agreements.
- commencing regular national reporting on the physical health of people with mental illness. This will include:
 - building on existing datasets and reporting mechanisms
 - identifying and addressing data gaps
 - seeking opportunities to share data across traditional boundaries.

Source: COAG Health Council (2017a, pp. 37–38).

Box 14.4 Equally Well Consensus Statement

Under the Equally Well Consensus Statement, governments and other organisations have committed to delivering:

- a holistic, person centred approach to physical and mental health and wellbeing
- effective promotion, prevention and early intervention
- equity of access to all services
- improved quality of healthcare
- care coordination and regional integration across health, mental health and other services and sectors which enable a contributing life
- the monitoring of progress towards improved physical health and wellbeing (NMHC 2016, p. 7).

The statement includes 48 actions aimed at achieving these commitments. The actions include (but are not limited to):

- developing resources for people with mental illness, their families and other support people to have the knowledge and tools to take positive action for their mental health, including information on the risks of developing a physical illness and screening protocols
- developing education and other resources for services and workers in partnership with colleges, associations, societies, professional bodies, and undergraduate and continuing professional education providers
- mental health services undertaking physical health and lifestyle assessments at first contact
- providing tailored support to help people with mental illness quit smoking
- Primary Health Networks and Local Hospital Networks working together to coordinate and integrate specialist mental health, GP and community services to support the prevention, early detection and treatment of physical illness
- developing and promoting anti-stigma initiatives aimed at the general public and health and mental health workers
- expanding and accelerating the use of e-health and personalised e-health records
- regularly assessing the positive and negative impacts of medication, and considering alternatives if medication is having a negative impact
- providing all mental health professionals with role-appropriate physical health assessment training as part of mandatory ongoing training
- having a single care plan for each person, covering physical and mental health, and over time, linked in with psychosocial support
- developing performance indicators that cover monitoring disease prevention and management, rates of early death, smoking, alcohol use, obesity and diabetes in people with mental illness, the level of stress/distress associated with physical illness, compliance with minimum standards of physical healthcare for people with mental illness, rates of access to health services and people's experiences with physical healthcare services (NMHC 2016).

As at January 2020, 90 organisations had signed up to Equally Well, including all State and Territory Governments, numerous PHNs and organisations representing specific health professions, consumers, carers and non-government service providers (Equally Well Australia, sub. 833, p. 5). However, it is not clear what actions most jurisdictions are taking in response to Equally Well. That said, in 2019, the Victorian Government released *Equally Well in Victoria: Physical health framework for specialist mental health services*. This framework provides information and guidance for clinicians and mental health services to help them:

- develop, implement and review policies, procedures and programs to help consumers make decisions about addressing physical health issues
- provide a positive experience of care and improve consumer outcomes
- create a consistent approach to physical healthcare in Victorian specialist mental health services (VIC DHHS 2019a; Victorian Government, sub. 483, p. 47).

Some governments have also undertaken other initiatives that are separate from, and are prior to Equally Well. For example, the New South Wales Government has produced the *Physical Health Care within Mental Health Services* policy directive (NSW Health 2017c) and the *Physical Health Care of Mental Health Consumers* guideline (NSW Health 2017b), which provide direction and guidance to mental health services in New South Wales on how to provide physical healthcare. Under the directive, mental health services are required to provide physical healthcare or facilitate the provision of this care, and train and support staff to implement the guideline. The Western Australian Government has also commissioned the development of clinical guidelines on physical care of people with mental ill-health (Stanley and Laugharne 2010).

In addition to the various government policy directives on physical care, some professional organisations have also provided information and training in this area (RANZCP 2017e, 2020). As well, some clinical practices have developed initiatives — for example, Cockburn Wellbeing is a nurse practitioner-led clinic focused on integrated multidisciplinary patient centred care (Dianne Wynaden and Karen Heslop, sub. 1, p. 4) and the GP Clinic in Mudgee, New South Wales, provides an integrated physical and mental health service that focuses on building local service provider relationships to be responsive to community needs and outcomes (Canberra Mental Health Forum, sub. 62, pp. 6-7; Fitzpatrick et al. 2018).

There are also international efforts to address physical comorbidities. For example, in 2018, the World Health Organization released guidelines on the management of physical health conditions in adults with severe mental disorders (WHO 2018b). However, it is not clear the extent to which these guidelines have been adopted by service providers and the National Mental Health Commission (sub. 118, p. 21) noted that despite the guidelines, problems remain.

Another international initiative is the *Healthy Active Lives (HeAL) Consensus Statement 2013*, which aims to improve the physical health of young people with psychosis. It had a five-year target that young people with psychosis should have the same risk of future physical health complications as their peers without psychosis (IPHYWG 2013). A number of Australian organisations endorsed this statement including the Mental Health Commission of New South

Wales, the Royal Australian and New Zealand College of Psychiatrists, the Mental Illness Fellowship of Australia and others (IPHYWG 2013). In 2013, the Mental Health Commission of New South Wales announced the principles of the statement would be adopted by the New South Wales Government (NSW MHC 2017a). But again, it is unclear what progress has been made in Australia and internationally against this statement.

Improving care provided to people with physical comorbidities

Addressing the life expectancy gap and disparity in physical health outcomes between people with mental illness and the general population should be a prime concern for governments. However, while there have been many initiatives aimed at improving treatment and outcomes for people with physical health comorbidities, many of these people do not receive care that meets their needs.

As discussed in chapter 4, people with mental illness, including people with physical comorbidities, require care that is person-centred, recovery focused and integrated. As Duggan (2015, p. 14) stated ‘collaborative care delivered in primary care settings involving multiple interventions to people with comorbidities can be cost effective’. In addition, VicHealth and Partners (sub. 131, p. 26) said:

Ultimately, we need to recognise that mental health and physical health are intertwined. We therefore need to get better at integrating the two at the level of prevention and management if we want to reduce the morbidity and mortality that these groups of conditions can cause individually, and which are further magnified when they occur together.

Achieving this for people with physical comorbidities requires governments to redouble their efforts under the Equally Well initiative and introduce a range of initiatives.

Other actions in this report — particularly related to single care plans and coordinated care for people with complex mental health and comorbidity needs (chapter 15), and addressing stigma and discrimination around mental illness (chapter 8) — would help to ensure that those people receive the care they need for their mental and physical health.

In addition, continuing to improve information sharing, including continuing to expand the use of digital records would improve the care consumers receive from providers (finding 10.1). PHNs have reported that My Health Record is:

... an enabler to improving communication and transition between services for people living with complex health needs. The centralisation of personal health data enables consumers to operate within a system that considers all of their health needs, which is critical for improving the physical health of people living with mental illness. (NMHC 2018a, p. 33)

However, these responses alone are unlikely to be enough and additional actions are required, including:

- embedding screening for physical health issues in mental health services
- increasing provision of preventative measures addressing physical health, including smoking cessation programs

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- improving the mental health workforce's capacity to help people meet their physical health goals, including through providing training and guidance
 - developing and providing guidance and information for consumers and carers on the physical health of people with mental illness
 - adopting an explicit target to reduce the gap in life expectancy between people with severe mental illness and the general population and improving monitoring and reporting on physical health treatment and outcomes.

Screening

As noted above, many people with mental illness are not screened on a routine basis for even very common physical health risks. Inquiry participants argued that physical health screening should be routine in mental health services (Bob Riessen, sub. 639, p. 8; The Mitchell Institute, sub. 744, p. 4; VicHealth and Partners, sub. 131, p. 6). Mental Health Victoria (sub. 580, att. 1, p. 46) stated:

Screening for chronic disease risk factors must be embedded into all mental health services with clear referral pathways to relevant services including for smoking cessation, weight management, exercise and behaviour change.

Some Inquiry participants also called for mental health screening in GP services (ACP, sub. 522, p. 19) and other services providing care for chronic health conditions (Stroke Foundation, sub. 281, p. 1; The Mitchell Institute, sub. 744, p. 4).

Mental health services should routinely undertake screening for common chronic health conditions that people with mental ill-health are at risk of developing (Action 14.1).

Prevention and lifestyle interventions

Even though much of the difference in life expectancy between people with and without mental illness is due to comorbid chronic physical health conditions, many people with mental illness do not receive interventions aimed at preventing or managing these conditions and associated risk factors. For example, many people with severe mental illness who smoke cannot access smoking cessation interventions adapted for people with mental illness. However, there is evidence that prevention and lifestyle interventions, such as interventions aimed at improving diet and physical activity levels, for people with mental illness are effective (RANZCP 2015; Rosenbaum et al. 2014).

Following screening, mental health services should provide people with mental illness with, or refer them to, effective prevention and lifestyle interventions where needed. The Fifth Plan stated that:

Ensuring that people living with mental illness receive better screening for physical illness, and that interventions are provided early as part of a person-centred treatment and care plan, will be critical to improving the long-term physical and mental health outcomes for people living with

mental illness and people with a chronic or debilitating illness who may be at a higher risk of a mental illness. This will lead to improved health outcomes, including better management of coexisting mental and physical health conditions, reduced risk factors and improved life expectancy. (COAG Health Council 2017a, p. 37)

Other stakeholders have also advocated for prevention and lifestyle interventions, such as those aimed at improving diet and exercise, and smoking and substance use cessation (MHV and VHA, sub. 1184, p. 11).

... Every time a consumer engages with a mental health service it provides an opportunity for clinicians to work together to understand physical health issues and how they impact on recovery goals and to offer help and support to address them. This includes working with the consumer's family, carers and support community to better understand their health needs and goals, and this applies across service settings (inpatient and community). (VIC DHHS 2019a, p. 14)

The RANZCP urges the Commission to recommend ... health promotion mechanisms (for example to quit smoking, undertake exercise, mitigate alcohol misuse) be adapted for delivery in all specialist mental health settings and become core elements in the service 'offer' in both inpatient and community settings [and] screening and lifestyle interventions, based on the best available evidence, be routinely offered to both people newly diagnosed with a serious mental illness and those with more long-standing illnesses in order to prevent unnecessary chronic conditions from developing. (RANZCP, sub. 1200, p. 5)

Ideally, all consumers with a mental illness in contact with mental health services should be asked about their smoking status and weight, diet and physical activity, and provided with evidence-based help to manage these risk factors. A systems-based approach means this action does not rely on the conscientiousness of individual clinicians, but rather becomes integrated into the holistic care of people with mental illness. (ACDPA and Quit Victoria, sub. 140, p. 7)

Smoking, in particular, is an important risk factor that needs to be addressed. People with mental illness are much more likely to smoke than the general population, leading to a range of poor outcomes. These people are also motivated to quit but often do not receive effective smoking cessation interventions (box 14.2).

All people with mental illness should be able to access targeted smoking cessation interventions. There are examples of effective interventions that have led to reduce smoking and improvements in mental and physical health (ACDPA and Quit Victoria, sub. 140; box 14.2). In Australia, the Tackling Tobacco framework looks promising (box 14.5).

Workforce development

Providing person-centred and integrated care for people with physical comorbidities requires a mental health workforce that has the skills and confidence to meet the needs of people with physical comorbidities. However, as discussed earlier, many workers do not have the skills or confidence. Duggan (2015, p. xii) stated:

Workforce development challenges, including skills deficits, must be addressed taking forward an integrated health care program. These deficits are located in all clinical arenas but have special impact in primary care, where most people at high risk of chronic illness are managed. There is, in

addition, a critical shortage of both people and skills in what might be termed the broad public health workforce, including specialists in health surveillance, disease prevention, infectious disease control, health promotion and health education. Local and regional access to all of these skills is as important as clinical skills if the aim is to keep people healthy, not merely respond to illness.

Box 14.5 Tackling Tobacco

The Tackling Tobacco program, developed by Cancer Council New South Wales, aims to reduce smoking-related harm among the most socioeconomically disadvantaged groups in New South Wales, including people with mental illness.

Through the Tackling Tobacco program, the Cancer Council New South Wales works with health and community services to address smoking. The framework consists of six key elements for success, including:

- committed leadership
- comprehensive smoke-free policies
- supportive systems
- consistent quit supports
- training and follow up
- systematic monitoring and data collection.

This framework is currently being trialled and rolled out in Victoria. While the evaluation is ongoing, interim data suggests that 60% of staff now rate their services' capability to provide smoking cessation as extremely or very capable, and consumers described the support as being essential, with outcomes including increased self-confidence and better financial situations.

Source: ACDPA and Quit Victoria (sub. 140, pp. 6–7); Cancer Council New South Wales (2020).

Workers in mental health services should have access to relevant training on physical health including:

- what the common physical health and substance use comorbidities are in people with mental illness and how to screen for them
- effective prevention and lifestyle interventions to prevent and manage physical health and substance use problems
- the side effects of medication for mental illness and effectively managing them
- where to refer people if physical healthcare cannot be provided in-house (Action 14.1).

Up-to-date and evidence-based guidelines and other resources would also be needed.

Governments, working with professional colleges, associations, and bodies, and education providers, should ensure that all of the relevant professions working in mental and physical healthcare have access to comprehensive guidelines and other resources on key physical health risks for people with mental illness (Action 14.1). Other actions to improve clinician prescribing and management of medication are discussed in chapter 10.

Information for consumers and carers

Many consumers do not have access to high quality information which would help them to manage and improve their physical health. Likewise accessible information for carers to assist them to understand the various options in physical healthcare is necessary. An important example is to ensure that consumers and carers are provided with adequate information on the physical health side effects of medications prescribed for mental illness (discussed above and in chapter 10).

Stakeholders argued the importance of providing this information to consumers.

There is a critical need to develop clear and accessible information for people with serious mental illness and carers as well as other professionals, particularly in relation to the need for physical health monitoring and risk reduction. It is also important that these groups know that there are evidence-based interventions available to people with serious mental illness to maintain and protect physical health. (RANZCP 2015, p. 20)

Resources for consumer and carer advocacy for quality physical health care also merit development. For instance, people living with mental illness are too often denied comprehensive physical health care when visiting the GP due to ‘diagnostic overshadowing’. Resources, (endorsed by the appropriate professional colleges) to support people living with mental illness to attain equal access to physical health screening and treatment would be result in a significant enhancement to mental health in Australia. (Equally Well Australia, sub. 833, p. 7)

Ensure consumers are provided with information by general practitioners and mental health professionals, about medications and their side-effects. (VCOSS, sub. 478, p. 27)

Governments and service providers should develop and provide information and guidance for people with mental illness and their carers on managing their physical health, including the side effects of medication, and the different types of physical healthcare available to them (Action 14.1).

Improving monitoring and reporting

Setting targets, and developing relevant indicators, to improve treatment and outcomes for people with comorbidities, and monitoring and reporting against these are essential to ensure that services are effective and people with comorbidities are achieving their goals. However, monitoring and reporting in this space appears to be inconsistent and there are gaps — for example, much of the monitoring and reporting associated with Equally Well and the physical health indicators under the Fifth Plan are still in development (NMHC 2018a).

The Productivity Commission is recommending that the Australian, State and Territory Governments develop a set of targets that specify key mental health and suicide prevention outcomes (Action 24.4). One of these targets should be to reduce the gap in life expectancy between people with severe mental illness and the general population.

As part of this, the Australian, State and Territory Governments should agree to interim targets, and the timeframes for achieving these. For example, in 2013, the Expert Reference Group to the COAG Working Group on Mental Health Reform recommended the following targets to reduce the gap in life expectancy:

- Reduce smoking rates of adults with mental illness by 30% in four years and 60% in 10 years.
- Increase the proportion of adults with mental illness who are screened every 12 months for physical and dental health issues by 40% in four years and 90% in 10 years (ERG 2013).

In addition, the Productivity Commission has recommended a person-centred, outcomes-focused approach to monitoring and reporting. This framework will include reporting on the effects of mental ill-health and outcomes for consumers of mental healthcare and supporting services (chapter 24). As part of this, we have suggested indicators relevant to physical health comorbidities including:

- rates of early death among people with severe mental illness
- rates of smoking, obesity, diabetes, hypertension and elevated cholesterol among people with mental illness
- proportion of consumers who received information on physical health and substance use (chapter 24, table 24.2).

This target, our recommended framework for monitoring and reporting (chapter 24) and the monitoring and reporting being developed under the Equally Well initiative, should help to ensure that the mental health system is meeting the needs of people with physical comorbidities and the gap in life expectancy is reduced.

Strengthening and successfully implementing Equally Well will improve outcomes

The Equally Well Consensus Statement includes a comprehensive set of actions that, if implemented, would significantly improve the outcomes of people with physical health comorbidities. As the National Mental Health Commission (sub. 118, p. 21) stated:

Implementation of Equally Well has the potential to see significant improvement at the primary health/acute care interface. It aims to reduce variation in care as well as address the often siloed-approach to treatment and care, and improve service effectiveness, efficiency and health outcomes for people living with mental illness and their families and carers.

However, as discussed above, Equally Well is still in its infancy (Equally Well Australia, sub. 833, p. 5), and it is also not clear what many jurisdictions are doing to implement Equally Well. And although the National Mental Health Commission is responsible for reporting on progress in implementing Equally Well, the Canberra Mental Health Forum (sub. 62, p. 6) noted, ‘as yet there is no comprehensive review or evaluation of initiatives taken as a result of Equally Well’.

Given the significant effect that physical health has on people with mental illness life expectancy, governments need to prioritise implementing the actions under the Equally Well

Initiative. As part of this, governments should be required to release clear statements covering how they intend to implement the Equally Well actions, including time frames and outcomes against which progress can be measured. The National Mental Health Commission should also report annually on the progress of governments in implementing Equally Well, including progress in reducing the life expectancy gap.

ACTION 14.1 — IMPROVING CARE FOR PEOPLE WITH CONCURRENT MENTAL ILLNESS AND PHYSICAL HEALTH CONDITIONS

The Australian, State and Territory Governments should introduce the reforms outlined in the *Equally Well Consensus Statement*.

Start now

- As part of the broader target-setting process (Action 24.4), the Australian, State and Territory Governments should agree to a target to reduce the gap in life expectancy between people with severe mental illness and the general population.
- The Australian, State and Territory Governments should release clear statements covering how they intend to implement the initiatives in the Equally Well Consensus Statement, including time frames and outcomes against which progress can be measured.

Start later

- The Australian, State and Territory Governments should implement all the actions in the Equally Well Consensus Statement, including:
 - requiring all mental health services to screen for physical health conditions that people with mental illness are at higher risk of developing
 - requiring all mental health services to directly provide, or refer consumers to other services that provide prevention and lifestyle interventions, including interventions aimed at improving diet and increasing physical activity
 - requiring all mental health services to provide smoking cessation support tailored to people with mental illness
 - ensuring workers in the mental health sector have access to the training and support they need to provide person-centred, effective and coordinated care to people with comorbidities
 - working with professional colleges, associations, and education providers to ensure that mental health services and workers have access to comprehensive guidelines and other resources on physical health in people with mental illness
 - ensuring people with mental illness and their carers have access to information on physical health problems, managing medications and their side effects, and the range of care and treatment options available to them
 - implementing effective and person-centred monitoring and reporting, as would be required under the recommended monitoring and reporting framework (Action 24.10).
- The National Mental Health Commission should report annually on Australian, State and Territory Governments' progress in implementing the Equally Well Consensus Statement and reducing the gap in life expectancy between people with severe mental illness and the general population.

14.2 Substance use comorbidities

There is a strong relationship between substance use disorders and other mental disorders, with many people who experience one also experiencing the other. People with substance use comorbidities experience worse outcomes than those with only substance use or other mental health disorders. And similar to physical comorbidities, people with substance use comorbidities often do not receive effective, integrated care.

Substance use comorbidities are common

Many people with mental illness also have a substance use disorder. According to the *2007 National Survey of Mental Health and Wellbeing*, 18% of people with a mood disorder and 12% of people with an anxiety disorder also had a substance use disorder (Teesson, Slade and Mills 2009, p. 608). The rate is even higher for people receiving treatment — for example, the 2010 survey of people with psychosis found that 50% of people with a psychotic disorder requiring treatment also had a lifetime history of alcohol use or dependence (FARE, sub. 269, p. 15; Morgan et al. 2011).

Looking at the relationship in the other direction, people with substance use disorder commonly have a co-occurring mental illness — in 2007, 21% had an affective disorder and 34% had an anxiety disorder (Teesson, Slade and Mills 2009, p. 608). Again, the rate is even higher for people receiving treatment (Matilda Centre for Research in Mental Health and Substance Use, sub. 280, p. 2). Uniting Vic.Tas (sub. 931, p. 9) stated ‘it is well recognised that the majority of people presenting to AOD [alcohol and other drug] services have co-occurring mental health needs’. A systematic literature review of the prevalence of comorbid mental disorders in people presenting for substance use treatment in Australia found rates ranging from 47% to 100% (Kingston, Marel and Mills 2016). In addition, a large number of people who present for substance use treatment display symptoms of mental disorders, while not meeting the full criteria for a diagnosis of a disorder (Marel et al. 2016, p. xi). The rate of substance use comorbidity among people who seek treatment is so high that it is considered ‘the expectation not the exception’ (SCMH 2006, p. 365).

Substance use comorbidities are more prevalent among some population subgroups, such as Aboriginal and Torres Strait Islander people (Wilkes et al. 2014, p. 129).

Similar to physical comorbidities, the relationship between substance use and other mental disorders is complex and bi-directional, with each contributing to the other (VicHealth and Partners, sub. 131, p. 17).

The overlap between drug misuse and mental health is not confined to acute episodes. Instead, drug use and mental health form part of a complex web of causality that can include inherited predisposition, poverty, experiences of trauma, lifestyle factors and cultural background. (Penington Institute, sub. 264, p. 4)

So there is a mental illness component that starts drug use, and I think it can be triggered at adolescence or by other things. And then taking drugs is a sort of downward spiral, very often; for some people, they are more inclined to become addicted than others. And then once you get

into that spiral, then you become even more mentally ill. (Families and Friends for Drug Law Reform, Canberra transcript, p. 83)

Factors contributing to this complex relationship include that many people with mental ill-health use alcohol and other drugs to alleviate the stresses of their mental ill-health, including the symptoms of their mental illness, the side effects of their medication, and the stigma and discrimination associated with mental ill-health. As well, using alcohol and other drugs can exacerbate mental illness and its symptoms, impair decision making, reduce the likelihood of recovery and reduce the effectiveness of some mental health medications (FARE, sub. 269, p. 14; MHYF Vic, sub. 628, pp. 11-12; Michael Epstein, sub. 656, p. 4; Progressive Public Health Alliance, sub. 723, p. 2; SCM 2006; Uniting Vic.Tas, sub. 931, p. 9; VicHealth and Partners, sub. 131, p. 18).

People with substance use comorbidities experience poor outcomes

Substance use comorbidity creates a greater impairment and worse prospects for recovery than either condition alone (Alcohol and Drug Foundation, sub. 288 p. 5; SANE Australia, sub. 130, p. 5). People with substance use comorbidities are more likely (than people with substance use disorder or other mental disorders alone) to experience:

- delayed and less effective treatment due to the complexity of the condition (ACT Government, sub. 210, p. 29; Alcohol and Drug Foundation, sub. 288, p. 8; VAADA, sub. 403)
- more frequent hospitalisations, longer stays in emergency departments and premature discharge from inpatient units (ACT Government, sub. 210, p. 29; MHV, sub. 580, att. 1, p. 19)
- poorer physical health outcomes and greater levels of disability (Prior et al. 2016)
- intimate partner violence (FARE, sub. 269, p. 16)
- behavioural problems, including intrusive behaviours, aggression and delinquency, particularly in young people, leading to increased contact with the justice system (FARE, sub. 269, p. 16)
- worse economic and social outcomes including problems with housing and homelessness, employment, income support and legal problems (ACT Government, sub. 210, p. 29; Marel et al. 2016, p. xi; MHV, sub. 580, att. 1, p. 19; Mission Australia, sub. 684, p. 4; Teesson, Slade and Mills 2009)
- higher levels of suicide ideation (MHV, sub. 580, att. 1, p. 19).

People with substance use comorbidities do not receive integrated care

Given the high prevalence of substance use disorders among people with other mental disorders, and the negative affects substance use comorbidities have on people with mental illness and the wider community, there is a strong rationale to intervene to improve

outcomes. However, there is strong evidence that people with substance use comorbidities are not receiving the care and support they need (box 14.6).

People with comorbidities often find it difficult to access treatment for both their mental and substance use disorders. Inquiry participants raised the fact people with comorbidities have to go to separate mental health and alcohol and other drug (AOD) services to receive care rather than receiving joint integrated care from the one service (Paul Haber and Katherine Conigrave, sub. 655, p. 1). For example, Matthew Macfarlane (sub. 2, p. x) stated:

People with comorbid mental health and substance use disorders often need to go to two separate services that liaise with each other only imperfectly. Individuals with comorbid physical and mental health issues, intellectual disabilities, or with psychogenic/functional symptoms who frequently present to physical health services, all find themselves unwitting victims of gaps in our systems.

Inquiry participants also reported that many people with other mental disorders are turned away from mental health services if they also have a substance use disorder (box 14.6). HelpingMinds (sub. 470, pp. 3–4) said:

Furthermore, mental health services will often refuse service to people who have a co-occurring substance use disorder, or a substance use disorder but no other mental health diagnosis. There is a strong link between substance use disorders and other mental health conditions, including an evidence base that integrated care is most effective however this is not evident in practice. People are often required to participate in a substance withdrawal program before they can access mental health services. As an example, the Mother and Baby Unit at Perth's King Edward Memorial Hospital will not provide a service to mothers with 'solely substance use issues'.

Inquiry participants also argued that there are insufficient dual diagnoses programs, or programs specifically aimed at treating people with substance use comorbidities. The Australian Medical Association (sub. 387, p. 12) stated that 'currently the wait for dual disability intervention is often well over a month or even unavailable for those with severe dual diagnosis'. Jeni Diekman (Sydney transcript, p. 153) said that there is 'only one dual diagnosis clinic in Sydney'. Inquiry participants also noted a lack of dual diagnosis services in the Northern Territory:

The NT Primary Health Network Alcohol and Other Drugs Needs Assessment found that there are "very few dual diagnosis treatment services in the Northern Territory and consumers with dual diagnosis report being turned away from both mental health and substance abuse services... Clinicians report a low number of people within the workforce who can offer dual diagnosis specialist support". (Northern Territory Mental Health Coalition, sub. 430, p. 19)

... we have no dual diagnosis capacity at all in the Northern Territory. We have significant issues of alcohol and other drug use as a very big contributor to both suicidality and to mental health difficulties, but no dual diagnosis framework system, not one scrap of funding going into that dual diagnosis area. (Mental Health Association of Central Australia, Darwin transcript, p. 70)

Box 14.6 **People with substance use comorbidities are missing out on services**

- Inner South Family and Friends (sub. 129, p. 4):

It has long been known that substance abuse and mental health issues frequently occur together and for successful management, integrated treatment is required. Despite the acceptance of this co-morbidity and the common reference to it as 'Dual Diagnosis' in Australia, there are few services dealing with the totality of the situation and generally each diagnosis is referred to separate services, each with different waiting times, focusing on separate issues and possibly not 'talking with the same voice'. These related conditions need one service and referring them to separate agencies is total folly not only causing waste of resources, but also penalizing those suffering the challenges of each issue. Individuals with [alcohol and other drug (AOD)] issues are commonly turned away from mental health services because of an AOD problem which shows basic lack of understanding of mental health and denies individuals their rightful treatment, thus leading them to needing government support, making it harder for them to gain recovery and to make economic contribution to our community. AOD and mental health services must become integrated.
- Uniting Vic.Tas (sub. 95, p. 11):

More coordinated work between mental health services and AOD services is also needed. Often there is handballing between the two services about what the primary need is and who should be providing support. Uniting clients repeatedly report that they were dropped by AOD services as they missed an appointment.
- Pennington Institute (sub. 703, p. 11):

People with co-occurring substance use and mental health problems 'fall through the cracks' – they cannot access the support they needed as AOD services lack the capacity to deal with the mental health issues, but clinical mental health services lack the capacity to deal with the AOD issues.
- Royal Australian and New Zealand College of Psychiatrists (sub. 1200, p. 4):

The overall consensus of research evidence and clinical expertise is that psychiatric or addiction-focused treatments on their own are not sufficient to manage comorbid mental health and addiction. This disconnect is regularly identified as an impediment to effective referral and holistic treatment.
- Mental Health Victoria and Victorian Healthcare Association (sub. 1184, p. 11)

In particular, we note that the dual diagnosis of mental ill health and substance use comorbidities is a significant challenge for service providers. Traditional 'mental health' and 'alcohol and other drugs' (AOD) services are often poorly equipped to manage the complex needs of consumers with these comorbidities, with a lack of available places and funding for specific dual diagnosis clinics and providers. As a result, many consumers end up caught between mental health and AOD services without access to dual diagnosis services targeted to their needs.
- Australasian College for Emergency Medicine (sub. 926, p. 6):

It is imperative that alcohol and other drug services are considered an integral part of the mental healthcare system. However, at present the lack of service integration and community assistance means that people requiring support for AOD use often seek support from EDs in crisis. Appropriate community provision of such services would likely prevent many of these ED presentations. In addition, for those who do present to EDs there is a need for integrated care pathways into specialist treatment programs.
- St Vincent de Paul Society National Council of Australia (sub. 1216, p. 3):

St Vincent de Paul Society NSW has found that people experiencing comorbidity struggle to access mental health services, especially supported living programs. People with a diagnosed mental illness often find it difficult to access alcohol and other drug (AOD) services.

A number of reasons have been put forward for these barriers. The Australian Medical Association (sub. 387, p. 12) noted there is an ‘artificial separation of mental health and drug and alcohol services’. While the level of integration between mental health and AOD services varies by jurisdiction (discussed below), generally mental health and AOD services have separate governance and funding arrangements. Stakeholders have argued this has impeded integration of these services.

The need for a stronger focus on integrating mental health and alcohol and drug services and suicide prevention services, and social and emotional wellbeing services with mental health was a consistent theme, albeit that the separate funding and reporting structures inhibit PHNs in achieving the desired level of integration. (PHN Advisory Panel 2018, p. 7)

However, in Australia the provision of specialist mental health services and alcohol and other drug services has historically been separated physically, administratively and philosophically. This can mean that patients receive attention only for either their mental health or substance disorder, depending on where they present. Consequently, while clinicians and workers often have the best intentions for helping people with comorbidities, they can be limited in their abilities to act due to constraints in mental health or substance abuse services and the linkages that exist between them. (ACT Government, sub. 210, p. 29)

Another reason put forward is insufficient funding for both mental health and AOD services. For example, the Australian Psychological Society (sub. 543, p. 25) suggested that insufficient funding has led public mental health services to implement rigid eligibility criteria that mean they turn away people with comorbid substance use disorders.

Inquiry participants also argued there is inadequate funding for AOD services (Orygen, The National Centre for Excellence in Youth Mental Health and headspace, National Youth Mental Health Foundation, sub. 204, p. 30; Progressive Public Health Alliance, sub. 723, p. 7). There is evidence of unmet demand for AOD services. Between 410 000 and 756 000 people are estimated to require substance use treatment and current treatment capacity is estimated to be 200 000 to 230 000 — a gap of 43.6% to 73.2% (RANZCP, sub. 385, p. 9; Ritter, Chalmers and Gomez 2019).

Inquiry participants commented that many mental health and AOD workers do not have the skills and training to treat people with comorbidities (Matilda Centre for Research in Mental Health and Substance Use, sub. 880, p. 8; MHCN, sub. 1231, att. 1, p. 13). The SA Mental Health Commission (sub. 477, p. 14) reported that people with comorbid substance use problems were being turned away from mental health services due to a lack of training for staff. The Matilda Centre for Research in Mental Health and Substance Use (sub. 280, p. 9) reported that AOD workers ‘feel overwhelmed and fearful when treating people with comorbid mental disorders, as their knowledge and the resources available to them are inadequate’.

The Penington Institute (sub. 703, p. 10) also noted that mental health services not being equipped to treat substance use disorders delays people receiving treatment.

Many mental health services are not equipped to work with people who are still using drugs, requiring prospective patients to have completed drug detoxification prior to accessing the service, creating a significant barrier for those who are unable to cease their substance use.

As with physical comorbidities, stigma and discrimination result in some people with substance use comorbidities not seeking treatment, and health professionals refusing to offer services to people with substance use disorders (Penington Institute, sub. 264, sub. 703; Windana, sub. 56, p. 2, sub. 738, p. 3). Inquiry participants stated that people with substance use disorders experience worse stigma and discrimination than those with other mental illness.

Stigma around AOD use remains considerably higher than for mental health issues, and lack of understanding about what treatment entails or fear of judgement result in many young people not seeking help or disclosing an AOD issue to a clinician to ensure a timely and effective treatment approach is taken to respond to the comorbidity. (Orygen, The National Centre for Excellence in Youth Mental Health and headspace, National Youth Mental Health Foundation, sub. 204, p. 30)

One of the reasons for this is that many people see substance use disorders as a moral failure and personal choice, rather than an illness influenced by social determinants of health, including disadvantage (Penington Institute, sub. 703, pp. 5–6; Windana, sub. 738, p. 3).

How have governments responded to substance use comorbidity?

Governments and other stakeholders have known for some time that many people with substance use comorbidities are not receiving adequate care. This has culminated in initiatives at the national, state and local levels.

National level

Nationally, substance use comorbidities has been a focus area for about 20 years. The National Comorbidity Project, launched in 2000, brought together the National Drug Strategic Framework and the Second National Mental Health Plan, and focused on greater collaboration between services and building the capacity for services to improve their response to comorbid mental health and substance use problems (DoH 2009). This was followed by the National Comorbidity Initiative in 2003-04, which was the national framework for responding to comorbidities. The initiative aimed to improve service coordination and treatment outcomes and included four priority areas:

- Developing resources and information for consumers.
- Providing support to GPs and other health workers to improve treatment outcomes.
- Improving data collection and systems to manage comorbidity more effectively.
- Raising awareness of comorbidity among health workers and promoting examples of good practice resources and models (Australian Government 2006).

It does not appear that this initiative was evaluated and stakeholders noted that, despite this initiative, comorbid mental health and substance use is still associated with poor quality of life and reduced mortality.

More recently, the *Fifth National Mental Health and Suicide Prevention Plan* acknowledged the importance of jointly considering substance use comorbidities in system and service planning. It commits governments to implementing the plan with reference to work committed to under the National Drug Strategy (COAG Health Council 2017a, p. 8). Moreover, it includes an action item that serves to better integrate mental health services for Aboriginal and Torres Strait Islander people with AOD services (COAG Health Council 2017a, p. 33).

The *National Drug Strategy 2017–2026* (DoH 2017b) is the national framework for preventing and minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities. It identifies people with mental ill-health as a priority and recognises the importance of collaboration and coordination across jurisdictions, portfolios and services. It comprises several sub-strategies that provide direction and context for specific issues, including the:

- *National Ice Action Strategy 2015* (PM&C 2015)
- *National Tobacco Strategy 2012–18* (Intergovernmental Committee on Drugs 2012)
- *National Aboriginal Torres Strait Islander Peoples Drug Strategy 2014–2019* (Intergovernmental Committee on Drugs 2014)
- *National Alcohol Strategy 2019–2028* (DoH 2019j).

State and territory level

The States and Territories have each taken different approaches and have undertaken different initiatives to address comorbidities.

Some states and territories have integrated mental health and substance use policy or commissioning of services. Queensland and Western Australia have joint mental health and AOD strategies, and their mental health commissions are responsible for both mental health and AOD policy (QMHC 2018; Western Australian Government, sub. 1227, p. 2; WAMHC 2019). The Queensland Mental Health Commission provides strategic direction and delivers public health promotion activities, while the Western Australian Mental Health Commission is directly involved in policy, commissioning and delivering services, and monitoring and evaluation. Both States had closer integration as their goal when implementing joint strategies and giving responsibility to their mental health commissions (Queensland Government 2012, p. 3; Western Australian Government, sub. 1227, p. 2).

Other state initiatives have focused on addressing comorbidity issues at the service level. For example, in 2008, New South Wales released its *Comorbidity Framework for Action*, which aimed to promote better health for people with comorbidity, improve intervention and assessment in relation to comorbidity and reduce long-term disability associated with comorbidity. Its four priority areas for action included workforce planning and development, improving infrastructure and systems development, improving responses in priority settings for priority clients and improving promotion, prevention and early intervention strategies (NSW Health 2008).

In addition, the Victorian Dual Diagnosis Initiative (VDDI) commenced in 2002. This is a state-wide network of specialist clinicians who focus on the development of the mental health and AOD sectors' and workers' capacity to recognise and effectively respond to people with mental illness and substance use comorbidities (VDDI 2019). Under this initiative, services are expected to:

... screen all clients for dual diagnosis issues and either assess or arrange for an assessment of people who screen positively. Those, for whom an assessment indicates the presence of dual diagnosis issues, should then have an integrated treatment plan developed which outlines how both substance use and mental health needs will be met. If the treatment involves two organisations, then the expectation is that the two organisations work to the one treatment plan. (AHA 2011, p. 3)

An evaluation of the VDDI found that although progress on specific actions had been variable, it had nevertheless successfully promoted the message that 'dual diagnosis is everyone's business' and helped break down some barriers between services (AHA 2011, pp. 3–5). Mental Health Victoria (sub. 580, att. 1, p. 21) noted that while the initiative had benefits it had also been criticised for 'creating a "third tier" or "niche" of specialised service provision which only exacerbates the likelihood of people falling through gaps'. Overall, it is not clear if the VDDI has led to improved outcomes for people with substance use comorbidities over time.

Other smaller government initiatives include, for example:

- funding for St Vincent's hospital to commence a psychiatric alcohol and non-prescription drug assessment unit within its emergency department (NSW Government, sub. 551, p. 37)
- dedicated dual diagnosis services and positions funded in the Southern New South Wales, St Vincent's, South Western Sydney and Northern Sydney Local Health Districts (NSW Government, sub. 551, p. 37)
- integrated mental health and AOD service hubs in six Victorian hospitals, which provide a point of referral for people requiring acute care (Windana, sub. 738, p. 2)
- creating two new specialist rehabilitation services for people with mental illness and substance use comorbidities (Victorian Government, sub. 483, p. 47).

Other initiatives

There are many smaller scale initiatives aimed at improving the care provided to people with mental illness and substance use comorbidities. For example, Jesuit Social Services' Connexions program began in 1996 as Victoria's first dual diagnoses service for young people. It provides intake, assessment, counselling, casework, advocacy and specialist assertive outreach services. The program also links with and refers people to clinical mental health services are required (Jesuit Social Services 2020, sub. 441, p. 18).

There have also been a range of initiatives aimed at improving the AOD workforce's ability to respond to comorbid mental ill-health. The *Guidelines on the management of co-occurring mental health conditions in alcohol and other drugs treatment settings* provide AOD workers with up-to-date and evidence-based information on the management of comorbid mental ill-health conditions in AOD treatment settings (Comorbidity Guidelines 2020b; Marel et al. 2016). There is also an associated website, which provides free online training. While it is primarily aimed at AOD workers, anyone can complete the training (Comorbidity Guidelines 2020a). Since 2017, over 3000 people have registered for the training, and an evaluation of the program showed:

... over 90% of participants who completed training agreed/strongly agreed that it helped improved their confidence, skills, and capacity to respond to co-occurring mental health and substance use conditions. (Matilda Centre for Research in Mental Health and Substance Use, sub. 880, p. 10)

Improving care provided to people with substance use comorbidities

Despite the numerous initiatives aimed at improving outcomes for people with substance use comorbidities, and previous reviews identifying the problems discussed above (NMHC 2014b; SCMH 2006), insufficient progress has been made and problems remain.

Therefore, further interventions and reforms are required to improve outcomes for people with substance use comorbidities. Similar to physical health comorbidities, the Productivity Commission's recommendations to improve referrals (Action 10.1), introduce single care plans (Action 15.3), increase availability of care coordination services (Action 15.4), and introduce a National Stigma Reduction Strategy (Action 8.1), should all improve the care provided to people with comorbidities.

However, further changes are required. It is important that both mental health and AOD services operate on a 'no wrong door' approach (chapter 4) and do not turn away people with comorbidities. Governments should require services to treat, or refer on, all people who present at their services (Action 14.2).

Other changes that would improve outcomes for people with substance use and other mental disorders include:

- investing in more dual diagnosis services, which provide integrated targeted care to people with substance use and other mental disorders
- developing the mental health and AOD workforces so they can better respond to comorbidities
- further integrating mental health and substance use at the policy, planning and commissioning levels.

Dual diagnosis interventions

Evidence suggests that for many people with comorbidities treating substance use and other mental illness concurrently within the same service is the best way to improve outcomes for people with comorbidities (Sax Institute 2015 VAADA, sub. 1205, pp. 2-3). However, as discussed earlier, many people are unable to access services where they receive parallel treatment for their comorbidities.

Inquiry participants argued strongly for additional investment in specialised services specifically for people with comorbid substance use and other mental disorders.

Increase funding for specialist dual diagnosis programs which provide integrated care to the significant number of clients who experience alcohol and drug and mental health co-morbidity. (Jesuit Social Services, sub. 441, p. 4)

Increase funding for AOD services and expand the provision of dual diagnosis services in the region, in particular provision of day care programs. (WentWest Limited, sub. 445, p. 38)

Additional investment in services which provide specialised models of care suitable for individuals with a dual diagnosis is critical to ensure individuals with the most complex needs have timely access to support. (MHCN, sub. 1231, att. 1, p. 13)

VAADA reiterates that a best practice model of care for the treatment of comorbid disorders is one which involves the provision of specialist programs that address AOD and mental health issues concurrently. Such a model goes well beyond ‘sectors working together... to deliver high quality mental health care’. Rather, such a model requires a fundamental up-skilling and capacity building across AOD and mental health. Under such a model, AOD would be included within the core mandate of care of mental health services and vice versa. (VAADA, sub. 1205, p. 2)

There is a significant crossover and interaction between mental health and alcohol and other drug (AOD) issues. It is therefore problematic to review mental health in isolation without concurrently taking AOD into consideration during the inquiry. Services need to be designed to address and manage these issues jointly as opposed to a siloed approach. (EMHS, sub. 152, p. 1)

Governments should invest in additional specialty services designed to treat substance use and other mental disorders simultaneously. The services needed will vary by region, and therefore, regional bodies should estimate gaps and demand for these services and plan and commission services as needed (Action 14.2).

That said, many people with comorbidities will not require speciality comorbidity services. Rather, they can receive effective and coordinated care from multiple providers, facilitated with a single care plan and, where service needs are more complex, a care coordinator (chapter 15).

Workforce development

Similar to physical comorbidities, many workers in both mental health and AOD services do not have the skills and training to provide care for comorbidities. Inquiry participants argued for more training for workers in mental health and AOD services.

... the Productivity Commission [should] recommend that all mental health services and alcohol and other drug services are required to ensure their staff have the capability to identify and assess all patients and clients for mental health and alcohol and drug problems. (Alcohol and Drug Foundation, sub. 288, p. 9)

Workforce training is a key method for facilitating integration between the AOD and mental health systems. Clinical staff working in mental health may be unsure of their knowledge of AOD issues, while those working in the AOD sector likewise may lack adequate understanding, experience and expertise in mental health issues. Staff should be trained specifically in dual diagnosis and its ramifications. (Penington Institute, sub. 703, p. 12)

Governments and service providers should ensure that workers in mental health and AOD settings have access to training that covers identifying and treating comorbidities, and how and where to refer people if care for comorbidities cannot be provided in-house (Action 14.2).

In addition, while guidelines do exist for workers in the AOD sector to help them work with people with comorbidities, there are limited guidelines available to professionals in the mental health sector. Governments, working with professional colleges, associations, and bodies, and education providers, should ensure that mental health services and professionals have access to comprehensive guidelines and other resources on substance use comorbidities (Action 14.2).

Further integrating mental health and substance use policy, planning and commissioning of services

As discussed above, given the close relationship between mental health and substance use, and the benefits of treating substance use and other mental illness together, there is increasing recognition of the potential benefits of integrating mental health and substance use at the policy, planning and commissioning levels, with some jurisdictions moving in this direction.

Many Inquiry participants advocated for integrated mental health and substance policy, planning and commissioning (for example, ACEM, sub. 926, p. 6; Families and Friends for Drug Law Reform (ACT), sub. 701, p. 2; MHV, sub. 580, att. 1, p. 21; Murrumbidgee Primary Health Network, sub. 1199, p. 9; Samaritans Foundation, sub. 785, p. 10; Youth Mental Health, North Metropolitan Health Service, sub. 99, p. 13), with many arguing AOD services should be included in the remit of the recommended Regional Commissioning Authorities (CBPATISIP and NATSILMH, sub. 1217, p. 7; Consortium of Australian Psychologists and Psychologists, sub. 882, pp. 33–34; Matilda Centre for Research in Mental Health and Substance Use, sub. 880, p. 5; TAMHSS, sub. 919, p. 16).

Governments should continue to progress integrating mental health and substance use policy, planning and commissioning of services. AOD services should also be included in the remit of the Regional Commissioning Authorities (Action 23.4).

Monitoring and reporting

As discussed in section 14.1, monitoring and reporting is essential to ensuring that services provided to people with comorbidities are effective and people with comorbidities are achieving their goals.

Governments should require monitoring and reporting on the outcomes for people with mental ill-health and substance use comorbidities. As part of the framework for monitoring, evaluation and research discussed in chapter 24, the Productivity Commission has recommended that governments report on the rates of substance use among people with mental illness and the proportion of people with mental ill-health who receive information on substance use as part of the care they receive. In addition, many of the Productivity Commission's other proposed indicators would benefit those with comorbidities, and help to improve outcomes (table 24.2).

ACTION 14.2 — INTEGRATING MENTAL HEALTH AND SUBSTANCE USE PLANNING, COMMISSIONING AND SERVICE PROVISION

Many people with mental illness also have a substance use disorder. Services to deal with both these conditions should be seamless from the consumers' perspective.

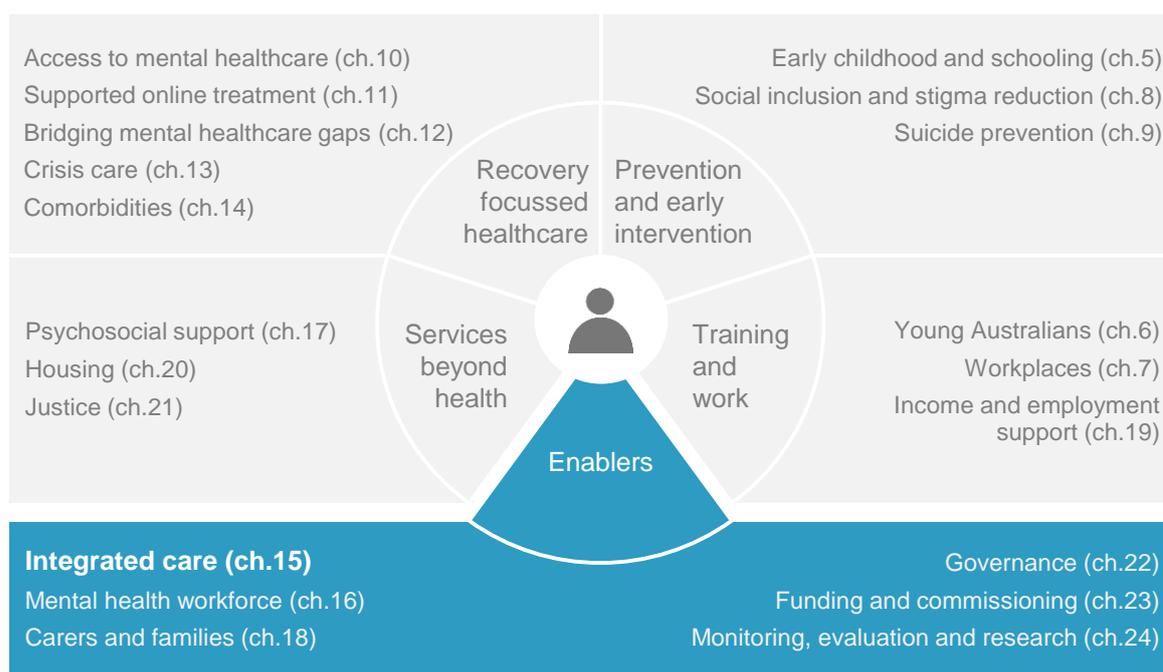
Start now

Regional commissioning bodies, in conjunction with the relevant State and Territory Government departments, should integrate commissioning of substance use and mental health services.

Start later

- Governments should require mental health services, including hospitals and clinical community health services, to ensure treatment is provided for both substance use and other mental disorders for people with both conditions.
- Governments should provide for this treatment within specialised, integrated mental illness and substance use disorder services ('dual diagnosis' services) to meet regional needs or by ensuring integrated treatment and care delivery where the mental health service and the alcohol and other drug services are organisationally separated.
- Governments should require mental health services and alcohol and other drug services to jointly develop and implement operational guidelines, including:
 - screening for substance use and mental illness
 - referral pathways between alcohol and other drug and mental health services, where service arrangements exist for the consumer with a comorbid condition
 - working with professional colleges, associations, and bodies, and education providers to develop and provide training, guidelines and other resources for mental health and alcohol and other drug workers so they can provide evidence-based, coordinated care for comorbid conditions.
- Governments should continue to monitor and report on outcomes for people with substance use comorbidities, consistent with the Productivity Commission's framework for monitoring, evaluation and research (chapter 24).

15 Linking consumers and services: towards integrated care



Integrated care matters because ...

- People's ability to access the services they need where and when they need them is a cornerstone of a person-centred mental health system. This is currently hampered by the overly complex and disjointed nature of the system.
- Limited information sharing and coordination between providers lead to delayed treatment and poorer outcomes.
- Care coordination for people accessing multiple services can improve their recovery process. But existing programs are inconsistent, leading to overlapping services for some consumers, while others miss out.

RECOMMENDATION 15 — LINK CONSUMERS WITH THE SERVICES THEY NEED

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

As a priority:

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

Additional reforms that should be considered:

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

The delivery of integrated care has been on the agenda for the mental health system for many years. For example, the first *National Mental Health Plan* agreed to in 1992 included improving integration and developing intersectoral linkages as key focus areas (AHMAC 1992). This was considered critical to the success of the *National Mental Health Strategy* (Whiteford 1994). However, implementation stalled and over 20 years later, in its response to the 2014 National Mental Health Commission review, the Australian Government reiterated its commitment to:

Moving from fragmentation, duplication and service gaps on the ground associated with current national and state programme delivery to a system that is planned, integrated, coordinated and delivered at a regional level. (DoH 2015a, p. 7)

Five years later, progress towards this goal still appears limited.

Unfortunately, a lack of integration and coordination continues to exist within – and between – our systems of care. Individuals often journey between silos of intervention, including hospital wards, systems in housing, education and employment, and community and non-government services. And many of these supports only cater to discrete aspects of an individual’s needs, overlooking whole-of-life considerations across the spectrum of need, potentially leading to no overall improvement to their quality of life. (DoH, sub. 556, p. 11)

Integrated and coordinated care can take many forms, only some of which are evident in parts of the mental health system (box 15.1). From the point of view of the consumer, integrated care means:

- person-centred care that accommodates individual needs
- access to the services they need when they need them
- continuity of care, based on effective information flows between clinicians and other services (Banfield et al. 2017).

But the ability to deliver integrated and coordinated care is hampered by fragmented approaches to planning and funding service delivery, the perverse incentives created by some funding approaches, and unclear division of responsibilities between different levels of government (PC 2017b). The Productivity Commission recommends an overhaul of institutional arrangements and funding mechanisms to address these issues (chapters 22 and 23). Implementing person-centred care consistently across the mental health system also requires a significant cultural shift. Factors enabling this shift include aspects of the mental healthcare system (addressed in chapters 4 and 10–14); workforce training (chapter 16); a more holistic and inclusive approach to families and carers (chapter 18); and an increased focus on monitoring and improving outcomes that matter to the individuals needing the services (chapter 24).

This chapter addresses the two other aspects of the consumer experience of integrated care — accessibility of services and continuity of care.

Box 15.1 **Defining integrated and coordinated care**

Integration refers to individuals and organisations in different areas and sectors working together and aligning their practices and policies to deliver high quality mental healthcare and achieve good outcomes (Bywood, Brown and Raven 2015). The Productivity Commission, in its 2017 Productivity Review, defined integrated patient-centred care as involving ‘the entire health care system, such that all services — community, primary, secondary, tertiary (and quaternary) — are integrated to achieve good health outcomes and to efficiently deliver a high quality of service to people over their lives’ (PC 2017b, p. 4).

This can encompass both vertical and horizontal integration. In the context of mental health, vertical integration refers to integration between the different levels of healthcare (for example, primary, secondary and tertiary healthcare), whereas horizontal integration refers to integration across different sectors and providers (for example, between physical and mental health services). Integration between the health sector and non-health sectors such as housing and employment can be vertical and horizontal (Oliver-Baxter, Brown and Bywood 2013).

There is no single model of integration. There are multiple ways to make a system more integrated and integration generally exists on a continuum, from informal information sharing and communication right through to a fully integrated system with one organisation meeting all consumer needs (Bywood, Brown and Raven 2015).

Coordination is a form of integration, which refers to different entities or providers working together to ensure that a consumer receives all the different types of care they need in an organised and efficient manner. There are different models of care coordination — some may involve only referrals and exchanges of information between clinicians, while in other cases a dedicated coordinator or care team helps the consumer to navigate the mental health system and connect them with all the supports they require (PC 2017b; WA DoH 2019a).

Across the mental health system, there have been numerous attempts at integrating care to improve the consumer experience. Examples include:

- joint regional planning and commissioning of mental health services between the Australian and State and Territory Governments by Primary Health Networks and Local Hospital Networks
- alliances and networks, such as the Western Australian Primary Health Alliance, which oversees the commissioning functions of the three Western Australian Primary Health Networks (WAPHA 2019a) and the Hunter New England Integrated Care Alliance (HNECCPHN 2019)
- co-location of services, or ‘hubs’ or ‘one-stop-shops’ such as headspace services (Orygen, The National Centre for Excellence in Youth Mental Health and headspace, National Youth Mental Health Foundation, sub. 204)
- shared care plans
- shared information and communication technology infrastructure
- care coordination and team-based care for people with mental illness and severe and complex needs.

15.1 Improving the consumer experience

In the current mental health system, many consumers face substantial difficulties accessing the services they require, navigating waiting lists and eligibility requirements, and telling their stories time and time again to new service providers.

This is a frustrating process for consumers and their carers, and can also be traumatising for consumers and exacerbate their health issues (for example, Healing Foundation, sub. 193, p. 10; Youth Mental Health, North Metropolitan Health Service, sub. 895, att. 3, p. 24). Community members told Anglicare Australia (sub. 376, p. 13) ‘we do not want to repeat our story to lots of people’. A carer also told the Loddon Mallee Mental Health Carers Network (sub. 52, p. 1):

Carers and their loved ones are tired of having to repeat their story to new workers/services/GP’s etc. – it’s traumatic to have to re-live what is a very sad time in their life.

It also involves significant time costs, and often results in delays in receiving care and support, or not receiving support at all (for example, Anglicare NT, sub. 53; Lorna MacKellar, sub. 406; Robert Davis, sub. 133; box 15.2).

Making the system more accessible, and improving the links between its individual parts, requires a number of different approaches. These approaches come together to create clear pathways for consumers interacting with the mental healthcare system (figure 15.1).

First, the initial point of contact between people and the mental health system — be it a phone line, website, GP or school counsellor — should give people accurate information suited to their needs. In the case of phone lines or online portals, the wide range of options available can be confusing and overwhelming (Connect Health & Community, sub. 94, p. 18; Matthew Macfarlane, sub. 2, p. 1). This needs to be simplified. Similarly, service providers themselves need assistance in navigating the complex and often convoluted referral pathways of the mental health system (box 15.2; section 15.2). The national digital mental health platform, described in detail in chapter 10, would go a long way towards addressing both these issues. It would offer individuals and service providers, from both health and non-health services, the ability to receive information about services available in their local area and to access evidence-based assessment, which would match people with the services best suited to their needs.

Second, for those people already ‘in the system’ and receiving care from multiple providers, the barriers to information sharing between providers and a lack of coordinated care planning can slow their recovery. These barriers need to be lowered, recognising that consumers should be at the centre and in control of their information. In more complex cases, individuals may require the services of a dedicated care coordinator (section 15.3).

Finally, there are several different institutional approaches to improving provider coordination, including co-location, service alliances and memorandums of understanding. These institutional approaches can assist in creating a culture of coordinated care (section 15.4).

Box 15.2 **The road to nowhere: Inquiry participants' views on navigating the mental health system**

Consumers and carers report that they find the mental health system difficult to navigate. These difficulties begin when consumers and carers first decide that they need information, treatment and/or support and are looking for a gateway into the system:

Looking at where to start to look for mental health services is overwhelming. I would do a google search on my mobile phone to source support. Navigating the system to try and find the right thing for yourself is difficult. (mental health carer, quoted in Connect Health & Community, sub. 94, p. 18)

Once consumers and carers are in the system, they can find it difficult to access help:

... people did not know where to go for assistance with mental health concerns ranging from mild distress to crisis to ongoing community support, or that once contact was made, the service system was difficult to navigate. Over and again people spoke to the critical nature of being able to access the right support at the right time without having to knock on several service providers' doors or jump through hoops to provide the services they need. This applied to people experiencing mental distress and also to their families, carers and friends. (SAMHC, sub. 477, p. 6)

Carers have reported to us that they find the mental health service system complex to navigate and distressing when they are dealing with multiple professionals across the public and private health systems, private practitioners, and community based mental health service providers. (MHCA, sub. 489, p. 10)

Navigation of our eating disorders service system currently can present a nightmare, complicated often by the fact that someone who is unwell with an eating disorder experiences high level of treatment ambivalence due to anxiety. It often falls to the families and carers or others to find services, negotiate treatment access and support, or even allow the person into treatment. (Eating Disorders Victoria, Melbourne transcript, p. 55)

I shouldn't have to chase five different organisations to get one whole integrated service. Because I'm having to call this, call that person, call that person, I'm playing snakes and ladders on the phone every week and I am bloody sick of it. (Gita Irwin, Sydney transcript, p. 201)

Navigating the system is particularly difficult for some groups, including people from cultural and linguistically diverse groups, Aboriginal and Torres Strait Islander people, or other groups experiencing disadvantage:

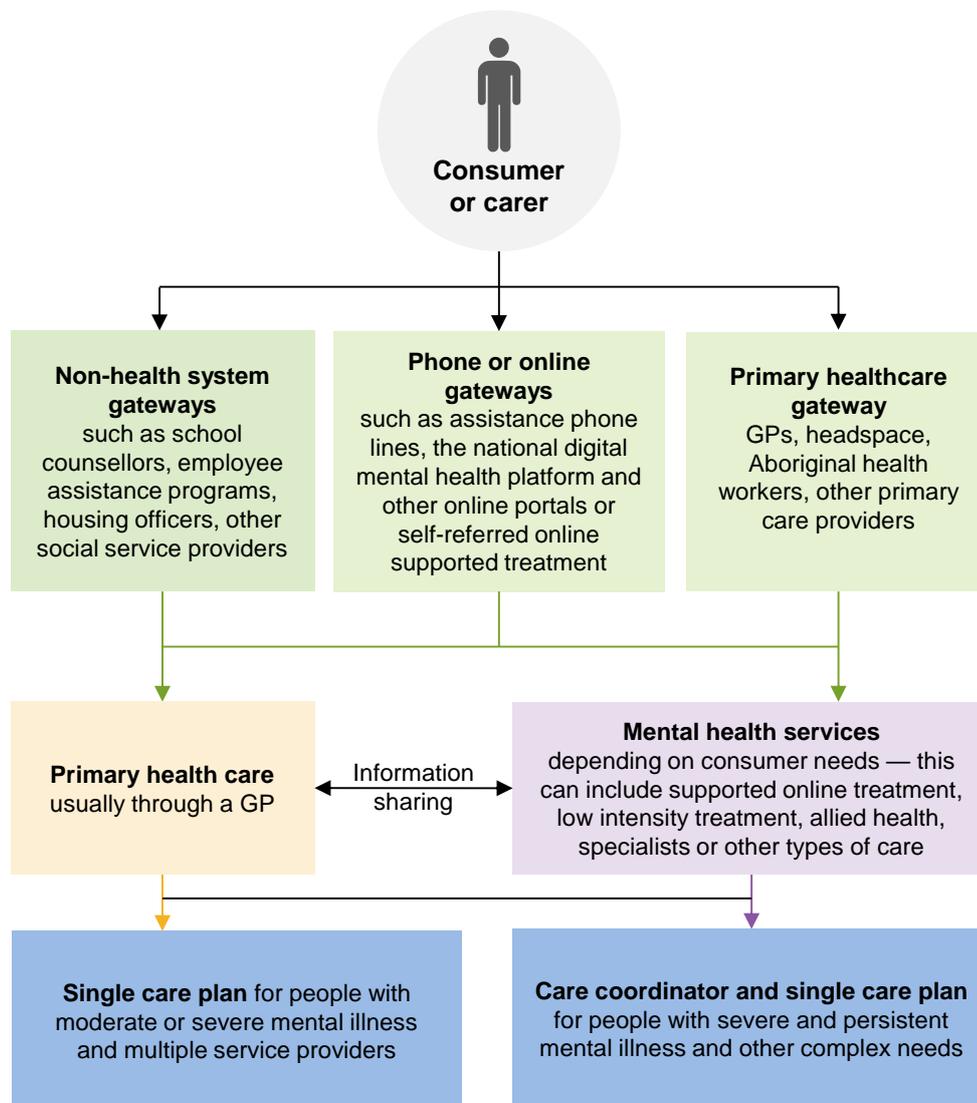
The current mental health system is a medical model where the client's needs are understood mainly in relation to clinical supports. It is left to individuals and families to navigate between the different agencies to access other supports ... and to resolve any service gaps or issues. For many people experiencing mental illness, it is difficult to do this because of complex and often overlapping needs e.g. financial and housing stress and vulnerabilities, such as relationship breakdown and trauma. Some have low literacy levels, or English as a second language and they may not understand entitlements, what supports are available or what they can expect from providers. (Anglicare Sydney, sub. 190, pp. 20–21)

Strategies are required to assist Aboriginal and Torres Strait Islander people to effectively navigate the mental health system ... to connect to appropriate support, particularly in regional and remote areas where service infrastructure is sparse. (Healing Foundation, sub. 193, p. 2)

Inquiry participants reported that service providers and people working in the system can also find it difficult to navigate:

The burden [of navigating the system] is carried by professionals (social workers, doctors, and others), who expend substantial effort and time in referring patients to relevant services and in assisting them with various kinds of paperwork. This can involve an inefficient use of resources, and a distraction from the vocational focus of the individuals concerned. Some of this effort probably is unavoidable, given that patients themselves are often unable to navigate the system for themselves; even so, improvement ought to be possible, through both attention to system design ... and careful review of case-management arrangements. (Name withheld, sub. 23, p. 2)

Figure 15.1 **The Productivity Commission’s model of consumer and carer pathways in the mental healthcare system**



Improving the way people access and navigate the mental health system is an essential part of achieving a person-centred system (chapter 4). In some cases, local service providers make substantial efforts to provide coordinated care and assist consumers to find the support they need. However, existing shortcomings in the mental health system can make it very difficult for these efforts to succeed, and there is no nationally consistent, systematic approach to supporting consumers to navigate the system. The recommendations in this chapter seek to address this gap.

15.2 Helping people to find services

In a time when information is more accessible than ever, it is perhaps surprising that consumers and carers have difficulty finding the mental health services they need. Nonetheless, confusion and difficulty finding information are substantial barriers to accessing mental health services. For example, 40% of parents whose children had a mental disorder were not sure where they could find help (Lawrence et al. 2015).

Like many other problems in the mental health system, these difficulties have been identified in numerous past reviews and there have been many attempts to address them. For example, the National Mental Health Commission stated in its 2014 review that a successful mental health system would have a ‘no wrong door’ approach, and consumers would be referred onto the appropriate service for their needs, regardless of their initial point of entry into the mental health system. While parts of the system are working towards a ‘no wrong door’ approach, this remains far from the norm (box 15.3).

For some people, their first interaction with mental health services is through an online search or a conversation with one of the many phone lines available. For other people, their first port of call is a face-to-face consultation, most commonly with a GP, although people can also be referred to mental health services by teachers, housing support workers, social workers and others. Overwhelmingly, submissions to this Inquiry suggest that all of these gateways are letting people down, with people often not being able to find the right initial gateway, or being abandoned to a mess once they enter a gateway (box 15.2).

Finding the right information — online or over the phone

An online search for mental health services yields a multitude of phone lines and websites, offering information, support and, in some cases, crisis intervention. Some have been in operation for a very long time, and have recognisable brands. Lifeline Australia (sub. 87, p. 15) is one example — its suicide prevention hotline receives a call every 32 seconds. From a consumer point of view, however, Lifeline is one of a very large number of support services. The Victorian Government’s Better Health Channel (2018) lists more than 20 different helplines consumers can choose from. Similarly, the Beyond Blue website lists 16 other national helplines and websites relevant to anxiety and depression (Beyond Blue 2020b). These telephone lines help consumers and carers find services appropriate to their needs, including offering targeted information for a particular condition, age range or geographic area. However, stakeholders have raised concerns about consumers’ and carers’ ability to work out which gateway is the right one for them (State of Victoria 2019). The problem of not knowing which gateway is right for the individual is not helped by services branding themselves with names that, in trying to avoid inflammatory or unhelpful terminology, end up camouflaging their focus. Matthew Macfarlane (sub. 2, p. 1) stated:

The fragmentation starts at the beginning of an individual’s journey into the system, and is well-illustrated by the website for this very Inquiry ... where there are six different numbers

offered for counselling. Why are there so many? The answer is that each one has a slightly different focus, and are run by different organisations with different funding models.

Box 15.3 The ‘no wrong door’ approach

The ‘no wrong door’ approach means that when a person approaches a service or gateway, they are not turned away, even if it is not the right service for them. Instead, they are helped to access care from the right place. The no wrong door approach is often used in the context of integrated care to describe a situation where people ‘can access a tailored combination of supports wherever they first ask for assistance’ (NMHC 2014d, p. 183). This approach is particularly important for people who require support from multiple services, such as those with a substance use disorder as well as a mental illness (NMHC 2014d).

The no wrong door approach in the mental healthcare system can be implemented in different ways, including equipping all providers of health and other services with the skills to recognise mental ill-health and assist consumers in accessing services; or ensuring that there are specialised staff in all primary care clinics (Orygen 2018a; RACGP 2016). Both approaches present substantial challenges.

Some service providers already operate a no wrong door approach (for example, First Step, sub. 557, p. 4; Orygen, sub. 1110, p. 10; Relationships Australia (National), sub. 103, p. 23). However, no wrong door approaches have not been implemented consistently across the mental health system (FOCP, sub. 758, p. 5; SAMHC, sub. 477, p. 9).

Participants’ views on the ‘no wrong door’ approach

Inquiry participants argued for the mental health system to adopt the no wrong door approach.

The first step in delivering an integrated service is for the service at which the client first presents to take responsibility for identifying all of the client’s needs. Thus, a common feature of our client-focused services is that they employ a ‘no wrong door’ approach. This means that the responsibility of providing care to address the whole range of a person’s needs, either directly or by referral, falls on the care provider/service where the person first presents. (Relationships Australia (National), sub. 103, p. 23)

Given the relatively low NT population, and vast geographic areas it should be possible to implement a no wrong door approach to improvement integration and reduce fragmentation in the mental health system, to link systematically clinical and community mental health services and programs. (Northern Territory Mental Health Coalition, sub. 430, p. 28)

Implement models and funding incentives to ensure a ‘no wrong door’ approach offering people with mental health issues and carers and families or people at risk appropriate assessment, treatment and/or referral in the setting first encountered. (Mental Health Commission of New South Wales, sub. 486, p. 20)

... a ‘no wrong door’ approach which supports referral from multiple community access points, would be preferable to being reliant on the person having a relationship with a GP clinic in order to navigate the system. (QAMH, sub. 714, p. 14)

The Alliance would like to take this opportunity to emphasise its support for employing a ‘no wrong door’ approach in the context of providing integrated, comprehensive support services and programs. This will help to ensure LGBTI people have access to a tailored combination of supports when they first ask for assistance. (National LGBTI Health Alliance, sub. 888, p. 6)

An ideal mental health sector would see ... better integration of clinical and psychosocial services with a no wrong door approach and clear referral pathways between systems ... (Mental Health Carers Australia, sub. 898, p. 4)

In 2014, the National Mental Health Commission (NMHC) found that there was duplication in some areas of online and telephone support (for example, in the emergency/crisis calls and youth areas) and that the current system of multiple call lines and online services is confusing for consumers (NMHC 2014c). The review concluded that:

Telephone helplines and other online services are not integrated, do not have common standards and are linked to few clinical pathways. Typically they experience major delays, confusing or conflicting notions of duty of care and/or subcontracting or referral to other agencies with technical, personnel or clinical capacity ...

There is limited availability of warm transfers, meaning that users generally need to re-tell their story when they are referred to another service. There is further potential for callers to be caught in a loop of being referred back and forth between services.

A streamlined approach will reduce duplication and increase efficiency and effectiveness of the mental health helpline sector. This will reduce confusion about the service offerings available and create a clear line of sight for individuals about what is available for them. By retaining the expertise of existing large and nationally recognised helplines and community-based brands and organisation[s], a limited number of first points of contact can be established, with simpler 'warm' transfers to the most appropriate service. (NMHC 2014c, pp. 125–126)

In response to the 2014 review, the Australian Government announced a new digital mental health gateway, which would be the first point of service for people looking for information, advice or an online psychological service, and would include a centralised telephone and web portal (DoH 2015a). Since then, the Australian Government has been reconsidering the idea of a centralised telephone service (DoH, pers. comm., 17 January 2020), but has launched Head to Health. This website includes information on services and resources for consumers and carers, and uses an automated triage system to assist people with sifting through the hundreds of resources listed (DoH nd).

Improving the existing online gateway

Since the launch of Head to Health in October 2017, it has averaged about 1200 sessions per day and there has been an average of about 5000 referrals to digital resources, peer support programs and structured online psychological treatment each month (DoH 2019a, p. 42).

The Australian Government has undertaken activities to increase knowledge and use of Head to Health. An advertising campaign costing about \$450 000 was undertaken from December 2018 to May 2019, which resulted in a 38% increase in traffic to the site immediately after the campaign launch (DoH 2019a, p. 43, pers. comm., 17 January 2020).

However, stakeholders have suggested that the community makes only limited use of Head to Health (Black Dog Institute, sub. 306, p. 24). There has also been some criticism of Head to Health as an effective portal.

... Head-to-Health is too generalist and cannot effectively engage or provide support with high risk populations, such as young people and First Australians. (yourtown, sub. 917, p. 3)

I mean, the Head to Health was a great example of what was to be a sort of ... a touchpoint of people who have low and very mild symptoms, to get them further information, more around the psychoeducation aspect, that was initially to enable them to engage other service providers, to enable first contact if they need more.

But it's really become more of a static website, and that was a bit of a lost opportunity in there. (Mental Health Australia, Canberra transcript, p. 15)

The Australian Government is continuing to develop and expand Head to Health. In the 2018-19 Budget, the Australian Government committed \$4.7 million for the continued operation of Head to Health. In addition, the Australian Government announced in March 2020 that some of an additional \$74 million in funding for mental health would go to making Head to Health:

... a single source of authoritative information and guidance on how to maintain good mental health during the coronavirus pandemic and in self-isolation, how to support children and loved ones, and how to access further mental health services and care. (Morrison, Payne and Ruston 2020)

Future improvements to Head to Health include a plan to expand the list of providers that are included (currently limited to Australian Government-funded organisations) and a Health Professionals page, which is intended to help practitioners use Head to Health and digital services in general with their clients (DoH 2018a, pers. comm., 17 January 2020; NMHC 2018a).

Inquiry participants were supportive of expanding Head to Health and undertaking further activities to promote its use (Almondale, sub. 735, p. 5; RANZCP, sub. 1200, p. 15). BrainStorm Mid North Coast (sub. 803, p. 2) stated:

We agree that the "Head to Health" portal is the best site to coordinate online and telephone services and should be expanded and promoted.

The idea of Head to Health — a central information portal bringing together digital information resources, apps, online programs, online forums and phone services — is a worthy step to help consumers navigate the system and find the services they need faster. Indeed, we consider that a national digital mental health platform to assist people in finding the services that are suitable to them is an important addition for the mental health system (chapter 10).

However, if Head to Health is to be a central point of information, it needs to make far better use of the information collated and managed in other parts of the mental health system. Some State and Territory health departments, primary health networks (PHNs) and other organisations maintain websites that list mental health services available in specific areas, and allow consumers to search for local providers. Head to Health could be integrated into the national digital mental health platform, so that consumers can find the range of services that are relevant to them, learn about the services that best meet their needs (including information on the success of services, as informed by outcomes for other consumers), and be referred to these services for timely help.

Improving assistance phone lines

There is also scope to improve the many phone lines available to individuals, which are a really important gateways into the system. Beyond Blue (sub. 877, p. 32) stated:

For some, the complexity of online navigation or the limits of internet connection mean a phone or text line is the fastest way to get help when they need it. Much like 000 is used to triage people into emergency clinical care, people need a single number to call or text to receive help from non-clinical options as their first port of call.

However, stakeholders have noted problems with the consumer assistance phone lines. Apart from the sheer number, which can be confusing for users, the limited data available suggests many of these phone lines do not have capacity to meet demand. For example, the Kids Helpline was unable to answer 48% of contact attempts in 2018, due to insufficient capacity (yourtown 2019). In addition, the Royal Commission into Victoria's Mental Health System found that the triage phone lines provided by clinical mental health services in Victoria did not have sufficient resources to meet demand (State of Victoria 2019). This situation can be exacerbated in times of crisis. For example, the Kids Helpline and Beyond Blue each reported a 40% increase in calls during the COVID-19 pandemic, and Lifeline reported a 25% increase (Dalzell 2020; SBS News 2020b).

The Northern Territory Mental Health Coalition (sub. 741, p. 13) noted that telephone support services are not used by people living in remote Aboriginal communities due to limited phone coverage, limited privacy to make calls, those answering the call not speaking the language or not having the appropriate skills, and it not being a culturally capable way to engage in personal conversations.

Also, when people do call phone lines and their call is answered, they are often told to try an alternative service and are consequently required to repeat their story multiple times (discussed above).

Some Inquiry participants were supportive of consolidating phone lines, or supported adding a helpline to Head to Health (for example, RANZCP, sub. 1200, p. 15). The 2018-19 Budget also stated that 'funding will ... be provided to the "Head to Health" Telephone Support Service in 2019-20' (DoH 2018c, p. 66). In its submission to this Inquiry, the Australian Government Department of Health (sub. 556, p. 23) also stated that 'a telephone channel, as an alternative to the website, is expected to be implemented later this year'. However, the Australian Government Department of Health (pers. comm., 17 January 2020) has since advised that the telephone is not being prioritised and that Head to Health users have not indicated that an accompanying phone line is needed in the feedback they have provided.

While a central phone line attached to the central online portal has merit, it would not solve the problems with the many other phone lines. Having different phone lines that specialise in different age groups, conditions and geographic locations would mean that people could get support tailored to their needs. However, improvements would need to be made to ensure consumers are receiving this support.

The Australian, State and Territory Governments should ensure that the phone lines they operate, such as the clinical triage lines, and support are adequately funded to improve access to and the responsiveness of these lines and to ensure that they meet the needs of consumers. In addition, referrals from phone lines to other services should be made in such a way as to minimise the need for the consumer to tell their story again. Phone lines should use active, ‘warm’ referrals. Warm referrals involve the person making the referral initiating contact with the organisation they are referring the consumer to, and explaining their circumstances and the reasons they believe the consumer would benefit from the service (QMHC 2015). While warm referrals will impose additional costs on phone line providers, they will benefit the consumer — not only will they reduce the need for people to tell their story again and again, they will also likely reduce the number of people who give up on seeking support after being turned away. The Australian, State and Territory Governments should require the phone lines they fund to implement warm referral processes. However, the Productivity Commission notes that systems and structures would likely need to be improved to allow warm referrals to occur, and as such, this is a longer-term goal.

ACTION 15.1 — LINKING PEOPLE TO THE SERVICES THEY NEED

Assistance phone lines and websites offering support for people with mental ill-health and their carers should improve the information provided on the services available and facilitate better exchanges of information between service providers.

Start now

- The Australian Government should continue to develop and improve Head to Health, including expanding the range of services listed.

Start later

- Head to Health could eventually be integrated with the national digital mental health platform (action 10.4) to provide a one-stop-shop for digital mental health resources.
- The Australian, State and Territory Governments should ensure that government-funded real time consumer assistance services provided by voice or text are receiving sufficient funding to meet consumer demand.
- The Australian, State and Territory Governments should include in contracts with real time consumer assistance services a requirement to implement warm referral processes that minimise the need for consumers to repeat information.

Support for the system's gateways — from GPs to teachers

The sheer scale of the mental health system makes the provision of up-to-date information on help available a challenging task — even for those people who work within the system:

... an important, but fixable, barrier to integrated and collaborative service provision is simply that all participants (users and service providers) do not have ready access to comprehensive and contemporary information about who can give what help and where or by what channels. (Relationships Australia (National), sub. 103, p. 19)

The professionals who act as gateways into the mental health system are not just limited to clinicians and allied health professionals — for example, teachers and education staff, aged care workers, Aboriginal and Torres Strait Islander service providers, psychosocial support workers, Centrelink staff and legal service providers all facilitate entry to the mental health system. However, many of these people neither know where to refer people, nor do they have access to high-quality information about what services are available or have capacity to help. Instead, many professionals rely on personal networks and relationships to find support for people who seek help. Online registries, or lists of providers (for example, Healthdirect (Healthdirect Australia 2020)) do exist in some areas, but too often these sources are incomplete, out of date, or provide insufficient information for people to work out which service is the right one for the particular consumer in front of them at the time.

PHNs are working to support service providers to make better referrals. Most PHNs around Australia, some in conjunction with State and Territory Departments of Health or other providers, have developed online portals, called HealthPathways, to provide information to GPs and other clinicians about referral pathways. The areas which have access to a HealthPathways portal cover 23 million Australians, about 90% of the total population (SNZ, sub. 820, p. 2). The WA Primary Health Alliance (Perth transcript, p. 71) — an alliance of the three Western Australian PHNs — stated:

We've done quite a bit of work around assisting general practice and specialists to navigate the system; so we use HealthPathways here as one of those enablers, both across the country and in Perth. I have to say, GPs aren't the easiest people to get to change a workflow, but to use HealthPathways enables them to do that, and to find the right service.

These websites are based on the HealthPathways model developed in New Zealand, and include detailed information on pathways that can be tailored to consumer needs (Spiller 2015). Not all HealthPathways portals include mental health pathways at this stage, but there are examples of detailed portals with a large range of information (figure 15.2).

Pathways included in these portals are developed in consultation with local service providers, to reflect their agreed model for consumer referrals within the local health system (DoH, sub. 556; SNZ, sub. 820). Developing the pathways is a beneficial process in its own right, as it brings a range of providers together, thinking about a continuum of care and the ways each of them can contribute to a person's recovery. It can uncover, and possibly help to overcome, different eligibility criteria for service access and possible duplication or gaps in service delivery. Further, this regional process of pathway development could potentially

encourage local providers to use the portal, as they contribute to its design and it includes information that is relevant for them. These benefits have been evident in the process of developing HealthPathways in New Zealand (Timmins and Ham 2013). The discussions between providers are a crucial part of developing the pathways — where these are missing, implementation and take up encounter substantial risks (Stokes et al. 2018).

Figure 15.2 **Example of an existing pathway for a person with mental illness in a HealthPathways portal**

Assessment

Making the diagnosis

The diagnosis of bipolar disorder is complex, can be time-consuming, and is ideally made by a psychiatrist.

Consider the phase and type of bipolar disorder:

- [Acute mania or hypomania](#)
- [Acute bipolar depression](#)
- [Mixed episode](#)
- [Rapid cycling](#)

Acute assessment

1. If suspected mania or hypomania, ask about [behavioural changes](#) that are out of character for the patient.
2. Perform [mental health screening](#).

Mental health screening

Look for:

- severity of symptoms.
- level of functional impairment.
- degree of insight.
- presence or absence of psychosis.
- [risk to self or others](#).
- medication compliance.
- use of alcohol, prescription drugs, or drugs of abuse.
- amount and quality of support from family and community services.

3. Assess risk to determine the most appropriate course of management. There is no quantifiable measure of risk – it is useful to think of it as a continuum, however some people will continue to use the [Brief Risk Assessment](#). Ultimately, the decision is based on clinical judgement.
4. If the patient is cooperative, examine to consider [other causes](#) (especially in patients with onset aged > 40 years), and assess for [complications](#).
5. Consider pathology tests e.g., FBC, LFT, TFTs, therapeutic drug monitoring, [urine drug screen](#), and [STI screening](#).
6. Obtain corroborative information where possible, especially if suspected psychosis or concerns about harm.
7. Decide whether the patient needs specialist assessment or can be [managed safely in the community](#).

Source: WA Primary Health Alliance (pers. comm., 4 October 2019).

Evaluations of HealthPathways portals in Australia have found that they were generally well received by GPs, but also underutilised due to lack of awareness, technological barriers and time constraints:

Barriers to implementation were lack of integration with existing GP systems, the inability to make electronic referrals from within HealthPathways, gaining broad penetration across general practices, the busyness of GPs and specialists and limited capacity to write new pathways and to capitalise on redesign opportunities identified in the development process. (Gray et al. 2018, p. 69)

The main barrier to using [HealthPathways] was forgetting to use it. (Gill et al. 2019, p. G)

This type of care navigation portal can provide valuable information to service providers, increase the efficiency of referral processes and lead to substantial cost savings. A recent evaluation found that the use of HealthPathways in Mackay reduced inappropriate referrals from GPs to specialists, generating savings well in excess of implementation costs. The use of four pathways (out of 544 listed on the portal) could result in an estimated saving of \$442 000 per year by reducing unnecessary referrals to specialists; the cost of maintaining the portal was about \$370 000 annually.¹²³ Systemic savings could be much more substantial — if HealthPathways was used for all relevant referrals, it has the potential to save \$3.6 million each year in health costs in the Mackay area alone (Blythe, Lee and Kularatna 2019).

Larger-scale evaluations in Canterbury, New Zealand, where the use of HealthPathways is widespread, have shown a reduction in hospital admissions due to improved integration in primary care, better use of hospital capacity and a substantial decline in patient waiting times (Gullery and Hamilton 2015; Timmins and Ham 2013).

As most areas in Australia have a HealthPathways portal, expanding these portals where required to include detailed mental health pathways, including information on non-clinical services such as social prescribing, appears to be a cost-effective way to deliver information to health professionals and others who are gateways into the mental health system. Access to these portals should be expanded beyond the health sector, in particular to schools and psychosocial service providers, where dedicated staff could use them to locate supports for people who need them. Other types of service providers that would benefit from access to the navigation portals include maternal and child health nurses, tertiary institution counselling services, Centrelink social workers and public housing tenancy managers. In expanding these portals to include non-clinical pathways and providing access to other service providers, it is important to ensure that the content is consumer centred, and developed in a way that is non-stigmatising and helps to empower consumers as part of overall cultural change.

Implementing HealthPathways in all regions in Australia, and expanding the portals, is estimated to include initial once-off costs of about \$2.6 million to \$4.3 million and ongoing annual costs of about \$3.4 million to \$5.7 million, in addition to the cost of developing and maintaining the mental health pathways for clinicians (appendix K).

Inquiry participants were supportive of providing service providers with access to online portals that include information on referral pathways (for example, Mental Health Australia, Canberra transcript, p. 16; MHCT, sub. 869, p. 6; TAMHSS, sub. 919, p. 8). The Consumers Health Forum of Australia (sub. 646, p. 14) stated:

This is a critical mechanism to ensure that providers are aware of the range of services available and can easily refer consumers to those services. Social and community programs that are beneficial for self-management and addressing social determinants (i.e. those used in social prescribing) could also be included in these platforms.

¹²³ There was also a cost of \$282 400 to establish the HealthPathways portal (Blythe, Lee and Kularatna 2019).

Mind Australia, Neami National, Wellways and SANE Australia (sub. 1212, p. 12) were also supportive, but noted that:

The proposed online navigation platforms [should be] developed collaboratively to minimise duplication and maximise the accuracy of information on pathways and entry to the mental health system.

The next step for these information portals is seamless integration with healthcare management software, to enable the creation of single care plans based on the consumer's pathway, and booking appointments with providers directly from the portal — rather than a consumer, carer or care coordinator having to make the booking. This already occurs in some areas in New Zealand, and has contributed to the benefits realised from the HealthPathways portals. A range of application programming interfaces (APIs) are being developed in Australia to allow for greater functionality of the HealthPathways portals (HealthPathways 2019b). Once developed and rolled out, such functionality will increase the usage rates and effectiveness of the portals, minimising the risks that consumers fall through the gaps when referred from one service to another.

The HealthPathways portals could also be linked to the national digital mental health platform. By linking the platform and the portals, users of the national digital mental health platform, such as GPs, would be provided with information on best practice referral guidelines and relevant clinical and non-clinical services for the consumer — and carers and family members — in their area (chapter 10).

One risk of investing in comprehensive information systems is that the information may quickly become outdated, and as a result, the target audience would not use the portals as intended. Maintenance of current information, even for local pathways covering a specific region, can be a costly exercise, but is paramount if the portals are to become a useful resource that is used routinely by clinicians and other providers (PC 2017b). Therefore, there should be a small dedicated team whose role it would be to ensure information is kept up to date, and to support users of each HealthPathways portal. PHN teams — already employed to develop and update HealthPathways in their region and map pathway portals — could fulfil a broader updating role and also assist service providers who do not usually use the services, such as Centrelink social workers (chapter 19).

ACTION 15.2 — ONLINE NAVIGATION PORTALS TO SUPPORT REFERRAL PATHWAYS

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

Start now

- All regional commissioning bodies should, either individually or collaboratively, develop and maintain an online navigation portal, including detailed clinical and non-clinical referral pathways. The HealthPathways portal model, which is already used by most PHNs, could be used as a basis.
- Access to these portals should be expanded beyond the health sector, in particular to schools and psychosocial service providers. Each regional commissioning body should also, either individually or collaboratively, fund a small dedicated team supporting the users of the online portals.

Start later

- All online navigation portals should be integrated with the national digital mental health platform (Action 10.4) and support the ability to book consultations with service providers directly from the platform.

15.3 Enabling coordination and continuity of care

Coordinated care is an important part of a consumer-oriented system, based on information sharing between all service providers involved in a person's care and joint planning of assistance and treatment. A lack of coordinated care can have substantial effects on consumer outcomes:

A mental health system that is not sufficiently connected exposes affected individuals, their families and carers, and their communities to increased risks of adverse health and social outcomes. For individuals living with anxiety or depression, a lack of integration and coordination between mental health services may frustrate their efforts in finding appropriate care and, over time, impact on their ability to remain gainfully employed. For individuals living with severe or chronic mental disorders, it may limit their ability to break the cycle of prolonged illness and dependency, ongoing discrimination and psychosocial disability. This increases their risk of poverty, isolation, marginalisation and homelessness. (DoH, sub. 556, p. 10)

Depending on the consumer's needs and preferences, and the number of providers supporting the consumer, the mental health system should take a tiered approach to providing care coordination support. This includes:

- information sharing — for all consumers, information sharing between service providers, with consumer consent, is the foundation of coordinated care. This can mitigate the need for consumers to retell their story every time they meet a new service provider, or act as an information conduit between various providers. While some digital information is being shared, much more information sharing can be achieved (finding 15.1)

-
- single care plans — people with moderate to severe mental illness¹²⁴ who access support from multiple providers (for example, due to physical comorbidities) would benefit from team-based care. These consumers should have access to single care plans, which will be accessible to the consumer and all providers and allow them to coordinate care and interventions (action 15.3)
 - care coordination services — people with severe and persistent mental illness and complex social or health needs should have access to both a single care plan and a care coordinator to help them oversee the implementation of their plan and access the services they need. These care coordinators would work directly with consumers, their carers, clinicians (or clinical coordinator) and providers from other sectors, to establish the connections to, and assist in sustaining engagement with, the range of services needed and facilitate coordinating those services (action 15.4).

Implementing these different forms of care coordination would allow the mental health system to focus more on a recovery-oriented approach — rather than dealing with crises. Healthcare providers would have access to the service components necessary for care plans to support their clients in stabilising their condition and improving their wellbeing.

Facilitating effective information sharing

Many consumers and carers access multiple services when receiving care and support; for example, 59% of people with long-term mental illness report having a co-existing physical illness (chapter 2).¹²⁵ There is also an estimated 354 000 people who require care coordination services due to the multitude of services they need (discussed below).¹²⁶

Information sharing between sectors and providers can improve efficiency and ensure that consumers and carers experience continuity of care. Mental Health Australia (sub. 864, p. 32) said:

An integrated, person-centred system will be reliant on information management systems that strongly protect consumers' data and privacy, while allowing them to grant access to shared information to chosen health professionals. Without information sharing, consumers unnecessarily bear the burden associated with seeking new services and have to tell their story again and again, which reduces help-seeking behaviours.

But in the existing mental health system, there are substantial barriers to routine information sharing between service providers, including:

- limitations, or perceived limitations, imposed by legislation
- information management systems that do not support data sharing
- cultural barriers to sharing information and collaboration (PC 2017a).

¹²⁴ Chapter 2 includes a description of the severe and moderate categories.

¹²⁵ In comparison, for those without a mental illness, the prevalence rate of a physical illness is 48% (chapter 2).

¹²⁶ Productivity Commission estimates using DoH (sub. 556).

For example, Bree Wyeth (sub. 579, p. 1) stated:

I am routinely in possession of crucial information and have an important role in the promotion of the wellbeing of mentally disordered offenders that also pose a real risk to themselves and others. I am however prevented from sharing this information by mindless bureaucratic processes that privilege the Justice and/or Health system and has long since lost sight of the persons concerned, both the workers and the service users.

Over the years, the Australian Government has made a number of attempts to improve the sharing of health data — mostly recently, through the creation of digital health records. My Health Record has been gradually rolled out since 2016, and by early 2019, 90% of Australians had a digital health record (ADHA 2019). There are also examples of jurisdictional digital health records, such as the eMR in New South Wales (Mental Health Commission of New South Wales, sub. 486, p. 30), and there are other digital tools that have been developed by the private sector, such as the InnoWell Platform, which collates health information from consumers that both the consumer and their health professionals can access (InnoWell Pty Ltd, sub. 153).

Stakeholders were divided in their views on the usefulness of a single digital health record for people with mental illness (box 15.4). While some raised concerns about the quality of the information involved, others called for broadening the scope of digital health records to encompass all parts of the mental health system, including non-clinical and other support service providers. The Aboriginal Medical Services Alliance NT (sub. 1190, p. 7) stated ‘the NT [Aboriginal Community Controlled Health Services] sector is a committed user of My Health Record and particularly recognise its importance for transient client populations’. In addition, the Primary Health Networks Cooperative (sub. 850, p. 27) said:

We agree that expanding the use of digital records in the mental healthcare system would facilitate greater information sharing and improve consumer experience ... The My Health Record system could provide an adequate platform for information sharing between providers of mental healthcare services and healthcare more generally.

The Consumers Health Forum of Australia (Canberra transcript, p. 33) also said:

My Health Record is a personally controlled health record. It’s not your full set of clinical notes. If anything, people with complex mental health conditions, multi-morbidity, are the greatest beneficiary of this.

The issue is utility, doctors using it, Allied Health using it ... connectivity and the social licence around public confidence and trust and ... I think the more it embeds and the [more] it gets used, ... the more it will become part of our health service landscape because, ... from a safety and quality point of view different clinicians involved in different aspects of someone’s care just being able to see what sort of meds people are on and the range of meds they’re on with consent are so important ... [There are] so many misadventures and missteps and people having to bounce backwards and forwards between clinicians because some of that basic stuff around a care plan is not immediately evident or shared.

Box 15.4 Participant views on digital health records

Digital health records are becoming increasingly common across the health system, although there are still barriers that curtail potential benefits, such as misinterpretation of legislation and concerns about data security. Some Inquiry participants were unequivocal in their support for digital health records. For example, the Mental Health Commission of New South Wales (sub. 486, p. 30) stated:

Electronic medical records support improved communication and sharing of information between health care providers. Perceived barriers to legally sanctioned information sharing must be overcome.

Others raised concerns about the quality of information included by service providers, as well as privacy concerns:

While there is an argument to be made for a single comprehensive clinical record as a means of centralising health information, the usefulness of such an instrument relies heavily on the quality of the information provided by services and programs. Since qualitative health data can be subjective and lack detail, and there can be administrative delays in finalising and uploading key resources such as discharge summaries, it is not so much the concept as the implementation of this measure that will determine its success in coordinating care. (ACT Mental Health Consumers Network, sub. 297, p. 8)

The use of electronic health records for mental illness poses many concerns and we do not believe e-health records should be compulsory or phased in as a necessary part of the stepped care model ... Some of these concerns include privacy, data retention and confidentiality. The use of e-health records needs to be [a] matter of individual choice, and not implemented without consent by the service provider. (Brainstorm Mid North Coast sub. 309, p. 3)

The psychiatrist wrote I have schizophrenia on myhealthrecord.gov.au [and] now I will not be able to find a doctor in Australia who doesn't think I have schizophrenia. That's the problem with electronic health record[s] if one doctor makes a mistake all the rest repeat it. (Tania Budimir, sub. 651, p. 13)

The whole information sharing is a worry for me, because it's not accurate information. So I avoid seeking services because they'll just share information. ... if I could have a reasonable input into My Health Record, I would probably have a My Health Record. (Colin Hales, Canberra transcript, p. 59)

Inquiry participants also stated that allied health professionals only have read access to My Health Record:

Allied health professionals are therefore restricted to read-only interaction through the National Provider Portal and are unable to upload information to the My Health Record system. As a result, many individual My Health Records will be missing important information from allied health practitioners that would support best-practice mental health care. Government support for allied health professionals to connect with and implement My Health Record will be essential to enable the record sharing described by the Productivity Commission. (AHPA, sub. 834, p. 3)

Some stakeholders argued for the need to create a joint digital record that would go beyond healthcare, to include psychosocial services and other types of support:

As part of improving integrated service delivery, there were also calls from people with lived experience and their families, and service providers for a shared data tool, both between government sectors and between government and NGOs, so that service users did not have to re-tell their stories over and over again. It was recognised that there may be privacy concerns around this, and that any shared database would require some level of client and/or carer consent. (SAMHC, sub. 477, p. 31)

Noting the links between mental health, alcohol and other drug use, family and domestic violence, and homelessness, DLGSC also encourages establishment of appropriate information sharing mechanisms between sectors to enable appropriate and effective service delivery to those affected. (DLGSC, sub. 78, p. 3)

(continued next page)

Box 15.4 (continued)

Others suggested that the mental health system required a fully integrated ICT system:

We believe that having an integrated ICT system has the potential to enable acute, primary, and community service providers to access more accurate and detailed clinical information to identify families at risk and inform clinical decision-making. It is essential for service coordination across the continuum of care, and could assist interagency communication across organisational boundaries, and provide evidence of outcomes. It also has the ability to integrate clinical and financial information across services, which is important for monitoring cost effectiveness. (RASA, sub. 420, p. 25)

... an integrated, streamlined and centralised information exchange portal providing a communication and referrals system for medical practitioners, emergency service workers, social services, the justice system, the education system and mental health support organisations [is needed] to adequately support people with mental health disorders and conditions. An example of how this portal could be used would be for police, ambulance and mental health services to keep one another advised and up to date regarding a person who is experiencing a mental health crisis and displaying aggressive behaviour so they can understand the situation and can respond in an appropriate manner. (Martha Henderson, sub. 65, p. 3)

Such integrated information management systems are likely to be very costly and complex to implement (PC 2017a). The existing system of digital health records provides an adequate platform for information sharing between mental healthcare providers — if it is used consistently, and records are current and comprehensive. However, issues including the low awareness of digital health records and their benefits, and clinicians not being required to input information into a health record if the consumer requests it, need to be addressed.

FINDING 15.1 — DIGITAL RECORDS WOULD FACILITATE INFORMATION SHARING

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

Single care plans for consumers accessing multiple clinical services

Digital health records that allow different healthcare providers to share information will be helpful in many cases, but people with moderate to severe mental illness, who access a larger number of services, are likely to require single care plans.

A single care plan is not intended to integrate all clinical and support records into one single record. It is intended, at a minimum, to identify the clinical and non-clinical support and care provided to an individual (as opposed to shared care plans, where multiple plans for an individual are developed independently by the various clinicians and other service providers with whom the consumer interacts and are shared between these providers).

An individual's single care plan would be developed and agreed on with the consumer, their carer (if applicable) and all the various service providers. The coverage of, and detail contained in, the plan would vary from person to person according to their needs and preferences at particular points in time, but could include a plan to address aspects such as mental healthcare, physical healthcare, cultural and spiritual needs, psychosocial needs, housing needs, community inclusion needs, the role of their carer or kinship group, and reintegration into education or the workforce. The consumer would choose which of their services providers will help them to manage their care plan, and the consumer would have the final say over what information in the plan is shared with each provider (discussed in more detail below).

The concept of a single care plan is well established in mental health services — for example, the 2010 National Standards for Mental Health Services include a requirement for a 'current individual interdisciplinary treatment, care and recovery plan, which is developed in consultation with and regularly reviewed with the consumer and with the consumer's informed consent, their carer(s) and the treatment, care and recovery plan is available to both of them' (Australian Government 2010, p. 25). The need for a comprehensive care plan was reiterated in the 2018 National Safety and Quality Health Service Standards (ACSQHC 2018).

The National Mental Health Commission's 2014 review recommended that a single care plan and eHealth record be implemented for those with complex needs. It stated that this approach 'gives public sector, NGO and private providers a vehicle to enable a whole-of-person approach to the care and support of people with complex needs' (NMHC 2014c, p. 70). The review recommended that, over time, the integrated care and support should extend beyond the health system and single care plans might include, for example, employment or housing services.

The current PHN guidance on primary mental healthcare services for people with severe mental illness states that, in the longer term, PHNs will be expected to:

... promote the use of a single multiagency care plan for people with severe and complex mental illness, to help link providers across multiple services involved in an individual's care and to promote a medical home approach. (DoH nd, p. 1)

There are examples of PHNs actively promoting the creation of single care plans. The Eastern Melbourne PHN is part of the Eastern Mental Health Service Coordination Alliance, which uses care plans when treating consumers in the Eastern Metropolitan region of Melbourne. The plan includes the consumer's identified goals, collaborative actions to be taken against the goals and roles and responsibilities of those involved in providing care (EMHSCA 2018). The Northern Territory PHN is working towards the implementation of an electronic shared care planning tool, that will support single care plans (NT PHN 2018). In addition, the Murrumbidgee Primary Health Network (sub. 1199, p. 7) is finalising a single care planning protocol and planning tool, which includes an online platform aimed at improving visibility and communication between service providers.

Inquiry participants were supportive of the use of single care plans.¹²⁷ The National Mental Health Commission (sub. 949, p. 14) stated:

The NMHC supports ... the development of single care plans for consumers with moderate to severe mental illness who are receiving services across multiple clinical providers. The NMHC has previously noted that a shared single care plan links providers into a person-centred approach with the positive outcome of a person with a lived experience only needing to tell their story once, not many times.

Relationships Australia (National) (sub. 103, p. 14) highlighted the implications for consumers when single care plans are not put in place:

Individualised interagency care plans that go with the client would be very helpful. This would include clear protocols over who is responsible for what, procedures to negotiate gaps, and short, medium and long term strategies for supporting clients, particularly those with severe and complex mental health issues. The absence of such a consistent approach often leads to crisis situations and presentations to what is often the only available alternative – busy Emergency Departments, and treatment approaches not always well matched to client needs.

Who needs a single care plan?

There are two categories of people who would benefit most from having a single care plan. The first group includes people with physical health and substance use comorbidities, where their mental illness is their primary condition, and who require coordination between primary care, specialist mental healthcare and other clinical service providers.¹²⁸ The second group includes people with moderate and severe mental illness who require psychosocial support services due to their mental illness, and are not receiving care coordination services (which would also include single care planning as discussed below).

There are about 400 000 people who require high intensity care who fall into these categories.¹²⁹ However, as discussed above, some people already have a single care plan; therefore, the number of people who would require a single care plan for the first time is lower.

¹²⁷ Alcohol and Drug Foundation (sub. 775, p. 3); BrainStorm Mid North Coast (sub. 803, p. 3); CHF (sub. 646, p. 14); DAA (sub. 766, p. 8); EACH (sub. 875, p. 2); EDV (sub. 892, p. 3); headspace Geraldton (sub. 617, p. 2); headspace – National Young Mental Health Foundation (sub. 947, p. 33); Lived Experience Australia (sub. 721, p. 1); Mental Health Carers NSW (Sydney transcript, p. 99); Mental Health Complaints Commissioner (Victoria) (sub. 916, p. 5); MHCT (sub. 869, p. 6); MHV and VHA (sub. 1184, p. 11); Mind Australia, Neami National, Wellways and SANE Australia (sub. 1212, p. 24); MNHHS, Brisbane North PHN, MSHHS and Brisbane South PHN (sub. 874, p. 5); Murrumbidgee Primary Health Network (sub. 1199, p. 7); NT PHN (sub. 1213, p. 15); QAI (sub. 889, p. 10); RAV (sub. 1197, p. 14); Robert Davis (sub. 772, p. 23); Samaritans Foundation (sub. 121, p. 6, sub. 785, p. 6); SAMHC (sub. 691, att. B, p. 3); TAMHSS (sub. 919, p. 8).

¹²⁸ Where their mental health issue is not their primary chronic condition, these people would benefit from a single care plan based around their primary chronic condition, which is outside the scope of this Inquiry.

¹²⁹ Productivity Commission estimates using DoH (sub. 556).

Arrangements needed to facilitate single care plans

Inquiry participants noted a range of things that must happen for single care plans to be effective, including ensuring the plans include services beyond the health sector and that these services have access to the necessary data sharing systems (MHCC, sub. 920, p. 16; QMHC, sub. 712, p. 5).

The effective development and operation of a single care plan would necessitate:

- protocols for sharing consumer information between service providers, as discussed above, and obtaining consumer consent for the creation of a single care plan
- clear accountability structures to allocate responsibility for plan development, follow-through and updating
- financial arrangements that incentivise this to occur.

The consumer and, if relevant, their carer, should be involved in deciding which service provider is responsible for developing and managing the plan with the consumer. In many cases, the consumer's primary treating clinician (or a nominated member of the clinical team) would end up being chosen to help develop and manage the plan. Consumers and where relevant carers should also be involved in all aspects of plan development, including selecting specific service providers, setting treatment outcomes and deciding which providers have access to each part of the care plan. Consumers should have ownership and control over their single care plan, similar to the arrangements for My Health Record. Inquiry participants argued strongly for consumers to be involved in the development and management of single care plans and be leaders in their own care (CHF, sub. 646, p. 14; Mental Health Australia, sub. 864, p. 11; Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212, p. 24). The ACT Government (sub. 1241, p. 8) stated:

There is considerable value in a single care plan with strong input and ownership by the person themselves and the plan having a recovery focus rather than a care focus. A single coordinated recovery plan would be a preferred approach. The plan should be able to comprehensively cover all aspects of a person's life that are relevant to their treatment and recovery including housing, community and economic participation and physical health. Rather than the system defining who will manage the plan, this could be an approach that is flexible and takes into account the person's preferences, the legal context in which the plan is made and a multi-disciplinary and multi-agency approach that actively involves the person. Further it will be critical to determine how the plan is amended and by whom.

In many cases, the consumer's GP would be responsible for developing and managing the care plan. The Medicare Benefits Schedule includes item numbers for the management of chronic disease, which cover the development and review of care plans, and could be used for mental health single care plans (box 15.5). The Productivity Commission has estimated that the cost of claiming the development and review of mental health single care plans (under the Medicare Benefits Schedule) could be \$38 million to \$61 million per year (appendix K).

Box 15.5 Medicare Benefits Schedule Chronic Disease Management items

The Chronic Disease Management Medicare items are for GPs to manage the healthcare of people with chronic or terminal medical conditions, including those requiring multidisciplinary, team-based care from a GP and at least two other health or care providers.

A chronic medical condition is one that has been, or is likely to be, present for six months or longer. There is no list of eligible conditions, however, examples include asthma, cancer, cardiovascular disease, diabetes, musculoskeletal conditions and stroke.

A summary of what each item covers is presented below:

- 721 — Preparation of a GP Management Plan
- 723 — Coordination of Team Care Arrangements
- 729 — Contribution to a Multidisciplinary Care Plan, or to a Review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility
- 731 — Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility
- 732 — Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements

Source: DoH (2016b, 2020g).

While there will be one person responsible for working with the consumer to oversee the care plan, all service providers would be responsible for updating the care plan on treatment progress over time using a shared electronic tool (My Health Record can be used for this purpose). Depending on individual circumstances, a wide range of care providers may need to contribute to the single care plan or update it with new information — either by accessing a digital health record, or via a face-to-face discussion. This is likely to be part of the routine care provided to the consumer (similar to the way psychologists are required to update referring GPs on the course of treatment under existing Medicare Benefits Schedule guidelines). The sharing of care information between service providers contributing to a single care plan should be mandatory.

Consumers with more complex needs are often treated by community-based mental health services, which are funded by State and Territory Governments. For these clients, single care plans are likely to be particularly important, given the severity of their symptoms and the likelihood that they require treatment and support from multiple providers. Therefore, the creation of a single care plan should be part of their routine care protocols, rather than attract separate funding.

ACTION 15.3 — SINGLE CARE PLANS FOR PEOPLE WITH MODERATE TO SEVERE MENTAL ILLNESS

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

Start later

Governments should develop and promote protocols for:

- consumer and, where appropriate, carer involvement in single care plans
- allocating responsibility for plan development and review, with consumers being directly involved in plan development and having choice over which of their service providers manages their care plan
- sharing consumer information between service providers and updating the plan, with consideration given to any legal issues that may arise as to who (apart from the consumer) is able to share the information contained in the plan.

Care coordination for consumers with complex needs and severe mental illness

Consumers with the most complex mental health needs should have both a single care plan and a dedicated care coordinator who works alongside service providers to oversee the implementation of the plan.

Complex mental health needs arise when a consumer is diagnosed with a severe and persistent mental illness, and also requires disability services due to an ongoing psychosocial disability, or social services, due to other adverse circumstances, such as unemployment or homelessness. These consumers often interact with a large number of service providers, within and beyond the health system (box 15.6). In these cases, a care coordinator can help ensure that the consumer accesses the services they need and does not ‘fall through the cracks’ in the system. This can support consumers’ wellbeing and prevent unnecessary hospitalisations. NT Shelter (sub. 879, p. 3) submitted:

The use of care coordinators for people with severe and complex mental illness is imperative in clients achieving their goals and maintaining stable housing tenancies.

There is scope to improve care coordination

There are already government-funded programs offering care coordination services to people with mental illness, including through the National Disability Insurance Scheme (NDIS). However, the coordination of care is often ad hoc, with Inquiry participants arguing that gaps and shortages exist. The ACT Government (sub. 1241, p. 20) said there is a gap in care coordination services for people with complex needs. And Launch Housing (Melbourne transcript, p. 50) stated that the availability of ongoing clinical case management is limited and difficult to access.

Box 15.6 Challenges faced by consumers with complex needs

It is not unusual for consumers of mental health services to interact with more than one service provider. Robert Parker (sub. 12) provided a case study of 'JS', a 40 year old male with chronic schizophrenia who potentially required 12 different services.

Example of services required by 'JS'

Service	Delivered by	Funded by
Hospital and community mental healthcare	Hospital and mental health service	State and Territory Governments
Specialist psychiatric review	Mental health service and private psychiatrist	Australian, State and Territory Governments
Medication	Hospital pharmacy and Pharmaceutical Benefits Scheme	Australian, State and Territory Governments
Primary care	GP and Aboriginal Community Controlled Organisation	Australian Government
Housing	State or Territory Government Department and non-government Organisation	Australian, State and Territory Governments
Psychological/trauma focused care	Psychologist (Medicare Benefits Schedule) and Aboriginal Community Controlled Organisation Social and emotional wellbeing worker	Australian Government
Crisis line and online mental health support	Crisis line and Beyond Blue	Australian Government
Drug and alcohol treatment	State or Territory Government Department and non-government organisation	Australian, State and Territory Governments
Forensic (prison)	Prison medical service	State and Territory Governments
Forensic (community)	Community corrections	State and Territory Governments
Community integration and workforce participation	Various	Australian, State and Territory Governments
National Disability Insurance Scheme support	National Disability Insurance Scheme	Australian, State and Territory Governments

Source: Adapted from Robert Parker (sub. 12, pp. 2–3).

In addition, while not all consumers who would benefit from a care coordinator have access to one, we have heard of cases where consumers have multiple care coordinators, with overlapping responsibilities:

I have lost count [of] how many case managers I have had between my employer, Comcare, rehab provider etc. The system doesn't allow for continuity of care. This leads to having to repeat oneself so many times that in itself contributed to the continued downward spiral (comment no. 8, consumers)

Jesuit Social Services notes that there may be a number of caseworkers from several organisations supporting a person with multiple and complex needs. Care coordination can be unclear and the sharing of information inconsistent, even when regular meetings are scheduled between caseworkers supporting the person. (Jesuit Social Services, sub. 441, p. 19)

Box 15.7 **Examples of mental healthcare coordination in Australia**

There are numerous examples of existing care coordination services that people with severe mental illness may be eligible for.

Primary health networks (PHNs) are expected to commission clinical care coordination services for people with severe mental illness (DoH nd). One example of a PHN-commissioned initiative is the Mental Health Integrated Complex Care program. Commissioned by the South East Melbourne Primary Health Network, the program is intended to assist consumers with severe mental illness and complex needs who need coordination of their care over an extended period of time. Services are matched to individual needs and can include clinical nursing services, family support and liaison, clinical and non-clinical care coordination and liaison, and improved access to psychiatrist and psychological care (SEMPHN 2019).

The Integrated Team Care program is also funded through PHNs, and supports Aboriginal and Torres Strait Islander people with chronic disease, which can include mental illness. In addition to care coordination services, it also assists mainstream services in delivering culturally competent care (DoH, sub. 556, p. 16).

Three PHNs are participating in the Link-Me trial, which includes an assessment of needs conducted in GP practices. Where required, people with severe or complex needs are referred to a care navigator, who works with them and their GP to develop a care plan and ensure that all parts of the plan are working together well (DoH, sub. 556, p. 49; NC PHN nd).

Some care coordination programs are funded by state and territory governments. For example, as part of the Victorian Multiple and Complex Needs Initiative, a care plan coordinator works with the consumer to develop a personalised care plan, which aims for stable housing, health, wellbeing and safety, and increased social connectedness. Services can include mental health services, housing services, drug and alcohol services, disability and health services, justice and correctional services, and services provided by Aboriginal community-controlled organisations (VIC DHHS 2019c). Similar programs, focusing on coordination of health services, exist in other jurisdictions as well (for example, WA DoH 2019a).

Inquiry submitters have also raised specific issues with the coordination support provided through the NDIS (for example, Aftercare, sub. 835, p. 16; VLA, sub. 818, p. 4). Inclusion of support coordination in plans for people with psychosocial disability is low (NMHC 2019a). Inquiry participants also noted that inclusion of support coordination in plans has not been consistent.

Specialist and Support Coordination services under the NDIS are typically underfunded, and frequently, an individual who receives Specialist Support Coordination in their first plan only receives Support Coordination in subsequent plans, despite the fact that their needs have not as yet changed. (APS, sub. 853, p. 27)

Currently, the inclusion of Support Coordination in NDIS plans for consumers has not been consistent and in many cases is removed from plans after the first year. Given the importance of care coordination for consumers with complex needs, we recommend that Support Coordination be stated as a key component of a consumer's NDIS plan. (Merri Health, sub. 855, p. 4)

Carers NSW (sub. 808, p. 11) also submitted that NDIS support coordination, including specialist support coordination is intended to be time limited and not long-term care coordination.

In response to concerns about support coordination, and more generally, the support provided to people with psychosocial disability in the NDIS, the NDIS is introducing recovery coaches, which will combine recovery and support coordination functions (Skatssoon 2020). The transition to the NDIS is discussed in detail in chapter 17. It is important that NDIS participants receive comprehensive care coordination services where required.

While estimates of number of consumers with severe and persistent mental illness who may need care coordination services exist (such as estimates from the National Mental Health Service Planning Framework), there are no reliable estimates of the number of consumers who receive care coordination services from existing programs. Nonetheless, evidence suggests service gaps exist. For example, inclusion of support coordination in plans for people with psychosocial disability is low. This is despite the fact that these people often need assistance in accessing support services and navigating the system (NMHC 2019a). More broadly, in its review of progress made in the implementation of the Fifth National Mental Health and Suicide Prevention Plan, the National Mental Health Commission (2018a, p. 22) found that ‘[d]espite ongoing efforts by governments and service providers, many people with severe and complex mental illness still do not receive the supports they need’.

In 2018, many of the relevant stakeholders (the Australian Government’s Department of Health, State and Territory Departments of Health, and PHNs) reported to the National Mental Health Commission that their work to improve coordination was ‘on track’. Initiatives undertaken included agreements to provide psychosocial supports, commissioning new services and assisting GPs (NMHC 2018a).

The National Mental Health Commission found substantial barriers preventing further progress towards better coordination of care. These included:

- the transition to the NDIS and the ensuing confusion around who can access psychosocial support services (including care coordination), which were identified as significant barriers to coordinated care for both State and Territory Departments of Health and PHNs. This issue is explored in detail in chapter 17, including recommendations to remedy the current situation
- structural weaknesses within the mental health system, including inconsistent shared care protocols, and the lack of defined referral pathways
- other issues such as resistance to change among providers and insufficient funding (NMHC 2018a).

Addressing these barriers requires a nationally consistent approach, based on a common benchmark for service delivery. The goal of the mental health system should be to ensure that all consumers with severe and persistent mental illness, who access multiple support services, have a single care plan and a care coordinator to help oversee it — and this should

be the benchmark against which service delivery levels are assessed. All governments and regional commissioning bodies need to ensure these services are available in the region they are responsible for, by either employing care coordinators directly or commissioning care coordination services.

The care coordinators should work directly with the consumer, their carer (if applicable) and service providers to ensure that all required supports are available to the consumer in a coordinated way. This includes non-clinical support, such as housing, employment and education. To ensure that consumers receive the best possible care, the consumer will need to agree to each of their care providers having access to the information about their treatment and needs that is necessary to receive a service.

Inquiry participants were supportive of the Productivity Commission's care coordination model.¹³⁰ However, some Inquiry participants argued for a broadening of the scope of the model. Mental Health Australia and Carers NSW argued for extending eligibility beyond those with severe and persistent mental illness:

... the scope of eligibility for care coordinators should be broadened beyond 'severe and persistent' to ensure the reformed system does not entrench the lack of access to services for those with moderate mental illness, the 'missing middle'. Severity of illness does not necessarily correlate to intensity of care or support services required, nor does it necessarily take into account co-morbidities which will require care coordination for consumers to receive truly integrated care and support across the mental health, health and social care systems. (Mental Health Australia, sub. 864, p. 31)

... Carers NSW feels that access to care coordination should be extended to people living with mild or moderate mental illness who have complex health and social needs to minimise the likelihood of further deterioration and ensure no additional strain is placed on carers to facilitate access to available supports. (Carers NSW, sub. 808, p. 11)

We are of the view that care coordination services should primarily be provided to people with severe and persistent mental illness, as it is this severe and persistent mental illness that can lead to the difficulties people face in managing their own care.

Inquiry participants also discussed the barriers that need to be overcome to implement effective care coordination. For example, Relationships Australia Victoria (sub. 1197, p. 14) stated that care coordination and single care plans 'would be greatly enhanced by effective shared case management software'.

¹³⁰ Alcohol and Drug Foundation (sub. 775, p. 3); AMSANT (sub. 1190, p. 8); APS (sub. 853, p. 27); Carers NSW (sub. 808, p. 11); Carers Victoria (sub. 664, p. 14); cohealth (sub. 846, p. 4); headspace (sub. 947, p. 33); Jeni Diekman (Sydney transcript, p. 154); Jesuit Social Services (sub. 1186, p. 1); Lived Experience Australia (sub. 721, p. 1); Mental Health Australia (sub. 864, p. 31); Mental Health Complaints Commissioner (Victoria) (sub. 916, p. 5); Merri Health (sub. 855, p. 4); MHCT (sub. 869, p. 6); MHV and VHA (sub. 1184, p. 11); NT Shelter (sub. 879, p. 3); Orygen (sub. 1110, p. 7); QAI (sub. 889, p. 10); RAV (sub. 1197, p. 14); Samaritans Foundation (sub. 785, p. 6); SAMHC (sub. 691, att. 2, p. 3); TAMHSS (sub. 919, p. 8).

Who should the care coordinators be?

Existing care coordination services employ staff with a wide range of skill sets — social workers, mental health nurses, GPs, psychologists, psychiatrists, occupational therapists and Aboriginal and Torres Strait Islander health workers. There is also a very wide range of training programs focusing on care coordination, including short online courses, Vocational Education and Training-level qualifications and units delivered as part of university degrees (myskills nd; Primary Health Tasmania 2016; Victoria University 2019).

The Productivity Commission’s model of care coordination focuses on connecting clinical and non-clinical supports for consumers and helping facilitate the navigation between them. Tasks the care coordinator would be required to undertake could include:

- helping to develop and implement the consumer’s care plan
- working with the different service providers (including clinical and non-clinical) to ensure the consumer is getting the care they need
- working with, involving and helping carers (where applicable)
- helping to link the consumer with other services that might be needed but could be outside the care plan
- for people admitted to hospital, overseeing the implementation of a comprehensive discharge plan¹³¹
- providing advice and guidance to the consumer, their carer and family members throughout the process.

While clinical skills may be helpful, perhaps the most important skill required from a care coordinator is the ability to relate to their client:

... care coordination is most importantly about building a positive working relationship with a person in order to develop care plans that address their needs, strengths, and goals. (AASW, sub. 432, p. 3)

An evaluation of Partners in Recovery, a psychosocial support program based around care coordination delivered by ‘support facilitators’, found that staff working directly with clients had a wide range of backgrounds, but their personal skills were particularly important:

The interpersonal skills of Support Facilitators are crucial for developing effective relationships with clients, carers and service providers ... Effective Support Facilitators reportedly persist in the face of challenges, are resilient and have a positive attitude. They are also required to be lateral thinkers, able to respond to opportunities as they arise, and develop creative and innovative solutions within service system constraints. It is also vital that Support Facilitators are patient as sometimes it can take some time to develop an effective relationship with a client and to see progress towards meeting their objectives in their Action Plan. Support Facilitators also need to be independent and non-judgemental in their approach with clients. ...

¹³¹ If the person lives in a different region from where they are admitted to hospital, a local care coordinator would ensure the relevant information is shared with the care coordination services closest to the person’s home.

Support Facilitators require a base level of skills including knowledge of the health and welfare sectors and experience working with people with mental illness. ... Some Support Facilitators are clinically trained in mental health, while others have community development or other services experience. ... Some [Partners in Recovery] Organisations suggested clinical training in mental health should be a mandated requirement of both the Support Facilitator role and intake officer to ensure staff had the appropriate knowledge and skills to manage risks. (Urbis 2015b, pp. 19–20)

Some care coordination programs funded by governments in the past were staffed by mental health nurses. For example, the Mental Health Nurse Incentive Program had a care coordination component, but nurses employed as part of the program also provided ongoing therapy as well as information and support on managing physical illness (DoH 2012). However, the care coordination model envisaged by the Productivity Commission does not include clinical intervention.

Inquiry participants had views on the qualifications and skills required by care coordinators (for example, DAA, sub. 766, pp. 8–9). Mind Australia, Neami National, Wellways and SANE Australia (sub. 1212, p. 25) said that care coordinators:

... must be highly skilled people, able to work at the top of their scope of practice (and be paid accordingly), who are conversant with psychosocial supports as well as being able to liaise with clinical services.

Carers Victoria (sub. 664, p. 14) also stated the importance of coordinators understanding and receiving training on the care relationship, the expertise of carers and the health needs of carers.

Evaluations of similar models have suggested that care coordinators should be recruited from outside of the existing mental health workforce, and hold vocational qualifications (Brophy et al. 2014). Vocational qualifications can give care coordinators the skills to navigate the mental health system, and support a culture of collaboration that puts the consumer's needs at its centre. The Productivity Commission believes that an expectation that all care coordinators have clinical training would create significant barriers to successful implementation of the care coordination model. The Productivity Commission's approach does not require care coordinators to have a clinical background.

A staged implementation approach

Part of the challenge facing local mental health services in implementing care coordination initiatives is a lack of clarity on the extent of demand for services. Programs implemented to date, such as the Mental Health Nurse Incentive Program, have been 'supply-driven', and services were expanded only when accredited staff became available (DoH 2012). At the same time, the different programs offering care coordination makes it difficult to know how many consumers are already receiving services and what gaps remain.

The lack of data is a challenge when planning the implementation of the care coordination model. To overcome this, the Productivity Commission proposes a staged implementation approach.

The first step involves local commissioning authorities undertaking a comprehensive audit of care coordination services available in their region, and building a clear picture of demand levels and services available, including those funded through the NDIS, using the National Mental Health Service Planning Framework.

Based on this audit, governments should set a benchmark for all commissioning authorities to ensure that all people with severe and persistent mental illness who require care coordination services due to their complex health and social needs and who want them are receiving them. About 354 000 people have severe and persistent mental illness with complex needs. About 64 000 of these people are expected to receive services through the NDIS (chapter 17). This leaves 290 000 people. However, some of these people would already be receiving care coordination services (although estimates of the number of people are not available). Therefore, the audit of existing services is likely to yield cost savings, as services are streamlined. This will also be beneficial for consumers, who will have one initial point of contact for all their coordination needs, rather than having to navigate between different services.

The care coordination needs of the 290 000 people will vary. For example, while some will require ongoing care coordination covering services and providers from a range of sectors, many will require short-term coordination, with the coordination task being more simple, covering fewer services and providers.

The Productivity Commission has estimated the annual cost of providing care coordination services to 290 000 people could be about \$138 million to \$353 million per year based on National Mental Health Service Planning Framework care profile costs and other costing assumptions (appendix K). However, this could be an over or underestimate of the actual cost for a number of reasons including:

- some people are already receiving care coordination support through PHN and state and territory government programs
- some people are receiving multiple care coordination services
- the National Mental Health Service Planning Framework does not include all non-clinical supports and may underestimate the amount of care coordination required for some consumers.

This expenditure is also likely to lead to cost savings elsewhere in the health system, as demonstrated by past programs, where care coordination led to reductions in hospital admissions (DoH 2012).

ACTION 15.4 — CARE COORDINATION SERVICES

People with severe and persistent mental illness should receive care coordination services where this is required to ensure their complex health and social needs are adequately met.

Start now

All Governments and regional commissioning bodies should:

- assess the number of people who require care coordination services in their region of responsibility, and the extent to which they are already accessing effective care coordination through existing programs, including the National Disability Insurance Scheme (NDIS)
- streamline care coordination arrangements and ensure that people with severe and persistent mental illness and complex needs requiring support from multiple agencies have access to effective care coordination. This includes care coordination services for those people with severe and persistent mental illness and complex needs who do not qualify for the NDIS, and people with severe mental illness who require care coordination for only brief periods of time.

To enable care coordination services to be delivered effectively, consumers would need to provide their consent for service providers to share any relevant information with other organisations.

Start later

Governments should set a national benchmark, based on the improved National Mental Health Service Planning Framework (Action 24.9) to ensure effective care coordination services are available and any gaps are addressed.

15.4 Enabling the delivery of integrated care

Transitioning to a model of mental healthcare based on collaboration and integration represents a substantial cultural shift compared with the siloed nature of existing services. Achieving this requires action on multiple fronts, from information management systems to workforce training (chapter 16). There are also a number of organisational approaches that can be effective in promoting greater integration in the mental health system. Three relatively common examples are:

- co-location of services
- partnerships and alliances
- memorandums of understanding (MOUs).

Each of these approaches can lead to clinical and non-clinical benefits for services and consumers through improved communication, greater mutual understanding and empathy, reduced red tape and improved service efficiency (Whiteford et al. 2014b).

Co-located services

Co-located services can improve integration by bringing together more than one service in the one physical location (Bonciani et al. 2018). This can include clinical and non-clinical services, such as co-locating physical health, mental health, drug and alcohol and vocational support services. There are many examples of successful co-location of mental healthcare and other services (box 15.8).¹³²

In recent years, there has been increasing interest and investment in co-located services. For example, the Australian Government announced in the 2019-20 Budget that it would be dedicating \$114.5 million over five years (from 2020-21 to 2024-25) to fund a trial of eight walk-in community mental health centres (DoH 2019e). In addition, Mental Health Victoria (sub. 479, p. 16) has commissioned KPMG to examine the options for Adult Community Mental Health Hubs with multidisciplinary teams including clinical and non-clinical workers drawing on stepped care approaches to provide a range of services, such as peer support, counselling, alcohol and drug programs, housing and employment.

The key benefit of co-located services is that they bring together multiple services into one location — in effect, a ‘one-stop-shop’ — making it easier for consumers to access the services they need. Other possible benefits of co-located services include:

- facilitating coordination and co-operation and improving information and resource sharing between staff and across services
- enabling clearer and easier referral pathways between services, and potentially reducing the need for consumers to tell their story multiple times
- improving staff knowledge of other types of sectors and services (for example, mental health workers can gain a better understanding of the services provided by employment service providers) (EMHSCA 2017).

¹³² Other examples include: headspace (headspace – National Young Mental Health Foundation, sub. 947), LikeMind (MHCC, sub. 214), the Logan and Southern Moreton Bay Islands Mental Health and Wellbeing Hub (Relationships Australia (National), sub. 103), Mindgardens Neuroscience Network (sub. 64) and the Visy Cares Hub (Hobsons Bay City Council, sub. 176).

Box 15.8 Examples of co-located services

Floresco

The Floresco centres in Ipswich (established 2014) and Toowoomba (established 2017) provide mental health-related services to people aged 18–64 years (QMHC 2019a; Queensland Health 2019b). The Ipswich Centre was established by a consortium of four non-government organisations (NGOs) — two mental health service providers, a disability support provider, and a tenancy service. The Queensland Government funded the consortium to deliver community-based psychosocial support services, including personalised support, group support, mutual support and self-help, and family and carer support. The Centre used a number of other strategies to support service integration, including:

- shared processes and systems, including a single intake and assessment process, a single care plan, a shared client information system and a single practice manual of policies
- a collaborative governance committee that included the four NGOs, the local public mental health service, and several other local community service providers (Beere et al. 2018).

The Ipswich Floresco Centre was evaluated and found to be operating effectively as a one-stop mental health service hub. There were also statistically significant improvements in self-reported mental health outcomes. However, it had encountered a range of barriers to service integration, which resulted in several planned features not yet working as planned, including:

- co-location of public mental health service staff had not proved feasible
- the shared client information system was not being used by all co-located service providers, resulting in clients sometimes having to tell their story multiple times
- there were no GP services and the availability of private mental health practitioners had been inconsistent
- the potential benefits of the different specialities of the NGOs were not realised as the mental health support workers employed at Floresco did not have any training in the specialty areas of the employing organisations (Beere et al. 2018).

Relationships Australia (National) (sub. 831, p. 5) stated that it viewed these issues ‘as kinks to iron out rather than flaws in the system’.

First Step

First Step is a co-located mental health and substance use service located in St Kilda, Victoria. First Step provides mental health, addiction treatment, legal support, social inclusion and meaningful engagement (such as employment and parenting) services in-house and links consumers to external housing services. First Step supports more than 2500 people each year and employs 26 staff. First Step’s funding is derived from a combination of Medicare Benefits Schedule billings, Primary Health Network funding, grants (including from the Victorian Department of Justice and Victorian Legal Services Board) and donations. In their submission First Step argued that there are three elements critical to the success of its model:

- Its services are accessible — there are no fees, no referral is required and there are no geographical catchment limitations (except for the Primary Health Network-funded services).
- It has a multi-disciplinary team on the one site and the team’s size means it is small enough that everyone collaborates with everyone else face to face.
- Its staff have a high level of expertise and qualifications, use a strengths-based approach, have endless persistence and a collaborative ethos (First Step, sub. 557).

Inquiry participants strongly advocated for the benefits of co-located services and community hubs, which may offer a wider range of non-clinical services.¹³³ The Health Services Union (sub. 237), for example, called for the development of ‘recovery and wellbeing hubs’, which would encompass physical and mental health clinics, community and social services as well as a community and social enterprise space. The Queensland Mental Health Commission (sub. 712, p. 8) advocated for:

Community centres/hubs where public, private and non-government service providers, including general practitioners and allied health professionals operating under the Medical Benefits Scheme, are not just co-located but operating in an integrated way offering clients one intake, assessment and triage process; one care plan; one client information system; as well as one set of outcome measures collected and provided to funders. These hubs could also offer access to other in-reach supports such as housing, employment, [alcohol and other drug] and other services as well as step-up/respice beds at a rate of, for example, one centre and 8-10 beds per 100,000 population, thereby easing the pressure on the acute system and providing care in a more person-centred and holistic community setting.

In addition, Sjon Kraan (Perth transcript, p. 30) said:

I think the colocation of GP, employment and outpatient community mental health services should occur as soon as possible. This colocation would emulate the comprehensive and cohesive model of headspace and enable adult mental health services to better respond to overall health and well-being needs of clients.

However, co-location of services is not sufficient on its own to deliver coordinated, integrated, person-centred services. Bipolar Australia (sub. 781, p. 11) cited research that found:

... merely placing relevant professionals together in a single location did not improve collaboration, with barriers including clinician disinterest in networking with other practitioners, a lack of evidence to support the colocation approach, and a lack of government mandates for collaboration being reported.

In addition, participants raised concerns about new co-located services replicating, or not being integrated with, existing services. Victoria Hughes (sub. 571, p. 1) stated:

I am concerned that the Health Minister appears to think the solution is stand alone buildings that provide services that are similar to headspace for adults. This seems to be creating yet another silo & is not sensitive to communities, nor does it address access [for] the majority of communities. I am fearful this is just a political legacy rather than a proven effective solution.

¹³³ For example: Aftercare (sub. 835); Brainstorm Mid North Coast (sub. 309); cohealth (sub. 231); Connect Health & Community (sub. 94); Consortium of Australian Psychiatrists and Psychologists (sub. 882); FOCP (sub. 758); Hobsons Bay City Council (sub. 176); Melbourne Children’s Campus (sub. 927); MHV (sub. 580, att. 1), Mind Australia, Neami National, Wellways and SANE Australia (sub. 1212); Moonee Valley City Council (sub. 106); NMHC (sub. 949); NMHCCF (sub. 476); QNADA (sub. 845); QNMU (sub. 229); QUT Faculty of Health (sub. 826); RAV (sub. 1197); Robert Davis (sub. 772); Sjon Kraan (sub. 667); The Salvation Army (sub. 871); VACSAL (sub. 225).

Evaluations of co-located services have identified key factors that contribute to their success. These include commitment from leadership, staff buy-in and willingness to embrace change, regular monitoring and evaluation of service effectiveness, learning from previous co-location initiatives and agreements to clarify roles and responsibilities (EMHSCA 2017). In addition, Relationships Australia Victoria (sub. 1197, p. 17) stated that these models are more likely to succeed if:

- all partners are aware of what to expect from others involved in the collaboration, and what their responsibilities are to improve accountability
- there is a strong and active central body enabling the existence of a consensus
- there is shared consensual inter-agency leadership
- client centred approaches supersede other allegiances
- client management systems are integrated, with clear information-sharing protocols established
- inter-agency trust leading to effectiveness (and therefore efficiency) is built from opportunities to meet and by shared activities, such as professional development
- information is shared between the organisations to monitor progress.

Given the Australian Government's recent commitments to establishing more co-located services (discussed above), it is important that these services do not duplicate and instead integrate or replace existing services. In addition, the necessary infrastructure and processes also need to be put in place, such as the use of single care plans (section 15.3) and other processes that facilitate collaboration and coordinated, integrated care.

Regional partnerships and networks

Partnerships, alliances and networks provide another means of improving service integration. Partnerships and networks between different services may vary in their level of formality, from an informal handshake agreement to refer consumers to each other, to more formal agreements that are backed up by documentation such as MOUs setting out responsibilities and expectations.

Often alliances and networks have a geographical component — services in a local area form agreements to provide consumers within the area with information and referral services in order to reduce the barriers associated with finding the right services, particularly for consumers who require several different services. Others may be formed around a shared goal that the alliance or network hopes to promote in the mental health space (box 15.9).

Partnerships, alliances and networks are most effective when there is clarity of responsibility or accountability. In some cases, partnerships may break down if there is a lack of mutual understanding of expectations or shared perspectives. Hence, in some situations there may be a need for more formalised links between parties.

Box 15.9 Examples of regional networks

No Wrong Door Mental Health Charter

The No Wrong Door Mental Health Charter is a commitment by organisations in South Western Sydney to a 'no wrong door' approach for recovery-oriented practice (Mental Health Commission of New South Wales, sub. 486). The 'no wrong door' approach means that all services are committed to the individual's needs, either by providing direct services or by linkage and care coordination, so that a range of services are available from multiple points of entry, rather than sending a person from one agency to another (box 15.3).

Organisations that sign the Mental Health Charter are provided with:

- access to an online portal, which assists communication and collaboration between services, facilitates referral exchange when a service cannot be provided by the initial organisation, or when a consumer requires multi-agency support
- mental health first aid training to build capacity of services in recognising signs and symptoms of common mental illnesses and how to provide support to someone in a crisis situation
- an invitation to the annual No Wrong Door Sector Collaboration Forum, as well as other opportunities for collaboration and partnership (No Wrong Door nd).

Tasmanian Suicide Prevention Community Network

The Tasmanian Suicide Prevention Community Network consists of community members, service providers, organisations and government representatives collaborating to reduce the rate and impact of suicide in Tasmania. Some of its activities include sharing information on initiatives to promote mental health, reduce stigma, deliver suicide prevention, early intervention and post intervention activities, and developing resources to assist the community and service providers to refer people to the most appropriate service for their needs (Relationships Australia (National), sub. 103, p. 31).

Murrumbidgee Mental Health, Drug and Alcohol Alliance

The Murrumbidgee Mental Health, Drug and Alcohol Alliance brings together the Murrumbidgee Primary Health Network, Murrumbidgee Local Health District, New South Wales Family and Community Services, the National Disability Insurance Agency, Aboriginal Community Controlled Health Organisations, major mental health and drug and alcohol service providers and consumers and carers in the region, with the aim of improving mental health and drug and alcohol outcomes (Murrumbidgee Primary Health Network, sub. 1199, p. 7). Projects the Alliance has worked on include:

- a common referral tool, which is now used across all agencies in the Alliance
- a single care planning protocol and planning tool, which is currently being finalised
- MapMyRecovery, which is an online resource that includes information on services available in the Murrumbidgee region (Murrumbidgee Primary Health Network, sub. 1199, p. 7).

Agreements and MOUs

A more formalised approach to partnership agreements is the MOU. A MOU is a documented agreement between two or more parties that sets out how their partnership will operate. Typically, it establishes a framework for collaboration between the organisations, such as around referrals and information sharing, and outlines the common goals or vision of the parties to the MOU (NFP Law nd). Though MOUs are non-legally binding documents, they provide structure to the collaborative process (Community Door 2020).

MOUs can support large-scale collaborations. For example, the Eastern Mental Health Service Coordination Alliance is a collection of 25 services and organisations operating in the Eastern Metropolitan Region of Melbourne that work together to provide coordinated care to people with mental ill-health and their carers.¹³⁴ The collaboration is formalised by a MOU, which sets out the principles, protocols and working arrangements to facilitate integrated practice across the participating services (EMHSCA 2016).

The use of MOUs can help ensure clients do not miss out on treatment and support:

One of the biggest risks in the referral of clients to external services is the potential for clients to ‘fall through the gaps’ and disappear from treatment altogether. People with comorbid conditions in particular often have difficulty navigating their way through the available services. The act of trying to navigate the health care system has been likened to a roundabout with many points of entry and many options regarding the direction to be taken. Therefore, it is crucial that the referral process focuses on linking the client with services as smoothly as possible. This may be assisted by the development of formal links between services regarding consultation, referral pathways, and collaboration, such as a memorandum of understanding. (Comorbidity Guidelines 2019)

MOUs can be drawn up between many parties. For example, they can be shared between service providers and a government body, different government departments (for example, School-Link (box 15.10)), or some combination of these (NSW Health 2018; Queensland Health 2019a).

Some of the barriers impeding successful service collaboration include a lack of shared perspective or mutual understanding, unclear accountability, and ‘turf issues’ arising from differences of opinion between service providers and disagreements regarding areas of responsibility (Whiteford et al. 2014b). MOUs, while enabling partnerships, alliances and networks, can also help in overcoming some of these barriers and improving the efficacy of co-location.

¹³⁴ Services include mental healthcare, alcohol and other drugs, community health, family and other community services, housing and homelessness and primary care partnerships.

Box 15.10 **The School-Link Initiative**

The New South Wales School-Link Initiative is a partnership between NSW Health and the Department of Education and Communities to work together to improve the mental health, wellbeing and resilience of children and young people in New South Wales. The partnership commenced in 1999 and was formalised through a memorandum of understanding.

School-Link aims to ensure:

- early identification of mental health issues for children and young people
- provision of evidence-based early intervention programs in schools
- early access to specialist mental health services.

The initiative aims to equip school and TAFE staff with skills to identify and manage emerging mental health issues in their students and to strengthen their understanding of where to refer young people for the help they need.

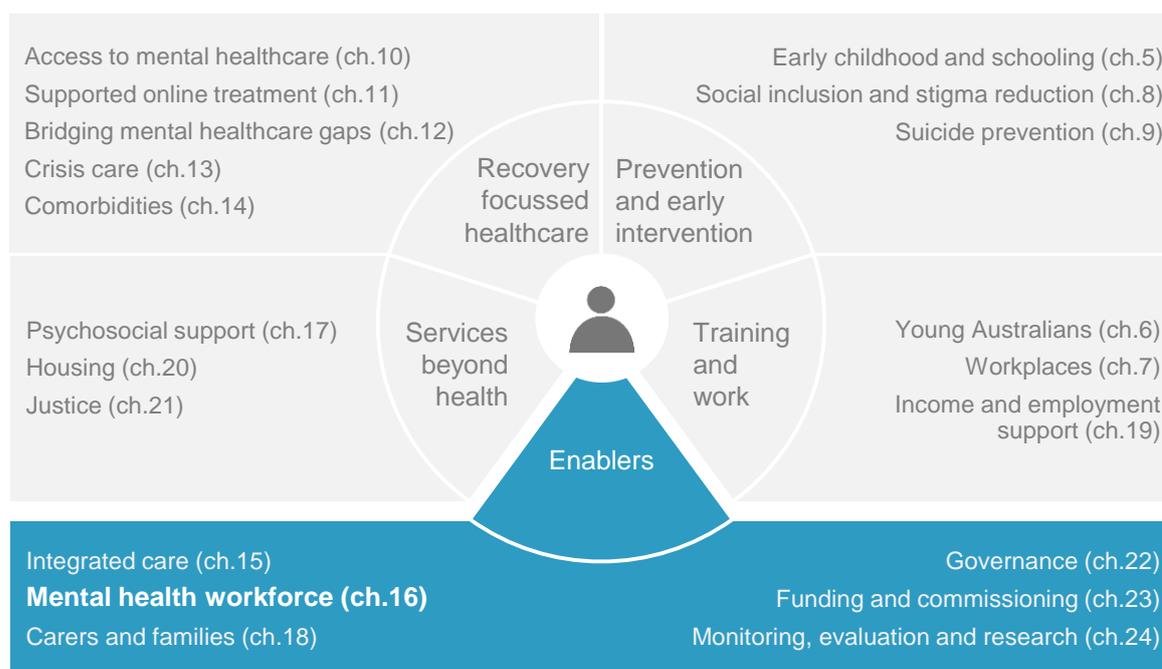
NSW Health funds the employment of School-Link Coordinators to implement the School-Link Initiative across approximately 3000 NSW schools and TAFEs in partnership with teachers, school counsellors and specialist mental health staff.

Source: NSW Government (sub. 551); NSW Health (2015c, 2017a).

FINDING 15.2 — SUPPORTING COLLABORATION BETWEEN SERVICE PROVIDERS

A range of approaches to collaboration, including co-location, alliances and networks, can improve service delivery and benefit consumers. However, each of these alone cannot overcome all the barriers to providing integrated, coordinated care. Addressing gaps and duplication in services, clear delineation of roles and responsibilities, workforce development, addressing cultural barriers and integrated systems are also required.

16 Mental health workforce



An effective health workforce matters because ...

- The functioning of the mental health system depends on the availability of high-quality workers with the right skills, who are allocated to tasks that use their skills efficiently.
- There are skill gaps among some essential workers — most evident in shortages of psychiatrists who specialise in treating older people, children and adolescents, and in the cultural capability of all clinicians treating Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds. Peer workers are underutilised and there are risks of future shortages in mental health nurses.
- Health workers are disproportionately concentrated in major urban areas.
- Negative workplace cultures in some services expose workers to stigma, stress and burnout, lead to high staff turnover and poor outcomes for consumers.

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

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

Reforms in workforce planning that should be considered:

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

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

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

A well-functioning mental health system capable of delivering quality care depends upon an effective workforce. The mental health workforce has a diverse range of practitioners (section 16.1), particularly in community-based services (section 16.5).

There are many ways to look at the capabilities and functioning of the mental health workforce. At the broad level, it is important to have a framework to plan the future workforce (section 16.2). At the micro level, the different occupations are subject to unique challenges, which requires separate analysis for each. The main clinical workforce (section 16.3), peer workers (section 16.4), and allied and community workers (section 16.5).

There are also some issues that affect the workforce more generally — such as mental health-related stigma among health professionals (section 16.7), the sometimes toxic and high-pressured environments in which people work (section 16.8) and the mal-distribution of the mental health workforce across Australia (section 16.9). There is also a need more generally to ensure that the workforce is properly equipped to deliver person-centred care and respond to local community needs, including the needs of culturally and linguistically diverse (CALD) populations and to deliver culturally capable care to Aboriginal and Torres Strait Islander people (section 16.6).

16.1 The diversity of the mental health workforce

The mental health workforce encompasses a broad range of professionals – from generalists such as GPs, Aboriginal health workers and allied health professionals; to highly specialised clinicians such as psychologists, psychiatrists, mental health social workers and mental health nurses (MHNs); to non-clinical workers such as counsellors and peer workers (box 16.1).

Estimating the size of the workforce is constrained by data inadequacies — particularly for community mental health workers and peer workers. The workforce comprises about 56 000 full-time equivalent¹³⁵ (FTE) clinical practitioners (figure 16.1), and approximately 20 000 paid peer and community mental health workers, as discussed later. Also not included in this total is the large, often overlooked, workforce of unpaid carers. Assessing the size of the community workforce is difficult, in part, because clinical workforce statistics typically equate the numbers employed with the number registered, rather than those whose job it is to provide services.

¹³⁵ FTEs measure the number of standard-hour (full-time) workloads worked by health practitioners. The FTE number provides a useful measure of supply because it takes into account both the number of practitioners who are working and the hours that they work.

Box 16.1 Occupational titles of people working in mental health

Medical practitioners are registered by the Medical Board of Australia and include the following:

- **General practitioners** provide primary healthcare in community settings. They are often the first point of contact for someone with a health problem; may provide lower-intensity psychological therapies; and play an important role in managing a person's overall health needs, including referring people for specialist treatment when needed.
- **Psychiatrists** are medical practitioners specialising in the diagnosis and management of typically more complex and severe mental illness using psychological and medical treatments.

Psychologists are registered with the Psychology Board of Australia and provide assessment and therapy to people experiencing mental ill-health.

Nurses perform tasks in the assessment and management of people's health, and are registered with the Nursing and Midwifery Board of Australia.

- There are three types of nurses — **enrolled nurses** (diploma-level training), **registered nurses** (undergraduate degree) and **nurse practitioners** (post-graduate).
- **Specialist mental health nurses** are registered nurses who have undertaken advanced training in mental health.

Community mental health workers generally work for non-government organisations delivering psychosocial support services on behalf of government to consumers in a non-clinical setting.

Peer workers are employed because of their own experiences with mental ill-health.

- **Consumer peer workers** use their own experiences with mental illness and recovery to provide emotional and practical support to people with mental ill-health.
- **Carer peer workers** play an analogous role for carers of people with mental ill-health.

Allied health professions are university-qualified practitioners with specialist expertise related to physical or mental health. They include psychologists and the following professions.

- **Occupational therapists** assist people with daily living and work skills.
- **Social workers** help people deal with personal and social issues through counselling and community engagement.
- **Pharmacists** dispense, and provide advice on, medicines used to treat mental and physical conditions.

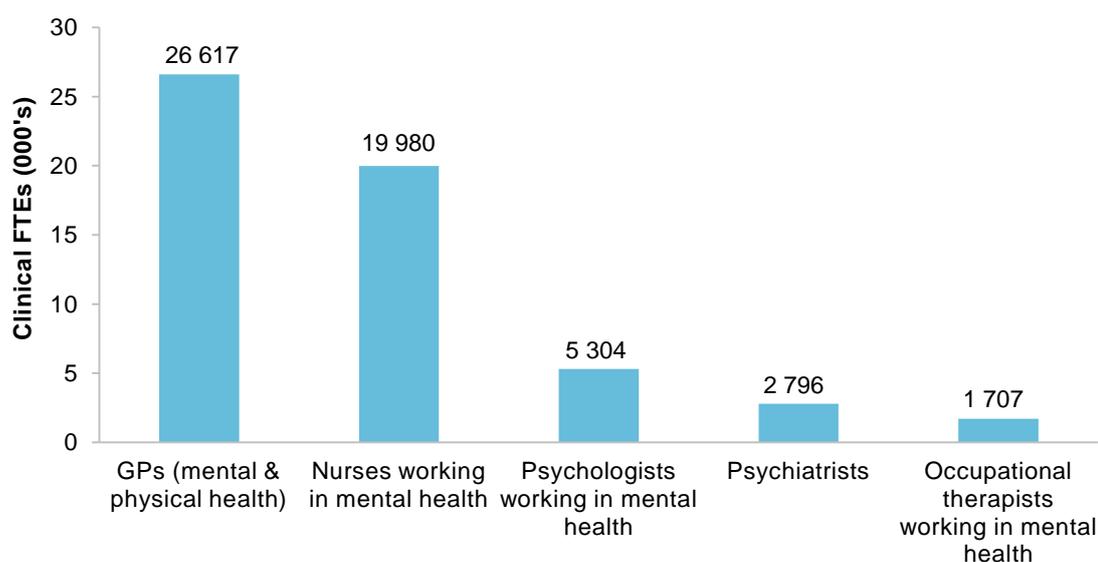
The **Aboriginal and Torres Strait Islander health workforce** emerged in response to a need to provide more culturally capable support for Indigenous people whose health needs were not being met by mainstream services. The workforce includes clinical and non-clinical roles. Those who provide clinical services are registered with the Indigenous Health Practice Board of Australia.

There are also groups such as **CBT coaches, counsellors and psychotherapists** — some of whom are university qualified — who deliver low-intensity psychological therapies in multidisciplinary teams across a range of settings.

There are many other health professions who are sometimes involved in the care of people experiencing mental ill-health. For example, dentists and dieticians may be needed to treat physical conditions arising from mental illness or its treatment.

There are vastly different levels of training and qualification requirements within the mental health workforce. For example, it takes more than a decade for psychiatrists to become registered (RANZCP 2017d). In contrast, community mental health workers and peer workers are not registered and some, despite having considerable skills and expertise, have no formal qualifications.

Figure 16.1 Health workers providing clinical services^a
By selected professions, full-time equivalent basis, 2018



^a Clinical full-time equivalents quantifies total hours worked in clinical roles (diagnosis, care or treatment) in terms of number of full-time workers registered and working in Australia. The number reported for GPs is for all clinical services, not just those related to mental health. Nurses were deemed to be working in mental health if their job area was mental health. Psychologists were considered to be working in mental health if their job area was mental health interventions. Occupational therapists were considered to be working in mental health if their job scope was mental health.

Source: DoH (2020).

Given the labour intensity of the mental health sector, the average wages and salaries of the different professions is the main determinant of the total cost of service delivery. These wages vary considerably across occupations, and are a function of awards under the industrial relations system, the structure of pay rates set by State and Territory governments, demand, the restricted rights to reimbursement through MBS payments, and scarcity.

Within-occupation variations in skills, age structure (which indicates both experience and impending retirement pressures) and experience may be as important for understanding the pressures on mental health workforces as the variations between occupations.

16.2 Workforce planning

The effectiveness of the mental health workforce depends on the number and occupational mix of mental health workers; the extent to which they learn, maintain and apply skills that have clinical efficacy; how they are regulated; their relative costs (including training), and how they are matched (geographically and clinically) to consumer needs. A critical assessment of workforce effectiveness would ideally pose fundamental questions about the:

- type, duration and cost of training for different professions
- scope of practice and accreditation arrangements
- scope for substitution between professionals (to achieve better outcomes for consumers and to lower costs)
- effectiveness of training and skills in achieving clinical and personal outcomes for people, and particularly, the degree to which there is a gap between practices that have demonstrated clinical efficacy in trials and their effect in day-to-day clinical settings
- extent to which the professionals and service providers are accountable to consumers and to their funders.

With such a wide scope, this report cannot examine all of these questions in depth. That should not be taken as implicit endorsement of the existing structures. Indeed, this chapter questions assumptions about the credentials and skills that are required by the mental health system, the concept and measurement of workforce shortages, and the degree to which the work of one profession might be undertaken by others (either as well, or instead). Governments' future workforce strategies and planning should probe these questions more deeply.

Credentials and training play a critical role, but should demonstrate value

Credentials can help signal to consumers, employers and funders that a practitioner has certain competencies and skills. This can be important where employers and supervisors find it hard to assess practitioner quality from their performance, work experience, or reviews.

However, the objective of obtaining skills should be to improve the quality of care, not to acquire skills per se. Robust evidence for the seemingly obvious proposition that higher skill levels in healthcare practitioners leads to higher quality of care is mixed. For example:

- meta studies have found that nurses substituting for GPs in first contact care (including urgent care), ongoing care for physical complaints, and follow-up of people with a particular chronic conditions such as diabetes can deliver equally good outcomes (Laurant et al. 2018)
- cognitive behavioural therapy is moderately effective for a range of mental disorders, such as panic and anxiety disorders (Carpenter et al. 2018; Cuijpers et al. 2019), and can be administered by providers with training focused on that treatment modality, such as cognitive behavioural therapy coaches (VIC DHHS 2020).

-
- skills mental health consumers value, including the ability to show empathy, the importance of navigation services, and preferences for community-based (rather than clinical) settings, are factors standard workforce models can often neglect.

In addition, credentials provided by an authorising body do not necessarily equate to actual competency. For example, many nurses with mental health training would be categorised as registered nurses only, even if they have postgraduate mental health training (Andrew Morgan, sub. 588, p. 2). Andrew Morgan gave the example of his workplace where 28 nurses would be eligible to apply for credentials as a specialist MHN, but where only one had done so.

Skills are acquired in several ways — formal education, experience on the job and professional development. So (usually) someone with the credentials has the skills, but lacking a credential does not equate to lacking skill.

Estimating the future mental health workforce

Many Australian governments undertake workforce planning to estimate future health service requirements. A national example is the forthcoming National Mental Health Workforce Strategy, but there are also state level plans, such as the NSW Health Professionals Workforce Plan (2012–2022) (NSW Health 2015a), and plans for specific professions such as Australia’s Future Health Workforce – Psychiatry (DoH 2016a).

The most relevant comparator for the forthcoming National Mental Health Workforce Strategy is the Health Workforce 2025 volumes (from 2012). These were undertaken for a wide variety of occupations providing mental health services, such as psychologists, MHNs, psychiatrists and GPs.

Like the Health Workforce 2025 reports, the upcoming National Mental Health Workforce Strategy uses knowledge of the current workforce, as well as the rate at which professionals enter and exit the workforce, to project the future workforce (DoH, pers. comm., 1 May 2020). The modelled workforce is progressively aged using knowledge of the rate of entry and exits to obtain the future workforce for each projected year (HWA 2012, p. 40). Demand for services is estimated based on projected population growth and service use rates.

A shortcoming of this approach is the reliance on pre-existing ways of delivering services. That is, if consumers demand a certain service, then the current mode of service delivery is assumed, rather than allowing for alternative professionals to deliver the service (or a blend of professionals) or where technological change alters services. Incorporating these broader economic aspects of workforce planning in a structured way would be difficult, but is ultimately a desirable direction for research and workforce modelling.

The broad implications for workforce planning of a new person-centred system

Workforce planning should be driven by what consumers and carers want, and what governments and providers can realistically deliver in the mental healthcare system, not just by correcting mismatches and shortages through recruitment and retention. Key improvements to workforce planning should factor in:

- reforms to promote greater utilisation of low-intensity and community-based services
- efficiency improvements, such as using technology to lower costs to consumers, or substituting lower cost professionals where they can achieve equivalent outcomes
- greater consumer and carer involvement, with more consideration of the role played by family and carers in recovery
- critical new data on carers, peer workers and community mental health workers.

The Productivity Commission's recommended new funding model (chapter 23) would increase the demand for low-intensity and community mental health services and associated workforces. Adherence to evidence-based practice would also offer scope for altering future workforce demands for some practitioner categories — such as by reducing or de-funding low-value or clinically-questionable treatments.

And there may be scope for labour saving technological progress in mental healthcare. Supported online treatment can reduce the time commitment required of health practitioners (chapter 11). We are proposing a new partly-automated assessment tool, which aims to reduce the amount of GP time required to undertake a holistic mental health assessment, so that GPs can spend more time on other valuable consumer-oriented activities, such as supporting consumers to choose between treatment options (chapter 10).

The use of artificial intelligence in the diagnosis of mental illness could also be an aid for clinicians (Graham et al. 2019). For example, in one experimental application, a mobile app was as good as clinicians in diagnosing severe mental illness among a group of people from the United States and Norway (Chandler, Foltz and Elvevåg 2020). These developments in diagnosis still need to be tested at a larger scale and would not *remove* the need for clinicians, though they may help in more rapid diagnosis and in assessing progress in the treatment process. Of course, such technologies may increase workforce demands, if they identify undiagnosed mental health conditions that require treatment by clinicians.

Workforce planning should also consider the role played by carers, who are (a typically unpaid) essential complement and substitute for the formal mental health workforce. Some have observed that 'without carers and the support they provide, our health system would be on its knees' (Diminic et al. 2017, p. viii). This informal workforce far outnumbers the formal mental health workforce, so its sustainability and capability are critical. Workforce planning frameworks should therefore formally project the availability of carers and the types of care they provide. The Productivity Commission has recommended that carer

supports be significantly strengthened (chapter 18), and such initiatives should therefore be reflected in workforce planning.

Most significantly, the mental health system could be made more cost-effective by considering where lower cost professions could be substituted for tasks without compromising effectiveness. This could include a greater reliance on supported online treatment (rather than face-to-face) to provide psychological interventions and support, and greater use of counsellors in low-intensity care and peer workers within settings such as emergency department alternatives.

Given the desired direction of mental healthcare reform, workforce planning should entail greater consultation with mental healthcare consumer, their families and carers, community mental health service employers and a wide range of mental health practitioners (including MHNs and community workers particularly), who otherwise tend to be given less voice.¹³⁶

Obtaining the data for quantitative assessment of the effects of mental health reforms on workforce needs is challenging. For instance, to factor in substitution between high and low cost practitioners, estimates of the potential magnitude of substitution are needed. Consequently, a planning framework would need to obtain data and develop analytical methods that go beyond a standard dynamic stock and flow model. This would include, for example, data on the community mental health workforce, the scope for increased use of technology, and the availability of carers and non-clinical workers.

¹³⁶ The membership of the Medical Workforce Reform Advisory Committee and the list of stakeholders so far consulted as part of the National Medical Workforce Strategy would suggest that MHNs and community workers are less frequently involved in such consultations.

ACTION 16.1 — THE NATIONAL MENTAL HEALTH WORKFORCE STRATEGY

The forthcoming National Mental Health Workforce Strategy and the National Medical Workforce Strategy should enable a person-centred mental health system.

Start now

The Australian Government should ensure that its development of a new Workforce Strategy includes the following actions:

- Set the objective of achieving a health workforce that aligns the skills, costs, cultural capability, substitutability, availability and location of mental health practitioners with consumer needs. This should be done by integrating the workforce strategy with service and infrastructure planning.
- Ensure that planning consultations give weight to the perspectives of consumers, carers, mental health workers and service providers, including the non-clinical community mental health sector.
- Examine how workforce needs would change under a business-as-usual scenario as well as under scenarios where alternative workers deliver service (particularly leveraging the non-medical workforce), where technologies can assist or replace face-to-face services, and where practices not supported by clinical evidence are de-funded.
- Assess the estimated future supply of specific skill sets and health professions, the extent to which these could fall short of needs, and policy measures that could meet needs cost-effectively.
- Identify data gaps or methods that limit the capacity to link workforce planning to broader mental healthcare reform, and develop strategies to address those data gaps. The data should cover community mental health workers and carers providing informal care, and workforce characteristics (for example, cultural capability to work with people from culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander communities).

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

16.3 Gaps in the clinical workforce

The key clinical workforce in the mental health system comprises psychiatrists, GPs, psychologists, mental health nurses, some Aboriginal health workers and some allied health workers, each with their distinctive challenges.

Shortages in psychiatrists

Psychiatry is a highly specialised profession that combines skills in physical and mental health, with some unique scopes of practice that would be undesirable to extend widely (such as assessing when a person meets criteria for involuntary admission to hospitals). They make up a small share of the total mental health clinical workforce (figure 16.1). Compared with other health professionals, psychiatrists generally treat people with more severe forms of mental illness.

There are multiple indicators of shortages — current or emerging — that, when taken together, build a good case for policy measures that ensure supply matches projected demand:¹³⁷

- While there has been a gradual upward trend in the number of employed psychiatrists and the amount of time they spend providing clinical services, this has not outpaced the apparent underlying demand pressure for psychiatric services (4.2% annually according to the Department of Health 2016a, pp. 25, 40). Given their highly specialised role, there is likely to be less (though still some) scope to use other occupations as a substitute for some of the functions of psychiatrists. Consequently, conventional workforce projections are likely to provide indicative projections of impending shortages. The estimated need for (FTE) psychiatrists in 2018 exceeded the observed workforce by about 70 psychiatrists (or about 2% of the workforce), with the gap projected to rise to about 125 by 2030 (or about 3% of the workforce) (DoH 2016, pp. 25–26).¹³⁸
- New South Wales mental health services have faced major difficulties in permanently filling psychiatry vacancies, with nearly 50% of staff specialist positions filled by locums in mid-2019 (NSW Health 2019d, p. 7). The National Medical Workforce Strategy also pointed to the excessive reliance on locums (DoH 2019k, p. 32). In Tasmania, particularly in the north-west, it has been difficult to fill vacancies (RANZCP (Tas) 2017, p. 4). The Productivity Commission has been told by participants that a vacancy crisis has continued. At the national level, vacancy rates for psychiatrists rose by more than 500% from January 2013 to January 2020 — much higher than for GPs, psychologists and registered nurses.¹³⁹
- Australia relies heavily on the immigration of overseas-trained psychiatrists. The share of psychiatrists trained overseas (excluding New Zealand) has grown from about 30% to over 36% from 2013 to 2018. Immigration has major advantages in reducing the time taken to increase the workforce, brings diversity of backgrounds and expertise, and reduces net training costs. However, overseas-trained clinicians may also encounter more pronounced language and/or cultural adjustment where treatment relies on good

¹³⁷ Unless otherwise specified, the numbers below are based on data extracted from the National Health Workforce Dataset (DoH 2020l).

¹³⁸ This projection is based on the inflow of overseas trained psychiatrists remaining at current levels. However, if this inflow of overseas trained psychiatrists halved, the shortfall is project to increase to about 360 by 2030 (or about 8% of the workforce).

¹³⁹ Productivity Commission estimates using Australian Government (2020b).

communication. In addition, it may not always be easy to attract such professionals and there are benefits in some self-sufficiency. Above all, the need to attract overseas-trained psychiatrists without existing Royal Australian and New Zealand College of Psychiatrists (RANZCP) registration is a sign of workforce pressures.

- The scope for psychiatrists to work longer hours is likely to be low as they already work long hours compared with most other professions in mental health. About 10% of psychiatrists work 50 hours or more per week compared with less than 2% of psychologists, 4% of MHNs, and 2% of occupational therapists.
- The workforce is ageing, with 41% of psychiatrists aged 55 years or more in 2018 and with about 20% expecting to continue to work in the profession for 5 or fewer years. Psychologists are younger in comparison, with about 28% aged over 55 years, and 10% expecting to continue for 5 or fewer years.
- There is concern about trainee burnout, with many trainees being overworked and not adequately supervised (RANZCP, sub. 1200, p. 18), and a mismatch between the number of trainee positions and the availability of psychiatrists to provide supervision.
- The Productivity Commission's consultations with experts suggested particularly significant shortages in child, adolescent and old age psychiatry, as has also been noted by other reviews (RANZCP 2019).
- Addressing such shortages through domestic supply involves a long lag time as psychiatrists take a *minimum* of 5 years to train after the 6 to 8 years of education and training to gain a medical degree. For newly appointed fellows in 2016, the average time taken to complete their psychiatric training was 7.3 years (RANZCP 2017a). A small offset is that people undertaking training nevertheless still provide psychiatric services (under supervision) in hospitals.

There have been recent reforms to Australia's psychiatric training that will help to reduce the future gap. One relief valve in resolving shortages is that unlike other medical professions, there is no formal cap on training places for psychiatrists. Rather, the supply of suitable applicants, the number of training placements and availability of supervisors, have constrained training. In addition, to the extent that the Productivity Commission's recommendations lead to some substitution between psychiatric services and those offered by less highly trained practitioners, shortages may also be partly alleviated. Furthermore, the Productivity Commission's recommendation for extension of MBS-rebated telehealth services to psychiatrists would go some way to alleviating the shortfalls in psychiatrists accessible to particular demographic groups or in particular parts of Australia.

However, there are five caveats to this optimistic outlook.

First, even if aggregate shortages are addressed, this may not resolve regional shortages (section 16.9). Nor will they necessarily resolve acute shortages for some sub-specialities. The public sector will remain the major provider of training placements, given the large share of psychiatric services it provides. State and Territory Governments (through their local hospital networks) should therefore increase the number of funded placements in their

facilities, particularly for advanced training in child and adolescent psychiatry. The precise increase should be informed by assessments of future workforce needs — not just in their hospitals but across their State/Territory — as part of broader workforce planning by government (Action 16.1).

Second, the above projections of shortages are founded on incomplete data. Given the time lag in resolving shortfalls, it is important that psychiatric workforce adequacy and obstacles be continually re-assessed. Shortfalls in a small workforce such as psychiatrists would have major adverse effects on access to care for those Australians with severe mental illnesses.

Third, exit and entry rates into psychiatry are affected by attitudes to the profession, and particularly the stresses in the public mental health system (section 16.8). The effects of such attitudes and their resolution is much less amenable to the approaches used in typical health workforce planning.

Fourth, the Productivity Commission’s recommendation for MBS-rebated, telephone-based advice from psychiatrists to GPs would result in increased demand for psychiatric services (Action 10.3) (to the extent that the new program does not suffer from the low level of demand that affected the predecessor program — ‘GP Psych Support’).

Finally, additional training placements will be of little benefit if there is no commensurate increase in trainee supervisors. A recent report (DoH 2016a, pp. 33–34) recommended that this be addressed by:

- adopting strategies to identify new supervisors and providing them with adequate support — such as online modules and peer support activities
- considering blended and remote models of supervision so that trainees can receive appropriate supervision in regional and remote areas.

The Productivity Commission has seen little evidence that governments or other stakeholders have adopted these recommendations. One exception is the RANZCP’s decision to review current supervision resources. This should lead to the identification of the resources that need to be developed, based on gap analysis, supervisor and trainee needs, and improvements that could be made to the supervisor accreditation and training process (RANZCP, pers. comm., 16 September 2019).

The possibility of increasing the use of remote supervision needs to be considered more thoroughly by governments and professional bodies. This is particularly the case given the small number of psychiatrists outside major cities who can act as supervisors in those locations (other options to increase the health workforce in remote areas are considered in section 16.9). A similar issue applies to advanced training in areas such as child and adolescent psychiatry due to a shortage of current practitioners in those fields of practice.

ACTION 16.2 — INCREASE THE NUMBER OF PSYCHIATRISTS

There is a shortage of psychiatrists, particularly in rural and regional Australia and in some sub-specialities.

Start now

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

This should be done in collaboration with the Royal Australian and New Zealand College of Psychiatrists, and form part of the broader Australian Government medical workforce strategies that are under development.

The plan should include actions to increase the availability of supervision for trainees, including by considering interventions recommended in the 2016 report by the National Medical Training Advisory Network, such as remote models of supervision for trainees outside major cities.

General practitioners

GPs have a central role in the mental health system. Notwithstanding the desirability that people should sometimes directly access mental health services (say through online cognitive behavioural therapy) without first going to a GP, under the Productivity Commission's recommended model of care, GPs would remain an important first point of contact for many people to manage their mental and physical health (chapter 10). GPs would also continue to refer people to specialist mental health services. Currently, GPs most commonly refer people with mental health-related problems to psychologists (about 50% of referrals) and psychiatrists (14% of referrals) (AIHW 2020g; table GP.4). Given their primary role, addressing any limitations in access to GPs or inadequacies in their training would be important to improving the functioning of the mental health system.

There is no evidence of a current Australia-wide shortage in GPs, with growth in the GP headcount (at an average 3% per year) significantly exceeding population growth from 2013 to 2018 (DoH 2020l). However, there are some pressures. As with psychiatrists, the GP workforce is exposed to retirement risks, with over 40% of GPs aged over 54 years in 2018, and nearly 22% expected to retire in the next 5 years. That said, the share of GPs aged over 54 years has crept up only incrementally from 2013, suggesting that no immediate changes in workforce planning are required.

Despite their central role in providing primary mental health services and prescribing medications, most GPs receive minimal training in mental healthcare in qualifying as a GP. This is mitigated by avenues for qualified GPs to gain specialist mental health skills — such as a (brief) module of training to be able to receive the maximum Medicare rebate for mental health

treatment plans. The Productivity Commission is not convinced that a mandated increase in the level of mental health training in a medical degree is necessary, particularly when the addition of more training in any qualification requires the displacement of other training. This is reinforced by evidence that the majority (about 80%) of people with mental illness say that their experience of care provided by GPs is excellent to very good, slightly better than satisfaction rates in Canada, a relevant comparison country (NSW BHI 2019, p. 33).

Nevertheless, there are several ways in which GPs could be supported in providing mental health services (chapter 10). The likely continuation of shortages of specialist mental health clinicians outside major cities means that GPs in regional and remote areas would continue to have fewer referral options than their city counterparts. Hence, the need for a different skill set among rural, regional and remote GPs would remain. However, policy is already moving to address this problem. There are distinct training pathways for GPs wishing to practise in regional and remote areas, which include a year of specialist training in a discipline such as mental health. The Australian Government has announced funding over 4 years from 2019-20 to rationalise these pathways into a nationally consistent approach, to be called the National Rural Generalist Pathway (AMA 2019).

Reorienting the mental health training of GPs

Some aspects of existing mental health training in medical school and continued professional development should be re-oriented. This includes screening for mental health problems (such as perinatal mental illness), attitudes to peer workers (section 16.4)), inclusion (with the support of their patients) of family and carers in treatment discussions (chapter 18), buy-in to a person-centred ethos and evidence-based clinical practices.

In the case of screening for mental health problems, there remains a need for GPs to have the skills to assess the likelihood that the symptoms with which an individual presents would subside as particular stressors abate; and to assess when there are underlying health, social or psychological issues that need addressing prior to, or instead of, medical intervention.

In the case of evidence-based clinical practices, there remain concerns about the clinical appropriateness of prescribing practices for mental health medications and approaches to managing side effects (ACSQHC 2017; Brijnath et al. 2017; Gardner 2014). While antipsychotic prescribing in aged care facilities is one element of this (as raised in the Aged Care Royal Commission), arguably a greater concern, given its frequency, is antidepressant prescribing (chapter 10).¹⁴⁰

While prescribing medications is a critical function of GPs, people often expect medications even where they are not likely to be effective. This presents a challenge in reducing the amount of antidepressants prescribed and promoting alternatives, such as non-pharmacological

¹⁴⁰ While relatively uncommon, this extends to the use of antidepressants as ‘active placebos’ (Faasse and Colagiuri 2019). An active placebo is a drug with no therapeutic benefit for the condition for which it is prescribed, but that produces noticeable side effects that help trigger a placebo benefit for the patient.

treatments. Recent initiatives in ‘social prescribing’ *may* also offer scope to alter consumer’s (and some GPs) expectations that medications are the first line treatment, rather than non-pharmacological, typically non-clinical interventions, such as social activities and exercise (Boydell 2019; Chatterjee et al. 2018). In New Zealand, the ‘Green Prescription’ works by having a GP issue a paper or electronic script similar to a drug script, but with reference to exercise (New Zealand Ministry of Health 2017). The script may give a legitimacy to the referred activity, that may not be present with mere verbal advice (Swinburn et al. 1998).

The challenge is how to change consumer (and GP) expectations about customary treatments, including that the most effective treatment for an individual may be non-medical. Initiatives are underway, often supported by professional bodies, such as the Royal Australian College of General Practitioners. For instance, there is a current clinical trial of a web-based intervention aimed at de-prescribing for antidepressant users (Liotta 2019). Continuing professional development, training and clinical guidelines also play a role in informing clinicians. However, the way in which information is diffused is important because merely providing new clinical practice guidelines does not necessarily change clinicians’ behaviour (Nguyen et al. 2020).

A broader issue — confronting the health system as a whole — is the degree to which GP assessments and treatments are genuinely person-centred, giving weight to effective communication, the individual consumer’s perceived experiences and outcomes, and their capacity to be collaborators in care (including through developing health literacy). There is a vast literature about the importance of person-centred care, and some of the issues are covered in other parts of this report and previous Productivity Commission work (PC 2017e). Most GPs would argue that they follow a person-centred approach, but GP ‘advocacy’ for a patient that focusses on clinical recovery alone and does not consider the environment in which the individual lives, and assist with the recovery of the individual within their family and community, risks not being enduring. Problematically though, even clinicians committed to a person-centred approach may struggle to fully involve the individual in their care, if the individual is reluctant to communicate with their clinician (Bell et al. 2011) or does not agree to the clinician involving their family or carer.

The Productivity Commission heard from an Inquiry participant with 15 years of professional experience in training GPs about a gap in medical training that may affect a person-centred approach:

Having the knowledge and technical skills, and being able to apply these, within a patient centred environment requires addition[al] skills. These skills are not a key part of medical training and yet vital to make the individual a competent and safe doctor. These skills include listening and hearing the patient, understanding the patient's perspective and the ability to adapt their management plan accordingly. There is also a need to be 100% present when seeing a patient. This is not always the case. (Deborah Barit, sub. 686, p. 1)

She recommended changes in cultural and management practices in medical training (for example, how to supervise, and the type of language and communication skills needed when dealing with people) — all of which should be considered.

The key message is that an effective workforce is more than the number of practitioners, but one that also embraces evidence-based clinical interventions and a person-centred focus, accompanied by a need for forms of training or messaging that achieve these outcomes.

ACTION 16.3 — IMPROVED MENTAL HEALTH TRAINING FOR MEDICAL PRACTITIONERS

Medical practitioners' training on medications and non-pharmacological interventions requires improvement.

Start now

Medical training and continuing professional development requirements for GPs should incorporate person-centred approaches to practice that recognise the importance of personal recovery (in addition to clinical improvement). This training should also include information on the indications for non-pharmacological interventions, appropriate prescribing of mental health medications and the management of medication side-effects.

- As part of this, the Australian Government should request the Australian Medical Council to review current medical training and continuing professional development requirements through a consultative process and make any changes necessary.
- Any such changes should be assessed for their impact on practices and outcomes for consumers.

In addition, for GPs and psychiatrists, the Australian Government should:

- promote and fund further trials of social prescribing as alternatives to other clinical interventions
- promote and fund de-prescribing initiatives that change practitioner and consumer expectations about the need for mental health medications once they are no longer clinically indicated.

Psychologists

The Productivity Commission found no evidence of a shortage in psychologists. However, one source of concern is the apparent weak relationship between students studying psychology and the number of registered psychologists.¹⁴¹ The absence of a close nexus between study completion and subsequent registration is not necessarily surprising given that psychology is a generalist degree with employment options outside the field. Nevertheless, the weak nexus has also been attributed to the limited availability of supervised internships after completing the required four or five years of study, aggravated

¹⁴¹ From 2008 to 2017, the FTE student load for 3-year bachelor degrees in psychology grew by 78%, honours degrees by 250% and professional postgraduate programs by 61%. Just under 10% of students enrolled in psychology programs in 2017 completed postgraduate training towards professional registration as a psychologist (HODSPA, sub. 362, pp. 3-7).

by a decline in the number of approved supervisors when transitional arrangements expired in 2018 (HODPSA, sub. 362, p. 11).

The lack of a close link between training and registration partly stems from the structure of training for psychologists. Psychology students must complete a bachelor sequence to be registered¹⁴² which consists of a 3 year bachelor degree or graduate diploma, plus an additional honours year or postgraduate diploma (APS 2019a). From this point, there are two options: the 4+2 pathway which consists of a two-year internship on top of the four years of study already completed; and the 5+1 pathway, which consists of a one year Grad Diploma/Masters plus one year of supervised practice.

The recent decision to phase out the 4+2 pathway (thereby reducing to 1 year the length of internships under the remaining 5+1 option) could reduce demand for supervisors, because each student would need only one year of supervision instead of two.¹⁴³ This decision was made to reduce the regulatory burden of psychology training (Grenyer and Phillips 2018). However, there are likely to be consequences (good and bad) for the nature of skills that trainees gather, and the implications for consumer outcomes are uncertain. There will be an adjustment for some education providers — New South Wales and Queensland have the most number of 4+2 interns in need of switching course, and there are currently no fifth year programs in the ACT, the Northern Territory and South Australia (PBA 2018, p. 27). However, there is ample time for adjustment before the 4+2 pathway is completely phased out in 2028.

Notwithstanding the frictions associated with the transition from study-completion to registration, the stock of registered psychologists in clinical roles has grown strongly, averaging 3% per year for clinicians (DoH 2020I) — noting too that average population growth has been less than 1.6% annually over this period. The share of psychologists aged over 54 years old was just under 30% in 2018, and unchanged from 2013, while the share intending to retire over the next 5 years was about 10% (DoH 2020I). This suggests low retirement risks for this occupation.

There has been strong growth in vacancies for psychologists of any type from 2013 to 2020 — an indicator of high demand¹⁴⁴ — but the limited data available do not suggest that it has been hard to fill these positions. For example, in Victoria, there is little evidence that vacancies are hard to fill, instead limited funding of public psychologist positions in the community (such as in public hospitals and community mental health services) is the primary

¹⁴² More advanced training is required to obtain an area-of-practice endorsement, which indicates additional specialist qualifications in a particular area. There are 9 different specialities that can be endorsed, but clinical psychology is by far the most common, with 28% of psychologists holding this endorsement in 2017, out of a total of 38% with an area-of-practice endorsement (AIHW 2020I).

¹⁴³ The Psychology Board of Australia has announced that the 4+2 pathway will be phased out to reduce the regulatory burden of psychology training. It will not accept applicants who begin a 4+2 program after June 2022 and will retire that pathway to general registration at the end of 2028 (PBA 2019).

¹⁴⁴ Based on the Australian Government 2020 Labour Market Information Portal Vacancy rates dataset (Australian Government 2020b).

constraint on meeting consumer demand (VIC DHHS 2018b, pp. 8, 32). The Royal Commission into Victoria's Mental Health System also found no shortage of psychologists in Victoria at an aggregate level, but found that some public mental health services have difficulty retaining experienced psychologists, partly because of the attraction of private practice (VIC MHT 2019).

Moreover, the Productivity Commission has recommended reforms to facilitate greater use of supported online treatment, low-intensity therapy coaches and peer workers. These changes would tend to divert psychologists away from the treatment of milder disorders, reducing future pressures on the workforce and allowing their expertise to be used by people with more intensive needs.

The greatest concerns about the psychologist workforce relate to shortages of all clinicians in regional and remote Australia (section 16.9).

Mental health nurses (MHNs) — a bigger role in the future

According to the Australian College of Mental Health Nursing (sub. 501, p. 3), a MHN works with people who have mental health problems, their family and community, to aid recovery, as defined by the individual. Several different types of nurses can serve this role, and not all need specific mental health qualifications (box 16.2). Nurses delivering mental healthcare work in a range of settings, including hospitals, community mental health services, and GP clinics.

Is there a shortage of MHNs?

Several Inquiry participants reported a shortage of MHNs:

By 2030, HWA [Health Workforce Australia] predicts the mental health nursing workforce will move to the largest undersupply of all sectors. (ACMHN, sub. 501, p. 11)

There is a need to increase the number of mental health nurses in Australia and this will need to be considered in the broader predicted nursing workforce shortage. (ACMHN, sub. 914, p. 2)

Further, a shortage of mental health nurses is expected to be ... of at least 19,000 nurses by 2030 ... Some states have commenced effective action plans to mitigate against these Health Workforce Australia (HWA) workforce projections. (Australian Nursing and Midwifery Federation, 317, p. 14)

There is a looming shortage of mental health nurses. (Mental Health Council of Tasmania, sub. 869, att. 1, p. 7)

Rostering and planning to ensure they address shortages in mental health nursing staff ... (NSW Nurses and Midwives Association, sub. 246, p. 4)

There is a severe shortage of mental health nurses. (Grant Family Charitable Trust, sub. 76, p. 4)

Box 16.2 The different types of nurses who work in mental health

The following types of nurses are involved in supporting people experiencing mental ill-health.

- **Enrolled nurses** are trained in the vocational education and training system with a focus on practical skills, and report to either a registered nurse or other person with higher qualifications. They comprise a small share of the mental health nursing workforce.
- **Registered nurses** are university trained (undergraduate degree), and over a longer period than enrolled nurses (3 years full-time), so have a more extensive set of skills.
- **Specialist mental health nurses** have advanced training in mental health that gives them specialist skills in supporting people with mental illness. This specialisation is not recognised under Australia's current registration system for nurses and so there are no legislated training standards. However, a national credentialing program has been established by the Australian College of Mental Health Nurses which requires candidates to first become a registered nurse and then complete a graduate diploma or master's degree in mental health, before applying for the credential.
- **Nurse practitioners** are authorised to diagnose and treat health conditions, order tests, prescribe medications, make referrals, and access Medicare Benefits Scheme rebates for some services, provided they work in a collaborative arrangement with a medical practitioner, such as being employed by them. Nurse practitioners must be registered nurses, have 3 years of experience at the clinical advanced nursing practice level, and have completed a master's degree.

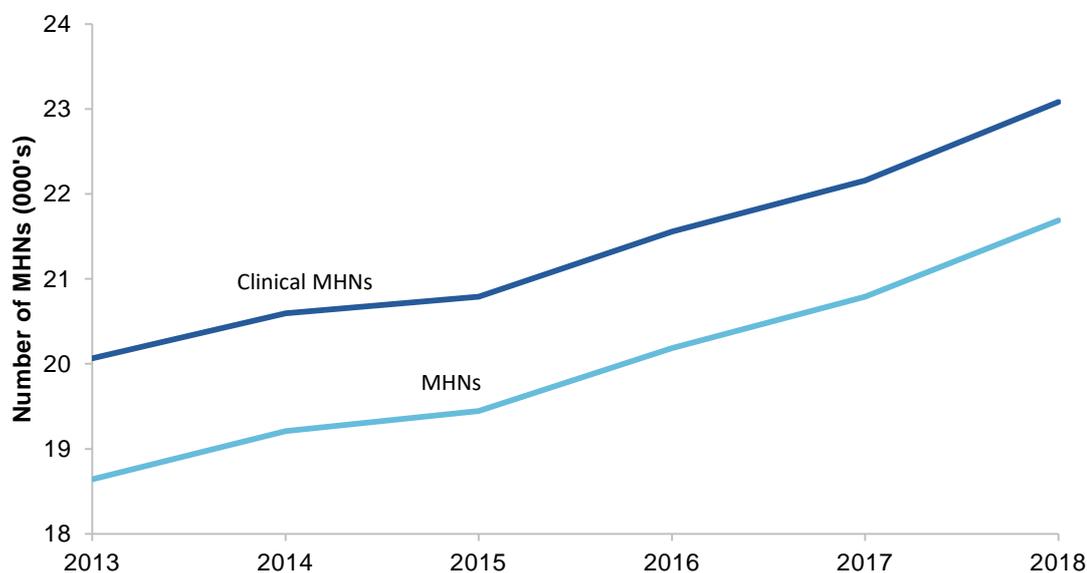
Providers of mental health services can usually employ any of the above types of nurses. A notable exception is public-sector mental health services in South Australia, where enrolment in, or completion of, a specialist mental health qualification is required under the relevant enterprise agreement.

For several of these submissions, the key empirical evidence of a shortage is Health Workforce Australia's projections (2014b, pp. 5, 52). It predicted the supply of MHNs would fall from 2012, with a projected shortfall of between 11 500 and 18 500 MHNs by 2030. It predicted roughly 23 500 MHNs would be required by 2018. Actual outcomes have not been consistent with this pessimistic outlook. National Health Workforce Data indicate the supply of MHNs was slightly more than 23 000 by 2018 (figure 16.2).

A critical assessment by the Independent Review of Nursing Education found that Australia does not have a shortage across nursing *as a general profession* — partly because universities responded to forecasts of nursing shortages by increasing nursing enrolments and completions dramatically (DoH 2019f, p. 29).

There is a potential explanation for the discrepancy between sector experiences and workforce data. As box 16.2 notes, specialist MHNs are not recognised under Australia's current registration system. Hence, workforce data combine both specialist MHNs and regular nurses working in mental health. So while the data may not indicate shortage, the sector may experience difficulty finding specialists.

Figure 16.2 **Mental health nurses^a**



^a Employed nurses who principally worked in mental health.

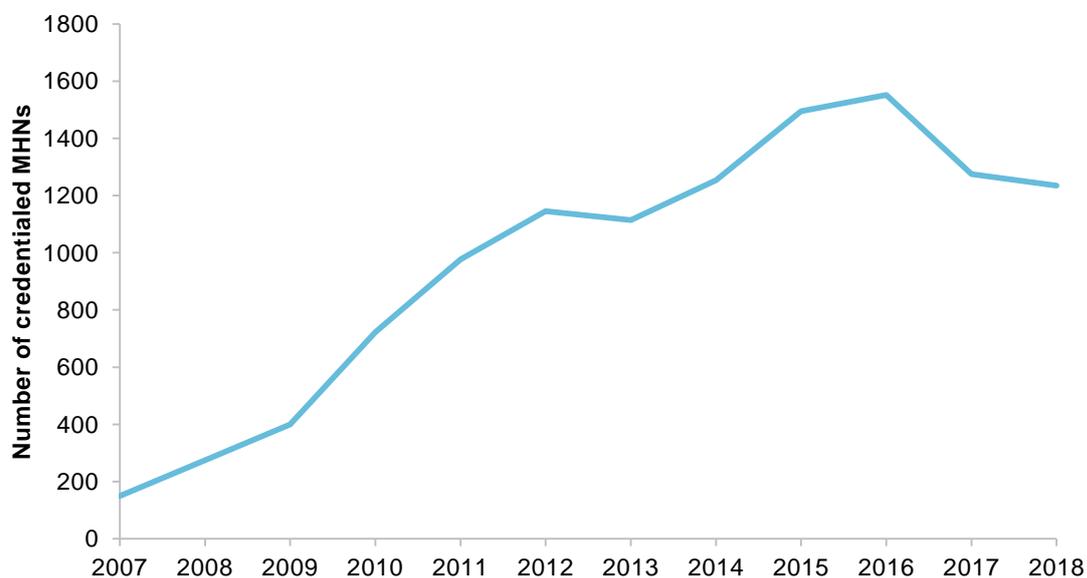
Source: (DoH 2020).

The Australian College of Mental Health Nurses (ACMHN) has a credentialing program allowing specialist MHNs who have done the requisite training to have their specialisation recognised. While this might seem the obvious way to capture the number of specialist MHNs, many do not obtain the credential and so using this form of identification is unreliable. Indeed, the incentive for MHNs to be credentialed was reduced when the Australian Government transferred funding responsibility for MHNs to Primary Health Networks in 2016.¹⁴⁵ As figure 16.3 shows, there was a considerable decline in credentialed MHNs from 2016.

Leaving aside issues with workforce data, the Productivity Commission's recommended reforms to community mental healthcare would create a substantial expansion in non-hospital community health services and see MHNs potentially perform functions that have been performed by other, more costly professionals, such as GPs or nurse practitioners (Laurant et al. 2018). Reforms that would augment the number of mental health beds in hospitals would also drive up overall demand for MHNs. Finally, there is a risk that the stresses posed by work overload associated with shortages may make mental health a less attractive specialisation for nurses, making it difficult to avoid shortages.

¹⁴⁵ When this transfer took place, the Australian Government removed the requirement for specialist MHNs to be credentialed in order to be engaged through a primary health network (ACMHN 2018, p. 7).

Figure 16.3 Credentialed mental health nurses^a



^a Nurses were credentialed by the ACMHN. The number of post-graduate specialists in 2008 was estimated as a linear interpolation of 2007 and 2009 values

Source: ACMHN (2018).

In part, the solution to emerging shortages would be to avoid attrition and encourage new enrolments to nursing with a mental health focus, however neither of these solutions is easily achieved.

Recruiting overseas-trained MHNs is unlikely to resolve long-run shortages

Australia has often relied on overseas-trained workers to address health workforce shortages. Registered nurses (mental health) are, with many other nurse categories, included in the Skilled Occupation List, a prerequisite for qualifying for skilled migration to Australia. Moreover, they are listed in the subgroup of the Skilled Occupation List — the Medium and Long-term Strategic Skills List — a reflection of concerns about long-run shortages in this qualification. Both public and private health services recruit overseas-trained nurses through employment and recruitment agencies (Ohr, Parker and Joyce 2010). The ACMHN (sub. 501, p. 10) identified examples in the media of international recruitment for public mental health positions in Tasmania and the ACT. NSW Health (2019a) noted that it recruits experienced registered nurses from overseas, typically to fill positions in mental health, or in regional and remote locations.

Nevertheless, recruitment overseas is unlikely to be a sustainable basis for resolving shortages, in part because of difficulties in attracting applicants. The number of skilled-migration visas granted to nurses who intend to work in a mental health setting has been small relative to the size of Australia's MHN workforce. About 190 skilled visas were granted to MHNs in 2018-19 (half of which were temporary) — making up less than 1% of the current stock of MHNs in Australia.¹⁴⁶ In recent years, about half of these migrants obtained their qualification in the United Kingdom (ANMAC 2018b). Yet the United Kingdom is facing its own shortage of MHNs and is aspiring to increase the number by more than 4000 by 2023-24 (NHS 2019, p. 54). This may make it difficult to continue to attract nurses from the United Kingdom.

Mental health skills among nurses

The current training standards for registered nurses *require* them to have received some instruction on mental health problems, but this only has to be delivered within units on broader subjects (ANMAC 2018a). The NSW Nursing and Midwifery Association was concerned that many nurses are being employed in acute mental health units with only basic mental health knowledge and education. They point out that this could compromise consumer's care and safety, resulting in poor outcomes for people, including higher use of seclusion, longer admission times and possible relapse following discharge (NSWNMA, sub. 246, pp. 22–23).

To the degree that entry level nurses are used to plug shortages of more experienced staff, this could pose a risk for consumer care. This may not reflect a lack of necessary skills in the workforce generally, but supply or retention issues at particular institutions where there is a lack of experienced staff.

Hence, any additional qualifications or new registration arrangements for mental nurses should be considered critically, as they should for any other health professional. The Independent Review of Nursing Education pointed out the costs of adding material to the nursing curriculum:

In their submissions to this review, critics of the current course advocated that more undergraduate teaching time be devoted to pain management, incontinence, intellectual disability, cancer care, substance abuse, mental health, sleep disorders, developmental disabilities, and a host of other topics. These are all serious matters, clearly worthy of study. However, because none of the submissions suggested which subjects might be dropped from the current course to make room for their proposed additions, adding more teaching would significantly lengthen the course ... make nursing less attractive to students ... increase their tuition debts and delay their entry to the workforce. From a societal viewpoint, a longer course would slow down the production of nurses. RN [Registered nurse] education is designed to produce generalist nurses who can slot into many different settings. Post-graduate study and experience are intended to build on a sound general base. (DoH 2019f, p. 12)

¹⁴⁶ Productivity Commission estimates using Department of Home Affairs (2019).

Nonetheless, that review concluded that given the high prevalence of mental health problems and comorbidities with physical conditions,¹⁴⁷ there were good grounds to give mental health greater prominence in training — for all nursing qualifications (DoH 2019f, pp. 57–58). The accreditation body for nurse training has proposed an update to the training standards that would include a discrete unit on mental health (ANMAC 2019). This appears to be a relatively low-cost option, with reasonable prospects that it will rapidly equip more generalist nurses to work in mental healthcare settings. There should, however, be no requirement for existing nurses to undertake further study unless they or their employers see it as valuable.

A direct entry pathway for specialist MHNs would partly alleviate future shortages and improve efficiency

Putting aside some legacy arrangements and separate arrangements for overseas-qualified nurses, registration as a specialist MHN requires postgraduate training in mental health nursing after a three-year general nursing degree. This is an unnecessarily restrictive model and sits in stark contrast to people who do specialist training in midwifery and to the training accepted in the mental health nurses recruited to Australia from the United Kingdom.¹⁴⁸ Registered midwives have three education and registration pathways — a direct-entry undergraduate qualification focusing on midwifery, a combined nursing and midwifery degree, or a post-graduate midwifery qualification for registered nurses (DoH 2013b). The direct-entry option was introduced in 2000, partly due to concerns about workforce shortages (Mason 2013; Stuhlmiller 2005) and it is now offered at 20 Australian universities.

A similar approach should be used for specialist MHNs by introducing a three-year direct entry degree in mental health nursing and recognising it as a way to qualify for registration as a specialist MHN. The shorter study duration reduces the cost of educating specialist MHNs, means students forgo less income, and is likely to attract more students to become specialist MHN than the post-graduate pathway, which would boost the supply of specialist MHNs.

Introducing a direct-entry degree in mental health would have scope of practice implications. Given the specialised nature of a direct-entry degree, graduates would have ample specialist skills but would lack the required skills to qualify for general nursing registration (which primarily relates to physical health). This would require a restricted scope of practice for graduates, unless students complete the additional units required for generalist nursing registration. Hence, graduates should receive a notation on their registration restricting their scope of practice to mental health, similar to the way foreign MHNs are recognised (AHPRA 2019).

¹⁴⁷ More than 25% of people with mental and behavioural conditions have two or more other chronic conditions (ABS 2018e, table 19).

¹⁴⁸ Mental health nurse training in the United Kingdom is possible via a three year undergraduate level degree (NHS 2020).

It is worth emphasising that the introduction of a direct-entry degree for specialist MHNs would not preclude a registered nurse from working in mental health. Employers would still be free to employ graduates with the level of skill that matches the services they provide. The bachelor degree simply provides an additional, quicker pathway to becoming a *specialist* MHN.

Recognition of prior learning — reducing the post-graduate training burden required to become a specialist MHN

In regard to the post-graduate pathway, the Productivity Commission views that more consideration should be given to recognition of prior learning as an alternative means to increase the supply of specialist MHNs. Registered nurses with years of experience working in mental health are likely to have developed significant expertise across areas that form part of post-graduate mental health nursing courses.¹⁴⁹ Recognising and granting exemptions from units where nurses can demonstrate an equivalent standard of knowledge would reduce training costs — both in time and money — which in turn would incentivise more nurses to specialise in mental health.

Exceptions should only occur for units where there would be little or no additional benefit likely to be derived by experienced MHNs. To ensure that recognition of prior learning is appropriately granted there would need to be oversight from stakeholders such as the Australian Nursing and Midwifery Accreditation Council. The oversight process should involve consultation with employers or supervisors to validate the work experiences of nurses against the units for which recognised prior learning is being considered.

¹⁴⁹ Recognition of prior learning in post-graduate mental health nursing degrees is already implemented at a few universities. For example some nurses with practical experience working within psychiatric inpatient units (as part of the University of Melbourne Transition to Mental Health Nursing Program) are automatically eligible for recognition of prior learning for three subject into the University of Melbourne Post Graduate Nursing Diploma in Mental Health (Barwon Health 2020).

ACTION 16.4 — MORE SPECIALIST MENTAL HEALTH NURSES

Mental health nurses are expected to form an important part of the workforce needed for a recommended expansion in services to bridge gaps in mental healthcare, particularly in community mental health services.

Start now

- A curriculum standard should be developed for a three-year direct-entry (undergraduate) degree in mental health nursing, similar to the option already available to midwives. The new standards should be developed by the Australian Government in collaboration with stakeholders. Nurses who complete the degree would have a notation on their registration restricting their scope of practice to mental health.
- The training of all nurses should include a discrete unit on mental health, though there should be no requirement that this apply to currently registered nurses.

16.4 Peer workers are increasingly important

Peer workers are people with a lived experience of mental ill-health (or carers of people with mental ill-health) who provide emotional and social support to others with a common experience (Orygen 2017b). Having experienced mental illness and recovery first-hand, peer workers exemplify the possibility of recovery to people experiencing mental illness, and are able to inspire hope, optimism and empowerment through genuine examples of overcoming adversity (Meagher and Naughtin 2018, p. 8; Orygen 2017b). As one peer worker noted:

I experienced a sense of loneliness or isolation. I know what it's like to be stripped of everything, to be sitting in a place of fear and total loss of control. I can offer the insight from that experience. That's powerful stuff that will get someone through. (Mental Health Council of Tasmania, sub. 869, att. 1, p. 11)

Peer workers offer consumers four unique contributions.

- The first is the ability to instil hope through self-disclosure, demonstrating that it is possible to go from being controlled by the illness to gaining some, if not complete, control over the illness.
- The second includes teaching self-care of one's illness and exploring new ways of negotiating day-to-day life (such as managing financial problems, unemployment, unstable housing, stigma and discrimination).
- The third is the peer worker's ability to form a relationship with the consumer based on trust, acceptance, understanding, and deeper empathy (including the ability to 'read' the consumer because of their own experience). (Davidson et al. 2012, p. 124)

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- The fourth follows from the unique position peer workers hold within the mental health system, as they have experienced services both as a consumer and as a worker. To consumers they can provide additional assistance navigating the system, and to organisations they can provide a consumer perspective to help make services more person-centred. As one worker remarked, ‘peer workers are an absolute asset to the mental health field. They are a wealth of knowledge and skills for people accessing services and workers within the service’ (Mental Health Council of Tasmania, sub. 869, att. 1, p. 14).

The pathway of peer workers into mental health services is quite different from the rest of the workforce in that their personal experience, not training, is the core basis of their value and competency — although many will also have formal mental health qualifications or are acquiring them (McCann and Moshudis 2018).

While people with past experience of illness or caring for people with illness have long worked (often voluntarily) in supportive roles in mental health services, peer workers are a relatively new and emerging workforce in Australia. There are already numerous examples of their use (box 16.3). They are often employed in hospital settings, community mental health services, aged care and disability services. Their different experiences may lend them to assisting in fields such as suicide prevention, perinatal mental health, the issues faced by military veterans, and in aged care facilities.

There is no estimate of the total number of peer workers in the mental health system. The evidence available suggests they currently play a role in State and Territory *specialised* mental health services — with 184 consumer peer workers and 69 carer peer workers (in FTEs) in these settings in 2017-18 (AIHW 2020b, table 34). However, there are many more peer workers employed by non-government service providers. For example, Flourish Australia (sub. 330, p. 5) employs about 200 peer workers across their services. Across New South Wales alone, it has been estimated that peer workers comprise about 11% of direct support roles in community managed organisations (MHCC and HCA 2019). The Queensland Lived Experience Leadership Roundtable (sub. 799, att. 3], p. 26) point to a 10-fold increase in peer workers across Metro South Addiction and Mental Health Services. In New South Wales, the expansion of the peer workforce is one of the key reforms to come out of *Living Well: A Strategic Plan for Mental Health in NSW 2014 – 2024* (Wellways, sub. 396, p. 9).

Box 16.3 Australian examples of peer workers

Connect Beyond Blue provides a low-intensity service for adults in the Greater Dandenong region with, or at risk of, mild to moderate depression and/or anxiety. The peer workers, or mentors, in the program speak a range of languages (Beyond Blue, sub. 275, p. 20).

Flourish Australia operates a community-based mental health support model with workers and volunteers, all of whom have lived experience of mental ill-health. The service was launched in 2011 in Hervey Bay, Queensland (Flourish Australia, sub. 330, p. 7).

Mind Australia has 65 people in designated peer roles. They are employed at all levels of the organisation, and include consumer and carer peers (Mind Australia, sub. 380, p. 25).

The **NSW Government's Peer Supported Transfer of Care initiative** gives people discharged from mental health services up to 6 weeks of support by an experienced and qualified peer worker to help them successfully transition back into the community. The peer workers are based in community mental health teams (NSW Government, sub. 551, p. 28).

The **Peer Support Worker program** provides peer support services to people in inpatient wards in Bloomfield hospital in Orange. This involves 7 full-time peer workers who work across a range of specialist mental health wards. An additional peer worker is based in the emergency department (Mission Aust, sub. 487, p. 36).

Roses in the Ocean is building a lived-experience workforce to contribute to suicide prevention. Its peer support program contributes to a better understanding of the perspectives of people with mental health conditions (Roses in the Ocean 2019).

St Vincent's Hospital in Melbourne has a peer worker employed in its emergency department and a nearby Safe Haven Cafe (ACEM, sub. 516, p. 9).

The **Western Sydney Recovery College** provides education to assist people in their recovery and increase knowledge, skills and awareness of mental health within the community. The courses are delivered by peer facilitators with lived experience of mental illness, and are co-designed with clinicians (Wentwest, sub. 445, p. 66).

Using peer workers more effectively

There are two ways to consider the value of peer workers. The first is to look at the evidence of their impact on consumer outcomes, and the second is to consider the value people experiencing mental illness place on them. The latter is particularly important in a person-centred mental health system.

Impact on consumer outcomes

With regard to evidence on their effectiveness, there is a growing literature assessing peer workers' impact on health outcomes and health system costs. Studies found that the inclusion of peer workers reduced the use of emergency services. (Lawn, Smith and Hunter 2008), decreased admissions to inpatient units (Cherrington et al. 2018), lowered the length of visits (Trachtenberg et al. 2013, p. 2) and reduced the rate of readmission (Lawn, Smith and Hunter 2008). Because of the high cost of emergency services and acute care, studies have

found financial benefits from employing peer workers in support services for people who might otherwise present at hospital emergency departments when experiencing an episode of mental illness (Lawn, Smith and Hunter 2008) because the cost of employing them is exceeded by the reduction in inpatient care costs, in some cases by a substantial margin (Trachtenberg et al. 2013, p. 2).

The evidence on peer workers' ability to reduce depressive symptoms is mixed. Pitt et al. (2013) found peer workers produced similar outcomes compared with more highly qualified staff in psychosocial, mental health symptom and service use outcomes (particularly case management). However, Lloyd-Evans et al. (2014) found little or no evidence that peer support was associated with positive effects on symptoms or satisfaction with services.

The key shortcoming of the evidence base is risk of bias. Large meta-studies looking at peer worker outcomes have pointed to the fact that study methods need improvement:

[T]he overall methodological quality of the evidence is poor. (Trachtenberg et al. 2013, p. 4)

The overall quality of the evidence is moderate to low. (Pitt et al. 2013, p. 2)

Deficiencies in the conduct and reporting of existing trials exemplify difficulties in the evaluation of complex interventions. (Lloyd-Evans et al. 2014, p. 1)

[There is a] need for a systematic and scientific and objective evaluation of programs. (Villani and Kovess-Masféty 2018, p. 457)

Consumers generally value the contribution of peer workers

Turning to how consumers value peer workers, the story is more uniformly positive. Consumers who participated in this Inquiry were very supportive of the value peer workers offered consumers:

Access to peer support was rated as the highest preferred service by over 80 per cent of consumers, carers, and service providers in the development of the alternative to ED model. (Consumers of Mental Health, Perth transcript, p. 5)

Many consumers who made submissions to the Royal Commission into Victoria's Mental Health System also testified to their worth:

Talking to someone who has been there and done that relieves the tension immediately.

[Peer Workers] hold the key to relating to consumers and carers that are going through this traumatic experience.

Expanding of the peer support workforce has been invaluable to have that voice in the space. It empowers people. They have a lot to offer. (State of Victoria 2019, p. 513)

There was also widespread support for peer workers among mental health service providers (Australian Red Cross Society, sub. 490, p. 12; Mission Australia, sub. 487, pp. 35–36; NMHCCF, sub. 476, p. 3; Wellways Australia, sub. 396, p. 2). Some advocate for more widespread use in clinical and community mental health services. For instance, Uniting SA (sub. 807, p. 6) recommended peer workers be available to provide support and advocacy

services in emergency departments from presentation through to discharge. Others argued that peer workers should be better integrated into all components of the mental health system, from prevention and early intervention through to complex care for people with serious mental illness, and alcohol and other drugs problems (EACH sub. 227, p. 3; Heffernan sub. 552, p. 4).

Although there is considerable evidence of the value peer workers can provide, there are nonetheless issues for policymakers to consider. Getting the most value from peer workers requires careful consideration of their role, workplace environment (including the attitudes of other workers), sufficient support for their own mental health, and training and professional development opportunities.

Obstacles to using peer workers

Notwithstanding recognition by service deliverers of the value of peer workers to their activities, Inquiry participants argued that several problems have hindered the development and effectiveness of a peer workforce. Their concerns centred on:

- insufficient recognition of the value of peer workers
- inadequate supervision and support
- poor professional development and career advancement
- the absence of a representative professional body.

These issues — discussed in detail below — have been recognised for some time. In 2014, the National Mental Health Commission recommended that some of these issues be addressed by developing national guidelines on peer workers (NMHC 2014d). The NMHC has since progressed work on role delineation, key roles and functions, guiding principles, minimum training, career progression pathways, peer supervision and mentoring, and principles for employment (such as reasonable adjustment, remuneration and safe workplaces) (NMHC 2018b, pp. 4–8, 2019b). These guidelines are part of Action 29 of the Fifth National Mental Health and Suicide Prevention Plan, and are set to be completed by 2021 (NMHC 2020a). Whether the guidelines provide enough clarity to overcome the issues should be assessed in the next few years.

Recognising the value of peer workers

Attitudes held by other mental health practitioners and indeed some consumers to peer workers can sometimes be negative, reducing the capacity for their full use (Aguey-Zinsou, Sommer and Yule 2018; Vandewalle et al. 2016; HealthWISE sub. 750, pp. 1–2). These negative attitudes do not seem widely prevalent, but where they exist, they take several forms: concerns about professionalism; confusion about their scope of practice, responsibilities, and how other health professions should work with them; and the vulnerability of peer workers when relieving the stress of others' mental health problems. For

instance, one survey respondent remarked that peer workers are sometimes seen by service providers as the lowest paid workers with the lowest expectations and the highest disposability (HealthWISE, sub. 750, p. 4). While the broader evidence seems to belie the observation, one sceptical respondent in a mental health staff survey remarked:

Most consumers (clients) I have worked with are not keen to talk to peer support persons. There have only been two out of 20 clients who accepted this offer; it was only for two sessions. (Aguey-Zinsou, Sommer and Yule 2018, p. 88)

Another peer worker remarked that clinicians tend to be less supportive of peer workers where there is an overlapping of roles (McCann et al. 2008). The Penington Institute (sub. 264, att. 1], p. 4) points to a lack of peer integration into harm reduction services, with peer-based initiatives treated like ‘add-ons’ or ‘stand-alone’ programs. Kaine (2018, p. 16) notes there is still a way to go for mental health services to operate under recovery oriented models and for organisations to embrace consumer and carer peer support workers.

A lack of understanding of the role and scope of peer workers could be limiting their deployment into a wider range of services — an issue that would be partially resolved by greater familiarity and training of traditionally-trained practitioners and greater clarity in peer worker job descriptions. For example, the Mental Health Commission NSW (sub. 948, p. 9) noted that while clinicians’ lack of acceptance was preventing widespread use of peer workers, attitudes change quickly once clinicians have the opportunity to work with them and see the benefits of their work first-hand.

The mental health sector is beginning to recognise the value of the peer workforce. For example:

The peer workforce is growing significantly, and is increasingly valued across government and the community sector for contributing to better outcomes for consumers and carers. (NMHC, sub. 949, p. 13)

Peer Work provides an opportunity for people with lived experience to use their experience of a mental health issue intentionally to support others with a lived experience. The benefits that arise are both in terms of the person receiving the support and their mental health recovery, but also the benefit of economic participation for the Peer Worker. (Flourish Australia, sub. 330, p. 5)

Enhancing supervision and support

Supervision is a universal practice across health professions, and is a key basis for acquiring and maintaining skills, and achieving accountability and quality care. Participants have noted that peer workers often receive inadequate support and guidance from their employers, which can create a sense of isolation, and put peer workers at risk of re-traumatisation from interactions with people experiencing mental illness (EACH, sub. 227, p. 3; HealthWISE, sub. 750, pp. 6–7; State of Victoria 2019, p. 518). As for all workers, peer workers should have ready access to supervision and support, including by experienced peer workers who can give support and guidance (HealthWISE sub. 750, p. 6). The personnel providing

supervision would sometimes desirably extend to other mental health professionals, but accompanied by training in understanding the role and benefits of peer workers.

Professional development and certification of skills

Limited or unclear career paths and a lack of professional development opportunities can frustrate peer workers' long-term vocation in mental health services (Mind Australia, sub. 380, p. 27; HealthWISE, sub. 750, pp. 6–7). One route — already available — is vocational education and training, such as a Certificate IV in Mental Health Peer Work. However, there may be a lack of attention given to ongoing training and professional development to help deepen peer worker knowledge and skills (State of Victoria 2019, p. 511). Ongoing training and development for peer workers could support the specialisation of peer support work, such as skills in particular settings or with particular types of mental illnesses, or could include the development of business or management skills (State of Victoria 2019, p. 516).

Service delivery contracts may limit the ability for organisations to devote resources to training and professional development of peer workers (as they similarly could for other mental health workers). The common one-year contracts create a great deal of uncertainty in the sector, making it hard to justify outlays on training for workers when contract extension is not guaranteed (as discussed further below). To add to this, contract tender processes consume considerable time and resources that could be devoted to training and service provision. This predicament affects smaller organisations more than larger ones, as they have smaller and less certain cash flows, and hence may be less willing to make risky investments.

There is some evidence that career paths for peer workers are becoming more defined. For example, the Victorian Public Mental Health Services Enterprise Agreement contains three distinct peer worker competency levels with associated wage scales (FWC 2017, p. 292). Entry level workers are placed under the supervision of clinical staff, level 2 workers can work independently, and level 3 workers are able to manage a team (FWC 2017, pp. 351–2). The NMHC's forthcoming peer worker guidelines may also assist by providing guidance on organisational readiness, recommended minimum training, peer supervision and mentoring, and the importance of leadership and career progression (NMHC 2018b, pp. 4–5). The NMHC could help guide professional development standards by recommending training resources as well as training models for organisations, such as work placements, internships or rotations.

Some have suggested that qualification requirements for peer workers are underdeveloped (HealthWISE, sub. 750, p. 6; Mind Australia, sub. 380, p. 27). The Royal Commission into Victoria's Mental Health System (2019, p. 515) notes that peer workers do not yet have broadly recognised 'entry to practice' requirements such as those that apply to other professions associated with mental health.

Having a more developed and standardised system of qualifications could give employers and peer workers common expectations for requisite training. However, it would be undesirable to *require* (through regulation or through specifications in provider contracts) minimum standardised qualifications. The unique value of peer workers is that they bring to bear their lived experience of mental ill-health and recovery, rather than qualifications obtained through education. Peer workers require certain key skills, rather than qualifications. Among others, these skills include the ability and empathy to translate their knowledge and experience effectively, and an understanding of recovery-oriented practice.

Some in the sector believe the Certificate IV in Mental Health Peer Work ought to play a greater role (McMahon 2019, p. 7). While it may be preferable that peer workers hold this qualification, mandating it could well create workforce shortages, impose unnecessary costs on peer workers, and reduce flexibility for employers to vary prerequisites. Mandating this qualification, for example, would restrict workforce growth in two ways — first all prospective peer workers would need to set aside six months to complete the qualification, forgoing wages and paying an average cost of \$4000 for the training (DESSFB 2020); and second, it would preclude entry of peer workers with other relevant qualifications, such as a Certificate IV in Mental Health (non-peer), Social Work or Psychology. As Wellways noted (sub. 396, p. 19) this may explain why in the United Kingdom rapid workforce growth was fuelled by a *decrease* in the number and level of qualifications in the workforce.

A less regulated model does not preclude any given provider from defining closely the task of peer workers or requiring certain qualifications, competencies, and experience when employing them. Some employers, such as Mind Australia, require applicants to have some formal training in a related field (Mind Australia 2020). Alternatively, employers offer workers the opportunity to complete a qualification while employed (Brook RED, sub. 799, att. 3, p. 26). Other employers may support workers in undertaking unaccredited training, or provide in-house training and professional development they believe satisfy the demands of the job. Setting minimum qualifications removes these options for employers and forces prospective peer workers to obtain another qualification, regardless of what training, qualifications and experience they already have.

These factors, alongside the empirical evidence cited above about the effectiveness of peer workers compared to other professions does not suggest an obvious payoff from mandatory minimum qualification requirements.

Occupational representation for peer workers

Some participants argued that the peer workforce needs its own professional organisation (Beyond Blue, sub. 275, p. 19; Tim Heffernan, sub. 552, att. 5, p. 5; PMHCCN, sub. 49, p. 4). The NMHC recently funded the Private Mental Health Consumer Carer Network to produce a feasibility study on a national peer workforce organisation. The Network's literature review (Kaine 2018, pp. 8–15) identified several functions such an organisation could perform, including:

- providing access to resources and training, example policies and best practice guidelines for organisations seeking to implement peer support initiatives
- offering access to training from lived experience facilitators for non-peer workers
- supporting role clarity by providing example peer worker job descriptions, access to resources to support a deeper understanding of the peer support worker role for peer workers, non-peer workers, organisations, and consumers
- access to communities of practice with experienced peer workers, in addition to offering access to specialised supervision and training.

The final report of this feasibility study was completed and provided to the Department of Health in June 2019 (McMahon 2019), although the Department of Health has not yet formulated its response. The report recommends the establishment of a professional body for peer workers, potentially assisted by government funding (McMahon 2019, pp. 5–6).

A professional organisation is likely to result in a better supported peer workforce and improved care overall. Given the nascent nature of this workforce and their typically low wages, a purely self-funded model for such an organisation may not be feasible in the short run. Accordingly, there are grounds for government seed funding for the creation of a professional organisation. However, in the long run, funding for such an organisation would ideally come from a combination of members and those entities advocating such an organisation. The role of the latter could ensure greater sector influence on the design and objectives of the organisation, which otherwise could be dominated by government objectives.

ACTION 16.5 — STRENGTHEN THE PEER WORKFORCE

Peer workers are a valuable but under-utilised part of the mental health workforce.

Start now

The Australian Government should provide once-off seed funding to create a professional association for peer workers.

Start later

The Australian, State and Territory Governments should, in consultation with stakeholders, develop a program to educate health professionals about the role and value of peer workers in improving outcomes for consumers.

16.5 Allied and community mental health workers

Consumers of mental health services and people with mental ill-health who have minimal need of clinical mental healthcare, sometimes require the services of different types of professionals to support their mental wellbeing and recovery in the community. Allied health workers — such as occupational therapists (OTs), physiotherapists, dieticians, some community mental health workers, some Aboriginal and Torres Strait Islander health workers, and some social workers — provide a range of interventions to help people experiencing mental ill-health. In addition, other professionals — such as counsellors and psychotherapists (box 16.4), peer workers, youth workers, arts and music therapists, and people focussing on CALD interfaces with other services — provide key supports, primarily in non-clinical settings. These diverse workforces face unique challenges.

Community mental health and support workers

This report uses the term community mental health and support worker to refer to those staff, generally employed in non-government organisations (NGOs), delivering a range of psychosocial support and community mental health services on behalf of a range of bodies such as faith-based groups, philanthropic organisations and governments. They work directly with consumers to aid rehabilitation through goal setting and attainment, positive risk-taking, care coordination, recovery assessment, motivational interviewing and trauma-informed practice (Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212, p. 18). In this way, community mental health and support workers can be a crucial linchpin in supporting the recovery of people with mental illness and their capacity to remain active, connected and contributing within their family and community.

Box 16.4 The role of counsellors and psychotherapists

Counsellors and psychotherapists play an important role in the delivery of some types of psychological therapies (most frequently talk-based therapy) to people with a range of mental health problems (Moloney 2016; Victorian Government 2020b). They work with, and within, multi-disciplinary mental health teams across a range of sectors (ACA 2016, PACFA, sub. 883).

The Productivity Commission received a number of submissions advocating for national recognition and higher utilisation of counsellors and psychotherapists.

- The Psychotherapy and Counselling Federation of Australia (sub. 883, p. 6) noted that expanding the use of registered counsellors and psychotherapists would increase access to health services, particularly for people in rural and remote areas, enhance consumer choice, achieve better client outcomes and reduce financial strain on the health system.
- EPICentre (sub. 725, p. 3) argued that recognition of university qualified counsellors as allied mental health professionals and higher utilisation as healthcare providers would assist to take pressure off the mental health workforce, reduce waiting times for therapy and save money.
- The Australian Register of Counsellors and Psychotherapists (sub. 337, p. 3) stated that there is an opportunity to achieve social and economic productivity gains and improve consumer choice by maximising the available workforce potential of registered counsellors and psychotherapists.

There is some evidence to suggest that counsellors and psychotherapists can be effective at improving the mental health of people with mild or moderate mental illness (American Psychological Association 2012; Moloney 2016). Moreover, counsellors and psychotherapists charge, on average, lower fees than psychologists (PACFA 2020b; Willis 2018). This lends support to the argument that higher utilisation of counsellors and psychotherapists has the potential to reduce out-of-pocket expenses for consumers, allow more people to access the help they need, and deliver cost savings to the health system. There are a number of recommendations in this Inquiry, for example to increase the delivery of psychosocial supports, that are likely to increase the demand for counsellors and psychotherapists in Australia's health system.

There are, however, concerns about the variable quality of services delivered and the extent to which the qualifications and credentials of counsellors and psychotherapists (which differ substantially) are related to the effectiveness of service delivery, or the fees charged (Moloney 2016; Pelling and Sullivan 2006). This problem stems from the fact that, unlike psychiatry and psychology, counselling as a profession is not formally regulated (PACFA 2020a). This means anyone can call themselves a counsellor — whether they have done a short online course that teaches the basics, or six years of university training.

To address concerns of quality control, the Australian Counselling Association and the Psychotherapy and Counselling Federation of Australia jointly established the Australian Register of Counsellors and Psychotherapists (ARCAP). The ARCAP register outlines a nationally consistent set of standards (for example in relation to professional qualifications and hours of supervised work) that counsellors and psychotherapists must satisfy in order to be registered (ARCAP 2020). While the development of a clearly defined and standardised set of requirements is an important step in alleviating some of the concerns about quality control, the Productivity Commission has not been able to find any strong evidence to suggest that those registered and meeting the registration requirements are associated with superior service delivery compared with those who are not.

(continued next page)

Box 16.4 (continued)

As such, requests that registered counsellors and psychotherapists are provided access to MBS-rebates and meaningfully differentiated from non-registered practitioners are not supported at this time.

The Commission has set out in chapter 23 the autonomy for commissioning bodies to plan and commission services to meet local need. There is no reason in principle why in some cases counsellors and psychotherapists could not be commissioned similar to other service providers that do not have an MBS rebate.

It can be difficult to encapsulate the role of community mental health and support workers, particularly because there are no predictable education pathways into the sector and their role can vary substantially between service providers. Box 16.5 sets out a case study for how these roles work in practice.

Box 16.5 Community mental health and support workers in practice

Libby is a 29-year-old woman who was diagnosed with bipolar disorder and has been in and out of mental health facilities since her late teens. When transitioning from an inpatient unit in hospital to a Step Up/Step Down facility, community mental health workers work with her to identify skills and steps for her recovery journey. Libby identifies a number of goals including living a healthier lifestyle, rebuilding the relationship with her family and exploring opportunities to participate more in the community, as well as identifying strategies for wellbeing and how to maintain this when she exits the facility. Libby is allocated several sessions with a Family Engagement worker to meet and work with her and her family to restore her relationship, and Libby's parents are provided with relevant information and details of local Carer Support groups they can contact for additional support. A community mental health worker meets with Libby two to three times a week to assist her in designing the actions required to meet her goals, including (but not limited to):

- developing her meal planning and preparation skills, focusing on healthy eating
- wellness planning
- identifying and connecting her with activities that align to her interests, such as community groups
- exploring options and supporting her to engage in local sporting events and exercise groups
- developing strategies to address any barriers in reaching her goals.

Upon her exit from the service, Libby is better connected with her family, friends, local services and the community, and has an improved resilience and capacity to self-manage and seek help with regard to her mental and physical health.

Source: Mind Australia, Neami National, Wellways and SANE Australia (sub. 1212, p. 19).

There is no systematic data collection for the community mental health workforce, so it is difficult to accurately assess the size of the workforce or the extent of formal qualifications.

- A national mental health NGO landscape survey was conducted by the National Health Workforce Planning & Research Collaboration, but this was in 2011 so it is conceivable

the workforce has since changed considerably — for example, with the rollout of the National Disability Insurance Scheme (NDIS).

- In 2011, the total workforce was estimated to range between 15-26 000 paid employees, with many working part-time (NHWPRC 2011, p. ix). They were mostly female (72%) and largely from non-clinical backgrounds.
- Although there are no mandated minimum qualifications, most were skilled workers — 43% of respondents had a bachelor degree or higher tertiary qualification and 34% of workers had a vocational qualification, with the majority of these being at the Certificate IV and Diploma levels (NHWPRC 2011, pp. 78, 105). There were also a significant number of volunteers and peer workers in the workforce.
- Some more recent estimates of formal qualifications have been taken from unions, NGOs and other organisations, though estimates vary considerably among sources. A survey of community mental health services in New South Wales found that the size of the New South Wales workforce totalled 4745 paid workers (both direct care and managers/administrators) and 4160 volunteers (MHCC and HCA 2019, p. 6).
- The Australian Services Union’s (sub. 791, p. 4) survey¹⁵⁰ of Victorian community mental health workers found 32% of respondents hold Bachelors or Honours Degrees, 29% hold Masters Degrees, and 8% hold a Certificate IV or lower as their highest completed qualification. The Community Mental Health Australia survey reported that in Victoria 90% of paid staff have a diploma or above (CMHA 2017; VCOSS, sub. 478, p. 22).

The community mental health sector is experiencing significant uncertainty due to the introduction of the NDIS and other changes in the sector. The transfer of funding for key Australian Government mental health programs to the NDIS¹⁵¹, as well as the diversion of State and Territory Government funding to the NDIS has reduced funds available for NGOs. Those who do obtain service delivery contracts find it difficult to create a stable and skilled workforce because contract funding cycles are too short. For example, the Mental Health Coordinating Council found that half the community mental health workforce in New South Wales were employed as casuals or on temporary contracts (MHCC and HCA 2019, p. 7).

Inquiry participants report several workforce challenges that have resulted from the introduction of the NDIS (Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212, p. 21).

- *Retention difficulties* — low NDIS prices¹⁵², funding uncertainty and short-term service contracts (often only one year) have reduced job security, leading to high turnover rates and increased workforce training costs (Australian Services Union, sub. 791, p. 8;

¹⁵⁰ Joint survey by the union’s Victorian and Tasmania Branch, as well as Mental Health Victoria.

¹⁵¹ The most commonly cited programs are Personal Helpers and Mentors Service, Partners in Recovery and Day to Day Living.

¹⁵² NDIS price levels have been a contentious issue for some time. In 2017 the Productivity Commission found that the National Disability Insurance Agency’s approach to setting price caps led to poor participant outcomes in some cases, especially for those with complex needs (PC 2017d, p. 304).

EMHSCA, sub. 578, p. 10; Health Services Union, sub. 237, pp. 22–23; One Door Mental Health, sub. 108, p. 11; Queensland Alliance for Mental Health, sub. 247, p. 10; VCOSS sub. 478, p. 21).

- *Deskilling and loss of recovery-focused support* — funding scarcity and uncertainty have inhibited the provision of additional training and professional development opportunities for workers, and put pressure on organisations to hire workers with lower skills on lower wages than the Social, Community, Home Care and Disability Services Industry Award.
- *Adverse work environments* — funding constraints and increasingly complex consumer needs (from substance use comorbidities) have increased staff workloads, stress, burnout and vicarious trauma.

Changes to funding arrangements and other system reforms (including the NDIS) are the most important vehicle for resolving these workforce challenges – in particular the length of government contracts for service delivery (chapter 17).

Under the Productivity Commission’s recommended reforms, community mental health and support workers would be recognised as an essential part of the mental health workforce. In order to conduct proper workforce planning, Australian, State and Territory Government health departments need to track the size, composition and roles of the community mental health and support workforce. This task is frustrated by a lack of data about community services — particularly of NGOs — and the mental health workers they employ (Mental Health Australia, sub. 864, p. 40; AIHW, sub. 370; p. 6; MHCC, sub. 214, p. 8). The Department of Health’s National Health Workforce Data Set notionally includes community health and community-based care, but information about the categories of workers is limited. The Community Mental Health Care National Minimum Dataset (NMDS) only covered government-funded services, and (understandably) was primarily about services delivered to consumers. The Mental Health Non-Government Organisation Establishments National Best Endeavours Data Set would have given a consistent national picture of community-managed mental health organisations, but would have sparse information on the workforce, and only Western Australia and Queensland implemented this data set. There is accordingly inadequate information about mental health community workers, their occupational categories, scope of practice, education, and demographic characteristics. This is a data vacuum that Australian governments should fill (as part of the data gathering exercises recommended in Actions 16.1 and 24.3).

Aboriginal and Torres Strait Islander health workers and practitioners

Aboriginal and Torres Strait Islander health workers meet a need for culturally competent workers to provide health services to Aboriginal and Torres Strait Islander people. There is no reliable estimate of the degree to which such workers specialise in mental health services, though the majority would — like GPs — have to address the mental health (broadly defined) of those they assist. The RANZCP (2016a) note that mental health in this context is a broader concept than that used in most clinical settings, encapsulating ‘multidimensional

factors, including emotional, social and spiritual well-being, connection to country, culture, ancestry, family and community'. This is consistent with the Productivity Commission's recommendation for the entire mental health system to be person-centred.

In defining the occupation of an 'Aboriginal and Torres Strait Islander health worker', the Australian Institute of Health and Welfare (2019a) distinguishes between Aboriginal and Torres Strait Islander health *workers* and *practitioners*. The *workers* hold a minimum qualification in primary healthcare or clinical practice, and their prime role is to 'liaise with patients, clients and visitors to hospitals and health clinics, and work as a team member to arrange, coordinate and provide health-care delivery in community health clinics'. The *practitioners* have completed a certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care, are registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia and may undertake higher levels of clinical assessment and care.

The Department of Health's National Health Workforce Dataset shows that there were about 550 registered Aboriginal and Torres Strait Islander *practitioners* in 2018, up by over 100% from 2013 (DoH 2020l). The most common setting for these workers was clinical roles in Aboriginal health services. This workforce has a particularly prominent role in remote and very remote Australia (representing about 40% of the total workforce in these areas compared with 15% in major cities), distinguishing them from other parts of the health workforce. However, growth in the number of Aboriginal and Torres Strait Islander practitioners has been greatest in major cities and inner regional Australia.¹⁵³

Australian, State and Territory Governments have devoted considerable effort to encouraging the growth of this workforce. For example, the Australian Government funds scholarship programs to assist students in health-related disciplines to complete their studies and join the health workforce, and to support health professionals with continuing professional development and postgraduate studies (DoH 2017a). The Victorian Government has a traineeship program for ten Aboriginal and Torres Strait Islander people to be employed in its area mental health services, and be provided with training and clinical placements over three years, while concurrently completing a university degree in mental health (VIC DHHS 2018a). The New South Wales Government has previously offered similar support to develop a workforce of Aboriginal mental health workers. There has been noteworthy growth across the mainstream mental health workforce among Aboriginal and Torres Strait Islanders. From 2013 to 2018 the nursing and midwifery workforce grew 60%, GPs grew 48%, psychiatrists grew 70% and psychologists grew 50% (DoH 2020l). While it is difficult to know whether this growth emanates from specific government programs, the growth is a positive development regardless.

Health Workforce Australia identified a range of issues faced by Aboriginal and Torres Strait Islander health workers (HWA 2014a). These included limited career opportunities, lack of understanding of the role and capabilities by other health professions, high turnover, and professional isolation for those health workers in remote locations.

¹⁵³ This may be fitting because the 2016 ABS census showed 37% of Aboriginal and Torres Strait Islander people lived in major cities while another 24% lived in inner regional areas (ABS 2019e).

The extent to which some of these issues can be addressed is limited. For example, there is limited scope to create a career pathway for a specialist role targeted at a small proportion of the population. However, some progress has been made in improving how other professions view the role. For example, the RANZCP (2016a) issued a statement acknowledging the value and skills Aboriginal and Torres Strait Islander health workers bring to the practice of psychiatry. There is now also a well-developed system of qualifications for Aboriginal and Torres Strait Islander health workers, including a university degree specialising in mental health.¹⁵⁴

That said, there is evidence of a health worker shortage in Aboriginal and Torres Strait Islander health organisations in remote and very remote Australia, which could be filled by Aboriginal and Torres Strait Islander health workers or other non-Indigenous culturally capable health workers. Vacancy rates for health workers in such organisations are about 10% in remote and very remote Australia compared with less than 5% in major cities (Productivity Commission estimate using AIHW 2019a). The excess demand in less dense areas of Australia appears to be even greater when it is estimated as the number of vacancies per 100 clients. Given the particularly high vulnerabilities of Aboriginal and Torres Strait Islander people in regional and remote parts of Australia, this suggests the need for initiatives to expand the culturally capable workforce.

The National Aboriginal Community Controlled Health Organisation (sub. 1226, p. 20) recommends expanding:

- regionally based, Aboriginal Community Controlled Registered Training Organisations to deliver Aboriginal Health Worker curricula in social and emotional wellbeing
- mental health and social and emotional wellbeing teams across Aboriginal Community Controlled Health Organisations to address the service gap.¹⁵⁵

Both options have merit, although if the key problem is an excess demand for workers, additional funding for services might not achieve the desired goal. This suggests that the initial challenge is increasing the number of Aboriginal and Torres Strait Islander health workers and the cultural capability of mental health workers more generally.

¹⁵⁴ Vocational courses range from Certificate II to an Advanced Diploma in Aboriginal and/or Torres Strait Islander Primary Health Care. Additional Certificate III and Certificate IV courses exist for Aboriginal and/or Torres Strait Islander Primary Health Care Practice (Australian Government 2019b). At degree level, Charles Sturt University provides a Bachelor of Health Science (Mental Health) exclusively for Aboriginal and Torres Strait Islander students. Students can exit after 1 year (full-time) with a diploma, 2 years with an associate degree, or 3 years with a degree (Charles Sturt University 2019).

¹⁵⁵ The National Aboriginal Community Controlled Health Organisation considers the establishment of multidisciplinary teams in Aboriginal Community Controlled Health Organisations would provide the necessary services communities need as well as professional development opportunities for Aboriginal and Torres Strait Islander health workers

16.6 Mental health professionals must be culturally capable

Language and cultural differences can be a barrier to accessing mental health services. In particular, Aboriginal and Torres Strait Islander people and people from CALD backgrounds are less likely to seek and receive mental health treatments than the general population (FECCA 2015; Kilian and Williamson 2018; Mollah et al. 2018).

Cultural capability in mental health professionals is a key element in enabling Aboriginal and Torres Strait Islander people and CALD people to access mental health services. We were unable to find any information collected on the cultural capability of Australia's mental health workforce. But comparatively poor outcomes for the mental health and wellbeing of Aboriginal and Torres Strait Islander people and some people in CALD communities would suggest there is significant scope for improvement (chapter 2).

In particular, mental health professionals should ensure their service delivery accounts for the following characteristics of some Aboriginal and Torres Strait Islander people and CALD people:

- lower levels of English proficiency (Amery 2017; FECCA 2015) — people with limited English proficiency are more likely to have difficulty navigating the often complex mental health system and experience problems communicating with health professionals
- higher perceived stigma and negative attitudes towards mental illness (NMHCCF 2014; US DHHS 2001) — such attitudes expose people to heightened feelings of shame or embarrassment which can lead people to conceal symptoms and avoid seeking care
- lower levels of mental health literacy (FECCA and NEDA, sub. 524, p. 3, Hart et al. 2009) — people with limited mental health literacy are more likely to have difficulty recognising the signs of distress in themselves (or others in their community) which can stop them from seeking support
- heightened experience of discrimination and trauma (intergenerational or recent) (CATSINaM, sub. 75, p. 7, Minas et al. 2013) — such experiences can lead to mistrust in health professionals and the medical system more broadly
- religious or spiritual beliefs that affect compliance with medication or other medical interventions (Hamrosi, Taylor and Aslani 2006; Zagodzoon and Wrotkowska 2017).¹⁵⁶

¹⁵⁶ While there are several explanations for the disparity in access to mental health services, the precise causal channels and interaction of factors in explaining the disparity are poorly understood. Moreover, these barriers are likely to operate to varying degrees for different individuals and groups, depending on life circumstances, cultural or ethnic background, age, gender, sexual orientation and spiritual beliefs (US DHHS 2001).

The need for mental health professionals to address these barriers in their service delivery was supported by a number of participants to this Inquiry.

- The Federation of Ethnic Communities' Councils of Australia (FECCA) and the National Ethnic Disability Alliance (NEDA) (sub. 524, p. 2) stated that in order to develop a mental health system that is truly person-centred, recovery-oriented and holistic, the cultural responsiveness and inclusiveness of services and data collection must be substantially improved.
- Woodville alliance (sub. 1203, p. 1) argued that it is essential that any service system reform or redesign include recognition of the diverse needs of the Australian population and the need for specialised and targeted mental health services for CALD communities.
- The South Australian Mental Health Commission (SAMHC) (sub. 477, p. 9) noted that solutions are needed to address cultural and health literacy barriers. Health practitioners should have improved engagement skills to build cultural knowledge and better communication with their CALD consumers.

In regard to the structural deficiencies, the Productivity Commission agrees that more needs to be done to ensure the mental health workforce is culturally responsive, diverse and inclusive of people from Aboriginal and Torres Strait Islander and CALD backgrounds. To achieve this, health services across the entire sector will need to develop and implement their own evidence-based initiatives. This includes:

- conducting assessments of, and improving the cultural competency of established work practice (NT Mental Health Coalition Inc, sub. 430, p. 22)
- providing cultural awareness and competency training to staff (ACSQHC 2020a)
- broadening where trainees undertake clinical placements (Action 16.7)
- reconsidering approaches to staff recruitment and retention to increase the number of bilingual and bicultural mental health employees, including peer workers, to meet community needs (FECCA and NEDA, sub. 524, p. 8).

Such interventions should be tailored based on an understanding of local community demographic profiles and designed and delivered in collaboration with local Aboriginal and Torres Strait Islander and CALD communities (Mental Health Australia, sub. 864, p. 12).

To help develop and target these interventions, the Productivity Commission supports calls for improved collection and use of CALD-specific data (Action 16.1, FECCA and NEDA, sub. 524, p. 2). Improved data collection and use would provide important insights into the characterises of the workforce (such to identify where gaps in skills and cultural competencies exist at a local level) and facilitate future examinations of the effectiveness of programs aimed at increasing access to (and take-up of) mental health services for specific community groups.

16.7 Stigma and discrimination by health professionals

Inquiry participants with mental illness reported experiencing stigma and discrimination in their interactions with the health sector (box 16.6). This can manifest in the form of disrespectful or condescending behaviours and health professionals changing their behaviours after becoming aware of a person's mental illness (MHCA 2011). More broadly, Morgan et al. (2016) conducted a nationally representative survey of Australian adults who either reported a mental health problem or scored highly on a mental health screening questionnaire. They found that a 'significant minority' (12%) reported discrimination from a health professional in the preceding 12 months. The most common perceived experiences of discrimination included health professionals treating people with mental illness dismissively or disbelieving them, judging them or being unwilling to listen.

Stigma and discrimination by health professionals can have a significant effect on the recovery and wellbeing of people with mental illness. It can discourage people from seeking help when they need it, alter the type of help they seek and the symptoms they describe, increase levels of psychological distress, lessen adherence to treatment regimes, and exacerbate mental illness (COAG Health Council 2017a). Of particular concern is the possibility of people being unable to access necessary care when presenting in suicidal distress to health services (chapter 9).

While only a small proportion — about 10% — of those reporting discrimination felt that health professionals ignored their health concerns (Morgan et al. (2016), the process of 'diagnostic overshadowing' is often raised as a particular concern (Allan Fels, sub. 303; Canberra Mental Health Forum, sub. 62; NMHC, sub. 118; VCOSS, sub. 478; Wellways Australia, sub. 396). Diagnostic overshadowing involves health professionals neglecting people's physical health once they have been diagnosed with mental illness, 'undermin[ing] diagnosis, treatment, and successful health outcomes' (Nyblade et al. 2019). Physical healthcare for people with mental illness is considered in more detail in chapter 14.

People with mental illness also report positive treatment from health professionals (Morgan et al. 2016). Over 40% of those with mental illness who were surveyed reported being treated more positively by health professionals due to their mental health problems. Behaviour by health professionals that was appreciated by survey respondents included referrals, being included in the treatment process, having their mental health status checked on, and provision of information.

In general, there is a lack of quality evidence about effective stigma reduction interventions for health professionals and students of health professions (Reavley et al. 2018). However, there is some potential for well-designed interventions targeting the interactions between health professionals and people with mental illness. In the general population, people who have regular contact with people with mental illness typically have less stigma toward mental illness (Jorm and Oh 2009). However, this is *not* typically the case with health professionals, who have high levels of contact with people with mental illness but are likely to maintain high levels of stigma.

Box 16.6 Experiences of stigma from health professionals

A number of submissions were received that described interactions with health professionals that were seen as evidence of stigma.

People with mental illness, particularly those experiencing psychotic disorders, report feeling similar levels of stigma from health professionals as from the general community. (MIFA, sub. 343, p. 27)

People with severe mental illnesses report being treated unfairly by friends and family, being discriminated against in finding or keeping a job, and feeling disrespected by mental health staff. (PHAA, sub. 272, p. 11)

I was automatically judged by the neurologist just because I had a mental health disorder. (FND Australia Support Services Inc., sub. 253, p. 13)

Some people understand one area/issue, although often [have] no or little knowledge/understanding in other areas. Often physical symptoms have been dismissed as mental. A huge mouth pain [was] dismissed by many until a dentist referred me to an oral specialist – [I] saw them and the next day a pre-mouth cancer cut out. I was told that if I'd gone public would've died waiting. (CHF, sub. 496, p. 16)

The mental health system and “the system” in general let me down enormously throughout the remainder of my adult life ... I was once given a drug that I had a pre-existing allergy to ... when I tried to tell the psychiatric liaison staff member this she told me to be quiet and gave it to me anyway. (Australian BPD Foundation, sub. 267, p. 12)

[S]ome mental health professionals do not have the time, tolerance, resilience and ability to listen to those experiencing the symptoms [of borderline personality disorder] ... Some continue to deny the disorder is a mental illness and label the disorder as purely ‘behavioural’. [Borderline personality disorder] may be described by some professionals as a nuisance in the mental health care system. (Aaron Fornarino, sub. 17, p. 2)

Many of the health professionals that I sought care from or was referred to simply did not have the education and skills to provide care specific to the perinatal period. My family and I had to spend many days and hours trying to find the right professionals that would be able to help ... I felt the public system fobbed me off and labelled me as ‘attention seeking’ because of my circumstances. (comment no. 37, consumers)

One aspect of the interaction between health professionals and people with mental illness that may allow stigma to persist is that interactions typically occur with health professionals in positions of relative power and when people with mental illness are at their most unwell (Reavley et al. 2018).

Interventions that involve contact between health professionals and people with mental illness in recovery *outside* of the healthcare setting, where both parties are of equal status and the interaction serves to discontinue negative stereotypes, could be more effective in reducing stigma. Programs that focus on the recovery process, draw on multiple types of social contact, seek to discount various myths that persist about people with severe mental illness and teach skills about what health professionals should say and do, are likely to lead to the greatest reductions in stigma (Knaak, Modgill and Patten 2014).

Recovery Camp is one such example. Recovery Camp is a recovery-oriented program with a dual purpose, providing (a) therapeutic activities to improve the health and quality of life of people with lived experience of mental illness and (b) an alternate form of clinical placement for students (typically of nursing, psychology, exercise science, nutrition and dietetics). It involves about 20 health professionals and/or students living and participating in a range of activities with about 30 people with lived experience of mental illness over a

five-day period. To date, the program has provided over 60 000 hours of professional experience placement for students from ten Australian universities, with the training recognised by the Australian Nursing and Midwifery Council.

The Recovery Camp is intended to encourage interaction and understanding between participants, allowing health professionals and/or students to witness that illness is episodic and that people who live with mental illness are more than their illness (Picton et al. 2018). Results indicate that in addition to reducing subsequent hospitalisation of those with mental illness, the camps may have a positive effect on stigma exhibited by health professionals and their capacity to assess clients. While it is unclear how long the positive effects for health professionals last, and whether they extend to students who do not self-select for the program (Moxham et al. 2016), the Recovery Camp would appear likely to be a cost-effective measure with potential benefits for both those with mental illness and health professionals. The cost of the camps is covered by student payments to undertake the placement.

ACTION 16.6 — TARGETING STIGMA AMONG HEALTH PROFESSIONALS

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

Start now

The Australian, State and Territory Governments should, in collaboration with professional bodies:

- increase interactions of health students and practising health professionals with people with mental illness (and their carers) outside of clinical environments
- incorporate stigma reduction programs targeted at health professionals and students into the National Stigma Reduction Strategy (Action 8.1).

16.8 Fostering more supportive work and training environments

The mental healthcare workforce — and indeed, much of the health workforce generally — is exposed to multiple stresses, particularly in the publicly-funded system.

For GPs in a mental health specialty, the most important stressors include high workloads, balancing work and life, the fear of making clinical errors, dealing with difficult consumers, and resource limitations (Beyond Blue 2013, pp. 143–151). Resource limitations and violence at work were much more frequent for GPs specialising in mental health than in medical practice more generally (with the rate of violence being more than 3 times greater). COVID-19 has exacerbated some of these issues in the sector, particularly in relation to workloads, and maintaining adequate safety protocols in the workplace (Cortis and van

Toorn 2020, p. 2). Specialised mental health workers also report high rates of physical violence at work — 34% in one (non-random) survey in Victoria (Tonso et al. 2016) and even greater rates (about 60%) among a large sample of New South Wales nurses (Pich 2019, p. 42).¹⁵⁷ The risks of violence are particularly high for paramedics and in hospital emergency departments — nurses working in ED triage areas have been found to be particularly at risk of violence from people with alcohol intoxication, substance misuse and mental illness (Pich, Kable and Hazelton 2017). Problematically, exposure to violence in health workplaces is not just a workplace health and safety issue, but has also been found to adversely affect consumer outcomes (Arnetz and Arnetz 2001).

Levels of disengagement and exhaustion seem to be very similar between medical, nursing, occupational therapy, psychology and social work (Scanlan and Still 2019), all with adverse effects on turnover. High rates of burnout are a common feature of mental health workforces globally, probably reflecting common stressors and shared inadequacies in addressing them (Morse et al. 2012; O'Connor, Neff and Pitman 2018). Health professionals working in more remote areas face the particular challenges of isolation from peer support, greater demands from consumers (including expectations to provide advice on issues outside their expertise), and limited opportunities to take time off to undertake professional development or have holidays because there are few other people to provide services. The level of burnout among mental health workers seems to be significantly worse in regional Australia — one of the precipitating factors for attraction and retention of workforces in these areas (ARHEN, sub. 444, p. 13; QAMH, sub. 247, p. 9 and sub. 714, p. 5; Moore, Sutton and Maybery 2010).

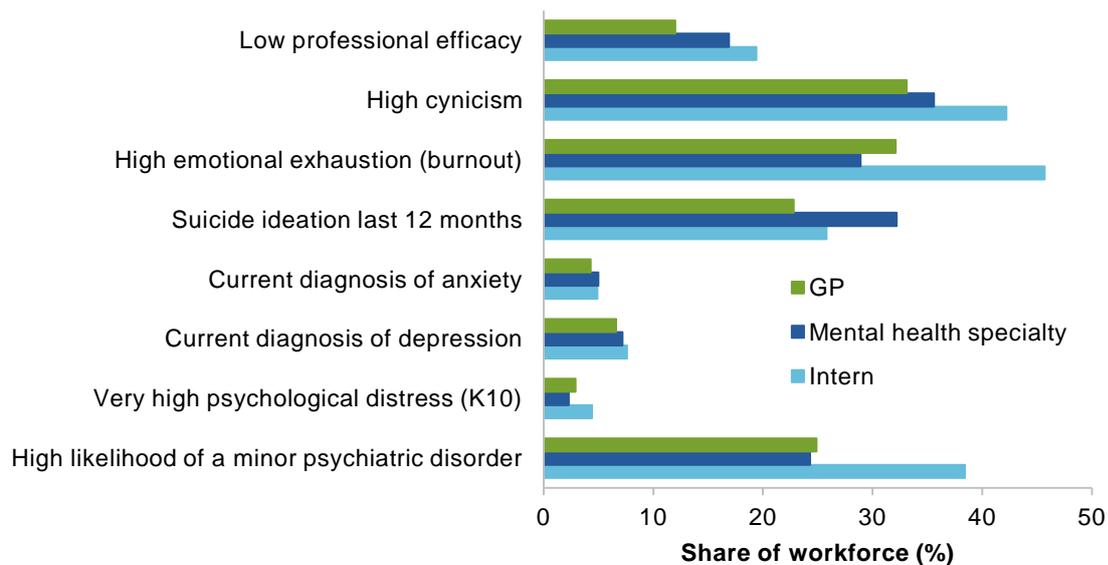
It is also a sad irony that being in the mental health workforce involves high risks of mental illness, suicidal ideation, burnout and cynicism (figure 16.4).¹⁵⁸ These risks are accentuated during the training stage of a medical degree (a prerequisite for registration as a psychiatrist or GP), in part likely reflecting the severity of the stresses posed by a long and demanding pathway to registration (Beyond Blue 2013, p. 103). A 2018 workforce survey of psychiatrists found higher rates of concerns about burnout for those working in the public sector, with more than 80% citing this as a negative aspect of their experience (RANZCP sub. 385, p. 30) — a perspective emphasised by qualitative assessments made by participants in this Inquiry (ASMOF sub. 233, p. 7). MHNs also have high recorded measures of distress and psychiatric illness (Lee et al. 2015).

¹⁵⁷ The high rates of physical violence to which mental health workers are exposed may seem at odds with the findings that the vast majority of people with mental health problems are no more likely to be violent than the general population (SANE Australia 2016; US DHHS 2017), and that only a very small proportion of people with mental illness in prisons are incarcerated as a result of violent crimes (chapter 21). This discrepancy can be explained by: the acute nature of particular mental illnesses among a small subset of people who often end up in hospital settings and in contact with mental health professionals (Stuart 2003); and by the high prevalence of alcohol and drug misuse in those who are violent in hospital emergency departments.

¹⁵⁸ For some key metrics, such as 12 month suicide ideation rates, the risks are much higher than the general population.

The same concerns about stigma that affect the general population also affect help-seeking behaviour and disclosure by GPs, with factors such as embarrassment, impact on registration and right to practice, and concerns about career development figuring prominently (Beyond Blue 2013, p. 66).

Figure 16.4 **Mental health problems affect the workforce^a**



^a Based on a survey of 11 379 doctors and 1799 medical students.

Source: Beyond Blue (2013).

Given the above experiences, students often perceive a career providing mental health services as unattractive. The RANZCP observed that GPs are discouraged from specialising in psychiatry because training placements are often in the most stressful settings in the public sector — such as acute care inpatient units:

A widespread negative perception of working in inpatient units prevails because they are high pressure environments. The pressure is created by the mix of high acuity patients, physical and verbal violence from patients, constant pressure to discharge patients to meet National Emergency Access Targets, and workforce shortages, particularly during on-call periods. The amount of on-call work has steadily increased and is now a problem – registrars (trainees or HMOs) are now working 8–9 hours per day on the weekend. The sum of these factors militates against being able to receive adequate support and the cumulative effect results in burnout. (RANZCP 2017c, p. 24)

It appears that the fissures in the work environment are worst in the public system. The RANZCP reported that many psychiatrists are choosing to work exclusively in the private system because of a lack of financial rewards; overwork and stress from workforce shortages; feeling undervalued; increasing bureaucracy and paperwork; lack of basic administrative support which reduces time available for clinical work; and increased risk of

violence and abuse from aggressive consumers in the public system (RANZCP 2017c). This has repercussions for the future workforce too, given the dominant role of the public system in training psychiatrists.

Many of the underlying issues would be addressed by recommendations elsewhere in this report, such as reducing stigmatisation of people with mental ill-health (chapter 8), redesigning the health system so that more effective care can be provided (chapters 10 to 14) and improving how mental health services are funded (chapter 23). But there also needs to be interventions specifically targeted at fostering more positive and supportive work environments in mental health.

This should include organisational leadership to improve workplace culture, raise job satisfaction, reduce stigma and promote a positive and safe workplace. For example, the RANZCP and New South Wales Health have been collaborating on a plan to improve workforce culture in psychiatry, enhance psychiatric leadership and focus on other drivers of burnout among psychiatrists. Good social and supervisor support of mental health workers, greater job control, recognition and adequate resourcing have been shown to reduce dissatisfaction, burnout and stress (Scanlan and Still 2019). Structural features of the mental health labour markets that intensify stresses — short-term contracts in community work and the regional mal-distribution of the workforce — can be mitigated (for example, through contract re-design and supported online treatment initiatives as recommended in this report).

There is also scope to redesign roles and workplaces to reduce stress for consumers and the health workforce that supports them. For example, the physical environment in emergency departments can be stressful for people experiencing mental illness. In chapter 13, the Productivity Commission has recommended changes that could include providing separate spaces for people with mental illness and, when emergency departments are built or renovated, the design should take account of the needs of people with mental health problems. Some hospitals employ health security guards to improve the safety of their staff (Victorian Government 2020a). While security staff would need to be sensitive to the condition of people presenting in distress, their role is only one component of improving the safety of those workplaces particularly at risk of violence.

Achieving more positive and supportive work environments in mental health is likely to counter the negative perception of mental health as a career option. To further speed this up, actions should also be taken to rebalance where mental health trainees do internships to a more representative mix of settings. As noted above, this has been an issue in psychiatry, prompting efforts to increase training placements in the private sector and beyond the stressful environment of inpatient units in the public sector (DoH 2016a; RANZCP 2017c).

ACTION 16.7 — MENTAL HEALTH SPECIALISATION AS A CAREER OPTION

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

Start now

- The Australian, State and Territory Governments should, in collaboration with professional bodies, rebalance where mental health trainees undertake clinical placements and internships to a more representative mix of settings. This includes increasing placements and internships in the private sector, community mental health services (including Aboriginal Community Controlled Health Organisations) and settings other than inpatient units.
- State and Territory Governments should mitigate burnout and poor mental health among the mental health workforce by targeting the key organisational and operational factors that may reduce the risk of adverse outcomes, including adequate supervision, professional support, resourcing and reducing the risk of exposure to work-related violence and aggression.

16.9 Addressing geographical mismatches

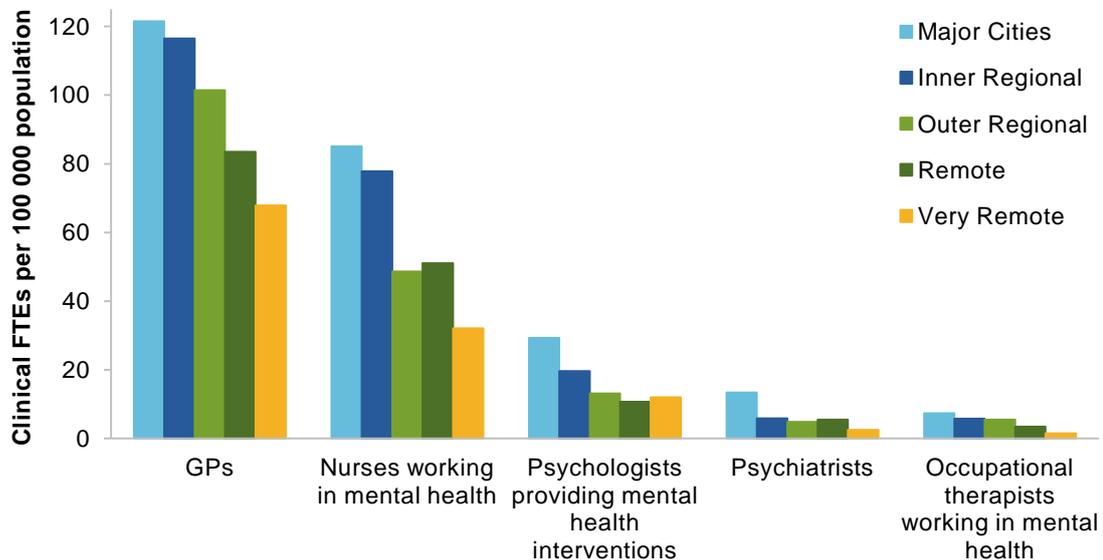
How big is the mismatch?

Distance is as problematic in its effect on access to mental health services as it is for almost all other services (figure 16.5). Access to mental health professionals, especially for specialist care, falls dramatically outside of major capital cities.¹⁵⁹ This includes GPs, notwithstanding some evidence to the contrary (box 16.7). Psychiatrists are the hardest professionals to access, so much so that there are only 6 FTE psychiatrists directly providing services to very remote Australians, compared with 2761 in major cities (DoH 2020l). The Royal Flying Doctors Service (sub. 685, p. 1) notes that for some regional and remote areas of Australia, no mental health service exists at all.

¹⁵⁹ As pointed out by multiple parties — psychologists (The Institute of Clinical Psychologists, sub. 447, p. 7), workers providing youth mental health and substance abuse treatment (Health Services Union, sub. 237, p. 10; VADA, sub. 403, p. 6), psychiatrists (RANZCP, sub. 385, p. 17), and social workers (MHCNSW, sub. 486, p. 26).

Figure 16.5 **Provision of clinical services per capita^a**

By region and selected professions, 2018



^a Measured as clinical full-time equivalents (FTEs) per 100 000 population, which quantifies total hours worked in registered clinical roles (diagnosis, care or treatment) in terms of number of full-time workers per head of population. Nurses were deemed to be working in mental health if their job area was mental health. Occupational therapists were deemed to be working in mental health if their scope of practice was mental health. Psychologists were deemed to be in mental health if their job area was mental health intervention. The estimated resident population for all categories bar GPs was for June 2018 and used the Australian Statistical Geography Standard (ASGS) 2016 Remoteness categories. The GP spatial distribution is estimated differently because of shortcomings in the National Health Workforce Dataset. Instead estimates of GP FTEs are based on 2018-19 Department of Health data that take into account the exact location of MBS services provided and estimates of the time taken for each MBS service, drawing on data additional to that of the National Health Workforce Dataset.

Source: Productivity Commission estimates using ABS (*Regional Population Growth, Australia*, Cat. no. 3218.0) and DoH (2020i, 2020e).

Box 16.7 Are there shortages of GPs in regional and remote Australia?

The story for general practitioner (GP) accessibility is less clear than for other occupations providing mental health services because of conflicting results from two datasets — differences that have been a source of confusion (NRHA 2013) and that have generated errors in regional workforce projections (Cornerstone & Deloitte 2019, p. 27). The National Health Workforce Dataset suggests that full-time equivalent clinical workforce GP numbers per 100 000 people are significantly higher in remote and very remote Australia (DoH 2020i). Other data also produced by the Department of Health show prevalence rates that steeply decline with remoteness. These divergent outcomes reflect different underlying methods used to gather the data, and the different purposes of the data collections.

The National Health Workforce Dataset is a good measure of the total Australia-wide number of registered and employed GPs, but it is an unreliable measure of the geographical location of GP services. For example, a GP locum employed usually in a city area, but working in a general practice in a remote area during the relevant survey week, would be recorded as a remotely-located GP.

In contrast, the alternative Department of Health database on the general practice workforce is more spatially accurate as it captures the multiple areas where GPs make Medicare claims and takes account of the volume of services (DoH 2020k, 2020j). There are fewer Medicare-subsidised mental health services in remote and very remote areas.¹⁶⁰ The MBS claims data do not include GPs who do not claim Medicare rebates — for example, salaried GPs in regional and remote areas working in Aboriginal Medical Services (AMS) or hospital clinics. MBS claims data may also result in GPs being counted multiple times across lower geographic classification levels.

Consistent with this data, patient experience information also reveals longer waiting times to see GPs (for any condition) in more remote locations (ABS 2019i). The gap in GP access has somewhat narrowed from 2014-15, with growth in GP full-time equivalents in very remote areas growing by 4% per year compared with 2.5% per year in major cities. This may reflect government policies aimed at reducing regional disparities in GP access.

Turnover of GPs is also significantly higher in regional and remote areas than in urban areas (Mazumdar and McRae 2015; McGrail and Humphreys 2015), making it difficult for people to build rapport and establish a longstanding link with their GP. In the Northern Territory, there are very high rates of turnover among the health workforce generally — with disruptive effects on vulnerable population groups (Russell et al. 2017).

Lower levels of access to mental health workers would not be problematic if the incidence and prevalence of mental ill-health was correspondingly lower. However, prevalence rates of mental ill-health are much the same across Australia (NRHA 2017), and indeed suicide rates are significantly higher outside major population centres (chapter 9).

Poor access to clinical services in remote and very remote Australia not only affects consumer wellbeing, but as noted above, also places a relatively high burden on the health professionals who do work in those areas.

¹⁶⁰ The number of out-of-hospital non-referred attendances to a GP per capita was 5.6 for major cities, 5.5 for inner regional, 5.3 for outer regional, 4.3 for remote, and 3.0 for very remote. The estimates are based on MBS statistics from the Australian Government Department of Health for 2018-19.

Why is the health workforce less likely to be in remote areas?

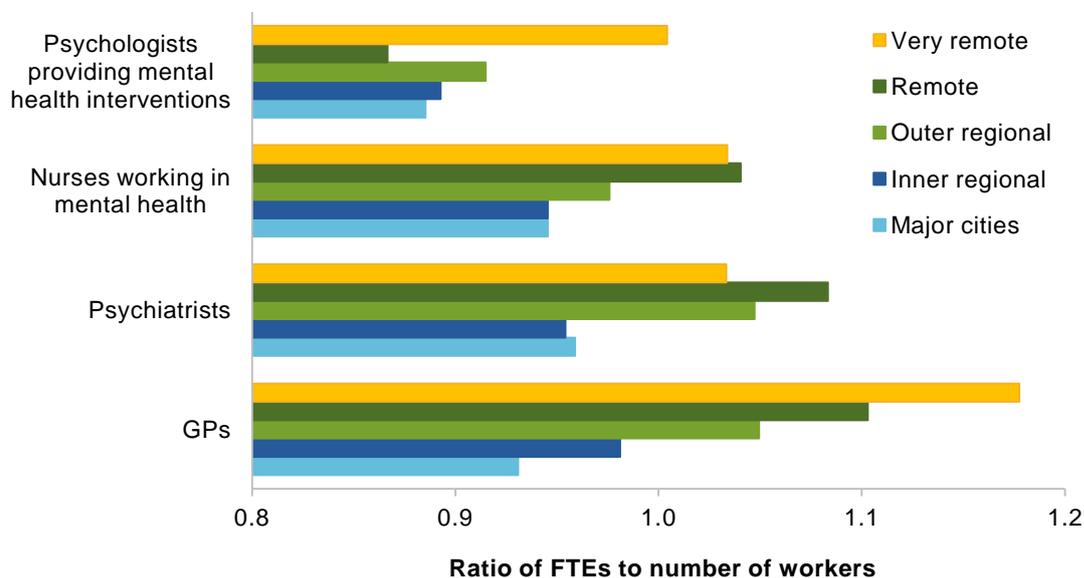
There are multiple factors explaining the shortage of mental health professionals in remote and regional Australia.

- *Professional loneliness* — face-to-face professional training opportunities and access to peers is necessarily poorer in dispersed populations far from other practices, hospitals and universities. In part, these stresses have been reduced through government initiatives targeting particular types of training and professionals in designated zones, often through distance training or through reimbursement of costs for travel to training locations.¹⁶¹
- *The personal costs* of isolation can be very high. One GP who worked in remote Queensland and the Northern Territory emphasised the hardships: extreme heat, poor local services, limited food choices ('the milk is always rotten'), and concerns about family safety (Grindlay 2017). There also tend to be fewer job opportunities for spouses in regional and remote areas and schooling options for families. The scope to take time off when sick or for holidays is sometimes limited by scarcity of locums or casual relief (ACN 2018).
- *Heavy workloads* — the workload can be higher and less flexible because there are few, if any, other local practitioners, and high on-call demands. One reflection of this is that the ratio of FTEs to number of workers¹⁶² tends to rise with remoteness, which is accentuated for GPs (figure 16.6). From a personal perspective, it can reduce the scope to take breaks from work at a time of their choosing.
- *Inertia* — the training of health professionals often occurs in major cities. People tend to build lives within their local community during their years of training and find it hard to leave once they are qualified.

¹⁶¹ These include (among others) the Victorian Government's Medical Professional Development Program (for ongoing professional development of GPs, registrars, graduates and interns); the Australian Government's Health Workforce Scholarship Program (which provides professional development support to GPs, nurses and allied health); the Victorian Government's Rural Allied Health Support Program (for specific allied health professionals); and the Australian Government-funded Remote Vocational Training Scheme (which involves 3 or 4 years of distance training for medical practitioners, giving them a qualification that meets requirements for registration of the Australian College of Rural and Remote Medicine and the Royal Australian College of General Practitioners).

¹⁶² The ratio is calculated as the number of employees on full-time equivalent basis divided by the total unadjusted number of staff. A ratio greater than 1 indicates that the average hours of work provided by staff is more than a standard full-time workload (40 hours per week for medical practitioners and 38 hours for all other practitioners).

Figure 16.6 Workloads tend to be higher in remote areas, 2018^a



^a A value greater than 1 indicates that the average hours of work provided by staff (by geographic region and profession) is more than a standard full-time workload. The definitions of professionals is the same as in figure 16.1. Note that absolute GP counts in the National Health Workforce Dataset are not reliable at the geographically granular level, though the ratio of full-time equivalents (FTEs) to numbers of workers may still be a reasonable estimate given both the denominator and numerator will be subject to similar biases. Nevertheless, the GP estimates will likely be less accurate than for other professions.

Source: Productivity Commission estimates using DoH (2020).

What can be done about the locational mismatch?

There is a locational mismatch, and we largely know why it exists. But can it be eliminated? The type and extent of any new initiatives depends on any gaps and flaws in the wide array of existing arrangements. It is not obvious that there are severe drawbacks in those arrangements.

Australian governments fund locum services for all the key professions through various approaches — specific programs (like the Australian Government’s Rural Locum Assistance Program and the Western Australian Government’s GP locum placement service) and nationally for GPs through primary health networks. These programs allow for professionals working in regional and remote locations to have a temporary worker step in to provide services while they take time for professional development or planned holidays (Rural LAP 2019). But such ‘fly in, fly out’ services cannot realistically address unplanned absences, nor can they permanently increase the supply of professionals in the area. There is also little evidence that demand for such programs exceed supply. For instance, the Productivity Commission has been told that demand for the Rural Locum Assistance program is not oversubscribed (DoH, pers. comm., 26 March 2020).

A drawback of using a visiting workforce is that people may not have continuity of care with the same health professional over time, which can be a significant issue for people experiencing mental ill-health. This has led some clinicians to express concerns about an increasing reliance on locum psychiatrists in public sector service providers, particularly in regional and remote locations (Fitzsimmons 2019). There are legitimate concerns about ongoing use of visiting locums when there is a sufficiently large local population to keep a local workforce fully employed. However, in the most sparsely populated regions, the only viable option for face-to-face contact can be a visiting health professional, or for consumers to travel to a population centre.

Governments also use various incentives to encourage health professionals to work in regional and remote areas. One of the broad approaches has been to make working in those locations a condition of gaining professional registration, eligibility to bill Medicare, or being given a supported place in medical school. Many of the health professionals subject to such requirements have been overseas-trained medical practitioners, which means they account for a high proportion of GPs in regional and remote areas. Expanding this much further is difficult because additional supervision and support is often needed to assist overseas-trained medical practitioners to align with Australian clinical practices and understand the local culture of the people they are there to help.¹⁶³

There is evidence that health professionals are more likely to work in regional and remote locations if they did their training there, or had resided there prior to training elsewhere (Kwan et al. 2017; McGrail, Russell and Campbell 2016). Governments have for many years sought to capitalise on this by supporting the provision of training in regional and remote areas for health professionals, and training more people from those areas. In 2018, the Australian Government announced a range of changes under the banner of a Stronger Rural Health Strategy that are increasing its support for rural-based training and trainees over time (DoH 2018d). These included specifying targets for:

- 50% of GP training to be outside major cities in each year from 2018-19 to 2021-22
- an increase in Specialist Training Program activity in rural areas from 40% in 2018-19 to 45% by 2020-21, and maintained at that level in the following year.

Financial incentives are also used to encourage health professionals to work in regional and remote areas. These includes subsidies paid by the Australian Government to medical practitioners providing primary care in such areas, with additional subsidies for general practices employing nurses or allied health professionals.¹⁶⁴ The Practice Incentives Program (which encourages improvements in service quality, like eHealth) includes a rural loading (DoH 2013c). There are also increased MBS rebates for medical practitioners who bulk bill services for children and concession card holders in regional and remote areas.

¹⁶³ A further issue is that the Australian Government is gradually reducing the overall number of overseas-trained GPs allowed to enter the country to work in primary healthcare in order to reduce an oversupply of GPs in metropolitan areas over the longer term (DoH 2019o).

¹⁶⁴ Originally these subsidies were provided through the General Practice Rural Incentives Program and the Practice Nurse Incentive Program, but from January 2020 these were reformulated as components of a Workforce Incentive Program (DoH 2019q).

While there is little rigorous evaluation of the effect of such incentives on regional service provision, the payments are sufficiently large (for example, up to \$60 000 annually under the GPs stream of the Workforce Incentive Program) that it would be surprising if they did not have some impact (DoH 2019p). GPs themselves rate increased remuneration as the most important intervention to motivate attraction and retention in remote and regional Australia (Jones, Humphreys and Adena 2004). In a case study of Australia, the World Bank assessed such incentives as important to the viability of regional and remote practices (Cashin and Chi 2011, p. 10).

State and Territory Governments also have a financial lever through their funding of positions for health workers in public sector providers. This Inquiry has recommended that State and Territory Governments increase the number of funded training placements and supervisors for trainee psychiatrists in public sector health providers (Action 16.2). Moreover, in other chapters of this report the Productivity Commission has recommended an expansion of services to fill major gaps in available care, which would require public sector providers to hire more health professionals outside major cities. If the funding flows, it is likely that — with the existing incentives and other initiatives — the workforces would respond.

A recent Senate inquiry examined many of the issues of remote access to mental health services — some of them relating to workforce disparities (SCARC 2018). The Australian Government has supported nearly all of its recommendations — which would, if implemented, address some gaps (Australian Government 2019a).

The ultimate and biggest barrier to replicating the same quality and access to care in remote Australia is that attracting additional personnel requires either greater coercion (requirements for health professionals to serve in a remote area) or higher wage rates. Given other recommendations in this report that should help regional communities, the existing (comprehensive) range of workforce initiatives, and finite taxpayer funds, the Productivity Commission considers further initiatives at this stage to increase the numbers of highly-trained mental health practitioners in remote Australia unlikely to be effective on a large scale.

However, there are three factors that can mitigate the effect of workforce disparities.

- Remote provision is effective and reducing in cost. Modern communication technologies provide a good option for achieving better service quality in remote areas (chapter 11), even if it is not feasible to have the same workforce physically present. However, in some locations internet coverage is either poor or non-existent. Governments have already made several efforts in this area. The Australian Government expanded the MBS-rebated psychological therapy program in 2017 to include MBS rebates for psychological services provided by videoconference to people in regional and remote areas (DoH 2019d, 2019c). There are also MBS items for psychiatry delivered by videoconference or telephone (chapter 12).¹⁶⁵

¹⁶⁵ The Australian Government also funds mental health services provided by the Royal Flying Doctor Service where supported online health technology was not available or too costly (DoH, sub. 556, p. 37).

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- The greater availability of help lines for regional and remote GPs to consult city-based psychiatrists about how best to help individuals would be beneficial (chapter 10). Persistent drought, widespread fires and the COVID-19 pandemic in 2020 has led to greater recognition of the value of supported online health in dealing with population-wide health problems. A practical outcome of these events is that consumers and practitioners may have learned more about how to use the technology (for mental and physical health issues) and be more accepting of its value, paving the way for its ubiquitous use. The ability or inclination of clinicians to accept supported online health has been a key factor determining its uptake (Sweet 2020; Wade, Elliott and Hiller 2014).
 - The use of substitute for *some* subsets of the work of highly trained mental health specialists is feasible in all parts of Australia (not just regional and remote areas). As noted earlier there is scope to increase the role of community mental health workers, peer workers and Aboriginal and Torres Strait Islander health workers in the provision of services — for instance through block grants¹⁶⁶ to community agencies. These workers have the advantage that their training levels are lower, they can be drawn from the communities where services are needed, and they are more likely to be culturally competent. The Royal Flying Doctors Service (sub. 685, p. 4) recommended this type of mitigation measure, as well as other forms of substitution such as increased medication-prescribing capabilities for nurse practitioners.

FINDING 16.1 — SUPPORTING THE RURAL, REGIONAL AND REMOTE MENTAL HEALTH WORKFORCE

Physical access to mental health professionals, especially for specialist care, is significantly lower outside of major capital cities, and is particularly low in remote parts of Australia. There are many government programs aimed at alleviating these shortages, but there are practical and budgetary obstacles to ensuring that physical access is equal across different locations.

Several recommendations in this report would assist Australians with mental illness in regional Australia, including:

- greater use of clinician-supported online mental health treatment to overcome lower physical accessibility to services (Action 11.1)
- increased scope for GPs in regional Australia to consult psychiatrists in other parts of Australia about how best to help individual consumers (Action 10.3).
- increased use of videoconference and telephone for people to interact with, and receive therapy from, their psychologist or psychiatrist. (Action 12.2)

¹⁶⁶ As recommended by the Senate Community Affairs References Committee inquiry into the accessibility and quality of mental health services in regional and remote Australia (2018, p. 43).

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