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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).
Dear Treasurer

In accordance with section 11 of the *Productivity Commission Act 1998*, we have pleasure in submitting to you the Commission’s final report into *Mental Health*.

Yours sincerely

Stephen King
Presiding Commissioner

Julie Abramson
Commissioner

Harvey Whiteford
Associate Commissioner
Terms of reference

Inquiry into the economic impacts of mental ill-health

I, Josh Frydenberg, Treasurer, pursuant to Parts 2 and 3 of the Productivity Commission Act 1998, hereby request that the Productivity Commission (the Commission) undertake an inquiry into the role of improving mental health to support economic participation and enhancing productivity and economic growth.

Background

In 2014-15, four million Australians reported having experienced a common mental disorder.

Mental health is a key driver of economic participation and productivity in Australia, and hence has the potential to impact incomes and living standards and social engagement and connectedness. Improved population mental health could also help to reduce costs to the economy over the long term.

Australian governments devote significant resources to promoting the best possible mental health and wellbeing outcomes. This includes the delivery of acute, recovery and rehabilitation health services, trauma informed care, preventative and early intervention programs, funding non-government organisations and privately delivered services, and providing income support, education, employment, housing and justice. It is important that policy settings are sustainable, efficient and effective in achieving their goals.

Employers, not-for-profit organisations and carers also play key roles in the mental health of Australians. Many businesses are developing initiatives to support and maintain positive mental health outcomes for their employees as well as helping employees with mental ill-health continue to participate in, or return to, work.

Scope

The Commission should consider the role of mental health in supporting economic participation, enhancing productivity and economic growth. It should make recommendations, as necessary, to improve population mental health, so as to realise economic and social participation and productivity benefits over the long term.
Without limiting related matters on which the Commission may report, the Commission should:

- examine the effect of supporting mental health on economic and social participation, productivity and the Australian economy;
- examine how sectors beyond health, including education, employment, social services, housing and justice, can contribute to improving mental health and economic participation and productivity;
- examine the effectiveness of current programs and initiatives across all jurisdictions to improve mental health, suicide prevention and participation, including by governments, employers and professional groups;
- assess whether the current investment in mental health is delivering value for money and the best outcomes for individuals, their families, society and the economy;
- draw on domestic and international policies and experience, where appropriate; and
- develop a framework to measure and report the outcomes of mental health policies and investment on participation, productivity and economic growth over the long term.

The Commission should have regard to recent and current reviews, including the 2014 Review of National Mental Health Programmes and Services undertaken by the National Mental Health Commission and the Commission’s reviews into disability services and the National Disability Insurance Scheme.

**Process**

The Productivity Commission should undertake broad consultation, including with carers and consumers, and by holding hearings in regional Australia, inviting public submissions and releasing a draft report to the public.

The final report should be provided to the Government within 18 months.

**The Hon Josh Frydenberg MP**
**Treasurer**

[Received 23 November 2018]
Disclosure of interests

The Productivity Commission Act 1998 specifies that where Commissioners have or acquire interests, pecuniary or otherwise, that could conflict with the proper performance of their functions during an inquiry they must disclose the interests.

Professor King has advised the Commission that he is Adjunct Professor at Monash University. He is married to a Psychologist who is in private practice.

Ms Abramson has advised the Commission that she is a Council Member and Chair of the Regulatory Risk Committee of the Photography Studies College, a dual sector higher education provider.

Professor Whiteford has advised the Commission that he is a Fellow of the Royal Australian and New Zealand College of Psychiatrists and has served previously as the Director of Mental Health for the Queensland Government, the Director of Mental Health for the Australian Department of Health and as a National Mental Health Commissioner.

With his appointment at the University of Queensland, Professor Whiteford’s research funding has included grants and contracts from the National Health and Medical Research Council and the Australian Department of Health. He has regularly provided clinical and technical advice on mental health service reform to the Australian Department of Health and to State Governments. His research team at the University of Queensland is currently contracted to undertake revisions of the National Mental Health Service Planning Framework on behalf of the Australian, State and Territory Governments.
Contents

The Commission’s report is in three volumes. This volume 1 contains the overview and recommendations. Volume 2 contains chapters 1 to 16 and references. Volume 3 contains chapters 17 to 25 and appendix A and references. Below is the table of contents for all volumes.

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Acknowledgments

The Productivity Commission thanks the members of the community, and numerous organisations and government agencies who have provided data and other information for use in the inquiry. A number of service providers shared their time with us, and explained and walked us through the operations of their services, which considerably enhanced our understanding. We would particularly like to thank those people with lived experience who shared their stories with us — in individual meetings, in hearings and through submission and comments to this Inquiry. The insights provided by people who are or have lived with mental ill-health, and their families and carers, have been invaluable. We cannot express our appreciation strongly enough.

The commissioners express their strong and deep appreciation to the Inquiry Assistant Commissioner Rosalyn Bell and the Inquiry team who have undertaken one of the largest inquiries in the Productivity Commission’s history. It involved extensive consultations across Australia, the most submissions ever received by the Commission, drafting of the report and preparing the underlying analysis.

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Ralph Lattimore
George Steel

and 14 additional unnamed Commission staff who made significant contributions during the Inquiry.
## Abbreviations

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<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>AOD</td>
<td>Alcohol and other drug</td>
</tr>
<tr>
<td>ATAPS</td>
<td>Access to Allied Psychological Services</td>
</tr>
<tr>
<td>CALD</td>
<td>Culturally and linguistically diverse</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>CAT</td>
<td>Crisis assessment and treatment</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive behavioural therapy</td>
</tr>
<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
</tr>
<tr>
<td>COVID-19</td>
<td>Coronavirus Disease 2019</td>
</tr>
<tr>
<td>CPI</td>
<td>Consumer Price Index</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health (Australian Government)</td>
</tr>
<tr>
<td>DSP</td>
<td>Disability Support Pension</td>
</tr>
<tr>
<td>DSS</td>
<td>Department of Social Services (Australian Government)</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>FTE</td>
<td>Full-time equivalent</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>GST</td>
<td>Goods and services tax</td>
</tr>
<tr>
<td>HILDA</td>
<td>Household, Income and Labour Dynamics in Australia</td>
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<tr>
<td>IPS</td>
<td>Individual Placement and Support</td>
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<tr>
<td>LGBTIQ</td>
<td>Lesbian, gay, bisexual, transgender, intersex and queer</td>
</tr>
<tr>
<td>LHN</td>
<td>Local Hospital Network</td>
</tr>
<tr>
<td>MBS</td>
<td>Medicare Benefits Schedule</td>
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<tr>
<td>NAPLAN</td>
<td>National Assessment Program – Literacy and Numeracy</td>
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<td>NDIA</td>
<td>National Disability Insurance Agency</td>
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<td>NDIS</td>
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<td>NGO</td>
<td>Non-government organisation</td>
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<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
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<td>NMHC</td>
<td>National Mental Health Commission</td>
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<tr>
<td>NMHSPF</td>
<td>National Mental Health Service Planning Framework</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>NSQHS</td>
<td>National Safety and Quality Health Service</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
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<tr>
<td>PHN</td>
<td>Primary Health Network</td>
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<tr>
<td>RANZCP</td>
<td>Royal Australian and New Zealand College of Psychiatrists</td>
</tr>
<tr>
<td>RCA</td>
<td>Regional Commissioning Authority</td>
</tr>
<tr>
<td>SEIFA</td>
<td>Socio-Economic Indexes for Areas</td>
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<tr>
<td>WHS</td>
<td>Workplace Health and Safety</td>
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OVERVIEW
Key points

Australia’s mental health: we would all benefit from an improved mental health system

- Mental ill-health affects all Australians either directly or indirectly. Almost one in five Australians has experienced mental illness in a given year. Many do not receive the treatment and support they need. As a result, too many people experience preventable physical and mental distress, disruptions in education and employment, relationship breakdown, stigma, and loss of life satisfaction and opportunities.

- Reform of the mental health system would produce large benefits. These are mainly improvements in people’s quality of life — valued at up to $18 billion annually. There would be an additional annual benefit of up to $1.3 billion due to increased economic participation. About 90% of the benefits — about $17 billion — could be achieved by adopting identified priority reforms, requiring expenditure of up to $2.4 billion and generating savings of up to $1.2 billion per year.

To create a person-centred mental health system, Australia needs reforms that …

Focus on prevention and early help: early in life and early in illness.

- The mental health of children and families should be a priority, starting from help for new parents and continuing through a child’s life. Schools should have a clearly defined role in supporting the social and emotional wellbeing of students, with effective pathways to care.

- Prevention and early intervention should continue through tertiary education and employment. Mentally healthy workplaces that focus on psychological safety as much as physical safety, and access to early treatment funded through workers compensation schemes, are part of our reforms.

Provide the right healthcare at the right time for those with mental illness.

- People should have real choices in managing their own mental health and be empowered to choose the treatment and supports that are right for them.

- Technology should play a larger role by improving assessment and referrals, and increasing access to, and the range of, treatments and supports. For people who choose face-to-face treatment and support, these should be affordable and in line with clinical evidence.

- The cycling of people in and out of hospital at great personal cost and cost to taxpayers, should be addressed. Emergency departments – or alternatives – should be adapted to work for those experiencing mental illness, and hospital discharges into homelessness should be avoided.

Make sure effective services support recovery in community.

- Community treatments and supports should be expanded for people who do not require hospital care but do require more care and support than provided by a GP. Seamless care between hospital and community services for people recovering from a suicide attempt should be a priority, as should reducing the life expectancy gap for people with severe mental and physical illness. And the consideration and involvement of families, kinship groups and carers, wherever possible, would be expected of providers to improve outcomes.

- Housing, employment services and services that help a person engage with and integrate back into the community, can be as, or more, important than healthcare in supporting a person’s recovery. Clinical and community services should be coordinated to create a system of care that promotes recovery, with care coordinators to help people with complex needs.

Provide seamless care, regardless of the level of government providing the funding or service.

- The ‘back office’ to our mental healthcare system needs redesigning with local planning to meet local needs. Providers and governments should be held to account through the transparent monitoring, reporting and evaluation of what works, with meaningful input from those with lived experience of mental illness, and their carers.
## Priority reforms

### 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 mental healthcare

- Create a person-centred mental health system
  - Evidence-based mental health assessment and referral processes that help people find the services that are best for them
  - Identify, support and include families and carers as part of mental healthcare
- Get people the right services at the right time
  - Expand supported online treatment, group therapies and access to mental healthcare via telehealth
  - Review limits on psychological treatment funded through Medicare and trial variations
  - Alternatives to emergency departments that are designed for people with mental illness
  - Expand community-based mental healthcare, including hospital outpatient clinics and outreach services
- Improve mental healthcare outcomes
  - Address adverse outcomes from prescribing practices of mental health medication
  - Reduce the gap in life expectancy for people with severe mental illness and physical illness
- Care continuity and coordination

### Improve people’s experiences with services beyond the health system

- Meet demand for community support services that help people with mental illness recover and live well in the community
- Commit to no discharge from care into homelessness
- Increase 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
- Expand the individual placement and support program for people with mental illness

### Instil incentives and accountability for improved outcomes

- Develop implementation plans for national strategies that integrate healthcare and other services
- Commit to regional planning, decision making and commissioning, with systemic cooperation and creation of new commissioning agencies if outcomes not improved
- Expand the remit and independence of the National Mental Health Commission
- Consumer and carer participation and advocacy in all aspects of the mental health system
- Strengthen evaluation culture, focusing on outcomes that matter to people and reporting at service provider level
A mental health system for our future

Mental ill-health affects all Australians, either directly or through our families, colleagues, friends and loved ones. It does not discriminate. But Australia’s mental health system has not kept pace with our needs. This Inquiry report presents a series of recommendations to rectify this situation and set Australia on a path for sustainable, generational reform of its mental health system.

Some Australians are more likely to experience mental health problems, including young Australians, single parent families, the unemployed and Aboriginal and Torres Strait Islander people (figure 1). But anyone can be affected by mental ill-health. It can occur at any stage of life and some Australians will face the debilitating effects of mental illness across their lives. Australia’s mental health system needs to support all people who require care, wherever they live in Australia, and whatever their age, cultural background or health condition.

Mental illness covers a wide range of conditions: anxiety disorders, depressive disorders, personality disorders, bipolar disorder, schizophrenia, to name just a few. The effects, severity, treatment and consequences of these conditions vary widely. Some people can have multiple conditions while others may need to access care without a specific diagnosis. And mental illness can go hand-in-hand with physical illness. Australians with severe mental illness on average die 10 to 15 years earlier, usually as a result of physical comorbidities. Australia’s mental health system needs to focus on the individual and their life circumstances to address this diversity. It needs to be holistic and person-centred.

Multiple factors can adversely affect mental health including biological, environmental and social factors. Mental ill-health can be founded in trauma and stress, potentially from early childhood. It can originate in social conditions, such as the stress experienced by many Australians during the COVID-19 and 2019-20 bushfire crises. Some of these risks can be mitigated or will dissipate in time; with others, it is about dealing with the resulting stresses early to contain the impact on mental health. Australia’s mental health system needs to focus on prevention and early intervention, whether early in life or in the progress of illness. And it needs to be flexible, to ramp up and down as individual and social needs and stresses change.

Mental illness can impact all aspects of our life: relationships, home life, schooling, work, and social interactions. To help people have lives that are meaningful to them and productive, Australia’s mental health system needs to offer the right mix of community and clinical supports for people — noting that for some people, clinical treatment will not be part of their solution. Recovering from mental illness is about so much more than clinical care; it means rebuilding relationships, strengthening skills, finding and maintaining secure housing and employment.
### Figure 1  Who is mentally distressed and unwell

#### Prevalence of mental illness by age

![Graph showing prevalence of mental illness by age.]

#### Suicide

- **3046** people died in 2018
- 3 out of 4 deaths are males
- Leading cause of death for 15 to 44 year olds
- 50% higher rate of death outside capital cities
- 65% people who die by suicide had a mental illness
- **30 000 – 90 000** suicide attempts in 2018

#### Household type

<table>
<thead>
<tr>
<th>Household type</th>
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<tr>
<td>One parent family</td>
<td>34%</td>
</tr>
<tr>
<td>Group household</td>
<td>29%</td>
</tr>
<tr>
<td>Lone person</td>
<td>23%</td>
</tr>
<tr>
<td>Couple family</td>
<td>19%</td>
</tr>
<tr>
<td>Couple only</td>
<td>14%</td>
</tr>
<tr>
<td>Other</td>
<td>23%</td>
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#### Education and employment

- % by level of psychological distress:
  - Employed
  - Higher education
  - Vocational training
  - Unemployed

#### Indigenous status

- People in high or very high psychological distress:
  - Aboriginal and Torres Strait Islander people: 31%
  - Non-Indigenous Australians: 14%
Mental illness is stigmatised. Social views of mental illness have improved but still trail a long way behind our knowledge of how mental illness affects people’s lives. This stigma creates barriers to individuals seeking care and can reduce the effectiveness of that care. Australia’s mental health system (and the professions charged with assisting people) need to be stigma-free, empowering individuals who seek care.

Australia’s current mental health system is not comprehensive and fails to provide the treatment and support that people who need it legitimately expect. The clinical care system has gaps, including, but not limited to, the so-called ‘missing middle’. The recommendations in this report aim to fill these gaps. The system of community supports in Australia is ad hoc, with services starting and stopping with little regard to people’s needs. Our recommendations aim to establish a comprehensive community support system that operates seamlessly and in balance with the clinical care system, based on consumer and carer input and local requirements.

Australia’s mental health system does not focus on prevention and early intervention. Too many people are treated too late. Young Australians at risk and their families cannot easily access support. And those with developing mental health problems can face a bewildering array of unpredictable gateways to care: they know what services they need, but timely access is not possible. Our recommendations aim to refocus the mental health system, recognising the truth in the adage that ‘prevention is better than cure’.

Australia’s mental health system does not empower those who need it. People with mental illness often have little say in their own treatment and are deprived of the information and other resources that they need to manage and make decisions about their own care. Providers of clinical and community services too often deliver what they think consumers need, sometimes based on ill-informed assumptions about the decision-making capacity of the consumer and sometimes based just on the symptoms presented to them rather than a holistic view of the individual. Our recommendations aim to empower the service users, in partnership with their families and carers, to have real input into the health decisions that affect their lives. In part, this will require community-wide efforts to reduce the stigma that acts as a barrier to informed choice and deliberate steps to prioritise the recovery of people within their communities.

Put simply, Australia’s mental health system is not ‘person-centred’. It should be.

**Reform direction: a person-centred mental health system**

What we are aiming at

Our vision is for a person-centred mental health system with the following features.

- Information and supports that help people to live well within their communities, managing their own mental health where possible.
A focus on prevention and early intervention — both early in life and in the development of a condition — to minimise the harm that mental illness can cause.

For those who need additional care, services that are accessible, affordable and timely, with their quality, cultural relevance, mode of delivery and effectiveness reflecting the consumer’s values and what recovery means for the individual and their relationships with family and kinship groups.

Participation of the consumer’s family or carer actively sought to add to the value and effectiveness of the clinical or support service.

Treatment and support that is seamless for people, regardless of the gateway by which they enter the mental health system. There would be no gaps in care over a person’s lifespan or as their condition changes.

The outcomes for the consumer would be what matters for every clinical and support provider, and this would underpin the hiring and training of staff and the culture of service settings. The consumer — rather than the provider — would be the focus of service delivery.

Measurement and transparent reporting of all service outcomes, as perceived by the people using services, would be used to enhance ongoing improvement in both the effectiveness and efficiency of services, and to facilitate individual choices.

This vision of a person-centred mental health system is consistent with the National Mental Health Commission’s Vision 2030. The components have been presented to us by the many people who contributed to this Inquiry. But implementing this vision will not be easy. It will take resources and time. Most importantly, it will require a change in culture and the way that Australian society views mental health. The recommendations in this report provide a long-term roadmap for this reform.

What gaps and barriers need to be addressed

The problems with Australia’s mental health system extend beyond clinical mental healthcare to the interaction of mental healthcare with the physical healthcare system and with sectors beyond healthcare that are important for a person’s recovery. In particular, reform of Australia’s mental health system means addressing the key gaps and barriers that lead to poor outcomes for people, including the following.

- A narrow view of people seeking treatment and support — mental health services are often based on an incomplete picture of what people are seeking, failing to look beyond the symptoms being presented to work out what help an individual needs to recover and remain well in the longer term, and how to most effectively deliver that help.

- Under-investment in prevention and early intervention — the result is that too many people live with mental ill-health for too long.
• Disproportionate focus on clinical services — overlooking other determinants of, and contributors to, mental health, including the important role played by family, kinship groups and carers, and providers of social support services, in facilitating a person’s functional recovery within their community.

• Difficulties in finding and accessing suitable support — sometimes because the relevant and culturally capable 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 needed are not linked together to provide seamless care as people’s conditions evolve and circumstances change.

• Supports that are below best practice — in part due to a lack of measurement and evaluation of what works, and in part due to a culture of superiority that places clinicians and clinical interventions above other service providers, consumers and their families and carers.

• Stigma and discrimination — in how people view themselves, and how people with mental illness and those who support them are viewed by the community and service providers.

• Dysfunctional approaches to the funding of services and supports — leading to poor incentives for service providers, and increased costs to both the people seeking support and to taxpayers.

• A lack of clarity across the tiers of government about roles, responsibilities and funding — leading to persistent wasteful overlaps, yawning gaps in service provision and limited accountability.

The report recommends reforms to address these gaps and barriers. The objective is a person-centred but flexible mental health system: one that can 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, cultural changes and small but important adjustments to existing supports.

That said, this report is bounded. Broader issues of health and social services reform lie beyond the scope of this Inquiry — although some of these issues have been the subject of previous Productivity Commission work (such as the Reforms to Human Services and Shifting the Dial reports). And we do not and cannot make recommendations that would eliminate mental ill-health. There are a range of risk factors, such as those arising from deeply entrenched social, economic and environmental challenges, which lie beyond the scope of this Inquiry. While our recommendations would deliver a mental health system that is ready for the next major recession, pandemic, climate-change crisis or other shock to our community, we do not purport in this Inquiry to eliminate the risk of these and other social and environmental challenges.
What lack of progress on mental ill-health is costing us

The benefits for Australia of even modest reforms could be extensive. The number of people directly impacted by poor mental health is very large (figure 2). Almost half of all Australian adults have met the diagnostic criteria for a mental illness at some point in their lives, and almost one in five Australians have met the criteria in a given year. These numbers are likely to rise, at least in the short term, given the multiple crises faced by the Australian community in 2020. And while mental ill-health affects people of all ages, about three quarters of adults with mental illness first experience mental ill-health before the age of 25 years.

The vast majority of people manage their health themselves (such as through the support of family and friends, the use of online resources, social interactions and positive adjustments to their diet, exercise or sleep). For those who need help, the consequences of them either getting (or not getting) the help that is right for them, and as early as possible, are substantial. Care that enables people with mental ill-health to reach their potential in life, have purpose and meaning, and contribute to the lives of others, benefits both the individual and the wider community: it reduces preventable physical and mental distress; allows more rewarding relationships with family and friends; provides more opportunities for carers; scope for a greater contribution through volunteering and community groups; a more productive workforce; and an associated expansion in national income and improvement in living standards.

It is not necessary to quantify the cost of mental illness and suicide to understand the damage that they impose on the lives of individuals and the community as a whole. But quantifying these costs helps to identify where reform efforts should be focused.

The cost to the Australian economy of mental illness and suicide is estimated (conservatively, given data limitations) to be up to about $70 billion per year. We currently spend at least $0.5 billion per year on attempting to lessen the prevalence of mental ill-health and prevent suicide, and $9.2 billion per year treating people who have nevertheless developed mental illness. These costs have been rising over time, with no clear indication that the mental health of the population has improved. Additional to this is a further (largely avoidable) cost of approximately $150 billion per year associated with diminished health and reduced life expectancy for those living with mental illness (table 1).

These are large numbers. In total, mental illness, on a conservative basis, is costing Australia about $200-220 billion per year. To put that in context, this is just over one-tenth of the size of Australia’s entire economic production in 2019. The cost is between $550 million and $600 million per day. Not all of this cost is avoidable, but there is considerable scope for Australia to do better.
These costs of mental illness and suicide are not just numbers, they are very personal — borne by those people with lived experience of poor mental health and of caring, and also by their families and friends, governments (through current and future taxpayers), employers, insurers, and the broader community. These costs include:

- the resources used for healthcare and other services and supports, as well as the time and effort spent by family members and friends in caring for and supporting people with mental illness
- the lost opportunities and lower living standards that arise when young people disengage from education and when those with mental illness and their carers have reduced hours of work, cannot work, or are less productive when at work
- the social and emotional costs of pain, suffering, exclusion and in some cases, premature death
- the loss to the community as a whole from not having the unique and valued contribution of a significant group of its people.
Table 1  **Estimated costs of mental illness and suicide**  
2018-19

<table>
<thead>
<tr>
<th>Cost category</th>
<th>$ billion per year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental healthcare and related services</strong></td>
<td>15.5</td>
</tr>
<tr>
<td>Government healthcare expenditure</td>
<td>9.7</td>
</tr>
<tr>
<td>diagnosis and treatment (Cth, State and Territory Governments)</td>
<td>9.2</td>
</tr>
<tr>
<td>research, strategy, promotion and prevention (Cth Government)</td>
<td>0.5</td>
</tr>
<tr>
<td>Related services &amp; supports expenditure (Cth, State and Territory Governments)</td>
<td>4.1</td>
</tr>
<tr>
<td>housing, justice, employment services, NDIS</td>
<td>4.1</td>
</tr>
<tr>
<td>preschools, schools, tertiary education providers(^a)</td>
<td>—</td>
</tr>
<tr>
<td>Individual out-of-pocket expenses</td>
<td>0.7</td>
</tr>
<tr>
<td>Insurer payments for healthcare</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Informal care provided by family and friends</strong></td>
<td>15.3</td>
</tr>
<tr>
<td><strong>Loss of participation and productivity</strong></td>
<td>12.2 – 39.1</td>
</tr>
<tr>
<td>Lower participation</td>
<td>12.2 – 22.5</td>
</tr>
<tr>
<td>Absenteeism</td>
<td>9.6</td>
</tr>
<tr>
<td>Presenteeism</td>
<td>7.0</td>
</tr>
<tr>
<td><strong>Cost to economy</strong> (excluding the cost of diminished health and wellbeing)</td>
<td>42.9 – 69.8</td>
</tr>
<tr>
<td><strong>Cost of disability and premature death</strong> (for those living with mental illness or self-inflicted injuries, and/or dying prematurely)</td>
<td>150.8</td>
</tr>
<tr>
<td>Mental illness</td>
<td>122.0</td>
</tr>
<tr>
<td>Suicide and self-inflicted injuries</td>
<td>28.8</td>
</tr>
<tr>
<td>Income support payments for those with mental illness and carers(^b)</td>
<td>10.9</td>
</tr>
</tbody>
</table>

\(^a\) Government departments were unable to consistently provide separate estimates for mental health related expenditure in preschools, schools and tertiary institutions.  
\(^b\) Income support payments are not included in the ‘total cost to economy’ because they are a transfer between different members of the community, rather than a cost to the community as a whole.

**How reform should proceed**

This Inquiry report presents a long-term reform agenda for a person-centred mental health system that is responsive and flexible. The recommended changes are substantial but would set Australia on a path for sustainable, generational reform of its mental health system.

The Productivity Commission’s recommended reforms fall into five broad areas:

1. helping people to maintain their mental health and reduce their need for future clinical intervention, including by tackling early mental health problems and suicide risks
2. improving people’s experience of the mental healthcare system to ensure the care received is person-centred, timely, consistent with treatment needs and does not impose undue burden on either the consumer or their carers
3. improving the experience of people with mental illness and their carers beyond the healthcare system, recognising that there are numerous gateways in the community through which people enter the mental health system and a range of services beyond healthcare — in particular, psychosocial services, housing and justice — that are important for an individual’s social and emotional wellbeing and recovery

4. helping people to remain engaged in education and stable employment; reforms designed to support and enable Australians with mental health problems to reach their potential in life, have purpose and meaning to them, and contribute to the lives of others

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

Unsurprisingly, many of the reforms recommended in this Inquiry report have been proposed before. Some were not accepted due to inadequate evidence at the time. Others faced barriers to implementation.

This Inquiry addresses both of these issues. We consider evidence that has emerged, and we tackle the implementation barriers.

Reforms to create a person-centred mental health system are not without cost. However, substantial gains can be made by reprioritising and coordinating existing expenditure — in terms of services, location of supports and the timing of interventions. More efficient and effective use of current spending is possible in a number of areas, but there is also scope to change the trajectory of spending in some areas over time. Some reforms, such as those in early intervention and prevention, are investments paid for today that could be expected to reduce expenditure on more costly services in the future.

Nonetheless, we are starting from a position in which there are significant and costly gaps in services, so reforms to establish a flexible and accessible mental health system and reduce the ongoing costs to Australia of mental ill-health would require extra government expenditure. Additional taxpayer funding would require Governments to make choices and identify priorities, not just within the mental health system but across all areas of public expenditure — a dollar spent in mental health represents a dollar not spent on another, potentially equally important, area of need.

An important part of this Inquiry is for the Productivity Commission to provide an implementable roadmap to reform. This includes ranking reforms — what should be done first and, when trade-offs are needed, what reforms are more fundamental. To facilitate this, we have identified priorities in each area of reform based on the following criteria:

- *Potential to improve lives at either the individual or community level* — Some reforms can be expected to significantly improve the quality of life for a small number of people (such as follow-up care after suicide attempts). Other reforms can be expected to improve the quality of life in a small way but for a large portion of the community (such as access to online services). We estimated the extent to which each reform area is likely to lead to improved health-related quality of life.
• **Benefits to the economy and expenditure required to achieve these** — The economic benefits that have been estimated are the increase in labour force participation for consumers and carers 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 reflect a reduced need by people for costly services in the longer term, including a reduction in people’s out-of-pocket costs associated with using services, a reduction in insurer payments for healthcare, and a reduction in informal care provided by family and friends. Estimated expenditure to implement reforms is confined to government outlays.

• **Ease of implementation** — Reforms that involve the redeployment of existing resources, involve comparatively little disruption to other parts of the community, and require changes by just one government or government agency, were considered easier to implement than reforms requiring the significant redirection of resources from other programs, or the cooperation of multiple agencies.

• **Sequencing** — Many reforms would need to be implemented in stages with the feasibility of some measures dependent on the success of earlier actions. Some reforms require trials to first generate a sound evidence base on how implementation could be cost-effectively achieved to deliver the desired benefits, before they can be implemented on a national scale. Others may first require negotiation and agreement between multiple governments, or additions to the skilled workforce to deliver relevant services. For example, improving the way the education system supports the wellbeing of students would involve training the relevant workforce and developing evaluation processes for schools.

With many of the prioritised reforms, there should be an understanding that the expected benefits, while potentially substantial and widespread, may not be evident for many years into the future. For example, reforms such as improving the social and emotional wellbeing of young Australians could provide substantial benefits in quality of life and income opportunities, but these benefits would be realised over the longer term. Furthermore, major changes, such as many of those presented in this Inquiry report, require continuous feedback and learning, to make sure that the reforms are working to improve the lives of Australians.

A number of recommended reforms are not priorities but would nevertheless 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.

**How much could reform benefit Australia?**

The benefits of key recommended reforms have been estimated in terms of people’s additional capacity to work and earn higher wages, and in terms of their improved health-related quality of life. However, some benefits could not be readily quantified, such as the benefits of improvements to system governance, the use of trials to improve the evidence base for later interventions, the benefits of reforms for those people interacting with the justice system, the flow-on benefits for an individual’s family of providing secure housing, or the broader community benefits associated with improved mental health.
In this sense, the benefit estimates presented in this report should be viewed as *lower bounds* on what could be achieved. When only some benefits can be measured, there is potential for bias. What gets measured, gets done — even if the real but unquantifiable benefits from other reforms are greater. To avoid this bias, when determining the relative priority of reforms, we supplemented the quantified benefit estimates with evidence received by the Inquiry on the qualitative benefits of reforms (such as improvements in how individuals would be able to live their lives).

The economic benefits of the recommended reforms to Australia’s mental health system were estimated to be up to $1.3 billion per year as a result of the increased economic participation of people with mental ill-health. About 85% of these economic benefits ($1.1 billion) could be achieved from the identified priority reforms alone. Achieving the benefits associated with the priority reforms would necessitate additional expenditure in the order of $1.9–$2.4 billion per year, but is also likely to result in annual savings (primarily reduced government expenditure) of between $0.9–$1.2 billion per year.

Not surprisingly, additional benefits to the economy are estimated to be small. This reflects two aspects. First, the analysis does not quantify the longer term social investment benefits of reforms — that improving an individual’s mental health early in their life can have lifelong benefits for both that individual and those they interact with, while at the same time potentially reducing their lifetime demand for Australia’s healthcare services (both physical and mental healthcare). Second, there is no disguising the extent to which some of the recommended reforms are about addressing deep-seated cultural and societal problems — including cultural inequities, stigma, homelessness — that have benefits which cannot be readily quantified.

Indeed, the main benefits of this Inquiry’s recommended reforms would be a substantial increase in the quality of life for a large number of Australians. These gains were estimated to be the equivalent of up to $18 billion per year (an improvement of 84 000 quality-adjusted life years), were the full list of recommended reforms implemented. Ultimately though, the benefits of reform extend to all Australians: those who are currently receiving or require treatment and support for their mental health; their carers, families and colleagues; and those who are well now but may one day seek help for themselves or someone they know. You do not have to be unwell now to benefit from improvements to Australia’s mental health system.

While there are substantial reforms within the healthcare system that would offer net benefits to the Australian economy and increase the quality of people’s lives, the most significant increases in net benefits and quality of lives are estimated to be possible in sectors beyond health.

Some reform benefits could be achieved relatively quickly by redirecting existing resources and/or achieve a net saving in expenditure. Reforms in these areas that should be considered priorities for action include:

- assess the treatment and support needs and then plan for service provision in every region of Australia, as necessary first steps in improving the availability and distribution of services for people, and reducing current inefficiencies in the way resources are directed
• add rigour to individual mental health assessment and referral processes to enable people to make informed choices on evidence-based treatment options
• expand access to telehealth (videoconference or telephone) treatment with psychologists and psychiatrists to enhance accessibility and convenience benefits to consumers and potentially reduce healthcare expenditure
• provide follow-up support for people after a suicide attempt, with immediate benefits in saving lives, improving quality of lives and reducing ongoing health costs.

Beyond these clearly beneficial reforms that could be implemented relatively quickly, a tradeoff between gains in economic net benefits and improved quality of life for people, would likely be required. For some reforms, benefits may be immediate; for others, there should be an expectation that they would likely take time to implement on a scale that would be fully effective.

A number of the Productivity Commission’s priority reforms warrant government attention on the basis of the estimated improvement likely in the quality of life for people (figure 3). These particularly include reforms to:
• help schools support the social and emotional wellbeing and mental health of their students
• augment community ambulatory services
• meet gaps in demand for psychosocial supports
• adopt family and carer inclusive practices.

In the case of some interventions — such as those to improve the social and emotional wellbeing of families with young children — it is anticipated that the benefits would initially be evident in family workforce participation and school engagement, but persist for some years beyond the intervention, improving connections with community, outcomes from education and work, and ongoing mental health. Reforms to psychosocial support arrangements are estimated to significantly improve the quality of life for recipients, but come at a net cost to the economy.

Reforms likely to provide significant economic benefits that should be prioritised for prompt implementation include:
• expand individual placement and support for people with mental illness entering the workforce
• require provision of no-liability early treatment for people with mental health related workers compensation claims
• expand supported online treatment
• support new parents in the perinatal period
• instigate a national campaign for stigma reduction
Figure 3  **Recommended reform areas**

- **a, b** Chart shows only those reforms that were able to be quantified. Dotted orbits represent uncertainty in estimates for each reform, showing the range of simulated estimates between the 5th and 95th percentiles for changes in costs and quality-adjusted life years (QALYs).
- **b** Shaded areas show thresholds of cost effectiveness — darker shading indicates lower cost effectiveness (appendix I). Reforms that sit above zero are cost saving. Reforms that sit below zero and outside the shaded areas cost less than $33,000 per QALY gained. Reforms that sit in the lightest shaded area cost $33,000–$64,000 per QALY gained. Reforms that sit in the medium shaded area cost $64,000–$96,000 per QALY gained and are considered marginally cost effective. Reforms that sit in the darkest shaded area cost more than $96,000 per QALY gained and are considered not cost effective.
- **c** ‘Net benefit’ is the estimated cost savings and additional employment income generated by the reform that exceeds the estimated cost of implementing the reform (every dollar spent will generate a benefit of more than one dollar).
- **d** ‘Net cost’ means the estimated cost of implementing the reform is larger than the estimated cost savings and additional employment income generated by the reform (every dollar spent will generate a benefit of less than one dollar).
- **e** QALYs measure the improvement in health experienced by reductions in the duration and severity of illness.
A number of individual reforms, highlighted throughout this report, were considered very likely to provide significant net benefits (and therefore should be considered seriously as reform options), but quantification of individual estimates was not feasible. Legal representation for people detained and receiving mental health treatment involuntarily is one such example. Similarly, we acknowledge that there would be regional variations in the net benefits of some reforms (such as housing support) and differences between States and Territories in the extent to which some recommended reforms have already been implemented (such as in support for police responding to incidents involving people who have mental illness). While we were unable to take such regional variations into account in assessing the net benefits of reforms at a national level, it could be expected that with more detailed knowledge of regional needs and service gaps, the States and Territories would be able to do so.

Some of the relevant reforms would not be easy or quick to implement, requiring negotiation between multiple government agencies and/or an up-skilling of the relevant workforce and changes in deep-seated workplace and community cultures. However, the Productivity Commission considers that these limitations should not deter policy makers from pursuing highly beneficial reforms.

1. Prevention and early help for people

<table>
<thead>
<tr>
<th>PRIORITY REFORMS</th>
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</thead>
<tbody>
<tr>
<td>• Support the mental health of new parents</td>
</tr>
<tr>
<td>• Make the social and emotional development of school children a national priority</td>
</tr>
<tr>
<td>• National stigma reduction strategy</td>
</tr>
<tr>
<td>• Follow-up care for people after suicide attempts</td>
</tr>
<tr>
<td>• Empower Indigenous communities to prevent suicide</td>
</tr>
</tbody>
</table>

Early intervention — either early in life or early after the detection of risk factors that may lead to mental illness — is important to prevent the onset of illness or curtail a deterioration in mental health. However, up to one million people with mental illness have never accessed mental health services nor seen their GP about their condition. This may not be a significant problem for some people with mild mental illness, which can dissipate as the individual’s risk factors subside. But for others, untreated mental illness may percolate throughout their life, reducing the wellbeing and standard of living of the affected individuals and often those around them.

Interventions early in people’s conditions are discussed in the context of the key gateway at which they present to the mental health system — be it health, housing, justice, further education, workplaces, or some other community facility. This section focuses on the issues and priority reforms regarding: prevention of mental illness; early identification of risks in, and help for, young children and families; cultural and social barriers to improving wellbeing; and suicide prevention.
Prevention

The aims of prevention are to reduce the incidence of mental illness and the recurrence in those who have previously experienced mental illness. These aims can be achieved by reducing exposure to risk factors, assisting individuals to strengthen resilience and coping skills, and providing supports that mitigate the effects of economic, social or environmental stresses. There is increasing evidence to support the effectiveness of some programs that promote mental wellbeing and prevent mental illness. Such programs can target a whole population, people within a population who are at increased risk, or people showing early signs of mental ill-health. In the latter case, prevention can delay the onset of severe mental illness or help an individual toward a less debilitating outcome.

Early identification of risks and help for families and children

Early identification of risks to children offers the greatest potential for improving health, social and economic outcomes. Supporting the social and emotional wellbeing of young Australians and helping them to thrive is expected to set them up to better cope with future risks to their mental health, and lead to improved long-term academic outcomes (figure 4) and post-school opportunities.

There are many opportunities to support children and their families from a very young age, but priority reforms for governments should be: (i) screening and support for new parents; and (ii) in all schools, the creation of clear dedicated strategies, including leadership and accountability structures, to deliver wellbeing outcomes for their students.

Support the mental health and wellbeing of new parents

The mental health of parents has a strong influence on the wellbeing of infants and young children, including their emotional, social, physical and cognitive development. This suggests a strong case for supporting parents, particularly at times of major life transitions, such as in the perinatal period (pregnancy and the weeks following birth). About one in ten women experience depression during pregnancy, and one in seven women in the year following the birth. One in five women experience anxiety in the perinatal period, and one in ten new fathers or partners experience perinatal depression and/or anxiety.

Governments should, as a priority reform, put in place strategies to reach universal screening for mental ill-health of new parents. This may include use of existing maternal and child health services, online screening and outreach services. The frequent interactions of families with healthcare providers in the perinatal period afford a valuable opportunity to improve detection of mental ill-health and offer early intervention — indeed, the potential to improve people’s lives from an early age and the relative ease of implementation of this measure contribute to it being a priority reform.
Support social and emotional wellbeing for school age children

Identification of children at risk (either because of their own ill-health or that of a family member) is simply a starting point. Schools need to be effective gateways for students and their families to access help.

All schools should have dedicated clear strategies, including leadership and accountability structures, to deliver wellbeing outcomes for their students, in the context of the student’s family life and school environment. As with interventions for new parents, this priority reform has strong potential to improve the quality of lives for children from an early age. It is also an important early step in a sequence of recommended reform options for helping schools to support their students’ social and emotional wellbeing.

Many schools have wellbeing policies and dedicated staff, and governments have developed numerous frameworks and policies. Schools are already funded to provide social and emotional wellbeing programs. However, they face a confusing and disjointed proliferation of poorly evaluated programs and services, along with a multitude of uncoordinated government interventions. There is no clear policy framework that defines the role that teachers, principals and the education system more broadly are expected to play in supporting mental health and wellbeing, and what outcomes they are expected to achieve.

The National School Reform Agreement, which sets out governments’ expectations for the education system, funding structures, and reporting requirements, should be updated to include student wellbeing as one of its outcomes. This would place wellbeing on an even footing with academic progress and student engagement as an important goal that schools across all sectors of the education system must work towards, and report on their progress.

Designating student wellbeing as one of the outcomes of the National School Reform Agreement would require all jurisdictions to monitor and evaluate the progress that schools make towards improving wellbeing. This is a complex, multi-faceted goal, and as such would require not only the collection of data, but also extensive evaluation of the policies and processes that schools put in place to support their students. These processes should include clear leadership and accountability structures, such as having a dedicated wellbeing leader or team responsible for whole-of-school strategies, supporting individual students and their families, and building links with services in the local community.

While most teachers are well able to identify behaviour that is atypical, we were advised that many teachers find that their training has generally not equipped them to either identify mental health risks or respond effectively. The initial training of early childhood educators and of teachers should include more explicit instruction in child and adolescent social and emotional development with practical tools to support students. Training on social and emotional development should also form part of teacher professional development requirements and is a necessary step to enable success of the priority reform to support student social and emotional wellbeing.
Nationally consistent wellbeing measurement should be rolled out across all schools, with principals accountable for annual reporting on outcomes and improvement over time. Data collected should contribute to an evidence base for future interventions. It is expected that dedicated additional funding through a flexible funding pool in the order of $150 million per year nationally would be needed to deliver these improvements in wellbeing programs delivered for Australia’s school children.

Figure 4  
**Children with mental illness fall behind in school**

<table>
<thead>
<tr>
<th>School year</th>
<th>No mental illness</th>
<th>Mental illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years 1–6</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Years 7–10</td>
<td>11</td>
<td>23</td>
</tr>
<tr>
<td>Years 11–12</td>
<td>12</td>
<td>26</td>
</tr>
</tbody>
</table>

Other reform options to improve mental health from early in life

Beyond these priority reforms, there are a number of other reform options in Australia’s education and health systems that the Productivity Commission considers would offer significant benefits for the mental health of young people.

Up to one in five children starting school have high levels of emotional problems, which are likely to get worse as they get older and make it harder for them to learn. 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. The expansion of the existing optional physical development checks of Australia’s 1.25 million 0 to 3 year olds in community health services to incorporate social and emotional wellbeing aspects of development would enable necessary assistance to be made available to both the child and parents/carers.
Some children face a much higher risk of mental ill-health from a very young age. Children who are exposed to trauma (that either affects them directly or their family), those who are affected by entrenched disadvantage in their communities and children in the out-of-home care system face substantial risks to their mental health — but at the same time, they are also far less likely to have access to care and support, compared with other children in the population. Children affected by mental illness fall behind in their educational achievement (figure 4); they are more likely to disengage from school and may face substantial barriers to go back to school, and later on, enter the workforce or go on to higher education.

Timely access for students with mental illness (and indeed, all students) to educational adjustments in schools would be a relatively low-cost way to improve engagement with education, and in turn, improve a child’s future outcomes. In addition to supports within their school, children should be linked into mental health treatment and support services in the local community (provided the complementary reforms are acted on to fill gaps in child and adolescent mental health services in communities). Continued engagement in education of those children with mental illness would require a partnership between schools and local mental health services. In addition, Departments of Education should put in place clear policies for outreach services to proactively engage with students and families referred to them, once a student’s attendance declines below a determined level, and monitor their implementation.

**Cultural and societal barriers to improving mental health and wellbeing**

Some cultural and societal influences, such as stigma toward mental illness, exacerbate the cost of mental ill-health. They contribute to a reluctance for people to seek help (particularly in some cultural groups and in smaller communities where it is difficult to receive care without others becoming aware of this), alter the types of help people seek and the symptoms they experience, delay diagnosis, compromise adherence to treatment, and reduce the availability of social supports to both the consumer and their family and carer.

Most people with mental illness report experiencing stigma, although the degree, nature and experience of stigma and consequent discrimination varies with the type of mental illness, and with the person’s age, gender and culture. People with mental ill-health can also experience self-stigma. For example, in the workplace, an individual with mental ill-health may feel that they are ‘letting down their colleagues’. Reducing stigma (both self-stigma and that of the community) about mental illness can relieve some of this pressure by making it more acceptable for people to seek help.

**Address stigma, cultural and social barriers**

Effective stigma reduction requires an ongoing commitment over a long time period in order to ensure that reductions in stigma persist. As a priority reform to address stigma toward mental illness, the National Mental Health Commission (NMHC) should develop and drive the implementation of a renewed national long-term stigma reduction strategy that: targets stigma reduction messages for different audiences (such as health
mentally ill); focuses on the experiences of people with those mental illnesses that are poorly understood by the community; addresses different aspects of stigma including perceptions of danger and unpredictability; and identifies and draws on a small number of national ambassadors for mental health.

Additional reform options to address cultural and social barriers

Given the cultural diversity within Australia, the training of all clinicians should include measures that instil an understanding of how people’s cultural background affects the way they describe their mental health and their compliance with treatment options. This, and more, should be done for the mental healthcare of Aboriginal and Torres Strait Islander people. Best practices should be evaluated for partnerships between mainstream mental health services and traditional healers — who protect and heal the physical, emotional and social wellbeing of individuals and communities — to support Aboriginal and Torres Strait Islander people with mental illness and facilitate their recovery in their community.

Suicide prevention

The facts on suicide in Australia are stark. Just over 3000 people are lost to suicide each year in Australia, an average of more than 8 people per day. It has been the leading cause of premature death in Australia’s young adults, accounting for around one-third of deaths among people aged 15-24. Suicide rates of Aboriginal and Torres Strait Islander people are more than double that of other Australians, with young males and those in regional communities particularly at risk. And there has been no significant and sustained reduction in the death rate from suicide over the past decade, despite ongoing efforts to make suicide prevention more effective. For every death by suicide, hospital records show there are as many as 30 attempts of suicide. However, ambulance data suggests this could be much higher, as not everyone who intentionally self-harms is admitted to hospital. The debilitating effects of non-fatal suicidal behaviour on the subsequent quality of life for those who experience long term harm, and their families, can be substantial.

Only a very small proportion of those with mental illness self-harm or have suicidal thoughts; two thirds of people who die by suicide had a reported mental illness. However, 15-25% of people who attempt suicide will re-attempt, with the risk being significantly higher during the first three months following discharge from hospital after an attempt. Half of those discharged from hospital after a suicide attempt do not attend follow-up treatment and the responsibility of services and accountability for follow-up is unclear and inconsistent.

Follow-up care for people who attempt suicide

Adequate aftercare could reduce the number of people who are in hospital emergency departments, having attempted suicide, by about 20%, and all suicide deaths by 1%. This is equivalent to preventing 35 people per year from dying by suicide, and a further 6100 people
per year from attempting suicide that results in some level of incapacity for them. It is estimated that effective aftercare could conservatively provide a long-term return on investment of $2.37 to $6.90 for every dollar spent, depending on the extent of aftercare provided and the income earned by people whose suicide or suicide attempt was prevented. As a return on investment, this exceeds (and in some cases, far exceeds) the return from investing in a range of high priority projects currently identified by Infrastructure Australia, some of which are estimated to deliver a return of less than $2 for every dollar spent.

A program to provide access to timely, effective aftercare for every person who presents to a hospital, GP or community mental health service following a suicide attempt or in suicide distress should be provided, as a priority intervention by governments. Aftercare should include support prior to discharge or leaving the service, as well as immediate and sustained follow-up support. The priority of this reform reflects its significant potential to save and improve lives. But we have assessed that the reform is also likely to reduce medical, administrative and other costs of suicide attempts that would exceed the cost of providing aftercare, and it could be incorporated into existing care with relative ease.

For Aboriginal and Torres Strait Islander people, suicide attempt aftercare and other suicide prevention activity should, as a priority, have Indigenous-controlled organisations as the preferred providers, to increase the likelihood that program provision is sensitive to the experiences, culture and specific social issues faced within particular communities. Stronger connection of individuals with their culture and control over services have reduced suicide risk and improved social and emotional wellbeing in some communities.

Additional reform options to support suicide prevention

A range of suicide prevention trials are underway in different parts of Australia, and due to be evaluated over the next few years. A key aspect of these trials is that they reflect the needs of local communities in a coordinated approach to preventing suicide. The features of these programs that are evaluated as effective should be determined and published, to enable other localities across Australia to similarly adopt effective suicide prevention measures.

Beyond the short term, the linkage of data on agreed risk factors for suicidal behaviour could be useful in preventing some suicides. While privacy needs to be respected, as does an individual’s control over their data, this should not be used as an excuse to limit the sharing of data that would preserve someone’s life.
2. Improve people’s experiences with mental healthcare

**PRIORITIZE REFORMS**

- Create a person-centred mental health system
  - Evidence-based mental health assessment and referral processes that help people find the services that are best for them
  - Identify, support and include families and carers as part of mental healthcare
- Get people the right services at the right time
  - Expand supported online treatment, group therapies and access to mental healthcare via telehealth
  - Review limits on psychological treatment funded through Medicare and trial variations
  - Alternatives to emergency departments that are designed for people with mental illness
  - Expand community-based mental healthcare, including hospital outpatient clinics and outreach services
- Improve mental healthcare outcomes
  - Address adverse outcomes from prescribing practices of mental health medication
  - Reduce the gap in life expectancy for people with severe mental illness and physical illness
- Care continuity and coordination

Implementing person-centred care consistently across the mental health system would be a significant cultural shift. This shift would require structural changes to aspects of the mental health system, workforce training, a more holistic approach to families and carers and an increased focus on monitoring and improving outcomes for people.

In developing recommended reforms to improve mental health, the Productivity Commission has recognised that the right care for an individual can involve a mix of healthcare services, but also supports from sectors beyond the health system (figure 5). There are a host of non-healthcare measures and supports that can be just as (or more) important as healthcare in facilitating a person’s mental wellbeing and recovery — including, for example, psychosocial support services, housing services and supports in workplaces.

In reforming the mental health system to be person-centred, we are primarily interested in ensuring people are able to access services and supports in ways that are right for them, when they need them and at prices they can afford. Just as the intensity of clinical care should change with an individual’s clinical needs (as in a stepped care model), so too should the intensity of other services adapt as an individual’s needs vary.

This section focuses on the issues and priority reforms in healthcare: making entry into care person-centred; getting people the services that are right for them; improving outcomes for people; and enabling care continuity and coordination.
Figure 5  **A care mix that adapts to people's needs**

<table>
<thead>
<tr>
<th>Mental healthcare needs</th>
<th>Complex care</th>
<th>Moderate intensity care</th>
<th>Low intensity care</th>
<th>Self-management</th>
<th>Preventative care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatient services; larger care team</td>
<td>GP and MBS-rebated psychological treatment</td>
<td>Clinician-supported online treatment; group therapy</td>
<td>(Of symptoms) self help information and resources</td>
<td>(No symptoms) e.g. through education and employment</td>
</tr>
<tr>
<td></td>
<td>Specialised psychosocial supports* (e.g. daily task support, care coordination, Individual Placement and Support, and Housing First)</td>
<td>– within scope of this inquiry</td>
<td>Higher intensity community supports from mainstream government services (e.g. public housing)</td>
<td>– outside scope of this inquiry</td>
<td>– outside scope of this inquiry</td>
</tr>
<tr>
<td></td>
<td>Psychosocial supports* by dedicated government programs (e.g. Disability Employment Services and supported housing)</td>
<td>– within scope of this inquiry</td>
<td>Moderate intensity community supports from mainstream government services (e.g. jobactive)</td>
<td>– outside scope of this inquiry</td>
<td>– outside scope of this inquiry</td>
</tr>
<tr>
<td></td>
<td>Low intensity community supports from mainstream government services (e.g. Centrelink)</td>
<td>Low intensity community supports from mainstream government services (e.g. Centrelink)</td>
<td>– outside scope of this inquiry</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* 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.

**Make entry into the health system person-centred**

When people recognise they are becoming mentally unwell, there are three main health gateways through which they typically seek help — online resources, community health services (such as GPs) and hospital emergency departments. Some important features of gateways into healthcare are that they should be readily accessible to people as and when they need help, be affordable, culturally capable, and connect to services that individuals value. Priority reforms for Governments to make entry into the health system person-centred are: (i) improved mental health assessment and referral processes; and (ii) provision of alternatives to hospital emergency departments for people experiencing a mental health crisis, particularly outside standard hours.
Resources for people who can help themselves

The first port of call for many Australians are online resources. The recent bushfire disaster in many communities and the COVID-19 pandemic have seen sharp spikes in people seeking online information about managing stress and anxiety. Many Australians experiencing psychological stress or mild mental illness are able to manage their mental health without formal clinical intervention and without significant impact on their relationships or engagement in activities. What is needed to allow this is access to relevant information and the capacity to act on that information (such as by adjusting sleep patterns or diet, exercising, or learning stress management techniques).

There is much information already freely available. But directing people to information that is evidence-based and effective would be improved through: an expansion of online portals to include more information on e-health; telehealth and group therapy services, and mental health pathways in local communities; as well as information on how specific aspects of mental ill-health can impact people’s functionality and ability to participate in education, work and the community.

Improve the gateways into healthcare for people

For people who prefer face-to-face assistance, the most common gateway used to access mental healthcare is via a community mainstream health service — a GP clinic, Aboriginal Medical Service, or a primary health network (PHN)-commissioned service (such as a headspace centre).

As an entry point to healthcare, people rightly expect clinicians to either have the professional competency and cultural capability to assess and treat them, or be able to refer them to someone who can.

Yet there can be significant delays in getting a GP appointment in some (urban and regional) areas, attending appointments can be very expensive and time consuming (sitting in waiting rooms), and not everyone experiences their GP as a useful, accessible or culturally capable person with whom to discuss their mental health. The way most GPs are subsidised creates a financial incentive for them to limit their discussion time with each person, and not all GPs are competent in relating to the variety of cultural backgrounds of people who may need their help. Furthermore, while many GPs do an excellent job, some lack knowledge and skills in mental health, and rely too readily on medication as a treatment option. More competency is required in: identifying risks, diagnosing conditions, assessing and recognising the physical health consequences of prescribed treatments, and connecting people with other services (including online mental health services, allied health services and non-clinical services such as counsellors).
Create a new person-centred pathway to care

Providing people with information on potential mental healthcare options so that when they reach a clinician they are an informed consumer, is a key part of creating a person-centred mental healthcare system. To provide people with more information on care options that might be suitable to their needs, empower them to seek and directly access help that is most suitable to their circumstances — and assist GPs in referring people to supports that are suitable — the Productivity Commission recommends establishment of a ‘national digital mental health platform’. As a priority reform, creation of the platform should occur as soon as possible, as it underpins other reforms directed at helping people get services that are right for them.

The principal focus of the platform would be on ensuring that the multiple gateways by which people seek mental healthcare all enable people to access services and supports that are accessible, effective and affordable and match their needs and circumstances.

A core component of the platform would be a tool for a common approach to assessment and referral, consistent with the Department of Health’s guidance on Initial Assessment and Referral. This tool should be accessible at no charge to both individuals and clinicians (regardless of whether they are in urban or regional parts of Australia), would enable clinician-supported assessments and online treatment, and make clinician-endorsed recommendations for referral to culturally relevant online or face-to-face psychological and psychosocial services within the individual’s local region. The assessment and referral tool would replace mental health treatment plans as a requirement for accessing MBS-rebated psychological therapy, and offer clear and structured guidance to referring clinicians and consumers on the types of services likely to best meet the individual’s needs and preferences.

The platform would also include some low-cost, accessible and evidence-based low-intensity digital services (discussed further below) and provide an entry point to other clinical treatment and non-clinical support services, delivered digitally or face-to-face.

Giving substance to these components, the platform would, in time, connect to a new online navigation portal in each region that would detail specific services that are of relevance to particular mental health needs. These regional navigation portals should be accessible to clinicians and other providers in the health system, and to those who facilitate entry of consumers to the mental health system via non-health pathways — such as schools, aged care facilities, Indigenous service providers and correctional facilities. The portals should act as centralised online and phone gateways, be able to identify services available and directly book consumers into a service. The HealthPathways portal model, which is already used by most PHNs, could be used as the basis for navigation portals.

GPs would remain a primary gateway to mental healthcare for people who have ready access to them locally and/or have physical as well as mental health concerns. While many people are likely to receive a prescription for medication if consulting a GP about a mental health problem, one in five people receive a referral, usually to a psychologist, or less commonly, to a psychiatrist. With mainstream community health services (including GPs) linked to the
new national digital mental health platform, people would be assured they are receiving an assessment that is rigorous and treatment recommendations that are evidence-based and match their needs.

Many of the components required to establish such a digital platform already exist — the next step would be making them easily accessible to all consumers and health services and promote community recognition of the platform as a gateway into mental health treatment and support services.

Provide pricing information to help people choose services

In addition to provision of information on services available, greater transparency in pricing information would help people choose between care options, where choices exist. While treatment effectiveness should be a key consideration in service choice, the reality is that for many people, any out-of-pocket cost (such as that incurred for a GP consultation, outpatient consultations with a psychiatrist, or a MBS-rebated psychological therapy session) can reduce their compliance with a recommended course of treatment.

The Australian Government should include on the Medical Costs Finder website the fees and areas of specialty of all individual psychiatrists, paediatricians and allied health providers for MBS-rebated therapy.

Improve the ED experience and provide alternatives

People experiencing a severe episode of mental illness often (re)enter mental healthcare via a hospital emergency department (ED). The rate of mental health presentations at EDs has risen by about 70% over the past 15 years, in part due to the lack of community-based alternatives to ED, particularly in the evenings and on weekends.

Compared to people with other health conditions presenting at an ED, people with mental illness are:

- nearly twice as likely to arrive by ambulance
- ten times more likely to arrive by police or correctional services vehicles
- twice as likely to be in ED for more than 8 hours
- overrepresented among those kept waiting in ED for an inpatient bed
- even more overrepresented among those delayed in leaving ED due to an inpatient bed not being available.

While reforms are underway at some hospitals, the typical ED experience too commonly exacerbates the distress of those with mental illness, frustrates and diverts emergency clinicians, paramedics and police, and is an entry point that is very expensive for the community. One option to reduce ED presentations is to have mental health workers
accompany police when they attend a person experiencing an acute episode of mental illness (discussed below).

Complementing this, State and Territory Governments should, as a priority reform, aim to provide more and better alternatives to EDs for people with mental health problems. This may include providing separate spaces in or near EDs for people with mental illness, or otherwise creating a more de-escalating environment, such as peer- and clinician-led after-hours services and mobile crisis services. The ‘Safe Haven’ spaces created in Melbourne and planned in Queensland provide an effective model for this. The provision of alternatives to EDs are estimated to be cost-saving and could substantially improve the mental health outcomes for people benefiting from them. When EDs are built or renovated, the design should take account of the needs of people with mental health problems.

The right services for people at the right time

Consistent with a person-centred approach, we want a mental healthcare system that allows people to choose and access care options that are right for them, given their needs and circumstances. This means that there needs to be a range of different ways that services are delivered, to be accessible as and when people need them, that are not just clinically effective and culturally relevant, but impose minimum burden on the individual seeking care. People are more likely to choose, persist with, and benefit from, treatment that matches their needs.

Priority reforms to help people get the services that are right for their needs are: (i) provision of supported online treatment; (ii) a review of the effectiveness and targeting of MBS-rebated psychological therapy, with a trial of additional sessions; (iii) enabling access to MBS-rebated psychological therapy and psychiatry via telehealth regardless of where people live; (iv) expanding community mental healthcare.

Bridge the care gaps

There are significant gaps in Australia’s mental healthcare system and people typically discover these gaps when they are in most need of care. Up to one million people with mental illness are estimated to be receiving no clinical care. Some are able to self-manage their health or are accessing non-clinical supports; but some need clinical help and have encountered gaps in the options available to them.

While people encounter barriers to most forms of mental healthcare, we identified two key gaps in care that are particularly detrimental to mental health outcomes for a large number of Australians — a gap in low intensity services, and a gap known as the ‘missing middle’.

The low intensity gap is a large gap in the utilisation of low cost, low risk, and easy to access services. Two groups of people encounter a low intensity gap — an estimated 500 000 people who would benefit from low intensity care but are not accessing any care; and up to 2 million people who are being treated with medication and/or individual therapy that are more costly
for them than what is necessary and who could have their treatment needs equally well met through services that offer a lower treatment burden (in terms of time, financial cost, and treatment adverse side-effects).

That many people are not accessing services that are right for them is evidenced by treatment drop-out rates. For example, close to half of those people accessing MBS-rebated psychological therapy use three or fewer sessions (rarely enough to enable recovery, in those for whom psychological therapy is the most appropriate intervention), while about half of those people who commence the NewAccess low-intensity therapy program complete the full course of six sessions.

The Productivity Commission has concluded that the low intensity gap exists primarily because of under-provision of low cost, low risk and easy to access services, and because of a lack of information — for referring clinicians and for consumers — about the existence of such services and their clinical and cost effectiveness.

The missing middle gap is a service gap encountered by several hundred thousand people who have symptoms that are too complex to be adequately treated by a GP and the limited MBS-rebated individual sessions with psychologists. But their condition also does not reach the threshold for access to State or Territory funded specialised mental health services. Alternative services, such as private psychiatrists or private hospitals, may be inaccessible due to long waiting lists or very high out-of-pocket costs.

The Productivity Commission has assessed that the missing middle gap primarily reflects a lack of community mental health services, but this gap is larger for some groups of people and in some parts of Australia.

For example, some groups in the community — such as Aboriginal and Torres Strait Islander people — face additional barriers to care because of a lack of culturally capable services and discrimination. And people in some rural, regional and remote communities can face further barriers associated with lack of availability or continuity in the trained workforce.

Recommended reforms address these healthcare gaps by increasing the range and accessibility of relevant services for people to choose from, including by ensuring there is an appropriately skilled workforce available to deliver the services that people choose and sufficient capacity in community and hospital facilities to cater for people’s needs.

**Expand supported online treatment as a flexible option for people**

Supported online mental health treatment expands consumer choice of flexible treatment options and helps fill the low intensity gap in healthcare, complementing other treatments people may choose, and improving the person-centred focus of the mental health system.

For many people, supported online treatment provides a convenient, effective, low cost way for them to manage their mental ill-health. It allows people to undertake treatment at a place and time that is suitable and convenient for them — for example, in their own home, at a local
health service, or at a psychosocial support hub or clubhouse. One online service reported that almost half of the people using its site accessed it outside of normal business hours, and that access occurred all days of the week.

Supported online treatment has been available as a trial or for routine care for more than two decades. It is now well established that clinician supported online treatment is as effective as face-to-face treatment for some conditions. In particular, supported online treatment is an effective intervention for people with high prevalence mental illness (such as anxiety and depression). There is also some evidence that supported online treatment may be effective in complementing specialist mental health treatment for severe and less prevalent conditions, such as schizophrenia, bipolar disorder and bulimia nervosa. Online treatment carries the added benefit of fidelity of the treatment (it avoids individual providers administering their own personal versions of the intervention), could be made culturally appropriate, and can be cost effective to provide to a large number of people.

About 20,000 people per year access online mental health information and services, with about 4000 of these receiving online treatment supported by a clinician. As a starting point to more widespread use of supported online mental health treatment options, the Australian Government should, as a priority reform, expand the capacity of online treatment services. The initial beneficiaries of greater access to supported online treatment would be those people who have faced so many barriers to accessing treatment, that they have gone without help. A gradual expansion would recognise that it may take time for both individuals and clinicians to increase their knowledge of this means of accessing treatment and that expanding capacity within the sector should be undertaken in ways that preserve the quality of treatment for people and include only services with a strong evidence base.

The recommended expansion of supported online treatment forms part of the broader vision of the national digital mental health platform that is offering a person-centred pathway to assessment and treatment, supporting both individuals and health professionals to make decisions about the right treatment options. It is estimated to be a cost-effective reform for both consumers and taxpayers and should be implemented regardless of government and service provider progress on the new platform.

Enable psychological therapy to meet the needs of people who would benefit most

Approximately 1.3 million people currently receive MBS-rebated sessions of face-to-face psychological therapy (individual or group) each year. The ‘Better Access’ program provides psychological therapy services at a significantly lower per-session rate than comparable services funded through means other than the MBS. However, face-to-face psychological therapy (and the workforce who deliver it) should be focused on helping some of those people who are encountering the missing middle gap in the mental health system.

The recommended introduction of more rigorous and consistent assessment and referral processes to access mental health treatment needs (discussed above), combined with a recommended replacement of the current mental health treatment plans (which show no evidence of having improved either GP referral practices or mental health outcomes for
people) with a structured mental health assessment and referral tool, should help people get the treatment they need. In particular, these measures would have the dual effect of ensuring that people with low intensity treatment needs are not directed into higher intensity treatment options that come at a higher cost to them, and that people with moderate to high intensity treatment needs (who stand to gain the most from face-to-face psychological therapy) are able to access these services when needed.

The Productivity Commission estimates that up to 10% of those accessing individual therapy would benefit from an increase in the number of subsidised sessions (predominantly those people with moderate to high intensity treatment needs). A trial on the number of MBS-rebated psychological therapy sessions should be undertaken to assess the merits of increasing the current number of rebated sessions.

The Better Access program should, as a matter of priority, be rigorously evaluated to ensure that it is delivering cost-effective benefits for those who need it.

Enable ongoing access to telehealth

Ironically, access can be an issue with the Better Access program. Use of the program, and other MBS-rebated mental health services, is disproportionately by people in Australia’s large urban centres (figure 6). This reflects the location of most psychologists and psychiatrists. Group sessions and sessions via telehealth are significantly underutilised.

For people who have difficulty accessing psychological therapy (for example, because they live in a part of Australia where there are no psychologists or for reasons related to their mental illness, transport access, or family scheduling), access to psychological therapy by videoconference should be widened as a priority reform. Some mental illnesses (such as anxiety) can, at times, include symptoms that prevent an individual leaving their home to attend face-to-face therapy. Regardless of whether an individual resides in an area designated as a ‘telehealth area’, if they have been assessed as benefiting from psychological therapy, then they should be able to access MBS rebates for psychological therapy via videoconference. In large part, this would involve a continuation of the universal video-psychological therapy approaches adopted during the COVID-19 crisis.
Figure 6  **Regional access to low and moderate intensity care services**

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

% of population accessing MBS-rebated mental health services

Users of supported online treatment are geographically widespread

% of population accessing MindSpot
A workforce competent in mental healthcare to fill the gaps

Empowering people to access the mental health treatments that are right for them means ensuring there is a competent workforce able to deliver the treatments needed, and that embraces evidence-based clinical interventions and a person-centred focus.

**Improve the competency of mainstream health services in mental healthcare**

Even with a recommended ramping up in the use of clinically-supported mental health assessment, referral and treatment options, GPs would likely remain a dominant provider of mental healthcare services. All GPs need to be competent in treating people with mental illness. In any given year, at least 5 million Australians see their GP for assistance with their mental health, including treatment of a mental illness. Of these people, 6 in 10 are prescribed medication by the GP; 3 in 10 receive some counselling, education or advice. Only 2 in 10 receive a referral to a psychologist or a psychiatrist; about 400 000 people see private psychiatrists and 1.3 million people see psychologists.

Despite their central role in providing primary mental healthcare services and prescribing medications, most GPs receive minimal training in mental healthcare when qualifying as a GP (although some subsequently gain specialist mental health skills). Aspects of existing GP mental health training and professional development that should be re-oriented include: more rigorous approaches to assessing mental health (including consideration of cultural influences, relationships and trauma); inclusion of carers and family in diagnosis and treatment discussions; attitudes to peer workers; buy-in to a person-centred ethos; and adherence to evidence-based clinical practices (including the clinical appropriateness of GP’s prescribing practices for mental health medication, management of medication side effects and de-prescribing).

**Mental healthcare specialists**

Most people who access care from a mental healthcare specialist do so for a limited time until their recovery reaches a point where less intensive care is sufficient. For a small proportion of the community, mental health specialists are an ongoing and regular part of their mental health treatment and support network. Lack of specialists in some parts of Australia and long wait lists are issues for many people needing care. Trust — that the specialist will regard the individual, their concerns and preferences as important — and finding (and retaining) a specialist with whom the individual feels some rapport, can be additional major challenges that many people never surpass.

Among those providers who work specifically in mental health in Australia, there is considerable disparity in workforce numbers between urban and regional areas, and between the public and private sectors, and an inefficient use of skilled professionals (such as mental health nurses) in administrative roles that could likely be undertaken by non-clinical staff. There are also notable gaps in the availability of some specialists in a number of parts of Australia.
Access to psychiatric care is particularly constrained, with high costs and long wait times in some areas. The number of psychiatrists for Australia’s population is at the low end of rates in developed countries. The profound difficulty of children and adolescents, people in aged care and people in rural, regional and remote areas in accessing psychiatrists, should particularly be addressed. Governments should collectively develop a national plan to increase the number of practising psychiatrists, including an increase in the availability of supervision for trainees, with a focus on sub-specialties and localities where there are substantial shortfalls.

Mental health nurses are a critical part of the current mental health workforce, being the largest clinical occupational group dedicated to mental health, and one of the most geographically dispersed and cost-effective sources of expertise for combined management of mental and physical health, and care coordination. The number of mental health nurses practicing in Australia — in GP clinics, community health services, and aged care facilities — should be significantly increased to support the recommended expansion in community mental health services and inpatient bed-based services. Recommended measures to promote this are focused on training, because Australia is unlikely to be able to continue to rely on recruiting mental health nurses from overseas. The development of a three year direct entry (undergraduate) degree in mental health nursing, similar to options available in midwifery in Australia and for nurse training in the United Kingdom, is recommended.

Peer workers — people employed on the basis of their lived experience of mental illness — are well placed to support people with mental illness during their recovery. Indeed, evidence to the Inquiry made it clear that this type of assistance was highly valued by people with mental illness. The nature of the experience and training required to allow peer workers to be most effective and the circumstances in which they can best be included, is the subject of ongoing work in the sector. A barrier to more widespread use of peer workers is the acceptance of their role by clinicians. A program to build support among clinicians for the role and value of peer workers should be developed and implemented in collaboration with the relevant professional bodies.

Beyond these general measures to strengthen the mental health workforce, we consider that technology is a primary means to overcome those gaps in access to mental healthcare in rural, regional and remote parts of Australia that are a result of workforce shortfalls. This includes technology to enhance consumer access and technology to augment training and supervision opportunities for remote clinicians. Ultimately, attracting more workers into these areas requires either mandating their presence (such as through internships) or increasing their reimbursement. Governments have tried both options with uncertain success. The Productivity Commission considers the continuation of these measures — along with increased use of telehealth, a new online assessment and referral platform, online psychiatric assistance for GPs, clinician-supported online treatment, and devolution of service provision for Aboriginal and Torres Strait Islander people to Aboriginal Community Controlled Health Services — as the most effective ways to get culturally capable mental health services and supports to people in rural, regional and remote Australia.
Higher intensity care options for those who need them

People experiencing severe episodes of mental illness require higher intensity, often multidisciplinary care, from specialist services such as those delivered through MBS-rebated or government salaried psychiatrists and community-based clinical services.

For many people, community mental healthcare services are a first step to receive more intensive care as an alternative to being admitted to a hospital psychiatric unit, or after discharge from a psychiatric unit. These services comprise non-acute residential care within the community and ambulatory care (including hospital outpatient services and day programs, and outreach services into people’s homes or aged care facilities). Ramping up such care options within the community — so that people can live in the community, instead of being in an acute hospital bed for extended periods — eases pressures on hospitals, is an important part of filling the gap in mental healthcare for people and supports a recovery model of care as discussed below.

As a priority reform, an expansion in community ambulatory services across Australia is needed to meet the needs of — in particular — children, adolescents and older people with mental illness. While this expansion would require more community mental healthcare workers in some regions, the Productivity Commission has assessed that, with increases in time spent on consumer-related activities, there could be scope to provide some additional community ambulatory services within current levels of resourcing.

In addition to community ambulatory services, there are only about 3400 non-acute mental health beds in the public system — an estimated half the number likely to be required. Gaps in non-acute services in communities lead to avoidable hospital admissions. Increasing the number of non-acute beds would therefore improve the path of care for individuals in need. Individuals who are best treated in the community would face fewer delays in discharge from hospitals, and as acute inpatient beds in hospitals become available, this would reduce waiting times in EDs. Increasing the number of non-acute mental health beds to meet population needs, would come at an initial net cost to Governments but is expected to reduce the costs of healthcare over time (through lower use of acute inpatient beds) and improve mental health outcomes for people (particularly where these beds are in the community). Accordingly, each State and Territory Government should provide sufficient residential care within their communities to accommodate demand from those with mental illness, as an alternative to admitting people into, and/or retaining them within, hospital acute care.

Not all hospitalisations are avoidable; inpatient beds will be needed by some people experiencing severe episodes of mental illness. Areas of high population growth may need to increase their number of acute inpatient beds in order to meet demand, even after filling gaps in non-acute services. Lack of mental health inpatient beds for children and adolescents seems to be a particular shortfall in some States and Territories. All States and Territories should provide child and adolescent mental health beds that are separate to adults and configure mental health wards to allow gender segregation. Where it is not possible to provide these beds in public hospitals, State and Territory Governments should contract with
private facilities, or if suitable given the individual’s condition and their home environment, provide care as hospital-in-the-home or day programs.

**Improve mental healthcare outcomes for people**

The extent to which mental healthcare is delivering improved outcomes for people is determined by those who experience the care, not by those who provide it. Quality outcomes encompass not just the effectiveness of treatment received but aspects such as the way treatment is delivered to an individual, the extent to which treatment addresses the longer term recovery needs of the individual within their community, the adverse consequences that treatment may impose on an individual, and treatment of comorbid conditions. Consumers, families and carers who participated in the Inquiry made it apparent that there are significant shortfalls in the quality of outcomes delivered by Australia’s mental health system.

Priority reforms to improve mental healthcare outcomes are: (i) adoption of family and carer inclusive practices; (ii) rigor and clarity in medication prescribing practices; and (iii) commitment to reducing the life expectancy gap for people with severe mental illness and comorbid conditions.

**Focus on personal and relational recovery**

Recovery-oriented mental health services — embracing the concept of the personal recovery of an individual within their family, carer, community and cultural context, rather than a narrow focus on clinical recovery — has been endorsed by Australian health ministers. But it is not yet evident in the care received by people. The wellbeing of people with mental illness and their families and carers are interdependent; mental illness can affect the quality of relationships, which contributes to social isolation and impedes recovery.

Families can hold a lifetime of information on family members who have mental illness, which clinicians typically ignore in forming a diagnosis and care plan for people. This hampers clinician’s own capacity to effectively help the individual in their recovery. Clinicians who see themselves as an ‘advocate’ for their patient, but deal with only the ‘symptoms’ that the individual reveals to them, and/or are dismissive of the concerns of the individual’s family and carers, are not supporting the personal recovery of the individual.

The mental health system also ignores the effects that a person’s mental illness (and the attitude of clinicians) has on carers and family — to the system’s detriment. An effective carer is one who feels informed and secure — a distressed or exhausted carer is not well-placed to support a person’s recovery.

Information on the outcomes of mental health service provision should be collected from people at the time that services are delivered, and publicly reported to assist in moving healthcare provision toward a person-centred delivery approach. As a **priority reform**, the Australian Government should extend MBS-rebates for psychologists and other allied
mental health professionals to include consultations with carers and family members. This has the potential to substantially improve mental health outcomes for both the consumer and their consulted carer and family members.

Reduce the adverse consequences of mental health treatment

We heard distressing evidence in the Inquiry about the side effects that some people experience with some mental health medication, including dramatic weight gain, disabling lethargy and increased suicidality. (Reducing the adverse consequences faced by people who face involuntary detention and treatment due to mental illness are discussed later below.) Australians are the equal third most frequent users of anti-depressants among OECD countries; yet for many mental health conditions, psychological therapy is at least as effective as medication, except without the adverse side-effects.

Person-centred care means not only that people would be provided with the relevant information about any medications they are prescribed, but that they would be provided with this information prior to deciding whether medication or some other form of treatment is right for them. As a priority reform, clinicians offering mental health medication as treatment should be required to inform the consumer of the side effects prior to prescribing and offer alternative non-pharmaceutical treatment options.

The clinical benefits of many mental health medications (particularly for conditions that are not severe) and the long term physical and mental health outcomes for people who use them, are disputed, with severe side-effects in some population subgroups and substantial over-prescribing for others. More research focused in these areas, and uptake of its resulting lessons among treating clinicians, could generate significant improvements in mental healthcare treatment outcomes.

Target the life expectancy gap for people who have both mental and physical illnesses

Physical ailments are more common when a person has mental illness and can contribute to early death. The link goes both directions, with mental illness (and often the medication taken for it) contributing to physical poor health, and physical illness contributing to mental illness. Compared to people without mental illness, those with mental illness are significantly more likely to have respiratory disease, type 2 diabetes, cardiovascular disease, some types of cancers, chronic pain, osteoporosis, and are more likely to be overweight or obese.

One Australian study estimated that physical illnesses cause almost 80% of the gap in average life expectancy between people with a severe mental illness and the general population, compared with 14% of the gap being due to suicide. As a priority reform that could substantially increase the quality of life for people with mental illness, Governments should commit to an explicit target to reduce the gap in life expectancy between people with severe mental illness and the general population, with an implementation plan to reach the target and annual monitoring.
As part of addressing the gap in life expectancy, Governments should also implement all initiatives in the widely supported Equally Well Consensus Statement developed by the National Mental Health Commission. This includes requiring all mental health services to screen for physical health conditions that people with mental illness are at higher risk of, and either provide or refer people to other services for early intervention and/or treatment of these conditions.

Substance use comorbidity is common for individuals with some types of mental illness, and a large proportion of people who present for substance use treatment display symptoms of mental illness. However, people with substance use comorbidities often do not receive adequate care for both conditions. Governments should ensure that mental health and drug and alcohol services address both mental health and substance use needs, by directly providing services, or referring the person to other services where appropriate.

Eliminate stigma in the way care is delivered

The stigma that people with mental illness can experience in the community extends into healthcare and can significantly affect people’s recovery. While most people with mental illness report being treated positively by health professionals, a significant minority (about one in ten) consider they have experienced discrimination from a health professional. This can manifest as disrespectful or condescending behaviour from the health professional, treating people with mental illness dismissively, or disbelieving or judging them. Such action by health professionals discourages people from seeking help when they need it, alters the type of help they seek and the symptoms they describe, increases levels of psychological distress, lessens adherence to treatment regimes, and exacerbates mental illness. It can also contribute to diagnostic overshadowing — with the health professional neglecting people’s physical health once they have been diagnosed with mental illness.

While there is a lack of quality evidence about effective stigma reduction interventions, there is potential to improve outcomes for people through well-designed interventions targeting the interactions between health professionals and people with mental illness. Accordingly, the training and professional development of health students and practising health professionals (both within and outside mental health) should include interaction with people with a mental illness outside of a clinical environment (such as the Recovery Camp model for alternate clinical placements for students).

**Care continuity and coordination**

**Care plans**

Some Australians with episodic or persistent severe mental illness have complex needs arising from their illness. In particular, their mental illness can be accompanied by: physical health conditions that require other clinical services; impaired psychosocial functioning due to the severity of the mental illness; and extreme social adversity. People with complex needs typically
require care from a team of clinical and/or non-clinical service providers. A single care plan should be introduced for these people to help coordinate treatment.

The coverage of the plan would vary from person to person according to their needs at particular points in time, but could include a plan to address aspects such as mental healthcare, physical healthcare, cultural and spiritual needs, psychosocial support needs, housing needs, community inclusion needs, the role of their carer or kinship group, and reintegration into education or the workforce. The effective development and operation of the care plan would necessitate: a sharing of patient information between professions that is not currently evident (even within the health sector); someone to have responsibility for plan development, follow-through and updating the plan; and financial arrangements that incentivise this to occur. An effective care plan would be based around the individual, their treatment needs and their preferences. Many people with complex needs already have at least one care plan. So for many, this reform option would be about ensuring consistency and coordination between these.

**Care coordination**

Improving outcomes for people with complex needs requires that they have access to the services needed (both clinical care and broader psychosocial and community supports), when they are needed, with effective information flows and coordination between clinicians and other services. People with severe mental health illness and the most complex needs (approximately 354 000 people) should, as a **priority reform**, have both a single care plan developed with and for them and a care coordinator provided to oversee the implementation of the plan. While 64 000 of these people are expected to receive services through the National Disability Insurance Scheme (NDIS), the remaining 290 000 people should also be provided with care coordination. The Productivity Commission estimates that only 75 000 people from this group are receiving psychosocial supports from other Australian, State or Territory Government-funded programs, and the number with adequate care coordination is unknown. Persisting gaps in support services can lead to a deterioration in mental health and, potentially, unnecessary hospitalisation.

Care coordinators would work directly with the consumers, their families and carers, clinicians (or clinical coordinator) and providers from other sectors, to establish the types of services needed and provide access to those services. The level of support would be adjusted according to need — for people with the most complex needs, the care coordinator should bring together a care team, comprising the various services the individual requires, and put in place a detailed plan for their support. For those admitted to hospital, care coordinators would be linked in with the hospital discharge planning, to provide continuity of care.

There are already some government funded programs offering care coordination services to people with a mental illness. However, the coordination of care is often ad hoc, relies on personal contacts of individuals rather than established networks, is delivered by care coordinators of variable competency, and is provided under short-term funding arrangements that encourage premature closure of cases and relapse in mental illness. And while not all
consumers who would benefit from a care coordinator have access to one, some people have multiple care coordinators with overlapping responsibilities.

Efficient and effective care coordination would replace many of these services and would partly be based on existing funding. Furthermore, expenditure for care coordination could be expected to lead to cost savings elsewhere in the health system, as demonstrated by past programs, where care coordination led to reductions in hospital admissions.

Evaluations of other smaller-scale models have suggested that care coordinators should be recruited from outside of the existing mental health workforce, hold vocational qualifications, and be defined more by their ability to relate to their clients than by other skills. Our recommended reforms would not require a clinical background for care coordinators.

3. Improve people’s experience with services beyond the health system

<table>
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<th>PRIORITY REFORMS</th>
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<td>• Meet demand for community support services that help people with mental illness recover and live well in the community</td>
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<td>• Commit to no discharge from care into homelessness</td>
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<td>• Increase assistance for police responding to mental illness related incidents</td>
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There are a range of services beyond the health sector that support people (often those with severe mental illness) to live meaningful and productive lives within the community, including psychosocial supports and housing services. The justice system also plays an important role in the lives of some people with mental illness — for those who interact with police as first responders in a crisis, those who commit offences or are victims of crime, and those who confront legal issues associated with their mental health treatment. These services often are not delivered in ways that account for the nature of mental illnesses, impeding recovery or contributing to a relapse in illness.

This section focuses on the issues and priority reforms in: psychosocial supports for people with mental illness; housing services; and interactions with the justice system. Services related to further education and employment are discussed separately below.

**For people needing psychosocial supports**

Recovery from mental illness necessarily involves recovery not just of the individual alone, but recovery within their family and community context. For all people with mental illness, social inclusion — the capacity to live contributing lives and participate as fully as possible in the community — is a necessary, but too often neglected, part of a recovery plan.
Psychosocial supports are a key facilitator of recovery, can help alleviate some risks of illness relapse and support people as they develop skills to self-manage the effects of variations in their mental health. Services typically provided under this label include respite services, building social skills and relationships in a culturally supportive way, assistance with transport, tenancy or household management and finances, and coordination and support in complying with clinical treatment needs.

Approximately 690,000 people with a mental illness are estimated to be likely to benefit from access to psychosocial support services, were they available to them (about 290,000 of these people have a severe and persistent mental illness). But there is a massive gap in Australia’s provision of psychosocial supports. Only about 34,000 people with a primary psychosocial disability receive psychosocial supports under the NDIS (just over 50% of those expected to be eligible once the scheme completes its roll out); and about 75,000 people receive psychosocial support directly from other Australian, State and Territory Government-funded programs.

The gap is a result of a ‘perfect storm’ of problems within the sector, including: a large but unknown number of small-scale, poorly defined and measured services; little transparency around who is delivering what supports to which people and what outcomes they achieve; confusing and inconsistent eligibility criteria for some supports with delays in application approval; very short funding cycles with funding provision that is unrelated to the number of people receiving support; a lack of job security and consequent difficulty retaining high quality staff; and a loss of funding and staff to NDIS funded services.

Pschosocial supports to meet regional demand

The recommendations of this Inquiry aim to rectify these issues and create a coherent system of regional funding for psychosocial supports designed in partnership with, and that work for, people with mental ill-health. As a priority, the Productivity Commission recommends that regional demand for psychosocial supports for people with mental illness be estimated, with a view to expanding services to meet any shortfall. The priority afforded to this reform reflects the potential for access to psychosocial supports to improve the quality of life for a larger group of people with mental illness.

Of course, many other people who do not have mental illness would also gain from improved supports. But our recommendations here relate to those people whose psychosocial support needs arise from their mental illness. Some people with a need for psychosocial supports arising from a mental illness may not have had their mental illness formally diagnosed. Where this is the case the person should be assisted by the support service to obtain a timely assessment to verify that it is mental illness that underpins their need and that they are receiving the full range of treatment and care required. Without this, people with mental illness may miss out on the psychosocial supports they need.
Additional reforms for people receiving psychosocial supports

To enhance the continuity of care for people, Governments should extend the funding cycle length for all psychosocial support programs from what is typically a one-year contract term to a minimum five-year term and develop a transparent plan for ongoing future support provided to people with mental illness in need of psychosocial supports. For those people who are eligible for the NDIS, the psychosocial disability action plan should be fully rolled out across all NDIS sites by the end of 2020, incorporating lessons learned from the Independent Assessment Pilot into the NDIS access and planning processes.

For people needing housing services

Suitable housing — that is secure, affordable, of reasonable quality and of enduring tenure — is a particularly important factor in preventing mental ill-health and a first step in promoting long-term recovery for people experiencing mental illness. Some 16% of people with mental illness live in unsuitable accommodation (homelessness, overcrowding, at risk of eviction or of substandard quality).

Discharge people to stable accommodation

One quarter of all people admitted to acute mental health services are homeless prior to admission and most are discharged back into homelessness. While it is not always obvious that a person in hospital is otherwise homeless, there can be pressure to discharge people to free-up costly hospital beds for others needing care and a lack of suitable accommodation for discharged people to go to. Not only is an individual’s recovery challenged by unstable accommodation, but follow-up care after discharge is more difficult (which, in turn, can lead to a cycling of people back through hospital EDs). These same problems of discharge into homelessness are also evident for people with mental illness leaving correctional facilities.

There are some notable examples of hospitals with programs to avoid discharging patients into homelessness (such as the Royal Perth Hospital Homeless Team). Key elements of program success include: staff who are trained to identify at risk patients; care coordinators who make thorough discharge assessments well ahead of discharge and provide timely and assertive follow up; and ready access to transitional housing that meets the long term recovery needs of people.

As a priority reform, each Government should commit to, monitor and report on, a nationally consistent policy of not discharging people with mental illness from hospitals, correctional facilities and institutional care into a situation of homelessness. This reform offers potential for significant improvements in quality of life for people who would otherwise be homeless, and is likely to be cost effective in the longer term (evaluation of housing support worker programs, for example, found they provided benefits estimated at about $9 for every $1 invested).
Additional reforms for people with mental illness and housing needs

The costs of not adequately addressing the accommodation needs of people with mental illness is evident not just in poorer mental health outcomes but through increased expenditure in the health sector. Surveys suggest that about 30% of admitted patients (about 2000 people) in psychiatric wards could be discharged if appropriate housing and community services were available. For each individual retained in an acute hospital bed, who could be treated (at least as well) in a non-acute bed-based service, the health system is overspending (figure 7).

For those people with severe mental illness that necessitates low to moderate intensity care on a regular basis, supported housing places (integrated housing and mental health supports) in the community provide long-term housing stability, scope to actively interact with the community and provide life satisfaction. There are currently 4 600 supported housing places across Australia. But an estimated 9 000 to 12 500 additional places are required to accommodate individuals with severe mental illness who are at significant risk of housing instability. Evaluations of supported housing programs suggest improved housing and mental health outcomes for participants, with the costs of running a program offset to some extent by a reduction in the use of other relatively high cost services, such as hospitals. Each State and Territory Government, with support from the Australian Government, should address the shortfall in supported housing places in their jurisdiction for people with severe and persistent mental illness.

There are 15 000 to 19 000 people with mental illness in need of stable longer-term housing solutions. To reduce homelessness among people with mental illness, each State and
Territory Government, with support from the Australian Government, should work towards meeting the unmet demand for homelessness services. Small scale measures to address long-term housing needs of people with mental illness (in Australia and overseas) have seen significant associated reductions in use of health, justice and community services.

Some of these additional homelessness services for people with severe mental illness who are persistently homeless, should follow a Housing First approach — rapid access to long-term housing and mental health supports that is not conditional on participants becoming housing ready or engaging with support services. Several trials of Housing First programs in Australia and around the world have been effective at housing thousands of people with severe mental illness, with participants reporting improved quality of life, and reduced health service usage. In some cases, trials show a small net cost or a potential net benefit. Some Housing First programs should be tailored to particularly vulnerable population sub-groups with mental illness, including young people and Aboriginal and Torres Strait Islander people.

**For people interacting with the justice system**

The mental health system and the justice system are intertwined: the police (as first responders) are an important gateway for many people into mental healthcare; correctional facilities are a setting in which some people first come to need and receive mental healthcare; and people with mental illness are more likely than others in the community to be victims of crime and be in need of advocacy services to resolve legal problems (noting that acute mental illness is one of the few remaining conditions that allows involuntary confinement and treatment of an individual in Australia).

**Support police and people with mental illness in their interactions**

Responding to mental health related incidents occupies an increasing proportion of police time. Mental health related incidents have been reported as accounting for about 10% of police time in New South Wales, and as having increased by nearly 90% in Victoria in recent years. The interactions between police and people experiencing acute mental illness appears to vary considerably and at its worst, can be extremely traumatising to both the individual and the police involved.

Timely availability of crisis support services can prevent or reduce ED presentations and be an alternative diversion point for police and other crisis first responders. For example, in Queensland, mental health clinicians are co-located in the police communications centre, supported by an on-call forensic psychiatrist; mental health staff accompany police and provide on-site clinical interventions; and police, health and ambulance services partner to identify issues, discuss complex cases and develop preventative interventions, alternative referral pathways and review procedures.
To support both individuals with mental illness when interacting with responding police as well as the police workers, a systematic approach that incorporates mental health expertise at multiple stages of police interaction should be implemented as a priority reform. This includes potentially embedding mental health professionals in emergency communication centres and as part of co-response teams (with police and paramedics) attending to incidents. The priority of this reform reflects the potential for improving outcomes for a large number of people experiencing acute episodes of mental illness, their families and carers, and the police workers they interact with.

Additional reforms for mental healthcare at all stages of the justice system

Among those who formally enter the justice system, people with mental illness are overrepresented at every stage. Among police detainees, about 43% of men and 55% of women were reported to have a previously diagnosed mental disorder; while about 40% of prison entrants have been told they have a mental health disorder (including substance use disorder) at some stage in their life — double the rate among the general population. Rates of mental illness are even higher for particular demographic groups within correctional facilities, such as women and Aboriginal and Torres Strait Islander people. While the majority of prisoners with mental illness spend relatively short periods of time in custody before returning to the community, inadequate healthcare in correctional facilities and poor transition support services are likely to raise the burden on the community healthcare system and increase recidivism.

An early intervention approach should be taken to address the over-representation of people with mental illness across all stages of the criminal justice system. In particular, people with mental illness who are at high risk of interaction with the justice system should be identified and provided with mental health support that facilitates their inclusion in the local community and reduces their risks of offending. Some States and Territories have programs in this area already, and they should be endorsed more broadly. For example, NSW’s multi-agency Youth on Track program for young people aged 10-17 years who are at medium to high risk of offending, offers support in physical and mental health, education and employment, to attempt to reduce contact with the criminal justice system.

Comprehensive mental health screening and assessment of all individuals (sentenced or awaiting sentencing) should be undertaken on admission to correctional facilities, and on an ongoing basis where mental illness is identified. Those who have an ongoing mental illness should, prior to release, be connected with a relevant community-based service (and care information shared with consent with this service) to enable individuals with mental illness to receive continuity of care post-release. In the case of Aboriginal and Torres Strait Islander people, services within correctional facilities and post-release care should be culturally capable. More generally, the Australian Commission on Safety and Quality in Health Care should review how the national safety and quality standards that apply in the health sector can be implemented in correctional facilities.

For the benefit of those people with mental illness who have further contact with the justice system (as either offenders or victims of crime), State and Territory Governments should
continue to develop and implement Disability Justice Strategies to ensure the rights of people with mental illness are protected in their interactions with the justice system.

**Advocacy for people facing mental health tribunals**

Legal representation is an important protection for those people who face involuntary detention and treatment due to mental illness. Such people are among the most vulnerable in our community. For example, people who are represented when appearing at a mental health tribunal have been found to receive a longer hearing, shorter periods of compulsory treatment orders, and have a substantially lower likelihood of being subject to electro-convulsive treatment. However, State and Territory legal assistance providers have reported that they have inadequate resources to represent all but a small proportion of clients appearing before mental health tribunals.

While there are many legitimate claims on legal aid budgets, we consider that representation when facing involuntary detention and treatment due to mental illness is a priority. To meet this need, governments should provide a grant to legal assistance providers specifically for assisting with mental illness-related legal issues. This could be modelled on the approach taken under the NDIS, whereby legal aid commissions apply to the relevant government department for grants to provide legal assistance in cases outside of the ordinary legal aid guidelines, with consideration of the applicant’s capacity to self-represent or obtain other legal assistance. We were unable to quantify the benefits of this reform, but we consider its implementation to be a priority for ensuring basic human rights for people who face involuntary detention and treatment.

**4. Increase people’s participation in further education and work**

This section focuses on the issues and priority reforms for: participation of young adults in higher education and/or work; mentally healthy workplaces; and income support and employment services. 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. Therefore, successful interventions to address mental ill-health in younger people — who tend to experience poorer mental health than other age groups — can also improve the mental health of the workforce and the broader population, in the future.
Economic participation of the young adult population

The years of 16 to 24 are an important transition point in a person’s life regardless of their mental health. Many are studying, but some are also (or alternatively) working — usually on a non-permanent basis in industries such as retail, tourism and the food services sector that are particularly vulnerable to external economic shocks and sharp changes in the need for employees.

Of all age groups, young adults have the highest rates of mental illness — 26% of 16-24 year olds have an anxiety, mood or substance use disorder — and report relatively high rates of psychological distress.

For tertiary students with mental ill-health

Mental illness in tertiary students — more so than physical health problems — is associated with poorer engagement in education, lower average grades, and higher drop-out rates. Psychological distress has been found to be particularly high among international undergraduate students, and under-reporting (associated with differing cultural views of mental illness) is a significant problem.

The level and types of mental health support offered to students varies substantially between tertiary education providers. At a minimum, tertiary institutions should have a student mental health and wellbeing strategy as a requirement for their registration.

Online services for student mental health should be expanded to meet student needs and include the collection of de-identified data on student mental health to enable ongoing improvements in the effectiveness and relevance of mental health supports. Institutions should arrange for their international students to have private healthcare insurance that includes adequate coverage for any required mental health treatment.

For young adults who are disengaged

About 12% of Australia’s 15 to 24 years olds seeking help for mental health problems were not engaged in employment, education or training.

For those young adults with mental illness who are disengaged from both education and work, the Individual Placement and Support (IPS) program (involving a rapid job search, followed by on-the-job training and ongoing support from case workers) may be effective in helping them re-engage with either education or work. The program has been found very effective overseas for adults with severe and complex mental illness. Preliminary outcomes of the Australian trial of IPS for youth with less severe mental illness suggest that a youth focused IPS would need to take account of how the employment support needs of young people differ from those of adults, in particular their education and training needs, and their limited employment history and experience.
Equip workplaces to be mentally healthy

There are particularly 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 a number of avenues through which employment can improve mental health:

- working can give people a sense of identity, and provide regular interaction and shared experiences with people outside of an individual’s immediate family
- the collective effort and purpose of work can provide a sense of personal achievement
- structured routines associated with work help give direction to the day and promote the need for prioritisation and planning
- increased employment of people with mental illness can reduce the stigma of mental illness throughout the workforce.

The lost opportunities and missed chances experienced by those with mental illness to work productively and fruitfully creates economic costs for the individual (in terms of lost income) and the community (in terms of lost output or reduced productivity). These costs are particularly high because the effects of mental illness fall mainly on people during their working lives, as opposed to the burden of most other diseases, which commonly affect older people.

About 2.8 million working Australians have mental illness, requiring time off work to maintain their wellbeing; a further 440,000 working Australians are carers of someone with mental illness. People with mental ill-health took an average of 10 to 12 days per year off work due to psychological distress. Estimates for the cost of workplace absenteeism due to mental ill-health were up to $10 billion per year. Mental ill-health can lead to presenteeism, affecting a person’s ability 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 per year because of their psychological distress — costing up to $7 billion per year. As with physical ill-health, the costs of mental ill-health can go beyond just the immediate loss in activity of the person concerned, but also extend to impacts on the productivity of their work colleagues.

There is a growing focus on the role businesses can play in maintaining the mental health and wellbeing of their workforce — particularly the potential high returns to employers in terms of lower absenteeism, increased productivity and reduced compensation claims from investing in strategies and programs to create mentally healthy workplaces. While businesses already have some obligations to ensure the (physical and mental) wellbeing of their staff, we recommend ways to strengthen these and provide additional clarity on what is expected. For the most part, businesses want to have a mentally healthy workplace, they just need to know what evidence-based measures they should take to achieve this.
Explicitly include mental health in workplace health and safety

Psychological hazards in the workplace receive less attention than physical hazards, as they are often harder to define and investigate. However, such hazards, including workplace bullying, are increasingly identified as significant contributors to psychological injuries. For an employer, meeting their duty of care to ensure psychological health and safety in a workplace that is also the employee’s home — as was increasingly the case during the COVID-19 pandemic — may present particular difficulties and challenges.

Workplace mental health and productivity would be improved by making psychological health and safety as important as physical health and safety in practice. The same risk management approach that applies to physical health and safety (an approach familiar to employers and employees) should be applied, as a priority, to psychological health and safety. This reform would not only improve the mental health of workplaces, but is estimated to generate savings (as reduced presenteeism and absenteeism) in excess of the cost of implementing the reform.

Workers compensation schemes to fund clinical treatment

While only about 6% of all workers compensation claims in Australia are for work related mental health conditions, the cost of these claims is typically about 2.5 times the cost of other workers compensation claims, involve 2.5 times more time off work (the median time off work for mental health related workers compensation claims is 16 weeks, compared with 6 weeks for other claims), and are much less likely to be accepted.

In some workers compensation schemes, there can be delays in providing treatment while liability is being determined, which in turn delays recovery and return to work. Over recent years, occupations with the most work-related mental health claims have been police, fire fighters and defence force members (9% of all serious claims), school teachers (8%), followed by health and welfare support workers (6%) (figure 8).

To get people back to healthy lives, including working productively, as quickly as possible, early identification and treatment of mental illness should be encouraged by amending, as a priority, workers compensation schemes to fund clinical treatment (including any required rehabilitation) for all mental health related workers compensation claims. This should be provided 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 who are self-insurers. There would be no compensation under this provision for loss of income.
Figure 8  **Mental stress related workers compensation claims**

**Mental stress claims as a share of all serious accepted claims (2017-18)**

![Map showing mental stress claims by industry](image)

**Incidence of serious accepted mental stress claims by selected industry**

<table>
<thead>
<tr>
<th>Industry</th>
<th>Claims per 1000 employees (5 year average to 2017-18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public administration and safety</td>
<td>1.9</td>
</tr>
<tr>
<td>Health care and social assistance</td>
<td>1.1</td>
</tr>
<tr>
<td>Education and training</td>
<td>1.0</td>
</tr>
<tr>
<td>Transport, postal and warehousing</td>
<td>0.6</td>
</tr>
<tr>
<td>Retail trade</td>
<td>0.3</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>0.3</td>
</tr>
<tr>
<td>Construction</td>
<td>0.2</td>
</tr>
<tr>
<td>Australian total</td>
<td>0.6</td>
</tr>
</tbody>
</table>

**Increase in costs per employee of providing clinical treatment for 6 months**

<table>
<thead>
<tr>
<th>Industry</th>
<th>Cents per worker in 2017-18 (2019 dollars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care and Social Assistance</td>
<td>87c</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>65c</td>
</tr>
<tr>
<td>Retail</td>
<td>63c</td>
</tr>
<tr>
<td>Construction</td>
<td>33c</td>
</tr>
<tr>
<td>All Industries</td>
<td>57c</td>
</tr>
</tbody>
</table>

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*a* Serious claims are those that resulted in at least a week’s absence from work.  
*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.
We estimated that this provision would cost in the order of 0.6% of the total annual premium revenue received by insurers. At the enterprise level (were insurers to pass on the cost of this), the provision would translate to a very small annual additional cost per worker. Given the very small additional costs involved, coupled with the significant benefits achievable through early intervention and early return to work, funding treatment through workers compensation schemes would be an effective approach to improving outcomes for mental health related workers compensation claims. This reform would not only get people experiencing mental illness the help they need earlier, but it is estimated to increase the value of economic production for those businesses that offer such support to their employees.

**Additional reforms to motivate improved workplace mental health**

Complementing these priority reforms, workplace health and safety agencies should develop and implement codes of practices to assist employers, particularly small employers, to better manage psychological risks in the workplace. They should also monitor (potentially through industry associations) and build a better evidence base on employer-initiated interventions and advise employers of interventions that would likely be effective in protecting and improving the mental health of their employees. This will bring clarity for employers, in what is currently a highly complex web of legal requirements and expectations, and help them and their employees gain the benefits of reduced absenteeism and presenteeism in their workplace.

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, workers compensation schemes should provide for more flexibility in premiums.

**For people with mental illness who are searching for work**

Although most people with mental illness indicate that they want to work, some find it nearly impossible to either secure a job or retain it while experiencing mental illness.

As a **priority reform** for people with mental illness, Individual Placement and Support (IPS) programs, like those mentioned above for young adults, should be rolled out on a staged basis for all job seekers with mental illness, allowing for the incorporation of lessons learned at each stage, across Australia. Approximately 40 000 people with mental illness are estimated to potentially benefit from participation in IPS. The expenditure to implement IPS is estimated to be lower than the substantial healthcare cost savings, a reduction in costs associated with Disability Employment Services, and some additional employment income.

We identified additional reforms that should also be considered for people with mental illness who participate in Australia’s current employment support services — jobactive, Disability Employment Services and the Community Development Program. These services tend to place participants with mental illness (including those with complex needs) into programs that offer limited assistance with job searching and penalise participants when they
fail to complete mutual obligation requirements, where required. The assessment tools for these services should be reviewed, with consideration given to adding a mental health diagnostic instrument to the job seeker classification instrument and supplementing the employment services assessment with a personal and social performance measure.

The Australian Government should also ensure that employment service providers are meeting their obligations to provide personalised job plans that are useful to the individual, targeted at job seekers with complex needs. This should include extending the period of time that participants have to consider and propose changes to their job plan and greater flexibility in the application of the targeted compliance framework for those participants experiencing mental illness.

For those people with mental illness in need of income support

Australia’s income support system would ideally enable people with episodic mental illness to flexibly transition on and off income support as their functional capacity to earn income changes with their health. Similarly, those who care for someone with mental illness should have access to income support that is flexible to their circumstances. The episodic nature of many mental illnesses can mean that study or work that is on a part-time rather than full-time basis not only remains possible but is essential to a person’s recovery and continued social inclusion.

Approximately 191,000 people with a mental illness receive income support through the JobSeeker Payment or Youth Allowance. A further 259,000 people receive the Disability Support Pension (DSP) because of a psychological or psychiatric disability — this is about one third of all DSP recipients, although one estimate suggests that over half of all DSP recipients have a mental illness. And 76,000 Australians receive Carer Payment to support someone who has a psychological or psychiatric disability, while a number of other carers of people with mental illness receive the Age Pension, JobSeeker Payment or Youth Allowance.

While DSP recipients with psychological or psychiatric disabilities may work while continuing to receive a benefit, very few do so. Many recipients have a limited capacity to work, but for those who do, the weekly hour limit above which the DSP is not payable should be increased from 30 hours to 38 hours, to reduce any disincentive to engage in employment.

To better meet the needs of carers whose care recipient has a mental illness, the Australian Government should amend eligibility criteria for the Carer Payment and Carer Allowance to reflect that: the nature of care provided for someone with mental illness is not necessarily as ‘constant’ as that for a physical illness, can vary substantially from day to day, and is less likely to relate to the care recipient’s ‘bodily functions’. To provide more flexibility for the carer in undertaking their own economic and social activity, the restriction on hours that the carer can work should be evaluated over a month rather than each week, and the restrictions on study and volunteer activity should be removed.
Use of insurance to enable ongoing economic and social participation

Given the large number of people who experience mental illness, the negative impact that mental illness has on capacity to earn an income, and the extent to which insurance is used to offset personal financial risk, it is not surprising that the insurance sector is particularly relied on by some people with mental illness. Access to insurance — including life insurance, income protection insurance, temporary or permanent disability insurance, private health insurance and travel insurance — that covers mental illness has been raised as a concern during the Inquiry. One survey found that of those who identified as a mental health consumer and had applied recently for income protection insurance, only 8% had received the product without exclusions or additional premiums.

Insurer practices pertaining to mental health — such as blanket exclusions, the extent to which differences between different types of mental illness are taken into account in assessing risk, information provided to applicants and claimants, and insurer access to clinical records — should be independently reviewed.

5. **Instil incentives and accountability for improved outcomes**

<table>
<thead>
<tr>
<th>PRIORITY REFORMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Develop implementation plans for national strategies that integrate healthcare and other services</td>
</tr>
<tr>
<td>• Commit to regional planning, decision making and commissioning, with systemic cooperation and creation of new commissioning agencies if outcomes not improved</td>
</tr>
<tr>
<td>• Expand the remit and independence of the National Mental Health Commission</td>
</tr>
<tr>
<td>• Consumer and carer participation and advocacy in all aspects of the mental health system</td>
</tr>
<tr>
<td>• Strengthen evaluation culture, focusing on outcomes that matter to people and reporting at service provider level</td>
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</tbody>
</table>

To reform Australia’s mental health system we need to reform the way our governments manage that system.

A range of the reforms canvassed in this report, including a new national digital mental health platform for rigorous assessment and referral, and the integration and coordination of support services to provide seamless care for people, necessitate institutional change within and between each tier of Australia’s governments. A whole-of-government approach, whereby different tiers of government work together to improve the mental health system, would be required, with the Australian and the State and Territory Governments held jointly accountable for the outcomes of the mental health system for people (figure 9).

This section focuses on the priority reforms to: deliver integrated care for Australians with mental illness; motivate the funding and commissioning of services that are needed locally by people; and inject accountability to deliver improved outcomes for people. We were
unable to quantitatively assess the net benefits of reforms in these areas, but consider many of these to be important underpinnings of a more flexible and integrated mental health system for Australia’s future. In some cases, reforms could be expected to significantly improve the efficacy of expenditure in the mental health system.

Arrangements to lock in integrated care

As the above discussion makes clear, creating a person-centred mental health system requires coordinated reform beyond health. It requires the health system to work together with community and Indigenous services, social security, public housing, education, justice and employment relations.

A number of the recommended reforms detail ways to enhance service integration on the ground. But the only way to make these arrangements endure beyond current players and government interests is to reform the underpinning governance and funding arrangements that create incentives and accountability.

The Productivity Commission recommends, as a priority reform, a whole-of-government commitment to a new national mental health strategy. This strategy should comprehensively integrate the roles played by health and non-health sectors, identifying (in collaboration with consumer, carer and cultural diversity representatives) necessary action by not just health agencies, but also by relevant non-health agencies in the Commonwealth and the States and Territories. Additional to this commitment, the Australian Government should, as a priority reform, expedite the development of an implementation plan for the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2017–2023.

An important step in the implementation of such a strategy would be the creation of an interjurisdictional special purpose mental health council (SPMHC). The SPMHC would comprise Australian, State and Territory Government health (or mental health) ministers plus ministers of selected social policy portfolios on 18 month rotations. The SPMHC would report annually to Governments on progress against the National Mental Health Strategy and prioritised actions, in integrating mental healthcare between health and non-health agencies.

Reforms to funding and commissioning

Current funding arrangements in the mental health system contribute to persistent gaps in care (including the missing middle described above), inefficient use of taxpayer funds, and poor consumer outcomes. For example, in healthcare, funding arrangements mean that local hospital networks have few incentives to minimise hospitalisations and avoid repeated presentations to EDs. Beyond the healthcare system, funding for other services such as psychosocial supports is fragmented and based on short contract cycles, which make it harder to deliver quality services on a continuous basis to people. Similarly, mental health
interventions delivered in schools and other types of community services are funded through a very wide range of programs, leading to duplication, inefficiency and unnecessary red tape.

To deliver improved outcomes for people involves both addressing the current gaps in care and investing in prevention and early intervention to reduce the future costs and generate long term economy-wide benefits.

In working toward a person-centred mental health system, Governments should reform how they fund and commission mental health services. Reforms aim to improve outcomes for people by:

- creating effective incentives for both intra-government and inter-government coordination and cooperation with clear responsibility and accountability for consumer outcomes
- regional decision making, founded on comprehensive regional level planning of needs and services to eliminate gaps in care.

**Cooperative regional planning and service funding to address care gaps**

In the Inquiry draft report, we presented two options for how to reform mental health funding and commissioning arrangements. The first — the ‘Renovate Model’ — was largely a continuation of the current approach, with some changes that would give more flexibility to PHNs. The second — the ‘Rebuild Model’ (the Productivity Commission’s stated preferred approach) — was to have most mental health funding held in regional funding pools controlled by each State and Territory Government and administered by Regional Commissioning Authorities (RCAs). The RCAs were intended to overcome unnecessary and inefficient care discontinuities, duplication and gaps that would otherwise persist at the interface between Australian Government and State and Territory Government responsibilities.

Feedback on these options was mixed and we concluded that no single approach was likely to work in all States and Territories, given the diversity of positions they are starting from. Instead, we recognise that each State and Territory would need to assess for itself the trade-offs it needs to make to set it on a path to achieving the goals for improved funding and service commissioning.

In this final report, the Productivity Commission recommends a flexible approach that would allow each jurisdiction — States, Territories and the Commonwealth — to determine as a **priority reform**, if, and how, planning and service delivery at a regional level can occur cooperatively with current PHN–LHN groupings. If this can occur, then it should be tried and tested. If such cooperation is not possible, or if it is tried and proves unsuccessful in driving improved consumer outcomes, then the Productivity Commission considers that the creation of RCAs (under the State or Territory Government), with no involvement by PHNs in mental health commissioning, offers the best chance for getting people the services that they need at a regional level.
Some States or Territories, particularly those where existing PHN-LHN relationships are poor, may seek to create RCAs immediately, recognising that this is their best path to improve mental health and psychosocial support service commissioning. Other States or Territories with strongly cooperative PHN-LHN groupings may prefer to retain existing institutional structures that are working for consumers. However, the option of establishing RCAs to administer pooled mental health funding from both tiers of government and to commission mental health and psychosocial support services should remain available to any State or Territory at any stage. In order to incentivise cooperation and reform, all Governments should commit to the creation of RCAs in the event that PHN-LHN cooperation does not achieve sufficiently improved outcomes within an agreed time period.

Separate (and additional) to the decision about retaining existing PHN-LHN groupings or creating RCAs, considerable reform is necessary by all Governments to deliver improved outcomes.

From the Australian Government:

- Guidance on evidence-based practices, public transparency on aspects such as PHN activities, funding, compliance with assessment and referral requirements and with developing and implementing regional plans cooperatively with LHNs, are essential for accountability and ongoing improvement in outcomes, and for credibility on a commitment to improving mental health outcomes.

- Also necessary would be reforms to the way services are commissioned through PHNs. All currently funded services should be required to publicly demonstrate to their region’s PHN how they contribute to filling service gaps identified in the relevant joint regional plan. Ongoing funding for these services would then be a decision for the PHN, subject to ministerial approval. In the case of mental health services for Aboriginal and Torres Strait Islander people, Aboriginal Community Controlled Health Services should be identified as preferred providers.

From State and Territory Governments:

- Extending activity-based funding to community ambulatory mental health services would both increase their efficiency (by motivating a higher proportion of time to be spent on consumer-related activities) and reduce incentives of local hospital networks to prioritise hospital-based care.

- Increased transparency on funding to, and outcomes delivered by, non-government organisations (NGOs) and other providers of mental health services would also promote improved outcomes for people and represent a necessary first step to delivering integrated services for people.

- For those States or Territories that establish RCAs, the above recommended funding and commissioning reforms for PHNs should similarly be applied to RCAs.

These arrangements should be underpinned by a new intergovernmental agreement. The National Mental Health and Suicide Prevention Agreement would clarify the roles and responsibilities of the Australian Government and State and Territory Governments and establish funding commitments by both levels of government.
**Reforms to governance of the mental health system**

**Strategy**

**Aim:** Commit to a more strategic and cross-portfolio approach to mental health that prioritises prevention, early intervention and recovery.

**Action:**
- Develop a new whole-of-government *National Mental Health and Suicide Prevention Strategy* that aligns the collective efforts of health and non-health sectors.
- Establish a *Special Purpose Mental Health Council* comprised of health or mental health ministers plus ministers of selected social policy portfolios to facilitate mental health reforms across health and non-health portfolios.
- Expedite the development of an implementation plan for the national strategy for improving the social and emotional wellbeing and mental health of Aboriginal and Torres Strait Islander people.

**Funding and commissioning of services**

**Aim:** Promote efficient use of funds underpinned by clear government responsibilities and regional decision-making.

**Action:**
- Bolster cooperative arrangements between PHNs and LHNs through rigorous joint regional planning and stronger oversight.
- If PHN–LHN cooperation fails to improve outcomes, State and Territory Governments to establish *Regional Commissioning Authorities* on a State/Territory-specific basis to pool mental health funds from both levels of government and undertake all commissioning.

**Monitoring, reporting and evaluation**

**Aim:** Develop a self-learning mental health system by improving the evidence base for policy and program development, strengthening accountability for implementation and building a strong evaluation culture.

**Action:**
- Give the *National Mental Health Commission* statutory authority to:
  - monitor and report on progress towards achieving system-wide outcomes across health and non-health portfolios
  - monitor and report on PHN–LHN cooperation or development of Regional Commissioning Authorities
  - lead transparent evaluation of significant mental health and suicide prevention programs funded by governments, including non-health related programs.
- Task the *Australian Institute of Health and Welfare* to lead development of mental health services data and gap analyses at a State, Territory and national level.
Monitoring, evaluation and reporting for improved outcomes

Improved monitoring, reporting and evaluation are needed to drive the shift to a person-centred, outcomes-focused mental health system that is flexible to Australia’s mental health needs. Key aspects of this are instilling accountability for outcomes and an expectation of continuous improvement in service and program delivery for people.

Require accountability for outcome improvements

National leadership, guidance and coordination of the mental health system needs to be strengthened and a culture of transparent evaluation created. Central to this, the National Mental Health Commission (NMHC) should, as a priority reform, be afforded statutory authority status as an interjurisdictional body. The NMHC would be tasked with:

- leading the development of the new national mental health strategy and the next national mental health action plan
- monitoring and reporting on progress with joint regional planning and the implementation of plans through cooperative regional commissioning
- reporting independently on whole-of-government implementation and performance of mental health reforms, including system performance and efficacy, and the priority reforms of benchmarking mental health outcomes against agreed targets, and consumer and carer involvement and advocacy
- creating an evaluation culture in which evaluations and a culture of learning and improvement would be embedded into program design and regular reporting, including before interventions are funded and scaled up, during implementation and when their intended impacts are realised
- undertake transparent evaluation of prioritised mental health and suicide prevention programs that are funded by the Australian, State and Territory Governments, and other programs that have strong links with mental health outcomes, including those in non-health sectors.

Rigorous evaluations of programs and policies in the mental health system are very important — and very rare. Evaluation should be embedded into program design, not only to ensure that public funds are spent efficiently (for example, by requiring estimates of program cost-effectiveness in funding applications for programs) but also to ensure that programs contribute positively to mental health and wellbeing, and that any lessons learned can be included in future delivery of these and subsequent programs. All Australian Governments should work toward shifting evaluations from a monitoring of program outcomes to measuring the attributable impact of programs.

Underpinning these functions would be an increased focus on use of data to inform decision making of governments (on the efficient use of taxpayer funds), clinicians and other service providers (on the effectiveness and appropriateness of intervention and referral options), and consumers (on the choice of service providers and treatment options). Vast amounts of data

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are collected throughout the mental health system, but the system as a whole is data rich and information poor: there is limited use of data to either improve people’s choices, experiences and outcomes, or inform improvements in service delivery and effectiveness. For example, data on specialised mental health services collected by State and Territory Governments, data on services commissioned by PHNs, and data in the National Outcomes and Casemix Collection are all underutilised.

Governments should, as a priority reform, require monitoring and reporting at the service provider level and services should expect to report outcomes of their activities in exchange for the substantial taxpayer funding and subsidies they receive. Such reporting should include the performance of MBS-rebated mental health services and government subsidised NGO-provided services (such as psychosocial support providers). This would encourage improvements in service quality, transparency and accountability, and inform consumer choice. Long time frames and the interaction of multiple services to improve outcomes complicate reporting on service outcomes, but there is agreement on some basic indicators, to which outcome measures recommended in this report should be added. The Australian Institute of Health and Welfare should be resourced to bring together and publish the additional mental health system data, as a priority — including regional level data to be used by regional commissioning bodies for the analysis of gaps between each region’s needs and the services delivered — and to undertake such gap analyses at State, Territory and national levels.

Additional reforms to support continuous improvement in the mental health system

Supporting the priority reforms are other data collection and use measures that should be implemented by all Governments and service providers, and research gaps that should be addressed, to support continuous improvement in the mental health system.

There remain considerable gaps in data from some service providers (including PHN-commissioned services and NGO-provided services) and in outcomes of programs, as determined by the people who use them. While reporting information back to governments might seem secondary to providing services to people in need, programs evidenced by data are more likely to be viewed credibly by consumers, referring clinicians, and funders, and have greater scope to improve over time.

Research to fill crucial gaps in the evidence base of what interventions are effective and under what circumstances, is needed to inform best practice treatment that enhances people’s wellbeing and ongoing life within their family, kinship groups and community, in both the short and long term. Collaborative centres for research are one approach that has potential to drive research improvements. However, in the first instance, an expansion in research in a coordinated way should be supported by the establishment of a national clinical trials network in mental health and suicide prevention.
RECOMMENDATIONS
For ease of cross-referencing, the number of each recommendation is aligned with the relevant chapter that provides the supporting detail for the recommendation. There are no recommendations associated with chapters 1, 2 or 3.

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).
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)
# 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)
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)
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.
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.
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)
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)
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:
  - supported online treatment and short-course, structured therapy by telephone or videoconference across Australia, under a prominent and trusted brand, using 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)
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)
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)
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)
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)
The delivery of psychosocial supports — including a range of services to help people manage daily activities, rebuild and maintain social connections, build social skills and participate in education and employment — has been hampered by inefficient funding arrangements and service gaps. This is affecting the recovery of people with mental illness and their families, who can benefit substantially from improved access to psychosocial supports.

As a priority:

- Governments should ensure that all people who have psychosocial needs arising from mental illness receive adequate psychosocial support. To achieve this:
  - The shortfall in the provision of psychosocial supports outside the National Disability Insurance Scheme (NDIS) should be estimated at a regional and State and Territory level. (Action 17.3)
  - Over time, State and Territory Governments, with support from the Australian Government, should increase the quantum of funding allocated to psychosocial supports to meet the estimated shortfall. (Action 17.3)

Additional reforms that should be considered:

- As contracts come up for renewal, commissioning agencies should extend the length of the funding cycle for psychosocial supports from a one-year term to a minimum of five years. Commissioning agencies should ensure that the outcome for each subsequent funding cycle is known by providers at least six months prior to the end of the previous cycle. (Action 17.1)

- State and Territory Governments and the National Disability Insurance Agency should streamline access to psychosocial supports both for people eligible for supports through the NDIS and for people who choose not to apply for the NDIS or are not eligible. (Action 17.2)

- State and Territory Governments should continue working with the National Disability Insurance Agency to clarify the interface between the mainstream mental health system and the NDIS. (Action 17.3)
RECOMMENDATION 18 — SUPPORT FOR FAMILIES AND CARERS

Governments assist families and carers by funding support services and income support payments. There is scope to improve access to these supports and to improve how families and carers are included by mental health services.

As a priority:

- All mental health services should be required to consider family and carer needs, and their role in contributing to the recovery of individuals with mental illness. (Action 18.1)
  - State and Territory Governments should be collecting and reporting on the Carer Experience Survey to encourage carer-inclusive practice.
  - The Australian Government should amend the Medicare Benefits Schedule to provide rebates for family and carer consultations.
  - State and Territory Governments should ensure the workforce capacity exists in each region to implement family- and carer-inclusive practices within their mental healthcare services.

Additional reforms that should be considered:

- The recommended National Mental Health and Suicide Prevention Agreement (Action 23.3) should state that State and Territory Governments will be responsible for planning and funding carer support services related to the mental health caring role and family support services for families affected by mental illness. (Action 18.2)
- The Australian Government Department of Social Services should evaluate the outcomes achieved for mental health carers from its carer support program. (Action 18.2)
- The Australian Government should amend the eligibility criteria for the Carer Payment and Carer Allowance to reduce barriers to access for mental health carers. (Action 18.3)
RECOMMENDATION 19 — TAILOR INCOME AND EMPLOYMENT SUPPORTS

Employment can be important for maintaining good mental health for people. There is considerable scope to reduce barriers to employment faced by people with mental illness and increase their workforce participation.

As a priority:

- All governments should act to extend the Individual Placement and Support (IPS) model of employment support beyond its current limited application through a staged rollout to community ambulatory mental healthcare services. (Action 19.4)
  - The rollout should be staged to allow Governments to thoroughly test and review how to tailor the IPS program in a cost effective manner to particular demographic groups and for people with different types of mental illness.
  - The program should initially be open to all non-employed working age consumers of community ambulatory mental healthcare services who express a desire to participate. Participation in the program should be considered to fulfil any mutual obligation requirements for income support recipients.
  - At each stage of the rollout, data should be shared between IPS sites, with a mechanism put in place to share lessons and best practice between programs on what works for particular targeted groups of participants. If the net benefits of the program apparent on a small scale to date are not replicated as the program is scaled up, its design (and if necessary, its desirability) should be re-appraised.

Additional reforms that should be considered:

- Processes for streaming of participants into employment support programs via improved employment support assessment tools should be tailored to people with mental illness by relevant governments. (Action 19.1)
- The Department of Education, Skills and Employment should ensure that the New Employment Services program includes design features that explicitly consider the needs of participants with mental illness as it is developed and later rolled out as a national program. (Action 19.2)
- For job seekers with complex needs, employment support providers should be required to assist with personalised Job Plans that go beyond meeting compliance obligations. (Action 19.3)
- Over time, the Australian Government should improve the work incentives for Disability Support Pension recipients and recipients should be well informed of their entitlement to work for a period without losing access to the Disability Support Pension by Services Australia. (Action 19.5)
RECOMMENDATION 20 — SUPPORTIVE HOUSING AND HOMELESSNESS SERVICES

Housing and homelessness services help prevent people with mental illness from experiencing housing issues and support people with mental illness to find and maintain housing in the community. But their current capacity falls well short of need.

As a priority:

- State and Territory Governments should, with support from the Australian Government, commit to a nationally consistent policy of no exits into homelessness for people with mental illness who are discharged from institutional care, including hospitals and correctional facilities. (Action 20.2)
  - People with mental illness who exit hospitals, correctional facilities or institutional care should receive a comprehensive mental health discharge plan and have ready access to transitional housing.

Additional reforms that should be considered:

- State and Territory Governments should provide mental health training and resources to social housing workers, and work with the relevant bodies, including the real estate institutes, to assist them in organising training and resources on mental health for private sector real estate agents. (Action 20.1)
- State and Territory Governments should review housing policies to better consider the needs of people with mental illness. This should include information sharing between housing authorities, acute mental healthcare facilities and correctional facilities. (Action 20.1)
- Tenants with mental illness who live in the private housing market should be provided the same ready access to tenancy support services as those in social housing. (Action 20.1)
- The effects of forthcoming reforms to residential tenancy legislation, including ‘no grounds’ evictions, should be assessed by State and Territory Governments to better understand the implications for people with mental illness. (Action 20.1)
- With support from the Australian Government, State and Territory Governments should address the shortfall in the number of supported housing places and the gap in homelessness services for people with severe mental illness. (Action 20.3)
- The National Disability Insurance Agency should continue to amend its Specialist Disability Accommodation strategy and policies to encourage development of long-term supported accommodation for National Disability Insurance Scheme recipients with severe and persistent mental illness. (Action 20.3)
- As part of the next negotiation of the National Housing and Homelessness Agreement, there would be benefit from governments increasing the quantum of funding for housing and homelessness services, including for the expanded provision of services for people with mental illness. (Action 20.3)
RECOMMENDATION 21 — IMPROVE MENTAL HEALTH OUTCOMES FOR PEOPLE IN THE JUSTICE SYSTEM

People with mental illness are over-represented throughout the justice system, including in correctional facilities and as victims of crime. There is considerable scope for improved mental healthcare for people in all parts of the justice system, and improved access to justice for people with mental illness and legal needs.

As a priority:

- State and Territory Governments should implement a systematic approach for responding to mental health related incidents to support all parties involved. Mental health professionals should be embedded in police communication centres and police, mental health professionals and/or ambulance services should be able to co-respond to mental health related incidents. (Action 21.2)

- State and Territory Governments should ensure that people appearing before mental health tribunals, and other tribunals hearing matters arising from mental health legislation, have a right to access legal representation. To facilitate this, State and Territory Governments should adequately resource legal assistance services for this purpose. (Action 21.8)

Additional reforms for people in the justice system that should be considered:

- An early intervention approach should be introduced to identify people with mental illness at high risk of contact with the criminal justice system, and provide supports to reduce the risks of them offending. (Action 21.1)

- State and Territory Governments should work to ensure that people with mental illness who would benefit from mental health court diversion programs, are able to access them. (Action 21.3)

- The Australian Commission on Safety and Quality in Health Care should review the National Safety and Quality Service Standards to determine how they can be implemented in correctional settings. (Action 21.4)

- State and Territory Governments should ensure that people with mental illness in correctional facilities have access to timely and culturally capable mental healthcare. (Actions 21.4, 21.6)

- The forensic mental health component of the National Mental Health Service Planning Framework should be completed and used by governments to inform planning and funding. (Action 21.5)

Additional reforms to improve access to justice that should be considered:

- State and Territory Governments should develop disability justice strategies and work towards integrating legal and health services (including through health justice partnerships) so that people with mental illness are better supported to resolve legal matters and participate in the justice system. (Action 21.7)

- Supported decision making by and for people with mental illness should be promoted through improved access to individual non-legal advocacy services (Action 21.9) and mental health advance directives. (Action 21.10)

- Governments should ensure that treatment orders in mental health legislation are mutually recognised between States and Territories. (Action 21.11)
Governments should, in collaboration with consumers and carers, commit to a more strategic and cross-portfolio approach to mental health that promotes genuine accountability and that prioritises prevention, early intervention and recovery.

As a priority:

- 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. (Action 22.1)
- The Australian Government should expedite the development of an implementation plan for the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2017–2023. (Action 22.2)
- The Australian, State and Territory Governments should establish a clear, ongoing role for consumers and carers in all aspects of mental health system planning, design, monitoring and evaluation. (Action 22.4)
- The National Mental Health Commission should have statutory authority. It should lead the evaluation of government-funded mental health and suicide prevention programs, and other government-funded programs that have strong links with mental health outcomes, including those in non-health sectors. (Action 22.7)

Additional reforms that should be considered:

- The Australian, State and Territory Governments should establish a Special Purpose Mental Health Council to facilitate mental health reforms across health and non-health portfolios. (Action 22.3)
- The Australian Government should fund separate representative peak bodies to represent the views, at the national level, of people with mental illness, and of families and carers. (Action 22.4)
- A national, independent review of Australia’s system for handling consumer complaints that relate to the use of mental healthcare services and supports should be instigated. (Action 22.5)
- Where a body does not exist, State and Territory Governments should each establish a body (such as a mental health commission) that is responsible for strengthening government capability to pursue continuous policy and program improvement and fostering genuine accountability for mental health reform. (Action 22.6)
MENTAL HEALTH

RECOMMENDATION 23 — FUNDING ARRANGEMENTS TO SUPPORT EFFICIENT AND EQUITABLE SERVICE PROVISION

Mental health planning and funding arrangements should be reformed to remove existing distortions, clarify government responsibilities and support regional decision making.

As a priority:

- Governments should strengthen cooperation between Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) by requiring comprehensive joint regional planning and formalised consumer and carer involvement.
  - The National Mental Health Commission should independently monitor and report on compliance by PHNs and LHNs against their commitments. (Action 23.1)
- The Australian Government should support State and Territory Governments that choose to establish regional commissioning authorities (RCAs) to administer mental health funding as an alternative to PHN-LHN groupings. (Action 23.4)

Additional reforms to clarify government roles that should be considered:

- State and Territory Governments should take on sole responsibility for psychosocial supports outside of the National Disability Insurance Scheme. (Action 23.2)
- All Governments should develop a National Mental Health and Suicide Prevention Agreement to clarify responsibilities and the new role of the National Mental Health Commission. It should also specify additional mental health and psychosocial support funding contributions by each level of government. (Action 23.3)

Additional reforms to funding arrangements that should be considered:

- The Australian Government Department of Health should reform the way that it allocates funding to PHNs (or RCAs) to support greater regional equity and remove incentives to engage in cost shifting. (Action 23.5)
- The Australian Government Department of Health should:
  - provide guidance on the evidence base that underpins different types of interventions and require PHNs (and RCAs) to demonstrate that they have commissioned evidence-based services that meet their catchment’s needs
  - permit regional commissioning bodies to redirect to alternative services funding hypothecated to particular providers, if these providers are shown to not be meeting the service needs identified in regional plans
  - position Aboriginal Community Controlled Health Services as the preferred providers of services to Aboriginal and Torres Strait Islander people. (Action 23.6)
- The Independent Hospital Pricing Authority should review the Australian Mental Health Care Classification and develop an interim (simplified) model to allow State and Territory Governments to use activity-based funding for community ambulatory mental healthcare. (Action 23.7)
- The Australian Government Department of Health should establish a Mental Health Innovation Fund to trial new system organisation and payment models. (Action 23.8)
- The Australian Government should review the regulations that prevent private health insurers from funding community-based mental healthcare activities, and permit life insurers to fund mental health treatments for their insurance clients on a discretionary basis. (Actions 23.9, 23.10)
RECOMMENDATION 24 — DRIVE CONTINUOUS IMPROVEMENT AND PROMOTE ACCOUNTABILITY

A robust information and evidence base is needed to improve programs, policies, and outcomes for people with mental illness and carers. This requires that governments support data collection and use, transparent monitoring and reporting, program evaluations and practical research.

As a priority:

- The Australian, State and Territory Governments should agree on a set of targets and timeframes that specify key mental health and suicide prevention outcomes.
  - These targets should be co-designed with consumers and carers and include both quantitative and qualitative evidence and data.
  - Aboriginal and Torres Strait Islander people and the National Federation Reform Council Indigenous Affairs Taskforce should be included in discussions about any targets that may affect Aboriginal and Torres Strait Islander people (Action 24.4).

- The Australian, State and Territory Governments should require monitoring and reporting at the service provider level that is focused on consumer and carer outcomes (Action 24.5).

- The Australian Institute of Health and Welfare should publish data on mental health services at a national, State and Territory, and regional level that is aligned with the National Mental Health Service Planning Framework (NMHSPF); and gap analyses against NMHSPF benchmarks. Each regional commissioning body should report a regional-level gap analysis in their joint regional plan (Action 24.8).

Additional actions that should be considered:

- The Australian Government should fund regular national surveys of mental health and wellbeing (Action 24.2) and the establishment of a national clinical trials network in mental health and suicide prevention (Action 24.12).

- The National Mental Health Commission should include outcomes, activities and reforms from all relevant health and non-health portfolios in its national monitoring and reporting (Action 24.10).

- The Australian, State and Territory Governments should:
  - develop a strategy to improve the usability of data collections (Action 24.1) and ensure prioritised data and information gaps are addressed, including data on non-government organisations that provide mental health services (Action 24.3).
  - develop standardised and outcome-focused reporting requirements for service providers and report all data relating to the performance of services at a regional level (Actions 24.6, 24.7).
  - enhance and make all parts of the NMHSPF publicly available (Action 24.9).
  - require funding applications for mental health programs to include an assessment of their expected cost-effectiveness and require all new programs to have been trialled as pilots, before they can be scaled up (Action 24.11).
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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
The Commission’s report is in three volumes. Volume 1 contains the overview and recommendations. This Volume 2 contains chapters 1 to 16 and references. Volume 3 contains chapters 17 to 25 and appendix A and references. Below is the table of contents for all volumes.

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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%). 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

<table>
<thead>
<tr>
<th>Well population</th>
<th>At risk</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.3m</td>
<td>5.9m</td>
<td>2.3m</td>
<td>1.2m</td>
<td>0.8m</td>
</tr>
</tbody>
</table>

Spectrum of mental illness in Australia

Episodic 0.5m
Persistent 0.3m

\[a\] 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.

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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**

<table>
<thead>
<tr>
<th>Social setting / stage of life</th>
<th>Prenatal period and early childhood</th>
<th>Childhood</th>
<th>Adolescence</th>
<th>Adulthood</th>
<th>Old age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment</td>
<td>Socioeconomic disadvantage</td>
<td>Poor access to services</td>
<td>Poor housing/living conditions</td>
<td>Poor civic amenities</td>
<td>Local, national, international crises (economic, environmental, health and security)</td>
</tr>
<tr>
<td></td>
<td>Adverse learning environment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>Trauma or maltreatment</td>
<td>Neighbourhood violence/crime</td>
<td>Discrimination and stigma</td>
<td>Isolation and social exclusion</td>
<td>Political and social stability</td>
</tr>
<tr>
<td></td>
<td>Cultural isolation</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Peer pressure</td>
<td></td>
<td></td>
<td></td>
<td>Elder abuse</td>
</tr>
<tr>
<td>Family</td>
<td>Trauma or maltreatment</td>
<td>Family violence or conflict</td>
<td>Genetics</td>
<td>Child, sibling, parental mental illness</td>
<td>Cultural and kinship connections</td>
</tr>
<tr>
<td></td>
<td>Insecure attachment; family separation</td>
<td></td>
<td></td>
<td></td>
<td>Family detachment</td>
</tr>
<tr>
<td>Individual</td>
<td>Physical ill-health</td>
<td>Poor nutrition</td>
<td>Limited physical exercise</td>
<td>Inadequate sleep</td>
<td>Harmful alcohol or drug use</td>
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<td></td>
<td>Low self-esteem</td>
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<tr>
<td></td>
<td>Criminal or anti-social behaviour</td>
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<tr>
<td></td>
<td>Stress/uncertainty about the future</td>
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<td></td>
<td>Job satisfaction</td>
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<td></td>
<td>Labour force participation</td>
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<td></td>
<td>Lack of choices, personal time</td>
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<tr>
<td></td>
<td>Low self-esteem</td>
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<td></td>
<td>Criminal or anti-social behaviour</td>
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<td></td>
<td>Stress/uncertainty about the future</td>
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*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; RDAO, 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 (ACO, 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; CBPATSISP 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 Allowance 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).

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

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>
<thead>
<tr>
<th>Table 1.1 Coverage of mental disorders by this Inquiry</th>
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</thead>
<tbody>
<tr>
<td><strong>In-scope</strong>a</td>
</tr>
<tr>
<td>• Psychosis (including schizophrenia)</td>
</tr>
<tr>
<td>• Mood disorders (including depression and bipolar disorder)</td>
</tr>
<tr>
<td>• Anxiety disorders (including panic and compulsive disorders)</td>
</tr>
<tr>
<td>• Personality disorders</td>
</tr>
<tr>
<td>• Child behavioural disorders</td>
</tr>
<tr>
<td>• Eating disorders</td>
</tr>
<tr>
<td>• Substance use disorder</td>
</tr>
</tbody>
</table>

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
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).
- 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

<table>
<thead>
<tr>
<th>Persons</th>
<th>Males</th>
<th>Females</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Prevalence rate (%)</th>
<th>Any lifetime mental illness</th>
<th>Any 12-month mental illness</th>
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<tbody>
<tr>
<td>Any lifetime mental illness</td>
<td>40%</td>
<td>45%</td>
</tr>
<tr>
<td>Any 12-month mental illness</td>
<td>30%</td>
<td>35%</td>
</tr>
</tbody>
</table>

\(^{a}\) 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

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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**

*Age-standardised point prevalence rates in 2017*

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*The developed countries shown here are those with the highest Human Development Index with data available on prevalence rates. Does not include substance use disorders. Some rates are modelled rather than being collected from a nationally representative survey and have confidence intervals. 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.


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 declines 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

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\(^a\) 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’.

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

Intentional self-harm accounts for the highest number of years of potential life lost (figure 2.4). Causes of deaths in 2018

<table>
<thead>
<tr>
<th>Cause</th>
<th>Years of potential life lost ('000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intentional self-harm</td>
<td>110</td>
</tr>
<tr>
<td>Ischaemic heart disease</td>
<td>80</td>
</tr>
<tr>
<td>Bronchus and lung cancer</td>
<td>60</td>
</tr>
<tr>
<td>Colon, sigmoid, and rectum cancer</td>
<td>40</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>20</td>
</tr>
<tr>
<td>Chronic lower respiratory disease</td>
<td>10</td>
</tr>
</tbody>
</table>

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.

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

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. 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**

*Adults aged 16–85 years in 2007*

<table>
<thead>
<tr>
<th>Status</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessed services during past 12 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accessed services during lifetime</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haven’t accessed services during lifetime</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% of people within severity level</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 10 20 30 40 50 60</td>
</tr>
</tbody>
</table>

**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).*

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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

<table>
<thead>
<tr>
<th>Mood disorders</th>
<th>Eating disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormalities of emotional state</td>
<td>An eating pattern that causes unhealthy changes in weight</td>
</tr>
<tr>
<td>Affects 6% of Australian adults</td>
<td>Affects 1% of Australian adults</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anxiety disorders</th>
<th>Personality disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intense and debilitating anxiety</td>
<td>Behaviour which deviates markedly from the expectations of the individual’s culture</td>
</tr>
<tr>
<td>Affects up to 14% of Australian adults</td>
<td>Affects 7% of Australian adults</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychotic disorders</th>
<th>Substance use disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delusions and hallucinations</td>
<td>Impaired control over use of substances</td>
</tr>
<tr>
<td>Affects 0.5% of Australian adults</td>
<td>Affects 5% of Australian adults</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Childhood behavioural disorders</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Disorders with onset during childhood</td>
<td></td>
</tr>
<tr>
<td>2% of children and adolescents have a conduct disorder</td>
<td></td>
</tr>
</tbody>
</table>

---

*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.

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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).
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.

Figure 2.8  More people with mental illness also have a physical illness

Adults aged 16–85 years in 2007

![Graph showing the percentage of adults with mental illness and physical conditions](image)

**Note**: 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).*
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 (Olff 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). 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,

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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). Between 2014-15 and 2018-19, the number of prescriptions increased by an average of 3% per year. This has been predominantly driven by the growth of ‘under co-payment’ prescriptions. 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.

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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

<table>
<thead>
<tr>
<th>Drug group</th>
<th>Effects and indications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressants</td>
<td>Drugs used to treat the symptoms of clinical depression.</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>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.</td>
</tr>
<tr>
<td>Anxiolytics</td>
<td>Drugs prescribed to treat symptoms of anxiety.</td>
</tr>
<tr>
<td>Hypnotics and sedatives</td>
<td>Hypnotic drugs are used to induce sleep and treat severe insomnia. Sedative drugs are prescribed to reduce excitability or anxiety.</td>
</tr>
<tr>
<td>Psychostimulants and other nootropics</td>
<td>Agents used for attention-deficit hyperactivity disorder and to improve impaired cognitive abilities (nootropics).</td>
</tr>
</tbody>
</table>

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\textsuperscript{a}

<table>
<thead>
<tr>
<th>Medication Type</th>
<th>Average annual % change in number of prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressants</td>
<td></td>
</tr>
<tr>
<td>Antipsychotics</td>
<td></td>
</tr>
<tr>
<td>Anxiolytics</td>
<td></td>
</tr>
<tr>
<td>Hyponotics and sedatives</td>
<td></td>
</tr>
<tr>
<td>Psychostimulants</td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{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 (\textit{years lived with disability})
- how many years of life are prematurely lost due to the condition (\textit{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**\textsuperscript{a,b}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure2.14.png}
\caption{Mental illness is the fourth largest cause of overall health loss and the second highest cause of disability.\textsuperscript{a,b}}
\end{figure}

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

\textit{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](image)

**Figure 2.16  Mental illness as a proportion of the total health loss<sup>a,b,c,d</sup> 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

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\textsuperscript{a}
12-month prevalence rates in 2013-14

Prevalence rate by disorder and severity for young people

Severity of mental illness by age group

\textsuperscript{a} The population in the top figure were aged 4–17 years.

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\textsuperscript{a,b}
People aged 18 years and above during 2017-19

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

[Diagram showing hospitalisation rates for mental health-related conditions over different age groups and years.]

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

*Source: AHW (2015), 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

![Graph showing suicide rates](image)

\(^{a}\) 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). 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

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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**

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

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*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

2016 Medicare Benefits Schedule services data

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*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**

*2017-18*

![Graph showing MBS-rebated mental health services by provider type and remoteness category.](image)

- 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).
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

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

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). 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

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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>
<thead>
<tr>
<th>Table 3.1 Estimated cost of mental ill-health and suicide</th>
<th>$ billion per year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cost category</strong></td>
<td><strong>Lower</strong></td>
</tr>
<tr>
<td>Mental healthcare &amp; related services</td>
<td>15.5</td>
</tr>
<tr>
<td>Government healthcare &amp; related expenditure (includes prevention)</td>
<td>4.1</td>
</tr>
<tr>
<td>Related services &amp; supports</td>
<td>4.1</td>
</tr>
<tr>
<td>Individual out-of-pocket expenses</td>
<td>0.7</td>
</tr>
<tr>
<td>Insurer payments for healthcare</td>
<td>0.9</td>
</tr>
<tr>
<td>Loss of productivity</td>
<td>12.2</td>
</tr>
<tr>
<td>Lower participation and productivity</td>
<td>12.2</td>
</tr>
<tr>
<td>Absenteeism</td>
<td>—</td>
</tr>
<tr>
<td>Presenteeism</td>
<td>—</td>
</tr>
<tr>
<td>Informal care provided by family and friends</td>
<td>15.3</td>
</tr>
<tr>
<td>Cost to economy</td>
<td>42.9</td>
</tr>
<tr>
<td>Cost of disability and premature death</td>
<td>150.8</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Not working</th>
<th>Absent from work</th>
<th>Reduced effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>$12 − $22 b</td>
<td>up to $10 b</td>
<td>up to $7 b</td>
</tr>
<tr>
<td>• More unemployment</td>
<td>• Due to mental illness</td>
<td>• Doing less when at work</td>
</tr>
<tr>
<td>• Higher % not in the labour force</td>
<td>• 10–12 days</td>
<td>• On up to 18 days</td>
</tr>
</tbody>
</table>

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 persona

\begin{figure}
\centering
\includegraphics[width=\textwidth]{life_trajectory.png}
\caption{Life’s trajectory: a stylised example of the lived experience of one young person\textsuperscript{a}}
\end{figure}

\textsuperscript{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

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*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.

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

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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, focusing 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

<table>
<thead>
<tr>
<th><strong>Prevention and early help for people</strong></th>
<th><strong>Support the mental health of new parents</strong></th>
<th><strong>Make the social and emotional development of school children a national priority</strong></th>
<th><strong>Select reforms affecting children</strong></th>
<th><strong>Select reforms affecting young people</strong></th>
<th><strong>National stigma reduction strategy</strong></th>
<th><strong>Follow-up care of people after suicide attempts</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Support the mental health of new parents</td>
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<td></td>
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<td>$3$</td>
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<td></td>
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<td></td>
<td></td>
<td>$50$</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Improve people’s experiences with healthcare</strong></th>
<th><strong>Alternatives to emergency departments</strong></th>
<th><strong>Expand supported online treatment</strong></th>
<th><strong>Telehealth with psychologists and psychiatrists</strong></th>
<th><strong>Expand access to group therapy</strong></th>
<th><strong>Select reforms affecting healthcare</strong></th>
<th><strong>Select reforms affecting carers</strong></th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td>$-362 – -143$</td>
<td>$4 – 128$</td>
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<td></td>
<td>$10 280 – 15 280$</td>
<td>$4390 – 6390$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Improve people’s experiences with services beyond the health system</strong></th>
<th><strong>Meet demand for community services that support people’s recovery</strong></th>
<th><strong>Select reforms affecting housing</strong></th>
<th><strong>Elevate importance of psychological health and safety in workplaces</strong></th>
<th><strong>Select reforms affecting workplaces</strong></th>
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<tbody>
<tr>
<td></td>
<td>$79 – 177$</td>
<td>$8 – 21$</td>
<td>$–$</td>
<td>$12$</td>
</tr>
<tr>
<td></td>
<td>$-830 – -332$</td>
<td>$-406 – -146$</td>
<td>$18$</td>
<td>$170 – 310$</td>
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<td>$170 – 310$</td>
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<td></td>
<td>$270 – 430$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Equip workplaces to be mentally healthy</strong></th>
<th><strong>No-liability clinical treatment for mental health-related workers compensation claims</strong></th>
<th><strong>Select reforms affecting workplaces</strong></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>$12$</td>
<td>$12$</td>
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<td>$3$</td>
<td>$21$</td>
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<tr>
<td></td>
<td></td>
<td>$170 – 310$</td>
</tr>
</tbody>
</table>

**Notes:**

- Table 4.2 shows the estimated benefits of select key 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. 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. 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:** Appendices I and K.

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\(^a\) The Productivity Commission has modelled the effects of key select reforms, where sufficient information was available to quantity 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. 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. 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:** Appendices 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**

- **Healthcare**
- **Carers and families**
- **Income & employment support**
- **Housing**
- **Psychosocial supports**
- **Early childhood & school**
- **Young adults**
- **Workplaces**
- **Social participation**
- **Suicide prevention**

<table>
<thead>
<tr>
<th>% of simulated outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 20 40 60 80 100</td>
</tr>
</tbody>
</table>

- **Cost saving**
- **Very cost effective**
- **Cost effective**
- **Marginally cost effective**
- **Not cost effective**

*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)
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’.
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

- Social inclusion
- Reduced stigma
- Improved access to housing
- More responsive services (e.g. justice, income support)
- Improved access to information, support and services
- Positive learning environment and supports in school
- Supportive workplaces
- Assistance in further education
- Effective employment support

Perinatal period and early childhood  Childhood  Adolescence  Adulthood  Old age

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 preventions 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 $10\ 280\text{–}15\ 280$ 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 $501\text{–}718$ 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). 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.’
Clinical care and community support services should work together to support recovery

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

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.
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.\(^\text{17}\) Periodic checks primarily assess the physical development of the child,

\(^\text{17}\) 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)

- 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

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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. 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.

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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. 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)

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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.
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).

Expectations 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. 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.

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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).

<table>
<thead>
<tr>
<th>Box 5.2</th>
<th><strong>Victoria’s school readiness funding initiative</strong></th>
</tr>
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<tbody>
<tr>
<td>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).</td>
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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)

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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.
• 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.
Only 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.

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. 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)

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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

State Department of Education funds:
- School counsellors/psychologists
- Student support officers (different models and responsibilities across and within jurisdictions)
- Wellbeing team to support teachers and principals – for example, regional mental health coaches in Queensland
- Employee assistance programs for teachers and principals

State Department of Health funds:
- Mental health services
- Allied health services (occupational therapy, speech pathology)
- Specific programs for schools (School-link coordinator in NSW, Healthy Schools program in Victoria)

The Australian Government funds:
- Be You
- Emerging Minds
- STEPS (framework for schools to evaluate wellbeing programs)
- National chaplaincy program
- Australian Early Development Census
- Nationally Consistent Collection of Data (for children with social and emotional difficulties and other disabilities)

School staff:
- Teachers
- Teacher aides and support staff
- Principal and deputy principal
- Wellbeing / student services coordinator
- School counsellor and/or psychologist
- Other staff (may not be present in all schools): nurses, doctors, social workers, mental health workers, chaplains, Aboriginal and Torres Strait Islander education workers

Frameworks and policies:
- Australian curriculum
- Australian student wellbeing framework
- State curriculum
- State wellbeing framework
- Anti-bullying policies
- School-specific policies

External Providers
Hundreds of external providers of wellbeing services for students

External Providers
Hundreds of external providers of professional development programs for teachers

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*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:

Educators 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 ‘unscrewed 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**

<table>
<thead>
<tr>
<th>Student wellbeing to be recognised as an outcome for all schools in the National School Reform Agreement</th>
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<tr>
<td>New guidelines for the accreditation of initial teacher education programs and professional development courses for teachers, to include social and emotional learning (section 5.4)</td>
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<tr>
<td>New guidelines for the accreditation of social and emotional learning programs offered to schools by external providers (section 5.5)</td>
</tr>
<tr>
<td>New national minimum dataset, to be collected by all schools on the wellbeing of their students and be included in schools’ performance monitoring and reporting (section 5.6)</td>
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<table>
<thead>
<tr>
<th>What this means for teachers:</th>
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<tr>
<td>• Better preparation in initial teacher education programs, and professional development</td>
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<tr>
<td>• Clearer support structures within schools</td>
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<table>
<thead>
<tr>
<th>What this means for schools:</th>
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<tr>
<td>• Accountability for wellbeing outcomes</td>
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<tr>
<td>• Consistent data to monitor performance</td>
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<tr>
<td>• Access to accredited wellbeing programs</td>
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<tr>
<td>• Access to funding for wellbeing initiatives</td>
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<tr>
<th>What this means for regulators:</th>
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<tr>
<td>• Accreditation processes in line with new guidelines</td>
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<td>• Evaluation processes for school wellbeing policies</td>
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<table>
<thead>
<tr>
<th>What this means for students</th>
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<tbody>
<tr>
<td>Active consideration of wellbeing in all aspects of education</td>
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<tr>
<td>Clear pathways to access support within schools</td>
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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.  

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). In other words, a small average improvement in wellbeing across all children could result in a significant improvement in educational achievement for the population.

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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. (Australian 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. 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)

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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. 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.

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### 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 focused on making schools mentally healthy rather than focusing 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)

Due 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.

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. 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.\textsuperscript{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.

\textsuperscript{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 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 in 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. 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.

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).
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). 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. 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)

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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:

- 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/advice 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

- 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).

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).
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).
The tertiary education sectors

Tertiary education in Australia is made up of two sectors: higher education and Vocational Education and Training (VET). These sector 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, Cherastidtham 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, Cherastidtham 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\(^a\)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Higher education</th>
<th>VET</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>42.9</td>
<td>50.8</td>
</tr>
<tr>
<td>Female</td>
<td>57.0(^b)</td>
<td>45.1</td>
</tr>
<tr>
<td>Located in:(^c)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major cities</td>
<td>79.6(^d)</td>
<td>59.2</td>
</tr>
<tr>
<td>Regional</td>
<td>19.3(^d)</td>
<td>26.7</td>
</tr>
<tr>
<td>Remote</td>
<td>0.8(^d)</td>
<td>2.5</td>
</tr>
<tr>
<td>Full-time</td>
<td>71.3</td>
<td>10.7(^e)</td>
</tr>
<tr>
<td>Aboriginal or Torres Strait Islander</td>
<td>1.5</td>
<td>3.4</td>
</tr>
<tr>
<td>With disability</td>
<td>6.4(^d)</td>
<td>4.1</td>
</tr>
<tr>
<td>At school</td>
<td>na</td>
<td>8.4</td>
</tr>
<tr>
<td>Apprentice or trainee undertaking off-the-job training</td>
<td>..</td>
<td>7.7</td>
</tr>
<tr>
<td>Socio-economic indexes for areas (SEIFA) quintile:(^e)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 (most disadvantaged)</td>
<td>na</td>
<td>17.3</td>
</tr>
<tr>
<td>2</td>
<td>na</td>
<td>18.3</td>
</tr>
<tr>
<td>3</td>
<td>na</td>
<td>19.6</td>
</tr>
<tr>
<td>4</td>
<td>na</td>
<td>17.4</td>
</tr>
<tr>
<td>5 (most advantaged)</td>
<td>na</td>
<td>14.9</td>
</tr>
<tr>
<td>Low socioeconomic status(^d)</td>
<td>18.3</td>
<td>na</td>
</tr>
<tr>
<td>International student</td>
<td>26.9</td>
<td>4.4(^e)</td>
</tr>
</tbody>
</table>

\(^a\) 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.  
\(^g\) Not available.  
\(^h\) not applicable.

Source: DoE (2019a); NCVER (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

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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**

People aged 16–65 years

- **Moderate**
- **High**
- **Very high**

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).*

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**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).

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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).
Suicides among international students have received significant attention in recent years. In 2019, a Victorian Coroner investigated the death of Zhikai Liu, 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).

<table>
<thead>
<tr>
<th>Box 6.3</th>
<th>Disability Discrimination Act and Disability Standards for Education</th>
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<tbody>
<tr>
<td>The <em>Disability Discrimination Act 1992</em> (Cth) makes it unlawful to discriminate of the basis of disability (including mental illness) in areas such as education, employment, the provision of goods and services, and access to public buildings.</td>
<td></td>
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<tr>
<td>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:</td>
<td></td>
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<tr>
<td>(a) to eliminate, as far as possible, discrimination against persons on the ground of disability in the area of education and training; and</td>
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<tr>
<td>(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</td>
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<tr>
<td>(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.</td>
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<tr>
<td>The Standards are to be reviewed every five years, with the next review expected to take place in late 2020.</td>
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</table>

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
• 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 require 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)
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 expect 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 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 countries 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

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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.
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.
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 ‘trialling’ 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); NCVER (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 Organisations, 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).

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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 incompletion 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).
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).
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**

<table>
<thead>
<tr>
<th>Job design</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Demand and control</td>
</tr>
<tr>
<td>• Resources and management</td>
</tr>
<tr>
<td>• Job characteristics</td>
</tr>
<tr>
<td>• Exposure to trauma</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Workplace support</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Support from colleagues and managers</td>
</tr>
<tr>
<td>• Quality of interpersonal relationships</td>
</tr>
<tr>
<td>• Leadership</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home/work conflict</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Conflicting demands</td>
</tr>
<tr>
<td>• Significant life events</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Genetics</td>
</tr>
<tr>
<td>• Personality</td>
</tr>
<tr>
<td>• Resilience</td>
</tr>
<tr>
<td>• Early life events</td>
</tr>
<tr>
<td>• Cognitive and behavioural patterns</td>
</tr>
<tr>
<td>• Mental health history</td>
</tr>
<tr>
<td>• Lifestyle factors</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organisational factors in the workplace</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Organisational support</td>
</tr>
<tr>
<td>• Recognition and reward</td>
</tr>
<tr>
<td>• Organisational changes</td>
</tr>
<tr>
<td>• Organisational justice</td>
</tr>
<tr>
<td>• Psychosocial safety climate</td>
</tr>
<tr>
<td>• Physical environment</td>
</tr>
<tr>
<td>• Stigma</td>
</tr>
</tbody>
</table>

**Mental health and wellbeing outcomes**


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. 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

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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 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).

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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**<sup>a</sup>

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of claims</th>
<th>Time lost from work (weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000-01</td>
<td>9000</td>
<td>20</td>
</tr>
<tr>
<td>2002-03</td>
<td>8000</td>
<td>18</td>
</tr>
<tr>
<td>2004-05</td>
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</tr>
<tr>
<td>2010-11</td>
<td>4000</td>
<td>10</td>
</tr>
<tr>
<td>2012-13</td>
<td>3000</td>
<td>8</td>
</tr>
<tr>
<td>2014-15</td>
<td>2000</td>
<td>6</td>
</tr>
<tr>
<td>2016-17</td>
<td>1000</td>
<td>4</td>
</tr>
</tbody>
</table>

<sup>a</sup> 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**<sup>a,b</sup>

<table>
<thead>
<tr>
<th>Year</th>
<th>Aus Govt</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>SA</th>
<th>WA</th>
<th>Tas</th>
<th>NT</th>
<th>ACT</th>
<th>Aus Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-14</td>
<td>15</td>
<td>13</td>
<td>11</td>
<td>10</td>
<td>8</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>2014-15</td>
<td>12</td>
<td>11</td>
<td>10</td>
<td>9</td>
<td>7</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>2015-16</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>2016-17</td>
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<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
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<tr>
<td>2017-18</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

<sup>a</sup> Serious claims are those that resulted in at least a week’s absence from work. Data for 2017-18 is provisional.  
<sup>b</sup> 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 workplace 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.

Figure 7.4  
Rejection rates for mental health-related workers compensation claims\textsuperscript{a,b,c}  
5 year average 2014-15 to 2018-19

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure7.4.png}
\caption{Rejection rates for mental health-related workers compensation claims\textsuperscript{a,b,c}  
5 year average 2014-15 to 2018-19}
\end{figure}

\textsuperscript{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.  \textsuperscript{b} Rejected claims only includes claims that were initially rejected, and does not include those rejected claims which may later have been overturned.  \textsuperscript{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

![Bar chart showing the percentage of serious mental health-related claims by type of mental stress for selected years (2006-07, 2011-12, 2016-17).](chart.png)

- **Work pressure**
- **Work related harassment and/or workplace bullying**
- **Exposure to workplace or occupational violence**
- **Exposure to traumatic event**
- **Other mental stress factors**
- **Other harassment**
- **Suicide or attempted suicide**

*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\textsuperscript{a,b}

Claims per 1000 employees, 5 year average 2013-14 to 2017-18

\textsuperscript{a} Serious claims are those that resulted in a least a week's absence from work. Data for 2017-18 is provisional. \textsuperscript{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.

\textit{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**

<table>
<thead>
<tr>
<th>Scheme type</th>
<th>How premiums are set</th>
<th>Exemptions from claims history</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW Hybrid (Private insurers operate as scheme agents on behalf of Icare)</td>
<td>Claims performance rate is calculated by comparing the employers claims performance with other similar NSW businesses</td>
<td>Previous claims do not affect premiums for those employers with an average premium less than $30,000</td>
</tr>
<tr>
<td>Vic Hybrid (Private insurers operate as scheme agents on behalf of WorkSafe Victoria)</td>
<td>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</td>
<td>Previous claims do not affect premiums for employers with rateable remuneration less than $200,000. Premiums are set on an industry average</td>
</tr>
<tr>
<td>Qld Government scheme (WorkCover operates the scheme and no private insurers are involved)</td>
<td>For employers with payrolls &lt;$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</td>
<td>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</td>
</tr>
<tr>
<td>SA Hybrid (Private insurers operate as scheme agents on behalf of ReturnToWork SA)</td>
<td>Based on remuneration, industry and claims experience in the previous year</td>
<td>Sole business operators and some small business pay a flat premium of $200 in 2018-19</td>
</tr>
<tr>
<td>WA Private&lt;sup&gt;a&lt;/sup&gt;</td>
<td>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)</td>
<td>There are no exemptions from claims history, but loadings are limited by the regulator</td>
</tr>
<tr>
<td>Tas Private&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Based on remuneration, industry and claims experience</td>
<td>No exemptions from claims history</td>
</tr>
<tr>
<td>NT Private&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Based on the industry type, claims history, payroll and number of employees</td>
<td>No exemptions from claims history</td>
</tr>
<tr>
<td>ACT Private&lt;sup&gt;d&lt;/sup&gt;</td>
<td>Based on the industry type, claims history, payroll and number of employees</td>
<td>No exemptions from claims history</td>
</tr>
<tr>
<td>Cth Government scheme (Comcare)</td>
<td>Based on the industry type, claims history, payroll and number of employees</td>
<td>Claims history is relevant</td>
</tr>
</tbody>
</table>

<sup>a</sup> 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.  
<sup>b</sup> The Tasmanian WorkCover Board monitors premium rates at the scheme level, but is not able to influence the premiums charged by the licensed insurers.  
<sup>c</sup> The NT legislation does not regulate minimum or maximum premiums or establish advisory premiums and insurers operate with commercial independence.  
<sup>d</sup> 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 businesses 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 —

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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.
Incentives for employers to reduce the risks of workplace-related psychological injury and mental illness can be improved through workers compensation schemes.

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; Skatsoon 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

<table>
<thead>
<tr>
<th>State</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>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.</td>
</tr>
<tr>
<td>Vic</td>
<td>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.</td>
</tr>
<tr>
<td>Qld</td>
<td>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.</td>
</tr>
<tr>
<td>SA</td>
<td>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.</td>
</tr>
<tr>
<td>WA</td>
<td>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.</td>
</tr>
<tr>
<td>Tas</td>
<td>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.</td>
</tr>
<tr>
<td>ACT</td>
<td>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.</td>
</tr>
<tr>
<td>NT</td>
<td>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.</td>
</tr>
<tr>
<td>Comcare</td>
<td>No legislated time frame for claims decisions. The only requirement to make determinations accurately and quickly.</td>
</tr>
</tbody>
</table>

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 then 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 compensations 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

![Bar chart showing the share of mental health claims by work time lost, with the highest share being for 53+ weeks.]

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.

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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.
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 million\(^{48}\) — 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).
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 though manager and leadership training and personal resilience through workplace health promotions and cognitive behavioural therapy.
MENTALLY HEALTHY WORKPLACES

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

<table>
<thead>
<tr>
<th>Approach</th>
<th>All businesses</th>
<th>Large (&gt;200 FTE employees)</th>
<th>Medium (20–199 FTE employees)</th>
<th>Small (5–19 FTE employees)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated and sustained approach</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Effective action</td>
<td>9</td>
<td>15</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Limited action</td>
<td>14</td>
<td>15</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Intention</td>
<td>29</td>
<td>31</td>
<td>33</td>
<td>28</td>
</tr>
<tr>
<td>Basic awareness</td>
<td>19</td>
<td>8</td>
<td>12</td>
<td>21</td>
</tr>
</tbody>
</table>

**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, policies 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

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of resources</td>
<td>25%</td>
</tr>
<tr>
<td>Lack of support and commitment from upper</td>
<td>20%</td>
</tr>
<tr>
<td>management</td>
<td></td>
</tr>
<tr>
<td>Mental health is not viewed by the organisation</td>
<td>15%</td>
</tr>
<tr>
<td>as relevant to the workplace</td>
<td></td>
</tr>
<tr>
<td>Not knowing where or how to start taking action</td>
<td>10%</td>
</tr>
<tr>
<td>Lack of practical tools, guidelines for employers</td>
<td>8%</td>
</tr>
<tr>
<td>Other priorities have pushed ahead</td>
<td>5%</td>
</tr>
<tr>
<td>Lack of time</td>
<td>2%</td>
</tr>
</tbody>
</table>

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, 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

<table>
<thead>
<tr>
<th></th>
<th>Job control/design</th>
<th>Cognitive Behavioural Stress management therapy</th>
<th>Workplace health promotion/physical activity</th>
<th>Health screening</th>
<th>Psychological return to work programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>KPMG and Mental Health Australia</td>
<td>1.3</td>
<td>1.7</td>
<td>2.0</td>
<td>2.0</td>
<td>4.7</td>
</tr>
<tr>
<td>Yu and Glozier for SafeWork NSW</td>
<td>1.56 (SME)</td>
<td>1.56 (SME)</td>
<td>2.86 (SME)</td>
<td>na</td>
<td>3.9 (SME)</td>
</tr>
<tr>
<td></td>
<td>0.96 (Large)</td>
<td>2.39 (Large)</td>
<td>4.01 (Large)</td>
<td></td>
<td>3.74 (Large)</td>
</tr>
<tr>
<td>PwC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.3</td>
</tr>
</tbody>
</table>

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

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\(^{49}\) 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.

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**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 Everyminder’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.
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.
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)

[the 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. 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.
Mental ill-health is associated with social exclusion<sup>a,b,c</sup>

Percentages of people deeply and marginally socially excluded

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**

- **Demographics and health**
  - 15–24
  - 25–44
  - 45–64
  - 65 +
  - Female
  - Male
  - Aboriginal or Torres Strait Islander people
  - Immigrant, English speaking country
  - Immigrant, Non-English speaking country
  - Long-term health condition

- **Household characteristics**
  - Couple
  - Couple with dependent children
  - Single parent
  - Single person

- **Region**
  - Major city
  - Inner regional
  - Outer regional, remote or very remote

- **Housing**
  - Owner occupier
  - Owner with mortgage
  - Private renter
  - Public housing

- **Highest educational attainment**
  - Tertiary education
  - Vocational education
  - Year 12
  - Year 11 or below

- **Total**

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**Source**: Productivity Commission estimates using *Housing, Income and Labour Dynamics Australia*, wave 18.

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Social exclusion is measured using the Social Exclusion Monitor. People with a social exclusion score greater than two are considered deeply excluded. 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. Responses are population weighted.
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, Highet 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; Zaske 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 (Zaske 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
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)

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.
### 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 (Thornicroft 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. Insurance gives people a way to financially protect themselves against a range of potential outcomes.

51 Similar concerns were also raised as part of the Parliamentary Joint Committee on Corporations and Financial Services Inquiry into the Life Insurance Industry (PICCFS 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:

- Empirical 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:

- 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

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’

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^{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.

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’

\[\text{Mental health quintile} \]

\[\begin{array}{c}
\text{(Poorest mental health)} \\
\text{(Best mental health)}
\end{array}\]

\[\text{Slightly agree} \quad \text{Moderately agree} \quad \text{Strongly agree}\]

\(^{a}\) 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.


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-focused 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).

(continued next page)
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’:

[ne]ighbourhood 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).
Arts and cultural events are seen to improve social participation and have beneficial effects on participants’ mental health.

Creative expression and cultural activities can improve quality of life, self-esteem, resilience, social engagement and confidence, as well as reduce stress and stimulate interest in further learning. (Australian Government Department of Communications and the Arts, sub. 82, p. 4)

Museums 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)

People 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.

[As 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)

The 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).

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).

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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

Proportion of people with high or very high levels of psychological distress

<table>
<thead>
<tr>
<th></th>
<th>Female 15–24</th>
<th>Female 25–44</th>
<th>Female 45–64</th>
<th>Female 65+</th>
<th>Male 15–24</th>
<th>Male 25–44</th>
<th>Male 45–64</th>
<th>Male 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>15–24</td>
<td>30%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
<td>30%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
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<tr>
<td>25–44</td>
<td>20%</td>
<td>10%</td>
<td>5%</td>
<td>2%</td>
<td>20%</td>
<td>10%</td>
<td>5%</td>
<td>2%</td>
</tr>
<tr>
<td>45–64</td>
<td>10%</td>
<td>5%</td>
<td>2%</td>
<td>1%</td>
<td>10%</td>
<td>5%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>65+</td>
<td>5%</td>
<td>2%</td>
<td>1%</td>
<td>0.5%</td>
<td>5%</td>
<td>2%</td>
<td>1%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

*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

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 well-being 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.
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).

‘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). 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

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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’. Proportionally, we are the most incarcerated people on the planet. We are not an innately criminal people. Our children are aliened 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 Yanku 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.
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. 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.

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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**

*Age-standardised suicide rate per 100 000 people, 1907–2018*

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**

*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

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any mental or behavioural disorder</td>
<td>65.0%</td>
</tr>
<tr>
<td>Mood disorder</td>
<td>49.2%</td>
</tr>
<tr>
<td>Substance use disorder</td>
<td>39.5%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>40.6%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>3.3%</td>
</tr>
<tr>
<td>Any psychosocial risk factor</td>
<td>57.1%</td>
</tr>
<tr>
<td>Previous self-harm</td>
<td>17.3%</td>
</tr>
<tr>
<td>Separation or divorce</td>
<td>28.9%</td>
</tr>
<tr>
<td>Relationship problems</td>
<td>26.5%</td>
</tr>
<tr>
<td>Any physical health issue</td>
<td>47.7%</td>
</tr>
</tbody>
</table>

*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

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**a** Age-standardised rate. Financial years. **b** Age-specific rate. 2011-12 to 2015-16.

*Source: AIHW (2018f, 2019g).*
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\textsuperscript{a}
Age-specific suicide rate per 100 000 people, 2009–2018

\begin{center}
\includegraphics[width=\textwidth]{figure9_5.png}
\end{center}

\textsuperscript{a} Data is for New South Wales, Queensland, South Australia, Western Australia and Northern Territory only.

\textit{Source:} ABS (\textit{Causes of Death, Australia, 2018}, unpublished data, Cat. no. 3303.0).

Figure 9.6  Suicide rates are higher in regional areas\textsuperscript{a}
Age-standardised suicide rate per 100 000 people, 2018

\begin{center}
\includegraphics[width=\textwidth]{figure9_6.png}
\end{center}

\textsuperscript{a} Greater capital cities and rest of the State or Territory.

\textit{Source:} ABS (\textit{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). 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).

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

<table>
<thead>
<tr>
<th></th>
<th>Suicide</th>
<th>Non-fatal suicide behaviour</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intangible costs</td>
<td>$28.6b</td>
<td>$0.3b</td>
<td>$28.8b</td>
</tr>
<tr>
<td>Other indirect costs</td>
<td>$51.4m</td>
<td>$917.8m</td>
<td>$1.0b</td>
</tr>
<tr>
<td>Direct costs</td>
<td>$414.4m</td>
<td>$237.9m</td>
<td>$0.7b</td>
</tr>
<tr>
<td>Total</td>
<td>$29.0b</td>
<td>$1.4b</td>
<td>$30.5b</td>
</tr>
</tbody>
</table>

*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)
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.

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 Nielsen 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 maybe 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. Krysinska 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).

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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). 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. 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).

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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

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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 (Thirrilli 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: ATSISPEP (2016b); Dickson et al. (2019); Fogliani (2019); Thirrili 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 (ATSISPEP 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, 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).

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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).
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.

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**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 developed 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; Krysinska 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 responsibility 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**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>What does this measure?</th>
<th>Data source</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>System-level outcomes indicators</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rates of suicide</td>
<td>The number of suicides per 100 000 Australians</td>
<td>ABS Causes of Death</td>
<td>Available</td>
</tr>
<tr>
<td>Rates of suicide attempts</td>
<td>The number of suicide attempts per 100 000 Australians</td>
<td>AIHW Injury due to self-harm</td>
<td>Partial measure</td>
</tr>
<tr>
<td>Rates of suicide ideation</td>
<td>The number of people reporting suicide ideation per 100 000 Australians</td>
<td>ABS National Survey of Mental Health and Wellbeing</td>
<td>Available (decade-long intervals)</td>
</tr>
<tr>
<td><strong>Service-level performance indicators</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide of persons in inpatient mental health units</td>
<td>The number of suicides that occur in admitted patient specialised mental health services</td>
<td>State and Territory hospital data</td>
<td>Requires development</td>
</tr>
<tr>
<td>Rates of follow-up after suicide attempt/self-harm</td>
<td>Proportion of presentations to hospital for which there was a follow-up in the community within an appropriate period</td>
<td>Data linkage of State and Territory clinical mental health and patient administration systems</td>
<td>Requires development</td>
</tr>
<tr>
<td>Post-discharge community care</td>
<td>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</td>
<td>State and Territory clinical mental health data systems</td>
<td>Available</td>
</tr>
<tr>
<td>Rates of suicide ideation in patients presenting to services</td>
<td>Level of suicidal ideation or behaviour experienced by patients presenting to services, before and after support</td>
<td>Suicidal Ideation Attributes Scale; Suicidal Behaviours Questionnaire-Revised</td>
<td>Requires development</td>
</tr>
<tr>
<td>Suicide stigma and literacy</td>
<td>Level of suicide-related stigma and literacy of service staff and the community, and proportion of service staff trained</td>
<td>Literacy of Suicide Scale; Stigma of Suicide Scale; Service admin data</td>
<td>Requires development</td>
</tr>
<tr>
<td>Expenditure on suicide prevention activities</td>
<td>Total expenditure on suicide prevention activities defined in a consistent way</td>
<td>State and Territory Governments</td>
<td>Requires development</td>
</tr>
</tbody>
</table>

* 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. 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.

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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 2020), 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).

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

![Figure 10.1](image)

a Other referral destinations include sleep clinics (1.1%), paediatricians (0.8%), and patient support groups (0.4%).


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 provider 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). 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. **GP**s 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).

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).
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 Procare 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 Procare 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.
Procare (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).

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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.

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**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.\(^7^6\)

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.

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\(^7^6\) 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 Workers 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 form 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

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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

- Consumer

  - Visits
  - Self-refers

- GP

  - Visits
  - Refers

- GP assessment and referral

  - Using the national digital platform assessment and referral tool

- Other non-mental-health specific services

  - (e.g. Aboriginal health worker, nurse practitioner, school counsellor)

- Online clinician-supported assessment and referral

  - Using the national digital platform assessment and referral tool

- Referral pathways for mental health services

  - Mental health services only accessible through GP
    - Mental health medication
  - Mental health services provided on the national digital platform
    - Clinician-supported online therapy
    - Short-course, structured therapy delivered digitally
    - Self-help information
  - Other mental health services
    - MBS-rebated psychological therapy
    - Other digital and face-to-face low-intensity clinical services
    - Non-clinical services, such as counselling or support groups
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 by 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 included non-clinical services, and that a broader range of service providers should be able to access the resource (chapter 15).
- 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.

<table>
<thead>
<tr>
<th>Inform</th>
<th>Enrol</th>
<th>Treat</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learn about mental health</td>
<td>Complete assessment</td>
<td>Complete online lessons</td>
<td>Talk with clinician</td>
</tr>
<tr>
<td>Take quiz</td>
<td>Enrol in course</td>
<td>Practise</td>
<td></td>
</tr>
</tbody>
</table>

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**

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.  

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).

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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

<table>
<thead>
<tr>
<th>Category</th>
<th>MindSpot</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Born overseas</td>
<td>24</td>
<td>13</td>
</tr>
<tr>
<td>Rural and remote</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>LGBTIQ</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

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).
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).
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 ‘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**

<table>
<thead>
<tr>
<th></th>
<th>MindSpot consumers</th>
<th>People with mental ill-health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>61%</td>
<td>62%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>11%</td>
<td>6%</td>
</tr>
<tr>
<td>Not in labour force</td>
<td>28%</td>
<td>32%</td>
</tr>
</tbody>
</table>

*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 (Andersson 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) (Andersson 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 (Andersson 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).

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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).


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 (CRUIAD 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. 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).

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).

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 Acierno 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 underserviced 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 (CRUIAD 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 (CRUIFAD 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.

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### 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>
<thead>
<tr>
<th>Program</th>
<th>Developer</th>
<th>Mental ill-health</th>
<th>Type</th>
<th>Population</th>
<th>Therapy</th>
<th>Cost</th>
<th>No. of courses</th>
<th>Course length</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>Swinburn University</td>
<td>anxiety, depression</td>
<td>supported self-guided</td>
<td>adults</td>
<td>CBT</td>
<td>free</td>
<td>7</td>
<td>12 weeks</td>
</tr>
<tr>
<td>Online</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MindSpot</td>
<td>Macquarie University</td>
<td>stress, anxiety, worry, low mood, depression, post-traumatic stress, obsessive behaviour</td>
<td>supported</td>
<td>adults, Indigenous, young adults older people</td>
<td>CBT</td>
<td>free</td>
<td>7</td>
<td>8 weeks</td>
</tr>
<tr>
<td>THIS WAY UP</td>
<td>St Vincent Hospital</td>
<td>depression, anxiety</td>
<td>supported self-guided</td>
<td>adults^a</td>
<td>CBT</td>
<td>free^c</td>
<td>18</td>
<td>13 weeks</td>
</tr>
<tr>
<td>Brave</td>
<td>b</td>
<td>anxiety</td>
<td>supported self-guided</td>
<td>3–7, 8–12, 12–17 year olds (with parent involvement)</td>
<td>CBT</td>
<td>free</td>
<td>4</td>
<td>10 weeks (based on one session per week)</td>
</tr>
<tr>
<td>Cool Kids</td>
<td>Macquarie University</td>
<td>anxiety</td>
<td>supported</td>
<td>3–6, 7–12, 13–17 year olds</td>
<td>CBT</td>
<td>$710</td>
<td>2</td>
<td>..</td>
</tr>
<tr>
<td>Chilled Out</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>MyCompass</td>
<td>Black Dog</td>
<td>stress, anxiety, depression</td>
<td>self-guided</td>
<td>Adults</td>
<td>CBT, problem solving therapy, interpersonal psychotherapy &amp; positive psychology</td>
<td>free</td>
<td>14</td>
<td>..</td>
</tr>
<tr>
<td>BITE BACK</td>
<td>Black Dog</td>
<td>wellbeing</td>
<td>self-guided</td>
<td>13–16 year olds</td>
<td>positive psychology</td>
<td>free</td>
<td>1</td>
<td>6 weeks</td>
</tr>
<tr>
<td>HeadGear</td>
<td>Black Dog</td>
<td>common mental disorders</td>
<td>self-guided</td>
<td>Employees male dominated industries</td>
<td>behavioural activation &amp; mindfulness</td>
<td>free</td>
<td>1</td>
<td>..</td>
</tr>
<tr>
<td>MoodGym</td>
<td>ANU</td>
<td>depression, anxiety</td>
<td>self-guided</td>
<td>adults and youth</td>
<td>CBT</td>
<td>free</td>
<td>1</td>
<td>..</td>
</tr>
<tr>
<td>e-couch</td>
<td>ANU</td>
<td>depression, anxiety, relationship breakdown, and loss and grief</td>
<td>self-guided</td>
<td>adults and youth</td>
<td>CBT, interpersonal therapies, relaxation &amp; physical activity</td>
<td>free</td>
<td>1</td>
<td>..</td>
</tr>
</tbody>
</table>

^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 one

- 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 2019I, 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.\footnote{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).}

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.
4.3 million people
received a mental health related **prescription**

1.4 million people
accessed **6 million** sessions of psychological therapy

700 000 people
received a mental health related **prescription and psychological therapy**

20 million visits
to the GP involved a psychological problem

100 000 young people
accessed help through **headspace centres**

4000 people
accessed supported online treatment through **Mindspot**

435 000 people
accessed State and Territory community ambulatory care

410 000 people
accessed **private psychiatric care**

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**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 services 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
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
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.

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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

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.

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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.

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

![Graph showing percentage of MBS-rebated consultations with no co-payment by quintile of socioeconomic disadvantage.](image)

*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.

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Table 12.1  **Medicare Safety Nets**

<table>
<thead>
<tr>
<th></th>
<th>2020 Thresholds(^a)</th>
<th>What counts towards the threshold?</th>
<th>What benefit is paid above the threshold?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Medicare</td>
<td>$477.90</td>
<td>The individual’s or family’s cumulative ‘gap amount’(^b) for the calendar year</td>
<td>100% of the ‘gap amount’(^b) for out-of-hospital services</td>
</tr>
<tr>
<td>Safety Net</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended Medicare</td>
<td>$692.20 (for concession card holders and families eligible for Family Tax Benefit Part A) $2169.20 (for everyone else)</td>
<td>The individual’s or family’s cumulative co-payments for the calendar year</td>
<td>80% of co-payments for out-of-hospital services(^c)</td>
</tr>
<tr>
<td>Safety Net</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) 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 underserviced 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

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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 underserviced 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.

- **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)

- **eheadspace** — in 2019, about 37 000 young people used eheadspace, 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 headspace (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 2019I, 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.

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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).

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BRIDGING THE MENTAL HEALTHCARE GAPS 539
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. 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).

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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 2020i).

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 session (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).

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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.
• 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; Garcia-Lizana and Munoz-Mayorga 2010; Hyler, Gangure and Batchelder 2005; Monnier, Knapp and Frueh 2003; O’Reilly et al. 2007; Richardson et al. 2009). Pakruyek 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 background 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.

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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 2020).
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 areas 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 cities 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 areas 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).
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

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).

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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

<table>
<thead>
<tr>
<th></th>
<th>Psychological therapy</th>
<th>Psychiatry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone</td>
<td>(COVID)</td>
<td>(COVID)</td>
</tr>
<tr>
<td>Video</td>
<td>(COVID)</td>
<td>(COVID)</td>
</tr>
<tr>
<td>Video</td>
<td>(Bushfire)</td>
<td>(Standard)</td>
</tr>
<tr>
<td>Video</td>
<td>(Standard)</td>
<td>(Standard)</td>
</tr>
<tr>
<td>Phone</td>
<td>(COVID)</td>
<td>(COVID)</td>
</tr>
<tr>
<td>Video</td>
<td>(COVID)</td>
<td>(COVID)</td>
</tr>
<tr>
<td>Video</td>
<td>(Standard)</td>
<td>(Standard)</td>
</tr>
</tbody>
</table>

- '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.

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 therapist should be kept in place permanently, replacing existing telehealth items for psychiatry and psychological therapy.

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).

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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.
• 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). 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).

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 the 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.\(^\text{104}\)

**Box 12.4 PHN-commissioned psychological therapy**

All PHNs must commission psychological therapy services for ‘underserviced 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 2019i, p. 16).

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\(^{104}\) 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

<table>
<thead>
<tr>
<th>Program</th>
<th>Target population</th>
<th>Total average cost per session (2019 dollars)</th>
<th>Average cost to consumers per session</th>
<th>Effect size (pre–post)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MBS-rebated individual therapy (box 12.2)</td>
<td>General population</td>
<td>$145a</td>
<td>57% of sessions had a co-payment, averaging $68a</td>
<td>No rigorous evaluation of effectiveness</td>
</tr>
<tr>
<td>headspace centres (chapter 10)</td>
<td>Young people aged 12–25 years</td>
<td>$275b</td>
<td>Mostly free</td>
<td>0.7 (K-10)c</td>
</tr>
<tr>
<td>PHN-commissioned therapy (box 12.4)</td>
<td>Underserviced groups</td>
<td>$240–$310d</td>
<td>Mostly free</td>
<td>No rigorous evaluation of effectiveness</td>
</tr>
<tr>
<td>NewAccess (box 12.1)</td>
<td>Low–moderate needs, those not currently getting help</td>
<td>$141–$317e</td>
<td>Free</td>
<td>1.23 (PHQ-9) 1.25 (GAD-7)f</td>
</tr>
<tr>
<td>PORTS Tele-CBT (chapter 10)</td>
<td>Financial hardship, geographical disadvantage</td>
<td>$88f</td>
<td>Free</td>
<td>1.0 (K-10)h</td>
</tr>
</tbody>
</table>

\(a\) 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**

Total cost per service, including government and consumer out-of-pocket costs

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
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. 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. 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

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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).
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.

‘public reporting of these outcomes so consumers and carers have greater visibility over the outcomes achieved by the services they are using’.
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.
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
2019a

![Graph showing the distribution of the number of sessions per consumer.]

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

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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 is 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)
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. 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. 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.
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).

**Figure 12.11 Psychological therapy sessions recommended by NICE**

<table>
<thead>
<tr>
<th>Disorder and intervention</th>
<th>Number of sessions*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social anxiety disorder</td>
<td></td>
</tr>
<tr>
<td>CBT (Heimberg protocol)</td>
<td>15 sessions*</td>
</tr>
<tr>
<td>CBT (Clark and Wells protocol)</td>
<td>14 sessions*</td>
</tr>
<tr>
<td>Generalised anxiety disorder</td>
<td></td>
</tr>
<tr>
<td>Supported self-help treatment</td>
<td>5–7 sessions</td>
</tr>
<tr>
<td>CBT</td>
<td>12–15 sessions</td>
</tr>
<tr>
<td>Manual-based applied relaxation</td>
<td>12–15 sessions</td>
</tr>
<tr>
<td>Panic disorder (with or without agoraphobia)</td>
<td>4–14 sessions</td>
</tr>
<tr>
<td>Obsessive–compulsive disorder</td>
<td>10 sessions</td>
</tr>
<tr>
<td>CBT + response prevention</td>
<td></td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td></td>
</tr>
<tr>
<td>Trauma-focused CBT</td>
<td>8–12 sessions*</td>
</tr>
<tr>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>Guided self-help</td>
<td>6–8 sessions</td>
</tr>
<tr>
<td>CBT</td>
<td>16–20 sessions</td>
</tr>
<tr>
<td>Interpersonal therapy</td>
<td>16–20 sessions</td>
</tr>
<tr>
<td>Alcohol use disorder</td>
<td></td>
</tr>
<tr>
<td>Individual CBT</td>
<td>12 sessions</td>
</tr>
<tr>
<td>Behavioural therapy</td>
<td>12 sessions</td>
</tr>
<tr>
<td>Social network or environment-based therapies</td>
<td>8 sessions</td>
</tr>
<tr>
<td>Behavioural couples therapy</td>
<td>12 sessions</td>
</tr>
<tr>
<td>Bulimia nervosa</td>
<td>16–20 sessions</td>
</tr>
</tbody>
</table>

CBT = cognitive behavioural therapy. NICE = National Institute for Health and Care Excellence. *These figures do not include initial assessment sessions, which are typically required to confirm and refine diagnosis. + Signifies the current cut-off of Better Access sessions. † Some sessions longer than 60 minutes recommended. (Recommended in conjunction with pharmacotherapy for moderate to severe presentations).

*Source: Crome and Baillie (2016, p. 343).*
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.
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). 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).\(^{113}\)

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\(^{113}\) 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**

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). 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

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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 underestimate 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

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Required (67% of time consumer-related)</th>
<th>Required (29% of time consumer-related)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child &amp; adolescent</td>
<td>2000</td>
<td>8000</td>
<td>2000</td>
</tr>
<tr>
<td>Adult</td>
<td>4000</td>
<td>10000</td>
<td>10000</td>
</tr>
<tr>
<td>Older person</td>
<td>6000</td>
<td>16000</td>
<td>16000</td>
</tr>
</tbody>
</table>

\[ FTE = \text{Full-time equivalent. Adult services refers to General (not age specific) services.} \]

\[ \text{Source: Current: AIHW (2019m, table FAC.41). Required: Productivity Commission estimates using unpublished AIHW data and the National Mental Health Service Planning Framework (chapter 24).} \]

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).

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\(^{115}\) 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 size\(^{116}\) 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).

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\(^{116}\) 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.
More consumer-related time means larger benefits for consumers

Annual benefits from one additional clinical staff member\(^a\)

- 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).
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.
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.
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 (2019l) 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 2019l). 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 2019l). 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 2019l).

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).
Mental health-related ED presentations can be urgent but only about one-third of people are admitted\(^a\) 2017-18

**End status of mental health-related ED presentations**

**Triage categories**

\(^a\) 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).*
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 fluorescent 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

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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 separations\textsuperscript{119} 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.

\textsuperscript{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**

*Public acute hospital separations by mental health legal status*

2017-18

![Bar chart showing public acute hospital separations by mental health legal status](chart13.4)

Data for the ACT is not presented here as a majority of separations were not reported as voluntary/involuntary.

*Source: AIHW (2020k).*

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Figure 13.5  **Specialised mental health hospital beds, 2017-18**

![Bar chart showing specialised mental health hospital beds](chart13.5)

*Specialised mental health hospital beds, 2017-18*

*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.
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:

Anecdotaly 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 2020).

- 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
• 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). 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).

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121 Child and adolescent beds are targeted at those aged under 18 years, and youth beds for those aged 18–24 years.
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.

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**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.
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**

<table>
<thead>
<tr>
<th></th>
<th>Excl. older adults</th>
<th>Incl. older adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMHSPF benchmark</td>
<td>3000</td>
<td>4000</td>
</tr>
<tr>
<td>Beds available</td>
<td>2000</td>
<td>3000</td>
</tr>
</tbody>
</table>

*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).

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**Figure 13.10 An acute hospital bed is the most expensive care option**

2017-18 dollars

- Acute bed, public hospital
- Non-acute bed, public hospital
- Community residential (24-hr staffing)
- Community residential (non-24-hr staffing)
- Community ambulatory

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**Source:** AIHW (2020e); SCRGSP (2020b, chapter 13).

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**Note:**

- 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).
- 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).

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**Figure 13.10 An acute hospital bed is the most expensive care option**

2017-18 dollars

- Acute bed, public hospital
- Non-acute bed, public hospital
- Community residential (24-hr staffing)
- Community residential (non-24-hr staffing)
- Community ambulatory

---

**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

![Graph showing different mixes of hospital and community non-acute beds across states]

a Public sector non-acute hospital beds. b Community sub-acute and non-acute beds with 24-hour staffing.  
Source: AIHW (2020n).

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Figure 13.12  **More consumers have a good experience in community care** a  
2017-18

![Graph showing percentage of consumers with a positive experience of service]

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).
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).

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

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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’.
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.
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).
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.

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
• 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 comorbidity 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; SCMH 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.

- Penington 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 comorbidty 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 Tobacco Strategy 2012–18* (Intergovernmental Committee on Drugs 2012)
- *National Aboriginal Torres Strait Islander Peoples Drug Strategy 2014–2019* (Intergovernmental Committee on Drugs 2014)

**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 (CBPATSISP 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).
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).
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)
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 improve 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 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

*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. 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.

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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.

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**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 illness\textsuperscript{124} 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).\textsuperscript{125} There is also an estimated 354 000 people who require care coordination services due to the multitude of services they need (discussed below).\textsuperscript{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).

\textsuperscript{124} Chapter 2 includes a description of the severe and moderate categories.

\textsuperscript{125} In comparison, for those without a mental illness, the prevalence rate of a physical illness is 48\% (chapter 2).

\textsuperscript{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.
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)
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. 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. 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. 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. 572, 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


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.
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’

<table>
<thead>
<tr>
<th>Service</th>
<th>Delivered by</th>
<th>Funded by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital and community mental healthcare</td>
<td>Hospital and mental health service</td>
<td>State and Territory Governments</td>
</tr>
<tr>
<td>Specialist psychiatric review</td>
<td>Mental health service and private psychiatrist</td>
<td>Australian, State and Territory Governments</td>
</tr>
<tr>
<td>Medication</td>
<td>Hospital pharmacy and Pharmaceutical Benefits Scheme</td>
<td>Australian, State and Territory Governments</td>
</tr>
<tr>
<td>Primary care</td>
<td>GP and Aboriginal Community Controlled Organisation</td>
<td>Australian Government</td>
</tr>
<tr>
<td>Housing</td>
<td>State or Territory Government Department and non-government Organisation</td>
<td>Australian, State and Territory Governments</td>
</tr>
<tr>
<td>Psychological/trauma focused care</td>
<td>Psychologist (Medicare Benefits Schedule) and Aboriginal Community Controlled Organisation Social and emotional wellbeing worker</td>
<td>Australian Government</td>
</tr>
<tr>
<td>Crisis line and online mental health support</td>
<td>Crisis line and Beyond Blue</td>
<td>Australian Government</td>
</tr>
<tr>
<td>Drug and alcohol treatment</td>
<td>State or Territory Government Department and non-government organisation</td>
<td>Australian, State and Territory Governments</td>
</tr>
<tr>
<td>Forensic (prison)</td>
<td>Prison medical service</td>
<td>State and Territory Governments</td>
</tr>
<tr>
<td>Forensic (community)</td>
<td>Community corrections</td>
<td>State and Territory Governments</td>
</tr>
<tr>
<td>Community integration and workforce participation</td>
<td>Various</td>
<td>Australian, State and Territory Governments</td>
</tr>
<tr>
<td>National Disability Insurance Scheme support</td>
<td>National Disability Insurance Scheme</td>
<td>Australian, State and Territory Governments</td>
</tr>
</tbody>
</table>

*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. 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’.

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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); headscape (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 plan
- 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. …

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. Fist 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. 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/respite 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); Sjorn 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. 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.

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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.
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.
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 a 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 equivalent\(^\text{135}\) (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

<table>
<thead>
<tr>
<th>Clinical FTEs (000's)</th>
<th>GPs (mental &amp; physical health)</th>
<th>Nurses working in mental health</th>
<th>Psychologists working in mental health</th>
<th>Psychiatrists</th>
<th>Occupational therapists working in mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>26 617</td>
<td>19 980</td>
<td>5 304</td>
<td>2 796</td>
<td>1 707</td>
</tr>
</tbody>
</table>

\(^a\) 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 (2020i).*

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.
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 projected to increase to about 360 by 2030 (or about 8% of the workforce).

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 Collage 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).

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

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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 by...

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 registered\(^ {142} \) 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 2020l) — 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 2020l). 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 demand\(^ {144} \) — 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 2020l).

\(^ {143} \) 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)
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.
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. 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.

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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).
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. 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)

Nonetheless, that review concluded that given the high prevalence of mental health problems and comorbidities with physical conditions, 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. 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. 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)
The fourth follows from the unique position peer worker 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 drug 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 reliving 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.
Occasional 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)
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) survey 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 NDIS, 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 prices, 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; Community Mental Health Australia, sub. 478, p. 22).

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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).
• 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 2020). 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.

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 2020). 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.

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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; Zagozdzon and Wrotkowska 2017).\(^\text{156}\)

\(^{156}\) 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 of 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
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). 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). 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).

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.

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**

![Bar chart showing share of workforce (%)](chart.png)

- Low professional efficacy
- High cynicism
- High emotional exhaustion (burnout)
- Suicide ideation last 12 months
- Current diagnosis of anxiety
- Current diagnosis of depression
- Very high psychological distress (K10)
- High likelihood of a minor psychiatric disorder

Data based on a survey of 11,379 doctors and 1,799 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).
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. 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.

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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

- **Provision of clinical services per capita**a
- **Clinical FTEs per 100,000 population**
- **Region and Professions**
  - Major Cities
  - Inner Regional
  - Outer Regional
  - Remote
  - Very Remote

**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 (2020l, 2020e).
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 2020l). 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. 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 workers\(^{162}\) 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.

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\(^{161}\) 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).
6. Workloads tend to be higher in remote areas, 2018<sup>a</sup>

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.


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**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).
• 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).
References

2nd National Aboriginal and Torres Strait Islander Suicide Prevention Conference 2018, ‘Conference Recommendations’, Perth, November.


ABS (Australian Bureau of Statistics) 2004, Characteristics of Wage and Salary Earners in Regions of Australia, 2000-01: Main Features - Inner Regional Australia, Cat. no. 6261.0.55.001, Canberra.

—— 2008, National Survey of Mental Health and Wellbeing: Summary of Results, Cat. no. 4326.0, Canberra.

—— 2009, Microdata: National Survey of Mental Health and Wellbeing, Basic and Expanded CURF 2007, Cat. no. 4326.0.30.001, Canberra.

—— 2015, National Health Survey: Mental Health and Co-Existing Physical Health Conditions Australia 2014-15, Cat. no. 4329.0.00.004, Canberra.

—— 2016, National Aboriginal and Torres Strait Islander Social Survey 2014-15, Cat. no. 4714.0, Canberra.

—— 2017, Census of Population and Housing: Australia Revealed, 2016, Cat. no. 2024.0, Canberra.

—— 2018a, Australian Demographic Statistics, December, Cat. no. 3101.0, Canberra.

—— 2018b, Causes of Death Australia 2017, Cat. no. 3303.0, Canberra.

—— 2018c, Causes of Death Australia 2017 Intentional Self-Harm Key Characteristics, Cat no. 3303.0, Canberra.

—— 2018d, Labour Force, Australia, August 2018, August, Cat no 6291.0.55.003.

—— 2018e, National Health Survey: First Results 2017-18, Cat. no. 4364.0.55.001, Canberra.

—— 2018f, Population Projections, Australia, 2017 (Base) - 2066, Cat. no. 3222.0, Canberra.

—— 2019a, Australian Demographic Statistics, September, Cat. no. 3101.0, Canberra.

—— 2019b, Causes of Death Australia 2018, Cat. no. 3303.0, Canberra.

—— 2019c, Characteristics of Employment, Australia, August 2019, Cat. no. 6333.0, Canberra.

—— 2019d, Labour Force, Australia, Aug 2019, Cat. no. 6202.0, Canberra.

—— 2019e, Microdata: Census of Population and Housing 2016, Cat. no. 2037.0.30.001, Canberra.

—— 2019f, Microdata: Multi-Agency Data Integration Project Australia, Cat. no. 1700.0, Canberra.

—— 2019g, National Aboriginal and Torres Strait Islander Health Survey 2018-19, Cat. no. 4715.0, Canberra.

—— 2019h, National Health Survey 2017-18, Basic Confidentialised Unit Record File (CURF), Cat. no. 4324.0.55.001, Canberra.

—— 2019i, Patient Experiences in Australia: Summary of Findings 2018-19, Cat. no. 4839, Canberra.

—— 2019j, Psychosocial Risk Factors as They Relate to Coroner-Referred Deaths in Australia 2017, Research Paper, Cat. no. 1351.0.55.062, Canberra.

—— 2019k, Schools Australia 2018, March, Cat. no. 4221.0, Canberra.

—— 2020a, Household Impacts of COVID-19 Survey, 14-17 Apr 2020, Cat. no. 4940.0, Canberra.

—— 2020b, Household Impacts of COVID-19 Survey, 29 April - 4 May 2020, Cat. no. 4940.0, Canberra.
ACA (Australian Counselling Association) 2016, *Scope of Practice for Registered Counsellors*, Newmarket, Queensland.


— 2015, *Health and Physical Education: Sequence of Content F-10 Strand: Personal Social and Community Health*.


ACN (Australian College of Nursing) 2018, *Submission to the Senate Community Affairs References Committee Inquiry into Accessibility and Quality of Mental Health Services in Rural and Remote Australia*.


AFL (Australian Football League) 2019, *AFL Mental Health Framework*.


—— 2017a, Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report, Canberra.

—— 2017b, National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing: 2017-2023, Canberra.

AHMC (Australian Health Ministers’ Conference) 2009a, National Mental Health Policy 2008, Canberra.


AHPRA (Nursing and Midwifery Board of Australia) 2019, Fact Sheet: Internationally Qualified Nurses with a Sole Qualification in Mental Health, Disability or Paediatric Nursing.


AIHW (Australian Institute of Health and Welfare) 2003, Australian Expenditure on Mental Disorders in Comparison with Expenditure in Other Countries, Cat. no. RWP 1, Canberra.

—— 2007, Disability in Australia: Acquired Brain Injury, Cat. no. AUS 96, Canberra.

—— 2008, Rural Regional and Remote Health: Indicators of Health Status and Determinants of Health, Cat. no. PHE 97, Canberra.

—— 2011a, Aboriginal and Torres Strait Islander Child Safety, Cat. no. IHW 50.

—— 2011b, Principles on the Use of Direct Age-Standardisation in Administrative Data Collections, Cat. no. CSI 12, Canberra.

—— 2011c, Substance Use Among Aboriginal and Torres Strait Islander People, Cat. no. IHW 40, Canberra.

—— 2011d, Young Australians: Their Health and Wellbeing 2011, Cat. no. PHE 140.

—— 2012a, Comorbidity of Mental Disorders and Physical Conditions 2007, Cat. no. PHE155, Canberra.

—— 2012b, Perinatal Depression - Data from the 2010 Australian National Infant Feeding Survey, Information Paper, Cat. no. PHE 161, Canberra.

—— 2019q, National Suicide Monitoring of Serving and Ex-Serving Australian Defence Force Personnel: 2019 Update, Cat. no. PHE-222.

—— 2020a, Australia’s Children, Cat. no. CWS 69, Canberra.

—— 2020b, Child Protection Australia 2018-19, Cat. no. CWS 74, Canberra.


—— 2020d, Mental Health Services in Australia - Expenditure on Mental Health Services 2017-18 Tables, Canberra.

—— 2020e, Mental Health Services in Australia - Key Performance Indicators for Australian Public Mental Health Services Tables, Canberra.

—— 2020f, Mental Health Services in Australia - Medicare-Subsidised Mental Health-Specific Services 2018-19 Tables, Canberra.

—— 2020g, Mental Health Services in Australia - Mental Health Services Provided by General Practitioners 2015-2016 Tables, Canberra.

—— 2020h, Mental Health Services in Australia - Mental Health-Related Care in General Practice 2015-16 Tables, Canberra.

—— 2020i, Mental Health Services in Australia - Mental Health-Related Prescriptions, Canberra.

—— 2020j, Mental Health Services in Australia - Mental Health-Related Prescriptions 2018-19 Tables, Canberra.

—— 2020k, Mental Health Services in Australia - Overnight Admitted Mental Health-Related Care 2017-18 Tables, Canberra.

—— 2020l, Mental Health Services in Australia - Psychologist Workforce, Canberra.

—— 2020m, Mental Health Services in Australia - Restrictive Practices Key Concepts, Canberra.

—— 2020n, Mental Health Services in Australia - Specialised Mental Health Care Facilities 2017-18 Tables, Canberra.


AITSL (Australian Institute for Teaching and School Leadership) 2011, Australian Professional Standards for Teachers, Melbourne.


—— 2019, Accreditation of Initial Teacher Education Programs in Australia - Standards and Procedures, AITSL, Melbourne.


AMSA Student Mental Health and Wellbeing Committee (Australian Medical Students’ Association Student Mental Health and Wellbeing Committee) 2013, Current University Student Mental Health Interventions, Canberra.


Andrews, D. (Premier) 2018, New Mental Health Hubs to Treat More Victorians Sooner, Media release, Melbourne, 10 May.


ANMAC (Australian Nursing and Midwifery Accreditation Council) 2018a, Review of Registered Nurse Accreditation Standards, Consultation paper 2, Canberra.


ANU (Australian National University) 2016, Mental Health Strategy, Canberra.


APHA (Australian Private Hospitals Association) 2018, Private Hospital-based Psychiatric Services: 1 July 2016 to 30 June 2017, Canberra.


ASQA (Australian Skills Quality Authority) 2015, Training for Early Childhood Education and Care in Australia, Strategic Review, Melbourne.


ASRC (Asylum Seeker Resource Centre) 2020, Submission to Select Committee on COVID-19, Melbourne.


— 2016b, *Suicide Prevention in Indigenous Communities: Literature Review*, School of Indigenous Studies, University of Western Australia.


REFERENCES


Bennett, J. 2019, ‘Compulsory treatment “gets a bad rep” but it saved this Victorian woman’s life’, ABC News, 8 July.


—— 2013, National Mental Health Survey of Doctors and Medical Students.

—— 2015, Stigma and discrimination associated with depression and anxiety, Information Paper.

—— 2016, Submission to the Australian Government Treasury Review of the financial system external dispute resolution framework, Melbourne.

—— 2017, Submission to the Senate Economics References Committee Inquiry into Consumer protection in the banking, insurance and financial sector, Melbourne.


Submission to the Parliamentary Joint Committee on Corporations and Financial Services Inquiry into the life insurance industry, Melbourne.


National Suicide Prevention Symposium: A snapshot of sites, systems approaches and learnings, May, Sydney.

Blythe, R., Lee, X. and Kularatna, S. 2019, HealthPathways: An Economic Analysis of the Impact of Primary Care Pathways in Mackay Queensland, Australian Centre for Health Services Innovation, Queensland University of Technology, Brisbane.


Burlingame, G.M., Janis, R.A., Seebeck, J.D. and Whitcomb, K.E. 2016, ‘Outcome differences between individual and group formats when identical and non-identical treatments, patients, and doses are compared: a 25-year meta-analytic perspective’, *Psychotherapy*, vol. 53, no. 4, pp. 446–461.


Cash, M. (Minister for S. and F.B., Skills and Vocational Education 2018a, Mental health linked to economic productivity in small business, Media release, 9 December.

——— 2018b, Small Business Mental Health Stakeholder Roundtable, 12 December.

Cashin, C. and Chi, Y. 2011, Australia: The Practice Incentives Program (PIP), World Bank.


CMHA (Community Mental Health Australia) 2017, *Community Mental Health Australia Submission to the Review of National Disability Insurance Scheme (NDIS) Costs Study*, Sub. 11, Melbourne.


Community Hubs Australia 2019, Submission to the Victorian Legislative Assembly Legal and Social Issues Committee, Melbourne.


ConNetica (ConNetica Consulting Pty Ltd) 2010, Suicide and Suicide Prevention in Australia: Breaking the Silence, Lifeline Australian and Suicide Prevention Australia.


COPE (Centre of Perinatal Excellence) 2017, Mental Health Care in the Perinatal Period, Australian Clinical Practice Guideline, Melbourne.


CRUfAD (Clinical Research Unit for Anxiety and Depression) 2019, Supplementary Information provided to the Productivity Commission Inquiry on Mental Health, Unpublished.


Dementia Australia 2017, *What is Dementia?*, Canberra.


—— 2019, *Temporary resident (skilled) visa holders pivot table*.


DMIRS (Department of Mines Industry Regulation and Safety, Western Australia) 2019, *Code of practice: Mentally healthy workplace for fly-in fly-out (FIFO) workers in the resources and construction sectors*.


—— 2019c, *Broad categories of disability used in the NCCD*.


—— nd, *PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Primary Mental Health Care Services for People with Severe Mental Illness*, Canberra.


— 2013c, Practice Incentives Program Rural Loading, November, Canberra.


— 2015a, Australian Government Response to Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services, Canberra.


— 2016a, Australia’s Future Health Workforce – Psychiatry, Canberra.


— 2016c, PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Psychological Therapies Provided by Mental Health Professionals for Underserviced Groups, Canberra.


— 2018a, Head to Health: Service Provider Information Pack, Canberra.

— 2018b, PHN Program Performance and Quality Framework, September.


— 2019b, Australia’s Long Term National Health Plan to Build the World’s Best Health System, Canberra.


— 2019h, Medicare Benefits Schedule Book - Category 1 Operating from 1 July 2019, Canberra.


—— 2019m, PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Psychological Therapies Provided by Mental Health Professionals for Underserviced Groups - 2019 update, Canberra.

—— 2019n, PHN Primary Mental Health Care Flexible Funding Pool Programme Guidance – Stepped Care, Canberra.


—— 2019q, Workforce Incentive Program (WIP): Factsheet, Canberra.

—— 2020a, Australian Government Mental Health Response to Bushfire Trauma, Canberra.


—— 2020c, COVID-19 Temporary MBS Telehealth Services: GPs and Other Medical Practitioners, Canberra.

—— 2020d, COVID-19 Temporary MBS Telehealth Services: Mental Health Services, Canberra.

—— 2020e, General Practice Workforce providing Primary Care services in Australia - Statistics by financial year, Dataset, 20 January.


—— 2020h, Medicare Benefits Schedule Book - Operating from 1 March 2020, Canberra.

—— 2020i, Mental Health Support for Australian Affected by the 2019-20 Bushfires: Frequently Asked Questions, Canberra.

—— 2020j, Method Paper: General Practice Full Time Equivalent (GPFTE) - Workforce, Canberra.

—— 2020k, Method summaries - GP headcount and workload methods, Canberra.

—— 2020l, National Health Workforce Dataset 2018, Canberra.


—— 2020n, Supporting the Mental Health of Australians Through the Coronavirus Pandemic, Fact Sheet: Coronavirus (COVID-19) National Health Plan, Canberra.

DoHA (Department of Health and Ageing) 2006, COAG Mental Health Funding for Telephone Counselling, Self Help and Web-based Support Programmes.

—— 2013, National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, May.


DUSC (Drug Utilisation Subcommittee) 2013, Use of Antipsychotics in the Middle Aged, Canberra.


Dubecki, L. 2017, 80% of Australians have a regular GP: The importance of continuity of care.

Duggan, M. 2015, Beyond the Fragments: Preventing the Costs and Consequences of Chronic Physical and Mental Diseases, Issues Paper no. 2015-05, Australian Health Policy Collaboration, Melbourne.


Eager, K. and Steele, P. 2016, Review of the Framework for Mental Health in Multicultural Australia, Final report, Australian Health Services Research Institute, University of Wollongong.

Eastly, H. 2018, ‘I had to find a loophole to get mental health care’, Herald Sun, 16 October.

Education Council 2017, 2017 Data on Students in Australian Schools Receiving Adjustments for Disability, Melbourne.

—— 2019, Alice Springs (Mparntwe) Education Declaration.


EMHSCA (Eastern Mental Health Service Coordination Alliance) 2016, Memorandum of Understanding, Melbourne.


Fair Work Commission 2018, *Reasonable management action carried out in a reasonable manner*.


FECCA (Federation of Ethnic Communities’ Council of Australia) 2015, *Pathways to Better Mental Health: Overcoming Barriers, Exploring Reform, Creating Constructive Solutions*, ACT.

REFERENCES


Fletcher, P. 2020, ‘Key lessons from bushfire failures’, *The Australian*, 4 May.


Fogliani, R.V.C. 2019, *Inquest into the Deaths of Thirteen Children and Young Persons in the Kimberley Region, Western Australia*, 25/2017, Western Australia State Coroner.


Foley, M. 2015, *New Joint Clinical And Police Response To Help People With Mental Illness In Melbourne’s North-East*, Media release, Melbourne, 23 September.


FSC (Financial Services Council) 2013, FSC Standard No. 21 Mental Health Education Program and Training, 22 August.

—— 2019, FSC Standard No. 26 Consent for accessing Health Information, 21 June.

FSRC (Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry) 2019, Final Report.


Governance Institute of Australia 2019, *Ethics Index*.


Grindlay, D. 2017, ‘Why $400,000 house and car packages are not enough to attract GPs to stay in the bush’, *ABC Rural*, 11 October.


References

Harvey, S.B., Joyce, S., Modini, M., Christensen, H., Bryant, R., Mykletun, A. and Mitchell, P.B. 2012, Work and Depression/Anxiety Disorders: A Systematic Review of Reviews, University of New South Wales, Sydney.


—— 2019c, headspace Centre Young Person Follow Up Study.


Higgins, C. 2019, Temporary Protection Visas and Safe Haven Enterprise Visas, Andrew and Renata Kaldor Centre for International Refugee Law, University of New South Wales, Sydney.


Hillier, L., Jones, T., Monagle, M., Overton, N., Gahan, L., Blackman, J. and Mitchell, A. 2010, Writing Themselves In 3: The Third National Study on the Sexual Health and Wellbeing of Same Sex Attracted and Gender Questioning Young People, Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne.


—— 2019a, *$70 million for residential eating disorders treatment centres across Australia*, Media release, Canberra, 2 April.

—— 2019b, *Building a Mentally and Physically Healthy Australia*, Media release, Canberra, 14 August.


REFERENCES

Hunter, F. 2019, ‘Education minister Dan Tehan wants to see stronger English language tests for international students’, The Courier, 31 May.

HWA (Health Workforce Australia) 2012, Health Workforce 2025 - Doctors, Nurses and Midwives - Volume 1, Adelaide.
— 2014a, Aboriginal and Torres Strait Islander Health Workers: Practitioners in Focus, Canberra.


IHME (Institute for Health Metrics and Evaluation) 2019, Global Burden of Disease Results Tool, Global Health Data Exchange, University of Washington, Seattle.

IndianCare 2019, IndianCare 6th Annual General Report, Melbourne.

Infrastructure Australia 2020, Infrastructure Priority List: Project and Initiative Summaries.


Integrated Regional Planning Working Group 2018, Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services: A Guide for Local Health Networks (LHNs) and Primary Health Networks (PHNs), National Mental Health Strategy, COAG Mental Health Principal Committee.

Intergovernmental Committee on Drugs 2012, National Tobacco Strategy 2012-2018, Canberra.

IPHYWG (International Physical Health in Youth Working Group) 2013, Healthy Active Lives (HeAL) Consensus Statement 2013.


Jenkins, B. and Katz, I. 2015, Adolescents’ and young adults’ use of Emergency Departments:, Evidence Check rapid review brokered by the Sax Institute for NSW Kids and Families, Sydney.


Kings Fund 2017, What is social prescribing?


Knight, B. 2012, Evolution of apprenticeships and traineeships in Australia; an unfinished story, NCVER Occasional Paper, National Centre for Vocational Education Research.


KPMG 2013, The Economic Cost of Suicide in Australia, Report prepared for Menslink.

and Mental Health Australia 2018, *Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform*.


REFERENCES


Livingston, J.D. 2013, Mental illness-related structural stigma: The downward spiral of systemic exclusion.


Lowitja Institute 2018a, Journeys to Healing and Strong Wellbeing - Final Report, Lowitja Institute, Melbourne.


McGorry, P. 2019, ‘Mental illness is more ubiquitous than cancer. How can we help the “missing middle”?’, The Guardian, 26 April.
McMahon, J. 2019, Towards Professionalisation: A Project to Undertake a Feasibility Study into the Establishment of a Member Based Organisation for the Peer Workforce in Australia, Private Mental Health Consumer Carer Network (Australia) Limited.


Mental Health Australia 2018, Submission to the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry.


MHCA (Mental Health Council of Australia) 2011, Consumer and carer experiences of stigma from mental health and other health professionals.


MHV (Mental Health Victoria) 2018, Saving lives. Saving money., June, Melbourne.

Miles, S. 2019, $62 million to fight suicide, Media Release, Brisbane, 6 June.


—— 2019b, *Pre-Budget Submission: MindSpot 2.0*.

Minister for Health and Hunt, G. 2018, $9 million Boost for Youth Mental Health, Media release, Canberra, 5 September.


Mission and ReachOut 2018, *Lifting the weight: Understanding young people’s mental health and service needs in regional and remote Australia*.


Moloney, L. 2016, *Defining and Delivering Effective Counselling and Psychotherapy*.


Monnier, J., Knapp, R.G. and Frueh, B.C. 2003, ‘Recent advances in telepsychiatry: an updated review’, 

Monti, F., Tonetti, L. and Ricci Bitti, P.E. 2014, ‘Comparison of cognitive-behavioural therapy and 
psychodynamic therapy in the treatment of anxiety among university students: an effectiveness study’, 

——, ——— and ——— 2016, ‘Short-term effectiveness of psychotherapy treatments delivered at a university 

Moore, T., Sutton, K. and Maybery, D. 2010, ‘Rural mental health workforce difficulties: a management 
perspective’, *The International Electronic Journal of Rural and Remote Health Research*, vol. 10, 
no. 1519, pp. 1–10.

treatment from health professionals: A national survey of adults with mental health problems’, *Australian 
and New Zealand Journal of Psychiatry*, vol. 50, no. 8, pp. 754–762.

effectiveness of unguided internet cognitive behavioural therapy for mixed anxiety and depression’, 
*Internet Interventions*, vol. 10, pp. 47–53.

Morgan, V.A., Waterreus, A., Jablensky, A., Mackinnon, A., McGrath, J.J., Carr, V., Bush, R., Castle, D., Cohen, 

——, ———, ———, ———, ———, ———, ———, Cohen, M., Harvey, C., Galletly, C., Stain, H.J., Neil, A.L., 
second Australian national survey of psychosis’, *Australian and New Zealand Journal of Psychiatry*, 
vol. 46, no. 8, pp. 735–752.

‘Telemedicine versus in-person delivery of cognitive processing therapy for women with posttraumatic 
stress disorder: a randomized noninferiority trial’, *Depression and Anxiety*, vol. 32, no. 11, pp. 811–820.


Morrison, S., Payne, M. and Ruston, A. (Prime Minister, Minister for Foreign Affairs and Women and Assistant 
Minister for Health, Minister for Families and Social Services) 2020, *$1.1 Billion to Support More Mental 
Health, Medicare and Domestic Violence Services*, Media release, Canberra, 29 March.

Services: A Review of the Problem and Its Remediation’, *Administration and policy in mental health*, 

Moxham, L., Taylor, E., Patterson, C., Perlman, D., Brightin, R., Sumskis, S., Keough, E. and Heffernan, T. 
2016, ‘Can a clinical placement influence stigma? An analysis of measures of social distance’, *Nurse 

Mulder, A.M. and Cashin, A. 2015, ‘Health and wellbeing in students with very high psychological distress 
from a regional Australian university’, *Advances in Mental Health*, vol. 13, no. 1, pp. 72–83.

childhood and mental health service use: findings from a longitudinal population-based study’, *The British 

Munkholm, K., Paludan-Müller, A.S. and Boesen, K. 2019, ‘Considering the methodological limitations in the 
evidence base of antidepressants for depression: a reanalysis of a network meta-analysis’, *BMJ Open*, 
vol. 9, no. 6.

Murali, V. and Oyebode, F. 2004, ‘Poverty, social inequality and mental health’, *Advances in Psychiatric 


National Collaborating Centre for Mental Health (UK) 2010, ‘Chapter 8 - High-intensity Psychological Interventions’, *Depression: The Treatment and Management of Depression in Adults (Updated Edition)*, NICE Clinical Guidelines, British Psychological Society, Leicester, UK.


NHMRC Centre of Research Excellence in Suicide Prevention 2015, Care After a Suicide Attempt, Report prepared for the National Mental Health Commission, Sydney.


—— 2020, Course finder - NHS health careers, https://www.healthcareers.nhs.uk/career-finder?field_leading_to_a_career_in_tid=188&field_qualification_type_tid=64&field_study_mode_tid=All&field_region_tid=All&field_provider_name_tid=All (accessed 5 May 2020).


—— 2014b, Contributing Lives Thriving Communities: Report of the National Review of Mental Health Programmes and Services - Summary, Sydney.

—— 2014c, Contributing Lives Thriving Communities: Report of the National Review of Mental Health Programs and Services - Volume 1, Sydney.


—— 2017a, Educational interventions to reduce older persons’ loneliness.

—— 2017b, e-Health interventions to reduce older persons’ loneliness.

—— 2018a, Monitoring Mental Health and Suicide Prevention Reform: Fifth National Mental Health and Suicide Prevention Plan Progress Report, Sydney.


2019b, Outcomes of Workshops at the 2019 NSW Consumer Peer Workers’ Forum, 29 October.


NRHA (National Rural Health Alliance) 2013, How many doctors are there in rural Australia?, Fact sheet, December.

— 2017, Mental Health in Rural and Remote Australia.


NSW BHI (NSW Bureau of Health Information) 2019, *People’s Use and Experiences of Mental Health Care in NSW*, Sydney.

NSW Education Standards Authority 2018, *NSW supplementary documentation: subject content knowledge requirements*.


---


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2018c, *Workers compensation market practice and premiums guidelines. For premium filings on or after 1 March 2018*.


---


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NSW Minister for Health and Minister for Medical Research and Hazzard, B. 2019, *All overseas visitors should have health cover*, Media release, Sydney, 31 January.


—— 2017b, What is peer work?

—— 2018a, A Better Fit - Improving the Access and Acceptability of Youth Mental Health Services, Melbourne.

—— 2018b, Vocational Education and Training (VET) Student Mental Health, Melbourne.


PBA (Psychology Board of Australia) 2018, Reducing Regulatory Burden: Retiring the 4+2 Internship Pathway to General Registration, Public Consultation.


—— 2011, Disability Care and Support, Report no. 54, Canberra.

—— 2012, Schools Workforce, Research report, Canberra.

—— 2013, PC Productivity Update 2013, May, Canberra.


—— 2016a, National Education Evidence Base, Report no. 80, Canberra.

—— 2016b, PC Productivity Update 2016, Canberra.

—— 2017a, Data Availability and Use, Report no. 82, Canberra.


—— 2017d, National Disability Insurance Scheme (NDIS) Costs, Study Report, Canberra.

—— 2017e, Shifting the Dial: 5 Year Productivity Review, Report no. 84, Canberra.

—— 2018a, Competition in the Australian Financial System, Report no. 89, Canberra.


PIAC (Public Interest Advocacy Centre) 2017, *Submission to the Parliamentary Joint Committee on Corporations and Financial Services Inquiry into the life insurance Industry*, Sydney.


PwC (PricewaterhouseCoopers) 2014, Creating a Mentally Healthy Workplace: Return on Investment Analysis, Melbourne.


QCMHR (Queensland Centre for Mental Health Research) 2016, National Mental Health Service Planning Framework: Service Element and Activity Descriptions: AUS V2.2, University of Queensland, Brisbane.

— 2019, Introduction to the National Mental Health Service Planning Framework, Brisbane.

QMHC (Queensland Mental Health Commission) 2015, Service Integration and Referral Mapping for Mental Health and Alcohol and Other Drugs, Regional Report 2015, Brisbane.


— 2020, Day Program Model of Service - Queensland Public Mental Health Services, Brisbane.

Quin, N. 2015, ‘Firefighters’ compensation and presumptive legislation’.

RACGP (Royal Australian College of General Practitioners) 2013, Managing emergencies and pandemics in general practice: A guide for preparation, response and recovery, Royal Australian College of General Practitioners, Melbourne, Australia.


— 2017, Submission to the Parliamentary Joint Committee on Corporations and Financial Services Inquiry into the life insurance industry, Melbourne.

RACP (Royal Australian College of Physicians) 2018, Aboriginal and Torres Strait Islander Health Position Statement.


RANZCP (CEG Consulting) 2014, Keeping Your Head Above Water: Affordability as a Barrier to Mental Health Care, A report prepared for the Royal Australian and New Zealand College of Psychiatrists.

—— 2015, Keeping Body and Mind Together: Improving the Physical Health and Life Expectancy of People with Serious Mental Illness, Melbourne.

—— 2016a, Aboriginal and Torres Strait Islander Mental Health Workers, Position statement 50, Melbourne.

—— 2016b, The Economic Cost of Serious Mental Illness and Comorbidities in Australia and New Zealand, Melbourne.


—— 2017b, Submission to the Parliamentary Joint Committee on Corporations and Financial Services Inquiry into the life insurance industry, Melbourne.


—— 2017e, Your Health in Mind: Physical Health and Mental Illness, Melbourne.

—— 2019, Child and adolescent psychiatry: meeting future workforce needs, June.


RANZCP (Tas) (Royal Australian and New Zealand College of Psychiatrists, Tasmanian Branch) 2017, Submission to the Inquiry into acute health services in Tasmania, Hobart.


—— and EY 2015, A Way Forward: Equipping Australia’s Mental Health System for the Next Generation.


Regional and Rural Area Mental Health Services of Victoria 2019, Submission to Victoria’s Royal Commission into Mental Health, SUB.0002.0029.0415, Melbourne.


Royal Commission into Aged Care Quality and Safety 2019, Interim Report: Neglect, Volume 1, Canberra.


SA DoE (Department of Education (South Australia)) 2019, Wellbeing and Engagement Collection - South Australia 2018, Adelaide.


Safe Work Australia 2017, Comparison of Workers’ Compensation Arrangements in Australia and New Zealand 2017, 25th edn, Canberra/

— 2018a, Comparison of Workers’ Compensation Arrangements in Australia and New Zealand 2018, 26th edn.


— 2018c, Summary of Findings - Return to Work in Psychological Injury Claims, 4 July, Canberra.


SAMHC (South Australian Mental Health Commission) 2019, Mental Health Services Plan 2020-2025, Adelaide.

SAMHSA (Substance Abuse and Mental Health Services Administration) 2014, SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach, HHS Publication No. (SMA) 14-4884, Substance Abuse and Mental Health Services Administration, Rockville, MD.


Sax Institute 2015, Comorbid Mental Illness and Illicit Substance Use, An Evidence Check rapid review brokered by the Sax Institute for the NSW Mental Health and Drug and Alcohol Office, Sydney.


—— 2020b, ‘Coronavirus worries have Australian children calling Kids Helpline every 69 seconds’, 22 April.


SCARC (Senate Community Affairs References Committee) 2010, The Hidden Toll: Suicide in Australia, Canberra.

—— 2015, Out of Home Care, Canberra.


SCMH (Senate Select Committee on Mental Health) 2006, A National Approach to Mental Health: From Crisis to Community, Canberra.


SERC (Senate Economic References Committee) 2018, Regulatory Framework for the Protection of Consumers in the Banking, Insurance and Financial Services Sector, Canberra.


Skatsoon, J. 2020, “‘Recovery coach’ to be added as NDIS item for mental illness’, *Community Care Review*, 20 February.


South Eastern Melbourne PHN 2018, *Mental Health Integrated Complex Care (MHICC)*.


SSCOAGBC (Senate Select Committee into the Abbot Government’s Budget Cuts) 2015, *Senate Select Committee into the Abbot Government’s Budget Cuts*, Canberra.


en


TNS Social Research 2014, State of Workplace Mental Health in Australia, Report for Beyond Blue, Melbourne


Trachtenberg, M., Parsonage, M., Shepherd, G. and Boardman, J. 2013, Peer Support in Mental Health Care: Is It Good Value for Money?, Centre for Mental Health, London.


Turner, J. 2015, Telephone versus Face-to-Face Psychological Therapy in an Improving Access to Psychological Therapies (IAPT) Low-Intensity Service: An exploration of practitioners’ and patients’ experiences and its effectiveness, University of Southampton, Southampton, UK.


University of Queensland 2016a, Technical Appendices for the NMHSPF, Version AUS V2.2, Commissioned by the Australian Government Department of Health, Brisbane.


US DHHS (United States Department of Health and Human Services) 2001, Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General, Rockville, MD.


VAGO (Victorian Auditor-General’s Office) 2010, The Effectiveness of Student Wellbeing Programs and Services, Victorian Auditor-General’s Report, 2009-10:14, Melbourne.


VDDI (Victorian Dual Diagnosis Initiative) 2019, Submission to the Royal Commission into Victoria’s Mental Health System, Melbourne.


——— and Street, A. 2012, Unfinished Business: Student Perspectives on Disclosure of Mental Illness and Success in VET, National Centre for Vocational Education Research, Adelaide.


VIC DHHS (Department of Health and Human Services (Victoria)) 2015, Victoria’s 10-Year Mental Health Plan, Melbourne.


VIC MHT (Victorian Mental Health Tribunal) 2019, Submission to the Royal Commission into the Victorian Mental Health System, SUB.1000.0001.0979, Melbourne.


Victorian Government 2019, Submission to the Royal Commission into Victoria’s Mental Health System, Sub. 5000.0001.0002, Melbourne.


Volunteering Australia 2017, Submission to the Transitioning Regional Economies Study, Sub. DR61, Canberra.


WA TWD (Department of Training and Workforce Development (Western Australia)) 2012, Staying the Course: A Guide to Working with Students with Mental Illness, Perth.


— 2004a, Prevention of Mental Disorders - Effective Interventions and Policy Options, Geneva.
— 2004b, The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines, Geneva.
— 2013, How to Use the ICF: A Practical Manual for Using the International Classification of Functioning, Disability and Health (ICF), Exposure draft for comment, Geneva.
— 2014b, Social Determinants of Mental Health, Geneva.
— 2018b, Management of Physical Health Conditions in Adults with Severe Mental Disorders, WHO Guidelines, Geneva.


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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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The Commission’s report is in three volumes. Volume 1 contains the overview and recommendations. Volume 2 contains chapters 1 to 16 and references. This Volume 3 contains chapters 17 to 25 and appendix A and references. Below is the table of contents for all volumes.

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17 Psychosocial support – recovery and living in the community

Improving psychosocial supports matters because...

- Psychosocial supports — which include a range of services to help people manage daily activities, rebuild and maintain connections, build social skills and participate in education and employment — can facilitate recovery in the community for people experiencing mental ill-health.

- Not everyone who needs psychosocial supports is able to access them. Significant service gaps stem from ad hoc funding arrangements, short funding cycles and lack of economies of scale.

- The transition of service provision to the National Disability Insurance Scheme (NDIS) has led to uncertainty for both service providers and consumers, which may affect access to services.
RECOMMENDATION 17 — IMPROVE THE AVAILABILITY OF PSYCHOSOCIAL SUPPORTS

The delivery of psychosocial supports — including a range of services to help people manage daily activities, rebuild and maintain social connections, build social skills and participate in education and employment — has been hampered by inefficient funding arrangements and service gaps. This is affecting the recovery of people with mental illness and their families, who can benefit substantially from improved access to psychosocial supports.

As a priority:

- Governments should ensure that all people who have psychosocial needs arising from mental illness receive adequate psychosocial support. To achieve this:
  - The shortfall in the provision of psychosocial supports outside the National Disability Insurance Scheme (NDIS) should be estimated at a regional and State and Territory level. (Action 17.3)
  - Over time, State and Territory Governments, with support from the Australian Government, should increase the quantum of funding allocated to psychosocial supports to meet the estimated shortfall. (Action 17.3)

Additional reforms that should be considered:

- As contracts come up for renewal, commissioning agencies should extend the length of the funding cycle for psychosocial supports from a one-year term to a minimum of five years. Commissioning agencies should ensure that the outcome for each subsequent funding cycle is known by providers at least six months prior to the end of the previous cycle. (Action 17.1)

- State and Territory Governments and the National Disability Insurance Agency should streamline access to psychosocial supports both for people eligible for supports through the NDIS and for people who choose not to apply for the NDIS or are not eligible. (Action 17.2)

- State and Territory Governments should continue working with the National Disability Insurance Agency to clarify the interface between the mainstream mental health system and the NDIS. (Action 17.3)
Psychosocial supports help people experiencing or recovering from mental illness to achieve higher levels of wellbeing and engage with their communities. They are mainly delivered by community-based organisations, with funding from the Australian, State and Territory Governments, and the National Disability Insurance Scheme (NDIS), which funds long-term care and support for people with severe or profound disabilities.

Estimates from the National Mental Health Service Planning Framework (NMHSPF) suggest that about 690,000 people with mental illness would benefit from some type of psychosocial support in 2019-20. Among them are 290,000 people with severe and persistent mental illness who are most in need of psychosocial support. However, many of these people do not receive any support or the level of support falls short of what is needed.

The provision of psychosocial supports, which has long been affected by inefficient and duplicative funding arrangements, is currently in a state of transition as the NDIS roll-out is in progress. The transition to the NDIS, while providing for some, appears to have left a significant gap in service provision for many others. When the NDIS roll-out is completed, about 64,000 people with the highest psychosocial needs would access individualised supports through the NDIS. Some people would be able to access services funded by State and Territory Governments — but the Productivity Commission estimates that up to 154,000 people would not be able to receive the services they require, based on current policy settings.

Improving psychosocial supports requires a systemic shift in the way these supports are planned and funded, recognising their importance for consumers in the mental health system and incorporating them into this Inquiry’s broader reform agenda. This chapter recommends a number of actions to achieve this. Systemic issues are explored in detail in other chapters, including reforms to governance (chapter 22), overhauling funding arrangements (chapter 23), the integration and coordination of services (chapter 15) and workforce arrangements for the community mental health sector (chapter 16).

In this chapter, section 17.1 explores what psychosocial supports are, why they are important, and who accesses them. Section 17.2 considers how the delivery of mainstream psychosocial supports has been affected by issues arising from funding arrangements and the impact of the transition to the NDIS. Section 17.3 provides a brief overview of the NDIS, discusses the experiences of people with psychosocial disability within the NDIS and what is being done to improve their experience. Section 17.4 presents solutions to improve the delivery of psychosocial supports, including through meeting the shortfall in the provision of psychosocial supports and improving the interface between mainstream psychosocial supports and the NDIS.

166 There is a larger group of people accessing low intensity psychosocial supports through peer forums and other types of services — these are discussed in chapter 12. This chapter focuses on people who need more intensive psychosocial supports. Additional psychosocial supports are covered in detail in other chapters, such as services aimed at carers (chapter 18), housing (chapter 20) and care coordination (chapter 15).

167 The Department of Health estimated this at approximately 282,000 people in 2016. Incorporating population growth using the ABS Estimated Resident Population, the number of people with severe and persistent mental illness who are most in need of psychosocial support is estimated to be 290,000 people in 2018-19 (DoH 2017b).
17.1 Programs and services that support recovery

‘Psychosocial’ refers to the interaction between psychological and social or cultural components of life, giving recognition to the potential impacts of mental ill-health on a person’s ability to take part in day-to-day activities (Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212, p. 7). Accordingly, psychosocial support addresses a person’s emotional, social, mental and spiritual needs (OVCSupport 2020). Psychosocial supports can facilitate recovery in the community for people experiencing mental ill-health at all levels of severity and across a diverse range of backgrounds.

Psychosocial supports for people with mental ill-health are predominantly delivered by non-government organisations (NGOs) and funded by the Australian, State and Territory Governments. The supports provided to people can vary greatly due to personal requirements — as they are targeted to the specific needs of the person — and service availability. Supports include those that assist with participating in the community, managing daily tasks, undertaking work or study; helpline and counselling services; advocacy and promotion; finding accommodation; and improving connections with friends and family (CMHA 2012; NWMPHN 2019; QAMH, sub. 714) (figure 17.1). Supports may be provided through individual, group and community programs (box 17.1).

Psychosocial supports comprise psychosocial disability supports and psychosocial rehabilitation.

- **Psychosocial disability** refers to processes, interventions and services that aim to support an individual to maintain their current level of independence. Supports can include those that assist with managing daily living needs, establishing or maintaining a tenancy, rebuilding and maintaining connections, and developing social skills to build friendships and relationships.

- **Psychosocial rehabilitation** aims to enhance and increase skill development, maximising the potential to manage everyday life, participate in the community and increase independence (Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212, p. 8).

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168 A psychosocial disability is an impairment or restriction, arising due to mental illness, that can limit, for example, an individual’s ability to function, think clearly, enjoy full physical health or manage their social and emotional welfare. However, in this context, the terminology refers to the support being provided, rather than the mental ill-health that a person may experience.
Rehabilitation focuses on ‘doing with, not for, by supporting people to develop their skills to manage the ups and downs on their own’ (MHCSA, sub. 794, p. 9). Similarly to how someone who is physically injured may require long-term physical rehabilitation to help them recover, people recovering from mental ill-health may require supports to mend and rebuild emotionally, cognitively, practically and socially, helping them to develop or regain skills necessary to be able to fully participate in society (Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212, p. 8).

The nongovernment agencies across Australia provide thousands of people with psychosocial support to help them live a more fulfilling life in the community … in between their 30 minute monthly appointment with their psychiatrist or case manager, they have a life to live, and psychosocial support assists them to lead that life. (Joe Calleja, Perth transcript, p. 24)

Psychosocial support is not a quick fix. It is about a relationship building, relationship modelling, it is about identifying and developing skills you already have as an individual, as a partner, as a couple, as a family. (VMIAC, Melbourne transcript, p. 162)

It’s primarily community focused, has family life at its heart and deals with the real world. So we’ve got the personal and interpersonal aspects of a recovery approach or psychosocial support, if you like. Then you’ve got the community level psychosocial supports which connect the people
to stable accommodation, income, vocational support, connect people into clubs, social activities and other activities that lead to social inclusion, participation and contribution to family and community life. (MIFA, Brisbane transcript, p. 20)

Box 17.1 Examples of programs providing psychosocial support

There is a broad range of psychosocial programs funded by Australian and State and Territory Governments. Two examples of Australian Government-funded supports were Personal Helpers and Mentors (PHaMs) and Support for Day to Day Living in the Community (D2DL) programs.

PHaMs provided assistance to people with severe functional limitations resulting from mental illness to participate economically and socially in their communities. PHaMs services provided coordinated access to support services such as housing support, employment and education, independent living skills courses and clinical services (AIHW 2019g). The D2DL program funded organisations that provided structured and socially-based day activities that help to improve the quality of life of individuals with severe and persistent mental illness. These activities included cooking classes, vocational activities, creative arts and social outings (DoHA 2010).

Funding for PHaMs and D2DL transitioned to the NDIS on 1 July 2019 (DoH 2019f; DSS 2019m). Providers of these programs received an extension of funding to support participants to transition over to the NDIS (Fletcher and Hunt 2019).

Examples of State-funded psychosocial support include supportive housing (e.g. the Housing and Accommodation Support Initiative (HASI) in New South Wales, Tasmania and Northern Territory, discussed in detail in chapter 20); psychosocial rehabilitation and support services; centre-based day care; individualised supports (e.g. Early Intervention Psychosocial Support Response in Victoria, and Individualised Community Living Strategy in Western Australia); coordination and case management services (e.g. Lead Support Coordination Service in Tasmania, Integrated Services Response Program in the ACT).

Other examples of programs providing psychosocial support include social inclusion programs, community and drop-in centres, advocacy programs, individual psychosocial rehabilitation, and support services and clubhouses.

Who uses psychosocial supports?

In 2016-17, approximately 90–95 000 people were receiving psychosocial disability support from Australian, State and Territory Government-funded programs (DoH 2017b). While users of psychosocial supports are predominantly people who have mental illness with severe and complex needs, some people with moderate clinical needs also require (sometimes significant) psychosocial supports (Mental Health Australia, sub. 407; Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212). Mood disorders and schizophrenia were the most common diagnoses among users of psychosocial supports (figure 17.2). Many have major comorbidities and present complex diagnoses. For example, in 2014-15, an estimated 37.5% of Personal Helpers and Mentors (PHaMs) participants had a physical disability (AIHW 2019g).

169 This figure does not account for client turnover, which would result in a greater number of people accessing the supports over time.
The use of psychosocial supports is not only limited to people experiencing mental illness as psychosocial needs can also arise from social and personal life stressors. Psychosocial supports may be needed by anybody who would benefit from assistance with daily living, rebuilding and maintaining social connections, or skill development. There is some evidence of the efficacy of psychosocial interventions for people experiencing numerous conditions, including cancer, substance use disorder and intellectual disability (Cancer Australia 2020; Dagnan 2007; Grassi, Spiegel and Riba 2017; Hunt et al. 2013). The psychosocial supports referred to in this report are for people whose need for the supports arises from mental ill-health.

**Why are psychosocial supports important?**

Psychosocial supports play a vital role in enabling those living with mental illness to live well, to recover in their communities, and to counter the stigma and discrimination they may face (Duff et al. 2011; MIFA, sub. 897; Tew et al. 2012; Victorian Government 2019a). Psychosocial supports can empower people to achieve independence, increase control over daily life, and promote self-determination (MHCC, sub. 214; MIFA sub. 897; Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212). They are often critical in helping people manage their mental illness.

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**Figure 17.2** Common mental illness diagnoses of psychosocial support users\(^a,b\)

<table>
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<th>PIR</th>
<th>PHaMs</th>
<th>D2DL</th>
</tr>
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<tbody>
<tr>
<td>Mood disorders</td>
<td>53%</td>
<td>43%</td>
<td>30%</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>30%</td>
<td>35%</td>
<td>23%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>33%</td>
<td>19%</td>
<td>7%</td>
</tr>
<tr>
<td>PTSD</td>
<td>29%</td>
<td>14%</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>24%</td>
<td>20%</td>
<td>16%</td>
</tr>
</tbody>
</table>

\(^a\) Participants may be in more than one category and totals sum to greater than 100%. For Partners in Recovery (PIR) and Personal Helpers and Mentors (PHaMs), organisations list all diagnoses, while for Support for Day to Day Living in the Community (D2DL), many organisations only keep primary diagnoses, so the number of participants with each diagnoses may be an underestimation for D2DL. \(^b\) Diagnostic data is based on 2678 individuals for PIR, 2257 for PHaMs and 1127 for D2DL.

*Source: Community Mental Health Australia and University of Sydney (2019a).*
If we use that analogy of stepping up and stepping down, we imagine a staircase … psychosocial services are the handrail[s] that help people step up and step down … the thing that keeps everything stable and allows people … to just hang on to while they’re working stuff out. So it doesn’t matter whether they’re stepping up or stepping down or just staying where they are at the moment, because where I am is just okay, that handrail is a thing that keeps them safe at that point in time. (Skylight Mental Health, Adelaide transcript, pp. 26–7)

[Psychosocial interventions] have the potential to reduce the experience of impairment and provide early assistance that maximises people with psychosocial disabilities’ potential to work, improve their relationships with their families and others, gain new skills, stabilise their housing and self-manage. (Hayes et al. 2016)

Several Inquiry participants spoke of the importance of psychosocial supports to a person’s recovery, describing them not only as important foundations to complement and support clinical interventions, but as critical to the effectiveness of clinical care (CSSA, sub. 202; Joe Calleja, Perth transcript, p. 23; MIFA, sub. 897, Brisbane transcript, p. 19; Skylight Mental Health, Adelaide transcript, p. 26; UnitingSA, sub. 807). Psychosocial supports can be particularly effective in promoting recovery, especially when applied early (QAMH, sub. 714; Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212).

A person’s cultural and linguistic background will affect how they interpret and respond to life experiences (WA DLGSC, sub. 78; RASA, sub. 420). As such, it is important that psychosocial supports are targeted and adapted to address the needs of people from culturally and linguistically diverse (CALD) backgrounds (Mental Health Australia, FECCA and NECA, sub. 524; Mental Health Coalition SA, sub. 794; SAMHC, sub. 477). Culturally capable psychosocial support providers are essential to preventing relapse in people from CALD backgrounds, can provide cultural interpretation and help people integrate into their communities (Rickwood 2006), which can bolster social inclusion (chapter 8).

The provision of psychosocial support not only directly benefits the psychosocial capability of users, but is also associated with benefits to the wider community, such as greater social inclusion, participation and contribution to the community through employment and volunteering (MHACA, sub. 726, p. 1; Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212; VMIAC, Melbourne transcript, p. 165).

There can also be benefits to governments, as psychosocial supports may reduce demand for more expensive interventions (LELAN, sub. 771; MHACA, sub. 726; MIFA, sub. 897; QAMH, sub. 714; TeamHEALTH, sub. 756). For example, an evaluation of a South Australian Government-funded psychosocial support service found a 39% reduction in mental health-related hospital admissions and a 16% reduction in the average length of hospital stay for people accessing the service (UnitingSA, sub. 807). The National Mental Health Commission (NMHC 2014b, p. 28) estimated that:

… for people with complex needs, such as a person with severe bipolar disorder, optimal care (based upon greater GP contact, increased support from community mental health teams and continued access to care coordination and psychosocial supports) can yield savings over nine years of $323,000, with about half of that saving being directly to the states through reduced acute care costs (admissions) … and about one-third to the Commonwealth.
In the absence of adequate psychosocial supports, people’s needs can easily escalate to costlier services.

When these supports are unavailable or break down they can exacerbate or even become the precursor to a period of illness that requires an emergency response that is expensive, can be distressing for consumers and their families, and may contribute to further disengagement with the system. (Mental Health Australia, sub. 407, p. 22)

Currently, there is an overreliance on crisis services, emergency departments and admission to acute or inpatient facilities due to a lack of community mental health support that could intervene early (Fels 2018; Mental Health Commission of New South Wales, sub. 486, p. 11; WAMHC 2015a). This is discussed further in chapter 13.

Who provides psychosocial supports?

Psychosocial supports are provided mainly by NGOs, sometimes referred to as ‘community managed organisations’, in the community mental health sector (QAMH, sub. 714; MHCC 2015) (box 17.2). These psychosocial supports complement clinical treatment to improve consumer outcomes.

Australia’s community mental health (CMH) services are distinct from, yet complement clinical mental health services … CMH services focus on supporting the recovery goals of consumers through various psychosocial approaches. CMH services offer holistic, person centred support with the many life domains which impact on mental health. (ASU, sub. 177, p. 3)

NGOs provide a wide range of supports, and often are ‘best placed to provide essential links into the community and between services’, with a ‘capacity to run flexible and consumer-centred care’ (SCMH 2006, p. 228). The supports they offer encompass a wide range of services that affect people’s recovery from mental ill-health.

While a number of organisations are funded to provide targeted services to people with mental illness, many social service organisations support people with mental illness indirectly through the provision of a wide range of social services including homelessness support, children, youth and family support services, alcohol and drug support, employment services and other health and wellbeing services. (NTCOSS, sub. 408, p. 1)

There is no national data collection on psychosocial support providers. The Mental Health Non-Government Organisation Establishments National Best Endeavours Data Set is currently being implemented, but has only been initiated in Western Australia and Queensland (AIHW 2015; CMHA, Sydney transcript, p. 106). Overall, data collection is not comprehensive and possibly inconsistent across jurisdictions. Broader issues and recommendations regarding data collection in mental health are discussed in chapter 24.

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170 ‘Psychosocial supports’, ‘community mental health supports’ and ‘community mental health services’ are often used interchangeably by the sector. Our report considers community mental health services to comprise all mental health services provided outside hospitals (chapters 10, 12, 13).
Box 17.2  Examples of providers of psychosocial supports

**Mind Australia** is a community-managed specialised mental health service provider that supports people dealing with the day-to-day impacts of mental illness, as well as their families and carers. Mind provides recovery-focused, person-centred support including residential rehabilitation, personalised support, family and carer services, and care coordination. They deliver outreach and residential services in partnerships with clinical agencies. Mind also conducts research and advocacy work.

**One Door Mental Health** is a mental health recovery organisation providing psychosocial support programs, care coordination, housing, clinical and peer-supported services for people living with severe and complex mental illness across New South Wales. They deliver trauma-informed and recovery-oriented support through the NDIS for people with psychosocial disability.

**UnitingSA** is a member of the Mental Health Coalition of SA and provides community services, housing and aged care to support people across South Australia. UnitingSA workers provide significant mental health support to people accessing their services that include employment, aged care, family and homelessness services.

**Culture in Mind** is a multicultural, community-based mental health support and recovery service supporting the mental wellbeing of people from culturally and linguistically diverse (CALD) backgrounds in Brisbane. Their cultural support workers and wellbeing support coordinators work with individuals, family and carers to provide wrap-around culture-based care through individual and group-based programs.

*Source: Culture in Mind (2018); Mental Health Australia, the Federation of Ethnic Communities’ Councils of Australia and the National Ethnic Disability Alliance, sub. 524; Mind Australia, sub. 380; One Door Mental Health, sub. 856; UnitingSA, sub. 807.*

A survey conducted in 2009-10 found that there were 798 organisations in Australia providing psychosocial supports, and it is likely that their number has grown since then. Most providers are small organisations. In 2014-15, the 47 NGOs delivering psychosocial supports across Western Australia had an average of 3.92 (paid) full-time equivalent staff (WAMHC 2016b). A 2019 survey found that, in New South Wales, 83% of the workforce was employed by under one-fifth of the total number of organisations, suggesting that the sector is dominated by a few large NGOs while most are very small (MHCC and HCA 2019).

The community mental health sector’s work is often underpinned by staff with lived experience, resulting in greater sensitivity to people’s individual needs:

[We] employ skilled professional mental health workers that deliver different types of services within their discipline and scope of practice. Many of our staff have lived experience, which enables our organisations to draw upon their expertise to inform and deliver our services … The support they provide is flexible and personalised, provided at various intensities as per intensive and moderate, to enable capacity building of individual and family/carer. (Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212, pp. 16–18)
17.2 The delivery of psychosocial supports is hampered by inefficient funding mechanisms

There is a variety of psychosocial supports available across Australia, funded by both the Australian Government and State and Territory Governments (box 17.1). Prior to the introduction of the NDIS, funding for psychosocial supports was already a complex web of different streams. States and Territories held the primary responsibility for psychosocial support services, including funding, delivering and/or managing specialised mental health services that were then delivered through NGOs. The Australian Government held responsibility for the oversight and funding of a range of additional services and programs that were primarily provided or delivered by private practitioners or NGOs (DoH 2017a).

Current funding arrangements remain largely similar in structure, though there is also some funding through the NDIS (for eligible participants). States and Territories have, to varying degrees, transferred some psychosocial support funding to the NDIS. Most Australian Government funding of psychosocial supports (outside of the NDIS) is now administered through the 31 Primary Health Networks (PHNs), which commission, but do not directly provide, psychosocial supports.

At the State and Territory level, total expenditure on psychosocial supports (approximated by specialised mental health service grants to NGOs) has increased ten-fold over the past 25 years, from approximately $43 million in 1992-93 to $438 million in 2017-18. The growth in spending on psychosocial supports has outpaced overall growth in State and Territory specialised mental health services — rising from 2% of all specialised mental health services in 1992-93 to 7% in 2017-18 (figure 17.3). However, spending on psychosocial supports is still much lower than spending on State and Territory clinical community ambulatory services, which totalled about $2.25 billion in 2017-18 (AIHW 2020c, table EXP.1). This is partly a function of clinical services being inherently costlier to administer.

At the Australian Government-level, in 2017-18, about $170 million was spent on psychosocial programs for which funding was later folded into the NDIS (figure 17.4).

The ways in which psychosocial supports are funded create challenges for consumers and providers. These challenges stem from the very large number of funding channels and short funding cycles. More recently, the transition to the NDIS has created additional uncertainty.

171 Examples of service types included in ‘grants to non-government organisations’ include counselling, advocacy, accommodation, community awareness/health promotion, prevention, independent living skills, education, employment and training, group and mutual support, care coordination, service integration, recreation, respite and self-help (AIHW 2020c, tables EXP.15 and EXP.16).
Figure 17.3  **Spending on psychosocial supports has increased over time**

<table>
<thead>
<tr>
<th>Year</th>
<th>Recurrent expenditure in constant prices</th>
<th>As a proportion of total State and Territory expenditure on specialised mental health services, 2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993-94</td>
<td>$0 to $50 million</td>
<td>Approx. 1% to 2%</td>
</tr>
<tr>
<td>1996-97</td>
<td>$100 million to $200 million</td>
<td>Approx. 2% to 4%</td>
</tr>
<tr>
<td>1999-00</td>
<td>$250 million to $350 million</td>
<td>Approx. 3% to 5%</td>
</tr>
<tr>
<td>2002-03</td>
<td>$300 million to $400 million</td>
<td>Approx. 4% to 6%</td>
</tr>
<tr>
<td>2008-09</td>
<td>$400 million to $500 million</td>
<td>Approx. 5% to 7%</td>
</tr>
<tr>
<td>2011-15</td>
<td>$450 million to $550 million</td>
<td>Approx. 6% to 8%</td>
</tr>
<tr>
<td>2017-18</td>
<td>$500 million to $600 million</td>
<td>Approx. 7% to 9%</td>
</tr>
</tbody>
</table>

**a** State and Territory spending on psychosocial supports approximated by specialised mental health service expenditure provided as grants to NGOs. **b** Based on national expenditure. Constant prices are referenced to 2017-18 and are adjusted for inflation. Expenditure excludes depreciation.

*Source:* Productivity Commission estimates based on AIHW (2020c, tables EXP.3).

**There are too many funding channels**

Many psychosocial support providers receive funding from both Australian, and State and Territory Governments. Sourcing funding from a variety of funding streams allows an organisation to reduce the risk of not being able to continue delivery of some of its functions if one funding source dries up. However, Inquiry participants described these arrangements as ‘wasteful’ (Wellways Australia, sub. 396, p. 25), and reported that the multiple funding channels for psychosocial support may lead to poorer consumer outcomes. From the point of view of providers, multiple funding channels have led to excessive administrative burden and a lack of coordination and cooperation. Wellways Australia (sub. 396) gave the example of one of its regional offices, offering one core service, that sources its funding via four different contracts with three separate funders, each with different administrative requirements.

**Excessive administrative burden**

Inquiry participants have argued that the current funding arrangements lead to significant costs arising from reporting, compliance and data collection (MHACA, sub. 726; MHCC, Sydney transcript, p. 176). When funding for one organisation comes from various funding streams,
there are greater compliance requirements and more work involved in applying for continuance of funding. This is as different programs, agencies and levels of government may require different reporting at different times and frequencies. These inconsistent compliance obligations result in significant red tape and draw resources away from front-line services (NMHC 2014b). There has also been criticism that ‘reporting requirements for funding [are] often onerous, focusing too much on outputs rather than outcomes’ (MHCC ACT, sub. 517, p. 27).

This compliance burden is further exacerbated by providers not taking advantage of potential economies of scale. The psychosocial supports sector is dominated by a few large NGOs operating nationwide and a large number of small providers. In other sectors, providers would resolve issues resulting from small organisation size by either amalgamating organisations or sharing ‘back-office’ functions. The absence of this in the provision of psychosocial supports may partly reflect the specialisation of some providers (for example, services for people with a particular type of mental illness), the lack of information on who is providing what to whom, and/or the competitive environment created by very short funding cycles (discussed below).

While the administrative requirements can be particularly onerous for smaller organisations, the difficulties are not limited to these:

> Without national incentives to have contracts with the same specifications and performance reporting, community organisations that have a national footprint … face a future where they are overwhelmed by contract administration if their service is to be available across the country. (Grow Australia, sub. 194, p. 4)

Since the establishment of the PHNs, there is the additional regulatory burden for some service providers to report to multiple PHNs. Nationwide, there are 31 PHNs all commissioning psychosocial supports and each has a different set of compliance and reporting requirements. For example, Aftercare (sub. 480, p. 10), a national mental health charity, operates in 16 PHNs with close to 30 State-based organisations, each with different strategies, tender processes, reporting requirements and stakeholder complexities.

Apart from inconsistent reporting requirements, the involvement of multiple levels of government has added considerable confusion (for both providers and consumers) on what services and supports governments are prioritising, to whom and where. The introduction of the PHNs to this space appears to have increased rather than lessened the confusion. The seemingly ad hoc funding of services in a region without coordination with the relevant State or Territory Government is not a new issue, as the National Mental Health Commission review (NMHC 2014b, p. 81) stated:

> Concerns also were raised about the lack of clarity in Commonwealth and state and territory roles, including that the Commonwealth’s direct funding of local service providers has been without proper consultation, local planning and engagement, and has created even greater uncertainty for people with lived experience and providers, and even more confusing pathways for people with lived experience.

In chapter 23, the Productivity Commission recommends that State and Territory Governments take on sole responsibility for psychosocial supports outside the NDIS. As well as clarifying
responsibilities, this offers scope to standardise reporting requirements across regions. State and Territory Governments would need to be mindful of any onerous administrative burden on smaller organisations and should look to streamline the reporting requirements or look to create different reporting requirements by size, similar to the approach taken by the Australian Securities and Investments Commission and the Australian Taxation Office.

Lack of coordination and cooperation

Contracting, when done well, creates competition between bidding organisations, encourages innovation and the potential for bids by consortia. Yet some Inquiry participants argued that the competitive nature of current funding arrangements for psychosocial support provision fails to incentivise coordination and cooperation between providers and undermines policy objectives.

[Competition between services [is] driven by questionable assumptions that competitive tendering is a necessary and sufficient pre-condition of innovation and efficiency; typically, however, grants of funding also call on services to act collaboratively — artificially creating a competitive dynamic that can undermine achievement of the policy objectives. (Relationships Australia (National), sub. 103, pp. 11–12)

The lack of coordination and cooperation can lead to limited sharing of innovative practices that could improve consumer outcomes (SA Mental Health Commission, sub. 477). Service providers operating in the same regions are often limited in their ability to plan or work together for the benefit of a common set of consumers; the NSW Government (sub. 551, p. 24) expressed concerns that ‘while these … arrangements have benefits, they can deter providers from planning, working together and coordinating care for patients’.

This is not only an issue between providers of psychosocial supports. Stakeholders also described disjointed links between services in the psychosocial and clinical spheres, and between NGO-provided psychosocial supports and government-provided supports (SAMHC, sub. 477). The Mental Health Community Coalition of the ACT (sub. 517, p. 23) argued that ‘professional cultural barriers often prevent better integration between clinical and non-clinical mental health services’.

There have been some initiatives to help remedy the situation. For example, in Victoria, the Early Intervention Psychosocial Support Response model explicitly brings together health services and community-managed mental health providers to deliver services to clients with a psychosocial disability (VIC DHHS 2019a). The Northern Territory Department of Health has funded the development of an industry-led workforce strategy for human service sectors, including community mental health, which would require major NGOs in the sector to cooperate with each other (NTHSIP 2019).

The Commission discusses improvements to the coordination between clinical and non-clinical providers in chapter 15, the multiplicity of funding channels in chapter 23, and policy coordination in chapters 22 and 23.
Short funding cycles limit the effectiveness of services

NGOs providing psychosocial supports receive a substantial portion of their funding via short-term government contracts, and annual funding cycles are widespread in the sector. Short funding cycles create certainty for governments as they provide a regular interval for the government to assess the quality of the services being provided and greater flexibility to change funding priorities (PC 2017b). But short funding cycles create a climate of constant uncertainty for providers, significantly inhibiting the provision of services and continuity of care for people with mental illness.

Some of the limitations of short funding cycles for psychosocial support provision include:

- **difficulties in program development and long term planning** — Overly short-term arrangements can be a barrier to planning, implementation and outcomes measurement for existing programs and the creation of new programs. Inquiry participants spoke of the challenges involved in building awareness and trust in the community and trying to invest in long-term partnerships when a contract expiry is looming and ongoing service existence is uncertain. WayAhead Mental Health Association NSW stated:

  As a small [not-for-profit] working in the mental health sector, our biggest barrier to program development, partnerships and outcome measurement is the annual funding cycle. Relying on one-year funding rather than 5-year funding restricts long-term planning and the sustainability of our programs. So much effort is put into ensuring we will receive funding for the next financial year, that we are at risk of losing sight on why we are providing certain services. If we had longer term funding, we could put much more effort into ensuring we are delivering the outcomes we are being funded to do and be more accountable for the funds we receive. (sub. 310, p. 6)

- **staffing challenges** — Inquiry participants reported difficulties attracting and retaining qualified staff in an environment lacking job security, which in turn leads to high staff turnover (box 17.3). This is particularly pertinent for services targeting marginalised and/or regional and remote communities where there are already greater barriers to attract qualified and culturally capable staff (Wesley Mission, sub. 840). It can also be a barrier to long-term workforce planning and investment in skill and capability development of staff (MHCC, sub. 920).

- **difficulty developing and maintaining stable and therapeutic relationships with consumers** — There is an inherent mismatch between the short-term nature of current funding arrangements and the long-term investment required to improve psychosocial outcomes (Aftercare, sub. 480). Some providers noted the need to place their consumers in short-term temporary care arrangements while they secure their next round of funding (SAMHC, sub. 477). This leads to uncertainty for both the provider and consumer. The consumer could experience the loss of a support worker, the possibility of multiple transitions of care and increased psychological stress. This also creates difficulties

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172 For example: Aftercare, sub. 480; ASU, sub. 791; Kim Devlin, sub. 158; Merri Health, sub. 120, sub. 855; Mind Australia, Melbourne transcript, p. 35; Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212.

173 For example: EACH, sub. 227; Kim Devlin, sub. 158; Merri Health, sub. 120; Neami National, sub. 254.
working with clients from culturally and linguistically diverse backgrounds, as staff are not afforded the time to develop the transcultural awareness, knowledge and skills that are important to winning the trust of a client (Gabb and McDermott 2008).

- *diverting resources away from the core purpose* — Faced with short-term contracts, providers allocate scarce time and resource to re-tendering instead of delivering and improving services (NCOSS, sub. 143; SAMHC, sub. 477).

While it is difficult to identify the exact costs associated with short funding cycles, Inquiry participants provided evidence to highlight the financial costs associated with just one of the consequences of short funding cycles — higher staff turnover.

It costs about $30,000 to replace an employee in terms of advertising, recruiting, training, on boarding and providing a shadow shift to a new staff member. There can also be the cost of paying a casual for the period between which the position becomes vacant and is filled. Funding instability, the combination of commissioning models, short-term contracts, delays in contracting and short-term notice periods for the end of contracts, are a key factor underlying staff turnover. (Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212, p. 21).

Previous reviews have also noted the issue of short contract cycles. The Productivity Commission’s 2017 Human Services inquiry recommended that default contract lengths be extended to seven years for most contracts and ten years for service delivery in remote Aboriginal and Torres Strait Islander communities (PC 2017b). At the end of this period, contracts should be retendered to find a balance between providing continuity and retaining the benefits of periodic contestability (NMHC 2014b; PC 2017b).

Longer term contracts would help to mitigate many of the problems discussed. As stated by participants (box 17.3), greater continuity facilitates stability and certainty for the providers and consumers. This is especially important to aid in recovery for psychosocial conditions. Providers also have the opportunity to improve their service delivery with the ability to make longer term plans and invest in staff, relationship building and new initiatives that are necessary to deliver effective services (PC 2017b; Relationships Australia (National), sub. 103). Inquiry participants were strongly supportive of extended cycle lengths.  

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174 For example: Australian Council of Social Services, sub. 1208; ASU, sub. 791; CHF, sub. 646; Mental Health Australia, sub. 864; MHCC, sub. 920; Mental Health Victoria & Victorian Healthcare Association, sub. 1184; CMHA, sub. 851; National Mental Health Commission, sub. 949; Queenslanders with a Disability Network, sub. 662; Relationships Australia, sub. 831; SA Mental Health Commission, sub. 691, att. B; UnitingSA, sub. 807.
Box 17.3 Participants’ views on cycle length

Australian Council of Social Services (ACOSS):
Increasing contract lengths (accompanied by effective service management by funding agencies) would be a cost-free way to impact the quality of service delivery and improve the viability of community sector organisations. They would also provide longer periods for evaluation and outcomes measurement, improving our understanding of the quality of service delivery and the outcomes achieved. (sub. 1208, p. 9)

HelpingMinds:
... short-term funding arrangements for the NGO sector have major implications for clients, staff and organisations. Continuity of care is severely affected on a cyclical basis, during and up to the time at which contracts are renewed or renegotiated. The lack of job security ... forces staff to seek alternate employment due to the uncertain, and often late, contract negotiations. Clients are left with short term, temporary care arrangements that lead to higher levels of psychological distress. The consequences being acute presentations to hospital emergency departments and lengthy inpatient stays.

Longer term funding will also enable organisations to develop programs that target vulnerable and marginalised groups, such as the LGBTQI+ community, Aboriginal people, and people from CALD backgrounds ... these organisations are often small and lack resources needed to develop business strategies within short timeframes ... the need to resource and fund tender submissions significantly reduces capacity to deliver grassroots care ... these cohorts need staff with specialist skillsets – recruitment for short-term contracts is always challenging. (sub. 470, p. 4)

NT Mental Health Coalition:
The uncertainty associated with short-term funding cycles results in a sector which is not equipped to invest in building the long-term partnerships necessary for integrating between services and across professions. Reaching out beyond the mental health sector is even less likely. (sub. 430, p. 5)

SA Mental Health Commission:
... the short term funding models for NGOs and also for specific regional or Aboriginal programs, leads to difficulty attracting and retaining staff and can result in lack of continuity of service provider, inability to forward plan, inability to build relationships which may be critical to longer term program outcomes, and difficulty collecting data to inform these longer term outcomes. (sub. 477, p. 33)

Volunteering Australia:
... there are many organisations working in community mental health that are restricted by short-term grants and funding cycles. These funding arrangements don’t allow for the strategic workforce planning required to operate successful programming and service delivery. Volunteering Australia stresses that long-term, ongoing funding is necessary to ensure the best outcomes for consumers. (sub. 412, p. 3)

WayAhead:
One of the ongoing workforce challenges the Mental Health Promotion and Prevention sector faces is funding uncertainty. For quite some time now funding in NSW has been provided on short term contracts, in our case, on annual contracts. Only having short term contracts makes it incredibly hard for our sector to take a longer-term approach to meet the needs of the communities which we serve and adequately plan for the community’s longer-term needs. (sub. 704, p. 8)

Some governments have recognised that this is an issue and have begun introducing changes. For example, the Australian Government extended annual funding cycles to three-year funding for PHNs in July 2019 to offer greater job security for staff and continuity of care for consumers (Aubusson 2019; Hunt 2019). However, as far as we are aware, the PHNs have not passed on the benefits of their own longer funding cycles to the services they commission — there is no requirement for the PHNs to enter into longer-term contracts with service providers.
(ASU, sub. 177; NMHC 2019b). The Australian Government should require PHNs to enter into longer-term contracts when commissioning psychosocial services.

At the State and Territory level, the Northern Territory Department of Health extended funding for all NGOs for five years to 2022 to support the transition to the NDIS (NT Government, sub. 1220, p. 16). The NT Mental Health Coalition (sub. 430, p. 34) has welcomed this change:

The community mental health sector is encouraged by the NT Department of Health’s move to five year Service Agreements and notes that the NT Primary Health Network is working towards three year funding agreements. Longer-term funding arrangements will have a positive impact on staff retention, make programs more sustainable, and have a flow-on effect of strengthening cross-sectoral and inter-sectoral collaboration.

The NT Mental Health Coalition (sub. 430, p. 32) further states that, ‘At a minimum, agreements covering co-designed services should extend for at [least] 5 years.’ Providers concur, with WayAhead (sub. 310, p. 6) recommending that, ‘across all governments, grants … should be for a minimum of 5 years’ and Aftercare (sub. 480, p. 11) recommending ‘the development of longer-term funding investment models (5–10 years).’ Some participants called for longer contract, of seven to ten years (ACOSS, sub. 1208, p. 9; cohealth, sub. 231, p. 28). Warwick Smith (sub. 937) suggested that all services should have ongoing funding with annual indexation.

Longer-term cycles may create risks to efficient use of taxpayer funds. Participants noted the ‘need to balance ongoing certainty with evidence-based analysis’ (ACT Government, sub. 1241, p. 21). The risk of poor provider performance could be reduced either before contracts are awarded (through more stringent requirements and assessment during the funding application process), or after contracts are delivered on (through rigorous reviews of service effectiveness) (PC 2017b). A shorter contract could be granted in exceptional circumstances, such as for pilot programs that have yet to be evaluated.

The Victorian Government (sub. 1228, p. 14) raised concerns over whether extending contract lengths would provide ‘sufficient flexibility to introduce any potential changes to models for funding services providers.’ The use of short contracts to give governments flexibility to alter funding priorities would be a lower priority were governments to recognise the long-term needs of people who require psychosocial supports. Short-term priorities can still be achieved in the context of long-term partnerships, with adequate performance management arrangements in place (chapters 23 and 24).

Although it is difficult to identify an ideal contract length, it is clear that, for many programs, the current length is far too short to provide effective and culturally capable support. Many in the sector call for a minimum five-year term.175 The Productivity Commission suggests this could be adopted as a starting point, subject to evaluation in future. It is also important

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175 For example: ASU, sub. 791; CHF, sub. 646; Mental Health Australia, sub. 864; MHCC, sub. 920; NT Mental Health Coalition, sub. 430; QDN, sub. 662; WayAhead, sub. 704.
for providers to receive sufficient notice of the outcome of the subsequent funding cycle for
the purposes of service planning and staff employment security (discussed further below).

**ACTION 17.1 — EXTEND THE CONTRACT LENGTH FOR PSYCHOSOCIAL SUPPORTS**

Short funding cycles create uncertainty for providers of psychosocial supports, which
can negatively affect consumers and support workers.

*Start now*

The Australian, State and Territory Governments should extend the funding cycle length
for psychosocial supports from a one-year term to a minimum of five years, and ensure
that the outcome for each subsequent funding cycle is known by providers at least six
months prior to the end of the previous cycle.

The Australian Government should require Primary Health Networks to enter into
longer-term contracts when commissioning psychosocial services, in line with the longer
funding cycles that have been introduced more generally for Primary Health Networks.

**What the folding of psychosocial support funding into the NDIS has meant for people with mental illness**

The gradual roll out of the NDIS is having a significant impact on the availability of
psychosocial supports and has exacerbated existing challenges for consumers and providers
of psychosocial supports. Funding for many Australian, State and Territory
Government-funded supports has been, or is in the process of being, folded into the NDIS
due to the close alignment of some program goals with the NDIS (Australian
Government 2018a; Masters and Shelby-James 2017).

Of the 17 Australian Government programs that have been folded into the NDIS, four were
designed to support people with mental illness:

- Partners in Recovery (PIR)
- Personal Helpers and Mentors (PHaMs)
- Support for Day to Day Living in the Community (D2DL)
- Mental Health Respite: Carer Support (MHR:CS).

The first three were intended for people with severe mental illness impacting functioning,
while the latter was for carers of people with severe mental illness. Approximately
30 100 people received support through PIR, PHaMs and D2DL in 2017-18 (unpublished
data supplied by the Department of Social Services (DSS) and DoH)\(^{176}\) and approximately
40 600 carers were supported by MHR:CS in 2014-15 (DSS 2016c). From 1 July 2019, no

\(^{176}\) Derived from PIR and D2DL client numbers in the 2018 calendar year and PIR client numbers in the
2017-18 financial year.
new clients have been accepted into these programs in areas where the NDIS has been rolled out, though some stop-gap measures for previous users of PIR, PHaMs and D2DL have been introduced (discussed later).

However, not every person who has been accessing psychosocial support services is eligible for the NDIS. Of the estimated 290 000 Australians with severe and persistent mental illness who are most in need of psychosocial supports, only an estimated 75 000 people receive such supports from Australian, State and Territory Government-funded programs, and 64 000 people (with a primary psychosocial disability) are expected to access individualised supports under the NDIS once the scheme is fully rolled out (figure 17.4).

Figure 17.4  The level of need and funding for psychosocial support

![Diagram showing the level of need and funding for psychosocial support]

- 290 000 People with mental illness with most urgent need of psychosocial support
- 75 000 People accessing psychosocial services outside the NDIS
- 64 000 People meet the eligibility criteria of the NDIS

The diagram illustrates the distribution of funding sources:

- PHN funding for commissioned services
- State and territory programs ($454 million)
- NDIS funding ($2.6 billion at full roll out); includes programs that have ceased (PIR, D2DL, PHaMS) and funding transferred from States and Territories
- CoS funding $36.6m per year until June 2022
- NPS-M funding $20m + $20m per year until June 2021
- NPS-T funding $150m Until June 2021

This represents the number of people expected to access individualised supports under the NDIS once the scheme is fully rolled out. As at March 2020, 34 200 people with a psychosocial disability were receiving funding from the NDIS, therefore overall outlays were lower than those expected at full roll out. State and Territory program funding is based on the latest available figures, from 2017-18, inflation adjusted to 2019-20 dollars. Figures for CoS and NPS-M are inflation adjusted to 2019-20 dollars. Based on an aggregation of the initial $121.3 million for 2019-20 and additional $28.3 million extension package for 2020-21.

Source: AIHW (2020c) DoH (2020e); Morrison, Payne and Ruston (2020); NDIA (pers. comm., 27 Mar 2020); NMHSPF estimates; adapted from Mental Illness Fellowship of Australia (sub. 343, p. 9).
New measures introduced while the NDIS is being rolled out

There are three major sources of Australian Government funding to support people with psychosocial disability until the NDIS is fully rolled out:

- Continuity of Support (CoS)
- National Psychosocial Support Measure (NPS-M)
- National Psychosocial Support Transition (NPS-T) (DoH 2020e).

The specific source of funding used in each individual case is dependent upon whether or not the person was previously in receipt of Australian Government-funded psychosocial support and in some cases, whether or not they have applied for the NDIS (figure 17.5).

<table>
<thead>
<tr>
<th>Previously on PIR, PHaMs or D2DL (active on 30 June 2019)</th>
<th>Not previously on PIR, PHaMs or D2DL (as at 30 June 2019) but require support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have applied to the NDIS</td>
<td>Contact local PHN about support</td>
</tr>
<tr>
<td>Have yet to apply to the NDIS</td>
<td></td>
</tr>
<tr>
<td>Eligible</td>
<td>Be supported through the NPS-T</td>
</tr>
<tr>
<td>Ineligible</td>
<td></td>
</tr>
<tr>
<td>NDIS</td>
<td>Be supported through the NPS-M</td>
</tr>
<tr>
<td>CoS</td>
<td></td>
</tr>
<tr>
<td>NPS-T</td>
<td></td>
</tr>
<tr>
<td>Apply for NDIS</td>
<td>Apply for NDIS</td>
</tr>
<tr>
<td>Eligible</td>
<td>Eligible</td>
</tr>
<tr>
<td>Ineligible</td>
<td>Ineligible</td>
</tr>
<tr>
<td>NDIS</td>
<td>CoS</td>
</tr>
<tr>
<td>NDIS</td>
<td>CoS</td>
</tr>
<tr>
<td>NPS-M</td>
<td>NPS-M</td>
</tr>
<tr>
<td>NPS-M</td>
<td></td>
</tr>
</tbody>
</table>

Figure 17.5 How are people accessing psychosocial support during the NDIS rollout?

a Acronyms: Partners in Recovery (PIR), Personal Helpers and Mentors (PHaMs), Support for Day to Day Living in the Community (D2DL), National Disability Insurance Scheme (NDIS), Primary Health Network (PHN), NPS-T (National Psychosocial Support Transition), NPS-M (National Psychosocial Support Measure), CoS (Continuity of Support).

Source: DoH (2019b); South Eastern Melbourne PHN (2019).

Also sometimes referred to as the Transition Support Program or the Psychosocial Extension Program.
There is uncertainty around program eligibility and continuity

Governments committed to continue providing support to participants in programs that were rolled into the NDIS; however, decisions have been poorly communicated.

Just a few months prior to the announcement of extensions, many providers had little knowledge of what supports would be provided in place of the programs being folded into the NDIS, who would be eligible for them, and what the timeline for programs would look like (Anglicare Australia, sub. 376; ASU, sub. 177; NMHC, sub. 118). The announcement to extend funding (from the NPS-T) to previous providers of PIR, PHaMs and D2DL was made just three months prior to the date when all funding for the Australian Government programs was initially slated to cease.

The folding of programs into the NDIS and creation of stop-gap programs with little transparency has increased the funding and accessibility uncertainties already dominating the psychosocial support sector (Sjon Kraan, Perth transcript, pp. 29–30). Inquiry participants claimed that not all organisations received NPS-T funding to continue for 12 months, and some PHNs only gave three months of funding (CMHA, Sydney transcript, p. 105). There also remains considerable uncertainty as to the long-term arrangements for people accessing psychosocial supports outside of the NDIS. Currently, NPS-M and NPS-T are only funded until the end of June 2021 and CoS until the end of June 2022.

The fact that State and Territory funding is also being transferred (to varying extent) to the NDIS, while not all clients of State and Territory programs are receiving support from the NDIS, has raised concerns. Each State and Territory withdrew their funding to a different extent. For example, the Commission heard that South Australia saw a 25% cut to NGO-provided mental health services (ASU, sub. 791), while Victoria had transitioned its funding for psychosocial support (from the Mental Health Community Support Service) into the NDIS (Uniting Vic.Tas, sub. 95; Victorian Government 2019a). After committing the funds spent on existing psychosocial support for severe and permanent mental illness, it became apparent that some former clients were not eligible for the NDIS.

While some States have now reinvested some of these funds back into mainstream supports (for example, the Victorian Government’s Early Intervention Psychosocial Support Response), the ad hoc transition process exacerbated the uncertainty in the sector.

The community mental health services, of course, have lost their funding in light of the NDIS transition. So they’re often not able to help … we’re in that sort of no man’s land in between. (Tandem, Melbourne transcript, p. 68).

Clinicians referring consumers to psychosocial support services also expressed confusion:

Understanding how and what support is available would be great. In my sector the NDIS has us baffled. The system changes and it can be very hard to learn how to navigate the new system and I don’t have a mental health issue to make it harder. (ASMOF, sub. 233, p. 10)
An evaluation of NPS-M and CoS is expected to be completed in 2021, assessing the implementation process, outcomes, costs and program delivery (DoH 2020e). To afford some momentum and certainty around the psychosocial supports that are emerging in some States, the Australian Government, working with State and Territory Governments, should develop and make public long-term arrangements for people with mental illness who are not eligible for the NDIS. These arrangements must provide clarity for consumers, carers and providers as to what supports are available, who is eligible and how they can be accessed.

Psychosocial support services are experiencing staffing challenges

The uncertainty around programs being folded into the NDIS, stop-gap programs, and the NDIS rollout have all added to the staffing challenges faced by psychosocial support providers. By the time service providers had information on funding from the NPS-T, many workers had ‘moved on’ (ASU, Sydney transcript, p. 58) or were ‘already seeking employment elsewhere as organisations [were] unable to provide guarantees of employment after this date’ (One Door Mental Health, sub. 108, p. 11).

As a result, many skilled and experienced workers have left the mental health sector. Workers who have left are unlikely to return until employment opportunities in the sector stabilise, leading to lower skill levels across the psychosocial support workforce and lower quality care for consumers (ASU, sub. 177, sub. 791, Sydney transcript, pp. 55–60; CHA, sub. 463; CMHA, Sydney transcript, p. 105; EMHSCA, sub. 578; Jennie Fitzhardinge, Perth transcript, p. 120; Merri Health, sub. 120, sub. 855). Staff shortages may also increase waiting times for consumers to access services:

The NPS-M (National Psychosocial Support Measure) which was funded as a stop gap strategy because of the winding up of PIR and PHaMS has a fraction of the resources and is experiencing huge demand and long waiting lists. In Adelaide there is a current waiting list of 160 distressed people with a team of five workers. This will be replicated across the country. (ASU, sub. 791, p. 5).

Ensuring people can access required psychosocial supports

The Productivity Commission heard from Inquiry participants that previous clients of the Australian Government-funded psychosocial supports (PIR, PHaMs and D2DL) were being asked to test their eligibility for the NDIS — and have their application turned down — before they are given access to CoS (Anglicare Australia, sub. 376; EACH, sub. 227; MHCC, sub. 214; OTA, sub. 141; QAI, sub. 116).

Stakeholders noted that the requirement was in place regardless of the consumer’s likelihood of being eligible for the NDIS, resulting in many people needlessly being required to engage in a lengthy application process to access continued supports (CMHA and USYD 2019a; QAI, sub. 116, p. 14). Some former participants decided not to have their eligibility tested and disengaged from the system. Providers expressed concern that this risked their clients’ ability to access continuity of support measures, which would undermine progress towards their recovery (Anglicare Australia, sub. 376).
While this requirement is still in place, transition to the NDIS is progressing at a steady pace. Recently, the Australian Government announced a $28.3 million in funding (as part of the Mental Health Support Package for people experiencing the impacts of the COVID-19 pandemic) and 12-month extension of the NPS-T deadline (DoH 2020d). This is likely to assist in the full transition to the NDIS before other supports run out.

Nonetheless, the current processes have led to poor consumer outcomes and uncertainty in the sector, even among professionals, and many consumers do not want to apply for the NDIS (Mission Australia, sub. 487). People who need psychosocial support should be able to obtain it without going through a long and difficult application process. Some assessment should be expected, to determine whether psychosocial support is appropriate and whether the need for it stems from mental ill-health, but access should not be dependent on previous use of psychosocial supports or require applications to other programs (NDIS) for which the individual has no need to apply. Such barriers cause people to disengage from the system or endure long processes that risk damaging their mental health.

The decision to apply to the NDIS must be the consumer’s, should they have the capacity to make such a decision (figure 17.6). People who require psychosocial supports with needs stemming from mental ill-health should be free to apply for the NDIS only if they wish to access the NDIS and not be motivated to do so only to pass a requirement to receive continuity of support. As such, the requirements for former participants to continue accessing supports should be altered to allow for this (Action 17.2).

Further, people should be supported throughout the transition to the NDIS. Stop-gap measures such as the NPS-M must run for a sufficient period, until States and Territories take on sole responsibility for psychosocial supports outside of the NDIS (chapter 23). (NDIA 2020f; Robert 2020b). By 2022, the Australian Government should evaluate the NPS-M to better understand why people who are potentially eligible for the NDIS are not applying. Following such an evaluation, there can be work to remove the barriers to applying for the relevant groups so that they may eventually access the NDIS. Those who remain ineligible for the NDIS would then be on programs commissioned by States and Territories. Inquiry participants strongly supported providing such continuity of support for consumers.\(^{178}\)

The principle of person-centred care extends beyond clinical services and should also apply to psychosocial support … [Consumers Health Forum of Australia] calls for access to psychosocial support to be expanded to allow care to be provided while a person is applying for the NDIS or if a person chooses not to apply for the NDIS. Psychosocial support should be provided based on the person’s need for it, not based on the category the system has placed that person in. This is also critical for continuity of care as we know that many people experience long waits while their NDIS application is being processed. (CHF, sub. 646, p. 13)

\(^{178}\) For example: Carers NSW, sub. 808; Elucidate, sub. 755; Flourish, sub. 729; Lived Experience Australia, sub. 721; Mental Health Australia, sub. 864; MHCC, sub. 920; National Mental Health Commission, sub. 949; Royal Australian and New Zealand College of Psychiatrists, sub. 1200; SA Mental Health Commission, sub. 691, att. B; Victoria Legal Aid, sub. 818.
Figure 17.6  **Recommended eligibility for psychosocial supports**

![Diagram](image_url)

- **CONSUMER**
  - Wants to apply to the NDIS
    - Be supported through the application (NPS-M, NPS-T)
      - Eligible
        - NDIS
      - Ineligible
        - CoS / NPS-M
  - Does not want to apply to the NDIS
    - NPS-M

Evaluation

Commissioning body
**ACTION 17.2 — GUARANTEE CONTINUITY OF PSYCHOSOCIAL SUPPORTS**

People with mental illness who require psychosocial supports should be able to continue accessing them, regardless of changes to the source of funding for the service.

*Start now*

People who choose to apply for the National Disability Insurance Scheme (NDIS) should continue to be supported by their current service providers during the application process.

People who choose not to apply for the NDIS should be allowed to continue to access support through the National Psychosocial Support Measure, should they require it, until it has been phased out.

*Start later*

The Australian Government should evaluate the National Psychosocial Support Measure. Evaluation outcomes should be used to remove barriers that people with mental illness face when applying to the NDIS. When the National Psychosocial Support Measure is phased out, participants should either access support through the NDIS, if appropriate, or access the replacement psychosocial support.

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### 17.3 Improving the delivery of psychosocial supports in the NDIS

The application process and supports received from the NDIS may not always meet the objectives of people with psychosocial disability. The NDIS funds long-term disability care and support for people with severe or profound disabilities (box 17.4). The NDIS operates under the *National Disability Insurance Scheme Act 2013* (Cth) (NDIS Act), and is administered by the National Disability Insurance Agency (NDIA). Funding for the NDIS is shared between the Australian and State and Territory Governments.

In 2011, the Productivity Commission recommended that people with psychosocial disability be supported through the NDIS on the basis of their support needs and care requirements (PC 2011).

**Is the NDIS working well for people with psychosocial disabilities?**

People with psychosocial disability have the potential to benefit substantially from the NDIS. It presents an opportunity for people with psychosocial disability to increase their social and economic participation through NDIS funded supports (NDIA 2019e). In addition, the NDIS gives people in the scheme choice and control over how their supports are provided (PC 2017c; Warr et al. 2017).
Box 17.4  **NDIS psychosocial disability requirements**

A prospective participant would meet the disability requirements if each of the following requirements in section 24 of the *National Disability Insurance Scheme Act 2013* (Cth) is met:

- the prospective participant has a disability that is attributable to … one or more impairments attributable to a psychiatric condition (s. 24(1)(a))
- the prospective participant's impairment/s are, or are likely to be, permanent (s. 24(1)(b))
- the prospective participant’s impairment/s result in substantially reduced functional capacity to undertake, or psychosocial functioning in undertaking, one or more of the following relevant activities: communication, social interaction, learning, mobility, self-care, self-management (s. 24(1)(c)).
- the prospective participant's impairment/s affect their capacity for social or economic participation (s. 24(1)(d))
- the prospective participant is likely to require support under the NDIS for their lifetime (s. 24(1)(e)).

Impairments that vary in intensity (for example, because the impairment is of a chronic episodic nature) may be permanent and a prospective participant may still require support under the NDIS for their lifetime despite the variation (s. 24(2)).

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**Fewer people are in the Scheme than expected**

The NDIA estimated that by full rollout of the Scheme (2019-20), there would be 460 000 participants, with 13.9% (64 000 people) expected to have a primary psychosocial disability (NDIA 2017e). As of March 2020, the NDIS had 365 000 participants, and 9.4% (34 200 people) had a primary psychosocial disability (NDIA 2019b) (figure 17.7).

The proportion has been steadily rising over time, reflecting improvements in access to the Scheme for people with psychosocial disability. However, nationally it remains significantly below its target (NDIA 2020b). A lower number of people with psychosocial disability participating in the NDIS may place additional pressures on the mainstream mental health system outside of the NDIS (as discussed in section 17.2).

People with psychosocial disability can encounter several difficulties in the NDIS, including:

- the application process to gain access to the NDIS can be overwhelming
- comparatively poorer experiences upon entering the Scheme for some participants
- many choosing not to apply for the NDIS even though they would likely be eligible
- the unclear interface between the NDIS and mainstream services.
Application rates are lower than expected

The relatively low proportion of people with psychosocial disability in the Scheme arises from both low application rates and comparatively low rates of success for those who do apply.

Only 48% of participants across the major Australian Government-funded psychosocial support programs — PIR, PHaMs and D2DL — applied for the NDIS between August 2018 and June 2019. The two most cited reasons for not applying were that the client was still collecting evidence for an application (22%) or that the client did not want or intend to apply (19%) (CMHA and USYD 2019a, p. 9). Anglicare Australia (sub. 376, p. 54) stated that clients are reluctant to apply for a range of reasons, including:

- not identifying as having a ‘permanent’ disability, as their illness is episodic,
• not being at a point in their mental wellbeing where connecting with a formal application, assessment and planning process is possible for them to contemplate, and
• a lack of understanding or scepticism about the benefits of an NDIS package.

A complex application process

Stakeholders contend that the high proportion of people who said they were still collecting evidence speaks to the complexity of the application criteria and the barriers that continue to exist for those with psychosocial disability. They have also suggested that consumers’ unwillingness to apply for the NDIS highlights that there is ongoing work required to demystify the scheme and streamline the application process (CMHA and USYD 2019a; Mental Health Australia 2018b, 2018a; USYD and CMHA 2018). The NDIS application process can be time-consuming and especially daunting for people with psychosocial disability (Lorna MacKellar, sub. 406; MHCSA and LELAN, sub. 360). Providers of psychosocial supports outside of the NDIS trying to help their clients transition over have described some major challenges of collecting the evidence required by the NDIA, including:
• GPs or specialists lack an understanding of NDIS, the client or psychosocial disability
• limited or lack of evidence available due to limited service engagement
• clients’ fluctuating mental health and ability to manage the application process
• the cost of gaining expert evidence
• barriers and time delays in accessing data from other services
• program staff have limited time to help collect evidence (CMHA and USYD 2018, 2019a, 2019b).

There is also concern over the costs associated with applying, with the Queensland Advocacy Incorporated (sub. 116, p. 14) stating that ‘the cost to undertake assessments for reports can be crippling for many people, and that actually becomes a real gamble that for too many people doesn’t pay off’.

People with severe and complex mental illness often struggle to advocate for their own support needs and hence find it especially difficult to engage in the NDIS application process (Anglicare Australia, sub. 376; Inner South Family and Friends, sub. 129). The Victorian Government (sub. 483, p. 13) suggested an ‘uplift in funding for advocacy services for people living with mental illness who may not be well placed to self-advocate due to their condition’.

The introduction of a specialised psychosocial disability action plan demonstrates that the NDIA is aware of the unique needs and challenges of those with psychosocial disability and this is an area that may gradually improve (Fletcher and Henderson 2018; Mental Health Australia 2018a; Quinlan 2018). Details of the specialised action plan are discussed below.
**Interpretation of eligibility requirements**

There is significant confusion about the eligibility criteria with respect to demonstrating permanency for psychosocial impairments and whether diagnoses are sufficient evidence of functional impairment (Tune 2019). There are reports that many people with psychosocial disability are finding it difficult to prove their eligibility, contributing to lower participation rates.

Acceptance rates for people with psychosocial disability are lower than many other disability categories. Up to March 2020, cumulatively, only 70% of applicants to the NDIS with a primary psychosocial disability had their access approved, compared to 85% for all disabilities (NDIA 2020b). Some Inquiry participants believe that there have been many rejections even in cases where the applicant has a good claim to become a NDIS participant (Anne Mill, sub. 348; Peter Kent, sub. 352). Common reasons for ineligibility that the NDIA have given include insufficient evidence showing a functional impairment or disability; or insufficient evidence showing that the functional impairment or disability is lifelong; or that the impairment or disability could not be treated elsewhere (CMHA and USYD 2018, 2019a).

A recent review into the NDIS Act found that the assessment process can be inconsistent, resulting in people with similar clinical and psychosocial disability needs and circumstances receiving different outcomes. The review found that this inconsistency may be a result of insufficient guidance being provided about the form of evidence required and the lack of a working definition and no clear guidelines for assessing ‘permanency’ in the context of mental illness (Tune 2019, p. 73).

The review recommended that the NDIS Act and Rules be amended to provide clearer guidance in considering whether a psychosocial impairment is permanent, in terms of both the criteria and evidence that takes into account the episodic or fluctuating nature of some psychosocial impairments and also emphasises the language of empowerment, capacity building and recovery over that of disability, impairment and illness (Tune 2019). The Productivity Commission supports this recommendation.

**Long wait for application outcomes**

Most participants of PIR, PHaMs and D2DL wait between three and nine months after their NDIS application to receive their assessment outcome (CMHA and USYD 2018, 2019a, 2019b). As noted by the Mental Illness Fellowship of Australia (sub. 343, p. 14), ‘an emerging issue is the number of NDIS applications that are now stalling in the system, resulting in protracted decisions about the eligibility of participants’.

Inquiry participants have raised the concern that significant waiting times hamper a person’s recovery, as it can be emotionally exhausting and psychologically damaging (Lorna MacKellar, sub. 406). Such delays in access to support may lead to ‘increases [in the] risk of deterioration, relapse and results in discharge delays from bed-based mental health treatment services’ (Victorian Government, sub. 483, p. 12).
To reduce these risks, people with psychosocial disability are able to access supports before and while testing eligibility through the NPS-M (DoH 2019b). However, there may be a significant difference in the level of funding per person on the transition supports as opposed to PIR and PHaMs, with an even larger difference when contrasted with the NDIS. Some providers reported the level of funding under the transition programs is inadequate (WAAMH, sub. 416).

It is important that people applying for the NDIS who require support are not disadvantaged by the application process and still receive the appropriate level of support they may require through non-NDIS services while they are waiting for a result (action 17.2).

What about those who get accepted into the NDIS?

Overall, participant satisfaction with the NDIS is high (75–79%, depending on which stage the participant reached) (NDIA 2019b). However, there is evidence that the experience of people with primary psychosocial disability accepted into the NDIS can be marred by inappropriate plans and difficulties finding services (USYD and CMHA 2018).

Unsuitable plans

Some stakeholders argued that people with psychosocial disability are receiving unsuitable plans under the NDIS. Issues include disproportionate funding packages, unskilled planners who lack understanding of psychosocial disability and its inherent episodic nature, as well as a lack of appropriate supports and coordination.

The funding allocated to NDIS participants can be greatly disproportionate to the level of need. Mind Australia (sub. 380, p. 44) noted a ‘lack of consistency between the [functionality or disability] scores and ultimate package size for those who have plans with Mind’. The Victorian Government (sub. 483, p. 12) stated that NDIS planners do not ‘adequately, or flexibly, [consider] the impacts of psychiatric crisis and [the] fluctuating needs of participants with a psychosocial disability’. Further, Anglicare Australia (sub. 376, p. 55) submitted that:

> For people with psychosocial disability who have been successful in applying to the NDIS, there are still gaps in the service model. Poor assessment by the NDIA often results in no or low support available to people with psychosocial disability in their NDIS plans for daily living support.

Once a person has met the requirements for eligibility and received their plan, some experience difficulties in navigating the complex system. Anglicare Australia (sub. 376, p. 55) expressed concern that people with severe and complex mental illness are ‘unable themselves to navigate and use their NDIS funding’. The Victorian Government (sub. 483) stated that there is insufficient support coordination in NDIS plans, despite the major benefits

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180 According to Commission estimates, funding per client per year was roughly $10–12 000 on PIR and $6000–7000 on PHaMs. The NDIA places the average per participant expenditure for PIR, PHaMs and D2DL to be roughly $6500 and under the Victorian MHCSS to be $11 000. Through the NDIS, the average committed funding per active participant with psychosocial disability was $38 900 (NDIA 2019f).
it would confer. The NDIS is introducing a new support item — ‘psychosocial recovery coaches’ — which may assist with coordination of supports (discussed further below).

That some participants’ plans may be unsuitable is reflected in the particularly low utilisation rates (the share of a participant’s budgeted supports that has been used) for those with psychosocial disabilities (figure 17.8). In a submission to the Productivity Commission’s 2017 study into NDIS Costs, the NDIA suggested that utilisation rates would reach a steady state of 80–95% (NDIA 2017f, p. 70). So far this is not the case, especially for participants with psychosocial disability, whose utilisation rates are lower than all other scheme rates. However, the utilisation rate gap between psychosocial disability participants’ plans and all scheme participants’ plans tends to decrease over time as plans are reviewed (figure 17.8).

**Figure 17.8** Utilisation rate of committed supports increases over time

Utilisation rate of committed supports, by plan number, 1 April 2019 to 30 September 2019

![Utilisation rate of committed supports increases over time](image)

- **Plan number** refers to which plan a participant is on. For example, a new participant would be on plan number one. Following a plan review, they would move onto plan number two, and so on. Plans are generally for one year periods, but can vary according to individual circumstances.
- **‘Total’ average utilisation rate includes participants who were partly through their first plan (those whose first plan approval date was between 1 April 2019 and 30 September 2019) and had substantially lower utilisation rates than other participants.

*Source: Unpublished data provided by the NDIA (pers. comm., 4 May 2020).*

Inquiry participants raised concerns that when the packages are not being used, package values can decrease at the next review. This is especially concerning when considered in light of the episodic nature of psychosocial disability (ACT Government, sub. 210; Victorian Government, sub. 483). Inherent to the episodic nature of psychosocial disability are fluctuations in the mental illness of the individual. It is important that a participant’s NDIS...
plan is able to quickly respond to changes in their level of need, both during periods of health and illness. One Door Mental Health (sub. 856, p. 12) suggested a specialised response:

One Door supports a reform to the NDIS to let people with psychosocial disability come in and out of service as dictated by the nature of their recovery; with supports scaled up and down according to their need, and without penalty against their NDIS plan based on utilisation.

The COAG Disability Reform Council (DRC) Mental Health Senior Officers Working Group recently recommended enhancements to the NDIS planning and supports processes to increase responsiveness to the episodic nature of psychosocial disability. Work is underway by the NDIA — adapting current practices to quickly adjust plan budgets and supports to reduce waiting times for unscheduled reviews and increase planner discretion for top-up funding where increases in disability are associated with a deterioration in mental health (COAG DRC 2019c, 2019a). Improvement activities are planned to commence by mid-2020.

**Difficulty obtaining required supports**

Despite being successful in receiving an NDIS plan and funding for supports, participants sometimes find it difficult to purchase needed supports as they may not exist in their community or may be ill-suited to their needs (VCOSS, sub. 478; Carers NSW, sub. 808). This is especially the case in remote communities (CRRMH, sub. 465; NT Mental Health Coalition, sub. 430; RRMH, sub. 97; TeamHEALTH, sub. 756).

The issues surrounding acquisition of supports stem from two major reasons. The first is that the prices set by the NDIA for services may be too low. Inquiry participants raised concerns that providers are unable to meet the prices set by the NDIA (ACT Government, sub. 210; LELAN, sub. 771; MHACA, sub. 726; One Door Mental Health, sub. 856; VCOSS, sub. 478). Anglicare Australia (sub. 376, p. 55) expressed concern that ‘many organisations have discontinued providing such daily living support services as the price set by the NDIA is simply unfeasible’. The Australian Services Union (sub. 791, p. 8) noted that ‘some key NDIS supports … do not include critical activities and overlook the diverse circumstances in which support is provided.’ In addition, many Inquiry participants have stated that the low pricing has led to workers leaving the sector or providers decreasing the quality of services (box 17.5).

The NDIS 2019-20 Price Guide included increases in price points that made the delivery of core supports more viable for psychosocial support providers. However, Inquiry participants noted that many providers may still struggle to deliver core supports without cross-subsidisation from other income sources (Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212). The Victorian Government (sub. 483, p. 13) recommended that the Australian Government work collaboratively with the State and Territory Governments to ‘review current NDIS price settings as a pathway to independent price setting to ensure the sustainability of a specialist psychosocial disability workforce and quality and safety outcomes for participants with a primary psychosocial disability’. Chapter 16 discusses other challenges facing the community mental health sector workforce.
The other major reason for difficulty obtaining required supports is that there may be ‘thin’ markets, with a small number of people in a region needing psychosocial disability supports and few local providers. The NDIS market model does not work particularly well in thin markets and, as a result, many people are not able to access services and supports that they are funded to receive (NT Mental Health Coalition, sub. 430; TeamHEALTH, sub. 155; Victoria Legal Aid, sub. 500).

**Box 17.5 Low NDIS prices are leading to workers leaving the sector**

One Door Mental Health:

While the NDIS does not directly set the amount a service provider can pay an employee, the NDIS price for services are lower than what is needed to maintain the current skill of the workforce. Provisions for basic support items allow for the employment of only minimally qualified staff. The displacement of qualified staff to other sectors is currently impacting on the ability for providers to recruit good staff and is likely to have indications for the provision of quality community mental health programs. (sub. 108, p. 11)

The cost model for Disability Support Workers under the NDIS is insufficient. There is grossly inadequate funding provided for office costs, service quality, accreditation and genuine overheads. The community sector has been subsiding provision of NDIS service to the value of millions of dollars. The outcome of this insufficiency is that people eligible for the NDIS are not receiving the quality of support they need, and some service providers are ‘going under’. (sub. 856. pp. 11-12)

Mental Health Community Coalition of the ACT:

The downward pressure on wages in community mental health services since the introduction of the NDIS should not be underestimated … we are seeing the emergence of a market where the least qualified and lower paid workers are employed in NDIS services, while more qualified and highly paid workers are employed in non NDIS services. This is concerning given that the NDIS is for people with the most severe and enduring disability. (sub. 517, p. 19)

Eastern Melbourne Mental Health Service Coordination Alliance:

The lower pricing for supports under NDIS have meant that pre-transition staff are leaving the sector and a new, less skilled and experienced workforce is emerging with limited capacity to attend care team and linkage meetings and capacity building activities such as cross-sector workshops (sub. 578, p. 10)

While some consumers are only able to use a portion of their package as there are not enough suitable services in their region, some NDIS providers are pulling out of unviable markets, leading to even fewer services for consumers to choose from. This issue is especially prevalent in rural and remote settings (SCARC 2018). There are concerns that where there are few psychosocial supports available in a community, people have to leave their communities to access supports, which can lead to social isolation and loss of connection to land and community supports (NT Mental Health Coalition, sub. 430). This inequitable access may disproportionately affect Aboriginal and Torres Strait Islander people in regional and remote areas, whose cultural needs may also not be met by mainstream services.

**NDIA initiatives to improve consumer outcomes**

The NDIA has acknowledged that changes are needed to improve outcomes for people with primary psychosocial disability and has introduced a number of initiatives to achieve this.
**Initiatives to address thin markets**

Where there is insufficient market supply or where providers have failed to provide care, responsibility to remedy the situation falls to the NDIA (NMHC 2018a, 2019b). Under Provider of Last Resort (POLR) arrangements, the NDIA will directly commission and procure disability supports for participants. As part of these arrangements, contingency funding should be available when crises arise for NDIS participants, and crisis and respite accommodation must be able to be secured at short notice (OPA Victoria 2018).

While the NDIA has yet to release a POLR framework, it has temporarily increased prices of some NDIS supports (NDIA 2020a). These price increases should be accompanied by the public release by NDIA of a POLR framework to help inform the appropriateness and effectiveness of market interventions where market development has not otherwise occurred.

The NDIA and the DSS commissioned the NDIS Thin Markets Project in 2019 to develop strategies to address supply gaps in thin markets in the NDIS. An output of the project is a roadmap for developing and delivering practical trial projects (DSS 2019l).

At the December 2019 meeting of the COAG DRC, the Council agreed to a more flexible approach to address market challenges in the NDIS, ‘recognising that one-size-fits-all approach to delivering the NDIS is not suitable to address market gaps faced by certain geographic locations, particular cohorts or disability support types’ (COAG DRC 2019b). The agreement was accompanied by a number of projects to address thin markets in all jurisdictions. Trial projects are being scoped and implemented in all jurisdictions in consultation with the DSS (NDIA, pers. comm., 27 March 2020). However, information on these projects is currently limited. A rollout plan is expected by December 2020 (NDIA, pers. comm., 4 May 2020).

**Psychosocial disability action plan**

The psychosocial disability action plan (termed the ‘psychosocial disability stream’ prior to October 2019) includes a variety of initiatives intended to improve the responsiveness of the NDIS to participants with primary psychosocial disability, their families and carers (NDIA 2019f). It has been in development since late 2018 (Fletcher and Henderson 2018). Improvements so far include:

- foundational psychosocial disability training for NDIA planners and Local Area Coordinator staff to better understand psychosocial disability. This training was completed in June 2019 and has also been incorporated into the standard induction training for all new staff

- the rollout of the Complex Support Needs Pathway, which commenced in March 2019, to provide specialised support for people who require additional support to access and engage with the NDIS, and have a greater need for coordination of multiple services

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181 The loading begins at 7.5% in 2019–20 and will steadily reduce over five years (NDIA 2020a).
- more consistent contact points, improvements in the consistency and robustness of functional assessments, the provision of customised support for people with psychosocial disability to better respond to specific disability requirements and the piloting of a new Typical Support Package for participants with a psychosocial disability (NDIA 2019f).

From 30 April 2019, streamlined access for people with psychosocial disability became available to prospective participants from State-based programs in all States and Territories. As part of the streamlined access process, prospective participants can:

- verbally begin their access request with a support worker or a trusted other person
- provide consent for their support worker or another trusted person to be the NDIA contact for the duration of the access process
- where required, re-test access to the NDIS with the support of a trusted person (NDIA 2019f).

**Psychosocial recovery coach**

In October 2019, the COAG DRC announced the creation of a new ‘psychosocial recovery coach’ support item, which will be included in the NDIS support catalogue and price guide in 2020-21 (COAG DRC 2019a; NDIA, pers. comm., 4 May 2020).

The recovery coach combines recovery and support coordination and is intended to fulfil a role that has been performed in the past by services outside of the NDIS (Skatssoon 2020). The recovery coach is intended to provide support to people with psychosocial disability to live a full and contributing life. They will work with participants to build their resilience, to develop their capabilities and to gradually take responsibility for their recovery and the ongoing management of psychosocial disability supports (NDIA 2019f). Participants who choose to have psychosocial recovery coaching will be able to select a coach with either lived experience or learnt experience competencies (NDIA, pers. comm., 4 May 2020).

**Response to the COVID-19 pandemic**

Given the face-to-face nature of a number of psychosocial supports, the provision of supports has been affected throughout the COVID-19 pandemic. Physical distancing requirements have created difficulties for service delivery. To maintain continuity of support, many providers have used telehealth to deliver some one-on-one outreach supports while group activities were cancelled. However, the Productivity Commission heard that many consumers are not able to access videoconferencing facilities due to a lack of access to suitable equipment, low technical literacy, inability to afford access to large data packages and unstable internet connection in some areas, especially in regional areas (Mind Australia, pers. comm., 7 May 2020).
A number of initiatives were announced to support NDIS participants.

- NDIS plans to be extended by up to 24 months, ensuring continuity of support and increasing capacity of NDIA staff to focus on urgent and required changes to plans (Robert 2020b).
- Face-to-face planning shifted to telephone meetings where possible (Robert 2020b).
- For five months, eligible participants able to flexibly use existing NDIS plan funding to purchase low-cost assistive technology, including smart devices, to enable continued access to disability supports through telehealth (Robert 2020a).
- Proactive outreach to high-risk participants and sharing of data with states and territories to ensure continuity of supports (Robert 2020b).
- Prioritising individuals whose disability and current health status places them at the greatest risk from COVID-19, including people who have complex supports needs, to undertake the activities of daily living (Hunt 2020).

Financial assistance was also offered to providers to help retain workers, including: one-month advance payments based on monthly average supports delivered in the previous quarter, a temporary 10% COVID-19 loading on some supports and increased flexibility to NDIA cancellation pricing policies (NDIA 2020f; Robert 2020b).

### 17.4 Improving access to, and delivery of, psychosocial supports

#### Addressing the shortfall in the provision of psychosocial support

Australia has long suffered a shortfall in the provision of psychosocial support. Only about 110 000 people were receiving psychosocial supports in 2019-20 (both within and outside of the NDIS), well short of the 290 000 people estimated by the NMHSPF to have severe and persistent mental illness who are most in need of psychosocial supports.

To address the gap in services, governments need to make the existing funding work more efficiently and increase funding overall.

To make existing funding work more efficiently, the Productivity Commission recommends that State and Territory Governments take on sole responsibility for the commissioning of psychosocial supports outside of the NDIS (chapter 23). This approach would assist in clarifying ambiguous governmental roles, reduce the number of separate funding streams, improve planning and accountability, and create opportunities for better links with the

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182 This comprises 34 200 people with psychosocial disability participating in the NDIS, and approximately 75 000 people that the Commission estimates receive psychosocial support from Australian, State and Territory-funded programs outside of the NDIS (including transition and stop-gap measures).
clinical services required by consumers. This approach would also help in determining how much funding is required to address community needs.

While system changes can improve funding efficiency, the overall level of funding may need to increase as well. There is a large service gap and improvements in efficiency will only go so far to bridge the gap. Many Inquiry participants have argued for funding increases for psychosocial supports to meet demand (For example: Elucidate, sub. 755; Mental Health Victoria & Victorian Healthcare Association, sub. 1184; MHCC, sub. 920.,).

Current funding levels have not been sufficient to meet demand … [there is a] need for additional and growth funding to ensure the adequate provision of psychosocial supports into the future. (Merri Health, sub. 855, p. 2)

Gaps have been identified over and over … we are seeing a reduction in funding to community managed organisations rather than the increases required. (Lived Experience Australia, sub. 721, p. 3)

Governments across Australia are increasingly transferring responsibility for service provision to the community sector, but without providing adequate indexation or growth funding. Services are seeing increased demand. And this is arising from a range of structural issues, such as lack of affordable housing, declining regional economies, slow wages growth. And yet services are expected to respond to this by stretching existing resources which are not sufficient to cover basic cost increases, let alone rising demand. (NCOSS, Sydney transcript, p. 83)

However, it is difficult to estimate the size of this gap due to the NDIS transition process and the lack of a national consistent dataset on community mental health services (Mental Health Australia, sub. 864). As a first step, each regional grouping of PHNs and their Local Hospital Networks should estimate the shortfall in the provision of psychosocial supports outside of the NDIS in their region, relative to NMHSPF benchmarks. This should be done as part of their broader joint regional planning processes, and repeated annually by regional commissioning bodies (chapters 23 and 24). If (and when) collection for a national NGO dataset is implemented, the Australian Institute of Health and Welfare should also perform State/Territory- and national-level gap analyses of psychosocial supports against NMHSPF benchmarks (chapter 24).

Once the level of need has been estimated, funding for psychosocial supports should be matched to the level of need across the jurisdiction. This should occur over time, and with support from the Australian Government. The Productivity Commission estimates that expanding the provision of psychosocial support to about 154 000 people who may currently miss out on services could cost approximately $610 million (2019-20 dollars) per year and result in significant improvement in the quality of life of people accessing them (appendix K).183

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183 The NMHSPF estimates the number of people with severe and persistent mental illness who are most in need of psychosocial services to be 290 000 people. Of these, 110 000 people receive support, leaving a gap of about 180 000 people. As the NDIS approaches full rollout, an additional 30 000 NDIS clients are estimated to be receiving support for a psychosocial disability and about 3000 people would transition from existing services to the NDIS. Therefore, the gap in psychosocial support services would be about 154 000, assuming the provision of supports remains similar outside of the NDIS.

The total costs were estimated using (1) the estimated number of people with unmet needs based on NMHSPF (2) approximate number of people currently receiving services, and (3) assumptions about...
Access to psychosocial supports

Several Inquiry participants have expressed the importance of ensuring support can be provided in the absence of a clinical diagnosis (Anglicare Australia, sub. 376, sub. 1206; ASU, Sydney transcript, pp. 62-64; CMHA, sub. 449; SJGHC, sub. 77).

People with psychosocial needs arising from mental illness should be able to access supports if they require them and should not be deterred by the immediate need for a clinical diagnosis upon referral to a service (including self-referral). At entry to the service, potential participants should not be required to have a clinical diagnosis of mental illness. Rather, they should undergo an initial functional assessment that identifies their potential areas of functional limitation (similar to the PHaMs Eligibility Screening Tool) and whether they have a psychosocial need (figure 17.9).

Some people may have a need for psychosocial supports that does not stem from mental illness and therefore a mental health psychosocial support service may not be the most appropriate service for them. Where the information provided by the consumer and the assessment indicate that the need for psychosocial support arises from mental illness, but there is no clinical diagnosis, the psychosocial support service should work with the consumer to facilitate their timely access to a clinical assessment (figure 17.9). As many people with mental illness may have had previous negative experiences with the clinical system, there must be a trusted non-clinical support worker, for example someone who is trained in a trauma-informed approach, to help guide the consumer through the process.

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**proportion of people and their severity of need using data from former Australian Government-funded psychosocial supports, PHaMs and D2DL, and the cost per client for these programs (from $2400 to $7000 per person, in 2018-19 dollars). PIR was excluded to avoid double counting as the additional cost of requiring coordination support is accounted for in chapter 10 estimates (appendixes I, K).**

**184 The PHaMs Eligibility Screening Tool assigned a score to nine potential areas of functional limitations across personal capacity activities, community participation activities and independent living activities (AIHW 2019g). It is an example of a functional assessment tool, which is used to determine the impact of mental illness on a person’s level of functioning, and distinguish it from impacts caused by environmental and social factors. It also considers the person’s functioning in the context of the available supports, including their carer, family or mental health services (NADA 2013).**
Figure 17.9  **Reformed access criteria for psychosocial services**

![Diagram of access criteria]

- A trusted non-clinical psychosocial support worker should be available to support the consumer as required.

**Interface with other services**

To ensure that people receive the most appropriate supports for their needs, an important consideration is the boundaries, or the interface between the mainstream mental health system and the NDIS.

A seamless interface between the two systems is a particularly important nexus for enhancing the social and economic participation of people affected by mental illness. It is a legal requirement that the support received by an NDIS participant is most appropriately provided and funded by the Scheme and not by another service or system (NDIS Act s. 34(f)). The NDIS is not intended to replace mainstream psychosocial support services, but to work alongside them (ANMF, sub. 317). There should not be incentives for individuals or service providers to preference one system over another. Otherwise, there may be undue pressure on one system to provide for too many people or some may miss out.
Creating an effective interface between the NDIS and the rest of the mental health system has been difficult as inter-system policies and operational guidelines were not established prior to rollout (Summer Foundation 2018).

Despite the multitude of documents and legislation setting out boundaries, Inquiry participants have stated that the interface remains underdeveloped, inhibiting agencies in reaching agreement on responsibility for service provision and clients missing out (CHA, sub. 463; NT Mental Health Coalition, sub. 430; Victoria Legal Aid, sub. 500). As acknowledged by the Victorian Government (sub. 483, p. 11), ‘unclear delineation between the NDIS and mental health system … [has resulted] in scope creep, gaps in service provision and duplication of services’.

Previous reviews have noted similar issues. They found boundary issues, funding disputes and cost-shifting behaviour leading to service gaps, confusion for NDIS participants, poor quality planning and inconsistent decisions about when a support is reasonable and necessary (JSC 2018, 2019; PC 2017c, pp. 247–248, 2019b; Tune 2019). Recommendations from previous reviews include that the National Disability Agreement should set out the responsibilities of the Australian, State and Territory Governments to provide disability services outside the NDIS (PC 2019b) and that there should be work with the COAG DRC to address boundary and interface issues (JSC 2018, pp. xi–xii).

There is work underway to address a number of interface issues between the NDIS and the mental health system (NDIA 2019f). In October 2019, the COAG DRC Mental Health Senior Officers Working Group released an implementation plan for mental health and psychosocial disability interfaces, to ensure that the NDIS and the mental health system work closely together. This includes developing a nationally consistent approach to the coordination of roles and responsibilities of the NDIS and the mental health system in hospital and community-based settings (COAG DRC 2019c, 2019a).

In future, it is important that the Australian mental health system reaches a stage where regardless of their NDIS status, people are able to access the supports they need.

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185 Interactions between the NDIS and mainstream services are guided by the ‘Principles to Determine the Responsibilities of the NDIS vs Other Service Systems’ (COAG 2015). The principles outline many of the linkages with supports that lie outside of the NDIS. Examples of other documents include: NDIS (Supports for Participants) Rules; Mainstream Interface Working Arrangements (for each State and Territory); Bilateral agreements between NDIA and some governments; and Practice Guidelines (by NDIA and some States and Territories).
ACTION 17.3 — MEET UNMET DEMAND FOR PSYCHOSOCIAL SUPPORTS

All people who have psychosocial needs arising from mental ill-health should have access to adequate psychosocial support.

Start now

- Access criteria for psychosocial supports should be adjusted such that potential participants would not be required to have a diagnosis of mental illness before approaching a service. However, an initial functional assessment must be undertaken by the service to determine the individual's psychosocial needs and the level of support required.
  - Where the information provided by the participant and the functional assessment indicate that the need for psychosocial support arises from a mental illness, the provider should work with the participant to facilitate their timely access to a clinical assessment and any necessary clinical intervention.

- The shortfall in the provision of psychosocial supports outside of the National Disability Insurance Scheme should be estimated and published at both State and Territory and regional levels.

- State and Territory Governments should continue working with the National Disability Insurance Agency to clarify the interface between the mainstream mental health system and the National Disability Insurance Scheme.

Start later

- State and Territory Governments, with support from the Australian Government, should, over time, increase the quantum of funding allocated to psychosocial supports to meet the estimated shortfall.

- The demand for psychosocial support services by people with mental illness in a region should be estimated as a component of integrated regional planning.

- Psychosocial support services should provide data to their regional commissioning body on the number and nature of functional assessments they have undertaken of individuals receiving their support services.
Support for carers and families matters because …

- Almost 1 million carers provided regular assistance to a partner, family member or friend with mental illness in 2018.
- This caregiving role provides great value to people with mental illness, carers and the broader community.
- Carers could also be of great assistance to service providers, if service providers were more willing to draw on the understanding and insights of carers.
- Caring also has costs — it affects some people’s mental and physical health, social participation, career trajectory, educational attainment and financial security.
- Carers are not the only ones affected by a family member’s mental illness — children who have a parent or sibling with mental illness may particularly need support.
Governments assist families and carers by funding support services and income support payments. There is scope to improve access to these supports and to improve how families and carers are included by mental health services.

As a priority:

- All mental health services should be required to consider family and carer needs, and their role in contributing to the recovery of individuals with mental illness. (Action 18.1)
  - State and Territory Governments should be collecting and reporting on the Carer Experience Survey to encourage carer-inclusive practice.
  - The Australian Government should amend the Medicare Benefits Schedule to provide rebates for family and carer consultations.
  - State and Territory Governments should ensure the workforce capacity exists in each region to implement family- and carer-inclusive practices within their mental healthcare services.

Additional reforms that should be considered:

- The recommended National Mental Health and Suicide Prevention Agreement (Action 23.3) should state that State and Territory Governments will be responsible for planning and funding carer support services related to the mental health caring role and family support services for families affected by mental illness. (Action 18.2)
- The Australian Government Department of Social Services should evaluate the outcomes achieved for mental health carers from its carer support program. (Action 18.2)
- The Australian Government should amend the eligibility criteria for the Carer Payment and Carer Allowance to reduce barriers to access for mental health carers. (Action 18.3)
Family members, partners and friends provide significant support to many people with mental illness, and this support can be critically important to their wellbeing and recovery. A caregiving role is often challenging, and mental health carers are more likely than other carers to report consequences for their own mental health and wellbeing. As Mental Health Carers Australia (sub. 489, p. 3) noted:

There are significant, well documented impacts on carers associated with the caring role, including but not limited to: emotional distress, depression, financial insecurity, employment insecurity and loss of connections with their own family, friends and community.

Governments assist carers by funding carer support services and income support payments. The Productivity Commission heard that there is scope to improve access to these supports for mental health carers. Inquiry participants also described how mental health professionals often fail to exchange information with carers that would contribute to their own wellbeing and the recovery of the person with mental illness.

Family and friends of people with mental illness who do not provide regular support and assistance may also be affected by the mental illness. Relationships within families and social networks can sometimes be strained as a result of the symptoms of mental illness, and children in families affected by mental illness may particularly need support.

This chapter examines reform options to improve supports for families and carers. Section 18.1 describes the experience of carers and family members of people with mental illness. Section 18.2 discusses how mental health services can better identify and support carers and family members of people with mental illness, and include carers as part of the care team. Section 18.3 proposes improvements to family and carer support services. Section 18.4 explores changes to income support payments for carers that would make them more accessible.

18.1 Mental health carers provide a valuable contribution to the community

A recovery approach with an emphasis on families and carers

In 2013, the Australian Health Ministers’ Advisory Council endorsed a national framework for recovery-oriented mental health services as a result of a growing movement embracing the concept of personal recovery, rather than a narrow focus on clinical recovery (AHMAC 2013). The role of families and carers has always been recognised as an element of recovery-oriented practice, but the importance of considering a person within their social context — their family, carers, and community — in supporting recovery is now emphasised.
To this end, Inquiry participants promoted the idea of relational recovery. With relational recovery, experiences such as hope, identity, meaningfulness and empowerment are inseparable from a person’s social context and relationships (Price-Robertson, Obradovic and Morgan 2017). For mental health policymakers and service providers, this has implications for why and how they should consider families and carers as relevant to their work.

The wellbeing of consumers and their families is interdependent. Family and carers often hold a lifetime of information about the consumer, which service providers frequently overlook in forming a diagnosis and care plan for the consumer. This may be to the detriment of the service provider’s capacity to help the individual in their recovery. An effective carer is one who feels informed and secure — a distressed or exhausted carer is not well-placed to support recovery. What must also be acknowledged, is that mental illness can affect the quality of relationships, which contributes to social isolation and impedes recovery.

At an interpersonal level, psychosocial supports build relationships with family and friends. These relationships are often fractured and people can become isolated. Without support from family and friends, clinical care often fails. (MIFA, Brisbane transcript, p. 19)

MHYF Vic is arguing for a mental health system that seeks solutions to mental health problems that might lie between people, rather than just within the body of a separated person. (MHYF Vic, sub. 628, p. 3)

Better outcomes can be achieved for people with mental illness when recovery is understood as a social process. For example, several participants urged this Inquiry to examine Open Dialogue, which is a model that views the consumer’s support network as fundamentally involved in their recovery (GFCT, sub. 76; MHCC, sub. 920; MHCSA and LELAN, sub. 360; SleeplessNoMore, sub. 100) (box 18.1). The evidence supporting this recovery- and family-oriented approach is promising.

The benefits of the reforms recommended in this chapter are based on the robust evidence-base about the effectiveness of family interventions and demonstrate the value of working with families and carers to support recovery. The Productivity Commission has modelled the effects of support for families and carers on the mental health of carers, care recipients, children of parents with mental illness, and the cost-savings from reduced hospital admissions and visits to the emergency department (appendix I). The annual economic benefits (from increased income and cost savings) from actions 18.1 and 18.2 totalled $164–$318 million, and exceeded the estimated annual costs of implementing these reforms ($160–$189 million).

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186 Arafmi, Brisbane transcript, p. 94; BPD Community, Melbourne transcript, p. 121; MHCA, Canberra transcript, p. 20; MHFFTas, Launceston transcript, p. 77; Mind Australia, Melbourne transcript, p. 36; Tandem, Melbourne transcript, p. 67.
This chapter analyses the potential gains for consumers, carers, families and the broader community that could be achieved from a more family and carer-inclusive mental health system. Cultural change that places greater emphasis on support for families and carers will take time but services that ignore the value of this are not operating in consumers’ long-term interests.

The Productivity Commission recommends several practical changes that will help move the mental health system in this direction. These include placing more people on the ground to promote family and carer work in mental health services, Medicare Benefits Schedule (MBS) rebates for consultations with carers and family, and improving transparency about the current state of family and carer work. The recommended reforms recognise that families and carers have needs of their own, and that meeting those needs would have broader benefits for consumers and the community.

**Box 18.1 The Open Dialogue approach**

The Open Dialogue approach was developed and implemented in the health district of Western Lapland, Finland in the 1980s. Early research focused on people experiencing first-episode psychosis but the model has been broadened. There are seven principles that define Open Dialogue, two of which are particularly relevant to family- and carer-inclusive practices: chosen members of the consumer’s social network will be invited to the first treatment meeting and treatment meetings aim to promote an equal dialogue between the consumer, their social network and the treatment team.

… clinical expertise is seen as only one of the contributions to the dialogue. It is considered as equal to the ideas and opinions of all others in the network. (Ong et al. 2019, p. 419)

This can be a confronting shift in practice for clinicians and when first implemented, staff were offered extensive training in family therapy and other relevant methods.

A study that followed up on three different cohorts of consumers with first-episode psychosis who received treatment according to this approach found that the average number of meetings with family or network members was 33, compared to an average of 30 attended by the patient and treatment team only. Over half of these consumers required only one hospital admission or none at all. Compared with first-episode psychosis patients elsewhere in Finland, the Open Dialogue group spent significantly less time in hospital, and spent less time on disability-related income support. After two years, 84% of the Open Dialogue patients were in full-time employment or study.

It is not known the extent to which the principles promoting the active participation of the family in care contributed to these results compared to other elements of Open Dialogue, such as holding the first meeting within 24 hours of initial contact and maintaining continuity in the treatment team. As this approach is introduced in more countries, including Australia, more research is needed — particularly since a 2019 review concluded that the evidence base lacked methodological rigor.

*Source: Bergstrom et al. (2017, 2018); Freeman et al. (2019); Ong et al. (2019).*
According to the *Mental Health Statement of Rights and Responsibilities*, carers and support persons have the right to:

- comprehensive information, education, training and support to facilitate their caring role
- receive services that assist them to provide care and support
- receive support for their own difficulties that may be generated as a result of caring
- participate in treatment decisions, and seek and receive additional information about the mental health consumer’s support, care, treatment, rehabilitation and recovery (with the consent of the mental health consumer) (Standing Council on Health 2012).

Other commitments to support carers exist outside of mental health policy. The Australian Government and most State and Territory Governments, except Tasmania and the ACT have introduced legislation to recognise the contribution and role of carers. For example, the *Carer Recognition Act 2010* (Cth) states that all carers should have the same rights, choices and opportunities as other Australians.

These stated objectives provide a good basis for assessing: how mental health services draw on and support families, and partner with carers (section 18.2), the effectiveness of support services for families and carers (section 18.3), and income support services for carers (section 18.4).

**Who are mental health carers?**

There were 2.65 million family and friend carers in Australia in 2018 — more than one in ten people (ABS 2019b). Approximately 971 000 (37%) people were caring for someone who had mental illness (Productivity Commission estimates using ABS 2020b) (figure 18.1). For 414 000 (43%) of these mental health carers, mental illness was the *main* condition of their main care recipient, but for the majority of mental health carers, mental illness was a comorbid secondary illness.

The Carer Recognition Act defines a carer as someone who provides personal care, support and assistance to another individual who needs it because they have a disability, medical condition, mental illness or are frail and aged. They are typically relatives, partners or friends of the person who needs support, although they may not identify as carers themselves. Carers are also known as informal carers because the assistance they provide is unpaid, in contrast to paid carers who are part of the formal mental health workforce.

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187 Of the 1.9 million carers who lived with their care recipient, 700 000 were caring for a person with mental illness. Due to data limitations, the Productivity Commission estimated how many of the 718 000 carers who did not live with their care recipient were mental health carers. This was based on the proportion of people who did not live with their carer that had mental illness (38%).

188 Using an earlier version of the same survey, Diminic et al. (2017) found there were 240 000 carers of people whose main condition was mental illness. Their methodology differed from the Productivity Commission’s in that they excluded carers of people with substance use disorder or under the age of 16 years.
A carer providing the most assistance to a person is called the primary carer. We know most about primary carers relative to other carers because they are a focus of the ABS Survey of Disability, Ageing and Carers. There were approximately 273,000 people acting as primary mental health carers in Australia in 2018 — 96,000 (35%) were primary carers to someone whose main illness was mental illness (ABS 2020b). But this understates the number of primary mental health carers because it excludes primary carers who do not reside with their care recipient.

Carers can be any age (figure 18.1). Carers over the age of 65 years may find it difficult to maintain a caring role as their own health needs increase. Young carers are those less than 25 years old. Hamilton and Redmond (2019) reported that 5% of children aged 9 to 14 years old in 2014 provided care to a family member who had mental illness or who were using alcohol or other drugs.

Figure 18.1  **Who are Australia’s mental health carers?**

- **971,000 people** were mental health carers in 2018
  - That’s 4% of Australians and 37% of all carers
  - 43% cared for someone whose main condition was a mental illness

- **700,000 people** were mental health carers who lived with the person they cared for
  - 10% were aged 15 to 24
  - 18% were over 65
  - 1 in 4 cared for more than one person

- **273,000 people** were the primary carer of someone with mental illness
  - 68% were female
  - 41% had been providing care for at least 10 years
  - 1 in 2 provided at least 30 hours of care per week

*Source: ABS (Microdata: Disability, Ageing and Carers, Australia, 2018, Cat. no. 4430.0.30.002).*

How are mental health carers different from other carers?

All carers typically provide support with practical tasks. For mental health carers, this often includes navigating the complex mental health system and advocating for their care recipient to receive the services they need (Name withheld, sub. 104).

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189 All references to ABS (2020b) throughout this chapter are Productivity Commission estimates.
As these parents described it:

I am my daughter’s advocate … My daughter constantly has stated … Nothing is working. Nobody is helping me. (Name withheld, sub. 392, pp. 1, 9)

Over her 3 years in Perth, one of us typically visited [our daughter] weekly to assist with cleaning, shopping, getting to class, Centrelink, Drs or psych appointments, general mood lifting and problem solving etc, and our other daughters provided ‘respite’ & ‘crisis’ accommodation when required … we saw how easily she would have slipped into homelessness without our support. Due to the BPD [borderline personality disorder], the challenge of dealing with these issues on her own was overwhelming and she would just avoid them. (Robert Davis, sub. 133, p. 11)

Mental health carers have different needs and experiences compared with other carers due to characteristics associated with mental illness.

First, compared with carers of people with a physical health condition as their main condition, mental health carers are more likely to provide emotional and psychosocial support and less likely to assist with activities of daily living, such as washing, dressing, or eating (Diminic et al. 2017). Emotional and psychosocial support does not just encompass providing encouragement, reassurance and managing behaviours; for mental health carers, this often includes the difficult tasks of guarding against self-harm and managing crises (Carers Victoria 2013). For some parents, caring can include an extremely challenging role, reflected for example, in the vigilance needed to prevent their children from attempting suicide (Name withheld, sub. 392; Robert Davis, sub. 133).

Second, the symptoms of mental illness can sometimes strain relationships, and this can make providing support more difficult and stressful.

People with BPD [borderline personality disorder] experience relational dysregulation. This means that those who are closest to them are often subjected to the more extreme behavioural and emotional dysregulation. This is a burden that affects the mental health of these loved ones. (BPD Community, sub. 74, p. 3)

Third, the episodic nature of mental illness has implications for the caring role. Fluctuations in the duration and intensity of needs can make the caring role more unpredictable (Carers NSW, sub. 183; MHFFTas, sub. 391; MIFA, sub. 343). In 2018, about one quarter of primary mental health carers only needed to provide care during periods or episodes when the care recipient’s condition deteriorated (ABS 2020b). Even for those providing care, hours of care provided can increase significantly during an episode or crisis (Carers Victoria 2013). When they are not actively providing care, mental health carers often remain on-call, in case support is required (Diminic et al. 2017).

Intensive and episodic care responsibilities can affect a carer’s ability to juggle caring with employment and education (Mind Australia, sub. 380). Carers Australia (sub. 372, p. 7) described how:

… structuring flexibility into jobs works best when carers are caring for people who, except in relatively unusual circumstances, have predictable care needs. Carers of people with unpredictable episodic conditions, especially when these episodes are frequent, may find it harder to plan their working responsibilities around their caring role.
Fourth, mental illness typically has an earlier age of onset than many physical health conditions (MHCN, sub. 245; Tandem, sub. 502). The toll on a mental health carer’s life can be significant given that many are in this role for many years and often from a relatively young age.

Finally, stigma associated with mental illness can further complicate the role (Carers NSW, sub. 183; MHFFTas, sub. 391). It contributes to isolation, a lack of understanding and reduced support from service providers and the broader community, compared with what might be experienced by other types of carers.

Many families, including carers within those families, find it hard to tell other people that they have a family member with a mental illness. They may feel that to do so would be a form of betrayal of that person. This is especially the case for carers in some culturally and linguistically diverse communities where, for cultural reasons, the level of stigma is very high. (Carers Australia, sub. 372, p. 7)

Carers are still suffering isolation and poor health … Small town syndrome (stigma) for carers who live in rural towns is very real; they suffer in silence and eventually become a shadow in their own community. (LMMHCN, sub. 52, p. 2)

[I]t is the stigmatisation and discrimination in the services that are supposed to be a support that hurts the most. From psychiatrists to nurses, to admin staff, help line personnel and social workers, discrimination is a unifying feature of the experience of all carers and people with BPD [borderline personality disorder]. (BPD Community, sub. 74, att. 1, p. 1)

Differences in the roles and challenges faced by mental health carers compared with other carers translate into differences in the types of support they need from government, employers and the broader community.

The ‘hidden carers’

Hidden carers — people who do not identify as carers or who are not recognised as carers by service providers — often do not know that carer support services exist or how to access them.

Mental health carers often do not identify as carers, at least initially. People may associate the word ‘caring’ with the tasks related to assistance with daily living rather than the emotional and practical support that is commonly provided by mental health carers. Also, care recipients may not realise their family member or friend is providing informal care.

Certain types of carers are more likely to be hidden from services systems and miss out on support. Aboriginal and Torres Strait Islander carers and culturally and linguistically diverse carers may not access services because of a lack of culturally capable services or awareness of services (DSS 2016c; Hill et al. 2016). In these communities, the caring role may be shared with many in the community and this makes it difficult to identify who is a carer (Mind Australia et al. 2016; Northern Territory Mental Health Coalition, sub. 741). Cultural norms about family responsibilities and stigma about mental illness also contributes to lower rates of service use among people from culturally diverse backgrounds (Carers Victoria 2013; Diminic et al. 2017; MHFFTas, sub. 391). Carers Victoria (sub. 664) stated
that LGBTIQ carers can experience additional difficulties in the healthcare system if staff do not recognise or support their relationship.

Young carers are another group who are more likely to be hidden from support and services, and often have unmet needs (Tandem, sub. 502). They may not identify as carers, or conceal their caring role because they:

- do not realise that what they do is different to what occurs in other families
- are not taken seriously by service providers because of their age
- fear stigma and bullying
- are concerned about intervention from child protection services (Carers NSW 2020; Cass et al. 2009; Hamilton and Redmond 2019; HelpingMinds, Geraldton transcript, p. 12).

Many carers see themselves as a mother or daughter or husband rather than as a carer. However, when they are not also recognised as a carer, they can miss out on support that would benefit them. For example, Mental Health Carers NSW (sub. 245, p. 18) described carers who ‘prior to their contact with our organisation, did not know that they were eligible for income support based on their caring role, some of whom, had undertaken substantial caring responsibilities at significant personal cost for extended periods of time.’ People not recognised as carers also miss out on being included by service providers in ways that would enhance the care recipient’s recovery.

To what extent is caring a choice?

Many carers value their caring role. Most have chosen to take on this role because they want to provide support to a loved one and because it is the best choice available for their family. The majority of primary mental health carers assumed a caring role out of a sense of family responsibility — 26% stated they had no other choice (ABS 2020b).

The decision to provide informal care, and the hours provided, depend on a range of factors, including: the person’s preferences, their own situation (such as what type of job they have and whether they have child raising responsibilities), the needs of the person with mental illness, and the availability and quality of appropriate formal care for that person.

A primary caring role is typically equivalent to a full-time job. The average number of caring hours provided by all mental health carers (including primary carers) was 11 hours per week, whereas it was 40 hours per week for primary mental health carers (Diminic et al. 2017, p. 138). Time spent caring significantly reduces the time available for the carer to participate and thrive in the community, through employment, education and social interactions.

Some carers prefer to provide a significant level of care themselves regardless of services available or used by the consumer. Others would like to provide fewer hours if suitable service options were available. Several Inquiry participants described how there was a lack of appropriate services available to meet the needs of their care recipient (LMMHCN,
sub. 52; Mental Health Carers ARAFMI Illawarra, sub. 161; Name withheld, sub. 66; Name withheld, sub. 104; Name withheld, sub. 392).

Tandem (sub. 502, p. 2) stated that mental health carers often have no option but to ‘provide extensive social and practical support in the absence of support services’. When Diminic et al. (2017, pp. 89, 91) surveyed mental health carers, they heard that ‘there is nowhere near enough support for mental health carers’ and that carers were ‘tired of filling … the shortfall in services’.

SANE Australia (sub. 130) and Mind Australia (sub. 380) observed that while the shift from institutional care to community-based care over recent decades is a positive change for the community overall, it has resulted in an increased reliance on informal care provided by family. The transition to the National Disability Insurance Scheme (NDIS) has reduced access to psychosocial supports for people not eligible for that program (chapter 17), and may be contributing to increased demand for informal care.

For young carers it is less clear that providing significant hours of care is their choice to make. The Productivity Commission heard from several Inquiry participants about young people taking on a caring role (AIFS, sub. 753; HelpingMinds, sub. 470; One Door Mental Health, sub. 108). Carers Australia (sub. 372, p. 9) provided extracts from applications for the Young Carer Bursary program, which it administers, including this story from a 14 year old boy:

> It is just Mum, me and my brothers living at home. I have been caring for my family since I was 8 years old. Mum suffers from drug addiction and mental illness. Because Mum is sick, it is up to me to get my brothers up and ready for school, including making lunches, breakfast, getting them ready and getting them to school. I also have to take them to appointments, clean the house, make dinner. I also care for Mum which includes personal care, and providing heaps of emotional support. I get worried about keeping everyone safe and sometimes I can’t sleep from worry and being scared.

Support services targeted to young carers are important. However, if the mental health system framed young carers differently, as being part of a family affected by mental illness, this may lead to more whole-of-family support. The best thing for many young carers may be to reduce the intensity of care they need to provide by increasing the psychosocial supports provided to the care recipient. The risks to their education and work outcomes, and wellbeing over their lifetime are significant. This increases the importance of governments taking a prevention and early intervention approach to supporting young carers, rather than taking actions to mitigate against poor outcomes later.

Although the Productivity Commission is recommending changes to policies that directly affect carers in this chapter, carers will also benefit from reforms recommended elsewhere in this report that aim to improve access to the right mental health services, at the right time and place. A more effective service system for mental health consumers would give carers more choice in how much care they provide and reduce the stressors related to caregiving.

> … the best outcomes are achieved when caring is a choice, rather than a sacrifice made in the absence of any other satisfactory alternative to ensure that a loved one receives support. (MHCN, sub. 245, p. 3)
The effects of caregiving

Benefits of caregiving

The value to the community of the informal care provided by mental health carers is immense. Carers provided over 200 million hours of care in 2015, which would have cost taxpayers $13.2 billion (2015 dollars) to replace with formal support services that were fully-funded by government (Diminic et al. 2017).

One parent described how their support contributed to the recovery of their child:

My child (I believe) is one of the lucky ones. I have been the one to pick her up after suicide attempts, I have been the one to get her back after running away from a health practitioner session, I have been the one staying home making sure she ate, keeping the family together, dealing with outbursts and all the ups and downs that comes with it! I have been the one to research, fight and demand assistance for my child, to get people to listen. (Name withheld, sub. 66, p. 3)

For some people with mental illness, the support they receive from family and friends is irreplaceable. Tandem (sub. 502, p. 3) noted that if ‘a carer is no longer able to provide ongoing support, the person with mental illness can become more at risk of hospitalisation, homelessness and suicide’. Johnson and Chamberlain (2011) found that the ongoing support from family was an important factor in preventing young people with mental ill-health from becoming homeless.

The benefits of caring described above — reduced expenditure on government-funded services and reduced homelessness — are tangible and measureable. Other benefits for both carers and consumers, although very real, are more difficult to measure:

The sense of personal connection and belonging generated by positive informal support networks is critical to the recovery process … Some carers report that caring can be a rewarding experience and many derive a sense of pride and accomplishment from their caring role. In some circumstances, relationships between family members can be strengthened when they are able to cooperate to overcome difficult circumstances. (MHCN, sub. 245, pp. 3, 8)

Costs borne by carers

Time and effort spent providing informal care imposes costs on some carers — including costs to their health and financial security. Mental Health Families and Friends Tasmania (sub. 391, p. 3) stated that the ‘practical, physical, economic and emotional demands of supporting a loved one with a mental illness can be enormous’. While not all carers are negatively affected by their caregiving role, those who provide care to someone with severe disability, or who work full-time and provide a high level of care, are more likely to face significant costs (Diminic, Hielscher and Harris 2018; Kenny, King and Hall 2014).

Carers are facing greater challenges since the COVID-19 pandemic. A survey by Caring Fairly found that as a result of the COVID-19 pandemic, many carers have experienced increased stress from their caring role and experienced a deterioration in their own mental health.
health (Mind Australia, pers. comm., 7 May 2020). Some carers reported working fewer hours due to their caring responsibilities. Mind Australia (pers. comm., 7 May 2020) noted that when formal supports were not accessible, it is carers who are left to replace the support not being provided. Carers were affected by worsening mental health of their care recipients, who were unable to leave the home for respite.

**The physical, emotional and mental costs of caregiving**

Stress associated with caring can take its toll. One study found that carers experienced clinical levels of depression at a rate 1.8 times higher than the general population (Productivity Commission estimate based on Edwards et al. 2008). Being a carer of a person with mental illness can be particularly stressful and have a larger effect on mental wellbeing (table 18.1).

### Table 18.1  The emotional and mental effects of caregiving

<table>
<thead>
<tr>
<th></th>
<th>mental illness (main condition)</th>
<th>mental illness (secondary condition)</th>
<th>other behavioural or cognitive conditions</th>
<th>physical conditions</th>
<th>All carers&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Not a carer&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kessler 10 indicator of psychological distress:</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Low distress level</td>
<td>32</td>
<td>38</td>
<td>46</td>
<td>54</td>
<td>53</td>
<td>60</td>
</tr>
<tr>
<td>Moderate distress level</td>
<td>25</td>
<td>29</td>
<td>29</td>
<td>26</td>
<td>23</td>
<td>21</td>
</tr>
<tr>
<td>High distress level</td>
<td>24</td>
<td>18</td>
<td>16</td>
<td>14</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Very high distress level</td>
<td>19</td>
<td>14</td>
<td>9</td>
<td>7</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Effects explicitly attributed to caring by carers:</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Had a stress-related illness</td>
<td>20</td>
<td>17</td>
<td>12</td>
<td>8</td>
<td>..</td>
<td>..</td>
</tr>
<tr>
<td>Feels weary or lacks energy</td>
<td>53</td>
<td>43</td>
<td>47</td>
<td>31</td>
<td>..</td>
<td>..</td>
</tr>
<tr>
<td>Feels worried or depressed</td>
<td>43</td>
<td>37</td>
<td>33</td>
<td>22</td>
<td>..</td>
<td>..</td>
</tr>
</tbody>
</table>

<sup>a</sup> 2018.  <sup>b</sup> 2017.  <sup>c</sup> Throughout this chapter, mental illness includes: depression and mood affective disorders; schizophrenia and other psychoses; phobic and anxiety disorders, obsessive-compulsive disorder, and other neurotic; stress-related and somatoform disorders; aggression; mental disorders due to alcohol and other psychoactive substance use; eating disorders; adult personality and behavioural disorders; attention deficit disorder/hyperactivity; speech impediment; insomnia; and other mental and behavioural disorders. Other behavioural and cognitive conditions includes: dementia; intellectual disability, autism, developmental learning disorders, coordination disorder, and other intellectual and developmental disorders; dyslexia; dyslalia; memory loss and problems; agitation or confusion; and acquired brain injury. Physical conditions included all other conditions. .. not applicable.

*Source:* Productivity Commission estimates using ABS (Microdata: Disability, Ageing and Carers, Australia, 2018, Cat. no. 4430.0.30.002) and wave 17 of the Household, Income and Labour Dynamics in Australia (HILDA) Survey.
The challenges faced by mental health carers were evident in the stories they shared with the Productivity Commission:

My husband and I have had many sleepless nights, whether because we are worried about what she might do to herself while we are asleep, or waking to hear her distraught hysterical crying. (Anonymous Parent, sub. 399, p. 3).

In the past 18 months I’ve observed my daughter’s decline. It’s a nightmare that evolves and it’s getting more frightening … I’m already stretching my emotional and mental limitations. (Name withheld, sub. 392, pp. 24, 29)

Carers are more likely than their peers to have physical health problems. Kenny, King and Hall (2014) found that females providing 20 or more hours of care per week had poorer physical functioning after two years as a carer, relative to non-carers in an otherwise similar life situation. Edwards et al. (2008) found that 29% of carers were in poor health compared with 17% of the general population.

**Lower labour force participation and productivity**

Time spent caring means less time available for employment. The Productivity Commission has analysed the effect of caring on the likelihood of being employed for the Australian population between 2001 and 2018 (table 18.2). About 70% of carers were in employment the year before becoming a carer but providing more than 10 hours of care significantly reduced their likelihood of being in employment. The effect was largest for carers providing over 30 hours of care per week; their likelihood of employment was 14.8 percentage points lower than if they were not providing care. The negative effect of caring on employment remained after people ceased providing care.

Not only does providing care reduce the probability of employment it also reduces the hours of work undertaken by carers who remain employed (table 18.2). For example, employed carers who provide care for 30 or more hours per week worked 3.2 fewer hours on average than if they were not providing care.

There was little difference in the rate of employment for working-age primary mental health carers (51%) compared to other primary carers (52%) in 2018 (ABS 2020b). Some mental health carers would like a job or to work more hours (figure 18.2). There are a range of reasons why carers were not in work or were working part-time, including raising children and retirement. However, over one third of mental health carers who were not employed stated that the main reason they stopped work was due to their caring role (figure 18.2).
Table 18.2  **The effect of caring on employment**a
Regression results using HILDA waves 1–18

<table>
<thead>
<tr>
<th>Carer status (variables of interest)</th>
<th>Employment (regression coefficient)</th>
<th>Hours of work per week (regression coefficient)b</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–9 hours of care provided each week</td>
<td>0.008 ***-0.654</td>
<td></td>
</tr>
<tr>
<td>10–19 hours of care provided each week</td>
<td>***-0.060 ***-1.677</td>
<td></td>
</tr>
<tr>
<td>20–29 hours of care provided each week</td>
<td>***-0.084 ***-2.775</td>
<td></td>
</tr>
<tr>
<td>30+ hours of care provided each week</td>
<td>***-0.148 ***-3.225</td>
<td></td>
</tr>
<tr>
<td>Ex-carer (was a carer in the previous 3 years)</td>
<td>***-0.063 ***-1.163</td>
<td></td>
</tr>
</tbody>
</table>

**Model statistics**
- Observations (total): 139,493
- Observations (persons): 20,462
- Number of carers in the sample: 4,890
- R squared: 0.68

a For people aged 25–64 years old, a linear fixed effects model was estimated: Employment\(_{i,t}\) = β × Carer_status\(_{i,t}\) + Xβ' + Individual + Time + ε\(_{i,t}\), where Individual and Time are individual and year fixed effects and Xβ' is a vector of covariates (age quadratic, marital status, education level, number of children), consistent with Leigh (2010). A person is considered an ex-carer if they are not providing care but provided 10 or more hours of care in any of the previous three years. The comparison group for carer status is ‘not a carer’. Robust standard errors, clustered at the person level. *** denotes statistical significance at the 1% level. Cross sectional weights were applied.

b The sample for hours of work includes those employed only.


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Figure 18.2  **Carers’ labour market transitions and aspirations**
Working-age co-resident primary carers of people with mental illness

- **32%** Employed carers who reduced working hours due to caring role
- **37%** Part time carers who would like to work more hours
- **39%** Carers who were not working who stopped work due to caring role
- **44%** Carers who were not working who would like to work while caring

Source: ABS (Microdata: Disability, Ageing and Carers, Australia, 2018, Cat. no. 4430.0.30.002).
Lower labour force participation has flow-on effects. At the community level, it reduces economic growth and tax revenue, and can raise government expenditure on income support. On a personal level, it not only affects income, but also precludes other benefits of employment, such as the social connection and feelings of empowerment and achievement that employment can provide.

Employment and education can provide an opportunity for carers to spend time away from the caring role and to focus on other aspects of their identity and wellbeing. (MHCN, sub. 245, p. 21)

For carers, work can be the best form of respite from caring. It is well established that carers can become very socially isolated. Work can provide them with the opportunity to socialise with other people and to have an identity and a focus beyond their caring role. (Carers Australia, sub. 372, p. 6)

Carers experience significant barriers to employment. The intensity of the caring role and lack of alternative formal services are two such barriers, but there are others (MHCA, sub. 489; Tandem, sub. 502). Many years spent caring can reduce confidence to re-enter the labour force and leave carers without the skills and work experience of their peers (MHFFTas, sub. 391, Mind Australia, sub. 380). Carers may not be attractive as potential employees if employers make assumptions based on their time out of the workforce (cohealth, sub. 231). Carers may also have difficulties finding a job that offers work arrangements with the level of flexibility needed to accommodate caring responsibilities (Caring Fairly, sub. 427).

Lower workplace productivity and educational attainment is also associated with caring. Mental health carers were more likely to be in low-skilled occupations than other types of carers and non-carers in 2015 (Diminic, Hielscher and Harris 2018). A survey undertaken by Carers Victoria (2013) found that the caring role affected some mental health carers’ performance at work and led others to switch to a lower paying job.

Carers may need time off from work due to their caring responsibilities. For employed working-aged primary mental health carers in 2018:

- 14% had to leave work for at least 3 months to provide care
- 23% needed time off work at least once a week because of care responsibilities
- 25% needed time off work because of caring but not as often as once a week (ABS 2020b).

One carer described their experience juggling caring and work responsibilities:

I have had to take significant time off work (have utilised a large portion of my accrued sick leave) and my wife has taken a year’s leave without pay, so as we can afford our daughter every opportunity to support/care, manage flare ups, attend to appointments/meetings and reintegrate back into mainstream society (school, home, community). (Name withheld, sub. 392, p. 2)
Reduced engagement in education and work for young carers

Disruptions to education and employment due to caregiving responsibilities are particularly consequential for young carers. For young people in general, not being in education and/or work at such an important time of transition and skill development is associated with increased vulnerability to their career and broader wellbeing throughout their life (chapter 6).

Several studies have found that young carers generally are at risk of poorer educational outcomes than their non-carer peers. Warren and Edwards (2016) found that the difference in Year 9 NAPLAN results between young carers with significant responsibilities and other children was equivalent to more than one year of schooling. Cass et al. (2011) reported that young carers (and potential young carers who did not identify as carers in the 2006 census) were less likely than their peers to be participating in either education or employment.

Outcomes are even worse for young mental health carers. Hamilton and Redmond (2019) found that children aged 9 to 14 years old who were caring for someone with mental illness were less engaged in school than non-carers and carers of people with a physical disability or chronic illness. The rate of participation in either work or education was lower for young mental health carers aged 15 to 24 years compared with other carers and non-carers in 2015 (Diminic, Hielscher and Harris 2018, table 3.2).

Poorer educational outcomes for young carers may reflect lack of time to do their homework; being late to, or missing, school more often; worrying about their care recipient while at school; and low participation in extra-curricular activities (Hamilton and Redmond 2019).

The effects of being a young carer are often compounded by other risk factors for poor educational attainment. The young carers surveyed by Hamilton and Redmond (2019) were more likely to have a disability or live in a materially disadvantaged household. Some of these risk factors for school engagement apply to children and young people without caring responsibilities in families affected by mental illness (discussed below).

Despite its challenges, Caring Fairly (sub. 765) noted that caregiving can help some young people to have an increased: emotional maturity level, ability to relate to adults better, problem-solving skills, and ability to work well independently.

Effects on income and financial hardship

Less time in formal employment affects carers’ incomes and savings and can contribute to financial hardship (Carers Victoria, sub. 461; MHCA, sub. 489; MHFFTas, sub. 391; Mind Australia, sub. 380; Tandem, sub. 502). In 2018, 41% of primary carers of people with mental illness reported difficulty meeting everyday living costs as a result of caring (compared with 30% for other primary carers) (ABS 2020b). Women’s Health Victoria (sub. 773) and Caring Fairly (sub. 765) noted that reduced workforce participation caused by caring responsibilities results in less superannuation accumulation and retirement income, and that women are disproportionally affected because more women are carers.
Carers also tend to incur expenses associated with their caring role that are over and above what can be covered by the income of the person they are caring for (Carers Victoria 2013). Costs include those related to healthcare for the person they are caring for, the cost of travelling to appointments, and property damage and debts associated with symptoms of mental illness (BPD Community, sub. 74; Carers Victoria, sub. 461; LMMHCN, sub. 52; Montelukast (Singulair) Side Effects Support and Discussion Group, sub. 197; Name withheld, sub. 104; Robert Davis, sub. 133).

I was hit with the harsh fact I had to quit my job to nurse my child around the clock, while accumulating regular considerable medical expenses, losses, and property damage repairs. (Carers NSW, sub. 183, p. 5)

The whole process is time consuming and costs me a great deal of time off work, and with ongoing expenses out of my pocket that are not covered for mental health services, no one can afford these on a disability pension. If I was not able to assist my child with these expenses, they would be unable to attend! (Name withheld, sub. 66, p. 2)

**Reduced social participation**

Less time in work, more time spent in the home providing informal care and increased stress, can reduce social participation, strain relationships of the carer with their family and friends, or lead to social isolation (figure 18.3).

The costs associated with carers experiencing stress, poor health or financial hardship extend to carers’ families and the broader community. Carers who do not receive support when they need it may come to need mental health services for themselves. Moreover, if burnt-out carers become unable to continue their caring role, this would lead to greater demand for formal mental health services for the person receiving care.

**Figure 18.3 Social costs of caregiving**

Primary mental health carers who co-reside with their care recipient

- 26% had not participated in social activities away from home without their care recipient in the previous 3 months
- 31% felt that their relationship with the care recipient was strained
- 53% felt that relationships with the other household members were strained or they had less time to spend with them
- 34% had lost or were losing touch with existing friends

*Source: ABS (Microdata: Disability, Ageing and Carers, Australia, 2018, Cat. no. 4430.0.30.002).*
Costs to families affected by mental illness

When a family member has mental illness, this affects not just their carer but the entire family. Children and young people may face risks to their education due to the stressors related to growing up with a sibling with mental illness (Siblings Australia, sub. 124). And stigma associated with mental illness can affect any family member, not just carers.

It’s a very traumatic experience for a family to have the police or something come on in, and sometimes literally drag your care recipient out, and the damage that does both to the person and the other person, is ginormous to me. (CMHA, Sydney transcript, p. 108)

Having a family member with mental illness can affect family relationships and dynamics (Robinson, Rodgers and Butterworth 2008). Parents described how their child’s illness affected the household’s relationships and functioning:

It was an incredibly stressful period without any path forward that pushed both myself and my husband close to breaking point. It increased the arguments between us as we couldn’t agree on how to solve the issue … Frequently when my husband got home from work he would just go straight to bed, without even eating dinner. Basic life tasks broke down — the housework piling up, eating takeaway and fast food rather than healthy home cooked meals, sometimes not leaving the house at all. (Anonymous Parent, sub. 399, p. 3)

Throughout my child’s struggle, I have found little understanding and support for myself and my other children – who have also suffered through this time. (Name withheld, sub. 66, p. 2)

One of the most vulnerable groups are dependent children of a parent with severe mental illness. As many as 44% of children and adolescents aged 4 to 17 years old in 2013-14 lived with a parent (primary or secondary carer) who had ever been diagnosed with mental illness (including alcohol or drug dependence) (Productivity Commission estimate based on table 1 of Johnson et al. 2018). Prevalence is considerably lower for children of parents with severe mental illness — 11.4% of children and adolescents aged 4 to 17 years old had a primary carer who reported high or very high psychological distress in the previous four weeks and 4.6% reported that mental health problems had interfered with daily activities most or all of the time since the child was born (Johnson et al. 2019). The symptoms of, and treatment for, mental illness can affect parenting and disrupt a family’s daily life. Environmental factors associated with mental illness — such as financial hardship or lack of social support — can also contribute to adverse outcomes for children (Campbell et al. 2020; Goodyear et al. 2015; Reupert, Maybery and Kowalenko 2012; Riebschleger et al. 2017).

Inquiry participants described some of the intergenerational effects of mental illness. For example, the mental health of children of refugees has been linked to the mental ill-health associated with trauma and grief experienced by their parents (AIFS, sub. 753). Traumatic experiences in childhood (such as parental mental illness, substance use or parental separation) increase the risk of suicide, substance use, mental illness and comorbid physical illness for those children in their adulthood (Emerging Minds, sub. 455).
Adolescents aged 10 to 14 years in New South Wales whose parents had used specialised mental healthcare services were: more likely to enter out of home care, more likely to interact with the justice system, less likely to finish high school and more likely to have an alcohol and other drugs-related hospital admission in the future (Taylor Fry 2018).

### 18.2 Family- and carer-inclusive practices

Family- and carer-inclusive practices in mental health services acknowledge the importance of family and friends, and ask clinicians to identify and support the consumers’ families and carers, and consider how best to include carers as part of the care team.

Considering a consumer’s social context as part of their care does not equate to always including family and carers in treatment.

For some, recovery may necessitate disconnecting from certain relationships and establishing firmer boundaries. From the perspective of relational recovery, however, even these assertions of autonomy and boundary-setting are seen as interpersonal acts; acts that only have meaning within the context of relationships … (Price-Robertson, Obradovic and Morgan 2017, p. 116)

… when we look at family engagement it’s not about necessarily involving the family completely, it’s about navigating ethically when … to involve the family and how to respond to the family in a way that is supportive of what the consumer wants as well. (MHCN, Sydney transcript, p. 101)

Families and carers should be included and supported in a way that upholds the rights of consumers and protects the safety of all involved. Consumers should be in a position to give informed consent to include their family or carer in their treatment. The National Standards for Mental Health Services stated that mental health services must uphold the rights of consumers to nominate if they wish to have or not have others involved in their care (to the extent that it does not impose serious risks) (Australian Government 2010).

### A partnership model between carers and mental health services

Carer-inclusive practice is a way of working that treats carers as partners in care. HelpingMinds (Geraldton transcript, p. 7) described the ‘triangle of care’ — communication and partnership between the consumer, the clinicians and the carer. For example, when a person is discharged from hospital and their care is placed in the hands of a carer, they should be supported with the information and skills they need to execute this role safely and effectively. And as partners in care, the direction of information should be two-way — carers often have insights on how best to support the recovery and wellbeing of their care recipient and mental health services may be disadvantaging consumers by not recognising this.
Inquiry participants raised concerns that their role, views and needs as carers are not being recognised and respected by mental health services (box 18.2). Frequently, the reason given for not engaging with carers is to protect the privacy of the consumer (ACT Government, sub. 210; Carers NSW, sub. 808; Name withheld, sub. 32; Name withheld, sub. 63). However, there is a lot that service providers can and should do to support carers without breaching confidentiality (box 18.3). For example, protecting privacy is not a valid reason for not listening to the views of carers or for not providing carers with general information (Mind Australia et al. 2016).

There’s sometimes some confusion about what it is that families want to know and it often is not the content of the conversation between the consumer and the clinician. They really want to know is everything going to be okay. Is everything all right? Or, “Because I’m the carer at home, is there something that I need to know to look out for?” (MHFFTas, Launceston transcript, p. 79)

**Box 18.2  The scope to improve carer-inclusive practice**

Inquiry participants shared the experiences of some carers, including that:

- carers were not being given sufficient information about diagnosis, treatment or the mental health system
- carers’ views about the consumer’s history and care needs were not sought or were disregarded
- carers were excluded from care and marginalised in decision-making processes
- carers were not given enough information or support when the consumer was discharged from inpatient care
- carers were not given information about prescriptions, even though they may be assisting the consumer with taking medication
- mental health professionals blamed carers and assume that carers were a cause of the consumer’s problems
- carers own needs were not considered or supported.

*Source:* ACT Government, sub. 210; Carers NSW, sub. 183; Carers Victoria, sub. 461; HelpingMinds, sub. 470; Mental Health Carers ARAFMI Illawarra, sub. 161; Mental Health Complaints Commissioner, sub. 916; MHC of NSW, sub. 948; MHCA, sub. 489; MHFFTas, sub. 648; Name withheld, sub. 392; Name withheld, sub. 66; Name withheld, sub. 8; Northern Territory Mental Health Coalition, sub. 430; Private Mental Health Consumer Carer Network (Australia), sub. 547; Robert Davis, sub. 133; Sarah Sutton, sub. 508; Tandem, sub. 502.
Box 18.3 National Standards for Mental Health Services: Standard 7

The National Standards for Mental Health Services, which were agreed to by all Health Ministers, includes Standard 7, which relates to carers. Some of the criteria within this standard that mental health services should meet include:

- having clear policies and protocols:
  - to enable staff to effectively identify carers as soon as possible in all episodes of care, and this is recorded and prominently displayed within the consumer’s health record.
  - to address the issue of sharing confidential information with carers in accordance with privacy legislation and guidelines
- in circumstances where a consumer refuses to nominate a carer, the service reviews this status at regular intervals during the episode of care
- providing carers with a clear written statement and verbal explanation of their rights and responsibilities
- providing non-personal information about the consumer’s mental health condition, treatment and ongoing care
- actively seeking information from carers in relation to the consumer’s condition during assessment, treatment and ongoing care and recording that information in the consumer’s health record
- engaging carers in discharge planning prior to discharge from all episodes of care.


Mental health services can enable and promote carer-inclusive practice by providing training to their staff and through organisational policies and procedures. This includes processes for identifying a consumer’s carers and documenting whether consent to share information has been granted to them by the consumer.

Mental health professionals should possess the attitude and skill to understand and be responsive to carers’ rights specified under each State’s and Territory’s mental health legislation. In certain circumstances, mental health professionals are obliged to share information with carers. For example, the Mental Health Act 2014 (Vic) includes specific obligations for service providers to consult with and inform carers when a consumer is subject to compulsory treatment. The Mental Health Act 2007 (NSW) enables consumers to nominate up to two ‘designated carers’ and gives these carers rights. If no carer is nominated by the consumer, then the designated carer can be assumed in some cases (such as spouses of consumers).

Several State and Territory Governments have prepared guidelines to describe mental health services’ responsibilities to families and carers under mental health legislation, and to assist them to put it into practice. Examples include: the Victorian Chief Psychiatrist (2018) guideline for working with families and carers; Queensland Health’s (nd, ndb) fact sheets on information sharing and rights of family under the Mental Health Act 2016 (Qld); and the South Australian Office of the Chief Psychiatrist’s (2017) plain language guide to the Mental Health Act 2009 (SA).
In addition to technical knowledge, mental health professionals also need to develop ways of working effectively with carers and consumers to enable carers to be included and supported. Inquiry participants commented on the scope to improve the skills and confidence of clinicians to engage with carers (ADACAS, Canberra transcript, p. 63; Arafmi, Brisbane transcript, p. 96).

Many participants promoted the use of *A Practical Guide for Working with Carers of People with a Mental Illness* (Arafmi, Brisbane transcript, p. 94; Carers Tasmania, sub. 660; HelpingMinds, sub. 470; MHCA, sub. 898; MHFFTas, sub. 648; Mind Australia, Melbourne transcript, p. 36; Private Mental Health Consumer Carer Network (Australia), sub. 550). This guide provided examples of strategies that staff might use to help identify carers and share information with them:

> Asking “who are your carers?” rarely receives a positive outcome. … If you work in an acute inpatient unit, you might say “Your husband/wife/partner brought you to hospital today. They seem very concerned about you. Would it be okay to nominate them as your primary carer? We will agree what information you feel comfortable sharing with them. It seems like they will be important to have involved in any plans we make.” (Mind Australia et al. 2016, p. 19)

This guidance is accompanied by free online training modules and a mobile application to help individuals and organisations to improve their skills and complete the self-assessment against the guide’s Partnership Standards, and to allow organisations to access reports that describe how well it is implementing the standards (Private Mental Health Consumer Carer Network, sub. 550).

It is important to make sure that consumer preferences about information sharing with carers are both actively sought, documented, and acted upon. There are many options available and each service will need to have its own policies and procedures for this. One option is attaching a carer nomination form to admission forms, such as the one included in the appendix of *A Practical Guide for Working with Carers of People with a Mental Illness* (Mind Australia et al. 2016). Alternatively, if the service is using electronic medical records, equivalent fields for nominating carers and sharing information could be added to this system.

The best option may depend on the relevant provisions in state and territory mental health legislation. For example, the Queensland Mental Health Act requires the chief psychiatrist to maintain electronic records of advance health directives and appointments of nominated support persons. Some other State and Territory Governments, including New South Wales, Victoria and South Australia, have prepared forms that enable carers to be nominated in line with their legislation (NSW Health nd; SA Health 2017; Victorian Government 2014).

Each mental health service’s procedures should also cater to cases where consumers have nominated their carer in advance. ACT Disability, Aged and Carer Advocacy Service (Canberra transcript, p. 61) stated that supported decision making is a good frame through which to improve information sharing with carers. Mental Health Carers NSW (sub. 1231, p. 9) noted that for ‘individuals with fluctuating decision-making capacity due to mental ill-health, services should support them to prepare an advance care directive which outlines their wishes regarding how personal information should be shared when they are very
Legal documents for supported decision making are called different things in different States and Territories — including Advance Care Plans, Advance Statements, and Advance Health Directives. Consumers who go to the effort of preparing these legal documents should be able to expect that clinicians will at least attempt to abide by them. The Mental Health Legal Centre (Melbourne transcript, pp. 169, 172) described how it supports people to create concise Advance Statements and works with mental health services to encourage their use. Advance care plans can also be uploaded to a person’s My Health Record (ADHA 2019).

The Productivity Commission is proposing ways to improve the take-up and use of advance directives, statements or agreements, including more help with creating these documents, formal recognition of them in mental health legislation and making them more easily accessible by any mental health service (action 21.10).

Greater use of care coordination services and adoption of single care plans for people with severe mental illness may also help with identifying carers and keeping track of requests and decisions related to consent to share information (recommendation 15).

**Encouraging change by improving transparency about service quality**

Several Inquiry participants suggested that there should be stronger regulatory requirements to mandate carer-inclusive practice (Carers Tasmania, sub. 660; HelpingMinds, Geraldton transcript, p. 7; MHCN, sub. 1231; MHFFTas, sub. 648; MHV, sub. 580, att. 1; Mind Australia et al., sub. 1212).

... we’re told time and time again, “We’d love to do it, but we’re just too busy.” (MHCA, Canberra transcript, p. 25)

Many mental health services are already subject to quality standards related to carer-inclusive practice, either under Standard 7 of the National Standards for Mental Health Services (NSMHS) (box 18.3) or the National Safety and Quality Health Service (NSQHS) Standards (ACSQHC 2018b; COAG Health Council 2017a). Although the NSQHS Standards are less explicit about facilitating information sharing with carers than the NSMHS, several of the actions in the Partnering with Consumers and Comprehensive Care Standards include carers (ACSQHC 2017b).

Despite this, the experiences reported by carers (box 18.2) suggest that some services are not meeting these standards. The Productivity Commission has considered what else can be done to encourage improvements and is recommending greater monitoring and reporting of how well services are providing carer-inclusive practice. Fortunately, the first steps have already been taken to enable this. Under action 23 of the Fifth National Mental Health and Suicide Prevention Plan, State and Territory Governments agreed to implement surveys for monitoring consumer and carer experiences of care by 2021 (COAG Health Council 2017b).
These surveys have been developed by the Australian Mental Health Outcomes and Classification Network and are known as the Your Experience of Service (YES) survey for consumers and the Carer Experience Survey (CES) (AMHOCN 2019c).

The CES survey was designed for inpatient and community state and territory mental healthcare services. The survey includes questions to carers about whether they were identified as a carer and ‘given opportunities to discuss the care, treatment and recovery of your family member, partner or friend (even, if for reasons of confidentiality, you could not be told specific information)’ (AMHOCN 2016, p. 1). Inquiry participants supported the national implementation of the CES (Carers Victoria, sub. 664; Mental Health Complaints Commissioner, sub. 916; NMHC, sub. 949; St Vincent’s Mental Health Family and Carer Reference Committee, sub. 1193).

Collecting surveys from carers is not new — the Australian Institute of Health and Welfare reported that carer satisfaction surveys were used in 67% of specialised mental health service organisations in 2017-18 (AIHW 2020h, table FAC.10). However, the design of the CES built upon previous surveys. It was co-designed with carers, consumers and clinicians nationally; trialled, tested and improved upon; and found to be highly regarded by carers and to perform well and reliably (AMHOCN 2017). Moreover, carer experience survey collection and use has not been systematic in the past. What is missing is widespread collection of a nationally consistent survey, transparent reporting and benchmarking of results to encourage behaviour and culture change in services.

Except for Queensland and New South Wales, most State and Territory Governments were not yet collecting responses to this survey from carers as of April 2020 (Queensland Health 2019b). The Australian Mental Health Outcomes and Classification Network, which is working on the development of a range of resources to support implementation and the use of results, stated that all jurisdictional representatives expressed an ongoing commitment to measuring and reporting the CES (AMHOCN 2019a).

The New South Wales Government implemented the paper-based version of the survey in its services in 2018 and released an online version in 2019, which is available in 26 languages (Mental Health Carers NSW 2018; NSW Government 2020). A range of reports have been developed to enable team managers and directors within the Local Health Districts to assess their performance against the survey results over time and compared to other services (when and where the number of surveys collected is sufficient) (NSW Ministry of Health, pers. comm., 24 February 2020).

The CES should be collected routinely by services and results should be used to drive continuous improvement in carer-inclusive practice. Greater use of and reporting against the CES would improve incentives for staff to identify carers and work in partnership with them. This is consistent with action 24.5 where the Productivity Commission is proposing that the Australian Institute of Health and Welfare provides more of its reporting at the regional level. In addition, reports describing detailed results should be developed for service managers to enable them to monitor and improve practices over time.
Services with good practices in place would have this reflected in their CES results and this can count towards their next NSQHS or NSMHS assessment. It is possible that the CES results may identify shortcomings in carer-inclusive practice that relate to a service’s culture rather than the absence of procedures and training opportunities. Promoting a carer-inclusive culture may take time but increasing transparency about the status of services is a first step to encourage change and improve outcomes for consumers and carers.

How services improve their practices in response to below average results should be determined in consultation with carers, as per Standard 3 of the NSMHS, which relates to consumer and carer participation.

**Family-inclusive practice**

Family-inclusive practice requires mental health services to consider the needs of family members and the role of a person’s family in their recovery. People who may need support include spouses, siblings or parents. Two elements of a more family-focused mental health system are discussed below — support for families where a parent has mental illness and family interventions.

**Families where a parent has mental illness**

Inquiry participants described the importance of mental health services identifying consumers who are parents with dependent children, and taking this into account in supporting recovery and the family’s wellbeing.

In terms of prevention … the importance of family recovery and supporting parents who are living with mental health issues to ensure that the family can stay well and people can stay living with their families … (WAAMH, Perth transcript, p. 86)

We should have a system … that there’s active outreach and engagement with parents and not a presumption that we don’t want these services for our children. … there are discrimination issues about parents with serious mental illness lacking the insight to want better for their children … (Helena Willan, Brisbane transcript, p. 14)

To improve the wellbeing of the whole family, mental health professionals may need certain skills to work sensitively with their clients who are parents. For example, parents may anticipate stigma associated with being a parent with mental illness or fear intervention by child protection departments (Cuff 2019). Maybery et al. (2014) found that skills, knowledge and confidence to provide family-inclusive practice when treating a parent with mental illness varied between psychiatric nurses, social workers and psychologists.

As with carer-inclusive practice, guidance and training to improve practice in this area exists for those who seek it out, but a focus on family is not embedded in all mental health services.

The Australian Government funded Emerging Minds to implement the Children of Parents with a Mental Illness initiative from 2001 to 2017 (Emerging Minds, sub. 944). This work
produced evidence-based resources and guidance that aimed to improve outcomes for children of parents with mental illness. The Children of Parents with a Mental Illness website has information and resources, which are targeted separately to parents, children and young people, family and friends, and professionals (Emerging Minds 2016). Emerging Minds continues to produce resources to assist health professionals with family-inclusive practice as part of its broader work program (for example, Emerging Minds 2019).

In addition, policy and procedures are needed at the organisational level. Emerging Minds (sub. 944) suggested a need for clear pathways of support between adult mental health services and relevant child health, mental health, and parent support services. Reupert et al. (2012, p. 9) stated that it:

… is imperative that there are procedures to identify the parenting status of patients, to screen for competence in various domains (parenting, child wellbeing and family dynamics) and, at a minimum, to refer parents and/or children to appropriate services if required.

Progress in supporting families where a parent has mental illness in mental health services is evident in some States and Territories (box 18.4).

**Box 18.4 Examples of efforts to improve family-inclusive practice**

The Victorian Government commenced the Families where A Parent has a Mental Illness (FAPMI) strategy in 2007 to reduce the effects of parental mental illness on all family members, particularly dependent children. The strategy includes employing local FAPMI coordinators in each catchment area. FAPMI coordinator tasks include ‘building capacity of the mental health workforce and partner agencies through education and training, referral pathways and procedure development to improve identification and support for parents and their children’ (Falkov et al. 2016, p. 183). The FAPMI strategy has been statewide since 2016.

The New South Wales Children of Parents with a Mental Illness (COPMI) Framework sets directions for its mental health services, such as the provision of services for families, strengthening the capacity of interagency partners and supporting the workforce to provide family-inclusive practice (NSW Health 2010). It provides detailed instructions on ways to achieve the directions, including the use of COPMI coordinators. The NSW COPMI initiative has since been renamed Family Focused Recovery (NSW Government, sub. 551).

The Queensland Government has also produced a guideline for working with parents with mental illness and the ACT Government has a COPMI families policy (ACT Health 2013; Queensland Health 2010).

A targeted preliminary evaluation of the Victorian Government’s Families where A Parent has a Mental Illness (FAPMI) strategy was completed in 2012. It compared two catchment areas with a FAPMI coordinator with two catchment areas without a FAPMI coordinator (Maybery et al. 2012). The evaluation found that adult mental health clinicians in the catchment areas with a FAPMI coordinator provided more family-inclusive practice. These clinicians had greater skills and knowledge regarding the effects of parental mental illness on children and were better able to provide referrals to family support services. In catchments
with a FAPMI coordinator, the staff of mental health services and family support services had greater access to secondary consultations, resources and training related to FAPMI.

The Victorian Government also funded a trial and research project for the ‘Let’s Talk about Children’ program. The program is an evidenced-based 2 to 3 session, psycho-educational intervention designed for parents with mental illness, where mental health professionals are trained to have conversations that empower consumers as parents and support their families (Allchin et al. 2020; Solantaus et al. 2010). It was trialled at 11 mental health and family support services in Victoria and is being rolled out elsewhere in the State (Monash University 2016; The Bouverie Centre 2019).

Beyond clinical services, psychosocial support services may be in a good position to assess family context and needs:

… every time a [psychosocial support] team member is going … to do an intake process we identify who is around — you know, are there young children in the house, are other people, family members within the house, and look at [what] are the needs … (HelpingMinds, Geraldton transcript, p. 12)

The Productivity Commission has identified a need for clearer policy responsibilities and better service planning for psychosocial supports at the State and Territory Government level (chapter 17). The role of family assessments and family support for people with psychosocial disability could be considered as part of this.

Family interventions and inclusion in care discussions

The process of identifying families and carers, and assessing their needs, is the minimum level of care that should be offered to all families and carers of people accessing mental health services but some families will have greater needs (Mottaghipour and Bickerton 2005). Family interventions may be needed, including psycho-education, carer or family consultations, family or relationship counselling, or family therapy. Psycho-education aims to provide carers with problem solving and coping strategies to help them be effective in their caring role or improve family functioning. Psycho-education may be provided to a carer by the care recipient’s clinician but is often delivered as part of a structured program, and as such, is discussed in section 18.3. This section focuses on consultations, counselling and family therapy.

Family interventions have been shown to be an effective way to improve outcomes for many consumers, carers and families affected by mental illness. For example:

- the Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia note that the evidence base for family interventions for schizophrenia is strong (Galletly et al. 2016)
- behavioural family therapy programs for schizophrenia reduce carer burden and improve consumer mental health (Macleod, Elliott and Brown 2011)
- a systematic review of family interventions as an adjunct to treatment for bipolar disorder was found to be effective for patients and carers (Reinares et al. 2016)
- results from two randomised control trials showed that family therapy as part of treatment for anorexia nervosa may be more effective than individual treatment in the short term at least (Fisher, Hetrick and Rushford 2010)
- family-based models of care are among the most effective approaches for treating both adults and adolescents with drug problems (Rowe 2012).

For children and adolescents, family interventions are effective for a range of mental health problems (Carr 2018). The Centre for Excellence in Child and Family Welfare (sub. 211) stated that the best interventions for children with emotional and behavioural needs are holistic, family-centred supports.

The National Mental Health Service Planning Framework (NMHSPF) provides a benchmark of community need for mental health services across Australia. This model makes provision for $185 million worth of structured psychological therapies (such as psycho-education counselling and family therapy) for carers and other family members of people with mental illness in 2019-20 nationally.

The aim of family interventions varies but is typically to meet the needs of the consumer or the carer, or to improve family functioning and relationships. For example, support for families to work through family conflict and strengthen relationships can help with a consumer’s recovery.

… social inclusion is trying to reconnect with family members that have been disengaged because of the illness and try and connect with those support networks and mediate those support networks … (Anglicare Central Queensland, Rockhampton transcript, p. 43)

Without peoples’ links to culture and community, and without positive connections with family and friends, people’s self-esteem, resilience and sense of individual and collective identity may suffer, to the detriment of their mental health and wellbeing. (Victorian Government 2019a, p. 23)

Given that family relationships are an important determinant of health for Aboriginal and Torres Strait Islander people, this type of support may be particularly important for Aboriginal and Torres Strait Islander people’s social and emotional wellbeing. To be effective, services also need to be culturally capable. For example, the Bouverie Centre (sub. 719) developed a family therapy service tailored to the needs of Aboriginal families in Victoria and provides postgraduate training in family therapy for Aboriginal and/or Torres Strait Islander Workers.

190 The NMHSPF was initially developed by the NSW and Queensland Governments and is being revised by the University of Queensland, with funding from the Australian, State and Territory Governments, to quantify the level and mix of mental health services needed to meet the needs of Australia’s population. NMHSPF national estimates of services costs are indicative only, and require adjustments to wages by the jurisdiction or service using the planning support tool.
Family therapy, when delivered by a specially qualified family therapist, is on the higher end of the family intervention spectrum in terms of complexity of needs and intensity of the intervention (Mottaghipour and Bickerton 2005). In addition to highly qualified practitioners, family therapy often requires a significant commitment and motivation from the participants due to the number of sessions and long-term nature of the intervention.

Several Inquiry participants discussed the benefits of family and carer consultations, provided as a brief intervention. The Bouverie Centre (sub. 719) promoted the use of Single Session Family Consultation and noted that is relatively straightforward model for private practitioners with little training in family work. Some of the settings where this model has been used include some Child and Adolescent Mental Health Services in Victoria, Tasmania and the ACT, and a trial within headspace centres (Fry 2012). An evaluation of the headspace trial described positive reports from clinicians, consumers and families (Poon et al. 2019). headspace Geraldton (sub. 617) stated that Single Session Family Consultation sessions can often be a fast way to address some issues in families and bring about positive change.

Inquiry participants described the importance of meetings between clinicians and carers, to share their views and ask questions.

It’s the lack of ‘me’ time that is concerning … you must afford ‘me’ the time to validate and clarify any embellishments or skewed reality that my daughter articulates. It also gives me the opportunity to discuss my feelings, views and understanding with respect to treatment, progress and prognosis. (Name withheld, sub. 392, p. 22)

[There is] limited scope for case management meetings … GP’s, Psychologists and Psychiatrists should be provided with Medicare codes to undertake case management meetings, more extensive communications with other professionals, and patient ‘decision making’ meetings (with their Advocates). (Robert Davis, sub. 133, pp. 8, 19)

However, Inquiry participants also described the barriers to accessing family interventions. Relationships Australia (sub. 103) stated that there is under-recognition of the value of family therapies. Limited funding was also a concern. Orygen and headspace (sub. 204, p. 36) stated that ‘support of families is critical in young people’s treatment, yet there is no funding stream to support their involvement in treatment’. And Mental Health Australia (sub. 864) stated that funding models tend to focus on individual interventions. The other main barrier is skills; professionals have low confidence or reluctance in delivering family interventions due to lack of training (Emerging Minds, sub. 944; The Bouverie Centre, sub. 719).

Family-based intervention is more difficult than intervention with individuals, because there is more complexity in the transactions … Family therapy has long demonstrated its capacity to find workable problem solutions in less time. But there needs to be a change in practitioner mind set … Most post-graduate courses do not provide adequate training in family-based responding and intervening. (MHYF Vic, sub. 628, p. 6)
Increasing access to funding for family interventions

For services reliant on MBS rebates, there is need to amend the MBS to better accommodate work with families and carers. The Australian Government should provide MBS rebates for family interventions, both with and without the presence of the family member receiving treatment for mental ill-health.

The MBS has items that support consultations between psychiatrists and carers without care recipients present, but there is no equivalent for psychologists.\footnote{MBS item numbers 348, 350 and 352 allow psychiatrists to consult with non-patients (including carers and multidisciplinary clinicians) (DoH 2020b). Rebated sessions are unlimited if undertaken in the course of initial diagnostic evaluation (first month) and limited to four sessions per year thereafter.} Claims for these items have increased significantly over the past 10 years (unpublished MBS data and RANZCP 2018). Psychiatrists claimed each of these items for between 15,500 and 25,000 people in 2018-19 and total benefits paid was $10.6 million (unpublished MBS data). Nearly 40% of these consultations related to patients under the age of 25 years (RANZCP 2018).

The Bouverie Centre (sub. 719, p. 2) stated that funding for relevant non-patients would provide ‘access to much needed support for families in circumstances where the care recipient may not be agreeable to family participation in sessions’. Melbourne Children’s Campus (sub. 927, p. 21) noted that this is ‘particularly pertinent for young children with mental health problems where the most effective approaches are through moderating the parenting styles which necessarily requires one on one work with parents, not the child’.

The MBS Review Mental Health Reference Group (2018) stated that sessions for carers were a fundamental element of evidence-based best practice and that they would enhance collaboration and recognition of carers. Their draft report recommended that a new family and carer MBS item should be created for psychologists and allied mental health professionals, with a four-session limit per year. The Queensland Mental Health Commission (sub. 228) supported this recommendation by the Mental Health Reference Group and the Australian Psychological Society made the same recommendation (APS 2019).

The Productivity Commission agrees. A limit of four sessions per 12 month period is proposed due to the precedent set by the existing MBS items for psychiatrists. However, the next time there is an MBS review, the limit should be aligned with the latest evidence about what works to improve outcomes for consumers, families and carers. The average number of consultations per patient in 2018-19 was fewer than two for the existing MBS items (unpublished MBS data). However, a four session limit may be insufficient for some clients:

Working in this collaborative manner with carers has been stipulated as a basic requirement, particularly in the field of child and adolescent psychiatry, and intellectual and developmental disability psychiatry and geriatric psychiatry, and usually requires separate interview time at each substantial consultation. (RANZCP 2018, pp. 11-12)
The second change the Productivity Commission is proposing is to expand access to family interventions under the MBS when both the consumer and their family are present. MBS-rebated sessions with the consumer and family present can be provided by medical practitioners and clinical psychologists.\textsuperscript{192} However, registered psychologists and other allied mental health professionals may only provide family interventions that align with the list of acceptable psychological strategies approved for MBS rebates, such as psycho-education or parent management training (DoH 2019d).\textsuperscript{193} Orygen (sub. 1110) suggested a need for a dedicated MBS item for single-session family consultations. The MBS Review Mental Health Reference Group (2018) recommended adding family interventions to the list of approved interventions that can be delivered by allied health professionals. The Productivity Commission agrees with this recommendation.

\textbf{Workforce capacity for family- and carer-inclusive practices}

For state and territory specialised mental health services, funding should be available in each region to ensure that dedicated staff have the time and resources to develop family- and carer-inclusive practices. These staff would balance dual roles; building greater capacity within services and supporting families and carers directly where needed. They would promote training opportunities for family- and carer-inclusive practices as well as advising managers about organisational changes, such as the introduction of carer nomination forms. Each State and Territory Government should determine whether staff are based in hospital or community settings, or within a regional commissioning body.

Although all mental health services should have this capacity, the proposed action focuses on supporting improvements in the same community and inpatient services required to collect the Carer Experience Survey. As results from the CES provide greater transparency about areas for improvement, these staff will promote improved practices on the ground.

Given the evidence of improved family-inclusive practice in Victoria, services should have identified people with responsibility for coordinating support and training to staff working with families where a parent has mental illness. This view was supported by the Victorian Mental Health Complaints Commissioner (sub. 916). These coordinators would: work with mental health professionals who seek advice about how best to support the families of their patients; assist with service referral; and improve networks with other relevant agencies.

Some services already adopt elements of the proposed approach. In New South Wales, $2.3 million was provided to Local Health Districts in 2018-19 to improve family- and carer-inclusive practices as part of its Family and Carer Mental Health Program (NSW Ministry of Health, pers. comm., 22 July 2019). How this funding is spent is determined by

\textsuperscript{192} Medical practitioners may provide family therapy under items 170, 171, 172, 342, 344 and 346. Clinical psychologists providing psychological therapy under items 80000 to 80021 may use any clinically relevant evidenced-based therapies (DoH 2019d, p. 42).

\textsuperscript{193} The range of acceptable strategies are: psycho-education; cognitive-behavioural therapy; relaxation strategies; skills training, including parent management training; interpersonal therapy; and narrative therapy (DoH 2019d, p. 49).
each Local Health District, but some services have used it to employ staff to support the
skills and knowledge of other mental health professionals. Mental Health Carers NSW
(Sydney transcript, p. 101; sub. 1231) stated that the use of family and carer workers has
driven quality improvement related to family and carer engagement within those districts.

South Australia has carer consultants supporting carers in its public mental health services.
Sarah Sutton (sub. 737), a carer of two brothers with schizophrenia, stated that carer
consultants provide support with navigation, information about their rights and emotional
support, and are particularly important for those who are new to a service. She emphasised
the importance of lived experience for people in these roles and would like carer consultants
employed in all mental health services.

Carer peer workers should be considered to fill dedicated roles when services have
opportunities to recruit new staff. Carer peer workers use their experience of caring for
someone with mental illness in providing support to other carers. The use of carer peer
workers in specialised mental healthcare services is highly variable within and across States
and Territories (table 18.3). Victoria and Queensland more commonly employ carer peer
workers in specialised mental health facilities, but a number of other States also employ carer
peer workers. Several Inquiry participants supported the use of carer peer workers in mental
health services to promote carer-inclusive practice (Anne Barbara, sub. 910; Mind Australia,
Melbourne transcript, p. 35; MHCN, Sydney transcript, p. 97; St Vincent’s Mental Health
Family and Carer Reference Committee, sub. 1193).

A carer peer workforce harnesses and validates the lived experience of carers, and uses their
unique skill set … to complement the clinical staff skill set, allowing for a stronger caring team
(MHFFTas, sub. 648, p. 6)

<table>
<thead>
<tr>
<th>State or Territory</th>
<th>Count of FTE carer peer workers</th>
<th>FTE carer peer workers per 100 000 people in the population</th>
<th>% of specialised mental health service organisations employing at least one mental health carer</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>3</td>
<td>—</td>
<td>11</td>
</tr>
<tr>
<td>Victoria</td>
<td>35</td>
<td>0.6</td>
<td>55</td>
</tr>
<tr>
<td>Queensland</td>
<td>24</td>
<td>0.5</td>
<td>45</td>
</tr>
<tr>
<td>South Australia</td>
<td>5</td>
<td>0.3</td>
<td>57</td>
</tr>
<tr>
<td>Western Australia</td>
<td>1</td>
<td>—</td>
<td>3</td>
</tr>
<tr>
<td>Tasmania</td>
<td>1</td>
<td>0.1</td>
<td>27</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>ACT</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Australia</td>
<td>69</td>
<td>0.3</td>
<td>27</td>
</tr>
</tbody>
</table>

* Carer peer workers are defined as persons employed specifically for their expertise developed from their lived experience as a mental health carer. Carer peer workers employed in the community managed sector are not included. — rounded to zero.

*Source: AIHW (2020h, tables FAC.34, FAC.36 and FAC.5).
Chapter 16 describes ways to support the effectiveness and growth of the peer workforce, including by improving their access to professional development, and professional supervision and support.

**The costs and benefits of reform**

The cost of the recommended reforms to improve family- and carer-inclusive practices is estimated to be $74 million to $102 million in the first year and $73 million to $101 million per year thereafter. This was estimated based on:

- approximately $900 000 for one FTE senior project officer for one year to support the implementation of the Carer Experience Survey in each State and Territory, except New South Wales
- $10–$23 million per year for MBS-rebated family and carer consultations without the care recipient present
- $4–$10 million per year for MBS-rebated family and carer consultations provided by registered psychologists and other allied health professionals to provide family and carer consultations with the care recipient present
- $60–$68 million per year for family and carer workers based in each region, comprising:
  - $26–$29 million per year for additional peer workers
  - $20–$24 million per year for manager-level staff
  - $14–$16 million per year for coordinators for families where a parent has mental illness (except in Victoria, which already has them).

Assumptions behind these calculations are described in appendixes I and K. The combined benefits of reform were calculated once for both actions 18.1 and 18.2. These actions are expected to improve the mental health of carers, care recipients and children of parents with mental illness, and are likely to provide net benefits to the community (through increased incomes and cost-savings). For example, the modelling results show that family interventions provided as part of treatment for people with schizophrenia and other psychoses would reduce government expenditure by $40–$73 million per year as a result of reduced hospital admissions and emergency department presentations (appendix K).
ACTION 18.1 — FAMILY- AND CARER-INCLUSIVE PRACTICES

Family- and carer-inclusive practices require mental health services to consider family members’ and carers’ needs, and their role in contributing to the recovery of individuals with mental illness. This includes children in families affected by mental illness.

Start now

- Where this is not already occurring, state and territory community and inpatient mental healthcare services should routinely collect responses to the Carer Experience Survey. The data collected should be sufficient to enable benchmarking and to provide services with evidence of their compliance against the related sections of the National Standards for Mental Health Services and the National Safety and Quality Health Service Standards.
- The Australian Institute of Health and Welfare should use the data to report annually on survey collection rates and carer experiences at the regional level.
- The Australian Government should amend the Medicare Benefits Schedule so that family interventions provided by psychologists and other allied mental health professionals are rebated.
  - Family and carer consultations with the consumer present should count towards session limits for psychological therapy.
  - Family and carer consultations without the consumer present should be limited to four per 12 month period.
- State and Territory Governments should, over time, work towards ensuring the workforce capacity exists in each region to implement family- and carer-inclusive practices within State and Territory community and inpatient mental healthcare services. These services should identify people with responsibility for:
  - supporting family and carer participation in co-design and service improvement processes
  - providing and supervising carer peer work within mental healthcare services
  - providing advice to clinicians and managers about how to improve family- and carer-inclusive practices
  - facilitating training opportunities to improve family- and carer-inclusive practices
  - promoting the use of effective family interventions.

18.3 Family and carer support services

Given the challenges faced by some carers (section 18.1), carers may need support services to help them achieve their goals and meet their needs. The Australian Government Department of Social Services (DSS) has classified a range of carer needs according to the areas of life in which carers most typically need support (figure 18.4).
Services for carers are provided by non-government organisations (NGOs), for-profit providers and state and territory specialised mental health services. Some NGOs are carer-specific service providers and others are providers of psychosocial supports. Services are mostly government funded, but some are also funded from private donations and consumer charges (MHCN, sub. 245). Funding for carer support services has long been provided by both the Australian Government and State and Territory Governments.

Inquiry participants described how carer support services are valued by those who use them.

I have found [organisations like ACT Carers] to be the most useful source of information and support, especially the educational workshops, access to counselling and respite care they provide to carers of loved ones with mental health issues. (Name withheld, sub. 104, p. 2)

Since Oct 2015, BPD Community has had a Family & Friend’s Group meeting monthly. … The quarterly report for 2019 indicates a usefulness of the sessions at 90%, 98% indicated they felt more confident, 99% felt supported and 78% reported an improvement in their relationship with their loved one with BPD [borderline personality disorder]. (BPD Community, sub. 74, p. 6)

It wasn’t long before my health was affected. After several biopsies, I am a survivor, building up resilience thanks to the carer support connection, education and respite I used to benefit tremendously from, leading to my now volunteer advocacy position. (MHCN, sub. 245, p. 9)
There is good evidence that demonstrates the effectiveness of specific interventions for families and carers, particularly psycho-education (box 18.5). However, there are few publicly available evaluations of the programs run in Australia. Therefore, it is not clear the extent to which the mix of services available here is effective and aligns with best practice.

**Box 18.5  Evidence of the effectiveness of carer support services**

A review of the evidence base for psycho-education concluded that multifamily psycho-education groups were ‘associated with significantly improved problem-solving ability and a reduced burden on families, compared with control groups, among other strong outcome effects’ (Lyman et al. 2014, p. 416).

A randomised control trial of a structured group psycho-education and skill development program for carers of people with borderline personality disorder demonstrated that this intervention improved family relationships and carer empowerment (Grenyer et al. 2019). The program participants valued the peer support they gained by meeting and interacting with other carers. The mental health of participants in the intervention improved in the 12 months that followed.

A randomised control trial evaluated the efficacy of a brief version of an existing psycho-education program for carers of people with an eating disorder, and found that it reduced carer burden, and improved self-efficacy, skills and knowledge (McEvoy et al. 2019).

Young people aged 13 to 17 years who nominated caring adults to support them following suicidal ideation or attempt as part of the Youth-Nominated Support Team program were significantly less likely to die in the 14 years that followed, compared with a control group (King et al. 2019). Nominated carers were provided with psycho-education and weekly support by telephone.

A review of what works for mental health nurses in supporting carers of people with schizophrenia found that supportive family education reduced carer burden and that there was some evidence that peer support groups reduced burden and improved coping (Macleod, Elliott and Brown 2011).

A carer peer worker-led group psycho-education and skills-building program in the United Kingdom resulted in statistically significant improvements in carer mental wellbeing, carer burden and family empowerment based on surveys of the 60 carers who completed the program (Chiocchi et al. 2019).

A meta-analysis of various interventions for carers of people with eating disorders reported that most interventions reduced carer distress and burden (Hibbs et al. 2015).

**Australian Government funded services**

Carer support services funded by DSS are in transition. Six programs providing carer support services have ceased and been replaced with the new Integrated Carer Support Service (ICSS) and funding from another two programs has been redirected into the NDIS (DSS 2018n, 2019j).\(^{194}\) Once transition is complete, total funding of the ICSS is expected to be $134 million in 2020-21 and then increase to $143 million in 2021-22 (DSS 2019d, p. 3).

\(^{194}\) Funding from an additional program, the Young Carers Respite and Information Services program, is transitioning in part to the ICSS and in part to the NDIS.
All services funded under the ICSS are delivered through the Carer Gateway. The Carer Gateway website and phone line provides a service entry point, as well as digital services such as information about caring, phone counselling, self-guided coaching and online skills courses. For face-to-face services, a lead Carer Gateway provider has been selected for 16 regions that span the country. Ten lead organisations and their consortium partners commenced delivery of these services in April 2020, including carer support planning; tailored support packages; in-person counselling, peer support and coaching; and emergency respite care (Ruston 2019).

The ICSS was designed through consultation with carers, and has an outcomes-based needs assessment, and monitoring and evaluation framework (DSS 2018g, 2018j). Each carer seeking assistance will work with a Carer Gateway provider to record a snapshot of their goals and needs, using a tool developed in the United Kingdom called the Carers Star that covers the areas of life described in figure 18.4. This then informs service planning — the carer’s Action Plan might include a mix of Carer Gateway services and other services that the support worker helps to coordinate. Service providers are required to collect data on the wellbeing of carers before and after they receive support, and this enables monitoring and evaluation of the outcomes achieved for carers over time (DSS 2019f).

Although Inquiry participants see the ICSS as a promising development, some were tentative about what the ICSS and NDIS transition means for mental health carers.

… a lot of work went into creating that and a lot of consultation with carers and it’s probably going to work quite well … (Sjon Kraan, Perth transcript, p. 30)

The Department of Social Services has undertaken one of the most extensive consultation processes in its history to co-design the Integrated Carer Support Service (ICSS), which will trade as the Carer Gateway. … for the first time, unpaid, informal carers will access supports through a single front door, namely a single 1800 number and website. (Carers Tasmania, sub. 660, p. 11)

The integrated carer support service … is a good concept, however, … our financial modelling shows the amount of services available through the allocated funding will not provide sufficient services to mental health carers … (HelpingMinds, Geraldton transcript, p. 7)

One of the programs that is being wound up due to the transition to the ICSS and NDIS — the Mental Health Respite: Carer Support — was just for mental health carers, whereas most of the other programs were for a broader range of carers or young carers. The Mental Health Respite: Carer Support program provided mental health carers with relief from caring through in-home or out-of-home respite or social and recreational activities, counselling, practical assistance, case management, education and information (DSS 2019f). Approximately 41 000 carers were supported by the program in 2014-15 and $64 million was allocated to the program in 2015-16 (DSS 2016c). Funding reduced each year thereafter as it was progressively transitioned over five years to the NDIS (DSS 2018f).
Having one comprehensive program for all carers, rather than many targeted programs, is likely to give service providers more flexibility to be responsive to carers’ individual needs and prioritise carers most in need. However, the Mental Illness Fellowship of Australia (sub. 343) expressed concern about the Mental Health Respite: Carer Support program ceasing and submitted that funding specifically for mental health carers should continue.

Some of the services that were available under the Mental Health Respite: Carer Support program will be available under the NDIS, for those people who qualify for the NDIS and choose supports for their carer as part of their plan. Supports funded under the NDIS that may give carers a break from caring include short-term accommodation, personal care supports provided in the home and community-based activities (DSS 2018k). The NDIS also funds services that can build a carer’s skills related to caring. The NDIS provided $1.2 million in 2018-19 to train carers and parents of people with primary psychosocial disability, predominately for training in behaviour management strategies (National Disability Insurance Agency, pers. comm., 8 August 2019).

However, Inquiry participants reported that the number of services providing support for mental health carers has reduced and that the types of services provided has changed (Anglicare Sydney, sub. 190; cohealth, sub. 231; LMMHCN, sub. 52; Mind Australia, sub. 380; One Door Mental Health, sub. 108; Tandem, sub. 502). Further, some State and Territory Government funding decisions relating to carer support services have been altered as a result of the transition to the NDIS. For example, the Queensland Department of Communities, Disability Services and Seniors transferred some of its funding for carer support services to the NDIS from 1 July 2019 (State and Territory Governments Survey).

Inquiry participants were also concerned that the NDIS’ focus on the choice and control of individuals with disability, rather than carers, would result in unmet needs for carers (MHCA, sub. 489; MHFFTas, sub. 391; Mind Australia, sub. 380; One Door Mental Health, sub. 108). Support for carers is included within NDIS guidelines, but there is no formal assessment of carers’ needs undertaken as part of the assessment process (PC 2017c).

In response to feedback for Mental Health Carers Australia and others, the National Disability Insurance Agency is working to introduce the psychosocial stream pathway to better support with people with psychosocial disability and their carers (chapter 17).

**State and Territory Government funded services**

State and Territory Governments fund services that support carers of people with mental illness. State and Territory Government expenditure on mental health family and carer support services delivered by NGOs totalled $20.3 million in 2017-18 (a 17% decrease on the previous year in 2018 dollars) (Productivity Commission estimate based on AIHW 2020c, table EXP.16).
This figure underestimates total State and Territory funding for mental health carer support services for two reasons. First, as this measure only includes NGOs; it would not include services delivered by state and territory government mental health services or for-profit providers. Second, this amount does not include programs funded for a broader range of carers (not just mental health carers). For example the Victorian Government has committed approximately $12 million per year for four years from 2019-20 for additional respite services (Andrews 2018; Carers Victoria 2019). The Productivity Commission was not able to determine the share of funding for mental health carers from these sorts of programs.

In addition to estimating community need for carer support services, the NMHSPF also estimates the amount of family support services needed in the community for families affected by mental illness. In scope within this planning framework are:

- support services for children in families affected by mental illness
- other family support services, such as family mediation and family-oriented counselling.

The NMHSPF estimates that only 43% of the funding for these services comes from mental health budgets (this is the component used to estimate the costs and benefits of reform below).

There are some family support services funded by State and Territory Governments. For example, the Western Australian Mental Health Commission funds Wanslea Family Services (2020) to provide support services to children affected by parental mental illness, including counselling and social recreational activities. Eastern Health (2020) in Victoria provides peer support services for children and young people with a parent with mental illness. An evaluation of one of these programs (called CHAMPS) found that the intervention resulted in significant improvements in self-esteem, coping and connections within the family, and reductions in relationship problems (Goodyear et al. 2009).

Sjon Kraan described the importance of support services for children and parents:

… children of parents who experience long-term mental health conditions should have access to a program which provides education on mental health conditions, … social inclusion and wellbeing activities in order to reduce isolation and disadvantage experienced by these young people … parents who experience a persistent mental health condition should be given access to peer and psychosocial support that enables them to retain their role as a parent or preserve their family functioning. Parents at risk of or demonstrating reduced parental capacity should have resources directed towards a family inclusive support plan to safe-guard the wellbeing of the family and avoid children leaving the parent’s care. (Perth transcript, p. 31)

However, EACH (sub. 875) stated that the needs of children and young people who have a parent with mental illness are often overlooked until such time as they also need mental health support.
Unmet need for carer support services

Inquiry participants’ views, survey data and the poor wellbeing outcomes of mental health carers described in section 18.1 indicate that many carers are unable to access the support they need. Over half of primary carers of people whose main condition was mental illness needed additional support in 2018 (table 18.4). The most common unmet supports needed were emotional support and support for the carer’s own health. And considering the cost of replacing the care they provide with formal services ($13.2 billion in 2015), it is in the interest of governments to identify how the needs of mental health carers can be better met (Diminic et al. 2017).

Participants stated that there are barriers to accessing carer support services, for reasons including: poorly coordinated services and fragmented funding, difficulties navigating service access, and insufficient funding and services available (LMMHCN, sub. 52; MHCN, sub. 245; MHFFTas, sub. 391; Northern Territory Mental Health Coalition, sub. 430).

Table 18.4  The level and nature of unmet carer needs, 2018
Co-residing primary carers of people whose main condition is mental illness

<table>
<thead>
<tr>
<th>Unmet sources of support for carersa</th>
<th>Number of carers</th>
<th>% of carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receives assistance and needs further assistance</td>
<td>17 500</td>
<td>18</td>
</tr>
<tr>
<td>Does not receive assistance and needs assistance</td>
<td>12 100</td>
<td>13</td>
</tr>
<tr>
<td>Dissatisfied with range of organised services available to primary carers</td>
<td>16 400</td>
<td>17</td>
</tr>
<tr>
<td>Would like more respite care</td>
<td>17 800</td>
<td>19</td>
</tr>
<tr>
<td>Would like more emotional support</td>
<td>32 800</td>
<td>34</td>
</tr>
<tr>
<td>Would like more support to improve carer’s own health</td>
<td>27 600</td>
<td>29</td>
</tr>
<tr>
<td>Would like more courses on how to care for persons with particular disabilities</td>
<td>24 500</td>
<td>25</td>
</tr>
<tr>
<td>Carers who fell into any of the above categories</td>
<td>54 900</td>
<td>57</td>
</tr>
<tr>
<td>All co-residing primary carers of people whose main condition is mental illness</td>
<td>96 300</td>
<td>100</td>
</tr>
</tbody>
</table>

a Multiple responses possible.

Source: ABS (Microdata: Disability, Ageing and Carers, Australia, 2018, Cat. no. 4430.0.30.002).

Employment support services for carers

One area that Inquiry participants suggested has scope for policy improvement was support to help carers achieve their employment goals (Carers Australia, sub. 372; Caring Fairly. sub. 427; MHFFTas, sub. 391; Mind Australia; sub. 380).

Over half of all working-aged primary mental health carers have a possible need for more employment-related support to maintain, improve or enter employment (Diminic, Hielscher and Harris 2018). For employed carers this included those providing over 40 hours of care per week, those who had reduced working hours to commence caring, those wanting to work more hours and those who wanted to make more use of special working arrangements (such
as leave and flexible hours). Also included were carers not in employment who had left employment due to their caring role and those who reported wanting to work.

The Australian Government funds employment support for job seekers. The jobactive program provides employment support nationally, but most clients are referred to this program as a result of receiving the JobSeeker Payment (chapter 19). Other programs funded by the Department of Education, Skills and Employment provide more tailored support to specific cohorts, including the Career Transition Assistance program and the Transition to Work program (DESE 2020b, 2020a). A Senate Committee examination of the jobactive program concluded that the Australian Government should examine the merits of providing more tailored career counselling and support services for carers (EERC 2019).

Employment support services that are designed with mental health carers’ circumstances and needs in mind should be available to carers and ex-carers who would benefit from them. To this end, supporting the employment goals of carers is within the scope of services provided as part of the ICSS (DSS 2018g).

Tailored employment support for mental health carers was trialled through DSS’ Carers and Work Program between 2015-16 and 2018-19. DSS provided about $1.5 million annually to trial the program within four services (two in Victoria, and one each in Queensland and New South Wales) (DSS 2017). Unfortunately, the trial finished without DSS undertaking a formal evaluation. DSS should nevertheless proactively incorporate lessons learned about what works in delivering employment support to mental health carers, to maximise the potential for Carer Gateway services to be an effective replacement in this area.

The effectiveness of the Carer Gateway’s employment support should be evaluated within five years of the services commencing in 2020. If the evaluation finds that the program is not helping carers to achieve their goals, then a new approach may be needed. One option is to improve the capacity to support carers within the programs funded by the Department of Education, Skills and Employment. The national reach of these programs could help with scaling up employment supports to mental health carers. Another option would be a greater policy focus on supporting workplaces to be more carer-inclusive, as proposed by Caring Fairly (sub. 427), Carers Victoria (sub. 664) and Carers NSW (sub. 808).

**Clarifying responsibilities for carer support services**

Clearer policy responsibilities are needed to improve the commissioning of carer support services for mental health carers. Currently, both Australian and State and Territory Governments partially fund carer support services, but neither is accountable for ensuring that services are effective and meet community needs. The Productivity Commission noted this lack of clarity in policy responsibility for carer support services in its review of the National Disability Agreement (PC 2019b). Mental Health Carers NSW (sub. 245, p. 3) described how having both levels of government and multiple departments funding carer support services results in fragmented services and ‘creates the potential for gaps in service provision to go unnoticed as well as for services to be duplicated needlessly’.
In the draft report, the Productivity Commission proposed that the responsibility for all carer support services for mental health carers should sit with one level of government. The State and Territory Governments were seen as a preferable option because of the specialised supports they could fund through the mental health system. For example, Tandem (Melbourne transcript, p. 69) stated that respite for mental health carers is not a generic service; staff need mental health skills to provide it effectively for people with mental illness. In practice, giving States and Territory Governments sole responsibility for carer supports would mean excluding mental health carers from Carer Gateway services and providing State and Territory Governments with additional funding to assess and meet the full range of carer needs.

Inquiry participants suggested this was not a feasible approach (Carers Tasmania, sub. 660). Excluding mental health carers from Carer Gateway services could lead to more fragmentation of services (Carers NSW, sub. 808). Mental health carers cannot be classified into a discrete category that separates them from other carers (Carers Australia, sub. 911). One quarter of mental health carers care for more than one person and many care for people with comorbidities (figure 18.1). Care recipients over 65 years of age could be interacting with both the aged care system and the mental health system. There would be significant duplication in policy development, infrastructure and administration.

Therefore, rather than assigning the responsibility for all carer supports to one level of government, the Productivity Commission is recommending a clearer division of roles for each level of government. Carer supports related to the mental health caring role should be planned for and funded by State and Territory Governments. State and Territory Governments, which are responsible for commissioning specialised mental health services, would be better placed to consult on and determine the sorts of mental health specific carer supports needed in each region. Moreover, they have greater incentive to continuously improve these services as consumers too would benefit from supports that improve carers’ capabilities. The Australian Government’s role would not change. Many mental health carers would still interact with the Carer Gateway because it considers their broader support needs and its services aim to meet goals related to other aspects of their lives (such as health, work, or financial advice).

This responsibility should be defined and supported under the recommended National Mental Health and Suicide Prevention Agreement (chapter 23). To improve accountability of State and Territory Governments for family support services for families affected by mental illness, this responsibility too should be included within the recommended agreement. Funding levels should be based on a transparent evidence-based planning framework, such as the NMHSPF. Planning processes should take into account the supports for mental health carers funded through the NDIS, although this is unlikely to represent a large share of carers’ needs.

This delineation clarifies the objectives of each level of government but there would still be some duplication in the services they fund. Psycho-education is clearly related to the mental health caring role so would be funded by State and Territory Governments; whereas peer support may be funded by both levels of government, depending on its context. This system would also rely on effective coordination and referral between the two systems. A carer trying to achieve their employment goals may need regular respite in the form of
psychosocial services funded by State and Territory Governments, while a peer worker counselling a carer at a mental health service may refer them to the Carer Gateway to receive advice about accessing Carer Payment. Protocols to enable information sharing between service providers may assist with service coordination, and reduce the burden on carers to tell their story multiple times.

With both levels of government continuing to fund services for mental health carers, monitoring and evaluation will be key to keeping governments accountable for their respective roles and preventing people from falling through policy cracks. For State and Territory Governments, the focus should be on monitoring outcomes related to the caring role and family wellbeing; and there are well established indicators in the literature related to carer mastery, carer burden, family and carer mental distress, family functioning and relationships, and recovery for consumers that can be incorporated into program design.

For Australian Government services, it will be relevant to know whether mental health carers as a group are achieving similar outcomes as other types of carers participating in the ICSS program. The effectiveness of referral pathways between Carer Gateway services and State and Territory Government carer supports should also be evaluated once both of these systems are established.

The broad scope and scale of the Carer Gateway may assist in meeting the needs of different parts of the community compared with programs just for mental health carers. Young carers, Aboriginal and Torres Strait Islander carers, and culturally and linguistically diverse carers face barriers to accessing appropriate supports (section 18.1). The effectiveness of services for these groups should also be actively monitored. The Northern Territory Mental Health Coalition (sub. 430) stated that further research is needed into the appropriateness and uptake of existing resources for Aboriginal people in caring roles.

Monitoring of outcomes for mental health carers should also exist at a system level to further encourage continuous improvement. The Productivity Commission is recommending the National Mental Health Commission report on outcomes derived from the Contributing Life Framework for people with mental illness and their carers (action 24.9). Chapter 24 suggests some relevant outcomes for carers, including the proportion of mental health carers: who feel weary, angry, worried or depressed due to caring role; who have unmet need for support; and who are not working, but would like to (all of which can be estimated using the Survey of Disability, Ageing and Carers undertaken every three years).
Government responsibilities for family and carer support services should be clarified.

**Start now**

The recommended National Mental Health and Suicide Prevention Agreement (action 23.3) should state that State and Territory Governments would be responsible for planning and funding:

- carer support services related to the mental health caring role
- family support services for families affected by mental illness.

**Start later**

The Australian Government Department of Social Services should use data it collects on changes in carer outcomes to evaluate and report publicly on:

- how well the Carer Gateway meets the needs of mental health carers relative to other types of carers
- how well the Carer Gateway meets the needs of young carers, Aboriginal and Torres Strait Islander carers and culturally and linguistically diverse carers
- the effectiveness of Carer Gateway services in achieving carers’ employment goals.

The evaluation should also assess the effectiveness of referral pathways between the Carer Gateway and mental health carer support services funded by State and Territory Governments.

The costs and benefits of reform

The NMHSPF (described in section 18.2) estimates that in 2019-20 it would cost $153 million to provide family and carer support services that meet the needs of the community. This includes:

- $17.0 million for individual and group based carer peer work delivered by specialised mental health community support services
- $101.6 million for day and flexible respite, and residential crisis and respite services
- $10.1 million for other carer support services
- $24.4 million for family support services funded by the mental health system.

The Productivity Commission used data about primary carers — collected as part of the 2018 Survey of Disability, Ageing and Carers — to identify the proportion of carers with unmet needs. Of the 96,300 co-residing primary carers of people whose main condition is mental illness, 57% recorded one of the measures of unmet need in table 18.4. Assuming this is proportional to the amount of services required, approximately $87.3 million per year in additional funding is needed to meet the unmet needs of mental health families and carers.
The benefits of action 18.2 were modelled together with the benefits from action 18.1 (appendices K and I). These reforms are expected to improve the mental health and health-related quality of life of carers, care recipients and children of parents with mental illness. The improvements in mental health from these actions would result in economic benefits (from increased income and cost-savings) worth $164-$318 million per year, which exceeds the combined annual costs of implementing these actions ($160-$189 million).

18.4 Income support payments for carers

Which income support payments are relevant to mental health carers?

In 2018, 69% of primary mental health carers reported receiving a government pension, allowance or benefit, the most common being the Carer Payment and Carer Allowance (ABS 2020b). Some carers receive the Age Pension, JobSeeker Payment or Youth Allowance instead of Carer Payment. Carers who receive JobSeeker Payment may be exempted from mutual obligation requirements that typically apply to this payment because of their caring role (DSS 2019a). Some carers may be eligible for the Health Care Card if they care for someone under the age of 16 years (DSS 2018m).

Some State and Territory Governments also provide financial support to carers. For example, the Victorian Government funds Tandem, a mental health carers peak body, to administer the Mental Health Carer Support Fund, which provides financial assistance for costs associated with caring (Tandem 2018). Carers in Victoria also receive benefits associated with the Carer Card (Carers Victoria, sub. 461).

Carer Payment and Carer Allowance

Carer Payment and Carer Allowance are fortnightly income support payments for carers of a person with a severe disability or medical condition or who is frail due to old age. Close to one third of all Carer Payment and Carer Allowance recipients cared for someone with a psychological or psychiatric condition as their main condition (table 18.5).

Expenditure on mental health carers was approximately $1.5 billion on Carer Payment and $733 million on Carer Allowance in 2018-19. As at the end of June 2019, 200 500 carers of a person whose main condition was a psychological or psychiatric condition received either Carer Payment or Carer Allowance and 70 400 of these carers received both payments (DSS, pers. comm., 22 April 2020).

195 The JobSeeker Payment replaced the Newstart Allowance in March 2020.
Table 18.5  **Receipt and funding of income support for carers**

<table>
<thead>
<tr>
<th>Care recipients of carers receiving a payment, as at June 2019</th>
<th>Expenditure, 2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Any medical condition</strong></td>
<td><strong>Main condition is psychological or psychiatric condition</strong></td>
</tr>
<tr>
<td>persons</td>
<td>persons</td>
</tr>
<tr>
<td>Carer Payment</td>
<td>280 999</td>
</tr>
<tr>
<td>Carer Allowance</td>
<td>673 564</td>
</tr>
<tr>
<td>Carer Supplement</td>
<td>na</td>
</tr>
<tr>
<td>Total</td>
<td>..</td>
</tr>
</tbody>
</table>

<sup>a</sup> Based on the first listed medical condition.  <sup>b</sup> Includes Commonwealth Rent Assistance  <sup>c</sup> Estimates based on the proportion of care recipients who have a psychological or psychiatric illness (27% and 32%).  na not available; .. not applicable.

**Source:** Productivity Commission estimates using DSS (2019e, table 2.1.15) and DSS (2019k).

Both payments have two streams: one for carers of adults and one for carers of children below 16 years. Although rates of payment are the same, different rules and eligibility exist for the adult and child streams. For example, a carer who qualifies for Carer Payment (child) automatically receives Carer Allowance for that child but the same rule does not apply for Carer Payment (adult). This rule was implemented after a review of the child streams of carer payments in 2007 (Carers Victoria 2013). However, unlike the child payments, the design of the adult versions of Carer Payment and Carer Allowance have not been comprehensively reviewed since 1999 (Campbell 2018).

The objective of the Carer Payment is to provide income support for people who are unable to support themselves through substantial paid employment due to the demands of their caring role (DSS 2020a). Carer Payment is classified as a pension and paid at the same rate as the Age Pension and the Disability Support Pension. As at 20 March 2020, the maximum rate was $944.30 for a single person per fortnight and $711.80 for a person in a couple (DSS 2020d).

Carer Allowance is an income supplement — currently $131.90 per fortnight (DSS 2020c). The purpose of Carer Allowance is to ‘recognises the care provided to a person with disability or medical condition in a private home’ (DSS 2018a). This leaves room for interpretation and the Productivity Commission has interpreted this to mean that the purpose of Carer Allowance is to offset some of the costs associated with caring. Anyone who receives Carer Payment or Carer Allowance automatically receives a third type of payment, the Carer Supplement — an annual lump sum payment of $600 for each eligible payment to assist with the costs of caring (DSS 2020b).
Eligibility for Carer Payment and Carer Allowance is prescribed in the *Social Security Act 1991* (Cth). Table 18.7 summarises the eligibility rules relevant to the discussion below. Other details can be found in the Act, such as the eligibility for carers who have more than one care recipient.

Carer Payment is means tested — income and asset tests apply to both the carer and their care recipient. Taper rates apply so that the payment level reduces as fortnightly income earned increases. Over a fortnight, a single carer’s payment is reduced by 50 cents for every dollar earned over $174. For couples, every dollar earned over $308 will reduce the Carer Payment in the same way (Services Australia 2020d).

**Mental health carers are disadvantaged in accessing Carer Payment and Allowance**

Inquiry participants raised three main shortcomings about Carer Payment and Carer Allowance. First, the eligibility criteria disadvantages mental health carers, relative to carers of people with a physical disability (for example, Private Mental Health Consumer Carer Network (Australia), sub. 49; Carers Australia, sub. 372). Second, some were concerned about how the eligibility criteria affects carers’ ability to work and study. Third, others considered the level of payment to be insufficient, especially to enable carers to save (BrainStorm Mid North Coast, sub. 309; Caring Fairly, sub. 427; Eating Disorders Victoria, sub. 892; NMHCCF, sub. 708).

A high-level analysis of access to Carer Payment and Carer Allowance provides some evidence to support claims that mental health carers are less likely to receive these payments than carers of people with a physical condition (table 18.6). For example, of those carers potentially eligible to receive Carer Payment, 53% of carers of people with mental illness received the payment compared with 61% of carers of people with physical conditions. Moreover, those carers providing continuous care were more likely to be on either payment than those providing episodic care (table 18.6).
Table 18.6 Receipt of Carer Payment and Carer Allowance, 2018
For a potentially eligible subset of carers

<table>
<thead>
<tr>
<th>Carers by main illness of care recipient</th>
<th>Mental illness</th>
<th>Other cognitive or behavioural condition</th>
<th>Physical condition</th>
<th>All conditions (total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carers on Carer Payment (n = 382)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>16 800</td>
<td>24 200</td>
<td>62 500</td>
<td>103 500</td>
</tr>
<tr>
<td>%</td>
<td>53%</td>
<td>52%</td>
<td>61%</td>
<td>57%</td>
</tr>
<tr>
<td>Carers on Carer Allowance (n = 1 174)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>24 100</td>
<td>65 500</td>
<td>140 700</td>
<td>230 300</td>
</tr>
<tr>
<td>%</td>
<td>34%</td>
<td>49%</td>
<td>44%</td>
<td>44%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Carers of people over 16 years old, by main illness of care recipient</th>
<th>Mental illness</th>
<th>Other cognitive or behavioural condition</th>
<th>Physical condition</th>
<th>All conditions (total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carers on Carer Payment (n = 270)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>14 200</td>
<td>13 400</td>
<td>57 100</td>
<td>84 800</td>
</tr>
<tr>
<td>%</td>
<td>65%</td>
<td>59%</td>
<td>63%</td>
<td>63%</td>
</tr>
<tr>
<td>Carers on Carer Allowance (n = 941)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>20 800</td>
<td>38 100</td>
<td>131 800</td>
<td>190 700</td>
</tr>
<tr>
<td>%</td>
<td>39%</td>
<td>50%</td>
<td>44%</td>
<td>45%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Carers by care recipient’s care needs</th>
<th>Continuous care</th>
<th>Episodic care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carers on Carer Payment (n = 382)</td>
<td>98 700</td>
<td>4 900</td>
</tr>
<tr>
<td>%</td>
<td>58%</td>
<td>45%</td>
</tr>
<tr>
<td>Carers on Carer Allowance (n = 1 174)</td>
<td>213 700</td>
<td>16 600</td>
</tr>
<tr>
<td>%</td>
<td>47%</td>
<td>23%</td>
</tr>
</tbody>
</table>

a For Carer Payment, this estimate is based on an analysis of primary carers who: provided care for at least 20 hours per week; were under 65 years old; did not receive the Age Pension or Disability Support Pension; resided with their care recipient; were not studying full time; were not working more than 25 hours; and either earned below average income (as an income unit, not personal income), had difficulty meeting everyday costs or reported financial support as their main source of unmet need. For Carer Allowance, this estimate was based on all primary carers who reside with their care recipient, provide more than 9 hours of care per week and earn less than the top income decile (as an income unit, not personal income). n is the survey sample size, estimates are the weighted population estimates. The numerator of the percentage calculations are included but the denominator is excluded to save space.

Source: ABS (Microdata: Disability, Ageing and Carers, Australia, 2018, Cat. no. 4430.0.30.002).
The Adult Disability Assessment Tool

One of the main eligibility tools for the adult stream of the Carer Payment and Carer Allowance is the Adult Disability Assessment Tool (ADAT). The ADAT contains two questionnaires, one to be completed by the carer and another by a health professional treating the care recipient. Each multiple choice response in the questionnaires is given a score and the scores are summed to measure the amount of help the care recipient needs to undertake daily activities. The questions and scores are set by the Adult Disability Assessment Tool Determination 2018.\(^{196}\)

The two ADAT questionnaires each have three sections intended to capture the types and intensity of care that a carer provides. The first section assesses activities of daily living (including washing, dressing, or eating), the second relates to cognitive function and the third records behaviours and symptoms related to mental illness. Inquiry participants were critical of the ADAT’s focus on activities of daily living relative to care tasks commonly performed by mental health carers (Brian Shevlane, sub. 147; Carers NSW, sub. 183; Carers Victoria, sub. 461; Peter Heggie; sub. 72). Carers Australia (sub. 911, p. 4) stated that it ‘is very hard to get a sufficiently high score for a qualifying ADAT’ based on the behaviour and mental health section alone.

The weightings allocated to the questions are not the only problem. The questions themselves do not adequately capture the care provided by mental health carers.

The first section focuses on basic self-care but has no questions about support required to organise and attend appointments or need for assistance with household chores. Since the ADAT was developed in 1999, the importance of psychosocial support for people with disability or severe illness has received greater attention. For example, in 2001 the World Health Organisation released the first iteration of the International Classification of Functioning, Disability and Health which included domestic responsibilities and a person’s ability to participate in the community as relevant to their overall functioning (WHO 2013a).

A Carers Victoria (2013) review found that the second section on cognitive functioning in the health professional’s questionnaire is skewed towards symptoms of dementia, but does not ask questions about symptoms of psychosis, such as hallucinations or delusions.

Mental Health Carers NSW (sub. 245, p. 19) stated that the questions in the third section on behaviour in the carer questionnaire ‘describe a small set of very specific symptoms which relate to some mental health conditions’. Moreover, in contrast to the questions on activities of daily living, which ask about the level of support required to support the care recipient, the questions in the third section on behaviour ask how often certain behaviours occur. This makes it harder for some mental health carers to reach the required score because the time they spend maintaining vigilance and supervision to prevent certain behaviours, such as self-harm, is not counted.

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\(^{196}\) The children’s equivalent of the ADAT is the Disability Care Load Assessment (Child) Determination 2010. Inquiry participants did not raise specific concerns about this form.
Finally, the health professional’s report portion of the ADAT can be completed by a medical practitioner, registered nurse, physiotherapist, occupational therapist, member of an Aged Care Assessment Team or an Aboriginal health worker in a geographically remote area (DHS 2018b). Psychologists are not on this list but are listed on the equivalent form for care recipients under the age of 16 years (DHS 2018a).

Restrictions on location of care

Regarding location of care, the rationale for the requirement that care must be provided in the home of the care recipient to be eligible is unclear. For Carer Allowance this goes further — for carers who do not reside with their care recipient to be eligible for this payment, they must be providing care that relates to the care recipient’s bodily functions or to sustaining their life. These restrictions are poorly aligned with the care tasks of mental health carers.

Care activities that may be provided outside of the care recipient’s home may include emotional support provided by telephone, time spent out of the home attending appointments, and time spent preparing meals. Almost half (45%) of the people who participated in a national survey of people with psychosis did not reside with their carers but had frequent contact with them (Poon et al. 2017).

The eligibility restriction related to location of care that has clearer policy intent, is the requirement that the care recipient resides in a private home. The care recipient is considered to reside in a private home if they carry out their main domestic functions there and there are no commercial care arrangements in place for the provision of personal care (DSS 2016b). This excludes supported housing such as a residential aged care facilities. There is scope to simplify the eligibility rules to better reflect this intent.

Restrictions on frequency of care

Carer Payment eligibility allows recipients to cease care to work, study or volunteer for up to 25 hours a week (including travel time). This is called the ‘25 hour rule’. In addition, temporary cessation of care provisions allow carers to take 63 full days off from constant care for any purpose throughout each calendar year. Eligibility restrictions on frequency of care have been relaxed significantly since the payments were first introduced. For example, rules were relaxed in 1993 to allow carers to work or study for 10 hours per week, increasing to 20 hours in 1997 and then to the current limit of 25 hours in 2005 (Edwards et al. 2008).

Despite flexibility to allow part-time work or study and to take days off from caring each year, the requirement that carers are otherwise providing ‘constant care’ restricts eligibility beyond the stated policy intent of Carer Payment. Constant care is expected to be ‘at least the equivalent of a normal working day’, including active care, supervision and monitoring (DSS 2015a). This is a high bar. People working full time generally work approximately

197 Social Security Act 1991, s. 954A.
40 hours a week over five days, equivalent to 104 days off per year. Yet, carers on Carer Payment cannot take more than 63 full days off from caring per year. The Productivity Commission’s analysis of the effect of caring on employment (table 18.2) found that providing as few as 10 to 19 hours or care per week reduced the likelihood of employment.

The requirement to provide constant care is even more challenging for carers of people with episodic care needs. In this case, the consistency in the level of care provided is not the choice of the carer. Indeed, having unpredictable hours of care likely weakens a carer’s ability to sustain substantial employment (NMHCCF, sub. 708). Given that Carer Payment is means tested and the intensity of care provided is assessed by the ADAT, the requirement to provide constant care may be an unnecessary barrier to Carer Payment, especially for carers of people with episodic illness. Victoria Legal Aid (sub. 818) supported the use of ‘regular care’ instead of ‘constant care’ to better reflect the realities of care provision.

A substantial proportion of carers already receiving Carer Payment in 2018 reported providing less than constant care, and some may no longer be primary carers at all (figure 18.5). This suggests that the requirement to provide constant care to access the payment is either not tested effectively initially or is not monitored sufficiently over time as carers’ circumstances change.

**Figure 18.5  **Hours of care provided by carers on Carer Payment, 2018

![Hours of care provided by carers on Carer Payment, 2018](image)

*Source: ABS (Microdata: Disability, Ageing and Carers, Australia, 2018, Cat. no. 4430.0.30.002).*

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198 Given constant care is expected to be ‘at least the equivalent of a normal working day’ and 63 days off from care per year is approximately one day off per week, the Productivity Commission interpreted constant care as 42 hours of care per week for carers not in employment or study and a minimum of 18 hours per week for those working or studying 25 hours per week.
Similarly, carers must provide ‘care and attention on a daily basis’ to be eligible to receive Carer Allowance. This means that except when carers are using their 63 temporary cessation of care days, they must provide care every day. However, costs associated with care are not limited to those who provide care every day.

**Restrictions on work and study**

Inquiry participants objected to the 25 hour rule for several reasons, some of which apply to mental health carers more than other carers. The general criticism was that the restriction on hours of work, volunteering and education was a perceived disincentive for carers looking to enter the workforce or develop their career prospects (MHCN, sub. 245). Although the 63 temporary cessation of care days can be used to prevent carers from exceeding the 25 hour rule and having their payment cancelled, this may not be clear to carers considering a temporary increase in their hours of work or study (DSS 2019b). Moreover, with opportunities for online education and working from home now more prevalent, there may be periods where carers can be on call to respond to their care recipient while working, studying or volunteering more than 25 hours per week.

Caring Fairly (sub. 427), Mental Health Carers Australia (sub. 489) and Tandem (sub. 502) expressed concern about the effect this rule has on carers of people with episodic conditions. Some of these carers would be willing and able to work more than 25 hours a week when their care recipient is well, but experience unpredictable periods where caring responsibilities intensify and financial support consistent with a pension is needed.

Although Carers Victoria (sub. 664) has long advocated for the removal of the 25 hour rule, they stated that greater flexibility in the rule would be a welcome step. They suggested the rule should be expanded to allow carers to work for 300 hours over a 13 week period, with carers advising that a three month block would allow them to pick up additional work while their care recipient had a period of improved health.

The effect of the 25 hour rule on young carers is particularly problematic (Mind Australia, sub. 380; One Door Mental Health, sub. 108). The rule may require young carers from low-income families to choose between pursuing full-time education or receiving less income support for their family.

**Reform options**

The ADAT is clearly in need of reform. It is not appropriate for mental health carers for the reasons outlined above. DSS commenced a review of the ADAT and started field testing new questions in September 2016 (DSS 2018h). Field testing of questions with carers and health professionals continued into 2018 (DSS 2019i). Although the review was not specific to mental health carers, Mental Health Carers NSW (sub. 245) reported that the revised ADAT questions that were field tested are better suited to assess the care responsibilities of mental health carers. However, as of May 2020, DSS’ analysis of the ADAT field tests was
ongoing and next steps for the review had not been announced (DSS, pers. comm., 8 May 2020). Once new questions are finalised, new weightings will also be required and these should be developed in consultation with carers and health professionals.

As part of the review, DSS should also update the list of professionals allowed to complete the health professionals report to include others of relevance to mental illness, such as psychologists and accredited mental health social workers. A broad list of professionals is preferable because this improves the likelihood that the carer can bring the form to someone who has a good understanding of the carers’ role and who has the skills to seek consent from the care recipient to share their personal information with the carer and Centrelink. It should not be assumed that these skills exist in all health professionals (section 18.2).

Beyond the ADAT review, additional changes to the eligibility of Carer Payment and Carer Allowance are also warranted in order to improve access to these payments for mental health carers. Recommended changes are summarised in table 18.7.

The Productivity Commission is recommending that the eligibility changes apply at this time to mental health carers only, given that the focus of this Inquiry is on those affected by mental illness, but there are clearly issues of broader application. Some of the recommended changes seek to better accommodate the often episodic nature of mental illness, and as Carers Australia (sub. 911, p. 10) noted, this is relevant to other carers too:

Multiple Sclerosis is also episodic, as is Parkinson’s Disease, rheumatoid arthritis, muscular dystrophy — the list is not exhaustive.

The 25 hour rule should not continue in its current form. The costs of preventing a mental health carer willing and able to invest in their education are difficult to justify. Similarly, volunteering can be an important stepping stone to employment. Maintaining a restriction on work hours only may assist with managing risks to the integrity of Carer Payment. However, there is need to allow more flexibility for people providing episodic care. A change to the time period over which work is assessed would achieve this — that is, a change from 25 hours per week to 100 hours per month.

A broader review of income support for carers could result in a system that is more coherent and flexibly meets the needs of carers. But as any such reforms would affect all carers, not just mental health carers, they are considered beyond the scope of this Inquiry. That said, the Productivity Commission has suggested principles that should be considered if there was a broader review.

McClure, Aird and Sinclair (2015, p. 9) found that changes to the social support service system over time had led to ‘complexities, inconsistencies and incoherencies’. Carers Victoria (2013, p. 10) noted that ‘complexity can bring its own barriers because it provides greater opportunity for misunderstandings and divergent interpretations of the legislation and its guidelines’. To improve the simplicity of the system, carers might be better served by one payment that is designed to meet the objectives of all three payments (Carer Payment, Carer Allowance and Carer Supplement).
Mental Health Carers Australia (sub. 489) and Tandem (sub. 502) called for a review of the payments to understand the effect that their design has on participation in work and education. The need for a more flexible safety-net for carers may become more important if the NDIS and future mental health reforms provide carers with greater opportunities to balance both a caring role and employment. If pursued, a review of Carer Payment should give consideration to the following elements proposed by McClure, Aird and Sinclair (2015) for the design of a new system of payments:

- clear and personalised information about how changes in earned income affect receipt of income support payments
- periodic discussions between carers and qualified staff about their goals for economic and social participation.

There are some good measures in place that support carers whose circumstances change over time. For example, when a person’s Carer Payment is cancelled because they are no longer eligible, carers may be able to re-apply for the payment through an abridged application process (if the health professional’s report for the ADAT is less than two years old) (DSS, pers. comm., 8 May 2020). It is important that these sorts of measures are advertised to carers, especially those caring for someone with episodic care needs.

FINDING 18.1 — INCOME SUPPORT FOR CARERS IS UNNECESSARILY COMPLEX

The existence of a Carer Payment, Carer Allowance and Carer Supplement that all achieve similar objectives, but have some arbitrary differences in eligibility, contributes to an income support system that is complex and not well understood by carers.
ACTION 18.3 — REDUCE BARRIERS TO ACCESSING INCOME SUPPORT FOR MENTAL HEALTH CARERS

Eligibility requirements for income support payments should change to better address the needs of mental health carers.

Start now

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

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

Start later

The Australian Government should amend the eligibility criteria for Carer Payment and Carer Allowance for mental health carers, and consider adopting these changes for other carers. Amendments for mental health carers should include:

- for both payments, replacing the requirement that care must be provided in a private residence that is the home of the care recipient with a requirement that the care recipient must reside in a private residence
- for Carer Payment, replacing the requirement to provide ‘constant care’ with the requirement to provide ‘care on a regular basis every week’
- for Carer Payment, replacing the 25 hour per week restriction on work, study and volunteering with a 100 hour per month restriction on work only
- for Carer Allowance, replacing the requirement to provide ‘care and attention on a daily basis’ with the requirement to provide ‘care on a regular basis every week’
- for Carer Allowance, removing the requirements for the carer to either live with the care recipient or to provide care that relates to the care recipient’s bodily functions or to sustaining their life and for more than 20 hours per week.
### Table 18.7  **Current and recommended eligibility criteria for Carer Payment and Carer Allowance**

For carers of an adult with severe illness or disability

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Carer Payment</th>
<th>Carer Allowance</th>
<th>Carer Payment</th>
<th>Carer Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intensity and types of care</strong></td>
<td>Minimum ADAT(^a) score of 25 points, including 10 from the health professional’s report.</td>
<td>Minimum ADAT(^a) score of 30 points, including 12 from the health professional’s report.</td>
<td>Minimum ADAT(^a) score to be determined following review.</td>
<td>Minimum ADAT(^a) score to be determined following review.</td>
</tr>
<tr>
<td><strong>Frequency of care(^b)</strong></td>
<td>Constant care. Work, study and volunteering cannot exceed 25 hours per week.</td>
<td>Care and attention on a daily basis.</td>
<td>For mental health carers: <em>Care on a regular basis every week</em>. Work cannot exceed 100 hours per month.</td>
<td>For mental health carers: <em>Care on a regular basis every week</em>.</td>
</tr>
<tr>
<td><strong>Expected duration of illness</strong></td>
<td>Condition is expected to continue for at least 6 months or the illness is terminal.</td>
<td>Condition is expected to continue for at least 12 months or the illness is terminal.</td>
<td>No changes recommended.</td>
<td>No changes recommended.</td>
</tr>
<tr>
<td><strong>Place of provision of care(^b)</strong></td>
<td>In a private residence that is the home of the care recipient.</td>
<td>In a private home that is the residence of the carer and care recipient or if the care recipient and carer do not co-reside, then the care must be in the care recipients home and must: relate to the care recipient’s bodily functions or to sustaining their life, be provided for at least 20 hours a week and be received in a private home.</td>
<td>The care recipient lives in a private residence (for mental health carers only).</td>
<td>The care recipient lives in a private residence (for mental health carers only).</td>
</tr>
<tr>
<td><strong>Income test</strong></td>
<td>Equal to that for Age Pension(^c). Another test applies to care recipient’s income.</td>
<td>Threshold is $250 000 in annual family income.</td>
<td>No changes recommended.</td>
<td>No changes recommended.</td>
</tr>
<tr>
<td><strong>Assets test</strong></td>
<td>For carer: same annual thresholds as Age Pension(^d). Care recipient: $716 750 (principal home excluded)</td>
<td>None applies.</td>
<td>No changes recommended.</td>
<td>No changes recommended.</td>
</tr>
</tbody>
</table>

\(^a\) The ADAT is the Adult Disability Assessment Tool. \(^b\) Carers are exempt from these criteria for up to 63 full days per year. \(^c\) Payment ceases for before-tax income earned over the fortnight above $2062.60 for a single person or $3155.20 for couples. \(^d\) Single homeowner: $263 250; single non-homeowner: $473 750; couple & homeowner $394 500; couple & non-homeowner: $605 000.

*Source: Social Security Act 1991 (Cth); DSS (2015b); Services Australia (2020a, 2020d, 2020c).*
The costs and benefits of reform

An increase in the number of people receiving Carer Payment and Carer Allowance does not impose a net cost on the community as a whole — rather it is a transfer in income from one part of the community to another. That said, increasing the total taxpayer funds allocated to income support payments is a cost to the Australian Government because it prevents it from using the funds to achieve other policy objectives.

The costs of the recommended changes to the eligibility criteria for Carer Payment and Carer Allowance are based on the Productivity Commission’s estimate of the additional carers that would receive these payments. If the review of the ADAT closed the gap between the rates of mental health carers and other carers on Carer Payment and Carer Allowance (table 18.6), then we would expect 3000 additional carers on Carer Allowance, at a cost of $10.3 million per year.

Relaxing the 25 hour rule may allow approximately 464 additional mental health carers to access Carer Payment, at a cost of $5.8 million per year. Approximately 880 mental health carers were working part time more than 25 hours per week, but otherwise might meet the criteria for Carer Payment (Productivity Commission estimate using ABS 2016b, 2020b). If the same proportion of these carers were on Carer Payment as those in table 18.6 (53%), then 464 additional mental health carers might receive Carer Payment. Mental health carers studying full time were not less likely to receive the payment than other carers that might meet the criteria for Carer Payment, so this change has not contributed to the estimated cost of the reform (Productivity Commission estimate using ABS 2016b, 2020b).

Primary carers that broadly met the eligibility criteria for Carer Payment were less likely to be receiving Carer Payment if they did not reside with their care recipient (48% compared with 67%) (Productivity Commission estimates using HILDA, wave 18).199 However, the Productivity Commission could not use this data to estimate how many additional carers would receive Carer Payment if the rules related to location of care were relaxed because it is unknown how many of the care recipients were not living in a private residence. These carers would remain ineligible for Carer Payment under the recommended reforms.

The Productivity Commission was also unable to estimate the cost of relaxing the requirements related to ‘constant care’ and ‘care and attention on a daily basis’ because it is unknown how many mental health carers would meet all the other eligibility criteria except for this one and how many would apply for income support.

The benefits of this reform were not able to be estimated but it is expected to improve the mental wellbeing of carers and their families who are able to receive Carer Payment or Carer Allowance as a result of the recommended changes. Mental wellbeing would improve as a result of reduced financial hardship. This a common issue among primary mental health carers — 41% of whom reported difficulties meeting everyday living costs in 2018 (section 18.1).

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199 Potentially eligible primary carers defined as those: providing at least 20 hours of care; under the age of 65 years, not on the Age Pension or Disability Support Pension; earned below the maximum income thresholds reported in table 18.7; were not working more than 25 hours per week and were not studying full time.
## Income and employment support

### Changes to income and employment support programs matter because …

- Employment can be important for maintaining good mental health for people with mental illness and for the broader population.
- People with mental illness are under-represented in the workforce and face barriers to employment.
- The Individual Placement and Support model of employment support, while still subject to further review, has resulted in increased numbers of people with severe mental illness finding and remaining in employment, compared with other programs.
- For people with mild to moderate mental illness, the upcoming shift toward online employment support programs offers scope for support that better meets their needs — however, further policy development is required for participants to be able to take advantage of this.
- Income support is an important safety net but there is scope to improve the incentives for Disability Support Pension recipients to return to work.

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<th>Access to mental healthcare (ch.10)</th>
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RECOMMENDATION 19 — TAILOR INCOME AND EMPLOYMENT SUPPORTS

Employment can be important for maintaining good mental health for people. There is considerable scope to reduce barriers to employment faced by people with mental illness and increase their workforce participation.

As a priority:

- All governments should act to extend the Individual Placement and Support (IPS) model of employment support beyond its current limited application through a staged rollout to community ambulatory mental healthcare services. (Action 19.4)
  - The rollout should be staged to allow Governments to thoroughly test and review how to tailor the IPS program in a cost effective manner to particular demographic groups and for people with different types of mental illness.
  - The program should initially be open to all non-employed working age consumers of community ambulatory mental healthcare services who express a desire to participate. Participation in the program should be considered to fulfil any mutual obligation requirements for income support recipients.
  - At each stage of the rollout, data should be shared between IPS sites, with a mechanism put in place to share lessons and best practice between programs on what works for particular targeted groups of participants. If the net benefits of the program apparent on a small scale to date are not replicated as the program is scaled up, its design (and if necessary, its desirability) should be re-appraised.

Additional reforms that should be considered:

- Processes for streaming of participants into employment support programs via improved employment support assessment tools should be tailored to people with mental illness by relevant governments. (Action 19.1)

- The Department of Education, Skills and Employment should ensure that the New Employment Services program includes design features that explicitly consider the needs of participants with mental illness as it is developed and later rolled out as a national program. (Action 19.2)

- For job seekers with complex needs, employment support providers should be required to assist with personalised Job Plans that go beyond meeting compliance obligations. (Action 19.3)

- Over time, the Australian Government should improve the work incentives for Disability Support Pension recipients and recipients should be well informed of their entitlement to work for a period without losing access to the Disability Support Pension by Services Australia. (Action 19.5)
The bulk of Australians with mental illness manage their lives without a negative impact on their employment (Orygen Youth Health Research Centre 2014). However, people with mental illness are under-represented in the workforce. In 2017-18, 55% of working age Australians with mental illness were employed, compared with 64% of the wider Australian workforce (ABS 2019c). Most people with mental illness would like to work (Consortium of Australian Psychiatrists and Psychologists, sub. 260; Merri Health, sub. 120; NSW Government, sub. 551; RANZCP, sub. 385) and avoid joblessness, which lowers psychological wellbeing and increases poverty (Murali and Oyebode 2004; Wilkinson and Marmot 2003).

The Australian Government provides employment support to assist people with and without mental illness to find and keep jobs. It also provides income support to alleviate the impacts of joblessness on household incomes. Given their distinctive barriers to employment, the design of employment and income support measures can affect labour market and wellbeing outcomes of many people with mental illness in different ways, compared with other jobless people. Australia achieves relatively poor labour market outcomes for people with mental illness compared with OECD leaders such as Switzerland and the Netherlands (OECD 2015). This suggests potentially significant payoffs from improved policy for employment support participants with mental illness — the prime focus of this chapter.200

19.1 The importance of income and employment support for people with mental ill-health

Employment is beneficial to mental health

Employment is beneficial to mental health. Llena-Nozal (2009) examined data from Australia, Canada, Switzerland and the United Kingdom and found that psychological distress levels fell (representing an improvement in mental health) after people moved into employment and rose after people moved into unemployment. Further, unemployment has been found to have a significant negative effect on mental health (in Australia, Germany, the United Kingdom and the United States), regardless of the duration of time spent unemployed (Cygan-Rehm, Kuehnle and Oberfichtner 2017).

There are a range of specific mechanisms through which employment can improve mental health.

- Employment (and re-employment) can act as a restorative psychological process (McClure, Aird and Sinclair 2015; OECD 2012).
- Working gives people a sense of identity, structures routines, increases social interaction, and provides regular communication and shared experiences with people outside the individual’s nuclear family, all of which are beneficial to mental health (Goodwin and Kennedy 2005; OECD 2012; Waghorn and Lloyd 2005; Wise Employment, sub. 186).

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200 Income support for carers of people with mental illness is discussed in chapter 18.
The collective effort and purpose of work provides a sense of personal achievement (FCDC 2012; OECD 2012; Waghorn and Lloyd 2005).

Increased employment of people with mental illness reduces the stigma of mental illness throughout the workforce, thereby benefitting more than these newly employed individuals (OECD 2012; Waghorn and Lloyd 2005).

Entering work can address key stressors impacting people with mental illness — unemployment, loneliness and lack of income (WISE Employment, sub. 186).

A range of other studies have established a positive association between employment and mental health, but not a causal relationship. Examples include Clark (2003), Michon et al. (2014), Modini et al. (2016), Stafford, Jackson and Banks (1980), Woodside, Schell and Allison-Hedges (2006). Likewise, suicide rates are higher for people unemployed than for people employed (Milner, Morrell and LaMontagne 2014; Rinaldi et al. 2008), and people receiving unemployment benefits are more than three times as likely to have depression or anxiety as wage earners (Collie, Sheehan and Mcallister 2019).

But not all jobs are created equal. Jobs with good working conditions where workers receive appropriate supervision, stress management and social and emotional support, and jobs with high job satisfaction are more beneficial to mental health than others (Faragher, Cass and Cooper 2005; Modini et al. 2016). Jobs with detrimental psychosocial environments (poor security, control and support) can adversely affect worker mental health (PHAA, sub. 272; as discussed in chapter 7).

For improved mental health, the number of hours worked does not have to be large. A recent United Kingdom study found that only 1–8 hours of work per week is required to gain the psychological benefits of employment (Kamerade et al. 2019). Indeed, working excessive hours may reduce mental health (Afonso, Fonseca and Pires 2017). The negative effects of unemployment may also depend on whether or not unemployment is ‘common’ in society. If unemployment is widespread (such as during a recession or in societies with entrenched unemployment), moving into unemployment can have a reduced (negative) impact on a person’s mental health (Clark 2003; Thill, Houssemad and Pignault 2019).

**People with mental illness face barriers to employment**

Most people who experience mild to moderate mental illness are able to manage their illness and mitigate its effect on their employment. But for some, especially those with more severe illnesses, there are barriers to employment at the individual and community levels.

At an individual level, a person’s mental illness can inhibit their ability to work. It can affect their interpersonal, perceptual, affective and cognitive abilities, thereby limiting potential employment options and the number of hours they are able to work (FCDC 2012). For

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201 Without causal analysis, the apparent benefit of employment on mental health can be conflated with the adverse impact of an existing mental health condition on employment probability.
example, schizophrenia may affect concentration and memory (FCDC 2012), while depression may reduce motivation levels and decision-making capacities (Peter Viney, sub. 149). For severe episodic mental illnesses, feelings of frustration and helplessness about relapses can undermine work performance (Rutman 1994). The side effects of new medication or dosage changes — such as blurred vision, light-headedness or tremors — can also negatively affect employment outcomes (Rutman 1994). People with mental illness also typically attain lower education levels, which can further reduce employment opportunities (Cook 2006; Orygen Youth Health Research Centre 2014; Waghorn et al. 2007).

At a community level, misconceptions and negative perceptions of people with mental illness pose barriers. While for some people, mental illness affects work performance, this is not true for every individual nor every mental illness. Employers can sometimes use the existence of mental illness as a crude and inaccurate indicator of employment or promotion potential. Moreover, they may generally discriminate against people with mental illness out of fear or prejudice, without an objective assessment of work capabilities (Cook 2006; Peter Viney, sub. 149). Even fear of this discrimination may prevent people with mental illness from entering the workforce (Orygen Youth Health Research Centre 2014).

Once in employment, some people with psychosocial disability fear they cannot disclose their mental illness without it limiting future opportunities (AHRC 2016). As a consequence, they may not seek treatment or request changes to workplaces that might improve their performance, such as alternative hours or tasks. This leaves them more vulnerable to dismissal or poor career prospects. More generally, low community expectations of the work capacity of people with mental illness may be self-fulfilling — leading to poorer employer training and encouragement, weaker ambitions and lower self-esteem — which, in turn, lowers job performance (Westcott et al. 2015).

**Employment support can help overcome these barriers**

The Australian Government’s main employment support programs are privately provided, with providers competing for participants and receiving additional remuneration if their enrolled participants find and stay in work.

People with mental illness may face additional barriers to employment, compared with other job applicants, and may require additional support to find a job. In a buoyant labour market, a job-ready unemployed person would usually have the option of choosing between many jobs and many employers. In a less buoyant labour market, and for those people with mental illness (particularly severe mental illness), job search outcomes are more sensitive to employer attitudes and the type of job in which the person can succeed. This additional complexity should be reflected in the design of employment support.

Clinicians could also improve employment outcomes by moving beyond a focus on good clinical outcomes (relief from symptoms) to also consider good functional outcomes from treatment (re-engaging people with their workplace and/or community) (Westcott et al. 2015). Some clinicians do not encourage consumers to find work, believing that it could
be harmful (FCDC 2012), or that it is ‘incidental’ to the recovery process (Crawley, Fitzgerald and Graham 2007). This is not to suggest that remunerated employment is appropriate for all people with mental illness, but clinicians should acknowledge and support employment aspirations where the consumer considers that this is an important part of their recovery. Effective employment support has the potential to generate better health outcomes and lower health costs, as well as benefits from higher personal incomes, lower welfare dependence and a more productive economy.

The key qualifier above is the imperative for effectiveness. Policy decisions about the form, funding and targeting of employment support depend on the net payoffs associated with variants of such services. Such a cost-benefit approach weighs the beneficial impact of such programs on employment (and its duration), wage income, healthcare savings and non-pecuniary gains (including the gains to consumers’ mental health), against the program costs. This framework is particularly useful for deciding how far to move toward more intensive and targeted forms of employment support (section 19.4).

**Income support is an important safety net**

Many people with mental illness who are outside the workforce or unemployed receive government-funded income support and access to concessions (such as lower cost access to pharmaceuticals or more general benefits from having a concession card). Australia has a well-developed social security system that is largely blind to the types of disadvantages that prompt disengagement from the labour market, but does take into account the permanence and severity of those disadvantages. For example, access to the Disability Support Pension (DSP) is not determined by the cause of disability (with some medical exceptions), but by its expected duration and impact on work capacity.

An ideal income support system would distinguish between people whose detachment from work does not reflect barriers to employment and those for whom it does, potentially due to mental illness. This report considers the latter, which comprises a group of people with a varying range of illnesses.

- People with permanent psychological or psychiatric disability whose likelihood of working consistently is low. The relevant income support for this group is the DSP.
- People with severe but episodic mental illness, for whom transition in and out of work is desirable, accompanied by the certainty of adequate income support where employment is not realistic. The appropriate form of support would be more complex than for others and could vary between individuals.
- People with less severe or temporary severe mental illness, which constrains employability but to a lesser extent than for those with severe and enduring conditions. Such people would typically receive the JobSeeker Payment or Youth Allowance.

Whether payments are at a level that represents an adequate safety net is contentious (particularly in relation to the JobSeeker Payment), but as noted in section 19.5, that concern is outside the scope of this Inquiry as it is not specific to people with mental illness.
However, the mental health benefits of employment are grounds to reassess the arrangements for accessing various income support measures and for (re)entering employment. Questions such as ‘I have an episodic mental illness. Am I eligible for the DSP? How can I show that? Can I get work when I am well?’ may identify various shortcomings. Of course, reforms in response to these concerns should consider the effects on people with other disabilities before implementing any policy change. These issues are the subject of section 19.5.

19.2 Current income and employment support payments and programs

The four major income support payments of relevance to working age people with mental illness are the:

- **JobSeeker Payment**, the main income support payment for all working age people. It replaced the Newstart Allowance and several other payments in March 2020. Recipients must be looking for work unless they are unable to do so due to sickness or injury
- **Youth Allowance (job seeker)**, an unemployment benefit paid to job searchers aged under 22 years
- **Youth Allowance (student and apprentice)**, a payment for full-time students or apprentices aged under 24 years
- **DSP**, a payment for people with enduring disabilities and a low probability of employment. Usually, the DSP is paid at a higher rate than the JobSeeker Payment and Youth Allowance (appendix C; table 19.1).

While data for the JobSeeker Payment are not yet available, at June 2019 there were more recipients of the DSP with severe mental illness than recipients of the Newstart or Youth Allowances who reported a mental illness combined (table 19.1), potentially due to the often enduring nature of DSP recipients’ disabilities. In this respect, it is notable that the most common reason for exit from the DSP is the transition to the Age Pension.

People with mental illness who are not working may also receive financial support through income protection payments or life insurance claims (chapter 8; Life Insurance Industry, sub. 821).

The majority of JobSeeker Payment and Youth Allowance (job seeker) recipients, and some DSP recipients aged under 35 years, are required to participate in employment support programs (appendix C; figure 19.1; table 19.1). Key programs are:

- **jobactive**, a program for a wide cohort of job seekers looking for full-time employment

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202 Recipients of the JobSeeker Payment and Youth Allowance are eligible for the temporary Coronavirus Supplement, meaning that – in effect – the JobSeeker Payment and Youth Allowance are currently paid at a higher rate than the DSP (appendix C).
• Disability Employment Services (DES), a program for jobless people whose main barrier to employment is a disability

• the Community Development Program (CDP), a program for job seekers in remote Australia.

In addition, some people with mental illness may receive employment support from other providers outside of jobactive, DES or the CDP, such as clubhouses (Stepping Stone Clubhouse Inc, sub. 647) or social enterprises (chapter 8).

Table 19.1 How many people with mental illness receive income or employment support?<sup>a</sup>

<table>
<thead>
<tr>
<th>Payment or program</th>
<th>Number of people</th>
<th>Estimated cost of payments or programs for people with mental illness (2018-19)&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income support payments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newstart Allowance&lt;sup&gt;c&lt;/sup&gt;</td>
<td>181 700 deemed to have a mental illness</td>
<td>$2 578 million</td>
</tr>
<tr>
<td>Youth Allowance (job seeker)</td>
<td>9 200 deemed to have a mental illness</td>
<td>$98 million</td>
</tr>
<tr>
<td>Disability Support Pension</td>
<td>258 600 with a primary psychological or psychiatric disability</td>
<td>$5 774 million</td>
</tr>
<tr>
<td><strong>Employment support programs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>jobactive</td>
<td>85 100 deemed to have a mental illness</td>
<td>$139 million&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td>Disability Employment Services&lt;sup&gt;e&lt;/sup&gt;</td>
<td>95 700 with a primary psychiatric disability</td>
<td>$328 million</td>
</tr>
<tr>
<td>Community Development Program&lt;sup&gt;f&lt;/sup&gt;</td>
<td>3 800 deemed to have a mental illness</td>
<td>$53 million</td>
</tr>
</tbody>
</table>

<sup>a</sup> The number of payment recipients in 2019-20 is likely to be significantly higher as the COVID-19 pandemic continues to affect unemployment rates and the broader economy.  
<sup>b</sup> Estimate is the product of the total program cost (as provided in the Department of Social Services (DSS) and Department of Jobs and Small Business Portfolio Budget Statements for 2019-20) and the proportion of recipients/participants with mental illness, psychiatric disability, or psychological or psychiatric disability.  
<sup>c</sup> The JobSeeker Payment replaced the Newstart Allowance and some other payments in March 2020.  
<sup>d</sup> This estimate was supplied by the Department of Education, Skills and Employment and is equivalent to the value of payments supplied to jobactive providers supporting job seekers deemed to have a mental illness.  
<sup>e</sup> May include other non-DES disability employment support (approximately $35 million in 2018-19).  
<sup>f</sup> Cost estimate uses 2017-18 data.  

Source: Productivity Commission estimates using ANAO (2017a); DJSB (2019); DSS (2019h, 2019k); unpublished data from Department of Social Services; Department of Education, Skills and Employment, and National Indigenous Australians Agency.
Most income support recipients are split between jobactive and Disability Employment Services programs\textsuperscript{a,b,c,d}

Income support recipients deemed to have a mental illness or related disability by employment program, June 2019

\textbf{19.3 Improvements to the employment support system}

\textbf{Effectiveness of employment support for people with mental ill-health}

Some service providers, service users and advocacy groups have argued that standard jobactive and DES supports are inadequate for people with mental illness and can exacerbate their illness, in part due the high ratio of participants to caseworkers (box 19.1, box 19.2).
Box 19.1  Stakeholder views about jobactive effectiveness

Advanced Personnel Management, a jobactive provider, told a recent Senate inquiry that mental health issues ‘are not currently being serviced appropriately’ under jobactive (EERC 2019, p. 73).

yourtown (sub. 511, p. 8), a jobactive provider, contended that:

[G]iven the structure and high case load of jobactive, it is extremely difficult to meet the mental health needs of young people who present with them through the program due to the lack of funding to support psychological and/or psychiatric interventions.

The National Social Security Rights Network (sub. 283, pp. 4–5), a peak community organisation in the area of income support law, policy and administration submitted that:

Job providers can assist people to actively engage and participate in the labour workforce. However, to do this effectively in the case of people living with mental illness, it is critical that the job provider have the expertise and capacity to understand their particular needs. In our members’ experience, job providers which are not specialist Disability Employment Service Providers often do not have this capacity or expertise … For example, it is common for job providers to offer a person living with mental illness employment that is incompatible with their condition and negatively impacts on their mental health.

Users of jobactive have criticised jobactive providers as being unhelpful to their job search or indicated that jobactive participation negatively affected their mental health:

They seem to be stretched so thin, I’m sure that individually they’re fine at their jobs but due to the sheer volume of people they need to deal with, you’d never know. (ACOSS 2018, p. 57)

My new job plan now states I must ‘take responsibility’ for finding my own work and to report (online) my attendances at all required activities. This begs the question. ‘What is the provider being paid to do?’ (EERC 2019, p. 61)

Employment agency and Centrelink requirements continue to be the number one reason in forcing me to stop work/study/volunteer work. (CHF, sub. 496, p. 41)

Sometimes it has made me feel suicidal. I feel depersonalised and a failure in general. That I don’t have the same rights as an employed person. (ACOSS 2018, p. 13)

In 6 years being registered with many different agencies, I have not been sent to one, not one job interview from an agency. Every fortnight, by compliance with the threat of Newstart Allowance suspension/cancellation if I miss it, I must attend these useless appointments … In the long term this is psychological torture and it affects me greatly where I once had a panic attack in the office and walked out halfway through the appointment and got a suspension. I felt useless and just a unit for the agency to make money off and felt degraded and dehumanised by the constant nothingness in a system that does nothing to help me gain employment. (Ewen Kloas, sub. 567, p. 1)

Outcomes for jobactive participants with mental illness are worse than for others. Between July 2015 and June 2019, people who reported a mental illness comprised 12% of the jobactive cohort, but only 7% of job placements (although participants with and without mental illness keep the jobs they are placed in at comparable rates)\(^{203}\) (unpublished data from the Department of Education, Skills and Employment). And at December 2018, 82% of jobactive participants who reported a mental illness spent more than 12 months in employment support, compared to 64% of the wider jobactive population (unpublished data from Department of Employment, Skills, Small and Family Business).

\(^{203}\) From July 2015 to June 2019, 63% of job placements among participants with mental illness resulted in the participant remaining in work for at least four weeks, compared with 64% of placements among people without mental illness. The equivalent statistics for 12 and 26 weeks were 54% vs. 56% and 33% vs 41%, respectively (unpublished data from the Department of Education, Skills and Employment).
Likewise, outcomes for DES participants with a primary psychiatric disability are worse than those for participants with other disabilities. People with a primary psychiatric disability comprised 41% of the DES cohort in January 2020, but accounted for only 21% of total employment outcomes in that month (LMIP 2020).

Box 19.2 Stakeholder views about Disability Employment Services effectiveness

Submitters to this Inquiry critiqued the effectiveness of Disability Employment Services.

Disability Employment Services [is] uneconomic, inefficient and ineffective … The Australian Government’s Disability Employment Services are ineffective at supporting those with a mental health diagnosis as they lack the understanding of lived experience. There is a lack of connection between the DES and Centrelink to provide wrap around support which is what an individual needs to support their healing and recovery. (David Clark, sub. 205, pp. 5, 28)

I applied for and was granted the disability support pension (DSP) in 2012. I then sought support from disability employment services (DES) because I desperately wanted to, in time, be back in employment and off the DSP. My experiences with the two DES providers I saw were not only unhelpful but highly distressing. This greatly exacerbated my mental health issues. I found that the DES staff I engaged with, lacked knowledge and expertise in working with people with mental health issues. (Name withheld, sub. 67, p. 3)

DES could be and should be more effective, particularly for people living with mental health issues … The significant majority of people who commence with an employment service should expect an employment outcome. (CMHA, sub. 449, pp. 11–12)

Disability Employment Services (DES) has great potential to improve lives however currently predisposes people with a mental illness to failure. People with a mental illness have the lowest success rates within DES and part of this is due to the one size fits all nature of the DES Performance and Funding Models. Providers are under resourced to give the support that is needed and as a result people with a mental illness fail to achieve employment outcomes. (Worklink Group Ltd, sub. 611, p. 1)

Further, a review of the Employment Services Assessment found anecdotal evidence that DES providers ‘seldom’ considered the barriers to employment and the recommended interventions detailed in a participant’s Employment Services Assessment report (EY 2019).

However, such figures are misleading indicators of program effectiveness. People with mental illness face significant barriers to employment and, as such, it is somewhat inevitable that they would achieve fewer employment outcomes when compared to participants without such illness.

And there are examples of DES and jobactive providers developing or funding additional (and successful) supports for participants with mental illness to improve employment outcomes (box 19.3). These show that the employment support system is potentially capable of addressing the employment support needs of people with mental illness.

That said, there are some clear ways to improve the employment support that people with mental illness receive.

- Assessment and streaming processes could be adjusted to more reliably detect mental illness in participants at the intake stage.
• New Employment Services (currently in development) could introduce complementary services like online peer support groups, and ensure participants with mental illness have access to face-to-face support if they need it.
• Compliance frameworks for mutual obligation requirements (MORs) could be applied more flexibly for people with mental illness.
• People with severe mental illness could receive more tailored support integrated with their clinical care via an Individual Placement and Support (IPS) program.

Box 19.3 Provider innovations for participants with mental illness

Psychosocial interventions
A Job Services Australia (the program that preceded jobactive) provider established psychosocial intervention workshops that aimed to increase employment outcomes by improving participant resilience, wellbeing and self-efficacy. The workshops increased overall job placements by 71%, with the sharpest improvements coming from participants deemed to be the least job-ready (Coppin et al. 2019).

your job, your way
yourtown, a national charity for children and young Australians and a jobactive provider, is piloting a new service for participants aged 16 to 21 years who have been unemployed for more than 52 weeks. Participants are provided a case manager and employment mentor who both have completed mental health training, and caseloads are small (approximately 25 participants). The results of the pilot have yet to be finalised (yourtown, sub. 511).

Mental Health Consultancy
EPIC Assist, a Disability Employment Services provider, supplements the work of its usual caseworkers with a trained psychologist in the role of ‘mental health consultant’. Disability Employment Services caseworkers can refer participants to this consultant, who then assists the caseworker with job searching and also provides services such as counselling and therapeutic support, referral to bulk-billing psychologists, help to navigate government services, and ongoing support after employment. During a 14 month pilot, 61% of referred participants achieved an employment outcome (Anglicare Australia, sub. 376).

Assessment and streaming process
The Job Seeker Classification Index (JSCI) and the Employment Services Assessment (ESAt) (appendix C) are used to stream jobless people into the different variants of employment support. But too often, these tools misclassify people with mental illness. Placing participants with severe mental illness into low support programs decreases the likelihood of them gaining employment and unnecessarily extends time spent unemployed. Conversely, placing job-ready participants into expensive, high support programs needlessly increases program costs. Even though the CDP does not have formal streams, improvements...
to the JCSI and ESA would also benefit CDP participants by better informing providers of participants’ vulnerabilities (including mental illness), which determine their MORs.

The Job Seeker Classification Instrument

The JSCI is a brief assessment, usually conducted over the phone in less than five minutes by an assessor from Services Australia (EERC 2019). This questionnaire relies on participants disclosing information about their employment barriers, including mental illness and its impact on their work capacity (the type of work they can complete and the number of hours they can work). Reliance on disclosure raises a significant concern that respondents who are unwilling to disclose a mental illness or who are unsure how it impacts their work capacity may be inappropriately placed in a lower support stream than necessary.

Two aspects of the questionnaire accentuate the risk of non-disclosure. First, participants are told that answering medical questions is voluntary. Second, the JSCI does not ask any specific question concerning mental illness, but instead two broad questions relating to any disabilities or medical conditions that affect working hours or job type (Australian Government 2018c). Without more specific guidance about what comprises an illness, people who do not have a formal diagnosis or do not see their problem through a medical or disability lens may not self-report an illness. As such, yourtown (sub. 511, p. 8) submitted that:

[The JSCI] has been found to not accurately stream clients, and as a result many clients with complex issues such as mental health, homelessness or post detention find themselves placed into Stream A, which is designed to assist participants with a high level of independence.

We know that many people do not disclose a mental illness during the JSCI questionnaire. The 2014-15 National Health Survey estimated that 42% of Newstart and 29% of Youth Allowance recipients had a mental illness (ABS 2015), but only 16% of Newstart and 7% of Youth Allowance recipients at June 2015 self-reported a mental illness when they completed the JSCI (Australian Government 2018b; unpublished data from Department of Social Services).

In principle, the accuracy and precision of the JSCI in detecting mental illness that affects work capability could be enhanced by adding more specific guidance to JSCI respondents about the kinds of disabilities or medical conditions that are relevant to the assessment. For example, specifically asking about the presence of anxiety or depression could trigger respondents to disclose their condition. If there is capacity to further expand the JSCI, a short tool assessing psychological distress or functional capacity should be added to better determine the presence of disabilities or medical conditions, as suggested by the OECD (2015). Crude estimates of the aggregate costs of adding a short tool (of, say, 10 questions) to the JSCI suggest it is not significant when compared to other administrative costs of employment support programs, and the personal and other costs of streaming people into the wrong level of support, but care should be taken to not overload the JSCI in its

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204 These data are not exactly comparable, as the JSCI is completed on entry into the payment (except where there is a reassessment) and the National Health Survey captures the mental health of recipients at a common point in time.
current form. Adding more detail on mental illness may set a precedent for other refinements, such as other medical conditions or factors impeding employment.

Offering online completion of the JSCI would substantially lower the incremental costs of additional questions, and allow for more specific guidance about, and examples of, what comprises an illness that negatively affects work capacity. Online completion of the JSCI has also been found in a recent trial to be slightly more accurate than assessments completed over the phone (Department of Education, Skills and Employment, pers. comm., 24 January 2020). And it could give respondents more time to fully consider their answers and de-stigmatise the process. Hence, while it is beyond the scope of this Inquiry to recommend that the JSCI be available online, if such a shift is made it should be accompanied by more substantial changes, such as the addition of a diagnostic tool and more specific guidance to respondents, to increase disclosure of mental illness.

The Employment Services Assessment

If the JSCI identifies sufficient barriers to employment, participants are referred to a more thorough assessment process — the ESAt. This is undertaken by an allied health professional and in a face-to-face setting in about 80% of cases (SSCEEWR 2013). However, there are concerns that it is too generic and not adequately geared toward the needs of people with mental illness.

Waghorn and Hielscher (2014, p. 3) proposed enhancing the ESAt by including specific measures tailored to participants reporting a mental health-related illness or disability:

[T]he DES eligibility classification system could be enhanced by providing assessors with specialised training in mental health, particularly psychosis. This could include developing a new assessment tool to classify the overall employment related severity of psychiatric disability. Promising components of such a tool include the Personal and Social Performance (PSP) Scale, as well as measures of duration of illness and course pattern of illness. The last two in particular are brief and can be assessed from treatment history, and all three are correlated with employment status in the second national survey of psychosis. Such a tool could be developed by policy makers. If found reliable and valid, it could prevent much of the misclassification of people with psychiatric disorders that is so often reported by those involved with job capacity assessments.

Before adding instruments to the ESAt, consideration of context, training and costs is necessary. The Personal and Social Performance scale may be a viable option based on positive reviews of its reliability (Burgess et al. 2016) and ability to predict employment outcomes (Waghorn and Hielscher 2014). However, further investigation should consider other equally suitable instruments before changes to the ESAt are implemented.

Workforce shortages in regional areas appear to hinder the use of ESAts, leading to inappropriate streaming toward lower levels of support and higher MORs (NSSRN, sub. 283). Increased provision of the ESAt over the phone may help relieve these shortages with no loss of quality. A recent review found that ESAts conducted over the phone and in-person produce comparable streaming outcomes (EY 2019).
Leveraging the new mental health assessment and referral tool

A further step would be to enhance the JSCI and ESAt with data collected elsewhere about participants’ mental health. This could allow for more accurate sorting at minimal additional administrative cost and prevent participants from having to tell and re-tell their stories.

The Productivity Commission has recommended the development of a mental health assessment and referral tool, which would include details of a consumer’s mental health treatment plan and functional capacity (action 10.4). Once this has been developed, the Department of Education, Skills and Employment should work with the Department of Health to allow employment support participants who have a mental health assessment generated by the new assessment tool to be able to share parts of it with Services Australia (for the purposes of streaming) and/or their employment support provider.

Participant choice and consent is vital. Participants should be able to choose which (if any) information is shared with Services Australia and/or their employment support provider.

### ACTION 19.1 — EMPLOYMENT SUPPORT ASSESSMENT TOOLS

Assessment tools that stream participants into different levels of employment support programs should be made more relevant to people with mental illness.

**Start now**

- The Department of Education, Skills and Employment should increase the Job Seeker Classification Instrument’s relevance for participants with mental illness by:
  - providing more specific guidance to job seekers about the types of impacts on their functionality resulting from illness or disability that are relevant to their employability and work capacity
  - adding a short form mental health assessment tool to the Job Seeker Classification Instrument.

- The Department of Social Services should supplement the Employment Services Assessment with the Personal and Social Performance Scale or similar instrument to more accurately assess the employability of participants with mental illness.

- Once the new mental health assessment tool is developed and in common use (action 10.4), participants should be given a choice to share the information contained in their clinical assessment when completing their employment assessment under the Job Seeker Classification Index or the Employment Services Assessment. Any sharing of information should require the participant’s explicit consent.
Future of the jobactive program

The anticipated Australia-wide extension of the current trial of online provision of jobactive services (appendix C) would, on face value, have benefits for participants, including those with mental illness. The new system offers the scope for more flexible activities to meet MORs. This is likely to benefit those with mental illness, as those who fail to meet requirements can face punitive measures of payment cuts and suspensions. In addition, participants would avoid travel costs for currently obligatory face-to-face meetings with service providers.

Moreover, Digital First is also open to all Australians, which may improve job accessibility for people with mental illness who are not on income support. And real-time data from a digital service also has the potential for more sophisticated matching of participants to jobs. This is likely to be of greatest benefit for those where matching is currently crude, including those with mental illness.

While not planned as a feature of the system, a digital approach to services also offers the scope for the low cost introduction of complementary services. Online peer support groups, for example, could add value. A recent German study found that participants using an online peer support group experienced higher self-efficacy (belief in capacity to job search and find employment) and were more likely to acquire skills relevant to employment (Felgenhauer et al. 2019). While this study focused on participants with a range of barriers to employment (physical and mental illness, ex-prisoners, single parents, people with low education levels, and others with high risk of long-term unemployment), the positive outcomes of emotional support from peers and reduced social isolation are likely to significantly benefit participants with mental illness. These are similar to benefits from social connection provided by generic online forums (Smith-Merry et al. 2019). The advantage of digital platforms is that the largest cost of any change is borne during the development phase, with the incremental costs close to zero for a developed service.

However, the new model does bring possible risks. Digital First targets people who are job ready and digitally literate, but many people with mental illness may be allocated to this stream despite being ill-suited to it. As noted above, many people with mental illness are not identified using the JSCI and will be expected to access employment support autonomously using Digital First. This suggests that where a participant provides additional evidence of illness (or signs of illness evident from a person’s patterns of use of the service), it should be straightforward to shift them from Digital First (no human support) to Digital Plus or Enhanced Services (where face-to-face assistance is available). This issue further reinforces the case for improving the capacity of the JSCI to determine the presence of mental illness in participants.
The scale of this risk could be significant as 16% of jobactive participants who self-reported a mental illness in February 2019 were allocated to Stream A jobactive services (DJSB, sub. 302). While this is the lowest level of support, face-to-face interactions still occur, which may reveal more serious obstacles to employment than suggested by the JSCI alone. Were this group to be enrolled in Digital First, then there would be no watchful human eye on each person’s vulnerabilities, and the cost of misclassification for the person and society could be significant.

It may be prudent not to allocate anyone disclosing a mental disorder to Digital First without first offering them the choice of a higher support stream or making further assessment of their capacity to seek a job unaided by any service provider. Further, Digital First participants who have not been able to find employment after an extended period of time could be referred to higher levels of support. Under a separate (ongoing) trial of online employment support, participants receive in person support if they do not find a job within six months (DESSFB 2019). Learnings from this trial should inform the development of New Employment Services.

A further concern is that some participants may struggle with using the technology, reducing their capacity to search for and find employment and placing them at higher risk of inadvertently breaching compliance requirements. Not everyone has reliable access to a computer or the internet, and some people struggle with language barriers or poor digital literacy (Citizens Advice Bureau New Zealand 2020). Clearly, no penalties should be imposed when online services are unavailable due to technical issues. Feedback to the New Employment Services trial suggested that payment suspensions or cancellations imposed for apparent non-compliance for someone using a purely digital system should be followed up in-person before they are applied (NESA 2018a; Nous Group 2018a). This would give providers the opportunity to review a participant’s capacity to meet their MORs and ensure they do not face unduly severe financial penalties, which would likely to contribute to a relapse in their mental illness. Participants moving between penalty zones under the new compliance framework should have their activity requirements reviewed (DSS 2018l), which should take this into account.
ACTION 19.2 — TAILOR ONLINE EMPLOYMENT SUPPORT

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

Start now

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

- ensure participants with inadequate digital literacy and/or mental illness are able to choose to maintain access to face-to-face services
- not allocate any participants who have reported a mental illness to Digital First unless they have chosen this stream or been determined to not be at high risk of long-term unemployment (potentially through an in-person assessment by the Job Seeker Classification Instrument or Employment Services Assessment)
- assess the potential for online peer group support for participants with mental illness as part of the Digital First software
- ensure scope for participants to inform service providers of a relapse in mental illness in a timely manner.

Mutual obligation requirements may impact participant mental health

MORs are regular activities almost all employment support participants must complete that aim to encourage participants to actively search for employment, improve their employment prospects or contribute to their community (appendix C). For the majority of participants, completion of these activities will be linked to their receipt of income support payments (figure 19.1).

Some Inquiry participants and advocacy groups viewed the existing MORs as excessive or overly punitive (appendix C). Whether or not MORs are reasonable should be determined by balancing their effectiveness in encouraging job search, achieving job outcomes, their cost and their incidental effects on the wellbeing of participants subject to them. Notably, weakening of MORs must, to some extent, reduce the quantity of job searches participants complete and potentially the quality of participation in employment support programs. While it is likely that more stringent MORs also impose stress on participants, little is known about the degree to which different intensities of MORs could precipitate clinically defined mental illness in previously well participants.

Given this, and the broad labour market impacts of changes to MORs for all participants, this report considers MORs from a narrower perspective. There are good grounds to be much more cautious from a policy perspective in implementing stringent MORs for people with pre-existing mental illness, as sound reasons and plausible evidence suggest this could aggravate their illness and increase distress (ADACAS, sub. 493; AMA, sub. 387; cohealth, sub. 231).
Existing policy settings already recognise that a participant’s illness or disability should be taken into account when setting MORs (box 19.4). The issue is whether these settings are reasonable for people with mental illness.

While, in principle, social security regulations provide many avenues for people with mental illness to avoid inappropriate sanctions, these avenues rely on being able to identify people experiencing mental illness. As noted earlier, the JSCI may not detect mental illness and this lack of detection may not be corrected quickly through subsequent re-assessment. Consequently, people with mental illness may too often be allocated to the less supportive streams of assistance and exposed to the risk of sanctions when they fail to achieve unrealistic MORs. For example, a person with significant depression may not be able to attend a job appointment or notify their jobactive provider that they have failed to do so. As a result, they would acquire demerit points, which can lead to payment suspensions, placing them at risk of worsening mental health. Surveys of jobactive participants suggest that improperly tailored Job Plans with copious MORs can adversely affect the mental health of income support recipients with pre-existing mental illness (ACOSS, sub. 270; CHF, sub. 496; JA, sub. 398).

This highlights the importance of refining the assessment processes for determining participants’ obstacles to work to avoid misclassification errors — as recommended above. Some have argued the Targeted Compliance Framework (used to impose penalties on jobactive and DES participants) should also be changed given its adverse impacts on some clients (EERC 2019). Similar criticisms have been made of the Job Seeker Compliance Framework, which is used for the CDP (Fowkes 2019). There are provisions to ensure participants with mental illness are not disproportionately affected by either compliance framework (box 19.4) and the first step should be to ensure these provisions are used as needed. The question of whether the compliance frameworks themselves should be less strict (for example, by requiring participants to accrue more demerits before receiving a financial penalty) on the grounds that they cause mental illness among participants without a pre-existing mental illness or exacerbate existing mental illness is more complex. There may be grounds for this, but the evidence is, so far, anecdotal. Ongoing assessment of any such causal links would be worthwhile.

Jobs Australia (sub. 398, p. 8) suggested greater flexibility for participants with mental illness:

[There is] value of providing greater flexibility in the application of the Targeted Compliance Framework (TCF) for jobseekers experiencing mental health concerns, with members indicating that the TCF can engender a greater level of stress for these jobseekers, detracting from their wellbeing and stability, generating barriers to employment. The utilisation of flexibility in how appointments are conducted (for instance, via phone or at a time when the office is less busy) can generate a more therapeutic environment.
Increased flexibility from providers in the application of compliance frameworks is likely to be beneficial to all participants, not just those with mental illness and could come in the form of improved Job Plans (as below), broadening the scope of activities that count toward MORs and increasing participants’ choice about the activities they undertake. In this last respect, Inquiry participants suggested activities that foster improved mental health and reduce social isolation could be counted as MORs for some participants with mental illness (NDS, sub. 777).

**Box 19.4 Reduced mutual obligation requirements for people with disability and illness**

Several measures aim to assist participants with limited capacity to meet mutual obligation requirements (MORs), and thereby avoid unduly punitive financial penalties under compliance frameworks. In particular, providers across all employment support programs are instructed to consider a participant’s mental illness when determining whether they have a reasonable excuse for not completing MORs outlined in their Job Plan (DSS 2018b; Fowkes 2019). This applies to the removal of demerit points and the reinstatement of payments if a mutual obligation failure has occurred. Under the Job Seeker Compliance Framework, Community Development Program participants must have the opportunity to complete a Comprehensive Compliance Assessment before extended financial penalties (withdrawal of payments for eight weeks) can be imposed. While not specific to people with mental illness, the outcome of these assessments can be a referral to mental healthcare or other specialist services (Australian Government 2017b).

Participants with a worsening illness who are unable to complete MORs for an extended period can apply for a ‘temporary incapacity’ exemption. Applicants must provide a medical certificate (detailing a diagnosis and prognosis) and be unable to work or complete another work-like activity for more than eight hours per week due to their medical condition (DSS 2018d). At June 2018, 17% of Newstart Allowance recipients with a self-reported mental illness held an exemption on this ground (20,100 recipients) (unpublished data from Department of Social Services). Centrelink grants this exemption, which lasts for 13 weeks, and may extend it up to 52 weeks in total without the provision of additional medical certificates, depending on the length of illness listed in original medical certificates (DSS 2018d). Subsequent extensions require an additional medical certificate. Long-term exemptions can be extended to 52 weeks (and sometimes by a further 6 months) if a participant has a serious illness and is receiving treatment in a mental health institution (DSS 2018d). A person with a severe and permanent (as defined by eligibility criteria) mental illness can apply for the Disability Support Pension at any time.

More generally, participants should have a Job Plan that is tailored (if needed) to their individual characteristics, including any barriers to employment and work capacity. The expected level of mutual obligation varies with a person’s assessed capacity. For instance, a participant with a partial capacity to work between 0–14 hours a week may be able to meet their MORs by attending a quarterly interview with Services Australia to discuss their participation and meeting the terms of their Job Plan. Such participants can volunteer to accept a referral to a suitable program of assistance recommended by medical assessments, but cannot be penalised for not accepting a referral (DSS 2018c). And some participants can meet their MORs by participating in mental health support, drug and alcohol rehabilitation or other non-vocational activities that aim to increase community participation (Australian Government 2019a).
Improving Job Plans

Where a participant needs little support to find suitable employment, the quality of their interactions with employment support providers and of the associated Job Plans are unlikely to have a substantial impact on their employment outcomes. Hence, most Job Plans should be similar (containing the standard number of required job searches and face-to-face provider meetings, among other requirements). However, for many people with mental illness — often comorbid with other obstacles to work — more personalised Job Plans are almost certainly needed. Many such participants will not have an illness serious enough to be covered by a scaled-up IPS program (section 19.4), increasing the grounds for ensuring Job Plans are customised.

However, Job Plans reflect mixed motivations. On the one hand, plans are effectively a social security compliance document. They are the primary means of recording the specific and quantifiable requirements expected of participants to retain benefits (such as number of job applications, enrolments in particular courses, specified voluntary work) (DSS 2015c). Those obligations may be reduced based on a participant’s circumstances, such as a limited capacity to work due to mental illness — again consistent with being a compliance instrument. On the other hand, plans must also take into account participants’ ‘personal needs’ and be focused on achieving sustainable employment — both more positive goals.

Participants and some providers of employment support programs largely view plans as compliance documents. A survey undertaken for the Department of Jobs and Small Business (Thinkplace 2018, p. 73) found that participants strongly perceived plans to be ‘a standard compliance activity more than anything else’, rating 4.2 out of scale from 0 (no agreement) to 5 (full agreement). In contrast, jobactive participants only weakly agree a Job Plan ‘considers my needs and requirements’ (2.6 out of 5), or ‘considers my ability to find work’ (2.7). These perceptions echoed the National Employment Services Association’s (2018b, p. 19) judgment that the plans have evolved to be a ‘purely … administrative function’. yourtown, a jobactive provider, stated that Job Plans are highly prescriptive and ‘do not give clients and employment consultants much room for personalisation’ (sub. 917, p. 15). However, this is based on a small non-representative sample of participants, which is insufficient to conclude that the quality of Job Plans is poor for people with complex needs.

One way of ensuring that such plans are meaningful for this group is to monitor the adequacy of plans as part of the quality assurance processes used by Department of Education, Skills and Employment. Though these processes are generally good (ANAO 2017b), data analytics could systematically check the degree to which Job Plans reflect the needs of those with more complex obstacles to employment (as revealed by the JSCI and ESAI). This could then inform feedback to providers about lifting their performance.

Another (and potentially complementary) way is to extend the time that participants with complex needs have to consider the terms of their Job Plan. Currently, participants have up to two business days of ‘think time’ to consider their plan and consult with a third party if they wish (although there is some anecdotal evidence this does not always occur
(EERC 2019)). Extending this period to one week (five business days) would allow, at least in principle, greater scope for participants to discuss their plans with a clinician or carer, and propose amendments. Increased ownership of Job Plans by participants could help promote participation in preparing and searching for employment. This flexibility could be reserved for participants identified as likely to require more intensive support (potentially 85 100 jobactive participants with a recorded mental illness or 181 700 Newstart Allowance recipients with a recorded mental illness as at June 2019 (unpublished data from Department of Education, Skills and Employment and Department of Social Services)).

**ACTION 19.3 — MUTUAL OBLIGATION REQUIREMENTS**

Mutual obligation requirements need to be adjusted so that they better assist job seekers with complex mental health needs to find employment.

*Start now*

The Departments of Human Services; Social Services; and Education, Skills and Employment should:

- provide greater flexibility in the application of the Targeted Compliance Framework and Job Seeker Compliance Framework for job seekers experiencing mental illness
- assess systematically whether employment support providers are meeting their obligations to provide personalised Job Plans that go beyond compliance, targeted at job seekers with complex needs
- extend to five business days the period of time that job seekers with both mental illness and complex needs have to consider and propose changes to their Job Plan.

**19.4 Toward an Individual Placement and Support model of employment support**

People whose complex, enduring or severe mental illness is their main barrier to employment require more intensive support than is usually provided via DES. An emerging model that integrates employment with on-the-job training and clinical supports is the Individual Placement and Support (IPS) program. The IPS model involves a rapid job search followed by on-the-job training (known as a ‘place-train’ focus), ongoing support from caseworkers after employment and tight integration between employment and clinical support (appendix C). This program holds promise for both existing employment support participants with severe mental illness and DSP recipients who access community ambulatory mental healthcare services but are not engaged in employment support
The provision of IPS to jobless adults with severe and persistent mental illness is supported by numerous participants in this Inquiry. At present, the IPS model operates in two forms in Australia.

- **Direct employment**, where mental healthcare services directly employ IPS specialists to work alongside clinical teams. Orygen Youth Mental Health employs 4 full-time equivalent IPS specialists and 14 headspace centres employ 31 full-time equivalent IPS specialists (Waghorn et al. 2019). The headspace IPS trial, which targets younger people whose symptoms of mental illness are relatively less acute, is discussed in chapter 6.

- **DES partnerships**, where a specialised DES provider partners with a mental healthcare service (in practice, a community ambulatory mental healthcare service) to offer an IPS program. The IPS specialists are employed by the DES provider, but seconded to the community ambulatory mental healthcare service. In 2018, 53 full-time equivalent IPS specialists were employed in this capacity (Waghorn et al. 2019).

However, participant take up across either format is low. At mid-2018, about 1800 people accessed an IPS service (including the headspace trial) (Productivity Commission estimate using Waghorn et al. 2019), whereas there were more than 193,000 DES participants at that time (LMIP 2018).

**Evidence underpinning the Individual Placement and Support model**

Individual trials and meta-analyses in Australia and abroad have shown that the IPS model outperforms conventional approaches, with superior vocational outcomes (greater employment of participants) and non-vocational results (improved mental health leading to reduced need for healthcare). The effects are often large — sometimes with employment rates of the order of 40 percentage points greater than conventional programs (table 19.2). This evidence also points to community ambulatory mental healthcare services as the logical clinical setting from which to base IPS services, as the evidence base mostly derives from studies of IPS in community ambulatory mental healthcare setting or international equivalents.

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205 For example, Aftercare, sub. 480; Allianz Australia, sub. 213; Australian Clinical Psychology Association, sub. 359; Black Dog Institute, sub. 306; Consortium of Australian Psychiatrist-Psychologists, sub. 260; Consumer Mental Health Australia, sub. 449; Jobs Australia, sub. 398; Mental Health Coordinating Council, sub. 214; Mental Health Victoria, sub. 580; NT Mental Health Coalition Inc, sub. 430; Olav Nielssen, sub. 37; Private Mental Health Consumer Carer Network, sub. 49; Public Health Association of Australia, sub. 272; Royal Australian and New Zealand College of Psychiatrists, sub. 385; Rehabilitation Counselling Association of Australasia, sub. 732; Robert Parker, sub. 12; Roger Gurr, sub. 40; Tim Heffernan, sub. 552; Victorian Government, sub. 483; and WAAMH, sub. 1112.
Table 19.2  Individual Placement and Support trial results
From Australian trials and international meta-analyses

<table>
<thead>
<tr>
<th>Reference</th>
<th>Location</th>
<th>Time frame</th>
<th>No. of participants</th>
<th>Findings</th>
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</table>
| Parletta and Waghorn (2016)    | Australia                       | 18 months  | 68 IPS, 107 control | • More IPS participants achieved a job commencement than the control group (68% vs 56%)  
  • IPS programs generated more net revenue for employment providers than the control group. |
| Killackey et al. (2008)        | Australia                       | 6 months   | 20 IPS, 21 control  | • 36% more IPS participants found employment, compared with the control group  
  • 25% less of the IPS group’s primary source of income was welfare (control group experienced no change)  
  • IPS group worked more weeks, more hours and earned more income over the course of the trial |
| Waghorn et al. (2014)          | Australia                       | 12 months  | 106 IPS, 102 control| • IPS participants were more likely to commence employment (43% of IPS group employed at 12 months, compared with 24% of control group) |
| Marshall et al. (2014)         | Meta-analysis (international)    | 6 months – 12 years | Varies (17 studies considered) | • IPS consistently demonstrated higher rates of competitive employment, fewer days until first competitive job, worked more hours over more weeks and earned higher wages |
| Kinoshita et al. (2013)        | Cochrane review (Australia and international) | 6–24 months | Varies (14 studies considered) | • IPS participants spent more time in competitive employment and in paid employment than control groups |
| Suijkerbuijk et al. (2017)     | Cochrane review (Australia and international) | 3 months – 5 years | Varies (48 studies considered) | • IPS and augmented IPS programs were the most effective interventions for people with severe mental illness to obtain and maintain employment (regardless of the trial duration)  
  • IPS participants had better mental health than the control group in the long term (> 12 months)  
  • IPS participants had better quality of life compared with participants who only received psychiatric care in the long term. |

Notwithstanding that the IPS model leads to better employment outcomes and reduced healthcare costs when compared with conventional employment support models (usually due to a reduction in the number of days participants spend hospitalised) (Heslin et al. 2011; Hoffman et al. 2014; Knapp et al. 2013), its more labour-intensive nature means that it costs significantly more to administer, raising the issue of cost effectiveness.
The Productivity Commission has estimated that providing IPS employment supports to a cohort of 40,000 participants (box 19.5) for one year would cost $108–286 million, but would:

- increase participants’ income from additional employment by $42–90 million
- result in savings to the healthcare system (mostly from reduced hospital admissions) of $137–575 million and savings to DES of about $49 million (as participation in IPS would substitute for participation in conventional DES programs for some participants)
- increase participants’ quality of life by 238-434 quality-adjusted life years (appendix K).

**Why hasn’t the Individual Placement and Support model been used more widely in Australia?**

Given the relatively strong case for greater take-up of IPS employment supports within community ambulatory mental healthcare services, why has take-up been so low? The Productivity Commission estimates that, in 2017-18, roughly 40,000 consumers of community ambulatory mental healthcare services could have benefited from participation in an IPS program (box 19.5), yet only an estimated 1,800 did so at mid-2018 (Productivity Commission estimate using Waghorn et al. 2019).

Funding barriers and unclear roles appear to be the dominant constraints to the diffusion of the IPS model, though each plays out in different ways for the two forms of IPS delivery.

State and Territory Governments could fund community ambulatory mental healthcare services to directly employ IPS specialists or these services could do so from their own budgets. However, despite the acknowledged importance of the recovery of people within their community, these services may not consider vocational rehabilitation as part of their core business (Waghorn and Hielscher 2014). Moreover, some State and Territory Governments may regard employment support to be an Australian Government responsibility.

Greater take-up by DES providers of IPS services in partnership with community ambulatory mental healthcare services looks ostensibly achievable and, at present, is more common than the direct employment form of IPS. The DES model gives considerable flexibility in how providers deliver employment support, with this applicable to all DES providers across Australia. However, an open question is whether the blended volume- and outcomes-based payments for DES providers are sufficient to fund the IPS model. Notwithstanding the views of DES providers, one assessment found that it was financially viable to adopt an IPS model within the 2010–2018 DES payment model, particularly when adopted for participants with more severe disabilities (Parletta and Waghorn 2016). But this study did not consider the transition costs that conventional DES providers would bear in making such a switch (such as additional staff training and the need to co-locate with a community mental health service). It is not clear whether the higher outcome payments for the most hard-to-place job seekers announced as part of the DES Reform in 2018 would be sufficient to fund these transitional costs, but the lack of a rapid take-up of IPS by DES providers since 2018
suggests not. The lack of widespread formation of new IPS partnerships post-2018 suggests that more active policy settings are needed to drive expansion of the model.

<table>
<thead>
<tr>
<th>Box 19.5</th>
<th>IPS target cohort for a new national program</th>
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<tr>
<td>A new national Individual Placement and Support (IPS) program should target jobless consumers of community ambulatory mental healthcare services with a severe mental illness who express a desire for employment. This would include consumers who would otherwise:</td>
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<tr>
<td>• participate in other employment support programs — participation in the IPS program would fulfil any mutual obligation requirements and negate their need to participate in these programs</td>
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<tr>
<td>• not participate in employment support programs — because they do not receive income support or receive the Disability Support Pension.</td>
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<tr>
<td>In a 2014 IPS trial run out of a community ambulatory mental healthcare service, 68% of the participants were DSP recipients and 74% had not received assistance with job seeking in the past year (Waghorn et al. 2014).</td>
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<td>How many participants nationally would this suggest? A rough estimate follows. In 2017-18 there were approximately 212,900 community ambulatory mental healthcare service consumers aged 18–44 years (AIHW 2019k). Not all of these consumers would be out of work. In 2010, the employment rate of Australians with psychosis was 22% (similar to an employment rate of 28% for people with schizophrenia in Victoria in 2006) (FCDC 2012; Morgan et al. 2012). If the former value were used as a rough estimate for all types of severe illness, then it would imply a population of about 166,100 jobless consumers. Not all consumers would need the IPS program (over other employment support options) because IPS is intended for consumers with the most severe illness (those receiving medium- to long-term treatment). This is approximately 41% of all consumers, leaving about 68,100 potential IPS participants (AIHW 2019k). Around 60% of surveyed people with schizophrenia want to work, leaving slightly more than 40,000 people (Waghorn and Hielscher 2014). These estimates are conjectural. Successful programs may attract additional participants, but may also reduce the longer-term need for the program as existing demand is met.</td>
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The route to broader adoption of the Individual Placement and Support model

These obstacles do not preclude the wider adoption of the IPS model. Cultural shifts could be achieved through transparent demonstrations of program achievements and purposeful diffusion among those not yet familiar with the model. And the benefits are sufficiently large as to be an attractive investment for either the Australian or State and Territory Governments.

Aside from its strong evidence base, three aspects favour the new model. There is good evidence of efficacy, the nature of the intervention has been very clearly defined (appendix C) so that governments know what to implement with some precision, and the target group for the intervention is established (box 19.5). Remaining questions about delivery, funding and implementation are discussed next.
Who should deliver Individual Placement and Support services?

The draft report sought feedback on two options for expanding IPS: direct employment of IPS specialists by community ambulatory mental healthcare services or a partnership approach (similar to DES, but with new funding arrangements that mandate that the contract holder deliver an IPS service and fee-for-service remuneration).

Inquiry participants generally favoured the direct employment option on the grounds that it is likely to encourage better integration between IPS specialists and clinical teams (Elucidate, sub. 755; Mind; Neami National; Wellways and Sane Australia, sub. 1212; Mitchell Institute, sub. 744; RANZCP, sub. 1200). The Productivity Commission agrees with this judgement. Better integration drives fidelity to the IPS model, which is linked to higher employment outcomes for participants (Bond et al. 2012) and can promote better communication between teams (Geoffrey Waghorn, Brisbane transcript, p. 30).

That said, wholesale adoption of the direct employment approach would disrupt established IPS programs based on DES partnerships (Consortium of Psychiatrists and Psychologists, sub. 882). While there are few of these partnerships in place, disbanding those that do exist in a dogmatic pursuit of national consistency has little merit and should be avoided. Any rollout of IPS should seek to preserve the existing programs in place.

How should Individual Placement and Support services be funded?

During the initial rollout and testing stages of the IPS program, a simple block funding approach is likely to be most appropriate. This would ensure adequate funding to get the program off the ground, when demand is likely to be uncertain and there are larger priorities than incentivising efficiency. As the program becomes more established, a transition to fee-for-service funding would be desirable so as to incentivise greater efficiency (with requirements to maintain fidelity to the IPS model). This funding model could involve loadings for participant complexity and other refinements so as to minimise any perverse incentives for community ambulatory mental healthcare services.

A further progression would be to add outcomes-based payments to the funding model (as suggested by the Consortium of Psychiatrists and Psychologists (sub. 882) and Geoffrey Waghorn (Brisbane transcript, p. 30)). This is a critical aspect of the jobactive and DES funding models, as these providers are given significant latitude to choose the ways they support participants into employment and need some incentive to run effective programs. But the need would be less critical for the IPS program as community ambulatory mental healthcare services would be required to follow evidence-based program guidelines and be subjected to fidelity reviews. Moreover, outcomes-based funding mechanisms are relatively complex to design and create financial risks for providers. So, while we are not opposed to including outcomes-based payments in the funding model, it should be less of a priority than other aspects of the rollout.
A related issue is which level of government should fund IPS services. Both levels of government would benefit from the national rollout of the IPS program. The Australian Government would save on DES program costs (as participation in the program would substitute for participation in DES for some participants) and both levels of government (although mostly State and Territory Governments) would save on healthcare costs. This suggests a cooperative funding model for IPS services could be established — potentially through a national partnership.

How should a rollout occur?

It would be impractical to immediately implement a full-scale rollout of the IPS program. Among other things, a workforce of IPS specialists needs to be created with coordination between clinical and employment support staff. About two years’ experience is usually required to develop an IPS skillset (Geoffrey Waghorn, Brisbane transcript, p. 29).

Further, adaptations to the model will likely be needed as it is implemented for different groups or as the empirical evidence grows. While the IPS model is the most evidence-based approach to providing employment support for people with severe mental illness (as noted by Waghorn et al. 2019), the existing evidence principally relates to people with psychosis and may not generalise to all conditions. There is also some weak evidence that so-called ‘augmented’ versions of the IPS model — which include IPS with other interventions such as cognitive skills training — may further improve outcomes (Suijkerbuijk et al. 2017). Other potentially valuable additions include using peer workers, engaging participants’ families or carers (Wellways Australia, sub. 396), focusing on education outcomes of young participants (Killackey, McGorry and Jackson 2008) and using cognitive skills training to improve participant psychosocial functioning (Warwick Smith, sub. 937).

Moreover, while there are many instances where the IPS model has been trialled, most have involved small numbers of participants. For example, of the 48 randomised controlled trials underpinning the Cochrane systematic review (Suijkerbuijk et al. 2017), the average number of participants per trial was 182 (of whom, roughly half received the usual employment support program as a control group, while the other half received IPS style services). It has generally been hard to replicate the outcomes of small scale social programs when delivered to large populations. For instance, while it is possible to build up the workforce of IPS specialists, it is difficult to ensure a uniform level of skill and erosion in fidelity of the model is a risk (Bond et al. 2016). Assessing fidelity with routine audits against established scales (appendix C) can reduce this risk. Additional ongoing monitoring of outcomes and periodic evaluation would be required to test that effectiveness is being maintained with program expansion and to identify potentially underperforming services.

And, while the numerous assessments of the IPS model have covered diverse populations (veterans, ex-prisoners, people from culturally and linguistically diverse backgrounds, younger and older people), the small scale of each program has not been sufficient to test differences in the effectiveness of the model across different types of people and different conditions. Effectiveness for different types of people and illness severities (and in different
locations and economic conditions) should be subject to testing as the model is expanded, and may lead to variations in eligibility conditions.

Bearing the above in mind, rollout of the IPS program should start with a review of a limited number of sites. Geoffrey Waghorn (Brisbane transcript, p. 34) suggested that 10-20 sites would be suitable. These sites — which should be reviewed through a randomised controlled trial format — should aim to uncover more information about the population groups for whom the IPS model is most effective and how the viability of the local economy impacts on its success. These sites should also collect data on participants’ healthcare utilisation, as studies from abroad have indicated savings to the healthcare budget to be a significant (and often largest) source of benefit from IPS, but Australian trials have yet to study this (Burns et al. 2007; Heslin et al. 2011; Hoffman et al. 2014; Shi 2011; van Stolk et al. 2014).

There are also learnings from the headspace IPS trial (chapter 6) that should be taken into account. This trial suggests there is value in developing forums for IPS specialists to share knowledge across sites and streamlining data collection processes so that data for evaluation and fidelity reviews can be collected together at minimal administrative cost (KPMG 2019). This could be achieved by establishing a central technical support team to collect this data and manage coordination (Geoffrey Waghorn, Brisbane transcript, p. 34). There may also be merit in considering how to develop career paths for IPS specialists to reduce turnover rates.

The rollout should follow a realistic timetable. A lesson from the rollout of the National Disability Insurance Scheme was that its implementation timetable was far too ambitious, placing pressures on quality and giving false hope to people about the likely access to services (PC 2017c). While the desired timetable for a rollout should be subject to critical assessment, five years may be enough. However, there should be explicit recognition that timetables may need to be extended, if ongoing monitoring and evaluation suggests it is unattainable.

**Systematic learning over time and ‘comfort for funders’**

The concept of fidelity with the original IPS model is an important mechanism for avoiding the erosion of service quality by particular providers as the program is scaled up. However, it could slow innovation and learning if it precludes any changes to the overall model in the long-run, and is not a guarantee of good outcomes (Geoffrey Waghorn, Brisbane transcript, p. 34). As noted earlier, there may be a role for augmentations of the IPS model. This suggests a flexible approach is needed in conducting fidelity reviews and interpreting results to promote best practice and allow for changes to the model.

Moreover, while requirements for providers to not exclude participants that meet the basic eligibility criteria help to avoid some providers prioritising some types of clients over others, this should not stop adjustments to eligibility criteria for the model as a whole, as learnings about effectiveness for different sub-groups becomes apparent. For instance, this may involve people with different severities of illness (widening eligibility) or excluding across all sites categories of people where the benefits of interventions are likely to be significantly exceeded.
by the costs. Or there may be merit in placing a time cap on participation for individuals who are unable to obtain any employment outcome after an extended period of high-level support.

As discussed above, the IPS model should be well-evaluated with systematic data collection and periodic nationwide evaluations. Formal channels should be put in place to share data between jurisdictions to promote best practice throughout Australia (for example, all evaluations should be made publicly available to share evidence on what works well). The institutions and processes for achieving this learning should be specified at the outset.

A monitoring and evaluation approach of this kind should provide comfort to funders that the program could be scaled up while maintaining the net benefits of the trials. If this is not apparent, there should be a re-think of the design of the scheme.

**ACTION 19.4 — STAGED ROLLOUT OF THE INDIVIDUAL PLACEMENT AND SUPPORT PROGRAM**

The Individual Placement and Support (IPS) model of employment support should be extended beyond its current limited application through a staged rollout to (potentially) all relevant State and Territory Government community ambulatory mental healthcare services.

*Start now*

- Governments should roll out and review the IPS program to better establish the factors that influence its cost-effectiveness to different demographic groups.
- The program should initially be open to all non-employed consumers of community ambulatory mental healthcare services who express a desire to participate. Participation in the program should fulfil any mutual obligation requirements for income support recipients.
- IPS specialists should be directly employed by community ambulatory mental healthcare services.

*Start later*

- The IPS program rollout should be accompanied by information sharing between IPS sites to allow dissemination of best practice. If a site does not demonstrate similar net benefits to the original IPS sites, the program’s design for that site (and if necessary, its desirability) should be re-appraised.
- Over the longer term, Governments should fund the IPS program on a fee-for-service basis, and require fidelity to the IPS model as a condition of this funding.
19.5 Income support benefits and incentives

This section focuses on how the current suite of income support payments can better meet the needs of people with mental illness, provided that some access issues and incentives are addressed. Because of their temporary nature, this section does not discuss changes to payments in light of the COVID-19 pandemic or relevant economic stimulus payments (outlined in appendix C).

As noted earlier, those with mental illness who are not eligible for the DSP, but remain in need of income support, may receive either the JobSeeker Payment or Youth Allowance. Submitters to this Inquiry raised concerns regarding the adequacy of the JobSeeker Payment (known as the Newstart Allowance at the time of submission), which have been further amplified through recent tightening of DSP eligibility criteria (box 19.6). For example:

I am receiving Newstart, but it is not enough to live on. … I’m struggling to pay my rent, I have to choose between food, medicine and paying my bills. … Living like this, without enough money or support: it is unspeakably awful: it makes you feel like no one cares, like you don’t matter. I want to see my psychologist but I can’t even afford to do that. I’m in a dark place. (Service consumer, ADACAS, sub. 493, p. 16)

I have severe anxiety and OCD. My main struggles have been finding help and having enough money to live … I’m on Newstart while my DSP application is assessed. I cannot afford a rental anywhere in Vic. I am 32 and I have been forced to move home, putting more financial strain on my mum, who already supports me a lot. Anyone without my level of family support would be homeless. (comment no. 34, consumers)

It was not until I finally got victims compensation and the DSP nearly six years after the rape that led to my PTSD diagnosis that I was able to do anything more than crisis management in therapy. All nine of my suicide attempts and all of my involuntary hospitalisations occurred during this period of insecurity and debt. I urge the Commission to recommend raising Newstart and the DSP … (Scarlett Franks, Sydney transcript, p. 162)

The rates of Newstart are so low that they make living with a mental illness a constant struggle. Accessing treatment, maintaining social connections, eating healthy food and engaging in exercise all support a person’s recovery. However, many people on Newstart have very little money to pay for such things after their housing costs are accounted for. (MHLC, sub. 1222, p. 6)

[T]he extreme level of poverty experienced by people reliant on income support payments, particularly Newstart Allowance, is a serious concern for mental wellbeing. This payment is now so far below all poverty benchmarks that it works against the ability of people to seek work and contributes to social isolation and marginalisation … (cohealth, sub. 231, p. 10)

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206 These included Anglicare Australia, sub. 376; ACOSS, sub. 270 and 1208; cohealth, sub. 231; Consumers Health Forum of Australia, sub. 404; Ewen Kloas, sub. 567; JA, sub. 398; Jesuit Social Services, sub. 1186; Joe Calleja, sub. 422; Karen Donnelly, sub. 90; KLC, sub. 469; MHCT, sub. 314; MHLC, sub. 1222; Name withheld, sub. 136; NSSRN, sub. 283; CCL, sub. 484; Mission Australia, sub. 487; Piers Gooding and Yvette Maker, sub. 933; QAI, sub. 116; St Vincent de Paul Society National Council of Australia, sub. 1216; Uniting VIC-Tas, sub. 95 and 931; VLA, sub. 500; VCOSS, sub. 478, and Ian Webster, sub. 626.
Box 19.6 Impacts of changes to Disability Support Pension eligibility criteria

The number of successful Disability Support Pension (DSP) applicants and the number of applicants with a primary psychological or psychiatric disability fell following a tightening of the DSP eligibility criteria in 2012-13. The number of new recipients with a primary or psychiatric disability fell by 37% over three years, although the share of new applicants with primary psychological or psychiatric disability remained relatively high (DSS 2016d).

The tightening of the criteria corresponded with a sharp increase in the number of Newstart and Youth Allowance recipients who reported a mental illness (figure below), and an increase in the number of medical exemptions from mutual obligation requirements for people receiving the Newstart Allowance who reported a mental illness.

Trends in income support recipency

Newstart Allowance or Youth Allowance recipients who reported a mental illness and DSP recipients with a primary psychological or psychiatric disability, 2008-09 to 2018-19

There are also concerns about the adequacy of the DSP (ACT Mental Health Consumer Network, sub. 297; Mission Australia, sub. 487). In 2015-16, a substantial proportion (36%) of the total DSP cohort were living below the poverty line — a weekly income less than $433 (VCOSS, sub. 478). Although the DSP is paid at a higher rate than non-pension payments, there are concerns this does not adequately take into account the higher cost of living faced by people with a disability, which is generally driven by healthcare costs (Piers Gooding and Yvette Maker, sub. 933).

Relatedly, some participants raised concerns about the out-of-pocket cost of accessing mental healthcare (AMA, sub. 633; Balancing of Life, sub. 582; CHF, sub. 645), especially for income support recipients (ACOSS, sub. 1208). While acute mental healthcare is provided
free-of-charge in the public system, primary mental healthcare is subsidised (via Medicare Benefits Schedule (MBS) rebates) and clinicians may still charge consumers out-of-pocket.

While out-of-pocket costs are undoubtedly a barrier to care for some, income support recipients typically access lower cost primary mental healthcare than people not on income support. In 2016:

- 76% of Newstart Allowance recipients and 81% of Youth Allowance recipients who accessed MBS-rebated mental healthcare paid nothing out-of-pocket, compared with 58% of recipients of MBS-rebated mental healthcare who did not receive income support (figure 19.2), despite each of these groups receiving similar amounts of care (figure 19.3).
- 68% of DSP recipients who accessed MBS-rebated mental healthcare care paid nothing out-of-pocket (figure 19.2), and DSP recipients who accessed MBS-rebated mental healthcare received twice as many sessions of care as people who did not receive income support (driven mostly by higher utilisation of MBS-rebated psychiatry) (figure 19.3).

The issue of adequacy of these payments relates to all recipients, not just people with mental illness, and is beyond the scope of an inquiry focused on mental health. Also of relevance in determining the extent to which the income support system is meeting the needs of those with mental illness is whether:

- participants with mental illness on income support payments receive appropriate employment support, and whether mutual obligation requirements are moderated (or not applied) where they aggravate illness or are unlikely to improve work incentives
- the eligibility criteria for the DSP are reasonably robust in that recipients of the JobSeeker Payment or Youth Allowance genuinely have better longer-term employment prospects than DSP recipients (box 19.6)
- DSP recipients who are able to return to work are not unduly disincentivised from doing so.

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Some clinicians charge lower out-of-pocket costs to income support recipients than to people not on income support. In some circumstances, GPs receive incentive payments ($12.75 per session) if they provide mental healthcare at no out-of-pocket cost to concession card holders, including holders of Pensioner Concession Cards (DSP recipients) and holders of Health Care Cards (Jobseeker Payment (formerly Newstart Allowance) and Youth Allowance recipients) (DoH 2020a; Services Australia 2020b). These incentive payments reduce out-of-pocket costs for concession card holders (Wong et al. 2017). Many clinicians that do not receive incentive payments also charge lower out-of-pocket costs to concession card holders. A non-random survey of clinical psychologists found that 72% routinely reduced their out-of-pocket costs for some consumers, with the presentation of a concession card a common reason for doing so, and a non-random survey of registered psychologists found that 38% charged lower out-of-pocket costs to people on low incomes (again, with presentation of a concession card a determinant) (Harris et al. 2010).
Figure 19.2  **Distribution of out-of-pocket costs for Medicare-rebated mental healthcare**  
By type of income support payment, 2016

![Distribution of out-of-pocket costs for Medicare-rebated mental healthcare](image)

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

Figure 19.3  **Access to Medicare-rebated mental healthcare**  
By type of income support payment, 2016

![Access to Medicare-rebated mental healthcare](image)

**Source:** Productivity Commission estimates using ABS (*Microdata: Multi-Agency Data Integration Project, Australia*, Cat. no. 1700.0).
The Productivity Commission’s actions above about streaming tools, New Employment Services and MORs should address the first of these. The remainder of this section addresses the latter two points.

**Eligibility criteria for the Disability Support Pension**

In considering eligibility criteria for the DSP, an important point is that people without a primary psychological or psychiatric disability comprise two-thirds of DSP recipients. This means that any changes to the design of the payment on behalf of those with primary psychological or psychiatric disability must consider the implications for the broader population and for overall payment costs. Nonetheless, considering the implications of mental illness is important, given that estimates suggest more than half of the DSP cohort have some mental illness (ABS 2015).

Access to the DSP is a multi-stage process requiring independent clinical evidence and assessment of job capacity (appendix C). The most prominent misgiving about DSP eligibility criteria relates to the desirability of the requirement to prove that an illness or disability is ‘fully diagnosed, treated and stabilised’, and more likely than not to persist for more than two years (deemed a ‘permanent’ disability). Between 2012 and 2014, almost 43% of all claims were rejected on failing these criteria (DSS 2016d), although participants rejected on this basis may have otherwise been rejected on other grounds.

Read literally, the eligibility criteria seem to leave significant scope for people with severe mental illness to be denied the DSP. For instance, some Inquiry participants were concerned that the ‘fully stabilised’ criterion would exclude people with severe but episodic mental illness, such as bipolar disorder. However, as the term is applied for the DSP, such concerns should be unfounded. A stabilised condition ‘has a specific meaning and does not mean stable in the usual sense of the word’ (DSS 2015d). It is one where there are weak prospects that further treatment would significantly reduce the impact of an applicant’s disability on their functional capacity, which does not rule out episodic illnesses (DSS 2016a). Indeed, job capacity assessors are explicitly instructed to consider ‘the severity, duration and frequency of the episodes or fluctuations’ (DSS 2015d) when determining the functional impact of an episodic condition.

Some Inquiry participants also argued that the requirement to be ‘fully diagnosed and treated’ denies people access to the DSP because obtaining sufficient medical treatment and evidence can be challenging for people with mental illness (JA, sub. 398; KLC, sub. 469). However, the criterion does not, on face value, appear unreasonable. The formal requirement is that corroborating evidence shows the applicant has a diagnosed mental illness, and records of past and continuing treatment, or a treatment plan for the following two years (DSS 2016a). The absence of such a requirement would leave the DSP open to people with mental illness.

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208 For example, David Guthrey, sub. 902; Jobs Australia, sub. 398; Kingsford Legal Centre, sub. 469; and the National Mental Health Commission, sub. 118.
conditions that would improve with proper treatment or where the diagnosis was unclear or not verified, which would be inconsistent with proper risk management.

Nonetheless, there are cases where people find it hard to demonstrate they have been fully diagnosed and treated. The reforms suggested in this report for improved access and quality of mental healthcare services should partly address this concern. The ANAO (2018) has also made various recommendations in relation to improving DSP-specific assessments (the Job Capacity Assessment and disability medical assessment), and these have largely been acted upon. Finally, the various review processes already in place go some way to being a safety valve for addressing errors (ANAO 2018). However, there remains space to improve DSP eligibility assessments by increasing their test-retest reliability (whether an applicant’s outcome is the same after re-testing) and inter-rater reliability (whether different assessors reach the same outcome). This could be facilitated through ongoing monitoring of the decisions of those determining access to the DSP and the distribution of outcomes for Centrelink offices to ensure assessors are not overly harsh or generous in their assessments (PC 2011).

Some applicants with mental illness struggle to manage the bureaucratic requirements of the DSP application process, especially those with trauma experience (Mental Health Commission of NSW, sub. 486; MHLC, sub. 1222). While some applicants may be assisted by a carer, friend or family member, this is not an option for all applicants. Care coordinators are well-placed to assist in the DSP application process, as they already work with a number of service providers to assist consumers with complex needs. Improved access to care coordinators (as discussed in chapter 15), as well as coordinators taking on the burden of payment application for consumers, could reduce the bureaucratic burden for applicants and carers and help ensure equitable access to the DSP.

There may be some scope to improve incentives for Disability Support Pension recipients to work

Although DSP recipients with psychological or psychiatric disabilities may work while continuing to receive a proportion of their payment, few do.

- Only about 3% of recipients (with any type of disability) left the DSP to enter the workforce between 2001-02 and 2016-17 (PBO 2018), and less than 4% of DSP recipients with a primary psychological or psychiatric disability reported labour income of more than $50 per fortnight in June 2019 (unpublished data from the Department of Social Services).

- Less than 4% of DSP recipients with a primary psychological or psychiatric disability were engaged with DES or jobactive in June 2019 (figure 19.1).

- The Department of Social Services (2019g) estimates that, of the DSP recipient cohort aged 18 to 40 years and with a primary psychological or psychiatric disability (as at 30 June 2017), only 15% will have transitioned off the payment after 10 years (with one third of ‘transitions’ due to the death of the recipient).
This largely reflects that, given the eligibility criteria, DSP recipients have a limited capacity to work. Nevertheless, the design of the DSP provides incentives for recipients to work at least some hours if they can:

- A DSP recipient who works and earns less than the income threshold of $174 per fortnight (about 8.9 hours of work per fortnight at the minimum wage rate) keeps their payment in full. They may also receive the DSP if their earnings are more than this, but each dollar of additional earnings leads to a 50 cent reduction in the DSP payment, meaning that their income increases by 50 cents for each additional dollar earned. DSP recipients earning over $18 200 per annum ($700 per fortnight) will also pay income tax of 18 cents for each dollar they earn over $18 200, meaning that their total income increases by 32 cents with each additional dollar earned.\textsuperscript{209}

- A DSP recipient who works less than 30 hours per week but with earnings above the threshold for a DSP payment can still receive certain supplementary benefits and have their payment resumed if, within 2 years, their hours worked falls below the weekly threshold.

Accordingly, the DSP maintains some significant incentives for recipients to engage in some work. Possible caveats to this are if:

- DSP recipients fear that they will lose access to the payment if they work at all (Jobs Australia, sub. 398; Mental Health Commission of New South Wales, sub. 486), which could occur through ad hoc eligibility reviews (as provided for in the 2014-15 and 2016-17 Budgets (ANAO 2018))

- a recipient is dissuaded from working because a prospective job requires them to work to a point where their income support payments are reduced, or because the prospect of earning less than $174 per fortnight does not justify the upfront effort of finding and commencing work.

A more significant concern is that the design of the DSP may discourage recipients from earning at levels that are subject to the 50% taper rate (Mind Australia Ltd; Neami National; Wellways and SANE Australia, sub. 1212). In other words, people may choose to work for fewer hours than they could, choose jobs with a set number of hours or avoid jobs that pay higher wage rates — none of which are desirable outcomes. For these reasons, several participants supported increasing the DSP threshold and/or reducing the taper rate (Anglicare Australia, sub. 1206; Brainstorm Mid North Coast, sub. 803; Independent Private Psychiatrists Group, sub. 742).

\textsuperscript{209} This assumes the recipient works for less than 30 hours per week. If a DSP recipient works for more than 30 hours per week on an ongoing basis their payment is suspended for up to two years. Temporarily working for more than 30 hours per week — for example, over the Christmas period — does not result in payment suspension (DSS 2018e).
However, evidence of the impact of the 50% taper rate is scant. The distribution of DSP recipient earnings shows some clustering around the threshold (figure 19.4), but not to a large degree. More importantly, the available data give no direct indication of how earnings would differ under a counterfactual (lower) taper rate or (higher) threshold, so it is not possible to confidently draw any conclusions. As such, the Productivity Commission does not see a strong argument for changes to the DSP taper rate or threshold.

Figure 19.4  **Earnings of working Disability Support Pension recipients**

Distribution of the ratio of working DSP recipients’ fortnightly employment earnings to the income threshold at which the DSP begins to taper off, 2001–2018

A related issue is that a recipient would lose eligibility for the DSP after a sustained period of employment of more than 30 hours per week. This requirement is separate to the entry requirement to the DSP as it only applies to recipients. The rule means there is a substantial net cost for recipients when deciding whether or not to complete their 31st hour of work. The gain of an extra hour’s wages could be as low as $19.49 (the minimum wage), but the loss would be the remainder of the fortnightly payment (about $345 after means testing with the current taper), as well as any additional concessions for which the individual was eligible.

This provides a strong rationale for increasing the 30-hour rule to the ordinary hours of work in the National Employment Standards (38 hours), but maintaining the condition that working more than 30 hours a week for two years would result in cancellation of DSP eligibility. Anglicare Australia (sub. 1206) supported such a change.
More broadly, DSP recipients should be aware that they are able to work while receiving the payment and would likely benefit from additional communication or welfare counselling (where payment recipients receive personalised information on the impact of a change in employment or other income on their payment rate and eligibility). These tools may alleviate fears that a small amount of work or volunteering, or increasing employment hours, will lead to a DSP recipient losing eligibility for the payment. For some DSP recipients, welfare counselling will be provided through the IPS employment program, but for the majority of recipients, additional support will be required.

**ACTION 19.5 — WORK INCENTIVES FOR DSP RECIPIENTS**

Disability Support Pension (DSP) recipients with a capacity to work should have improved incentives to find employment.

*Start now*

The Australian Government should increase the weekly hour limit above which no DSP is payable from 30 to 38 ordinary full time hours of work. The requirement that a person would lose eligibility for the DSP if they work for more than 30 hours per week for more than two years should be retained.

Services Australia should ensure DSP recipients are well informed of their entitlement to work for a period without losing access to the DSP.

**Access to payments for part-time students**

Mental illness is relatively commonplace among university and vocational education and training students, and can adversely affect educational attendance and outcomes, with lifetime impacts (chapters 2 and 6). If a student has, or acquires a mental illness, they may not be able to study full-time, which can affect their income support eligibility. As a default, student payments (Youth Allowance, Austudy and ABSTUDY) require students to undertake at least 75% of their course’s full-time study load (Services Australia 2020e). However, this can, on a sustained basis, be beyond the capacity of some students with mental illness (Michelle Smith, sub. 126; Name withheld, sub. 122). That said, if a full-time student receiving the Youth Allowance temporarily cuts back their study to less than 75% of their course’s full-time load due to illness, they will remain eligible for the Youth Allowance, provided they have an intention to return to full-time study and remain enrolled in their course (DSS 2018d).

However, students with mental illness who are not working or looking for work, and who intend to study part-time on an ongoing basis are not covered by student or job seeker payments (barring those with an illness severe enough to qualify for the DSP).
The following points should be considered when determining whether this cohort should qualify for income support.

- Extending income support to part-time students with mental illness could allow people who would not otherwise study to do so on a part-time basis. This could raise their employment prospects (potentially working to close financial resource gaps between people with mental illness and the wider population, as well as ensuring part-time students with mental illness and limited financial resources are able to choose between work and tertiary education).

- In some instances, it would be undesirable for a student to continue a prolonged period of training on a part-time basis if this results in poor quality qualifications or a high likelihood of subsequently dropping out. Part-time students face a high risk of not completing university studies — 40% of all part-time students will not complete their course within 8 years (Norton and Cherastidtham 2018). Either a job (that takes into account potentially limited work capacity) or a shorter vocational course may be a better option until recovery, and a student headed down this path would be eligible for either the JobSeeker Payment or the Youth Allowance (job seeker).

- There would be a need to develop adequate eligibility requirements to ensure this arrangement was only available to people genuinely unable to participate in full-time study or work due to illness. Stricter requirements (for example, involving independent medical assessments) would reduce the risk of gaming, but could be expensive to administer. It would also be challenging to assess whether the number of people receiving the payment aligns with expectations, as there is no obvious way in existing data collections to identify the cohort to whom it should apply.

On balance, the Productivity Commission does not currently see a compelling argument for extending income support eligibility requirements beyond the current arrangements for students who intend to study part-time on an ongoing basis due to a mental illness who are not working or looking for work.
20 Housing and homelessness

Housing and homelessness services matter because ...

- Housing is a key protective factor against mental ill-health and promotes recovery for people with mental illness.
- Many people with mental illness live in unsuitable housing situations that negatively affect multiple aspects of their lives, including the recovery and management of their mental illness.
- Some people with mental illness require support to find and maintain stable housing in the community.
- In some regions, there is a chronic shortage of short- and long-term supported housing for people with moderate and severe mental illness.
RECOMMENDATION 20 — SUPPORTIVE HOUSING AND HOMELESSNESS SERVICES

Housing and homelessness services help prevent people with mental illness from experiencing housing issues and support people with mental illness to find and maintain housing in the community. But their current capacity falls well short of need.

As a priority:

- State and Territory Governments should, with support from the Australian Government, commit to a nationally consistent policy of no exits into homelessness for people with mental illness who are discharged from institutional care, including hospitals and correctional facilities. (Action 20.2)
  - People with mental illness who exit hospitals, correctional facilities or institutional care should receive a comprehensive mental health discharge plan and have ready access to transitional housing.

Additional reforms that should be considered:

- State and Territory Governments should provide mental health training and resources to social housing workers, and work with the relevant bodies, including the real estate institutes, to assist them in organising training and resources on mental health for private sector real estate agents. (Action 20.1)
- State and Territory Governments should review housing policies to better consider the needs of people with mental illness. This should include information sharing between housing authorities, acute mental healthcare facilities and correctional facilities. (Action 20.1)
- Tenants with mental illness who live in the private housing market should be provided the same ready access to tenancy support services as those in social housing. (Action 20.1)
- The effects of forthcoming reforms to residential tenancy legislation, including ‘no grounds’ evictions, should be assessed by State and Territory Governments to better understand the implications for people with mental illness. (Action 20.1)
- With support from the Australian Government, State and Territory Governments should address the shortfall in the number of supported housing places and the gap in homelessness services for people with severe mental illness. (Action 20.3)
- The National Disability Insurance Agency should continue to amend its Specialist Disability Accommodation strategy and policies to encourage development of long-term supported accommodation for National Disability Insurance Scheme recipients with severe and persistent mental illness. (Action 20.3)
- As part of the next negotiation of the National Housing and Homelessness Agreement, there would be benefit from governments increasing the quantum of funding for housing and homelessness services, including for the expanded provision of services for people with mental illness. (Action 20.3)
Housing plays a key part in preventing mental ill-health and promoting recovery for people with mental illness. This chapter discusses the close relationship between housing and mental health (section 20.1), and examines ways to improve housing and homeless supports for people with mental illness based on the severity of mental illness and housing needs (figure 20.1).

Figure 20.1 Framework: housing supports according to level of need

<table>
<thead>
<tr>
<th>Section 20.2 Lower need</th>
<th>Section 20.3 Higher need</th>
<th>Section 20.4 Homelessness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing people from losing their housing, by improving:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• tenancy support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• training for housing workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• laws and policies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support for people with mental illness to find and maintain housing through:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• integrated supported housing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• improved transition out of institutional care (such as hospital or correctional facilities)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• long-term supported accommodation with 24/7 support.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support for people with mental illness who are homeless to find and maintain housing through:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• homelessness services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• ‘housing first’.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In this chapter, the Productivity Commission has recommended reforms to deliver a range of housing and related mental health supports to better meet the needs of people with mental illness in Australia. Not all recommendations were able to be costed (appendix I). However, if implemented, the costed recommendations would require Australian, State and Territory Governments to increase estimated expenditure, in aggregate, by $740 million to $940 million each year. This would, in turn, be expected to improve the mental health, quality of life and economic participation of the relevant recipients of the housing supports. However, the net cost is estimated to be far lower as improved housing is likely to lead to reductions in the use over time of other government services, such as healthcare and the justice system (associated with estimated cost savings of $450 million to $790 million). There may also be additional, unquantified, spillover benefits from the recommended housing reforms, as improving an individual’s housing situation can facilitate workforce participation and also improve the wellbeing of the individual’s family.
20.1 Housing and mental health are closely linked

Suitable and secure housing is important for all Australians and is closely linked to good mental health. As a key protective factor against mental ill-health, suitable housing can be a first step in promoting long-term recovery for people with mental illness (Giuntoli et al. 2018), and an enabler for the delivery of other services and supports to an individual.

Until the need for suitable shelter is met people cannot begin to think of employment, participation in their community or health. (Eastern Health – Murnong Adult Mental Health, sub. 187, p. 1)

It’s very difficult for people to start their recovery journey if they don’t have a stable, secure and affordable place to live. (Launch Housing, Melbourne transcript, p. 49)

Mental health contributes to poor housing outcomes

Mental illness can affect a person’s ability to sustain their existing housing, including their capacity to independently manage housing tasks, such as budgeting, paying rent or utility bills on time, opening mail or maintaining a property. Symptoms of mental illness can also lead to unsociable behaviour (such as aggression) that causes disturbances or conflicts with family, flatmates, neighbours, landlords and employers (Jones et al. 2014; MHCA 2009; Patterson et al. 2008).

Many of our clients experience paranoia making it very difficult to sustain accommodation [which] often [leads to them] leaving due to a perceived fear of being unsafe from others … some have been known to be evicted due to disconnecting lights, appliances and smoke detectors due to the belief they are monitoring devices, some clients can become hostile believing they need to defend themselves from others which also leads to eviction. (Eastern Health – Murnong Adult Mental Health, sub. 187, p. 2)

Box 20.1 Case study: Threat of eviction for hoarding behaviours

Lydia is 53-year old woman living in a property managed by a social housing provider in Melbourne. Lydia has had some involvement with the criminal justice system and has spent some time in prison. She has been a victim of severe family violence.

Lydia has been affected by complex trauma and this manifests in hoarding behaviours. This has caused issues throughout her 12-year tenancy. Her relationships with some of the other occupants of the apartment building have broken down and they complain frequently to the housing provider about Lydia’s hoarding. The housing provider has issued Lydia with numerous breach of duty notices over the years, and has applied to Victorian Civil and Administrative Tribunal for possession of the property on multiple occasions.

Lydia’s case highlights how community and public housing providers can resort to eviction as the mechanism for managing tenants with complex behaviours directly linked to their mental health.

Source: adapted from VLA (sub. 500, pp. 16–17).
People living in less secure housing (such as renters and social housing tenants) also disproportionately experience higher levels of physiological distress (figure 20.2).

In some cases, people experiencing acute episodes of severe mental illness risk eviction, especially while temporarily incapacitated in hospitals or other institutions (MHCA 2009; MHLC, sub. 315, p. 3; SCMH 2006).

… due to the often episodic nature of mental illness, people hospitalised for acute care risk loss of housing or job because they have been unable to pay their rent or attend work. This further exacerbates stress and impacts people’s mental health. There is a call for more support to ensure that eviction or loss of job does not occur in these circumstances. (SAMHC, sub. 477, p. 17)

**Figure 20.2 Renters and people in social housing tend to experience higher levels of psychological distress**

<table>
<thead>
<tr>
<th></th>
<th>Low or None</th>
<th>Moderate</th>
<th>High</th>
<th>Very high</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home owner</td>
<td>37</td>
<td>31</td>
<td>31</td>
<td>30</td>
</tr>
<tr>
<td>Mortgagee</td>
<td>43</td>
<td>42</td>
<td>36</td>
<td>32</td>
</tr>
<tr>
<td>Private renter</td>
<td>23</td>
<td>27</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Social housing</td>
<td>2</td>
<td>4</td>
<td>13</td>
<td></td>
</tr>
</tbody>
</table>

Proportion of Australian population by level of psychological distress, 2017-18

*Psychological distress is measured using the K10 scale.*

*As K10 data is not available for people who are homeless, psychological distress levels for people who are homeless have been omitted from this chart.*

*Source: ABS (National Health Survey, 2017-18, Cat. no. 4324.0.55.001).*

Mental illness can also affect a person’s ability to find new housing. People with mental illness often face discrimination in the private rental market as many consider they are relatively difficult tenants and/or have reduced income stability (CLBB, sub. 146, p. 5; KLC, sub. 469, p. 9; MHV, sub. 580, att. 1, p. 29). In one survey, 90% of people with mental illness believed they had been discriminated against at some time, particularly in the private rental market, forcing them to accept unsafe or substandard housing (SANE Australia 2008).
Discrimination can take many forms. Prospective renters who disclose or reveal their mental illness tend to be less likely to: receive a response to their rental inquiries; be told that an advertised unit is available; be invited to inspect an available unit (Hammel et al. 2017); or be able to secure a private rental without first producing significant guarantees of support or references (Bleasdale 2007). As a result, some individuals and their carers may avoid telling agents about their mental illness (Browne and Hemsley 2010).

Mental illness can also affect an individual’s housing situation indirectly. For example, insecure housing can make it more difficult to find and maintain employment (chapters 7 and 19), thereby reducing the individual’s income and subsequent ability to afford and maintain adequate housing.

**Housing difficulties contribute to mental ill-health**

Not only can mental illness reduce a person’s ability to find and maintain housing, this relationship can also run in the opposite direction. Housing issues — such as accommodation that is of low quality, unhygienic, unsafe, of poor design, affected by noise and pollution, provides insecure tenure and affordability pressures — can contribute to mental ill-health and inhibit recovery from mental illness (Bonnefoy 2007; Evans, Wells and Moch 2003; Guite, Clark and Ackrill 2006; Pevalin et al. 2017; Singh et al. 2019). For example, overcrowding is an environmental stressor that is particularly detrimental to mental health — poor housing conditions can cause individuals to socially withdraw, which may lead to increased psychological distress (Wells and Harris 2007). An ABS survey found that 14% of Aboriginal and Torres Strait Islander people in remote areas cited overcrowding at home as a significant environmental stressor that could lower their mental health (ABS 2013).

Not surprisingly, homelessness can also exacerbate, or contribute to the onset of, mental ill-health (Brackertz, Davison and Wilkinson 2019; Scutella et al. 2014; Sullivan, Burnam and Koegel 2000). For example, Johnson and Chamberlain (2011) found that 16% of a sample of 4291 homeless people developed mental ill-health after they became homeless. Research tends to show elevated levels of psychosis, anxiety, depression, post-traumatic stress disorder and substance use disorder among people who are homeless (Muir et al. 2018). Losing the psychological support associated with adequate housing can be detrimental to an individual’s sense of order, trust, continuity and security (Hulse and Saugeres 2008; Muir et al. 2018). A lack of safety, privacy, sense of belonging or social connectedness can lead to feelings of social isolation, anxiety and stress, affecting mental health. People who are homeless are also likely to have higher rates of interaction with the health and justice systems, and tend to have poorer education and employment outcomes.

**Keeping people in the community**

People with mental illness often express that one of their goals is to live independently and participate in the community (Richter and Hoffman 2017; Vallesi et al. 2018). However,
many people with a diagnosed mental illness (about 16%) in 2016-17 were living in ‘unsuitable’ accommodation (AMHOCN 2019b). Common experiences included overcrowding, substandard facilities, unhygienic conditions, risk of eviction, homelessness or other housing problems that make it unsuitable or unsafe for someone with mental ill-health (Allan Fels, sub. 303, p. 4; Anglicare Sydney, sub. 190, p. 15; Eastern Health – Murnong Adult Mental Health, sub. 187, p. 2; MHLC, sub. 315, p. 2).

In some cases, this lack of suitable housing results in people being stuck in institutional care, which tends to be far more expensive for society. About 30% of mental health hospital inpatients — over 2000 people — could potentially be discharged if appropriate clinical and accommodation services were available in the community (chapter 13). The average ongoing cost of housing someone in the community, such as in a private rental or in social housing, is significantly lower than the cost of having someone either in hospital or in a residential mental healthcare facility (figure 20.3).

**Figure 20.3  Cost of alternative housing options for an individual**

Average daily ongoing cost, 2018-19 dollars\(^{a,b}\)

<table>
<thead>
<tr>
<th>Housing Type</th>
<th>Cost (Average Daily)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Housing</td>
<td>$200 - $400</td>
</tr>
<tr>
<td>Private Rental</td>
<td>$400 - $600</td>
</tr>
<tr>
<td>Mortgage</td>
<td>$600 - $800</td>
</tr>
<tr>
<td>Community Residential (non-24-hr staffing)</td>
<td>$800 - $1200</td>
</tr>
<tr>
<td>Long-term supported accommodation</td>
<td>$1200 - $1400</td>
</tr>
<tr>
<td>Community Residential (24-hr staffing)</td>
<td>$1400 - $1600</td>
</tr>
<tr>
<td>Forensic health services</td>
<td>$1600 - $1800</td>
</tr>
<tr>
<td>Hospital (acute)</td>
<td>$1800 - $2000</td>
</tr>
</tbody>
</table>

\(^{a}\) For public housing, private rental, mortgage and long-term support accommodation costs inflated using rent price index, other costs inflated using health wages index. \(^{b}\) 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 based on AIHW pers. comm., 17 March 2020). \(^{c}\) Includes recurrent government expenditure plus rent collected. \(^{d}\) 24-hour supported living arrangements. Estimated costs based on the annual cost of support in the Haven model (section 20.3).

Source: Productivity Commission estimates using ABS (Consumer Price Index, Australia, Jun 2019, Cat. no. 6401.0; Housing Occupancy and Costs, 2017-18, Cat. no. 4130.0), AIHW (2019f), Mind Australia Limited (sub. 380, p. 40) and SCRGSP (2020b, 2020c, unpublished data).
Improvements in mental health associated with improvements in housing supports can lead to subsequent potential savings in other areas of expenditure for government, with reductions in the use of other government services (such as healthcare or the justice system) and improved employment prospects. However, while such links are clear, there are a range of hurdles that need to be overcome when meeting housing needs for people with mental ill-health. These are discussed below.

**There is no one-size-fits-all housing solution**

There are a number of housing supports available to Australians, such as financial assistance to access the rental market, social housing and other supports to find and maintain housing, and homelessness services (figure 20.4). For some people (typically those with severe mental illness and a complex mix of clinical and social needs), governments also provide specialised supported housing, such as residential mental healthcare, to support individual’s recovery and facilitate their inclusion in the community. The forms of housing that work for a person at one stage in their life will inevitably change as the person ages and their life circumstances and health change.

Under the National Housing and Homelessness Agreement (NHHA), State and Territory Governments have primary responsibility for funding and delivering housing supports, with some funding and responsibilities shared by the Australian Government. State and Territory Governments are generally responsible for providing social housing and homelessness services, land use planning and development policy, and tenancy legislation and regulation. The Australian Government contributes some funding to State and Territory Governments for housing and homelessness services, and provides income support, Commonwealth Rent Assistance and some Australian Government housing and homelessness programs and services. Both levels of government also fund the National Disability Insurance Scheme (NDIS) which, in some limited cases, may contribute to the cost of accommodation for participants in need of specialised housing due to their disability.
### Figure 20.4 Main housing supports in Australia\(^a, b\)

<table>
<thead>
<tr>
<th>State and Territory Government support</th>
<th>Australian Government support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home ownership</strong></td>
<td><strong>Commonwealth Rent Assistance</strong></td>
</tr>
<tr>
<td>Financial assistance to support households to access or maintain their own home, such as direct lending and mortgage relief. (42,000 households in 2018)</td>
<td>Financial assistance to rent in the private market, equal to 75% of rent above a threshold, up to a limit. (1.3 million households in 2018)</td>
</tr>
<tr>
<td><strong>Private rental market</strong></td>
<td><strong>Affordable Housing</strong></td>
</tr>
<tr>
<td>Financial assistance to rent in the private market, such as bond guarantees and rent assistance. (88,000 households in 2017-18)</td>
<td>Rents set as a proportion (often 75%) of market rents.</td>
</tr>
<tr>
<td><strong>Social Housing</strong></td>
<td><strong>National Housing and Homelessness Agreement</strong></td>
</tr>
<tr>
<td>Housing to assist people who are unable to access a private rental. Rent is usually 25–30% of income. Housing is managed by governments (public housing) or not-for-profits (community housing). (400,000 households in 2017-18)</td>
<td>Involves a funding contribution to States and Territories to provide social housing and homelessness services.</td>
</tr>
<tr>
<td><strong>Homelessness</strong></td>
<td><strong>Residential Aged Care</strong></td>
</tr>
<tr>
<td>Assistance to prevent or respond to homelessness, such as crisis housing, tenancy support and mental health services. (290,000 people in 2018-19)</td>
<td>Subsidises residential aged care services for older people.</td>
</tr>
<tr>
<td><strong>Supported housing</strong></td>
<td><strong>In-home support</strong></td>
</tr>
<tr>
<td>Specialised accommodation for people with severe mental illness, including residential mental health care and hospitals. These tend to be recovery oriented and short-term.</td>
<td>Subsidises in-home support for older people, such as Home Care Packages.</td>
</tr>
</tbody>
</table>

\(^a\) The Australian Government also provides some supports for home ownership, such as the First Home Loan Deposit Scheme (NHFIC 2020). \(^b\) Supported housing, including Specialist Disability Accommodation, is also funded through the NDIS.

*Source: AIHW (2019d, 2019p).*
20.2 Preventing housing issues arising

A range of supports already exist to assist people to remain in their home in the community. Many Australians currently receive financial assistance from governments to remain in private housing (figure 20.4). And if a household struggles with their mortgage repayments as a result of mental illness, they can generally ask their lender for a hardship variation to make the loan more manageable, such as extending the loan period or temporarily postponing repayments (ASIC 2019). Temporary supports were also introduced by governments to assist people to maintain housing during the recent COVID-19 pandemic (for example, NSW DCJ 2020a). Further, many other existing instruments are designed to protect people’s financial security, such as general income and employment support (chapter 19) and workers compensation (chapter 7).

However, more can be done to deal with the specific issues faced by people with mental illness. Housing workers can often lack the understanding and knowledge to respond to housing issues experienced by people with mental illness and social housing policies often do not adequately take into account the needs of people with mental illness. Renters in the private market also often have limited access to tenancy support services to prevent housing instability.

Mental health training for front-line housing workers

Social housing workers and real estate agents play an important role on the ground to support people to maintain their tenancies. These frontline housing workers are often the first to identify vulnerable tenants and can then link tenants with supports.

However, in many cases, there is a lack of understanding and knowledge within these roles to identify, monitor and respond to housing issues among people with mental illness.

Early intervention is limited to giving tenants a short ‘Help is Available’ brochure that lists tenant support services at the start of each tenancy. Tenant support is typically not offered until disruptive behaviour incidents are reported. We found strikes were issued against tenants with complex mental health illness, family violence or inter-generational dysfunction. The Department [of Communities] does not direct resources towards early intervention for these tenants, instead following standard procedures to manage all disruptive behaviour. (OAGWA 2018, p. 8)

We need steps to provide each party with the necessary skills to construct positive relationships, to identify early signs and to refer to the appropriate service for the issue at hand in a timely fashion. Identifying vulnerable tenants for example is a skill and using eviction alone without offering other pathways should always be only a last resort. (Almondale, sub. 735, p. 14)
This lack of awareness extends to the private rental market, where it can lead to discrimination against prospective tenants with mental illness, potentially preventable evictions and, in some cases, blacklisting from future rental properties.

Real estate agents and landlords in this sector may have far less training or understanding of the multiple challenges faced by their tenants and fewer resources to handle difficult situations, and thus see eviction as a solution rather than a last resort. (Anglicare Australia, sub. 376, p. 31)

Further, some people might not tell their landlord or real estate agent that they are experiencing mental ill-health for fear they will be evicted from their home.

No-cause evictions are a tool that has been used to remove people from tenancies. This creates a substantial imbalance of power and a fear in tenants that prevents them from making complaints, requesting repairs and notifying landlords of hardship. (NT Shelter, sub. 333, p. 8)

Inquiry participants supported more mental health training for frontline housing workers.210 As NT Shelter (sub. 879, p. 3) stated, ‘mental health training and resources for social housing workers must be offered and encouraged’.

Training should incorporate awareness about how to identify early warning signs of mental ill-health (ACT Government, sub. 1241, p. 22; NT Shelter, sub. 879, p. 3; One Door Mental Health, sub. 856, p. 15). It should also communicate the benefits of early intervention, such as avoiding the costs associated with deterioration of housing issues or potential eviction. For example, a pilot program involving training for social housing workers in Queensland showed that with increased awareness and understanding of mental health and suicide among workers, there were fewer incidences of tenancy problems, decreased use of emergency departments and improved mental health outcomes (Walter, Parsell and Cheshire 2017). In many circumstances, building trust and a greater awareness of a tenant’s mental ill-health can support a more understanding relationship.

Training should also advise on effective ways to intervene and to refer tenants to appropriate supports (SAMHC, sub. 691, att. B, p. 4). This need not be costly or onerous, and can be as straightforward as connecting vulnerable tenants to existing tenancy support, mental health or suicide prevention services. For example, housing workers could use dedicated information portals to determine where best to direct tenants for support, or connect with the tenant’s care coordinator (chapter 15).

While some social housing workers are already offered some mental health first aid training (for example, ACT Government, sub. 1241, p. 22), there is scope for improvement in resources, uptake across front-line housing workers, and links into mental health services.

State and Territory Governments should ensure mental health training and resources are provided to all social housing workers (action 20.1). The average total cost of providing mental health first aid training to the 17 400 workers in non-aged residential care services is estimated to be $4.5 million (appendix K). This is likely to be an overestimation, as it is

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210 Anglicare Australia, sub. 1206, p. 16; breakthru, sub. 112, p. 11; Carers NSW, sub. 808, p. 12; Leonie Segal and Jackie Amos, sub. 468, p. 18; Uniting Vic.Tas, sub. 95, p. 8.
likely that only client-facing staff and managers would require such training. This would be a once-off cost to educate all current employees who require it, with lower ongoing costs for refresher courses and to educate new entrants into the industry.

Inquiry participants also argued that training and resources should be made available to private sector real estate agents (Almondale, sub. 735, p. 14; NMHC, sub. 118, p. 11). Mind Australia Limited, Neami National, Wellways and SANE Australia (sub. 1212, p. 35) stated:

It is the experience of many of the people who use our services that stigma and discrimination towards those experiencing mental ill-health on the part of landlords and real estate agents is a very significant issue.

The Sector Partners would advocate that each State and Territory Government, with support of the Australian Government engage with their relevant Real Estate Institute to commission community organisations to deliver mental health training to real estate agents …

Anglicare Australia (sub. 376, p. 31) also said that providing training, resources and establishing support networks for real estate agents can be a cost-effective way to help sustain complex tenancies. They also provided an example of a program of workshops run by the Northern NSW Health Service, which have shown positive results, and a similar program that was to be undertaken by Anglicare Southern Queensland in 2019.

The State and Territory Governments should work with the relevant bodies, including the real estate institutes, to help them organise training and resources on mental ill-health for private sector real estate agents as part of their professional development.

**Social housing policies that recognise the realities of mental illness**

Policies governing anti-social behaviour management and temporary absences can often be insensitive to the needs of people with mental illness. As such, there is scope to improve social housing policies to better protect the housing of people with mental illness and reduce the likelihood of housing instability and eviction.

**Anti-social behaviour**

Policies that govern how social housing providers manage anti-social behaviour of tenants aim to provide a safe and positive living environment for all tenants. However, these policies often negatively affect people with mental illness (Brackertz, Wilkinson and Davison 2018; Jones et al. 2014). If these policies do not adequately consider the circumstances of tenants with mental illness, tenants who exhibit episodes of unsociable behaviour as a symptom of mental illness may be issued with eviction warnings and potentially be evicted (CLBB, sub. 146, p. 5; Uniting Vic.Tas, sub. 95, p. 6). Eviction will necessarily remain the ultimate threat to induce compliance with tenancy conditions, but its success as a means of inducing compliance of those with some forms of mental illness is questionable. Most people evicted would experience stress; but the eviction of someone who already has a mental illness could exacerbate that illness and inhibit their recovery.
In some cases, social housing policies may be adequate, but poor implementation can cause unnecessary stress to tenants. Even if an eviction is ultimately overturned and the housing loss avoided, there remains an unnecessary cost of the process to government.

Our review of 5 applications for termination where mental health concerns were involved found the Court did not agree to terminate the tenancies. The eviction process can cause unnecessary stress for tenants and support workers and unsuccessful eviction processes may be an inefficient use of Court and Departmental resources. (OAGWA 2018, p. 20)

There is scope to review and improve existing state and territory policies governing how social housing providers manage anti-social behaviour. For example, many state and territory policies have provisions relating to ‘mitigating circumstances’ (for example, SA Housing Authority 2020). However, they do not have explicit provisions relating to mental illness. This may be a potential area for review and improvement, noting that better mental health training would assist in this (action 20.1).

Additionally, some States and Territories have stricter policies than others. For example, in South Australia, tenants who directly contribute to serious or moderate anti-social behaviour are excluded from being able to live in social housing for 12 months (SA Housing Authority 2020). This can be inconsistent with the episodic nature of mental illness, as the person may recover but then become unable to access housing again for a long time. It may be appropriate to consider a provision that allows a person to register to be re-housed, with approval from a mental health professional, once they have recovered.

Some jurisdictions have policies in place to help tenants who exhibit anti-social behaviour to maintain their tenancy. For example in Queensland, actions may be taken to help the tenant address their behaviour and maintain their tenancy, such as referral to a support worker or agency. Upon eviction from public housing, assistance may also be offered to find alternative housing in the private market through bond loan or referrals (Queensland Government 2016).

It may also be necessary to consider protections for carers of people with mental illness. As noted by Carers NSW (sub. 808, p. 12), about 70% of mental health carers live with their care recipients and may also face the risk of eviction due to their care recipient’s behaviour.

However, any review of the policies and their implementation would need to ensure a fair balance between the rights of the other tenants sharing the housing facility — to a safe, clean and peaceful environment — and the needs of the tenant with mental illness to experience as little unnecessary distress as possible (action 20.1).

Temporary absences

Temporary absence policies restrict the time that people are allowed to be absent from their tenanted dwelling. This can help to make sure the housing stock is being used efficiently and fairly, especially as there are often long waitlists for housing. However, these policies can also increase the risk of eviction for people with mental illness.
For example, people experiencing acute episodes of severe mental illness may need to temporarily reside in a mental health facility, such as a hospital or community residential facility (chapter 13). But if the housing policy does not allow longer absences, these tenants may be evicted while temporarily absent, causing additional stress and making it more difficult to find them a home when they recover (QAI, sub. 116). Clinical treatment teams can lose contact with consumers after they are discharged from hospital, increasing the risk of relapse and readmission to hospital.

The NSW Council of Social Services (sub. 659, p. 8) described the experience of one of their clients:

During his time in custody, John’s social housing was relinquished on his behalf without his knowledge or consent. After he was released, the police told him to return to his place of residence but John came home to find his house boarded up and belongings thrown away due to his absence. When John tried to gain access to his home again, the police were called and found him to have breached his Intensive Correction Order. John was taken back into custody for a further 8 months.

Upon release from custody, John’s house was no longer available to him and he had to seek emergency housing. This causes significant problems in satisfying his probation requirements as he does not have a fixed address. At no point during both periods of release was he given any care coordination or aftercare from government agencies to support his transition back into the community and help him find stable housing.

The length of absence and conditions for temporary absences varies in each State and Territory (table 20.1). The length of time people are able to be absent from their homes, for reasons such as hospitalisation or institutional care, can range from one month (in Western Australia and the Northern Territory) up to six months (in New South Wales). However, the tenant often must make arrangements to continue to pay their rent and water usage, and satisfy the social housing provider that the property will be adequately cared for while they are away, for example by an agent or house sitter (for example, NSW DCJ 2020b; Queensland Government 2019). These can be quite reasonable requirements, but accomplishing each of these tasks may be near impossible for a tenant experiencing an episode of mental illness.

Wei was a long-term social housing resident with significant psychiatric illness. He lived alone with assistance from community-based mental health services. During his tenancy he was hospitalised for a period of almost 6 months. The social housing provider sent Wei an eviction notice for not occupying his premises in breach of their “allowable absences” policy. This was despite the hospital nursing staff telling the housing provider that more time was required, and that eviction would have a very serious negative impact on Wei’s health.

The eviction notice was not withdrawn until Kingsford Legal Centre assisted Wei to make a discrimination complaint, which was eventually resolved through conciliation. (KLC, sub. 469, p. 10)
Table 20.1  **Temporary absence policies in each State and Territory**

<table>
<thead>
<tr>
<th>State</th>
<th>Maximum length (without notification)</th>
<th>Maximum length (with notification or approval)</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>na</td>
<td>Six months</td>
<td>• Reasons for which approval can be granted to be away from a property include, for example, to care for sick or frail family members, hospitalisation or admission to institutional care, or entering a correctional facility.</td>
</tr>
</tbody>
</table>
| Vic   | Six weeks                            | Six months                                  | • Tenant must provide written notification if they are going to be away for longer than six weeks.  
• Discretion can be provided for periods longer than six months. Reasons include receiving psychiatric care. |
| Qld   | Eight weeks                          | Five months in a 12 month period            | • Reasons approval can be granted include: hospitalisation, rehabilitation and carer responsibilities. |
| SA    | na                                   | Three or six months                         | • Tenants can be absent for up to three months with Housing SA’s approval. This can extend for further three months for circumstances such as hospitalisation, rehabilitation and carer responsibilities. |
| WA    | One month or any periods that combined exceed three months in a 12 month period in total | na                                           | • Must obtain written consent from the Housing Authority if absence is going to exceed one month or any periods that combined exceed three months in a 12 month period in total. |
| Tas   | Eight weeks                          | na                                          | • Required to appoint an agent if away for more than a few days.  
• Must apply for absence if away for more than eight weeks for reasons including medical treatment and prison. |
| NT    | 30 days                              | na                                          | • Required to seek permission from the Department of Housing if going to be absent for longer than 30 days. |
| ACT   | Three months                         | na                                          | • Required to seek approval to be absent for more than three months, but managers can exercise discretion based on the circumstances of the case.  
• Where there is concern about a tenant’s ability to maintain the property, properties can be voluntarily surrendered with the understanding that they will be supported to access priority housing when they exit institutional care.  
• Tenants can pay maximum of $5 per week rent when they are not in receipt of income or are accessing residential rehabilitation services. |

**na** Not available.

*Source: ACT Government (sub. 1241, p. 22); HousingVic (2018); NSW FACS (2020b); NT DHCD (nd); Queensland Government (2019); South Australian Government (2020, sub. 692, p. 7); TAS DoC (nd); VIC DHHS (2018b); WA Housing Authority (2019).*

In some cases, eviction due to a temporary absence may be a result of a lack of information sharing between mental health services and social housing authorities (or rental agents). Improving information sharing between these agencies (with agreement of the consumer) can reduce the likelihood of eviction. This is particularly important upon admittance to an inpatient psychiatric facility and again prior to discharge. The Productivity Commission has...
recommended ways to improve coordination across services through formal information sharing arrangements in single care plans and using care coordinators (chapter 15).

It is important that people experiencing acute episodes of mental illness do not lose their accommodation while requiring treatment in a mental health facility. State and territory social housing authorities should review their policies relating to temporary absences to provide greater consideration for people with mental illness to reduce the likelihood of housing instability and eviction (action 20.1). Any review of the policies will have the difficult task of balancing the housing needs of people with mental illness with the needs of other vulnerable people who may be on waiting lists for social housing properties.

**Expand tenancy support services for private housing**

Tenancy support services help people access housing, or intervene early to stabilise their tenancy and prevent them from becoming homeless. These services are often provided to people in social housing and, in limited circumstances, to people in private housing. Tenancy support services do not specifically target people with mental ill-health, but mental ill-health is a common reason for seeking support. Services can range from general housing advice to more intensive supports, including:

- help maintaining a tenancy — such as help with budgeting, support to access existing financial assistance, income support, tenancy advice, debt counselling, financial management and resolving rent arrears
- assistance to improve a tenant’s economic participation, such as help to find employment
- linking tenants with broader support services, such as mental health services (Costello, Thomson and Jones 2013; PC 2017b).

In general, tenancy support services can be very effective at stabilising housing. An evaluation of several tenancy support programs across Australia found that, as a result of support, 81% to 92% of people maintained their existing tenancy, 8% to 17% of people moved home (for a variety of reasons) and less than 4% of people were evicted (Zaretzky and Flatau 2015). The vast majority of tenancies were sustained for 12 months or longer. This was considerably fewer evictions compared with public housing tenants who do not receive tenancy support services (over 16%).

Tenancy support services can also be cost effective for governments when they prevent eviction, homelessness or a deterioration in mental health. For example, Zaretzky and Flatau (2015) estimated the average cost of assisting someone to maintain or access a tenancy was about $5400 per presenting unit head211 (2019-20 dollars) compared with about $11 100 per eviction event.212 In particular, preventing people from losing an existing home costs

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211 All costs from Zaretzky and Flatau (2015) are per ‘presenting unit head’, which is a group of people who present together for support. It is used as a proxy for a household.

212 Inflated using the ABS Producer Price Index for real estate services (number 672) (ABS 2020c).
significantly less than general support to access or maintain housing ($1800 compared with $8000). Further, it has been estimated that supporting evicted tenants through homelessness services in Victoria cost upwards of $50 000 per year (2019-20 dollars) (VIC DHS 2011).

However, there is unmet demand for tenancy support services (NT Shelter, sub. 879, p. 3). In 2018-19, about 15% of people who tried to access services to assist them to maintain their housing had their need unmet (AIHW 2019n). About 5500 people in this group experienced mental ill-health (AIHW Specialist Homelessness Services Collection, unpublished data). It is unclear how many of these people were living in social or private rental housing. The total cost of providing additional tenancy support services to meet demand across Australia for clients with mental ill-health was estimated to be $10 million to $44 million each year (appendix K).

While tenancy support services are generally associated with the social housing system, limited support services are also sometimes available for people in the private rental market — often called ‘private rental brokerage services’ (PC 2017b). Services may be funded and provided by governments, such as Housing Connect in Tasmania and Supportive Tenancy Service in the ACT, or through NGOs, such as the Private Rental Access Program (Launch Housing 2020; Tually et al. 2016; Woden Community Service nd). Services can include providing information, advice, referrals, advocacy and support to help people with complex needs — such as mental illness — to find and maintain housing.

Some Inquiry participants suggested there was a need to increase the availability of these services to people in private housing as well as social housing (Australian Red Cross Society, sub. 490, pp. 16–17; CHP, sub. 145, p. 7; MHV, sub. 580, att. 1, p. 32). As most people with mental illness reside in private rental housing, expanding services to this market has the potential to benefit large numbers of people with mental illness. There is limited accessibility of private rental brokerage services and the Productivity Commission has previously discussed the importance of State and Territory Governments ensure that people renting in the private market have the same access to tenancy support services as those in social housing (PC 2017b, p. 231).

It is also necessary to consider the carers of people with mental illness when expanding tenancy support services. As discussed above, approximately 70% of mental health carers live with the care recipient and in many cases their housing outcomes are intrinsically linked with the lease held by either the carer, the care recipient, or both (Carers NSW, sub. 808, p. 12). A potential consideration is to allow carers to also access tenancy support programs in both social housing and private housing.
Improve private rental tenancy laws

In the private rental market, there is scope to reduce the risk of eviction and its associated stresses for people with mental illness.

Laws that allow ‘no grounds’ evictions permit landlords to evict tenants without having to identify a particular reason, either at the end of a fixed term lease, or at any time during a periodic lease. Several submissions expressed concern that no grounds evictions create a substantial imbalance of power and can impose significant stress on renters (Anglicare, sub. 376, p. 9; NT Shelter, sub. 333, p. 2).

The constant threat of ‘no grounds’ evictions also remains a source of real stress for renters. A 2019 survey by Tenants’ Union NSW and Marrickville Legal Centre found over 60% of NSW renters report the possibility of a ‘no grounds’ eviction is a significant source of anxiety, and 90% report they would experience significant financial costs, emotional toll, anxiety and stress if forced to move. (NCOSS, sub. 143, p. 15)

Further, the legal minimum notice periods for rental terminations vary across Australia, but tend to be shorter than those internationally (PC 2019c, pp. 121–122). While notice periods are intended to give the party receiving the notice time to plan their future activities and save for the costs of moving, shorter notice periods increase the difficulty of securing alternative housing that meets their needs (such as proximity to support). This can be particularly stressful for people with mental illness.

The Productivity Commission has found in past research that reforms to prohibit no grounds evictions and extend notice periods for landlord initiated evictions would improve the welfare of vulnerable private renters by increasing their certainty of tenure and providing more time to make alternative arrangements (PC 2019c, p. 123).

However, an important consideration is that tenancy laws that limit landlords’ options may translate into higher rents over time, to cover an increase in risk to landlords associated with leasing activity (PC 2019c, p. 123). Additionally, it could also exacerbate discrimination by landlords and real estate agents against renters who have a mental illness.

Recent reforms in Victoria and New South Wales have sought to rebalance the interests of tenants and landlords within residential tenancy legislation (Consumer Affairs Victoria 2020; NSW Fair Trading 2020; PC 2019c, p. 118). However, reforms have not yet fully commenced, making it difficult to determine the likely effects of these changes on the private rental market. State and Territory Governments should monitor the effect of these forthcoming reforms to assess the potential benefits for people with mental illness to rent in the private market, including whether or not the reforms change the willingness of private landlords to rent to people with mental illness.

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213 These reforms are being staged over time. In New South Wales, changes to the residential tenancy legislation started on 23 March 2020 (NSW Fair Trading 2020). In Victoria, changes are scheduled to be implemented by 1 July 2020 (Consumer Affairs Victoria 2020).
20.1 Housing services should increase their capacity to reduce the risk of people with mental illness experiencing housing issues (such as housing that is of low quality or of insecure tenure) or losing their home.

Start now

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

- State and Territory Governments should work with the relevant bodies, including the real estate institutes, to help organise training and resources on mental health for private sector real estate agents as part of their professional development.

- State and territory social housing authorities should review their policies relating to anti-social behaviour, temporary absences and information sharing between institutional care facilities and housing authorities to provide consideration for people with mental illness, to reduce the risk of eviction.
  - The review of anti-social behaviour policies should take into account the episodic nature of mental illness and ensure a fair balance between the needs of the tenant experiencing mental illness and the needs of other tenants sharing a housing facility.

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

Start later

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

20.3 Support for people with complex needs to find and maintain housing

Many people with severe mental illness, and complex needs arising from their mental illness, find it difficult to locate or maintain suitable long-term housing in the community. While in some cases better integrated supports and financial assistance may be effective in helping people to live successfully in the community (section 20.2), in others, more intensive support may be needed. And in circumstances where people transition out of institutional care (such as hospitals or correctional facilities), support to find and maintain housing can reduce the risk of future housing problems.
Supported housing: integrated housing and mental health services

Integrated housing and mental health services (hereon described as ‘supported housing’) can be an effective way of providing support for people with severe mental illness. Supported housing programs integrate access to housing, tenancy (or psychosocial) support services and mental health services. These programs can help people to find and maintain a home, prevent homelessness, aid recovery and be more cost-effective than spending time in more acute clinical settings, such as hospitals (ACT Government, sub. 210, p. 16; Mind Australia Limited, sub. 380; TeamHEALTH, sub. 756). Supported housing can be achieved in either social housing, the private rental market or a hybrid of the two (such as headleasing).

Most states and territories have trialled (or are trialling) supported housing for people with mental illness in a social housing setting (box 20.2). These programs generally involve a close partnership between social housing, tenancy support services and mental health services. Where evaluations exist, results tend to show improved housing and mental health outcomes for participants. And in many cases, the cost of running the program is offset to some extent as participants reduce their use of other relatively high cost services, such as hospitals. The Housing and Accommodation Support Initiative (HASI) is a key example (box 20.2). The Mental Health Coordinating Council (sub. 214, p. 16) stated that ‘investment in additional HASI type services will return $1.20 per every dollar invested in the short term’.

Many submissions were supportive of HASI and similar initiatives. Supported housing can be achieved in either social housing, the private rental market or a hybrid of the two (such as headleasing).

HASI support helps people to achieve their own, unique goals. The types of support people receive depends on their individual needs and what they want to achieve … Findings from an evaluation conducted by the University of New South Wales in 2012 demonstrate that HASI has provided significant benefits for those who have received support from the program as well as the broader NSW community. (MHCC, sub. 920, p. 19)

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214 Beyond Blue, sub. 275, p. 29; EMHS, sub. 152, p. 3; FOCP, sub. 198, p. 4, sub. 758, p. 4; Mental Health Commission of New South Wales, sub. 486, p. 31; MHCC, sub. 214; MHV, sub. 479, p. 14; Mission Australia, sub. 487, pp. 15–16; NCOSS, sub. 143, p. 16; Northern Territory Mental Health Coalition, sub. 430, p. 24; One Door Mental Health, sub. 108, p. 14; RANZCP, sub. 385, p. 31; VCOSS, sub. 478, p. 37; WayAhead Mental Health Association NSW Ltd, sub. 310, p. 3.
Box 20.2  Integrated supported housing programs across Australia

Several states and territories have trialled supported housing programs for people with severe mental illness. Only some of these programs have been evaluated, with results showing that participants generally sustain housing, their mental health improves or remains stable, hospital usage falls and employment or training somewhat improves.

Results from integrated supported social housing programs around Australia

<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Sustained housing</th>
<th>Mental health</th>
<th>Hospital usage</th>
<th>Employment and training</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>Housing and Accommodation Support Initiative</td>
<td>90%</td>
<td>↑</td>
<td>↓</td>
<td>—</td>
</tr>
<tr>
<td>Qld</td>
<td>Housing and Support Program</td>
<td>83%</td>
<td>—</td>
<td>↓</td>
<td>↑</td>
</tr>
<tr>
<td>SA</td>
<td>Housing and Accommodation Support Partnership Program</td>
<td>93%</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
</tr>
<tr>
<td>WA</td>
<td>Individualised Community Living Initiative</td>
<td>na</td>
<td>↑</td>
<td>↓</td>
<td>na</td>
</tr>
</tbody>
</table>

na Not available.

Source: Bruce et al. (2012); Meehan et al. (2010); SA DoH (2013a); Smith (2015).

An example of a supported housing program is the Housing and Accommodation Support Initiative (HASI), a partnership between NSW Health, Housing NSW, community housing providers and providers of tenancy support (Bruce et al. 2012). The scheme aims to provide stable housing integrated with clinical and psychosocial rehabilitation services to people with mental illness. Tenants receive:

- tenancy support services and rehabilitation services from non-government organisations
- clinical care services from specialist mental health services
- housing from social housing providers (HASI services are also available for private renters).

An evaluation of the HASI in 2012 found:

- about 90% of participants successfully maintained their tenancy; of the remaining 10% who ended their tenancies, most left for planned reasons, such as moving to other housing
- a 59% decrease in the average number of days each year in a mental health inpatient hospital
- an improvement in life skills, and community participation and a reduction in behavioural issues.

The average (non-accommodation) costs of HASI was about $46 000 per person annually (2019-20 dollars), depending on the level of support needed (not including the cost of clinical mental health services). However, this was largely offset by an estimated $43 000 reduction in costs as a result of reduced use of mental health inpatient hospitalisations.215

Given these positive experiences, both the Northern Territory and Tasmania have begun piloting programs based on HASI (NT Shelter, sub. 333, pp. 6–7; Tasmanian Government, sub. 498, pp. 15–16, sub. 1242, p. 3). In its early stages, as at August 2019, each of the 50 people who have received services from Northern Territory HASI had maintained their tenancy (Northern Territory Government, pers. comm., 21 August 2019).

215 Costs inflated to 2019-20 dollars using CPI numbers for Health, weighted average of eight capital cities (ABS 2020a).
However, there is significant unmet demand for supported housing places in Australia (Brackertz et al. 2020; figure 20.5). In 2017-18, there were about 4600 supported housing places across Australia (AIHW 2020h)\textsuperscript{216} Yet, about 14 000 to 17 000 places were estimated to be needed across Australia. This is a gap of about 9000 to 12 500 places (figure 20.5). While these are estimates rather than exact figures, they are consistent with a broader understanding in the community that more supported housing places are needed.

There are a number of mental health supported accommodation packages via [Housing and Support Packages (HASP)] but not currently enough to meet demand. [The Office of The Public Advocate] understands that South Australia has 36 HASP packages. There is sufficient demand to increase the number of HASP packages available. (OPA South Australia 2017, p. 4)

But the level of housing supply needs to increase substantially. Estimates made for inner Melbourne by Launch Housing suggest that 500 people would benefit from some form of Housing First or permanent supportive housing each year. (Launch Housing, sub. 764, p. 3)

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure205.png}
\caption{Gap in supported housing places across Australia\textsuperscript{a,b}}
\end{figure}

\textit{Figure 20.5} \textbf{Gap in supported housing places across Australia}\textsuperscript{a,b}
\textit{As at 30 June 2018}

\textsuperscript{a} The needed range was estimated using assumptions in Siskind et al. (2012) that the optimal number of supported housing places lies between 70 to 88 places per 100 000 population. Existing places are reported by the Australian Institute of Health and Welfare (AIHW 2020h). The gap in the number of supported housing places is the difference between the existing number of places and the estimated number of places needed (using population estimates for people aged 18 years and over). \textsuperscript{b} The ACT reporting having zero supported housing places in 2017-18. In 2016-17, the ACT reporting having 11.8 places per 100 000 population.

\textit{Source:} Productivity Commission estimates using ABS (\textit{Australian Demographic Statistics, Sep 2019, Cat. no. 3101.0}); AIHW (2020h); Siskind et al. (2012).

\textsuperscript{216} While this is the most consistent source of data available to measure the existing number of supported housing places, it is not necessarily an accurate reflection of a jurisdiction’s mental health housing supports because not all schemes are in scope for this data collection.
Unless more supported housing places are developed, this gap can be expected to increase as the population grows. Currently, Western Australia is the only state or territory that reaches the estimated range of supported housing places needed, despite reporting a significant gap in community mental health services more broadly (WAMHC 2019).

Supported housing programs are generally provided through social housing (box 20.3). However, there are examples of supported housing being provided through the private market and through headleasing arrangements.

A key barrier to meeting the demand for supported housing places is a significant shortage of social and affordable housing. Across Australia, almost 190 000 people were on social housing waitlists as at 30 June 2017 — although this is likely to be an overestimate as some applicants may be on more than one waiting list (AIHW 2018a). While many on this list can access housing within three months, wait times of two years or more are not uncommon. Submissions noted that time spent on waitlists exceed 10 years in some areas (Eastern Health – Murnong Adult Mental Health, sub. 187, p. 1; Shelter WA, sub. 200, att. 1, p. 7). Supply constraints mean that, in all jurisdictions, most entries into social housing come from the priority list.

As a result, many submissions recommended an increase the social housing stock. However, fixing the broader social housing system is beyond the scope of this Inquiry. The Productivity Commission has recognised in a previous inquiry that the social housing system is ‘broken’ and recommended a single system of financial assistance across both social housing and private housing (among other recommendations) to address the underlying problems (box 20.4). However, to date, no state or territory has adopted this approach.

Inquiry participants were also supportive of expanding supported housing places. The South Australian Mental Health Commission (sub. 691, att. A, p. 2) stated:

> An increase in [supported housing] would provide a safe place for people experiencing mental health issues to go, and for those also experiencing housing distress, it would also provide more options for hospitals to discharge people into, increasing the availability of acute mental health bed[s] in hospitals for those in crisis.

Further to this, the Commission has also heard that an increase in supported housing options would provide much needed support to people who experience chronic conditions and complex circumstances, where general housing options may not be appropriate.

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217 ACP, sub. 522, p. 25; Anglicare Australia, sub. 376, p. 32; APS, sub. 543, p. 7; cohealth, sub. 231, p. 13; Jesuit Social Services, sub. 441, p. 5; KLC, sub. 469, p. 17; Launch Housing, Melbourne transcript, p. 49; Mind Australia, sub. 380, p. 37; Uniting Vic.Tas, sub. 95, p. 8; VCOSS, sub. 478, p. 36.

218 AHURI, sub. 885, pp. 23; Almondale, sub. 735, p. 14; CHF, sub. 646, p. 17; FOCP, sub. 758, p. 4; Jesuit Social Services, sub. 1186, p. 1; Mental Health Australia, sub. 864, p. 16; NT Shelter, sub. 879, p. 5; UnitingSA, sub. 807, p. 10; Uniting Vic.Tas, sub. 931, pp. 16–17.
Box 20.3  Different options to deliver supported housing

Social housing

Most supported housing is provided through social housing. A key benefit of using social housing is tenants have access to all the supports available in social housing. However, people with mental illness do face barriers to accessing social housing. In addition to the significant wait many people face to access social housing, when they do finally access housing they have little choice over the home in which they live (PC 2017b), and could end up far away from support services. In addition, navigating the administrative procedures for social housing can be particularly difficult for people with mental illness (APS, sub. 543, p. 32; MHCA 2009). In a survey of people with mental illness, 90% of respondents reported complexity in applying for public housing that created difficulties for them (SANE Australia 2008). Once people are in social housing, some may struggle to understand their tenancy obligations and what constitutes a breach (QMHC 2015).

Private rental

Supported housing in private rentals can provide significant benefits. It opens up a much larger pool of housing stock, which can provide greater choice and opportunity for people to find housing that meets their needs and preferences, such as proximity to support services. It can also provide an alternative to social housing, freeing up social housing places. Supported housing can help to overcome many of the barriers people with mental illness may face in accessing the private rental market, such as discrimination, difficulties managing housing tasks and unsociable behaviour (section 20.1). Coordination with the private rental sector would facilitate access to an immediate and greater supply of homes (NMHC, sub. 118, p. 10).

However, there are some barriers to providing supported housing through the private rental market. Tenancy support services are either lacking or not well integrated with other housing and non-housing supports. And vulnerable tenants, such as those with mental illness, face rental affordability issues (PC 2019c). Also, people with severe mental illness can find it difficult to secure private rental housing, even with a supported housing program, due to anxiety concerning lease length, stigma, absence of rental history, poor work history, making a poor first impression, poor literacy skills or reliance on financial assistance.

Doorway

An example of a supported housing program implemented through the private rental market is Doorway. Doorway is a housing and recovery support program funded by the Victorian Government and designed to improve the capacity of individuals with severe and persistent mental illness who are homeless or at risk of homelessness to live independently in the private rental market (Nous Group 2014). The program provides client support services (such as tenancy support) and a housing supplement to subsidise rent where required. This housing payment supplements Commonwealth Rent Assistance.

An evaluation of Doorway estimated the cost of the housing supplement at $10 136, the cost of client support at $7937 and operational costs of $1228 per person each year. About 85% of participants remained housed at the end of the evaluation period. Participants also showed improvements in mental health outcomes and greater interaction with others. Participants significantly reduced their use of health services, particularly bed-based mental health services, ambulatory care, emergency department presentations and hospital admissions. This led to an estimated $11 050 reduction in health service costs per person each year (Nous Group 2014).

(continued next page)
Box 20.3  (continued)

**Headleasing**

A headleased property is one that is owned by private individuals or corporations and leased to another party, such as government social housing providers who then enter into a separate sub-lease arrangement with a tenant. The private landlord is generally responsible for routine property maintenance, and the social housing provider is responsible for tenancy management (such as collecting the rent and passing on any maintenance requests). The social housing provider is usually liable (up to a cap) for any property damage after the application of the tenant bond and any insurance proceeds. These arrangements already exist for some community housing and Defence housing in Australia. About 20% (12,500 properties) of all community housing properties are headleased from the private market (PC 2017b).

Headleasing is a useful tool that State and Territory Governments can use more broadly to give social housing tenants a wider choice of home (PC 2017b). This option provides more long-term flexibility over property type and location than building new public housing, providing more choice to tenants.

Box 20.4  Previous recommendations to reform social housing

The Productivity Commission’s (PC 2017b) inquiry into Reforms to Human Services found that social housing in Australia is broken. Below are two of its key recommendations for improvement.

**One system of financial assistance**

The Productivity Commission recommended implementing a single system of financial assistance for tenants social and private housing, who currently can receive vastly different rates of financial assistance. Tenants would receive a single package of assistance that is portable between private and social housing. At its base, all eligible households in both markets would receive Commonwealth Rent Assistance (CRA). Some households would also receive income support payments or National Disability Insurance Scheme funding that are currently used to contribute to housing costs. Where these programs and CRA are not sufficient to meet a household’s rental payments, State and Territory Governments could pay a housing supplement to that household. This would bridge the gap between CRA, tenant contributions and market rent.

**Choice-based letting**

The Productivity Commission recommended that State and Territory Governments introduce choice-based letting for tenants in social housing. Choice-based letting involves ranking social housing applicants against selection criteria (such as waiting time, age and need) and offering the highest ranked applicant the property. This changes the allocation process from one driven by the housing provider to one driven by the preferences of the households. Choice-based letting has been implemented elsewhere, including the United Kingdom and the Netherlands.

While some governments are looking at implementing this reform, none have done so to date.
State and Territory Governments should develop or scale up existing supported housing programs that integrate housing, tenancy support and mental health services. A mix of supported housing options are likely needed to meet a variety of needs and preferences, including social and private housing, and headleasing arrangements.

The total expenditure required to meet the gap for supported housing places across Australia is estimated to be $230 million to $807 million each year (appendix K). Less than half of this cost is attributable to accommodation — about $108 million to $226 million each year. However, to the extent that supported housing avoids costs to other government services, the net cost to government is likely to be lower in the long term. For example, both the Doorway (about $16 300 per person each year) and HASI ($43 100) programs estimated significant reductions in average health service usage. This suggests the net cost to government is likely to be closer to $83 million to $267 million each year (appendix K).

Funding for this increased investment should be included in the renegotiation of the NHHA (section 20.5). State and Territory Governments should report annually to the National Mental Health Commission on their progress in meeting the gap in supported housing places in their jurisdiction (chapter 24).

**Long-term supported accommodation for people with severe and persistent mental illness**

Some Australians with severe and persistent mental illness and resulting psychiatric disability may lack the necessary social supports or financial capacity to access longer-term accommodation that provides the support they need to live in the community. As a result, they can end up effectively stuck in specialist mental healthcare facilities or hospital-like environments that are intended for short- to medium-term stays (chapters 12 and 13). Meanwhile, some others may cycle in and out of hospitals or homelessness if they cannot access support.

‘Long-term supported accommodation’ can give them the best opportunity to live a contributing life. It is a specific form of supported housing for people with severe and persistent mental illness who require mental healthcare, tenancy support services and daily living support to be available on site 24 hours a day, 7 days a week. Specialist housing may involve individual or congregated living arrangements in purpose-built units or houses that provide space for on-site support.

… in Australia and overseas there are models of housing that feature more flexible combinations of private and shared space, individual bedrooms with shared kitchen and living areas. Purpose built facilities have the advantage that they can also contain co-located health [and] employment support services and social participation opportunities to provide the supports that many people require to live independently and in communal settings. (AASW, sub. 432, p. 8)

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219 Productivity Commission estimates using Nous et al. (2014). The non-accommodation costs component primarily consists of costs incurred providing psychosocial supports such as helping people take part in social and community activities, improving relationships and building confidence in day-to-day tasks (Nous Group 2014).
Some State and Territory Governments are developing long-term supported accommodation (for example, ACT Government, sub. 210, p. 16; Tasmanian Government, sub. 498, p. 14). NGOs (with government assistance) have also entered this space. For example, the Haven Foundation model has led to improved outcomes for many of its participants (box 20.5).

**Box 20.5 The Haven model of long-term supported accommodation**

The Haven provides long-term supported accommodation to people with severe mental illness (Mind Australia Limited, sub. 380, p. 32). Residents live in their own self-contained apartment, with independent kitchen and bathroom facilities, within a block of units that also has some shared communal areas to encourage social interaction. The program provides 24/7 on-site psychosocial support staff to help residents to live successfully in the community.

Residents must meet strict eligibility criteria to live in the Haven. They must be diagnosed with a severe and persistent mental illness, receive a Disability Support Pension and be eligible for the National Disability Insurance Scheme (The Haven Foundation, pers. comm., 13 February 2019).

Residents enter into an open-ended lease with The Haven Foundation. They pay 25% of the Disability Support Pension and 100% of rental assistance to cover the cost of maintenance and repairs. Residents are responsible for paying their own utilities, such as electricity and water. Funding received under the National Disability Insurance Scheme covers the cost of on-site psychosocial and tenancy support (The Haven Foundation, pers. comm., 13 February 2019).

An evaluation of the pilot Haven model in South Yarra found that tenants have experienced:

> … the reduced need for acute psychiatry or residential rehabilitation service care, has enhanced participation in vocational or educational opportunities, has strengthened the link with carers and family members, and has assisted in establishing new connections with members of the broader community. (Lee et al. 2013, p. 15)

The Haven is estimated to cost about $100 000 per person each year (Mind Australia Limited, sub. 380, p. 40). This does not include an annualised cost of capital to fund the development of these units.

The first Haven site in South Yarra, Melbourne has 14 units. The model has subsequently been established in Frankston (18 units), with more sites in Geelong (16 units) and Laverton (16 units) and Whittlesea in the pipeline (Mind Australia, sub. 380, p. 40).

Many Inquiry participants were supportive of greater development of long-term supported accommodation for people with severe mental illness.220 Launch Housing (Melbourne transcript, p. 53) said that it was:

> … very keen for the Commission to consider permanent supportive housing options as recommendations in regards to longer-term housing options, because permanent supportive housing offers 24-hour supportive … trauma informed care to people. It’s secure, it’s safe, it’s affordable, and it can be done in scattered sites.

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220 For example, ACT Mental Health Consumer Network, sub. 297, p. 10; CHF, sub. 646, p. 17; Ian Webster, sub. 626, p. 5; KLC, sub. 469, p. 18; Launch Housing, sub. 764, p. 2; Mind Australia, sub. 380, Melbourne transcript, p. 36; Olav Nielssen, sub. 37, p. 1; SAMHC, sub. 477, p. 16, sub. 691, att. B, p. 9.
Long-term supported accommodation can also be more cost effective than residential mental healthcare and hospitals. The estimated recurrent (non-capital) cost of housing someone in the Haven is about $100 000 per year (Mind Australia, sub. 380, p. 40). This is significantly cheaper than the average annual recurrent cost of 24-hour staffed residential mental healthcare (about $210 000) and hospitals ($510 000) in 2018-19 (SCRGSP 2020b).

The Productivity Commission estimates that about 3000 people could be living in non-acute 24-hour staffed accommodation across Australia in 2019-20, were sufficient places available. However, we acknowledge the insufficient availability of long-term supported accommodation. For example, during 2017-18, 135 people had been living in residential mental healthcare for more than one year (AIHW 2019h). The South Australian Government (2018) estimated that 82 older adults with enduring mental illness would require this type of housing by 2021, and that 36 long-term accommodation places would be needed to help fill the gap in existing services.

Making use of the NDIS to encourage accommodation support

Many people with severe and persistent mental illness who require 24/7 mental health and housing support are likely to be eligible for disability funding under the NDIS (chapter 17). There are two streams of funding that can be used to help people find and maintain housing.

- Supported Independent Living (SIL) supports involve a person assisting with daily tasks to help people live as independently as possible, such as help cooking and budgeting (NDIA 2020e).
- Specialist Disability Accommodation (SDA) involves specialist housing solutions for people with very high support needs. This may involve developing new accommodation or retrofitting existing dwellings to satisfy particular support needs (NDIA 2020d).

SIL supports can help people with mental illness to manage their housing tasks. People who receive SIL supports may live in accommodation funded under SDA, or they may live in their own home, a private rental or social housing. The supports can be provided in a shared or individual arrangement. However, unlike SDA, funding for SIL cannot be used to pay for the cost of housing, such as rent. Further, Queensland Advocacy Incorporated (sub. 889, p. 13) noted that SIL can be unnecessarily restrictive on people’s choices.

SDA funding can be used to encourage development of long-term supported accommodation for people with severe and persistent mental illness with very high support needs (box 20.6). The National Disability Insurance Agency (NDIA) projects about 6% of NDIS recipients are intended to receive SDA funding, which should accommodate the estimated 3000 people in need of this type of housing (provided all 3000 people qualify for the NDIS).

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221 The average cost of residential care may be higher than this estimate as it does not fully account for reach-in services from state and territory providers.

222 Productivity Commission estimates using the National Mental Health Service Planning Framework. This projection is based on all other services being available.
Specialist Disability Accommodation (SDA) refers to accommodation for eligible participants of the National Disability Insurance Scheme who need specialist housing solutions to help cater for their significant functional impairment or very high support needs (NDIA 2018). SDA is intended to ensure that participants do not pay more for housing because of their disability.

SDA funding provides a return to investors to develop SDA to meet demand. Eligible participants receive ongoing payments to live in eligible SDA (in practice, SDA funding is paid to the SDA provider on behalf of the participant). Residents in SDA are still required to pay a reasonable rent contribution, limited to 25% of their Disability Support Pension plus applicable Commonwealth Rent Assistance (Beer et al. 2019). Some people may decide to develop their own SDA.

As at 31 March 2020, 13,944 participants were in receipt of SDA funding, at a cost of about $156 million, and 4,123 SDA dwellings were enrolled (NDIA 2020b). When the scheme is fully rolled out, about 28,000 households (6% of National Disability Insurance Scheme recipients) are expected to receive SDA funding. Funding is expected to reach about $700 million each year and is intended to attract an additional $5 billion in investment from the market to develop more than 12,000 purpose-designed dwellings (NDIA 2018; PwC and Summer Foundation 2017).

However, this housing solution is still in its infancy. As at 31 December 2019, 468 participants with primary psychosocial disability received SDA funding, though this is likely an underestimate (NDIA, pers. comm., 4 May 2020). This is just 1.6% of current NDIS participants with primary psychosocial disability — far from the 6% target and significantly lower than the almost 4,000 people projected. Ongoing funding for SDA is already budgeted (box 20.6), but SDA growth remains slow.

Growth in SDA may be slow for people with psychosocial disability for several reasons. First, barriers to accessing the NDIS has led to fewer people with psychosocial disability entering the scheme than expected (chapter 17). Second, according to National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016, SDA is generally restricted to housing five or fewer residents and is intended to reduce clustering of people with long-term psychosocial disability. This criteria potentially restricts the development of some successful congregated site models, such as the Haven model. Third, there is a requirement for participants to exhaust all other options before they can access SDA funding (COAG DRC 2019d). Finally, there may be a perception in the community that SDA funding is only available for NDIS participants with physical disability (Mind Australia, sub. 380, pp. 36–37).

In October 2019, the NDIA published the SDA Limited Cost Assumptions Review (NDIA 2019b, 2020c). The review recommended a number of price limit increases for some design categories and locations to encourage investment in SDA and improve the choice of living options for participants eligible for SDA. The NDIA has also introduced the SDA Design Standard to provide clarity for housing design requirements to encourage growth in the construction and development of SDA (NDIA 2019g).

However, there are several potential ways the NDIA can further encourage development of SDA, especially for people with mental illness. The NDIA can lift restrictions on the number...
of people who can share SDA in a congregated living environment. Beer et al. (2019) suggested several other ways the NDIA could encourage SDA development, including:

- support to increase investor certainty by building systems to estimate the number of people expected to be eligible to access SDA and where they live
- providing resources to assess and approve participants
- developing SDA policy about clients with complex, challenging or aggressive behaviours that may lead to significant property damage — these clients may not be an attractive investment proposition to SDA providers, but have some of the greatest needs.

The NDIA should amend its SDA strategy and policies so that they encourage the use of SDA funding to develop long-term supported accommodation for people with severe and persistent mental illness (action 20.3). As part of this, the NDIA should:

- lift restrictions on the number of people who can reside in newly developed SDA
- develop and report estimates of the number of people with psychosocial disability who are expected to be eligible to receive SDA funding, and where they live
- provide clarity about how the NDIA will deal with problems of liability concerning property damage for this cohort.

**Improving transitions out of hospitals and correctional facilities**

People with severe mental illness may require time in hospital or a specialised mental health facility to support their recovery (chapters 12 and 13). However, many of these people find it difficult to transition back into the community and find adequate housing, and either remain in care or are discharged into homelessness.

As noted in section 20.1, over 2000 mental health hospital inpatients could potentially be discharged if appropriate clinical and accommodation services were available (chapter 13). As well, nearly half of people leaving prison are expected to spend at least their first night in short-term or emergency accommodation (Baker 2014). In addition, the Council to Homeless Persons (sub. 145, p. 5) stated that:

Acute mental health services report that approximately 25 per cent of patients are homeless prior to admission, and most are discharged back into homelessness because of a lack of suitable accommodation options.

There are several reasons why people may be discharged from acute mental healthcare into unstable housing or homelessness or have to remain in care.

- Difficulty identifying people who are homeless or at risk of homelessness.
- Constraints on hospital capacity and non-acute bed-based services (chapter 13), and time pressures, can affect discharge assessments and lead to people being discharged too quickly.
• Delays or lack of follow up after discharge. While follow up with a hospital liaison officer is common practice in Australia, there can be significant delays. Follow up care and support are only possible if the individual has been discharged to a stable address.

• Difficulty accessing housing and community mental health services after discharge (Brackertz, Wilkinson and Davison 2018; NSW Ombudsman 2012).

Many Inquiry participants recognised the importance of improving transition out of institutional settings to prevent people being discharged into homelessness or eventually readmitted into these facilities.223

… we see the impact of housing instability and homelessness on people’s mental health treatment and recovery. This includes people being discharged from hospital into rooming houses or onto the streets, and the risk of readmission into hospital that this presents. (VLA, sub. 500, p. 17)

Clients who are mentally unwell and prematurely discharged from acute care facilities into inappropriate accommodation represent a risk for completed suicide or multiple presentations to ED … (ACP, sub. 522, p. 24)

Failed discharges increase the likelihood that people will end up back in hospital or other treatment settings. (MHV, sub. 580, att. 1, p. 31)

There are several examples of hospitals that have implemented programs that successfully avoid discharging people into homelessness (box 20.7). Some programs (such as Queensland’s Transitional Housing Teams) provide time-limited housing and thus are more costly, compared with other programs (such as the Royal Perth Hospital Homeless Team) that provide discharge planning and other supports. Successful programs tend have three key elements, including:

• staff are trained to identify at-risk patients

• care coordinators (such as case managers) make thorough discharge assessments, well ahead of discharge, and provide timely and assertive follow up after discharge

• people have ready access to transitional housing that meets their long-term recovery needs.

While jurisdictions have formal policies or guidelines that dictate discharge and transfer of care from hospitals and correctional facilities, many jurisdictions do not have a clear and explicit reference to prevent discharge into homelessness. For example, some jurisdictions told us that they have informal policies that no person should be discharged into homelessness, or that mental health inpatients who are discharged with no fixed address are offered basic hotel accommodation for three nights (State and Territory Governments Survey). Protocols and planning for people exiting hospital care are also often underdeveloped (Brackertz et al. 2020).

223 Adacas, sub. 493, p. 15; APS, sub. 543, p. 40; Beyond Blue, sub. 275, p. 31; breakthrough, sub. 112, pp. 10–11; CHF, sub. 646, p. 17; CHP, sub. 145; FARE, sub. 269, p. 20; FOCP, sub. 198, p. 4; Mental Health Commission of New South Wales, sub. 486, p. 23; MHCT, sub. 314, p. 39; Mission Australia, sub. 684, p. 3; NMHC, sub. 118, p. 10; Northern Territory Mental Health Coalition, sub. 430, p. 29; PPIMS, sub. 179, p. 9; VCOS, sub. 478, pp. 37–38.
Box 20.7  Programs preventing discharge into homelessness

**Transitional Housing Teams**

In 2005, Queensland established a Transitional Housing Team to provide time limited social housing and intensive support to clinically case managed patients with mental illness (Siskind et al. 2014). Participants entered the program upon discharge from an acute psychiatric inpatient unit or from the community. Staff trained the participants in living skills, such as cooking and shopping, provided crisis management and coordinated with other services.

Evaluation results showed that participants experienced significantly fewer inpatient bed days and improved living conditions. This reduced the average cost of health service use by about $38,600 per participant, and completely offset the $31,200 per participant cost of the program. As such, the program provided an estimated return on investment of about $1.24 per dollar invested (Siskind et al. 2014).

**Royal Perth Hospital Homeless Team**

The Royal Perth Hospital Homeless Team provides GP care, care coordination and discharge planning for patients who are homeless. The team is made up of a clinical lead, administration assistants, GPs, nurses and a caseworker.

An evaluation showed that contact with the team reduced emergency department presentations and mental health inpatient care (Gazey et al. 2019). Fewer patients also discharged themselves against medical advice. These improvements were estimated to reduce hospital use by about $8,400 per patient. Given the average cost of the program was about $5,100 per patient, this represented a return on investment of about $1.64 per dollar invested.

**Housing Support Workers**

In 2009, the National Partnership Agreement on Homelessness was established. One of the programs delivered under the agreement was the provision of Housing Support Workers who help people with severe and persistent mental illness who are either homeless or at risk of homelessness when discharged from a mental health inpatient unit.

Wood et al. (2016) estimated that this program reduced overall health costs by about $111,000 per person each year, largely as a result of fewer days in hospital and psychiatric care. These cost savings significantly outweighed the estimated cost of the program (about $12,700 per person, excluding housing costs). Therefore, the program delivered a positive return on investment of about $9 per dollar invested. Compared with other homeless prevention programs tested, this group delivered the largest cost savings and was most likely to retain their tenancies.

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Costs and savings inflated to 2019 dollars using CPI numbers for health, weighted average of eight capital cities (ABS 2020a).
Submissions discussed the need for formal, nationally consistent policies of no exits into homelessness.\textsuperscript{225}

Recommendations calling for a national commitment to ‘no exits’ from institutional care into homelessness for people with mental illness are fully supported by our organisation. (Uniting SA, sub. 807, p. 10)

Each State and Territory should commit to a nationally consistent formal policy of no exits into homelessness for people with mental illness who are discharged from institutional care, including hospitals and correctional facilities (action 20.2). Implementing this would require comprehensive mental health discharge plans linked to ongoing care coordination provided in the community where needed (chapter 15), and community services to meet the needs identified in the plans.

To ensure that State and Territories are working with service providers, State and Territories should monitor and report on discharging into homelessness under the next version of the NHHA agreement (action 20.2). This could require sharing of information between the relevant departments covering housing and homelessness, health and community services in each jurisdiction (Brackertz et al. 2020).

The Productivity Commission has estimated that the total cost of providing discharge support to help about 3000 people transition out of acute care and into suitable housing could be in the range of $15 million to $94 million each year (appendix K). This range reflects the fact that some people will need time-limited housing upon discharge from hospitals, whereas others may have access to housing and require relatively less expensive support to maintain it. However, programs such as these are likely to present an overall saving for taxpayers due to reduced use of health services, including hospital readmissions (box 20.7; Rudoler et al. 2018). Therefore, these programs could deliver an estimated net benefit of $10 million to $295 million each year (appendix K).

\section*{20.4 Responding to homelessness among people with mental illness}

Mental health is closely related to homelessness. As discussed in section 20.1, there is a two-way relationship with homelessness contributing to mental ill-health and vice versa.

Homelessness is not merely ‘rooflessness’. It includes a broader set of people, including those living in non-conventional accommodation (‘sleeping rough’), those living in short-term accommodation (such as shelters and hostels), and those staying with family and friends (‘couch surfing’) (AIHW 2019c).

\textsuperscript{225} CHF, sub. 646, p. 17; FOCP, sub. 758, p. 7; Launch Housing, sub. 764, p. 1; MHV, sub. 580, att. 1, p. 33; SAMHC, sub. 691, att. B, p. 4.
State and Territory Governments are generally responsible for providing or funding a range of homelessness services, including directly providing accommodation, tenancy support service, and other related services aimed at responding to or preventing homelessness, such as mental health, family violence, family or relationship, drug or alcohol counselling, legal and financial services (AIHW 2019o). This section examines the effectiveness of existing homelessness services to support people with mental ill-health, and identifies areas for improvement, such as meeting demand for these services, improving service coordination and implementing and scaling up Housing First initiatives.

Many homeless people experience mental ill-health

In Australia, there is a high prevalence of mental illness among the homeless population. Estimates of how many people are in this situation vary depending on the definition of homelessness and mental illness (Fazel et al. 2008; Fazel, Geddes and Kushel 2014), with some estimates of homeless people with mental illness being as low as 12% and others as high as 82% (Johnson and Chamberlain 2011). When substance use disorders are excluded, estimates generally cluster around one-third of the homeless population having mental illness (Flatau 2007; Hodder, Teesson and Buhrich 1998; Johnson and Chamberlain 2011; Rossiter et al. 2003).

Looking at the question in the other direction, it appears about 10–15% of people with mental illness are homeless (ABS 2016a; Culhane, Averyt and Hadley 1997; Folsom et al. 2005; Morgan et al. 2011), much higher than the 0.5% of the general population (ABS 2018a). Westoby (2016, cited in AHURI, sub. 885, p. 13) identified four typical cohorts of people with mental illness who are homeless, including people who:

- are homeless and do not receive mental health-related services
- are hospitalised and are not adequately supported when they are discharged from hospital back into the community
- are treated in a psychiatric facility in hospital and remain hospitalised without a discharge or exit strategy back into the community
- experience primary or secondary homelessness in substandard and insecure tenures and who struggle to manage their mental health.

The number of people with mental illness accessing homelessness services has almost doubled over the past seven years (figure 20.6). By 2018-19, about one-third of people (about 86 500 people) accessing these services experienced mental illness, considerably higher than one-fifth of the general population (chapter 2).
This increase in the reported prevalence of mental illness in the homeless population is likely not solely due to an actual increase in mental illness. Greater awareness and reduced stigma may improve identification and self-reporting of mental illness among homelessness service clients. Further, it might reflect improved accessibility or targeting of services. Regardless, as the number of people accessing homelessness services grows, it becomes even more important for services to be effective and efficient.

A variety of risk factors can contribute to homelessness, including mental illness, drug or alcohol abuse, physical health problems, domestic violence, inadequate family support, childhood abuse, neglect and disadvantage, unemployment, relationship breakdown, job loss and housing affordability issues (Australian Government 2008; CHP, sub. 145, p. 3; Ian Webster, sub. 626, p. 7). In many cases, mental illness coincides with one or more other risk factors. In 2018-19, over half of all homelessness service clients with mental ill-health also experienced domestic and family violence and/or problematic drug or alcohol use (AIHW 2019d).

Figure 20.6  **Number of people accessing homelessness services**\(^{a,b}\)

By mental health status\(^{c}\)

\[\text{Mental health issue} \quad \text{No mental health issue}\]

\[\text{19\%} \quad \text{30\%}\]

\[\text{2011-12} \quad \text{2012-13} \quad \text{2013-14} \quad \text{2014-15} \quad \text{2015-16} \quad \text{2016-17} \quad \text{2017-18} \quad \text{2018-19}\]

\(^{a}\) Includes people aged 10 years or older. \(^{b}\) Homeless status when first seeking assistance. ‘Homeless’ means the individual is living in no shelter, improvised dwelling, short-term temporary accommodation or couch surfing. ‘At risk’ means the individual is living in social housing, private housing or an institutional setting. \(^{c}\) The Australian Institute of Health and Welfare defines a person as having a current mental health issue if they received mental health services in the past 12 months, were referred by a mental health service, reported ‘mental health issues’ as a reason for seeking assistance, had been in a psychiatric hospital or unit in the past 12 months, or a need was identified for mental health services during their support period. Therefore, this is likely to be an underestimate of the proportion of people accessing homelessness services with mental ill-health.

*Source: AIHW (2019q).*
Some people are at higher risk of homelessness than others. In 2016, 1 in 28 Aboriginal and Torres Strait Islander people was homeless, and more than 1 in 5 homeless Australians were of Aboriginal and Torres Strait Islander descent (AIHW 2019a). NT Shelter (sub. 333, p. 1, sub. 879, p. 1) also noted that while Aboriginal and Torres Strait Islander people make up one-third of the Northern Territory’s population, they account for almost 90% of all homeless persons in the Territory. Evidence indicates that other groups at a higher risk of homelessness include men, people from regional and remote areas, LGBTIQ people and people from refugee and migrant backgrounds (CMY and MYAN, sub. 446, p. 16; Ian Webster, sub. 626, pp. 6–7; National LGBTI Health Alliance, sub. 888, p. 6).

What is the cost of homelessness?

Homelessness can be devastating for individuals and the people close to them. It can be traumatic and stressful, and can have broader effects on people’s mental and physical health, employment, education and productivity. Homelessness can also limit people’s ability to access mental health services.

Being homeless also limits people’s ability to access clinical mental health services. VCOSS members noted that in Victoria, clinical ‘catchment areas’ are assigned based on a person’s home address. If someone is homeless, they may not be assigned to any area. (VCOSS, sub. 478, p. 37)

Homelessness imposes significant costs on government services. In 2018-19, government expenditure on homelessness services across Australia was close to $1 billion, an average of approximately $3400 per person (SCRGSP 2020c). This was up from $777 million ($3000 per person) in 2014-15, reflecting increases in both the number of people accessing homeless services and the cost per person of providing homelessness services.

Mental ill-health increases the cost of delivering homelessness services. People with mental ill-health tend to use homelessness services more than people without mental ill-health. For example, specialist homelessness services clients with mental ill-health accessed a median 75 days of homelessness services, almost twice as many days as the general homeless population (44 days). People with mental ill-health were also more likely to be persistent users of homelessness services, returning to homelessness services 2.4 times each year, compared with 1.8 times for the general homeless population. (AIHW 2019p)

Homelessness also imposes costs on other government services, including health, justice and education and income support services. For example, the City of Port Philip (sub. 540, p. 7) provided the following case study:

Mr C is a man in his sixties who has been sleeping rough in the City for some time. … He has been assessed as having below average intelligence and went on to a Disability Support Pension due to a Psychological condition. He has been admitted to several emergency departments at different metropolitan hospitals over the past 2 years … He has had extensive involvement with Victoria Police since 1991 due to his antisocial behaviours and has been arrested over 30 times with convictions due to behavioural offences …
Zaretzky et al. (2013) estimated that the average client of homelessness services used $29,450 more in other government services than the population, on average, each year (2010-11 dollars). This included costs to health ($14,507), justice ($5,906), income support ($6,620), out-of-home care ($23,42) and evictions ($75). These costs can accumulate over a person’s lifetime and are likely to be greatest for young people. For example, Baldry et al. (2012) estimated the lifetime cost of homelessness to government services ranged from $900,000 to $5.5 million per person.

**Many homeless people with mental illness do not receive homelessness services**

Given the significant costs of homelessness and mental ill-health, and the interaction between the two, it is important that people with mental ill-health who are homeless are supported to find and maintain housing.

However, there is significant unmet demand for homelessness services, meaning that many people who require homelessness services cannot access them. In 2018-19, about 31,000 people with mental ill-health who were either homeless or at risk of homelessness had an unmet need for long-term housing across Australia (figure 20.7). Unmet need can vary greatly between jurisdictions, both in terms of overall numbers and the proportion of people. For example, the Northern Territory Mental Health Coalition (sub. 430, p. 23) and NT Shelter (sub. 879, p. 1) stated that unmet demand in the Northern Territory is twice as high as in other states.

Nevertheless, the number of housing places needed going forward is likely to be less than 31,000 places for two reasons. First, more than one service is sometimes recorded as being suitable for a client. Second, adopting recommendations to reduce the incidence of homelessness among people with mental ill-health (sections 20.2 and 20.3) can be expected to reduce the level of unmet demand for this cohort in the future. For example, assuming that supported housing (between 9,000 to 12,500 places) and housing for people discharged from hospitals (about 3,000 people) reduces the need for long-term housing, the unmet need would be closer to 15,000 to 19,000 people each year.

Inquiry participants have also noted the substantial housing shortfall. breakthru (sub. 112, p. 15) stated that one in four people are turned away from homelessness services. Shelter Tasmania (sub. 196, p. 2) noted:

The average number of daily unmet requests for assistance from homelessness services in 2017-18 increased to 28 requests (up from 25 unmet requests per day in the previous year, and 21 two years ago).
There is also evidence that not all clients of homelessness services achieve their goals, including having stable and secure accommodation. In 2018-19, over 60% of people with mental ill-health who were homeless when they began receiving support from homelessness services were still homeless by the end of that support (AIHW 2019p). Further, almost 15% of those who were housed, but at risk of homelessness when they began support became homeless by the end of the support. There was also little change in the non-housing outcomes of homelessness services in the short term. For example, after completing a period of support, the proportion of clients with mental ill-health who were employed increased by about two percentage points, and the proportion participating in education or training decreased by about half a percentage point (AIHW Specialist Homelessness Services Collection, unpublished data).

**Figure 20.7  Unmet need for selected services**

Number of homelessness service clients with a current mental health issue, 2018-19

<table>
<thead>
<tr>
<th>State</th>
<th>Long-term housing</th>
<th>Medium-term housing</th>
<th>Short-term housing</th>
<th>Mental health</th>
</tr>
</thead>
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<td>NSW</td>
<td>12000</td>
<td>10000</td>
<td>8000</td>
<td>6000</td>
</tr>
<tr>
<td>Vic</td>
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<td>12000</td>
<td>10000</td>
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<td>14000</td>
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<td>24000</td>
<td>22000</td>
<td>20000</td>
</tr>
</tbody>
</table>

*a ‘Unmet need’ means the person was identified as needing a service, but this service was not provided to them or they were not referred elsewhere. b Clients may have needs for more than one service. c The Australian Institute of Health and Welfare defines a person as having a current mental health issue if they received mental health services in the past 12 months, were referred by a mental health service, reported ‘mental health issues’ as a reason for seeking assistance, had been in a psychiatric hospital or unit in the past 12 months, or a need was identified for mental health services during their support period. Therefore, this is likely to be an underestimate of the proportion of people accessing homelessness services with mental ill-health.

Source: AIHW (Specialist Homelessness Services Collection, unpublished data).
Improving homelessness services

Responding to the needs of people with mental ill-health who are homeless will involve meeting the unmet demand for homelessness services by increasing the availability of housing (particularly longer-term housing), and improving the quality and integration of homelessness and mental health-related services for this cohort (discussed in section 20.5).

Addressing the unmet demand for homelessness services

As discussed above, the level of unmet need for homelessness services is estimated to be about 14,000 to 17,000 people. The cost of providing private rental accommodation or social housing for these people is estimated to be $278 million to $393 million each year (appendix K). That said, the final cost may be lower, given some people may have capacity to fund part of their housing costs. These costs do not include the cost of mental health services, which are considered more broadly throughout this report.

In addition, providing effective homelessness services reduces the cost of providing other services. It has been estimated that providing homelessness services reduces the costs of providing health, justice and income support services by about $10,600 per person for single women and $1,600 for single men (2019 dollars) (Zaretzky et al. 2013). The net cost to government is therefore expected to be $211 million to $261 million each year (appendix K). The savings could be particularly large if programs successfully target people with a diagnosed mental illness, because this cohort tends to have higher healthcare costs (Zaretzky et al. 2017).

To achieve these outcomes, the homelessness services provided need to be effective for people with mental illness. Conditions that require the person to be ‘housing ready’ before they can access housing, or that mandate eviction when rules are broken are particularly difficult for many people with severe mental illness. Nonetheless, there are services that have been shown to be effective in helping people with mental illness to maintain housing — Housing First services. In other words, while some homelessness services may fail to meet the needs of those with mental illness, services that are explicitly designed to meet the needs of those with mental illness can be successful.

Housing First for people with severe mental illness

Housing First programs have been shown to improve outcomes for people with severe mental illness who are persistently homeless, and are unlikely (or have failed) to respond positively to existing homelessness services that place strict conditions on housing. Housing First involves providing rapid access to long-term housing that is not conditional on participants becoming housing ready or engaging with support services. Once housing is secured, a multidisciplinary team of clinical and/or non-clinical support workers are available to provide mental health, tenancy support and other services. Unconditional housing is an important distinction. Relaxing the conditions to access and maintain housing gives people with mental
illness a better chance to remain housed. Housing First is likely to reduce the unmet need for homelessness services among this cohort (Johnson, Parkinson and Parsell 2012).

Programs that follow the Housing First model are effective at responding to homelessness among people with severe mental illness (table 20.2). Evaluations of programs have found that:

- most participants remain housed
- participants tended to reduce their need for other government services, particularly healthcare
- non-housing outcomes — such as mental health, employment and quality of life — tended to remain relatively stable, or slightly improve, in the short term (Baxter et al. 2019; Ly and Latimer 2015; Please 2016; Tsemberis 2010; Woodhall-Melnik and Dunn 2015).

That said, more evidence is needed to determine if longer-term outcomes improve and are sustained. Evaluations of Housing First programs tend to follow people for a few years to track their outcomes. This short time frame might explain why non-housing outcomes remain relatively stable. These programs primarily target chronic rough sleepers and people with very complex needs who are likely to take more time to recover and achieve their goals.

There have been several small-scale trials of Housing First programs in Australia that have successfully housed several hundred people with severe mental illness (table 20.2). In some cases, trials showed a small net cost or even a potential net benefit to these programs. Governments have an incentive to invest in programs that provide net benefits or small net costs by targeting the highest users of health and justice services, particularly if those programs deliver significantly improved outcomes for people.

Encouragingly, governments are moving in this direction, with more programs being implemented in Australia (table 20.2) and policies increasing including Housing First principles. For example, the Draft Western Australian Mental Health, Alcohol and Other Drug Accommodation and Support Strategy 2018–2025 supports a Housing First approach (WAMHC 2018b, p. 11, sub. 259). In addition, the Victorian Government (sub. 483, p. 26) noted that the Victorian Homelessness and Rough Sleeping Plan is underpinned by Housing First principles.

However, Inquiry participants have argued that some Housing First-related programs being implemented in Australia do not include all the elements of the successful overseas models (NMHC, sub. 118, p. 11). For Housing First interventions to be effective, these programs need to also include access to the non-housing supports people with severe mental illness require (One Door Mental Health, sub. 108, p. 14). The Queensland Mental Health Alliance (sub. 247, p. 13) stated:

One of our members [has] expressed that the Housing First approach will only be successful should adequate supports and services sit alongside the tenancy to ensure capacity building, independence, and financial management – for example paying rent and bills in a timely manner.
Table 20.2  Evaluation results of selected Housing First programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Location</th>
<th>People</th>
<th>Housing sustained (%)</th>
<th>Mental health</th>
<th>Quality of life</th>
<th>Health service use</th>
<th>Program cost&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Cost offsets&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Net cost (benefit)&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathways to Housing</td>
<td>USA</td>
<td>78</td>
<td>80</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>At Home/Chez Soi</td>
<td>Canada</td>
<td>1,158</td>
<td>62–84</td>
<td>↑</td>
<td>↓</td>
<td>CA$22,257</td>
<td>CA$21,375</td>
<td>CA$882</td>
<td></td>
</tr>
<tr>
<td>MISHA project</td>
<td>NSW</td>
<td>59</td>
<td>89–97</td>
<td>—</td>
<td>—</td>
<td>$13,683</td>
<td>$4,424</td>
<td>$9,260</td>
<td></td>
</tr>
<tr>
<td>Common Ground</td>
<td>NSW</td>
<td>52</td>
<td>&gt;63</td>
<td>↑</td>
<td>↑</td>
<td>$60,904</td>
<td>na</td>
<td>na</td>
<td></td>
</tr>
<tr>
<td>Way2Home</td>
<td>NSW</td>
<td>31</td>
<td>90</td>
<td>↑</td>
<td>↑</td>
<td>—</td>
<td>na</td>
<td>na</td>
<td></td>
</tr>
<tr>
<td>Common Ground</td>
<td>Qld</td>
<td>217</td>
<td>&gt;68</td>
<td>↑</td>
<td>↑</td>
<td>$14,329</td>
<td>$27,429 ($13,100)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Street to Home</td>
<td>Qld</td>
<td>42</td>
<td>95</td>
<td>↑</td>
<td>—</td>
<td>—</td>
<td>na</td>
<td>na</td>
<td></td>
</tr>
<tr>
<td>50 Lives 50 Homes</td>
<td>WA</td>
<td>147</td>
<td>88</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>$9,182</td>
<td>na</td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup> Average per person expressed as dollars in the years and countries in which the studies were evaluated.  
<sup>na</sup> Not available.  
Source: Bullen et al. (2015); Conroy et al. (2014); Gulcur et al. (2003); Johnson and Chamberlain (2015); Mental Health Commission of Canada (2014); Parsell et al. (2015); Parsell, Tomaszewski and Jones (2013b, 2013a); Tsemberis, Gulcur and Nakae (2004); Vallesi et al. (2018).

There is scope for governments to scale up trials of Housing First by increasing the availability of long-term housing set aside for Housing First programs. A lack of available long-term housing is a consistent theme throughout this chapter and a key barrier to providing rapid permanent housing to individuals targeted for a Housing First program (Bullen and Baldry 2018). This can be done through a mix of social housing, private rentals or headleasing a number of private rental properties (section 20.3). For example, the majority of housing in the At Home/Chez Soi program was provided through private rental units, and social housing was offered where available (Mental Health Commission of Canada 2014).

Many Inquiry participants argued for Housing First programs to be used to support homeless people with mental illness, and were supportive of State and Territory Governments scaling up Housing First programs. For example, the Queensland Mental Health Commission (sub. 712, p. 9) submitted:

… the QMHC agrees with the focus on a Housing First approach where safe and permanent housing is the first priority for people experiencing homelessness, with wrap-around support based on individual need.

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<sup>226</sup> Anglicare Australia, sub. 376, p. 32; APS, sub. 543, p. 7; Beyond Blue, sub. 275, p. 29; Launch Housing, Melbourne transcript, pp. 50–51; Mental Health Australia, sub. 864, p. 16; MHCC ACT, sub. 517, p. 21; Mind Australia Limited, sub. 380, p. 38; Private Mental Health Consumer Carer Network (Australia), sub. 49, p. 6; Tandem, sub. 502, p. 4, Melbourne transcript, p. 71; VCOSS, sub. 478, p. 37.
Scaling up Housing First programs provides the opportunity for governments to tailor programs to the most vulnerable cohorts at risk, potentially benefiting participants and increasing their rate of success. For example, the Council to Homeless Persons (sub. 145, p. 11) and Primary Mental Health Consumer Carer Network (sub. 49, p. 6) recommended that Housing First needs to be tailored to young people, the South Australian Mental Health Commission (sub. 691, att. B, p. 4) recommended it be tailored to women with children and older people, and the Northern Territory Mental Health Coalition (sub. 430, p. 24) identified the need for housing programs for Aboriginal and Torres Strait Islander people to be culturally capable.

The State and Territory Governments need to work towards meeting the gap for homelessness services among people with mental illness in their jurisdiction. This should include scaling up longer-term housing options such as Housing First programs (action 20.3).

20.5 Increasing the effectiveness of services and prioritising reforms

Housing and homeless services will not be effective in isolation

While housing and homelessness services are needed to help people to find and maintain housing, these services will have limited effectiveness for people with mental illness if they are not well integrated and coordinated with the other supports the person needs.

There is a need to integrate housing/homelessness services and mental health services, particularly for young people. Outside major metropolitan service areas, there are currently inadequate referral pathways and housing services staff are often unable to recognise the presentation of mental health issues until symptoms are quite severe. (Uniting Vic.Tas, sub. 95, p. 7)

Both housing and clinical services need appropriate resources to support people’s mental health, especially where people are facing both of these challenges. (Shelter Tasmania, sub. 196, p. 5)

Improving coordination of housing, homelessness and other services and improving information sharing will help ensure the effectiveness of housing and homelessness supports.

Improving coordination of services

Housing and homelessness services that are well coordinated with mental health and other services (such as drug and alcohol or family and domestic violence services) are more effective at supporting people who are homeless. Coordination becomes even more important for people who have severe and complex needs arising from their mental illness.

However, in many cases, the agencies providing these services work independently from each other. Several participants expressed a need to better coordinate or integrate housing, homelessness, mental health and other services (Beyond Blue, sub. 275; CHP, sub. 145; cohealth, sub. 231; Launch Housing, sub. 250; Wellways Australia, sub. 396). A failure to
coordinate is likely to mean each of the component services is less effective at supporting people who are homeless. Brackertz, Wilkinson and Davison (2018, p. 29) found that:

Analysis of state, territory and federal housing, homelessness and mental health policies shows that they are essentially separate systems with little integration … This contributes to poor housing and health outcomes for people with lived experience of mental ill health.

Coordination of services can be particularly difficult for people who remain homeless for long periods of time. Without a residential address, people’s ability to have a driver’s licence, open a bank account and receive income support payments is limited. Their access to clinical mental health services can also be reduced (VCOSS, sub. 478, p. 37).

The service eligibility criteria for step up/step downs [accommodation] require that a person has pre-existing accommodation or has secured accommodation in the community. Consequently, the services are not accessible to people who are homeless or who may have lost their accommodation during an extended hospital stay and are seeking to step down into community services. (OAGWA 2019, p. 23)

Care coordination has been shown to be an effective approach to service coordination that reduces homelessness and symptom severity for homeless people with severe mental illness (Brackertz, Fotheringham and Winter 2016; Coldwell and Bender 2007). This approach determines the optimal use of services for each individual, taking into account their circumstances and needs, to treat the person holistically. It involves someone who has responsibility for coordinating, facilitating and integrating the person’s service needs. In cases where individuals have particularly high needs, care coordination can encompass a multidisciplinary team, more intensive contacts and direct provision of services.

In Australia, there are some outreach programs that provide mental health and care coordination services for homeless people with severe mental illness, such as the Homeless Outreach Mental Health Service in Melbourne, which offers case management and mental health services to people with severe mental illness and a history of homelessness (cohealth, sub. 231, p. 16).

Chapter 15 recommends providing single care plans and care coordination services for people with moderate and severe mental illness who would benefit from these services. Care coordinators are well placed to work with these individuals and coordinate their homelessness, mental health and other services. Single care plans would also help ensure that the different services providers are communicating and have the information they need to provide integrated care.

Information sharing

Providing integrated, multidisciplinary, person-centred care requires information sharing between service providers. However, Inquiry participants raised concerns about a lack of information sharing leading to poor housing outcomes.

Prevention of people being discharged to no address. More support and information is required while people are admitted to avoid this. (breakthru, sub. 112, p. 11)
The need for effective information sharing across agencies and with support services is recognised as an important prerequisite for coordinated service delivery. Of course, all information sharing must comply with privacy requirements and several memoranda of understanding are in place to meet these requirements and support effective service delivery. (ACT Government, sub. 1241, p. 22)

An area where this has been identified as being a particular problem is people being evicted during a temporary absence due to a lack of information sharing between mental health services and social housing authorities (or rental agents). For example, an audit of the public housing system’s management of disruptive behaviour in Western Australia found that there was no formal information sharing arrangements between agencies and that current memoranda of understanding are out of date.

Staff are not routinely informed of the outcomes of referrals to mental health and child protection service providers for tenant support. This limits the [Department of Communities’] understanding and ability to effectively identify and help vulnerable tenants to succeed in public housing. (OAGWA 2018, p. 8)

Improving information sharing between people with mental ill-health, carers (where relevant), agencies and services providers will reduce the likelihood of poor housing outcomes such as evictions and being discharged from hospital with adequate housing. It will also help to ensure people receive coordinated care. The Productivity Commission has recommended ways to improve coordination across services through formal information sharing arrangements in single care plans and using care coordinators (chapter 15).

**Prioritising and costing reforms**

The Productivity Commission has made several recommendations to increase the capacity of housing and homelessness services to prevent people with mental ill-health from experiencing housing issues and support people with severe mental illness to find and remain in housing.

As a priority, State and Territory Governments, with support from the Australian Government, should improve the transition for people with mental illness out of hospital and correctional facilities. There is a clear economic benefit to supporting this cohort, who tend to be significant users of health services. Further, State and Territory Governments, with support from the Australian Government, should address the unmet demand for supported housing, long-term supported accommodation and homelessness services.

However, this is likely to take time. Therefore, governments should plan their approach for providing these services. This approach should prioritise providing transitional housing services for people with severe mental illness and who are homeless or at risk of homelessness. Evidence suggests that adequately housing this group can improve their quality of life and lead to significant reductions in costs elsewhere, such as health and justice services.
Overall, the Productivity Commission has estimated that implementing the range of recommendations presented in this chapter would require Australian, State and Territory Governments to increase estimated expenditure, in aggregate, by $740 million to $940 million each year (appendix K). A significant portion of this includes additional mental healthcare and psychosocial support services for people living in integrated supported housing and housing programs for people transitioning out of institutional care, while the remainder would be administered by the housing portfolio. While these investments should yield significant savings in acute healthcare (and other government services) that would be primarily captured by State and Territory Governments, it nevertheless involves a significant upfront increase in expenditure.

The Australian Government provides funding to State and Territory Governments to deliver housing and homelessness services according to the 2018 NHHA. This funding amounted to $1.7 billion in 2018-19 (COAG 2018b).

The Productivity Commission recommends that, as part of the next negotiation of the National Housing and Homelessness Agreement, governments should increase the quantum of funding for housing and homelessness services, with particular attention to expanding provision of housing and homelessness services for people with mental illness.

**ACTION 20.2 — NO DISCHARGE INTO HOMELESSNESS**

People with mental illness should be supported so that they are not discharged from hospitals, correctional facilities and institutional care into homelessness.

*Start now*

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

- Governments should ensure that people with mental illness who are discharged from hospitals, correctional facilities or institutional care receive a comprehensive mental health discharge plan, and have ready access to transitional housing, while services have the capacity to meet their needs. These programs should integrate care coordination and access to accommodation.

*Start later*

- As part of the next negotiation of the National Housing and Homelessness Agreement, a requirement should be included for State and Territory Governments to monitor and report on discharging into homelessness.
ACTION 20.3 — SUPPORT FOR PEOPLE TO FIND AND MAINTAIN HOUSING

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

Start now

- The National Disability Insurance Agency should continue to amend its Specialist Disability Accommodation strategy and policies to encourage development of long-term supported accommodation for National Disability Insurance Scheme recipients with severe and persistent mental illness. This should include lifting the restrictions of the number of people who can reside in newly developed Specialist Disability Accommodation, and providing more detail on how the NDIA will deal with liability problems concerning property damage.

- State and Territory Governments, working with housing support providers and with support from the Australian Government, should address the shortfall in the number of supported housing places for people with severe mental illness by providing a combination of long-term housing options for people with severe mental illness who require integrated housing and mental health supports.

- State and Territory Governments, with support from the Australian Government, should address the gap in homelessness services for people with mental illness, including scaling up longer-term housing options such as Housing First programs.
  - Housing First programs should target people who experience severe and complex mental illness, are persistently homeless, and are unlikely to respond to existing homelessness services.
  - This would require governments to invest in homelessness services that make long-term housing available specifically for these programs.

Start later

- As part of the next negotiation of the National Housing and Homelessness Agreement, governments should increase the quantum of funding for housing and homelessness services, with particular attention to expanding provision of housing and homelessness services for people with mental illness.
The justice system matters because ...

- People with mental illness are over-represented throughout the justice system, including in correctional facilities (where the majority are imprisoned for short sentences and often cycle in and out), and as victims of crime.
- They are more likely to experience legal problems (such as discrimination and housing issues), but often face barriers to resolving them.
- The justice system can contribute to improved mental health outcomes by diverting or connecting individuals to appropriate mental healthcare and ensuring they receive it.
- The justice system is responsible for ensuring people with mental illness have access to justice and services that address their legal needs.
People with mental illness are over-represented throughout the justice system, including in correctional facilities and as victims of crime. There is considerable scope for improved mental healthcare for people in all parts of the justice system, and improved access to justice for people with mental illness and legal needs.

As a priority:

- State and Territory Governments should implement a systematic approach for responding to mental health related incidents to support all parties involved. Mental health professionals should be embedded in police communication centres and police, mental health professionals and/or ambulance services should be able to co-respond to mental health related incidents. (Action 21.2)

- State and Territory Governments should ensure that people appearing before mental health tribunals, and other tribunals hearing matters arising from mental health legislation, have a right to access legal representation. To facilitate this, State and Territory Governments should adequately resource legal assistance services for this purpose. (Action 21.8)

Additional reforms for people in the justice system that should be considered:

- An early intervention approach should be introduced to identify people with mental illness at high risk of contact with the criminal justice system, and provide supports to reduce the risks of them offending. (Action 21.1)

- State and Territory Governments should work to ensure that people with mental illness who would benefit from mental health court diversion programs, are able to access them. (Action 21.3)

- The Australian Commission on Safety and Quality in Health Care should review the National Safety and Quality Service Standards to determine how they can be implemented in correctional settings. (Action 21.4)

- State and Territory Governments should ensure that people with mental illness in correctional facilities have access to timely and culturally capable mental healthcare. (Actions 21.4, 21.6)

- The forensic mental health component of the National Mental Health Service Planning Framework should be completed and used by governments to inform planning and funding. (Action 21.5)

Additional reforms to improve access to justice that should be considered:

- State and Territory Governments should develop disability justice strategies and work towards integrating legal and health services (including through health justice partnerships) so that people with mental illness are better supported to resolve legal matters and participate in the justice system. (Action 21.7)

- Supported decision making by and for people with mental illness should be promoted through improved access to individual non-legal advocacy services (Action 21.9) and mental health advance directives. (Action 21.10)

- Governments should ensure that treatment orders in mental health legislation are mutually recognised between States and Territories. (Action 21.11)
Interactions between the mental health and justice systems are important. People with mental illness are over-represented in the criminal justice system, and as victims of crime. They are also more likely to find themselves dealing with legal issues than the general population.

Mental illness and the justice system have a complicated relationship. Involvement with the justice system does not only mean people engaged in the criminal courts or who are incarcerated, but also includes people engaged with civil and family courts, police, and who are victims of crime. While most people with a mental illness, including those with major illnesses, do not commit crimes, people living with a mental illness are more likely to be involved within the justice system. (NMHC, sub. 949, p. 16)

The justice system is relevant to this Inquiry for two key reasons.

First, it can contribute to improved mental health outcomes, in particular, as interaction with the criminal justice system might be the first time a person can access mental healthcare. There are opportunities to connect people who interact with police, courts, corrective services and victim support services to mental healthcare and support. Correctional and forensic mental health facilities are also settings in which people receive mental healthcare. Although the criminal justice system has been subject to many inquiries, this Inquiry is different as it approaches the system through a mental health lens, in line with our terms of reference.

Second, the justice system can improve access to justice for people with mental illness. People with mental illness are more likely to experience legal problems, but face barriers accessing legal services, and initiating and participating in legal proceedings. Addressing these barriers can help people with mental illness resolve their legal problems.

This chapter focuses on how people with mental illness who make contact with the justice system can be better supported (the scope of the justice system and other key terms are defined in box 21.1). It analyses how people with mental illness:

- interact with the justice system (section 21.1) — the key ways in which people with mental illness can interact with the justice system, highlighting the important role the system can play in contributing to better outcomes for these individuals
- are connected to mental healthcare through the criminal justice system (section 21.2) — the extent to which the system acts as an effective gateway to mental healthcare for those engaged in offending behaviour and who are victims of crime, and the extent to which mental healthcare is available in correctional and forensic mental healthcare settings
- are able to gain access to justice (section 21.3) — the extent to which people with mental illness are able to resolve their legal problems and disputes, and the degree to which their ability to access justice is promoted and protected.

227 ALRC (2017a); Commissioner for Children and Young People Western Australia (2011); Forde, Thomason and Heilpern (1999); Johnston (1991); Office of the Inspector of Custodial Services (2018); SCARC (2016a); SCMH (2006); Victorian Ombudsman (2015).
### Box 21.1 Definitions of key terms

**Bail**: refers to when an individual who is charged with an offence is allowed to stay in the community, but required to attend court at a scheduled future date (Legal Aid NSW 2015).

**Correctional facility**: these facilities hold individuals under the responsibility of corrective services. They include government-operated prisons, privately-operated prisons, transitional centres and court cell complexes (SCRGSP 2019).

**Court diversion program**: a program that allows magistrates or judicial officers to adjourn matters while defendants engage in support services. Diversionary programs provide services for people who have been accused or convicted in the summary jurisdiction, who require assistance with addiction or mental health (ALRC 2017b).

**Criminal justice system**: the criminal justice system refers to the collection of interdependent agencies that deal with people suspected or convicted of criminal offences. It consists of the police and prosecution, criminal courts and correctional facilities, community corrections and probation and parole services (Daly and Sarre 2017).

**Diversion**: this term can have many meanings and is used inconsistently between jurisdictions. However, in this Inquiry it refers to identifiable stages in the criminal justice system at which interventions can effectively, proportionately and responsively be provided to an individual in contact with it (Freiberg et al. 2016, p. 57). This Inquiry does not use the term diversion to mean detours, deviations or cessation of legal proceedings.

**Forensic mental health services**: services providing assessment and treatment of people with mental illness and a history of criminal offending, or who are at risk of offending. They include services to support people found not guilty of an offence on the grounds of mental impairment and people with mental illness who offend or are at risk of offending (VIC DHHS 2014).

**Forensic patient**: an individual alleged to have committed a crime who is deemed unfit to plead, unfit to stand trial or not guilty on the grounds of mental impairment. As a result, a forensic or criminal mental health detention order is placed on them (SCARC 2016a).

**Justice system**: the collection of interdependent agencies including the police, prosecution legal teams, courts, community corrections, custodial corrective services, victim support services and defence legal teams that exist to uphold the rule of law, protect the rights of individuals and to ensure communities are safe and just. In Australia, State and Territory Governments are responsible for most policing and justice functions, with the exception of the ACT, where the Australian Federal Police conducts policing functions (Daly and Sarre 2017).

**Juvenile**: a juvenile is a person aged between 10 and 17 years of age who is subject to criminal justice proceedings (Richards 2011).

**Lower level offences**: these refer to low-level summary offences. Summary offences are dealt with in local courts, usually before a magistrate alone. They usually carry a penalty of less than two years imprisonment (Baldry 2014a).

**Mental health order**: refers to an order made by a mental health tribunal (or other tribunals that deal with matters under mental health legislation) that requires an individual to receive involuntary mental health treatment, either in the community, or in an inpatient mental health facility.

**Recidivism rate**: refers to the proportion of adults released from correctional facilities or community orders who returned to corrective services with a new correctional sanction within two years (SCRGSP 2019).

**Remand**: refers to individuals who are held in custody awaiting trial or sentencing (AIHW 2019r).
21.1 Interactions with the justice system

People with mental illness are over-represented in the criminal justice system

The majority of people with mental illness never make contact with the criminal justice system. As Forensicare notes:

Public perception of the interrelationship between mental illness and offending is disproportionate to the actual risks posed, with the majority of individuals living with mental illness never offending. Nevertheless, local and international evidence indicates that serious mental illness is a significant risk factor for offending. (Forensicare 2019, p. 4)

Nevertheless, people with mental illness are over-represented at all stages of the criminal justice system (box 21.2). Prevalence rates appear to vary between states and territories, although the data is not directly comparable (table 21.1).

Table 21.1 Prevalence of mental illness among people in correctional facilities\(^a\)

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Estimated prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>63% had a previous diagnosis of mental illness(^b)</td>
</tr>
<tr>
<td>Victoria</td>
<td>37% were allocated a psychiatric risk rating at reception assessment(^c)</td>
</tr>
<tr>
<td>Queensland</td>
<td>39% had a previous diagnosis of mental illness</td>
</tr>
<tr>
<td>South Australia</td>
<td>45% of people discharged from prison identified receiving mental health services(^d)</td>
</tr>
<tr>
<td>Western Australia</td>
<td>25% had a previous diagnosis of mental illness</td>
</tr>
<tr>
<td>ACT, Northern Territory, Tasmania</td>
<td>Reliable data was unavailable</td>
</tr>
<tr>
<td><strong>Australia</strong></td>
<td>40% of prison entrants had previously been told they had mental illness(^e)</td>
</tr>
</tbody>
</table>

\(^a\) Small sample sizes and different methods to estimate prevalence limit robust comparisons between jurisdictions. For example, Tasmania, the Northern Territory and the ACT each had fewer than 50 people surveyed (AIHW 2019r).  \(^b\) 2018-19, \(^c\) 2017-18, \(^d\) 2016-17.  \(^e\) Excludes New South Wales, which did not provide data.

Source: AIHW (2019r); JHFMHN (2019); State and Territory Governments Survey; Victorian Government, sub. 483.
Box 21.2 People with mental illness are over-represented across all stages of the criminal justice system

Police custody and courts

There is a high prevalence of mental illness among people whom police have arrested and detained at police stations (police detainees). For example, a national study of police detainees found that 43% of men and 55% of women reported a previously diagnosed mental illness Baksheev et al. (2010) found 76% of detainees from two Melbourne police stations met the criteria for mental illness.

Comparable prevalence is observed in courts. A New South Wales study found that 55% of court defendants had one or more psychiatric disorders (NSW LRC 2012). Similarly, over 50% of court defendants at a Western Australian Magistrates Court had mental illness (Baldry 2014b).

Correctional facilities

In 2018, about 40% of prison entrants had been told at some stage in their life that they have a mental illness (including substance use disorders) (AIHW 2019r). This proportion is much higher than that estimated for the general population aged 18 years and over (22%) (2018b), although data is not directly comparable.¹

New South Wales data shows depression as the most common diagnosis, for both men and women at 36% and 61%, respectively (JHFMHN 2017a). This is followed by anxiety disorders and drug abuse and dependence.

People in detention awaiting trial or sentencing

The prevalence of mental illness among people in detention awaiting trial or sentencing (remanded in custody) is estimated to be higher than for those sentenced (Ogloff et al. 2007). In New South Wales, for example, at least half of those remanded in custody are estimated to have some form of mental illness and/or cognitive disability (Baldry 2014b). Moreover, this is a growing population and has been increasing as a proportion of the incarcerated population (ABS 2018c).

¹ Estimates of prevalence of mental illness among the general population and prison population are not directly comparable because they are obtained from different surveys, which ask different questions to derive prevalence estimates and have different survey samples.

Prevalence of mental illness is higher among some demographic groups

For people held in correctional facilities, the prevalence of mental illness is higher among some demographic groups.

- Women entering prison are far more likely to report a history of mental illness than men (figure 21.1). In 2018, 35% of imprisoned men reported having a previous diagnosis of mental illness compared with 65% of women (AIHW 2019r). This disparity has persisted over decades (AIHW 2010; New South Wales Corrections Health Service 1997).

- Young people in juvenile detention centres have higher rates of mental illness compared to adults in correctional facilities. The latest New South Wales juvenile health survey found about 83% of young people met the threshold for at least one psychological
disorder (JHFMHN 2017b). The Victorian Youth Parole Board (2019) annual survey reported that about 48% of young people presented with mental health problems.

- Aboriginal and Torres Strait Islander people make up about 2% of the adult population, yet represent 27% of the national adult prison population (ALRC 2017a). In the youth justice system, young Aboriginal and Torres Strait Islander people represented between 55–62% of those in detention between June 2015 and 2019, but accounted for only 6% of the general population aged 10–17 years (AIHW 2019s). Despite having lower self-reported rates of mental illness relative to non-Indigenous people (33% compared to 44%, respectively) (AIHW 2019r), the literature shows prevalence among incarcerated Aboriginal and Torres Strait Islander people is 70% to 90% (Heffernan et al. 2012; Ogloff et al. 2013).

**Figure 21.1 Estimated prevalence of mental illness in the general population and among prison entrants by gender, 2018a,b**

![Graph showing estimated prevalence of mental illness in the general population and among prison entrants by gender, 2018](image)

a ABS general population data estimates prevalence based on the number of people reporting they had a current and long-term mental and behavioural condition. Prison entrants data estimates prevalence based on the number of people who had ever been told they had a mental health condition. b Data for the general population are not directly comparable to data for prison entrants.

Source: ABS (National Health Survey 2017-18, Cat. no. 4364.0); AIHW (2019r).

Studies by Heffernan et al. (2012) and Ogloff et al. (2013) used diagnostic or clinical assessment tools making them more reliable relative to self-reported surveys. Self-reported surveys can underestimate prevalence among Aboriginal and Torres Strait Islander people due to a lack of recognition of disorders and because of cultural bias (McCausland, McEntyre and Baldry 2017).
Overall, there is limited data on the prevalence of mental illness among individuals who make contact with the criminal justice system (box 21.3). This limits the extent to which research and analysis are able to support the development and improvement of services to support these people. There is scope to improve data collection as referred to in box 21.3, which the Productivity Commission supports.

Box 21.3 Data availability

There was limited data available for estimating the proportion of people with mental illness across all stages of the criminal justice system across all states and territories. Further, there is a lack of national data oversight in this area. The AIHW have partly addressed this gap with its prisoner health survey (the first form of national oversight), but not all states and territories consistently participate in the survey.

National data is even more scant for young people involved in the justice system (AIHW 2018c). There is no national set of standards to ensure this type of data is available and consistent across jurisdictions. Although some states (New South Wales and Victoria) conduct annual surveys of their youth justice populations, most do not. AIHW (2018c) recommended the development of a national data collection on the health of young people in the justice system, but ongoing support and funding for this collection has not been confirmed.

Individuals often have complex needs

People with mental illness in contact with the criminal justice system tend to have complex needs, including substance use comorbidities and cognitive and intellectual disabilities (Baldry et al. 2015).

- Substance use comorbidities are common among people in correctional facilities. Prevalence of co-occurring mental and substance use disorders was 29% and was significantly higher among women (46%) than men (25%) (Butler et al. 2011). Of the Aboriginal and Torres Strait Islander people in prison with mental illness, 77% also had a substance use disorder (Baldry et al. 2015).

- A high proportion of people in prison have cognitive and intellectual disabilities, and mental illness — of those with an intellectual disability, 68% also had mental illness or a substance use disorder (Baldry et al. 2015). Of the Aboriginal and Torres Strait Islander people in prison with mental illness, 36% also had a cognitive disability (Baldry et al. 2015).

Comorbidities and multiple diagnoses are prevalent among young people in juvenile custody as well. In New South Wales, about 80% of young people reported weekly use of illicit drugs and 96% reported hazardous and/or harmful levels of alcohol consumption (JHFMHN 2019). In addition, 59% had attention or behavioural disorders and 17% had an IQ in the intellectual disability range. In Victoria, 54% of young people had a history of alcohol and drug misuse, 38% had cognitive difficulties affecting daily functioning and 12% were registered with disability services (VIC DJCS 2019).
Many are sentenced with lower level offences and cycle in and out of correctional facilities over long periods of time.

The majority of people with mental illness in prisons have been sentenced with lower level offences (Baldry 2017), such as non-violent property damage and theft (figure 21.2) (Forsythe and Gaffney 2012; OPA Victoria 2012).

Many people cycle in and out of correctional facilities, over long time periods. Baldry (2017, p. 2) found that the majority of people ‘cycling in and out’ of prison are from severely disadvantaged backgrounds with serious mental health and disability concerns. However, there are mixed conclusions about whether recidivism rates are higher for people with mental illness, compared to those without (Bonta et al. 1998; Dias et al. 2018; Smith and Trimboli 2010).

**Figure 21.2  Offence types for participants in the Independent Third Person program**

*Victoria, 2005 to 2010*

<table>
<thead>
<tr>
<th>Offence Type</th>
<th>Number of Offences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theft</td>
<td>1200</td>
</tr>
<tr>
<td>Drugs</td>
<td>800</td>
</tr>
<tr>
<td>Property damage</td>
<td>400</td>
</tr>
<tr>
<td>Rape/sexual assault</td>
<td>200</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>100</td>
</tr>
<tr>
<td>Crimes against persons</td>
<td>50</td>
</tr>
<tr>
<td>Justice procedures</td>
<td>20</td>
</tr>
<tr>
<td>Weapons/arson</td>
<td>10</td>
</tr>
<tr>
<td>Public order</td>
<td>5</td>
</tr>
<tr>
<td>Homicide</td>
<td>2</td>
</tr>
</tbody>
</table>

*a The program assisted people with cognitive impairments and/or mental illness in police interviews.

Source: OPA Victoria (2012).

There is no simple correlation between mental illness and offending behaviour.

The over-representation of people with mental illness in the criminal justice system is complex and multi-factored, with no simple correlation between mental illness and offending behaviour, although mental illness can form part of the background to offending (NSW LRC 2012). However, some other drivers include: deinstitutionalisation without...
community supports, increased substance use, inadequate community mental health services and social determinants (box 21.4).

**Box 21.4**  **There are multiple factors behind the over-representation of people with mental illness in the criminal justice system**

Deinstitutionalisation (the closure of mental health facilities such as asylums) is a widely cited reason for why people with mental illness are over-represented in the criminal justice system. Commentators believe that deinstitutionalisation was not adequately accompanied by more community-based mental health services (Human Rights Watch 2018; NSW LRC 2012).

Increased use of illicit substances is another reason (Butler and Allnut 2003). Consequences include increased drug-related mental illness (mainly associated with cannabis and amphetamine dependency) and increased comorbidities (Ogloff et al. 2007). There is evidence that people with substance use comorbidities are at an increased risk of offending compared to those diagnosed with a non-substance mental illness alone (Smith and Trimboli 2010).

The limited capacity of mental health services to address the complex needs of this cohort is another reason. Community-based mental health services often work best for those who have reasonable support networks in the community. However, this group is often poorly integrated into the community, with poor access to a range of support services including housing support (Ogloff et al. 2007). Related factors include a lack of adequate diversionary options in the community, inadequate specialist community forensic psychiatric services and a high threshold for admission to appropriate mental health facilities (Butler and Allnut 2003).

Social determinants can also increase the risk of offending behaviour. Risk factors can include disrupted family backgrounds, family violence, abuse, unstable housing, economic insecurity, healthcare inequalities, isolation, a lack of social support, and structural stigma and discrimination (ALRC 2017a; Baldry et al. 2015; NSW LRC 2012). People with mental illness are often more likely to experience these risk factors, and their mental illness can be a significant reason why they experience them in the first place (QAI, sub. 889).

For Aboriginal and Torres Strait Islander people, inter-generational trauma, dispossession and displacement from traditional lands, weakening of culture, the separation of families through past government policies, and discrimination and racism have contributed to disadvantage, poor health and poor social outcomes. The majority of Aboriginal and Torres Strait Islander women in prison have experienced physical and sexual violence, and trauma (ALRC 2017a).

**Estimating attributable costs**

Commentators argue that the criminal justice system is costly and ineffective, given the high recidivism rates (ALRC 2017a; Jesuit Social Services 2014). Australia spends approximately $4.9 billion per year to house people in prisons (SCRGSP 2020a). Expenditure on police ($12.4 billion) and magistrates’ courts ($506 million) were also significant in 2018-19 (SCRGSP 2020a).
The direct costs of managing people with mental illness in the criminal justice system are difficult to determine (NSW MHC 2017). The Productivity Commission has used prevalence data to derive the relative likelihood of being sentenced to prison, given the state of an individual’s mental health. This was used to estimate expenditure by the criminal justice system that can be attributed to mental illness, which is about $1.1 billion per year (appendix H).

There are also indirect costs associated with imprisonment, particularly for the individual and their families. This includes disrupted housing and employment situations, which may be more complex for people with mental illness who often face additional stigma and disadvantage upon return to the community from prison (Baker 2014).

High rates of mental illness among victims of crime

People with mental illness are more likely to be victims of crime than perpetrators (Baksheev et al. 2013; OPI 2012). Rates of mental illness are higher among victims of crime compared to the general population (figure 21.3). Teplin et al. (2005) found that people with severe mental illness were about 11 times more likely to be a victim of crime compared to the general population. Moreover, this likelihood increases in line with the severity of mental illness, with people with severe and persistent mental illness even more likely to be victims of crime (Dowse et al. 2016). However, these studies did not determine if individuals had mental illness before, or as a result of, becoming a victim of crime — they only compared rates of prevalence or incidence. The odds of becoming a victim increased for specific groups of victims with mental illness, including those who were homeless, had a history of substance use and had poorer social and occupational function (Chapple et al. 2004).

Perpetrators with mental illness are also more likely to have been victims of crime. New South Wales data shows that 85% of offenders with mental illness and cognitive disabilities have experienced at least one instance of victimisation (becoming a victim) and over half (65%) have been the victim of violent crime (Dowse et al. 2016).

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229 This is likely to be an underestimate as it does not include expenditure on juvenile justice, courts, individuals held in forensic mental health facilities, or individuals held in police custody.
Legal issues are more common for people with mental illness

People living with mental illness are more likely to find themselves dealing with legal issues than the general population. In 2012, people with disability (physical or mental) were more than twice as likely to experience legal problems (Coumarelos et al. 2012). Of those with a physical or mental disability, 61% had experienced legal problems, compared with 47% of those who did not report any disability. Further, many often faced multiple legal problems.

Legal issues faced by people with mental illness often reflect their financial and social disadvantage, and the incapacity that may be caused by their illness (Karras et al. 2006). These include: legal issues relating to mental illness (such as those under mental health acts and adult guardianship issues); discrimination in relation to employment, education and insurance; housing issues; social security issues; or domestic violence. Individuals with mental and physical disabilities are relatively more vulnerable to experiencing legal issues across many different areas, including financial issues related to credit or debt (Coumarelos et al. 2012).

The over-representation of people with mental illness in the criminal justice system (as people who offend and as victims of crime) and higher likelihood of experiencing legal problems highlights the need for the justice and mental health systems to work together. There is potential for the justice system to: connect people to mental healthcare to obtain better outcomes, in particular, recognition of mental health problems for individuals...
involved in the criminal justice system (for example, through court diversion programs) (section 21.2); and to ensure people gain access to justice (section 21.3).

21.2 Connecting people in contact with the criminal justice system to mental healthcare

A person’s contact with the criminal justice system presents opportunities to improve their mental health, and to reduce the risks of future contact. Globally, governments are turning their attention to initiatives that intervene in earlier stages of the criminal justice system, to make sure people receive the mental healthcare they need, and to reduce the risk of incarceration later on.

For people with mental disorders who have been charged with committing minor offences, the introduction of mechanisms to divert them towards mental health services before they reach prison will help to ensure that they receive the treatment they need and also contribute to reducing the prison population. (WHO and ICRC 2018, p. 3)

In Australia, the focus is on pre-court responses, court diversion programs and mental healthcare in correctional facilities and forensic mental health facilities.

Pre-court responses

Investing in early intervention

Early intervention initiatives that target risk factors, such as unstable housing and isolation (box 21.4), can provide mental healthcare and other social support to individuals with high risks of offending.

Ideally, an early intervention approach, where people with cognitive and/or psychiatric impairment are identified and given appropriate supports, is a more preferable pathway and outcome than attempting to divert a person once they have been charged, are subject to forensic orders or are in prison. (SCARC 2016a, p. 117)

Early intervention initiatives can improve outcomes for individuals and be more cost-effective than imprisonment. McCausland et al. (2013) found that for early intervention initiatives in New South Wales, each dollar spent resulted in savings of between $1.40 and $2.40 in the longer term.

Evidence suggests programs targeting high-risk populations early in life are most effective (NZ OPMCSA 2018, p. 13). For example, a longitudinal evaluation of a US program supporting intellectual and social development for preschool children from disadvantaged backgrounds showed offending was significantly lower for program participants. It estimated that the program saved $7 for every $1 spent by the time participants were aged 27 years, and $16 for every $1 by age 40 years (NZ OPMCSA 2018, p. 13; Parks 2000). An
evaluation of a Canadian mental health program for children with identified behaviour problems saw an 18–33% reduction in offences (Farrington and Koegl 2015).

State and Territory Governments are investing in early intervention initiatives to mitigate risks of offending behaviour. Broadly, initiatives can be categorised into two groups: those that are relatively less targeted, assisting vulnerable groups in general; and those that are more targeted, aiming to support groups identified as being at higher risk of offending. The New South Wales Government’s Their Futures Matter reform is an example of the former. It aims to provide wrap-around care to vulnerable children, young people and families. However, one of its initiatives (A Place to Go) is more targeted, focusing on those in contact with the juvenile justice system — aiming to improve their wellbeing and decrease the likelihood of offending (NSW TFM 2018). The Youth on Track program is another example of a more targeted approach. It targets people aged 10-17 years, who have a medium to high risk of long-term contact with the criminal justice system (and often have already had formal contact). It aims to reduce further contact, by offering coordinated support to them and their families, including mental healthcare (CIRCA 2017; NSW MHC 2017).

Another approach that has emerged locally and internationally is ‘justice reinvestment’. Justice reinvestment first began in the United States, after recognition that many people who offend come from, and return to, a small number of communities (SLCA 2013). It is:

… a data-driven approach to reduce corrections and related criminal justice spending and reinvest savings in strategies designed to increase public safety. The purpose of justice reinvestment is to manage and allocate criminal justice populations more cost effectively, generating savings that can be reinvested in evidence-based strategies that increase public safety while holding offenders accountable. (Willis and Kapira 2018, p. 2)

There is no one settled definition of justice reinvestment, as different approaches have emerged across countries. In Australia, justice reinvestment is focused on reducing crime and strengthening communities. It has typically involved funding programs tailored to specific communities, particularly Aboriginal and Torres Strait Islander communities, to address factors contributing to crime. This often includes treatment programs to address mental illness and substance use.

Justice reinvestment has gained much support in Australia with several projects in operation (Willis and Kapira 2018). A relatively established one is the Maranguka Justice Reinvestment project in Bourke, New South Wales (Just Reinvest NSW 2019). Data showed an 18% reduction in major offences reported and an 8% reduction in reoffending within 12 months of release between 2015 and 2017 (Just Reinvest NSW, sub. 440). However, it is not yet known whether these outcomes are attributable to the project (KPMG 2018b).

Despite developments in the evidence base for early intervention initiatives, clear evidence on what works to reduce offending and imprisonment remains limited, in particular, for Aboriginal and Torres Strait Islander people — a challenge faced by justice reinvestment approaches in Australia (Willis and Kapira 2018). A justice reinvestment approach is dependent on the specific programs implemented being successful and require: cross-sector
support; an understanding of past and projected trends for the custodial population (including factors contributing to offending); and analysis to determine the communities that are disproportionally contributing to the growth in criminal justice populations. All of this requires government support to achieve.

The National Mental Health Commission (sub. 949, p. 16) said that ‘early intervention and prevention initiatives such as justice reinvestment … [are] reform areas of greatest potential’. State and Territory Governments should support an early intervention approach to address the over-representation of people with mental illness in the criminal justice system. Given that many in this cohort come from disadvantaged backgrounds, any approach should be holistic, addressing the multiple social determinants associated with an individual’s mental illness and risks of offending. State and Territory Governments should trial early intervention initiatives, and ensure frameworks are in place to promote associated evaluation and research, to build an evidence base around what programs work in reducing offending.

**ACTION 21.1 — EARLY INTERVENTION IN THE CRIMINAL JUSTICE SYSTEM**

An early intervention approach is needed to address the over-representation of people with mental illness across all stages of the criminal justice system.

*Start now*

State and Territory Governments should support an early intervention approach that would ensure people who are at high risk of coming into contact with the criminal justice system are identified, and provided appropriate support, such as mental healthcare and housing, to reduce their risk of offending.

In doing so, State and Territory Governments should continue trialling early intervention initiatives, such as the *Youth on Track* program, and ensure associated evaluation and research is undertaken to build an evidence base about specific programs that are effective in reducing offending.

A systematic approach to support police interaction with people with mental illness

Police and other emergency workers (chapter 13) often respond to people experiencing a mental health problem. The Police Federation of Australia (sub. 761, p. 2) said:

… policing services are one of the only services readily available on a 24/7 basis and … are often the first, and quite often, particularly in regional and remote locations, the only responders and then find themselves transporting and/or guarding such persons [with mental illness] in hospitals or other facilities.

Police also face increased risks of developing mental health problems, as they are more likely to be exposed to regular trauma (chapter 7).
All states and territories have mental health legislation that authorises police to apprehend people who appear to have mental illness, and transport them to appropriate treatment facilities. These interactions take up a significant — and increasing — amount of police time. In part, this is because police who transport individuals to hospitals, often must wait with them until they are assessed (Henry and Rajakaruna 2018). In 2018, New South Wales police completed about 14 700 orders under section 22 of the Mental Health Act 2007 (NSW) (State and Territory Governments Survey). Such interactions have been estimated to account for about 10% of police time (NSW LRC 2012). In Victoria, police facilitated about 14 000 ‘mental health transfers’ to hospital in 2017-18. The number of psychiatric-related events attended by police increased 88% from 2014-15 to 2017-18 (Victoria Police 2019). In Western Australia, police responses involving a mental health element increased from 4766 in 2007 to 18 902 in 2015 (Henry and Rajakaruna 2018). In South Australia, police attended 1130 mental health-related incidents that required transportation to hospitals, in 2018 (State and Territory Governments Survey).

Police are typically not mental health clinicians, so cannot adequately ‘triage’ people to appropriate mental healthcare. Broadly, police have three options to respond to mental health-related incidents:

- transport the individuals to emergency departments
- if an offence has been committed, progress the matter to the next stage of the criminal justice system
- handle the matter informally (Godfredson et al. 2010).

Crisis assessment and treatment services (chapter 13) exist to respond to mental health crises, but have been criticised for major time lags between when police initially respond and when those services arrive on site (Henry and Rajakaruna 2018). Further, and quite reasonably, crisis assessment and treatment teams are often reluctant to attend situations where there are concerns about risks to their health and safety (SCMH 2006).

Recognising this, most State and Territory Governments have implemented initiatives to better support police responding to mental health-related incidents (table 21.2). These generally fall into two categories (Puntis et al. 2018):

- ‘crisis intervention teams’ comprising police who receive mental health training
- ‘co-response models’ whereby mental health professionals and/or ambulance services directly assist police (Henry and Rajakaruna 2018), although variations of co-response models exist (box 21.5).

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230 Under the Act, a police officer may apprehend a person who appears to have a mental illness and take them to a declared mental health facility if: the person is committing or has recently committed an offence, it is probable that the person will attempt to cause harm to themselves or others, or it is beneficial to the person’s welfare.
### Table 21.2  Examples of programs to support police responding to mental health-related incidents

<table>
<thead>
<tr>
<th>Program name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td><strong>Mental Health Intervention Team</strong>&lt;br&gt;A unit of specially trained police officers responding to mental health-related tasks and providing mental health training to others in the agency</td>
</tr>
<tr>
<td></td>
<td><strong>Police Ambulance Clinician Early Response Program</strong>&lt;br&gt;A dedicated mental health clinician conducting assessments in the early stages of police responses to mental health crises. This program is currently subject to a six month trial</td>
</tr>
<tr>
<td>Victoria</td>
<td><strong>Police Ambulance and Clinical Early Response</strong>&lt;br&gt;A police officer and a mental health clinician attend mental health-related police tasks as secondary responders</td>
</tr>
<tr>
<td>Queensland</td>
<td><strong>Police Communications Centre Mental Health Liaison</strong>&lt;br&gt;Mental health clinicians are co-located in the Police Communications Centre. There are two full time clinical positions, supported by an on-call forensic psychiatrist</td>
</tr>
<tr>
<td></td>
<td><strong>Mental Health Co-responders program</strong>&lt;br&gt;Mental health staff accompany police and provide on-site clinical interventions</td>
</tr>
<tr>
<td></td>
<td><strong>Mental Health Intervention Project</strong>&lt;br&gt;A partnership between Queensland Police, Health and Ambulance Service to identify issues, discuss complex cases and develop preventative interventions, alternative referral pathways and review procedures</td>
</tr>
<tr>
<td>South Australia^a</td>
<td>na</td>
</tr>
<tr>
<td>Western Australia</td>
<td><strong>Police Mental Health Co-Response Team</strong>&lt;br&gt;A multiple staged co-response model which involves the placement of mental health practitioners in:&lt;br&gt;• the Police Operations Centre facilitating access to advice, consultation, risk assessment and crisis management&lt;br&gt;• District based mobile co-response teams&lt;br&gt;• in the Perth Police Watch House</td>
</tr>
<tr>
<td>Tasmania</td>
<td><strong>Mental Health Officers</strong>&lt;br&gt;Mental Health Officers liaise with police and mental health services in the community, and provide advice to police officers and the executive on policy and strategy</td>
</tr>
<tr>
<td>Northern Territory^a</td>
<td>na</td>
</tr>
<tr>
<td>ACT</td>
<td><strong>Mental Health Community Policing Initiative</strong>&lt;br&gt;Training is provided to frontline officers to help them understand how to recognise, relate and respond to incidents involving mental health consumers. Mental Health clinicians are also embedded into Police Operations Centres</td>
</tr>
<tr>
<td></td>
<td><strong>Police, Ambulance and Clinician Early Response</strong>&lt;br&gt;A proof of concept of the Mental Health Community Policing Initiative, which supports a tri-service response from police, ambulance and mental health clinicians</td>
</tr>
</tbody>
</table>

^a The South Australian and the Northern Territory Governments currently do not fund specific programs supporting police to respond to mental health-related incidents. na Not available.

*Source: ACT Policing (2019); Henry and Rajakaruna (2018); NSW Government, sub. 551; QFMHS (2016); Queensland Government (2018a); Tasmania Police (2019).*
Box 21.5  **Wide variation in co-response models**

There is wide variation in the implementation of co-response models. A systematic review identified 19 models that differed according to:

- operating times and days per week
- whether or not the co-response unit was a first or second response option
- whether the police officer and mental health worker were co-located
- whether a mobile mental healthcare unit was dispatched or not
- mode of transportation to the incident (marked or unmarked vehicle).

The study acknowledged that differences are likely due to local context and need.

This wide variation in co-response models should be recognised, as the name itself may suggest that it as a single model, where in practice they are not.


These initiatives are complementary (some states have implemented both) and evaluations of both types showed benefits. Crisis intervention teams were found to help police engage and work better with people with mental illness (Herrington and Pope 2014). Submissions emphasised the need for police to receive appropriate mental health training, including mental health first aid and de-escalation techniques (CHF, sub. 646; QAI, sub. 889; RANZCP, sub. 1200). The Mental Health Legal Centre (sub. 1222, pp. 11–12) said:

… police officers will inevitably come across people experiencing mental illness in their day to day policing work … [therefore] training about mental illness and how to respond to people experiencing it should be a core part of the education and training of officers.

Police training needs to be relevant to their role. In practice, this includes training related to mental health literacy, the Mental Health Act and how to respond to critical incidents involving people with mental illness. For example, Victoria Police (2019) said a key priority for them is equipping police with the knowledge and skills to deliver appropriately tailored policing responses and services to people experiencing mental health problems.

Co-response models have showed benefits in terms of resource allocation, safety and wellbeing of police and individuals whom police respond to, and greater inter-agency collaboration. For example, they can lead to fewer people being transported to emergency departments, because accompanying mental health professionals are able to effectively triage them and refer them onto appropriate mental healthcare. Evaluations showed transportation to emergency departments were between 27% and 63% lower under co-response models (Allen Consulting 2012; Henry and Rajakaruna 2018; Scott 2000). Police time is also saved. The Allen Consulting Group (2012) estimated that 2.8 hours spent by police per case (without the intervention) could be reduced to 0.7 hours per case (with the intervention).

Some State Governments have trialled and implemented more systematic co-response approaches, with mental health expertise incorporated at multiple stages of police response (box 21.6). This includes having mental health professionals located in police call centres.
and as part of co-response teams attending incidents on the ground. A systematic approach can support more efficient use of limited resources (health, police and ambulance services). For example, if mental health professionals are located in police communication centres, they can have state-wide oversight of all mental health-related cases, enabling them to prioritise calls for co-responders to respond to on the ground.

State and Territory Governments have also developed their own memoranda of understanding and other protocols between police, mental health services and ambulance services (PFA, sub. 761). These provide a systematic framework for managing people with mental illness, where different agencies are involved. This includes defining roles and responsibilities, and outlining inter-agency operational protocols (Herrington et al. 2009; NSW LRC 2012). For example, the memorandum of understanding between Queensland Health and the Queensland Police Service enables health information to be shared with mental health professionals and police (QLD FMHS 2016).

State and Territory Governments should implement a systematic approach for co-responding. In doing so, State and Territory Governments should consider what has been done in Queensland and Western Australia (box 21.6). Although what works in some jurisdictions may not work in others, the Productivity Commission sees merit in considering similar approaches. State and Territory Governments would also need to ensure evaluations are built into programs and may also need to tailor the approach to meet the needs of particular groups, including people from culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander people. For example, some Aboriginal and Torres Strait Islander people understand and experience mental health differently to many non-Indigenous Australians (chapters 4 and 8) and some may also have negative attitudes toward police due to strong historical antecedents (ALRC 2017a).

The Productivity Commission estimated the cost and potential cost savings of implementing systematic co-responses to support police. The total cost of implementing such an approach nationally was estimated to be between $15 million and $23 million. There are potential cost savings from reduced emergency department admissions of between $4 and $10 million (2019 dollars), and cost savings in police time estimated at $7 million (2019 dollars) (appendix K).
Box 21.6 Case studies: a systematic approach to co-responding in Queensland and Western Australia

In Queensland, multiple programs exist to improve interactions between police and people with mental illness. This ensures that police are better supported and people with mental health problems can be referred to appropriate mental health services.

**Police Communications Centre Mental Health Liaison Service** — Mental health clinicians are located in the police communications centre where triple zero calls are received and first response officers are dispatched (QLD FMHS 2016). The mental health clinicians access and interpret clinical information for police and advise them on how to manage the individual (including communication, de-escalation and engagement strategies).

**Mental Health Intervention Project** — a tri-agency partnership between police, health and ambulance services to share expertise, resources and respond effectively to mental health crisis situations. Mental Health Intervention Coordinators are established in each health district (Queensland Health, QLD PS and QLD JAG 2008). They liaise between police, ambulance, mental health staff and other relevant stakeholders.

**Mental Health Co-Responders program** — mental health nurses work alongside Queensland police to respond to police call-outs (where mental health may be a factor) to provide assessments and advice. The nurse can work with individuals on-site to de-escalate the situation and develop a care plan that suits their needs (Queensland Government 2018b).

In Western Australia, mental health expertise is incorporated at each stage of police response under its Police Mental Health Co-Response program. This includes: at the point of dispatch; at the point of physical contact at the scene; and post-arrest within the custody setting.

**Police Operations Centre** — a mental health practitioner is located within the Police Operations Centre to access health databases and inform dispatchers and radio supervisors. This is expected to improve resource allocation and decision making when responding to mental health-related tasks (Henry and Rajakaruna 2018).

**Mental Health Co-Response Mobile Teams** — a mental health practitioner co-responds alongside police to mental health-related incidents. The practitioner performs clinical and risk assessments, conducts checks on the mental health database, determines needs and levels of urgency and makes referrals to appropriate mental health and support services.

**Perth Watch House** — a mental health practitioner is located in the Perth Watch House, and conducts screening and assessment of detained individuals’ mental health status. The practitioner has access to health databases. This is expected to provide opportunities for early intervention and diversion, and streamline access to treatment and support.

An evaluation of Western Australia’s Police Mental Health Co-Response program recommended it be continued beyond the trial period and expanded beyond the trial districts. Funding has been allocated for the program to continue and expand.

*Source: Henry and Rajakaruna (2018); QFMHS (2016); Queensland Government (2018b); Queensland Health, QLD PS and QLD JAG (2008).*
Responses to mental health-related incidents should follow a systematic approach, to support both the individual with mental illness and the police responders.

**Start now**

All State and Territory Governments should implement initiatives that enable police, mental health and ambulance services to collectively respond to mental health-related incidents. Approaches undertaken in Queensland and Western Australia should be considered.

The initiatives should ensure that:

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

- police, mental health professionals and/or ambulance services are able to co-respond to mental health related incidents if necessary

- roles and responsibilities of all service providers are clearly defined and aligned with existing memoranda of understanding or other protocols between police, mental health services and ambulance services

- approaches are tailored to meet the needs of particular groups, such as Aboriginal and Torres Strait Islander people or people from culturally and linguistically diverse backgrounds.

Responses to mental health crises will not be fully successful on their own. They rely on the ability for individuals involved to access effective mental healthcare. However, there is evidence of ‘bounce back’ problems, where people transported by police to mental health facilities are unable to access care they may need (NSW LRC 2012). There are several reasons for this, including when:

- mental illness (as defined in mental health legislation) is not the primary impairment

- it is suspected that drugs or alcohol are involved

- the person is behaving violently

- the number of available mental health inpatient beds is limited.

For example, in Victoria, one in five individuals who were transported by police to hospital were assessed and released because they did not meet the criteria for involuntary admission under mental health legislation and did not want to be admitted (Ogloff et al. 2012). However, many of these people would likely benefit from follow up mental healthcare and other support services in the community. Their contact with the hospital — through the police — provides an opportunity to connect them to appropriate care and support.
Police also often interact with the same individuals repeatedly (Clifford 2010). Often these ‘frequent presenters’ do not receive adequate mental health and social support, contributing to repeat mental health-related incidents. The Police Federation of Australia (sub. 761, p. 2) said police ‘often find themselves in the “bounce back” scenario … where access to treatment for people suffering is limited and police find themselves continually being called back to deal with the same person on numerous occasions’. Available data on the number of frequent presenters is limited, but suggests they ‘account for a large proportion of mental health act events’ within a local area (Herrington et al. 2009, p. 49).

Ideally police should only respond to mental health-related incidents when there is a threat to public safety or when there is an imminent risk to staff involved (Mental Health Commission of New South Wales, sub. 948; Sisters Inside, sub. 1196; VLA, sub. 818). However, as long as mental health services are under-resourced in the community, there will be demand for police to respond. Police responses to people with mental illness can only be effective if there are adequate treatment and support services for police to refer individuals to. Police can be a functioning gateway to mental healthcare, however, people transported by police to hospital emergency departments may not be able to access care or may have to wait a long time for care. This Inquiry recommended actions to improve access to, and provision of, mental health services (chapters 10 and 12), including in emergency settings (chapter 13).

**FINDING 21.1 — POLICE RESPONSES RELY ON COMMUNITY MENTAL HEALTH SERVICES**

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

**Improving access to court diversion programs**

State and Territory Governments have developed court diversion programs that divert people with mental illness away from the criminal justice system, and are intended to enable the court system to respond more effectively to individuals with mental illness.

A better conceptual approach to schemes or programs currently labelled ‘diversionary’ is not to consider them as legal detours or deviations from a true path but as identifiable stages in the criminal justice continuum at which the law can intervene effectively, proportionately and responsively to an alleged crime and to the person who is alleged to have committed it. State actions at these junctures are therefore better described as ‘interventions’ rather than ‘diversions’ … Interventions can take many forms and take different forms for different purposes at different points of the criminal justice system. (Freiberg et al. 2016, p. 57)
This Inquiry concentrates on two particular types of programs: court liaison services; and mental health courts. All State and Territory Governments have adopted court liaison services, but only some have established mental health courts (table 21.3).

<table>
<thead>
<tr>
<th></th>
<th>Court liaison services</th>
<th>Mental health courts</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>Department of Health: Justice Health Forensic Mental Health Network, from 1999</td>
<td>None</td>
</tr>
<tr>
<td>Victoria</td>
<td>Victorian Institute of Forensic Mental Health (Forensicare), from 1994</td>
<td>The Assessment and Referral Court, from 2008</td>
</tr>
<tr>
<td>Queensland</td>
<td>Department of Health: Forensic Mental Health Service</td>
<td>None(^a)</td>
</tr>
<tr>
<td>South Australia</td>
<td>Department of Health: Forensic Mental Health Service, from 2013-14</td>
<td>Treatment Intervention Court (previously the Magistrates Court Diversion Program), from 1999</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Department of Health: State Forensic Mental Health Services</td>
<td>Start Court (adult program) and Links (children’s program), from 2013</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Department of Health and Human Services: Forensic Mental Health Service</td>
<td>The Diversion List, from 2007</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Department of Health: Forensic Mental Health Service, from 2016(^b)</td>
<td>None</td>
</tr>
<tr>
<td>ACT</td>
<td>Department of Health: Division of Mental Health, Justice Health &amp; Alcohol and Drug Services: Mental Health Forensic Services</td>
<td>None</td>
</tr>
</tbody>
</table>

\(^a\) The Queensland Mental Health Court performs a different role to that of the Mental Health Court programs in other jurisdictions. It is a specialist court which primarily determines issues of fitness to plead and criminal responsibility. \(^b\) Services are limited: the Northern Territory’s Forensic Mental Health Service conducts a small number of assessments in police watch houses and community mental health services on an ad hoc basis.

*Source: Bradford and Smith (2009); Davidson et al. (2015); Davidson (2018); Heffernan et al. (2015); Richardson and McSherry (2010).*

Court liaison services aim to identify people with mental illness who have been charged, and intervene as early as possible, often pre-trial or during the trial process (Davidson 2015). Services include conducting mental health assessments, providing clinical advice and assisting courts to divert individuals to mental health treatment (Davidson et al. 2016). They can also provide short-term mental health support. However, there are differences between jurisdictions. For example, only court liaison services in the ACT, New South Wales, Queensland, Victoria and Western Australia can access health databases to inform service delivery (Davidson 2015).

Mental health courts offer a different ‘court model’ and can operate alongside court liaison services. They provide a personalised, problem-solving approach that differs from a mainstream court process. Underpinning these models is the principle of ‘therapeutic jurisprudence’, which seeks to use the law as a therapeutic agent (Davidson 2015). Mental health courts differ between jurisdictions. For example, eligibility criteria can be different — for Victoria’s Assessment and Referral Court, people must meet diagnostic, functional and needs criteria (VLA, sub. 818, att. 1), whereas for Western Australia’s Start Court...
(box 21.7), consideration of the latter two is not explicit. Queensland also has a mental health court, but its role differs in that it specialises in matters relating to forensic patients (such as decisions about fitness for trial).

### Box 21.7 Western Australia’s Start Court Program

The Start Court in Western Australia is a solution-focused court, adopting principles of therapeutic jurisprudence for people experiencing mental health problems. It consists of experts that provide legal support, clinical and corrections support, social and community support, and drug and alcohol support. The Western Australian Government allocated $5.9 million (from 2019-20 to 2020-21) to mental health court diversion programs, including the Start Court, in the 2019-20 budget (Western Australian Government 2019b).

The Start Court process aims to run as follows:

1. A Magistrate in any metropolitan court refers an accused person to the Start Court. If the accused meets the eligibility criteria they can continue through the application process. An individual is eligible if they: have a diagnosable mental disorder; have entered or are likely to enter a guilty plea/pleas; are suitable for conditional bail; and provide consent to participate.

2. A clinical team conducts an assessment for inclusion, including interviews and screening.

3. The accused is either accepted or not accepted into the program. To be accepted, the accused must enter a guilty plea to at least a significant proportion of their charges.

4. During the program, the participant is required to ‘check-in’ to court weekly or fortnightly. An Individual Start Court Plan and outline of goals and strategies is developed and shared with the participant, their lawyer, the Magistrate and the Start Court Team. This may require the participant to attend appointments, including with a psychologist, a GP, a mental health clinic, urinalysis, counselling or employment specialist.

5. The program stage takes approximately six months.

6. The participant graduates from the Start Court Program. Leading up to graduation, a Recovery Plan will be developed for the participant.

7. In sentencing, the Magistrate takes participation in the program into account.

*Source: WA DOJ, WA DoH and WAMHC (2018; 2019).*

There are other types of court diversion programs that are not directly targeted to people with mental illness. An example is the Court Integrated Services Program that operates in Victoria (box 21.8), which provides case management support to individuals at the pre-trial or bail stage including mental health services and crisis accommodation. Another example is Victoria’s Neighbourhood Justice Centre, which is based on a community justice model, and includes a multi-jurisdictional court and support services, such as mental health, drug, alcohol and financial counselling (Morgan and Brown 2015).
Research shows that court diversion programs can result in benefits for individuals and the wider community (Kimberlie Dean, sub. 235). The Western Australian Mental Health Commission (sub. 259, p. 18) stated that:

A 2018 Evaluation of Start Court indicated positive results with 92 per cent of Start Court participants experiencing improvement in their health and wellbeing, and 68 per cent of Start Court participants show improvement in suicidality.

Box 21.8  **Victoria’s Court Integrated Services Program**

The Court Integrated Services Program (CISP) operates in the Magistrates’ Court of Victoria. It aims to improve treatment, court, sentence and recidivism outcomes. CISP offers a coordinated, team-based approach to the assessment and treatment of defendants at the pre-trial or bail stage. The services that it provides includes case management support and links to support services for drug and alcohol, crisis accommodation, disability support and mental health.

A typical CISP process for an eligible participant proceeds as follows.

1. A client is referred to CISP for initial eligibility screening.
2. A case worker completes a comprehensive assessment, including examination of criminal and legal history, the client’s need for social and economic support, drug and alcohol use, and physical and mental health needs.
3. The client returns to court where an order is made that they participate in CISP in several ways. Some magistrates make a bail order with conditions relating to CISP, while others merely recommend CISP engagement. In addition, some magistrates may order participants to re-appear at a later date for a progress review.
4. The case worker develops a case management plan for the client. This involves referral to a range of treatment and support agencies, and includes a plan for continued supervision.
5. At the end of the period of bail, the client returns to court, enters a plea (guilty or not guilty) and the sentencing outcome is determined. Participation in CISP may be taken into account in sentencing.

*Source: VIC DJR (2010).*

In addition to improving an individual’s health and wellbeing, evaluations have showed reduced recidivism rates among participants. In New South Wales, the recidivism rate was 12% lower for participants in its court liaison service (Albalawi et al. 2019). Evaluations of the mental health courts in Victoria, South Australia, Western Australia and Tasmania also found reduced recidivism rates (Chesser and Smith 2016; Lim and Day 2014; Skrzypiec, Wundersitz and McRostie 2004; WAMHC 2015b). In Victoria, participants of the Court Integrated Services Program had recidivism rates of about 40% compared with the control group’s 50% (PwC 2009); and clients of the Neighbourhood Justice Centre had recidivism rates of 33% compared with the control group’s 44% (Ross 2015).

Despite evidence of their success, court diversion programs are not accessible by all individuals who may need them (NSW MHC 2017). For example, Victoria Legal Aid (sub. 818, att. 1) said that the Court Integrated Services Program is available in fewer than half of all courts across Victoria. A study found only 57% of individuals deemed eligible for
diversion were diverted in New South Wales (Soon et al. 2018). Although the study could not explain why such a high proportion were not diverted, it found clear differences in socio-demographic and diagnostic profiles between those diverted, and those who were not. For example, individuals who were male, younger, and Aboriginal and Torres Strait Islander were less likely to be diverted.

Geographical limitations, resourcing and capacity limitations and access barriers to community services can affect an individual’s ability to access such programs. Just Reinvest NSW (sub. 440, p. 9) said ‘poor understanding of diversions from Police and the Courts, insufficient funding of solicitors and program staff and appropriate training’ can mean diversion programs are ‘theoretically available’, but ‘in reality do not exist’. Access to court diversion programs can also depend on the location of the court in which the charge will be heard. Therefore, people living in regional and remote areas (who have their charges heard in regional courts) may not be able to access mental health court programs, which are predominantly located in metropolitan areas (Davidson et al. 2016; AASW, sub. 432). Further, under-resourced mental health services in the community may be unwilling or unable to accept referred individuals (VAGO 2014).

State and Territory Governments could expand court diversion programs to improve access to them, but much like police responses, the success of court diversion depends on the availability of mental health and other support services in the community. As mentioned above, people may be diverted to community services, but rejected — either because community services face resource constraints or because they are unwilling to accept individuals referred from the criminal justice system. For court diversion programs to succeed, there needs to be coordination and planning at the agency-level, not just at the program- and service-level. For example, Victoria’s court diversion programs are secured through memoranda of understanding with police, health and human services (VAGO 2014).

The cost of expanding these programs to meet need could not be estimated, based on available data. There is little information (beyond anecdotal evidence) on the demand gap for these services. However, the Productivity Commission has estimated what the additional cost would be if court liaison services were provided in all courts, with expenditure scaling up proportionately (Davidson 2018), and if existing funding for mental health courts doubled (in States where mental health courts exist). This provides some indication of the additional expenditure needed to expand court diversion programs. Additional costs were estimated to be about $32 million (2019 dollars) for court liaison services and $13.5 million (2019 dollars) for mental health courts (appendix K).
ACTION 21.3 — IMPROVING ACCESS TO COURT DIVERSION PROGRAMS

Court diversion programs can be beneficial to people with mental illness.

Start now

State and Territory Governments should ensure that all individuals with mental illness who would benefit from court diversion programs — that link individuals to appropriate mental health treatment and social support — can access them. This should include ensuring court diversion programs are:

- available and accessible jurisdiction-wide, including in regional and remote areas
- adequately resourced, including funding and appropriately trained staff.

In doing so, State and Territory Governments should ensure there is adequate coordination with relevant agencies providing services to individuals who are referred by the court diversion program, particularly health and housing.

Further, the varied approaches across Australia, and the lack of coordinated evaluation and research, can make it difficult to determine what is best practice in this area (Davidson et al. 2016, 2017a). For example, eligibility criteria — which can be an access barrier to these programs (VLA, sub. 818, att. 1) — differ between jurisdictions, but there is limited evidence about what eligibility criteria would be most appropriate and which groups would benefit most from participating. A comparison of court diversion programs in Australia, and their effects on mental health, social and criminal justice outcomes of people, could be an area for further research (Davidson et al. 2017b).

Mental healthcare in correctional settings — equivalent to that in the community?

Correctional facilities are settings in which people with mental illness that have been sentenced for a crime, or are being held on remand, could receive mental healthcare.

Mental healthcare provided to people in correctional facilities has largely been left out of broader mental health reform. Currently, mental healthcare in correctional facilities is siloed — there are no national standards, no measurement of outcomes or even complete and reliable data on prevalence of mental illness and the mental health needs of this population. There is a common view that policies addressing the needs of people with mental illness in correctional facilities should sit separately from those in the community, but this approach is not improving mental health outcomes for people. As outlined earlier (section 21.1), many people with mental illness are sentenced for minor offences, returning back to the community after short periods of incarceration — and a consistent approach to their treatment and support is important.
Adult correctional facilities

Unlike in the community, State and Territory Governments are solely responsible for funding primary and specialised mental health services in correctional facilities (table 21.4).

<table>
<thead>
<tr>
<th>Responsible department(s)</th>
<th>Service model</th>
</tr>
</thead>
</table>
| **New South Wales Health** | Mental health services are provided by Custodial Mental Health, a service within NSW’s Justice Health and Forensic Mental Health Network.  
 ** Victoria Department of Justice and Community Safety** | Prison mental health services (provided by Forensicare) delivers treatment and care at prisons/remand centres.  
 ** Victoria Visiting consultant psychiatrists and nurse practitioners also provide services to all publicly-run prisons. Department of Justice and Regulation contracts primary health services.** |
| **Queensland Health; Queensland Corrective Services** | Health Hospital and Health Services provide specialist mental healthcare. Primary care is provided by the Offender Health Services. Corrective Services contract private providers of primary healthcare in the two private correctional facilities.  
 ** South Australia Department for Health and Wellbeing; Department for Correctional Services** | Visiting psychiatrists (coordinated by the forensic mental health service) provide care to prisoners and some forensic patients held in custody (via collaboration with Correctional Services). Psychology services are provided by Correctional Services, and primary healthcare is provided by the Prison Health Service.  
 ** Western Australia Partnership between the Department of Health and Corrective Services** | The North Metropolitan Health Service provides specialist mental healthcare. The Mental Health and Alcohol and Other Drug Service provides mental health and addiction services, and Corrective Services provides psychology and counselling services.  
 ** Tasmania Department of Health; Corrective Services** | Mental health services are provided from within a broader Mental Health and Statewide Services structure. Specialist services may also be provided by psychologists funded by Corrective Services.  
 ** Northern Territory Department of Health** | Mental health services are provided by the forensic mental health service, which is comprised of specialist multidisciplinary clinical staff. These services include at-risk assessments, advice regarding treatment and care and case management.  
 ** ACT ACT Health Directorate; Corrective Services** | Specialised mental health services are delivered by forensic mental health services, including screening, assessment, care-planning and psychiatric care. Corrective Services provide mild to moderate psychological services.  

**Source:** Productivity Commission analysis based on Clugston et al. (2018).
Because State and Territory Governments are responsible for funding correctional facilities and juvenile detention, people held in them do not receive Medicare and PBS funded services and products (AIHW 2019r; Cumming et al. 2018).231

Several reviews, inquiries and studies have highlighted key issues regarding healthcare provided in correctional facilities, including mental health (ALRC 2017a; Commissioner for Children and Young People Western Australia 2011; Office of the Inspector of Custodial Services 2018; SCMH 2006; Victorian Ombudsman 2015). These include poor screening and assessment upon reception, inadequate mental health services and use of practices in correctional facilities that can lead to, or exacerbate, mental illness.

First, the adequacy of screening and assessment processes in some jurisdictions has been questioned. Although all State and Territory Governments routinely screen for mental illness at reception to correctional facilities (Clugston et al. 2018), processes and practices vary. For example, in Victoria, people held in correctional facilities (sentenced and unsentenced) must have a medical screening within 24 hours (Victorian Ombudsman 2015), whereas in Western Australia, assessments are expected to be conducted within 28 days of sentencing (Office of the Inspector of Custodial Services 2019). In Queensland, some people are released from custody without being assessed by the prison mental health services due to long wait lists (Sofronoff 2016).

Screening practices can vary from the use of validated systematic screening protocols, to correctional facility officials merely asking a few questions about mental health history (Schilders and Ogloff 2014). For example, in Tasmania, screening and assessment is not standardised and depends considerably on the goodwill and expertise of staff (Tasmanian Custodial Inspector 2018). The Tasmanian Government has established a Prisoner Mental Health Task Force to examine processes and procedures relating to prisoner psychiatric care, including assessments (TAS DOJ 2018). JusTas Inc (sub. 346, p. 11) reiterated the importance of properly screening and assessing the mental health of people held in correctional facilities:

… if the mental health problems or illnesses of offenders are not adequately identified at [the] beginning of their entry to custody or to prison, such mental health problems will go unaddressed and untreated and individuals will fall through the gaps in regard to receiving effective and appropriate mental healthcare.

Submissions supported the need for screening and assessment to inform mental healthcare in correctional facilities, but emphasised that it must meet the following requirements.

- Conducted by mental health professionals — Sisters Inside (sub. 1196, p. 11) said it has learned from women it supports that ‘sometimes intake health screenings are conducted by prison staff … not medical professionals’. The Mental Health Legal Centre (sub. 1222) said that screening needs to be undertaken by qualified mental health professionals.

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231 Section 19.2 of the Health Insurance Act 1973 (Cth) states Medicare benefits are not payable if services receive funding from another level of government or statutory body. An exception is where medications fall under Schedule 100 of the PBS, known as the Highly Specialised Drugs Program.
• Complement existing mental health information from community mental health services — an individual’s community mental health treatment team could be contacted (if the individual consents to it) to further inform their mental healthcare while imprisoned. This would include information on existing medications. An Inquiry participant said that:

…it’s really quite daunting how many people have their medication removed the second they go into prison. Unless you can provide the evidence of what they were on prior to admission, it then takes quite some time to then get them back on medication. (Mental Health Legal Centre, Melbourne transcript, p. 171).

Second, there is a lack of mental health services available in correctional facilities. Several inquiries have highlighted that increases in prison populations have not been matched with increases in mental healthcare and services for people held in them (Human Rights Watch 2018; SCMH 2006; Sofronoff 2016; Tasmanian Custodial Inspector 2018). Fewer than 1% of prisoners assessed as having an acute or severe mental illness were transferred to appropriate mental health services for further assessment and treatment (Schilders and Ogloff 2014). Participants to this Inquiry (both government agencies and peak bodies) also highlighted difficulties that people held in correctional facilities face in accessing mental healthcare (Australian Red Cross Society, sub. 490; Mental Health Complaints Commissioner (Victoria), sub. 321; SAMHC, sub. 477).

Mental healthcare can be even less accessible for individuals detained while awaiting trial or sentencing, and for those serving short sentences. Individuals detained pre-trial are often released without medical or mental health follow up, as community services are not informed of their release (Stokes 2012). People in correctional facilities on short sentences may also miss out on appropriate mental healthcare due to long waiting lists (Sofronoff 2016).

People with mental illness in correctional facilities are entitled to mental healthcare that is equivalent to the level provided in the community. This is outlined in the Guiding Principles for Corrections in Australia, which represents a national intent for State and Territory Governments to guide the development of practices, policies and performance standards (CSAC 2018). Australia is also a signatory of the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules) (Mackay 2017).

However, in practice, this is not always the case. An indicator measure of this is the staffing profile for prison mental health services. The Sainsbury Centre for Mental Health estimated that for prison mental healthcare to be equivalent to community services, there needs to be 11 full-time equivalent (FTE) specialist mental health staff per 550 male prisoners. An additional 3.2 FTE is required to provide a substance use service (Clugston et al. 2018). Based on these estimates, only the ACT is funding mental health services in correctional facilities at a level equivalent to that in the community (figure 21.4).

Finally, some practices or conditions in correctional facilities may lead to or exacerbate mental illness (Jesuit Social Services, sub. 1186; Sisters Inside, sub. 1196). These can include the use of solitary confinement, restraints or other management regimes. The Australian Medical Association (2015) has said ‘solitary confinement is medically harmful
as it may lead to a number of physical and/or mental disorders’. Sisters Inside (sub. 1196, p. 10) said its staff ‘frequently support women who spend extended periods of solitary confinement and consequently suffer a deterioration of their mental health’. Such practices that are harmful to an individual’s mental health should be considered by any review on national standards of care (discussed further below).

Figure 21.4  Estimates of funded and occupied clinical mental health staff (full time equivalent per 550 prisoners)\textsuperscript{a,b,c}

As at 30 June 2016

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{chart.png}
\caption{Estimates of funded and occupied clinical mental health staff (full time equivalent per 550 prisoners)\textsuperscript{a,b,c}}
\end{figure}

\textsuperscript{a} Victoria did not respond to the survey and South Australia does not have a specific prison mental health service. \textsuperscript{b} Data from New South Wales was provided for 30 June 2017. \textsuperscript{c} Funded clinical full time equivalent (FTE) refers to the number of positions, which funding is allocated to and occupied clinical FTE refers to the number of positions filled, where staff occupying positions that deliver services. In Western Australia, the number of occupied clinical FTE is higher than the number of funded clinical FTE because additional ‘team leader’ staff were delivering services, but not included in the number of funded positions.

Source: Clugston et al. (2018); Davidson et al.(2019).

Juvenile detention centres

Similar to adult correctional facilities, inquiries and reports have raised issues with inadequate screening and assessment, and provision of mental healthcare in juvenile detention centres. This is despite the high prevalence of mental illness among young people in detention centres — up to about 80\% in some jurisdictions (JHFMHN 2017b).

Young people entering detention do not always receive adequate mental health screening and assessment. The Western Australian Auditor General (2008, p. 24) found there was no ‘structure or process to ensure that mental health and substance abuse problems associated with repeated offending … [were] identified’. The Royal Commission into the Protection
and Detention of Children in the Northern Territory found ‘… there were no systems in place to assess and diagnose children and young people with mental health problems [in Alice Springs]’ (White and Gooda 2017, vol. 2A, p. 362). Another review into juvenile detention centres in Victoria was also critical of assessment practices, calling initial health assessments ‘ad hoc’ (LSIC 2018).

Further, there are concerns that young people in detention centres do not have access to appropriate mental healthcare. A review found mental health services provided to young people in custody were inadequate to deal with the problems those young people presented with. Further, while mental healthcare may be available in theory, this is not always the case in practice. Young people may be prevented from attending counselling sessions or other services because of a lack of staff to escort them to their appointment — even in cases where services are available on-site (LSIC 2018). Youth Mental Health, North Metropolitan Health Service (sub. 895, att. 2, p. 1) said ‘… there are gaps in [mental health] service delivery and there is significant unmet need for young people in contact with the justice system’.

Reviewing national standards of care

Although a range of local and international guidelines and principles cover the provision of mental healthcare in correctional facilities, there are no national standards.

[There is a] lack of Commonwealth and State and Territory cooperation to establish and thereafter enforce national standards to protect, promote and maintain the health and well-being of people held in custody. (PHAA 2013, p. 2)

Within Australia, there are the Guiding Principles for Corrections in Australia (mentioned earlier) and the National Statement of Principles for Forensic Mental Health (AHMAC 2006). Primary themes that emerge across these principles are listed in box 21.9.

In the broader community, the National Safety and Quality Health Service (NSQHS) Standards apply to health and mental health service organisations, and are overseen by the Australian Commission on Safety and Quality in Health Care. The primary aims of the NSQHS Standards are to ‘protect the public from harm and to improve the quality of health service provision’ (ACSQHC 2017b, p. 1). A user guide has also been developed to support health service organisations implement the NSQHS Standards for mental health services (ACSQHC 2018c). Some health service organisations (such as, hospitals and day procedure services) require accreditation against the NSQHS.

Correctional settings are not explicitly included in the list of locations and settings in which healthcare is provided (ACSQHC 2017b, p. 72). And the Royal Australian and New Zealand College of Psychiatrists (sub. 1200, p. 22) noted that the NSQHS Standards are ‘geared’ towards health service organisations.
Box 21.9  **Main principles guiding correctional facilities in Australia**

There are five primary themes that emerge from international and Australian guidelines and standards regarding the provision of mental health services in correctional facilities.

**Equivalence of care**: those held in correctional facilities should receive healthcare, including mental healthcare, equivalent to that available in the community with regard to professional, ethical and technical standards.

**Early assessment**: those held in correctional facilities should be assessed as soon as possible on admission to facilitate the identification and immediate management of mental health problems. This should be accompanied by appropriate treatment plans.

**Timely treatment**: those held in correctional facilities should have access to treatment for mental illness; resource and staffing should ensure that detainees receive timely access to high-quality mental healthcare.

**Continuity of care**: ongoing monitoring and care, as well as linking mental health services in correctional facilities with those in the community.

**Transfer to hospital**: mental health workers should play a role in identifying and arranging for those held in correctional facilities who require involuntary mental healthcare to be transferred to appropriate authorised mental health facilities.

*Source: Tasmanian Custodial Inspector (2018).*

Nevertheless, the NSQHS Standards should apply to correctional settings to ensure that people in those settings receive safe and high quality mental healthcare equivalent to that expected in the community. This is particularly important given the high prevalence of mental illness among people in correctional facilities, and consequent demand for mental healthcare. Setting safety and quality standards can provide a quality assurance mechanism (ACSQHC 2018c).

Mental health care in prisons should be aligned with the standards and approaches of community based mental health services which includes providing support to manage mental illness within the general community setting of the prison and access to specialist mental health units as appropriate. (MHV and MHLC 2019, p. 16)

Submissions supported the NSQHS Standards applying to correctional settings, but some raised concerns that without additional funding, the NSQHS standards could not be practicably upheld. For example, although the Aboriginal Medical Services Alliance NT (sub. 1190, p. 17) supports a move to apply the NSQHS standards in correctional settings, they also stated that ‘a significant increase in investment, staffing as well as structural reforms’ would be needed. Sisters Inside (sub. 1196, p. 9) said ensuring correctional facilities are adequately resourced provides ‘the best chance of providing a level of mental healthcare approaching a community standard’. If the NSQHS Standards were to apply to correctional settings, governments would need to ensure that mental healthcare services are adequately resourced to effectively implement and uphold them.
Leaving correctional facilities

People leaving correctional facilities can face multiple barriers reintegrating back into the community. Incarceration disrupts a person’s housing, financial and employment situations, family responsibilities and social connections (ALRC 2017a; Office of the Inspector of Custodial Services 2019). Barriers to reintegration include: poverty, low levels of education, unemployment, homelessness, drug or alcohol dependencies, and a lack of social support or loss of family ties (QAI 2015).

Mental illness can act as an additional barrier to successful reintegration, and comorbidities (which are common, as discussed in section 21.1) presents further challenges:

… in One Door’s experience, people in this situation have very poor outcomes on exit from the facilities, for example: inability to maintain tenancies, and therefore homelessness; increased likelihood of substance misuse; lack of engagement with GPs and other practitioners to seek treatment, including medication and psychological supports; demonstration of frequent challenging or anti-social behaviours; and increased risk of reoffending and return to correctional facilities. (One Door Mental Health, sub. 856, p. 16)

Sisters Inside (sub. 1196, p. 12) said that ‘[i]t is unrealistic to expect that, immediately following release from prison, a person will be equipped to assume full responsibility for their health care’. People with mental illness can also find it harder to access suitable housing (chapter 20) and face barriers to employment (chapter 19), particularly if there is stigma associated with a criminal history as well as with mental illness (chapter 8).

People can also experience more severe symptoms of mental illness upon release from correctional facilities. People leaving prison had higher rates of hospitalisation for mental illness, compared with the general population (Hobbs et al. 2006; Kouyoumdjian et al. 2018). Average healthcare costs for people leaving prison with mental illness or a comorbidity were between two and three times higher than those without (Justice Health Unit – University of Melbourne, sub. 1237). Spittal et al. (2014) found the likelihood of dying by suicide was 14.2 and 4.8 times higher for women and men leaving prison compared to the general population.

As a result, continued access to mental healthcare can be pivotal. Programs aiming to improve primary care engagement among people leaving prison led to increased engagement with health services in the shorter term, including mental health and drug and alcohol treatment, and reduced emergency department presentations in the longer term (Kinner et al. 2016; Wang et al. 2012; Young et al. 2015). A recent study by the Kirby Institute, the New South Wales Department of Health and the New South Wales Department of Corrective Services found that reoffending decreased when the number of ‘mental health service clinical contacts’ increased, with the likelihood of reoffending five times higher for people with mental illness who did not receive mental healthcare in the community (NSW Government, sub. 1243, p. 19).
State and Territory Governments need to ensure continued mental healthcare is included in programs supporting people with mental illness to transition from correctional facilities to the community (transition support programs).

However, this is often not the case. Not all state and territory prison mental health services provide a transition service. Instead, referrals are made to community services (Clugston et al. 2018). There is a disconnection between ‘inside’ and ‘outside’ mental health services (Victorian Ombudsman 2015). Inquiry participants reported that:

… despite the fact that Australian correctional policy has for many years articulated a commitment to ‘throughcare’ to improve the continuity of care as people transition from prison to the community, little is done to maintain or build upon the success of custodial health services, after release from custody. (Justice Health Unit – University of Melbourne, sub. 339, p. 8).

There is a poor intersect between effective mental healthcare in a custodial setting and in the community … Although a discharge summary of medication is meant to be provided to the person upon release, this is often lost in transit. For these reasons, strengthening the relationship between health services in prisons and community health and mental health services is particularly important. (Jesuit Social Services, sub. 441, p. 21)

This appears true for people released on parole too. People released on parole are supervised in the community and often referred to services, including mental health services (Sofronoff 2016). However, people with mental illness can be ‘under-identified and underserved’ (Gelb, Stobbs and Hogg 2019, p. 99). Parole staff can lack experience or have caseloads that are too large, preventing them from adequately managing people with mental illness (Lurigio 2001). JusTas Inc (sub. 346, p. 15) highlighted this:

… [an ex-inmate at an Australian prison identified] that the parole officer assigned to him … [was] often too busy and had too high a case load to spend more time with him … He highlighted that inmates suffering from mental health illnesses should have to, as part of their parole and to ensure mental stability, see mental health professionals regularly. If not for these social work and mental health professionals, spiralling of the mental illness may occur for the person, as it did for him.

The NSW Mental Health Review Tribunal (sub. 409) stated that maintaining a person’s mental healthcare when they leave custody is difficult for several reasons. First, often, release dates can be difficult to predict. For example, a person who is remanded and awaiting trial may be discharged suddenly from court. Second, if there is uncertainty around a person’s living arrangements, the person cannot be linked to a local mental health team. And finally, community mental health teams may be reluctant to take on clients who have come out of custody. To address this, the NSW Mental Health Review Tribunal (sub. 409) has been asked to make community treatment orders for people in custody, creating a legal mechanism that requires a person to accept treatment. However, this would only be possible if the person met criteria for a community treatment order, as would apply to individuals in the broader community.

Notwithstanding, there are some examples of mental health transition services. Mind Australia, Neami National, Wellways and SANE Australia (sub. 1212) submitted that Queensland Health funds a transition program that includes the prison mental health service
developing a ‘transition plan’ with the individual and community mental health services prior to release to inform mental healthcare in the community. Further, the prison mental health service remains involved with the individual for up to two weeks after release. However, Mind Australia, Neami National, Wellways and SANE Australia (sub. 1212) also stated that coordination between the prison mental health service and community-based services needs to improve.

Overall, however, ensuring continued mental healthcare forms only one piece of the puzzle that supports reintegration. The Productivity Commission sought further information on the benefits and extent of transition support needed in the draft report. Many submissions responded with information on successful or promising transition support programs (box 21.10).

**Box 21.10 Examples of promising transition support programs and pilot programs**

- **Extended Throughcare Program** — provides case management for 12 months after release, giving support in five core areas: accommodation, health, basic needs, income and community connections. An evaluation of the program found that it reduced recidivism by 22.6%, helped clients secure or maintain housing because of assistance with advocacy, and had positive mental health and drug and alcohol outcomes (Griffiths, Zmudzki and Bates 2017).

- **ReConnect program** — supported high risk individuals transition back to the community, by providing targeted and intensive outreach services for up to 12 months (Jesuit Social Services 2020). This includes creating individualised transition plans, and providing assertive outreach and practical assistance. Recently, as part of a pilot project, a community health nurse was embedded in the program. An evaluation by the University of Melbourne found that it had significant benefits for participants and staff (Jesuit Social Service, sub. 1186, p. 2).

- **Throughcare Program, Northern Aboriginal Justice Agency** — provides intensive case management, tailored to Aboriginal and Torres Strait Islander people leaving correctional facilities. It is strength-based and provides support for rehabilitation, accommodation, employment, education and training, health, life and problem solving skills, and reconnection to family and community. It won the Australian Crime and Violence Prevention Award from the Australian Institute of Criminology in 2012 (North Australian Aboriginal Justice Agency 2020).

- **Detention Exit Community Outreach Program** — a recovery-focused outreach program providing intensive case management and psychosocial supports for up to three months (Wellways Australia Limited 2020). It helps people in areas including mental health, employment, education or training and housing. From 2015, 93% of participants have not reoffended (Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212, p. 40).

- **Time to Work Employment Service** — aims to assist people leaving correctional facilities find employment and reintegrate into the community upon release (DESE 2020c). Time to Work Employment Service has commenced in most states and territories, and is expected to expand to all.
To be successful, transition support programs must aim to help individuals overcome the multiple barriers to reintegration. This includes addressing accommodation, health, basic needs, income and community connections. In particular, many submissions highlighted the importance of securing suitable housing (Jesuit Social Services, sub. 441; Olav Nielssen, sub. 37; QAI, sub. 1222; Sisters Inside, sub. 1196).

Key principles underlying successful transition support include the following.

- **Holistic** — addresses a range of social supports that an individual needs, providing wrap-around, integrated care. For example, a person may need support from mental health services, but also drug and alcohol services, or housing and employment support.

- **Coordinated** — roles and responsibilities of services involved must be clearly defined.

- **Pre-release planning** — planning should occur well before release, while the individual is still held in a correctional facility. Many necessary tasks could be completed before release to ensure timely access to services in the community, for example, ensuring individuals have identification documents. There needs to be clear communication of release dates to all parties involved in an individual’s transition back into the community.

- **Flexible** — care and support should be mobile and flexible, including outreach services. Sisters Inside (sub. 1196) said this is particularly important for women leaving correctional facilities, who often depend on income support, and cannot afford to travel to access services. Further, many face a range of post-release requirements, such as parole conditions and obligations related to child safety and employment. Flexible and mobile care would help lift some of the load placed on these people who are returning back to the community.

- **Longer term** — care and support needs to be long enough so that individuals can establish reliable links with necessary community supports. The NSW Mental Health Review Tribunal (sub. 409) stated that longer periods of assertive community mental healthcare and other supports are instrumental to maintaining a person’s mental health.

Overall, people with mental illness who enter correctional facilities should have access to mental health services that are equivalent to the community, and the mental healthcare they receive should be continued seamlessly after they have left. State and Territory Governments should avoid disruption in care that distinguishes between the ‘inside’ and ‘outside’. Further, although people released from correctional facilities can receive case management (through their parole officer or transition support programs), these are time limited. To ensure this support is continued in the longer term, there should be adequate handover to care coordinators (action 15.4), if required.

The Productivity Commission estimates that improving mental health services in correctional facilities to the point that they are equivalent to those in the community would cost an additional $48 million to $110 million (2019 dollars) per annum nationally (appendix K).
MENTAL HEALTH

ACTION 21.4 — MENTAL HEALTHCARE IN CORRECTIONAL FACILITIES AND ON RELEASE

Mental healthcare in correctional facilities should be equivalent to that in the community and mental healthcare should be continued seamlessly as people enter and leave correctional facilities.

Start now

The Australian Commission on Safety and Quality in Health Care should review the National Safety and Quality Health Service Standards to determine how they apply to, and can be implemented in, correctional settings.

All State and Territory Governments should ensure that:

- there is mental health screening and assessment of all individuals (whether sentenced or not) by a mental health professional on admission to correctional facilities, and on an ongoing basis where appropriate
- mental health information obtained from screening and assessment is comprehensive enough to inform resourcing of mental health services in correctional facilities
- with consent from the individual, there is communication with any of their existing mental health providers to further inform mental health needs
- individuals in correctional facilities are able to access timely and appropriate mental healthcare, of a standard equivalent to that in the community
- mental health information obtained from screening and assessment is used to inform transition planning for the individual upon release. Transition planning should be completed and, with consent from the individual, shared with community based mental health services, case managers and other relevant parties, at a time before release that is reasonable for the planning of continued mental healthcare of the individual in the community.

Shortfalls in forensic mental healthcare

Mental health treatment is provided in forensic mental health facilities to people who are alleged to have committed a crime, but deemed unfit to plead or unfit to stand trial (forensic patients), and people who have been sentenced for a crime, but need inpatient mental healthcare. Often these individuals are very unwell and need intensive mental health treatment (MHLC, sub. 1222). In some cases, they require compulsory treatment, which cannot be provided in correctional facilities, as they are not designated mental health facilities.

The National Statement of Principles Relating to Persons Unfit to Plead or Found Not Guilty by Reason of Cognitive or Mental Health Impairment was developed by the Council of Attorneys-General, and endorsed by all states and territories, with the exception of South
Australia, at the time of writing. The principles aim to ensure that people who are unfit to plead or found not guilty by reason of cognitive or mental health impairment receive treatment that is tailored, inclusive and recovery oriented (Attorney-General’s Department 2019).

The national principles provide a framework to guide improvements in legislation, policy and procedures. However, much change is required to ensure these principles are implemented in practice.

There are serious shortages of forensic services and beds in inpatient forensic facilities in all states and territories, particularly for young people (Northern Territory Mental Health Coalition, sub. 430; Office of the Inspector of Custodial Services 2018; SCARC 2016a). As a result, people who are forensic patients can be placed in correctional facilities rather than hospitals. For example, the Mental Health Commission of New South Wales (sub. 948) said there were 30 male forensic patients in custody, waiting to be transferred to a forensic hospital as at 30 June 2019, and that people can wait up to four and a half years for this. People sentenced and held in custody who require inpatient treatment can also face long wait times. A report by the Office of the Inspector of Custodial Services (2018) found 61% of referrals from a custodial setting lapsed without a hospital placement. Inquiry participants also shared their own experiences:

Even now when [he] was found not guilty because of mental illness, he remained in gaol, put in corrections for 12 months. That is terrible by anyone’s word … they [said] he was transferred to other sections but gaol is gaol, there’s no ifs or buts. The law should be changed, once a person is found not guilty, they should be out of corrections within seven days, and the government needs to find enough money to finance this … There’s not enough beds in the mental health system and that’s causing a backlog in the gaol. They’re just held in gaol until they can get a bed … even now, [he’s] recently been approved to go to [a] unit. But there’s an approximately a six month wait, so that’s more proof there’s not enough beds in the system. (Patricia and Andrew Anderson, Sydney transcript, p. 9)

The shortage of forensic services and beds in inpatient forensic facilities prevents some people from accessing appropriate mental healthcare, and puts a heavy strain on the prison system more broadly (MHLC, sub. 1222).

Forensic mental healthcare is highly specialised and costly. On average, about $1200 per patient day is spent on forensic mental health services (AIHW 2020c). This compares to recurrent expenditure per prisoner per day of $310 (SCRGSP 2020a). There are fewer than 2000 forensic patients nationally (table 21.5). However, there is unreliable data on the number of people in correctional facilities who require inpatient treatment in forensic facilities.

While the South Australian Government supports the objectives of the National Principles, it has not endorsed them due to inconsistencies with current legislative provisions, policies and procedures (Attorney-General’s Department 2019).
Those receiving forensic mental healthcare generally receive a very high standard of mental healthcare, and treatment can be compulsory (NSW Mental Health Review Tribunal, sub. 409). It can be delivered in high security settings, such as forensic hospitals, or in medium and low security mental health units. Care is often not limited to psychiatric treatment, and may also include: individual therapies that support cognitive skills, drug and alcohol abstinence, a better understanding of mental illness, anger management and behavioural regulation. Forensicare (Victoria’s state-wide provider of clinical forensic mental health services) said the average period of inpatient treatment is 6–8 years (Forensicare 2019). Treatment often also includes a slow, graduated program of leave in the community.

### Table 21.5 Number of forensic patients/orders

<table>
<thead>
<tr>
<th>State</th>
<th>Estimated number of forensic patients/orders</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>618&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Victoria</td>
<td>173&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Queensland</td>
<td>798</td>
</tr>
<tr>
<td>South Australia</td>
<td>85</td>
</tr>
<tr>
<td>Western Australia</td>
<td>42</td>
</tr>
<tr>
<td>Tasmania</td>
<td>46&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>45</td>
</tr>
<tr>
<td>ACT</td>
<td>0&lt;sup&gt;e&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a</sup> These are estimates based on statistics from State and Territory Government annual reports and data collections, and are not directly comparable due to different definitions and reporting processes.  
<sup>b</sup> New South Wales data is the number of forensic and correctional patients.  
<sup>c</sup> Victorian data is the number of supervision orders under the State’s Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic).  
<sup>d</sup> Tasmanian data is the number of orders made during the period 2005–June 2018.  
<sup>e</sup> The ACT Civil and Administrative Tribunal has not made a forensic mental health order to date, as at 30 June 2019 (ACAT 2019).

Source: Forensicare (2018); McGrath et al. (2019); NSW MHRT (2019); Queensland Health (2019a); SA DHW (2019); Tasmania Law Reform Institute (2019) Western Australian Government (2019a).

Forensic mental healthcare is effective in improving mental health outcomes, as well as reducing reoffending. The NSW Mental Health Review Tribunal (sub. 409, p. 5) said many people would ‘benefit enormously from the intensive and holistic mental health treatment’ provided by forensic teams. Further, a study found that:

… the 12-month rate of re-offending for released forensic patients is 6.3% for a cohort accrued over the past 25 years … this compares to a rate typically over 40% for released prisoners in NSW. Our findings are consistent with those across jurisdictions internationally supporting the notion that forensic mental health services are effective at reducing post-release contact with the justice system, vital for supporting social and economic participation for this high-risk and high-needs group (Kimberlie Dean, sub. 235, p. 3).
State and Territory Governments should ensure forensic services and facilities are adequately resourced to reduce wait times for both forensic patients and people held in correctional facilities who require inpatient mental healthcare. Some investment has already been made. In 2017-18, the Victorian Government allocated $83 million toward forensic mental health in its 10-Year Mental Health Plan, including funding for a secure forensic mental health unit for youth justice clients (Victorian Government, sub. 483). The Western Australian Mental Health Commission has planned to develop a 92-bed forensic inpatient facility by the end of 2025 (WAMHC 2015a).

The National Mental Health Service Planning Framework does not include the provision for modelling forensic mental healthcare (WAMHC 2015a), a forensic mental health component is in development (Western Australian Mental Health Commission sub. 259). This will assist State and Territory Governments identify the gap between current and optimal levels of forensic services, and therefore help inform the resourcing of them. Upon completion of the forensic mental health component of the National Mental Health Service Planning Framework, State and Territory Governments should use it to quantify the level of unmet demand for forensic mental healthcare to inform planning and funding.

**ACTION 21.5 — FORENSIC MENTAL HEALTHCARE**

*Start now*

The Australian, State and Territory Governments should complete the forensic mental health component of the National Mental Health Service Planning Framework, which should then be used by State and Territory Governments to quantify the level of unmet demand for forensic mental healthcare. This should inform planning and funding of forensic mental healthcare, including forensic services and facilities, for adults and young people. The plans developed for forensic mental healthcare should be made publicly available.

The extent to which forensic orders are likely to lead to indefinite detention is a further issue. Most states and territories have limiting terms for forensic orders or mandatory reviews of orders on a regular basis. However, Victoria, Western Australia and the Northern Territory still allow for indefinite detention (SCARC 2016a). The Senate Community Affairs References Committee recently conducted an inquiry into this issue, although the Australian Government has not yet responded (Parliament of Australia 2019). The Productivity Commission recognises that indefinite detention is a complex issue, but a review of the relevant legislation in state jurisdictions is beyond the scope of this Inquiry.
Addressing the needs of Aboriginal and Torres Strait Islander people

The incarceration of Aboriginal and Torres Strait Islander people, its causes and devastating effects have been the subject of a number of inquiries and Royal Commissions, the most recent being the ALRC (2017a) inquiry. Aboriginal and Torres Strait Islander people are grossly over-represented in the criminal justice system and a large proportion are diagnosed with mental illness and cognitive disabilities (section 21.1).

However, in addition to the general issues raised in this chapter, mental health services for Aboriginal and Torres Strait Islander people in contact with the criminal justice system need to address three interconnected issues to be effective.

First, they need to be culturally capable. A study found ‘the current model of mental healthcare provided in prisons is not embedded within a culturally sensitive context and may not be meaningful to Koori people’ (Ogloff et al. 2013, p. 16). Where specific programs exist (such as healing programs), places can be limited (Ogloff et al. 2013).

Second, culturally capable care needs to deal with the specific underlying mental health problems facing Aboriginal and Torres Strait Islander people, which can differ from other population groups. For example, Aboriginal and Torres Strait Islander women who are imprisoned can face greater barriers to accessing culturally capable mental healthcare, which is often inextricably linked with traumatic experiences of family violence, victimisation, sexual abuse and addiction (Blagg et al. 2005; Heffernan et al. 2015). However, few programs in correctional facilities are designed for Aboriginal and Torres Strait Islander women (COAG 2016) and mental health problems are often addressed by issuing medication (Blagg et al. 2005).

... prisons do not appear to provide adequate support for people with mental health issues. It is reported that women with disabilities, particularly Aboriginal and Torres Strait Islander women with disabilities: experience higher rates of poverty, homelessness, domestic and sexual violence, and abuse than non-indigenous peers and peers without disabilities. Being put in custody often only heightens psychosocial disabilities associated with this trauma. (NSW Council for Civil Liberties, sub. 484, p. 6)

Third, many Aboriginal and Torres Strait Islander people are incarcerated for short periods of time (relative to non-Indigenous people in correctional facilities) — either on detention awaiting trial or sentencing or while serving a short sentence. Prison census data showed about 30% of Aboriginal and Torres Strait Islander people in correctional facilities were detained pre-trial (ABS 2019e) and almost half were handed sentences of less than six months (ALRC 2017a). As the Human Rights Law Centre (2019, p. 22) notes:

... [inadequate access to programs] is felt most acutely by Aboriginal and Torres Strait Islander people in prison, who are more likely to be held on remand and be incarcerated for short periods, and are therefore more likely to be in a situation where they are denied access to culture, community, education and mental health services.
Short periods of incarceration increase the importance of the justice system acting effectively as a gateway to culturally capable services in the justice system itself, and as a link to these services in the community.

According to the ALRC (2017a), culturally appropriate programs for Aboriginal and Torres Strait Islander people should be:

- designed, developed and delivered by Aboriginal and Torres Strait Islander organisations where possible
- trauma-informed, especially where being delivered to women in correctional facilities
- focused on practical application, particularly for those on remand or short sentences who need the skills to reintegrate once released.

A model of care that is growing in recognition is the Winnunga Holistic Health Care Prison Model in the ACT (box 21.11). Under this model, the Aboriginal Community Controlled Health Organisation, Winnunga Nimmityjah, provides dedicated in-reach health services under a standalone and defined model of care (ACT Government, sub. 210). The ACT Government has committed $8.3 million to integrate the Winnunga model at the Alexander Maconochie Centre correctional facility (Rattenbury 2019). South Australia recently developed a Model of Care for Aboriginal Prisoner Health and Wellbeing drawing on the Winnunga model, although it differs in scope (Sivak et al. 2017). The Productivity Commission estimated that implementing the Winnunga model nationally would cost about $170 million (2019 dollars) (appendix K).

In many instances, trauma-informed approaches should also be adopted. Many Aboriginal and Torres Strait Islander people in correctional facilities, particularly women, have experienced trauma. Approaches to trauma-informed care are well described internationally and locally (Heffernan et al. 2015). Historically, these have been at odds with conventional approaches, but experiences internationally and in Australia are changing views. For example, the Dilly Bag Program in Victoria provides ‘intensive assistance’ to Aboriginal women in correctional facilities who are recovering from traumatic experiences (ALRC 2017a).

In the Productivity Commission’s view, State and Territory Governments should continue working with Aboriginal and Torres Strait Islander organisations to ensure that Aboriginal and Torres Strait Islander health services in the community following release. Several submissions were in support of this, including Consumers Health Forum of Australia (sub. 646), Mental Health Commission of New South Wales (sub. 948), Sisters Inside (sub. 1196), South Australian Mental Health Commission (sub. 691) and Victoria Legal Aid (sub. 818).
Box 21.11  The Winnunga Holistic Health Care Prison Model

The Winnunga Holistic Health Care Prison Model (Winnunga model) is a model of care for Aboriginal prisoner health (Sivak et al. 2017). It was developed by Winnunga Nimmityjah Aboriginal Health and Community Service in 2007 (Sivak et al. 2017).

The Winnunga Model addresses:
- incarceration — provides holistic care during incarceration and planning for release
- release from correctional facilities — provides post-release health service coordination, and family and community reintegration strategies
- the cycle of incarceration — provides early family, and other intervention strategies.

In 2017-18, Winnunga Nimmityjah Aboriginal Health and Community Service provided 178 clients with 1281 occasions of service at the Alexander Maconochie Centre and Bimberi Youth Detention Centre. This represented a 26% increase in client numbers and a 75% increase in encounters from the previous year (Winnunga AHCS 2018).

Source: Poroch et al. (2011); Sivak et al. (2017); Winnunga Nimmityjah AHCS (2018).

ACTION 21.6 — ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE WHO ARE INCARCERATED

Start now

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

Supporting victims of crime with mental illness to access mental healthcare

The high prevalence of mental illness among people who are victims of crime (section 21.1) means that their interaction with victim support services can serve as a gateway to mental health and other support services. Establishing links between victim support and mainstream mental health services is necessary to ensure that this is efficient and effective.
State and Territory Governments acknowledge the mental health needs of people who are victims of crime, with each jurisdiction funding victim services that provide counselling (among other supports such as financial assistance) (Chan et al. 2013). Victim services have become increasingly formalised as State and Territory Governments assumed greater roles in providing these services (Freeman and Smith 2014). In some States, the number of counselling applications made by victims has been increasing. For example, in New South Wales, 16,730 counselling applications were lodged in 2017-18 — almost double the number reported five years earlier (NSW DoJ 2018).

It is desirable that these victim services serve as a gateway to mainstream mental healthcare for a number of reasons. First, timely access to support can be important to prevent mental health and social outcomes from deteriorating.

… for many people with complex needs [mental illness and cognitive disabilities], victimisation is understood as having multiple flow-on effects across their lives. Victimisation experiences that are not adequately recognised and addressed are seen to ultimately lead to further issues including homelessness, problematic substance use and poor mental health. (Dowse et al. 2016, p. 62)

Second, although victim of crime schemes provide counselling services, they may not always be appropriate. Severe mental illness can be prevalent among people who are victims of crime (Dowse et al. 2016). Counselling services alone may not adequately meet the needs of all victims with mental illness, particularly if they are short-term services. For example, the New South Wales’ victim counselling services limits counselling to 22 hours (NSW DCJ 2019), although the victim counselling services can approve more hours.

Finally, victims with mental illness may need support to access mental health services and other community supports. There are several reasons for this, including limited awareness of mental health services, difficulties in communication and difficulties in attending appointments (Dowse et al. 2016; McCart, Smith and Sawyer 2010).

For these reasons, it is desirable that State and Territory Governments ensure that this gateway to appropriate mental healthcare and other support is efficient and effective. Section 21.3 (action 21.7) outlines how governments can achieve this.

### 21.3 Improving access to justice

As discussed in section 21.1, people with mental illness are more likely to encounter legal issues, compared to the general population. Legal issues can range from fines, evictions and problems concerning welfare payments, to criminal charges or as victims of crime (Coumarelos et al. 2012). Issues can also result from mental health legislation.

However, people with mental illness often face barriers to participating in the justice system. These barriers can prevent them from initiating and participating in legal proceedings (box 21.12). There can be multiple reasons for this, including: poor knowledge about legal rights and available remedies (Balmer et al. 2010); communication problems (Karras et
al. 2006); and health and other non-legal needs (Coumarellos et al. 2012). People with mental illness can also face barriers in exercising their rights as victims (box 21.13).

As a result, there is unmet demand for legal assistance among people with mental illness.

Unresolved legal issues can lead to mental ill-health. There is a significant and strong association between legal problems and mental illness, with the incidence of legal problems being higher for people with mental illness (Pleasence and Balmer 2009). Moreover, legal problems can cause or exacerbate mental illness as well (Coumarellos et al. 2012). Unresolved legal issues can reinforce and entrench disadvantage (Health Justice Australia, sub. 749) — a risk factor for further contact with the justice system, including the criminal justice system (section 21.2).

**Box 21.12 Barriers to participating in the justice system**

**Initiating legal proceedings**

People with mental illness can face barriers to initiating legal proceedings. Many people with serious mental illness are financially disadvantaged, and therefore more reliant on legal aid, community legal centres and pro bono legal advice (Karras et al. 2006). It is well recognised that resource constraints exist in the legal assistance sector including specialist disability legal services (Law Council of Australia 2018; PC 2014). This has particular implications for people with mental illness who may require more intensive support. For example, they may have difficulties communicating, requiring more time with lawyers (Karras et al. 2006). In some instances, legal services may have to refer people with mental illness on to other services as they do not have resources to assist themselves.

**Participating in legal proceedings**

People with mental illness can face barriers to participating in legal proceedings due to the inflexible and adversarial nature of courts. The ACT Government (2019b, p. 10) stated that the justice system ‘is at its core an adversarial one … as such it is not a system designed for people who experience any degree of complexity in demonstrating legal capability such as people with [physical and mental] disabilities’. Karras et al. (2006, p. 153) said:

… it is apparent that people with a mental illness have particular needs that must be addressed during the legal process. They might need more time to communicate, [more] breaks in proceedings in order to address anxiety and stress, and clarification of the process itself.

Negative attitudes and stigma within the legal system is an additional barrier. The Law Council of Australia (2018, p. 34) found that ‘people with [mental and physical] disability continue to face negative stigma, prejudice and discrimination, which creates significant barriers to accessing justice’. This prejudice against people with mental illness can be seen across multiple areas in the justice system including the police and courts. For example, people with mental illness are often not viewed as ‘credible’ victims or witnesses (Karras et al. 2006).
Access to justice for victims of crime

Victims with mental illness can face barriers reporting crime and thereby accessing their legal rights. Low rates of crime reporting are evident for victims of crime more generally (McCart, Smith and Sawyer 2010), but people with mental illness can face additional barriers. For example, a person’s mental illness can affect their ability to explain and retell events properly. Further, victims with mental illness may mistrust or fear authority and the justice system, as a result of previous bad experiences, which discourages them from reporting crime (Law Council of Australia 2018).

Moreover, when people with mental illness do report crime to the police, they may not be taken seriously (Karras et al. 2006). Victoria Police (2019, p. 14) said:

… victims/survivors with mental health conditions [who] report abuses to organisations including hospitals and police … may have their story seen as a false report, and/or not have their case proceed to court … [because they may be] perceived as unreliable informants about their life experiences.

Victims with mental illness also face barriers accessing their legal rights even after reporting the offence. For example, they may face difficulties participating in the victims claims process. And often, they may have no knowledge of entitlements under victim compensation schemes (Karras et al. 2006). In cases where proceedings have commenced, processes that are not ‘trauma-informed’ can re-traumatise people (VLRC 2018). Slow and complex claims processes can further affect their mental health (Collie 2019).

Disability justice strategies

There are a range of different programs and initiatives that can alleviate the barriers discussed above, including: establishing mental health legal centres, case management, providing adequate training to staff working in the justice system, and involving independent intermediaries in police interviews and courts (box 21.14). Recognising that a range of initiatives and programs exist to promote access to justice for people with mental illness, an assessment of these programs is beyond the scope of this Inquiry.

However, it is desirable for State and Territory Governments to adequately fund and support programs that have been shown to be effective in promoting access to justice for people with mental illness. A mechanism through which this could be achieved is through disability justice strategies. The Australian Human Rights Commission (2014, p. 6) recommended State and Territory Governments each develop a Disability Justice Strategy that provides a holistic, over-arching response and sets actions to implement. Not all jurisdictions have established these strategies. State and Territory Governments should develop and implement disability justice strategies to ensure the rights of people with mental illness are promoted in the justice system.

Disability justice strategies should aim to holistically support the needs of individuals, connecting them to other support services they may need (beyond the justice system), including community mental health services. For example, the ACT’s Disability Justice Strategy 2019–29 has ‘better service delivery’ as a focus area, including effectively linking individuals in contact with the justice system with human services in the community to provide more ‘complete’ services and supports, benefiting the individual (ACT Government 2019a, p. 18).
Box 21.14 Some initiatives to reduce barriers to accessing justice

Helping people with mental illness initiate legal proceedings

Different initiatives aim to address barriers people face in initiating legal proceedings. This includes the establishment of specialist mental health legal centres that employ solicitors with appropriate communication skills (Karras et al. 2006). Examples include Victoria’s Mental Health Legal Centre and Western Australia’s Mental Health Law Centre. Additionally, legal aid and community legal centres provide training on mental illness to their solicitors, including on how to identify mental illness and how to work with people with mental illness (Karras et al. 2006).

Supporting people with mental illness participate in legal proceedings

An approach to support people with mental illness participate in legal proceedings is to provide case management. Case management can increase participation and improve the efficiency of proceedings by reducing delays (Karras et al. 2006). Even where informal legal processes (such as alternative dispute resolutions) are used, people with mental illness may still need support (Karras et al. 2006).

Providing adequate training to staff working in the justice system can help challenge those negative stereotypes about mental illness that can create barriers for people (Law Council of Australia 2018). Although the importance of training is recognised and supported in Australia, there are concerns that existing training is inadequate (Law Council of Australia 2018).

There are also initiatives that involve independent third parties supporting people with mental illness to better communicate and engage. For example, Victoria’s Intermediary Pilot Program places communication specialist intermediaries in police interviews with victims and at court. The program aims to support individuals with a range of needs, including mental illness and complex trauma (VIC DJR 2018; Victoria Police 2019).

Access to legal services in mental healthcare settings — health justice partnerships

People with mental illness are more likely to experience legal problems, but it also shows that they are more likely to speak to non-legal advisors about legal issues, including healthcare providers (Coumarelos et al. 2012). However, non-legal advisors often lack legal knowledge or knowledge about where to refer individuals to assist them (Karras et al. 2006). For example, in some states and territories, a person with mental illness is eligible to have their fines reviewed and revoked, if it can be shown that they had a mental illness at the time the fine was incurred (VLA 2019b). However, a specialist mental health professional may not know this.

Recognising this, there has been movement towards a more ‘integrated’ approach to support individuals (Coumarelos et al. 2012). Health justice partnerships (HJPs) (also known as medical justice partnerships) embed legal services into healthcare settings, providing a holistic approach to addressing vulnerable individuals who have both mental health and legal issues (NSW MHC 2016).
There were 73 HJPs operating in Australia in 2018, with most located in New South Wales and Victoria (table 21.6). HJPs have been gaining traction in Australia from 2014, increasing four-fold between 2014 and 2018 (Forell and Nagy 2019). Few HJPs are co-located within community mental health services, or focus on people with mental illness (Health Justice Australia 2020; Mind Australia 2018a). The structure and nature of HJPs can vary substantially, reflecting differences in local needs. However, common elements include: their promotion of integration, early intervention, systemic change and person-centred services. The legal support they provide varies across a spectrum of needs: from ‘advocating for public housing tenants to address untreated mould’ to ‘assisting people with accumulated fines or debt’ (Health Justice Australia 2019, p. 2).

<table>
<thead>
<tr>
<th></th>
<th>Estimated number of Partnerships</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>29</td>
</tr>
<tr>
<td>Victoria</td>
<td>28</td>
</tr>
<tr>
<td>Queensland</td>
<td>7</td>
</tr>
<tr>
<td>South Australia</td>
<td>1</td>
</tr>
<tr>
<td>Western Australia</td>
<td>1</td>
</tr>
<tr>
<td>Tasmania</td>
<td>0</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>3</td>
</tr>
<tr>
<td>ACT</td>
<td>4</td>
</tr>
<tr>
<td><strong>Australia</strong></td>
<td><strong>73</strong></td>
</tr>
</tbody>
</table>

*Source: Adapted from Forell and Nagy (2019).*

Evaluations of HJPs show they improved access to legal advice, built capacity among health professionals to identify legal issues and improved health outcomes for people (Ball, Wong and Curran 2016; Beeson, Mcallister and Regenstein 2013; Redfern Legal Centre 2015). They can be particularly effective for some population sub-groups — for example, Aboriginal and Torres Strait Islander people, and especially where the HJP included an Aboriginal Community Controlled Health Organisation (Allison 2019).

Health justice partnerships [with Aboriginal Community Controlled Health Organisations] … address people’s fears and distrust about the justice system. These partnerships provide a culturally safe setting in which to have conversations about legal matters. (NACCHO, sub. 1226, p. 12)

However, funding constraints have challenged the operation and expansion of HJPs. Youth Law Australia (sub. 433, p. 2) stated that the ‘primary barrier’ to expanding HJPs is funding, noting that HJPs are expensive — a well-resourced program would require mental health staff with training in identifying legal issues, and legal professionals to provide advice and advocacy support. Kingsford Legal Centre (sub. 469) and the Mental Health Legal Centre (sub. 1222) stated that more funding is required to support the expansion and ongoing operation of HJPs.
Currently, most HJPs are ‘single-site’, involving a single mental health service and a community legal service, but there is scope for HJPs in mental health to operate at a ‘multi-site’ level to help more people with mental illness access legal services. This is an innovative approach in Australia and has gained some support in practice. For example, Mind Australia recently received a $430 000 grant (which will be delivered over two and a half years) to expand its single-site HJP to a multi-site one, between its community mental health services and six community legal services (Mind Australia 2018b; sub. 380).

Multi-site HJPs would enable better evaluation and research to inform policy and program development in this area. Single-site HJPs can limit data collection and analysis because sample sizes can be small. For example, Mind Australia’s single-site HJP with WEstjustice assisted 38 clients over a period of 22 months (Mind Australia, sub. 380). Enabling better evaluation and research for local HJPs is important because the empirical evidence is underdeveloped (Health Justice Australia, sub. 749).

Multi-site HJPs could also enable opportunities to build system capacity, for example, by providing education and training programs, which are costly (and less worthwhile) for single-site HJPs with fewer staff.

Many submissions emphasised support for HJP approaches, and for government to help build the evidence base (for example, APS, sub. 543; MHLC, sub. 315; NMHC, sub. 949; QAI, sub. 889; VLA, sub. 500).

Health justice partnerships are relatively new in Australia, so properly-evaluated ‘empirical evidence’ of a standard likely to satisfy government is unlikely to exist. Rather, QAI urges the Commission to consider supporting such partnerships on the basis of (1) the significant body of research into their philosophy, approach and design, and (2) the underlying philosophy of coordinating and co-mingling cooperative health and legal services, given the identifiable needs of what are in practice many shared clients (about whom much is already well-known). (QAI, sub. 889, p. 10)

There is value in better integrating legal and health services, and HJPs show promise. Although qualitative evaluations support HJPs, the evidence base is underdeveloped. State and Territory Governments should fund pilot programs of multi-site (rather than single-site) HJPs to improve access to legal services for people with mental illness, which would also enable greater data collection for more rigorous evaluation and better inform future policy and program development. In doing so, State and Territory Governments should consult with relevant stakeholders to ensure a nationally coordinated approach. Assuming each pilot program costs $430 000 (as is the case for Mind Australia’s project), establishing them in other states and territories would cost about $1.2 million per year. However, the costs would depend on the number of mental health and legal services involved in the multi-site HJP and the number of multi-site HJPs established (appendix K).
**ACTION 21.7 — HEALTH JUSTICE PARTNERSHIPS AND DISABILITY JUSTICE STRATEGIES**

Integrating legal and health services for people with mental illness can lead to better outcomes for both individuals and the justice system.

**Start now**

State and Territory Governments should fund pilot programs of multi-site health justice partnerships to:

- improve access to legal services for people with mental illness
- enable larger volumes of data to be collected and build an evidence base
- inform future policy and program development in this area.

Funding should also be allocated to rigorous evaluations of the pilot programs.

State and Territory Governments should consult with relevant stakeholders to ensure a coordinated approach.

**Start later**

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

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

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**Legal representation in mental health tribunals**

All states and territories have mental health legislation that enables the involuntary commitment and treatment of people with acute psychiatric illness (RANZCP 2017) — referred to as ‘mental health orders’ in this report. Mental health orders require individuals to receive involuntary treatment in inpatient facilities or in the community. Individuals can also be subject to involuntary electro-convulsive treatment under mental health legislation. The number of mental health orders (both inpatient and community) has increased over the past several years (figure 21.5).

In most cases, mental health tribunals determine whether or not compulsory mental health treatment (as set out in legislation) applies to persons appearing before them. In South Australia and the ACT, civil and administrative tribunals hear those applications (RANZCP 2017). This chapter uses ‘mental health tribunal’ as an umbrella term to cover all tribunals that deal with matters under mental health legislation.

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Electro-convulsive treatment is a medical procedure that is used to treat a range of mental illnesses. The treatment induces controlled seizures by placing small electrodes at specific locations on the head.
There are concerns that people appearing before mental health tribunals often do not have legal representation. The Mental Health Legal Centre (sub. 1222) said rates of legal representation at mental health tribunals can vary widely across Australia. For example, in 2018-19, individuals had legal representation at only 13% of hearings at Victoria’s mental health tribunal (VIC MHT 2019a). This compares with 83% and 87% in New South Wales (NSW MHRT 2019) and the Northern Territory (NT MHRT 2019), respectively.

Figure 21.5  Estimated number of mental health orders made

Available data suggests there are differences in outcomes if people are legally represented. For example, Victoria Legal Aid (sub. 818, att. 1) stated that in hearings for electro-convulsive treatment where legal representation was provided, 50% had the application refused, compared with 14% overall.\textsuperscript{234} The Mental Health Legal Centre (sub. 1222) also said people who were legally represented were given longer hearings and shorter periods of compulsory treatment orders, compared with those who were not. There

\textsuperscript{234} Some caution needs to be taken in comparing these statistics as the Victoria Legal Aid sample is not representative of all individuals with matters before the tribunal. This is because Victoria Legal Aid applies a representation guideline and cannot represent those who do not have capacity to give instructions, or do not want legal representation (Victoria Legal Aid, sub. 818, att. 1)
may be several reasons for this, including: legal representation can help people with mental illness better present their cases, and may also encourage people to attend their hearing, influencing outcomes (Victorian Mental Health Tribunal, sub. 748). For example, in Victoria where legal representation is lower, 56% of hearings had individuals attend their own hearing, compared to an 86% attendance rate in New South Wales, where legal representation is higher (NSW MHRT 2019; VIC MHT 2019a).

However, the Victorian Mental Health Tribunal (sub. 748) submitted that care should be taken, when drawing conclusions about the link between legal representation and outcomes of mental health tribunals. Legal representation should not be asserted as a primary determinant of hearing outcomes, because there is a ‘complex mix of factors and potential biases’ (Victorian Mental Health Tribunal, sub. 748, p. 7). For example, individuals with more severe or complex mental illness are potentially under-represented in the cohort of people with mental illness who are legally represented, to the extent that they may face difficulties speaking to or instructing lawyers.

Regardless of other factors that also influence tribunal decisions, it is the Productivity Commission’s view that individuals appearing before mental health tribunals should have the right to access legal representation if they choose. Mental health tribunals make decisions that can affect some of the most fundamental rights of individuals. People with mental illness can face difficulties representing themselves, either because of their illness itself or other communication barriers (Law Council of Australia 2018). These difficulties can apply to court settings as well as in more informal settings, such as tribunals (Karras et al. 2006).

Currently, legal representation is not an automatic right in all states and territories. For example, in Victoria, it is the responsibility of the person appearing before a mental health tribunal to access legal assistance, as there is no automatic right to legal representation (MHLHC, sub. 1222). As a result, processes (at a system level) may not be in place to facilitate access to legal assistance. In Victoria, the provision of hearing lists, sharing of an individual’s information and access to individuals by legal assistance services, is largely at the discretion of mental health services (VLA 2019a).

Further, there is inadequate resourcing of legal assistance for these matters. The Mental Health Law Centre in Western Australia, Queensland Advocacy Incorporated and the Northern Territory Legal Aid Commission have stated that they face difficulties in providing assistance to individuals most in need (including those appearing before mental health tribunals) as a result of low levels of resourcing (Law Council of Australia 2018; NTLAC, sub. 410). In this regard, a review of South Australia’s Mental Health Act 2009 (SA) said increased legal assistance should be considered (Corkhill 2014). Even where mental health-focused legal assistance services are provided, resourcing constraints in the broader justice system can place pressure for resolution of cases (Law Council of Australia 2018).

Given persistent difficulties in lifting the resourcing of the overall legal assistance sector, one option is for State and Territory Governments to provide grants to legal assistance providers specifically for cases under mental health legislation. This could be modelled on the approach taken under the National Disability Insurance Scheme, where specific funding...
(separate from other legal aid funding) is made available to legal aid commissions for appeals relating to the scheme. In particular, grants decisions are made with consideration of the applicant’s capacity to self-represent or obtain other legal assistance (DSS 2018i).

The Productivity Commission estimated that the cost of ensuring people appearing before mental health tribunals receive legal representation was about $49 million (2019 dollars), based on an estimated cost of $1128 per case (2019 dollars) (appendix K).

**ACTION 21.8 — LEGAL REPRESENTATION AT MENTAL HEALTH TRIBUNALS**

People with mental illness require appropriate legal representation to protect their rights.  
*Start now*

State and Territory Governments should ensure people appearing before mental health tribunals and other tribunals that hear matters arising from mental health legislation have a right to access legal representation. To facilitate this, State and Territory Governments should adequately resource legal assistance services for this purpose — for example, through broader legal assistance funding or a specific legal assistance grant.

**The importance of supported decision making**

All states and territories have reformed or amended their mental health legislation, after the ratification of the *UN Convention of the Rights of Persons with Disabilities* in 2008 (Callaghan and Ryan 2016; Ouliaris and Kealy-Bateman 2017). Specifically, the aim was to replace the model of ‘substituted decision making’ with a ‘supported decision making’ model — where a person makes treatment decisions themselves, with support, if required. The Law Council of Australia (sub. 1204, p. 9) said ‘supported decision making model should always be the starting point, with substituted decision making a last resort’.

Not all Australian jurisdictions have achieved a supported decision making model (Ouliaris and Kealy-Bateman 2017). There are concerns that clinicians or tribunals can make treatment decisions on behalf of individuals. This contradicts the fundamental principle that people should be empowered to make their own choices about their own care and treatment (chapter 4).

A review of state and territory mental health and guardianship legislation was beyond the scope of this Inquiry, but the Productivity Commission has reviewed and recommended existing interventions and mechanisms to strengthen supported decision making, including:

- individual non-legal advocacy services
- mental health advance directives.
Individual non-legal advocacy services

The aim of state and territory mental health legislation is to ensure people are provided treatment and care, and that their rights are protected.

In theory, individuals at risk of, or subject to, compulsory treatment must have their participation in treatment decisions actively promoted. This is aligned with the broader principle that people should be involved in their treatment (ACSQHC 2017b). Having individuals participate in their treatment decisions can ensure that the least possible restriction is imposed on their freedom, as intended by mental health legislation. Although treating professionals and others may aim to consider the ‘best interests’ of the individual, it is important that, wherever possible, they support that person to present their own wishes about their treatment (VLA, sub. 500, att. 1).

However, in practice, individuals may face difficulties participating in treatment decisions. Some individuals subject to mental health orders have identified instances where mental health services have not provided treatment information, or adequately explained treatment to them (VLA, sub. 500, att. 1). Victoria’s Mental Health Complaints Commissioner (2019b, p. 36) said that:

> [it] is clear from complaints to the MHCC [Mental Health Complaints Commissioner] that many people receiving treatment, particularly compulsory inpatient treatment, do not receive sufficient support to exercise their right to make decisions about their mental health treatment.

Individual non-legal advocacy services can ensure the rights of people are better protected. They are provided by professionals from a range of backgrounds (including consumer advocacy and social work) who empower people, by advising them on their rights, representing their wishes in day-to-day decision making, and identifying and addressing issues (WA MHAS 2019b; VLA, sub. 500, att. 1). Non-legal advocacy services differ from legal advocacy or services, and are not substitutable. For example, non-legal advocates are not trained to interpret mental health legislation and cannot provide legal representation.

All State and Territory Governments fund non-legal advocacy services that assist people who are subject to, or facing the prospect of, involuntary treatment. However, service delivery models differ across jurisdictions.

- New South Wales and Victoria provide these services through parts of the state legal aid commissions (separate to the legal teams).
- Queensland and Tasmania provide these services through separate incorporated entities, with both State and Australian Government funding.
- South Australia and the ACT provide these services through their Office of the Public Advocate.
- Western Australia provides these services through the Chief Mental Health Advocate, which is a statutory office.
- The Northern Territory provides these services through its Community Visitor Program.
The Productivity Commission has not rigorously assessed the different delivery models across states and territories, but recognises some benefits of the Western Australian model, where non-legal advocacy services are established in legislation and provided by a statutory agency (Western Australia Chief Mental Health Advocate sub. 934). This can result in clearer functions and relatively strong powers for advocates — for example, the right to question mental health professionals and to view medical files. The model can also ensure greater responsibility and accountability, and can lead to more consistent funding.

There is merit in State and Territory Governments adequately funding non-legal advocacy services to promote supported decision making. Consumers value these services, and feel they improve their capacity to self-advocate (VLA, sub. 500, att. 1).

However, there are concerns these services are unable to meet demand as a result of under-resourcing. For example, an evaluation of the Individual Mental Health Advocacy (IMHA) program found insufficient resourcing as a key barrier to its continued success (VLA, sub. 500, att. 1). The IMHA needs ‘twice as many advocates’ to meet demand within the current system. In Western Australia, individuals are appointed an advocate as soon as they are subject to an involuntary hospitalisation or treatment order (unless they opt out) (Mental Health Act 2014 (WA), s. 357). However, concerns of under-funding have been raised in Western Australia as well (WA MHAS 2018).

Further, individuals subject to compulsory treatment, and their families and carers may be unaware of non-legal advocacy services. Elucidate (sub. 755, p. 1) said it ‘still encounters consumers and families that do not know [about the] Mental Health Advocacy Service’. One way to raise awareness could be through better education — mental health professionals and facilities could explain to individuals what these services are, how they are beneficial and how to access them. Another option could be to ensure non-legal advocacy services are automatically notified and referred cases where people become subject to involuntary hospitalisation or a treatment order, with the option for the individual to opt out. This was a recommendation made in the evaluation of IMHA (VLA, sub. 818). In the ACT, the public advocate must be notified, if an individual is detained at a mental health facility (Mental Health Act 2015 (ACT), s. 65). The Productivity Commission is of the view that the latter option has potential to be more effective.

The cost of non-legal advocacy services would vary depending on the number of mental health orders made. The number of orders varies by state and territory (table 21.7), although they are consistently small as a proportion of the population.
The cost of funding non-legal advocacy services was estimated based on data from the Western Australia Mental Health Advocacy Service. The total cost to provide such services nationally was estimated to be about $13 million. This assumes everyone subject to mental health orders demands non-legal advocacy services, which may not be the case (appendix K).

### Table 21.7 Estimated number of mental health orders\(^{a}\)

Made during 2018-19

<table>
<thead>
<tr>
<th></th>
<th>Inpatient treatment orders</th>
<th>Community treatment orders</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>5,521</td>
<td>5,599</td>
</tr>
<tr>
<td>Victoria</td>
<td>2,462</td>
<td>3,835</td>
</tr>
<tr>
<td>Queensland</td>
<td>941</td>
<td>4,392</td>
</tr>
<tr>
<td>South Australia</td>
<td>126</td>
<td>1,377</td>
</tr>
<tr>
<td>Western Australia</td>
<td>3,266</td>
<td>850</td>
</tr>
<tr>
<td>Tasmania</td>
<td>421(^{b})</td>
<td>na</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>281</td>
<td>209</td>
</tr>
<tr>
<td>ACT</td>
<td>608</td>
<td>13</td>
</tr>
</tbody>
</table>

\(^{a}\) These are estimates based on statistics from State and Territory Government annual reports and are not directly comparable. Data from Queensland and South Australia refers to the number of mental health orders as at June 2019. There are also variations across jurisdictions in the way involuntary mental health orders are defined. \(^{b}\) A break-down of Tasmanian data between inpatient and community treatment orders was not available. na Not available.

Source: ACAT (2019); NSW MHRT (2019); NT MHRT (2019); Queensland Health (2019a); SA DHW (2019); TAS MHT (2019); VIC MHT (2019a); WA MHAS (2019a).

**ACTION 21.9 — INDIVIDUAL NON-LEGAL ADVOCACY SERVICES**

Non-legal advocates can help support individuals subject to involuntary detention under mental health legislation.

**Start later**

State and Territory Governments should ensure individual non-legal advocacy services are available for any individual detained under mental health legislation. In particular, services should:

- focus on facilitating supported decision making by individuals
- be adequately resourced to provide assistance to individuals who require it
- not replace legal advocacy services.

Where an individual is detained under mental health legislation, or agrees to mental health treatment in lieu of being detained under mental health legislation, the treating facility should notify non-legal advocacy services and the individual’s family or carer.
Mental health advance directives

Mental health advance directives (also known as advance statements or agreements) are a key legislative tool available in some states and territories to formally facilitate supported decision making by mental healthcare consumers. They are prepared when a person anticipates they may become subject to compulsory mental health treatment in the future, due to the episodic nature of their illness (Maylea et al. 2018). Advance directives enable individuals to state their personal values and preferences regarding future treatment and their recovery (Henderson et al. 2008). This can include, for example, identifying preferences for medication, nominating carers and specifying the types of information to be shared with them (chapter 18), detailing previous trauma, asking for access to music or writing materials.

The ACT, Queensland, Victoria and Western Australia have recognised advance directives in legislation, but differences exist (table 21.8) (Ouliaris and Kealy-Bateman 2017).235

The ACT’s legislation appears to offer the strongest safeguards compared to other states and territories, with a mental health specific approach — allowing consumers to create an ‘advance agreement’ or ‘advance consent direction’ (Maylea et al. 2018, p. 3).236 In the ACT, the treating professional is legally required to tell individuals as soon as possible that they can enter into an advance agreement or advance consent direction. If an individual has an advance consent direction, the treating professional must receive consent from that individual or their guardian to deviate from it. Otherwise, the treating professional must apply to the ACT Civil and Administrative Tribunal to override it (Mental Health Act 2015 (ACT), s. 28).

Studies have found advance directives can reduce coercion, increase consumer satisfaction and improve therapeutic relationships (Maylea et al. 2018; Ouliaris and Kealy-Bateman 2017). However, research also found advance directives led to no significant difference in hospital admissions, compliance with treatment or self-harm (Campbell and Kisely 2009).

There is support for advance directives. Submissions highlighted their importance in empowering consumers (for example, Justice Action, sub. 929; MHLC, sub. 1222; MHV, sub. 580, att. 2; Karola Mostafanejad, sub. 570, att. 1). The Mental Health Legal Centre (2019) said its clients found completing advance statements (as they are referred to in Victoria) validating, helping them understand the trajectory of their treatment and recovery, and build trust and confidence in treatment. The ACT Mental Health Consumer Network

235 Mental Health Act 2007 (NSW), Mental Health Act 2014 (Vic), Mental Health Act 2016 (QLD), Mental Health Act 2009 (SA), Mental Health Act 2014 (WA), Mental Health Act 2013 (Tas), Mental Health and Related Services Act 1998 (NT), Mental Health Act 2015 (ACT).

236 An advance agreement is entered into by a consumer with their treating team. It sets out information relevant to their treatment, care or support that is not considered appropriate to include in an advance consent direction (such as nominated contact persons), as well as any preferences concerning practical help (such as arranging for payment of bills or caring for a close relative or friend). An advance consent direction can be made by a consumer to specify the treatment, care or support they consent to, including particular medications or procedures (Mental Health Act 2015 (ACT), ss. 26-27).
developed the *My Rights, My Decision* program, to support individuals to create advance agreements and advance consent directions (PACYPC, sub. 291).

### Table 21.8 Legislation provisions for advance directives 2020

<table>
<thead>
<tr>
<th>Legislation provision for advance directive?</th>
<th>Is the advance directive legally binding?</th>
<th>The advance directive does not need to be followed if:</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales No</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>Victoria Yes — advance statements</td>
<td>No. An authorised psychiatrist must have regard to the views and preferences expressed in a person's advance statement</td>
<td>The authorised psychiatrist is satisfied that the preferred treatment is not clinically appropriate or is not provided by the designated mental health service</td>
</tr>
<tr>
<td>Queensland Yes — advance health directives</td>
<td>Yes. An advance health directive must be used in preference to an involuntary order and an authorised doctor must take reasonable steps to find out if the person has one</td>
<td>The authorised doctor explains to the person reasons why the decision was made and records the reasons in the consumer's health records</td>
</tr>
<tr>
<td>South Australia No</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>Western Australia Yes — advance health directives</td>
<td>No. A person or body required under the Act must have regard to any treatment decision in an advance health directive</td>
<td>The psychiatrist records the reasons why the decision was made and provides a copy to the patient and other specified parties</td>
</tr>
<tr>
<td>Tasmania No</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>Northern Territory No</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>ACT Yes — advance agreement and advance consent direction</td>
<td>Yes. A person must be informed and given the opportunity to make an advance agreement or an advance consent direction and a mental health professional must take reasonable steps to find out if one is in force and act accordingly</td>
<td>A mental health professional believes on reasonable grounds that giving treatment, care or support in accordance with the advance consent direction is unsafe or inappropriate and the person or their guardian, health attorney or attorney gives consent; or The ACT Civil and Administrative Tribunal, on application by the mental health professional, makes an order to do so</td>
</tr>
</tbody>
</table>

*na* Not available.

*Source: Productivity Commission analysis based on Ouliaris and Kealy-Bateman (2017).*
Despite this, only a small proportion of mental health consumers complete advance directives. For example, in Victoria, only 2.8% of consumers of public mental health services had an advance statement recorded in 2018-19 (VIC DHHS 2019b). This compares with 15% of consumers at the ‘best performing’ mental health service in the State (OPA Victoria 2019, p. 14). There are a few reasons for the low uptake, including that:

- consumers are not aware of them (Maylea et al. 2018)
- consumers view them as having little value given enforcement limitations (VLA, sub. 500, att. 1)
- consumers can face difficulties drafting advance directives (MHLC 2019).

State and Territory Governments could do several things to increase the use of advance directives among consumers, to facilitate supported decision making. First, they could be made a requirement for mental health professionals to inform consumers of their right to complete advance directives. This is the case under ACT legislation (Mental Health Act 2015 (ACT), s. 25).

Second, State and Territory Governments could ensure advance directives are better safeguarded, to strengthen their ability to facilitate supported decision making, and therefore, their appeal to individuals. As table 21.8 shows, advance directives are only legally binding in Queensland and the ACT, and only specific to mental health in the ACT. State and Territory Governments could examine the regime in the ACT, to give mental health advance directives more weight, encouraging greater uptake. This would be a matter for further consultations for those jurisdictions.

Third, State and Territory Governments could make advance directives more accessible among mental health professionals. For example, in Victoria, the existence of an advance statement (as they are referred to in Victoria) is noted on an individual’s record, but not centrally located (MHLC, sub. 1222). Therefore, the individual must have ready access to their advance statement if they present at an unfamiliar mental health service — an unreasonable expectation if the person is experiencing a mental health crisis. In Queensland, the Chief Psychiatrist is required to maintain an electronic records system of advance health directives (Mental Health Act 2016 (QLD), s. 225). The Mental Health Legal Centre (2019) said a central repository for advance statements, with oversight from the mental health tribunal, could be considered. First responders could also have access, if the consumer consents (Mental Health Complaints Commissioner (Victoria), sub. 916; MHLC, sub. 1222).

Finally, State and Territory Governments could ensure individuals are supported to complete mental health advance directives, if needed. There are different ways to provide support to consumers — for example, it could be through outreach services located at mental health facilities (MHLC 2019), or through online resources and supporting workshops (ACT MHCN 2019).

However, service providers highlighted that there is inadequate funding for such support services. For example, Victoria Legal Aid (sub. 500, att. 1, p. 34) said its IMHA service
‘consistently passed on information [about advance statements] … but often did not actually provide support to make one’ due to insufficient funding.

The MHLC has spent over 12 years campaigning for and promoting advance statements which were introduced in the Mental Health Act 2014. We were concerned that the Department of Health and Human Services were not funding practical supports for people to prepare advance statements and sought philanthropic backing to support this critical service. (MHLC 2019, p. 9)

The cost of providing support would depend on the approach. For example, an outreach model would likely cost more than the provision of online resources and supporting workshops. The Productivity Commission was advised that the cost per advance statement under an outreach model was about $750 (General Manager, MHLC, pers. comm., 11 March 2020). This was multiplied with the number of mental health orders — which was used as a proxy for the number of people who want or need an advance directive. Based on this, the total cost to provide support services would be $22 million (2019 dollars) (appendix K).

**ACTION 21.10 — MENTAL HEALTH ADVANCE DIRECTIVES**

Mental health advance directives can help ensure that the wishes of a person with mental illness are able to be met.

*Start now*

State and Territory Governments should ensure that advance directives are:

- formally recognised in mental health legislation
- actively promoted to raise awareness among mental health consumers of the scope to use such an instrument to state their preferences regarding future treatment and recovery, to nominate a carer, and to specify the types of information to be shared with that carer
- contain safeguards that balance consumer choice against urgent treatment needs
- easily accessible by any mental health service.

State and Territory Governments should seek to ensure individuals can access support to help them complete an advance directive, if it is required.

**Mutual recognition of mental health orders**

Mental health orders created in one state or territory may not have effect in others — or, in other words, there is not always ‘mutual recognition’ of mental health orders. This stems from states and territories having their own mental health legislation.

As a result, this can hinder a consumer’s ability to receive seamless and continued care, if they are subject to a mental health order. The Productivity Commission heard of experiences where people had absconded from hospital and travelled interstate, but, because their mental
health order was not recognised, they did not receive ongoing mental healthcare, and became seriously unwell (David Asten, Tasmania transcript, p. 41).

Without mutual recognition of mental health orders, the capacity for states and territories to ensure seamless and safe care for individuals who wish to move interstate is compromised. It is difficult for care to be continued unless a similar order is made in the new jurisdiction.

State and Territory Governments have long acknowledged these issues, and have attempted to address them since the First National Mental Health Plan in 1993 (table 21.9). The Fifth National Mental Health and Suicide Prevention Plan included action 26, calling for governments to ‘improve consistency across jurisdictions in mental health legislation’ (COAG Health Council 2017a, p. 44). The Safety and Quality Partnership Standing Committee was tasked with implementing this (COAG Health Council 2017b, p. 28).

### Table 21.9  Attempts to ensure mutual recognition of mental health orders  
Between 1993 and 2015

<table>
<thead>
<tr>
<th>Committed actions and developments</th>
</tr>
</thead>
<tbody>
<tr>
<td>First National Mental Health Plan (1993–1998)</td>
</tr>
<tr>
<td>Third National Mental Health Plan (2003–2008)</td>
</tr>
<tr>
<td>Fourth National Mental Health Plan (2009–2014)</td>
</tr>
<tr>
<td>Fifth National Mental Health and Suicide Prevention Plan (2015–2020)</td>
</tr>
</tbody>
</table>


All states and territories have made legislative provisions for interstate arrangements; however, they are not all operational. For legislative provisions to come into force or be ‘activated’, bilateral (or Ministerial) agreements must be signed (Tasmanian Office of the Chief Psychiatrist 2019, p. 96). Western Australia, Tasmania and the Northern Territory do not have any bilateral agreements currently in place.
There are several reasons why states and territories have not developed or maintained bilateral agreements. For example, a recent review of Tasmania’s mental health legislation found that:

The legislation in place in jurisdictions uses distinct frameworks and terminology and imposes unique requirements for transfer, all of which makes development and implementation of agreements complex and time consuming. As a small jurisdiction Tasmania has also found it difficult to prioritise development of agreements over other work. (Tasmanian Office of the Chief Psychiatrist 2019, p. 96)

Recognising that bilateral agreements have unintentionally created barriers to interstate arrangements, the Safety and Quality Partnership Standing Committee (in implementing action 26 of the Fifth National Mental Health and Suicide Prevention Plan) has investigated better options for mutual recognition of mental health orders. A national legislative scheme has been proposed (Tasmanian Office of the Chief Psychiatrist 2019) although the Productivity Commission was informed that further scoping work is required before it can be progressed for review by Australian, State and Territory Government health ministers.

State and Territory Governments must ensure there is mutual recognition of mental health orders across Australia. Any national approach to ensure mutual recognition of mental health orders, whether it is a national legislative scheme or not, should also consider barriers to implementation and the development of a supporting implementation plan or strategy. For example, any such approach would need to consider how information would be accessed and shared between states and territories to ensure mutual recognition can work in practice. This may require development of appropriate information sharing systems.

**ACTION 21.11 — MUTUAL RECOGNITION OF MENTAL HEALTH TREATMENT ORDERS**

State and Territory Governments should ensure there is mutual recognition of mental health treatment orders across Australia.

*Start later*

The Safety and Quality Partnership Standing Committee should complete work on an appropriate national approach to ensure mutual recognition of mental health treatment orders. The national approach should consider both legislative mechanisms and implementation needs, and be agreed to by all State and Territory Governments. This should be completed by 2025.

All State and Territory Governments should work collaboratively to implement the national approach.
Part V – ENABLERS OF REFORM
Stronger governance of Australia’s mental health system matters because ...

- The mechanisms for holding jurisdictions accountable for mental health outcomes are weak and poorly developed.
- Strategic planning in mental health focuses on the health sector without adequately integrating other sectors.
- A lack of consumer and carer involvement in strategy, programs and accountability lowers the quality of decision making and system performance.
- The absence of a robust culture that requires demonstration of program impact and evaluation impedes system innovation and continuous improvement.
Governments should, in collaboration with consumers and carers, commit to a more strategic and cross-portfolio approach to mental health that promotes genuine accountability and that prioritises prevention, early intervention and recovery.

As a priority:

- 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. (Action 22.1)

- The Australian Government should expedite the development of an implementation plan for the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2017–2023. (Action 22.2)

- The Australian, State and Territory Governments should establish a clear, ongoing role for consumers and carers in all aspects of mental health system planning, design, monitoring and evaluation. (Action 22.4)

- The National Mental Health Commission should have statutory authority. It should lead the evaluation of government-funded mental health and suicide prevention programs, and other government-funded programs that have strong links with mental health outcomes, including those in non-health sectors. (Action 22.7)

Additional reforms that should be considered:

- The Australian, State and Territory Governments should establish a Special Purpose Mental Health Council to facilitate mental health reforms across health and non-health portfolios. (Action 22.3)

- The Australian Government should fund separate representative peak bodies to represent the views, at the national level, of people with mental illness, and of families and carers. (Action 22.4)

- A national, independent review of Australia’s system for handling consumer complaints that relate to the use of mental healthcare services and supports should be instigated. (Action 22.5)

- Where a body does not exist, State and Territory Governments should each establish a body (such as a mental health commission) that is responsible for strengthening government capability to pursue continuous policy and program improvement and fostering genuine accountability for mental health reform. (Action 22.6)
Major reforms are needed to the governance arrangements that underpin Australia’s mental health system. Inquiry participants concurred that the existing arrangements lack effectiveness and contribute to system failure.

Clearly the [Productivity] Commission, after meetings and consultations right across the country, has already heard the message that ‘the system’ is broken. Fragmentation, gaps, duplication, lack of accountability, lack of evaluation, lack of funding, lack of cohesion, lack of strategy, lack of governance. (Quinlan 2019)

The issue of governance is particularly important when addressing adverse experiences for people in emergency departments, and the interface of responsibilities of emergency department staff and mental health service staff, and the roles played by security staff in these environments. (Mental Health Complaints Commissioner (Victoria), sub. 321, p. 4)

These reforms are long overdue for issues have continued to accumulate, rather than abate. To begin with, governance has not kept pace with decision making by both the Australian and State and Territory Governments and issues raised in major reviews persist (box 22.1). Further, a shared responsibility and a vertical fiscal imbalance have seen the Australian Government shift from having no mental health responsibilities to playing a major role, particularly since the mid-2000s.

Box 22.1  Governance issues raised by major reviews

Dissatisfaction with funding arrangements prompted a national survey of the mental health system in 1955 when State and Territory Governments were responsible for all mental health services (Stoller and Arscott 1955). Although the Stoller Report regarded the extent to which the Australian Government should be involved in mental health as a political decision, it suggested several roles that it could take on, namely: funding (possibly including prevention), monitoring and reporting, and disseminating knowledge.

The Burdekin Report (HREOC 1993) applied standards set by the United Nations human rights principles to examine the effectiveness of accountability mechanisms, notably: quality assurance and accreditation, minimum standards and monitoring mechanisms, patient advocacy and complaints procedures. It recommended that the Australian Government should ensure that every jurisdiction had a consistent set of basic controls and standards for protecting the rights of people with mental illness and ensuring they receive appropriate care (HREOC 1993).

The need to resolve governance issues on a wide front had become acute by the time of the National Mental Health Commission’s (2014a) review. Along with numerous other independent and governmental reviews, it identified fundamental shortcomings in the structure of the mental health system and a record of ‘poor implementation or the failure to sustain initiatives’ (NMHC 2014c, p. 13). Many issues had stemmed from governance failures. The National Mental Health Commission recommended clarifying federal roles and strengthening accountabilities for outcomes.
This chapter is the first of three that aim to improve public governance. Chapter 23 focuses on reforms that clarify the funding roles and responsibilities of both tiers of government. Chapter 24 concludes with reforms to promote accountability through an improved framework for monitoring and evaluating system performance. The governance reforms recommended in this chapter are directed at:

- strengthening the National Mental Health Strategy (section 22.2)
- facilitating a cross-portfolio approach (section 22.3)
- enhancing consumer and carer involvement in system design, implementation and review (section 22.4)
- improving accountability (section 22.5)
- simplifying complaints processes (section 22.6)
- building a culture that expects demonstrable program performance (section 22.7).

Section 22.7 provides the institutional architecture needed to enable delivery of the reforms outlined in chapter 24 (Framework for monitoring, evaluation and research).

### 22.1 Current governance arrangements

Public governance is the framework of institutions, rules, conventions, systems, processes and informal customs that guide how government manages its business. The governance arrangements set by most jurisdictions tend to reflect four core principles: clarity of purpose, accountability to Parliament, transparency to the public and optimisation of efficiency and performance (Department of Finance 2015a). Good public governance plays three key roles:

- encouraging closer coordination and integration of services
- promoting public trust in decision making
- assisting governments to achieve the aims and actions to which they commit.

In the mental health sector, specific governance arrangements aim to: clarify roles and responsibilities; give decision makers powers to deploy public resources to improve mental health outcomes; create incentives for efficient resource allocations; facilitate engagement with non-government parties (including consumers and carers); enable monitoring of service use and outcomes; and maintain agreed levels of accountability. These cover the Australian and State and Territory Governments, which share responsibility for mental health.

### Australian Government roles and responsibilities

The Australian Government’s functions in the mental health and suicide prevention system primarily relate to national leadership, policy direction and funding. In its response to the National Mental Health Commission’s (NMHC 2014c) review, the Australian Government
declared that it would lead national mental health reforms and continue to fulfil its responsibilities for: promoting mental health; preventing mental ill-health; reducing stigma; supporting consumer and carer engagement; building the evidence base; and monitoring system performance (DoH 2015). It would also lead the development of national policies such as improving integration of mental healthcare within the primary health context through regional planning and commissioning (Australian Government Department of Health, sub. 556).

The Australian Government has a key role in supporting and funding primary mental healthcare, which includes early intervention, treatment and referral, as well as crisis helplines, mental health education and promotion (COAG 2012). In addition, the Australian Government provides some clinical and non-clinical community-based mental healthcare, partners with non-government organisations to provide a range of community and social support programs that relate to mental health, and subsidises private specialist mental healthcare via Medicare and the Pharmaceutical Benefits Scheme.

Of relevance to this Inquiry, the Australian Government has primary responsibility for physical health services subsidised by the Medicare Benefits Scheme and commissioned through the Primary Health Networks, and other services and supports that assist consumers and carers, namely:

- employment (including the provision of employment services)
- income support for people with psychosocial disabilities, carers and families
- majority funding for non-government schools and universities
- veterans’ affairs.

There are no formal arrangements to guide how the Australian Government as a whole should act to improve population mental health and the social and economic participation of people with mental ill-health, with one exception. The National Indigenous Australians Agency was established in 2019 ‘to lead and coordinate Commonwealth policy development, program design and implementation and service delivery for Aboriginal and Torres Strait Islander people’ (Australian Government 2019b). Health and wellbeing are focus areas among others.

The Department of Health is the mental health policy lead for the Australian Government. The Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) highlights its role in providing funding and policy direction, and its central role in supporting the infrastructure of the mental health system through funding research and digital service delivery (COAG Health Council 2017a). The Australian Government established the National Mental Health Commission in 2012 to play a leading role in the governance of Australia’s mental health system.
State and Territory Government responsibilities

State and Territory Governments, being based where service delivery occurs, play a key role by providing hospital-based, specialised, clinical and community-based mental health services to people with severe and persistent mental illness (COAG 2012). They provide these services both directly and through partnerships with non-government organisations. In addition, they play a role in promotion and prevention, as well as in reducing stigma and discrimination within the community. They also have primary responsibility for the planning and delivery of public health and hospital services, education, early childhood services, housing, disability services, drug and alcohol services, police, justice and corrections services.

In recent years, many States and Territories have established mental health commissions or a variant, often with strong stakeholder networks. Although they all share common purposes — to drive reform and improve accountability — they all differ according to their level of independence and role. There are currently mental health commissions in New South Wales, South Australia, Western Australia (which also commissions mental health services) and Queensland; an Office for Mental Health and Wellbeing in the ACT; and a Mental Health Complaints Commissioner in Victoria. The Victorian agency differs from the other mental health commissions by specifically handling mental health complaints, as well as having an oversight role in recommending service and system improvements. There is no mental health commission in the Northern Territory or Tasmania.

State and territory mental health commissions and the NMHC collaborate on a range of projects both as a collective whole and severally in areas where they have a common interest. These collaborations have underpinned the production of, among other things, the *Equally Well National Consensus Statement* (NMHC 2016), research by the Australian Housing and Urban Research Institute on the link between homelessness and mental health (Brackertz, Wilkinson and Davison 2018) and research on the potential economic and social gains from investing in mental health promotion, prevention and early intervention (NMHC 2019c). All parties recognise the innate usefulness of collaborating, including through biannual/ triannual Commissioners’ meetings (National, State and Territory Mental Health Commissions, sub. 731).

National arrangements

Two strategies outline the direction of mental health policy at a national level. These are the:

- *National Mental Health Strategy*
- *National Disability Strategy*.

The National Mental Health Strategy

The set of documents badged as the National Mental Health Strategy is the policy framework that guides mental health reform nationally. Its purpose is to define "a national direction and a framework for governments to work together to change a system that was widely
acknowledged as inadequate and long neglected by policy makers’ (National Mental Health Strategy Evaluation Steering Committee 1997, p. 3). The Strategy currently comprises:

- the National Mental Health Policy 2008, which states the strategic intent for Australia’s mental health system by: declaring its long-term aims and setting out its future direction; and providing context for, and influence over, the development of state and territory mental health plans (NT DoH 2019; VicHealth and Partners, sub. 131)

- the National Mental Health Statement of Rights and Responsibilities 2012, which ‘seeks to ensure that consumers, carers, support persons, service providers and the community are aware of relevant rights and responsibilities and can be confident in exercising them’ (Standing Council on Health 2012, p. 3)

- the Fifth Plan (COAG Health Council 2017b) and its associated Implementation Plan (COAG Health Council 2017b). The purpose of national plans is to achieve the intent of the National Mental Health Policy by governments agreeing to collaborative actions over a 5-year period. The Fifth Plan commits governments to integrate the mental health system and to improve its transparency, accountability, efficiency and effectiveness


Various national bodies contribute to mental health governance including: the Australian Commission on Safety and Quality in Healthcare; the Australian Health Practitioner Ombudsman and Privacy Commissioner; and the Australian Institute of Health and Welfare.

Until recently, COAG Health Council provided the overarching intergovernmental forum for cooperation on mental health issues, including implementation of the National Mental Health Strategy (COAG Health Council 2014). It comprised the Australian, State, Territory and New Zealand Government Ministers for health, and the Australian Government Minister for Veterans’ Affairs.

However, in mid-2020, the National Cabinet agreed to cease the COAG model and form the National Federation Reform Council to support its single agenda of creating jobs in the wake of the COVID-19 pandemic (Morrison, S. (Prime Minister) 2020a). The National Cabinet identified health as a priority areas of reform to be led by one of six National Cabinet Reform Committees (Morrison, S. (Prime Minister) 2020b). The extent to which the National Cabinet Reform Committee for Health would take over the work of the former COAG Health Council, including implementation of the Fifth Plan, had not been confirmed prior to the finalisation of this report.

The National Disability Strategy

The National Disability Strategy 2010–2020 is a 10-year plan for improving the lives of people with disability, their families and carers. It covers those with a psychosocial disability as defined in the Disability Discrimination Act 1992 (Cth). The National Disability Strategy aims to ensure that all mainstream services and programs across the country — including healthcare, education, Indigenous program reform and housing — address the needs of people with disability.
Responsibility for implementation of the National Disability Strategy has, until recently, rested with ministers responsible for disability and treasury portfolios through the COAG Disability Reform Council. Among other things, this council advised first ministers (the Prime Minister, premiers and chief ministers) on the implementation of the Principles to Determine the Responsibilities of the NDIS and Other Service Systems (COAG 2015), which clarify the interface between the NDIS and the mental health system (COAG 2018a). The National Cabinet had not announced future governance arrangements for the National Disability Strategy prior to finalisation of this report.

Gayaa Dhuwi Declaration

The Gayaa Dhuwi (Proud Spirit) Declaration (NATSILMH 2015) is a policy framework to embed and support Aboriginal and Torres Strait Islander leadership within the mental health system. It advocates an approach based on concepts of social and emotional wellbeing and cultural connection and healing, while working holistically with culturally capable clinical services to ensure the ‘best of both worlds’ (Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATSISP) and National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH), sub. 1217).

Underpinning the Declaration is an understanding that Indigenous concepts of mental health and social and emotional wellbeing differ among Aboriginal and Torres Strait Islander people, and more so when compared with those of some non-Indigenous people. Not understanding this challenges policy making and may, in turn, hamper the effectiveness of mental healthcare for Aboriginal and Torres Strait Islander people. Exacerbating this is the dominance of imposed non-Indigenous mental health paradigms, a lack of cultural competence among mainstream professionals and a lack of cultural capability in services and programs (NATSILMH 2015). The Declaration’s Implementation Guide (NATSILMH 2018, p. 5) emphasises the need for Aboriginal and Torres Strait Islander leadership across all parts of Australia’s mental health system to:

- champion and promote Aboriginal and Torres Strait Islander concepts of mental health and social and emotional wellbeing, and Aboriginal and Torres Strait Islander cultural strengths as sources of mental wellness, healing and resilience for Aboriginal and Torres Strait Islander people
- highlight mental health challenges faced by Aboriginal and Torres Strait Islander people
- champion and promote Aboriginal and Torres Strait Islander mental health as a specialised area of practice.

The Fifth Plan (COAG Health Council 2017a, p. 52) affirms that the Gayaa Dhuwi Declaration’s five themes (box 22.2) are central to developing and implementing its actions. More specifically, action 12.3 of the Fifth Plan states:

Governments will improve Aboriginal and Torres Strait Islander access to, and experience with, mental health and wellbeing services in collaboration with ACCHSs [Aboriginal Community Controlled Health Services] and other service providers by: … recognising and promoting the
importance of Aboriginal and Torres Strait Islander leadership and supporting implementation of the Gayaa Dhuwi (Proud Spirit) Declaration. (COAG Health Council 2017a, p. 34)

**Box 22.2 Themes of the Gayaa Dhuwi (Proud Spirit) Declaration**

The Gayaa Dhuwi Declaration comprises five themes containing 14 articles. The five themes are:

1. Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing should be recognised across all parts of the Australian mental health system, and in some circumstances support specialised areas of practice.

2. Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing combined with clinical perspectives will make the greatest contribution to the achievement of the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples.

3. Aboriginal and Torres Strait Islander values-based social and emotional wellbeing and mental health outcome measures in combination with clinical outcome measures should guide the assessment of mental health and suicide prevention services and programs for Aboriginal and Torres Strait Islander peoples.

4. Aboriginal and Torres Strait Islander presence and leadership is required across all parts of the Australian mental health system for it to adapt to, and be accountable to, Aboriginal and Torres Strait Islander peoples for the achievement of the highest attainable standard of mental health and suicide prevention outcomes.

5. Aboriginal and Torres Strait Islander leaders should be supported and valued to be visible and influential across all parts of the Australian mental health system.

*Source: National Aboriginal and Torres Strait Islander Leadership in Mental Health (2015, pp. 2–3).*

**International obligations**

Australia has ratified several United Nations conventions that aim to protect the rights of people with mental ill-health. In particular, the *Convention on the Rights of Persons with Disabilities* (Article 25) obliges Australia to promote, protect and ensure that persons with mental ill-health have the right to enjoy the highest attainable standard of health. The introduction of Australian legislation establishes much of the machinery of enforcement of Australia’s international obligations. Other conventions that have influenced Australian mental health policy include the:

- *Optional Protocol*[^237] to the *Convention on the Rights of Persons with Disabilities*
- *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*
- *International Covenant on Economic, Social and Cultural Rights*

[^237]: An optional protocol complements or adds to a treaty. It is optional because it is not automatically binding on countries that have already ratified the original treaty.
In addition, Australia has signed the Declaration on the Rights of Indigenous Peoples. Unlike conventions, declarations are not intended to be legally binding by their adoption — they are intended to represent the aspirations of signing countries (UN nd). Under this declaration, Australia has agreed that Aboriginal and Torres Strait Islander people have rights to:

- life, physical and mental integrity, liberty and security of person (article 7.1)
- the enjoyment of the highest attainable standard of physical and mental health. (article 24.2).

**22.2 Revitalising a national approach to mental health**

The National Mental Health Strategy has guided reforms to mental health services and supports since it was introduced nearly 30 years ago. It now falls well short of consumer and carer expectations and should be strengthened by: facilitating a genuine whole-of-government approach; linking funding with strategy; setting a clearer vision; ensuring greater coherence; and widening stakeholder engagement.

**Facilitating a genuine whole-of-government approach**

The National Mental Health Strategy remains focused primarily on clinical aspects of mental health. While the National Mental Health Policy 2008 declares that it ‘provides a strategic vision for further whole-of-government mental health reform in Australia’ (AHMC 2009a, p. 1), non-health portfolios neither share the vision nor collaborated in its development. The strategy does not articulate how health and non-health sectors should collaborate. In particular, it is unable to catalyse broader system reform because it lacks clarity about specific roles and responsibilities across all mental health-related services and suicide prevention activities. Although the national strategy aims to integrate mental health services and attendant supports, its main approach relies on an important, but nevertheless small and often ineffective aspect of the system — the collaborative efforts of Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) (COAG Health Council 2017b).

Developing and implementing a truly whole-of-government strategy is necessary for both tiers of government to be able to address prevention and early intervention. It could, over the long run, make an enduring improvement to mental health outcomes by reducing the adverse risks that various societal and non-health factors present for many individuals. Without participating in the development of a whole-of-government strategy, non-health portfolios will struggle to improve policies in their own areas that affect mental health outcomes and improve people’s lives, and to fund programs that would lead to cost savings in health portfolios, possibly many years hence.

The Australian, State and Territory Governments should develop a new National Mental Health Strategy that comprehensively integrates health and non-health sectors. This is necessary to guide the efficient allocation of resources over the long term. Without an agreed strategy that aligns the collective efforts of relevant sectors in all jurisdictions, there will be
undue reliance on health-centric solutions and too little attention given to addressing the wider determinants of mental health. Inquiry participants generally agree with the imperative to develop a strategy that integrates all relevant government portfolios and industry sectors. Section 22.3 recommends specific reforms to facilitate cross-portfolio collaboration.

**Linking funding with strategy**

The National Mental Health Strategy is not specifically linked to funding commitments. In the view of some participants, this omission explains why governments have failed to successfully implement past mental health reforms.

Proposed reforms have generally not been supported by an appropriate funding investment, which makes them difficult to realise. (Queensland Advocacy Incorporated, sub. 116, p. 6)

[Previous reforms] … were major social infrastructure projects and they failed because they were underfunded, just as you cannot construct a physical bridge that will stay up if it is seriously underfunded. (Community Mental Health Australia, sub. 449, p. 5)

Chapter 23 of this report recommends a new intergovernmental agreement — the National Mental Health and Suicide Prevention Agreement — that codifies new funding arrangements to improve mental healthcare outcomes. However, progress in implementing the strategy will depend in large measure on the extent to which governments allocate matching funding.

**Setting a clearer vision**

There is no clear vision for mental health in Australia. The national vision is largely for a better system, whereas State and Territory Governments have typically adopted person-centred visions that pursue individual wellbeing (table 22.1). No jurisdiction refers to the national vision in its mental health strategies.

The Australian, State and Territory Governments should develop a national vision statement that reflects the mental health outcomes that have value to consumers and carers, with a commensurate level of ambition for national mental health reforms. This would serve to align the collective efforts of all stakeholders more closely and focus attention on outcomes rather than activities.

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238 Advocacy for Inclusion, sub. 935; Anglicare Australia, sub. 1206; Australian Medical Association, sub. 633; Community Services Industry Alliance, sub. 915; Consumers Health Forum of Australia, sub. 646; Flourish Australia, sub. 729; Mental Health Carers NSW, sub. 1231; Mental Health Victoria, sub. 942; Mind Australia Limited, Neami National, Wellways and SANE Australia, sub. 1212; Office of the National Rural Health Commissioner, sub. 1185; People Power International Pty Ltd, sub. 690; PHN Cooperative, sub. 850; Prevention United, sub. 768; Psychotherapy and Counselling Federation of Australia (PACFA), sub. 883; Queensland Mental Health Commission, sub. 712; Relationships Australia Victoria, sub. 1197; SA Mental Health Commission, sub. 691; SuperFriend, sub. 873; TAL Life Limited, sub. 643; and Women’s Health Victoria, sub. 773.
Table 22.1  Government mental health vision statementsa

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Vision statement</th>
</tr>
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<tbody>
<tr>
<td>New South Wales</td>
<td>The people of NSW have the best opportunity for good mental health and wellbeing and to live well in their community and on their own terms.</td>
</tr>
<tr>
<td>Queensland</td>
<td>A fair and inclusive Queensland where all people can achieve positive mental health and wellbeing and live lives with meaning and purpose.</td>
</tr>
<tr>
<td>Victoria</td>
<td>… all Victorians enjoying the highest attainable standards of health, wellbeing and participation at every age.</td>
</tr>
<tr>
<td>South Australia</td>
<td>South Australia is internationally recognised as a resilient, compassionate and connected community that takes a whole-of-person, whole-of-life, whole-of-government and whole-of-community approach to building, sustaining and strengthening the mental health and wellbeing of South Australians in order to grow the state’s mental wealth.</td>
</tr>
<tr>
<td>Western Australia</td>
<td>A Western Australia where everyone works together to encourage and support people who experience mental health problems and/or mental illness to stay in the community, out of hospital and live a meaningful life.</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Tasmania is a community where all people have the best possible mental health and wellbeing.</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>A community that understands social and emotional health and wellbeing, mental health and mental illness, and that all Territorians, including the most marginalised have access to timely and appropriate early intervention services, integrated recovery-focused and evidence-based treatment and care, and community supports that enable and encourage full participation in the community.</td>
</tr>
<tr>
<td>ACT</td>
<td>A kind, connected and informed community working together to promote and protect the mental health and wellbeing of all.</td>
</tr>
<tr>
<td>National</td>
<td>The vision … is for a mental health system that: a) enables recovery; b) prevents and detects mental illness early; and c) ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community.</td>
</tr>
</tbody>
</table>


Ensuring greater coherence

The current practice of augmenting the National Mental Health Strategy with each new national mental health plan, rather than replacing previous ones, means that it lacks coherence. The strategy currently comprises seven documents totalling over 300 pages. Insofar as it retains priorities of past plans, it risks everything becoming a priority and little being fully accomplished.

The Australian, State and Territory Governments should ensure that the National Mental Health Strategy is a single, coherent document that outlines a comprehensive approach to improving mental health outcomes. This would better enable all stakeholders to align their own strategies with the national strategy. We note that the Australian Health Ministers’ Advisory Council has committed to renew the National Mental Health Policy, which would
support development of a sixth plan (COAG Health Council 2017b). This would be an opportunity to draw up an enduring vision and high-level strategy by separating longer-term strategic intent from shorter-term action plans that are subject to periodic renewal. Among other things, a new National Mental Health Strategy should include and be based on the aims and principles set out in the National Mental Health Policy, as scheduled for review.

The Australian, State and Territory Governments should take a long-term view in developing a new strategy. Given that poor outcomes have persisted over the 28-year life of the current strategy, a time planning horizon that is generational — about 30 years — would be appropriate. The new strategy should begin by clearly aligning stakeholder expectations and avoiding any notion that governments can dislodge deep-seated mental health issues within a term of government, or worse, a 12-month funding period for organisations tasked with providing essential services and supports in this area.

**Widening stakeholder engagement**

In response to the Inquiry Draft Report, participants provided feedback directed at improving the relevance of the existing strategy by widening the range of stakeholders engaged in its development. A lack of collaboration with key stakeholder groups in strategic planning leads to inefficient planning and resource allocation.

Various participants raised concerns about the current strategy not adequately reflecting the role and significance of the private mental health sector (Anthony Jorm, sub. 45; Beyond Blue, sub. 275; Health Services Union, sub. 237; Youth Health Forum, sub. 404). For example:

… the National Mental Health Strategy including the Plans rarely if ever, reflect on the private sector. As a consequence, consumers and carers which our Network represents feel that their mental illnesses don’t count, are seen to be less acute, feel invalidated and forgotten. The people obtaining services from mental health settings within the private sector are a significant volume of those seen across Australia. (Private Mental Health Consumer Carer Network (Australia), sub. 49, p. 24)

There are examples where governments have undertaken reforms involving the private sector in parallel with the national strategy rather than as an integral component. For example, the Australian Government unilaterally undertook reforms (Better Access being a prime example) and provided funding to the Primary Mental Health Alliance, which is the private sector equivalent of the Australian Mental Health Outcomes and Classification Network.

In recent years, health ministers have sought to strengthen engagement with the private sector. For example, in 2017, they established a Mental Health Expert Advisory Group (now the Mental Health Reform Stakeholder Group), which includes representatives from the private sector (COAG Health Council 2017b, p. 12). Current membership includes peak bodies that represent professions predominantly employed within the private sector.

Various participants voiced similar concerns regarding the role of local governments, which is sometimes overlooked, yet can be key to leading improvements in mental health and
wellbeing in local communities (Centre for Rural and Remote Mental Health, sub. 465; David Clark, sub. 809; Hobsons Bay City Council, sub. 176; Local Government Association of SA, sub. 242; Moonee Valley City Council, sub. 670; National Rural Health Alliance, sub. 353; Wesley Mission, sub. 840).

The Australian, State and Territory Governments should ensure that broad consultation distinguishes the development of the new strategy. While its co-design must involve consumers and carers (consistent with action 22.4), applying this approach with all stakeholder groups would be beneficial, including with the private sector and local governments. Apart from enhancing its effectiveness, authentic collaboration serves to cement the legitimacy of the strategy. The Community Services Industry Alliance (sub. 915, p. 2) also noted the benefit of:

… stronger connection to and understanding of the role and significance of community services in supporting better mental health outcomes for people. This includes but is not limited to community mental health and disability services.

**NMHC’s strategic work presents an opportunity**

Since the Inquiry Draft Report’s release, the NMHC has progressed its strategic work and released a consultation version of its blueprint for mental health and suicide prevention in Australia — *Vision 2030* (box 22.3). It has now turned to developing long-term strategies and plans to realise this vision as part of its Roadmap project.

The NMHC’s strategic work presents an opportunity insofar as it addresses some of the recommendations of our Inquiry Report. *Vision 2030* articulates desired outcomes for the performance of the mental health system as well as for the lives of individual people living with mental ill-health (NMHC 2020). The NMHC’s work also goes some way to separating long-term strategic intent (as set out in Vision 2030) from medium-term planning, which the Roadmap project will articulate. While there is no suggestion that the lives of all individuals would be transformed to the stated level of ambition, nor within the nominated 10-year time frame, an enduring vision would nevertheless help governments to remain focused on working towards achieving the outcomes that matter most for consumers and carers.

*Vision 2030* identifies two fundamental systemic changes that the NMHC (sub. 949) believes are necessary for delivering the vision, namely:

1. shifting from a mental health ‘alone’ approach to a wellbeing approach, which necessitates establishing connections with the physical healthcare system and social determinants of mental health, including housing, education and employment

2. formulating a balanced community-based approach across the mental health and suicide prevention system, which offers choice in the delivery of prevention, assessment, treatment and recovery, to better match the varied contexts and needs of diverse communities.
Box 22.3 Vision 2030 and the Roadmap

In July 2019, the National Mental Health Commission (NMHC) began a national conversation through the Connections Project to develop a long-term strategy to guide investment and coordination in the mental health and suicide prevention systems. The NMHC connected with over 3000 people (including many consumers and carers) and organisations to hear about their experiences of mental healthcare and their needs and expectations of an improved system.

This information was analysed to identify key themes and consensus about the barriers experienced, community needs and opportunities to improve the experience of mental healthcare. Led by these themes, the NMHC developed Vision 2030; Blueprint for Mental Health and Suicide Prevention.

Vision 2030 casts a national direction for mental health and wellbeing in Australia. It is a long-term blueprint for a successful, connected, and well-functioning mental health and suicide prevention system meeting the needs of all Australians.

Vision 2030 will be accompanied by an implementation Roadmap. The Roadmap will identify the strategies for investment, coordination, development and performance measurement required to achieve the goals and objectives of Vision 2030.

A draft of Vision 2030 was completed in December 2019 and is available to inform consultation on the development of the implementation Roadmap. The NMHC is working with States and Territories as partners with the Commonwealth, alongside a range of community stakeholders to ensure a collaborative, consistent approach to Vision 2030 and its Roadmap. The final Vision 2030 Blueprint including Roadmap is to be completed in 2020.


The Australian, State and Territory Governments should authorise the NMHC to lead development of the new national mental health strategy and the next national mental health action plan in collaboration with all jurisdictions. There are clear advantages in giving this role to the NMHC. The NMHC brings a mandate to work across all areas that impact on mental health and it has a strong interest in realising a strategic approach to investment across the multiple outcome areas and government portfolios (NMHC, sub. 949). Further, the NMHC has established working relationships with a wide range of stakeholder organisations, governments and state and territory mental health commissions.

Stronger implementation oversight of a national strategy

Successful implementation of the new national strategy, including through the next version of the national mental health plan, will require independent and transparent oversight. This is particularly important as accountability for mental health outcomes will remain shared across multiple portfolios within jurisdictions and across both tiers of government, notwithstanding the funding reforms recommended in chapter 23.
To improve accountability for the strategy’s implementation, the Australian, State and Territory Governments should:

- authorise the NMHC to undertake annual monitoring and reporting on the strategy’s implementation; this responsibility should bring a perspective to the strategy as a whole, as well as progress against implementing agreed commitments in the next national plan
- ensure that progress in implementing the strategy is independently and transparently reviewed and improvements recommended every five years.

**ACTION 22.1 — A NEW WHOLE-OF-GOVERNMENT MENTAL HEALTH STRATEGY**

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

*Start now*

The Australian, State and Territory Governments should develop a new National Mental Health Strategy that comprehensively integrates the roles played by health and non-health sectors. In developing the new strategy, they should ensure that:

- it involves broad collaboration with relevant health and non-health portfolios of Australian, State and Territory Governments, consumers and carers, and the private and community sectors
- its vision reflects the outcomes that consumers and carers value and a corresponding level of ambition for mental health reforms
- it is a single coherent document that outlines a comprehensive approach to improving mental health outcomes
- it has the demonstrable support of consumers and carers.

The Australian, State and Territory Governments should request the National Mental Health Commission to lead development of the new national mental health strategy and the next national mental health action plan in collaboration with all jurisdictions and for endorsement by them. The strategy should identify priority areas for whole-of-government action to be considered by all governments for inclusion in the work program of the recommended interjurisdictional Special Purpose Mental Health Council (action 22.3).

To improve accountability for the strategy’s implementation, the Australian, State and Territory Governments should:

- request the National Mental Health Commission to undertake annual monitoring and reporting on the strategy’s implementation
- ensure that progress in implementing the strategy is independently and transparently reviewed and improvements recommended every five years.
Improving planning and service delivery with Aboriginal and Torres Strait Islander people

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2017–2023 (AHMAC 2017) is the national strategy for improving the social and emotional wellbeing and mental health of Aboriginal and Torres Strait Islander people. Its guiding principles aim to fundamentally improve the way reforms to mental health and wellbeing services delivered by both Aboriginal and Torres Strait Islander and mainstream providers are conceived, developed, implemented and improved (box 22.4).

Box 22.4 Principles of the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2017–2023

1. Aboriginal and Torres Strait Islander health is viewed in a holistic context, that encompasses mental health and physical, cultural and spiritual health. Land is central to wellbeing. Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal and Torres Strait Islander ill health will persist.

2. Self-determination is central to the provision of Aboriginal and Torres Strait Islander health services.

3. Culturally valid understandings must shape the provision of services and must guide assessment, care and management of Aboriginal and Torres Strait Islander people’s health problems generally, and mental health problems, in particular.

4. It must be recognised that the experiences of trauma and loss, present since European invasion, are a direct outcome of the disruption to cultural wellbeing. Trauma and loss of this magnitude continues to have inter-generational effects.

5. The human rights of Aboriginal and Torres Strait Islander people must be recognised and respected. Failure to respect these human rights constitutes continuous disruption to mental health. Human rights relevant to mental illness must be specifically addressed.

6. Racism, stigma, environmental adversity and social disadvantage constitute ongoing stressors and have negative impacts on Aboriginal and Torres Strait Islander peoples’ mental health and wellbeing.

7. The centrality of Aboriginal and Torres Strait Islander family and kinship must be recognised as well as the broader concepts of family and the bonds of reciprocal affection, responsibility and sharing.

8. There is no single Aboriginal or Torres Strait Islander culture or group, but numerous groupings, languages, kinships, and tribes, as well as ways of living. Furthermore, Aboriginal and Torres Strait Islander people may currently live in urban, rural or remote settings, in traditional or other lifestyles, and frequently move between these ways of living.

9. It must be recognised that Aboriginal and Torres Strait Islander people have great strengths, creativity and endurance and a deep understanding of the relationships between human beings and their environment.

Source: AHMAC (2017, p. 3).
From a governance perspective, the centrality of ‘Aboriginal and Torres Strait Islander leadership, engagement and partnership in the planning, delivery, evaluation, and measurement of services and programs is critical in fostering greater trust, connectivity, culturally appropriate care and effective outcomes’ (AHMAC 2017, p. 12). In this respect, the Gayaa Dhuwi (Proud Spirit) Declaration provides the policy framework for embedding and supporting Aboriginal and Torres Strait Islander leadership within the mental health system while also promoting a ‘best of both worlds’ approach — clinical and culturally capable practice (section 22.1).

Many Inquiry participants voiced concerns that Governments had not fully implemented the Framework. In their view, this inaction was impeding efforts to improve the health of Aboriginal and Torres Strait Islander people.

The efficacy of Aboriginal and Torres Strait Islander specific programs depends on the amount of community input there is in designing them. The most effective programs are those delivered by communities, for communities … Informed frameworks such as the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing … continue to highlight this fundamental principle yet little action results from them. (National Aboriginal Community Controlled Health Organisation, sub. 507, p. 7)

The Closing the Gap 10 Year Review (Close the Gap Campaign Steering Committee for Indigenous Health Equality (Australia) 2018, p. 4) proposed that an implementation plan for the Framework be ‘developed, costed and implemented by the end of 2018 in partnership with Aboriginal and Torres Strait Islander health leaders and communities’.

The Australian Government should expedite the development of an implementation plan for the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2017–2023. Implementation of the Framework would serve to infuse the principles in the Gayaa Dhuwi (Proud Spirit) Declaration into the mental health system and expand access to culturally capable, effective mainstream services. There is little benefit in not implementing a strategy that was endorsed by the Australian Health Ministers’ Advisory Council and is highly regarded by both Indigenous and non-Indigenous peak bodies. Many participants supported this recommended action.239

239 Allan Fels (sub. 303); Beyond Blue (subs. 275, 877); Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATSISP) and National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) (sub. 1217); Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) (sub. 75); Institute for Urban Indigenous Health (sub. 1108); Mental Health Australia (sub. 864); Mental Health Carers NSW (sub. 1231); Mental Health Victoria (sub. 942); Mental Health Victoria (MHV) and Victorian Healthcare Association (VHA) (sub. 1184); National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH), Indigenous Allied Health Australia (IAHA) and Australian Indigenous Psychologists Association (AIPA) (sub. 418); National Aboriginal Community Controlled Health Organisation (subs. 507, 1226); Queensland Aboriginal and Islander Health Council (sub. 1235); Queensland Mental Health Commission (sub. 712); Royal Australian and New Zealand College of Psychiatrists (sub. 1200); Thririli Ltd (sub. 549); Mental Health Victoria (MHV) and Victorian Healthcare Association (VHA) (sub. 1184).
Further, the Australian Government should entrust development of the implementation plan to Aboriginal and Torres Strait Islander people and their representative leaders in mental health. The peak body for Indigenous social and emotional wellbeing, mental health and suicide prevention, Gayaa Dhuwi (Proud Spirit) Australia, working with the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group, should lead its development, including the costing of putting it into practice. The Australian Government should support adequate resourcing for the development and operationalisation of the implementation plan to ensure that it effectively guides and informs reforms.

**ACTION 22.2 — IMPROVING PLANNING AND SERVICE DELIVERY WITH ABORIGINAL AND TJORRES STRAIT ISLANDER PEOPLE**

The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2017–2023* has not been fully implemented, to the detriment of the mental health of Aboriginal and Torres Strait Islander people.

**Start now**

The Australian Government should:

- expedite the development of an implementation plan for the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2017–2023*
- entrust development to Gayaa Dhuwi (Proud Spirit) Australia, working with the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group
- ensure that development and operationalisation of the implementation plan is well resourced.

**Leadership**

Effective leadership is central to reforming the mental health system.\(^{240}\) It ‘breathes life’ into governance, embeds values and behaviours, and promotes interagency collaboration (Edwards et al. 2012; ’t Hart and Uhr 2008). It is also what Australians want.

People asked for strong leadership and clear governance, responsibility and accountability for a whole-of-government approach to mental health and wellbeing, with mechanisms in place to oversee resourcing and implementation of government-wide strategic actions. (SA Mental Health Commission, sub. 477, p. 34)

\(^{240}\) Latrobe Health Advocate (sub. 364); Mental Health Complains Commissioner (Victoria) (sub. 321); Relationships Australia South Australia (sub. 420); WentWest Limited (sub. 445).
In the view of many Inquiry participants, a lack of system leadership contributes to poor integration, resourcing and access, and absolved responsibilities. As the Mental Health Commission of New South Wales (sub. 486, p. 13) put it:

Leadership for implementation is often missing. Policy documents, strategic plans and roadmaps abound. What is often missing is leadership and skilled oversight of the implementation of these policies.

The complexities of Australia’s mental health system impose particular leadership challenges — in particular, the array of health and non-health portfolios that need to coordinate to improve consumer outcomes, plus multiple levels of government across which this coordination is necessary.

Effective leadership will be essential if the national mental health strategy is to significantly improve outcomes for people with mental ill-health and their carers. Good strategies usually fail because of poor execution (Wery and Waco 2004). More broadly, effective leadership will be necessary to implement the wide-ranging reforms recommended in this Inquiry, both in the short to medium term and in the decades to follow. While this is generally true for policy reform, it is especially true for mental health, where complex policy issues require cross-portfolio solutions and, in some cases, deep-seated cultural change.

Addressing these challenges requires ‘leaders who are willing to embed purpose and drive change — and who are both empowered and required to do so’ (Commonwealth of Australia 2019, p. 27). The Australian Mental Health Leaders Fellowship, which was developed by the NMHC in 2018, is an example of one initiative designed to meet the needs of emerging leaders with a passion and commitment to mental health. In addition, the Australian Government recently appointed Australia’s first Deputy Chief Medical Officer for Mental Health (Australian Government Department of Health 2020). However, it is imperative that governments and other stakeholders further consider, resource and develop the skills and experience necessary to drive the systemic and cultural changes that are required to improve population mental health outcomes.

### 22.3 Facilitating a cross-portfolio approach

#### The cross-portfolio challenge

The challenge to efficiently balance mental health expenditure on treatment with that on prevention, early intervention and recovery becomes greater when the solutions for these lie beyond the health portfolio. Policies and programs in portfolios such as housing, workplace/employment support, social/community services, justice and education can promote mental health, or present risk factors that contribute to mental ill-health. However, all other things equal, there is little incentive for health ministers to fund reforms of matters

241 For example, David Clark (sub. 205); NSW Nurses and Midwives’ Association (sub. 246); Rural Doctors Association of Australia (sub. 475, appendix A).
for which other ministers have responsibility, would accrue budgetary benefits and would realise political kudos (Knapp and Iemmi 2016).

Public sector reviews have long sought to improve cross-portfolio collaboration and strategic leadership (Advisory Group on Reform of Australian Government Administration 2010). The Thodey Review (Commonwealth of Australia 2019, p. 27) recently re-emphasised the need for the Australian Public Service to be run as an integrated organisation. It saw single agencies that work largely independently as missing opportunities to deliver high-quality services in complex areas that cut across portfolio boundaries. Its conclusion about the need for more frequent cross-portfolio collaboration applies to all governments, especially on mental health issues, one of the most complex policy spaces.

The Fifth Plan recognises the need for closer cross-portfolio collaboration (as did previous national mental health plans), but focusses on promoting it at a regional level. Some issues can be solved at the regional level, but change at a jurisdictional or national level is often necessary to create an enabling environment. Better cross-portfolio coordination is also essential to address the social, economic, health, occupational, cultural and environmental factors involved in suicide prevention (Suicide Prevention Australia, sub. 523). For its part, this report makes many recommendations that will require action by non-health portfolios to improve the lives of consumers and carers.

Of course, health and other portfolios have collaborated on specific mental health matters. Under the former COAG Health Council, the Mental Health Principal Committee worked with other ministerial advisory bodies through its sub-committees and informal channels, typically on a topic-by-topic basis. In addition, the Committee has established two formal groups with members from outside mental health:

- the Action 9 Working Group, which includes members from the Mental Health subgroup of the Disability Reform Council Senior Officers Working Group
- the Steering Group for the National Mental Health Policy Renewal, which includes members from first ministers’ Departments who bring a whole-of-government perspective when discussing the renewal of mental health policy.

**Authorising cross-portfolio action through a new national council**

Facilitating effective cross-portfolio action in a nationally consistent manner requires an authorising environment at the ministerial level (Commonwealth of Australia 2019, p. 233). It requires a forum or mechanism that would enable health and non-health portfolios to consider (jointly, systematically and comprehensively) how their policies interact in order to develop more effective and efficient approaches for improving mental health.

A key area where national coordination and oversight can be beneficial is in monitoring and advocating for redistributions of funds across portfolios where there are opportunities to improve the investment mix (NSW Government, sub. 1243). Various participants highlighted the need for, and benefits of, a more strategic approach to investment and/or stronger cross-portfolio collaboration between the Australian, State and Territory
Governments. For governments to reallocate resources more efficiently across portfolios, there needs to be:

- a shared understanding of the relationships and long-term effects of social determinants on prevention, early intervention, recovery and mental health outcomes more broadly
- an agreed policy framework to guide consideration of, and decision-making on, cross-portfolio resource allocations over the long term
- reform actions that will serve to prevent or reduce avoidable harm and disadvantage that arises from mental ill-health. These may involve considering budgetary mechanisms that take account of the costs and benefits that ‘spill-over’ administrative boundaries.

The scale and complexity of many mental health policy issues has thus far exceeded the design of national committee structures. There is currently no national cross-portfolio ministerial forum that is well suited to leading a truly whole-of-government approach to social policy issues such as mental health. We do not consider that the National Cabinet should necessarily take on this lengthy commitment themselves.

Instead, the Australian, State and Territory Governments should establish a Special Purpose Mental Health Council (SPMHC) to facilitate a whole-of-government approach to prevention and early intervention in mental health. Membership of the new council should comprise Australian and State and Territory Government health/mental health ministers as permanent members plus ‘partnering’ ministers from selected social policy portfolios on, say, 18-month rotations. It is envisaged that partnering portfolios would likely include housing, workplace/employment, social and community services, justice and education.

This progressive or staged approach to policy reform is necessary to support closer cooperation and collaboration between health/mental health and other social policy portfolios. For the reasons outlined above, it would not be practicable to undertake a single reform project that simultaneously involves tens of ministers from both tiers of government who are responsible for all the social policy portfolios that are relevant to mental health.

The objective of the SPMHC would be to develop and implement a series of national 5-year action plans that serve to promote prevention, early intervention and recovery in mental health. Each plan would be developed collaboratively by health and partnering social policy portfolios, each reflecting the new national mental health strategy (section 22.2). It is not practicable to develop simultaneously a single cross-portfolio action plan.

To support effective implementation, each action plan should include a requirement for partnering portfolios to arrange for the preparation and publication of a final report, independently prepared, that:

- discusses and evaluates implementation of their action plan (including impediments and successes)

242 For example, ACT Government (sub. 1241); Mental Health Australia (subs. 407, 538, 544); Mental Health Commission of NSW (sub. 486); NSW Government (sub. 1243); NMHC (sub. 949); VicHealth and Partners (sub. 31); Victorian Government (sub. 483).
• presents and analyses results against KPIs
• examines what more needs to be done.

It is envisaged that a group of Senior Officials and an interjurisdictional working group would support the new council. These would comprise officers from health/mental health portfolios and members from each social policy portfolio as they rotate in every 18 months. Each jurisdiction should ensure that adequate resources are allocated to accomplishing this task.

Health ministers would remain responsible for the oversight of mental health reforms that are distinctive to the health and mental health sectors. In addition, they would become jointly responsible for mental health reforms endorsed by the SPMHC.

**Work plan development**

Without limiting the scope of the SPMHC’s work program, the NMHC would be best placed to provide key cross-portfolio topics for its consideration. It is envisaged that other reform areas would emerge as each partnership matures over the rotation. In all instances, work plan development would be guided by the national vision for the mental health system (action 22.1), but be sufficiently flexible to address the biggest issues of the day in the event that some change in direction or scale is warranted.

In identifying potential reform areas, each portfolio partnership could consider the scope to improve the ways their sectors intersect through three lenses:

• governance (for example, coordination and arrangements for sharing care data and escalation protocols between portfolios)
• administration (for example, to ensure that policies and procedures in non-health portfolios do not exacerbate mental health issues)
• strategic policy (to consider the scope for joint approaches to realising better outcomes about long standing issues).

In addition, these collaborations provide an ideal opportunity to consider the integration of their existing strategies. A significant weakness of the current mental health governance arrangements is that other national strategies that affect mental health outcomes are not well integrated with the National Mental Health Strategy. Some, such as the *National Disability Agreement*, do not articulate their role in improving mental health, yet they assist a large number of people with mental ill-health.
Many participants noted the importance of integrating mental health strategies with other strategies. In particular, closer alignment with mental health was advocated for:

- alcohol and drug policies and programs (Families and Friends for Drug Law Reform, sub. 701; Prevention United, sub. 768)
- a new LGBTIQ mental health prevention strategy (National LGBTI Health Alliance, sub. 494; Rainbow Health Victoria, sub. 695)
- a new suicide postvention workforce strategy (United Synergies Ltd, sub. 682)
- a National Pain Strategy (Painaustralia, sub. 680)
- a new national mental health research strategy (ANU College of Health and Medicine, sub. 669).

As part of their action plans, each partnering portfolio could commit to ensuring that its relevant national, Australian Government, and State and Territory Government agreements and strategies that affect mental health outcomes articulate explicitly how they contribute to meeting the aims of the new National Mental Health Strategy.

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**ACTION 22.3 — FACILITATING A CROSS-PORTFOLIO APPROACH**

All Governments should commit to a nationally consistent whole-of-government approach to prevention, early intervention and recovery in mental health.

*Start later*

The Australian, State and Territory Governments should establish a Special Purpose Mental Health Council (SPMHC) to facilitate a whole-of-government approach to prevention, early intervention and recovery in mental health.

- Membership of the SPMHC should comprise Australian and State and Territory Government health/mental health ministers (permanent members) plus ministers of selected social policy portfolios on 18-month rotations (partnering members).
- The SPMHC should develop and implement a series of national 5-year cross-portfolio action plans that serve to promote prevention, early intervention and recovery in mental health.
- Each partnering portfolio should adequately resource its contribution to the SPMHC.

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243 ACT Government (sub. 210); Brotherhood of St Laurence (sub. 394); cohealth (sub. 231); Douglas McIver (sub. 181); Kingsford Legal Centre (sub. 469); Mental Health Coordinating Council (sub. 214); Mental Health Council of Tasmania (sub. 869); National LGBTI Health Alliance (sub. 494); Relationships Australia South Australia (sub. 420); Victorian Council of Social Service (sub. 478).
22.4 Enhancing consumer and carer collaboration

Many participants raised concerns about governments not collaborating with consumers and carers in all aspects of system governance, including mental healthcare system planning, design, monitoring and evaluation. In their view, governments are forgoing insights and advice that are useful for developing and implementing more efficient and effective policies. Moreover, it is important for both consumer and carer voices to be clearly heard — noting that many people who are users of mental health services and supports, and many family members who support them, do not think of themselves as either ‘consumers’ or ‘carers’, respectively, but their voices should nevertheless be heard and valued (chapter 18 discusses hidden carers).

While consumers and carers often share similar experiences, this is not always the case. And even where they have similar experiences, consumers and carers bring different perspectives and perceptions to those experiences. As discussed below, governments can improve system performance by fully committing to consumer and carer collaboration, strengthening systemic advocacy and supporting the establishment of national peak organisations.

Fully committing to consumer and carer collaboration

Many participants regarded the level of consumer and carer participation in system governance as inadequate and not at a level where it could significantly improve policies. They were unsure whether their engagement was authentic or tokenistic — whether policy makers genuinely sought their views and perspectives, or ‘ticked boxes’ (Private Mental Health Consumer Carer Network (Australia), sub. 547, p. 2). Some contended that a lack of authentic consultation had curbed the effectiveness of past reforms (Queensland Advocacy Incorporated, sub. 116; Community Mental Health Australia, sub. 449). The Mental Health Community Coalition of the ACT noted that while many factors can limit the efficacy of reforms, an important one is the:

… lack of a true partnership approach from government with service providers, consumers and carers which values the range of expertise, experience and perspectives they bring … A partnership approach leads to better outcomes and helps avoid costly mistakes … (Mental Health Community Coalition ACT, sub. 517, p. 16)

A former auditor with lived experience concluded:

The reason why it, the Federal Government, has continually failed is due to its unwillingness to engage the voices of lived experience in the design, delivery and evaluation of fit for purpose mental health services … Taxpayers monies are wasted due to Government failure to listen to the voices of lived experience … (David Clark, sub. 205, pp. 2–4)

Consumers and carers are becoming more embedded in policy and planning. At the national level, they have been serving on various national committees (Mental Health Information Strategy Standing Committee, the Safety and Quality Partnership Standing Committee and the Mental Health Principal Committee) and there is also representation on working groups established under the Fifth Plan.
Notwithstanding this (and the fact that mental health has already considerably more consumer involvement than some other health areas), participants maintained that collaboration should be improved. Some urged governments to listen to the voices of lived experience and increase their involvement in the management and delivery of services (Community Mental Health Australia, sub. 449). The Private Mental Health Consumer Carer Network (Australia) (sub. 547, p. 2) stated ‘surely it is crucial to design services to meet the needs of consumers, rather than designing services first and expecting consumers to fit the services’. The Brotherhood of St Laurence (sub. 394) argued for co-designing of policy frameworks with consumers and providers.

Expectations about consumer and carer collaboration in system governance

Consumers and carers should expect to participate in the design of government policies and programs that affect their lives. The Australian, State and Territory Governments have codified this right in the National Mental Health Policy 2008, which states that people with mental illness:

… have the right to contribute to the formulation of mental health legislation and policy, and to the design, implementation and evaluation of mental health services at national, state/territory and local levels to ensure that services comprehensively meet their needs, including from a cultural perspective. (AHMC 2009a, p. 12)

Two sets of standards guide the extent to which consumers and carers should participate in governance: the National Standards for Mental Health Services (Australian Government 2010) and the National Safety and Quality Health Service Standards (ACSQHC 2017b). These require health organisations to develop processes that enable consumers and carers to be actively involved in the governance of the services they receive. Standard 2 (‘Partnering with consumers’) of the National Safety and Quality Health Service Standards applies to organisations with system-wide responsibilities — government departments and/or whole health services. It emphasises the need to partner with consumers, carers and their representatives as ‘full members’ of key governance committees (ACSQHC 2018d, p. 2). Similarly, governments expect LHNs and PHNs to partner with consumers and carers in developing regional plans (DoH 2018a).

Consumers and carers expect collaboration to entail:

… meaningful and significant or genuine partnership (co-design) approach founded on mutual respect right at the very beginning, where all parties are equal, have expertise in different areas, and bring real value and shared knowledge to the table. (Private Mental Health Consumer Carer Network (Australia), sub. 547, p. 3)

In this regard, the National Mental Health Consumer and Carer Forum declared that ‘it is only co-production and/or co-design if consumers and carers agree that it is’ (box 22.5).
Challenges in fostering collaborative partnerships

Adopting a genuine co-design approach to governance challenges the established way of doing things. It may require professionals to ‘let go’ and let administrative systems become more responsive, or consumers and carers to think about mental healthcare in different ways (Foot et al. 2014). In addition, while some consumers and carers may understand how the system worked (or did not) in their own situation, or be able to identify gaps and shortcomings in access to services, they may not have sufficient system literacy, confidence or skills to engage in system-wide co-design and co-production (Consumers Health Forum of Australia, sub. 496; Sarah Sutton, sub. 508).

Of course, not all consumers and carers have the same experience. Consumer and carer input are most valuable when there is alignment between the issues being considered and the consumers’ and carers’ experience. For example, in planning a service for eating disorders, it is important to have consumers and carers with lived experience with such disorders providing input to the planning process.

Box 22.5  Co-design and co-production defined

Consumers and carers should expect to participate in developing policies that directly affect them and to receive strong assurances from government about its commitment to this approach. This expectation is not unique to mental health, nor Australia. Rather, it reflects growing dissatisfaction in governance arrangements that struggle to address many of the big issues facing society (Barnes, G. in Richards (2019, p. 44)).

Peak lived experience organisations distinguish traditional consultation and mere participation from ‘authentic partnerships’ that are underpinned by ‘early engagement, inclusivity, transparency, shared power and equity of knowledge’ (Mental Health Australia 2017, p. 1). The National Mental Health Consumer and Carer Forum (NMHCCF 2017) provides the following definitions and test.

- **Co-design**: identifying and creating an entirely new plan, initiative or service, that is successful, sustainable and cost-effective, and reflects the needs, expectations and requirements of all those who participated in, and will be affected by the plan.

- **Co-production**: implementing, delivering and evaluating supports, systems and services, where consumers, carers and professionals work in an equal and reciprocal relationship, with shared power and responsibilities, to achieve positive change and improved outcomes.

- **Test**: irrespective of how governments may describe their consultation and engagement processes, ‘it is only co-production and/or co-design if consumers and carers agree that it is’.

Further, consumers and carers have different lived experiences. For example, the lived experience of an eating disorder for a consumer is clearly different to the lived experience of the carer(s) who assist that same consumer. While this lived experience is a crucial input to all stages of mental health service design and delivery, it is important to recognise that consumers and carers necessarily speak with different voices and reflect different experiences. They are not substitutes. Both are needed.
Mistakes made by organisations seeking to partner with consumers and carers include:

- involving consumers and carers too late
- using consultation processes to inform rather than to genuinely get input
- underestimating the value that consumers and carers can add to service design
- failing to plan for a role for consumers and carers in implementation and review, particularly given the important role of consumers in supporting accountability (Integrated Regional Planning Working Group 2018b).

Benefits of strong consumer and carer collaboration

Inquiry participants emphasised the benefits of strong consumer and carer collaboration. In their view, consumers and carers are an essential source of information about mental health services, on service availability, accessibility, appropriateness, effectiveness and quality. They know what does and does not work as they are the ‘experts on the impact of mental ill-health and the types of measures and initiatives that are genuinely helpful’ (Queensland Advocacy Incorporated, sub. 116, p. 5). Their insights can complement official statistics as an effective feedback channel to drive innovation and continuous improvement.

Enabling consumers and carers to be more involved in governance should enhance the performance of a system which exists to meet their needs. Although there is not yet an agreed best-practice approach (ACSQHC 2018d, p. 2), governments nevertheless regard their involvement in all planning steps as ‘vital … to get the best results’ (Integrated Regional Planning Working Group 2018b, p. 20). In particular, consumer and carer input in developing goals, standards, programs and monitoring regimes has the potential to drive a more efficient allocation of resources (Angelmar and Berman 2007).

Governments should commit to collaboration

In the Inquiry Draft Report, we recommended that the Australian, State and Territory Governments should collaborate with consumers and carers in all aspects of mental healthcare system planning, design, monitoring and evaluation. This is additional to reforms elsewhere in this report that aim to empower individual consumers, including to actively participate in decisions about their own recovery (chapter 4).

Many participants strongly agreed with the general thrust to strengthen consumer and carer participation, while suggesting ways to achieve this. Some emphasised the importance of

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244  headspace – National Youth Mental Health Foundation, sub. 947; Mental Health Commission of New South Wales, sub. 486; National Mental Health Consumer and Carer Forum, sub. 476; Penington Institute, sub. 264; Queenslanders with Disability Network (QDN), sub. 662; Victorian Government, sub. 483.

245  Advocacy for Inclusion (sub. 935); ANU College of Health and Medicine (sub. 669); Commissioner for Children and Young People (WA) (sub. 640); Consumers Health Forum of Australia (sub. 646); headspace – National Youth Mental Health Foundation (sub. 947); Mental Health Complaints
explicitly articulating the need to involve people with lived experience from the beginning of all decision-making processes (Mental Health Complaints Commissioner (Victoria), sub. 916). Others emphasised the importance of ensuring that particular subgroups were not overlooked in the co-design of mental health services and programs, namely:

- children and young people (Commissioner for Children and Young People (WA), sub. 640)
- consumers and carers in rural and remote Australia — Aboriginal people, Torres Strait Islander people and non-Indigenous Australians (Royal Flying Doctor Service, sub. 685)
- women and girls with lived experience and those who are carers (Women’s Health Victoria, sub. 773)
- gender diverse consumers and carers (Women’s Health Victoria, sub. 773)
- people in prisons, hospitals, ‘care’ homes and detention centres (Justice Action, sub. 929).

Governments should, at a minimum, adhere to Standard 2 ‘Partnering with consumers’ of the National Safety and Quality Health Service Standards. Obviously, it is not practicable to have every population subgroup involved in every design, implementation, delivery and evaluation process. But it is reasonable to have consumer and carer representatives from particular population subgroups where they are the policy target. In this regard, all Governments should collaborate with consumers and carers in the development of a new whole-of-government National Mental Health Strategy (action 22.1). And 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 should not just be led by Aboriginal and Torres Strait Islander people, but should include Aboriginal and Torres Strait Islander people who have lived experience of mental illness and who are carers.

**Systemic advocacy**

Some participants contended that governments underinvest in systemic advocacy (One Door Mental Health, sub. 108; Sarah Sutton, sub. 508; Victorian Government, sub. 483). Systemic advocacy enables people with lived experience to participate collectively in system governance through an advocate (box 22.6). Mental Health Australia questioned whether governments see it as an integral part of the mental health system.

> It appears that both individual and systemic advocacy are largely missing from the ecosystem imagined by governments. An ideal mental health system includes independent voices that hold governments to account for their commitments and encourages continuous improvement, through systemic advocacy. (Mental Health Australia, sub. 407, p. 36)
Governments fund independent systemic advocacy for several reasons, although this is not without contention. On the one hand, funded advocates may have greater means to openly criticise government decisions and demand greater government accountability. On the other hand, systemic advocates can inform the development of policies and programs, and play an implementation role by acting as a trusted conduit between their members and government, and be a low cost source of information on some (localised) aspects of system shortcomings (Mental Health Australia, sub. 407).

Box 22.6  What is systemic advocacy and why fund it?

Advocacy is ‘taking action to help people say what they want, secure their rights, represent their interests and obtain services they need’ (Lewington and Clipson 2004, p. 4, quoted in Daly, Barrett and Williams 2017, p. 10). Systemic advocacy is speaking up for, or taking action on behalf of, groups of people who face common issues, such as barriers and discrimination. It enables consumers and carers to have an influence over the design of policies and programs that affect their lives. In particular, it gives a voice to the disadvantaged and vulnerable to ensure their interests are represented in the policy process.

Systemic advocacy differs from individual advocacy, which supports individuals to exercise their rights and to promote, protect and defend their welfare and justice (chapter 21). However, the two are related. Organisations that represent consumers and carers, and some non-government service providers and legal advocates often take individual experiences and turn them into policy advice to improve the mental health system or into test cases to reform the justice system (Mental Health Australia, sub. 407; Victoria Legal Aid, sub. 500). Peak mental health bodies also supply representatives with lived experience who can collaborate with government in system planning, monitoring and evaluation.

The improvements in program design and implementation possible with consumer and carer involvement can lead to a more efficient allocation of mental health resources. However, the extent to which additional funding for systemic advocacy would necessarily lead to more efficient resource use is unclear. For example, a lack of consumer and carer involvement can reflect a ‘free rider’ problem:

Even though consumers in aggregate might place a high value on consumer advocacy, each individual consumer has an incentive to ‘free ride’ on the contributions of others, meaning that consumer organisations may find it difficult to attract commensurate resources — whether in the form of volunteered time or donated money — from them. (PC 2008, vol. 2, p. 279)

Testing for funding adequacy

There is little data publicly available for assessing whether governments are underinvesting in systemic advocacy compared with other mental health activities as governments do not routinely collect data on expenditure for this purpose. However, the returns to mental health advocacy could be relatively high. For example, Daly, Barrett and Williams (2017, p. 44) estimated a benefit cost ratio for independent disability advocacy of 3.5:1, which they argue is a high return relative to other government investments in Australia.
One test for funding adequacy is material gaps in consumer and carer input into policy processes. Although such gaps may be difficult to detect and attribute to underfunding, some participants presented evidence of increased demand for systemic advocacy, including:

- increased calls by government for consumer and carer engagement and participation across the mental health sector (National Mental Health Consumer and Carer Forum, sub. 476, p. 8)
- calls for a national consumer and carer peak body and/or peak bodies in some jurisdictions\textsuperscript{246}
- a lack of resources limiting the ability to be a ‘strong voice’ (Mental Health Carers Australia, sub. 489, p. 13)
- the need to include the views of children and young people at a systemic level, which are often overlooked (Commissioner for Children and Young People (WA), sub. 640, p. 7).

Concerns about funding adequacy are more acute when considered against the backdrop of short funding cycles. These create a challenging operating environment for some organisations, which negatively affects service delivery and support, as discussed for other parts of the mental health system elsewhere in this report (chapters 17 and 23). Mental Health Australia described the current situation:

> Peak bodies, which carry out systemic advocacy, are subject to funding uncertainty created by unpredictable and short term contracts that do not provide enough funding to ensure organisational sustainability. This has resulted in inadequate support for robust systemic advocacy in a period of significant change and upheaval, precisely when such activities are needed most. (Mental Health Australia, sub. 407, p. 36)

Total government funding for peak consumer and carer bodies has varied significantly over the past 10 years (figure 22.1). In some States and Territories, year-on-year funding fluctuations were considerably greater.\textsuperscript{247}

### Reliability in the funding of system advocacy

In the Inquiry draft report, we recommended that governments should strengthen systemic advocacy by making funding more predictable. It is inefficient to contract on a short-term basis with peak representative bodies that have an enduring role, yet expect them to develop strong capabilities to provide high-quality advice. Specifically, we recommended funding cycles of at least five years to improve business planning and capability development. We also recommended that renewal negotiations should conclude well before contracts expire. This would enable peak bodies to operate more efficiently and to better manage risks of losing high-performing staff. Last minute indecision by government about future arrangements compounds business uncertainty.

\textsuperscript{246} Including, for example, Being and Consumers of Mental Health WA (sub. 928); Consumers Health Forum of Australia (sub. 496, p. 12); Mental Health Australia (sub. 407, pp. 26–27); Mental Health Coalition of South Australia and the Lived Experience Leadership & Advocacy Network, (sub. 360, p. 17); National Mental Health Consumer and Carer Forum (sub. 476, p. 4); Tim Heffernan, (sub. 552, attachments 2–5).

\textsuperscript{247} The coefficient of variation (a statistical measure of variability) was up to 78\% for some jurisdictions compared with 10\% for the nation as a whole.
Figure 22.1  **Estimated total government expenditure on mental health systemic advocacy via peak consumer and carer bodies**

![Graph showing estimated total government expenditure on mental health systemic advocacy via peak consumer and carer bodies from 2010 to 2019.](image)

Values adjusted for the effect of inflation and expressed in 2018-19 dollars. Includes core funding provided by Australian, State and Territory Governments to peak mental health bodies plus estimated expenditure on mental health advocacy by some peak health bodies. Excludes ad hoc amounts for building systemic advocacy capacity and systemic advocacy undertaken via other channels, including government advocacy bodies, non-peak systemic advocacy bodies, non-government service providers and legal advocates.

**Source:** Productivity Commission estimates based on information collected from Australian, State and Territory Governments and peak bodies representing mental health and health consumers and carers.

Carers Victoria summarised the views of a number of Inquiry participants about longer funding cycles for peak bodies, suggesting they would:

… increase efficiency in the workplace by providing greater certainty in business and workforce planning, reducing the costs of staff turnover including the associated loss of knowledge and expertise. (Carers Victoria, sub. 664, p. 10)

We recommend that governments should extend the default contract length for peak bodies that represent consumers and carers to at least five years (action 22.4).

To support implementation of these recommendations, the Australian, State and Territory Governments should disclose total expenditure by their departments and agencies on systemic advocacy in mental health that is provided by peak representative bodies. The Australian, State and Territory Government health ministers should task the Australian Institute of Health and Welfare with collecting this data annually. At the Commonwealth level, the Department of Health and the Department of Social Services should both supply expenditure data.
In addition, the NMHC should report annually on the state of systemic advocacy for mental health in Australia, including total expenditure by jurisdiction. This would serve to underscore the importance of systemic advocacy for mental health and enable stakeholders to form views about the adequacy of public funding.

**Lived experienced representation at the national level**

Various Inquiry participants called for stronger lived experience representation at the national level. While multiple bodies represent consumers and carers nationally, the lack of a body that focuses solely on consumers, in particular, and that chooses representatives independently of government processes, has been raised by Inquiry participants as a concern (box 22.7).

**Why consumers should have a separate voice**

At issue is whether existing organisations adequately represent the views of consumers at the national level. There is a contested view about whether a peak body should be for consumers and/or carers (National Mental Health Commission, sub. 949).

On the one hand are organisations that represent both consumers and carers — in particular, Lived Experience Australia and the National Mental Health Consumer and Carer Forum. While they can speak separately for either, much of their work covers areas of shared concern. In this regard, the roles of consumers and carers can interchange — when a consumer is or becomes a carer and vice versa (Emerging Minds, sub. 944). Moreover, development of effective solutions often requires consumers and carers to collaborate.

Discussions about engagement and participation must include all people who are impacted, whether they are primary users of the system, or families and other support people. There is extensive recognition that everyone needs to be in this together — that a ‘them and us’ approach is not the pathway to success. (NMHC 2018b, p. 8)

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248 Being (sub. 918); Being and Consumers of Mental Health WA (sub. 928); Consumers Health Forum of Australia (subs. 496, 646); Emerging Minds (sub. 944); Mental Health Australia (sub. 407); Mental Health Coalition of South Australia (MHCSA) and the Lived Experience Leadership & Advocacy Network (LELAN), subs. 360 and 771; National Mental Health Consumer and Carer Forum (subs. 476, 708); Sarah Sutton (sub. 737); Tim Heffernan (sub. 552); Victorian Mental Illness Awareness Council (VMIAC, sub. 844).
Box 22.7  Consumer and carer representation at the national level

Various organisations advocate for mental health consumers and carers at the national level. Mental Health Australia represents a broad range of stakeholders through peak bodies that represent consumers, carers, special needs groups, clinical service providers, public and private mental health service providers, researchers, and state and territory mental health peak bodies. For some peak bodies, mental health consumer and carers form a subgroup of their membership, such as Consumers Health Forum of Australia and Carers Australia. Listed below are those that focus on mental health consumers and carers.

The National Mental Health Consumer and Carer Forum, which is a national voice for mental health consumers and carers. Its membership comprise a consumer and a carer from: each state and territory; each of blueVoices, Carers Australia, Consumers Health Forum of Australia, Grow Australia, Mental Health Carers Australia, Lived Experience Australia, and CALD Mental Health Consumer and Carer Group Australia; and Aboriginal and Torres Strait Islander peoples.

Lived Experience Australia, previously the Private Mental Health Consumer Carer Network (Australia), which is a representational organisation for Australian mental health consumers and carers. Its State Advisory Forums exist to identify issues and needs of consumers and carers.

The National Register of Mental Health Consumer and Carer Representatives, which is a pool of trained mental health consumer and carer representatives from across Australia who work at the national level to provide a strong consumer and carer voice. Mental Health Australia provides its secretariat.

Mental Health Carers Australia, which is the only national advocacy group solely concerned with the wellbeing and promotion of mental health carer needs. Its members are State and Territory carer peak bodies: Arafmi Queensland; HelpingMinds – WA; Mental Health Carers ARAFMI NSW; Mental Health Carers Tasmania; Mental Illness Fellowship of Australia (NT); Mind Australia (National member); and Tandem (Victoria).

The National Consumer Peak Alliance, which is an alliance of State and Territory consumer peak bodies that recently committed to the establishment of a National Consumer Peak Alliance to influence, lead and advocate on behalf of people who experience mental health challenges (CoMHWA 2019). It would be led and owned by six consumer peak bodies: Victoria (VMIAC), New South Wales (Being), Tasmania (Flourish), South Australia (South Australia Lived Experience Leadership and Advocacy Network), the ACT (ACT Mental Health Consumer Network) and Western Australia (Consumers of Mental Health WA).

Source: Consumers of Mental Health WA (2019); Lived Experience Australia (2020); Mental Health Australia (2020b, 2020a); Mental Health Carers Australia (2020b); NMHCCF (2020).

On the other hand, proponents of a national consumer peak body contend that consumer and carer groups should not necessarily belong together (Being, sub. 918; Being and Consumers of Mental Health WA, sub. 928; Victorian Mental Illness Awareness Council, sub. 844). While they acknowledge the large amount of work that has been done collaboratively, they see an autonomous consumer peak body as having more influence on national policy. In their view, consumers and carers often share experiences, but in fundamentally different ways — Being (sub. 918, p. 14) report view of three consumers:

No one knows what I have been through, not even my family. How can they advocate for me when they didn’t receive the drugs, the ECT, or get locked in seclusion. They can’t, they saw it from a different perspective.
I don’t have family, I live in isolation, why are carers representing me through advocacy. We need our own voice, our own advocates, our own national peak body.

I love my carers, I need them and I want them in my life particularly when I am unwell. But should they be representing me at a state and national level, absolutely not!

Being (sub. 918) and Being and Consumers of Mental Health WA (sub. 928) stated other reasons which, in their view, support the establishment of a consumer-only peak body, namely:

- power imbalances when carers speak on behalf of consumers, which may negate consumer experiences and/or potentially lead to reforms that could compromise the health outcomes for consumers
- the health and wellbeing risks of combined consumer and carer organisations further disenfranchising and inadequately representing consumers who do not have carers
- rights under the UN Convention on the Rights of People with Disability (article 21) to express opinions on an equal basis with others, such as national carer organisations.

Australia’s adoption of the UN Convention on the Rights of People with Disability in 2006 has supported efforts for consumers to be able exercise autonomy and independence, including the freedom to make their own choices on an equal basis with others. To this end, Australia’s National Standards for Mental Health Services recognise the right for consumers to involve or not involve carers (Standard 1, criteria 1.11) and to independently determine who represents their views (Standard 3, criteria 3.4) (Australian Government 2010).

The Commission’s assessment

The recognised rights of consumers, in conjunction with the individuality of the consumer experiences, create a case for there being a peak body for consumers at a national level that is separate to the representation of carers. However, for governments to understand the views of consumers and carers collectively, they must also appreciate the diversity of circumstances and needs — to enhance the effectiveness and efficiency of their policies and programs. Engaging the relevant lived experience is important. Some participants highlighted particular groups of consumers and carers who would benefit from a stronger voice nationally, including children, parents and families (Emerging Minds, sub. 944).

The Australian Government should facilitate a process through Mental Health Australia to establish peak bodies that are able to represent the diverse views of consumers and of carers at the national level. The process should be developed in collaboration with national, state and territory organisations that represent mental health consumers and carers. Given the extent of preparatory work that has already been undertaken (Craze Lateral Solutions 2009; DoHA 2011; Mental Health Australia 2015), a successful outcome within two years should be achievable.

Further, the new peak bodies should have transparent processes for engaging with consumers and carers and representing them. Although a single voice cannot fully represent every consumer or carer, a single body for each should be able to establish processes to effectively
fulfil this role at the national level. This includes considering the mechanisms by which consumers and carers determine who represents them. Where possible, the new consumer peak body should liaise with other peak organisations (such as the Consumers Health Forum of Australia) to develop consistent policy positions. The new carer peak body should similarly collaborate with other family and carer organisations (such as Mental Health Carers Australia). Mental Health Australia should create formal mechanisms to bring the new consumer and carer peak bodies together regularly to progress issues of mutual interest and develop common policy positions and advice.

The Australian Government should provide funding for the new national mental health consumer and carer peak bodies. Compared with State and Territory Governments, the Australian Government is set to benefit more from stronger consumer and carer engagement on issues that affect all consumers and carers. Strong independent consumer and carer voices would improve understanding of: needs and priorities; the policies and programs that are most effective for people; and the extent to which policies and programs are working effectively and efficiently. Requiring State and Territory Governments to provide additional funding for consumer and carer peak bodies in their own jurisdictions to support a national organisation risks a ‘free riding’ problem where some jurisdictions fail to contribute, yet their consumers and carers benefit.

The level of funding should cover initial establishment and ongoing functions of the new peak bodies. The role for these bodies is large and complex given the diversity of consumers and carers and the extent to which co-design should underpin all aspects of system planning, design, monitoring and evaluation.

In considering an appropriate level of resourcing, the Australian Government should recognise that without additional funding, it is difficult to see how they could meaningfully engage with consumers (and carers) given the scale of reforms this Inquiry recommends.

This increased level of engagement adds to existing work on national policies and programs that continue to generate issues for mental health consumers and carers, including:

- NDIS (National Disability Insurance Scheme) transition issues (Being, sub. 918)
- privacy issues relating to My Health Record (Being, sub. 918; Mental Health Legal Centre, sub. 1222)
- issues related to accessing and maintaining access to the Disability Support Pension for people with psychosocial disabilities (Being, sub. 918)
- calls for the development of nationally consistent guidelines for appropriate consumer and carer remuneration in the development of policies and programs.249

249 BrainStorm Mid North Coast (sub. 803); Justice Action (sub. 929); Mental Health Carers Australia (sub. 898); National Mental Health Consumer and Carer Forum (subs. 476, 708); NSW Government (sub. 1243); Western Australian Department of Local Government, Sport and Cultural Industries (sub. 78).
ACTION 22.4 — ENHANCING CONSUMER AND CARER COLLABORATION

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

**Start now**

- The Australian, State and Territory Governments should establish a clear, ongoing role for consumers and carers to participate in all aspects of mental healthcare system planning, design, monitoring and evaluation and seek involvement from people with lived experience from the beginning of these processes.
- The National Mental Health Commission should report annually on the state of systemic advocacy in mental health in Australia at a State, Territory and national level.
- The Australian Government should facilitate a process through Mental Health Australia to establish peak bodies that are able to represent the separate views of mental health consumers, and of carers and families, at the national level. It should provide sufficient funding to cover the development, establishment and ongoing functions of these peak bodies.

**Start later**

- Mental Health Australia should create formal mechanisms to bring the new peak bodies together regularly to progress issues of mutual interest and develop common policy positions and advice.
- The Australian, State and Territory Governments should extend the funding cycle length for their relevant peak bodies to at least five years.

22.5 Improving accountability

‘The heart of good governance is having a razor sharp focus on understanding genuine accountability and making it happen in a practical way on a daily basis’ (Comley 2017). Good governance is essential for implementing strategies successfully. All parts of the mental health system should be accountable for their performance. Stakeholders who have an enduring interest in genuine accountability within Australia’s mental health system include:

- consumers and carers, for the quality of care and standard of services
- taxpayers, for the outcomes and economic return on government interventions
- communities, for decisions that have community-wide consequences
- service providers, for professional satisfaction and integrity.
Lack of accountability was the major governance issue raised by participants. Many submissions from a wide cross-section of stakeholders (particularly peak organisations) pointed directly at this issue. In their view, a lack of accountability for expenditure on mental health and individual outcomes significantly contributed to strategic failures in the mental health sector. As Rosenberg and Salvador-Carulla (2017, p. 50) concluded:

Leaving aside the inability to use benchmarking for service quality improvement, Australia’s current outcome blindness means it is not possible to justify existing spending or call for more resources in mental health. This is a vulnerable position when competition for health resources is fierce.

Chapter 24 discusses the chief means for promoting accountability — transparent monitoring, reporting and evaluation — as well as the case for setting specific targets.

### 22.6 Simplifying complaints processes

Failures in individual services or in the mental health system as a whole have the potential to harm people (Mental Health Victoria, sub. 479). A fair, effective and efficient complaints system is thus important for two reasons. First, consumers and carers have the right to complaint and redress mechanisms (ACSQHC 2019b; Standing Council on Health 2012, pp. 14, 19). For individual consumers, an effective complaints system might include an ability to obtain financial compensation, an apology in relation to treatment and/or a mechanism to ensure that other people do not have the same experience. It is an important safeguard that formally makes services and the practitioners within them accountable for their actions (Being, sub. 918, p. 16). Second, it helps to improve system performance where issues are not just individual, but cultural or systemic. This is often a particularly important aspect of the work of complaints bodies and Ombudsmen.

### Poor consumer experience with complaints system

Participants described the systems and processes for handling complaints as arduous and ineffective. They raised many issues, such as processing delays (Name withheld, sub. 10), resistance to investigations (Australians for Safe Medicines, sub. 313) and challenges faced by

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250 For example, Law Council of Australia (sub. 492); Mental Health Australia (subs. 407, 544); Mental Health Commission of New South Wales (sub. 486); Mental Health Victoria (sub. 479); National Mental Health Commission (sub. 118); SA Mental Health Commission (sub. 477); and the Victorian Government (sub. 483).

251 Being (sub. 918); Consumers Health Forum of Australia (sub. 496); Coronial Reform Group (sub. 39); Emma Spinks (sub. 573); Ian and Rhonda McNees (sub. 505); Independent Private Psychiatrists Group (subs. 473, 742); Kingsford Legal Centre (sub. 469); Matthew Fitzpatrick (sub. 936); Mental Health Carers NSW Inc (sub. 1231); Mental Health Complaints Commissioner (Victoria) (sub. 916); Mental Health Victoria (sub. 580); Name withheld (sub. 482); Name withheld (sub. 592); Niall McLaren (sub. 44); Northern Territory Mental Health Coalition (sub. 430); Patricia Sutton (sub. 173); Sarah Sutton (sub. 508); Sjon Kraan (sub. 667); SleeplessNoMore (Eyrie Pty Ltd) (sub. 100); Victoria Legal Aid (sub. 500); Western Australian Association for Mental Health (sub. 416).
young people (Commissioner for Children and Young People Western Australia, Perth transcript, p. 63). Others saw missed opportunities to make full use of complainants’ information to improve services (Matthew Fitzpatrick, sub. 936; Niall McLaren, sub. 44). Consumers frequently described efforts to complain about government services that did not relate to involuntary treatment as ‘frustrating and fruitless’ (Being, sub. 918, p. 17).

Difficulties in making complaints about psychiatric care drew particular attention. A common experience was feeling dismissed, as though no one was treating them seriously (Niall McLaren, Brisbane transcript, p. 103; Justice Action, sub. 929; Christine Newton, Brisbane transcript, p. 44; Supportive Residents and Carers Action Group Inc, sub. 11). For some, the stress of feeling unlistened to further damaged mental health (Matthew Fitzpatrick, sub. 936).

I think it’s incredibly hard to complain about a treatment at the hands of a psychiatrist. And I think most people just don’t bother. (Pippa Ross, Launceston transcript, p. 33)

In addition, some people found the network of complaints bodies to be complex. The different levels of governments, jurisdictional limits and regulations of professions involved in the health sector complicate the complaints process with a plethora of multiple ‘possible’ complaints mechanisms. For example, there is rarely a single contact point to lodge complaints about multiple services that can be involved in a single admission to a mental health facility (Matthew Fitzpatrick, sub. 936). Mental Health Victoria (sub. 479) maintained that there was no clear mechanism to raise complaints about personal safety and human rights matters. Participants also raised concerns regarding the lack of clarity about processes for making complaints about mental health complaints bodies themselves or the outcomes of formal complaints (Emma Spinks, sub. 573; Matthew Fitzpatrick, sub. 936). For example:

The NSW Minister for Health and the Director of Mental Health informed me that they have no jurisdiction over the NSW HCCC [Health Care Complaints Commission]. (Name withheld, sub. 564, p. 2)

Moreover, bringing complaints is challenging, and negative perceptions that inhibit people from approaching the complaints system in the first place are common (for example, Matthew Fitzpatrick, sub. 936; NSW in Mental Health Carers NSW Inc, sub. 1231, att. 1; Victoria Legal Aid, sub. 500, att. 1). While there are third parties such as advocates and Community Visitor schemes that assist individuals in making complaints or accessing other advocacy services (NSW Ombudsman 2016; Office of the Public Advocate (Victoria) 2019; VIC DHHS 2016a), these are limited and resources constrained.

Looking forward, the mental health complaints system is likely to face greater demand. Over the five years to 2018-19, the number of complaints and enquiries received by Victoria’s Mental Health Complaints Commissioner has grown by 10% a year on average (Mental Health Complaints Commissioner 2019a, p. 14). Comparable complaints bodies are experiencing similar growth (for example, HaDSCO 2019; HCCC 2019; NHPOPC 2019). Most complaints are multi-issue (Mental Health Complaints Commissioner 2019a, pp. 16-17).
Towards a simpler, transparent and fair complaints system

Consumers should have access to a simple and transparent complaints system that manages complaints fairly and allows them to ‘tell their story’. Not only is this vital for meeting justice objectives for individual consumers, but also for ensuring that it is an effective mechanism for systemically improving mental healthcare. Additionally, a fair and transparent complaints system affords natural justice to the parties against whom a complaint is made.

Several past reviews into aspects of the complaints system are relevant to this Inquiry. For example, the Productivity Commission (2014) examined Australia’s consumer complaints arrangements and found that disadvantaged Australians (which includes many people living with mental ill-health) are more susceptible to, and less equipped to deal with, legal disputes, and that a greater focus on the consumer was needed. More recently, a Senate inquiry into complaints handling by the Australian Health Practitioner Regulation Agency (Ahpra) heard concerns from health practitioners that echoed those raised in this Inquiry. In some instances, the process for dealing with notifications (that is, complaints involving health practitioners registered with National Boards under the National Registration and Accreditation Scheme) appeared to lack transparency, independence, timeliness and sensitivity (SCARC 2016b, 2017).

Work is being done by complaints bodies to improve complainant experiences. For example, following the Senate inquiries into the performance of Ahpra, Ahpra introduced a new role dedicated to considering and improving the experience of both notifiers and health practitioners — the National Engagement Advisor. Further, the National Health Practitioner Ombudsman and Privacy Commissioner works with Ahpra to continuously improve the notifications experience. It uses its complaints data to identify systemic issues and make recommendations or suggestions for improvement (for example, NHPOPC 2019, p. 26).

However, more could be done. As a first step towards developing a complaints system that meets objectives such as simplicity, transparency and fairness for mental health consumers, the Australian Government should request the Australian Commission on Safety and Quality in Health Care develop better practice guidelines on complaints management for complaints bodies handling mental healthcare complaints. It is noteworthy, for example, that about 57% of the complaints investigated by the National Health Practitioner Ombudsman and Privacy Commissioner in 2018-19 were resolved when it provided the complainant with a better explanation of the decision or action that they had concerns about (Richelle McCausland, National Health Practitioner Ombudsman and Privacy Commissioner, per. comm. 12 June 2020). These guidelines should be co-designed with mental health consumers and include standards and best-practice communication protocols. While comparable resources exist for healthcare services (ACSQHC 2004, 2005), these do not currently exist for the complaints bodies themselves.
Participants suggested various structural reforms to the health complaints system, including establishing a Federal Health Ombudsman or Australian Mental Health Ombudsman (SleeplessNoMore (Eyrie Pty Ltd), sub. 100; Sjon Kraan, sub. 667), and a Mental Health Complaints Commissioner in all states (Being, sub. 918, p. 7). Others sought stronger legal mechanisms, including for people who have experienced negligent mental health treatment (Mental Health Carers NSW Inc, sub. 1231, att. 1, p. 22) and for whistle-blowers (Law Council of Australia, sub. 492; Maurice Blackburn Lawyers, sub. 239; SleeplessNoMore (Eyrie Pty Ltd), sub. 100; and Supportive Residents and Carers Action Group Inc., sub. 11).

It is not practicable for the Productivity Commission to recommend reforms that are specific to mental health without taking into account the broader consequences on other functions performed by complaints bodies that service the health sector or other policy sectors. In some instances, health and mental health services are intertwined, especially regarding the treatment of comorbidities. In other instances, for example, health practitioners who treat people with mental ill-health also treat other health conditions. More generally, both complainants and practitioners have experienced similar frustrations with Ahpra complaints notification and management processes, feeling it was ‘not fair or impartial, and lacked transparency and adequate updates’ (Biggar, Lobigs and Fletcher 2020, p. 7).

To avoid unintended consequences, these broader issues would need to be taken into account in developing effective and efficient reforms.

The Australian, State and Territory Governments should instigate a national, independent review of Australia’s system for handling consumer complaints that relate to mental health issues. In undertaking a review of mental health complaints, given the fact that mental health sits within the health sector, and its complaints mechanisms more broadly, governments may wish to consider if there should be a broader approach to dispute resolution and the role of existing dispute bodies. A similar type of review was recently undertaken for the financial system external dispute resolution and complaints framework (Australian Government Treasury 2017).
ACTION 22.5 — SIMPLIFYING COMPLAINTS PROCESSES

All consumers should have access to a simpler and more transparent complaints system that is fair, effective and efficient and provides for systemic improvements to the mental health system overall.

Start now

The Australian Government should request the Australian Commission on Safety and Quality in Health Care to develop better practice guidelines for bodies handling mental healthcare complaints.

The Australian, State and Territory Governments should instigate a national, independent review of Australia’s system for handling consumer complaints that relate to the use of mental healthcare services and supports.

22.7 Building an evaluation culture

In chapter 24, we find that evaluation and research activities are not doing enough to drive continuous improvement in mental health policies, programs and services. There is scant routine evaluation across the system and where evaluations are undertaken, they do not always lead to practical knowledge and evidence. Moreover, where evidence to improve practice is developed, it is not well communicated or implemented. This section considers the arrangements that are necessary to build a strong evaluation culture that will lift system effectiveness and efficiency.

A national body to lead evaluation

A national body should lead Australia’s mental health and suicide prevention system in building an evaluation culture. This role would include having evaluations of policies and programs of national significance undertaken. Several reasons support this approach.

- Formally tasking a body to lead evaluations ascribes accountability to the role which, unlike monitoring and reporting, no institution currently performs. This would help overcome disincentives for governments to fund independent evaluations.
- Continuously scanning all relevant policies and programs would enable the body to identify priority areas for evaluation nationally.
- A national body would be able to engender analytical consistency and robustness. This would facilitate comparing program outcomes across multiple jurisdictions and enhance knowledge transfers more generally.
- Its corporate knowledge about interventions that are most effective and efficient (or not) would be a resource for stakeholders in all jurisdictions.
It would be well placed to build linkages between policy practitioners and researchers by undertaking policy-relevant research to support strategic decision making and working with stakeholders to fill key information gaps identified in the course of evaluations.

More specifically, the national body would be responsible for:

- promoting a culture of evidence-based policy and program development across all areas of the mental health and suicide prevention system
- developing a work program independently, but in close consultation with stakeholders
- commissioning transparent and robust program evaluations
- developing evaluation capacity and capabilities based on internationally recognised best practice approaches
- adopting and promoting rigorous evaluation quality control processes
- providing independent advice on evaluation as an input to program design
- communicating and translating findings and evidence to enable practical improvements of policies and programs
- sponsoring associated research and evaluation activities
- building and maintaining partnerships with stakeholders, particularly consumers and carers, research institutes, government departments, state and territory mental health commissions (or equivalence), and mental health service planners and providers.

Expanding the NMHC’s functions to include program evaluations

Broadly defined, the ‘system’ that supports mental health includes not only mental health and suicide prevention programs, but numerous other programs that intersect with mental health outcomes, including in non-health sectors. Further, a robust culture of program evaluation would benefit from expert input at all stages. It begins with program design, where consideration is given to the data that should be collected and made available to enable proper evaluation later on and continues through program implementation to conclude with a final evaluation following decommissioning.

While a new body could be created for this function, the Productivity Commission considers it expedient to extend the functions of an existing body. In particular, the NMHC should be authorised to perform this role. The NMHC already has a mandate to work across all areas that impact mental health including education, housing, employment, human services and social support (National Mental Health Commission, sub. 118). This is important given that mental health involves expenditure in non-health sectors. In addition, the cost of expanding the NMHC’s role would be lower than establishing a new body. It already has well developed relationships with a wide range of stakeholders. Further, there are synergies with the NMHC’s existing monitoring and reporting functions. Monitoring, evaluation and research complement and support each other in driving continuous improvements (chapter 24).
While the NMHC is already authorised to perform aspects of the recommended evaluation function (box 22.8), it does not have a clear mandate for conducting independent and transparent program evaluations. Nor does it have a cross-jurisdictional purview — a necessity given the scale of mental health-related activity across both tiers of government. An expansion of its functions would require matching funding.

Box 22.8 Current functions of the National Mental Health Commission

The National Mental Health Commission (NMHC) is an executive agency of the Australian Government located within the health portfolio. It is a non-corporate Commonwealth entity for the purposes of the Public Governance, Performance and Accountability Act 2013 (Cth). Its foundational objectives, set by the Prime Minister of the day, positioned the NMHC as the independent governance pillar of the mental health system. The objectives are to:

- plan more effectively for the future mental health needs of the community
- create greater accountability and transparency in the mental health system
- give mental health prominence at a national level (Gillard 2011).

The NMHC (sub. 118, p. 1) summarised its purpose as having a national remit:

… to provide insight, advice and evidence in ways to continuously improve Australia’s mental health and suicide prevention system and act as a catalyst for change to achieve system improvements. The Commission also has a mandate to work across all areas that impact on mental health, including education, housing, employment, human services and social support.

Formally, the NMHC’s current functions are to:

- develop, collate and analyse data and information to ensure a cross sectoral perspective is taken to mental health policy development and reform
- build and maintain effective working relationships with stakeholders in Australia and internationally to inform the work of the Commission
- provide independent and impartial advice to Government to improve mental health services and support within the Australian community
- manage, administer and publicly release evidence-based information in order to promote mental health and wellbeing
- review, analyse and promote research and best practice to support better treatment outcomes across the mental health sector
- promote a person-centred approach to mental healthcare that engages and values the participation of people with lived experience, their families, carers and communities; and
- undertake other relevant tasks as the Minister may require from time to time. (Order dated 27 September 2018 in Australian Government Notices Gazette C2018G00764).

Need for greater independence for evaluations

As with any body tasked with assessing performance, independence is vital. A body that is separate from policy and program funding, design and implementation would promote
greater independence and objectivity. It would also promote transparency by publishing its findings where privacy constraints do not exist.

In considering the level of independence that the NMHC should have, it is important to first identify any risks to it effectively delivering on its statutory responsibilities. In reviewing the NMHC, Deloitte (2017, p. 17) argued that its current institutional form as an executive agency enabled it to provide reporting and policy advice to Government that was free from direction ‘other than the confines of scope and government policy’. In its view, the NMHC had a sufficient degree of independence from the Department of Health because:

- there is no requirement for the Department of Health to approve NMHC deliverables
- the NMHC’s Chief Executive Officer and Commissioners are appointed by the Minister (not the Department’s Secretary) and are not Australian Public Sector employees
- the accountable authority, which is the Chief Executive Officer, reports to the Minister.

However, these protections are inadequate for the new role. The NMHC would need to be able to provide independent advice on evaluation as an input to program design, carry out those evaluations and then publish its findings, including recommended improvements. Fulfilling these responsibilities presents the difficulty of commenting on the merits or otherwise of government policies while upholding stakeholder confidence about its independence and objectivity.

There are good reasons to position the NMHC outside of political influence and process (Mental Health Australia, sub. 544, p. 12). High-quality evaluations drive change best when all parties involved in that change view them as independent, including both tiers of government. Moreover, independence needs to endure beyond the goodwill and intentions of current office holders and staff.

Accordingly, a level of professional independence that goes beyond merely a lack of direct veto power by the Department of Health is vital. At times, the NMHC would need to evaluate programs that are championed by key stakeholders. Here, it could face a situation where its public reporting of outcomes was contrary to that of key stakeholders (such as a department) or, potentially, political office holders (such as a minister).

Thus, the NMHC would need to clearly view itself as independent and not under any obligation to the Department. Moreover, to maintain the credibility of its work, stakeholders would also need to perceive the NMHC as independent. In particular, the design of its governance arrangements would need to assuage any concerns from State and Territory Governments about the NMHC acting primarily as an arm of the Australian Government.

**The case for a statutory authority**

For some time, various commentators have recognised the need for the NMHC to evolve and play a stronger role. Mendoza et al. (2013, p. 49), for example, argued that for the NMHC to be effective, it must become:
… a more genuinely independent body, with statutory powers of inquiry and reporting functions to the Australian Parliament. A revamped Commission must have both the statutory powers and resources necessary to develop, monitor and independently report on national mental health policy, programs and outcomes in Australia.

Notwithstanding, some have argued against statutory independence. Deloitte (2017, pp. 24–25) contended that the strong rationale required by Government was not evident and that the current arrangements offered sufficient independence. In its view, strengthening the NMHC’s capacity and capability, and clarifying the roles and responsibilities of its Commissioners would address stakeholder perceptions about insufficient independence. However, their conclusion assumed no change to the NMHC’s functions.

In our view, it is not credible that the NMHC could build an evaluation culture across Australia’s mental health and suicide prevention system, which includes evaluating nationally significant policies and programs itself, without statutory independence. Statutory powers are appropriate for bodies that scrutinise public sector activities (Australian Government Department of Finance 2018). They are generally necessary where there is a need for enabling legislation to specify the powers and functions of the body, its level of independence and its accountability to Parliament.

The NMHC should be given statutory authority to enable it to effectively fulfil the recommended evaluation role which, among other things, would require it to publish rigorous analyses and evaluations of mental health policies and programs. Together with its existing monitoring and reporting roles, these functions would enable the NMHC to develop policy positions and provide advice to governments across the full gamut of mental health services and supports.

This role is analogous to the policy capability of other Commonwealth statutory agencies, including regulatory bodies such as the Australian Competition and Consumer Commission and the Australian Securities and Investments Commission. Statutory powers would also facilitate building an analytical culture within the NMHC that would be at arm’s length from policy makers and practitioners. Moreover, greater independence would create a more stable operating environment over the long term for it to perform its role, irrespective of changes in personnel within the Department of Health, the Ministers’ office and the NMHC itself.

As a statutory authority, its prescribed functions would enable the NMHC to clearly differentiate itself from other bodies that operate in the mental health sector. Some participants raised issues about a lack of clarity in this regard (ACT Government, sub. 210; Mental Health Council of Tasmania, sub. 314). Two issues are relevant: data and advocacy.

As a statutory authority, the NMHC:

- would continue to work closely with other bodies (such as the Australian Bureau of Statistics, the Australian Institute of Health and Welfare, and the Australian Commission on Safety and Quality in Health Care) to minimise duplication in monitoring and reporting
should not advocate, defend or publicly canvass the merits of government or opposition policies, including policies of previous governments — these are activities of peak bodies, including Mental Health Australia and Suicide Prevention Australia. Rather, the NMHC would position itself as an ‘honest broker’ in providing evidence-based advice to ministers and informing the wider community of ‘what’s working and what’s not’. Such arrangements would maximise the NMHC’s influence.

**The NMHC to be an interjurisdictional body**

There is wide stakeholder support for the NMHC to become an independent statutory authority with an interjurisdictional role whose responsibilities include strategic national evaluation, monitoring and reporting. Establishing the NMHC as an interjurisdictional body would enable it to operate effectively across a system that spans both tiers of government. In particular, it would create an authorising environment that would enable it to work more closely with State and Territory Governments, which deliver and/or commission the bulk of clinical and psychosocial services, and a range of other services that directly affect mental health outcomes in sectors such as housing, justice and education. Close cooperation should include the timely exchange of data to support robust evaluations and assistance with interpreting and contextualising that data.

Interjurisdictional bodies are not new. A variety exist under intergovernmental agreements in Commonwealth statutes, or in state and territory legislation. The nature of their interjurisdictional interactions varies according to prescribed activities and processes. For example, the Australian Institute of Health and Welfare Act 1987 (Cth) (section 7) requires the Australian Government minister to consult with each State health minister before giving a direction that relates to the health-related functions of the Australian Institute of Health and Welfare.

However, performing an interjurisdictional role does not obviate the responsibility for all governments to be first and foremost responsible for ensuring their stock of policies and programs remain fit for purpose. New evidence, rising public expectations and changes in the broader policy environment can cause programs that were once best practice to become ineffective, inefficient or inequitable. Therefore, it is incumbent on governments to build evaluation into program planning, to maintain oversight through effective monitoring and reporting regimes, and to periodically conduct assessment of programs. To this end, some

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252 Advocacy for Inclusion (sub. 935); Consumers Health Forum of Australia (sub. 646); headspace – National Youth Mental Health Foundation (sub. 947); Mental Health Victoria (sub. 942); MindSpot (sub. 666); National, State and Territory Mental Health Commissions (sub. 731); Queenslanders with Disability Network (sub. 662); Royal Australian and New Zealand College of Psychiatrists (sub. 1200); SA Mental Health Commission (sub. 691); Transforming Australia’s Mental Health Service Systems (sub. 919); and WayAhead – Mental Health Association NSW (sub. 704).

253 Examples include the National Blood Authority, National Health Funding Body, the Australian Commission on Safety and Quality in Health Care, the Independent Hospital Pricing Authority and the Australian Health Practitioner Regulation Agency.
State and Territory Governments have charged their mental health commissions with evaluation responsibilities.

It is within this context that the NMHC’s ability to build and maintain co-operative partnerships with all jurisdictions would be critical for its effectiveness in leading improved performance of the mental health system over the long term. This would involve, among other things, consulting closely with jurisdictions to discern where and when it could best value add, and being mindful of its relative strengths and weaknesses. On the one hand, evaluation of State programs by a national body risks an approach that fails to fully recognise or account for service and consumer requirements that are unique to individual States and Territories. On the other hand, being independent of the development and implementation of programs would afford it considerable objectivity and perspective. Notwithstanding, it is difficult to conceive circumstances that would warrant the NMHC unilaterally duplicating the work of state and territory mental health commissions.

As a precursor to the design of the NMHC’s statutory arrangements, the Australian, State and Territory Government health ministers should endorse the NMHC to take on a broad-ranging evaluation role. This support should include a statement agreeing to a set of principles for undertaking the evaluation role (discussed below).

Relationship with State and Territory Government mental health commissions

In many States and Territories, mental health commissions or equivalents provide an oversight role of the mental health system, or on aspects of it (section 22.1). Their work is informed by dedicated mental health advisory councils in New South Wales, Queensland, South Australia, and Western Australia, which may include issues relating to alcohol and other drugs. Mental health advisory councils also assist ACT Health and the Mental Health Complaints Commissioner in Victoria. Although there are no dedicated mental health advisory councils in the Northern Territory and Tasmania, there are general health advisory committees.

In addition to mental health commissions, there are multiple institutions that evaluate aspects of state and territory mental health systems, however, these tend to be reactive or ad hoc, with varying levels of independence. Auditors General occasionally conduct performance audits and reviews of specific mental health programs. Royal Commissions can be established to inquire into system-wide failures.

In response to the Draft Report, the National, State and Territory Mental Health Commissions (sub. 731, p. 1) warned against the NMHC duplicating work performed by state and territory mental health commissions. In particular, the Mental Health Commission of New South Wales (sub. 948, p. 12) noted that one of its statutory functions is:

… to review and evaluate, and report and advise on, the mental health and well-being of the people of New South Wales including conducting systemic reviews of services and programs provided to people who have a mental illness and other issues affecting people who have a mental illness. (Mental Health Commission Act 2012 (NSW), section 12(1)(c))
To avoid unnecessary duplication, the NMHC needs to maintain links with an array of institutions in all jurisdictions beyond just mental health commissions.

Key to maximising the NMHC’s value add is for it to focus on evaluating aspects of the system that are of national significance or that relate to multiple jurisdictions. The NMHC should be able to publicly justify its work program, which includes being accountable for the effective and efficient use of public resources for defined purposes, as required of it now. While this approach does not rule out the NMHC evaluating individual State or Territory programs, ideally such a decision would be made in close consultation with jurisdictions and/or their mental health commissions.

A broader question relates to the leadership roles that State and Territory mental health commissions (and equivalents) should play at the interface of government and the mental health service sector. As noted in section 22.2, effective leadership is central for realising systemic change. The reforms recommended in this report are wide ranging and complex. Without aligned effort across multiple agencies, dysfunction, duplication and gaps will continue to compromise the system’s effectiveness and efficiency.

Participants suggested ways in which mental health commissions could strengthen system governance. They recognised that not all jurisdictions have a mental health commission and, among existing ones, there is much variation (section 22.1). Nevertheless, it was commonly agreed that they should play a stronger and more collaborative role in system governance.

- State and Territory Mental Health Commissions (sub. 731, p. 1) jointly agreed that:
  - existing state and territory commissions be retained and all States and Territories should establish mental health commissions (or equivalents)
  - consideration be given to having some common roles and responsibilities, including local monitoring and reporting
  - all mental health commissions should work more closely together to help develop a clear and consistent picture of mental health services development and reform.

- Transforming Australia’s Mental Health Services Systems (sub. 919, p. 15) suggested that State mental health commissions should collaborate with a strengthened NMHC ‘to provide expert leadership’.

- The SA Mental Health Commission (sub. 691, attach. 2, p. 10) went as far as proposing that every state and territory should establish independent statutory mental health commissions that work closely with the NMHC, or that the NMHC should expand into each jurisdiction to eventually replace existing mental health commissions.

A stronger network of mental health commissions would better serve the interests of consumers and carers. It would support more effective, efficient and integrated decision making and implementation over the long term. In addition to collaborating with the NMHC as they do now, their governance role at the State and Territory level should include:
maturing the capability of jurisdictions to pursue continuous policy and program improvement by providing evidence-based advice and a multi-sectoral perspective, which may also require capabilities for monitoring and evaluation activities

fostering genuine accountability for policy commitments, strategy implementation and mental health outcomes.

To this end, each State and Territory Government should have a mental health commission (or equivalents) that can fulfil these roles. This may require them to strengthen or expand an existing body, or establish a new body, as the case may be. However, we are not suggesting a particular organisational form as some mental health commissions play other roles and, in any case, various governmental arrangements would suit. Rather, to ensure mental health commissions can effectively fulfil their essential system governance role, we recommend that State and Territory Governments should adopt the following operating principles:

- enduring, that is, expected to continue indefinitely
- appropriately resourced to match their roles and responsibilities
- independent of, but integral to, government mental health policy making
- authorised to take a cross-sectoral view
- authorised to request and receive information and data from other government departments and bodies.

**ACTION 22.6 — STRENGTHENING THE MENTAL HEALTH CAPABILITY**

All States and Territories should have the capability to have innovative and accountable mental health services.

*Start now*

Where a body does not exist, State and Territory Governments should each establish a body (such as a mental health commission) that is responsible for promoting continuous policy and program improvement, and fostering genuine accountability for their mental health reform commitments. States and Territories should adopt the following principles to ensure that the relevant bodies operate effectively:

- enduring, that is, expected to continue indefinitely
- appropriately resourced to match their roles and responsibilities
- independent of, but integral to, government mental health policy making
- authorised to take a cross-sectoral view
- authorised to request and receive information and data from other government departments and bodies.
Powers to compel information

As a national monitoring and reporting agency, the NMHC requires consistent and timely access to appropriate information. While the NMHC works with governments, agencies and others to access the information needed to fulfil its current functions, on occasions this approach has not been successful (Consumers Health Forum of Australia, sub. 646; National Mental Health Commission, sub. 118). Circumstances that limit the NMHC’s reporting function include that:

- information collected by agencies is not made public
- information is collected by agencies for public release, but is not released in time for the NMHC to use
- information collected by agencies does not support the NMHC’s reporting needs
- agencies are either not able or willing to supply information.

Tasking the NMHC with an evaluation role would increase its existing challenges with accessing information. In addition to its current monitoring and reporting functions, the recommended evaluation role would require the NMHC to:

- evaluate and report on mental health and suicide prevention system outcomes and impacts
- evaluate and report on the strategies and plans that contribute to system outcomes
- engage broadly with multi-jurisdictional, cross-portfolio and non-government stakeholders to support a national approach to evaluation
- develop new information collection and evaluation processes to support outcome and impact evaluations
- rely more heavily on non-publicly released information.

Some of these potential challenges with accessing information to support the recommended evaluation role could be overcome by negotiating a co-operative and mutually supportive arrangements for information sharing.

Notwithstanding, the NMHC should be given legislative powers to make reasonable requests for information from Australian, State and Territory Government agencies when required to fulfil its statutory functions. These powers would be necessary where standard practices for obtaining information are not successful. As an example, the Productivity Commission Act 1998 (Cth) provides powers to compulsorily obtain information relevant to its functions. Participants such as the Consumers Health Forum of Australia (sub. 646) and the Royal Australian and New Zealand College of Psychiatrists (sub. 1200) supported such powers for the NMHC.
Governance arrangements

The following outlines particular governance arrangements for the NMHC to operate effectively as an interjurisdictional statutory authority.

Board

The NMHC should be governed by a Board, to mitigate any risk (real or perceived) that the NMHC becomes unduly aligned with the interests of any one jurisdiction, especially the Commonwealth. As such, accountable authority should shift from the Chief Executive Officer to the Board. In addition, the Board should be granted full powers to act in the interests of the NMHC in fulfilling its statutory obligations, including powers to appoint and remove a chief executive officer.

The NMHC board should be skill-based, rather than representational, to ensure that it has the depth of capabilities to adequately support its role as the accountable authority. Board effectiveness depends on obtaining the right mix of skills, experience and attitude to successfully acquit board responsibilities. Consistent with its independent remit, the NMHC board should establish a nominations committee to ensure that it maintains an adequate mix of relevant skills, pursues best-practice board renewal and complies with standard government diversity objectives.

To this end, the inclusion of at least one non-executive director with lived experience would enhance board effectiveness. Although mental health is intrinsically a diverse area and individual experiences would differ greatly, their first-hand experience would complement those of other board members. More particularly, their expert knowledge is an inherent characteristic that would help to ensure board effectiveness. For the same reasons, reserving a board position for an Aboriginal and Torres Strait Islander person is similarly important and consistent with the Gayaa Dhuwi (Proud Spirit) Declaration (box 22.2).

Transparency and reporting

It would be important for legislators to balance the powers recommended for the NMHC with transparent processes for consulting with those responsible for the design and performance of Australia’s mental health and suicide prevention system.

The intent is for governments to view the NMHC as a change agent for promoting effective and efficient policy that improves mental health and social and emotional wellbeing outcomes for all Australians. In order to elicit full stakeholder cooperation, broad consultation and strong engagement should remain a hallmark of NMHC operations, including in developing its work plan. In this regard, some participants highlighted stakeholders potentially at risk of being overlooked, including the Commonwealth Ombudsman and the Office of the Commonwealth Ombudsman as the National Preventive Mechanism Coordinator (Advocacy for Inclusion, sub. 935).
To this end, the NMHC should:

- develop a consultation process and consult with, at a minimum, the Australian Government’s Department of Health, the Department of Social Services and the National Indigenous Australians Agency, State and Territory Government health/mental health departments and mental health commissions, consumer and carer peak bodies, non-government organisations and the private sector.

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

- as part of its annual planning cycle, prepare a rolling 3-year schedule of evaluations of mental health policies and programs, and policies and programs that have strong links to mental health outcomes. This would ensure stakeholders, including all governments, have clear visibility of its intentions and work to minimise duplicative effort.

- prepare an annual report that, among standard requirements, reports on its forward program of evaluation activities as well as those commenced and completed.

Principles for conducting program evaluations

The Australian, State and Territory Governments should agree to a set of principles by which the NMHC would undertake its evaluation function. At a minimum, these principles should be based on those listed in box 22.9 to ensure that evaluations are robust, reliable and relevant. These principles should be set and agreed by the Australian, State and Territory Government health ministers in consultation with relevant stakeholders. As discussed in section 24.3, in developing these principles, the Council should ensure they reflect the importance of:

- shifting towards evaluations that focus on measuring the attributable impact of programs (through methods that incorporate control groups), rather than purely monitoring program outcomes.

- promoting processes that enable lessons from program implementation to be determined and disseminated before programs reach their impact evaluation stage.

Evaluations of programs involving Aboriginal and Torres Strait Islander people

The Australian Government has asked the Productivity Commission to develop a whole-of-government Indigenous Evaluation Strategy. A draft Strategy was released in June 2020, and was informed by engagement with Aboriginal and Torres Strait Islander people, organisations and communities, government organisations, service providers, evaluators, academics and other interested parties.
Box 22.9 **Principles for program evaluations by the NMHC**

- Consumer and carer participation and engagement — consumer and carers should be involved in undertaking evaluations, sharing their knowledge, experience, perspectives and priorities.
- Independence — evaluators should have some degree of independence from policy makers and program managers, to ensure evaluations are objective and unbiased.
- Ethical conduct — evaluation commissioners and evaluators should behave in an ethical manner, following ethical guidelines for evaluation.
- Robust, evidence-based and impact-focused — robust evaluation methodologies and analytical methods should be used to understand the effects of programs, and inform program design and implementation. Evaluations should be impact-focused, testing the causal link between programs and their impact on communities.
- Transparency and accountability — evaluations should be made public on completion. There should also be transparency and accountability about how policy makers and program funders/managers respond to evaluation findings.
- Relevant and integrated — evaluations should support learning, evidence-based decision making, improvements in programs and service delivery, and inform policy decisions. Evaluation should not be viewed merely as a compliance activity.

The objective of the Strategy is to improve the lives of Aboriginal and Torres Strait Islander people by having policy and program decisions informed by high quality and relevant evaluation evidence. The draft Strategy sets out principles to guide what agencies and evaluators should do when they are planning, conducting, reporting and using evaluation, as well as outlining approaches to setting evaluation priorities, sharing and translating knowledge, building evaluation capability, and monitoring evaluations undertaken under the Strategy.

The Indigenous Evaluation Strategy will apply to all Australian Government agencies with responsibility for designing and/or implementing policies and programs affecting Aboriginal and Torres Strait Islander people. This will include the NMHC. It will cover Indigenous-specific policies and programs as well as mainstream policies and programs that affect Aboriginal and Torres Strait Islander people.

The Productivity Commission released the draft Strategy for public comment and plan to submit the final Strategy to the Australian Government in October 2020 (PC 2020). When finalised and endorsed by the Australian Government, the NMHC should adopt the Strategy when leading evaluations of programs that involve Aboriginal and Torres Strait Islander people.

In addition, the NMHC should follow the Gayaa Dhuwi (Proud Spirit) Declaration, which provides specific guidance on evaluations of mental health policies and programs that affect Aboriginal and Torres Strait Islander people (section 22.1). This approach is consistent with commitments under the Fifth Plan. For such evaluations, theme 3 of the Declaration requires that: Aboriginal and Torres Strait Islander people should lead the development of evaluation frameworks; and all parts of the Australian mental health system should use Aboriginal and
Torres Strait Islander values-based social and emotional wellbeing and mental health outcomes measures.

**ACTION 22.7 — BUILDING A STRONGER EVALUATION CULTURE**

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

*Start now*

The National Mental Health Commission (NMHC) should have statutory authority and lead the evaluation of mental health and suicide prevention programs funded by the Australian, State and Territory Governments, and other programs that have strong links with mental health outcomes, including those in non-health sectors.

- The NMHC should be an interjurisdictional body. All health ministers should endorse the NMHC to take on a broad-ranging evaluation role.
- The NMHC should be governed by a skills-based Board. It should be granted full powers to act in the interests of the NMHC in fulfilling its statutory functions, including powers to appoint and remove a Chief Executive Officer.
- The NMHC should have legislative provisions to make requests for information from Australian, State and Territory Government agencies in order to fulfil its statutory functions.
- The NMHC should not advocate, defend or publicly canvass the merits of governments’ or oppositions’ policies.

As part of its annual planning cycle, the NMHC should prepare and publish a rolling 3-year schedule of program evaluations. It should, in consultation with key stakeholders, develop and publish a process for prioritising policy and program evaluations, including decision-making criteria.

The Australian, State and Territory Governments should agree to a set of principles by which the NMHC would undertake its evaluation function and for the mental health sector more broadly. These principles, which should be developed in consultation with relevant stakeholders, should reflect the importance of:

- shifting towards evaluations that focus on measuring the attributable impact of programs (through methods that incorporate control groups), rather than monitoring program outcomes
- promoting processes that enable lessons from program implementation to be determined and disseminated before programs reach their impact evaluation stage.

The Gayaa Dhuwi (Proud Spirit) Declaration should guide any evaluation by the NMHC of programs affecting Aboriginal and Torres Strait Islander people.
Funding and commissioning

Reforms to funding and commissioning arrangements matter because...

- The gaps in mental health services described throughout this report are partly a reflection of inadequate levels of funding allocated to mental health services in some regions of Australia. But they are also a consequence of distortionary funding arrangements and unclear government responsibilities.
- Cooperation and coordination between the Australian Government’s Primary Health Networks and State and Territory Governments’ Local Hospital Networks is very patchy, which undermines accountability for delivering improved consumer outcomes.
- Primary mental healthcare funding arrangements:
  - do not fully reflect differences in needs between regions
  - incentivise an overreliance on Medicare Benefits Schedule-rebated care, which is not suited to all consumers’ needs
  - rely too heavily on centralised decision-making, when regional decision-making would be more appropriate.
- Local Hospital Network funding arrangements permit inefficiency in community ambulatory mental healthcare services and incentivise relative overreliance on hospital-based care.
- Private health insurance and life insurance regulations prohibit insurers from investing in the mental health of their consumers.
MENTAL HEALTH

RECOMMENDATION 23 — FUNDING ARRANGEMENTS TO SUPPORT EFFICIENT AND EQUITABLE SERVICE PROVISION

Mental health planning and funding arrangements should be reformed to remove existing distortions, clarify government responsibilities and support regional decision making.

As a priority:

- Governments should strengthen cooperation between Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) by requiring comprehensive joint regional planning and formalised consumer and carer involvement.
  - The National Mental Health Commission should independently monitor and report on compliance by PHNs and LHNs against their commitments. (Action 23.1)
- The Australian Government should support State and Territory Governments that choose to establish regional commissioning authorities (RCAs) to administer mental health funding as an alternative to PHN-LHN groupings. (Action 23.4)

Additional reforms to clarify government roles that should be considered:

- State and Territory Governments should take on sole responsibility for psychosocial supports outside of the National Disability Insurance Scheme. (Action 23.2)
- All Governments should develop a National Mental Health and Suicide Prevention Agreement to clarify responsibilities and the new role of the National Mental Health Commission. It should also specify additional mental health and psychosocial support funding contributions by each level of government. (Action 23.3)

Additional reforms to funding arrangements that should be considered:

- The Australian Government Department of Health should reform the way that it allocates funding to PHNs (or RCAs) to support greater regional equity and remove incentives to engage in cost shifting. (Action 23.5)
- The Australian Government Department of Health should:
  - provide guidance on the evidence base that underpins different types of interventions and require PHNs (and RCAs) to demonstrate that they have commissioned evidence-based services that meet their catchment’s needs
  - permit regional commissioning bodies to redirect to alternative services funding hypothecated to particular providers, if these providers are shown to not be meeting the service needs identified in regional plans
  - position Aboriginal Community Controlled Health Services as the preferred providers of services to Aboriginal and Torres Strait Islander people. (Action 23.6)
- The Independent Hospital Pricing Authority should review the Australian Mental Health Care Classification and develop an interim (simplified) model to allow State and Territory Governments to use activity-based funding for community ambulatory mental healthcare. (Action 23.7)
- The Australian Government Department of Health should establish a Mental Health Innovation Fund to trial new system organisation and payment models. (Action 23.8)
- The Australian Government should review the regulations that prevent private health insurers from funding community-based mental healthcare activities, and permit life insurers to fund mental health treatments for their insurance clients on a discretionary basis. (Actions 23.9, 23.10)
There are gaps and overlaps (but mostly gaps) in the delivery of mental health services. Most notable are the ‘missing middle’ (the shortfall in clinical and non-clinical community-based mental health services for people with moderate to severe mental illness) and the ‘low intensity gap’ (the shortfall of low intensity services that increases demands on less appropriate Medicare Benefits Schedule (MBS) rebated care) (chapters 12 and 17; appendix G).

These service gaps have emerged, in part, because the funding allocated to mental health services in some regions of Australia is insufficient to meet the needs of consumers of mental health services and their families and carers (chapters 12, 13, 15, 17 and 18). But it is also a consequence of the way that the existing funding is administered and used. Distortionary funding arrangements and unclear government responsibilities beset the planning, funding and delivery of mental health services.

- Australian Government and State and Territory Government responsibilities for clinical mental healthcare, psychosocial supports, suicide prevention services, and mental health carer supports are neither clear nor consistently implemented — either in intergovernmental agreements or ‘on the ground’ (appendix G).

- Mechanisms for funding mental health services create incentives to direct consumers toward hospital-based care and MBS-rebated care ahead of other forms of mental health services, permit low productivity among services such as community ambulatory mental healthcare, and prevent private insurers from investing in the mental health of their consumers (appendix G).

Hence, while more funding is needed in some areas, reforms are also needed to the way that funds are allocated and services are delivered to ensure that the available funding is put to best use. To this end, this chapter proposes reforms to funding and commissioning arrangements that aim to improve outcomes for consumers via two approaches:

- Decisions about allocating funding should primarily be made at the regional level by regional decision-makers that undertake rigorous assessments of their region’s needs to guide their decision making (this reflects the principle of subsidiarity (appendix G)). Both levels of government should support these regional decision-makers and hold them accountable for their decisions. And funding flows between levels of government and from governments to regional decision-makers should target consumer outcomes rather than provider-centric considerations. That is, funding to regional decision-makers should not incentivise them to favour some services over others.

- Australian Government and State and Territory Government investments in mental health should be integrated. There should be no ambiguity about which level of government (or its regional body) is responsible for providing a particular type of service or servicing a particular group of consumers or carers. And services that are separately funded by different levels of government ought to be seamlessly connected.

These approaches should not be controversial. They already underpin Priority Area One of the Fifth National Mental Health and Suicide Prevention Plan (the ‘Fifth Plan’) — the national strategy to impose a coherent regional architecture on an otherwise fragmented
system (COAG Health Council 2017a). Moreover, they are consistent with the recent commitment by all governments to create a mental health system that is ‘simple, unified and integrated’ (COAG Health Council 2019, p. 4).

What we are recommending is a stronger and more comprehensive set of reforms to give effect to these approaches.

- Sections 23.1 to 23.3 recommend structural reforms to funding and commissioning arrangements. The Inquiry draft report proposed two options for reforms to funding and commissioning, termed ‘Renovate’ and ‘Rebuild’. Following further analysis and stakeholder feedback (appendix G), we recommend an approach that incorporates elements of both these options. This approach has two parts:
  - Addressing the flaws in the current approach to strengthen cooperation between Australian Government-funded Primary Health Networks (PHNs) and State and Territory Government-funded Local Hospital Networks (LHNs) (hereafter ‘PHN–LHN groupings’) and clarify responsibility for psychosocial supports outside of the National Disability Insurance Scheme (NDIS) (sections 23.1 and 23.2). (This is a strengthening of the approach outlined in the Fifth Plan.)
  - Transitioning, on a State/Territory-specific basis, to an alternative approach whereby State and Territory Governments establish Regional Commissioning Authorities (RCAs) to pool and administer PHN and LHN mental health funds, if this is preferred by a particular State or Territory Government or if PHN–LHN cooperation fails to deliver sufficient improvement in mental health outcomes in a particular State or Territory (section 23.3).

- Section 23.4 proposes complementary reforms to how governments fund regional commissioning bodies (defined in this report to mean either PHNs or RCAs) and LHNs to reduce distortionary incentives and promote more efficient use of funds. The Australian Government should integrate the accounting of the funding it provides to regional commissioning bodies with the funding it administers via MBS rebates for mental healthcare, and distribute funding more equitably among regions. State and Territory Governments should use activity-based funding for community ambulatory mental healthcare services to increase their productivity. And regional commissioning bodies should trial and evaluate innovative new funding models with the support of an Australian Government-funded ‘Mental Health Innovation Fund’. These reforms could be pursued independently of the structural reforms outlined in sections 23.1 to 23.3.

- Section 23.5 proposes reforms to leverage insurance funds by removing restrictions that prevent private health insurers and life insurers from investing in the mental health of their consumers. Again, these reforms could be pursued independently of other reforms outlined in this chapter.
23.1 Strengthening the Primary Health Network–Local Hospital Network nexus

Under current government policy (as outlined in the Fifth Plan) PHN–LHN groupings are tasked with coordinating Australian Government and State and Territory Government funding for clinical mental healthcare and psychosocial supports outside of the NDIS and integrating the services funded by each level of government (appendix G). Governments should undertake reforms to support the PHN–LHN nexus, either on an ongoing basis or until they establish Regional Commissioning Authorities (RCAs; section 23.3) to administer the funding currently held by PHNs and LHNs.

PHN–LHN cooperation

Effective cooperation between PHNs and LHNs is essential for them to fulfil their mandate. Ideally, each PHN–LHN grouping would act as though it were a single entity holding a single pool of mental health funds that could be held singularly accountable for mental health service commissioning in its region. But financial incentives impede cooperation between PHNs and LHNs and undermine accountability for consumer outcomes (appendix G), so effective cooperation is unlikely to emerge without reform.

In principle, joint regional planning — the approach that the Fifth Plan takes to drive cooperation — seems the most likely approach to succeed, but there should be more stringent requirements on PHN–LHN groupings and an increased monitoring role by the National Mental Health Commission (NMHC).

Joint regional planning as a foundation for addressing service gaps

Joint regional planning is the process by which PHN–LHN groupings determine the mental health service needs of their region (taking into consideration the supply of services funded through other means — such as MBS-rebated services) and decide how they should allocate the resources they jointly have available to best meet these needs. The plans that result from these processes are an essential first step in addressing the gaps in provision of mental health services and thereby improving outcomes for consumers.

Joint regional planning should be the primary basis on which governments drive PHN–LHN cooperation. Joint regional plans should:

- clarify roles and responsibilities within each PHN–LHN grouping (including for integrating services)
- enable governments to hold PHNs and LHNs accountable for their subsequent commissioning and service delivery
- be developed with consumer and carer input.
However, the current guidelines for developing joint regional plans are not sufficiently stringent to effectively drive any of these outcomes, because: they do not prescribe what joint regional plans must contain; there is no clear way to determine that joint regional plans have been followed; and the deadline for producing plans has been delayed (appendix G). The Australian, State and Territory Governments should revise these guidelines to include the following of joint regional plans:

- A requirement that each PHN–LHN grouping reports, annually, a ‘gap analysis’ comparing services on the ground (whether provided/commissioned by the grouping or funded through other means) with National Mental Health Service Planning Framework (NMHSPF) benchmarks. The Australian Institute of Health and Welfare (AIHW) should supply data about current service provision to the PHN–LHN groupings and assist them with using the NMHSPF to produce these analyses. PHN–LHN groupings should develop and maintain capacity to use the NMHSPF in order to undertake gap analyses, having regard for the NMHSPF assumptions and limitations as they apply to their region. This is discussed further in chapter 24.

- A requirement that PHN–LHN groupings prepare and update annually, using a standard form template, a schedule detailing the mix of services that the PHN and LHN(s) would commission or provide over the following 3-year period (box 23.1). The AIHW should assist with developing this template to ensure it is congruent with current data collections.

- Guidance on minimum standards of service availability across all service types, as recommended by the PHN Cooperative (sub. 850).

- A requirement to clearly lay out how consumer, family and carer input was sought and whether any aspects of the plan conflict with this input.

- A requirement that joint regional plans be made publicly available (this is currently the case and should remain so).

**Box 23.1 Planning horizon**

Current guidelines require joint regional plans to cover a period of at least five years (Integrated Regional Planning Working Group 2018b). This requirement encourages PHNs and LHNs to take a longer term view when faced with immediate resource allocation decisions.

However, it is not feasible for PHN–LHN groupings to produce plans with the level of detail recommended by this Inquiry over an entire 5-year horizon. For one thing, PHNs know the quantum of mental health funds the Australian Government Department of Health will provide them only three years prior. As such, details about the mix of services that PHNs and LHNs plan to commission/provide should have a horizon of three years and be updated annually with an additional years’ data.

The NMHC — the primary entity responsible for monitoring PHN–LHN cooperation, as discussed later — should ensure that each joint regional plan and rolling 3-year schedule meet the new requirements and, where necessary, request further information or detail from PHN–LHN groupings.
Including psychosocial supports in joint regional planning

Existing requirements for joint regional plans are focused too narrowly on clinical services. The Fifth Plan predates PHN commissioning of psychosocial supports, and guidelines for joint regional planning are vague on the expectations of PHN–LHN groupings in regards to psychosocial supports (appendix G). But joint regional planning for psychosocial supports remains essential:

- to clarify roles — initially, responsibility for psychosocial supports for people outside of the NDIS would remain shared across governments (State and Territory Governments should, over time, take on sole responsibility for psychosocial supports outside of the NDIS, as discussed later)
- to manage, in detail, the transfer of PHN psychosocial support commissioning to State and Territory Governments
- to ensure that the psychosocial supports that consumers receive, including those delivered by the NDIS, are effectively ‘joined-up’ with the clinical mental healthcare that they receive.

Hence, the revised guidelines for joint regional planning should ensure that PHN–LHN groupings treat — in their joint regional planning — psychosocial supports outside of the NDIS in a similar way to the more rigorous approach they would be required to take with clinical mental healthcare. Further, guidelines should require PHN–LHN groupings to coordinate the clinical mental healthcare they commission with the psychosocial supports delivered by the NDIS.

Strengthening independent oversight

Independent and stronger oversight of PHN–LHN cooperation is needed, as current processes lack the independence and rigour necessary to critically assess the performance of PHN–LHN cooperation (appendix G). Providing statutory independence for the NMHC and recasting it as an interjurisdictional body is recommended (recommendation 22), with the NMHC then leveraging this status to be ‘frank and fearless’ in its assessments. But other changes are necessary.

Specifically, the NMHC should report separately on each PHN–LHN grouping. Its current reporting emphasises national-level conclusions, which provides a view of the general extent of PHN–LHN cooperation. But the purpose of monitoring and reporting on PHN–LHN cooperation should be to distinguish effective from ineffective performance, as this would allow governments to take remedial action for those groupings that are not cooperating effectively (including by establishing RCAs (section 23.3)).

Reporting by the NMHC should be based on objective measures of PHN–LHN cooperation (discussed next), as a complement to its current reporting, which is largely based on subjective assessment.
Improved monitoring of PHN–LHN outputs

The NMHC’s reporting on PHN–LHN cooperation should include an assessment of how PHN–LHN groupings are engaging with consumers and carers, allocating their respective funds and integrating their services.

Monitoring ongoing consumer and carer engagement

The NMHC should report on the extent of consumer and carer engagement with PHN–LHN groupings. To feed into this, each PHN–LHN grouping should be required to:

- develop and commit to a Consumer and Carer Engagement Framework that specifies their approach to engaging with consumers and carers, and a set of verifiable measures that indicate whether such engagement has taken place (for example, the number of times a consumer and carer reference group met annually)
- report annually to the NMHC on their performance against their Consumer and Carer Engagement Framework.

Comparing actual services against commitments

The NMHC should report on the mix of services that PHN–LHN groupings are commissioning/providing, including a transparent comparison against joint regional plan commitments. To enable this, the AIHW should supply the NMHC with data about services on the ground in each PHN–LHN region, that the NMHC can then compared with each PHN–LHN grouping’s commitments (as outlined in the standard form template).

The NMHC could also report each PHN–LHN grouping’s gap analysis against NMHSPF benchmarks for comparative purposes, but this is less critical as this information ought to already be in the public domain (chapter 24).

Improved outcomes monitoring

The outcomes of PHN–LHN cooperation — the extent to which PHNs and LHNs improve the mental health of the populations they serve — are what ultimately matter. Services only matter if they deliver the outcomes that consumers require. To this end, the NMHC’s reporting on PHN–LHN cooperation should include reporting of joint key performance indicators (KPIs) at the PHN–LHN grouping level. Although innate differences limit the usefulness of across the board comparisons between regions, within-region changes in KPIs and comparisons between regions with comparable populations and geographies would facilitate greater accountability and system improvements.

We are not proposing a list of KPIs that should be reported on. Further work is needed to determine which data could usefully be leveraged. Although the performance indicators in the Fifth Plan provide a good starting point from a conceptual standpoint, none are currently reported at the PHN–LHN grouping level (table 23.1). Our recommendation that AIHW report data at the PHN or LHN level (recommendation 24) would facilitate the reporting of
some of these at the PHN–LHN grouping level. The NMHC should work with the providers of the other data sources to determine whether they can be reported at the PHN–LHN level and, if not, how this could be achieved.

### Table 23.1 Fifth National Mental Health and Suicide Prevention Plan performance indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Frequency and mode of collection</th>
<th>Lowest geographic level currently reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>The proportion of adults with very high levels of psychological stress</td>
<td>Collection via the ABS National Health Survey every three years</td>
<td>Available at State/Territory level, possible available at lower geographic level</td>
</tr>
<tr>
<td>The proportion of people with a mental illness reporting participation with family, social and community groups.</td>
<td>Collection via the ABS General Social Survey every four years</td>
<td>Possibly available at State/Territory level</td>
</tr>
<tr>
<td>The proportion of mental health consumers and carers who report a positive experience of care.</td>
<td>Variable (chapter 24)</td>
<td>Variable (chapter 24)</td>
</tr>
<tr>
<td>The proportion of episodes of mental healthcare where significant improvement was identified between admission and review or discharge.</td>
<td>Annual collection via the National Outcomes and Casemix Classification</td>
<td>Within scope of recommendation 24 that it should be reported at the PHN–LHN grouping level</td>
</tr>
<tr>
<td>The proportion of people who receive clinical mental healthcare from a general practitioner, private psychiatrist, private hospital or public specialised mental health service.</td>
<td>Annual collection via various sources</td>
<td>Within scope of recommendation 24 that it should be reported at the PHN–LHN grouping level</td>
</tr>
<tr>
<td>The 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.</td>
<td>Annual collection via State and Territory Government mental healthcare services; follow-up by non-government services not captured</td>
<td>Within scope of recommendation 24 that it should be reported at the PHN–LHN grouping level</td>
</tr>
<tr>
<td>The number of suicides per 100 000 Australians.</td>
<td>Annual collection via ABS Causes of Death</td>
<td>Available at State/Territory level</td>
</tr>
<tr>
<td>Proportion of presentations to hospital for which there was a follow-up in the community within an appropriate period.</td>
<td>Under development</td>
<td>Likely at State/Territory level, lower levels of geography may not be feasible</td>
</tr>
</tbody>
</table>

**Source:** Productivity Commission analysis based on COAG Health Council (2017a).

The NMHC should also consider what other KPIs it should report as indicators of the effectiveness of PHN–LHN cooperation in addressing service gaps for consumers. For example, when considered in the context of the service mix commissioned/provided by a PHN–LHN grouping, reductions in the number of mental health-related emergency department presentations and hospital admissions (currently reported by the AIHW) could indicate better integration of PHN and LHN community-based services.
ACTION 23.1 — IMPROVING PHN–LHN COOPERATION

Start now

The Australian, State and Territory Government health ministers should significantly strengthen the guidance on joint regional planning for Primary Health Network (PHN)—Local Hospital Network (LHN) groupings to require each to:

- undertake gap analyses of current service provision against National Mental Health Service Planning Framework benchmarks (action 24.8)
- specify the mix of mental health services that they will commission/provide over the next 3 years and update this annually
- include all commissioned psychosocial supports outside of the National Disability Insurance Scheme within the scope of joint regional plans, and require joint regional plans to coordinate clinical mental healthcare with National Disability Insurance Scheme psychosocial supports
- set out how they consulted with consumers and carers in the development of the plan, whether any aspects of their plan conflict with the input of consumers and carers, and justify why this is the case.

Governments should require each PHN–LHN grouping to develop a ‘Consumer and Carer Engagement Framework’ that specifies an organised approach to engaging with consumers and carers and a set of benchmarks against which to report the extent of that engagement.

The National Mental Health Commission (NMHC) should develop a set of key performance indicators that capture the extent to which PHN–LHN cooperation is driving improved outcomes for consumers and carers, and seek to improve these indicators over time.

Start later

Governments should require PHN–LHN groupings to develop joint regional plans that comply with the revised guidelines and ensure that PHN–LHN groupings are adequately resourced to do so. The NMHC should ensure that joint regional plans are compliant.

The NMHC should report annually on the performance of each PHN–LHN grouping. Its reporting should comprise:

- a comparison of actual services commissioned/provided against joint regional plan commitments
- a description of the PHN–LHN grouping’s Consumer and Carer Engagement Framework and the extent of compliance with it
- reporting of key performance indicators at the PHN–LHN grouping level
- observations about the effectiveness of each PHN–LHN grouping.

The Australian Institute of Health and Welfare should provide data and analysis to the NMHC as required to facilitate this work.

The requirements on each PHN–LHN grouping should transfer to Regional Commissioning Authorities in States/Territories where they are established.
Responsibility for psychosocial supports

Clear responsibility for psychosocial supports outside of the NDIS is needed. Currently, both the Australian Government and State and Territory Governments provide psychosocial supports to those not eligible under the NDIS, with blurred division between the types of supports that each level of government offers (chapter 17). This has resulted in unclear responsibilities, leading to gaps and overlaps in service provision and inefficient service delivery (chapter 17). Responsibilities are clear for consumers that receive NDIS psychosocial supports, although there is a need for PHN–LHN joint regional planning to ensure that these services are integrated with clinical mental healthcare, as previously discussed.

One level of government should be solely responsible for providing psychosocial supports outside of the NDIS. Many Inquiry participants supported this principle.254 With both levels of government supplying such comparable services, it appears unlikely that joint regional planning or other cooperative processes could satisfactorily delineate responsibilities. In addition, we have recommended significantly expanding funding for non-NDIS psychosocial supports (chapter 17), meaning that accountability problems that are not fixed now would intensify.

Which level of government should take sole responsibility?

State and Territory Governments should take on sole responsibility for psychosocial supports outside of the NDIS — that is, the Australian Government should step back from making decisions about commissioning and region- or provider-specific funding allocations for non-NDIS psychosocial supports (although the broad public benefits of psychosocial supports for people with mental illness warrants ongoing funding by the Australian Government). We considered several criteria to reach this conclusion:

- The ability to integrate psychosocial supports with clinical mental healthcare and other services. Neither level of government is clearly better placed by this criterion. The Australian Government could readily integrate non-NDIS psychosocial supports with primary mental healthcare by devolving responsibility for them to the PHNs. It has already done this for its existing non-NDIS psychosocial supports (the National Psychosocial Support Measure and Transition and the Continuity of Support arrangements (chapter 17)). Meanwhile, State and Territory Governments provide clinical treatment for consumers with the most severe mental illness (who are likely to require higher levels of psychosocial support) and could better integrate psychosocial supports with the range of non-health services that they supply. For example, housing services (supported housing services (chapter 20) combine housing services with

254 Consumers Health Forum (sub. 646); Mental Health Coalition of South Australia (sub. 794); Mental Health Victoria (sub. 942); UnitingSA (sub. 807); Uniting Victoria and Tasmania (sub. 931); WA Association for Mental Health (sub. 1112).
psychosocial supports), Individual Placement and Support employment supports (chapter 19) and services for people in the justice system (chapter 21).

- **Continuity in service provision in the event that a State or Territory Government transitions to RCAs (section 23.3).** State and Territory Governments are most suited to commissioning psychosocial supports by this criterion, as they would take on psychosocial support commissioning (via RCAs) if RCAs were established.

- **Participant views.** Many consumers and psychosocial support providers supported the recommendation in the Inquiry draft report that State and Territory Governments take sole responsibility for psychosocial supports. In contrast, there was no support for PHN involvement, except from the PHN Cooperative itself (sub. 850).

That said, it is more important that responsibility is placed with a single level of government than which level of government this is. Our view is that governments should agree that State and Territory Governments should be solely responsible for providing psychosocial supports outside of the NDIS. But if this cannot be agreed, then governments should instead agree to the Australian Government taking on this responsibility and tasking the PHNs with commissioning all psychosocial supports outside of the NDIS.

**Governance of the transfer of responsibility**

The transfer of responsibility for psychosocial supports outside of the NDIS to State and Territory Governments should not occur before mid-2022. The immediate priority should be to continue managing the NDIS transition, including continuity of support for people who are not eligible for the NDIS (chapter 17). Transferring responsibility concurrent to this risks causing further disruption.

However, Governments should decide on an appropriate date for the formal transfer to occur and include this decision (as well as the funding commitments by all governments) in the National Mental Health and Suicide Prevention Agreement (section 23.3). PHNs, LHNs, and State and Territory Governments should each manage the process ‘on the ground’ via comprehensive joint regional planning processes.

This process should also not inhibit the pursuit of longer-term funding cycles for psychosocial supports (chapter 17 recommends that contracts with psychosocial support providers should be for a minimum of five years).

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255 Consumers Health Forum (sub. 646); Mental Health Carers NSW Inc. (sub. 1231); Mental Health Victoria (sub. 942); UnitingSA (sub. 807); Uniting Victoria and Tasmania (sub. 931); and the WA Association for Mental Health (sub. 1112).

256 This would provide for a minimum of one year without disruption following the expected end (June 2021) of the PHN National Psychosocial Support Transition measure (which is targeted at recipients of pre-NDIS Australian Government psychosocial support programs who have yet to have their eligibility for the NDIS determined) and aligns with the end of the psychosocial support funding currently committed to PHNs under the Continuity of Support measure (June 2022) (chapter 17).
ACTION 23.2 — RESPONSIBILITY FOR PSYCHOSOCIAL SUPPORTS

Start later

State and Territory Governments should take sole responsibility for commissioning psychosocial supports outside of the National Disability Insurance Scheme, supported by additional Australian Government funding. The Australian, State and Territory Governments should codify this transition in the National Mental Health and Suicide Prevention Agreement (Action 23.3). Primary Health Networks and Local Hospital Networks should manage the transition ‘on the ground’ through joint regional planning in States/Territories that have not created Regional Commissioning Authorities. To ensure continuity of support during the National Disability Insurance Scheme transition, the formal transfer of responsibility should not occur prior to mid-2022.

If the Australian, State and Territory Governments cannot agree to the State and Territory Governments taking on sole responsibility for commissioning psychosocial supports outside of the National Disability Insurance Scheme, then they should instead agree to the Australian Government taking on this responsibility and tasking the Primary Health Networks with commissioning all psychosocial supports outside of the National Disability Insurance Scheme.

23.2 A National Mental Health and Suicide Prevention Agreement

The reforms outlined in section 23.1 would require the agreement of both levels of government, as would the broader recasting of the NMHC as an interjurisdictional statutory authority (recommendation 22), and the need to clarify government roles and responsibilities for; mental healthcare; psychosocial supports; mental health carer supports and suicide prevention services (chapters 9 and 18; appendix G). There would also be a need for additional Australian Government financial transfers to State and Territory Governments to support the transfer of responsibility for psychosocial supports to State and Territory Governments and to assist with filling the sizeable gaps in State and Territory Government provision of clinical mental healthcare and psychosocial supports (chapters 12, 13 and 17).

Administering these reforms and funding flows via a single intergovernmental agreement is preferable to a patchwork approach of making modifications to existing agreements or negotiating a range of smaller new agreements (appendix G). Hence, Australian, State and Territory Governments should develop an intergovernmental agreement — the National Mental Health and Suicide Prevention Agreement (NMHSPA) — to fulfil this purpose.
Scope of the Agreement

The NMHSPA would serve three key purposes: clarifying roles for mental healthcare, psychosocial supports, mental health carer supports and suicide prevention; authorising Australian Government transfers to State and Territory Governments to support provision of these services; and establishing arrangements for monitoring, reporting, and evaluation.

Government roles and responsibilities

The NMHSPA should clarify existing Australian Government and State and Territory Government roles and responsibilities for mental healthcare, psychosocial supports, mental health carer supports and suicide prevention; and govern transitions to new roles and responsibilities. This requires a different approach in each sector.

- **Mental healthcare and suicide prevention:** the NMHSPA should outline the roles and responsibilities of each level of government as closely as practicable and task PHN–LHN groupings with precisely delineating Australian Government and State and Territory Government responsibilities to reflect this on a region-by-region basis, as reflected in their joint regional plans.

- **Psychosocial supports:** the NMHSPA should outline the transition to State and Territory Governments taking on sole responsibility for psychosocial supports outside of the NDIS.

- **Mental health carer supports:** the NMHSPA should outline responsibilities as set out in chapter 18.

These arrangements would be superseded in those States/Territories that transition to RCAs, because those States/Territories (via their RCAs) would take on the responsibilities that would otherwise lie with the Australian Government.

Intergovernmental transfers

The NMHSPA should govern additional Australian Government transfers to support expansions in State and Territory Government expenditure on mental healthcare and psychosocial supports (chapters 12, 13 and 17). At a minimum, this should include funding to cover the transfer of responsibility for psychosocial supports from the Australian Government to State and Territory Governments. But, given the substantial increases in State and Territory Government expenditure that are required, there is scope for the NMHSPA to cover a much larger transfer of funds. Again, there are differences by sector.

- **Mental healthcare:** State and Territory Government expenditure would need to grow by about $829 million per annum to meet existing gaps in service provision (recommendations 12 and 13). Some share of the growth in this funding could come via growth in National Health Reform Agreement (NHRA) payments, although scope

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257 This comprises $403 million to fill gaps in community ambulatory mental healthcare and $426 million to fill gaps in bed-based care.
for this is uncertain and likely to be limited (appendix G). While the share of these additional costs borne by each level of government would be the outcome of negotiations, it is likely that additional Australian Government funding provided under the NMHSPA would be necessary and desirable given the Australian Government’s access to more efficient tax bases (with the exception of State/Territory land taxes and municipal rates) and greater scope to raise additional tax revenues (PC 2011).

- **Psychosocial supports**: State and Territory Government expenditure would need to grow by $373–1 085 million per annum to meet existing gaps in service provision (recommendation 17). Again, while negotiations between the Australian Government and State and Territory Governments would determine how these additional costs would be shared, it is likely that additional Australian Government funding provided under the NMHSPA would be necessary to fill this gap.

Arrangements for additional funding to State and Territory Governments provided under the NMHSPA should be carefully designed to ensure that it is used as intended. The NMHSPA should specify additional own-source funding commitments by State and Territory Governments, as well as the Australian Government transfers, to ensure that any Australian Government funding is additional and does not replace existing State and Territory Government contributions. Moreover, safeguards would likely be needed to ensure that this funding is funnelled toward the areas of greatest need as identified in the regional gap analyses.

**Role of the National Mental Health Commission and Australian Institute of Health and Welfare**

The NMHSPA should clarify the new role of the NMHC as an interjurisdictional evaluation body (recommendation 22) and its expanded remit in monitoring and reporting on PHN–LHN cooperation. The next National Mental Health and Suicide Prevention Plan (chapter 22) would provide scope to outline the specifics of this role in more detail.

The NMHSPA should also outline the role of the AIHW in facilitating and performing gap analyses using the NMHSPF (chapter 24).

**Transition to Regional Commissioning Authorities**

All governments should agree under the NMHSPA that any State/Territory could, at any time, transition some or all of its PHN–LHN groupings to RCAs (section 23.3).

Governments should also agree via the NMHSPA that, if the NMHC’s reporting indicates that PHN–LHN cooperation is weak in a given State/Territory, then that State/Territory should transition to RCAs. Indicators of weak cooperation would include failure by PHN–LHN groupings in that State/Territory to:

- address gaps indicated by gap analyses with the NMHSPF
- commission/provide services in accordance with their joint regional plan commitments
• engage effectively with consumers and carers
• improve outcomes for consumers and carers, as indicated by outcome measures.

This would help to mitigate any policy inertia preventing a State/Territory with poorly cooperating PHNs and LHNs from transitioning to RCAs.

**Governance and collaboration**

The Australian, State and Territory Government health ministers should be responsible for developing the NMHSPA. They should ensure that consumers and carers are key partners in its development. The agreement would constitute a major shift in government policy that aims to improve the lives of people with mental ill-health, and their carers, families and community groups. Accordingly, governments should ensure early consultation with people with lived experience to determine the most effective approach to co-design the NMHSPA. Further, they should ensure that the co-design process is properly resourced and managed to effect real change. There is now a considerable body of information about best practice co-design, including resources prepared by peak bodies that represent consumers and carers (for example, Private Mental Health Consumer Carer Network (Australia) (now Lived Experience Australia), sub. 547).
**ACTION 23.3 — NATIONAL MENTAL HEALTH AND SUICIDE PREVENTION AGREEMENT**

Governments should agree to and clarify responsibilities for mental health service delivery, funding, monitoring, reporting and evaluation.

*Start now*

The Australian, State and Territory Governments should develop a National Mental Health and Suicide Prevention Agreement that:

- sets out the shared intention of the Australian, State and Territory Governments to work in partnership to improve mental health and suicide prevention outcomes for all Australians
- governs the transfer of psychosocial support responsibility outside of the NDIS and associated Australian Government funding to State and Territory Governments
- clarifies the responsibilities of each level of government for providing mental healthcare, psychosocial supports, mental health carer supports and suicide prevention services
- specifies minimum funding commitments by both levels of government and governs the transfer of Australian Government funding to State and Territory Governments to support expansion of mental healthcare and psychosocial supports
- declares the role of the National Mental Health Commission as an interjurisdictional evaluation body and its role in monitoring Primary Health Network–Local Hospital Network cooperation
- commits all governments to establishing Regional Commissioning Authorities if cooperation between Primary Health Networks and Local Hospital Networks does not drive sufficiently improved outcomes
- sets out clear and transparent performance reporting requirements.

The Australian, State and Territory Government health ministers should be responsible for developing and implementing the National Mental Health and Suicide Prevention Agreement. Governments consult thoroughly with consumers and carers to inform the development of the agreement.

### 23.3 Transition to Regional Commissioning Authorities

The reforms outlined above should go some way toward increasing the scope for cooperation between PHNs and LHNs by resolving the confusion and discontinuities brought about by the federal split in responsibility for mental health service commissioning. However, if funding incentives (appendix G) that undermine such cooperation and inhibit delivery of improved outcomes for consumers remain, the Australian Government should remove itself from the commissioning process and transfer the funds with which it commissions services to State and Territory Governments. State and Territory Governments should, in turn, establish RCAs that would pool mental health funds from both levels of government and commission services in their jurisdiction. The principal advantage of RCAs over PHN–LHN
groupings is that RCAs would better clarify responsibility for mental health service commissioning, thereby reducing gaps in service provision to consumers.

Transition to RCAs should occur on a State/Territory-specific basis, at the relevant State/Territory Government’s discretion, and at the timing of the relevant State/Territory Government’s choosing (the Australian Government should agree to this). The success of PHN–LHN cooperation is likely to vary across Australia, meaning that establishing RCAs may be an appropriate policy response in some States/Territories and not others (appendix G). Moreover, State and Territory Governments would be well-placed (especially with the benefit of enhanced reporting on PHN–LHN cooperation by the NMHC and AIHW) to determine if and when they should establish RCAs. The overwhelming majority of the funds that RCAs would hold are currently administered by State and Territory Governments, and by agreeing to establish RCAs, State and Territory Governments would be accepting additional responsibility and accountability.

This section considers the scope, structure and governance of RCAs, noting that the finer details about these issues should also be determined on a State/Territory-specific basis.

For which services should Regional Commissioning Authorities be responsible?

The Inquiry draft report proposed that RCAs should be responsible for commissioning:

- mental healthcare and suicide prevention that PHNs currently commission from the Mental Health Flexible Funding Pool
- mental healthcare and suicide prevention provided by LHNs and commissioned by LHNs or State and Territory Government health departments, with the exception of justice and forensic mental healthcare
- psychosocial supports and mental health carer supports commissioned by State and Territory Governments, noting that we have recommended that all psychosocial supports outside of the NDIS ought be commissioned by State and Territory Governments (section 23.1).

We have not changed our view that these services should fall within the scope of RCAs. But should additional services should be brought within the scope of RCAs?

Chapter 14 concludes that policy, planning, and delivery of mental health and alcohol and other drug services should be integrated. This would mean that RCAs should include in their remit not just mental health commissioning, but also PHN and State/Territory Government health department alcohol and other drug commissioning responsibilities.

In 2017-18, PHN funds for services in-scope of RCAs totalled $0.6 billion, whereas State and Territory Government administered funds (inclusive of Australian Government transfers under the National Health Reform Agreement) for services in-scope of RCAs totalled 6 billion (AIHW 2020c; unpublished data from the Department of Health).
There is also a strong case for the funding of an RCA to fall in proportion with the cost of mental health-related emergency department (ED) presentations and hospital admissions in general or paediatric wards (about 42% of all mental health-related admissions to public hospitals in 2017-18 (AIHW 2020f)) in its region. Reflecting the cost of these hospital-based services through reductions to RCA budgets would create an incentive for RCAs to minimise avoidable ED presentations and hospital admissions by commissioning more appropriate services in the community. As regards EDs, the Western Australian experience may provide some evidence that not having ED costs reflected in community mental healthcare funding can lead to increased demands on EDs from people who would be more appropriately treated in community mental health facilities (box 23.2).

It should be noted that reflecting, in the relevant RCA’s funding, the costs of mental health-related ED presentations and hospital admissions in general or paediatric wards does not imply that the RCA is commissioning (or has any control over) these services. State and Territory Government health departments should remain responsible for commissioning all services in EDs and general and paediatric wards, as these are not mental health-specific facilities (hence, there would be no additional separation of mental and physical health services in these facilities from a consumer perspective).

However, where feasible, the recurrent costs of providing mental health-related services in these facilities should be ‘billed’ to the corresponding RCA. State and Territory Governments should have flexibility in how they manage this process, as different data management systems and budget processes would lend themselves to different ways of putting this into practice. It suffices to note here that this ought to be feasible in most cases, as ED presentations and hospital-based care are typically funded via activity-based funding, which would usually allow for the recurrent costs of providing mental health-related and non-mental health-related care in general facilities to be apportioned. It is unlikely to be feasible in smaller rural and regional hospitals, where all services are generally block funded and costs are more difficult to apportion as mental health-related and non-mental health-related.

RCAs would also be well placed to fund consultation-liaison psychiatry, as these services are typically provided by clinicians who work within psychiatric wards. Providing this funding on an activity basis seems impractical at this time, as existing data collections do not usually indicate whether consultation-liaison psychiatric care has been provided (IHPA 2019). It would, however, be feasible for RCAs to block fund psychiatric wards to provide consultation-liaison services to other wards.
Box 23.2 Emergency department funding — the Western Australian experience

The Western Australian Mental Health Commission’s funding is not adjusted for the cost of mental health presentations at EDs, although it directly commissions mental health observation areas that operate alongside EDs in two hospitals (OAGWA 2019). Since the Western Australian Mental Health Commission took on mental health commissioning responsibilities, emergency department (ED) presentations per capita have grown substantially faster in Western Australia than in Australia as a whole (figure a). And this issue is particular to mental health-related presentations, as the share of all presentations that are mental health-related has grown more sharply in Western Australia than in Australia as a whole (figure b).

Recent reviews have noted that the services commissioned by the Western Australian Mental Health Commission do not reduce the demands on EDs. The Western Australian Auditor General (OAGWA 2019, p. 26) noted:

The [Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025] set out a mix of services to allow people to escalate the intensity of care as their mental health deteriorates. However, continuing gaps in the range of community-based services make it difficult for people to do this, and result in them seeking care through EDs. This is often not the most appropriate care setting for them, and increases the pressure and cost in EDs.

And Chapman et al. (2019, p. 28) noted:

The reform direction of the [Western Australian Mental Health Commission] has been provision of standalone nonclinical and community based services for those with lower acuity illness. This group account for only 10 per cent of acute admissions, and it would be expected that this approach will have minimal impact on ED and hospital use.

Mental health related emergency department presentations

a. Annual mental health-related emergency department presentations

b. Share of emergency department presentations that are mental health-related

Source: AIHW (2019).
Establishment of Regional Commissioning Authorities

Organisational form

RCAs should be established as separate entities at arms’ length from ministerial control, although their boards should be accountable to a State/Territory Government cabinet minister. They should be separate from LHNs to prevent conflicts of interest (as RCAs would commission services from LHNs) and sufficiently separate from State/Territory Government health departments to prevent a hospital-centric bias from having disproportionate influence (appendix G). And independence would reduce political influence over their decision-making (appendix G).

Box 23.3 contains our recommended corporate governance arrangements for RCAs.

Integration with the broader health system

By design, RCAs would allow for seamless integration of the services currently commissioned or provided by PHNs and LHNs to the benefit of consumers and carers. The services that they commission should — from a consumer and carer perspective — be seamlessly integrated with the mental health and physical health services supplied in the broader health system.\(^ {259}\) This should occur via regional planning and clearly defined interfaces with State and Territory Government health departments, LHNs and PHNs.

Regional planning

Like PHN–LHN groupings, RCAs should engage in regional planning to guide their commissioning decisions. This regional planning should be holistic — including RCA-commissioned mental health services and mental health services not commissioned by RCAs, such as MBS-rebated mental healthcare and mental health-related ED presentations and hospital admissions in general or paediatric wards. As we recommend for PHN–LHN joint regional planning, RCA regional planning should include a gap analysis using the NMHSPF and a process to rectify those gaps over time, subject to any funding limitations.

\(^ {259}\) Some participants did not favour creating RCAs on the grounds that they considered this would silo the provision of mental and physical health services. These criticisms are not well grounded as they conflate separated commissioning of services with separated delivery of services (appendix G).
Box 23.3  **Recommended corporate governance arrangements for Regional Commissioning Authorities**

**Governing boards**

Boards should be granted full powers to act in the interests of their Regional Commission Authorities (RCAs) in fulfilling their statutory functions, including powers to appoint and remove a Chief Executive Officer.

They should be skill-based, not representational. Board effectiveness depends on obtaining the right mix of skills, experience and attitude to successfully acquit board responsibilities. A particular strategic challenge that is likely to face RCA boards is overseeing a strategic plan that can adapt as the organisation changes in response to an evolving operating environment. To the extent that Australia’s mental health system needs to change to address long-standing issues, boards will need to have a strategic mindset. For example, RCA boards will likely face opportunities that will be presented by new and emerging technologies, an ageing and more diverse population, higher expectations about recovery outcomes from consumers and more intense scrutiny of the performance of publicly-funded mental health entities such as RCAs. Reserving board positions for representational reasons would, all other things being equal, constrain the ability of RCA boards to meet these challenges.

One exception is that the inclusion of at least one director with lived experience would enhance board effectiveness. Although mental health is intrinsically a diverse area and individual experiences differ greatly, their first-hand experience would complement that of other board members, and help ensure RCA board effectiveness.

To avoid creating a conflict of interest (real or perceived), representatives of Local Hospital Networks (LHNs) should not be appointed to RCA boards. RCAs would typically direct significant resources to commission services from LHNs. On this issue, it is less clear whether a similar conflict of interest would necessarily attach to a representative of a Primary Health Network.

**Advisory councils**

RCA boards should be supported by advice from advisory councils. To be effective, RCA boards would need to consider the varied needs of a diverse range of stakeholders, including: consumers and carers (including culturally and linguistically diverse groups), all three tiers of government and government agencies, providers (public, non-government (including Aboriginal Community Controlled Health Services) and private), academia and the research community, the wider community and potentially other RCAs. A broad range of views and a diversity of input from such councils would enhance board effectiveness. In contrast to board membership, representatives from LHNs or Primary Health Networks could be included on RCA advisory councils. Indeed, there may be significant value in regularly canvassing their views and experiences.

To enable this, the Australian Government should ensure that data on utilisation of MBS-rebated mental health services is provided to RCAs promptly (ideally in real-time), and the relevant State/Territory Government should ensure that RCAs similarly have prompt data about mental health-related ED presentations and mental health-related hospital admissions in general or paediatric wards.
Regional planning should also incorporate the diverse views on regional priorities for mental health service delivery. Most obviously, this would come from RCAs’ advisory councils (box 23.3). LHNs should also be afforded a special role in regional planning, as discussed below.

*Role of State and Territory Government health departments*

Establishing an effective relationship and split in responsibilities between RCAs and their State/Territory Government health department would be critical. State/Territory Governments establishing RCAs should, at the outset, decide on and codify the respective roles of their health department and RCA(s) and how they will work together. The Western Australian experience suggests that RCAs should be made fully responsible for all aspects of mental health service commissioning (box 23.4), but there ought to be options for how RCAs commission mental healthcare from LHNs.

- RCAs could commission mental healthcare directly from LHNs. This ought to be the default arrangement. RCAs and their health department could opt to streamline their contracts with the LHNs so as to minimise the burden to LHNs of having ‘two masters’.
- RCAs could commission LHN-provided mental healthcare from their health department, which would then subcontract with LHNs. This should not amount to the RCA passing responsibility for the commissioning back to their health department — rather, the health department would merely act as an intermediary.

**Box 23.4 Roles and responsibilities — the Western Australian experience**

In Western Australia, responsibility for LHN-provided clinical mental healthcare is effectively split between the Mental Health Commission and the Department of Health. These services are, in the main, funded by the Mental Health Commission, but monitoring of safety and quality is performed mostly by the Department of Health. A recent review was highly critical of these arrangements, finding that they created an arrangement of ‘two “system managers” with no single point of accountability or authority’ (Chapman et al. 2019, p. 2).

This suggests that the same organisation that funds LHN-provided clinical mental healthcare ought to also monitor the safety and quality of these services. In our context, it would be logical for RCAs to perform both roles.

*Source*: Chapman et al. (2019).

*Role of Local Hospital Networks*

The service provision role of LHNs would be largely unchanged if a State or Territory were to transition to RCAs, as LHNs would remain providers of hospital-based and community ambulatory mental healthcare.

However, the role of LHNs in planning mental health services and their accountabilities would change.
• LHNs should be afforded a special advisory role in RCA regional planning. Some balance in the influence that LHNs have over how RCAs allocate funds is needed. Granting veto power to LHNs risks creating a conflict of interest. (For this reason, LHN representatives should not be appointed to RCA boards (box 23.3), and nor should their endorsement of RCA plans be mandatory requirement.) But LHNs should have some input into how RCAs allocate funds as they would be both the most significant service providers that RCAs contract with and the de facto ‘providers of last resort’ as managers of public hospitals. RCAs should consult thoroughly with LHNs in the development of plans and should seek their endorsement of completed plans.

• LHNs would be accountable to RCAs for their performance, whether directly via direct contracts or indirectly via streamlined contracts with their health department (as outlined previously).

LHNs would also need to ensure that the health department-commissioned services and the RCA-commissioned services that they supply are integrated from the consumer’s perspective.

Role of Primary Health Networks

If a State or Territory were to transition to RCAs, the mental health role for that State/Territory’s PHNs should mirror the role that PHNs play in the broader health system (unless RCAs task them with a larger role, as discussed below). Most significantly, they should work to integrate GPs and other physical healthcare providers with MBS-rebated and RCA-commissioned mental healthcare. To maximise the scope for this, each RCA should establish formal links with the PHNs that operate in its region.

RCAs should have the option to fund PHNs to commission some services on their behalf if circumstances suggest that this would produce better outcomes for consumers and carers. While this may sound like a backward step to some, the incentives under such an arrangement would be far better aligned than under the current arrangements.

Monitoring and reporting

As much as practicable, States/Territories transitioning to RCAs should leverage the approaches to monitoring and reporting already in place. Chapter 24 makes broad recommendations about improvements to monitoring and reporting, including improved monitoring and reporting at the regional level (recommendation 24) which should continue to apply if a State or Territory transitions to RCAs.
Likewise, the recommended architecture around supporting, monitoring, and reporting on PHN–LHN cooperation should transfer over to RCAs as much as practicable (action 23.1). While the original impetus for the architecture would largely vanish if RCAs were established, there is merit to retaining this as strong oversight of RCA activity.

**ACTION 23.4 — TRANSITION TO REGIONAL COMMISSIONING AUTHORITIES**

*Start now*

The Australian Government should, at any time, permit any State/Territory Government to establish Regional Commissioning Authorities (RCAs) to commission mental healthcare, alcohol and drug services, psychosocial and mental health carer supports outside of the NDIS, and place-based suicide prevention services. State and Territory Governments should establish RCAs if there is not sufficient cooperation between Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) in their jurisdiction to drive improved mental health outcomes.

As part of this transition, the Australian Government and the relevant State/Territory Government should agree to:

- establish RCAs as separate entities at arm’s length from ministerial control
- transfer PHN Mental Health Care Flexible Funding Pool and PHN alcohol and drug funding to the corresponding RCA.

The requirements on PHN–LHN groupings to undertake joint regional planning and the National Mental Health Commission monitoring of PHN–LHN cooperation (Action 23.2) should apply to RCAs.

### 23.4 Reforms to funding arrangements

Regardless of the extent of the reforms that are made to strengthen the PHN–LHN nexus or establish RCAs in its place, all governments should also seek to reform the ways in which they allocate funding to regional commissioning bodies and LHNs, regulate how this funding must be used, and support the development of new funding models. This section proposes reforms to funding arrangements that would:

- promote more equitable access to primary mental healthcare
- reduce incentives for regional commissioning bodies to shift costs to the MBS and provide them with greater scope to pursue innovate funding models that blend MBS rebates with contributions from the Mental Health Care Flexible Funding Pool.
- increase PHN (or RCA) flexibility to use new payment models and commission services that best meet their regions’ needs
- increase the productivity of community ambulatory mental healthcare services
- support trials and evaluations of new funding models and ways of organising services.
Primary Health Network funding arrangements

Primary mental healthcare funding arrangements — MBS rebates for psychiatrists and allied mental health professionals and services commissioned by PHNs from the Mental Health Care Flexible Funding Pool260 — suffer from several shortcomings:

- Total primary mental healthcare funding (MBS rebates for psychiatrists and allied mental health professionals plus services commissioned by PHNs from the Mental Health Care Flexible Funding Pool) is somewhat inequitably allocated between regions (appendix G).
- PHNs face incentives to shift costs to MBS-rebated services, as these services are funded from outside PHN budgets and substitute for PHN-commissioned care (appendix G). This means that service offerings are driven less by what consumers need and more by the design of the dominant MBS program.

We are recommending a new process for determining the size of the PHN Mental Health Care Flexible Funding Pool and how it is allocated among PHNs to address both of these issues. This same process should be used to determine Australian Government contributions to RCAs where applicable, and its desirable properties would apply to RCAs.261 It would also allow restrictions that prevent PHNs (and would prevent RCAs) from co-funding MBS-rebated mental health services (appendix G) to be removed, which would grant PHNs/RCAs greater flexibility to engage with MBS-rebated practitioners.

Our recommended process is as follows:

- The Australian Government Department of Health should determine the share of total primary mental healthcare funding that each PHN/RCA region ought to receive. This determination should support regional equity — the principle that consumers should have access to a similar standard of primary mental healthcare regardless of where they live (appendix G). To inform the determination, the Department of Health should develop an evidence-based weighting scheme that accounts for factors that influence differences in cost of provision (such as remoteness) and the demand for services (such as the prevalence of mental illness among the population) between PHN/RCA regions.262 The weighting scheme, and the underpinning analysis, should be made publicly available.
- The Australian Government Department of Health should apply this determination to allocate total primary mental healthcare funds among PHN/RCA regions. A region’s share

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260 PHNs receive funding via the Mental Health Care Flexible Funding Pool (totalling $506 million in 2018-19) to commission mental healthcare (unpublished data from the Australian Government Department of Health). PHN funding to commission psychosocial supports is provided separately (chapter 17).

261 The funding process would be more effective if applied to RCAs, as it would negate incentives of all commissioning bodies to shift costs to the MBS. When applied to PHN funding, it is not able negate incentives for LHNs and State and Territory Government health departments to shift costs to the MBS (appendix G).

262 While a relevant factor when determining regional differences in funding need, the new weighting scheme should not account for the proportion Aboriginal or Torres Strait Islander people in a population. We are recommending that funding for Aboriginal and Torres Strait Islander mental health services remain hypothecated within the PHN Mental Care Health Flexible Funding Pool, so the funding for these services should be determined separately.
of the Mental Health Care Flexible Funding Pool should be determined as that region’s allocation of total primary mental healthcare funds, less the MBS rebates for psychiatrists and allied mental health professionals billed in that region. To guarantee PHNs/RCAs three years of funding certainty, there should be a lag of three years between when MBS rebates for psychiatrists and allied mental health professionals are billed and the consequent Mental Health Care Flexible Funding Pool allocation is provided to the PHN/RCA.

Appendix G provides a detailed explanation of the recommended process. This process would:

- promote regional equity, as the share of total primary mental healthcare funding that each PHN/RCA catchment receives would be determined on the basis of need
- reduce PHNs’/RCAs’ incentives to shift costs to MBS-rebated services, as each dollar billed to the MBS for mental healthcare would result in a one dollar reduction to the corresponding PHN’s/RCA’s Mental Health Care Flexible Funding Pool allocation in three years’ time
- maintain three years of funding certainty for PHNs/RCAs during both the transition phase and once the new process has been established.

Once this new process has been established, the regulations under the Health Insurance Act 1973 (Cth) that prevent PHNs (and would prevent RCAs) from shifting costs to MBS-rebated mental health services would become somewhat redundant (appendix G). As they hamper PHNs’ scope to pursue more innovative funding models that could better meet consumer needs (appendix G), there would be a strong case for removing them. One proviso would be to ensure that PHN/RCA-commissioned services could only be permitted to receive co-funding from MBS-rebates with the PHN’s/RCA’s consent. Without this, there is a heightened risk of fraudulent ‘double dipping’ by providers.

Introducing additional flexibility would enable other potentially desirable funding arrangements. In States/Territories that do not establish RCAs, the rules would not permit State and Territory Governments (including LHNs) to provide co-funding to MBS-subsidised clinicians unless an exemption is in place. These restrictions have both positive and negative impacts. On the one hand, it would be desirable for a State/Territory Government to co-fund MBS-rebated clinicians if this were to reduce avoidable hospitalisations. On the other, allowing this in all instances would allow State and Territory Government services to shift costs to the MBS.

A sensible solution would be to allow State/Territory Government co-funding of MBS-rebated mental healthcare on the condition that it is governed by an agreement with the relevant PHN. The PHN would bear the cost of the MBS rebate, and so could be relied upon to judiciously determine whether the action should be allowed.

Other situations are more complex. MBS-rebated out-of-hours GP services (which are not billed under mental health-specific codes) may be particularly useful at preventing mental health-related presentations at EDs (chapter 13), and so State and Territory Governments may...
wish to co-fund MBS items for them. But PHNs would not bear the cost of these MBS items, and so should not be automatically relied on to determine whether a State/Territory Government should be able to co-fund the service in question. A pragmatic solution would be to allow State/Territory Governments to co-fund these services with the agreement of the PHN, with the Australian Government (which would bear the additional costs) issuing guidance to PHNs on the circumstances under which they should allow or disallow these requests.

**ACTION 23.5 — PRIMARY MENTAL HEALTHCARE FUNDING ARRANGEMENTS**

*Start now*

The Australian Government Department of Health should reform the methodology that it uses to determine the size of the Primary Health Network (PHN) Mental Health Care Flexible Funding Pool and how it is allocated between regional commissioning bodies to allow for greater geographic equity in primary mental healthcare funding and to reduce funding biases that favour MBS-rebated care.

Once this has occurred, the Australian Government Minister for Health should issue a direction in relation to the *Health Insurance Act 1973* (Cth) to allow regional commissioning bodies to co-fund MBS-rebated mental health services, and allow other Australian, State and Territory Government agencies to co-fund MBS-rebated mental health services with the consent of the corresponding regional commissioning body.

The Minister for Health should also issue a direction in relation to the Health Insurance Act to allow State and Territory Government agencies to co-fund MBS-rebated out-of-hours GP services with the agreement of the corresponding PHN. The Australian Government should direct PHNs to approve these requests if there is a reasonable prospect that additional out of hours GP services would yield reductions in mental health related emergency department presentations.

**Controls on Primary Health Network funding**

A consistent and transparent approach should underpin the level of flexibility that PHNs have in deciding how to allocate the Primary Mental Health Care Flexible Funding among providers. Where applicable, these same reforms should apply to the equivalent component of Australian Government funding to RCAs.

**Funding hypothecated to particular providers**

At present, PHNs receive neither the support they need nor the flexibility to commission the mental health services that best meet the needs of their region. For example, the Australian Government Department of Health binds PHN commissioning of all existing headspace centres by requiring that about one third of the Mental Health Care Flexible Funding Pool be devoted to headspace centres. The arguments in favour of this type of hypothecation are not compelling (appendix G). Meanwhile, the Department of Health otherwise provides too
little guidance on PHN commissioning — specifically, there is insufficient guidance on the
types of evidence-based services that PHNs ought to commission (appendix G).

A middle ground is needed that recognises and draws on the relative strengths of the
Australian Government Department of Health to identify standards of service delivery and
the PHNs/RCAs to deliver services to meet local need. Specifically:

- PHNs generally have (and RCAs generally would have) superior knowledge and
  contextual understanding of the particular needs of their region, the performance of
  existing services in their region, and the suitability of prospective new providers
- the Department of Health has greater scope to draw on and assemble higher level expertise
  about which types of service models are the most effective for different cohorts of people.

This suggests that the Australian Government Department of Health should not hypothecate
PHN/RCA funding to particular providers (such as headspace centres). PHNs/RCAs are best
placed to decide whether a particular type of service addresses the needs identified in their
regional gap analysis. Many participants agreed with a draft recommendation to this effect.263

However, we acknowledge that continuity of support is desirable. For this reason, we
recommend that:

- existing service providers to which funding has been hypothecated, such as headspace
  centres, continue to be funded while each PHN–LHN grouping/RCA estimates the need
  for specific services, including those tailored to particular demographic groups, as part
  of its joint regional planning process
- once the planning process is complete, each service provider to which funding has been
  hypothecated should transparently demonstrate to the PHN–LHN grouping/RCA how
  they can meet the need for services (or a component of the need) within the region as
  identified in the regional plan
- if the existing service provider does not subsequently perform this role to an adequate
  standard, the PHN/RCA should engage with it and headspace National to seek to rectify
  the issues or, if the PHN/RCA considers that this engagement is unsuccessful, seek to
  redirect the funding to another provider of the relevant services.264

The Australian Government Department of Health should develop and provide guidance to
PHNs/RCAs about the evidence base that underpins different types of interventions and
require PHNs/RCAs to demonstrate that they have commissioned evidence-based services.

263 ACEM (sub. 926); ACPA (sub. 727); Bipolar Australia (sub. 781); CHF (sub. 646); Consortium of
Australian Psychiatrists and Psychologists (sub. 882); Martin Whitely (sub. 1198); Mental Health
Commission of New South Wales (sub. 948); National Rural Health Alliance (sub. 1192); PHN
Cooperative (sub. 850); Samaritans Foundation (sub. 785).

264 In this context, ‘service providers to which funding has been hypothecated’ does not refer to service
providers that provide Aboriginal and Torres Strait Islander mental health services. Funding to Aboriginal
and Torres Strait Islander mental health services is discussed next.
This point was well made by Transforming Australia’s Mental Health Service Systems (sub. 919, p. 16):

We do believe that there needs to be good advice, and at times clear guidelines, based on the current evidence for the design of models of care, including specific interventions and service delivery vehicles, and adherence to fidelity … Good commissioning in mental health needs high level expertise, and 31 PHNs are unlikely to have that capacity.

This guidance should be updated over time as more services are evaluated. It should draw on:

- the recommended evaluation of MBS-rebated psychological therapies (recommendation 12)
- the evaluations led by the NMHC, in its recommended evaluation role (recommendation 22)
- evaluations funded via the recommended Mental Health Innovation Fund (action 23.8)
- input from the National Centres of Excellence (such as the Orygen National Centre of Excellence in Youth Mental Health) established by the Australian Government for the purpose of providing advice on the evidence base that underpins different types of service provision and interventions.

Aboriginal and Torres Strait Islander mental health services funding arrangements

About 8% of the Mental Health Care Flexible Funding Pool is hypothecated to mental health services for Aboriginal and Torres Strait Islander people. This hypothecation is different from that which applies to headspace centres. In the headspace case, funding is hypothecated to a particular provider, whereas in this case funding is hypothecated to ensure that PHNs commission services for Aboriginal and Torres Strait Islander people.

The question that arises in this context is whether the competitive procurement processes that PHNs use are appropriate for Aboriginal and Torres Strait Islander mental health services. PHNs are required to engage with Aboriginal and Torres Strait Islander communities and Aboriginal Community Controlled Health Services (DoH 2016b), but are free to contract any organisation to provide Aboriginal and Torres Strait Islander mental health services, whether an Aboriginal Community Controlled Health Service or not (DoH 2019a).

Our view is that Aboriginal Community Controlled Health Services should be made preferred providers of Aboriginal and Torres Strait Islander mental health services, on the grounds that competitive procurement processes are not effective in this context (appendix G). This is consistent with recommendation 9, which applies to suicide prevention activities. In practice, this means that the Australian Government Department of Health should direct PHNs to allocate funds for Aboriginal and Torres Strait Islander mental health and suicide prevention to Aboriginal Community Controlled Health Services unless they can clearly demonstrate that alternative providers could produce better results in terms of access to culturally capable services and service outcomes. This same condition should apply to RCAs.
ACTION 23.6 — CONTROLS ON REGIONAL COMMISSIONING

Start now

The Australian Government Department of Health should reform the controls that it places on the services that regional commissioning bodies (currently PHNs) can commission from the Mental Health Care Flexible Funding Pool.

- It should provide guidance to regional commissioning bodies about the evidence base that underpins different types of interventions, and require regional commissioning bodies to demonstrate that they have commissioned evidence-based services that meet their catchment’s needs.

- It should permit regional commissioning bodies to redirect funding hypothecated to headspace centres and other particular providers to alternative services, subject to these services demonstrably not meeting the service needs identified in regional plans. This does not include funding hypothecated for the purpose of ensuring that regional commissioning bodies commission services to Aboriginal and Torres Strait Islander people.

- It should require regional commissioning bodies to treat Aboriginal Community Controlled Health Services as preferred providers of Aboriginal and Torres Strait Islander mental health services.

Local Hospital Network funding arrangements

Reform is also needed to LHN funding arrangements, for two reasons. First, productivity is poor in community ambulatory mental healthcare services (chapter 12). Second, the existing arrangements incentivise LHNs to prioritise hospital-based mental healthcare ahead of community ambulatory mental healthcare (appendix G).

The national model for funding LHNs — as used by the Independent Hospital Pricing Authority (IHPA) — comprises activity-based funding (ABF) for hospital-based mental healthcare and block funding for community ambulatory and residential mental healthcare (section 23.3). Some reform is underway on this front — IHPA is developing a new ABF classification system (the ‘Australian Mental Health Care Classification’ (AMHCC)) that would change the basis on which ABF works for hospital-based mental healthcare and extend ABF to community ambulatory mental healthcare (discussed later).

In principle, there are many ways that LHNs could be remunerated for providing mental healthcare. But payment models for mental healthcare are underdeveloped relative to physical healthcare, meaning that more research is needed before these can be contemplated. While the next subsection plots a path to the development of new payment models, this subsection focusses on those that will be feasible in the near term — block funding, ABF, and variants thereof. Its conclusions apply regardless of whether health departments or RCAs fund LHNs.
The aims of payment model reform

Incentivising greater productivity in community ambulatory mental healthcare services is the most pressing aim of payment model reform. Across Australia, only about 29% of clinical staff time at community ambulatory mental healthcare services was spent on consumer-related activities (20% with consumers present and 9% without) in 2017-18. This falls well short of National Mental Health Service Planning Framework benchmark rate of 67% (chapter 12).

While excessive paperwork may be part of the problem (chapter 12), payment model reform could help. Existing block funding arrangements do little to incentivise productivity as the funding provided is independent of the amount of care provided. This provides a rationale for a payment model for community ambulatory mental healthcare that rewards greater activity — ABF, or some variant thereof. (The practicalities of this are discussed later.)

Another aim is to rebalance hospital-based mental healthcare and community ambulatory and residential mental healthcare. Current arrangements incentivise LHNs to preference hospital-based care ahead of community ambulatory and residential mental healthcare, although these effects may be weak (appendix G). There are two (potentially complementary) approaches that could improve LHN incentives in this regard — using block funding for all settings or using ABF for all settings.

The first approach would mean returning to block funding for hospital-based mental healthcare. This would remove incentives for LHNs to draw activity into hospitals. But we do not favour shifting from ABF to block funding for hospital-based mental healthcare, for two reasons.

- ABF for hospital-based mental healthcare creates both desirable and perverse incentives for LHNs (albeit with scant empirical evidence to support either having a substantial impact; box 23.5), but there is scope to mitigate the perverse incentives by altering ABF to penalise LHNs for unplanned mental health-related readmissions (this is discussed later).
- ABF for hospital-based mental healthcare facilitates improved data collection and cost benchmarking, allowing for greater transparency.

The second approach would involve using ABF for community ambulatory and residential mental healthcare. With this in place, LHNs would receive payments that reflect the cost of service provision regardless of the setting in which they treat people. This would also reduce their incentive to draw activity into hospitals.

Hence, in principle, there is a strong case for State and Territory Government health departments (or RCAs — section 23.4) using an ABF payment model (or some variant thereof) to remunerate their LHNs for providing hospital-based mental healthcare, community ambulatory mental healthcare and residential mental healthcare.
Box 23.5  **Impacts of activity-based funding on hospital-based mental healthcare**

Activity-based funding (ABF) generates incentives for hospitals to reduce the unit cost of each hospital admission. Local Hospital Networks receive a payment for each person they treat at a public hospital, and hence benefit by treating those people at lower costs. This can be primarily achieved through reductions in the length of hospital stays, as this is the primary cost driver for mental health-related admissions (IHPA 2020a).

Shorter hospital stays can have both positive and negative consequences, and there is scant empirical evidence to support either. On the one hand, shorter stays are less costly and, when adequate treatment and services are available in the community, consistent with achieving good outcomes for consumers (chapter 13). And shorter stays ought to reduce delayed discharge (chapter 13). The introduction of ABF to public hospitals in Australia did result in a reduction in unit costs of admissions (Ettelt et al. 2006), but mental health-specific effects are less clear. Across Australia, the average length of acute inpatient stays declined from 14.1 days in 2013-14 (when ABF was first applied to inpatient mental healthcare at a national level) to 13.1 days in 2017-18, but these declines had already been underway since at least 2010-11. Moreover, there were sharper than average declines in Victoria, and Queensland had the lowest average length of stay of any State/Territory in most years between 2010-11 and 2017-18 despite neither of these States using ABF for hospital-based care (appendix G; AIHW 2020d).

On the other hand, ABF could incentivise hospitals to prematurely discharge and then readmit consumers. A meta-analysis of the impacts of hospital ABF ‘suggested a possible increase in readmission [to hospital] with ABF’ (Palmer et al. 2014). However, data on 28 day readmission rates to acute mental healthcare services in Australia are not sufficiently comparable over time to draw any conclusions about the impacts of ABF (AIHW 2020d), and studies do not consistently find a relationship between length of stay and readmissions for mental healthcare (Hyland et al. 2008).

**Practical difficulties with activity-based funding**

**In practice,** implementing ABF for mental healthcare — especially community ambulatory mental healthcare — has proved challenging.

First, ABF requires a ‘casemix classification’ — a system that groups episodes of care into classes for which the average costs of treatment are similar. Classifications are usually based on ‘diagnosis-related groups’, but diagnosis has less ability to predict treatment costs for mental healthcare than for other services (IHPA 2015). A further problem is defining what marks the beginning and end of an episode of care. For inpatient care, an episode generally runs from admission to discharge, but there is no such obvious marker for community ambulatory mental healthcare.

A poor classification (one for which there is high cost variability within classes) generates perverse incentives and/or undermines the viability of ABF. Where cost variations within a class are predictable, it creates incentives for LHNs to preference consumers with simpler to treat illnesses ahead of consumers with illnesses that are more complex to treat (Jacobs et al. 2019; QMHC, sub. 712). Unpredictable within-class cost variability does not generate these perverse incentives, but can hamper the viability of ABF. Several participants
submitted that this is a particular issue for mental healthcare. Allan Fels (sub. 303, p. 2) argued that:

Whilst there is a good case for activity based funding for many medical procedures with predictable average costs, the unpredictability and variability of mental health costs make an ABF system highly problematic for mental illness.

And Transforming Australia’s Mental Health Service Systems (sub. 919, p. 6) said:

ABF may work in hospital settings where there is a single disorder in focus, such as a myocardial infarction or an appendicitis needing surgery, where the treatment is well defined and there is low variability in outcomes, compared to mental health, where the diagnosis is a minor component of variance and a wide range of interventions are required, whether clinical, psychosocial, relational, and/or attending to neglected physical health care, beyond the narrow direct health intervention of medication etc.

Second, the classification and the prices associated with each class should ideally reflect the costs of providing best practice care. If these are determined on the basis of historical data, then existing shortfalls in quality of care risk being perpetuated (Transforming Australia’s Mental Health Service Systems, sub. 919).

That said, it would be unwise to require a classification to be of too high a standard before ABF can be contemplated. The alternative — block funding — does not incentivise LHNs to provide best practice care nor to treat more people with more complex needs (the risks of a poor ABF classification). And ABF ought to incentivise higher productivity even when supported by a suboptimal classification.

Efforts to establish activity-based funding

The AMHCC, the national mental healthcare case mix classification that IHPA is currently developing, provides a basis on which to apply ABF to community ambulatory mental healthcare (and a way to apply ABF to hospital-based mental healthcare without relying on diagnosis-related groups) (box 23.6). While IHPA’s eventual use of the AMHCC would be to determine Australian Government transfers to State and Territory Governments under the NHRA (appendix G), State and Territory Government health departments could also use ABF underpinned by the AMHCC to fund LHNs to deliver community ambulatory mental healthcare.

However, there are concerns about the AMHCC. The first relates to reliability of the relatively new ‘phase of care’ variable used to separate classes. An IHPA-commissioned study of the ‘inter-rater reliability’ of the variable (the degree to which different clinicians would assign the same phase of care in identical situations) concluded that the variable had ‘poor to fair’ reliability (Coombs 2017).
Box 23.6  **Structure of the Australian Mental Health Care Classification**

The Australian Mental Health Care Classification is a mental health-specific case mix classification developed by the Independent Hospital Pricing Authority. It has separate structures for admitted and community ambulatory settings.

- The admitted setting structure uses four ‘splitting variables’ — phase of care, age group, mental health legal status, and patient complexity as measured by the Health of the Nation Outcome Scales. These create 45 classes of admitted patients, each intended to have its own price per episode of care.

- The community ambulatory setting structure also uses four ‘splitting variables’ — phase of care, age group, the Health of the Nation Outcome Scale, and the Abbreviated Life Skills Profile, which measures how successfully people with schizophrenia or with a chronic mental illness live in the community. These create 46 classes of community patients, each intended to have its own price per episode of care.

The Australian Mental Health Care Classification does not cover residential mental healthcare services.

*Source: IHPA (2018).*

The second concern relates to the integrity of the ‘costing study’ that IHPA commissioned to inform the development of the AMHCC. In his capacity as a professor at the University of Queensland, Professor Philip Burgess (a senior clinical advisor of IHPA’s Mental Health Working Group) (pers. comm., 2 September 2019) advised us that the study did not adequately isolate the treatment costs of individual consumers to produce comparable data across jurisdictions. His overarching view is that the AMHCC is not fit-for-purpose at this time.

The third relates to the AMHCC being developed on the basis of existing standards of care, rather than evidence-based practice. This is standard practice in the development of ABF classifications. In this regard, Transforming Australia’s Mental Health Service Systems (sub. 919, p. 6) said:

> There is no consensus even within the IHPA Mental Health advisory networks, as to the definition or description of these phases, as deliberations continue as to whether ABF for episodes and phases should pertain to traditional episodes or phases of care, e.g. prolonged in-patient or maintenance care, and whether they should encourage contemporary evidence based good practice: that is whether there should be incentives to provide less life disruptive and more cost effective contemporary, recovery oriented, proxies for these phases in the community.

State and Territory Governments appear uncommitted to the AMHCC. IHPA had intended to use it to ‘shadow price’ NHRA mental healthcare transfers in 2020-21, but was forced to abandon this for community ambulatory mental healthcare services as only the Queensland Government provided the necessary costing data to allow shadow prices to be determined (IHPA 2020a). And they have previously urged caution in its use. In 2018, Queensland Health submitted to IHPA that ‘it may be several years before the AMHCC is sufficiently robust for funding purposes’ (Queensland Health 2018b, p. 8), and the Victorian Department

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265 The shadow pricing exercise is expected to proceed for admitted care, but the Northern Territory and Tasmania did not provide costing data to inform pricing for these services either.
of Health and Human Services urged a cautious approach to implementing the AMHCC involving several further years of testing (VIC DHHS 2018a). Moreover, the Victorian Government has embarked on developing its own ABF classification for hospital-based and community ambulatory mental healthcare (Victorian Government, sub. 1228).

We are not in a position to make determine whether the AMHCC is fit-for-purpose. However, there is sufficient concern among informed parties to warrant consideration of whether it needs revision. Our view is that IHPA should immediately launch a review of the classification to determine:

- whether the structure of the AMHCC and the variables within it should be refined or changed (especially the ‘phase of care’ variable)
- if the ‘phase of care’ variable is retained, how it could be refined to improve inter-rater reliability
- whether there are aspects of the alternative mental health ABF classification that the Victorian Government is developing that should be adopted by the national model
- if a new costing study is required
- a revised timeframe for implementing the classification.

Developing a simpler payment model

If the recommended review proceeds, it may delay the introduction of the AMHCC or suggest that a fundamental reconsideration of ABF for community ambulatory mental healthcare is necessary. Given the issues outlined above, it would not be ideal for community ambulatory mental healthcare services to remain block funded during this time.

The question arises as to whether there is a simpler payment model that could improve the productivity of community ambulatory mental healthcare services. An obvious approach is to draw on the fee-for-service payment model (chapter 12) and fund community ambulatory mental healthcare services on the basis of time spent treating people. Such a funding model would be activity-based, like conventional ABF, but the funded unit of activity would be, say, an hour of care rather than an episode of care.

Victoria is using a similar model to fund its contribution to community ambulatory mental healthcare services. The Victorian Department of Health and Human Services funds clinical community care at 18 LHNs on the basis of ‘community service hours’ (VIC DHHS 2019a). There may be value in further refining this funding model to establish, for example, different prices for hours spent with consumers present, hours spent on consumer-related activities for which consumers are not present, and hours spent in and out of office.

This payment model has several advantages over block funding.

- It would incentivise services to devote more time to consumer-related activities (although this would appear to have had limited success for Victorian community ambulatory mental healthcare services (chapter 12)).
• It would be unlikely to incentivise treating consumers with simpler to treat illnesses ahead of consumers with illnesses that are more complex to treat (a concern about poorly designed ABF systems), as the variation in the cost of providing an hour or care ought to be greatly lower than that of providing an episode of care.

• While it could theoretically incentivise ‘over-servicing’ by community ambulatory mental healthcare services, this ought to be of little concern given the shortages of these services (chapter 12).

• It would nullify incentives for LHNs to preference hospital-based care ahead of community-based care.

How should such a model be developed? One option is to task IHPA with developing a national model. IHPA is well placed to do so and could liaise with the Victorian Government about the aspects of its current model that have been more or less successful. However, under standard IHPA processes (which are to develop payment models to determine Australian Government transfers to State and Territory Governments), this risks it becoming a drawn-out process. IHPA’s development of the AMHCC has been underway since 2012.

Hence, it may be preferable for IHPA to develop a national model to be used only as a means for State and Territory Government health departments to fund their LHNs (i.e. not for the purposes of determining Australian Government transfers to State and Territory Governments, which would remain block funded). This would allow model development to be expedited.

Another option would be for State and Territory Governments to each determine their own payment models. While this risks some duplication between State/Territory Governments, it has merit. State and Territory Government health departments would likely need to adapt a national model to meet their particular needs anyway (as they often do with other ABF classifications). And the costs of developing the recommended model ought not to be restrictively high. Even if IHPA is not actively involved in the development of the model, it could facilitate communication between jurisdictions to reduce duplication of effort.

In summary, IHPA should review the AMHCC and the Australian Government should direct IHPA to negotiate with State and Territory Governments to determine how best to implement a fee-for-service model for community ambulatory mental healthcare in the interim period. This could become an ongoing alternative to ABF depending on the findings of IHPA’s review.

Adjustments for unplanned readmissions

As noted in box 23.5, ABF for hospital-based care can incentivise LHNs to prematurely discharge consumers.

IHPA is currently developing adjustments to its ABF classifications that would penalise LHNs for ‘avoidable hospital readmissions’, thereby reducing incentives for premature discharge (and other aspects of poor quality care that lead to hospital readmissions) (IHPA 2020b). Thus far, mental health-related hospital readmissions are effectively outside
the scope of this work insofar as none of the conditions that would constitute an avoidable readmission relate to mental health (ACSQHC 2019a).

Extending these adjustments to mental healthcare would reduce incentives for LHNs to prematurely discharge consumers. But how ought this be done? We consider it reasonable to consider all unplanned hospital readmissions for mental health reasons within a reasonable timeframe following a mental health-related separation to be avoidable for the purposes of ABF. However, determination of an appropriate timeframe and any exemptions should be subject to a clinical review. The Australian Commission on Safety and Quality in Healthcare (which maintains the list of conditions considered to constitute an avoidable readmission) should undertake such a review.

**ACTION 23.7 — ACTIVITY-BASED FUNDING**

**Start now**

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

- whether its structure and splitting variables should be refined or changed (especially the ‘phase of care’ variable)
- if the ‘phase of care’ variable is retained, how it can be refined to improve inter-rater reliability
- if a new costing study is required
- a revised timeframe for implementing the classification.

As an interim measure, IHPA should work with State and Territory Governments to develop a simpler activity-based payment model for community ambulatory mental healthcare services based on hours of care provided. State and Territory Governments should use this payment model to fund community ambulatory mental healthcare services. It should not be used to determine Australian Government National Health Reform Agreement transfers if this would significantly delay its development.

The Australian Commission on Safety and Quality in Healthcare and IHPA should seek to incorporate mental health-related avoidable hospital readmissions into broader activity-based funding reforms.

**Toward new payment models**

So far, this chapter has recommended granting PHNs the ability to blend MBS rebates with co-funding from the PHN Mental Health Care Flexible Funding Pool and extending an activity-based payment model to community ambulatory mental healthcare. While these are important reforms that should be pursued as soon as practical, they are not the endpoint of improvements to mental healthcare payment models.
Unfortunately, there has been relatively little research in Australian and abroad about more sophisticated ways of paying providers of mental health services.\(^{266}\) It is worth considering ways to foster the development of new models.

What might work better?

Recent years have witnessed a shift from funding physical healthcare providers on the basis of individual episodes of care toward a smaller number of payments that cover all care provided over a given timeframe, known as *capitation* or *bundled* payments. When well-administered, these payments can incentivise providers to minimise the costs of achieving good clinical and functional outcomes for consumers, usually by better coordinating care and shifting care to lower cost settings.

For example, rather than receiving a payment each time they provide an episode of care to an individual (as is the case under ABF), LHNs could instead receive a quarterly payment for each individual within their care and have flexibility to provide care in the most appropriate setting. This would strongly incentivise the LHN to *prevent* avoidable hospitalisations, whereas the ABF approach can *encourage* hospitalisations (appendix G; NSW Government, sub. 551).

Other innovative approaches include outcome-based payment models, where providers are partially remunerated on the basis of improvements in measurable outcomes. Aftercare (sub. 835) and the Queensland Mental Health Commission (sub. 712) and suggested that these payment models should be considered where applicable.

However, these newer payment models have shortcomings. Capitation can encourage ‘underservicing’ (PC 2017d). And it can be complex to administer. The LHN example above would require a more sophisticated casemix classification than an ABF classification, as it would need to adequately predict the efficient cost of providing treatment over a forthcoming time period (as opposed to just the current episode of care). Likewise, outcome-based approaches are feasible only in instances where (desirable) outcomes are measurable and can be attributed to the intervention being funded. For instance, mainstream employment support programs are funded on an outcomes basis (chapter 19), because the desired outcome (employment of more than 8 hours per week) is easy to measure and clearly attributable to the program at hand. But suitable outcome measures are more difficult to identify for mental healthcare and psychosocial supports.

\(^{266}\) For example, a recent literature survey of 23 studies of the impacts of bundled payment models did not include any studies of bundled payments for mental healthcare (Strujs et al. 2020), and a recent literature survey of 70 studies of the impacts of ‘accountable care organisations’ (a way of organising healthcare delivery wherein a cluster of organisations is funded on a capitation or similar basis to provide all healthcare for an enrolled population) included only one study that specifically considered mental health services (Peiris, News and Nallathiah 2018).
Hence, across-the-board shifts to these kinds of payment models is premature. Instead, policy should focus on encouraging and learning from regional innovations.

Rigidities in the existing system

Are there barriers that prevent regional decision makers (PHNs, LHNs, or — in the future — RCAs) from pursuing innovative payment models for mental health services? If so, what can be done about them?

The MBS is a barrier to payment model reform. While it is currently the most suitable way to fund most primary mental healthcare (notwithstanding that MBS-rebated psychological therapy should be subject to a rigorous evaluation (recommendation 12)), it does not permit much experimentation with new ways of funding or providing care. Several stakeholders raised the possibility of ‘cashing out’ MBS rebates — delisting items from the MBS and instead administering funding via regional commissioning (Deakin Health Economics, Institute for Health Transformation, sub. 156; Grattan Institute, sub. 816; Joanne Enticott, Anton Isaacs, Sebastian Rosenberg, Frances Shawyer, Brett Inder and Graham Meadows, sub. 836; RANZCP, sub. 385).267 And the Western Sydney PHN has previously proposed primary mental healthcare funding arrangements that would involve a partial cash-out of MBS payments (WentWest 2015).

In our view, universally cashing out MBS rebates for psychiatry and allied mental health is not advisable. These services are generally administered at much lower cost when funded via the MBS (chapter 12). Moreover, requiring all PHNs to commission MBS-equivalent services would involve a large expansion to their responsibilities and infrastructure. Currently, PHN-commissioned services treat about 190 000 consumers per year, whereas about 1.2 million consumers receive MBS-rebated allied mental healthcare and 400 000 consumers receive MBS-rebated psychiatry each year (DoH 2019e).

Otherwise, there is ample flexibility to allow for payment model experimentation. There are no restrictions on the types of payment models that PHNs may use when commissioning services from the Mental Health Flexible Funding Pool, and action 23.5 would only add to the flexibility available to PHNs. As regards LHN-provided care, there is scope under the NHRA for the Australian Government to convert an existing ABF funding stream to block funding should a State/Territory Government indicate that it wishes to trial an innovative funding model (IHPA 2019). At present, this model is being used for the Victorian Government’s ‘HealthLinks: Chronic Care’ program, which uses a capitation funding model to provide integrated support to consumers with chronic and complex health needs (VIC DHHS 2017) (Unfortunately, consumers admitted to hospital for mental health reasons are not eligible for the model.)

267 Some of these participants suggested doing so on the grounds that MBS funding is poorly targeted (to the benefit of wealthier people living in urban areas). We propose managing these shortcomings through changes to the way that the PHN Mental Health Care Flexible Funding Pool is allocated (action 23.5).
Trials and evaluations are needed

Just because PHNs, RCAs or State/Territory Governments could pursue new payment models does not mean that they will do so, that these models will be suitably evaluated, or that the learnings of these evaluations that result will be shared across Australia.

Only carefully designed and evaluated trials will give an indication of which new approaches will work. But trialling and evaluating a new way of doing things is costly and risky for all parties (most notably consumers, whose care may be disrupted). A concern is that PHNs, State/Territory Governments and/or RCAs will be unwilling to take on these risks when they could wait for a counterpart to do so. This suggests that the Australian Government should provide additional funding to support trials, on the proviso that they are independently evaluated to a high standard and the findings published.

There is precedent for the Australian Government playing such a role within the mental health sector.

• the Australian Government Department of Health has designated several PHNs as ‘Mental Health Reform Lead Sites’ and contributed funding for evaluations of new initiatives in regional planning and service integration, stepped care, low-intensity services, services for youth with severe mental illness, and clinical care coordination for adults with severe and complex mental illness (University of Melbourne 2019). The evaluations of these trials are ongoing.

• The Australian Government committed funding to support the ‘National Mental Health Integration Program’, a series of ambitious trials that ran from 1999 to 2003 in Inner Urban East Melbourne, Illawarra, and Far West NSW and considered ways to fund and integrate private and public psychiatric care. These trials were evaluated (Eagar et al. 2005).

There is also precedent in the broader health system. The Australian Government has recently established a ‘Health Innovation Fund’. Under this arrangement, New South Wales and Western Australia received $50 million in 2018-19 toward ‘delivery of new projects that support health prevention and the better use of health data’ (COAG 2018c, p. 2). These States are required to report performance data and provide an evaluation of these projects to the Australian Government.

To this end, the Australian Government should establish a Mental Health Innovation Fund to support high quality trials and evaluations by PHNs, LHNs and State/Territory Governments (or, potentially, RCAs). PHN–LHN groupings or RCAs, with the support of State/Territory Governments, would submit proposals for new payment or system organisation models to the Australian Government. If approved, the Australian Government would provide funding to support the evaluation component of the new model.

The Inquiry draft report’s proposal for a Mental Health Innovation Fund was supported by several PHNs (COORDINARE, sub. 1194; Murrumbidgee PHN, sub. 1199; PHN Cooperative, sub. 850), the Consumers Health Forum (sub. 646), and Transforming Australia’s Mental Health Service Systems (sub. 919). We have since given further thought...
to the governance and scope of the Mental Health Innovation Fund so as to maximise its potential and minimise any risks.

- The Mental Health Innovation Fund should cover only the additional administrative costs of running and evaluating the trials. In particular, it should not provide additional funding for mental health services.

- Proposals that integrate psychosocial supports and mental healthcare should be considered (a suggestion of Uniting Vic.Tas, sub. 931).

- If PHN–LHN groupings propose new models to integrate PHN-funded and LHN-provided care, their respective responsibilities must be clearly specified.

- The Australian Government should consider the past performance of PHN–LHN groupings or RCAs when deciding whether to approve the projects.

- The Australian Government should permit MBS rebates for allied mental healthcare and/or psychiatry to be cashed out for trial purposes, but only if a suitably detailed proposal for redirecting this funding is provided and the PHN–LHN groupings or RCA commits to not removing access to services for consumers currently receiving MBS-rebated care or to maintaining access to the MBS for consumers who choose to continue receiving MBS-rebated care.

- The Australian Government should consider granting exemptions to section 19.2 of the Health Insurance Act as necessary if proposals involve co-funding MBS-rebated GP consultations. As well as supporting a GP’s role in mental healthcare, this would allow for models that attempt to better integrate physical healthcare (a suggestion of the Canberra Mental Health Forum, sub. 687).

**ACTION 23.8 — MENTAL HEALTH INNOVATION FUND**

*Start later*

The Australian Government should establish a Mental Health Innovation Fund to trial innovative service delivery, system organisation and payment models. The Mental Health Innovation Fund should allow Primary Health Network–Local Hospital Network groupings and Regional Commissioning Authorities to apply for funding to trial new models under the proviso that the models are independently evaluated and the findings are published.
23.5 Leveraging private insurance to better use

Private health insurance

Private health insurance (PHI) is a significant component of Australia’s mental health system. In 2016-17, private health insurers paid approximately $50 million in benefits for hospital-based mental health treatment, equivalent to about 20% of mental health-related hospital costs.

Longstanding regulation has dictated that the roles of PHI in Australia are to subsidise private hospital care (which also attracts MBS rebates for clinician fees) and to fund services outside of hospitals that are not eligible for MBS rebates (box 23.8). It is outside the scope of this Inquiry to analyse this policy. As such, we have not formed a view on whether it would be desirable to substantially change the scope of PHI. Nor have we examined the appropriateness of the subsidies and tax breaks that consumers receive for taking out PHI, or the issue of public hospitals treating private patients. These issues are not specific to mental healthcare and would warrant more thorough consideration than is possible here.
Box 23.8  Private health insurance in Australia

There are two forms of private health insurance in Australia — hospital cover and extras/ancillary cover.

Hospital cover

Hospital insurance subsidises the cost of care in private hospitals (or the cost of care when admitted as a private patient in a public hospital). The Medicare Benefits Schedule provides rebates for clinicians fees for these services, so the insurer’s role is to fund (not necessarily in full) additional expenses such as accommodation and theatre fees and clinician gap payments. There are four tiers of hospital cover on offer (gold, silver, bronze and basic) that each cover different suites of treatments.

Extras/ancillary cover

Extras/ancillary insurance covers out-of-hospital treatments that are not eligible for Medicare Benefits Schedule rebates (including psychology).

Regulatory environment

The private health insurance market is tightly regulated.

- All private health insurance is ‘community rated’, meaning that insurers:
  - are not permitted to discriminate against prospective insureds (they cannot prevent people with pre-existing medical conditions or people that are statistically more likely to make claims from taking up insurance)
  - must charge a uniform price for each of their products. An exception operates through the Lifetime Health Cover loading scheme, which applies surcharges to people that first take out hospital insurance when aged over 30 years (to incentivise people aged under 30 years, who typically make fewer claims, to take out private health insurance).

- The risk equalisation scheme complements community rating by re-distributing money from insurers paying less than average in benefits to those paying greater than average in benefits. This ensures that insurers that face a riskier demographic profile (for instance, those that market to older people) are not disadvantaged by community rating.
Role of private health insurance in mental healthcare

Public and private hospital roles differ. In 2017-18, private hospitals provided 81% of mental health-related same day admissions, 21% of multiple day admissions and 27% of days of care among those multiple day admissions (figure 23.1). Private Healthcare Australia (sub. 222) noted that schizophrenia and other acute psychiatric disorders are predominantly treated in public hospitals, while anxiety and eating disorders are primarily treated in the private hospitals.

Figure 23.1 Public and private hospital admissions and days of care \(a,b\)
Number of mental health-related public and private hospital admissions and days of care, 2017-18

\(a\) Public hospital same day admissions are counted by separations, while private hospital same day admissions are counted by days of care. \(b\) Counts of separations for multiple day admissions indicate the number of multiple-day episodes of care completed. For example, if a person is admitted for a three day period, this will be recorded as three days of care and one separation.

Source: AIHW (2020g, 2020f).

Should insurers be permitted to fund more community-based care?

As indicated above, it is outside the scope of this Inquiry to consider whether private health insurers should be permitted (or required) to develop products that would fund comprehensive primary mental healthcare. That said, we consider that the private health insurance regulatory framework should recognise and leverage the fact that private health insurers face strong incentives to prevent avoidable hospitalisations among their insureds.

- Regulations should permit private health insurers, on a discretionary basis, to fund services outside of hospitals that could prevent their hospital cover holders from requiring hospitalisation. This does not suggest an expansion of PHI into new products
that cover additional care outside of hospital whenever demanded by a consumer — a concern raised by the Doctors Reform Society (sub. 746). Such considerations are beyond the scope of this Inquiry. Rather, it suggests that private health insurers should not be prevented from choosing to fund community-based care when consumers want it.

- Regulations should require private health insurers to fund hospital services to the extent agreed in the insurance contract whenever it is clinically necessary.

The current regulations are designed to permit some preventative care, but are not aligned toward doing so for mental healthcare. The restrictions in place prevent private health insurers from funding services outside of hospitals that are eligible for MBS rebates (irrespective of whether the rebate is claimed or not). There are exceptions for some services:

- Those that are designated as ‘hospital substitutes’ (under the *Private Health Insurance (Health Insurance Business) Rules 2018* (Cth), s.10). As Bupa (sub. 485, p. 10) notes:
  
  This list has been extremely helpful in encouraging innovative models of care, which Bupa has seen in the Oncology specialty. Many funds now offer cancer treatment at home as an option for consumers. However, the items that can be provided as Hospital-Substitute under the MBS has not ‘kept-pace’ with the evolution of alternative models of care.

  There are no mental health-related items currently designed as hospital substitutes.

- Those that form part of a ‘chronic disease management program’. This allows private health insurers to fund MBS-eligible allied mental health professionals, including psychologists and ‘mental health workers’. That said, Bupa (sub. 485, p. 10) criticised the chronic disease management program exemption as too prescriptive:
  
  It is our experience that [the chronic disease management rule] is drafted in a manner which prevents us from doing all we can to assist our customers. We believe [the chronic disease management rule] does not promote best practice evidence, which would support a wider variety of providers (such as mental health nurses) in the provision of chronic condition prevention and management.

Some private health insurers aim to prevent hospitalisations by providing services outside of hospitals that are not eligible for MBS rebates (and, hence, are not restricted). For example, Australian Unity offers the ‘MindStep’ program, a 6-week telephone-based program of cognitive behavioural therapy for insureds who have previously been admitted to hospital with depression and anxiety. Average days in hospital and readmissions fell for people enrolled in the program, leading to a reduction in average claim costs of $7800 per person per year for those enrolled in the program. Australian Unity saved $4 million in the program’s first year (Potter 2017).

**Options for reform**

Private Healthcare Australia and Bupa both argued for greater flexibility in the existing regulations. Private Healthcare Australia (sub. 222, p. 21) proposed amendments to the *Private Health Insurance Act 2007* (Cth) to remove the restrictions on health funds insuring out-of-hospital care for forms of care ‘that have been demonstrated to deliver patients
improved choice and outcomes’, via a formal schedule of exceptions rather than a general removal of the rule. Similarly, Bupa (sub. 485), proposed that additional MBS-funded mental health services be deemed ‘hospital substitutes’ (therefore permitting PHI co-funding). It would appear that these approaches could produce similar results, and hence we do not have a preference between them.

In addition, Bupa (sub. 485, p. 11) suggested that the chronic disease management rules should be amended to remove the requirement that chronic disease programs fund allied mental health professionals.

We believe this is unnecessarily restrictive and we support a change to the rule that would allow [us] to decide which providers (for example nurses and social workers) we want to fund to provide chronic disease prevention and management services to our customers.

Some efforts at reform are currently underway. In 2018, the Private Health Ministerial Advisory Committee convened a Mental Health subgroup of the Improved Models of Care Working Group to consider, among other things:

[I]dentification of the most clinically appropriate and efficient settings for the delivery of mental health services, including consideration of:

- home based care;
- community based care; and
- other non-admitted day programs. (DoH 2018b)

The Private Health Ministerial Advisory Committee was unable to provide the Productivity Commission with a copy of the subgroup’s report. However, the minutes of a subsequent meeting of the Improved Models of Care Working Group reveal that the report found that existing regulations did not prevent alternative models of care from being adopted, but that uptake of alternative models of care is low and existing regulation may be discouraging them (DoH 2018c).

Many participants supported the Inquiry draft report’s recommendation that this work be extended to become a larger and more public review of the current regulatory framework for mental health-related private health insurance. Among them were private health insurers (Bupa, sub. 1191; Medibank, sub. 700; PHA, sub. 815), consumer groups (Bipolar Australia, sub. 781; CHF, sub. 646) and a provider group (PACFA, sub. 883). It remains our view that a more substantial and transparent review is necessary.
Start now

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

Life insurance

Life insurers, which provide income protection insurance products, are currently not permitted to fund mental healthcare for their consumers.

The incentives that life insurers face are similar to those of private health insurers. They have a strong interest in preventing mental ill-health among their consumers, lest it lead to insurance claims in the event that they become unable to work. For these reasons, we recommended in the Inquiry draft report that life insurers be permitted to fund mental healthcare on a discretionary basis. Life insurers strongly supported this recommendation (Life Insurance Industry, sub. 821; SuperFriend, sub. 873; TAL Life Limited, sub. 643).

Some participants had reservations. Doron Samuell (sub. 720) argued that:

- there is limited evidence underpinning the impact of access to mental healthcare on claim volumes. Hence, if life insurers were to fund mental healthcare, this would increase their costs and put upward pressure on premiums
- the arrangements would effectively allow life insurers to enter the PHI market, creating confusion over treatment liability.

Requiring that funding of mental healthcare be on a discretionary basis ought to nullify these concerns. The proposal is not that life insurers be permitted to offer mental healthcare insurance products — merely that they should have the option of funding mental healthcare treatment. If doing so is not in their financial interest (i.e. if the expected cost of the treatment exceeds the expected reduction in claims), then they are unlikely to fund those treatments. Likewise, there would be no confusion over treatment liability, as life insurers would have no liability in this regard.

A third concern is that such arrangements would create ethical conflicts, as clinicians funded by life insurers could be incentivised to inappropriately recommend that a person return to work (Beyond Blue, sub. 877; Doron Samuell, sub. 720). We acknowledge these concerns, but consider that appropriate regulation and ethical convictions on the part of clinicians (as well as regulatory oversight by the Australian Securities and Investments Commission) should be sufficient to manage such issues. For example, the life insurance industry code of conduct could be amended to prevent life insurers making incentive payments to clinicians to return
consumers to work or otherwise pressuring clinicians to engage in such behaviour. The Life Insurance Industry (sub. 821) itself suggested that any funding of mental healthcare should be with consumer’s consent and choice of clinician.

Some life insurers suggested that the arrangements should be extended to consumers of ‘total and permanent disability’ products as well as ‘income protection’ products (Life Insurance Industry, sub. 821; SuperFriend, sub. 873). We agree, as the same arguments made above apply to all life insurance consumers.

**ACTION 23.10 — LIFE INSURANCE AND FUNDING OF MENTAL HEALTHCARE**

*Start now*

The Australian Government should permit life insurers to fund mental health treatments for their income protections and total and permanent disability insureds on a discretionary basis. The Australian Securities and Investments Commission should work with the life insurance industry on the preconditions necessary for this to occur.
While the mental health system collects substantial amounts of data, this is rarely used to inform decisions made by consumers and carers. There are only limited evaluations to inform governments, service commissioners and providers how they are tracking on outcomes. And for some key indicators, data either does not exist or is out of date.

- Using data collections to their full potential is key to creating a person-centred mental health system. Collecting better data on service effectiveness and building a culture of service evaluation would shed light on what is working well for people and what is cost effective.

- Monitoring, evaluation and research, underpinned by data, are essential to ensure accountability, improve policies and services; and ultimately achieve the outcomes valued by the people who use the mental health system.
RECOMMENDATION 24 — DRIVE CONTINUOUS IMPROVEMENT AND PROMOTE ACCOUNTABILITY

A robust information and evidence base is needed to improve programs, policies, and outcomes for people with mental illness and carers. This requires that governments support data collection and use, transparent monitoring and reporting, program evaluations and practical research.

As a priority:

1. The Australian, State and Territory Governments should agree on a set of targets and timeframes that specify key mental health and suicide prevention outcomes.
   - These targets should be co-designed with consumers and carers and include both quantitative and qualitative evidence and data.
   - Aboriginal and Torres Strait Islander people and the National Federation Reform Council Indigenous Affairs Taskforce should be included in discussions about any targets that may affect Aboriginal and Torres Strait Islander people (Action 24.4).

2. The Australian, State and Territory Governments should require monitoring and reporting at the service provider level that is focused on consumer and carer outcomes (Action 24.5).

3. The Australian Institute of Health and Welfare should publish data on mental health services at a national, State and Territory, and regional level that is aligned with the National Mental Health Service Planning Framework (NMHSPF); and gap analyses against NMHSPF benchmarks. Each regional commissioning body should report a regional-level gap analysis in their joint regional plan (Action 24.8).

Additional actions that should be considered:

1. The Australian Government should fund regular national surveys of mental health and wellbeing (Action 24.2) and the establishment of a national clinical trials network in mental health and suicide prevention (Action 24.12).

2. The National Mental Health Commission should include outcomes, activities and reforms from all relevant health and non-health portfolios in its national monitoring and reporting (Action 24.10).

3. The Australian, State and Territory Governments should:
   - develop a strategy to improve the usability of data collections (Action 24.1) and ensure prioritised data and information gaps are addressed, including data on non-government organisations that provide mental health services (Action 24.3).
   - develop standardised and outcome-focused reporting requirements for service providers and report all data relating to the performance of services at a regional level (Actions 24.6, 24.7).
   - enhance and make all parts of the NMHSPF publicly available (Action 24.9).
   - require funding applications for mental health programs to include an assessment of their expected cost-effectiveness and require all new programs to have been trialled as pilots, before they can be scaled up (Action 24.11).
A robust evidence base is necessary for improving outcomes for consumers and carers, and for using taxpayers money effectively and efficiently.

… information on [the prevalence of mental disorders, the costs of mental ill-health, treatment outcomes and service quality] is crucial if policy makers are to commit greater resources to mental health care, to prioritise areas of greatest need, and make sensible decisions about effective and efficient care for mental ill-health. A better information infrastructure will be the foundation of stronger mental health systems. (OECD 2014, p. 19)

Australia’s National Mental Health Plans have prioritised data development and information management since Australian, State and Territory Government health ministers endorsed the first plan in 1992. Decision makers rely on a range of data and information to develop and fund mental health and suicide prevention policies, programs and services.

However, many Inquiry participants and past reviews highlighted the limitations of the current arrangements (AIHW, sub. 370; CHF, sub. 496; Mendoza et al. 2013; NMHC 2014b; NMHC, sub. 118). Inadequate data and information to guide decision making and promote accountability generate significant costs. They can lead to expenditure on ineffective and costly interventions, which reduce public confidence in the mental health system, and to unnecessary data collection (AHMC 2009a, 2009b).

The Productivity Commission also experienced significant data and information limitations during the course of this Inquiry, which restricted the type and level of analysis that could be undertaken in some cases. In particular, data on mental health outcomes and activity in non-health areas (such as justice) was limited, as highlighted in other chapters (section 24.1).

Currently, there is no policy framework to guide monitoring, evaluation and research in mental health and related sectors. Consequently, some aspects are overlooked. For example, the Queensland Mental Health Commission (sub. 228) observed that while a lot of monitoring activity occurs in mental health, less attention is paid to evaluations and other initiatives that would address data issues and information gaps.

The Productivity Commission proposes a framework of improved processes and institutional arrangements to generate the right information to drive continuous improvement, and promote accountability through better monitoring, evaluation and research (figure 24.1). It is based on a set of principles identified by the Productivity Commission (box 24.1).

The recommended actions in this chapter are intended to complement the forthcoming Indigenous Evaluation Strategy, which will set out a whole-of-government framework for Australian Government agencies when evaluating policies and programs affecting Aboriginal and Torres Strait Islander people (PC 2020). The draft strategy was released on 3 June 2020 and outlined a principles-based framework — the over-arching principle was about centring Aboriginal and Torres Strait Islander people, perspectives, priorities and knowledges. This strategy will be relevant to mental health and suicide prevention programs for Aboriginal and Torres Strait Islander people, and will be particularly important given the lack of quality evaluations of those programs (AH&MRC, sub. 206; NMHC, sub. 118). The strategy is expected to be finalised in October 2020.
Figure 24.1  Framework for monitoring, evaluation and research

<table>
<thead>
<tr>
<th>Processes and governance arrangements</th>
<th>Collecting the right data through…</th>
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</thead>
<tbody>
<tr>
<td>Surveys</td>
<td>National Minimum Data Sets</td>
</tr>
<tr>
<td>National Outcomes Casemix Collection</td>
<td>Other data sets</td>
</tr>
<tr>
<td>Consumers and carers</td>
<td>Service providers</td>
</tr>
<tr>
<td>Service commissioners</td>
<td>Governments</td>
</tr>
</tbody>
</table>

… to inform decision makers including…

… to promote continuous improvement.

Translating, communicating and applying learnings and evidence into practice

Implementation Monitoring
Translation and communication Evaluation and research

Using data to generate information and evidence about what works best and how to implement it

Source: Adapted from Productivity Commission (2016).

Box 24.1  Principles to guide monitoring, evaluation and research

The Productivity Commission’s framework for monitoring, evaluation and research (figure 24.1) is based on the following principles:

- fit-for-purpose — data collected should inform decision making at all levels of the mental health system, including by consumers and carers, governments, service planners and commissioners and providers
- maintains social licence — data collection and use should meet public expectations
- supports continuous improvement — information from monitoring, evaluation and research should support continuous improvement of mental health outcomes
- independent — bodies tasked with monitoring, evaluation and research should be independent of areas responsible for policy, program development and implementation
- transparent — monitoring, evaluation and research should be made publicly available through appropriate, ethical and collaborative consent processes
- person-centred — monitoring, evaluation and research should aim to improve outcomes for people with mental ill-health and their carers. Monitoring should include measures of consumer reported experiences and outcomes
- culturally capable — bodies undertaking monitoring, evaluation and research should consider different cultural needs that may affect approaches and aim to address them
- generating a net value — resources should only be allocated to monitoring, evaluation and research if the benefits outweigh the costs.
The Productivity Commission has applied this framework to analyse issues and propose reforms to:

- data collection and use (section 24.1)
- monitoring and reporting (section 24.2)
- evaluation (section 24.3)
- research (section 24.4).

### 24.1 Data collection and use

To undertake effective monitoring, evaluation and research, the right data needs to be collected. This involves investing in data that is of high quality. This section describes the existing data landscape, highlights areas where data is underutilised and gaps exist, and identifies and recommends reforms to address these issues.

#### Maintaining a social licence

Maintaining a social licence is a critical consideration for data collection and use (PC 2017a; CHF, sub. 646). Social licence can be defined as a community’s tacit acceptance or approval of data use. It requires organisations (including governments, companies and research institutions) to meet public expectations about data being used to create value for the community, and for the public to have trust in those institutions, their processes and their people.

This is important for both principled and pragmatic reasons, as individuals are more willing to share their data when they trust how it is being used and feel they have some control over it (PC 2017a). Public institutions are obliged to operate consistently with the public trust placed in them, which includes ensuring that data use is managed fairly and respectfully. Pragmatically, data use initiatives will likely fail if the community does not understand or believe they generate benefits. When community expectations are not met or are breached, individuals may withdraw their consent for their data to be used.

To maintain a social licence, fundamental values or standards should be embedded to guide data collection, sharing and use (PC 2017a, box 24.2). These fundamental standards include embedding: a sense of shared control; a right to choose to participate, where possible, in the benefits of data collection and use (such as better service delivery, or personal benefits); and a belief that accountability and integrity is upheld by data collectors and users.

Embedding these fundamental standards is central to realising the full value of data, particularly in mental health where stigma and discrimination are concerns. People with mental illness may be reluctant to share their data, due to fears they could be identified and discriminated against, for example, when seeking insurance (chapter 8). Further, specific considerations to maintaining a social licence may be required in some instances. For example, a lack of trust in institutions can be more evident among Aboriginal and Torres Strait Islander...
people, due to historical and political context. Collection and use of Aboriginal and Torres Strait Islander people’s data would need to recognise and respect this.

… the accumulation of many generations of Aboriginal and Torres Strait Islander peoples’ experiences of colonial and post-colonial interventions have coloured our relationship with data. We have an abiding concern, shaped by historical legacies of distrust, in knowing what data are collected and how this information is used, both with and without our consent. (NACCHO, sub. 1226, p. 21)

## Box 24.2 Fundamental standards to maintaining a social licence for data collection and use

- **Shared value**: value derived from data should be shared among stakeholders (private sector, public sector, researchers, not-for-profits, community groups, and individual consumers), where privacy or consent issues do not prevent it.
- **Control**: individuals should be informed about who holds their data and how it is used, and be able to exercise control over this, subject to the context in which the data is being used.
- **Trust**: embedding genuine safeguards into data frameworks to assure people their data is being used safely.
- **Genuine accountability**: data management in Australia should build trust and confidence in the system by being transparent, promoting responsible data stewardship, and safeguarding privacy and data security.

*Source: Productivity Commission (2017a).*

## Data landscape

At the national level, the amount of data collected in mental health is large relative to other areas of health and welfare (AIHW, sub. 370; table 24.1).

Supporting these collections is a long standing governance structure for information development in mental health that does not necessarily exist for some other areas of health. The Australian, State and Territory Governments established the Mental Health Information Strategy Standing Committee to advise the Australian, State and Territory health ministers on mental health information and data issues (box 24.3).

The Mental Health Information Strategy Standing Committee has led recent developments in the national data landscape, including:

- Your Experience of Service National Best Endeavours Data Set (NBEDS) — which includes data on consumer- and carer-rated experiences of care in public sector specialised mental health services in New South Wales, Victoria and Queensland
- Seclusion and Restraint NBEDS — which aims to monitor restrictive practices in hospitals and mental health units.
Table 24.1  Major data collections in mental health

<table>
<thead>
<tr>
<th>National population surveys</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>ABS National Survey of Mental Health and Wellbeing (1997, 2007)</td>
<td>Prevalence of selected mental disorders, demographics, medication, comorbidity, employment and education characteristics of people aged 16–85 years</td>
</tr>
<tr>
<td>ABS National Health Survey (pre-2000, 2004-05, 2007-08, 2011-12, 2014-15, 2017-18)</td>
<td>Psychological distress, various mental health conditions, demographics, medications, comorbidity, employment and education characteristics of people aged 15 years and older</td>
</tr>
<tr>
<td>Low prevalence (psychosis disorder) surveys (1998, 2010)</td>
<td>Prevalence of psychosis for people aged 16–64 years seen by public sector mental health services, their personal, social and living circumstances, service use by people with psychotic illness and effect of illness (including on functioning)</td>
</tr>
<tr>
<td>Child and adolescent surveys (1998 and 2014)</td>
<td>Prevalence of selected mental disorders, severity, effect on schooling, service use of people aged 4–17 years</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>National Minimum Data Sets</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health establishments</td>
<td>Expenditure and activity (for example, bed and staff numbers) for public sector specialised mental health services</td>
</tr>
<tr>
<td>Admitted patient care</td>
<td>Same day and overnight admitted mental healthcare</td>
</tr>
<tr>
<td>Residential mental healthcare</td>
<td>Care in residential mental health services. non-government organisation services receiving government funding is optional</td>
</tr>
<tr>
<td>Community mental healthcare</td>
<td>Community ambulatory mental healthcare services</td>
</tr>
<tr>
<td>Primary mental healthcare</td>
<td>Activity and outcomes data of primary mental healthcare services commissioned by primary health networks</td>
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<th>National Outcomes and Casemix Collection</th>
<th>Description</th>
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<tbody>
<tr>
<td>National Outcomes and Casemix Collection</td>
<td>Consumer outcomes data from state and territory public sector specialised mental health services</td>
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<table>
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<tr>
<th>Other datasets</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Medicare Benefits Schedule and Pharmaceutical Benefits Scheme</td>
<td>Administrative payments data</td>
</tr>
<tr>
<td>National Health Workforce Dataset</td>
<td>Registration and survey data collected through the registration process for registered health practitioners</td>
</tr>
<tr>
<td>Your Experience of Service survey</td>
<td>National consumer and carer experience surveys implemented in New South Wales, Victoria and Queensland</td>
</tr>
<tr>
<td>Mental health non-government organisation establishments</td>
<td>Non-government organisations involved in providing mental healthcare services, including data on the number of organisations and number of full-time equivalent staff</td>
</tr>
<tr>
<td>NBEDS\textsuperscript{a}</td>
<td>Seclusion and restraint events at the hospital level for public sector specialised mental health hospital acute service units, including short stay mental health units</td>
</tr>
</tbody>
</table>

\textsuperscript{a} NBEDS is a dataset for which there is a commitment to provide data nationally on a best endeavours basis, but not formally mandated for national collection (AIHW 2019m).

These datasets can — and should — be used to inform service improvement and promote accountability. For example, the Victorian Mental Illness Awareness Council (2019) recently used this data to rank Victorian hospitals on seclusion rates to inform the public and hold hospitals accountable.

However, the mental health sector has been criticised as being ‘data rich but information poor’ (Rosenberg and Salvador-Carulla 2017, p. 38). Much more can be done to improve the
collection and use of mental health data to inform decision making and improve outcomes for consumers and carers. In the absence of high-quality and informative data, many decisions about service and program priorities are being made without evidence of either clinical or cost effectiveness, nor robust consideration of alternatives.

**Box 24.3 The Mental Health Information Strategy Standing Committee**

The Mental Health Information Strategy Standing Committee provides expert technical advice and, where required, recommends policy for consideration by the Australian, State and Territory health ministers.

The Mental Health Information Strategy Standing Committee brings together jurisdictional mental health data representatives and key stakeholders including consumers, carers, clinicians, peak bodies and key organisations. It provides a national collaborative forum for the development and implementation of national initiatives in mental health information, national monitoring, reporting and benchmarking of mental health publications and resources. It facilitates communication and collaboration regarding mental health information with government, private sector and non-government agencies. It also leads the development of national data collections.

*Source: AIHW (2020b).*

**Optimising data collection to get more information**

Data collection can be costly and burdensome

Establishing and maintaining data collections can be complex and costly for governments and those required to collect data. Governments allocate resources to support data collection, which include investments in new data infrastructure and ongoing maintenance of data collections. For example, the Australian Government (2012) allocated $240.3 million to build and operate the information technology system required to collect and analyse data to monitor consumer outcomes and performance under the National Disability Insurance Scheme (NDIS). Moreover, additional resources and systems are required to ensure datasets are translated into useful information.

Data collection is a complex exercise, and one which requires additional resources and systems at the level of both funded services but also for the funder, who needs mechanisms for collecting de-identified data from commissioned services, as well as systems for secure storage, analysis and interpretation. These are non-trivial undertakings and if implemented poorly can result not only in unreliable data, but also a considerable waste in effort. (MindSpot, sub. 178, p. 7)

Forming nationally consistent datasets can add additional complexity as data must be collected from a ‘disparate state-based assortment of mental health services’ (Holloway, Alam and Griffiths 2012, p. 23). In addition, State and Territory Governments often use data definitions and structures that are not consistent with each other, adding to the time and resources required to achieve nationally consistent collections.
For many service providers, the costs of data collection can also be significant. The Victorian Council of Social Service (sub. 478, p. 20) reported that ‘overly burdensome reporting and regulation … [is] costing organisations valuable time that could be used for frontline service delivery’. This is particularly the case for non-government organisations (NGOs), which often receive funding from various government agencies with different reporting requirements (chapter 17).

Further, service providers often view data collection as a lower priority relative to service delivery, especially if funding does not extend to data collection. While this is understandable, overlooking data collection is a very short-term view. It ignores the value of data in informing improvements in service delivery and outcomes for consumers, and is inconsistent with the pursuit of innovative, person-centred service delivery.

The most effective programs and services find ways to embed data collection into their delivery models and provide timely information back to data collectors and/or service users. One example is the Link-Me trial, which ensured data collection allowed for a randomised control trial evaluation to be undertaken (Le et al. 2019). Governments can facilitate data collection by standardising reporting requirements, which reduces the burden on service providers (section 24.2).

Data is underutilised

There are concerns that few quality insights have been gathered from mental health data to date (Rosenberg and Salvador-Carulla 2017). The National Mental Health Commission (NMHC) (sub. 118, p. 32) reported that ‘[m]ore can be done to improve the collection and value of mental health data’. The Department of General Practice at the University of Melbourne (2019, p. 1) stated that ‘Australia lags behind other developed countries in the collection, storage and use of patient centred healthcare data’. Service providers also questioned the value of their time spent collecting and submitting data.

[Health Services Union] members report doing ‘hours of paperwork’ … However, they also report a sense of the data ‘going nowhere’ and of ‘systems that do not talk to each other’ so the real benefits of that information, those that can support the delivery of efficient, holistic and individualised care, are not realised. (Health Services Union, sub. 237, p. 12).

To illustrate, a review by the Office of the Auditor General Western Australia found that the Western Australian Mental Health Commission and the Western Australian Department of Health did not use data effectively to manage service delivery and reform. Although they knew the volume of mental healthcare being provided, they did not know how many people accessed care, or if they were using services as intended (OAGWA 2019). This was because they were tracking the number of times a service was delivered, not who was using a service. The review found that by:

Focusing on each discrete activity in the mental health system, rather than how people use services … the MHC [Mental Health Commission] lack[ed] some of the information needed to effectively quantify demand, prioritise investment and demonstrate its expected benefits. (OAGWA 2019, p. 10)
Inquiry participants provided other examples of underutilised datasets in response to an information request (box 24.4). Although no particular dataset stood out, the feedback is evidence of a widespread problem.

There are three key reasons why datasets are being underutilised.

First, datasets are underutilised because of restrictions on access and use (Murrumbidgee Primary Health Network, sub. 1199; WentWest Limited, sub. 445). For example, the NMHC (sub. 118) and the Australian Institute of Health and Welfare (AIHW) (sub. 370) remarked that although data on individuals with psychosocial disability who access the NDIS is collected, it is currently not available for reporting on. The Victorian Government (sub. 483) stated that there are opportunities to improve data sharing between the Australian, State and Territory Governments to better inform service delivery. Service commissioners can also face barriers to accessing timely data that could be used to inform regional assessment and planning (Murrumbidgee Primary Health Network, sub. 1199). Further, restrictions can limit research opportunities, and the ability for consumers to make informed decisions and exercise choice (WentWest Limited, sub. 445).

More specifically, access issues can be caused by privacy legislation, health legislation and a ‘culture [in health] that prioritised the protection of data, rather than promoting its use to improve program design and service delivery’ (PC 2017a, p. 538). For example, under the Privacy Act 1988 (Cth), health information is considered a particularly sensitive type of personal information and there are additional requirements for its protection (PC 2017a). However, a risk averse culture that avoids sharing and releasing data can be an even greater barrier to data access. Parts of the public sector remain reluctant to share data (even when genuine legislative barriers do not exist) due to fear that data would be misused or misinterpreted (PC 2017a).

Second, the low quality of data can limit its potential use (MHCT, sub. 314; Suicide Prevention Australia, sub. 1189). Data can be considered low quality and unsuitable for further analysis if it is unreliable, incomplete, inaccurate or inconsistent. For example, Suicide Prevention Australia (sub. 1189) reported that data collected on suicidal ideation and behaviour presentations in emergency departments varies significantly in its completeness and quality. In their view, this data cannot be reliably used to inform suicide prevention policy and services because of non-standardised definitions and classifications.
Box 24.4  **Examples of underutilised datasets**

The Independent Private Psychiatrists Group (sub. 473, p. 2) highlighted the poor use of outcomes data collected.

Outcome measures have been collected in both the public and the private mental health sectors for around 15 years. Unfortunately, no significant use has been made of that outcome measurement data, since its inception. Useful data are available in those databases, and is available to both the Commonwealth and State and Territory governments, which could guide the type of service systems that need to be developed and implemented.

The Australian Institute of Family Studies (sub. 753, p. 14) said existing longitudinal datasets can support mental health research, but are underutilised.

… there are a number of longitudinal datasets that are used to examine issues related to mental health, including [the Longitudinal Study of Australian Children, Building a New Life in Australia], the Australian Longitudinal Study on Women's Health, [Ten to Men: The Australian Longitudinal Study on Male Health and the Household, Income and Labour Dynamics in Australia survey]. Overall, these data assets are under-utilised in relation to mental health research for numerous reasons, including:

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

Grow Australia (sub. 847, p. 19) said that a lot of data is publicly available at the national level, but underutilised, because reporting is too high-level and is not analysed effectively.

… the reality is that there are significant amounts of data which are publicly available but unused (not analysed) or which can be extracted from existing data sets if the right questions are asked of the data custodians (and of course sometimes this involves additional costs). Yet while the data are available, much national reporting currently does not go into the level of granularity which is available through effective analysis and hence the magnitude of the impact and prevalence of behaviours, barriers and activities for particular age groups (e.g. children and young people) or specific at risk groups (e.g. LGBTIQ) can be masked and diluted by population-wide approaches.

Participants stated that there are developed private sector datasets that could be better utilised.

Medicare subsidised psychology sessions have not been fully evaluated to date because outcome monitoring has not been mandated and there is no public dataset. One dataset that taps into private psychology outcomes is NovoPsych’s longitudinal data (over 150,000 patients). This provides an opportunity to undertake an evaluation of this [program] right now. NovoPsych is yet to statistically evaluate broad outcomes but would be happy to do so with a partner. (NovoPsych Pty Ltd, sub. 645, p. 4)

Before new outcome measures and quantitative monitoring programs are suggested, we would strongly support the idea of actually using the data that is already available. We note as a starting point, that there is still no exact number for consumers treated in the public system in Australia. On the contrary, there is an exact number of Australians being treated by the private sector which is well known and has been documented for years. (Independent Private Psychiatrists Group, sub. 742, p. 17)

Third, some datasets, on their own, provide insufficient information to be useful for informing decision making. Participants highlighted that many do not provide valuable insights and information (One Door Mental Health, sub. 856; QMHC, sub. 228). For example, the Queensland Mental Health Commission (sub. 228, p. 12) stated:

… it is often difficult to gain meaning from the data that enables a clear understanding of the outcomes and impacts of policies, programs and investments. Measuring outputs or comparing
health expenditure alone provides no insight into achieving the best outcomes for people or providing the evidence-base for a future course of action.

Data linkage

A significant weakness of the existing evidence base is that many datasets sit in isolation from one another. On their own, they provide limited insights on how policies, programs and services can be designed and enhanced to meet consumer and carer needs, and improve outcomes. The AIHW (sub. 370, p. 4) stated:

… the mental health sector’s information activities necessarily reflect Australia’s federated model of funding and delivery of the health and welfare sectors, and is fragmented. Consequently, there is no single ‘unified information system’ with consistent definitions and structure which policymakers and researchers can use to assess whether programs and support services are ‘making a difference’ and effectively supporting Australians living with mental ill health or experiencing mental health issues.

Data linkage techniques can improve data use by extracting more information from existing datasets. By matching records on the same individuals contained in different datasets, richer insights can be gathered (PC 2017a). For example, the Australian Government’s Multi-Agency Data Integration Project provides insights into the employment status of sub-groups of people with mental illness who use Medicare Benefits Schedule (MBS)-rebated mental health services. It demonstrated that individuals with low education, who were unemployed and living in regional areas, were less likely to be prescribed talking-based therapies and more likely to be prescribed medication (NMHC, sub. 118).

Reviews of the mental health system have consistently highlighted the significant potential for data linkage to improve data analysis (KPMG and Mental Health Australia 2018; NMHC 2014b; Nous Group 2018c). Many participants also highlighted its potential (AIHW, sub. 370; MHCT, sub. 314; NSW Government, sub. 551). Broadly, better use of data linkage in mental health could enable assessment of:

- consumer and carer outcomes that are realised over a long period of time
- the relationship over time between the use of services in one sector (such as psychosocial supports) and outcomes in another sector (such as health)
- the social determinants and predictors of mental illness or self-harm
- an individual’s access to services and pathways of care as their condition and circumstances change.

The extent to which datasets should be linked depends on the evaluation or research questions being asked. If the aim is to evaluate the outcomes of specific interventions, then only data relevant to the intervention’s intended outcomes may need to be linked. For example, linking correctional and health data could help evaluate programs that aim to help ex-prisoners with mental health problems transition back into the community (VAADA and Justice Health Unit 2019).
On the other hand, if the aim is to address broader questions around social determinants and consumer pathways of care, multiple datasets may be required (KPMG and Mental Health Australia 2018). Many participants argued linking health service data with non-health data such as education, housing, employment, social security, employment, justice and NDIS data is essential (for example, Melbourne Disability Institute, sub. 144; NSW Government, sub. 551; PHNs, sub. 377).

However, there are impediments to data linkage that should be reduced or removed, subject to maintaining appropriate protections for individuals.

First, legislative and cultural barriers exist. The complex legislative environment governing the management of personal information and a risk averse culture among data custodians and ethics approval committees can impede greater use of data linkage (PC 2017a). Legislation especially restricts data linkages in health (PC 2017a). For example, MBS and Pharmaceutical Benefits Scheme data is not allowed to be linked routinely. The NMHC (sub. 118) observed that access to the Multi-Agency Data Integration Project is often granted on a project-by-project basis, which can limit access to routine and ongoing analysis. Further, where analysis through data linkage projects occur, results are often not shared or made public, preventing wider learning.

Second, technical complexities can impede data linkage. The AIHW (sub. 370, p. 7) said ‘limitations inherent to administrative datasets can make data extraction, linkage and merging of different mental health datasets challenging in the absence of a nationally agreed linkage methodology’. Further, the Victorian Government (2019a, p. 27) said that ‘changes in sampling methods, methodologies and gaps in data collection reduces [the Victorian Government’s] ability to link data [in mental health]’. The Murrumbidgee Primary Health Network (sub. 1199, p. 10) stated that:

… critical changes to the Primary Mental Healthcare Minimum Data Set are required in order to link service data across a person’s entire mental health service journey within the Primary Mental Healthcare Minimum Data Set. Currently, individual data is linked to an episode of care that is oriented around the service provider. Therefore, the data of the same individual accessing a subsequent service is not connected.

Notwithstanding, there is scope to improve the use of mental health data by improving its access and quality, and through linkage separate datasets. As a result, the Australian, State and Territory Governments should develop a strategy to improve data usability in mental health. The strategy should consider potential data linkage projects and identify datasets that are underutilised because of restrictions imposed on access and use, or because they are of low quality and unsuitable for further analysis (for example, due to inconsistent definitions and classifications). Subsequently, projects to improve data usability should be prioritised, barriers to implementing projects should be identified and solutions to address them should be developed.
ACTION 24.1 — A STRATEGY TO IMPROVE DATA USABILITY

There is significant mental health data currently collected — but much of it is underutilised.

Start now

The Australian, State and Territory Governments should develop a strategy to improve data usability in mental health and suicide prevention including identifying:

- data linkage projects between Australian, State and Territory Government datasets
- datasets that are underutilised due to access barriers, in particular, access barriers faced by State and Territory Governments and regional commissioning bodies
- datasets that are underutilised due to low data quality, including inconsistent definitions and classifications.

This strategy should identify high-priority projects in consultation with relevant stakeholders, assess the barriers to implementing such projects and develop solutions to address them.

Addressing data gaps

Many participants identified data gaps as impeding efforts to improve system performance (for example, AIHW, sub. 370; NMHC, sub. 118; MHCN, sub. 245). Data gaps limit opportunities to inform policy, program, service decisions and consumer decisions. Their existence is well understood by all governments:

Better data is required to understand the mental health needs and subsequent outcomes for Australians from all walks of life, from all parts of Australia and across their life span … Previous National Mental Health Plans have supported significant investment in measurement and reporting and provided data on many of these issues, but gaps remain. (COAG Health Council 2017a, p. 17)

The data gaps that are most limiting relate to:

- prevalence and service utilisation data that is outdated
- mental health services provided by NGOs and MBS-rebated providers (psychologists and psychiatrists)
- particular demographic groups
- non-health sectors.

Prevalence and service utilisation data is outdated

The main source of population level data is outdated. The ABS *National Survey of Mental Health and Wellbeing* was last collected in 2007. Although the Australian Government recently announced that it will re-establish the survey (NMHC 2019a), the time gap from the 2007 survey is too wide to provide any guidance on the effectiveness of existing
interventions or the need for new measures in particular populations or regions. The Australian Government should ensure the survey is conducted *routinely*, no less than every 10 years. In addition, the survey design should enable consistent comparisons over time. The re-established survey is expected to form a part of the $90 million *International Health and Mental Health* Study, consisting of four surveys on: mental health and wellbeing, health characteristics and chronic health conditions, nutrition and physical activity and various other health measures (AHHA 2019). However, the Australian Government has not committed to undertake these surveys routinely.

Routine national surveys are important because they enable data to be collected on people who do not access mental health services. The 2007 survey found that 65% of people with mental illness did not access a health service for that problem. As such, the survey is essential for planning and monitoring purposes by governments and service providers alike.

Decision making in relation to mental health would benefit by receiving a range of population level data that is much broader than the performance of, and access to specified mental health services. Mental health services only provide service to a very small proportion of the people in the population with poor mental health, and it is important that strategic decision-making is also informed by an understanding of who is not accessing these services, as well as who is. (Anglicare Victoria, sub. 312, p. 25)

A range of participants supported routine national surveys (for example, CHF, sub. 646; ACCI, sub. 1202; SAMHC, sub. 691).

Fundamentally, a national survey on mental health and wellbeing should provide data that is person-centred, outcomes-focused and used to drive improvements. It should allow for:

- the monitoring of changes in prevalence and effects of mental health conditions
- analyses to help decision makers understand patterns of use for mental health and other support services, and their effect on individual outcomes over time.

It should adequately represent demographic groups. Some demographic groups have diverse needs and may be more vulnerable to mental illness. For example, people who identify as LGBTIQ are more at risk of mental illness and self-harm, but there is a paucity of data collected on this community (Mental Health Australia, sub. 864; Senate Select Committee on Health 2015). People from culturally and linguistically diverse backgrounds can face a number of barriers — for example, in some cultures, cultural norms or taboos about mental illness can make people less willing to seek help or have it known that they are experiencing mental illness (chapters 2 and 8). Current framing of data collection may mean mental illness is under-reported for these groups. It is desirable to track mental health outcomes for particular demographic groups to improve program planning and for evaluation purposes.

The ABS should consider methods to improve response rates of people with mental illness, and to ensure demographic groups are adequately represented. This could include the ABS conducting more targeted surveys or oversampling certain demographic groups. A criticism of the previous survey was the low response rate, which may bias survey samples and undermine the validity of results. At the national level, the response rate in 2007 was 60%
(ABS 2007), which was lower than the National Health Survey response rate of 76% (ABS 2019d). The majority of people who refused to participate stated that they were ‘too busy’ or ‘not interested’. Others refused because the content was ‘too personal’ (ABS 2009). Internationally, investigations into low response rates for mental health surveys found people with high levels of mental distress had increased rates of non-response (Torvik, Rognmo and Tambs 2011). Increased rates of non-response may reflect difficulties in locating people, social anxiety and lack of willingness to participate.

The survey should also consider opportunities for linkage with other datasets. As mentioned above, data linkage can provide more comprehensive information from existing datasets, particularly in mental health. A higher response rate would also assist with data linkage.

**ACTION 24.2 — ROUTINE NATIONAL SURVEYS OF MENTAL HEALTH**

Mental health data at a national level needs to be systematically updated over time.

*Start later*

The Australian Government should support the Australian Bureau of Statistics to conduct a National Survey of Mental Health and Wellbeing no less than every 10 years. Its design should enable:

- consistent comparisons over time
- monitoring changes in prevalence and effects of mental health conditions
- analyses to understand patterns of use for mental health and other support services, and their effect on individual outcomes over time.

The survey design should ensure that it adequately represents demographic groups who may have diverse needs and involve consumers and carers in its design. Opportunities for linking the survey data with other datasets should be considered.

Mental health services

At the national level, the development of data collections has largely been based on Leginski et al. (1989), including for mental health national minimum datasets and key performance indicators developed for Primary Health Networks (PHNs) (AIHW 2004; DoH 2016c; box 24.5). To enable adequate performance monitoring of mental health services, the Leginski framework states data collection should determine: who receives what from whom at what cost and with what effect? The Leginski framework is widely applied in practice. For example, the New Zealand Government used it to develop its National Mental Health Information Strategy (New Zealand Ministry of Health 2005).
Box 24.5  **The Leginski framework for monitoring in mental health**

The Leginski framework posits that the performance areas a manager needs to know about are: who receives what from whom at what cost and with what effect?

- **Who receives?** ‘Who’ refers to the clients served by the organisation. Data collected would include demographic and clinical characteristics of mental health consumers.

- **What services?** ‘What’ refers to details of the mental health services delivered. Details include volume and type of service, usually split along the dimensions of staffing, types of client, services, products and costs.

- **From whom?** ‘Whom’ refers to service characteristics and details of the staff, for example, professional training, demographic characteristics and salary. The ‘whom’ should apply to the full organisation and not only those directly involved in providing the services.

- **At what cost?** ‘Cost’ refers to expenditures of the mental health service. Note that cost is primarily driven by two other areas: what services are delivered and by whom.

- **With what effects?** ‘Effects’ refer to the outcomes or benefits of the service. It is frequently assessed in terms of either an improvement in the client’s condition or a prevention of deterioration and requires data such as severity of symptoms and continuity of care.

*Source:* Leginski et al. (1989); New Zealand Ministry of Health (2005).

Despite much data being collected in the mental healthcare system, there remain gaps against what is considered adequate under the Leginski framework. For some key areas of service provision, there is very little or no nationally consistent data collected (figure 24.2). These gaps prevent stakeholders from assembling a comprehensive view and analysing the sector’s inputs, activity, outputs and outcomes. In particular, there are significant gaps in data collected by MBS-rebated service providers and NGOs.

**MBS-rebated service providers**

A lack of data on outcomes for people using MBS-rebated mental health services was a key issue raised by consumers, peak bodies and service providers (box 24.6). MBS-rebated providers (psychologists and psychiatrists) deliver mental healthcare to a large proportion of people seeking support (chapter 12). While MBS data provides some information on activity, data on what services are provided and associated outcomes (from both the provider and service user perspectives) are limited. It would be desirable for services to be funded only if their effectiveness could be evaluated, preferably through outcomes data. The lack of outcomes data and evaluation for MBS-rebated mental health services — which cost the government approximately $1.2 billion per year (AIHW 2019e) — is concerning.
Data gaps in areas of mental health service provision\textsuperscript{a,b,c,d,e,f}

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\textsuperscript{a} A ‘No data’ label shows that no ongoing, nationally consistent, consolidated collection of data exists. \textsuperscript{b} Although there is no data on NGO consumer outcomes, data on consumer experiences is ‘in initial development’. \textsuperscript{c} For GPs and MBS-rebated providers, consumer information on demographics (such as age and gender) is nationally consistent, but no data is collected on diagnoses. MBS-rebated providers are office-based specialists (such as psychologists and psychiatrists). \textsuperscript{d} Although PHN data on consumer experiences is only partially available, data on consumer outcomes is ‘available, but needs improvement’ — PHNs are mandated to collect outcomes data. \textsuperscript{e} Specialised community care includes public community and residential mental health services only. For specialised community care data, data on consumer experiences is partially available, but data on consumer outcomes is ‘nationally consistent’. \textsuperscript{f} Public and private hospital care includes admitted mental health services only (excludes emergency departments). Outcomes data is ‘nationally consistent’, or ‘available, but needs improvement’, for public hospital care and private hospital care, respectively, but data on consumer experiences is only partially available.

Source: Productivity Commission analysis based on Mental Health Information Strategy Standing Committee unpublished data.

In undertaking the MBS Review, the Mental Health Reference Group recommended outcomes measurement be built into the MBS and the Better Access program in particular (MBS Review Mental Health Reference Group 2018). Chapter 12 discusses the potential benefits of embedding feedback-informed practice, involving routine outcomes monitoring.
Box 24.6  **Participant views on the lack of outcomes data**

Inquiry participants raised concerns that data regarding MBS-rebated mental health services is focused on activity, but not outcomes.

… currently the only data to inform planning of MBS funded psychology services relate to activities, not outcomes … Unfortunately, due to the limited administrative requirements for receiving funding for services from the MBS, data are only collected about activity rather than outcomes … As a consequence, decision-makers and funders are unable to make high quality, strategic decisions and, consequently, may be funding inefficient and ineffective services. (ACPA, sub. 359, pp. 32-34)

… the collection of output data still dominates most mental health service level data, particularly in the public mental health sector. State/territory mental health services and Primary Health Networks have adopted what has been described as an ‘audit society’ … that focuses more on the achievement of targets and key performance indicators than the quality of care delivered and clinical outcomes. There is also no requirement for psychiatrists, GPs, psychologists or other allied health professionals to report on outcomes for services delivered under Medicare. (APS, sub. 543, p. 36)

As with primary care more generally, there is little or no collection or analysis of patient-level data on the diagnosis, treatment, and outcomes of Medicare-funded mental health services. (Grattan Institute, sub. 816, p. 6)

… the Australian Government spent $1.2 billion on benefits for Medicare-subsidized (MBS) mental health-specific services … Unfortunately, the data obtained from MBS funded mental health services relate to activities, not outcomes [Medicare Benefits Schedule, 2019]. As a consequence, little is known about the consumers using such services, their diagnoses, symptom severity, level of disability or impairment, social and environmental difficulties, or other information which helps inform treatment planning. In addition, little is known about the actual clinical outcomes of MBS subsidized services on consumers’ mental health and impairment. (MindSpot, sub. 178, p. 4).

**NGO support services**

The NGO sector has grown strongly and delivers a range of community support services to people with mental illness, including psychosocial supports (chapter 17). Expenditure on specialised mental health services grants to NGOs increased ten-fold (in real terms) over the past 25 years — from $43 million in 1992-93 to $438 million in 2017-18 (AIHW 2020c).

However, there is little data collected on NGO activity and performance. Multiple Inquiry participants highlighted this as a data gap (for example, AIHW, sub. 370; DoH, sub. 556; MHCC, sub. 214).

… a clear data gap currently exists in the activity of non-government organisations in providing mental health services, which are not included in national data collections. (DoH, sub. 556, p. 51)

The Australian, State and Territory Governments have begun work to address data gaps in the NGO sector, but substantial gaps remain (Schess et al. 2018). In 2011, the AIHW commenced the Mental Health Non-Government Organisation Establishments national minimum dataset project to collect nationally consistent data on NGOs (DoHA 2013a). Collection was due to rollout nationally in 2015, but only Queensland and Western Australia implemented it — effectively reducing it to a National Best Endeavours Data Set (NBEDS). The national rollout was disrupted by the NDIS, which led to uncertainty about the number of NGOs transferring to disability services and concerns about implementing new reporting
requirements on NGOs while they transitioned to the NDIS. The Mental Health Coordinating Council (Sydney transcript, p. 180) said that limited resources and competing priorities have since prevented some jurisdictions from implementing the dataset.

Ensuring adequate data on mental health-related NGO services is important for two key reasons. First, NGOs account for an important and growing part of the mental health system. Second, collection of NGO data is required for undertaking accurate gap analyses and service planning (section 24.2). Without adequate data on NGO services, it is impossible to monitor, effectively evaluate and research, or plan for mental healthcare provided by NGOs. Gaps in the provision of important services such as psychosocial supports cannot be estimated, let alone filled. The NGO sector does itself a disservice by not ensuring the governments that fund it have quality information on its activities and consumer outcomes.

Although the Mental Health Non-Government Organisation Establishments NBEDS is a good start, it is too output (rather than outcome) focused.

… it would be very helpful for the Commission to recommend that all States and Territories participate in the … [Mental Health Non-Government Organisation Establishments NBEDS] … because at the moment there’s only two states that are collecting that data and it makes it difficult to tell the national story about what the CMO [community managed organisations] sector are delivering if we don’t have national data. Now, there’s some I guess again weaknesses in what would be collected because it would be largely output data but at least it’s a start. (Mental Health Coordinating Council, Sydney transcript, p. 178)

NGOs may also require ongoing guidance to ensure high quality (and useful) data is collected. For example, in Western Australia (where an online portal is used to collect NGO data) a user guide was developed to enhance reporting consistencies and the Western Australian Mental Health Commission maintains a helpdesk to assist NGOs assess their data before submitting (MHCC 2018, 2019). The aim of providing this support is twofold: to improve consistency and quality of data, and to streamline the reporting process to minimise reporting burden.

The Australian, State and Territory Governments should ensure that a national dataset on mental health-related NGO services is established in all states and territories. The data should allow for analyses on how NGOs improve outcomes for consumers and enable accurate gap analysis and service planning. The Mental Health Non-Government Organisation Establishments NBEDS should be considered, however, it may need further development — for example, it could be more outcomes-focused. The AIHW should be tasked and funded to lead this, to ensure nationally consistent data is collected where appropriate.
Demographic groups

There is limited data for demographic groups of interest. For example, there is limited data on the degree to which Aboriginal and Torres Strait Islander people access mental health services and the extent to which their outcomes improve (NMHC 2014b). The AIHW highlighted the lack of data for specific demographic groups as an issue.

Information on the mental health support needs and subsequent support provided to a number of specific sections of Australian society: Aboriginal and Torres Strait Islander people, Culturally and Linguistically Diverse people, Lesbian Gay Bisexual Transgender and Intersex (LGBTI) people, people with experience of suicide, refugees and victims of traumatic crime is not currently available for national reporting purposes. (AIHW, sub. 370, p. 6)

Data that is collected on demographic groups needs to improve. For example, the quality statement for the National Community Mental Health Care Database notes that data on Indigenous status should be interpreted with caution due to the varying quality of Indigenous identification — Indigenous status is missing for 7% of contacts in the dataset (AIHW 2017).

Acknowledging that data gaps exist in mental health, the Australian, State and Territory Governments have tasked the Mental Health Information Strategy Standing Committee with updating the National Mental Health Information Priorities (COAG Health Council 2017a). This should provide strategic priorities for information development over a decade. Work on this is currently underway, with a draft version completed for consultation. The Productivity Commission has consulted with the Mental Health Information Strategy Standing Committee regarding this, and understands data gaps identified as priorities largely align with data gaps identified in this Inquiry. This includes data regarding MBS-rebated providers, NGOs and certain demographic groups, such as people from culturally and linguistically diverse backgrounds and people identifying as LGBTIQ.

However, the National Mental Health Information Priorities is a statement of common intent, rather than a binding prescription for Australian, State and Territory Governments. This means there is a need for greater accountability. To help ensure this, the Australian, State and Territory Governments should commit to developing and adequately funding strategies to address identified data gaps and information priorities in the statement on National Mental Health Information Priorities. In addition, the NMHC should publicly report on progress made against the statement on National Mental Health Information Priorities. The first progress report should be conducted five years after the statement’s release and a second 10 years after the statement’s release.
ACTION 24.3 — ADDRESSING DATA GAPS

High-quality and fit-for-purpose data should be collected to inform decision making and improve service delivery, and outcomes for people with lived experience and carers.

Start now

- The Australian, State and Territory Governments should complete Action 24 in the Fifth National Mental Health and Suicide Prevention Plan to update the statement on National Mental Health Information Priorities (NMHIP).
- The Australian, State and Territory Governments should develop and adequately fund strategies to address identified data gaps and information priorities in the statement on NMHIP. This should include consultation on how best to:
  - collect the data in a way that imposes the least regulatory burden to ensure data is high-quality and fit-for-purpose
  - publish the data in ways that are useful to policy makers, service providers, and importantly, consumers and the public.
- The Australian, State and Territory Governments should ensure a nationally consistent dataset is established in all States and Territories of non-government organisations that provide mental health services. In doing so, they should:
  - ensure data collection focuses on outcomes for people that are valued by them (not just outputs and activity)
  - ensure data collection informs service planning at the regional level
  - adequately fund and provide ongoing support to non-government organisations to collect this data, to ensure the data is of high quality
  - task and adequately fund the Australian Institute of Health and Welfare to lead and coordinate the implementation nationally.

Start later

- The National Mental Health Commission should publicly report on the progress made against the statement on NMHIP, five and ten years after its release. The National Mental Health Commission should highlight which data gaps and information priorities were addressed, which were not and why.

Non-health sectors

There is a dearth of information on mental health outcomes and activity in non-health areas, as highlighted in many chapters of this report, in particular the following.

- Chapter 5 found that large volumes of data is collected by schools on their students, but it remains difficult to assess which of the many varieties of interventions improve children’s and young people’s mental health and wellbeing.
• Chapter 6 reports the absence of a regular, national data collection on the mental health of tertiary students in Australia, with most research into student mental health having been in the form of optional self-reported surveys, mostly of university students.

• Chapter 9 establishes that data recording suicide attempts and ideation are incomplete. And, although data recording suicide deaths are reasonably well reported, it lacks information about individual characteristics, such as physical and mental health history, employment and family circumstances. There is also no consistent reporting of state and territory suicide prevention expenditure and activity.

• Chapter 21 highlights that limited data is available on the prevalence of mental illness across all stages of the criminal justice system for many states and territories.

This section focused largely on national, state and territory data collection. However, data is also important at the commissioning and service provider level. For example, regional commissioning bodies (PHNs or RCAs) would require data to inform their service planning analysis. Organisations delivering services require data to monitor and assess their performance, highlighting areas where improvements are needed. The next section discusses this, with a focus on collecting and using data for monitoring and reporting purposes.

24.2 Monitoring and reporting

Monitoring is essential to improve policies, programs, services and ultimately outcomes. In mental health, the focus needs to be on tracking progress against intended outcomes and the relative performance of different services (Mendoza et al. 2013). In turn, monitoring and reporting activities serve to drive better outcomes through improved transparency and accountability. They act as a catalyst for change by highlighting where there is slow progress or poor performance (Nous Group 2018c).

The need for better monitoring and reporting of system performance has long been acknowledged by governments (Nous Group 2018b). However, commentators noted that current monitoring activities are sub-optimal, providing little information about the state of mental health and mental illness in Australia (Mendoza et al. 2013). This section examines existing monitoring and reporting arrangements, proposes reforms to rationalise and strengthen these arrangements, improve transparency and drive improvements for people experiencing mental ill-health and their carers.

Current arrangements

Roles and responsibilities

There are many organisations that contribute to the monitoring and reporting landscape for mental health and suicide prevention (Nous Group 2018b). This includes both Australian and State and Territory Government agencies (box 24.7).
Government agencies that undertake monitoring and reporting in mental health and suicide prevention

At the national level, several Australian Government agencies undertake monitoring and reporting in mental health and suicide prevention.

- The National Mental Health Commission plays a lead role in monitoring and reporting, and has a mandate to work across all areas that affect mental health. This includes sectors that influence the social determinants of mental health, such as education, housing, employment, human services and social support (NMHC 2017, sub. 118). Under the National Mental Health Strategy, the Council of Australian Governments (2017a) tasked the National Mental Health Commission with monitoring and reporting on the implementation of the Fifth Plan, including annual progress in implementing agreed actions and key performance indicators.

- The Australian Institute of Health and Welfare (AIHW) monitors and reports nationally on public mental health services (AIHW 2019e). It produces annual reports which provide an overview of key statistics and related information in mental health (AIHW 2018b). In particular, it monitors key performance indicators for state and territory mental health services, and trends in Medicare Benefits Schedule and Pharmaceutical Benefits Scheme activity. AIHW’s reporting is constrained by the availability of comparable national data, as most data is sourced from national minimum datasets.

- The Steering Committee for the Review of Government Service Provision reports annually on the Australian, State and Territory Governments’ management of mental health through the Report on Government Services (SCRGSP 2020b). This focuses on state and territory specialised mental health services and mental health services subsidised under the Medicare Benefits Schedule. These metrics cover aspects of equity, efficiency and effectiveness.

- The Australian Commission on Safety and Quality in Health Care reports on the variation of some mental health activity (based on Medicare Benefit Schedule, Pharmaceutical Benefits Scheme and admitted patient care data) through its Australian Atlas of Healthcare Variation reports (ACSQHC 2018a). This data is made available by local geographical level (Statistical Area Level 3), remoteness and socioeconomic status.

State and Territory Governments undertake their own monitoring and reporting activities, although differences exist between jurisdictions. Most jurisdictions use their own frameworks to monitor progress against strategies and service activity. For example, the Western Australian Mental Health Commission monitors and reports on population outcomes and key indicators using data from the ABS, AIHW and Western Australian Department of Health, and its own data (WAMHC 2018a). In Tasmania, monitoring and reporting is limited to national minimum data reporting requirements (TAS DHHS 2015).

Coverage of monitoring

The National Mental Health Performance Framework (NMHPF) sets out the broad architecture for monitoring in mental health (AIHW 2019l). It was developed in 2005 to facilitate a culture of continuous quality improvement in mental health service delivery (figure 24.3). In addition to monitoring the performance of mental health services for consumers and carers (tier 1), the NMHPF highlights the importance of monitoring the social determinants of mental health and broader effects of illness on functioning (tiers 2 and 3).
### National Mental Health Performance Framework, 2020

#### Health service performance (tier 1)

<table>
<thead>
<tr>
<th>Accessible</th>
<th>Appropriate</th>
<th>Continuity of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>People can obtain healthcare at the right place and right time, taking account of different population needs and the affordability of care</td>
<td>Service is a person centred, culturally appropriate, rights-based, trauma-informed and recovery oriented. Consumers and carers are treated with dignity and confidentiality and encouraged to participate in choices related to their care, including reporting positive experiences through PROMs and PREMs</td>
<td>Ability to provide uninterrupted and integrated care or services across programs, practitioners and levels over time. Coordination mechanisms work for mental health consumers, carers and healthcare providers. Care and support is holistic and includes psychosocial and physical dimensions</td>
</tr>
</tbody>
</table>

#### Effectiveness
Care, intervention or action achieves the desired outcome from both the clinical and mental health consumer and carer perspective, as reflected in patient-reported outcomes. Care is based on evidence-based standards

#### Efficiency and sustainability
The right care is delivered at minimum cost and human and physical capital and technology are maintained and renewed while innovation occurs to improve efficiency and respond to emerging needs. Members of the work force receive appropriate support and report positive experiences

#### Safety
The avoidance of, or reduction to, acceptable limits of actual or potential harm (physical or psychological) from healthcare or the environment in which healthcare is delivered. Includes aspects of the safety of care delivered to consumers (including patient-reported incidents and restrictive practices) as well as safety of carers and workforce

#### Determinants of health (tier 2)

<table>
<thead>
<tr>
<th>Environmental Factors</th>
<th>Health Behaviours</th>
<th>Personal biomedical factors</th>
<th>Personal history</th>
<th>Socioeconomic Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, chemical and biological factors such as water, food and soil quality</td>
<td>Attitudes, beliefs, knowledge and behaviours such as patterns of eating, physical activity, smoking and alcohol consumption</td>
<td>Genetic-related susceptibility to disease and other factors such as blood pressure, cholesterol levels and body weight</td>
<td>Factors such as experience of trauma</td>
<td>Income, employment, housing, education and social inequalities</td>
</tr>
</tbody>
</table>

#### Health status and outcomes (tier 3)

<table>
<thead>
<tr>
<th>Deaths</th>
<th>Health conditions</th>
<th>Human Function</th>
<th>Wellbeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age- or condition-specific mortality rates</td>
<td>Prevalence of disease, disorder, injury or trauma or other health-related states</td>
<td>Alterations to body, structure or function (impairment), activities (activity limitation) and restrictions in participation</td>
<td>Measures of physical, mental, social and emotional wellbeing of individuals</td>
</tr>
</tbody>
</table>

Source: AIHW (2019).
Despite the large amount of monitoring and reporting activity, there are gaps in coverage (Nous Group 2018b). While the NMHPF advocates monitoring for all three tiers, in practice, monitoring and reporting largely focuses on the performance of mental health services (tier 1). Currently, much of the data and information development in mental health aims only to refine these indicators (NMHPSC 2013). Further, key performance indicators under tier 1 are reported annually, but indicators under other tiers are not reported at all. It is also important to note that all key performance indicators under tier 1 relate to state and territory funded services only — there are none yet for MBS-rebated services and other services provided by the private sector (AIHW 2020a).

As such, there is scope to extend the coverage of monitoring activities to cover social determinants and the effect of mental ill-health on other outcomes related to people’s functional capacity and recovery (Mental Health Australia, sub. 538), such as the effect of illness on a person’s ability to engage and participate in certain activities.

Rationalising national reporting

Inquiry participants called for some rationalisation of monitoring and reporting activity.

Consideration could be given to rationalising the multitude of mental health-related reporting activities in the interests of creating a simpler, authoritative system. (AIHW, sub. 370, p. 8)

There would be significant benefit to clarifying the different roles of reporting agencies (AIHW, ABS, ROGS, National Mental Health Commission) to reduce duplication and to streamline and enhance the overall reporting and analysis. It is recommended that a single national multilayer reporting and monitoring framework be developed which clarifies and incorporates the different agencies roles. (ACT Government, sub. 210, p. 36)

However, there are sound reasons for tasking different agencies with particular monitoring responsibilities. In part, due to the sheer scale and associated complexities of what can and could be monitored (as illustrated by the NMHPF).

Notwithstanding, there should be greater clarity about roles and responsibilities, namely that:

- the NMHC should lead monitoring and reporting of the performance of the mental health system (all areas that affect mental health including employment and social services), including progress made against reforms (under plans and strategies)
- the AIHW should lead monitoring and reporting on the performance of mental health services (such as those provided by NGOs, GPs and MBS-rebated providers).

The NMHC, AIHW and other Australian Government agencies (principally, the Steering Committee for the Review of Government Service Provision and the ABS) should minimise unnecessary duplication of effort in monitoring and reporting. Reforms to strengthen the roles and responsibilities above are discussed in the next section.
Strengthening monitoring and reporting

Throughout this Inquiry, participants emphasised the importance of a person-centred, outcomes-focused approach to monitoring and reporting (Mental Health Australia, sub. 407; Mental Health Commission of New South Wales, sub. 486; NMHC, sub. 949; RASA, sub. 420). This approach places the individual at the centre, underlining that the overall objective of mental health policy is to improve outcomes and wellbeing for people with mental ill-health. There has been a shift towards person-centred, outcomes-focused monitoring and reporting in health and other areas, such as the disability sector. Examples include the Victorian Government’s *Victorian Public Health and Wellbeing Outcomes Framework* (VIC DHHS 2016b) and the National Disability Agency’s performance framework (PC 2019b).

However, in mental health, a person-centred, outcomes-focused approach to monitoring and reporting has not been achieved in practice. For example, the NMHC (sub. 949, p. 26) stated ‘there is still much to do to move the routine monitoring and reporting focus towards consumer and carer outcomes and include social determinants through a cross-portfolio remit’. Given the importance of social determinants and the effects of mental ill-health on a person’s functioning, a lack of monitoring and reporting on personal factors, such as employment, physical health and income, is a significant shortcoming.

Further, where mental health-related data is collected, and could contribute to person-centred, outcomes-focused monitoring and reporting, it is unclear to what extent it is used. For example, chapter 5 highlights that, in schools data is inconsistently collected and reported, but there is no consistent evaluation of outcomes. This could be in part because mental health is not seen as a key area of responsibility of non-health portfolios. This shortcoming reveals the lack of focus by these portfolios on outcomes for the people whom they are serving. There is considerable scope to strengthen monitoring activities in areas beyond health.

A person-centred, outcomes-focused approach

To achieve a person-centred, outcome-focused approach to monitoring and reporting in mental health, a national agency should lead and coordinate it, and have the remit to do so. The Productivity Commission recommends that the NMHC should undertake this role. Although the NMHC already has a mandate to work across all sectors that relate to mental health, it should give greater emphasis to the social determinants of mental health (such as socioeconomic status), the effect of mental ill-health on people’s functional capacity (such as ability to participate in education and work) and outcomes for people receiving mental health treatment and support services.

The NMHC’s monitoring and reporting role across health and non-health sectors would be better supported through a whole-of-government mental health strategy (action 22.1). Further, giving the NMHC statutory independence (action 22.7) would likely strengthen its monitoring capability. And while the primary motivation of this is to support recommended
evaluation responsibilities, placing it at arm’s length from policy makers and practitioners is likely to better support its monitoring and reporting effectiveness as well.

The NMHC’s Contributing Life Framework offers a broad set of outcomes that captures the type of lives people with mental illness wish to attain and provides a promising framework to determine outcomes that could be monitored (box 24.8). The framework was developed in consultation with users of mental health services and their carers, and identifies areas that are important to individuals’ abilities to lead a ‘contributing life’ (DoHA 2013a). Inquiry participants also highlighted the importance of this.

Consumers can, and want to make meaningful contributions to their communities through social and economic participation. Being able to return to a ‘contributing life’ is a recovery goal for many people who experience mental ill health. (ACT Mental Health Consumer Network, sub. 297, p. 3)

The National Mental Health Commission’s concept of a ‘contributing life’ is insightful in describing what a good life looks like and is based on extensive consultation with people with lived experience. (MHCSA and LELAN, sub. 360, p. 8)

Box 24.8 The Contributing Life Framework

The Contributing Life Framework offers a whole-of-life perspective on mental health. It states that measuring success must centre upon people’s quality of life and the related determinants such as access to housing, education and meaningful employment, and leading a life free from discrimination. The National Mental Health Commission consulted with consumers and carers in developing the framework, which underpins its monitoring and reporting work. As such, it describes what it means to live a contributing life:

… a fulfilling life enriched with close connections to family and friends, and experiencing good health and wellbeing to allow those connections to be enjoyed. It means having something to do each day that provides meaning and purpose, whether this is a job, supporting others or volunteering. It means having a home and being free from financial stress and uncertainty (NMHC 2013, p. 13).

There are five elements of the contributing life framework: thriving, not just surviving; maintaining connections with family, friends, community and culture; ensuring effective care, support and treatment; something meaningful to do; and feeling safe, stable and secure.


The NMHC should monitor progress against outcomes derived from the Contributing Life Framework. This would represent a shift from the current health-centric monitoring under the NMHPF (figure 24.3) toward monitoring of outcomes that are meaningful to consumers.

To operationalise this new approach, indicators for measuring progress against outcomes would need to be chosen. Often a set of indicators is necessary as no single indicator can capture changes in an outcome area. A set of criteria would need to be applied to select effective indicators (PC 2018). An example of indicators to track progress against the Contributing Life Framework outcomes and suicide prevention were identified, based on analysis undertaken throughout this Inquiry (table 24.2).
Table 24.2 **Indicator examples to measure progress against outcomes**

**Thriving, not just surviving**
- Life expectancy gap from premature death among people with mental illness (action 14.1)\(^a\)
- Rates of substance use and smoking among people with mental illness (ABS National Survey of Mental Health and Wellbeing, Cat. no. 4326.0; ABS National Health Survey, Cat. no. 4364.0)
- Rates of obesity, diabetes, hypertension and elevated cholesterol among people with mental illness (ABS National Survey of Mental Health and Wellbeing, Cat. no. 4326.0; ABS National Health Survey, Cat. no. 4364.0)
- Proportion of consumers who received information on physical health and substance use\(^b\)
- Prevalence of mental illness and age of onset\(^c\), prevalence and distribution (by geography) of psychological distress (ABS National Health Survey, Cat. no. 4364.0)
- Proportion of mental health carers who feel weary, angry, worried or depressed due to caring role (ABS Survey of Disability, Ageing and Carers, Cat. no. 4430.0)

**Ensuring effective care, support and treatment**
- Number of people receiving low intensity treatments (the clinical subset of low-intensity treatments as discussed in chapter 12) (AIHW 2020e; MindSpot 2019)\(^d\)
- Proportion of MBS-rebated psychological therapy that is bulk-billed\(^e\)
- Number of people for whom mental health medications are dispensed by age and region, compared to number of people referred for non-pharmacological treatments by age and region\(^f\)
- Proportion of PHN services that are using assessment and referral practices based on Initial Assessment and Referral (chapter 10)\(^c\)
- Proportion of PHN–LHN groupings that have developed joint regional plans and among these, the extent of compliance with their plans (action 23.1)\(^a\)
- Proportion of consumers who experienced reduced clinical symptoms, and are satisfied with care\(^g\)
- Proportion of clinical staff time in community ambulatory mental healthcare services spent on consumer-related activities (chapter 12) (AIHW 2020h, table FAC.42; AIHW, unpublished data)\(^h\)
- Proportion of preschool children who have undergone a comprehensive development assessment, including social and emotional development\(^i\)
- Rates of utilisation of workplace Employee Assistance Programs mental health services\(^j\)
- Proportion of people in correctional facilities with a mental health condition (AIHW 2019r)\(^k\), relative to expenditure on mental health services in correctional facilities\(^c\)
- Proportion of mental health-related emergency department presentations seen on time (AIHW 2019j)
- Rate of readmission to hospital (within 28 days of discharge) (AIHW 2020a)
- Carer Experience Survey collection rates and results to measure carer-inclusive practice (action 18.1)\(^a\)
- Proportion of mental health carers with unmet need for support (ABS Survey of Disability, Ageing and Carers, Cat. no. 4430.0)

**Engaged in meaningful activity**
- Proportion of schools achieving wellbeing outcomes (actions 5.3 and 5.7)\(^a\)
- Proportion of children with mental ill-health disengaged from schooling (attendance under 30%)\(^c\)
- Proportion of teachers completing personal development programs on child social and emotional development and wellbeing (action 5.4)\(^a\)
- Number of people claiming mental health-related worker’s compensation and average time off work for each claim (Safe Work Australia 2020)
- Usage of counselling services for mental health conditions by university students\(^c\)
- Labour force engagement by people with mental illness (ABS National Health Survey, Cat. no. 4364.0)

(continued next page)
### Table 24.2  (continued)

<table>
<thead>
<tr>
<th>Description</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of income support recipients with a mental health condition earning an income, participating in employment support programs, or leaving the payment for employment</td>
<td>Department of Education, Skills and Employment and Department of Social Services data, unpublished.</td>
</tr>
<tr>
<td>Proportion of mental health carers who are not working, but would like to (ABS Survey of Disability, Ageing and Carers, Cat. no. 4430.0)</td>
<td>Source: Productivity Commission analysis.</td>
</tr>
<tr>
<td>Level of consumer and carer participation in the design of policies and programs, to be determined in collaboration with consumers and carers</td>
<td>Department of Education, Skills and Employment and Department of Social Services data, unpublished.</td>
</tr>
</tbody>
</table>

**Maintaining connections with family, friends, community and culture**

<table>
<thead>
<tr>
<th>Description</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of people with lived experience of mental illness experiencing high levels of social exclusion and disadvantage (Housing, Income and Labour Dynamics in Australia (HILDA) survey data)</td>
<td>Department of Education, Skills and Employment and Department of Social Services data, unpublished.</td>
</tr>
<tr>
<td>Experiences of stigma among people with mental illness, including interactions with health workers</td>
<td>Department of Education, Skills and Employment and Department of Social Services data, unpublished.</td>
</tr>
<tr>
<td>Experiences of loneliness among people with and without mental illness (HILDA survey data)</td>
<td>Department of Education, Skills and Employment and Department of Social Services data, unpublished.</td>
</tr>
<tr>
<td>Attitudes among the general population towards people with severe mental illness</td>
<td>Department of Education, Skills and Employment and Department of Social Services data, unpublished.</td>
</tr>
<tr>
<td>Number of people participating in clubhouses, day drop-ins and recreation services</td>
<td>Department of Education, Skills and Employment and Department of Social Services data, unpublished.</td>
</tr>
<tr>
<td>Connection to culture, country, spirituality and community</td>
<td>Department of Education, Skills and Employment and Department of Social Services data, unpublished.</td>
</tr>
<tr>
<td>Proportion of mental health carers who have strained relationships with family or are losing touch with friends due to caring role (ABS Survey of Disability, Ageing and Carers, Cat. no. 4430.0)</td>
<td>Department of Education, Skills and Employment and Department of Social Services data, unpublished.</td>
</tr>
</tbody>
</table>

**Feeling safe, stable and secure**

<table>
<thead>
<tr>
<th>Description</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of people with mental illness in unsuitable housing (AMHOCN 2019b)</td>
<td>Department of Education, Skills and Employment and Department of Social Services data, unpublished.</td>
</tr>
<tr>
<td>Estimated gap in supported housing places (chapter 20) (ABS Australian Demographic Statistics, Cat. no. 3101.0; AIHW 2020h; Siskind et al. 2012)</td>
<td>Department of Education, Skills and Employment and Department of Social Services data, unpublished.</td>
</tr>
<tr>
<td>Proportion of people who are discharged into homelessness (AIHW 2019q)</td>
<td>Department of Education, Skills and Employment and Department of Social Services data, unpublished.</td>
</tr>
<tr>
<td>Gap in Housing First-type places (chapter 20)</td>
<td>Department of Education, Skills and Employment and Department of Social Services data, unpublished.</td>
</tr>
<tr>
<td>Rate (per 100 000 people) of mental health-related incidents that involved a police response</td>
<td>Department of Education, Skills and Employment and Department of Social Services data, unpublished.</td>
</tr>
<tr>
<td>Number of people diverted to appropriate mental healthcare through court diversion programs</td>
<td>Department of Education, Skills and Employment and Department of Social Services data, unpublished.</td>
</tr>
<tr>
<td>Rate (per 100 000 people) of mental health orders made; proportion of cases before mental health tribunals where the individual: attended; had legal representation; or received non-legal advocacy</td>
<td>Department of Education, Skills and Employment and Department of Social Services data, unpublished.</td>
</tr>
<tr>
<td>Proportion of separations, episodes of care and service contacts, where the mental health legal status was reported as involuntary (AIHW 2019i)</td>
<td>Department of Education, Skills and Employment and Department of Social Services data, unpublished.</td>
</tr>
</tbody>
</table>

**Preventing suicide**

<table>
<thead>
<tr>
<th>Description</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of ambulance and police attendances for self-harm and suicidal ideation</td>
<td>Department of Education, Skills and Employment and Department of Social Services data, unpublished.</td>
</tr>
<tr>
<td>Number of hospital attendances of self-harm and suicidal ideation</td>
<td>Department of Education, Skills and Employment and Department of Social Services data, unpublished.</td>
</tr>
<tr>
<td>Rates of follow-up after suicide attempt/self-harm</td>
<td>Department of Education, Skills and Employment and Department of Social Services data, unpublished.</td>
</tr>
<tr>
<td>Number of deaths by suicide per 100 000 people (ABS Causes of Death, Cat. no. 3303.0)</td>
<td>Department of Education, Skills and Employment and Department of Social Services data, unpublished.</td>
</tr>
</tbody>
</table>

**Source:** Productivity Commission analysis.
Although the indicators in table 24.2 provide an example of how monitoring against outcomes could be done in practice, there should be broader consultation with consumers and carers, stakeholders, sector experts and service providers collecting data to inform a final set of indicators.

In doing so, the NMHC should consult with Aboriginal and Torres Strait Islander people to determine what social and emotional wellbeing outcomes and indicators could be monitored. The Aboriginal Medical Services Alliance NT (sub. 434, p. 15) stated ‘there are currently no national [key performance indicators] to measure [social and emotional wellbeing]’ for Aboriginal and Torres Strait Islander people. An established model of social and emotional wellbeing outlines domains or outcomes that are important to Aboriginal and Torres Strait Islander people (chapter 8). The NMHC may need to undertake additional monitoring under this model.

Scope to broaden reporting on mental health-related expenditure

Monitoring expenditure on interventions is necessary for assessing their efficiency relative to alternative allocations. This information is critical for decision makers seeking to improve mental health outcomes by reallocating resources.

There is scope to expand routine reporting of expenditure on mental health, to include sectors outside of health. The NMHC (sub. 118, p. 31) stated:

At present, the [National Mental Health] Commission’s role in monitoring and reporting on mental health reform is somewhat limited due to the fact that mental health activity (and expenditure) is spread across multiple government agencies and the private sector (including individual co-payments), and data on inputs, outputs and outcomes is not always readily available … Currently, available data sits outside the health portfolio, limiting the ability for the Commission as well as other agencies to influence the data that is reported publicly.

Routine reporting of Australian, State and Territory Government expenditure on mental health across all sectors (health and non-health) would be beneficial for several reasons. First, it would enable more complete monitoring and reporting of governments’ response to mental ill-health. For example, the NMHC (sub. 118, p. 32) considered ‘it would be desirable to report expenditure beyond the health portfolio such as in housing, justice, and education’ to obtain a more ‘accurate view of expenditure’. Second, it would better support whole-of-government planning and service integration insofar as portfolios would have better visibility of mental health expenditure in other portfolio areas. This could enable more integrated and holistic service delivery for consumers. Third, it would enhance accountability by increasing transparency over the use of public resources. Finally, this data could be used to inform priority setting of evaluations (section 24.3).

The NMHC should consult with stakeholders and sector experts to determine which additional sectors could be in scope for routine reporting of mental health expenditure. This would include the AIHW, which currently curates, analyses and reports on mental health-related expenditure data, including non-health data, such as, specialist homelessness.
services (AIHW, sub. 370). Additional sectors that could be considered for inclusion in routine reporting include social and human services, education and training, employment and justice. Although these sectors are closely linked with mental ill-health (as discussed throughout this report), in some instances they are not reported on. For example, routine data on mental health expenditure in correctional facilities is not reported (chapter 21). It may also be informative to report on private sector expenditure, such as out-of-pocket expenses.

Cooperation between multiple government portfolios is necessary to collect appropriate data, and pre-conditions should be formalised to encourage such cooperation. Options used elsewhere in government to encourage data sharing between multiple portfolios include: memoranda of understanding, letters of exchange and ministerial agreements (PC 2017a). Further, new data legislation — which will be known as the Data Availability and Transparency Act when it passes Parliament — will formalise data sharing at the Australian Government level and facilitate increased sharing with the states and territories.268 In addition, chapter 22 recommends the NMHC be given legislative powers to make reasonable requests for data from Australian, State and Territory Governments (action 22.7), if necessary.

**Reporting on the progress of mental health reforms**

Reporting on reform progress is important to track whether commitments made in mental health plans and strategies are being met (COAG Health Council 2017a). This includes monitoring progress against action items and outcomes for consumers and carers that the reforms aim to achieve. For example, the NMHC reports annually on progress in implementing the Fifth National Mental Health and Suicide Prevention Plan and performance against its indicator set.

In addition, this Inquiry has made recommendations that may require the NMHC to undertake additional monitoring and reporting of reforms. For example, chapter 23 requires the NMHC to take a more active role in monitoring cooperation between PHNs and Local Hospital Networks (LHNS), to identify PHN–LHN groupings that appear not to be cooperating effectively (action 23.1).

This an important component in national monitoring and reporting, and the NMHC should continue to expand its role in monitoring progress against mental health reforms under the National Mental Health Strategy (action 22.1).

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268 The Australian Government planned to introduce the *Data Availability and Transparency Bill* in the first half of 2020, but this has been delayed due to the COVID-19 pandemic.
Establishing targets for key mental health outcomes

Once governments commit to monitoring and measuring outcomes, the question emerges as to whether they should set specific targets. Targets are a well-established accountability tool. They go beyond measuring dimensions of service performance and into setting ‘the desired standard of performance to be achieved on a given performance indicator’ (AHMC 2009b, p. 86).

There are various advantages in setting targets. At a system level, they can send a clear signal about priorities for system participants and galvanise energy around those priorities (Kelman and Friedman 2009). However, there can be disadvantages. They may excessively narrow the focus of system participants to the goals being measured — only what is measured gets noticed. As a consequence, important aspects of system performance get missed, particularly if system actors shift their effort towards the measured parts (Kelman and Friedman 2009). ‘Gaming’ may be another downside, where efforts are made to improve the statistic being measured without improving the underlying quality of service that is meant to drive that statistic (Kelman and Friedman 2009).

Australia has generally not adopted targets as a means of spurring mental health and suicide prevention reform, with one recent exception. The Prime Minister set a target of zero suicides in Australia, albeit without a date for achievement (Morrison 2019). The Australian, State and Territory Governments have considered targets, but never adopted them. They prioritised setting targets within the first year of the Fourth National Mental Health Plan (AHMC 2009b), but this did not happen. In 2013, the Australian, State and Territory Governments sought advice from its Expert Reference Group (2013, p. 3) on a set of ‘ambitious and achievable national, whole of life, outcome-based indicators and targets for mental health that will be understood by the community and drive systemic change’. The Expert Reference Group (2013) proposed 10 targets, but Governments did not formally agree to them. A subsequent attempt by the NMHC (2014b) to secure agreement from all Governments on a revised set of targets was not successful.

Internationally, there are many targets in mental health — most commonly related to suicide prevention. Experience suggests that targets can play an important role in progressing system priorities, particularly if they are visible to frontline service delivery staff (New Zealand Government Inquiry into Mental Health and Addiction 2018; Scottish Executive 2002; WHO 2013b Global target 3.2).

Many participants believe that well designed and implemented targets could help improve Australia’s mental health system. This involves ensuring that:

- targets reflect sensible and achievable aspirations (Briscoe 2004)

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269 Advocacy for Inclusion (sub. 935); Australian Medical Association (sub. 387); Australasian College for Emergency Medicine (sub. 926); Community Services Industry Alliance (sub. 915); Consumers Health Forum of Australia (sub. 646); Dieticians Association of Australia (sub. 766); drummond street services (sub. 718); Grow Australia (sub. 847); Melbourne Children’s Campus (sub. 927); Mental Health Australia (sub. 407); Mental Health Carers NSW (sub. 1231); Mental Health Commission of New South
- actions demonstrably link to achieving targets (Department of Finance 2015b)
- there is a meaningful baseline for setting targets (AHMC 2009b)
- those responsible for achieving targets are clearly identified and committed (House of Commons Library 2010)
- there is transparency, monitoring and reporting (ANAO 2019).

However, focusing exclusively on quantitative targets can lead to a decline in outcomes that are not easily measured, or to increased effort that improves metrics but not service quality. Kelman and Friedman (2009) suggest various approaches to pre-empting and mitigating unintended responses. In particular, targets based on qualitative evidence, not just quantitative evidence, should be used, and any response to a target needs to be moderated to avoid bias towards achieving that target at the expense of other unmeasured outcomes. For example, it is important to temper responses to newly-introduced targets. Putting a spotlight on areas of poor performance in a system can elicit strong public responses, especially where swift change is unlikely. Mental Health Victoria (sub. 479, att. 1, p. 15) suggested:

… governments and political parties are reluctant to set targets, probably because they are afraid of what happens when they are not met. But without targets, plans … remain aspirational documents full of well-meaning but unfulfilled intent.

The Australian, State and Territory Governments should agree on a set of realistic targets that specify key mental health and suicide prevention outcomes that Australia should be able to achieve over a defined period of time with sustained effort. To ensure these targets are relevant and fit-for-purpose, they should develop a process for setting them that, among other things, involves co-design with consumers and carers, and includes both quantitative and qualitative evidence and data. There could be consideration of targets that have been proposed by previous reports, including those proposed by the Expert Reference Group (2013) and from this Inquiry (Action 14.1).

The Australian, State and Territory Governments should engage Aboriginal and Torres Strait Islander people and the National Federation Reform Council Indigenous Affairs Taskforce in discussions about any targets that may affect Aboriginal and Torres Strait Islander people. Following this collaborative process, they should publish the targets and an explanation of how they were set and will be monitored and reported.
ACTION 24.4 — ESTABLISH TARGETS FOR KEY MENTAL HEALTH OUTCOMES

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

Start now

The Australian, State and Territory Governments should agree on a set of targets that specify key mental health and suicide prevention outcomes that Australia should achieve over a defined period of time.

- To ensure these targets are relevant and fit-for-purpose, they should develop a process for setting them that, among other things, involves co-design with consumers and carers and includes both quantitative and qualitative evidence and data.
- They should engage Aboriginal and Torres Strait Islander people and the National Federation Reform Council Indigenous Affairs Taskforce in discussions about any targets that may affect Aboriginal and Torres Strait Islander people.

Following this collaborative process, the Australian, State and Territory Governments should publish the targets and an explanation of how they were set and they will be monitored and reported.

Service-provider level reporting can enhance service quality

Benchmarking analyses

Monitoring and reporting can lead to improvements in service quality through benchmarking analyses. Benchmarking analyses should aim to drive a quality improvement cycle by enabling services to access regular reports on performance relative to similar services. Benchmarking can be defined as:

… the systematic process of searching for and implementing a standard of best practice within an individual service or similar groups of services. Benchmarking activities focus on service excellence, customer/client needs, and concerns about changing organisational culture. (AHMAC and MHSC 2009, p. 4)

Examples of benchmarking initiatives have emerged in mental health, but it is far from ‘the norm’. For example, the Australian Government Department of Health funds a program called MedicineInsight, which gathers GP data across Australia to inform quality improvements and population mental health outcomes (NPS MedicineWise, sub. 175). The program’s findings are made available to policy makers, health systems and professionals. However, not all GPs participate in the program, with data collected from only 650 GPs. Further, a review of the Australian Mental Health Outcomes Classification Network found that it had improved outcomes measurement, but it had not yet lived up to its initial vision of supporting benchmarking activity (DoH 2011).
Some State Governments have implemented systemic approaches to benchmarking, where central health authorities exist to facilitate and coordinate state-wide benchmarking. For example, the System Information and Analytics Branch in the New South Wales Department of Health has a primary role to support data and information needs of the state’s health system (NSW Health 2017). The branch includes an Information for Mental Health unit that coordinates and facilitates benchmarking of mental health services within the state and provides data to inform policy making by LHNs and the State Government (AHMAC and MHSC 2009; NSW Health 2018a).

Nationally, clinical quality registries (CQRs) provide another model to facilitate and coordinate benchmarking analyses (box 24.9). CQRs systematically monitor quality by routinely collecting, analysing and reporting health-related information (ACSQHC 2014). The information is used to identify benchmarks, significant outcome variance and inform improvements in healthcare quality. They can be managed by one or multiple organisations, and can operate in physical locations or virtually. Currently, CQRs exist for some forms of healthcare (such as joint replacement), but there are no CQRs in mental health. The Australian Government’s Draft National Clinical Quality Registry Strategy listed mental health as a ‘clinical domain priority’ for national CQRs development (DoH 2019c).

There is an economic case for Australian CQRs. An evaluation of five well-established CQRs (prostate cancer, trauma, intensive care, dialysis and transplantation, and joint replacement) found that each led to a significant net positive return on investment, with the benefit-to-cost ratios ranging from 2:1 to 7:1 (ACSQHC 2016a). The Consortium of Australian Psychiatrists and Psychologists (sub. 260) highlighted some overseas examples of mental health CQRs contributing to evidence-based decision making. For example, the Swedish National Quality Registry for Psychosis Care evaluated outcomes based on a nationwide patient registry and identified a reduction in psychiatric beds had likely caused a higher mortality rate amongst patient being treated for severe mental illness.

Benchmarking analyses in mental health can have positive effects on service providers and support quality improvements in services. The National Mental Health Benchmarking Project found benchmarking had helped service providers identify areas for improvement in their business and clinical processes (AHMAC and MHSC 2009). In particular, service providers were better able to use indicators to guide and evaluate service improvement activities, and gain access to a developed knowledge base. A key benefit from the benchmarking project was that it led to a collaborative environment that supported information sharing and learnings from peers.

However, barriers to implementation need to be addressed before the benefits of national benchmarking can be realised. A key issue is data quality (AHMAC and MHSC 2009). In particular, variation in the completeness of provider data (due to variable compliance with data entry) and comparability of data (due to varying protocols, processes and definitions) challenge broader implementation of benchmarking analysis. The evaluation of CQRs also found that issues such as low coverage, inadequate reporting and inadequate collection of information about patient outcomes limits the effectiveness of some CQRs (ACSQHC 2016a).
Clinical quality registries (CQRs) systematically measure and monitor the quality (appropriateness and effectiveness) of healthcare, within specific clinical domains (for example, musculoskeletal disorders or strokes). CQRs routinely collect, analyse and report health-related information, including longitudinal data (ACSQHC 2014) (example below).

Information collected from CQRs can be used to inform improvements in healthcare quality and safety within those domains. In addition to improved consumer outcomes, the use of CQRs can improve compliance with evidence-based guidelines and standards and informs the development of new guidelines and standards (ACSQHC 2014).

To date, there is no overarching Australian strategy to guide and optimise the contribution of CQRs to improved outcomes for consumers and ensure that returns on investment are maximised. However, a national strategy is in development (DoH 2019c). Moreover, there are no CQRs in mental health in Australia. The Australian Commission on Safety and Quality in Healthcare now recognises mental health, especially schizophrenia and major affective disorder, as a prioritised domain (ACSQHC 2016b).

Service providers and Inquiry participants called for the Australian Government to facilitate and coordinate some form of national benchmarking. For example, there was support from service providers to make the National Outcomes and Casemix Collection data available at an organisational level to facilitate benchmarking (DoH 2011). The Australian Psychological Society (sub. 543, p. 36) said that:

… [the society] and its members are committed to being accountable for their work under Medicare and accordingly have submitted to the Department of Health a proposal for an easy-to-use, secure online point-of-service data collection system that could support the delivery of psychological services under Medicare.
The Australian, State and Territory Governments should actively address barriers to implementing national benchmarking, and fund the facilitation and coordination of it. National benchmarking at the service provider level would improve service quality and outcomes for consumers and carers. Although some States (such as New South Wales) have implemented systemic approaches to benchmarking mental health services, it is largely underutilised across Australia. The Australian, State and Territory Governments should consider different models for facilitating and coordinating benchmarking analyses, including through CQRs, or by establishing a central authority to undertake the role (such as in New South Wales). Different funding arrangements should also be considered, including cost sharing models with service providers. Barriers to implementing national benchmarking should be identified and addressed.

Publishing data at a service provider level

Publishing data at the service provider level can also improve service delivery, particularly if it focuses on safety and quality (ACSQHC 2019c). In this chapter, the service provider level refers to mental health service organisations (for example, clinics, centres, hospitals, psychosocial support services, counselling centres), rather than individual clinicians. The benefits would largely be realised through:

- informing consumer choice (consumers are provided more information, enabling them to seek out better performing providers)
- self-improvement by providers (through comparison with their peers).

Although much of the literature shows this level of public reporting rarely influences consumer choice, there is evidence that it encourages healthcare providers to engage in self-improvement activity, largely because of the peer-pressure effect (ACSQHC 2019c; PC 2017b). For example, a systematic review undertaken by the United States’ Agency for Healthcare Research and Quality found that public reporting is more likely to result in improvements in quality, if the clinician or hospital is operating in a competitive market (ACSQHC 2019c).

Despite evidence that public reporting at the service provider level can improve service quality, its use in Australia is limited, particularly in mental health. A notable exception is the recently established National Seclusion and Restraint NBEDS, which provides seclusion rate data across Australia by hospital (AIHW 2019i). The Australian Government developed the MyHospitals website in 2010, to provide accessible and user friendly information about the performance of Australian hospitals (ACSQHC 2019c), however, it does not report any mental health-related indicators. The Productivity Commission has previously found that there was scope to significantly improve the MyHospitals website and recommended improvements (PC 2017b).
The limited availability of mental health data at a service provider level severely impedes self-improvement among providers, and consumer choice. While the Fourth National Mental Health Plan aimed to address this by establishing transparent web-based reporting to compare similar services around Australia (AHMC 2009b), and the Fifth Plan implies that this is important, such data remains unavailable.270

Public reporting of mental health services occurs at the service provider level in other countries. For example, England makes performance data accessible online in formats that enable consumers, families, carers and clinicians to compare the performance of service providers (providing psychological therapies) across domains such as recovery rates and outcome improvement rates (box 24.10). Clarke et al. (2018) found that publishing this data improved transparency, enabled identification of sources of local variability in mental health outcomes and facilitated improvements in service provision. While some provider level data is also publicly available for those providing services in the community, including NGOs (NHS 2020a), it is typically limited to information on access.

In Australia, there are concerns that the mental health sector is not yet ‘ready’ for public reporting and benchmarking analysis (discussed above) at the service provider level. There are claims that this level of reporting could lead to mistrust of relevant providers, that consumers might be confused (because data provides a static snapshot of performance at a given point in time that may not always reflect current performance) or that providers might ‘game’ the system, misreport or distort data to create a good impression, or focus attention on some performance measures at the expense of others (Trauer 2011).271 Some providers want to delay the publication of information on their performance and limit scope for consumer-choice driven quality improvements. For example, NovoPsych Pty Ltd (sub. 645, p. 3) said that ‘[i]n due course standardized approaches to publishing outcome data for public consumption could be developed, providing more transparency when mental health consumers are making health care choices’, but any movement towards this needs to be ‘[led] from within the profession, with an emphasis on self-directed quality improvement’.

270 Actions to provide such data under the Fourth National Mental Health Plan were suspended following the creation of the National Health Performance Authority, which was expected to undertake quarterly public reporting of every LHN (and the hospitals within it), private hospitals and Medicare Locals (COAG 2011). However, the National Health Performance Authority was abolished in 2016, with its functions transferred to the AIHW (AIHW 2016). And although the same goal for making data available was not explicitly included in the Fifth Plan, Action 25 of the Fifth Plan implies it should be, stating ‘Governments will ensure service delivery systems monitor the safety and quality of their services and make information on service quality performance publicly available’ (COAG Health Council 2017b, p. 28).

271 Publication of provider level data initially met with a number of concerns in England. England’s NHS providers considered that publishing such data would adversely impact public trust and professional morale (Adab et al. 2002).
Box 24.10  England’s National Health Service monitoring and reporting

In England, data is gathered from across the National Health Service (NHS) into one place so professionals and the public can easily compare the performance of healthcare and other support services over a range of measures.

The NHS website allows users to compare information for many NHS service providers. Indicator information may cover the quality and safety of a hospital, as well as information about facilities provided, such as the cost and availability of car parking.

The NHS website publishes data on the performance of organisations providing psychological therapies in England under the Improving Access to Psychological Therapies program.

An adapted example of the web interface is provided below.

The development of service-provider level public reporting requirements should certainly involve consultation with both the relevant service providers and consumers to understand the benefits of provider level data for improving service quality and consumer choice. To delay this reporting until service providers feel comfortable with it, however, would be reinforcing the misconception that the (largely publicly subsidised) service providers are more important than the consumers whom they are supposed to be helping. Inquiry participants were supportive of more transparent public reporting, which provides consumers and carers greater visibility over services (CHF, sub. 646; Mental Health Australia, sub. 864).

Transparent provision of data at the service provider level is an essential element of a person-centred mental health system — information that would enable consumers and carers to make informed decisions on care and support options. The public reporting of activity, outcomes and performance data for hospitals, specialists and allied health professionals would be especially informative in this regard (PC 2017b). As a result, the Australian, State and Territory Governments should strengthen and expand commitments to public reporting at the service provider level.
ACTION 24.5 — MONITORING AND REPORTING AT THE SERVICE PROVIDER LEVEL

The Australian, State and Territory Governments should require monitoring and reporting at the service provider level that is focused on consumer and carer outcomes, to encourage improvements in service quality, improve transparency and accountability, and inform consumer choice.

Start now

- The Australian, State and Territory Governments should fund the facilitation and coordination of benchmarking analyses. In doing so, different models of facilitation and coordination should be considered, such as through a national clinical quality registry in mental health or by tasking a central authority. Different funding arrangements should also be considered, including cost sharing models with service providers. Australian, State and Territory Governments should identify and address any implementation barriers.

- The Australian, State and Territory Governments should require all publicly funded mental health service providers (clinical and non-clinical) to commit to public reporting at the service provider level. This would support consumers and carers to exercise choice, and encourage performance improvement by service providers. Lessons from overseas examples should be drawn on, for example, the National Health Service website that is used to inform consumers and carers in England.

Enhancing regional monitoring

Performance monitoring at the regional level

Although data is often available at a state or territory level, it is less available at the finer geographic area at which service decisions are made for the communities where consumers and carers live.

Governments have been working to improve data availability at local and regional levels. Action 1 in the Fifth National Mental Health and Suicide Prevention Plan calls for better integrated planning and service delivery at the regional level, including making data available to inform regional-level planning (COAG Health Council 2017a). To deliver on this, the AIHW is currently working to improve data availability at a more local level (by Statistical Area Level 3 and PHN regions). This has been completed for some mental health datasets already, including residential and community mental healthcare data (AIHW 2019h, 2019k). The AIHW is also developing a single ‘portal’ for a range of datasets (possibly including Medicare, the Pharmaceutical Benefits Scheme and hospital and community mental health services) to support local mental health planning activities (Integrated Regional Planning Working Group 2018a).
The Atlas of Healthcare Variation reports provide some information by local geographical Statistical Area Level 3, however data is limited to information on access to mental health treatments and reporting is inconsistent between annual reports (ACSQHC 2018a).272

At the very least, data must be available and reported at a level that is useful, given regional boundaries of PHNs, LHNs or Regional Commissioning Authorities (RCAs) if established (chapter 23). Which regional boundary should be used depends on the data collection in question and its uses. For example, state and territory data collections should be available at the LHN level, whereas primary mental healthcare data should be available at the PHN level.

Regional-level data is important for two key reasons. First, regional reporting would hold regional commissioning bodies (PHNs or RCAs) accountable to the public. For example, data at the PHN and LHN level is needed to strengthen monitoring and reporting, and evaluation of PHN–LHN groupings (action 23.1). The PHN Advisory Panel (2018, p. 9), which includes several PHN members, supported increased transparency:

> All Panel members agreed that enhanced visibility of the performance of PHNs would be well received, as currently there is limited information publicly available to those outside the PHNs and the Department, despite significant amounts of data being collected by PHNs.

Second, reporting (and collecting data) at regional levels allows for more informed service planning and commissioning by regional commissioning bodies (PHNs or RCAs). For example, the Primary Health Networks Cooperative (sub. 377, p. 13) stated:

> There are rich information datasets at the national and state levels. However, this unfortunately is not consistently the case at regional and local levels, making planning and commissioning processes challenging.

The opaqueness of PHN activities and PHN-commissioned services presents a significant data gap that inhibits integrated planning and service delivery at the regional level.

Reporting data at regional levels also enables planners and researchers to compare experiences across regions with similar demographics and social determinants. This creates opportunities for regional commissioning bodies (PHNs or RCAs) to learn from those that are performing well, and to improve outcomes in their own regions.

> In a country the size of Australia, state by state comparisons are of limited value. It may be far more useful to compare, say, the Barwon and Hunter regions than to compare Western Australia with Tasmania. (Rosenberg and Salvador-Carulla 2017, p. 50)

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272 The 2015 release includes data on GP mental health treatment plans, and dispensing of antidepressant and antipsychotic medicines. However, this data was not included in the 2017 release, and only data on antipsychotic medicines dispensed was included in the 2018 release.
There is an opportunity to strengthen monitoring and reporting at a regional level. The Australian Government should release data collected on and by PHNs for annual publication by the AIHW. The Australian, State and Territory Governments should authorise the AIHW to report all data relating to the performance of mental health services, that it currently reports, at a regional level (as defined by PHN and LHN regional boundaries) in addition to existing reporting at state, territory and national levels. Reporting at regional levels already occurs in health more broadly (for example, the Healthy Community Indicators at a PHN level), and for some mental health datasets, including residential and community mental healthcare data (AIHW 2019h, 2019k).

In addition, the AIHW should ensure this data is readily accessible to the public, including a historical time series, to maximise its usefulness for planning and research. The Australian Government should provide AIHW with additional resources to establish service performance reporting at the regional level and to make this data publicly accessible.

**ACTION 24.6 — REPORTING SERVICE PERFORMANCE DATA BY REGION**

Transparency at a regional level is required to make sure mental health services are meeting local needs.

*Start now*

- The Australian Government should release data collected on and by Primary Health Networks for annual publication by the Australian Institute of Health and Welfare (AIHW).
- The Australian, State and Territory Governments should authorise the AIHW to report all data relating to the performance of mental health and suicide prevention services at a regional level, as defined by Primary Health Network and Local Hospital Network regional boundaries, as well as at a State and Territory and national level.
  - The AIHW should ensure that this data is readily accessible to the public, including as historical time series, to maximise its use for planning and research.
  - The Australian Government should continue to provide AIHW with additional resources to establish service performance reporting at the regional level and to make this data accessible to commissioning bodies and the public.

**Standardising reporting requirements**

Australian, State and Territory Governments should provide national guidance to standardise reporting requirements across regions. This would reduce administrative burdens for service providers and facilitate comparisons on a consistent basis for planning and research purposes.

PHNs have developed their own reporting requirements to monitor services delivered by providers that they commission. This includes ensuring adequate reporting requirements are built into contracts. Although the Australian Government Department of Health discusses
the importance of monitoring and evaluation to commissioning in the *PHN Commissioning Framework* (DoH 2016a), the framework does not provide a standardised approach for reporting, allowing PHNs flexibility to determine their own reporting needs.

As a result, individual approaches have emerged, imposing a sizable administrative burden on some service providers that operate across multiple PHN regions. This can be especially challenging for NGOs providing psychosocial supports across the country (chapter 17), as highlighted by Jesuit Social Services (sub. 441, p. 20):

> … each PHN has different reporting and evaluation requirements, which places a sizable administrative burden on specialist programs such as Support After Suicide. Establishing consistent reporting requirements across different PHNs would help ensure greater efficiency, particularly for service providers with limited resources.

Further, without standardised reporting, it is difficult to systematically compare service performance across regions. This has negative effects on transparency (and accountability) and reduces opportunities for commissioning agencies (PHNs or RCAs) to learn from one another and improve.

Any standardised approach needs to be outcome-focused and needs to allow some flexibility for how outcomes are achieved at a regional level. PHNs are independent organisations, commissioning mental health services to meet the needs of people in their regions, with an aim to improve consumer and carer outcomes. The needs of people in one PHN region can differ significantly from the needs of people in another region. As a result, any standardised approach needs to recognise this, and allow for some regional flexibility on how outcomes are achieved by PHNs. However, at the same time, undue reporting burdens should not be imposed on service providers.

There is scope for both the Australian Government, and State and Territory Governments to consult with regional commissioning bodies (PHNs or RCAs), to develop standardised, outcome-focused monitoring and reporting requirements for the service providers they commission services from. This should ensure undue regulatory burden is not imposed on service providers and facilitate inter-regional comparisons. The Australian, State and Territory Governments should provide guidance and support to all regional commissioning bodies (PHNs or RCAs) to implement this, and monitor and report on compliance.
**ACTION 24.7 — STANDARDISED REGIONAL REPORTING REQUIREMENTS**

Service providers operating in multiple regions should face consistent outcome-focused reporting requirements across those regions.

*Start now*

The Australian, State and Territory Governments should develop, in consultation with regional commissioning bodies, standardised and outcome-focused reporting requirements for service providers. This should ensure undue regulatory burden is not imposed on service providers and facilitate inter-regional comparisons. The Australian, State and Territory Governments should provide guidance and support to regional commissioning bodies to implement this, and monitor and report on compliance.

**Gap analyses using the National Mental Health Service Planning Framework**

The National Mental Health Service Planning Framework (NMHSPF; box 24.11) and its accompanying Planning Support Tool can be used to generate ‘benchmarks for optimal service delivery across the full spectrum of mental health services in Australia’ (University of Queensland 2019, pp. 5, 30).

**Box 24.11 The National Mental Health Service Planning Framework**

The National Mental Health Service Planning Framework (NMHSPF) was developed by the Australian, State and Territory Governments as an action arising from the Fourth National Mental Health Plan. The NMHSPF and its accompanying Planning Support Tool allow users to estimate need and expected demand for mental healthcare and the level and mix of mental health services required for a given population. These estimates can be used to guide strategic planning and future investment in the mental health system at the national, State/Territory and regional level.

The NMHSPF has been used across Australia as a nationally consistent tool for service planning.

The Commonwealth and the states and territories have demonstrated a commitment to the refinement and application of the NMHSPF through the Fifth Plan. The department encourages PHNs and LHNs to use the NMHSPF in their regional planning. (DoH, sub. 556, pp. 42)

For example, in both Tasmania and the Northern Territory — which each have only one primary health network — the State Health Department and the primary health network are collaborating to develop joint regional plans based on the NMHSPF (NT Government 2019; Tasmanian Government, sub. 1242). Both Western Australia and South Australia have used the NMHSPF as a key input into their longer-term strategic mental health plans (chapter 12). And we have used the NMHSPF to estimate service gaps presented in this report — for community ambulatory mental healthcare services (chapter 12), bed-based services (chapter 13), psychosocial support services (chapter 17), housing (chapter 20), and carers (chapter 18).
Comparisons of services ‘on the ground’ with NMHSPF benchmarks (known as ‘gap analyses’) could serve both to guide resource allocation decisions and to hold governments, PHNs, LHNs, and (potentially) RCAs to account for their resource allocation decisions. The Fifth National Mental Health and Suicide Prevention Plan prioritised the first of these functions — it required PHNs and LHNs to use the NMHSPF to guide their joint regional planning. It also required governments to support PHNs and LHNs in their planning and facilitate ongoing improvement of the NMHSPF (COAG Health Council 2017a). However, there have been few efforts to use the NMHSPF to drive accountability. Gap analyses could reveal whether governments, PHNs and LHNs (or RCAs) are allocating adequate funding to particular types of mental health services.

Producing gap analyses requires: access to (and competency with) the NMHSPF; and data about what services are being provided to allow a comparison with the NMHSPF benchmarks.

Access to the NMHSPF is currently limited to PHNs, LHNs and government agencies (Australian Government Department of Health, sub. 556) (although the Productivity Commission recommends that it be made publicly available — action 24.9). Inquiry participants stated that some PHNs and LHNs are still building capability with the NMHSPF.

Much of the relevant data about mental health services on the ground is already collected, but some (such as data on services provided by PHNs) is not published, and some (such as data on psychosocial supports) is not collected systematically. As well, much of the available data does not align with the NMHSPF. To address this:

… the AIHW and the University of Queensland are undertaking work to map data from existing national mental health data collections to the NMHSPF outputs, and enable reporting of these results at the PHN, LHN and SA3 level. Mapping of Medical Benefits Schedule funded services to NMHSPF outputs has already been completed and made available to licensed users. (University of Queensland 2016, p. 6)

Once this work is complete, the AIHW should publish annually data from all relevant sources in a way that aligns with the NMHSPF. This data should be published at a national level, a state and territory level, and a regional (PHN) level. Publishing this data would make it available for use by all governments, by PHN–LHN groupings/RCAs and by service providers, and would improve the transparency of both service provision and gap analyses.

Regional gap analyses

Region-level gap analyses (conducted at the PHN–LHN grouping/RCA level) should form part of the broader joint regional planning process. They should be undertaken each year and published within regional plans. This is consistent with the focus of the Fifth National Mental Health and Suicide Prevention Plan on joint regional planning backed by the NMHSPF (COAG Health Council 2017a) and with the Productivity Commission’s support for regional planning (chapter 23).
Each PHN–LHN grouping should be provided with support to undertake gap analyses.

- The AIHW should ensure timely provision of data about services on the ground to PHN–LHN groupings/RCAs in a format that aligns with the NMHSPF.
- The AIHW should assist PHN–LHN groupings/RCAs that have not developed the capacity to use the NMHSPF to generate NMHSPF outputs.
- The AIHW should verify all completed gap analyses.

Governments should provide additional resourcing to the AIHW to support its expanded role. However, PHN–LHN groupings/RCAs that require the AIHW to generate NMHSPF outputs should fund the AIHW to do so from their own budgets. Governments should expect PHN–LHN groupings to acquire and maintain expertise with using the NMHSPF, and resourcing arrangements should reflect this.

**State/Territory gap analyses**

Timely and consistent gap analyses must also be available to inform government policy development and decision making at a state, territory or national level, and promote transparency. The Productivity Commission recommends that the AIHW undertakes and publishes this analysis for all jurisdictions, including:

- benchmarking of service levels for all types of mental health services included in the NMHSPF (including primary care, community ambulatory care, and bed-based services), at both a state and territory, and national level
- gap analyses, based on a comparison of these benchmarks, with services that are currently provided (where this data is available), at both a state and territory, and national level.

Empowering (and funding) the AIHW to publish gap analyses covering the whole mental health sector for each state and territory, and for Australia as a whole would increase accountability at both levels of government, and provide a necessary basis on which governments could take action to address service gaps and undertake strategic mental health planning.

In addition, for community ambulatory services, all State and Territory Governments should give permission for the AIHW to publish data each year on the amount of time that clinical staff spend on consumer-related activities (with and without the consumer present). This data is crucial to understanding the level of these services that consumers are receiving, and what additional resources are needed to ensure that all consumers receive adequate services (chapter 12). The AIHW already collects this data from the states and territories each year, but it is not published (although all State and Territory Governments, except the ACT, gave permission for the Productivity Commission to publish the data as part of this Inquiry — chapter 12). The AIHW should publish this data side-by-side with its state and territory level resource gap analyses, to make clear that both the ‘resource gap’ and the ‘productivity gap’ need to be addressed for consumers to get adequate services.
ACTION 24.8 — GAP ANALYSES USING THE NATIONAL MENTAL HEALTH SERVICE PLANNING FRAMEWORK

Start now

As work to map data from existing national mental health data collections with National Mental Health Service Planning Framework (NMHSPF) outputs is completed, the Australian Institute of Health and Welfare (AIHW) should annually publish all relevant data on mental health services in a format that aligns with the NMHSPF at a national, State/Territory, and regional level.

Each Primary Health Network–Local Hospital Network grouping or regional commissioning authority should annually report, in their joint regional plan, a gap analysis using the NMHSPF.

The Australian Government, and all State and Territory Governments, should give the AIHW permission to annually publish, at both a national and State/Territory level:

- independent estimates of NMHSPF benchmarks of all mental health services, including psychosocial support services, included in the NMHSPF, at both a national and State/Territory level
- gap analyses based on a comparison of these benchmarks with services that are currently provided (where this data is available)
- data on the amount of time that clinical staff in community ambulatory mental health services are spending on consumer-related activities (with and without the consumer present).

The National Mental Health Service Planning Framework should be improved

While the National Mental Health Service Planning Framework (NMHSPF) is already widely used, it needs improvement. For example, it does not currently cover forensic mental health services (chapter 21). And while it accounts for differences in age distributions when estimating population needs, the NMHSPF leaves it to jurisdictions or local PHN/LHN planners to account for other differences that may affect population needs, specifically the resource estimates for Aboriginal and Torres Strait Islander people and for populations in regional and remote areas.

The benchmarks from the NMHSPF are sensitive to certain assumptions in the model, which are more optimistic than the actual rates ‘on-the-ground’. Chapter 12 highlights this issue in discussing how much time community ambulatory staff spend on consumer-related activities, which is significantly less than the targets used in the NMHSPF. Benchmarks for acute beds rely on assumptions about occupancy rates and readmission rates that are similarly optimistic.

The NMHSPF does not deal well with substitution between types of care. When considering the required level of one service, the NMHSPF assumes that all other services are at their
required levels. For example, if a State Government decided to provide more non-acute beds in the community than recommended by the NMHSPF, this would not change the number of sub-acute beds in hospitals that would (according to the NMHSPF) be needed to meet population needs. The Consortium of Australian Psychiatrists and Psychologists (sub. 882) argued that Australia needs more hospital beds than suggested by the NMHSPF, and raised concerns with assumptions related to how demand for hospital services are affected by the provision of services in the community, and to the optimal split between community and hospital non-acute beds.

Participants have also questioned whether the NMHSPF is flexible enough to account for large temporary shocks to population mental health — such as natural disasters or recessions. This flexibility is particularly important for the COVID-19 pandemic, with the threat of infection, social distancing rules and the consequent economic downturn and job losses all expected to adversely affect people’s mental health.

Work is underway to improve the NMHSPF.

The Australian Department of Health (in conjunction with State and Territory Governments) has commissioned the University of Queensland to undertake a program of work to further develop and refine the NMHSPF. Priorities for development include revising the epidemiology of the NMHSPF to incorporate the latest evidence and refining the care profiles of the NMHSPF to better account for the needs of key populations including Aboriginal and Torres Strait Islander populations and people living in rural and remote areas (Australian Government Department of Health, pers. comm., 24 March 2020).

We support these efforts to make the NMHSPF more accurate and useful.

Greater transparency is needed

The NMHSPF (and the Planning Support Tool) are not publicly accessible, although some documentation is published (NMHSPF 2017). This limits ‘external scrutiny of regional service planning’ (NMHC, sub. 118, p. 30).

The Australian Government Department of Health (sub. 556, p. 42) told us that:

Over 200 users from PHNs, LHNs and state and territory government health agencies have been trained and given access to use the NMHSPF. In 2019, NMHSPF licence arrangements will be expanded to allow access for a broader range of users with a legitimate government role in planning and resourcing of mental health services.

But access is not available to academics, clinicians and other stakeholders for whom the NMHSPF would be valuable. The Consortium of Australian Psychiatrists and Psychologists (sub. 882, p. 18) submitted that:

Because the bases of the assumptions underlying NMHSPF’s modelling of Australia’s bed numbers aren’t publicly available, it isn’t possible to readily engage in a fact-based debate about them.
Greater transparency would allow much needed scrutiny over the assumption and mechanics of the model, and increase trust in the NMHSPF’s output. To this end, we are recommending that the NMHSPF and the Planning Support Tool are made publicly available, along with all supporting documentation.

**ACTION 24.9 — INCREASING THE TRANSPARENCY OF THE NATIONAL MENTAL HEALTH SERVICE PLANNING FRAMEWORK**

The key planning tool used for mental health — the National Mental Health Service Planning Framework (NMHSPF) — should be transparent to facilitate its improvement.

*Start now*

The Australian, State and Territory Governments should enhance and make all parts of the NMHSPF publicly available, including the Planning Support Tool and all supporting documentation.

*Start later*

Over time, the NMHSPF should:

- be able to account for substitution between types of care
- be expanded to include forensic mental health services
- be made more flexible so that it can account for large but temporary ‘shocks’ to population mental health, such a natural disasters, epidemics or recessions.

### 24.3 Evaluation

Monitoring and reporting alone may not be enough to drive improvements in policy, programs and services, but they can underpin evaluation. For example, in some cases, monitoring can inform evaluation and research priorities by revealing weaknesses or problem areas, but by itself, cannot provide reliable information on the effectiveness and efficiency of interventions. The Mental Health Commission of New South Wales (sub. 486, p. 13) said that ‘robust monitoring of investment and person, community and service outcomes, needs to be matched by robust evaluation systems’.

Evaluation is the systematic process of collecting and analysing information to enable an assessment of an activity, project, policy or program (PC 2019a). Good evaluations generate valuable information and contribute to a wide range of initiatives and objectives (HM Treasury 2011). In particular, they can: provide reliable information on the effectiveness and efficiency of programs; inform the development of new programs and improve existing ones; and promote accountability by enhancing transparency. Evaluation can improve the effectiveness and efficiency of governments’ multi-billion dollar investments in mental health, securing better outcomes for people using services and programs, and their carers.
Current arrangements

Apart from some notable exceptions, program evaluations in mental health across Australia are, for the most part, ad hoc, uncoordinated and lacking in objective evidence.

Some State Governments have developed their own evaluation capability. Notably, the Western Australian Mental Health Commission established a Performance, Monitoring and Evaluation team to manage datasets and undertake system evaluations (WAMHC 2016a). In addition, it employed a full-time evaluation officer to support the State’s Suicide Prevention 2020 strategy (Western Australian Mental Health Commission, sub. 259). The role includes coordinating external evaluations and evaluating projects, as well as the overall strategy.

However, participants noted that Australia generally has a lack of routine program evaluation and evidence gathering to inform funding allocations and program improvements in mental health. The Mental Health Commission of New South Wales (sub. 486, p. 13) observed that:

There is limited insight into costs, benefits and quality of services across the whole care economy. This lack of information is a challenge to informing decisions to strengthen prevention, early intervention and care in a community setting, and for evaluating the financial and human benefits.

And where evaluations are undertaken, it is not clear if they are used to improve programs.

There are significant concerns that, when service evaluation raises issues regarding the efficacy of that service, this has not necessarily resulted in changes in funding or changes in the service model to ensure high quality, high value service delivery. (ACPA, sub. 359, p. 34)

There are multiple reasons for the lack of program evaluations. First, levels of program funding may be insufficient (Borzycki 2005). Evaluation is resource intensive, which Anglicare Victoria (sub. 312, p. 27) noted makes it hard to obtain sufficient funding:

… despite the obvious benefits for system-wide learning … It remains the case that when negotiating costs with funding bodies, including governments, evaluation is often the first casualty.

In addition, there are weak incentives for program funders and managers to prioritise evaluations. For large, long-standing programs in particular (such as Better Access), the incentives may be weakened by potential political risks. Such programs may be seen as an accepted part of service delivery, with strong opposition to any proposed changes that might flow from evaluations (Anthony Jorm, sub. 45). In other situations, programs end because of changes in political priorities, creating no incentive or funding to evaluate the de-funded program, even when there are opportunities to extract key lessons for future program design.

Moreover, the benefits of some mental health programs are likely to be realised in other sectors (or portfolios), possibly many years later. The AIHW (sub. 370, p. 5) noted this:

Some outcomes are not observed or cannot be observed while a program is operating as they require generational change. Early childhood education is a good example — some of main benefits of early childhood education are not apparent until participants are teenagers.
Benefits that are largely realised in the long term and in other sectors (or portfolios) dull incentives to evaluate programs in the short to medium term (Knapp and Iemmi 2016).

Inquiry participants were also concerned that current approaches to program evaluations:

- lack transparency, accountability and independence (RANZCP, sub. 385)
- are not shared more broadly within government to support improvement (Mental Health Commission of New South Wales, sub. 486)
- do not provide meaningful findings due to funding constraints (One Door Mental Health, sub. 108)
- are not prioritised — there is a lack of funding for formal evaluation of programs or services and external evaluations are not always funded as part of service agreements (Northern Territory Mental Health Coalition, sub. 430).

The NMHC should lead evaluations nationally

While the lack of evaluation could be addressed at a state, territory and regional level, this is only a partial solution. It would unlikely lead to nationally consistent datasets, which would limit consistent comparisons across states and territories, and between regions. It would also make it harder to learn about ‘what works, and what does not work’ on a national scale.

On the other hand, assigning responsibility for program evaluations to a national body could address many shortcomings by ensuring consistency in data, evaluations and learning. Although Inquiry participants did not call for the establishment of a national evaluation body, they did highlight the need for a more structured approach to evaluation (APS, sub. 543; Anthony Jorm, sub. 45). Suicide Prevention Australia (sub. 523, pp. 9–10) highlighted the importance of ‘working toward nationally consistent and reportable evaluation practice’ across the system.

For these reasons, chapter 22 recommends that a national body — the NMHC — be tasked with leading evaluations of mental health and suicide prevention programs. This includes programs funded by Australian, State and Territory Governments, and programs in non-health sectors that have strong links with mental health outcomes. Chapter 22 discusses the recommended role of the NMHC in more detail, but broadly, the NMHC is expected to evaluate aspects of the system that are of national significance or that relate to multiple jurisdictions. This would involve close consultation with jurisdictions to discern where and when the NMHC could best add value.

Expanding the NMHC’s functions to include evaluation would also complement and strengthen its role in monitoring and reporting. As mentioned above, monitoring can underpin good evaluation — it can reveal weaknesses in areas of the mental health system that need further investigation, identifying areas where evaluation should be prioritised. The NMHC (sub. 949, p. 26) stated that a ‘monitoring, evaluation and reporting function’ would mean
ongoing and continuous monitoring is reinforced, in addition to the periodic evaluations and the scheduled reporting’.

**ACTION 24.10 — STRENGTHENING MONITORING AND REPORTING**

Monitoring and reporting should be more focused on consumer and carer outcomes, and broadened beyond health portfolios.

*Start now*

- The National Mental Health Commission (NMHC) should lead monitoring and reporting on mental health and suicide prevention outcomes, activities and reforms across portfolios. This includes monitoring and reporting on:
  - outcomes derived from the Contributing Life Framework for people with mental illness, their carers and suicidal behaviour annually
  - mental health and suicide prevention expenditure (including in non-health sectors), with the NMHC to determine frequency of reporting
  - the progress of mental health reforms (including strategies and plans) annually.
- The NMHC should consult with stakeholders, including consumers and carers, Aboriginal and Torres Strait Islander people and sector experts in finalising a set of indicators to monitor and report on progress against outcomes derived from the Contributing Life Framework.
- The NMHC should consult with stakeholders and sector experts to identify mental health related expenditure in non-health sectors, such as justice and education, that could be routinely reported on.
- The NMHC should continue to monitor and report on progress against mental health reforms under the National Mental Health Strategy.
- The NMHC’s monitoring and reporting activities should inform and support its recommended evaluation function (Action 22.7).

**Evaluations that reveal program effectiveness**

Evaluations should support learning, evidence-based decision making, improvements in programs and service delivery, and inform policy decisions. However, some approaches to program design, implementation and data collection limit the extent to which evaluations can support these aims. For example, if a program evaluation does not measure the effect of a program, then it cannot conclude whether the program has improved consumer and carer outcomes.
Shifting towards impact evaluations

Where evaluations of mental health programs have been undertaken, they have tended to be ‘monitoring evaluations’. That is, they simply report on how program use and occasionally outcomes vary between participant demographic groups (for example, by age or gender). For example, an evaluation of a program might show that, on average, the mental health of participants in a program improved by 10%, with a higher improvement for women. However, was this improvement due to the program or ‘something else’?

Evaluations of mental health programs are most useful when they reveal the effectiveness or the ‘impact’ of a program. Often, this is best achieved by establishing a control group — a group of individuals who did not participate in the program, but have similar characteristics to those participating in the program. Having a control group is important to establish a ‘base’ to judge the program, providing information on how a program affects outcomes, rather than just an observation of changes in outcomes. For example, the lack of a control group, amongst other aspects, meant that an evaluation of the Better Access program was unable to properly assess program impact (Anthony Jorm, sub. 45). In contrast, a randomised control trial of Mindspot’s web-based, help-seeking navigation tool Link, compared quality-adjusted life years273 gained by the intervention group with a control group (Le et al. 2019; Deakin Health Economics Institute for Health Transformation, sub. 156).

Notwithstanding these comparisons, there will be instances where it is not feasible (or is potentially unethical) to include a control group. In such situations, evaluations need to be planned and implemented using alternative approaches — such as careful measurement of changes in mental health over time, controlling for any other factors that change during the evaluation period.

Evaluating program implementation and progress

Evaluations can also be undertaken earlier on, before programs reach an impact evaluation stage. In particular, there are two types that are considered below.

First, program evaluations can be conducted as a program is being rolled out, to monitor implementation progress and inform improvements. For example, the Department of Industry, Innovation and Science’s Evaluation Strategy includes: ‘post-commencement’ evaluations to identify any issues related to initial implementation, design and delivery of the program; and monitoring evaluations to consider the program’s progress in improving short- and medium-term outcomes (DIIS 2017).

This is important to ensure lessons learned can be used for ongoing improvements in program implementation and consumer outcomes, and to inform the development of new or similar programs. To do otherwise wastes accrued knowledge. For example, interim

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273 Quality-adjusted life year is a measure of disease burden. It is used in economic evaluation to assess the value of medical interventions. One quality-adjusted life year equates to one year in perfect health.
evaluations may identify valuable lessons regarding barriers or challenges to implementation and possible ways to address them, without waiting for the final impact evaluation.

Second, program evaluations can be undertaken to estimate the impact of evaluations before they reach an impact evaluation stage. Research shows that early measurable indicators, that are reliable proxies for likely long-term outcomes of an intervention, can be extremely useful in early evaluations. For example, Athey et al. (2019) found that long-term effects of programs on labour market outcomes can be predicted accurately by combining several short-term treatment outcomes into a ‘surrogate index’.

These types of evaluations can be useful in mental health, given many programs are, for a variety of reasons, defunded before their impact can be evaluated. Inquiry participants highlighted that a number of programs have been stopped due to changes in funding arrangements (Ken Barnard, sub. 924, att. 1; Sharon Blake, sub. 584; Northern Territory Mental Health Coalition, sub. 430). For example, the introduction of the NDIS led to the transfer of funding from several mental health programs to the scheme (chapter 17). Programs can also stop due to changes in government and political priorities (ConNetica 2013). Programs aiming to improve long-term outcomes may not transcend election cycles, and be defunded before outcomes are realised (and evaluated).

For the reasons above, Australian, State and Territory Governments should ensure that evaluation principles (action 22.7) reflect the importance of:

- shifting towards evaluations that focus on measuring the attributable impact of programs (through methods that incorporate control groups), rather than monitoring program outcomes
- promoting processes that enable lessons from program implementation to be determined and disseminated before programs reach their impact evaluation stage.

Evaluate first, rollout later

Some of Australia’s large scale mental health programs have been rolled out nationally, with very little information on which to gauge their likely value and little planning for how to subsequently determine this. Jorm (sub. 45, p. 5) stated ‘[i]t would have been preferable for Better Access and headspace to be trialled on a smaller regional scale with comparisons made with control regions, before a decision was made on national rollout’.

Rolling out programs before trialling and evaluating them can lead to governments funding programs that are not the most effective or efficient way to improve outcomes for consumers and carers. This may arise, for example, where proposed programs have a sound rationale, but may face practical barriers to ‘work’ in practice (such as a lack of appropriately skilled staff). Similarly, a program may work overseas and improve consumer outcomes, but may not work locally without adaption to meet cultural needs or local circumstances. Ensuring programs are trialled and evaluated before they are rolled out nationally provides information on how to improve consumer outcomes in practice.
Further, such an approach would avoid governments becoming unintentionally ‘locked’ into funding unproven programs. If a program is rolled out nationally and then subsequently found to not deliver the intended outcomes, it can be difficult for governments to revert to exploring alternatives.

In some cases, pilot trials are evaluated to have positive impacts, but similar results are not observed when the program is scaled up (ACOSS, sub. 1208). This may occur if the program is not implemented in the same way as the pilot trial. There may be, for example, differences in workforce skills and experiences, or in the characteristics of participants.

There are various strategies to minimise this risk. First, a pilot trial could be progressively scaled up (rather than fully scaled up), as further evaluation and learning comes to light. Second, a particular level of workforce skills and experience (that is aligned with the pilot trial) should be required for the scaled up program. Finally, evaluations of pilot trials should inform eligibility requirements for program participants, to ensure participants in a scaled up program are part of the appropriate target group.

The Australian, State and Territory Governments should fund trials of newly proposed programs and associated evaluations before any program is scaled up — this should be a pre-requisite. Pilot trials are not only a practical way of informing better designed policies and programs, but also a strategy to help governments manage risks and responses to new problems and an avenue for innovation in program design (PC 2017d). There are some examples of pilot trials being used, for example, in suicide prevention (chapter 9), although, concerns have been raised about the implementation of these trials, including that they have been slow and uncoordinated.

**Cost-effectiveness evaluations**

Cost-effectiveness evaluations are necessary to support government decision making on which interventions are most efficient to fund. While multiple evaluation approaches exist, each with their own strengths and limitations, cost-effectiveness evaluations are widely recognised as a useful approach for measuring and comparing the value for money of different health interventions (NICE 2018).

Cost-effectiveness analysis uses an outcome measure (for example, a life year saved, a death averted, or a year free of symptoms) and assesses the cost per unit of achieving it — comparing the cost of different methods to achieve the same outcome. Assessing the cost-effectiveness of interventions can help decision makers ensure the maximum benefits are achieved from limited budgets. Common types of health economics analysis, including different forms of cost-effectiveness evaluations are summarised in the United Kingdom’s National Institute for Health and Care Excellence (NICE) (2014) guidelines manual.

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274 Although results, including comparative results between programs, can depend on the exact outcome measure used.
Cost-effectiveness is different to clinical effectiveness. An intervention may be effective at a clinical level (for example, leading to significant benefits per individual treated), but may have low cost effectiveness if it has a high cost per individual. In this situation, implementing the high-cost intervention may lead to consumers getting less — and less effective — mental health treatment in aggregate compared to them being able to access a range of alternative, more cost-effective interventions. Cost-effectiveness evaluations are key to ensuring that consumers receive the best possible mental healthcare, recognising that health budgets will always be finite. Measuring cost-effectiveness should be a standard element of research into mental health interventions. Allocating funds to cost-effective mental health programs and interventions avoids unnecessary expenditure.

In the United Kingdom, NICE uses cost-effectiveness evaluations to inform its decision making about what mental health interventions, services or programs to recommend (box 24.11). NICE have developed guidelines that provide evidence-based recommendations for health and social care, with several guidelines for mental health and behavioural conditions (NICE 2019).

Economic evaluation plays a significant role in the development of NICE guidelines for evidence-based treatments. Its aim is to ensure that NICE guidelines do not introduce ‘cost pressure[s] into the health and social care system unless … [it] is convinced of the benefits and cost effectiveness of the recommendations’ (NICE 2014, p. 122).

Some participants were concerned that requiring cost-effectiveness evaluations would not be practicable or would be too narrow in their focus. For example, headspace – National Youth Mental Health Foundation (sub. 947) stated that such evaluations can be very complex, and based on many assumptions, which may not be evident until after the program is funded and implemented. Submissions also highlighted that cost-effectiveness evaluations may not consider program benefits that may be realised in the longer term, or in other government portfolios. For example, program costs may be borne by health departments, but costs-savings may be realised by justice agencies (SAMHC, sub. 691, att. 2).

However, NICE’s incorporation of cost-effectiveness into its guidelines shows that it is largely practicable. Further, whether or not cost-effectiveness evaluations include long-term outcomes, or benefits realised in other government portfolios, would depend on the intended outcomes of a program. NICE states that the time horizon for a cost-effectiveness evaluation should be long enough to fully reflect costs or outcomes of programs and take a holistic view, including any cost savings realised by a government agency that did not fund the program (NICE 2014).

The Australian, State and Territory Governments should require all funding applications for mental health programs or interventions to include an assessment of the expected cost effectiveness of the proposed program or intervention. This should inform decision making on how funding should be allocated. To ensure a consistent approach for cost-effectiveness evaluations, the Australian Government, in consultation with State and Territory Governments, should develop a set of general principles and reference cases, as is the case in England.
Box 24.11 The United Kingdom’s National Institute for Health and Care Excellence and its evidence-based recommendations

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care in England. Decisions on how NICE guidance applies in other UK countries is determined by their respective governments. NICE uses the best available evidence to develop recommendations to improve health and social care. Its guidance includes the development of NICE guidelines, which cover clinical, social care, public health and medicines practice. These guidelines are developed for a range of stakeholders, including practitioners, local authorities and service commissioners. Although practitioners are expected to take NICE guidelines fully into account, they are not mandatory.

Multiple NICE guidelines have been developed for mental health and suicide prevention including guidelines for: depression in children and young people, generalised anxiety disorder and panic disorder in adults, common mental health problems and preventing suicide in community and custodial settings. Gyani et al. (2013) found consumers receiving NICE-recommended treatments for depression were more likely to recover compared to those who did not receive NICE-recommended treatments.

The development committee considers the cost-effectiveness of programs and interventions when developing NICE guidelines. This occurs in two stages. First, a literature review is undertaken. If existing economic evidence is inadequate or inconclusive, then a second stage of analysis may be undertaken, whereby economic modelling is conducted. This includes adapting existing economic models or building new models. In general, the committee requires more robust evidence for programs or interventions that have a substantial effect on resources.

The NICE guideline development team are expected to follow a set of general principles and reference cases if economic modelling is required (NICE 2014). This helps ensure a consistent approach for cost-effectiveness evaluation. Reference cases specify the evaluation methods that should be considered, and can differ, depending on whether the intervention focus on health, non-health or social care outcomes. An example is provided below.

<table>
<thead>
<tr>
<th>Element of assessment</th>
<th>Interventions with health outcomes</th>
<th>Interventions with health and non-health outcomes</th>
<th>Interventions with a social care focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perspective on costs</td>
<td>Health and social services</td>
<td>Public sector, societal perspective, other (for example, employer)</td>
<td></td>
</tr>
<tr>
<td>Perspective on outcomes</td>
<td>All direct health effects (including for carers)</td>
<td>All health effects, non-health effects may also be included</td>
<td>Effects on people for whom services are delivered (including for carers)</td>
</tr>
<tr>
<td>Type of analysis</td>
<td>Cost-utility analysis</td>
<td>Cost-utility, cost-effectiveness, cost-consequences, cost-benefit, or cost-minimisation analysis</td>
<td></td>
</tr>
<tr>
<td>Time horizon</td>
<td>Long enough to reflect all important differences in costs or outcomes between the programs or interventions compared</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measuring health effects</td>
<td>Quality-adjusted life years: the EQ-5D is the preferred measure of health-related quality of life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measure of non-health effects</td>
<td>na</td>
<td>Decided on a case-by-case basis</td>
<td>Capability or social care-related quality of life measures</td>
</tr>
</tbody>
</table>

New programs should be cost effective and trialled before being scaled up.

Start later

- As part of their commissioning processes, governments should require all funding applications for mental health programs or interventions to include an assessment of the expected cost-effectiveness of the proposed program or intervention. Allocation of funding should only be considered for programs or interventions that are expected, on the basis of evidence provided in the funding request, to be cost effective. The Australian Government, in consultation with State and Territory Governments, should develop a set of general principles and reference cases to ensure a consistent approach.

- All new mental health programs or interventions should be first trialled as pilot programs, before they can be progressively scaled up. Only pilot trials with positive impact evaluations that have been shown to improve outcomes in practice should be scaled up.

24.4 Research

Research plays an important role in improving the lives of, and outcomes for people with lived experience and their carers. It is an essential component of a well-functioning mental health system because it generates reliable information on which to base decisions and policies. Importantly, it can shed light on the importance of causal mechanisms, such as: what contributes to mental ill-health, what are its effects and why interventions do or do not support recovery. It can provide information on what works best for consumers and carers in terms of the most effective interventions and models of service delivery. While evaluations may inform efforts to improve program effectiveness, research increases the stock of knowledge for devising new policies, programs or services to improve outcomes for people with mental illness and their carers (Mind Australia and CHP 2011).

Roles, responsibilities and funding

Mental health research in Australia is carried out by multiple agents, including academics, clinicians and governments. It is funded by the Australian, State and Territory Governments, philanthropy, the private sector and universities. Governments have set up a number of bodies to administer mental health research funding (KPMG 2018a). The National Health and Medical Research Council (NHMRC), followed by the Australian Research Council and the Australian Government are the main funding bodies for mental health research in Australia — based on the number of publications citing the funder (Pollitt et al. 2016).
Reliable estimates of the total amount of research funding in mental health are unavailable due to the variety of funding sources and differences in reporting. But data from the NHMRC shows it allocated an average of about $103 million per annum (2019 dollars) over the decade to 2019 towards mental health research — with the amount and share (as a proportion of the NHMRC’s Medical Research Endowment Account) increasing over time (figure 24.4). The Australian Research Council provided an average of $15.2 million per annum (about $17.4 million in 2019 dollars) between 2010 and 2014 (NMHC 2014c).

Figure 24.4  

**NHMRC expenditure on mental health research**

2000 to 2019

![Chart showing NHMRC expenditure on mental health research from 2000 to 2019](image)

- **a** The Productivity Commission has inflated NHMRC expenditure to 2019 dollars.
- **b** Percentage of the Medical Research Endowment Account is based on actual NHMRC expenditure figures.

*Source: Productivity Commission analysis based on NHMRC unpublished data.*

Compared to other areas of health and given its contribution to Australians’ total burden of disease, mental health has received relatively less funding from the NHMRC. For example, funding for research in cancer was between 2.2 to 2.5 times larger than for mental health, over the past five years to 2018 (NHMRC 2019c). In contrast, the share of the total burden of disease for cancer (18%) is only 1.5 times larger than that for mental health and substance use disorders (12%) (AIHW 2019b).

However, there are reasons why comparing the share of research funding to burden of disease is not an ideal indicator for a target amount of research funding. For example, funding amounts needed depend on the type of research undertaken, which can differ between areas of health research (Chinnery et al. 2018). Although several submissions (for example, Future Generation, sub. 1118; APS, sub. 543; PRCBHM – University of Newcastle and Society for Mental Health Research, sub. 759) stated that more funding...
should be allocated to mental health research, it is difficult to evaluate and conclude if this is the case, and if so, how much more is needed.

Notwithstanding, the Australian Government has allocated more funding to mental health research in recent years. For example, in the 2018-19 budget, the Australian Government announced $125 million over 10 years to the Million Minds Mental Health Research Mission (through the Medical Research Future Fund), which will be administered by the NHMRC (2019a). Further, in the 2017-18 budget, the Australian Government announced $15 million to support mental health research (Australian Government 2017a), and in June 2017, there was $12 million for Suicide Prevention Australia to establish a National Suicide Prevention Research Fund (Suicide Prevention Australia 2017).

Supporting practical mental health research

Australia’s performance in mental health research is well-regarded. International rankings place Australia in the top five, internationally, in terms of both quantity and quality of research publications (Christensen et al. 2011).

However, there are concerns it is not performing as well as it could to improve outcomes for people with lived experience. There are two main reasons.

First, mental health research has been criticised for being misaligned with both national strategic priorities and current ‘real world’ problems. For example, the intent of mental health policy in the past decade has largely shifted to prevention and promotion, and whole-of-life support, but research in these areas appear to be under-represented (NMHC 2014c). Christensen et al. (2013) found that mental health research funding and publication output has remained largely unchanged, despite significant policy reforms. This has created crucial gaps in the evidence base, particularly for interventions that address ‘real world’ problems (NMHC 2014c).

Inquiry participants highlighted many areas requiring further research (box 24.12). A particular concern is that some mental health treatments have little evidence of their effectiveness (Dalton et al. 2017). Where treatments have been tested and found to work effectively, differing implementation models have led to varying outcomes, compared to the intervention design itself (Skvarc et al. 2018). For example, an intervention may have different effects depending on whether it was delivered by a GP, psychologist, mental health nurse or peer worker. Further, the physical health outcomes of some mental health medications (such as atypical antipsychotics) have been raised as a concern (DUSC 2013; Nasrallah 2008). And, given the very high prevalence of mental illness among transgender people (chapter 2), the lack of research evidence on the longer term mental health outcomes associated with common medical interventions for these people (Nobili, Glazebrook and Arcelus 2018; White Hughto and Reisner 2016) should be addressed.

Recent national and international crises, such as the bushfires during the summer of 2019-20 and the COVID-19 pandemic, have highlighted the need for more research on the effects of...
community crises on mental health. For example, the longer term effect of social isolation on mental health, resulting from COVID-19 lockdowns, are unknown, and the evidence base about mental health risks, and how to manage them under pandemic conditions is limited (Holmes et al. 2020). Information on how such crises can affect mental health would better equip the mental health system to respond, including by providing guidance on how much additional capacity is needed, and identifying how particular cultural needs might best be addressed and where the additional capacity should be focused.

Box 24.12 Participant views on the lack of research about what works

Inquiry participants highlighted various gaps in existing mental health research:

What we particularly lack is research on how to reduce the big risk factors for mental disorders, which are adverse childhood experiences. (Anthony Jorm, sub. 45, p. 4)

The truth is we do not have a great deal of data on the impacts of mental ill-health in Australia and there is a lack of research conducted into the impact of many mental illnesses. (One Door Mental Health, sub. 108, p. 3)

There is a lack of detailed research on the outcomes delivered by community mental health services. (Mind Australia, sub. 380, p. 20)

Given the absence of research in personalised approaches to mental healthcare for anxiety disorders, we also have limited knowledge of how to deliver the right care to the right child at the right time. (Centre for Emotional Health, sub. 384, p. 4)

… there is a need to research best practice community support models to accompany and guide increased investment in this part of the mental health sector. There is currently a paucity of research in this area, and future investment should be evidence informed and based on contemporary trauma-informed and recovery-based approaches. (WAAMH, sub. 416, p. 9)

Rather than piecemeal information on costs of outcomes we need a broader holistic understanding. How do each of the social determinants of health interact and affect individuals? How do we identify earliest practical intervention for an individual? How do we best help those who need guidance to bounce back or to manage? What system is best to provide financial support? Work is good for one’s health but is a sense of wellbeing a workplace responsibility? Where does the workplace fit in? We need more research. (Carolyn Davis, sub. 192, p. 19)

There is limited research in the area of effective programs for Aboriginal and Torres Strait Islanders both mental illness, social disadvantage and who are at-risk or have offended. A strong evaluation process within these services is necessary to better understand what works among this population. (APS, sub. 853, p. 29)

These research ‘gaps’ have arisen, in part, because there are few national mechanisms for prioritising and overseeing mental health research, to ensure it is aligned with policy priorities and challenges faced in practice (NMHC 2014c; State of Victoria 2019) — a ‘top-down’ approach to prioritising research. Most research funded is investigator-initiated (or ‘bottom-up’), meaning researchers (or investigators) propose what research they wish to undertake in their areas of interest. Although targeted calls for research in mental health have been made in recent years, most research undertaken is investigator-initiated.

Further, people with lived experience of mental illness and carers are often insufficiently involved in research. Historically, there have been no mechanisms to involve consumers systematically in prioritising research and across all stages of research (NMHC 2014c). The Royal Commission into Victoria’s Mental Health System found that including people with
lived experience in academic institutions is ‘far from systemic’ and that there is a risk that it can become tokenistic (State of Victoria 2019, p. 410).

Second, commentators have said research generates little evidence that is translated into practice or disseminated widely. The NMHC found that ‘planners and providers of services do not always take account of research and evaluation findings’ (NMHC 2014c, p. 138). An Australian study on the quality of mental healthcare found only 26% of consumers received an evidence-based intervention (Harris et al. 2015). VicHealth and Partners (sub. 131, p. 8) highlighted the lack of evidence-based practice:

Evidence-based prevention programs do exist, but many are poorly utilised. Priority should initially be given to increasing the reach and adoption of those strategies that have been developed locally and evaluated rigorously, especially those that have positive results from randomised controlled trials and economic analyses.

There are several reasons why research evidence is not being translated into practice or diffusing across the sector. For example, research may not be relevant to the needs of policy makers and practitioners, or not presented in a user-friendly format (DoHA 2013b). This is critical for staff who may have little time to read research findings, or assess and determine their relevance to their service settings.

Both these issues are evident in health more broadly. The McKeon Review found that Australian health and medical research is not ‘sufficiently driven by a nationally coordinated set of priorities’ with no ‘nationally agreed mechanism for facilitating this’ (DoHA 2013b, p. 103). Additionally, the review found there was a weak link between research and health policy, and the delivery of healthcare services.

The Australian, State and Territory Governments have recognised these shortcomings and are supporting initiatives to address them. The Fifth National Mental Health and Suicide Prevention Plan’s Action 28 requires the NMHC to lead the development of a national mental health research strategy to improve treatment outcomes (COAG Health Council 2017a). The NMHC has established a steering committee of consumers and carers, government representatives, research funding bodies and prominent researchers, with the strategy to be completed by the end of 2020 (NMHC 2019b). Through its recommended evaluation function (action 22.7), the NMHC would be well-informed about evidence gaps in the sector, and could sponsor relevant research in the future.

Further, the Australian Government’s Million Minds Mental Health Research Mission (mentioned above) seeks to ‘support research that addresses key national mental health priorities’ (DoH 2020c). This includes research into the causes of mental illness, the best early interventions, and prevention and treatment strategies. It applies a ‘top-down’ approach to funding research, aligning research with national priorities. The mission’s advisory panel includes consumer and carer advocates. The priorities for the first tranche of funding included: eating disorders, child and youth mental health, and Aboriginal and Torres Strait Islander mental health and suicide prevention (DoH 2020c).
Additionally, the NHMRC (2019b) recently announced funding for a special initiative in mental health — to establish a national centre for innovation in mental healthcare that will support a collaborative network. The collaborative national network is intended to undertake innovative, high quality implementation research to improve outcomes for people experiencing mental illness. It is expected to be virtual, and involve key institutions and existing networks. Similarly, the Royal Commission into Victoria’s Mental Health System recommended the establishment of a Collaborative Centre for Mental Health and Wellbeing, in its interim report, which is expected to deliver collaborative research, enable research translation and knowledge dissemination, and involve people with lived experience (State of Victoria 2019).

Establishing national research infrastructure and networks that enable coordinated and collaborative research can lead to greater alignment between research and the needs of consumers, policy makers and practitioners, and help achieve translation and dissemination of research evidence (UK Department of Health 2017). Without them, collaboration would likely occur on an ad hoc basis (around programs and grants), rather than sustained over the longer term. They can also engage researchers from different disciplines, which is particularly important in mental health. The social and environmental determinants and effects of mental ill-health warrants interdisciplinary research (State of Victoria 2019).

Inquiry participants highlighted the importance of infrastructure which enables coordinated and collaborative research (Consortium of Australian Psychiatrists and Psychologists, sub. 882; Mind Medicine Australia Limited, sub. 1106). For example, Mind Medicine Australia Limited (sub. 1106, pp. 7–8) stated that:

… a Centre of Excellence [could be established] to maximise and extend our understanding of Medicine-Assisted Psychotherapies … [it] would focus on, among other things: … research into the practical use of Medicine-Assisted Psychotherapies … the development of local trials and participation in global multi-site trials … [and] the education of health sector professionals and medical schools around Australia.

FINDING 24.1 — SUPPORT FOR PRACTICAL COORDINATED RESEARCH

Mental health and suicide prevention research in Australia has largely been misaligned with both national strategic priorities and current ‘real world’ problems, and has generated evidence that is not translated in practice or widely disseminated. As a result, mental health and suicide prevention research appears to be disconnected from policy making, program development, service models and delivery, and desired consumer outcomes.

While Governments have recognised these shortcomings and are supporting some initiatives to address them — including through steps to align mental health research with national strategic priorities and funds to establish a national centre for innovation — more can be done to ensure research is coordinated and making efficient use of research funds.
Establishing a clinical trials network

Currently, fragmentation and poor coordination of clinical trials in healthcare generally and mental health specifically are a source of duplication and other inefficiencies. There is scope to improve existing activity.

Clinical trials test the effectiveness and cost-effectiveness of interventions, often through randomised control trials. They are complex, require considerable methodological expertise and training, and large participant numbers (ACTA 2015). This can be particularly difficult in Australia, given its small and geographically dispersed population (AHRA 2019).

Trials conducted by independent researchers (as distinct from those by commercial organisations) can face inefficiencies to the extent that they rely on coordination between other clinicians and appropriate experts for larger participant numbers and network infrastructure (ACTA 2015). Clinical trials can also ‘waste’ knowledge and expertise when skills and resources are lost at the end of trials, and are not used to inform new trials.

Inquiry participants and commentators have raised concerns that clinical research in mental health can be especially inefficient. This can be due to fragmented network infrastructure and a shortage of willing participants (March et al. 2005), which increases the time that researchers spend coordinating with clinicians and other experts. Research efforts can also be duplicative, resulting in an inefficient use of resources. For example, there are concerns of duplication in suicide prevention research (Suicide Prevention Australia 2018; Black Dog Institute, sub. 306).

To address these deficiencies, clinical trials networks have been developed in other areas of healthcare. These are organised groups of clinicians and researchers who share research infrastructure, enabling them to conduct clinical trials across multiple centres dispersed geographically (ACTA 2015). Their functions include direct coordination and management of trials, data management and statistical analysis, and preserving and sharing knowledge and expertise (ACSQHC 2017a). Dozens of clinical trials networks exist in Australia to date, covering a range of health areas including breast cancer, strokes and kidney disease, and disciplines such as primary care and anaesthesia (ACTA 2015).

The Australian Commission on Safety and Quality in Health Care (2017a) found that clinical trials networks play a key role in the success of clinical trials. Networks can improve structural efficiency, enable long-term sustainability and can enhance the implementation of evidence into practice. However, it also suggested actions to further identify best-practice models of network operation, barriers and enablers to drive the implementation of trial results through networks, and opportunities for greater integration with existing data sources. Overall, it found networks returned a net benefit, estimating a $5.80 return for every $1 invested (ACSQHC 2017a).
Despite the benefits of clinical trial networks, there is no national network for mental health (ACTA 2015). The Australian Clinical Trials Alliance (ACTA) and the Australian Health Research Alliance highlighted the need for a clinical trials network in mental health (ACTA 2015; AHRA 2019). Bupa (sub. 485, p. 14) also called for a clinical trial network in mental health to support more comprehensive and coordinated research:

One barrier to the development of a strong evidence base in mental health care is the lack of a clinical trial network for mental health ... We propose Australia’s first Mental Health Clinical Trial Network be established in partnership with [ACTA] and key mental health research institutes, key partners and stakeholders including patients with lived experience/patient advocacy bodies across Australia. The Clinical Trial Network could focus initially on young people, as this is where the major impact of mental disorders occurs and there has been extensive new clinical infrastructure assembled in recent years in which large scale clinical trials (with subsequent translation of outcomes) are now feasible.

A national clinical trials network in mental health would complement current efforts to improve the efficiency of clinical research in mental health and leverage off existing expertise. For example, NHMRC-funded Centres of Research Excellence in mental health could serve as a platform or ‘nexus’ for a mental health clinical trials network. Further, existing expertise in ACTA including in developing new networks and involving consumers in developing, conducting and reporting trials could provide valuable support (ACTA 2019).

Submissions were generally supportive of a national clinical trials network, but emphasised the need for research to cover all areas of the mental health system, including care provided in community settings (QAMH, sub. 714; Black Dog Institute, sub. 1207). The Productivity Commission agrees with this, but notes that clinical trials networks are not limited to clinical settings. For example, ACTA stated existing networks actively undertake research across a range of settings including acute, non-acute, primary care and community (ACTA 2015). Notwithstanding, a national clinical trials network in mental health must cover all areas of the mental health system, including care provided in the community.

The Australian Government should fund the establishment of a national clinical trials network in mental health. This would improve the efficiency of clinical trials, improve the translation of research into practice and drive better consumer and carer outcomes through higher quality care. This network should consider research across all areas of the mental health system, including care provided in community settings. In developing this network, there should be consultation with relevant bodies, including the NHMRC and ACTA.
A clinical trials network can improve the community alignment and application of mental health and suicide prevention research.

Start now

The Australian Government should fund the establishment of a national clinical trials network in mental health and suicide prevention. This network should consider research across all areas of the mental health system, including care provided in community settings. In developing this network, the Australian Government should consult with bodies that work in this area including the National Health and Medical Research Council, the Australian Clinical Trials Alliance and other relevant stakeholders, including people with lived experience.
### Successful reform requires ...

- There are a range of effective interventions that could significantly improve people’s mental health and the quality of life for individuals, and their carers and families.
- In the long run, economic growth and savings in government expenditure would also follow from a healthier and more productive population.
- Cooperation and commitment by all levels of government, providers over services and supports to people, and workplaces, is essential for success.
- The implementation of major reforms would be strengthened by recommended changes to governance, monitoring and evaluation, and funding arrangements.
- Recommended reforms have been prioritised based on the potential benefits to quality of life, the cost-effectiveness of reforms, reform dependencies and implementation readiness.
- A number of recommended reforms are not priorities but would nevertheless 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.
25.1 The long-term benefits of mental health reform

This Inquiry report presents a comprehensive set of recommended reforms — covering healthcare, community supports and many other areas of people’s lives — that are intended to set the mental health system on a path towards a person-centred model.

If governments commit to implementing all recommended reforms included in this Inquiry report, it would take time to realise the full extent of expected benefits. Working towards a person-centred mental health system would entail changes to policy settings and improvements to services, which, in turn, would support people with mental ill-health to achieve the outcomes that matter to them, and lead to community-wide health and economic benefits (figure 25.1).

Figure 25.1 How mental health reforms benefit the whole community

The mental health system that would result from the recommended reforms would:
- focus on prevention, drawing on the beneficial outcomes for mental health of education, employment and social participation
- improve access to evidence-based self-help resources and online services via a new national digital mental health platform
- facilitate easier access to culturally capable, joined-up and affordable services quickly in the community to prevent a deterioration in mental health
- empower those who need additional care to choose evidence-based services that are relevant to their personal and clinical recovery, and to be supported by service providers to achieve those outcomes
- consistently incorporate the views of consumers, carers, families and kinship groups
- support continuous improvement through monitoring and reporting that focuses on providing service providers and policymakers feedback on outcomes that matter to consumers, carers and families.
Mental health reform would translate into practical outcomes for people with mental ill-health, their carers and their families (figure 25.2). Recovery from mental illness and staying well requires a focus beyond healthcare, and this Inquiry has considered ways to sustain and improve the mental health of people as they interact with psychosocial support, education, justice, housing, and income and employment support systems.

**Figure 25.2 What do reforms mean for people with mental ill-health, carers, families, and the broader community?**

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<thead>
<tr>
<th>People with mild mental illness and those at-risk</th>
<th>People with moderate mental illness</th>
<th>People with severe mental illness</th>
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<tbody>
<tr>
<td>Timely and culturally appropriate access to group therapy and digital treatment options</td>
<td>Greater access to mental health services in the community</td>
<td>Improved access to:</td>
</tr>
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<td>Early intervention, including effective social and emotional wellbeing support in early childhood education and schools</td>
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<td></td>
<td>Practical application of mental health strategies by all employers and tertiary training providers</td>
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<td>• peer workers</td>
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<td>• legal aid and advocacy services</td>
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All mental health consumers, carers, families and kinship groups

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The broader community

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Chapter 4 describes the expected benefits from individual recommendations and actions. This includes both the costs and benefits of many key reforms that the Productivity Commission was able to quantify (appendices I, J and K) as well as other non-quantifiable benefits. This analysis contributed to the selection of reform priorities from among all of the recommended actions. The priority reforms include actions that would result in better use of existing expenditure or that can improve mental health with little additional recurrent expenditure, as well as reforms that, while more expensive, are cost effective when weighed against the potential gains in quality of life and
that should be expanded or trialled. A number of recommended reforms are not priorities but would nevertheless 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.

This chapter describes the expected long-term benefits of the reforms recommended as part of this Inquiry. Section 25.2 examines how the reforms would improve people’s experiences with the mental health system. An implementation plan is outlined in section 25.3.

### 25.2 Looking beyond the numbers

When summed together, the net benefits of implementing the Productivity Commission’s reforms would be substantial. Most of these benefits would be in terms of improvements to the health-related quality of people’s lives. Reforms are estimated to add up to 84,000 quality-adjusted life years — the equivalent of $18 billion per year for Australians (chapter 4 and appendix I). The estimated net benefits for the Australian economy are relatively modest, up to $1.3 billion per year, as a result of increased employment and productivity — equivalent to 0.1% of GDP (Productivity Commission estimate using ABS 2019a).

The relatively small estimate for the economic benefits of reforms is not surprising. First, the analysis does not quantify the longer-term social investment benefits of reforms — that improving an individual’s mental health early in their life can have life-long benefits for both the individual and those they interact with, while at the same time potentially reducing their lifetime demand on Australia’s healthcare system (both physical and mental healthcare). Second, some of the recommended reforms are about addressing deep-seated cultural and societal problems — including stigma and homelessness — and ineffective governance arrangements, or inefficient funding practice. The benefits of these reforms are not readily quantified.

It is difficult to fully appreciate all the ways that the recommended reforms could affect people’s lives by looking at the numbers alone. The examples that follow are fictional, but are a reflection of the many stories in submissions, comments and public hearings that the Productivity Commission has received from people with lived experience of mental illness, their carers and families, and support services throughout the Inquiry. They demonstrate how the recommended reforms could improve access to a range of supports for each individual, their carers and family. These vignettes describe the effects of reforms for people with mild, moderate or severe mental illness and with varying needs for psychosocial and other supports.
Early intervention to support young children and their families

Jessica and Matthew have two children, 3 year old Charlotte and 4 month old Oliver. Matthew has been short-tempered and irritable since Oliver’s birth, and feels that he will never be a good enough father now that he has to divide his limited time between two children. Charlotte has always been a quiet child, but has become more withdrawn in recent months and rarely talks to or plays with other children.

As a result of the recommended reforms, there is enhanced screening for postnatal depression by the child health nurse when Jessica and Matthew take Oliver for his baby health check. The nurse identifies that Matthew is at high risk of postnatal depression, and suggests that he might like to talk with a counsellor (Action 5.1). After speaking with the counsellor, Matthew is relieved to learn that many new fathers feel the same way. He continues to attend counselling sessions and gradually finds it easier to cope.

Jessica and Matthew attend a parenting education program at their local child health centre (Action 5.2). They learn that children’s social and emotional development is best supported through play and reprioritise their busy lives to spend more time playing with Charlotte and Oliver.

Charlotte’s preschool teacher has recently participated in additional training on children’s social and emotional development. She has concerns about Charlotte’s withdrawn behaviour, and seeks advice from a mental health professional. With additional support from her teacher, Charlotte grows in confidence and starts to spend more time playing with her classmates (Action 5.2).

Better support for school students

Nicole is in Year 9 at high school and, until recently, was a very good student. But now she is no longer participating in class and has trouble concentrating. When her teacher asks her about this, she opens up about problems she has been having and that she has been self-harming. Nicole’s teacher is concerned but does not know what to do to get help for her.

As a result of the Productivity Commission’s reforms, Nicole’s school has a wellbeing strategy (action 5.6). As part of the strategy, the school has a wellbeing leader. Nicole’s teacher seeks advice from the wellbeing leader on how to make reasonable adjustments for Nicole in the classroom (action 5.8). The wellbeing leader uses the navigation portal to put Nicole in contact with a mental health service to meet her needs (action 15.2). With Nicole’s consent, the school receives information from her psychologist about the type of support Nicole would benefit from, and implements these suggested supports (action 5.8).

Other teachers reported there were children in the school dealing with issues like Nicole, so the Principal decided to have an evidence-based social and emotional wellbeing program delivered throughout the school (action 5.5). This helped the whole school community get a greater understanding of mental health and know

The annual costs of perinatal depression and anxiety have been estimated at $877 million (chapter 5).

12% of girls and 4% of boys aged 12 to 17 years self-harmed in the previous 12 months (chapter 2).
that effective treatment is available. It also helped Nicole and other students with mental health problems face less discrimination in school.

Nicole’s teacher was also able to learn more about social and emotional development and wellbeing as part of her professional development (action 5.4), which better prepared her for these issues in the future.

Services that support people to achieve their goals

Kim is 24 years old and recently left a traumatic domestic relationship. Money is tight and she finds it hard to make ends meet for her young son and herself. She feels anxious and sometimes overwhelmed by the pressures in her life. She does not have the time or money to go to a psychologist, even though she feels she should.

Anxiety and depression contributed to Kim dropping out of university in the past but she wants to get a post-school qualification to try for a better job and improve her financial security. She is enrolled in an online vocational training course. This time, when she is unable to complete a module, the staff at the training provider are able to provide her with the support she needs to finish her qualification (recommendation 6).

Kim’s GP uses the navigation portal to help her access therapy that would work best for her (action 15.2). She chooses to see a psychologist over videoconference because it is affordable and appointments fit flexibly around caring for her son, work and study commitments (action 12.2).

Mentally healthy workplaces are productive workplaces

Jade is a nurse at a small regional hospital. She works closely with people recovering from mental illness. Her work is highly valued by consumers and co-workers but she often feels stressed and is not sure how much longer she will continue in this line of work.

She is dealing with the trauma and suffering of others daily, making difficult decisions about balancing people’s safety and their independence, and is often exposed to verbal abuse. While the nature of the work is challenging, Jade had been able to manage the risks to her health and wellbeing in the past when she was well supported by her employer.

Jade’s workplace has started having issues with staff retention, recruitment and turnover, which have contributed to a loss of skills and a reduced staff-to-patient ratio. She has less time for non-urgent tasks and feels rushed with clients and their families. There is less capacity for co-workers to provide supervision and support, and she is unable to take as much time off to recharge as she would like.

The government introduces a range of health, governance, funding and monitoring reforms recommended by the Productivity Commission. Gaps in funding for regional services start to close. Changes to the mental health workforce help Jade’s hospital reduce the staff turnover (actions 16.1, 16.2 and 16.7) and make it easier to recruit new mental health nurses (action 16.4).

In addition, Jade’s hospital makes workplace mental health a higher priority and takes risks to the mental health of staff as seriously as physical health and safety.
risks (actions 7.1 and 7.2). Jade’s employer develops a better understanding of what they can do to support staff, and jobs start being redesigned to reduce the risk of staff burn-out. Not only is there greater clarity and guidance, but additional incentives also contribute to change — initiatives that reduce the risks of workplace-related psychological injury are used to lower workers compensation scheme premiums (action 7.3).

As a result of these changes, Jade makes the decision to stay on at the hospital. Her employer has found that by committing to a mentally health workplace, the quality of care provided has improved and costs associated with staff recruitment have declined.

A comprehensive and trusted source for self-help, assessment and referral

Sam went to the GP to have his routine annual check-up, which showed he was in good physical health. While there, he mentions that work has been stressful, he is getting easily frustrated and not sleeping as well as usual. He is starting to avoid catching up with friends, something he used to look forward to. The GP practice nurse assists Sam to complete a mental health assessment using the new assessment and referral tool available on the national digital mental health platform (action 10.4). Sam and his GP then discuss the results.

The tool recommends several options that are likely to meet Sam’s needs, selected from a broad range of treatment and support services. After discussing the assessment results and the service recommendations with his GP, Sam decides that self-help resources available on the national digital mental health platform would be a good option for now. These resources are free, come from a trustworthy source and can be accessed at whatever time suits him best.

Reduced barriers to treatment for mild mental health problems

Angelo is 52 years old and recently had a serious health scare. Within a fortnight he was out of hospital but even though his physical health has improved, he does not feel like himself. He avoids unfamiliar places, finds it harder to concentrate at work and he often needs to step outside alone to calm his nerves. Angelo knows little about mental health and does not feel comfortable seeking help or talking about such things. As a result of recommended reforms, he:

- learns about the benefits of clinician supported online treatment through a public information campaign, and enrols in a service via the national digital mental health platform (actions 10.4 and 11.1)
- feels comfortable enough to speak to his GP at his next check-up and the GP encourages him to keep in contact about his experience with online treatment. Angelo chooses to forward the outcomes data from the online treatment to his GP (action 11.1).

He values clinician supported online treatment because it is discreet and he can use it from home in the evening. He begins to feel better and able to participate more at work and in his community. As a result of this treatment and with a better understanding of his mental health, he has gained a level of protection against mental health problems in the future.
Better mental health can improve physical health too

Omar is 40 years old, has a psychosocial disability arising from his mental illness, and also has diabetes. He lives with his father, Nasir, but often feels lonely, especially since the death of his mother. He has not been able to work or study because of his disability, and finds it difficult to form friendships. Nasir provides Omar with significant emotional support, cooks his meals and helps him to manage his health. However, as Nasir gets older, he is finding it increasingly difficult to continue this role. Nasir regularly attends a community centre where he has friends from his country of origin and occasionally Omar accompanies him.

As a result of the recommended reforms, a psychosocial support worker starts working at the community centre and, after speaking to Nasir, begins to provide Omar with regular support (action 17.3). The psychosocial services become more effective over time as the funding cycle becomes more stable (action 17.1).

Omar slowly builds trust in the relationship with the psychosocial support worker who helps him to better manage his health and everyday activities more independently. Omar starts attending the community centre regularly and volunteers to help in the community garden. The social connections that he forms over time contribute to his mental health improving, and he becomes more proactive at managing his diabetes with the help of a diabetes educator (action 14.1). Nasir also was assisted to support Omar when the psychosocial support worker connected him with culturally capable carer support services available in his local area (action 18.2).

Care planning and coordination before and after discharge from acute care

Alex has been admitted to hospital many times as a result of symptoms related to psychosis. Last time, Alex was discharged from acute inpatient care in a rush to make a bed available for someone else being admitted from the emergency department. The discharge plan did not make adequate arrangements for coordinating his mental healthcare in the community or for somewhere to live.

Alex had no place to stay; he lost his rental accommodation just before he was admitted to hospital. He gave his mother’s address to the hospital but has not communicated with her for years. After being discharged from hospital, he finds temporary accommodation at a homeless shelter, runs out of the medication he was given on discharge from the hospital and soon becomes unwell again. Alex misses his follow-up appointment and the clinical team cannot contact him as he is not staying with his mother. The homeless shelter call the police when Alex starts showing unusual behaviour but, as a result of the recommended reforms, what happens for Alex this time is different.

The police have access to real-time information from mental health professionals (action 21.2). A mental health worker is available to assist the police and paramedics who attend to Alex. There is an alternative to taking Alex to the emergency department, and he is assessed by a clinician at an after-hours service while a peer worker gives him support (action 13.1).

Alex agrees to a voluntary admission to hospital so his medication can be restarted, avoiding compulsory treatment as occurred in the past. During the admission Alex is assigned a care coordinator who takes responsibility for
organising the services in his discharge plan and ensuring there is continuity of care (action 15.4). Care coordination of Alex’s clinical and support needs is made easier by having a single care plan that is shared with his service providers in the community (action 15.3). Importantly, his care coordinator is able to find him housing that integrates with mental healthcare and support to maintain his housing (action 20.3).

Care that considers the needs of the whole family

Michelle is a single mother who lives with a longstanding depressive disorder and has three children under the age of 14 years. Her eldest child oversees the housework, provides emotional support to Michelle, helps the other children with their homework, and sometimes misses school as a result of these responsibilities.

As a result of the Productivity Commission’s recommended reforms, Michelle’s treating clinician has received additional professional training that enables her to provide care that considers the needs of Michelle’s whole family (action 18.1). As a result, Michelle has been provided with access to psychosocial supports that assist her in carrying out activities of daily life made more difficult by her depression (action 17.3). This reduces the caring responsibilities of her eldest child. Michelle’s children are also provided with access to support services that help them understand mental illness and connect with children in similar situations (action 18.2).

Coordinated access to a range of supports for people with complex needs

Tom is 32 years old and lives in a regional town. He has lived with a personality disorder since his teens. There have been periods when he has been well enough to work but he has been unable to sustain employment for more than a year. Tom gets into arguments with his landlord because his irregular income means he sometimes pays his rent late and his symptoms contribute to him neglecting housekeeping. There is a private psychology clinic in town but he cannot afford the treatment he needs and the waitlist is long.

Tom is able to have an assessment by a psychiatrist by videoconference and the psychiatrist is able to provide timely advice to Tom’s GP (action 12.2). As a result of the recommended reforms, more mental healthcare options become available for people in regional areas. There are more peer workers employed locally (action 16.5), and Tom finds increased hope for recovery after receiving support from a peer worker who has lived experience of a personality disorder.

Identifying and building on Tom’s strengths helps him to take more control over his life and feel more confident. His peer worker suggests he consider part-time work using the Individual Placement and Support employment support model (action 19.4). This employment support is integrated with his mental healthcare and having the two services working together helps him to gain and maintain employment. Tom also receives tenancy support services that help him maintain his private rental by negotiating with his landlord and helping him resolve late payments (action 20.1).

Mental illness is more prevalent among people who are unemployed (31%) compared with those in work (19%) (chapter 2).
25.3 Reform implementation

The vignettes above describe how people would benefit from increased access to effective services. However, the implementation of reforms to individual services across the mental health system would not be sustainable without structural and cultural changes to support these reforms.

Effective implementation is requires supportive organisational cultures, where the values, beliefs and attitudes of policymakers, employers, and those employed by service providers align with the aim of a person-centred mental healthcare system. But currently, too many clinicians focus on symptoms of mental ill-health, rather than the person and their environment and too many policymakers focus on commissioning healthcare rather than reducing the need for healthcare. Changes are needed to the incentives and capabilities at every level, and this in turn contributes to the cultural change within government, service providers, and the community that is needed for long-term reform.

System-level changes are vital to reform success

While the Productivity Commission’s vision is for a person-centred mental health system, the service-level reforms needed to create such a system must be built on foundational reforms in areas such as governance, funding, service planning, monitoring and evaluation (chapters 22, 23 and 24). These system-level reforms would enable a significant change in culture across the mental health system, which would encourage a focus on people, their needs and preferences, and close monitoring of their progress towards the outcomes that matter to them. For example, available services would better reflect what is valued by those who use them if regional planning processes were required to incorporate the voices of consumers and carers (action 23.1).

Ways to encourage more effective service delivery

Reforms to both the collection and use of data would provide major incentives for change, and in time would drive much needed cultural change towards a recovery-oriented and person-centred mental health system.

Better data on effectiveness of services at the provider level would encourage high-performing service providers, and would empower consumers to make informed choices about their care (action 24.5). This would be a significant change to ways of working for many providers. The recommended trial to make use of patient reported outcome measures to assess the effectiveness of psychological therapy would provide timely feedback to individual clinicians about their performance (action 12.3). A focus on outcomes and feedback on performance would provide a feedback loop to mental health services that encourages continuous improvement and person-centred service delivery.
Information is critical to know what works. The recommended reforms to collect better data on service effectiveness and build a culture of service evaluation would shed light on what is working well and what is cost-effective (chapter 24). This would enable governments to better direct expenditure to achieve the desired outcomes, which makes the system more sustainable over time.

Ways to encourage a whole-of-government and whole-of-life approach to mental health policy

One of the shifts that is needed is greater inter- and intra-governmental cooperation. Non-health government agencies need to increase their policy focus on mental health. However, they currently have little incentive to do so. A new whole-of-government National Mental Health Strategy would align the collective efforts of health and non-health sectors (action 22.1). Implementation of the strategy would be facilitated by an interjurisdictional Special Purpose Mental Health Council, which would comprise Health Ministers as permanent members and other relevant Ministers on 18-month rotations (action 22.3).

These changes will be needed to support implementation of actions that aim to improve the focus on mental health in specific sectors.

- In justice, improving mental health services provided within the criminal justice system would require government agencies with responsibility for health and for correctional services to work together (action 21.4).

- In housing, to operationalise the commitment to no person with mental illness being discharged from hospital or a correctional facility into homelessness (action 20.2), both health, housing and corrections policy ministers would need to agree on how they will jointly achieve this goal.

- In school education, despite improvements over time, government policies to support the social and emotional wellbeing of school students are fragmented, complex and inconsistent (chapter 5). In part this is because there is no clear delineation over where education policy responsibilities end and where the health policy responsibilities take over. The responsibilities that schools should have over student wellbeing should be clarified in the National School Reform Agreement (recommendation 5). All schools would have greater incentive to improve student wellbeing once they have good data on how well their school is performing, and they are required to report on wellbeing outcomes, in addition to literacy and numeracy outcomes.

- In tertiary education, institutions would have a greater focus on the mental health of their students were they required to develop a student wellbeing strategy that demonstrates how they would meet their existing regulatory and legislative requirements (action 6.3).

- In workplaces, the reforms would strengthen incentives for employers to promote mentally healthy workplaces. In future, workplace health and safety legislation would ensure psychological health and safety in the workplace is given similar consideration to physical health and safety (action 7.1). This outcome is further supported by improving workers
compensation schemes so that employers who implement workplace initiatives that protect mental health would have capacity to pay lower insurance premiums (action 7.3).

- In employment support services, coordinated action would be required by health and employment Ministers to co-locate employment and mental health support as part of the Individual Placement and Support model (action 19.4). And as individual participation increases, this would have positive benefits for mental health.

In each of these cases, the accrued benefits of improved mental health outcomes would be evident in the performance reporting and expenditure of multiple levels of government and across government departments. But, most importantly, these whole-of-government and whole-of-life reforms have the potential to improve the lives of millions of Australians.

Achieving cultural change across the community

There are cultural barriers to reform that will take time to dismantle. For example, systemic discrimination and stigma affecting people with mental illness are major obstacles that governments and the community have only started to tackle. This Inquiry does not resolve these issues, but it recommends steps towards changing the perceptions of mental illness — at the community level, at the government level, for those who plan and deliver services, and for those who seek help.

To support cultural change, a range of actions are needed to embed greater mental health literacy and skills within service providers. Within health services, the Productivity Commission is recommending:

- a national mental health workforce strategy with the aim to align health workforce skills and cultural capability to consumer needs (action 16.1)
- training and professional development for GPs to incorporate person-centred approaches to practice that recognise the importance of personal recovery (action 16.3)
- training of all nurses to include a discrete unit on mental health (action 16.4)
- mental health stigma reduction programs are incorporated in the training and professional development of health professionals (actions 16.6 and 8.1)
- actions to support the growth of employment in peer workers, including educating health professionals about their role and value (action 16.5)
- embedding more family and carer workers in specialised mental healthcare services to improve the capabilities of these services to provide family- and carer-inclusive practices (action 18.1)
- access to training and support for mental health workers to provide person-centred, effective and coordinated care to people with comorbidities (action 14.1).
Beyond health services, other actions to improve and embed mental health skills include:

- supporting early childhood education and care staff to access professional development related to mental health and professional advice, when needed (action 5.2)
- development of standards for initial teacher education and professional development programs, to incorporate social and emotional development and mental health (actions 5.3 and 5.4)
- development of guidance and provision of training for tertiary education providers to help them best support student social and emotional wellbeing (actions 6.3 and 6.4)
- mental health expertise and information for police responding to mental health-related incidents (action 21.2)
- mental health training and resources for social housing workers (action 20.1) and insurers (action 8.2).

At the community level, a national stigma reduction strategy would help dispel some of the myths and misconceptions that continue to surround mental illness (chapter 8). While societies’ views about mental illness have progressed, people with less prevalent conditions continue to face discrimination in health services and in the community. Attitudes about seeking help would also change over time as people become familiar with the national digital mental health platform and its self-help resources (action 10.4).

Enabling a person-centred mental health system requires the removal of barriers hindering the good work of passionate individuals. The Productivity Commission was struck during the course of this Inquiry with the level of dedication and care that so many workers in community settings have for the people they support, notwithstanding difficulties in funding and access to services. Extending the typical contact length for psychosocial services from one year to at least five years is an example of a simple reform that would remove a barrier to quality care created by the uncertainty about service and provider continuity (action 17.1). Similarly, actions to improve service navigation, such as clear information about the services available in the local area, would empower both service providers and service users (action 15.2).

**Implementation timeframe**

There are many improvements needed to create a person-centred mental health system. Some can be achieved in the short term, by reallocating existing resources and priorities with little or no increase in government expenditure. Others involve considerable expenditure, but can lead to a significant improvement in quality of life — either across the community or for those consumers who face the most pressing needs. Some reforms deal with specific parts of the mental health system, such as clinical assessment. Others involve the whole community, such as a national campaign to reduce stigma.
While this Inquiry presents a comprehensive reform agenda, it is a matter for governments to decide when and where to prioritise their efforts and expenditure. However, the Productivity Commission has been cognisant that providing a road map to a person-centred mental health system is an important part of what we have been tasked with on this Inquiry. To assist governments, the Productivity Commission has suggested priority reforms that should be started as soon as possible (figure 25.3).

The Productivity Commission has prioritised its recommended reforms based on the following criteria: the potential to improve lives at both the individual and community level; benefits to the economy and taxpayers; implementation readiness; and dependencies between reforms (chapter 4). Some of the reforms are relatively simple to implement, requiring little consultation or coordination. For example, the recommended changes to the Medicare Benefits Schedule (MBS) for telehealth were already introduced on a temporary basis as a response to COVID-19.

For more complex reforms, the recommended timeframes consider the benefits of a staged approach to implementation. Large-scale change will not only take time, it will inevitably face implementation challenges and errors. A staged approach allows for more meaningful consultation with consumers and carers, minimises the effects of mistakes and allows for continuous improvement. For example, a staged rollout is recommended for the Individual Placement and Support model (recommendation 19) and is suggested for the national digital mental health platform (recommendation 10).

The timing of recommendations also considers dependencies between reforms. Some reforms stand alone — for example raising the understanding and importance of mental health in the workplace. But other reforms are part of a sequence — reforms need to be started today to create the foundations for further reform tomorrow. For example, before governments can implement several of the priority reforms — to fund mental healthcare, psychosocial supports and care coordination services to meet community need — governments would need to undertake regional planning to assess shortfalls in the current supply. The recommended process for Local Hospital Networks and Primary Health Networks to develop joint regional plans would support this first stage of reform (action 23.1).

The priority reforms span across the policy responsibilities of the Australian Government, and of State and Territory Governments, as well as shared responsibilities. The Australian Government could start implementing reforms by focusing on identified priority reforms to:

- amend the Medicare Benefits Schedule for group therapy, telehealth, and family and carer consultations (actions 12.1, 12.2 and 18.1)
- develop the national digital mental health platform (action 10.4) and expand clinician-supported online treatment (action 11.1)
- require mental health professionals to discuss possible side effects of medication (action 10.2)
• develop an implementation plan for the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2017–2023* (Action 22.2).

These actions would improve the range and quality of services available to people and make them more accessible, especially for people with mild symptoms. And combined with evaluating and trialling policy changes to MBS-rebated psychological therapy (action 12.3), this would enable Australian Government funding to be used more effectively and reach more people across the spectrum of needs in the community.

State and Territory Governments could start implementing reforms by focusing on identified priority reforms on:

• regional planning to assess any shortfalls in the supply of psychosocial supports, mental health community ambulatory services, and care coordination services (actions 12.4, 15.4, 17.3)

• building capacity for mental health services to support and partner with families and carers (action 18.1)

• preventing unnecessary presentations to emergency departments by providing more alternatives (action 13.1)

• committing to no exits from hospital inpatient units and correctional facilities into homelessness (action 20.2).

These actions would improve mental healthcare for people with moderate or severe clinical needs. At the same time, State and Territory Governments could focus on priority reforms beyond health, which would relieve the pressure on healthcare services, including:

• collecting data on screening for perinatal mental illness (action 5.1)

• increasing support and information for police responding to mental health-related incidents (action 21.2)

• access to legal representation at mental health tribunals (action 21.8)

• expanding the Individual Placement and Support model (action 19.4).

Together, governments could start reform implementation by collaborating on:

• establishing a clear, ongoing role for consumers and carers in all aspects of system planning, design, monitoring and evaluation (action 22.4)

• improving monitoring and reporting at the service provider level (action 24.5)

• strengthening joint regional planning arrangements and establishing Regional Commissioning Authorities for those States and Territories who choose to do so (actions 23.1 and 23.4)

• developing a new whole-of-government National Mental Health Strategy (action 22.1)

• making student wellbeing a clear outcome of the education system (action 5.3)
• suicide prevention by offering effective aftercare and renewing an Indigenous-led National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and Implementation Plan (actions 9.1 and 9.2)

• improving care to people with comorbidities and accountability for their physical health outcomes (action 14.1)

• putting psychological health and safety on par with physical health and safety in the workplace and amending workers compensation schemes to provide no-liability treatment (actions 7.1 and 7.4).

These actions that clarify roles and responsibilities help align incentives in the system towards prevention, earlier intervention, and a healthier population. This set of priority reforms are complex but once they are in train, they would enable many more practical changes to follow – both actions recommended as part of this Inquiry and changes to everyday practice to align with this new policy paradigm – to create a person-centred mental health system.

As a priority, it is also recommended that governments start work to establish the National Mental Health Commission as an interjurisdictional statutory authority, with responsibility for: leading evaluation; developing the National Stigma Reduction Strategy; monitoring reform progress; and reporting on progress towards system-level targets developed in consultation with consumers, carers and the community (actions 8.1, 22.7, 23.1, 24.4 and 24.10). This would provide reform momentum by improving accountability of government to the public for the outcomes that matter to them, and encouraging continuous improvement of services.
### Implementation timeframes for some key reforms

All priority reforms included and some non-priority reforms included. Non-priority reforms marked with *

<table>
<thead>
<tr>
<th>Actions to improve mental health services include:</th>
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<tbody>
<tr>
<td>Establish the national digital mental health platform, with more clinician-supported online treatment (10.4, 11.1)</td>
<td>Evaluate online treatment services (11.1)</td>
</tr>
<tr>
<td>More group, video and telephone therapy (12.1, 12.2), and trial and evaluate changes to MBS psychological therapy</td>
<td>Rollout what works from trials of psychological therapy (12.3)</td>
</tr>
<tr>
<td>Create target and implementation plan to reduce gap in life expectancy for people with severe mental illness, provide more alternatives to the ED, and improve information about medication side effects (10.2, 13.1, 14.1)</td>
<td>Report on outcomes from the Equally Well Consensus Statement and progress in addressing the gap in life expectancy (14.1)</td>
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<td>Regional planning to assess any shortfalls in the supply of community mental healthcare services, care coordination and psychosocial supports (12.4, 15.4, 17.3)</td>
<td>Increase funding to address service shortfalls (15.4, 17.4)</td>
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<tr>
<td>Improve capacity in mental health services for family- and carer-inclusive practices (18.1)</td>
<td>Educate health professionals about the value of peer workers (16.5)*</td>
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<table>
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<th>Actions to improve services beyond the mental health system include:</th>
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<tr>
<td>Expand the Individual Placement and Support program</td>
<td>Disseminate best practice for IPS (19.4)</td>
</tr>
<tr>
<td>No exits into homelessness from hospitals and correctional facilities (20.2)</td>
<td>Increase funding for housing (20.3)*</td>
</tr>
<tr>
<td>Increase support for police responding to mental illness-related incidents (21.2)</td>
<td>Disability justice strategies (21.7)*</td>
</tr>
<tr>
<td>Legal representation at mental health tribunals (21.8)</td>
<td>Non-legal advocacy (21.9)*</td>
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<tr>
<td>Actions towards universal screening for perinatal mental illness (5.1)</td>
<td>Fund trials to improve child social and emotional wellbeing (5.7)*</td>
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<tr>
<td>Add student wellbeing to the National School Reform Agreement (5.3)</td>
<td>Improve schools’ data, teacher training &amp; wellbeing programs (5.4, 5.5, 5.7)*</td>
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<tr>
<td>Raise importance of workplace psychological health and safety, and workers compensation schemes fund mental healthcare regardless of liability (7.1, 7.4)</td>
<td>Disseminate information on workplace interventions (7.6)*</td>
</tr>
<tr>
<td>National Stigma Reduction Strategy (8.1)</td>
<td>Monitor interventions provided in tertiary education (6.3)*</td>
</tr>
<tr>
<td>Universal aftercare following a suicide attempt, &amp; National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (9.1, 9.2)</td>
<td>Rollout what works from suicide prevention trials (9.3)*</td>
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<tr>
<th>Governance and funding reforms include:</th>
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<tr>
<td>Whole-of-government National Mental Health Strategy, with more consumer and carer participation (22.1, 22.4)</td>
<td>Special Purpose Mental Health Council (22.3)*</td>
</tr>
<tr>
<td>Improved monitoring and reporting at the service provider level (24.5)</td>
<td>Establish Mental Health Innovation Fund to trial innovative service delivery, system organisation and payment models (23.8)*</td>
</tr>
<tr>
<td>PHN–LHN cooperation; transition to Regional Commissioning Authorities (23.1, 23.4)</td>
<td>Agreement on responsibilities for psychosocial supports (23.2)*</td>
</tr>
<tr>
<td>Expanded and independent role for the National Mental Health Commission (22.7)</td>
<td>New programs are cost effective and trialled before being scaled up (24.10)*</td>
</tr>
</tbody>
</table>
A Inquiry conduct

This appendix describes the stakeholder consultation process undertaken for the Inquiry.

Inquiry terms of reference

The terms of reference for the Inquiry — reproduced in the preliminary pages of this report — was received from the Treasurer on 23 November 2018. The Inquiry was advertised in *The Australian* on 5 December 2018.

Consultations

Throughout the Inquiry, the Productivity Commission held and benefited from the following consultations processes:

- 11 roundtables
  - Youth, South Australia Mental Health Commission Youth Advisory Group (20 February 2019)
  - Culturally and linguistically diverse people, South Australia Mental Health Commission (21 February 2019)
  - Hospital and community mental health services, Royal North Shore Hospital and Ryde Community Centre (27-28 February 2019)
  - Consumers and carers, and NSW Mental Health Commission (4 April 2019)
  - Consumers and carers (4 February 2020)
  - Mental health modelling (11 February 2020)
  - Workplace mental health (11 February 2020)
  - Aboriginal and Torres Strait Islander people in urban areas (13 February 2020)
  - Early childhood services (17 February 2020)
  - Education system (17 February 2020)

- 13 days of public hearings
  - Canberra (15 November 2019)
  - Melbourne (18-19 November 2019)
  - Geraldton (20 November 2019)
  - Perth (21 November 2019)
– Sydney (25-26 November 2019)
– Broken Hill (28 November 2019)
– Rockhampton (2 December 2019)
– Brisbane (3 December 2019)
– Launceston (9 December 2019)
– Adelaide (5 February 2020)
– Darwin (27 February 2020)

- Hearings were advertised: in newspapers (The Australian on 24 October 2019, the Midwest Times on 13 November 2019 for the Geraldton hearing, and the Barrier Daily Truth on 16 November 2019 for the Broken Hill hearing); through Facebook and Twitter; through a flyer emailed to key stakeholders for distribution; and through an email to registered Inquiry participants.

- About 300 meetings were held with individual stakeholders across Australia

- The Productivity Commission received 1244 public submissions during the Inquiry and also provided facilities on the Inquiry website for interested stakeholders to lodge a brief comment. A total of 488 comments were received (table A.1). All public submissions and comments are available on the Inquiry website.

To facilitate our ongoing interaction with State and Territory Governments during the Inquiry, a State and Territory Government Consultative Group was formed for the inquiry. The group was convened via teleconference on four occasions and was used as both an avenue through which to gather together information on mental health programs and supports delivered by State and Territory Governments and an avenue through which the Productivity Commission shared updates on Inquiry developments and understanding.

A separate document on the Inquiry website only, lists parties who contributed to the Inquiry through meetings, roundtables, hearings and submissions or comments.

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<tr>
<th>Table A.1</th>
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<tr>
<td></td>
<td>Pre-draft</td>
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<tr>
<td>Submissions</td>
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<tr>
<td>Comments</td>
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Figure A.1  **Submissions and comments received**

### Nature of the participant

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<td>Peak body or advocacy group</td>
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<td>Carer or family member</td>
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<td>21%</td>
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<td>Academic or researcher</td>
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<tr>
<td>User of mental health services or supports</td>
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<td>22%</td>
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<td>Employer or manager</td>
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<tr>
<td>Other</td>
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### Participant-nominated key topics in their submission or comment

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<td>Prevention and early intervention</td>
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<tr>
<td>Issues relating to users of mental health services</td>
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<td>Youth mental health (including schooling system)</td>
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<td>Mental health workforce</td>
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<td>Older persons mental health</td>
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<td>Suicide and suicide prevention</td>
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<td>Rural regional and remote issues</td>
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<td>Mental health in the workplace</td>
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<td>Cultural diversity issues</td>
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<tr>
<td>Mental health issues in the justice system</td>
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<td>2%</td>
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<tr>
<td>Seeking, gaining or maintaining employment</td>
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</tr>
<tr>
<td>Housing and homelessness</td>
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<tr>
<td>National Disability Insurance Scheme (NDIS)</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>7%</td>
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</table>
Data and information requests

The Commission is very appreciative of the data and information provided by: a number of Australian, State and Territory Government agencies; industry, business and employee representative organisations; and number of non-government service providers during the course of the Inquiry. Where possible, the Commission has published this data and information in detail in the Inquiry report.

This inquiry uses unit record data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey. The HILDA Project was initiated and funded by the Australian Government Department of Social Services (DSS) and is managed by the Melbourne Institute of Applied Economic and Social Research (Melbourne Institute). The findings based on HILDA data that are reported in this inquiry are those of the Productivity Commission and should not be attributed to either DSS or the Melbourne Institute.

Unit record data from the Multi-Agency Integration Project (MADIP) dataset has also been used. The project creating this dataset is a partnership among Australian Government agencies combining healthcare, education, government payments, personal income tax and population demographics over time. The findings based on MADIP data that are reported in this inquiry are those of the Productivity Commission.

The Commission also collected some data for this Inquiry by serving formal notice under section 48 of the Productivity Commission Act 1998 (Cth). For this purpose, the Commission served a formal notice on SafeWork NSW.

Documents produced by the Inquiry

The following public documents were prepared by the Commission in this Inquiry:

- Issues paper — released 21 January 2019
- Draft Report — released 31 October 2019
- Final Report — delivered to Government on 30 June 2020 (to be publicly released within 25 parliamentary sitting days.)
References


—— 2012, National Health Survey 2011-12 TableBuilder, Cat. no. 4324.0.55.001, Canberra.

—— 2013, Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia 2012-13, Cat. no. 427.0.55.001, Canberra.

—— 2015, National Health Survey 2014-15 TableBuilder, Cat. no. 4324.0.55.001, Canberra.

—— 2016a, Mental Health and Experiences of Homelessness, Australia, 2014, Cat. no. 4329.0.00.005, Canberra.

—— 2016b, Microdata: Disability, Ageing and Carers, Australia 2015, Cat. no. 4430.0.30.002, Canberra.

—— 2018a, Census of Population and Housing: Estimating Homelessness, 2016, Cat. no. 2049.0, Canberra.

—— 2018b, National Health Survey: First Results 2017-18, Cat. no. 4364.0.55.001, Canberra.

—— 2018c, Prisoners in Australia 2018, Cat. no. 4517.0, Canberra.

—— 2019a, Australian System of National Accounts, Cat. no. 5204.0, Canberra.

—— 2019b, Disability, Ageing and Carers, Australia: Summary of Findings, 2018, Cat. no. 4430.0, Canberra.

—— 2019c, National Health Survey 2017-18, Basic Confidentialised Unit Record File (CURF), Cat. no. 4324.0.55.001, Canberra.


—— 2019e, Prisoners in Australia 2019, Cat. no. 4517.0, Canberra.

—— 2020a, Consumer Price Index, Australia, March 2020, Cat. no. 6401.0, Canberra.

—— 2020b, Microdata: Disability, Ageing and Carers, Australia, 2018, Cat. no. 4430.0.30.002.

—— 2020c, Producer Price Indexes, Australia, Mar 2020, Cat no. 6427.0, Canberra.

ACAT (ACT Civil and Administrative Tribunal) 2019, Annual Review 2018-19, Annual Report, Canberra, ACT.

ACOSS (Australian Council of Social Service) 2018, Submission on future employment services, August, NSW.


—— 2017b, National Safety and Quality Health Service Standards, 2nd edn, Sydney.


—— 2018b, Map of the National Safety and Quality Health Service Standards (Second Edition) with the National Standards for Mental Health Services., Sydney.


—— 2018a, *Housing Assistance in Australia 2018*, Cat. no. HOU 296, Canberra.

—— 2018b, *Mental Health Services — In Brief 2018*, Cat. no. HSE 211, Canberra.


—— 2019a, *Aboriginal and Torres Strait Islander People: A Focus Report on Housing and Homelessness*, Cat. no. HOU 301, Canberra.


—— 2019e, *Mental Health Services — In Brief 2019*, Cat. no. HSE 228, Canberra.


—— 2019n, *Specialist Homelessness Services 2018-19 Data Tables*, Cat. no. HOU 318, Canberra.


—— 2020d, *Mental Health Services in Australia - Key Performance Indicators for Australian Public Mental Health Services Tables*, Canberra.


—— 2020f, *Mental Health Services in Australia - Overnight Admitted Mental Health-Related Care 2017-18 Tables*, Canberra.

—— 2020g, *Mental Health Services in Australia - Same Day Admitted Mental Health-related Care Tables*, Canberra.


AMHOCN (Australian Mental Health Outcomes and Classification Network) 2016, Mental Health Carer Experience Survey - Sample Copy, Sydney.


—— 2019a, AMHOCN Update - October 2019, email update, Sydney.


—— 2017b, jobactive: Design and Monitoring, Performance Audit, Report no. 4 2017-18, Canberra.


Andrews, D. (Premier of Victoria) 2018, Caring for our carers with more respite and support, Media release, Melbourne, 13 September.


Aubusson, K. 2019, ‘$1.45 billion for mental health removes uncertainty for local services’, *Sydney Morning Herald*, 16 January.


—— 2018c, *Job Seeker Classification Instrument (JSCI) Assessment*.


Borzycki, M. 2005, Interventions for Prisoners Returning to the Community: A report prepared by the Australian Institute of Criminology for the Community Safety and Justice Branch of the Australian Government Attorney-General’s Department, Canberra.


CMHA (Community Mental Health Australia) 2012, Taking Our Place, Sydney.

—— and USYD (Community Mental Health Australia and The University of Sydney) 2018, Commonwealth Mental Health Programs Monitoring Project: Tracking transitions from PIR, PHaMs and D2DL into the NDIS, Interim Report, Phase One, Sydney.

—— and —— 2019a, Commonwealth Mental Health Programs Monitoring Project: Tracking transitions from PIR, PHaMs and D2DL into the NDIS, Interim Report, Phase Two, Sydney.

—— and —— 2019b, Commonwealth Mental Health Programs Monitoring Project: Tracking transitions from PIR, PHaMs and D2DL into the NDIS, Final Report, Sydney.

COAG (Council of Australian Governments) 2011, National Health Reform Agreement, Canberra.


—— 2015, Principles to Determine the Responsibilities of the NDIS and Other Service Systems, Canberra.


—— 2018b, National Housing and Homelessness Agreement, Canberra.

—— 2018c, Project Agreement for the Health Innovation Fund - Stage 1.

COAG DRC (Council of Australian Governments Disability Reform Council) 2019a, COAG Disability Reform Council Communique 9 October 2019, Gold Coast.


—— 2019c, Mental Health and NDIS Psychosocial Disability Interfaces, Gold Coast.


—— 2017a, The Fifth National Mental Health and Suicide Prevention Plan, Canberra.


Collie, A. 2019, The Mental Health Impacts of Compensation Claim Assessment Processes, School of Public Health and Preventive Medicine, Faculty of Medicine Nursing and Health Sciences, Monash University, Insurance Work and Health Group.


Commissioner for Children and Young People Western Australia 2011, Report of the Inquiry into the Mental Health and Wellbeing of Children and Young People in Western Australia, Subiaco.


ConNetica (ConNetica Consulting Pty Ltd) 2013, Final QMHC Strategic Plan Report 2: Findings and Analysis, Caloundra.


Coombs, T. 2017, Mental Health Phase of Care Inter-rater Reliability Study, Final Report for the Independent Hospital Pricing Authority, April.


Craze Lateral Solutions 2009, Discussion Paper: Scoping Study to Inform the Establishment of a New Peak National Mental Health Consumer Organisation, prepared for the Australian Government Department of

CSAC (Corrective Services Administrators’ Council) 2018, Guiding Principles for Corrections in Australia, Canberra.

Cuff, R. 2019, Public Hearing Transcript for the Royal Commission into Victoria’s Mental Health System, Day 9, Melbourne Town Hall, Melbourne.


Davidson, F. 2015, Mental Health Liaison and Diversion: Court Liaison Services and Mental Health Court Programs in Australia, The Australian Centre for Research Excellence in Offender Health, Sydney.

—— 2018, Benchmarking for Australian Mental Health Court Liaison Services, NHRMC Centre for Research Excellence in Offender Health, Sydney.


DHS (Department of Human Services) 2018a, *Carer Payment and Carer Allowance - Medical Report for a Child Under 16 Years (SA431)*, Canberra.
— 2018b, *Carer Payment and/or Carer Allowance Medical Report (SA332a) for a Person – 16 Years or Over*, Canberra.


— 2016b, *Primary Health Networks (PHNs) and Aboriginal Community Controlled Health Organisations (ACCHOs) - Guiding Principles*, Draft as at 16 March 2016.
—— 2019a, Aboriginal and Torres Strait Islander Mental Health Services, PHN Primary Mental Health Care Programme Guidance.

—— 2019b, Fact Sheet for Partners in Recovery, Support for Day to Day Living and Personal Helpers and Mentors providers, Canberra.

—— 2019c, Maximising the Potential of Australian Clinical Quality Registries: Using Data to Drive Improvements in Patient Care and Outcomes, A National Strategy 2019-2029, Canberra.

—— 2019d, Medicare Benefits Schedule Book - Category 1 Operating from 1 July 2019, Canberra.


Dowse, L., Dean, K., Trofimovs, J. and Tzoumakis, S. 2016, People with Complex Needs who are the Victims of Crime: building evidence for responsive support, University of New South Wales, Sydney.


—— 2015c, 3.2.8.30 What is a job plan?

—— 2015d, 3.6.3.05 Guidelines to the rules for applying the impairment tables.

—— 2016a, 1.1.F.240 Fully diagnosed, fully treated and fully stabilised (FDTS) (DSP).


—— 2019j, Carer Programs - What is Changing?, Canberra.


DUSC (Drug Utilisation Subcommittee) 2013, Use of Antipsychotics in the Middle Aged, Canberra.


Eastern Health 2020, Programs for Families Where a Parent Has a Mental Illness in the Eastern Region. Term 1 2020, Melbourne.


EERC (Standing Committee on Education and Employment) 2019, jobactive: Failing Those It Is Intended to Serve, Australian Senate, Canberra.


—— 2019, Six Ways to Support Child-Focused Practice in Adult Services.

ERG (Expert Reference Group to COAG Working Group on Mental Health Reform) 2013, National Targets and Indicators for Mental Health Reform, Final Report, Canberra.

Ettelt, S., Thomson, S., Nolte, E. and Mays, N. 2006, Reimbursing highly specialised hospital services: the experience of activity-based funding in eight countries, A report commissioned by the Department of Health and prepared by the London School of Hygiene and Tropical Medicine, 8 December.

EY (Ernst and Young) 2019, Disability Employment Services Assessment Review.


FCDC (Family and Community Development Committee) 2012, Inquiry into workforce participation by people with mental illness, Parliamentary Paper no. 174, Melbourne.


Fels, A. 2018, ‘Please don’t dismiss the PC inquiry into mental health as “just another inquiry”’, The Conversation, 19 October.


Fletcher, P. and Henderson, S. (Minister for Families and Social Services and Assistant Minister for Disability Services) 2018, Government announces improved NDIS mental health support, Media release, Canberra, 10 October.

—— and Hunt, G. (Minister for Families and Social Services and Minister for Health) 2019, Morrison Government continues funding to support people with mental illness to transition to the NDIS, Media release, 21 March, Sydney.


Fowkes, L. 2019, The application of income support obligations and penalties to remote Indigenous Australians, 2013-18, Australian National University, Canberra.


Health Justice Australia 2019, Submission to the Royal Commission into Victoria’s Mental Health System, SUB.0002.0028.0245, Melbourne.


Human Rights Law Centre 2019, *Submission to the Royal Commission into Victoria’s Mental Health System*, SUB.0002.0029.0215, Melbourne.

Hunt, G. (Minister for Health) 2019, $1.45 billion to strengthen mental health services and support job security, Media release, Canberra, 16 January.

—— 2020, Immediate response plan to focus on people with disability during coronavirus, Media Release, Canberra, 4 April.


Integrated Regional Planning Working Group 2018a, Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services: A Compendium of Resources to assist Local Health Networks (LHNs) and Primary Health Networks (PHNs), National Mental Health Strategy, COAG Mental Health Principal Committee, Canberra.

—— 2018b, Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services: A Guide for Local Health Networks (LHNs) and Primary Health Networks (PHNs), National Mental Health Strategy, COAG Mental Health Principal Committee.


Jesuit Social Services 2014, A Criminal Justice System that Builds a Safer Community, Melbourne.


—— and —— 2015, Evaluation of the Melbourne Street to Home Program, Centre for Applied Social Research, RMIT University, Melbourne.


JSC (Joint Standing Committee on the National Disability Insurance Scheme) 2018, Transitional Arrangements for the NDIS, Canberra.


KPMG 2018a, Economic Impact of Medical Research in Australia, Melbourne.
——— and Mental Health Australia 2018, Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform.


— 2018a, National Disability Insurance Scheme: Psychosocial Disability Pathway, Canberra.


— 2019b, The Royal Commission into Victoria’s Mental Health System, SUB.400.0001.0179, Melbourne.

MHCA (Mental Health Council of Australia) 2009, Home Truths: Mental Health, Housing and Homelessness in Australia, Canberra.


— 2015, Further Unravelling Psychosocial Disability – Experiences of the National Disability Insurance Scheme in the NSW Trial Site: A Mental Health Analysis, Sydney.


MHLC (Mental Health Legal Centre) 2019, Submission to the Royal Commission into Victoria’s Mental Health System, Submission, SUB.0002.0032.0106, Melbourne.

MHV and MHL (Mental Health Victoria and Mental Health Legal Centre) 2019, Submission to the Royal Commission into Victoria’s Mental Health System, SUB.0002.0029.0006, Melbourne.


— 2018b, Media Release: Funding for Legal Assistance for People with Mental Ill-Health.

— and CHP (Mind Australia and Centre for Health Policy) 2011, Research and Evaluation Framework, Melbourne.

MindSpot 2019, Data Report to the Productivity Commission: e-Mental Health Information and Services, MQ Health.


Morrison, S., Payne, M. and Ruston, A. (Prime Minister, Minister for Foreign Affairs and Women and Assistant Minister for Health, Minister for Families and Social Services) 2020, $1.1 Billion to Support More Mental Health, Medicare and Domestic Violence Services, Media release, Canberra, 29 March.


Morrison, S. (Prime Minister of Australia) 2019, Making Suicide Prevention a National Priority, Media release, 8 July, Canberra.


NDIA (National Disability Insurance Agency) 2016a, COAG Disability Reform Council Quarterly Report - Quarter 1, 2016-17, Geelong.

—— 2016b, COAG Disability Reform Council Quarterly Report - Quarter 2, 2016-17, Geelong.

—— 2017a, COAG Disability Reform Council Quarterly Report - Quarter 1, 2017-18, Geelong.


—— 2017e, Key Data on Psychosocial Disability and the NDIS - as at 31 March 2017, Canberra.


—— 2018a, COAG Disability Reform Council Quarterly Report - Quarter 1, 2018-19, Geelong.


—— 2018e, Specialist Disability Accommodation Provider and Investor Brief, Geelong.


—— 2019f, National Disability Insurance Agency Submission to the Royal Commission into Victoria’s Mental Health System, SUB.7000.0001.0071, Geelong.


NESA (National Employment Services Association) 2018a, NESA’s response to the next generation of employment services.

—— 2018b, Submission to the Senate Inquiry into the appropriateness and effectiveness of the objectives, design, implementation and evaluation of jobactive.


—— 2019b, NHMRC Special Initiative in Mental Health Guidelines, Australian Government, Canberra.


—— 2014b, Contributing Lives Thriving Communities: Report of the National Review of Mental Health Programs and Services - Volume 1, Sydney.


NSW Health nd, *Nomination of Designated Carer(s)*, NH606713.


NT DHCD (Department of Housing and Community Development (NT)) nd, *Extended Absences and Caretaker Arrangements*, Darwin.
REFERENCES


OPA South Australia (Office of the Public Advocate (South Australia)) 2017, *Submission to the Mental Health Strategic Plan for South Australia*, Adelaide.


OPI (Office of Police Integrity) 2012, *Policing People Who Appear to be Mentally Ill*, Melbourne.


Patterson, M., Somers, J.M., McIntosh, K., Shiell, A. and Frankish, C.J. 2008, *Housing and Support for Adults with Severe Addictions and/or Mental Illness in British Columbia*, Centre For Applied Research in Mental Health and Addiction, Simon Fraser University, British Columbia, Canada.


—— 2017a, *Data Availability and Use*, Report no. 82, Canberra.


Pleace, N. 2016, Housing First Guide Europe, University of York and FEANTSA.


Poroch, N., Boyd, K., Tongs, J., Sharp, P., Longford, E. and Keed, S. 2011, We’re Struggling in Here! The Phase 2 Study into the Needs of Aboriginal and Torres Strait Islander People in the ACT Alexander Maconochie Centre and the Needs of their Families, Winnunga Nimmityjah Aboriginal Health Service, Canberra.


PwC (PricewaterhouseCoopers) 2009, Department of Justice: Economic Evaluation of the Court Integrated Services Program, Final Report, Melbourne.
—— and Summer Foundation (PricewaterhouseCoopers and Summer Foundation) 2017, NDIS Specialist Disability Accommodation: Pathway to a Mature Market, Canberra.

QAI (Queensland Advocacy Incorporated) 2015, dis-Abled Justice: Reforms to Justice for Persons with Disability in Queensland, South Brisbane.

QLD FMHS (Queensland Forensic Mental Health Service) 2016, Police Communications Centre Mental Liaison Service: Evaluation Report, Brisbane.

QMHC (Queensland Mental Health Commission) 2015, Social Housing: Systemic Issues for Tenants with Complex Needs, Ordinary Report, Brisbane.
—— 2018, Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023, Brisbane.


Queensland Health nd, Information Sharing Between Mental Health Staff, Consumers, Family, Carers, Nominated Support Persons and Others, Brisbane.

—— nd, Rights of Family, Carers and Other Support Persons, Brisbane.


—— 2017, Chief Psychiatrist Annual Report 2016-17, Brisbane.

—— 2018a, Chief Psychiatrist Annual Report 2017-18, Brisbane.


——, QLD PS and QLD JAG (Queensland Health, Queensland Police Service and Queensland Department of Justice and Attorney-General) 2008, Queensland Government’s Final Response to the Coroner’s Recommendations Following an Inquest into Police Shooting Deaths of Messrs Dion Waite, Meing Huynh, James Jacobs and James Gear, Brisbane.


RANZCP (Royal Australian and New Zealand College of Psychiatrists) 2018, Medicare Benefits Schedule Review Taskforce: Supplementary Submission, Melbourne.

—— 2017, RANZCP Mental health legislation - comparison tables as at 30 June 2017.


Reupert, A.E., Maybery, D.J. and Kowalenko, N.M. 2012, ‘Children whose parents have a mental illness: prevalence, need and treatment’, _MJA Open_, vol. 1, pp. 7–9.

Richards, D. 2019, ‘Does Australian democracy need a reboot?’, _Company Director Magazine_, vol. 35, no. 1, p. 44.


Robert, S. (Minister for the National Disability Insurance Scheme) 2020a, _Further initiatives to support NDIS participants and providers during coronavirus pandemic_, Media release, Canberra, 27 April.

——— 2020b, _New measures to support NDIS participants and providers through COVID-19_, Media release, Canberra, 21 March.


Rossiter, B., Mallett, S., Myers, P. and Rosenthal, D. 2003, _Living Well? Homeless Young People in Melbourne_, Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne.


Ruston, A. (Minister for the Department of Social Services) 2019, _Unprecedented Support for Australia’s Carers_, Media Release, Canberra, 21 August.


SAMHC (South Australian Mental Health Commission) 2017, South Australian Mental Health Strategic Plan 2017-2022, Adelaide.


SCARC (Senate Community Affairs References Committee) 2016a, Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia, Canberra.


—— 2017, Complaints Mechanism Administered under the Health Practitioner Regulation National Law, Canberra

—— 2018, Accessibility and Quality of Mental Health Services in Rural and Remote Australia, Canberra.


SCMH (Senate Select Committee on Mental Health) 2006, A National Approach to Mental Health: From Crisis to Community, Canberra.


Senate Select Committee on Health 2015, Mental Health: A Consensus for Action, Fourth interim report, Canberra.
References


Skatssoon, J. 2020, “‘Recovery coach” to be added as NDIS item for mental illness’, Community Care Review, 20 February.


SLCA (Senate Legal and Constitutional Affairs Committee) 2013, Value of a Justice Reinvestment Approach, Canberra.


Smith-Merry, J., Goggin, G., Campbell, A., McKenzie, K., Ridout, B. and Bayliss, C. 2019, ‘Social connection and online engagement: insights from interviews with users of a mental health online forum’, JMIR Mental Health, vol. 6, no. 3.


SSCEEWR (Senate Standing Committee on Education, Employment and Workplace Relations) 2013, Questions on notice, additional estimates 2012-13: DEEWR Question No. EW0874_13: Job Capacity Assessments, Canberra.


Standing Council on Health 2012, Mental Health Statement of Rights and Responsibilities, Canberra.


Stokes, B. 2012, Review of the Admission or Referral to and the Discharge and Transfer Practices of Public Mental Health Facilities/Services in Western Australia, Western Australia Department of Health, Perth.


TAS DHHS (Department of Health and Human Services (Tasmania)) 2015, Rethink Mental Health: Better Mental Health and Wellbeing - A Long-term Plan for Mental Health in Tasmania 2015-2025, Mental Health Alcohol and Drug Directorate, Hobart.
REFERENCES

TAS DoC (Department of Communities (Tasmania)) nd, *If You Are Going To Be Away Fact Sheet*, https://www.communities.tas.gov.au/housing/about/tenants/tenancy_facts_and_policies/living_conditions/if_you_are_going_to_be_away (accessed 13 February 2020).


The Bouverie Centre 2019, *Families where a Parent has a Mental Illness (FaPMI) Strategic Priorities 2019 – 2022*, Melbourne.


University of Melbourne, Department of General Practice 2019, *Submission to the Royal Commission into Victoria’s Mental Health System*, SUB.0002.0028.0609, Melbourne.


VAADA and Justice Health Unit (Victorian Alcohol and Drug Association and Justice Health Unit) 2019, *Submission to the Royal Commission into Victoria’s Mental Health System*, SUB.0002.0029.0453, Melbourne.


VIC DJR (Department of Justice and Regulation (Victoria)) 2010, *Court Integrated Services Program: Tackling the Causes of Crime*, Melbourne.


Victoria Police 2019, Submission to the Royal Commission into Victoria’s mental health system, SUB.0002.0029.0370, Melbourne.


——— 2019a, Submission to the Royal Commission into Victoria’s Mental Health System, Sub. 5000.0001.0002, Melbourne.


Victorian Ombudsman 2015, Investigation into the Rehabilitation and Reintegration of Prisoners in Victoria, Melbourne.

VLA (Victoria Legal Aid) 2019a, Response to Question on Notice: Royal Commission into Victoria’s Mental Health System, Melbourne.


WA DOJ, WA DoH and WAMHC (Western Australia Department of Justice, Western Australia Department of Health and Western Australia Mental Health Commission) 2018, Your Guide to Start Court: Participant Manual, Perth.

———, WA NMHS and WAMHC (Western Australia Department of Justice, Western Australia North Metropolitan Health Service and Western Australia Mental Health Commission) 2019, Start Court Guidelines: Revised May 2019, Perth.

WA Housing Authority (Housing Authority (Western Australia)) 2019, Housing Authority Rental Policy Manual, Perth.

WA MHAS (Mental Health Advocacy Service (Western Australia)) 2018, Annual Report 2017-18, Perth.


WA MHT (Western Australia Mental Health Tribunal) 2017, Mental Health Tribunal Annual Report 2017, Annual Report, Perth.


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—— 2016b, Western Australia Mental Health Non-Government Organisation Establishment: In-Brief 2014/15, Perth.


WentWest 2015, High Performing Mental Health in Primary Care: Options for System and Funding Innovation, Sydney.


—— 2019b, Western Australia State Budget 2019-20: Budget Paper No. 2 - Budget Statements Volume 1, Perth.


—— 2013a, How to Use the ICF: A Practical Manual for Using the International Classification of Functioning, Disability and Health (ICF), Exposure draft for comment, Geneva.


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B Public consultations

This appendix describes the stakeholder consultation process undertaken for the Inquiry and lists the organisations and individuals who have participated.

Consultations

The Productivity Commission convened the following consultations processes.

- 6 roundtables: Consumers and Carers; Early Childhood Services; Aboriginal and Torres Strait Islander People in Urban Areas; Mental Health Modelling; Education System; and Workplace Mental Health (table B.5).

- 13 days of public hearings Adelaide (5 February 2020); Brisbane (3 December 2019); Broken Hill (28 November 2019); Canberra (15 November 2019); Darwin (27 February 2020); Geraldton (20 November 2019); Launceston (9 December 2019); Melbourne (18-19 November 2019); Perth (21 November 2019); Sydney (25-26 November 2019) and Rockhampton (2 December 2019) (table B.4).

- Hearings were advertised in *The Australian* on 24 October 2019; the *Midwest Times* on 13 November for Geraldton hearing and *Barrier Daily Truth* 16 November 2019 for Broken Hill and through Facebook and Twitter; through a flyer that was emailed to key stakeholders for distribution and additional information distributed to Inquiry registered participants.

- 278 meetings with individual stakeholders across Australia (B.3).


The Productivity Commission also provided facilities on the Inquiry website for interested stakeholders to lodge a brief comment (table B.2). A total of 488 comments were received — 191 comments prior to the Draft Report and 297 in response to the Draft Report.
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<td>Wesley Mission</td>
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<td>Western Australian Association for Mental Health (WAAMH)</td>
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<td>Western Australian Network of Alcohol and Other Drug Agencies (WANADA)</td>
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<td>William Archer-Blackwood</td>
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<td>Windana</td>
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<td>Youth Health Forum (Consumers Health Forum of Australia)</td>
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<td>Youth Mental Health, North Metropolitan Health Service</td>
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<td>Yvette Litchfield</td>
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<td>Zero Suicide Institute of Australasia</td>
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<td>Zina Coraci</td>
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<td>Zsolt Szabo</td>
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Table B.2  Emailed comments received

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<td>Carers or family members</td>
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<td>Mental health workers and providers</td>
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<td>Other interest persons</td>
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<td>Single focus on early childhood development</td>
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Table B.3  Consultations

Aaron Frost
Aboriginal Health Council of Western Australia
Aboriginal Housing Office
ACT Public Service
ACT Chief Minister, Treasury and Economic Development Directorate
ACT Health Directorate
ACT Corrective Services Directorate
ACT Human Rights Commission
ACT Education Directorate
ACT Community Services Directorate
Adult Community Mental Health Services (Parkside)
Alan England
Alan Woodward
Albury Wodonga Aboriginal Health Service
Alison Jones
Allan Fels
Andrew Robb
Anthony Jorm
Apunipima Cape York Health Council
ARAFMI Illawarra
Arie Frieberg
Australian Bureau of Statistics
Australian Clinical Trials Alliance
Australian College of Mental Health Nurses
Australian Council of Social Services
Australian Council of Trade Union
Australian Counselling Association
Australian Federal Police Association
Australian Government Department of Education
Australian Government Department of Education, Skills and Employment
Australian Government Department of Employment, Skills, Small and Family Business
Australian Government Department of Finance

(continued next page)
## Table B.3  
(continued)

Australian Government Department of Health  
Australian Government Department of Human Services  
Australian Government Department of Jobs and Small Business  
Australian Government Department of Prime Minister and Cabinet  
Australian Government Department of Prime Minister and Cabinet – Indigenous Affairs  
Australian Government Treasury  
Australian Government Department of Social Services  
Australian Housing and Urban Research Institute  
Australian Industry Group  
Australian Institute of Criminology  
Australian Institute of Family Studies  
Australian Institute of Health and Welfare  
Australian Institute for Teaching and School Leadership  
Australian Medical Association  
Australian Mental Health Outcomes and Classification Network  
Australian Psychological Society  
Australian Secondary Principals Association (Andrew Pierpoint)  
Bendigo Community Health Services  
Bendigo Health  
Beyond Blue  
Bill Buckingham  
Black Dog Institute  
Bonny Parkinson  
Brain and Mind Centre  
Brisbane North Primary Health Network  
Brotherhood of St Laurence  
BUPA  
Business SA  
Butterfly Foundation  
Call to Mind  
Carers Australia  
Caroline Johnson  
Carolyn Davis  
Cathy Mihalopoulos  
Central Australia Health Services  
Central Australian Aboriginal Congress  
Centre for Community Child Health, The Royal Children’s Hospital  
Centre for Mental Health – Melbourne School of Population and Global Health, University of Melbourne  
Chief Psychiatrist for Tasmania  
Child and Adolescent Mental Health Services Tasmania (North West)  
Clinical Research Unit for Anxiety and Depression  
Colony47  
Consumers Health Forum of Australia  
Coordinare (South Eastern Primary Health Network)

(continued next page)
Table B.3  (continued)

Darling Downs and West Moreton Primary Health Network
Darren Coppin
David Butt
Delmont Private Psychiatric Hospital
Directors of Student Services of Australia and New Zealand
Disability Advocacy Service
Edward Koch Foundation
Eileen Baldry
Emma Donaldson
Education First Youth Foyer
Eoin Killackey
eOrygen
Evaluate Consulting Pty Ltd
Everymind
Faculty of Education and Arts, University of Newcastle
Forensicare
Foyer Oxford
Gateway Health
Gelnunga International High School (Wendy Johnson)
Genia Janover
Geoff Waghorn
Gippsland Primary Health Network
Grand Pacific Health
Grant Sara
Grattan Institute
HC Innovations
headspace
headspace Toowoomba
headspace Wollongong
Healing Foundation
Helen Milroy
Henry Cutler
Illawarra Shoalhaven Local Health District
Independent Higher Education Australia
Independent Hospital Pricing Authority
Institute of Clinical Psychologists
Intensive Family Parenting Services
Jacinta Hawgood – Australian Institute for Suicide Research and Prevention
James Ibrahim
James Ogloff
Jane Gunn
Jane Pirkis
Jenny Campbell
Jennifer Taylor

(continued next page)
Table B.3 (continued)

| Jenny George – Converge International |
| Jesuit Social Services |
| Joe Coyne |
| Julian McNally |
| Justice Action |
| Justice Health Unit – Melbourne School of Population and Global Health, University of Melbourne |
| Latrobe Health Advocate |
| Leonie Segal |
| Lesley Russell |
| Lifeline Central Australia |
| Lindsay Schofield |
| Lisa Paul |
| Lisa Wood - School of Population and Global Health, University of Western Australia |
| Liz Schroeder |
| Liza Brock |
| Loddon Mallee Mental Health Carers Network |
| Luis Salvador-Carulla – Australian National University |
| Lynette Pierce |
| Kevin Allan – Mental Health Commissioner of New Zealand |
| Marathon Health |
| Martin Hensher |
| Margaret Grigg |
| Marilyn Campbell |
| Martin Knapp – Department of Health Policy, The London School of Economics and Political Science |
| Maureen Dollard |
| Matt Tyler |
| MBS Review Taskforce |
| Melbourne Graduate School of Education (Jim Wattereston) |
| Mental Health Association of Central Australia |
| Mental Health Australia |
| Mental Health Australia Policy Network |
| Mental Health Australia’s CALD Mental Health Consumer and Carer Group |
| Mental Health Families and Friends Tasmania (MHFFTas) |
| Mental Health Complaints Commissioner |
| Mental Health Coordinating Council |
| Mental Health Council of Tasmania |
| Mental Health Information Strategy Standing Committee |
| Mental Health Legal Centre |
| Mental Health Victoria Mentally Healthy Workplace Alliance - CEO Steering Group |
| Mental Illness Fellowship of Australia (MIFA) |
| Michael Woods |
| Millbrook Rise |
| Mind Australia |
| MindSpot |

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### Table B.3 (continued)

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<td>National Disability Insurance Agency</td>
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<td>National Employment Services Association</td>
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<tr>
<td>National Health Practitioner Ombudsman and Privacy Commissioner</td>
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<td>National Indigenous Australians Agency</td>
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<td>National Mental Health Commission</td>
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<td>National Mental Health Consumer and Carer Forum (NMHCCF)</td>
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<td>National Social Security Rights Network</td>
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<td>National Suicide Prevention Project Reference Group</td>
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<td>National Workforce Centre for Child Mental Health</td>
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<td>Neami Wollongong</td>
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<td>Nicola Reavley</td>
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<td>Nolan House (Albury Wodonga Health)</td>
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<td>North West Melbourne Primary Health Network</td>
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<td>NovoPsych</td>
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<td>NPY Women’s Council</td>
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<td>NSW Department of Premier and Cabinet</td>
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<td>NSW Family and Community Services</td>
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<td>NSW Health</td>
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<td>NSW Mental Health Commission</td>
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<td>NSW Police Mental Health Intervention Team</td>
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<td>NT Aboriginal Medical Services Alliance</td>
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<td>NT Council of Social Services</td>
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<td>NT Department of the Attorney-General and Justice</td>
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<td>NT Mental Health Coalition</td>
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<td>Office for Mental Health and Wellbeing</td>
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<td>One Door Sydney</td>
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Table B.3 (continued)

OzHelp
Pandsi
Peer Participation in Mental Health Service Network
Peggy Brown
Philip Burgess
Primary Health Network Tasmania
Qantas
QBE Insurance
Queensland Alliance for Mental Health
Queensland Centre for Mental Health Research
Queensland Department Communities, Disability Services and Seniors
Queensland Department of Housing and Public Works
Queensland Health
Queensland Mental Health Commission
Queensland Office of the Chief Psychiatrist
Recovery Camp
Regional and Rural Mental Health Services
Regional Australia Institute
Relationships Australia
Relationships Australia South Australia
Review of the Clinical Governance of Public Mental Health Services in Western Australia Panel
Richardson and Lyons
Rivendell Clinic (North West Private Hospital)
Rod Astbury
Rosebud Secondary College (Clorinda Semienowcz)
Roses in the Ocean
Rowena Jacobs
Roy Fagan Centre
Royal Australian and New Zealand College of Psychiatrists
Royal Australian College of General Practitioners
Royal North Shore Hospital
Rural & Remote Mental Health
Rural Health Tasmania
Ryde Community Centre
Safe Work Australia
SA Department of Education
SA Department of Health
SA Mental Health CALD Community Conversation
SA Mental Health Commission
SA Mental Health Commission’s Youth Advisory Group
SA Office of the Chief Psychiatrist
Sally Sinclair
SA Office of the Public Advocate
School of Education and Professional Studies – Griffith University

(continued next page)
| School of Public Health – University of Queensland |
| Sebastian Rosenberg |
| South Adelaide Local Health Network |
| South East Melbourne Primary Health Network |
| Specialist Aboriginal Mental Health Service |
| St. Charles Borromeo Primary School |
| Steps Employment |
| Suicide Prevention Australia |
| Superfriend |
| Tandem |
| Tangentyere Council |
| Tasmanian Department of Health and Human Services |
| Tasmania Suicide Prevention Community Network |
| Telethon Kids Institute |
| Tertiary Education Quality and Standards Authority |
| Tim Heffernan |
| The Bouverie Centre |
| The Haven Foundation |
| The Royal Commission into Victoria’s Mental Health System |
| Their Futures Matter – NSW Government |
| Therapeutic Goods Administration |
| Timothy Marney |
| Universities Australia |
| Vanguard Laundry Services |
| Victoria Legal Aid |
| Victoria Magistrates Court |
| Victorian Automobile Chamber of Commerce |
| Victorian Department of Education and Training |
| Victorian Department of Health and Human Services |
| Victorian Mental Health Complaints Commissioner - Advisory Council |
| Western Australian Association for Mental Health |
| Western Australian Child and Adolescent Health Service |
| Western Australian Department of Communities |
| Western Australian Department of Health – Mental Health Unit |
| Western Australian Department of Premier and Cabinet |
| Western Australian Magistrate |
| Western Australian Mental Health Commission |
| Western Australian Primary Health Alliance |
| Wellways |
| WISE Employment |
| Youth Insearch |
### Table B.4 Public Hearings

**Canberra — 15 November 2019**
- Mental Health Australia
- Mental Health Carers Australia (MHCA)
- Consumers’ Health Forum of Australia
- Early Childhood Australia
- Perinatal Wellbeing Centre
- Diana Rendell
- Colin Hales
- ACT Disability, Aged and Carer Advocacy Service (ADACAS)
- batyr
- Mental Health Community Coalition ACT
- Families and Friends for Drug Law Reform
- Develop Daily
- Terry De Luca
- Julianne Christie
- Fox Fromholtz
- Jane Jervis
- Mary Cormick
- David Lovegrove
- Julianne Christie
- Joan Lipscombe

**Melbourne Day 1 — 18 November 2019**
- Ben Goodfellow and Campbell Paul
- Centre for Social Impact, Swinburne
- Australian Nursing and Midwifery Federation (Victorian Branch)
- Australasian Sleep Association
- Victoria Legal Aid
- Mind Australia
- Restart Health Services
- Launch Housing
- Eating Disorders Victoria
- Ann Moir-Bussy
- Michael Blair
- Tandem
- Consortium of Psychiatrists
- Monash University
- Andrew Morgan
- First Step
- Health and Community Services Union
- David Clark
- Tess Reilly-Browne
- Donna Hansen-Vella
- Borderline Personality Disorder Community

(continued next page)
Table B.4 (continued)

**Melbourne Day 2 — 19 November 2019**
- People Power International
- Mental Health Victoria
- Beyond Blue
- Prevention United
- Vikein Mouradian
- Victorian Mental Illness Awareness Council
- Mental Health Legal Centre
- CyberValues.org
- Australia Music Therapy Association
- Debra Scott
- Royal Australian and New Zealand College of Psychiatrists, Victoria
- Australians for Mental Health
- Independent Private Psychiatrists Group
- The ACT of Living
- Prue Lynch

**Geraldton — 20 November 2019**
- HelpingMinds
- Headspace, Geraldton
- Elucidate
- Cathy Fox
- Geraldton Regional Aboriginal Medical Service

**Perth — 21 November 2019**
- Consumers of Mental Health Western Australia
- HBF Health
- St Bartholomew’s House Inc
- Mr Sjon Kraan
- Beyond Words Counselling
- Patricia Owen
- Mike Anderson
- Commissioner for Children and Young People Western Australia
- WA Primary Health Alliance
- John Dallimore
- Western Australian Association for Mental Health (WAAMH)
- Jay Anderson
- David Napoli
- David Hillman
- Joseph Naimo
- Michael Finn
- Jenne Fitzhardinge
- Hannah McGlade
- Andris Markovs
- Pamela Scott-Gale
- Rebecca James

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| **Sydney Day 1 — 25 November 2019** | Patricia and Andrew Anderson  
Suicide Prevention Australia  
Royal Australian and New Zealand College of Psychiatrists, Sydney  
Marie Butler-Cole  
MetLife and Financial Services Council  
Being  
Wisa Wellbeing in Schools Australia  
Better Health Generation  
Australian Services Union  
University of Sydney and the Woolcock Institute of Mental Research  
School Nurses Australia  
Orygen  
New South Wales Council of Social Service  
Headspace Sunshine  
Vicious Cycle PMDD.  
Mental Health Carers NSW (MHCN)  
Community Mental Health Australia (CMHA)  
Emma Spinks and Ian Thompson  
National LGBTI Health Alliance  
Matthew Fitzpatrick |
| **Sydney Day 2 — 26 November 2019** | Jeni Diekman  
Mitchell Peacock  
Ron Spielman  
Scarlett Franks  
Mental Health Coordinating Council  
Alicia Boyd  
Roger Gurr  
Grief Journeys  
Gita Irwin  
Grassroots Approach Programs  
Citizens Commission on Human Rights  
Andrew Pryor  
Libby Ducasse  
Deborah Barit |
| (continued next page) |
### Table B.4 (continued)

#### Broken Hill — 28 November 2019
- Jan Hayman – Lifeline Connect
- Marisa Pickett and Len White (Board Member) – Lifeline
- Joanie Sanderson
- Maxine Hinton
- Glenda Beeston
- Peter Gough – Maari Ma Aboriginal health Corporation
- Vanessa Smith – Broken Hill Community Mental Health, Drug and Alcohol Service
- Jode Callegher – Catholic Care
- Christy McManus – Far West Local Health District
- Les Jones – Murdi Paaki Regional Assembly, Maari Ma Health, Murdi Paaki Regional Housing Corporation
- Vanessa Latham and Emma Osman – Royal Flying Doctor Service
- Kayelene Crossing – Warra Warra Legal Service
- Famu Nachiappan – General Practitioner
- Jo-Anne Cole

#### Rockhampton — 2 December 2019
- Queensland Alliance for Mental Health
  - John Pink
  - Headspace, Bundaberg
  - Rise Above Aces Group
  - Anglicare Central Queensland
  - Eating Disorders Queensland
  - Triple P International
  - Robert Wellman
  - Anonymous

#### Brisbane — 3 December 2019
- Grow Australia
- Helena Williams
- Mental Illness Fellowship of Australia (MIFA)
- Geoffrey Waghorn
- Royal Australian and New Zealand College of Psychiatrists
- Christine Newton
- Tania Murdock
- Qld Nurses and Midwives Union
- Qld Council for LGBTI Health
- Beryl-Ann Anderson
- Qld Seafood Industry Council
- Kay Cogan
- Arafmi
- Niall McLaren
- Qld PHNs (North Brisbane, South Brisbane and Western Qld)
- Stefanie Roth
- Melissa Costin

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<td>Pippa Ross</td>
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<td>David Asten</td>
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<td>Tasmanian Life Counselling</td>
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<td>Caring Fairly</td>
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<td>Mental Health Families and Friends Tasmania (MHFFTas)</td>
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**Adelaide — 5 February 2020**

Australian Counselling Association

Bob Riessen

Skylight Mental health

Medical Consumers Association

Aaron Fornarino

GP Mental Health Standards Collaboration

Leanne Longfellow

Sally Tregenza

Patricia Sutton

Danielle Malone

Lived Experience Leadership and Advocacy Network

Mental Health Coalition South Australia

UnitingSA

Melissa Raven

Royal Australian College of General Practitioners

J Michael Innes

Salvation Army Ingle Farm

Emerging Minds

Lucy Trethewey

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<table>
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<td>Darwin — 24 February 2020</td>
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<td>Bob Napier</td>
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<td>Rosemary Clancy</td>
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<td>Linda Spencer</td>
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<td>Jos Van Der Sman</td>
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<td>Philip Benjamin</td>
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<td>Top End Women’s Legal Service</td>
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<td>Tanya Kretschmann</td>
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<td>Northern Territory Mental Health Coalition</td>
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<td>Mental Health Association of Central Australia</td>
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<td>Trinity Ryan</td>
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<td>Aboriginal Medical Services Alliance Northern Territory</td>
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<td>Saltbush Social Enterprises</td>
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<td>Australian Association for Infant Mental Health</td>
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<td>TeamHealth</td>
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</table>
### Table B.5  **Roundtables**

**4 February 2020 — Consumers and Carers**
- Andris Banders
- Anne Barbara
- Belinda Ryan
- Camilo Guaqueta
- Carmen H
- Cecil Camilleri
- Dannielle Post
- Darren Hunt
- Ellie Hodges
- Enaam Oudih
- Graham Deakin
- Jodus Madrid
- Keryn Robelin
- Leanne Galpin
- Lyn English
- Paola Mason
- Patricia Sutton
- Sarah Sutton
- Tanya Hunter

**11 February 2020 — Workplace Mental Health**
- Allianz
- Australian Chamber of Commerce and Industry
- Australian Council of Trade Unions
- Australian Industry Group
- Beyond Blue
- Carolyn Davis
- Chamber of Minerals and Energy WA
- Comcare
- Converge International
- Corporate Mental Health Alliance
- EAP Professionals Association of Australia
- Insurance Council of Australia
- Mentally Healthy Workplace Alliance
- icare NSW
- Superfriend
- Workcover Qld

Allianz: Mark Pittman
Australian Chamber of Commerce and Industry: Jennifer Low
Australian Council of Trade Unions: Liam O’Brien
Australian Industry Group: Tracey Browne
Beyond Blue: Greg Jennings
Beyond Blue: Jason Davies-Kildea
Carolyn Davis: Elysha Millard
Comcare: Natalie Bekis
Converge International: Jenny George
Corporate Mental Health Alliance: Kate Connors
EAP Professionals Association of Australia: Lana Schwartz
Insurance Council of Australia: Tom Lunn
Mentally Healthy Workplace Alliance: Lucy Brogden
icare NSW: Chris Harnett
Superfriend: Margo Lydon
Workcover Qld: Matt Bannon
### Table B.5  (continued)

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<th>Date</th>
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<td>11 February 2020</td>
<td>Mental Health Modelling</td>
<td>Peter Butterworth</td>
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<td></td>
<td>ANU College of Health and Medicine; Melbourne Institute</td>
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<tr>
<td></td>
<td>Bill Buckingham</td>
<td>David Johnston</td>
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<tr>
<td></td>
<td>Centre for Health Economics, Monash University</td>
<td>Cathy Mihalopoulous</td>
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<tr>
<td></td>
<td>Deakin Health Economics, Deakin University</td>
<td>Jian Wang</td>
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<td></td>
<td>Department of Health</td>
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<td>Economic Modelling Group, KPMG</td>
<td>Chris Schilling</td>
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<td>Royal Commission into Victoria’s Mental Health System</td>
<td>Phuong Nguyen</td>
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<td>Treasury</td>
<td>Phil Harslett</td>
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<td>Victoria Institute of Strategic Economic Studies, Victoria University</td>
<td>Kim Sweeney</td>
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<td>13 February 2020</td>
<td>Aboriginal and Torres Strait Islander People in Urban Areas</td>
<td>Lillian Gordon</td>
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<td>Aboriginal Affairs NSW</td>
<td>Anthony Seiver</td>
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<td>Aboriginal Affairs NSW</td>
<td>Renee Thomson</td>
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<tr>
<td></td>
<td>Aboriginal Counselling</td>
<td>Craig Brown</td>
</tr>
<tr>
<td></td>
<td>Aboriginal Medical Service (Redfern)</td>
<td>LaVerne Bellear</td>
</tr>
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<td></td>
<td>InCulture</td>
<td>William Trewynn</td>
</tr>
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<td></td>
<td>Karabena Consulting</td>
<td>Kerry Arabena</td>
</tr>
<tr>
<td></td>
<td>Lowitja Institute</td>
<td>Sanchia Shibasaki</td>
</tr>
<tr>
<td></td>
<td>Marrin Weejali Aboriginal Corporation</td>
<td>Cheryl Jackson</td>
</tr>
<tr>
<td></td>
<td>Ngaora Ltd</td>
<td>Ngiare Brown</td>
</tr>
<tr>
<td></td>
<td>NSW Health</td>
<td>Tom Brideson</td>
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<td></td>
<td>Ozchid</td>
<td>Dea Delaney-Thiele</td>
</tr>
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<td></td>
<td>Tharawal Aboriginal Corporation</td>
<td>Darryl Wright</td>
</tr>
<tr>
<td></td>
<td>Thirrili</td>
<td>Adele Cox</td>
</tr>
<tr>
<td></td>
<td>University of Western Australia</td>
<td>Helen Milroy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 February 2020</td>
<td>Early Childhood Services</td>
<td>Jason Mason</td>
</tr>
<tr>
<td></td>
<td>Ann Kennedy</td>
<td>Joanna Harrison</td>
</tr>
<tr>
<td></td>
<td>Australian Children’s Education and Care Quality Authority</td>
<td></td>
</tr>
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<td></td>
<td>Australian Government Department of Education</td>
<td>Samantha Page</td>
</tr>
<tr>
<td></td>
<td>Early Childhood Australia</td>
<td>Brad Morgan</td>
</tr>
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<td></td>
<td>Emerging Minds</td>
<td>Penny Markham</td>
</tr>
<tr>
<td></td>
<td>Goodstart Early Learning</td>
<td>Jan Finlayson</td>
</tr>
<tr>
<td></td>
<td>Maternal, Child and Family Health Nurses Australia</td>
<td>Frank Oberklaid</td>
</tr>
<tr>
<td></td>
<td>Murdoch Children’s Research Institute</td>
<td>Brigid Jordan</td>
</tr>
<tr>
<td></td>
<td>Murdoch Children’s Research Institute</td>
<td>Warren Cann</td>
</tr>
<tr>
<td></td>
<td>Parenting Research Centre</td>
<td></td>
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<td></td>
<td>Victorian Department of Education</td>
<td>Susan McDonald</td>
</tr>
<tr>
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**Table B.5** (continued)

<table>
<thead>
<tr>
<th>17 February 2020 — Education System</th>
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<tbody>
<tr>
<td>Australian Government Department of Education</td>
<td>Michelle Clewett</td>
</tr>
<tr>
<td>Australian Heads of Independent Schools</td>
<td>Beth Blackwood</td>
</tr>
<tr>
<td>Australian Institute for Teaching and School Leadership</td>
<td>Daniel Pinchas</td>
</tr>
<tr>
<td>Australian Primary Principals Association</td>
<td>Michael Nutall</td>
</tr>
<tr>
<td>Australian Psychologists and Counsellors in Schools</td>
<td>Marilyn Campbell</td>
</tr>
<tr>
<td>Australian Secondary Principals Association</td>
<td>Andrew Pierpoint</td>
</tr>
<tr>
<td>Be You</td>
<td>Jason Davies-Kildea</td>
</tr>
<tr>
<td>Beyond Blue</td>
<td>Louisa Ellum</td>
</tr>
<tr>
<td>Catholic Education Melbourne</td>
<td>Dennis Torpy</td>
</tr>
<tr>
<td>Headspace Schools</td>
<td>Kristen Douglas</td>
</tr>
<tr>
<td>La Trobe University</td>
<td>Joanna Barbousas</td>
</tr>
<tr>
<td>Melbourne Graduate School of Education</td>
<td>Jim Watterston</td>
</tr>
<tr>
<td>Murdoch Children’s Research Institute</td>
<td>Frank Oberklaid</td>
</tr>
<tr>
<td>NSW Education Standards Authority</td>
<td>Lyn Kirkby</td>
</tr>
<tr>
<td>Qld Department of Education</td>
<td>Hayley Stevenson</td>
</tr>
<tr>
<td>Rosebud Secondary College</td>
<td>Clorinda Siemenowicz</td>
</tr>
<tr>
<td>SA Department of Education</td>
<td>Katerina Eleutheriou</td>
</tr>
<tr>
<td>St Charles Borromeo Primary School</td>
<td>Sue Cahill</td>
</tr>
<tr>
<td>Victorian Department of Education</td>
<td>Justin McDonnell</td>
</tr>
</tbody>
</table>
C Income and employment support

This appendix provides further detail on:

- the current income and employment support system — including key payments (Disability Support Pension (DSP), JobSeeker Payment, Youth Allowance) and key employment programs (jobactive, Disability Employment Services (DES), Community Development Program (CDP))
- mechanisms that stream income support recipients into employment support programs (Job Seeker Classification Instrument (JSCI) and Employment Services Assessment (ESA))
- the Individual Placement and Support (IPS) model of employment support
- employment support program mutual obligation requirements (MORs)
- temporary changes to the income and employment support system in response to the COVID-19 pandemic.

C.1 The income and employment support system

Income support payments

Income support payments have different sized cohorts, payment rates and eligibility criteria (table C.1). Temporary changes were made to payments as part of the Australian Government response to the COVID-19 pandemic (section C.5).
### Table C.1  Comparison of key income support payments

**June 2019**

<table>
<thead>
<tr>
<th></th>
<th>Newstart Allowance&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Youth Allowance (job seeker)</th>
<th>Disability Support Pension</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cohort of interest&lt;sup&gt;b&lt;/sup&gt;</strong></td>
<td>181 700</td>
<td>9 200</td>
<td>258 600</td>
</tr>
<tr>
<td><strong>Estimated cost for cohort of interest&lt;sup&gt;c&lt;/sup&gt;</strong></td>
<td>$2.6 billion</td>
<td>$98 million</td>
<td>$5.8 billion</td>
</tr>
<tr>
<td><strong>Productivity Commission estimate of cohort of interest&lt;sup&gt;d&lt;/sup&gt;</strong></td>
<td>291 600</td>
<td>24 400</td>
<td>486 500</td>
</tr>
<tr>
<td><strong>Estimated cost for Productivity Commission estimate of cohort of interest</strong></td>
<td>$4.1 billion</td>
<td>$259 million</td>
<td>$10.9 billion</td>
</tr>
<tr>
<td><strong>Total recipients</strong></td>
<td>686 800</td>
<td>82 800</td>
<td>745 700</td>
</tr>
<tr>
<td><strong>Payment rate&lt;sup&gt;e&lt;/sup&gt;</strong></td>
<td>$565.70</td>
<td>$462.50</td>
<td>$860.60 (if aged over 21 years)</td>
</tr>
</tbody>
</table>

#### Eligibility criteria

- Aged 22–66 years
- Unemployed and looking for full-time work
- Willing to complete activity requirements
- Income and assets tests (individual and partner)
- Meet residency criteria

- Aged 16–21 years
- Unemployed and looking for full-time work
- Willing to complete activity requirements
- Income and assets tests (individual, partner and parent)
- Meet residency criteria

- Aged 16–66 years
- Have a permanent disability that reduces potential work capacity to less than 15 hours a week over at least the next 2 years (box C.1)
- Willing to complete activity requirements (if aged under 35 years)
- Income and assets test (individual and partner)
- Meet residency criteria

---

<sup>a</sup> The JobSeeker Payment replaced the Newstart Allowance and some other payments in March 2020.

<sup>b</sup> As determined by administrative data from the Department of Education, Skills and Employment and Department of Social Services. Newstart Allowance and Youth Allowance cohorts are recipients deemed to have a mental illness and the Disability Support Pension cohort is recipients with a primary psychological or psychiatric disability.

<sup>c</sup> Productivity Commission cost estimates based on the total cost of provision apportioned to the relevant proportion of recipients for 2018-19.

<sup>d</sup> Productivity Commission estimates of the proportion of separate payment recipients with any mental illness from the National Health Survey 2014-15, apportioned to the number of total recipients in June 2019.

<sup>e</sup> Payment rate for people who are single, aged over 18 years, with no children and no other income source.

**Source:** ABS (*Microdata: National Health Survey 2014-15*, Cat. no. 4364.0.55.001); Australian Government (2019b); DESE (unpublished); DJSB (2019); DSS (2018a, 2019a, unpublished); Parliamentary Library (2017); Services Australia (2020b, 2020e, 2020h).
Disability Support Pension

The DSP is an income support payment for people whose ability to work is impaired by a permanent physical, intellectual or psychiatric condition. Applicants with a manifest condition (for example, permanent blindness or terminal illness) are generally eligible if they meet age, residency and income and asset requirements (box C.1). All other applicants must have their eligibility determined through a range of criteria (as well as meeting the same age, residency and income and asset requirements as manifest applicants).

Box C.1 Disability Support Pension eligibility criteria

The Disability Support Pension application process gathers information about disability permanence, functional impairment caused by a disability and the impact of this functional impairment on an applicant’s employment prospects. Recipients must be aged between 16–66 years (those aged over 66 years receive the Age Pension) and income and asset limits also apply.

Applicants must:
- have their condition assessed as ‘fully diagnosed, treated and stabilised’ by a Job Capacity Assessor;
- be scored over 20 points across the Impairment Tables (discussed below) by a Job Capacity Assessor (who assesses functional capacity);
- complete an 18-month Program of Support (this requirement is void if the applicant scores at least 20 points on a single impairment table); and
- complete a Disability Medical Assessment by a government contracted doctor.

Impairment Table Five is used to assess the functional capacity of applicants with a mental illness (self-care and independent living, interpersonal relationships and concentration and task completion, among others (table C.2)).

Source: ANAO (2017b); Services Australia (2019).

Impairment tables

Job Capacity Assessors assess the functional capacity of DSP applicants using ‘Impairment Tables’. Applicants must score at least 20 points across the impairment tables to be eligible for the payment. Applicants who score 20 points or more over multiple tables but do not score at least 20 points on a single table are deemed to not have a severe impairment. These applicants must compete a Program of Support — 18 months of participation in an employment support program (such as jobactive or DES), before becoming eligible for the DSP. This is not a requirement for those who score over 20 on a single table.

Of particular relevance is Impairment Table Five, which assesses the impact of a psychological or psychiatric condition on an applicant’s functional impairment (table C.2).
### Table C.2 Summary of Impairment Table Five

<table>
<thead>
<tr>
<th>Activity</th>
<th>None (0 points)</th>
<th>Moderate (10 points)</th>
<th>Severe (20 points)</th>
<th>Extreme (30 points)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-care and independent living</strong></td>
<td>The person lives independently and attends to all self-care needs without support.</td>
<td>The person needs some support to live independently and maintain adequate hygiene and nutrition.</td>
<td>The person needs regular support to live independently.</td>
<td>The person needs continual support with daily activities and self-care and/or is unable to live on their own and lives with family or supported residential or secure facility.</td>
</tr>
<tr>
<td><strong>Social/recreational activities and travel</strong></td>
<td>The person goes to social or recreational events regularly without support and/or travels alone to new environments.</td>
<td>The person goes out alone infrequently and/or will often refuse to travel alone to new environments.</td>
<td>The person travels alone only in familiar areas.</td>
<td>The person is unable to travel away from own residence without a support person.</td>
</tr>
<tr>
<td><strong>Interpersonal relationships</strong></td>
<td>The person has no difficulty forming and sustaining relationships.</td>
<td>The person has difficulty making and keeping friends or sustaining relationships.</td>
<td>The person has very limited social contacts/involvement unless organised for them and/or often has difficulty interacting with other people and may need assistance/support to socialise.</td>
<td>The person has extreme difficulty interacting with other people and is socially isolated.</td>
</tr>
<tr>
<td><strong>Concentration and task completion</strong></td>
<td>The person has no difficulties concentrating on most tasks and/or is able to complete a training or educational course or qualification in the normal timeframe.</td>
<td>The person finds it very difficult to concentrate on longer tasks for more than 30 minutes and/or finds it difficult to follow complex instructions.</td>
<td>The person has difficulty concentrating on any task or conversation for more than 10 minutes and/or has slowed movements or reaction time due to psychiatric illness or treatment effects.</td>
<td>The person has extreme difficulty in concentrating on any productive task for more than a few minutes and/or has extreme difficulty in completing tasks or following instructions.</td>
</tr>
<tr>
<td><strong>Behaviour, planning and decision making</strong></td>
<td>There is no evidence of significant difficulties in behaviour, planning or decision-making.</td>
<td>The person has difficulty coping with situations involving stress, pressure or performance demands, has occasional behavioural or mood difficulties.</td>
<td>The person’s behaviour, thoughts and conversation are significantly and frequently disturbed.</td>
<td>The person has severely disturbed behaviour which may include self-harm, suicide attempts, unprovoked aggression towards others or manic excitement.</td>
</tr>
<tr>
<td><strong>Work/training capacity</strong></td>
<td>The person is able to cope with the normal demands of a job which is consistent with their education and training.</td>
<td>The person often has interpersonal conflicts at work, education or training that require intervention or changes in placement or groupings.</td>
<td>The person is unable to attend work, education or training on a regular basis over a lengthy period due to ongoing mental illness.</td>
<td>The person is unable to attend work, education or training sessions other than for short periods of time.</td>
</tr>
</tbody>
</table>

Disability Support Pension population and trends

A growing share of DSP recipients live with mental ill-health. The share of the working-age population receiving the DSP for mental health-related conditions increased from 1.1% to 1.7% between 2001 and 2015, but declined to less than 1.6% by 2019 (figure C.1). And between 2001 and 2019, the share of DSP recipients with a primary psychological or psychiatric condition increased from 23% to 35%. This reflects both an increase in the number of recipients with a mental illness-related condition and a fall in the number of recipients with a musculoskeletal impairment, which was previously the most common impairment type (figure C.2).

Figure C.1 Mental illness-related Disability Support Pension recipients
Share of working-age population and share of all DSP recipients who receive the DSP due to psychological or psychiatric disability

Source: Productivity Commission estimates using ABS (Australian Demography Statistics, June 2019, Cat. no. 3101.1) and DSS (2013, 2016, various years).

The increase in DSP recipients with primary psychological or psychiatric impairments mirrors international trends, as mental illness represents a growing share of new disability benefit claims in many OECD nations. The OECD suggests these trends are caused by:

- a greater awareness of mental health, which has led to shifts in diagnosed causes of the incapacity to work (with mental illness now more likely to be the root cause of work issues for people with comorbidities in particular)
- work becoming more psychologically demanding, which reduces the ability of people with mental illness to remain in work.
Payment rates

The rate at which the DSP is paid depends on participant characteristics (table C.3).

Table C.3  Disability Support Pension fortnightly payment rates
As at March 2020

<table>
<thead>
<tr>
<th>Individual characteristics</th>
<th>Maximum payment rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 21 years with no children</td>
<td></td>
</tr>
<tr>
<td>Single, under 18 years, live at parent/guardian’s home</td>
<td>$385.10</td>
</tr>
<tr>
<td>Single, under 18 years, independent</td>
<td>$594.40</td>
</tr>
<tr>
<td>Single, aged 18–20 years, live at parent/guardian’s home</td>
<td>$436.50</td>
</tr>
<tr>
<td>Single, aged 18–20 years and independent</td>
<td>$594.49</td>
</tr>
<tr>
<td>A member of a couple, aged or under 20 years</td>
<td>$594.40</td>
</tr>
<tr>
<td>21 years or over, with/without children, or under 21 years with children</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$860.60</td>
</tr>
<tr>
<td>Couple (each)</td>
<td>$648.70</td>
</tr>
<tr>
<td>Couple (each, separated due to ill-health)</td>
<td>$860.60</td>
</tr>
</tbody>
</table>

Source: Services Australia (2020b).
JobSeeker Payment

The JobSeeker Payment is the general payment for working-age income support recipients. It is available for people between the ages of 22 and 66 years who are looking for work, cannot work or study due to sickness or injury, or have recently lost their partner (Services Australia 2020e). This payment replaced the Newstart Allowance (which specifically targeted people looking for work), Sickness Allowance, Wife Pension, Widow B Pension and Bereavement Allowance in March 2020.

The rate at which the JobSeeker Payment is paid depends on participant characteristics (table C.4). As part of the Australian Government response to the COVID-19 pandemic, JobSeeker Payment recipients also received the Coronavirus Supplement (section C.5).

<table>
<thead>
<tr>
<th>Individual characteristics</th>
<th>Maximum payment rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single, no children</td>
<td>$565.70</td>
</tr>
<tr>
<td>Single, with a dependent child/children</td>
<td>$612.00</td>
</tr>
<tr>
<td>Single, aged 60 years or over, after 9 continuous months on payment</td>
<td>$612.00</td>
</tr>
<tr>
<td>Partnered (each)</td>
<td>$510.80</td>
</tr>
<tr>
<td>Single principal carer granted an exemption due to carer commitments(a)</td>
<td>$790.10</td>
</tr>
</tbody>
</table>

\(a\) Including foster caring, non-parent relative caring under a court order, home schooling, distance education or large family.

Source: Services Australia (2020e).

Youth Allowance

The Youth Allowance is income support for students and job seekers.

- **Student** recipients must meet any one of the following criteria:
  - aged 18–24 years and studying full-time
  - aged 16–24 years and undertaking a full-time Australian Apprenticeship
  - aged 16–17 years and independent or required to live away from home to study (Services Australia 2020j).

- **Job seeker** recipients must be aged 16–21 years and looking for full-time work (Services Australia 2020i).

The rate at which the Youth Allowance is paid depends on participant characteristics (table C.5). As part of the Australian Government response to the COVID-19 pandemic, Youth Allowance recipients also received the Coronavirus Supplement (section C.5).
Table C.5  **Youth Allowance fortnightly payment rates**  
As at March 2020

<table>
<thead>
<tr>
<th>Recipient characteristics</th>
<th>Maximum payment rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single, no children, under 18 years, live at parent/guardian’s home</td>
<td>$253.20</td>
</tr>
<tr>
<td>Single, no children, under 18 years, need to live away from parent/guardian’s home</td>
<td>$462.50</td>
</tr>
<tr>
<td>Single, no children, over 18 years, live at parent/guardian’s home</td>
<td>$304.60</td>
</tr>
<tr>
<td>Single, no children, over 18 years, need to live away from parent/guardian’s home</td>
<td>$462.50</td>
</tr>
<tr>
<td>Single with children</td>
<td>$606.00</td>
</tr>
<tr>
<td>Partnered, no children</td>
<td>$462.50</td>
</tr>
<tr>
<td>Partnered, with children</td>
<td>$507.90</td>
</tr>
<tr>
<td>Single, job seeker, principal carer and exempt from activity requirements(^a)</td>
<td>$790.10</td>
</tr>
</tbody>
</table>

\(^a\) Including foster caring, home schooling, distance education or large family.

*Source: Services Australia (2020h, 2020k).*

**Employment support**

The Australian Government’s main employment support programs are:

- **jobactive** — the general employment support program
- **DES** — employment support for people whose main barrier to employment is a disability
- **CDP** — employment support for people in remote areas (table C.6).

Participation in these programs is compulsory for job seekers who receive income support payments and have been assessed as able to actively look for work (that is, most JobSeeker Payment and Youth Allowance recipients, and some DSP recipients aged under 35 years) (ANAO 2017b).
Table C.6  **Comparison of key employment support programs**  

June 2019

<table>
<thead>
<tr>
<th></th>
<th>jobactive</th>
<th>Disability Employment Services</th>
<th>Community Development Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohort of interest(^a)</td>
<td>85 100</td>
<td>95 690</td>
<td>3 780</td>
</tr>
<tr>
<td>Estimated cost for cohort of interest(^a)</td>
<td>$139 million(^b)</td>
<td>$328 million(^c)</td>
<td>$53 million(^d)</td>
</tr>
<tr>
<td>Total number of participants</td>
<td>614 200</td>
<td>238 300</td>
<td>30 000</td>
</tr>
<tr>
<td>Program streams</td>
<td>A (12%), B (37%) and C (50%)</td>
<td>Disability Management Services (43%) and Employment Support Services (57%)</td>
<td>No streams</td>
</tr>
</tbody>
</table>

\(^a\) Jobactive and Community Development Program cohorts are participants deemed to have a mental illness and the Disability Employment Services cohort is participants with a primary psychological or psychiatric disability.  

\(^b\) Estimated from the total cost of provision and the proportion of recipients with a mental illness for 2018-19.  

\(^c\) This estimate was supplied by the Department of Education, Skills and Employment and is equivalent to the value of payments supplied to jobactive providers supporting job seekers deemed to have a mental illness.  

\(^d\) May include other non-DES disability employment services (valued at approximately $35 million).  

\(^e\) Estimate based on 2017-18 cost data.  

Source: ANAO (2017a); DESE (unpublished); DJSB (2019); DSS (2019a, 2019b, unpublished); National Indigenous Australians Agency (unpublished).  

In addition, there are various specialised employment support programs (box C.2).

**Box C.2  Specialised employment support programs**

**Transition to Work** is a work readiness program for young people aged 15–21 years that bridges the transition between education and employment. Participants are supported to find apprenticeships, traineeships or pathways to tertiary education. The program also organises ‘youth bonus wage subsidies’ of up to $10 000 over six months for some participating employers (DESE 2020a).

**Time to Work** is a national voluntary in-prison employment support program targeted at adult sentenced Aboriginal and Torres Strait Islander prisoners. This program aims to better prepare participants for employment and community re-integration after prison. The service provides employment barrier assessments, transition plans and links participants to an external employment support provider when their sentence ends (DESE 2020c).

**ParentsNext** is a support program to help parents set study and work goals and access community services. Participants are eligible if they are parents with children aged under six years and have received the Parenting Payment and not earned income in the past six months (Services Australia 2020f).

The Department of Education, Skills and Employment is currently piloting a new online employment support program that is intended to replace jobactive from 2022. Current trials are located in South Australia and New South Wales. As described below, Stream A participants received the new program first (July 2019), with Stream B and C starting the trial in November 2019 (DESE 2020b).
The current streams of jobactive will remain intact. Stream A (renamed Digital First) participants will complete all activity requirements and reporting obligations online and will not attend face-to-face provider appointments. Participants will have access to a contact centre via phone or online (DESE 2020b).

Stream B (Digital Plus) participants will complete activity requirements online and will receive face-to-face skills development or training through a contact centre. They may also receive support to pay for transport- or employment-related costs, be connected with an employment support provider and participate in complementary services (for example, Career Transition Assistance or PaTH Internships) (DESE 2020b).

Stream C (Enhanced Services) participants are assessed to face multiple barriers to employment. These participants will have access to the online platform but will receive individualised support from an employment support provider. Services include connecting a participant with training and education or work experience, career mentoring, counselling, job placement and post-placement support (DESE 2020b).

A key development in the new program is the establishment of a new points-based activity requirement system. This will give participants more choice and flexibility around the activities completed to register obligation requirements. More intensive activities (for example, job interviews and job search) receive more points, but other approved work focused activities will also contribute to meeting fortnightly targets (NSSRN 2019). Financial penalties will remain in place for participants who fail to meet their mutual obligation requirements and participants will be notified of these via their online dashboard (DESE 2020b).

## C.2 Mechanisms that stream income support recipients into employment support programs

Services Australia (branded as Centrelink) applies the JSCI and the (ESAt) to stream JobSeeker Payment and Youth Allowance recipients between jobactive and DES employment support programs (figure C.3).

There are also streams within jobactive and DES (figure C.3). Participants considered to have a low risk of remaining unemployed over the long term are referred to Stream A or B of jobactive, while participants who need more assistance are referred to Stream C. If the ESAt determines a disability to be an individual’s main barrier to employment, they are referred to DES. Of these participants, those who need only job search support are placed in Disability Management Services and those who are likely to require ongoing support after finding employment are referred to Employment Support Services levels 1 or 2.

Participants can be reassessed to ensure their level of support remains appropriate if they experience a change of circumstances (for example, worsening or improving health, moving to a town with different employment opportunities or becoming homeless).
Participants considered to have a low risk of remaining unemployed over the long term are referred to Stream A or B of jobactive, while participants who need more assistance are referred to Stream C. DES participants are split between Disability Management Services (DMS) and two levels of Employment Support Services (ESS). DMS provides job search support only, while ESS provides job search support and ongoing assistance after a participant finds employment (with ESS level 2 participants receiving more support than ESS level 1 participants).

Source: ANAO (2018); Australian Government (2019a); DSS (2018b); Services Australia (2020a, 2020c, 2020g).
The Job Seeker Classification Instrument

The JSCI is a brief assessment that aims to assess an income support recipient’s risk of long-term unemployment by considering their age, work and education history, English proficiency, access to transport, Indigenous status and any disability or medical conditions (Australian Government 2019a). The JSCI does not contain diagnostic questions about mental illness, but does offer participants a chance to disclose a mental illness with the following questions:

- Do you have any disabilities or medical conditions that affect the hours you are able to work?
- Do you have any disabilities or medical conditions that affect the type of work you can do?

If a participant discloses any disability/illness, they will be asked a follow-up question (or questions):

- Do you think you need additional support to help you at work as a result of your condition(s)?
- What is the most number of hours a week you think you are able to work?
- How long will your condition(s) affect your ability to work?
- What is/are the condition(s)?

This assessment places participants with no or low risk of long-term unemployment into jobactive Stream A or B services, and refers those deemed to have moderate or high risk of long-term unemployment for further assessment via the ESAf.

The Employment Services Assessment

The ESAf is a more thorough assessment process for participants deemed to have multiple or severe barriers to employment. Allied health professionals undertake ESAfs which, in about 80% of cases are face-to-face (OECD 2015). This assessment determines whether a participant should receive services from Stream C of jobactive or be placed in Disability Employment Services (in either Disability Management Support or Employment Support Services), based on an assessment of their barriers to work (related to disability, injury or illness, among others) and their work capacity in hour bandwidths (0–7, 8–14, 15–29 hours) (Australian Government 2019a). Those for whom a disability is deemed to be their main barrier to employment are placed in Disability Employment Services and other participants are placed into Stream C of jobactive.

1 Not all participants who disclose a medical condition or disability will be asked what the condition is. For example, they will not be asked what the condition is if they do not answer ‘yes’ or ‘don’t know/unsure’ to whether they have a condition that affects the type of work they can do (as opposed to the amount they can work), or to whether their condition will affect their ability to work for less than three months, they will not be asked what the condition is.
C.3 Individual Placement and Support

The IPS model of employment support was developed to assist people with severe mental illness find and maintain employment. It comes in two broad forms — the theoretical ideal form as conceptualised by the model’s designers and the real world models that have been implemented. The success of the IPS model (and the capacity to evaluate it rigorously) has been attributed to the extent to which its implementation in the real world reflects relatively high fidelity versions of the original ideal model (Kim et al. 2015).

IPS provides hands on, personalised and ongoing support to participants. Caseloads are small (prescribed at 20 in the ideal model) and IPS specialists spend most of their time (65% in the ideal model) engaging with the community or employers (which can include meeting with participants outside their office). Specialists are expected to develop a strong understanding of participant’s work capacity and workplace requirements, prioritise participants’ work preferences, take on the majority of the burden of job search and counsel participants about the impacts of work on the income support payments that they receive. Once in a job, participants continue to receive support from their IPS specialist (for example, job coaching, career development or help negotiating pay rises (Becker et al. 2015)).

IPS prioritises employment over training (known as a ‘place–train’ focus). This means that participants do not complete training programs during their job search, but focus their efforts on finding employment. If needed, they can complete training in the workplace.

IPS is also tightly integrated with participants’ clinical care. The roles of the IPS specialist and other providers are outlined in figure C.4.

Fidelity scales measure how closely IPS programs follow the ideal IPS model by assessing a program’s staffing, organisation and service provision (table C.7). Each assessment criteria is ranked on a scale of 1 to 5, with a higher score representing more fidelity to the model. A score of 74 or above out of 125 is necessary to ‘pass’ and be labelled an IPS program. Baseline fidelity reviews are conducted six to nine months after a program starts and the frequency of future reviews is determined by the baseline review’s score (Becker et al. 2015).
Figure C.4 **Roles and responsibilities under the Individual Placement and Support model**

<table>
<thead>
<tr>
<th>Senior employment specialist:</th>
<th>Clinical team manager:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Supervises employment specialists and maintains a small caseload of participants</td>
<td>• Performs a supervisory role (with a small caseload of patients, if desired)</td>
</tr>
<tr>
<td>• Organises training/personal development</td>
<td>• Promotes team integration and coordination with senior employment specialist</td>
</tr>
<tr>
<td>• Promotes team integration and coordination with clinical team manager</td>
<td>• Supports high fidelity to the IPS model</td>
</tr>
<tr>
<td>• Supports high fidelity to the IPS model</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employment specialist:</th>
<th>Clinician:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Supports participants into employment via individualised job development and placement, job coaching and on-going support</td>
<td>• Supports participant/patients’ clinical recovery</td>
</tr>
<tr>
<td>• Communicates with clinicians about participants’ employment goals and progress towards employment</td>
<td>• Informs patients about the IPS program and refers interested patients to employment specialist</td>
</tr>
<tr>
<td>• Provides welfare counselling</td>
<td>• Communicates with employment specialists and informs them of any changes in treatment and/or medication that could impact participants’ employment outcomes or work capacity</td>
</tr>
<tr>
<td>• Connects with employers and the wider community</td>
<td></td>
</tr>
</tbody>
</table>

**Participant**

---

**Grey arrows represent lines of communication.**

**Source:** Becker et al. (2015); Gilbert and Papworth (2017); Rinaldi et al. (2008).

---

**Table C.7 Summary of IPS fidelity assessment criteria**

<table>
<thead>
<tr>
<th>Staffing</th>
<th>Organisation</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Caseload size</td>
<td>• Integration of rehabilitation with mental health treatment through team assignment</td>
<td>• Work incentives planning</td>
</tr>
<tr>
<td>• Employment support staff only provide employment services</td>
<td>• Integration of rehabilitation with mental health treatment through frequent team member contact</td>
<td>• Assist participants with illness disclosure</td>
</tr>
<tr>
<td>• Employment support staff are vocational generalists</td>
<td>• Collaboration between IPS and government employment and income support staff</td>
<td>• Ongoing, work-based vocational assessment</td>
</tr>
<tr>
<td></td>
<td>• Vocational unit is comprised of two full-time employment specialists and a team leader</td>
<td>• Rapid job search for competitive jobs</td>
</tr>
<tr>
<td></td>
<td>• IPS unit is led by a IPS team leader</td>
<td>• Frequent, high quality employer contact</td>
</tr>
<tr>
<td></td>
<td>• All eligible people expressing interest become participants (‘zero exclusion criteria’)</td>
<td>• Diverse job types and employers</td>
</tr>
<tr>
<td></td>
<td>• Executive team support for IPS</td>
<td>• Individualised job search</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Time unlimited, individualised follow-along support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Assertive community engagement and outreach</td>
</tr>
</tbody>
</table>

---

**Grey arrows represent lines of communication.**

**Source:** Becker et al. (2015); Waghorn and Lintott (2011).
C.4 Mutual Obligation Requirements

What are Mutual Obligation Requirements?

Jobseeker Payment and Youth Allowance recipients participating in employment support programs are required to complete Mutual Obligation Requirements (MORs). Employment support providers determine participants’ MORs and are required to consider participants’ personal circumstances (including whether they have a mental illness) and the local labour market when doing so. MORs come in two forms:

- Job search activities (capped at 20 jobs per month).
- Annual activity requirements (usually participation in Work for the Dole). jobactive participants take on annual activity requirements after receiving income support for more than 12 months, while CDP participants usually acquire annual activity requirements at the outset.

Participants must also attend appointments with Services Australia and their employment support provider and attend or act upon any job interviews or job referrals from providers (Australian Government 2017, 2019b).

Under the New Employment Services, it is anticipated that MORs will transition to a points-based system. More intensive activities (for example, job interviews and job search) will receive more points than less intensive activities (DESE 2020b).

Complaints against Mutual Obligation Requirements and compliance frameworks

Some participants to this Inquiry raised concerns about potentially negative impacts of MORs, provider interactions and the Targeted Compliance Framework on participants.

With the crippling anxiety I was experiencing appointments with the [jobactive] provider sent it into overdrive. (ACOSS, sub. 270, p. 2)

Employment agency and Centrelink requirements continue to be the number one reason in forcing me to stop work/study/volunteer work … due to Mutual Obligation requirements and dramatically contribute to deterioration of Mental well-being. (CHF, sub. 496, p. 41)

Members [have indicated] that the TCF [Targeted Compliance Framework] can engender a greater level of stress for these jobseekers, detracting from their well-being and stability, generating barriers to employment. (JA, sub. 398, p. 8)

It is frustrating to see governments talk about improving mental health on one hand, and then introduce harsh penalties for vulnerable people on welfare, without seeming to recognise the barriers to employment for many with mental health problems. Cashless welfare cards, robo-debt policies and harsh measures against welfare recipients are likely to impact most specifically on those experiencing mental illness. (AMA, sub. 387, p. 6)
The last 15 years have seen increasingly punitive and inflexible requirements placed on recipients of income support payments … harsh sanctions regimes, unreasonable job search requirements, and proposals for random drug testing, all demonise and stigmatise people, and cause significant stress. (cohealth, sub. 231, p. 10)

I have been penalised a few times with suspensions and only on one of these occasions was it my own doing … When the sms comes at 4.55pm that your payments have been suspended, not knowing what for, it makes for high anxiety, especially when you know you've done nothing wrong. 99% of my suspensions have been an error on my agencies behalf. So, we live our lives daily with the unknown threat of non compliance. (Ewen Kloas, sub. 567, p. 2)

C.5 Temporary changes to income and employment support in response to the COVID-19 pandemic

As part of the Australian Government’s response to the COVID-19 pandemic, temporary changes have been made to income support payments and associated employment support programs. These include:

- introducing the Coronavirus Supplement, a fortnightly payment of $550 to non-pension income support recipients (including all JobSeeker Payment and Youth Allowance recipients) (Services Australia 2020b)
- introducing the First Economic Support Payment, a one-off payment of $750 in March 2020 to pension and non-pension income support recipients (Services Australia 2020c)
- introducing the Second Economic Support Payment, a one-off payment of $750 planned for July 2020 to pension and non-pension income support recipients who are not eligible for the Coronavirus Supplement (Services Australia 2020c)
- granting an exemption from MORs for participants isolated at home due to COVID-19 (Services Australia 2020b)
- allowing some employment support participants with caring responsibilities to be exempt from MORs (for example, a parent caring for a child whose school has been closed due to COVID-19) (Services Australia 2020b)
- expanding the eligibility criteria for the JobSeeker Payment and Youth Allowance to include sole traders, self-employed people, permanent employees who have lost their jobs, and people caring for someone with or isolated because of COVID-19 (DSS 2020)
- waiving assets tests and waiting periods for some payments and removing the requirement for proof of unemployment, rental arrangements and relationship status (Services Australia 2020a)
- reducing the maximum number of job searches that employment support participants must complete from 20 to 4 per month (Services Australia 2020d).
References


D Employment and mental health

Mental ill-health affects participation in employment in two major ways. For individuals in employment, mental ill-health can affect their productivity, whereas for individuals outside the workforce, it often acts as a barrier to gaining and maintaining employment.

D.1 The role of employment in mental health

It is widely recognised that employment has a positive impact on an individual’s mental health and there has been considerable research in this area (Modini et al. 2016; Waddell and Burton 2006; Waghorn and Lloyd 2005; Woodside, Schell and Allison-Hedges 2006).

In addition to income, employment provides a sense of identity and purpose, and a sense of structure and social connectedness. Being in employment is associated with better mental wellbeing, with lower rates of depression and anxiety (Harvey et al. 2012). Employment is also considered to play a key role in recovery from mental illness, and providing a pathway to employment can be critical to an individual’s recovery (FCDC 2012).

A report prepared for the World Health Organisation and the International Labour Organisation pointed to five key positive aspects of employment in relation to health:

- time structure (an absence of time structure can have a negative psychological impact)
- social contact
- collective effort and purpose (employment offers a social context outside the home and family)
- social identity (employment being important for defining oneself)
- regular activity (organising daily life) (Harnois and Gabriel 2000).

In contrast, unemployment typically has a negative effect on an individual’s mental health. The negative effects associated with unemployment include lower self-esteem, reduced social contact and poverty. There are strong links between unemployment and mental ill-health that are often exacerbated due to the related problems of social exclusion and poverty resulting from unemployment (Walsh and Tickle 2013).
The relationship between employment and mental health

There appears to be a bi-lateral relationship between employment and mental health. Bubonya, Cobb-Clark and Ribar (2017) in an analysis of the relationship between depressive symptoms and employment found that mental health problems are both a cause and, to a lesser extent, a consequence of unemployment. The more severe the depressive symptoms, the less likely an individual was to be in the labour force. The prevalence of depressive symptoms was higher the longer a person was out of the workforce.

This suggests that the loss of a job is likely to have a negative effect on mental health. While research has found the effects on mental health from the loss of employment were considered to be small to medium, these effects were often moderated by age, gender, occupation and the immediate economic environment (local unemployment rates, welfare system and demand for particular occupations). Men’s mental health tended to deteriorate as they exited employment whereas for women the deterioration typically occurred after they had been out of the workforce for a period of time (Bubonya, Cobb-Clark and Ribar 2017). For men, their role in the household may be a factor in the immediate deterioration in mental health following the loss of employment, particularly where they are the primary income earner in the household (Artazcoz et al. 2004; Kuhn, Lalive and Zweimüller 2009).

There is some evidence that unemployment is associated with worsening mental health for young people who are wanting to, but cannot enter the workforce (Buffel, van de Straat and Bracke 2015). People who are middle-aged may have higher expenses, increasing the financial stress caused by unemployment, exacerbating the negative effect on mental health. Older people may be less affected by job loss the closer they are to retirement.

The threat of impending job loss and the social and economic context in which the job loss occurs can also have a significant effect on mental health. Those facing job losses through closures of large manufacturing enterprises (such as car manufacturing or steel industries) in areas with pre-existing socio-economic disadvantage, where re-employment prospects were limited, were more likely to experience adverse psychological outcomes (Myles et al. 2017).

In further work on the relationship between depressive symptoms and employment, Bubonya, Cobb-Clark and Ribar (2019) found strong evidence that depressive symptoms were a cause of employment problems. However, the study found no evidence for men and only limited evidence for women that unemployment and non-participation in the labour force raised the risk of severe depressive symptoms.

Given the complex relationship between employment and mental health, Bubonya, Cobb-Clark and Ribar (2019) considered that reducing the economic costs of mental illness is a challenge that needs to be addressed from both sides — improving mental health by improving employment outcomes and reducing barriers to employment for those with mental illness.

Importantly, having a common mental disorder (such as anxiety or depression) does not stop people being employed, and, as noted by the OECD, the vast majority of those with mild or moderate mental illness work (Bubonya, Cobb-Clark and Ribar 2017). However, the more
severe the mental illness, the less likely an individual is to work. Fritjers, Johnston and Shields (2014) in a study of Australians with mental ill-health found that declines in mental health were associated with further declines in employment and those with more severe conditions were less likely to seek work.

Although employment is associated with better mental health than unemployment and shifting from unemployment to employment improves mental health, there is some evidence that jobs with poorly designed work and a poor work environment can exacerbate mental ill-health (Harvey et al. 2014). A study by Butterworth et al. (2011) found that moving from unemployment to a job characterised by low job control, high job demands, poor security and the perception of unfair pay could result in a decline in mental health compared to unemployment. The issues around mental health in the workplace are discussed in chapter 7.

D.2  Employment outcomes for those with mental illness

Employment outcomes for people with mental illness are worse than for the wider population. In 2017-18, 55% of working age Australians with mental illness were employed, compared with 64% of all working age Australians (ABS 2019). This is reflected in the share of people with mental illness not in the labour force or unemployed being higher than that of the wider working age population. In regard to part-time employment, the share of people with mental illness employed on this basis was slightly above that of the wider working age population (figure D.1).

The unemployment rate for people with moderate mental illness in Australia is about two and half times that for those without mental illness (figure D.2). For people with severe mental illness, it is more than five times the rate of those without mental illness. Switzerland and the Netherlands have the smallest differences in the rate of unemployment between people with severe or moderate mental illness and those without mental illness. In all countries, unemployment rates were higher for people with severe mental illness (figure D.2).

In comparing employment outcomes based on type of disability, unemployment rates for those with a psychological disability are higher than for those with an intellectual disability or physical disability, but slightly below those with a sensory and speech disability (figure D.3).
Figure D.1  **Labour force status for people with mental illness and the Australian population**  
Persons aged 16 to 64 years, 2017-18

![Bar chart showing labour force status for people with mental illness and the Australian population.](chart)

Source: ABS (Microdata: National Health Survey, 2017-18, Cat. no. 4324.0.55.001).

Figure D.2  **Unemployment rates by severity of mental disorder, selected OECD countries, 2015**

![Bar chart showing unemployment rates by severity of mental disorder.](chart)

There is also considerable variation in employment outcomes for those of working age with different reported mental health conditions (figure D.4). For example, a higher proportion of people with schizophrenia related conditions (76%) are not in the labour force compared with people with most other mental health conditions (between 40% and 50%).

In regard to unemployment rates (unemployment being defined as actively seeking work), those with bipolar disorder experienced unemployment rates significantly higher than those with other mental health conditions. For most reported mental disorders, the rate of unemployment was between 4% and 5%, except for attention deficit hyperactivity disorder (ADHD) where the rate was 8% (figure D.4).

The use of mental health services provided through the Medicare Benefit Schedule (MBS) and mental health medication provided through the Pharmaceutical Benefits Scheme (PBS) by labour force status highlights the poorer labour market outcomes for those with mental illness. In examining the use of MBS-rebated mental health services and PBS mental health medication, part-time workers and unemployed people use mental health services and medications at a higher rate than full-time workers. For those not in the labour market, the use of PBS mental health medications is more than 2.5 times the rate of the rest of the population (figure D.5).

---

**Figure D.3**  
**Unemployment rate by disability type**  
2012

<table>
<thead>
<tr>
<th>Disability Type</th>
<th>Unemployment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head injury, stroke, brain damage</td>
<td>28%</td>
</tr>
<tr>
<td>Sensory and speech</td>
<td>15%</td>
</tr>
<tr>
<td>Intellectual</td>
<td>10%</td>
</tr>
<tr>
<td>Psychological</td>
<td>10%</td>
</tr>
<tr>
<td>Physical restriction</td>
<td>5%</td>
</tr>
<tr>
<td>Total with disability</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
</tr>
</tbody>
</table>

**Source:** ABS *(Disability and Labour Force Participation, 2012, Cat. no. 44433.0.55.006).*
Figure D.4  **Unemployment and not in the labour force rates by type of mental illness**  
Persons with selected conditions, aged 16 to 64 years, 2017-18

Source: ABS (Microdata: National Health Survey, 2017-18, Cat. no. 4324.0.55.001).

Figure D.5  **Labour force status by use of MBS-rebated mental health services and PBS mental health medication**

Source: Productivity Commission estimates based on ABS (Microdata: Multi-Agency Data Integration Project, Australia, Cat. no. 1700.0)
The barriers to employment facing people with mental illness

The poorer employment outcomes for people with mental illness are often considered to be due to the employment barriers facing them. Most people with mild to moderate mental illness manage their health without experiencing negative employment outcomes (chapter 19). Others, particularly those with severe mental illness, face a number of barriers to gaining and retaining a job. These barriers relate either to the individual, to the community or to the mental health system (figure D.6).

Individual barriers

Many of the symptoms of mental illness and the medication to treat mental illness can impact on an individual’s ability to work. For example, mental illness can affect cognitive, perceptual, affective and interpersonal abilities. Depression can result in a loss of energy, motivation and self-confidence, and schizophrenia can result in fatigue and poor attention and concentration. This means that hours of consecutive work can be limited (FCDC 2012).

Medication may also produce side effects that limit an individual’s capacity to work, such as sedative effects. The episodic nature of mental illness can act as a barrier to people both gaining and retaining employment given that there are likely to be periods when treatment and support will require work demands to be reduced (FCDC 2012).

People with mental illness may also face educational disadvantage, poor physical health and homelessness, providing further barriers to employment.

Figure D.6  Barriers to employment

<table>
<thead>
<tr>
<th>Individual level barriers</th>
<th>Community level barriers</th>
<th>System level barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Impact of symptoms and side effects of medication on role functioning</td>
<td>• Stigma associated with mental illness</td>
<td>• Isolation of employment support and mental health service systems</td>
</tr>
<tr>
<td>• Episodic nature of mental illness</td>
<td>• Low community expectations</td>
<td>• Inappropriate employment services</td>
</tr>
<tr>
<td>• Educational disadvantage</td>
<td>• Inflexible jobs</td>
<td></td>
</tr>
</tbody>
</table>

Source: Derived from FCDC (2012).
Community barriers

There are also those barriers to employment that relate to how the community, such as employers, family, friends and healthcare professionals, view people with mental illness.

The stigma associated with mental illness is considered to be a significant barrier to both obtaining and maintaining employment for people with mental illness. VicHealth and Partners (sub. 131, p. 10) noted:

While some of these negative employment outcomes result from the impact of the condition or treatment, much is also driven by stigma, discrimination and a lack of support, which results in a lack of opportunity.

As a result, when seeking employment, people with mental illness are reluctant to disclose their mental illness to employers (One Door Mental Health, sub. 108; Jobs Australia, sub. 398).

Evidence provided to a Victorian Parliamentary inquiry into the workforce participation of people with mental illness noted that many employers in the selection process would overlook a potential candidate if they knew the applicant has mental illness as the perception was that they would be taking on an unreliable employee and possibly a liability (FCDC 2012). Employers expect workers with mental ill-health to have lower productivity and higher absenteeism than other workers, and will either fail to hire, or fail to promote those with mental ill-health (Cook 2006).

Moreover, for people in employment with mental illness, there is also a reluctance to disclose due to fears of discrimination and a lack of employer support. Research undertaken by SANE Australia found that 38% of those surveyed did not disclose their mental illness at work (Mentally Healthy Workplace Alliance, sub. 209).

There also may be concerns expressed by family, friends or carers to dissuade those with mental illness from seeking employment due to concerns that the stress of work may exacerbate their mental illness (FCDC 2012; Rinaldi et al. 2008).

When mental health professionals, employers and people themselves have low expectations, this can discourage those with mental ill-health from seeking out employment. A self-fulfilling prophecy may exist: clinicians (who often see people when they are most unwell) expect the person will struggle with the demands of a workplace, people with mental illness are not encouraged to join the workforce, and those who do, are more likely to leave the workforce (Rinaldi et al. 2008). This perpetuates the idea that those with mental ill-health are unlikely to succeed in the workforce.
System-wide issues

People with mental illness can also face barriers to employment due to a lack of coordination between clinical and employment services. There may also be issues as to the appropriateness and effectiveness of various employment services on offer.

Chapter 19 examines in detail the barriers facing people with mental illness and makes a number of recommendations to improve the effectiveness of employment support available to them.

D.3 The mental health of those in the workforce

The mental health of those in employment and the impacts of the workplace on their mental health is discussed in chapter 7.

Mental illness tends to be more prevalent in certain occupations and industries. By occupation, those working in sales and community and personal services are more likely to have had or have a mental health condition (figure D.7). However, these occupational categories do not separate out those high risk occupations such as police, emergency service workers and correctional officers, who are relatively more likely to develop a work-related mental illness or psychological injury (as discussed in chapter 7).

Figure D.7 Prevalence of mental illness by occupation

<table>
<thead>
<tr>
<th>Category</th>
<th>Anxiety and related disorders</th>
<th>Depression</th>
<th>Other disorders</th>
<th>Substance use disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sales workers</td>
<td>16%</td>
<td>12%</td>
<td>6%</td>
<td>2%</td>
</tr>
<tr>
<td>Community &amp; personal service workers</td>
<td>14%</td>
<td>10%</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>Clerical &amp; administrative workers</td>
<td>12%</td>
<td>8%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Professionals</td>
<td>10%</td>
<td>6%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Labourers</td>
<td>8%</td>
<td>4%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Managers</td>
<td>6%</td>
<td>3%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Technical and trades workers</td>
<td>4%</td>
<td>2%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Machinery operators and drivers</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
</tr>
</tbody>
</table>

a Share of people employed in each sector who have had or have various mental conditions.

Source: ABS (Microdata: National Health Survey, 2017-18, Cat. no. 4324.0.55.001).
For example, a survey conducted by Beyond Blue found that 8% of ambulance employees, 9% of fire and rescue employees and 11% of police employees have probable post-traumatic stress disorder (PTSD) compared to 4% of adult Australians and 8% of the Australian Defence Force. About 40% of emergency service employees and 33% of emergency service volunteers reported having been diagnosed with a mental health condition at some stage of their life compared to 20% of adult Australians (Beyond Blue 2018).

By industry sector, those workers who have had or have a mental health condition are lowest in agriculture, fishing and forestry and highest in accommodation and food services (figure D.8).

Figure D.8  Prevalence of mental health conditions by industry sector

<table>
<thead>
<tr>
<th>Industry Sector</th>
<th>Anxiety and related disorders</th>
<th>Depression</th>
<th>Other disorders</th>
<th>Substance use disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation and food services</td>
<td>14%</td>
<td>12%</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Information Media and Telco</td>
<td>13%</td>
<td>11%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Wholesale and retail trade</td>
<td>12%</td>
<td>10%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Other services</td>
<td>8%</td>
<td>7%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Mining</td>
<td>7%</td>
<td>6%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>5%</td>
<td>4%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Agriculture, fishing and forestry</td>
<td>4%</td>
<td>3%</td>
<td>2%</td>
<td>1%</td>
</tr>
</tbody>
</table>

*Source: ABS (Microdata: National Health Survey, 2017-18, Cat. no. 4324.0.55.001).*

**Are there differences between full-time and non-full-time employment?**

The growth in flexible work such as part-time, casual and fixed term contract employment in Australia has been well documented (Gilfillan 2019; Laß and Wooden 2019). However, the impact of different employment arrangements — full-time, part-time casual, fixed term contract — on mental health has not received the same attention as the impact of employment more broadly on mental health.

Some qualitative work on the impacts of casual employment on employees, households and communities undertaken in Australia found that casual work was detrimental to mental health due to uncertainty in employment and income, insecurity, often being an outsider in
the workplace and a lack of training opportunities for skill development and advancement (Pocock, Prosser and Bridge 2004).

International studies have found a higher prevalence of mental illness in non-permanent employment compared to permanent employees, although this varied by occupation (Virtanen et al. 2005). Quantitative research on temporary agency work in Europe indicated that temporary agency work is not consistently related to lower job satisfaction or mental health impairments, although job insecurity and poor working conditions could have adverse effects (Hunefeld, Gerstenberg and Huffmeier 2019). Results from an econometric study as to whether temporary employment was a cause or a consequence of poor mental health in the United Kingdom indicated that while those in temporary employment tended to have poorer mental health than those in permanent employment, those permanent workers with poorer mental health tended to shift into temporary employment (Dawson et al. 2015).

Comparing the usage of PBS mental health medication and MBS-rebated mental health services indicates very little difference between full-time and part-time workers. The share of part-time workers using PBS mental health medication is only 2% higher than for full-time workers and only slightly higher (1%) in relation to the use of MBS mental health services (figure D.5).

An Australian study by Richardson, Lester and Zhang (2012) using quantitative analysis found no evidence that casual or fixed-term contract employment was harmful to people’s mental health. In concluding, the study noted that their findings did not indicate that no one was harmed by being employed on a casual or fixed-term contract. However, there was no systemic relationship between harm to mental health and these working arrangements and for many people they were a preferred form of employment. It also considered that the protections and pay loadings provided to casual and contract workers acted to ameliorate any harmful effects (Richardson, Lester and Zhang 2012).
References

ABS (Australian Bureau of Statistics) 2019, *National Health Survey 2017-18*, Basic Confidentialised Unit Record File (CURF), Cat. no. 4324.0.55.001, Canberra.


E  Bullying and mental health

Bullying can have adverse impacts on physical and mental health, both in the short term and later in life. It can lead to physical injury, social problems, psychological injury and mental illness and in extreme cases, death. Victims of bullying are at an increased risk of developing mental health problems and for people who are bullied when younger, these adverse impacts can continue into adult life.

Bullying is generally defined as aggressive behavior intended to harm or disturb that occurs repeatedly over time. It is based on an imbalance of power — where the more powerful person or group attacks the less powerful one (Gruber and Finernan 2008). Bullying comes in many forms. For example, verbal bullying (denigrating and demeaning remarks or threatening physical harm), physical bullying (hitting, kicking and pushing), social bullying (spreading rumors, excluding people and embarrassing people in public) and cyberbullying (using social media platforms to denigrate and demean someone). Bullying can occur in a range of situations, but is typically associated with school and the workplace. This appendix focuses on bullying in those environments.

E.1 School bullying as a public health issue

Bullying is a significant issue for Australian schools: 27% of students in year 4 to year 9 report frequent bullying and 20% of young people aged under 18 years experience online bullying (or cyberbullying) in any given year (AUARA, sub. 431). While cyberbullying tends to peak in adolescence, it can also affect older students. A survey of university students has found that 14.5% had been victims of cyberbullying.

All forms of bullying — face-to-face, physical, verbal or cyberbullying — can be a trigger for mental illness in adolescence and later in life. This applies to victims, bullies and people who witness bullying. People who are affected by cyberbullying may be at greater risk of depression and suicide ideation compared with victims of other types of bullying (AUARA, sub. 431).

The strong link between bullying and mental illness has changed the way it is perceived by students, schools and policy makers:

Historically bullying has not been seen as a problem that needed attention, but rather has been accepted as a fundamental and normal part of childhood … however, this view has changed and schoolyard bullying is seen as a serious problem that warrants attention. Bullying is an age-old societal problem, beginning in the schoolyard and often progressing to the boardroom. (Campbell 2005, p. 2)
Bullying imposes an economic cost, both during the school years and after students leave school. Estimates of the cost of bullying for one cohort of students during their 13 years of compulsory education reach $525 million, mainly in the form of the time spent by school staff to address bullying behaviour. Long-term costs, however, are far higher, estimated at $1.8 billion over the 20 years after completing school. These costs are due to:

- reduced income potential of bullying victims, arising from the effects of bullying on their academic outcomes
- chronic mental illnesses, which impose substantial costs on individuals and the mental health systems
- continued bullying behaviour by perpetrators. For example, research has shown that bullying perpetrators are far more likely to instigate domestic violence, which in itself leads to substantial health (including mental health) costs (PwC 2018).

**Addressing bullying in schools**

Governments have made substantial efforts to tackle bullying behaviour among young people. These include national policy initiatives as well as school-based policies.

**National policy initiatives**

The Safe and Supportive School Communities (SSSC) Working Group brings together the Australian and State and Territory Governments and representatives of independent and Catholic schools. The group manages an online portal to assist schools in developing anti-bullying policies and provides additional resources for children and their parents. The group also coordinates a National Day of Action against Bullying and Violence, which in 2019 involved more than 5700 schools nationally (SSSC 2019).

In 2015, the Australian Government established the Office of the eSafety Commissioner, to improve the safety of children online and reduce cyberbullying (Department of Communications 2014). Since then, the role of the commissioner has expanded to assist Australians of all ages that encounter anti-social behaviour online. In 2017-18, the Office of the eSafety commissioner received about 400 complaints of serious cyberbullying from young people under the age of 18 years. The office works with social media services to remove cyberbullying material posted online. It also collaborates with schools to resolve complaints and accredits external providers of cyberbullying awareness programs delivered in schools (Office of the eSafety Commissioner 2018).

**School-based interventions**

Research has shown that both proactive and reactive interventions are important and effective in reducing bullying in schools. Proactive interventions include various practices engaging with students to promote positive behaviour and peer-support schemes that improve the overall school climate; and promoting social and emotional learning (SEL)
programs. Reactive interventions include sanctions imposed on the perpetrators of bullying; supporting victims of bullying; mediation and various approaches to restorative practices. Such practices can be helpful in tackling both face-to-face bullying and cyberbullying, however, they need to be tailored to the specific incidents and the school community (Rigby and Griffiths 2018). The most successful bullying reduction tends to require significant investments of time and resources, as well as effective teacher training and leadership (Pearce et al. 2011).

Australian schools have implemented a mix of these approaches, with an increased priority on proactive approaches (Rigby and Griffiths 2018). SEL programs are part of the Australian curriculum and implemented in all schools. Chapter 5 discusses in detail the quality of these programs, the barriers to their success and the ways they can be tackled.

Despite significant policy efforts, it appears that more can be done to strengthen school-based bullying prevention. A survey of schools in New South Wales, Victoria, Queensland, South Australia and Western Australia, found that, although all had explicit policies to tackle bullying, only half of students were aware that it existed.

Some educational leaders showed no surprise that so many students were unaware of the policy. They suggested that schools are currently required to have so many policies that producing anti-bullying policies tends to be regarded as an act of compliance. The policies themselves, according to one educational leader, are not user-friendly, out of date or contain minimal information. (Rigby and Johnson 2016, p. 67)

Only about 38% of children surveyed who were bullied reported the behaviour to the school. When bullied children did report the behaviour to teachers, they generally felt the school was helpful in addressing the issue. Some of the teachers surveyed raised concerns about their ability to deal with bullying, and responses reflected the need for additional pre-service training. Chapter 5 discusses the issues of education policies and teacher training in detail.

E.2 Workplace bullying

Bullying in the workplace — as well as in other situations and through social media platforms — has become a widely acknowledged cause of mental ill-health. It has also been increasing as a cause of work-related mental stress (figure E.1). Workplace bullying can have negative effects on mental health through depression, anxiety, stress and suicide (headspace 2012). Some studies have indicated that the prevalence of bullying in the workplace has increased, and this is supported by the increase in serious workers compensation claims resulting from workplace bullying (figure E.1).
How prevalent is workplace bullying?

There has been wide variation in the estimates of the prevalence of bullying in Australian workplaces, due to inconsistencies in the definition of bullying, varying survey questions, different time frames for reporting bullying and different measurement methods such as self-labelling of bullying experiences or by measurement of behavioural experience. These prevalence rates differ across different industries and occupations.

For example, over 95% of 2529 school employees (68% of whom were teachers) had experienced one of the 42 bullying workplace behaviours identified by the researchers in surveys conducted in 2005, 2007 and 2009. This research noted that while perceptions of bullying were extremely wide ranging, where an individual believed or perceived they were being bullied, their actions would reflect that belief (Riley, Duncan and Edwards 2012). In a 2018 survey of public school teachers in New South Wales, 20% reported that they had been subject to bullying in their workplace in the past 12 months (NSW Public Service Commission 2018). In response to a similar survey question, 13% of respondents to the 2019 Australian Public Service Census indicated that they had been subject to harassment or bullying in their workplace in the past 12 months (Australian Public Service Commission 2019). A 2015 online survey of members of the Royal Australian College of

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**Figure E.1** Accepted workers compensation claims, by type of mental stress

Share of total accepted serious claims in Australia, selected years

- Serious claims are those accepted claims that resulted in absence from work of a single working week or more. Data does not include Victoria and is provisional for 2017-18.

*Source: Safe Work Australia’s National Data-Set for Compensation-based Statistics.*
Surgeons, found that 39% of respondents reported having been subject to bullying behaviour in the workplace (Crebbin et al. 2015).

Prevalence can potentially be overestimated if the term ‘bullying’ captures other behaviours that may not actually be considered as bullying or underestimated if employees are reluctant to report bullying behaviour.

Safe Work Australia (2012) considers the most reliable estimate comes from the Australian Workplace Barometer study. The national prevalence rate for workplace bullying (based on population) drawing on the Australian Workplace Barometer project indicated that nearly one in 10 people (9.4%) surveyed reported being bullied in the workplace in 2014-15 (Potter, Dollard and Tuckey 2016). This was based on the definition of bullying set out in Workplace Health and Safety (WHS) regulations (repeated and unreasonable behaviour directed towards a worker or group of workers that creates a risk to health and safety).

The Australian Workplace Barometer Project indicated that these prevalence rates were higher than in the previous period between 2009 and 2011 where only 7% of workers reported that they had been bullied in the workplace. The growing awareness and media campaigns around the effects of workplace bullying may have resulted in increased prevalence rates as people have become more readily able to recognise bullying (Potter, Dollard and Tuckey 2016). There has also been an increasing focus on bullying in the workplace by WHS agencies. Safe Work Australia and State and Territory WHS agencies have produced guidelines to assist employers to determine what does and does not constitute workplace bullying. This is to separate out reasonable management action taken in a reasonable way to address workplace performance from bullying behaviour that creates a risk to health and safety (box E.1).

Bullying across different industries

By industry, workplace bullying and harassment (as a share of all serious claims caused by mental stress) was most significant in the manufacturing, financial and insurance services and professional, scientific and technical services industries (figure E.2).

Workplace bullying is found in all workplaces. For example, the Law Council of Australia (sub. 492, p. 29) drew on a survey of the Victorian Bar that asked, ‘How could your quality of working life be improved?’ and the most widely recorded response was, ‘better judicial behaviour’, referring to the prevalence of judicial bullying, including denigration and humiliation of counsel.

The Victorian Auditor General’s report on bullying and harassment in the Victorian health sector found that while its prevalence was not conclusively known, a recent survey suggested it was widespread in the sector. For example, a 2013 Victorian Public Sector Commission survey reported 25% of health agency employees reported experiencing bullying (VAGO 2016).
What is workplace bullying?
Workplace bullying is repeated and unreasonable behaviour directed towards a worker or a group of workers that creates a risk to health and safety. Repeated behaviour refers to the persistent nature of the behaviour and can involve a range of behaviours over time. Unreasonable behaviour means behaviour that a reasonable person, having considered the circumstances, would see as unreasonable, including behaviour that is victimising, humiliating, intimidating or threatening.

Examples of behaviour, whether intentional or unintentional, that may be workplace bullying if they are repeated, unreasonable and create a risk to health and safety include but are not limited to: abusive, insulting or offensive language or comment; aggressive and intimidating conduct; belittling or humiliating comments; victimisation; practical jokes or initiation; unjustified criticism or complaints; setting tasks that are unreasonably below or beyond a person’s skill level; and spreading misinformation or malicious rumours.

What is not workplace bullying?
Safe Work Australia points out that a single incident of unreasonable behaviour is not workplace bullying nor is reasonable management action taken to effectively direct and control the way work is carried out. It is reasonable for managers and supervisors to allocate work and give feedback on a worker’s performance. These actions are not workplace bullying if they are carried out in a lawful and reasonable way, taking the particular circumstances into account.

A manager exercising their legitimate authority at work may result in some discomfort for a worker. The question of whether management action is reasonable is determined by considering the actual management action rather than a worker’s perception of it, and where management action involves a significant departure from established policies or procedures and whether the departure was reasonable in the circumstances. The exception or defence based on reasonable management action being undertaken in a reasonable manner in regard to workers compensation claims for psychological injuries is discussed further in chapter 7.

Differences of opinion and disagreements are generally not workplace bullying. People can have differences or disagreements in the workplace without engaging in repeated, unreasonable behaviour that creates a risk to health and safety. Some people may also take offence at action taken by management, but that does not mean that the management action in itself was unreasonable. However, in some cases conflict that is not managed may escalate to the point where it becomes workplace bullying.
Figure E.2  Workplace harassment/bullying as share of all serious claims caused by mental stress, selected industries 2017-18\textsuperscript{a,b}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figureE2.png}
\caption{Workplace harassment/bullying as share of all serious claims caused by mental stress, selected industries 2017-18\textsuperscript{a,b}}
\end{figure}

\textsuperscript{a} Data for 2017-18 is provisional and does not include claims data from Victoria. \textsuperscript{b} Serious claims are those that resulted in at least a week’s absence from work.

\textit{Source:} Safe Work Australia’s National Data-Set for Compensation-based Statistics.

Bullying across jurisdictions

By jurisdiction, accepted workers compensations claims for bullying and harassment as share of all mental health-related claims vary. Of the jurisdictions that provided data to the Productivity Commission, these claims as a share of all accepted mental health claims ranged from just over 18\% to 40\%.

Workers compensation claims for bullying are likely to be rejected

As noted in chapter 7, mental health-related workers compensation claims are more likely to be rejected than non-mental health-related claims, with about 25\% to 60\% of claims rejected depending on the jurisdiction (figure 7.4). For workers compensation claims relating to bullying and harassment, rejection rates ranged from 30\% to nearly 80\%, for those jurisdictions where data was provided. Women accounted for a higher proportion of accepted work-related mental health claims between 2012-13 and 2016-17 compared with men (chapter 7; figure E.3).
Figure E.3  **Serious workers compensation claims for bullying, by gender, selected jurisdictions**

(Five year average from 2014-15 to 2018-19)

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**a** Does not include Victoria.

*Source*: Data provided by State and Territory workers compensation agencies and Comcare.

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**What drives workplace bullying?**

There are a number of reasons why workplace bullying occurs. A lack of managerial regard for the psychological health of their employees or a poor psychosocial safety climate has been associated with bullying (chapter 7). Other causes include the use of bullying to increase the productivity of the workforce, or as a means of maintaining power and status within a workplace. Poor quality work with poorly designed jobs and tasks, with high levels of demand, but low levels of control are also considered to give rise to bullying in the workplace (Potter, Dollard and Tuckey 2016).

The Productivity Commission heard personal stories of workplace bullying (for example, Jane Jervis, sub. 593; Joyce Noronha-Barrett, sub. 518). In some cases, people have felt that being good at a job is a risk factor for bullying, as it may cause envy among co-workers (confidential personal communication).

**Bullying versus harassment**

While often mentioned in tandem, bullying is considered to be different from harassment. Bullying involves repeated unreasonable behaviour whereas harassment can be inferred from a single incident. Safe Work Australia defines harassment as unwelcome behaviour
that intimidates, offends or humiliates a person and may involve sexual harassment or unlawful discrimination (whereby an individual or group of people are treated unfairly or less favourably based on a particular characteristic or due to belonging to a particular group of people) (Safe Work Australia 2016). It is also described as unwanted behaviour that offends, humiliates or intimidates a person and targets them on the basis of a characteristic such as race, gender or ethnicity. While the terms are often used interchangeably and share similar antecedents, bullying is viewed by some as being more severe than harassment (Potter, Dollard and Tuckey 2016).

Harassment is typically addressed through anti-discrimination legislation (such as the *Sex Discrimination Act 1984* (Cth), *Racial Discrimination Act 1975* (Cth) and the *Disability Discrimination Act 1992* (Cth)) rather than WHS and enables a victim of harassment to make a complaint to an external agency and, in effect, launch legal proceedings against the employer (Power 2017).

Anti-discrimination legislation provides for a prohibition of certain behaviour whereas WHS imposes a positive obligation to prevent harm. Enforcement under anti-discrimination legislation is mainly through an individual making a complaint followed by a private confidential conciliation process with the remedies granted primarily in the form of compensation to the complainant. With anti-discrimination legislation, enforcement rights are with the individual and, unlike with WHS regimes, there is no government agency in place to identify and prosecute any breaches (Smith, Schleiger and Elphick 2020).

**The estimated costs of bullying**

The costs of bullying in the workplace are estimates. In 2010, the Productivity Commission reported an estimated cost to business of between $17 billion and $36 billion — this estimate was founded on work by Sheehan et al. (2001) using an estimated prevalence rate of 15% (based on the approximate mid-point of two international estimates). Applying a more conservative international prevalence rate of 3.5%, produced an estimated annual cost to business of between $6 billion and $13 billion (PC 2010).

The $36 billion figure (the upper estimate at the higher prevalence rate) has since often been referred to as the annual cost of workplace bullying in Australia. More recent estimates undertaken by the Productivity Commission for this Inquiry using the same methodology, but with a prevalence rate of 9.4% (as estimated by the Australian Workplace Barometer study) and adjusting for population growth and inflation, produced an estimated cost of between $22 billion and $47.4 billion with a midpoint estimate of $34.7 billion in 2018.

These costs include loss of productivity, absenteeism, legal and compensation costs and redundancy and early retirement payouts. There are also the costs to management in dealing with bullying claims, investigating these claims, and workplace support measures and services provided to workers, such as though counselling.
Where bullying cases enter into the public domain there is also the risk of damage to the brand and goodwill of a business. There are also significant costs imposed on the victims of bullying, including isolation and withdrawal, fear of dismissal, stress and anxiety, low self-esteem and any related physical symptoms. Wider costs to the community can include any health and medical costs required to treat a victim of bullying, income support and other government benefits provided to victims of bullying who become unemployed.

In addition to the psychological harm that workplace bullying can cause, it can also impact on the physical health of the victim resulting in further costs due to their inability to participate and be productive. There is also the potential impact on bystanders who have observed the behaviour who may then withdraw themselves to avoid becoming a victim or suffer vicariously, whereas other bystanders may align themselves with the perpetrator or perpetrators to protect themselves (Working Well Together, sub. 266).

**WHS and workplace bullying**

The responsibility to prevent workplace bullying is contained in WHS legislation through the duty of care held by employers to provide a healthy and safe working environment for their workers. Workers also have the duty to ensure their actions, including their behaviour towards others, do not constitute a risk to the health and safety of themselves or other people in the workplace. While there is no explicit prohibition of bullying in WHS legislation, there is an implied duty of care, Safe Work Australia noted:

> All work health and safety laws in Australia recognise workplace bullying as work health and safety issue with the responsibility to prevent workplace bullying covered by the primary duty of care held by employers (House of Representatives Standing Committee on Education and Employment 2012).

However, bullying is a difficult issue in the workplace. Employers and WHS inspectors find bullying type claims to be more resource intensive, complex and difficult to resolve in comparison to WHS issues related to physical safety. Previous work by the Productivity Commission highlighted the difficulties surrounding cases of bullying as they were often emotive, and involved a range of different individual interpretations of events, making it more difficult to substantiate a claim.

A study of state and territory government WHS inspectors across different jurisdictions and their involvement with psychosocial hazards in the workplace highlighted that bullying cases were often linked to the performance of the complainant. It was often difficult for the inspector to resolve and or verify if the issues of performance were genuine or manufactured to delegitimise the complaint and how to balance competing claims when there often appeared to be fault on both sides. Moreover, as claims of bullying almost always involve criticism of co-workers or managers, there is a risk that investigation could involve further victimisation, particularly as people accused of bullying in being able to effectively respond to the allegation would need to be informed of the identity of the complainant (Johnstone,
Quinlan and McNamara 2008). A Victorian Government WHS inspector, in an interview for the study, highlighted the difficulties in dealing with cases of workplace bullying:

… it is such a grey area and it is so emotive and so personal to people and it’s a he-said, she-said, that you cannot investigate, that you cannot validate, that you cannot verify and people who put in the complaint, are generally wounded people for some other reason other than what has gone on with the scenario. (Johnstone, Quinlan and McNamara 2008)

Worksafe Western Australia commented that in its experience, alleged cases of workplace bullying are often confused with other issues such as discrimination or equal opportunity issues, a one off event of workplace conflict or aggression, legitimate management decisions or managing staff performance. It said:

A not uncommon scenario is where a worker is treated in a manner they consider to be inappropriate from which they then form the view that they are the subject of bullying. That worker can then develop selective attention and only focus on those behaviours by the alleged bully that fit their perception. At the same time if the original trigger was a performance issue, this performance issue continues, attracting more attention, thus further reinforcing a perception of bullying (Department of Commerce (Western Australia) and Worksafe Western Australia 2012, p. 11).

In a study of bullying of teachers in Catholic schools, the most significant form of bullying based on teachers responses was the targeting of negative comments about their work and the withholding of praise or recognition. The authors of the study noted that this finding could be partially explained as that poorly performing teachers viewed attempts by the principal or executive staff to improve performance as bullying and this in turn raised the issue of how senior staff should deal with performance issues. An alternative explanation was that teaching culture did not encourage the acknowledgement of professional achievement (Duncan and Riley 2005)

The Australian Industry Group (sub. 208) commented that in the industries it represented, psychological claims (including bullying) often occur when an employee has been subject to performance management, disciplinary action or an investigation due to a complaint about their behaviour.

WHS and workers compensation legislation makes it clear that reasonable management action undertaken in a reasonable manner does not constitute workplace bullying. For example, the Fair Work Act 2009 (Cth) points out that reasonable management action carried out in a reasonable manner provides a qualification as to the definition of workplace bullying. Similarly, workers compensation legislation provides a defence or an exception for the provision of compensation for psychological injuries (such as from workplace bullying) resulting from reasonable management action carried out in a reasonable manner or reasonable way. Reasonable management action typically relates to performance appraisals, ongoing meetings to deal with underperformance, counselling or disciplining an employee for misconduct, modifying an employees’ duties, dismissal of an employee and denying an employee a benefit in relation to their employment. Whether or not these actions were undertaken in a reasonable manner or reasonable way will depend on the type of action taken by management, the facts and the circumstances surrounding the action, the impact on the
worker and any other relevant matters. This is typically determined on the basis of whether or not the established policies and procedures of the employer were followed, whether the employer breached any of its own guidelines, whether the employer adopted procedural fairness in dealing with the matter and whether any investigations were carried out in a timely manner (Fair Work Commission 2018; Reilly 2010; Workplace Law 2017).

From another perspective, accusations of bullying, particularly when unfounded, can have detrimental effects on the alleged perpetrator and can amount to bullying itself.

Workplace conflicts and allegations of bullying in the workplace are often addressed by the employer contracting third parties to provide an independent and impartial investigation. This in turn has led to scepticism from some sources as to the quality and independence of these investigations (Bornstein 2014). For example, while these external investigations are usually conducted by people from a human resources or legal background there is no required minimum standard for such investigators. Also, there is the risk that the employer will exercise control over the process to engineer the desired outcome and there is a commercial incentive for the investigator to produce a report that meets the need of the employer. Depending on the findings, this can give the impression to the complainant that the process and outcome of the investigation has been manipulated by the employer, further damaging the mental health of the complainant (Bornstein 2014).

Other approaches to deal with workplace bullying

The Victorian Government in 2011 amended the Crimes Act 1958 (Vic) to alter the crime of stalking to include behaviour that is typically characterised as bullying. This is commonly known as ‘Brodie’s Law’. This followed the suicide of a waitress who was subject to recurring verbal and physical acts of bullying. While the employer and a number of co-workers were fined under the existing WHS legislation, a public campaign followed to have Victorian legislation changed so that acts of bullying in the workplace and in other situations could be punished by terms of imprisonment of up to 10 years.

In the following five years since its introduction, 58 offenders were charged by Victorian Police (Victoria Police 2016). Similar legislation has not yet been introduced outside of Victoria, although there has been some discussion in some other jurisdictions.

Following the introduction of the Victorian legislation, the Australian Government announced a House of Representatives inquiry into workplace bullying (House of Representatives Standing Committee on Education and Employment 2012). The report made a number of recommendations including the development of a national definition of workplace bullying and for Safe Work Australia to develop a code of practice to manage the risk of workplace bullying and provide advice and guidance material for employers. In response to that inquiry, changes were made to the Fair Work Act to enable the Fair Work Commission can make orders to prevent bullying behaviour in the workplace following an application by an employee. These orders could include:

- requiring the individual or group of individuals to stop the specified behavior
monitoring of behavior by an employer or principal
complying with an employer’s bullying policy
providing information, additional support and training to workers
reviewing the employer’s or principal’s bullying policy

However, the Fair Work Commission cannot issue fines or penalties or award compensation. Since the introduction of these powers in 2014 only a handful of orders have been made (Wilson 2018).

The Victorian Auditor-General, in its report on workplace bullying and harassment in the Victorian health sector, recognised the duties the WHS legislation placed on employers to eliminate or minimise health and safety risks in the workplace. It concluded that workplace bullying and harassment were best dealt with by having organisations apply a risk management approach to prevent it from occurring and responding quickly if it does occur. Early intervention was the key given that workplace conflicts and minor inappropriate behaviours could easily escalate. Fundamental to this was the need to create a positive workplace culture where everyone treats each other with respect. However, in the Victorian health sector it noted that the leadership had not given sufficient priority and commitment to reducing bullying and harassment in their organisations. It considered the key steps to reduce the risk of bullying and harassment in these organisations was through:

identifying the potential for workplace bullying through data and identifying organisational risk factors
implementing control measures to prevent, minimise and respond to these risks, such as through building a positive, respectful culture and having good management practices and systems including policies, procedures and training
monitoring and reviewing the effectiveness of these control measures (VAGO 2016).

Workplace bullying is primarily dealt with through the WHS legislative framework. These arrangements, through their risk management approach to psychological harm in the workplace, place the onus on the employer to prevent (as far as reasonably possible) workplace bullying from occurring, as well as requiring employers to appropriately respond to complaints of workplace bullying. The WHS laws also hold individual workers who participate in workplace bullying accountable. Although there are financial penalties provided in WHS legislation, it is still appropriate that serious cases of bullying can be addressed through criminal law. As Safe Work Australia (2012) noted, criminal acts whether committed in the workplace or elsewhere should be penalised under the relevant criminal laws.

Strengthening the focus on psychological risks and harm in the current WHS arrangements is discussed in chapter 7.
References


Department of Commerce (Western Australia) and Worksafe Western Australia 2012, *Submission to the House of Representatives Standing Committee on Education and Employment Inquiry into Workplace Bullying*, Perth.


PwC (PricewaterhouseCoopers) 2018, *The Economic Cost of Bullying in Australian schools*, Melbourne.


—— and Johnson, K. 2016, *The Prevalence and Effectiveness of Anti-Bullying Strategies Employed in Australian Schools*, University of South Australia, Adelaide.


VAGO (Victorian Auditor-General’s Office) 2016, *Bullying and Harassment in the Health Sector*, Melbourne.


Wilson, J. 2018, “‘Over the top’ discipline: rethinking bullying in the public service’, *The Mandarin*.

F Mental health and the workers compensation system

The workers compensation system in Australia provides payments to employees who incur a work-related injury or illness. This compensates them for the loss of income while not at work, and also for any medical and rehabilitation expenses. This appendix analyses the trends and features of the workers compensation system in Australia with regard to mental health claims. It draws on data that the Productivity Commission received from the states, territories and Comcare.

F.1 The national picture of mental health claims

To conduct its analysis, the Productivity Commission focused on claims arising from the past five financial years (2014-15 to 2018-19). This resulted in a dataset containing approximately one million observations across all the states, territories and Comcare. This amount includes all accepted and rejected physical and mental health claims. From this, the total number of mental health claims amounted to 70,000. Whilst this figure includes all rejected and accepted mental health claims, it does not include active or pending claims. Further, rejected claims only include those claims rejected on initial application, and so do not include those rejected claims which were later overturned.

The key trends and features of this data are that:

- the total number of mental health claims has gradually increased between 2014-15 and 2018-19 (figure F.1)
- the increase in mental health claims is reflected in a higher year-on-year percentage increase in mental health claims (compared with physical claims) (figure F.2)
- as a proportion of all claims lodged, mental health claims have been increasing over time (figure F.3)
- while rejection rates for physical health-related claims have been flat, rejection rates for mental health claims have been gradually decreasing over time (figure F.4).

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2 Some data for the 2018-19 financial year may not have completely matured at time of provision.
3 All jurisdictions provided data on mental health claims. South Australia and Victoria did not provide data on physical claims.
4 Consequently, all rejection rates reported below are for those claims which have been decided.
Figure F.1  Mental health claims have been increasing over time\textsuperscript{a}
Total number of mental health claims

\textsuperscript{a} Includes all states, territories and Comcare.
\textit{Source:} Data provided by state and territory workers compensation agencies and Comcare.

Figure F.2  Divergence between claim growth rates\textsuperscript{a,b}
Percentage change in total mental health and physical health claims

\textsuperscript{a} The total number of claims includes all accepted and rejected claims and does not include pending claims.
\textsuperscript{b} Physical claims do not include Victoria or South Australia data.
\textit{Source:} Data provided by state and territory workers compensation agencies and Comcare.
Mental health claims are increasing as a proportion of all workers compensation claims\textsuperscript{a,b}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{Mental_health_claims_increase.png}
\caption{Mental health claims are increasing as a proportion of all workers compensation claims\textsuperscript{a,b}}
\end{figure}

\textsuperscript{a} Percentage is calculated by dividing the total number of mental health claims by the sum of the total number of mental health and physical claims and multiplying by 100. The total number of claims includes all accepted and rejected claims. \textsuperscript{b} Physical claims do not include Victoria or South Australia.

\textit{Source:} Data provided by state and territory workers compensation agencies and Comcare.

Rejection rates have been decreasing over time\textsuperscript{a,b}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{Rejection_rates_decrease.png}
\caption{Rejection rates have been decreasing over time\textsuperscript{a,b}}
\end{figure}

Mental health-related claims compared with physical health-related claims

\textsuperscript{a} Percentage is calculated by dividing the total number of rejected claims by the sum of total accepted and rejected claims and multiplying by 100. \textsuperscript{b} Physical claims do not include Victoria or South Australia.

\textit{Source:} Data provided by state and territory workers compensation agencies and Comcare.
F.2 Mental health-related workers claims by gender and income

The Productivity Commission received data on the gender and income of those making a mental health-related workers compensation claim.

By gender

This analysis examined rejection rates and types of mental health claims, by gender. Table F.1 highlights the data collected.

<table>
<thead>
<tr>
<th></th>
<th>Mental health claims</th>
<th>Physical claims</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>29 066</td>
<td>635 756</td>
<td>664 822</td>
</tr>
<tr>
<td>Female</td>
<td>40 084</td>
<td>326 834</td>
<td>366 918</td>
</tr>
<tr>
<td>Total</td>
<td><strong>69 150</strong></td>
<td><strong>962 590</strong></td>
<td><strong>1 031 740</strong></td>
</tr>
</tbody>
</table>

Source: Data provided by state and territory workers compensation agencies and Comcare.

Females are more likely than males to make a mental health-related workers compensation claim (figure F.5). They account for more than half (58%) of the total number of mental health-related workers compensation claims, but form about 47% of the Australian labour force.5

Other key features relating to gender from the data include:
- males are more likely to have their claim rejected (figure F.6)
- work pressure was the most frequent claim made by males, and bullying for females (figure F.7). This pattern was consistent across all jurisdictions.

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5 ABS (Labour Force, Australia, Apr 2020, Cat. no. 6202.0)
Figure F.5  **Females are more likely to make a mental health claim**<sup>a,b</sup>
Mental health claims, by gender

- **Percentage** is calculated by dividing the number of total mental health claims by gender by the total number of mental health claims and multiplying by 100. The total number of claims includes all accepted and rejected mental health claims.
- **Between 2014-15 and 2018-19.**

**Source:** Data provided by state and territory workers compensation agencies and Comcare.

---

Figure F.6  **Males are more likely to have their mental health claim rejected**<sup>a</sup>
Rejection rates over time, by gender

- **Percentage** is calculated by dividing total rejected mental health claims by the sum of total accepted and rejected mental health claims and multiplying by 100.

**Source:** Data provided by state and territory workers compensation agencies and Comcare.
Figure F.7  **Top mental health-related claim categories, by gender**\textsuperscript{a,b}

Claim mechanism as a proportion of total mental health claims

<table>
<thead>
<tr>
<th>Category</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work related harassment and or workplace bullying</td>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td>Work pressure</td>
<td>25%</td>
<td>30%</td>
</tr>
<tr>
<td>Exposure to workplace or occupational violence</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Other mental stress factors</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Exposure to a traumatic event</td>
<td>15%</td>
<td>15%</td>
</tr>
</tbody>
</table>

\textsuperscript{a} Between 2014-15 and 2018-19. \textsuperscript{b} Total claims includes both rejected and accepted claims.

*Source: Data provided by state and territory workers compensation agencies and Comcare.*

**By income**

Data on the weekly income of claimants was also provided, which was then broken down into income quartiles and deciles for analysis. This analysis focused on rejection rates and type of mental health claim by level of income. To do this, only those with recorded weekly incomes of at least $100 were included. From this it appears that:

- higher incomes are associated with lower rejection rates for mental health-related claims (figure F.8)
- males have higher rejection rates across all incomes levels (figure F.8)
- higher incomes are associated with relatively more work pressure claims and fewer bullying claims (figure F.9). These are the two most common mental health claims.
Figure F.8  **Males across all income levels face higher rejection rates for mental health claims**\(^{a,b,c,d}\)

Rejection rates, by income quartile and gender (min weekly income of $100)

\[\begin{array}{c|c|c}
\text{Income Quartile} & \text{Percentage (Female)} & \text{Percentage (Male)} \\
\hline
\text{Top 25\%} & 10 & 20 \\
\text{50\%-75\%} & 15 & 25 \\
\text{25\%-50\%} & 20 & 30 \\
\text{Bottom 25\%} & 25 & 35 \\
\end{array}\]

\(^a\) Percentage is calculated by dividing the total number of rejected mental health claims by the total number of mental health claims and multiplying by 100. \(^b\) The total number of claims includes all accepted and rejected mental health claims. \(^c\) Between 2014-15 and 2018-19. \(^d\) The rejection rates in this chart differ from those in figures F.4 and F.6 as they only include observations for which weekly income was at least $100. This means, for example, observations where income was not recorded are not included.

**Source:** Data provided by state and territory workers compensation agencies and Comcare.

Figure F.9  **Bullying and work pressure over income deciles**\(^{a,b,c,d}\)

As a proportion of serious mental health claims (min weekly income of $100)

\[\begin{array}{c|c|c|c|c|c|c|c|c|c}
\text{Income Decile} & 1 & 2 & 3 & 4 & 5 & 6 & 7 & 8 & 9 \\
\hline
\text{Bullying (Female)} & 20 & 25 & 30 & 35 & 40 & 45 & 50 & 55 & 60 \\
\text{Work pressure (Female)} & 0 & 5 & 10 & 15 & 20 & 25 & 30 & 35 & 40 \\
\text{Bullying (Male)} & 15 & 20 & 25 & 30 & 35 & 40 & 45 & 50 & 55 \\
\text{Work pressure (Male)} & 5 & 10 & 15 & 20 & 25 & 30 & 35 & 40 & 45 \\
\end{array}\]

\(^a\) Between 2014-15 and 2018-19. \(^b\) Does not include Victoria. \(^c\) Serious mental health claims are those accepted claims resulting in at least one week off work. \(^d\) Income deciles range from 1 (lowest) to 10 (highest).

**Source:** Data provided by state and territory workers compensation agencies and Comcare.
G  Funding and commissioning arrangements: supporting detail

This appendix provides background to the reforms to funding and commissioning arrangements recommended in chapter 23.

- It summarises the evidence from elsewhere in the report that the funding currently allocated to mental healthcare and psychosocial supports is not spent to best meet consumer needs (section G.1)
- It analyses the role of Primary Health Networks (PHNs) in the context of broader primary mental healthcare funding arrangements, focusing on: regional equity in the distribution of funds; incentives arising from the interaction of Medicare Benefits Schedule (MBS) rebates and PHN funds; and the autonomy PHNs have in their commissioning decisions (section G.2)
- It analyses Local Hospital Network (LHN) funding arrangements, focusing on: the incentives arising from the different ways that hospital- and community-based services are funded; and the impacts of Australian Government contributions to LHNs under the National Health Reform Agreement (NHRA) (section G.3)
- It analyses the current approach to managing the federal split in government responsibilities for mental healthcare set out in Priority Area One of the Fifth National Mental Health and Suicide Prevention Plan (section G.4)
- It analyses the feedback to the two options for allocating responsibility for mental healthcare and psychosocial supports (‘Renovate’ and ‘Rebuild’) that were presented in the draft report (section G.5)
- It outlines some additional considerations that underpin recommended reforms (section G.6).

Many of the analyses in this appendix examine the extent to which the current arrangements support two normative positions that underpin the reforms outlined in chapter 23: that government agencies, providers and consumers should face incentives to take account of the full range of costs and benefits of their decisions; and that decisions should be made by those who have the best access to information about costs the benefits of their decisions.6 In the

6 The focus on incentives motivates arrangements either to formally pool funding for mental health services (such as by the creation of Regional Commissioning Authorities), or to create administrative or funding arrangements that mimic such pooling of funding (such as improved PHN–LHN cooperation and integration of the accounting of MBS rebates and PHN funds). The focus on information motivates regional decision-making backed by centralised support.
Productivity Commission’s view, aligning decision-making with incentives and information is most likely to lead to resources being allocated to best meet consumer needs.

G.1 Resources are not allocated to their best use

This Inquiry report provides evidence that mental health resources are not allocated to best meet consumer needs. Two particular issues stand out — the ‘missing middle’ and the relative shortage of low intensity mental health services (chapter 12).

Little has been done to meet these shortfalls in clinical services, despite widespread acknowledgement of the problems (chapter 12) and growth in mental healthcare funding for other services. Recent years have seen the Australian Government provide additional funding to primary mental healthcare services and State and Territory Governments increase funding for public hospitals (figure G.1). However, the Australian Government has largely not invested in services that target more acute cohorts (with the exception of private health insurance subsidies), and State and Territory Governments, at best, only appear to be maintaining their funding of community-based care in recent years, with real per capita expenditure on community ambulatory and residential mental healthcare declining between 2011-12 and 2016-17.

Figure G.1 Expenditure on mental healthcare\textsuperscript{a,b}

Selected items

\textsuperscript{a} MBS-rebated mental healthcare comprises MBS rebates for allied mental healthcare and psychiatry. \textsuperscript{b} State and Territory Government expenditure is inclusive of Australian Government contributions under the NHRA.

Source: AIHW (2020a).
G.2 Primary mental healthcare funding arrangements

Primary mental healthcare is funded via:

- MBS rebates for GPs, allied mental health professionals, and psychiatrists
- PHN commissioning, drawing from the Mental Health Care Flexible Funding Pool (chapter 12).

Regional inequities in primary mental healthcare funding

The total funding for primary mental healthcare (MBS rebates plus the PHN Mental Health Care Flexible Funding Pool) is not distributed equitably across regions. This is mainly due to the inequitable distribution of MBS rebates for mental healthcare (box G.1; TAMHSS, sub. 919).

Regional equity (the principle of horizontal equity applied to a geographical context) requires the share of all primary mental healthcare funds flowing to each PHN region to reflect its share of the total population weighted by factors that influence service need and provision costs. For example, regional and remote PHN regions should receive higher funding on a per capita basis than others as the cost of supplying services in these regions is higher. Similar variations would reflect the share of Aboriginal and Torres Strait Islander people and people from lower socioeconomic backgrounds (as these groups are more likely to have mental illness, and hence increase demands for services (chapter 2)).

Translating this principle to the distribution of the Mental Health Care Flexible Funding Pool (as opposed to the distribution of all primary mental healthcare funding) means also taking account of the existing regional inequities in the distribution of MBS rebates. Hence, the distribution of the Mental Health Care Flexible Funding Pool should be more aggressively weighted toward regions that receive a relative shortfall of MBS rebates than would otherwise be the case.

The way that the Mental Health Care Flexible Funding Pool is currently distributed between PHNs goes some way towards achieving regional equity. To demonstrate its impacts, the Productivity Commission has ranked PHN catchment regions by level of need for primary mental health funding (with higher needs reflecting higher costs of service delivery and/or higher demand for services) and examined the total amount of primary mental healthcare funding each receives on a per capita basis (figure G.2). Broadly speaking, PHNs whose catchments receive a lower volume of MBS rebates per capita receive a greater share of the Mental Health Care Flexible Funding Pool per capita. Moreover, total primary mental health funding per capita is highest in the PHN catchments with the greatest need.
Box G.1 Geographic inequities in the distribution of MBS-funded mental health services

Medicare Benefits Schedule rebates disproportionately benefit consumers who live in urban areas (figure below), as consumer use of all provider types decreases sharply with remoteness. This is driven by the Medicare Benefits Schedule payment model. Clinicians are paid a uniform rebate and are free to choose where to locate and whether to charge out-of-pocket payments to consumers. Hence, clinicians tend to favour locations that allow them to charge higher out-of-pocket payments for their services (typically wealthier areas) or otherwise meet their preferences in relation to amenities and the costs of living and doing business (Allan Fels, sub. 303; Meadows et al. 2015).

Medicare Benefits Schedule funding disproportionately benefits people living in urban areas
Relative utilisation of MBS rebates by remoteness of consumer for selected healthcare professions, 2007–2011

Source: Productivity Commission estimates based on Meadows et al. (2015, table 2).
Nevertheless, there are shortcomings in the process for allocating the PHN Mental Health Care Flexible Funding Pool that exacerbate these inequities (box G.2).

- Funding for some services (e.g. headspace centres) is allocated outside of standard processes or according to historical arrangements.
- While the distribution formula accounts for several factors that influence the cost of service delivery and/or the prevalence of mental illness in the community (rurality, socioeconomic status of the population, share of the population that are Aboriginal or Torres Strait Islander), the weights attached to these factors are not evidence-based.
- While the distribution formula accounts for the quantum of MBS rebates for allied mental healthcare that a PHN catchment receives, the way that it does so is ad hoc in that it does not consider funds delivered via the MBS and funds delivered via PHN commissioning to be one-to-one substitutes. And it does not account for the distribution of MBS rebates for psychiatry.
How PHN mental health funds are distributed

At present, the Primary Health Network Mental Health Care Flexible Funding Pool is allocated in several different ways.

- Quarantined funds for headspace, headspace Early Youth Psychosis services and trials and national projects are allocated according to historical arrangements or on a fixed grant basis.
- Quarantined funds for mental health services for Aboriginal and Torres Strait Islander peoples are allocated on an unweighted per capita basis.
- Funding previously apportioned to the Access to Allied Psychological Services program is allocated as follows:
  - 50% is allocated using a weighted per capita formula with the weights inversely related to fixed historical use of mental health services that attracted Medicare Benefit Schedule rebates.
  - 50% is allocated using a weighted per capita formula with weights that provide additional funding the higher the share of the population that are Aboriginal or Torres Strait Islander, the lower the average socioeconomic status of the region, and the more remote the region.
- Other funding is allocated in full according to the second of these two weighting schemes or a similar weighting scheme.

Source: DoH (pers. comm., 9 October 2019).

Interaction of MBS rebates with PHN and State/Territory Government health department commissioning

The interaction between the two different mechanisms for funding primary mental healthcare (MBS rebates and PHN commissioning) creates incentives for funding to be sub-optimally allocated, as does the interaction of MBS rebates with State and Territory Government health department commissioning of mental healthcare from LHNs and other providers.

The MBS is unique among funding instruments for mental health services. Other funding sources (including PHN Mental Health Care Flexible Funding Pool and State and Territory Government health department mental healthcare funding) are capped, and there is active management of the fixed pool of funds by an entity (a PHN or State/Territory Government health department) that contracts with service providers. By contrast, the MBS is uncapped and managed only in a passive way — by supply-side restrictions (limits on which practitioners can provide MBS-rebated services) and some demand-side restrictions, such as limits on the number of MBS-rebated services that each consumer can access.

These features render the MBS suited to expanding access to treatment. Since allied mental healthcare became eligible for MBS rebates with the introduction of the Better Access initiative in 2006, access to treatment expanded sharply.

- Rates of referrals to psychologists per depression-related GP contact grew more than threefold for both advantaged and disadvantaged socioeconomic groups and in major and
FUNDING AND COMMISSIONING ARRANGEMENTS: SUPPORTING DETAIL


- Whiteford et al. (2014) estimated that the population treatment rate for mental illness increased from 37% to 46% between 2006-07 and 2009-10, and attributed this rise to the introduction of the Better Access program.

However, the uncapped and passive nature of MBS funding invites cost shifting. Where managers of capped funding sources (PHNs and State/Territory Government health departments) are responsible for funding services that substitute for those listed on the MBS (box G.3), they face incentives to allow MBS-rebated services to take the place of the services that they would otherwise fund.

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**Box G.3 Substitutability of MBS rebated services and commissioned services**

Cost shifting to the Medicare Benefit Schedule (MBS) is possible only where MBS-rebated services substitute for services commissioned by Primary Health Networks (PHNs) and State and Territory Government health departments.

Evidence of such substitutability is strongest for MBS-rebated allied mental healthcare.

- From a consumer perspective, PHN-commissioned allied mental healthcare closely resembles some MBS-rebated allied mental healthcare (Bassilios et al. 2016), so it follows that these services are likely to be close substitutes.

- Figure G.3 suggests some substitutability of allied mental healthcare in public mental healthcare (commissioned by State and Territory Government health departments) and MBS-rebated allied mental healthcare.

The evidence of substitutability is somewhat weaker for MBS-rebated psychiatry.

- PHNs do not generally commission mental healthcare from psychiatrists, so there is less reason to assume that services commissioned by PHNs could substitute for the services of MBS-rebated psychiatrists. That said, there is some evidence of substitutability between MBS-rebated allied mental healthcare and psychiatry (Britt and Miller 2009), which — when combined with the conclusion above regarding MBS-rebated allied mental healthcare — indirectly suggests the possibility of substitution between MBS-rebated psychiatry and PHN-commissioned allied mental healthcare.

- Psychiatrists work in LHN-provided community ambulatory mental healthcare care services (commissioned by State and Territory Government health departments) (chapter 12), suggesting that these services could possibly substitute for MBS-rebated psychiatry.

It seems less likely that MBS-rebated general practitioner mental healthcare substitutes for commissioned mental healthcare given the unique gatekeeper role that general practitioners play in the mental health system (chapter 10).

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7 That said, the expansion in access was greater in major cities. Chapter 24 proposes funding mechanisms that should bring about more equitable access to treatment.
Our concern is that these dynamics may create a service mix that is dominated by MBS-rebated treatments because of funding biases rather than because these treatments best meet consumer needs. There is some evidence of this at both the PHN and State/Territory Government levels.

At the PHN level, there is a substantial shortfall in the supply of low intensity treatments (section G.1), which are mostly commissioned by PHNs rather than funded via MBS rebates. Moreover, there is a tendency for PHN-commissioned services to leverage MBS rebates as much as possible.

- At the public hearings for this Inquiry, the Australian Counselling Association (Adelaide transcript, pp. 11–12) explained that it is common practice for PHNs to require that contracted clinicians be eligible for MBS rebates so that they can be commissioned to provide a small amount of care and bill the remainder to the MBS. This effectively locks out service providers, such as registered counsellors, who are not eligible for MBS rebates.

- In 2017–18, headspace centres (which receive PHN funding to cover infrastructure, community awareness and engagement programs, and some salaried staff) received 44% of their funding from MBS rebates (headspace, pers. comm., 2 August 2019). Indeed, an evaluation of headspace noted that the model was ‘designed to leverage from the MBS’ (Hilferty et al. 2015, p. 107). Provided that there is adequate oversight of headspace centres, it would be preferable for headspace to be able to provide services in a way that best meets consumer needs, rather than in a way that meets the MBS billing requirements.

At the State/Territory Government level, there also appears to be cost shifting. The employment of psychologists by State and Territory Government specialised mental health services has been in relative decline since the introduction of Better Access (figure G.3).

While it appears that there is cost shifting to the MBS, there are restrictions in place that prevent ‘double dipping’ (clinicians receiving MBS rebates and other government funding when providing services), which serve to prevent particularly egregious forms of cost shifting. Section 19.2 of the Health Insurance Act 1973 (Cth) prevents the payment of MBS rebates ‘in respect of a professional service that has been rendered by, or on behalf of, or under an arrangement with’ the Australian, State and Territory or local Governments or an authority established by these governments. These restrictions serve to prevent PHNs from co-funding an MBS-rebated session rather than commissioning a provider in full.

However, the restrictions are somewhat arbitrary. For example, they do not allow a PHN-commissioned service provider to co-fund the MBS rebates that a clinician might receive, but do not appear to prevent that service provider from charging below ‘market rates’ for the clinician’s tenancy and/or administrative support — an effective subsidy that could be used to attract the clinician.

Moreover, some aspects of the restrictions are undesirable. They limit the flexibility of PHNs and State and Territory Governments to pursue more innovative funding models that blend MBS rebates with contributions from the PHN Mental Health Care Flexible Funding Pool.
Autonomy granted to Primary Health Networks

The expansion of regional decision making is a mostly positive aspect of mental health reform over the past several years (box G.4). However, some decisions about the use of the PHN Mental Health Care Flexible Funding Pool have been devolved to PHNs and some remain made centrally by the Australian Government Department of Health.

PHNs are afforded a large degree of choice over the types of services that they commission using most (about 60%) of the Mental Health Care Flexible Funding Pool. While the Australian Government Department of Health issues guidance documents that outline the various priority areas for PHN commissioning (DoH 2019c), PHNs determine the share of the Mental Health Care Flexible Funding Pool they allocate to services to meet each priority area, and have significant discretion about the types of services that they commission.
In recent years, both levels of government have devolved more decision making about mental health service provision to the regional level. The Australian Government tasked PHNs with commissioning programs that were previously administered centrally in response to the National Mental Health Commission’s 2014 review (DoH 2015), and the 2011 National Health Reform Agreement required State and Territory Governments to establish LHNs to manage public mental healthcare (COAG 2011).

Devolving mental health decision making and purchasing activities to the regional level is generally desirable, as it is consistent with the principle of subsidiarity. The Productivity Commission has previously argued strongly for a regionally governed healthcare system (PC 2017b), and these same arguments apply with equal force for mental health services. Australia is a large and diverse country, with regional variations in population density, socioeconomic status and culture. For these reasons, the needs of one area are unlikely to mirror those of another. Moreover, local people and agencies are generally better placed to take local context into account than distantly located bureaucrats, as they have more or better information at their disposal. This was pointed out by WentWest Limited (sub. 445, p. 53):

> The focus of mental health service planning, implementation and monitoring must move to regions. The diversity of our regions, even across the Sydney metro area, requires [LHN] and PHN integrated planning to be continuous and adaptive to rapidly changing community needs.

However, there are some circumstances where devolution is not appropriate.

- **Activities that can be more efficiently performed at scale are unsuited to devolution.** For example:
  - it would be prohibitively costly for each region to design its own activity-based funding classification for remunerating hospitals
  - some services, such as online treatments (chapter 11), may require little (if any) adaptation to local contexts, but may benefit from considerable cost savings if deployed over a large population base.

- **Decisions that require a high degree of specialised expertise are unsuited to devolution as not all regions will have such capacity.**

- **Devolution is also unsuitable where there are sufficiently large positive or negative ‘spillover’ effects of one region’s decision making on other regions.** A central decision maker faces incentives to take these spillover effects into consideration, whereas a regional decision maker does not.

Meanwhile, the Australian Government Department of Health controls how other parts of the Mental Health Care Flexible Funding Pool are spent:

- **About one third of the Mental Health Care Flexible Funding Pool is committed to headspace services (including the headspace youth early psychosis program) (PHN Advisory Panel 2018).** The quarantining of funds for headspace was originally a transitional arrangement, but seems to have become permanent. The Australian Government’s response to the National Mental Health Commission’s 2014 review said that PHNs would be provided with a ‘flexible’ funding pool, and made no mention of a quarantining funding for particular purposes (DoH 2015). And the Department of Health’s subsequent guidance to PHNs on child and youth mental health services stated...
that PHNs would be required to maintain the existing headspace network only until 30 June 2018 as ‘[i]n the longer term, PHNs will have greater flexibility in meeting the needs of local young people with, or at risk of, mild to moderate mental illness’ (DoH 2017, p. 3). However, the Australian Government has since announced additional hypothecated funding to PHNs until 2025-26 for existing headspace services and 30 new headspace centres (Australian Government 2019).

- A further 8% of the PHN Mental Health Care Flexible Funding Pool is hypothecated to mental health services for Aboriginal and Torres Strait Islander people. This hypothecation is different from that which applies to headspace — in the headspace case, funding is hypothecated to a particular provider, whereas in this case funding is hypothecated to ensure that PHNs commission services targeted at Aboriginal and Torres Strait Islander people.

Hypothecation of funding to headspace

Some arguments have been presented that support hypothecating PHN funding for headspace.

One is that the decision to commission a headspace centre in one region generates positive spillover benefits for other regions by reinforcing headspace’s national brand. If these spillovers were sufficiently strong, this could justify hypothecating funding to headspace, but their magnitude is uncertain and difficult to measure (box G.5).

Another is that the services provided by headspace centres are sufficiently effective to provide confidence that PHN funding for headspace centres could not better be spent elsewhere. The PHN Advisory Panel on Mental Health suggested that requirements on PHNs to commission headspace centres are justified as the ‘evidence base is strong’ (PHN Advisory Panel on Mental Health 2018, p. 9). Unfortunately, on our review, the evidence underpinning headspace’s effectiveness is not overwhelmingly strong (chapter 12), and certainly not sufficiently strong to discount the possibly that the funding allocated to headspace could be better spent on other services that PHNs commission.
Box G.5  Positive spillovers from headspace centres?

Requiring Primary Health Networks (PHNs) to commission headspace centres would be justified if the presence of a headspace centre in one PHN’s region generated sufficient benefits to consumers residing in another PHN’s region (known as ‘spillover’ benefits — box G.4). Headspace centres could generate positive spillovers by reinforcing headspace’s national brand. For example, suppose that a young person with a mental illness hears that a friend living in a different PHN region had a positive experience with headspace, and consequently decides to seek help at a local headspace centre.

Mental Health Victoria and the Victorian Healthcare Association (sub. 1184, p. 24) supported maintaining the existing hypothecation of funding to headspace on these grounds.

Relaxing requirements for PHNs to direct funds to headspace centres will result in further fragmentation of the service system, with access to headspace available in some regions and not others. We fear that this will provide a confusing message to the public and will be counter to efforts to encourage help-seeking.

There is some evidence that headspace’s value to young people partially derives from its national brand. As noted by a recent academic paper:

> Having a strong and consistent national brand that clearly identifies and promotes headspace centres is crucial, and something that is quite unique for a mental health service. The national brand and communication strategies, including national media, position headspace as the peak organization for youth mental healthcare across Australia. The brand has become a trusted and credible source of information and support that is highly visible and valued by young people, families and communities throughout Australia. (Rickwood et al. 2019, p. 164)

Headspace — National Youth Mental Health Foundation (sub. 947) also pointed to the value of its national brand:

> headspace is a nationally trusted brand, with 77% of young Australians recognising headspace as a youth-specific mental health organisation. (p. iii)

Our brand tracking data and community impact research tell us that young people and their parents have high trust and confidence in headspace. Independent analysis by Deloitte Access Economics placed a value of $54 million on the headspace brand, defining this as the incremental operating benefit generated by the brand for the headspace network. (p. iii)

> Young people access headspace because it minimises uncertainty for them — it is a national platform and a brand they recognise and trust. (p. 25)

And, at a meeting with the Productivity Commission, headspace’s Youth National Reference Group highlighted that headspace’s national brand signalled a youth friendly gateway into mental healthcare.

While the evidence presented above suggests that headspace’s national brand does enhance its value to young people, the magnitude of the effect is less clear. Moreover, the extent to which these benefits result from the activities of headspace National versus the incremental contributions of individual headspace centres is also not clear. The key issue for the Productivity Commission is that there should be bespoke services that best meet local needs.

Other arguments suggest that headspace funding should not be hypothecated.

- Setting aside the potential for headspace centres to generate positive spillovers to other regions, the criteria laid out in box G.4 suggest that headspace funding should not be hypothecated.
Decisions about funding headspace seem unlikely to realise economies of scale, as they must take into account regional context (which demands case-by-case decision making).

Decisions about funding headspace can be made locally on the basis of local evidence so long as the Australian Government Department of Health provides better guidance on the evidence base underpinning headspace and alternatives (recommendation 23).

Several participants suggested that the Australian Government Department of Health’s decisions about hypothecating PHN funding are motivated by politics rather than evidence (Martin Whitely, sub. 1198; TAMHSS, sub. 919).

On balance, these arguments suggest that, at least in the longer term, funding to headspace should not be hypothecated. Rather, like any commissioned service, headspace should be required to show how its services are meeting local needs in order to receive ongoing funding (chapter 23).

Hypothecation of funding to Aboriginal and Torres Strait Islander mental health services

As noted above, the hypothecation of funding to Aboriginal and Torres Strait Islander mental health services differs from that which applies to headspace. The question that arises in this context is whether the competitive procurement processes that PHNs use are appropriate for Aboriginal and Torres Strait Islander mental health services. PHNs are required to engage with Aboriginal and Torres Strait Islander communities and Aboriginal Community Controlled Health Services (ACCHSs) (DoH 2016b), but are free to contract any organisation to provide Aboriginal and Torres Strait Islander mental health services, whether an ACCHS or not (DoH 2019a).

Some participants contended that these processes, in effect, contribute to unmet need in a large proportion of Aboriginal and Torres Strait Islander communities. The National Aboriginal and Torres Strait Islander Leadership in Mental Health, Indigenous Allied Health Australia and Australian Indigenous Psychologists Association (sub. 418) argued that:

- idealised functioning ‘health markets’ do not exist for Aboriginal and Torres Strait Islander mental health services in many parts of Australia (the ‘thin market’ problem), so competitive processes are ineffective in maximising value for money
- where competitive tendering is possible, it risks favouring organisations that write strong applications, which are not those that necessarily improve access to services and deliver sustainable outcomes.

Hence, the Productivity Commission has considered whether ACCHSs should be preferred providers of Aboriginal and Torres Strait Islander mental health services, which would

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8 Congress and Aboriginal and Torres Strait Islander Nurses and Midwives (sub. 75), National Aboriginal Community Controlled Health Organisation (sub. 507) and Nunkuwarrin Yunti of South Australia (sub. 798).
effectively allow them access PHN mental health funds outside of standard competitive procurement process — the position supported by the National Aboriginal and Torres Strait Islander Leadership in Mental Health, Indigenous Allied Health Australia and Australian Indigenous Psychologists Association (sub. 418) and ACCHSs themselves (IUIH, sub. 1108; NACCHO, sub. 507).

Aside from the shortcomings of competitive procurement in this context, the argument in favour is that ACCHSs generally offer benefits for Aboriginal and Torres Strait Islander people.

- According to National Aboriginal and Torres Strait Islander Leadership in Mental Health, Indigenous Allied Health Australia and Australian Indigenous Psychologists Association (sub. 418, p. 9), they provide:
  … a more accessible service by being based in Aboriginal and Torres Strait Islander communities and providing a culturally safe service environment and a culturally competent service experience. In contrast, most other services tend to lack these community/cultural connections that are essential for promoting access to services.

- Despite concluding that there is ‘a lack of evidence in the academic literature on the effectiveness of ACCHSs compared with mainstream health services’, a literature review noted that ‘… a range of studies have been conducted which, while mostly small-scale, indicate that the services provided by ACCHS are valued by their Aboriginal clients’ (Mackey, Boxall and Partel 2014, p. 6).

The argument against ACCHSs being preferred providers of Aboriginal and Torres Strait Islander mental health services hinges on whether the current arrangements adequately promote choice for Aboriginal and Torres Strait Islander people. Various participants highlighted the importance of choice that enables Aboriginal and Torres Strait Islander people to best meet their needs and preferences, for example, the Aboriginal Health and Medical Research Council (sub. 206) and the Mental Health Commission of New South Wales (sub. 948). But it is not clear that competitive processes do enhance choice for Aboriginal and Torres Strait Islander people. As noted above, competitive procurement processes seem somewhat unsuited to this context. And, were ACCHSs to be made preferred providers of Aboriginal and Torres Strait Islander mental health services, many Aboriginal and Torres Strait Islander people would retain access to mainstream providers funded via other means.

For these reasons, chapter 23 recommends that ACCHSs should be made preferred providers of Aboriginal and Torres Strait Islander mental health services.

Guidance provided to Primary Health Networks

The lack of guidance provided to PHNs over the discretionary part of the PHN Mental Health Care Flexible Funding Pool is problematic. PHN guidance documents generally require PHNs to commission ‘evidence-based’ services, but there is no direction provided to PHNs about which services are suitably evidence-based. Not all PHNs have the scale to develop
sufficiently high-level expertise in commissioning (TAMHSS, sub. 919). A review by the PHN Advisory Panel on Mental Health noted that:

Three years on from their establishment, stakeholder input to this review suggests significant variability between PHNs with respect to their organisational capability and capacity to implement mental health reform. Some PHNs demonstrate significant progress and achievements as change agents and system integrators while others evidence less readiness for these roles, with At the State and Territory Government level, the focus on hospital-based care over community-based care appears somewhat of a product of funding arrangements. a commensurate diminution in their progress. (PHN Advisory Panel 2018, p. 4)

Chapter 23 recommends that the Australian Government Department of Health should provide more guidance to PHNs.

G.3 Local Hospital Network funding arrangements

While governance arrangements differ between jurisdictions, generally State/Territory Government health departments purchase public mental healthcare (hospital-based mental healthcare, community ambulatory mental healthcare and residential mental healthcare) from providers managed by LHNs (with the Western Australian Mental Health Commission playing the role of the health department in Western Australia). In most States/Territories, LHNs are remunerated on an activity basis (activity-based funding) to provide most hospital-based mental healthcare, and receive block funding to provide community ambulatory and residential mental healthcare (box G.6).

Box G.6 Public mental healthcare funding models by State/Territory

New South Wales, South Australia, Western Australia and Tasmania each follow the funding model for public mental health services used by the Independent Hospital Pricing Authority to calculate Australian Government transfers for these services (albeit with different prices paid for different service types) (SA Health 2018; Tas DoH 2019; WA DoH 2017). They use activity-based funding for admitted care in general hospitals and block funding for admitted care in psychiatric hospitals, community ambulatory mental healthcare, and residential mental healthcare.

Queensland’s model differs from these states in that it funds admitted care in general hospitals using a ‘per diem’ funding model (payments made per day of care provided) (Queensland Health 2019). By contrast, activity-based funding is paid per episode of care provided.

Victoria’s funding model differs further. It funds admitted and residential care on the basis of ‘available bed days’ (meaning that funding is conditional on bed availability, rather than utilisation). And it funds community ambulatory mental healthcare on the basis of ‘community service hours’ (VIC DHHS 2019).

The ACT Government did not provide us with a description of the funding models it uses for public mental healthcare and the Northern Territory Government did not respond to our requests for information about its funding models.
This creates a financial incentive for LHNs to preference public hospital-based care over community-based care. LHNs receive additional (and, generally, cost-reflective) funding for each additional consumer they admit to hospital or service at an emergency department, but no additional funding for providing community ambulatory or residential mental healthcare to each additional consumer.\(^9\) Several participants and commentators noted this phenomenon.

- The New South Wales Government (sub. 551, p. 26) said:
  
  Neither MBS nor [activity-based funding] within hospitals incentivise providers to invest in prevention and early intervention or address the underlying drivers of hospital admissions. They do not reward investments that support individuals using more appropriate and lower cost services (such as walk-in or community-based clinics).

- Wand (2014, p. 273) said:
  
  Another criticism of the [activity-based funding] model is the potential for ‘gaming’ the system. This refers to hospitals or [LHNs] exploiting the system to obtain more funding. One example of this is the diversion of patients from community-based services to the more lucrative options of inpatient admissions and EDs. Not only would this add to the current problems with overstretched EDs and bed block, but it is at odds with the evidence favouring the effectiveness of community-based mental health care and consumer preferences.

- During our consultations, one participant remarked that ‘LHNs just play the [National Weighted Activity Unit] game’ — meaning that their concern is with ensuring that they meet their targets for hospital admissions.

- WentWest (sub. 445) noted that LHNs are hospital-centric.

### Impacts of the National Health Reform Agreement

State and Territory Government health departments (or the Western Australian Mental Health Commission) could counterbalance LHNs’ incentives by specifying the mix of hospital-based, community ambulatory and residential mental healthcare that each LHN must provide. But Australian Government transfers to State and Territory Governments under the NHRA (box G.7) have created incentives for State and Territory Government health departments to favour hospital-based care (Allan Fels, sub. 303, attachment 2). From 2012-13 to 2016-17, the Australian Government subsidised 45% of the growth in the average cost of LHN-provided mental healthcare, lessening State and Territory Government incentives to limit cost growth in more expensive hospital-based care.

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\(^9\) The scope to shift marginal consumers to hospital beds is limited as hospital beds are often full (chapter 13), which moderates the effects of this incentive.
The 2011 National Health Reform Agreement sets out the framework through which the Australian Government funds State and Territory Governments to deliver health services (overwhelmingly hospital services) (COAG 2011).

The mental health-related component of these transfers amounted to $1.8 billion in 2018-19, or 29% of all State and Territory Government expenditure on specialised mental healthcare services in 2017-18 (the most recent year for which comparable data are available) (AIHW 2020a; unpublished data from DoH). The transfers grow at 45% of the growth in the national average cost of providing in-scope public mental healthcare, subject to an annual growth cap of 6.5% per annum that was introduced in 2017-18.

The agreement also sets out common devolved governance arrangements for State and Territory Government health services. It requires State and Territory Governments to establish LHNs as separate legal entities that directly manage health services under service agreements with State and Territory Governments.

The National Health Reform Agreement will expire on 31 June 2020. A 2020–25 agreement that maintains the existing funding parameters is expected to take effect from 1 July 2020 (all jurisdictions have signed a Heads of Agreement for this (COAG 2018)).

These incentives seem to have had some undesirable effects. Growth in expenditure on community ambulatory and residential mental healthcare generally exceeded growth in expenditure on public hospital-based mental healthcare prior to the NHRA taking effect (figure G.4). But since then, a much larger share of growth funding has gone to public hospital-based mental healthcare. This is despite National Mental Health Service Planning Framework benchmarks indicating that there are larger shortfalls in community ambulatory and residential mental healthcare than hospital-based mental healthcare, and frequent rhetoric about the need to build up services in the community to take pressure off hospitals (chapter 12).

Recent changes to the NHRA may have reduced its distortionary impacts, although it is too early to be certain. Since 2017-18, annual growth in total (mental and physical health related) Australian Government contributions to State and Territory Governments under the NHRA has been capped at 6.5% (box G.7). If this cap is reached (or if State and Territory Government health departments expect that it will be reached), then the distortion of State and Territory Government incentives — at least at the margin — would be neutralised. Funding growth in previous years has usually been sufficient to reach the cap. The cap was reached in 2018-19, but not in 2017-18 (the growth in Australian Government contributions in that year was 4.9% (NHFB 2020; pers. comm., 22 January 2020)). Years prior to the introduction of the cap saw growth in Australian Government funding comfortably exceed 6.5% — 11.5% in 2014-15, 11.1% in 2015-16 and 8.4% in 2016-17 (DoH 2019b).
Empirical evidence of the impact of the funding cap is scant. Growth in expenditure on community ambulatory mental healthcare rose and growth in expenditure on hospital-based mental healthcare declined in 2017-18 (figure G.4), which is consistent with the cap having some impact, but it would be unwise to draw conclusions from only one year of data.

The NHRA has also had other effects. As NHRA transfers are linked to growth in State and Territory Government mental healthcare costs, the NHRA (as interpreted by the Independent Hospital Pricing Authority) necessarily specifies the scope of State and Territory mental healthcare services that are eligible for Australian Government subsidies (box G.8).

There is an incentive for State and Territory Governments to preference in-scope services ahead of services that are not in scope. Since its introduction, the NHRA has provided comprehensive coverage of hospital-based mental healthcare, but not community-based services.

- Some community ambulatory mental healthcare services were not originally funded under the NHRA, but have since been brought within its scope. Older persons’ community mental health services and child and adolescent community mental healthcare services were deemed in-scope from 2014-15 and 2019-20, respectively (box G.8). All community ambulatory mental healthcare services now appear to be within scope, as Queensland Health indicated that all of its clinical mental healthcare services now fall within the scope of the NHRA (pers. comm., 2 September 2019), and
the Independent Hospital Pricing Authority has not received any further requests from State and Territory Governments to bring additional mental healthcare services within scope (Independent Hospital Pricing Authority, pers. comm., 28 August 2019).

- More generally, innovative approaches to service delivery and the funding of primary care and general counselling do not fall within the scope of the NHRA (PC 2017b).
- Psychosocial supports commissioned by State and Territory Governments are out of the scope of the NHRA (box G.8).

<table>
<thead>
<tr>
<th>Box G.8</th>
<th><strong>Scope of mental healthcare services funded under the National Health Reform Agreement</strong></th>
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<tbody>
<tr>
<td></td>
<td>The Independent Hospital Pricing Authority is tasked with interpreting the National Health Reform Agreement to determine which State and Territory Government mental healthcare services fall within the scope of the agreement.</td>
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<td>Admitted mental healthcare has been deemed to be within the scope of the agreement from the outset, as have forensic mental health inpatient services provided that they are recorded as within the scope of the 2010 Public Hospitals Establishment Collection.</td>
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<td></td>
<td>Over time, the agreement’s scope has expanded to include community mental healthcare services. The following community mental healthcare services have been within scope since at least 2013-14:</td>
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<td></td>
<td>• Adult integrated community mental health services</td>
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<td>• Crisis assessment and treatment (including telephone-based services)</td>
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<td></td>
<td>• Dual diagnosis services for patients with comorbid conditions</td>
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<td></td>
<td>• Home and community-based eating disorders programs</td>
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<td></td>
<td>• Mental health hospital avoidance programs</td>
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<td></td>
<td>• Mobile support and treatment services</td>
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<td></td>
<td>• Perinatal infant mental health services</td>
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<td></td>
<td>• Step-up step-down services</td>
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<td></td>
<td>• Telephone triage services.</td>
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<td></td>
<td>In 2014-15, older persons’ community mental health services became eligible for funding, as did child and adolescent community mental health services in 2019-20.</td>
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<td></td>
<td>Source: Independent Hospital Pricing Authority Pricing Framework for Australian Public Hospital Services (various issues).</td>
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</table>

**Changes to the National Health Reform Agreement are not feasible in the short term**

Given these shortcomings, the Inquiry draft report contemplated recommending that mental health funding be excised from the NHRA and provided to State and Territory Governments on a block funding basis under a new intergovernmental agreement. Doing so would remove the distortions outlined above. However, changes to the NHRA seem unlikely for at least
five years. The NHRA is due to expire on 31 June 2020, and a 2020–25 agreement that maintains the existing funding parameters is expected to take effect from 1 July 2020 (box G.7).

Instead, chapter 23 recommends other reforms to reduce these biases.

- Extending activity-based funding to community ambulatory mental healthcare, which is primarily to drive greater productivity at community ambulatory mental healthcare services but would also reduce LHNs’ incentives to preference hospital-based care ahead of community ambulatory mental healthcare.

- Establishing a National Mental Health and Suicide Prevention Agreement to govern Australian Government transfers to State and Territory Governments for clinical mental healthcare and psychosocial supports that are additional to the NHRA transfers. The National Mental Health and Suicide Prevention Agreement should clearly set out funding commitments by both levels of government and require that these new transfers are not channelled toward acute hospital beds.

**G.4 Current approach to managing split government roles**

As noted throughout this appendix, the Australian Government and State and Territory Governments share responsibility for clinical mental healthcare and psychosocial supports. The current split in responsibilities contributes to the missing middle, as it does not allow either level of government to be fully held responsible for the problem. The Australian Government funds primary mental healthcare and State and Territory Governments provide specialised mental healthcare in public hospital, community ambulatory and residential settings. Both levels of government fund psychosocial supports outside of the National Disability Insurance Scheme (NDIS).

The experience of participants to this Inquiry and other stakeholders supports the proposition that a lack of clarity in government roles has exacerbated the missing middle.

- The Primary Health Network Cooperative (sub. 377, p. 15) noted that consumers missing out on the services they need because of the missing middle ‘are at risk of falling through the silos and divides of our health system’.

- Rosenberg (2015, p. 1) attributed the problem to neither level of government clearly having ownership of it:

  It is widely accepted that on closing the asylums, Australia failed to invest in an alternative model of community mental health care. This means that for people seeking mental health assistance, there are few alternatives between the GP’s surgery and the hospital emergency department.

  These alternatives reflect the financial demarcation between the federal government, which pays for primary care, and the states and territories, which manage hospitals. Nobody currently ‘owns’ or has responsibility for community mental health services.
Transforming Australia’s Mental Health Service Systems (sub. 919, p. 16) said:
The lack of clarity of roles and planning for integration has given us the missing middle, between highly constrained state services and the fee for service single practitioner market with all its distortions and perverse incentives.

The Grattan Institute (sub. 816, p. 8) said:
The disjunction between Commonwealth Medicare-funded out-of-hospital services and state inpatient-oriented systems creates a yawning gap for people who need intensive community support but not inpatient care: the missing middle.

More broadly, participants submitted that the divide in government roles has fragmented service delivery by limiting integration between services (box G.9).

Efforts by governments to clarify roles and integrate services

The major intergovernmental agreements that lay out responsibilities for healthcare and disability supports do not satisfactorily clarify responsibility for mental healthcare and psychosocial supports.

- **Clinical mental healthcare** — the National Healthcare Agreement defines mental health services as a shared responsibility to be jointly funded (COAG 2012), while the National Health Reform Agreement (subject to the Independent Hospital Pricing Authority’s interpretation) defines the scope of State and Territory-provided public mental healthcare that is eligible for Australian Government co-funding (as previously discussed), but does not clearly lay out which mental health services the Australian Government is responsible for providing (COAG 2011).

- **Psychosocial supports outside of the NDIS** — the bilateral agreements between the Australian Government and State and Territory Governments accompanying the introduction of the NDIS prioritise continuity of support for existing recipients of psychosocial support who were not eligible for the NDIS (PC 2017a). While continuity of support is important, it does not assist with clarifying responsibility for providing services to the substantial number of people who need psychosocial support but do not currently receive it. And the National Disability Agreement does not clarify responsibility for psychosocial supports outside of the NDIS (PC 2019).

Priority Area One of the Fifth National Mental Health and Suicide Prevention Plan (COAG Health Council 2017) (hereafter the ‘Fifth Plan approach’) amounts to a more substantive attempt by all governments to clarifying government roles and integrate services. While it does not set out which level of government should deliver which type of service, it tasks co-located PHNs and LHNs (hereafter ‘PHN–LHN groupings’) with agreeing to a division of responsibilities and means of integrating services on a region-by-region basis by

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10 The Bilateral Agreements on Co-ordinated Care Reforms convey similar sentiments to the Fifth Plan approach, as do the amendments to the NHRA that accompany its 2020–25 extension (Council on Federal Financial Relations 2019).
undertaking joint regional planning, jointly commissioning services, and establishing care and referral pathways underpinned by shared clinical governance arrangements and data sharing protocols.

Box G.9  Participants’ views on the federal divide in mental health services

There are at least four vastly different mental health systems operating in parallel, rarely in concert. These are the public and private hospital system, community and primary mental health systems and the NDIS. At each level of care patients and carers experience deep frustration at the lack of interface between services; for example, between the public and private tertiary hospital system, between the tertiary system and community care and between the NDIS and all other forms of support. Fragmentation of the mental health system is fundamentally driven by siloed funding models and is particularly marked between the public and private sectors. Further fragmentation is introduced by the establishment of PHNs as commissioning bodies, with variable readiness and lack of joint commissioning approaches particularly with local health districts (LHDs) or private hospitals and continued inadequate funding across the sector. (CHA, sub. 463, p. 4)

The Australian Government and some state governments have recently introduced a number of mental health initiatives separately or in parallel that have added complexity to an already fragmented healthcare system. (PHN Cooperative, sub. 377, p. 11)

The complexity of Commonwealth/state relations acts as a barrier to designing good care for people with mental illness. The Australian mental health system is currently fragmented, with poor integration between public, private and non-government organisations. The current funding of mental health where the Commonwealth, State and Territory Governments all have responsibility for mental health creates an environment of cost shifting and blame and fragmentation of governance and reform. It is an environment that is difficult for clinicians to navigate, let alone consumers and families when they are unwell. (CAHS, sub. 255, p. 1)

One of the main factors that has impeded past reform efforts is the lack of cohesion between service responses provided by the State and Commonwealth governments. Service responses are often developed in isolation, leading to a service system that can be fragmented and lacking a whole-of-government direction/vision. (Merri Health, sub. 120, p. 2)

In Australia, one of the main issues around the management of mental health-related issues is the fragmentation of the system at all levels (especially the divide between the state/territory and federal). The [Royal Australian College of General Practitioners] highlights the significant shifting of responsibilities between state-funded or territory-funded mental health services and federally funded initiatives such as general practice incentives and Primary Health Networks (PHNs). This divide between state/territory and federal funding means that real mental health reform will continue to fail. Mental health care practitioners and patients often experience significant confusion because of a lack of system knowledge. (RACGP, sub. 386, p. 13)

The mental health sector is complex and fragmented, with multiple providers and siloed funding streams. Variability exists in both state government funded services and the federally funded Better Access program. Mental health care provision in the community is provided by general practice, Primary Health Networks, community health organisations, state hospital care, Headspace, the National Disability Insurance Scheme (NDIS) and aspects of private care, all contributing to fragmentation of the mental health system. Fragmentation results in limited consumer understanding of the services provided by these sources. Consumers and carers experience poor care and unmet needs due to overlaps, insufficiencies, poor planning and lack of coordination of services. (GPMHSC, sub. 395, p. 4)
Unfortunately, it is not yet possible to gauge how successful the Fifth Plan approach will be at clarifying government roles and integrating services, as its most important aspect — PHN–LHN groupings producing ‘comprehensive’ joint regional plans — is not expected to be completed until mid-2022 (Integrated Regional Planning Working Group 2018b).

Indicators of the progress made so far are mixed.

- The National Mental Health Commission’s (NMHC’s) progress report for 2017-18 was largely positive (table G.1), although lacking in detail. The NMHC’s 2018-19 progress report has not been published.

- Our consultations indicated that some PHN–LHN groupings were working well together, while others were not. In some instances, cooperation appears (at best) superficial with details of effective cooperation lacking.

- Some participants expressed frustration with the Fifth Plan approach. The Royal Australian and New Zealand College of Psychiatrists (Sydney transcript, p 23) said:

  So, I think this has been a sore on the side forever, since the first national mental health plan. The last plan went some way towards joint planning, joint commissioning, and eventually joint funding. So we're now three years down from that plan, and although we've got some joint planning, we have limited joint commissioning and we have no real joint funding. So the question is, yes, that's a great ambition, but when would that ever be achieved? I think that's the issue.

  And the ACT Government (sub. 1241, p. 17) said:

  It is noted that there are currently both overlap and gaps across the service system and while there is a move towards joint planning and co-commissioning, it is time consuming for all parties.

- Some PHNs provided the Productivity Commission with examples of where they had worked cooperatively with LHNs (box. G.10). These each appear promising.
<table>
<thead>
<tr>
<th>Action</th>
<th>PHN progress</th>
<th>State/Territory Government progress</th>
<th>Australian Government progress</th>
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<tbody>
<tr>
<td>1.1b — Development of joint regional mental health and suicide</td>
<td>3 PHNs ahead of schedule, 3 PHNs behind schedule,</td>
<td>1 State/Territory behind schedule, all others on track.</td>
<td>On track.</td>
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<tr>
<td>prevention plans</td>
<td>20 PHNs on track</td>
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<tr>
<td>1.1c — Public release of joint regional mental health and suicide</td>
<td>2 PHNs ahead of schedule, 8 PHNs behind schedule,</td>
<td>1 State/Territory behind schedule, all others on track.</td>
<td>On track.</td>
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<tr>
<td>prevention plans</td>
<td>17 PHNs on track</td>
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<tr>
<td>2.2 — Engaging with the local community, including consumers and</td>
<td>2 PHNs complete, 4 PHNs behind schedule, 21 PHNs</td>
<td>1 State/Territory behind schedule, all others on track.</td>
<td>On track.</td>
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<td>carers, community managed organisations, Aboriginal Community</td>
<td>on track</td>
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<td>Controlled Health Services, National Disability Insurance</td>
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<td>Scheme providers, the National Disability Insurance Agency, private</td>
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<td>providers and social service agencies</td>
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<td>2.3a — Primary Health Networks (PHNs) and Local Hospital Networks</td>
<td>5 PHNs ahead of schedule, 3 Behind schedule, 20 PHNs</td>
<td>1 State/Territory behind schedule, all others on track.</td>
<td>—</td>
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<tr>
<td>(LHNS) work towards data sharing to map regional service provision</td>
<td>on track</td>
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<tr>
<td>and identify areas of duplication, inefficiency and service gaps</td>
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<tr>
<td>2.3b — PHNs and LHNS utilise the National Mental Health Service</td>
<td>3 PHNs complete, 1 PHN ahead of schedule, 4 behind</td>
<td>1 State/Territory behind schedule, all others on track.</td>
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<tr>
<td>Planning Framework and other planning tools to facilitate regional</td>
<td>schedule, 20 PHNs on track</td>
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<td>needs assessment and planning</td>
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<td>2.5 — Develop joint, single regional mental health and suicide</td>
<td>1 PHN ahead of schedule, 7 behind schedule, 20 on</td>
<td>1 State/Territory behind schedule, all others on track.</td>
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<td>prevention plans and commissioning services according to those plans.</td>
<td>track</td>
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<tr>
<td>2.7 — Developing region-wide multi-agency agreements, shared care</td>
<td>5 PHNs behind schedule, 22 PHNs on track</td>
<td>1 State/Territory behind schedule, all others on track.</td>
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<td>pathways, triage protocols and information-sharing protocols to</td>
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<td>improve integration and assist consumers and carers to navigate the</td>
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<tr>
<td>system.</td>
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<tr>
<td>2.8 — Developing shared clinical governance mechanisms to allow for</td>
<td>8 PHNs behind schedule, 20 PHNs on track</td>
<td>1 State/Territory behind schedule, all others on track.</td>
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<tr>
<td>agreed care pathways, referral mechanism, quality processes and review</td>
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<td>of adverse events.</td>
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Box G.10  **Selected examples of PHN–LHN cooperation**

- The Brisbane North Primary Health Network (PHN) and Metro North Health and Hospital Service (its neighbouring Local Hospital Network) have created a ‘neutral space’ where separate parts of the health system can come together (the Health Alliance) and a shared governance mechanism (the Joint Board Committee) with rotating membership to progress shared goals (MNHHS, Brisbane North PHN, MSHHS and Brisbane South PHN, sub. 874).

- The Women's and Children's Hospital Network, Department of Human Services and Adelaide PHN funded an evidence-based therapy program for mothers with borderline personality disorder (PHN Cooperative, sub. 850).

- The Hunter New England Central Coast PHN and Hunter New England and Central Coast Local Health Districts (its neighbouring LHNs) both committed resources toward a dynamic simulation modelling for suicide prevention process to inform future commissioning of suicide prevention services. The same grouping also collaboratively commissioned a program to provide assertive outreach and linkage to primary care for people with complex psychosocial needs (PHN Cooperative, sub. 850).

Instead of drawing sharp conclusions about its success on the basis of this limited evidence, we have examined the fundamentals of the Fifth Plan approach — its potential strengths (regionalism) and weaknesses (misaligned incentives of PHNs and LHNs) and the effectiveness of how it is being pursued.

**A regional strategy is a sound foundation**

Regionalism is at the core of the Fifth Plan approach. Effectively, the Fifth Plan approach seeks to clarify PHN and LHN roles and integrate PHN-commissioned and LHN-provided services on a region-by-region basis, which allows for some regional variation in government roles and promotes regional approaches to integrating services across levels of government.

A regional approach to clarifying roles and integrating services seems the most likely to succeed, for three reasons:

- Government roles are *not* currently uniform across Australia. Australian Government funding for mainstream mental healthcare services is mostly via MBS rebates, which flow disproportionately to wealthier urban areas (section G.2). And while PHN funding counteracts these inequities, it only partially cancels out the differences when regional differences are taken into consideration (section G.2). As a result, the Australian Government share of total mental healthcare funding varies between States/Territories, from as high as 24% in Victoria to as low as 16% in Western Australia (figure G.5) — and this obscures regional differences within States/Territories.

- Regional differences suggest the ‘optimal’ service mix will differ between regions. A rigid approach to clarifying roles risks locking in a uniform service mix.

- Effective integration requires, among other things, personal relationships that can only be formed at the regional level (PC 2017b).
This conclusion comes with two important provisos:

- Regional-level role clarification does not subsume the need for national-level role clarification (which, as noted previously, is not adequate at present). Rather, national-level role clarification should set expectations about the types of services that each level of government is responsible for funding (whether via PHNs, LHNs, MBS rebates or other means), and PHN–LHN groupings should then take this allocation of roles at a national level as a starting point to clarify roles at a more granular level via joint regional planning.

- Regional-level role clarification is necessary only if responsibility for commissioning mental health services remains split across levels of government. If a single level of government were to take full responsibility for commissioning mental health services, then national-level role clarification would suffice (although regional commissioning would remain preferable for the reasons outlined in box G.4). We discuss the potential for placing all commissioning responsibilities with a single agency (a Regional Commissioning Authority) in section G.5 and chapter 23.
Existing incentives undermine the scope for PHN–LHN cooperation

The Fifth Plan approach requires cooperation between PHNs and LHNs. Cooperation is common, and there is no underlying reason why cooperation between PHNs and LHNs could not integrate mental health services and allocate resources to better meet consumer needs.

However, cooperation will only be an effective strategy where it is mutually beneficial to the relevant parties. A primary concern with the Fifth Plan approach is that neither PHNs nor LHNs face strong financial incentives to work together in a cooperative manner.

Consider the incentives of PHNs. As set out in chapter 12, there likely would be savings to the mental health budget by better servicing the missing middle. But these savings would likely come in the form of reduced demands on acute mental healthcare and non-health services, neither of which are captured by the PHNs. Moreover, the ability of the Australian Government to direct the PHNs to ‘internalise’ these potential savings appears limited. Reducing ‘potentially preventable hospitalisations’ is an objective in the PHN Program Performance and Quality Framework (DoH 2018), but there is no measure for potentially preventable mental illness-related hospitalisations (AIHW 2018). And while the general PHN Grant Program Guidelines note that an objective of establishing PHNs is to ‘help patients to avoid having to go to emergency departments or being admitted to hospital for conditions that can be effectively managed outside of hospitals’ (DoH 2016a), the Mental Health Care Flexible Funding Pool Guidance Documentation mentions hospital avoidance only in the context of clinical care and coordination delivered by mental health nurses, and only in passing.

On the LHN side — and as already discussed in section G.3 — activity-based funding for public hospital-based mental healthcare limits incentives to seek to service the missing middle. Coordinating with PHNs runs counter to this.

Supporting policy settings are inadequate

Given the current incentives that PHNs and LHNs face, well-designed regulation and strong oversight is likely to be necessary to drive PHNs and LHNs to cooperate. These are not in place at this time.

Joint regional planning is critical, but is not adequately mandated

Ideally, cooperative arrangements would see PHN–LHN groupings allocate resources and share information as though each grouping were a single organisation holding a single mental health budget and singularly responsible for providing/commissioning mental healthcare. To drive such behaviour, governments must clearly specify verifiable activities required of PHNs and LHNs that require them to behave in this way, while not being so prescriptive as to undermine the benefits offered by regionalism.
The activities required of PHN–LHN groupings under the Fifth Plan approach (box G.11) could be used to require groupings to behave in this way. In particular, activities 2.1–2.5 require each PHN–LHN grouping to jointly develop a regional mental health and suicide prevention plan and align their commissioning/service provision processes with this plan. The development of these plans could serve as objectively verifiable evidence that PHN–LHN groupings have cooperated with one another, and the plans could be used to hold PHN–LHN groupings accountable for their future resourcing allocations. And the requirement is not unduly prescriptive, as joint region planning is a necessary input to successful cooperation.

Box G.11  Cooperative activities required of PHNs and LHNs

Priority Area One of the Fifth Plan sets out that following actions that PHNs and LHNs must undertake.

- Utilise existing agreements between governments for regional governance and planning arrangements (activity 2.1) — commencing early 2018.
- Engage with the local community, including consumers and carers, community-managed organisations, ACCHSs, National Disability Insurance Scheme providers, the National Disability Insurance Agency, private providers and social service agencies (activity 2.2) — commencing early 2018.
- Undertake joint regional mental health needs assessments to identify gaps, duplication and inefficiencies to make better use of existing resources and improve sustainability (activity 2.3) — progressively from June 2018.
- Examine innovative funding models, such as joint commissioning of services and fund pooling for packages of care and support, to create the right incentives to focus on prevention, early intervention and recovery (activity 2.4) — commencing mid-2020.
- Develop joint regional mental health and suicide prevention plans and commission services according to those plans (activity 2.5) — foundation plans due mid-2020, comprehensive plans due mid-2022.
- Identify and harness opportunities for digital mental health to improve integration (activity 2.6) — completed mid-2020.
- Develop region-wide multi-agency agreements, shared care pathways, triage protocols and information-sharing protocols to improve integration and assist consumers and carers to navigate the system (activity 2.7) — completed mid-2021.
- Develop shared clinical governance mechanisms to allow for agreed care pathways, referral mechanisms, quality processes and review of adverse events (activity 2.8) — completed mid-2021.

Source: COAG Health Council (2017); NMHC (2018).
However, guidelines for joint regional plans developed subsequent to the Fifth Plan do not require PHN–LHN groupings to develop plans that would have sufficient detail to guide regional cooperation. The guidelines grant ‘significant flexibility, variation and innovation’ (Integrated Regional Planning Working Group 2018b, p. 14) in relation to, among other things:

- the format, structure and length of the plans
- whether the regional plan is endorsed by other local stakeholders
- whether detailed joint service mapping, planning and development is undertaken to inform the plan or is an agreed action over the life of the plan.

Further, PHN–LHN groupings are not expected to obtain approval from either the Australian Government or State/Territory Governments for their joint regional plans. Given the current incentives that PHNs and LHNs face, these weak governance processes create a risk that some PHN–LHN groupings will produce plans of little substance.

There appears to be no intention for either the Australian Government or State/Territory Governments to use the joint regional plans to hold PHN–LHN groupings to account. Even if a PHN–LHN grouping does produce a high-quality plan, the incentives for each party to stick to that plan are not strong. LHNs may commit to providing more community ambulatory mental healthcare at the outset, and receive (block) funding to support this, but will still face incentives to direct consumers toward activity-funded hospitals. PHNs may commit to integrating their services tightly with LHN services, but may subsequently find it easier to fall back into their traditional primary care sphere of influence.

The guidelines also fall short of ensuring adequate consumer and carer input. PHN–LHN groupings are expected to develop a ‘consultation plan’ that includes (among other things) a strategy for engaging with consumers and carers, but they are not required to publish these plans (Integrated Regional Planning Working Group 2018a). And there are no formal requirements on how planning processes should engage with consumers and carers, or whether they should endorse joint regional plans.

**Monitoring and reporting lacks independence and detail**

The National Mental Health Commission (NMHC) is responsible for monitoring and reporting on the implementation of the Fifth Plan approach. To do so, it mostly draws on surveys of PHNs and State and Territory Governments about the degree to which they have implemented the actions of the Fifth Plan approach (NMHC 2018).

We have two concerns with this approach:

- The NMHC is an executive agency of the Australian Government Department of Health (chapter 22), so some stakeholders would not perceive it as independent.
- The reporting is often subjective — it is based on the perceptions of PHNs and government agencies at both levels of government about progress made toward the activities laid out in box G.11. There have been comparatively fewer attempts to use objective data to examine the impacts that cooperation between PHNs and LHNs is having, such by reporting gap
analyses using National Mental Health Service Planning Framework benchmarks (chapter 24) and comparing actual service delivery with planned commitments. As regards the latter point, existing guidelines for joint regional planning are too vague to give hope that joint regional plans (as currently conceived) could feed into such analysis.

**Psychosocial supports need more attention**

The Fifth Plan approach is healthcare-centric. While it acknowledges the importance of non-health sectors, its focus is on the integration of primary and specialist mental healthcare.

This means that, with regard to psychosocial supports outside of the NDIS, it has become quickly outdated. Since its introduction, the Australian Government has devolved its residual psychosocial support programs outside of the NDIS to the PHNs (chapter 17). And LHNs in some states (for example, New South Wales) also commission psychosocial supports (Coordinare et al. 2018).

Integration of Australian Government and State and Territory Government psychosocial support programs outside of the NDIS may have deteriorated in recent times. The Australian Government’s National Psychosocial Support program — a funding boost to psychosocial supports — offered an opportunity to clarify federal responsibilities. Instead, both tiers of government increased funding to psychosocial supports, but did so in an uncoordinated way. On this point, Mental Health Australia (sub. 544, p. 7) said:

> The commissioning service model was intended to be developed in collaboration by the Australian Government, state and territory governments and PHNs in an attempt to ensure it is flexible and attributable to all involved parties. The approach to date has, however, followed a similar uncoordinated path, with the Commonwealth funding PHNs to address the diminishing Partners in Recovery (PIR) and Personal Helpers and Mentors Service (PHaMs) programs and some states and territory governments selecting programs that were already being delivered and committing some new and some already allocated funding through them. This is an example of an unintended consequence resulting from inadequate Commonwealth and state negotiations in relation to significant social services reform.

Joint regional planning guidelines do mention that: ‘Governments expect that joint regional planning by LHNs and PHNs will support the planned implementation and coordination of psychosocial support services for people with severe mental illness and associated psychosocial impairment who are not more appropriately supported through the NDIS’ (Integrated Regional Planning Working Group 2018b, p. 38). But, consistent with the shortcomings of expectations of joint regional planning discussed above, precisely what is expected of PHN–LHN groupings in this regard has not been made clear.

**G.5 To renovate or rebuild the system?**

In recognition of the need to clarify government roles for mental healthcare and psychosocial supports, the draft Inquiry report proposed two options for reform to commissioning
arrangements, termed ‘Renovate’ and ‘Rebuild’. Box G.12 provides a recap of these options, including how they would integrate with other reforms to funding arrangements that were proposed in the draft Inquiry report.

Box G.12  Two models in the Inquiry draft report: Renovate and Rebuild

**Renovate**

Renovate sought to rationalise psychosocial support funding, integrate the accounting of Medicare Benefits Schedule (MBS) rebates for allied mental healthcare with Primary Health Network (PHN) funds, and embraced PHN–Local Hospital Network (LHN) cooperation as a mechanism to coordinate mental health services funded by both levels of government.

- State and Territory Governments would take on sole responsibility for commissioning psychosocial supports outside of the National Disability Insurance Scheme, supported by additional Australian Government funding.
- PHN mental health funds and MBS rebates for allied mental healthcare would be drawn from fixed/capitated regional pools, with PHNs free to co-fund MBS-rebated allied mental healthcare as they see fit.
- Responsibilities for clinical mental healthcare services would remain largely unchanged. Renovate would continue the current approach of supporting PHNs and LHNs to work cooperatively to create a unified mental health system, as set out in the first priority area of the Fifth National Mental Health and Suicide Prevention Plan (COAG Health Council 2017).

**Funding flows under the Renovate model (proposed in the Inquiry draft report)**

(continued next page)
**Box G.12 (continued)**

**Rebuild**

Rebuild — a more significant change — would place responsibility for all mental health service commissioning with a single agency in each region and integrate the accounting of MBS rebates for allied mental healthcare with these agencies’ funding pools.

- Under Rebuild (as proposed in the draft report) (figure below), State and Territory Governments would establish ‘Regional Commissioning Authorities’ (RCAs) that commission:
  - all mental healthcare (that is, mental healthcare currently commissioned by PHNs, and State and Territory Government health departments), excepting MBS-rebated mental healthcare (GPs, allied mental health and psychiatry)
  - all psychosocial supports outside of the National Disability Insurance Scheme.
- Each region would have a fixed/capitated mental health funding pool comprising pooled Australian Government, and State and Territory Government funds (MBS rebates for GPs and psychiatrists would sit outside this pool). To give effect to this, the Australian Government would transfer a needs-based block of funds to each RCA, but deduct from this transfer the volume of MBS rebates for allied mental healthcare billed in that RCA’s catchment.

**Funding flows under the Rebuild model (proposed in the Inquiry draft report)**

- **Australian Government**
  - Medicare Benefits Schedule (GPs, psychiatrists)

- **State/Territory Governments**
  - Fixed/capitated funding pool
  - Medicare Benefits Schedule (allied mental health)
  - Regional Commissioning Authorities

- **Local Hospital Networks**
  - Activity-based funding

- **Consumers and carers**
  - Mental health funds
  - Mental health services

- **Non-government clinical service providers**
  - Psychosocial support service providers
Feedback following the draft report exposed both benefits and limitations of each approach. Consequently, this report recommends a third option that combines elements of both Renovate and Rebuild (chapter 23). This section summarises the further analysis that underpins this third option.

**Rebuild resolves structural shortcomings**

Rebuild would better clarify roles and reduce funding distortions than would Renovate. This is for two reasons.

First, Rebuild would assign clearer responsibilities for mental health service provision (especially to the missing middle) by assigning all commissioning to a single agency in each region — a Regional Commissioning Authority (RCA). Many participants and commentators agreed on the importance of establishing clear responsibilities,\(^\text{11}\) including some State and Territory Governments (box G.13). By contrast, under Renovate, responsibility for commissioning would remain spread across both tiers of government.

Second, Rebuild would be more likely to reduce the existing distortions that incentivise relative overinvestment in hospital-based care and Medicare Benefits Schedule-rebated (MBS-rebated) services (sections G.2 and G.3) than would Renovate. It would establish, for each RCA catchment, a fixed/capitated needs-based mental health funding pool from which nearly all mental health services would be funded — thus neutralising the scope for cost shifting between levels of government. Under Renovate, however, incentives would remain for State/Territory Government health departments to shift costs to MBS-rebated care (as these would remain funded from outside their budgets).

\(^{11}\) AFMH, sub. 1195; MHCSA, sub. 794; QUT Faculty of Health, sub. 826; RANZCP, Sydney transcript; TAMHSS, sub. 919; The Mitchell Institute, sub. 744.
Box G.13  **State and Territory Government views on the two models**

The New South Wales Government (sub. 1243) did not support either model because both would see mental healthcare continue to be funded via the Medicare Benefits Schedule, but leaned toward Renovate. It raised concerns that Rebuild would silo physical and mental healthcare.

The Victorian Government did not comment in detail as it did not wish to pre-empt the recommendations of its ongoing Mental Health Royal Commission. It acknowledged that Rebuild could ‘support better collaboration between different levels of government’ (sub. 1228, p. 17), but raised high-level concerns about a separation of physical and mental health.

The Western Australian Government (sub. 1227, attachment) supported Rebuild in-principle, and suggested that it could pilot the model with its mental health commission acting as a State-wide Regional Commissioning Authority (RCA).

The South Australian Government (sub. 692, p. 6) did not comment substantially, other than to urge consideration of any unintended consequences of creating RCAs.

The Tasmanian Government did not specify a position, but urged flexibility in the design of RCAs. It would ‘welcome a simplified approach to commissioning which recognises that the current situation can result in overlapping agendas and mismatch of need’ (sub. 1242, p. 3).

The ACT Government (sub. 1241, p. 17) supported Rebuild in-principle, noting that it ‘reduces the number of funding sources and simplifies commissioning and funding activities to a level that could provide substantial beneficial efficiencies’.

The Northern Territory Government (sub. 1220, p. 5) said only that Rebuild would ‘need further consideration and investigation prior to implementation in the NT’.

The Queensland Government did not submit a response following the release of the Inquiry draft report.

**Rebuild is unlikely to hamper coordinated physical–mental healthcare**

Various participants, including the PHNs (box G.14) and some State/Territory Governments (box G.13), raised concerns that administering funds via RCAs would weaken coordination between the physical and mental healthcare that consumers with comorbid physical–mental illness receive. For example:

- the Consumers Health Forum of Australia (sub. 646, p. 24) highlighted a risk of ‘fragmentation between mental and physical health services’

- the Mental Health Coordinating Council (sub. 920, p. 23) said ‘establishing separate mental health specific commissioning bodies may impact negatively on systemic capacity to further drive integrated care for people with mental health issues’

- the PHN Cooperative (sub. 850, pp. 10–11) said that implementing Rebuild could lead to mental health becoming ‘increasingly “siloed” and distanced from the broader health system within which it functions’, and that it ‘signals the delinking of mental health and physical health which would be the antithesis of the principles of integrated care, to which the government has publicly committed, and moves away from meeting the full healthcare needs of individuals and communities’.
Box G.14  **PHN views on Renovate vs. Rebuild**

Many Primary Health Networks (PHNs) (including WA Primary Health Alliance, sub. 722; WentWest Limited, sub. 788; Victorian and Tasmanian PHN Alliance, sub. 849; PHN Cooperative, sub. 850; COORDINARE, sub. 1194; and Murrumbidgee Primary Health Network, sub. 1199) strongly rejected Rebuild, under which they would no longer be responsible for commissioning mental health services.

PHN arguments against Rebuild include that it would:

- reduce the influence of GPs on mental health commissioning decisions and/or lead to primary care being disregarded (WA Primary Health Alliance sub. 722; PHN Cooperative, sub. 850; COORDINARE sub. 1194)
- introduce an extra layer of bureaucracy and cost (PHN Cooperative, sub. 850)
- disrupt the gains made by PHNs (WentWest Limited, sub. 788; COORDINARE, sub. 1194).

The PHNs proposed a variant on Renovate, termed ‘Repurpose’. It would involve PHNs taking on sole responsibility for commissioning psychosocial supports (which sat with State and Territory Governments under Renovate), but is otherwise very similar to Renovate.

These concerns warrant careful consideration given the high rates of comorbid physical–mental illness (chapter 14). However, in our view, they are overstated because they conflate coordinated delivery of care from a consumer’s perspective with the funding of that care. Indeed, these concerns are symptomatic of a system that is ‘funder’ centric and places less emphasis on consumers’ experiences of services.

Under Rebuild, RCAs would be responsible for mental healthcare commissioning and PHNs and State and Territory Government health departments would be responsible for physical healthcare commissioning. The issue is whether separating mental and physical healthcare commissioning responsibilities would be likely to reduce coordination of physical and mental healthcare. In part, this depends on the extent to which, under the current arrangements, coordination is contingent on a single funder commissioning both physical and mental healthcare.¹²

There is limited scope for this to be the case for primary healthcare, because the PHNs do not commission much primary physical healthcare (it is overwhelmingly funded via MBS rebates). The bulk of Australian Government funding to PHNs is mental health related (62% in 2018-19; figure G.6). Moreover, 67% of the non-mental health funding (or 26% of all funding) is ‘core funding’, much of which does not go toward commissioning services. By contrast, only about 8% of total government health expenditure in Australia goes toward mental health services (AIHW 2020a). Put differently, this evidence demonstrates that PHNs are themselves almost specialist mental health service commissioners, so transferring their mental health commissioning responsibilities to different specialist mental health service

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¹² Examples of care coordination activities that are not contingent on a single funder commissioning both physical and mental healthcare include GPs managing the care of consumers with comorbid physical–mental illness and PHNs establishing referral pathways and other linkages between mental healthcare providers (whether MBS-rebated or PHN-commissioned) and GPs (MBS-rebated). These could continue under Rebuild.
At the State/Territory level, there currently are single funders (State/Territory Government health departments) commissioning both physical and mental healthcare in every State/Territory except Western Australia. Hence, any coordination problem under Rebuild is more likely to arise due to the split of commissioning responsibilities at this level than at the PHN level.

However, recent experience from Western Australia suggests that the separation of physical and mental healthcare commissioning at the State/Territory level need not undermine the coordination of physical and mental healthcare from a consumer perspective. Since 2010, the Western Australian Government has tasked its Department of Health with commissioning physical healthcare from LHNs and its Mental Health Commission with commissioning mental healthcare from LHNs and other mental health services from non-government providers — a practical example of separate physical and mental health commissioning (RCAs) would be closer to a straight transfer of responsibilities between two mental health commissioning bodies rather than an undermining the coordination of primary physical and mental healthcare.

Figure G.6  **Australian Government funding to Primary Health Networks**

![Graph showing Australian Government funding to Primary Health Networks](chart)

<table>
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<tr>
<th>Year</th>
<th>Psychosocial supports</th>
<th>Mental healthcare</th>
<th>Drug and alcohol</th>
<th>Core funding</th>
<th>After hours</th>
<th>Aboriginal and Torres Strait Islander healthcare</th>
</tr>
</thead>
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<tr>
<td>2015-16</td>
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<td>0</td>
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</tr>
<tr>
<td>2016-17</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2017-18</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<td>2018-19</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<td>0</td>
</tr>
</tbody>
</table>

62% of PHN funding goes to commissioning mental health and drug and alcohol services

a ‘Psychosocial supports’ includes Partners in Recovery, the National Psychosocial Support Measure and Continuity of Support programs. ‘Mental healthcare’ is the Primary Mental Health Care Flexible Funding Pool. ‘Aboriginal and Torres Strait Islander healthcare’ includes Integrated Team Care and other Indigenous health programs. ‘Core funding’ includes general practice support.

*Source: Unpublished data supplied by the Australian Government Department of Health.*
service commissioning. There is little to suggest that these arrangements resulted in a lessening of physical–mental healthcare coordination. While two recent reviews (Chapman et al. 2019; OAGWA 2019) were highly critical of the Western Australian arrangements, both primarily critiqued the lack of clarity in, and duplication of, the roles and responsibilities of the Western Australian Mental Health Commission and the Western Australian Department of Health for various aspects of the funding and delivery of mental health services alone.

The findings and recommendations of these reviews do, however, provide important learnings for any future attempt to establish RCAs that we have incorporated into our recommendations (chapter 23).

An immediate and wholesale transition to Regional Commissioning Authorities is not justified

While moving to RCAs, as outlined in the Rebuild option presented in the draft report, would eliminate many of the existing undesirable incentives that hinder regional coordination in mental health, an immediate and wholesale transition to a RCAs in every region of Australia cannot be justified at present.

- The implementation of RCAs would undoubtedly prove more disruptive in some parts of Australia than either maintaining or improving on the current cooperative arrangements between PHNs and LHNs.

- The long-term benefits of having RCAs relative to cooperative arrangements between PHNs and LHNs depend heavily on whether or not these cooperative arrangements can be improved. Moreover, while the Productivity Commission has concerns about the prospects of PHN–LHN cooperation — at least for some parts of Australia — no concrete determination of its prospects can yet be made as most PHN–LHN groupings are yet to commence critical milestones — examining co-commissioning approaches (from mid-2020) and producing comprehensive joint regional plans (by mid-2022) (section G.4).

As such, the Productivity Commission considers that a better approach is to allow for individual States and Territories to take bespoke approaches. PHN–LHN cooperation should be strengthened through reforms to improve oversight and strengthen joint regional planning. However, individual States and Territories should be able to, at any time, choose to move to RCAs. For example, if a State or Territory either considers that PHN–LHN cooperation is unlikely to be successful even with these reforms or, if after implementing the reforms they consider that cooperation is not delivering a person-centred mental health system, that State or Territory can work with the Australian Government to implement regional commissioning of mental health services through RCAs.
G.6 Additional considerations underpinning chapter 23 reforms

This section provides additional detail on three reforms proposed in chapter 23:

- The case for developing a National Mental Health and Suicide Prevention Agreement.
- Considerations underpinning proposed RCA governance arrangements.
- The proposed method for determining the allocation of Mental Health Care Flexible Funding Pool funds to PHNs (and RCAs).

The case for a National Mental Health and Suicide Prevention Agreement

Chapter 23 argues that it is necessary secure the agreement of all governments to:

- recast the NMHC as an interjurisdictional statutory authority;
- clarify government responsibilities for mental healthcare, psychosocial supports, mental health carer supports and suicide prevention services; and
- administer additional Australian Government financial transfers to State and Territory Governments to both support the transfer of responsibility for psychosocial supports to State and Territory Governments and to assist with filling the sizeable gaps in State and Territory Government provision of clinical mental healthcare and psychosocial supports.

The Productivity Commission’s view is that such agreement is best sought via a new Intergovernmental Agreement — a National Mental Health and Suicide Prevention Agreement. This is because the alternatives of a) modifying existing agreements, or b) negotiating a range of new smaller agreements are less suited to achieving the changes necessary.

The nature and scale of the relevant recommendations in this Inquiry rules out option a).

- Transferring responsibility for non-NDIS psychosocial supports from the Australian Government to State and Territory Governments (recommendation 23) would necessitate a corresponding transfer of funds. While these changes could (and should) be reflected in the National Disability Agreement, the transfer of funds to support them would need another authorising agreement.13
- The significant increases to State and Territory Government expenditure on mental healthcare and psychosocial supports recommended by this Inquiry (about $1.2-1.9 billion per annum (chapter 23)) would also necessitate additional transfers from the Australian Government to State and Territory Governments, as the Australian Government’s has access to more efficient tax bases (with the exception of

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13 The Productivity Commission’s (2018) Review of the National Disability Agreement recommended that a new National Disability Agreement be developed that would clarify responsibilities for disability support (including psychosocial supports) outside of the NDIS and be a ‘living document’ (meaning that its schedules are updated as required).
State/Territory land taxes and municipal rates) and greater scope to raise additional tax revenues (PC 2011). Again, these transfers would require an authorising agreement. As noted above, the National Disability Agreement is unsuited to governing the transfer of additional funds for psychosocial supports. Meanwhile, a renegotiation of the NHRA (which provides intergovernmental transfers to support mental healthcare) seems unlikely and the mechanism it uses to determine transfers is unsuited to incentivising additional investment where it is most needed (section G.3).

- It would be desirable for all jurisdictions to consent to the NMHC becoming an interjurisdictional statutory authority that could evaluate State and Territory Government mental health programs (recommendation 22) and more thoroughly monitor and report on PHN–LHN cooperation (recommendation 23). This requires a new agreement.

- All governments should formally commit to establishing RCAs on a State-by-State basis if PHN–LHN cooperation is lacking (recommendation 23). This also requires a new agreement.

Option b) (negotiating a range of smaller agreements) is also not advised. Although governments could potentially negotiate a series of smaller agreements, administering tightly interlinked reforms through separate agreements risks creating inconsistencies. For example, it would not be desirable to specify the role of the NMHC in monitoring and reporting on PHN–LHN cooperation (recommendation 23) separately from its role as an evaluation body and its broader interjurisdictional reporting remit (recommendation 22).

Moreover, combining the reforms under a single agreement would enable the Australian Government to leverage the offer of additional funding to seek reforms to governance, monitoring, reporting and evaluation that State and Territory Governments would otherwise have little incentive to pursue. Several Inquiry participants noted that past reforms without commensurate funding commitments have failed (Queensland Advocacy Incorporated, sub. 116; Community Mental Health Australia, sub. 449).

Hence, negotiating a single new comprehensive agreement is preferred. The Australian, State and Territory Governments should develop a single national agreement to govern funding transfers, specify government roles and responsibilities and set out the new role for the NMHC — a National Mental Health and Suicide Prevention Agreement. The proposal in the Inquiry draft report for such an Intergovernmental Agreement received overwhelming support from participants.14

14 ANU College of Health and Medicine (sub. 669); Australasian College for Emergency Medicine (sub. 926); Black Dog Institute (sub. 1207); Community Services Industry Alliance (sub. 915); Consumers Health Forum (sub. 646); Consortium of Australian Psychiatrists and Psychologist (sub. 882); Dietitians Association of Australia (sub. 766); Health Justice Australia (sub. 749); Mental Health Australia (sub. 864); Mental Health Carers NSW (sub. 1231); Mental Health Coordinating Council (sub. 920); Mental Health Council of Tasmania (sub. 869); Roses in the Ocean (sub. 710); SA Mental Health Commission (sub. 691); UnitingSA (sub. 807); WAAMH (sub. 1112); Western Australian Government (sub. 1227).
Governance of Regional Commissioning Authorities

Where RCAs are established, chapter 23 noted that they should be separate entities at arms’ length from Ministerial control. The Productivity Commission considered three options to reach this conclusion:

- **Establishing RCAs within LHNs.** This option is not preferred, as conflicts of interest would arise when RCAs commission services from LHNs. Grow Australia (sub. 847, p. 16) summarised this point well:
  
  … if Regional Commissioning Authorities are just LHNs/LHDs/HHSs in disguise, that will be a backward step. These bodies are already conflicted because they operate as both funders and providers (unlike PHNs), hence we have seen no significant shift in funding patterns away from acute services (which LHNs fund and operate) to community based services which keep people out of hospital.

- **Establishing RCAs within State/Territory Government health departments.** This could assuage concerns about RCAs undermining the integration of physical and mental healthcare (although such concerns are overstated; section G.5), and generate administrative cost savings if RCAs and health departments are able to share staff. But some participants highlighted that, for cultural reasons, health departments tend to prioritise acute hospital services ahead of community-based mental healthcare.

  Historically our experience has been that state entities are very focused on their own ‘clinical’ services and bed-based hospital services, and less interested in the role that community-based mental health services play. (Aftercare, sub. 835, p. 8)

  The acute nature of hospital services, their higher political profile, and the generally higher status of their staff, conspire to make it easier for hospitals to attract funding and for their needs to be seen as more urgent and more important. They are often able to gain additional funding at the expense of community services. (Grattan Institute, sub. 816, pp. 10–11)

  Hence, this option is not preferred.

- **Establishing RCAs as separate entities at arms’ length from Ministerial control.** This would counter health departments’ cultural preferences for acute care. It would also remove the potential for political influence on RCA decision-making (TAMHSS, sub. 919). For these reasons, this option is preferred.

Chapter 23 also proposed that RCAs should be governed by skills-based boards with lived experience representation. These boards would be supported by diverse advisory councils.

Several participants suggested modifications to these arrangements.

Some participants called for Australian Government representation in RCAs. The Consortium of Australian Psychiatrists and Psychologists (sub. 882, p. 34) suggested that the boards of RCAs ought to ‘have proportionate representation of Commonwealth and State governments based on funding provided by these respective tiers of government’. Relatedly, Aftercare (sub. 835) suggested that RCAs should be interjurisdictional bodies. The Productivity Commission is concerned that such arrangements would allow for blame shifting to occur. By
contrast, establishing RCAs as State/Territory Government entities allows State/Territory Governments to be held solely responsible for how funds are allocated.

Other participants called for greater representation of Aboriginal and Torres Strait Islander people in RCA governance. The National Aboriginal Community Controlled Health Organisation (sub. 1226, p. 18) suggested that RCAs should be required to ‘establish Aboriginal and Torres Strait Islander governance groups with majority Indigenous membership including [Aboriginal Community Controlled Health Organisations], and decision-making powers including consultation and agreement on funding decisions’. And the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention and National Aboriginal and Torres Strait Islander Leadership in Mental Health (sub. 1217) suggested that each RCA’s board should include at least one Aboriginal or Torres Strait Islander person.

Greater community control over Aboriginal and Torres Strait Islander mental health service delivery is essential. The primary way to achieve this would be to ensure that ACCHSs remain preferred providers of the Aboriginal and Torres Strait Islander suicide prevention and mental health services that were funded by PHNs prior to the establishment of RCAs (recommendation 23).

**Recommended Primary Health Network/Regional Commissioning Authority funding allocation model**

Chapter 23 sets out that the Australian Government Department of Health should reform the way it determines the amount of Mental Health Care Flexible Funding Pool funds that each PHN/RCA receives. The detailed mechanics of the recommended funding allocation model are set out in figure G.7 and box G.15.

Several other considerations informed the development of the funding allocation model.

- **MBS-rebated services included in funding allocation model.** The draft Inquiry report proposed that only allied mental health MBS-rebated services ought to be included in the funding allocation model, on the grounds that they are most clearly substitutes for PHN-commissioned services (box. G.3). We have now expanded this scope to include psychiatry MBS-rebated services, both because this would promote greater geographic equity and because some substitution between psychiatry MBS-rebated services and PHN-commissioned services is probable. However, it remains our view that the case for including allied mental health MBS rebates in the process is stronger than is the case for including psychiatry MBS rebates.

- **Digital mental health services included in funding allocation model.** Chapter 10 recommends an expansion of digital mental health services (recommendation 10). We do not favour including the funding to these services in the funding allocation model. There is no strong equity case for doing so, as online services do not typically suffer the same regional inequities in access as do face-to-face therapies. And doing so would be unlikely to significantly change PHN’s/RCA’s commissioning decisions, as digital
mental health services are cost effective low intensity treatments (hence, PHNs/RCAs would be unlikely to seek to commission other services in preference to them).

- **The lag between when an MBS item is billed and a deduction is made to the corresponding PHN’s/RCA’s budget.** There is a trade-off here. A shorter delay would more strongly reduce PHN/RCA incentives to shift costs to the MBS and better allow PHNs/RCAs to pursue new models of care that might result in higher commissioned expenditure and lower MBS expenditure. Meanwhile, a longer delay would guarantee greater certainty of funding for PHNs/RCAs. We have recommended a three year delay, but only because this aligns with the time horizon over which PHNs/RCAs are currently granted funding certainty (Hunt 2019). We now do not favour the ‘real time’ reconciliation that the draft Inquiry report contemplated, as this could create significant uncertainty for PHNs/RCAs.

**Figure G.7 Proposed process for determining PHN/RCA Mental Health Care Flexible Funding Pool allocations**
Box G.15  **Recommended process for determining PHN/RCA Mental Health Care Flexible Funding Pool allocations**

Let:

- $x_1, x_2, x_3, ..., x_{31}$ such that $\sum x_i = 1$ be the Australian Government Department of Health’s determination of the share of total primary mental healthcare funding that the $i$th Primary Health Network (PHN) region ought to receive
- $MBS_{i,t}$ be the total MBS rebates for allied mental healthcare and psychiatry billed in the $i$th PHN’s region in year $t$
- $MHCFFP_{i,t}$ be the total Mental Health Care Flexible Funding Pool funds allocated to the $i$th PHN in year $t$.

**Stage 1**

At the beginning of year 1, the Department of Health would announce the amount of total funding $T$ that it intends to allocate to year 1 MBS rebates for mental healthcare (which are unknown at this stage) and the year 4 Mental Health Care Flexible Funding Pool. That is:

$$T = \sum_i MBS_{i,1} + \sum_i MHCFFP_{i,4}$$

The Department of Health would also announce the allocation of the total funding $T$ among PHNs ($T_i$ for all $i$) by applying the determination:

$$T_i = x_i T$$

**Stage 2**

At the beginning of year 2, the Department of Health would deduct year 1 MBS rebates for mental healthcare (which are now known) in each PHN’s region from the allocation determined one year prior. The remainder would become each PHN’s year 4 Mental Health Care Flexible Funding Pool allocation:

$$MHCFFP_{i,4} = x_i T - MBS_{i,1}$$

This process would then repeat each year.

**Additional considerations**

- If actual year 1 MBS rebates for mental healthcare were substantially higher than expected across Australia, the Department of Health could retrospectively increase the total funding $T$. In general, $T$ should increase over time in line with population growth, inflation, and expected increases in MBS rebates for allied mental healthcare and psychiatry due to increases in the number of MBS-eligible allied mental health professional and psychiatrists.
- The size of the Mental Health Care Flexible Funding Pool could be insufficient to correct for regional inequities in the distribution of MBS rebates, meaning that this method would suggest a negative Year 4 Mental Health Care Flexible Funding Pool allocation for some PHNs (i.e. if $MBS_{i,1} > x_i T$ for some $i$). If this is the case, it could be necessary to establish a minimum level of per capita Mental Health Care Flexible Funding Pool funding that each PHN must receive.

Note: this assumes that no States/Territories have transitioned to Regional Commissioning Authorities (RCAs). In States and Territories that have transitioned to RCAs, Mental Health Care Flexible Funding Pool funds would be transferred to the corresponding RCA.
References


COAG (Council of Australian Governments) 2018, *Heads of Agreement between the Commonwealth and the States and Territories on public hospital funding and health reform*.


Coordinare, South Eastern NSW PHN, Southern NSW LHD and Illawarra Shoalhaven LHD 2018, *South Eastern New South Wales Regional Mental Health and Suicide Prevention Plan 2018-2023*.


—— 2016a, *Primary Health Networks Grant Programme Guidelines, Version 1.2*.

—— 2016b, *Primary Health Networks (PHNs) and Aboriginal Community Controlled Health Organisations (ACCHOs) - Guiding Principles*, Draft as at 16 March 2016.

—— 2017, *Child and Youth Mental Health Services*, PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance.


—— 2019a, *Aboriginal and Torres Strait Islander Mental Health Services, PHN Primary Mental Health Care Programme Guidance*.


Hunt, G. (Minister for Health) 2019, *$1.45 billion to strengthen mental health services and support job security*, Media release, Canberra, 16 January.


Integrated Regional Planning Working Group 2018a, *Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services: A Compendium of Resources to assist Local Health Networks (LHNs) and Primary Health Networks (PHNs)*, National Mental Health Strategy, COAG Mental Health Principal Committee, Canberra.

—— 2018b, *Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services: A Guide for Local Health Networks (LHNs) and Primary Health Networks (PHNs)*, National Mental Health Strategy, COAG Mental Health Principal Committee.


PC (Productivity Commission) 2011, *Disability Care and Support*, Report no. 54, Canberra.


PHN Advisory Panel on Mental Health 2018, *Reform and System Transformation: A Five Year Horizon for PHNs*.


Tas DoH (Department of Health (Tasmania) 2019, *Revised Tasmania Health Service 2019-20 Service Plan*.


WA DoH (Department of Health (WA)) 2017, *WA Health Funding and Purchasing Guidelines 2017-18*.


This appendix provides greater detail on how the Productivity Commission has calculated the cost of mental ill-health and suicide in Australia (presented in chapters 3 and 9). The aim is to quantify costs in monetary terms, using data from the Australian, State and Territory Governments, survey data, estimates from the literature and our own assessments. Nonetheless, data is limited in some areas. Our aggregate estimate of the cost of mental ill-health should, therefore, be considered a reasonable and informative estimate, based on the available data. Future attempts to calculate the cost of mental ill-health and suicide in Australia should review the available data sources and endeavour to improve estimation techniques. Future researchers should also provide feedback on possible improvements in data collection.

There are other costs that cannot be quantified, such as the emotional costs of stigma and lower social participation. These costs are discussed in chapter 3 and throughout the report qualitatively. The lack of quantification of these costs does not diminish their importance.

H.1 Mental healthcare and related expenditure

Government expenditure on mental health-related services

Total Australian, State and Territory Governments direct recurrent expenditure on mental healthcare and related services was estimated to be about $10 billion in 2018-19 (table H.1). State and Territory Government outlays on specialised mental health services accounts for about two-thirds of this total government expenditure, consisting primarily of expenditure in public hospitals and community healthcare.15

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15 Australian Government contributions for state and territory public hospital services are paid under the National Health Reform Agreement (NHRA). This arrangement includes grants and activity-based payments specifically tied to the operation of specialist mental health services delivered by state- and territory-managed public hospitals. While the quantum of funding made for mental health specific services under the NHRA is significant and identifiable, expenditure of those funds continues to be attributed to states and territories on the basis of their role as system managers of Australia’s public hospital services. Current estimates available to the Department of Health, based on public reports of the National Health Funding Body indicate that mental health specific payments made by the Australian Government under the NHRA in 2018-19 totalled $1.79 billion. Allocating this funding to the Australian Government will change the relative split of expenditure for Australian Government (51%) and State and Territory Government (49%) (AIHW 2020b).
Table H.1  
**Estimated mental healthcare expenditure**  
2018-19\(^a\)  

<table>
<thead>
<tr>
<th></th>
<th>$\text{billion}</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Australian Government</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Benefits Schedule</td>
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<td></td>
</tr>
<tr>
<td>Pharmaceutical Benefits Scheme</td>
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<td></td>
</tr>
<tr>
<td>Mental healthcare(^b)</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>Alcohol and other drugs services</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>Strategy, research, promotion and prevention</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td><strong>Australian Government total(^c)</strong></td>
<td>3.1</td>
<td></td>
</tr>
<tr>
<td><strong>State and Territory Government</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public hospitals (admitted patients)</td>
<td>2.7</td>
<td></td>
</tr>
<tr>
<td>Community mental healthcare services</td>
<td>2.3</td>
<td></td>
</tr>
<tr>
<td>Alcohol and other drugs services</td>
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<td></td>
</tr>
<tr>
<td>Other(^d)</td>
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<tr>
<td><strong>State and Territory Government total(^c)</strong></td>
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<td></td>
</tr>
<tr>
<td>Individual out-of-pocket expenses(^e)</td>
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<td></td>
</tr>
<tr>
<td>Private health insurers(^f)</td>
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<td></td>
</tr>
<tr>
<td>Workers compensation insurers</td>
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<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>11.3</td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) Some expenditure converted to 2018-19 estimates using the health index of the CPI inflator. This indexing does not take into account growth in expenditure due to population growth in programs where funding is uncapped.  
\(^b\) Includes Department of Health managed national programs and initiatives that are treatment focused and private health insurance premium rebates related to the provision of mental healthcare services.  
\(^c\) Components do not necessarily sum to the total due to rounding errors.  
\(^d\) Includes grants to non-government organisations.  
\(^e\) Only includes out-of-pocket expenses for MBS and PBS items.  
\(^f\) AIHW have advised that this estimate does include some expenditure by workers compensation insurers but is mostly private health insurers expenditure (AIHW, pers. comm., 23 Apr 2020). Consequently, there may be a small amount of double counting with the private health insurers and workers compensation expenditure estimates.  

Source: Productivity Commission estimates based on ABS (Consumer Price Index, June, Cat. no. 6401.0; Microdata: Multi-Agency Data Integration Project, Australia, Cat. no. 1700.0); AIHW (2020a); DoH, pers. comm., 23 Sep 2019; Safe Work Australia’s National Data-Set for Compensation-based Statistics; Ritter et al. (2014).  

This estimate should be considered conservative as a range of other expenditure is not covered (box H.1). For example, there is an under attribution in the amount assigned to mental health from the Medicare Benefits Schedule (MBS). It is projected that the Australian Government spent approximately $1.3 billion on MBS-rebated mental health specific services in 2018-19 (table H.1). However, this estimate only captures those MBS numbers associated with mental health. It does not capture mental health services under other MBS items, such as a standard consultation with a GP that deals with mental health problems. The Australian Institute of Health and Welfare (AIHW) (2020b, p. 1) consider the underestimate to be substantial.  

It is unclear how many additional people receive GP mental health-related care that is billed as a consultation against generic GP MBS [Medicare Benefits Schedule] item numbers; however, the
results of the 2015-16 Bettering the Evaluation and Care of Health (BEACH) survey suggest that this number is likely to be substantial. The BEACH survey estimated that, in 2015-16, 12.4% (18 million encounters or 749.9 encounters per 1,000 population) of all GP encounters were mental-health related. In the same year about 3.2 million (or 135.5 services per 1,000 population) Medicare-subsidised mental health-specific services were provided.

Box H.1  What is counted in AIHW government expenditure?

Estimated Australian Government expenditure reported covers only those areas of expenditure that have a clear and identifiable mental health purpose. Broadly, this covers:

- programs and services principally targeted at providing assessment, treatment, support or other assistance
- population-level programs that have as their primary aim the prevention of mental illness or the improvement of mental health and wellbeing
- research with a mental health focus.

Expenditure by specialised mental health services is taken from the Mental Health Establishments National Minimum Data Set. It includes all specialised mental health services managed or funded, partially or fully, by state or territory health authorities. Specialised mental health services are those with the primary function of providing treatment, rehabilitation or community health support targeted towards people with mental illness. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental healthcare function. While expenditure is notionally allocated to State and Territory Governments, some expenditure is funded by the Australian Government.

Source: AIHW (2020b).

There is also unaccounted expenditure on suicide prevention programs. The Australian Government spent over $50 million on suicide prevention under its National Suicide Prevention Program in 2017-18 (AIHW 2020a, table EXP.31). State and Territory Governments also provide and fund their own suicide prevention plans and activities, designed to meet local needs. However, data on the expenditure and service activity for these plans are not publicly available in a consolidated form for all jurisdictions (chapter 9). Nevertheless, the NSW Government (sub. 551, p. 6) submitted that they had committed $19.7 million in 2019-20 to support implementation of key suicide prevention initiatives.

No administrative overheads associated with management of the mental health items within the MBS and Pharmaceutical Benefit Scheme (PBS) are covered in the Australian Government expenditure data (AIHW 2020b).

To minimise unaccounted expenditure, some estimates are based on research literature and unpublished sources. For example, national data collections for mental health do not include the expenditure of publicly-funded treatment for substance use disorders. Nevertheless, based on the estimates by Ritter et al. (2014) and data from the Australian Department of Health, healthcare costs of substance use disorders are estimated to be in the order of $1 billion in 2018-19 (Productivity Commission estimates).
Mental healthcare expenses by non-government parties

Out-of-pocket costs to individuals

Individuals also incur costs associated with mental healthcare known as out-of-pocket costs. These costs can represent the full cost of a service or a shared payment, over and above any amount paid by the Australian Government or a private health insurance fund. There are many examples of how out-of-pocket costs can be incurred.

Based on administrative data, out-of-pocket costs for consultations and medication (that had an associated government rebate) for people with mental ill-health was $0.7 billion in 2018-19 (table H.1). Of the mental health services that the Australian Government provides rebates for through the MBS, such as services from a GP, individuals contributed an estimated $0.3 billion in 2018-19 (Productivity Commission estimates based on AIHW 2020a). Based on PBS data, the total patient contribution for mental health prescriptions in 2018-19 was $0.4 billion (Productivity Commission estimates using ABS 2018). Co-payments for products and services under the MBS and PBS are just two possible sources of out-of-pocket costs (chapter 3).

In the draft report, we sought additional sources of data for out-of-pocket costs. We appreciate the information that some participants provided on the cost of their programs, how out-of-pocket costs could be reduced and the barrier they creates in accessing services (for example, Independent Private Psychiatrist Group, sub. 742; Bupa, sub. 1191). However, this information was not sufficient to provide aggregate estimates of existing expenditure beyond out-of-pocket expenses associated with MBS and PBS expenditure.

Future surveys represent a possible source of aggregate out-of-pocket costs data, particularly the ABS surveys. For example, the ABS is in the process of designing the next Mental Health and Wellbeing survey, which could gather information on costs that consumers incur outside the PBS and MBS, such as private prescriptions, full treatment costs or associated travel and accommodation costs.

Private insurance costs

Private health insurers also fund mental healthcare, which is estimated to be approximately $0.6 billion in 2018-19 dollars (table H.1).

Similarly, workers compensation insurers fund mental healthcare for work-related claims (chapter 7). According to Safe Work Australia, over 7000 Australians are compensated for...
work-related psychological claims each year, equating to $0.3 billion paid in workers compensation (Safe Work Australia’s National Data-Set for Compensation-based Statistics).

H.2 Expenditure on other services and supports

In addition to direct expenditure on mental healthcare and related services, governments also fund a range of programs and services that help support people. However, as only some of these services are used as a direct result of a person’s mental illness, assumptions are necessary to attribute expenditure (box H.2).

Box H.2 Attributing expenditure on services and supports to mental ill-health

For specialised mental healthcare and related services, all expenditure relates to mental ill-health. This is less clear for other social services. In most cases, the expenditure on other support services attributable to mental ill-health would be less than 100% of the aggregate expenditure.

People using these support services may or may not have mental illness, and for those who do, it may not be the factor motivating them to access the service. For example, some people with mental ill-health may be accessing public housing primarily because they work in a low income occupation, and therefore are eligible for this service. Whereas other people with mental ill-health may be accessing public housing because their mental ill-health prevents them from working, which is the direct cause of their low income and eligibility for public housing. Ideally, expenditure from the latter should be included in any estimate of the cost of mental ill-health, whereas the former should not.

There are a number of options for attributing expenditure on other support services to mental ill-health.

- **Use data collected on the reason a person is accessing the service.** Some services collect this data and it provides some indication of the motivating reason for accessing the service. However, as mental health is highly correlated with a number of other likely factors, self-reporting may not be entirely accurate.

- **Use the ‘population attributable fraction’.** This calculates the proportion of people accessing services as a result of their mental illness. It does so by estimating the increased likelihood of accessing a support service given mental illness and uses this to derive the number of people for whom mental illness is a plausible determining factor in their use of a service.

- **Assume that every person with mental illness** who is involved with a service does so because of their mental health disorder. While likely to be an overestimate, it may be the only method available due to data limitations.
Homelessness services

The Australian, State and Territory Governments provide many forms of housing support (chapter 20).

In 2018-19, total net recurrent expenditure on homelessness services was $990 million (SCRGSP 2020b). This includes expenditure on specialist homelessness services funded by governments under the Council of Australian Governments National Affordable Housing Agreement and the National Partnership Agreement on Homelessness. Government and non-government specialist homelessness service providers deliver a range of services to clients — including supported accommodation, counselling, advocacy, links to housing, healthcare, education and employment services, outreach support, brokerage and meals services, and financial and employment assistance.

Mental ill-health is prevalent among those seeking homelessness services, but not all services are sought because of mental ill-health. In 2017-18, about one-third of clients of specialist homelessness services reported a mental illness. About half of those with mental ill-health reported this as a reason for seeking assistance from homelessness service providers (18% of all clients) (AIHW 2019b). Based on this data, it is estimated that homelessness services provided as a result of a person’s mental ill-health was approximately $174 million in 2018-19 (table H.2).

Social housing

In 2018-19, State and Territory Government net recurrent expenditure on social housing was $4.0 billion (SCRGSP 2020b). Social housing is subsidised rental housing provided by not-for-profit, non-government or government organisations to assist people who are unable to access suitable accommodation in the private rental market. It includes public housing, State owned and managed Indigenous housing, community housing and Indigenous community housing.

As eligibility for social housing is primarily based on income, not all people accessing social housing with mental illness will do so because of their mental disorder. However, a person’s mental health affects their ability to complete schooling, undertake further education, and participate in the labour market, all of which can have flow on effects to their income. That said, as the indicator of mental illness was collected based on households, it is not possible to calculate the attributable proportion (a person-based measure).

As a result, expenditure on social housing was assumed to be related to mental health based on the proportion of households in social housing utilising mental health services in the past 12 months. In 2016, across the various types of social housing, the following proportions of households reported that they had utilised mental health services in the past 12 months:

- public housing (20%)
- State owned and managed Indigenous housing (14%)
- community housing and Indigenous community housing (24%) (AIHW 2017).
Based on this, approximately $811 million of social housing net recurrent expenditure was estimated to be related to mental health costs in 2018-19 (table H.2).

**Employment support**

The Australian Government funds employment support to help eligible jobseekers find and maintain employment (chapter 19). Employment support providers are contracted to deliver a range of programs. The two major employment support programs are:

- **jobactive**, which is designed to provide support to most jobseekers who are in receipt of unemployment benefits. In 2018-19, total expenditure on jobactive was $1.4 billion (DJSB 2019).

- **Disability Employment Services (DES)**, which is a specialist service that assists people with disabilities find employment. In 2018-19, total expenditure on DES was $0.8 billion (DSS 2019).

In jobactive, approximately 14% of participants had mental illness (Department of Employment, Skills, Small and Family Business, unpublished data). Based on administrative data, approximately $139 million in jobactive payments were made for job seekers who had disclosed a mental illness in 2018-19 (Department of Education, Skills and Employment, pers. comm., 11 June 2020). However, this is likely to be an underestimate as it relies on self-disclosure by the job seeker that they have mental illness, something that they may not be inclined to do given the potential discrimination that could result (chapter 9).

Some people with mental illness are eligible for specialist disability employment services because of their mental health disorder. In June 2019, about 40% of DES clients were eligible for assistance because of disability due to mental illness (Department of Social Services, unpublished data). In 2018-19, approximately $328 million of expenditure on DES is estimated to be attributable to mental illness.

The Australian Government also funds the Community Development Program for job seekers in remote Australia. Approximately $53 million of the expenditure from this program is attributable to mental illness (chapter 19).

**Psychosocial supports**

Psychosocial support services help people experiencing or recovering from mental illness to achieve higher levels of wellbeing and to increase their social and economic participation (chapter 17). Supports can include those that assist with participating in the community, managing daily tasks, undertaking work or study, helpline and counselling services, advocacy and promotion, finding accommodation and making connections with friends and family. Australian, State and Territory Governments fund psychosocial support services.
The Australian Government provides psychosocial supports for people with mental illness through the National Disability Insurance Scheme (NDIS) (chapter 17). Allocated funding for these supports was estimated to be $1.1 billion in 2018-19. Approximately 56% of these funds were actually spent in 2018-19 (NDIA, pers. comm., 27 Mar 2020). Given this, the cost of the NDIS support for people with mental illness was estimated to be about $0.6 billion in 2018-19.

In 2018-19, the Australian Government also funded psychosocial support programs, such as Partners in Recovery, Personal Helpers and Mentors, Day-to-Day Living and Mental Health Respite: Carer support (chapters 17 and 18). Australian Government funding for psychosocial support programs is estimated to be about $0.4 billion (AIHW 2020a; DoH 2019).

State and Territory Governments have responsibility for funding, delivering and/or managing specialised mental health services, including psychosocial support services (chapter 17). Total expenditure on psychosocial supports was estimated to be $0.5 billion in 2018-19 (AIHW 2020a).

**Education**

All educational institutions have requirements to provide healthy environments that promote and support mental health and wellbeing for children and young people. These span early childhood education and care centres, primary and secondary schools, higher education institutions as well as vocational education and training providers (chapters 5 and 6). Consequently, these institutions have been tasked to develop and implement policies to create these healthy environments, along with the delivery of a range of mental health and wellbeing services and initiatives that span from mental health promotion, prevention, early intervention to treatment. Examples of services and initiatives that educational institutions deliver or implement include:

- early childhood education and care providers implementing wellbeing frameworks, such as Beyond Blue’s Be You program
- explicitly teaching a social and emotional wellbeing curriculum in primary school and up to year 10 in secondary school
- undertaking an assessment of the wellbeing of young children through the Australian Early Development Census
- providing school counselling and support services in schools, including individual and grouped sessions
- higher education institutions and vocational education and training authorities providing mental health, counselling and welfare services
- making ‘reasonable adjustments’, such as extra tuition, to ensure that students with disabilities, including those with mental illness, are able to access and participate in education and training on the same basis as other students.
Despite these institutions dedicating considerable resources to supporting the mental health and wellbeing of children and young people, we are unable to provide an estimate of the overall cost of these activities (chapter 5). Before coming to this conclusion, we sought information from stakeholders in the draft report — with some participants acknowledging the difficulty of this task (for example, The Mitchell Institute, sub. 744; Monash University, sub. 698). Chapter 5 outlines the challenges for collecting expenditure data in the schooling sector. Similar issues arise in the university and vocational education and training sectors.

**Justice**

As the costs of mental illness in the criminal justice system are difficult to determine (chapter 21), we have calculated the cost of people being imprisoned that is attributable to mental illness. This is estimated to be $1.1 billion in 2018-19 (table H.2).

- In 2018-19, State and Territory Governments total net operating expenditure and capital costs on prisons was approximately $4.9 billion ($310 per day with an estimated prison population of 43 000 people) (SCRGSP 2020a).
- Based on prevalence data of mental illness in the population and in prisons, approximately 23% of the cost of housing people in prisons is attributable to mental illness (Productivity Commission estimates using SCRGSP 2020a).

<table>
<thead>
<tr>
<th>Service or support area</th>
<th>$ million</th>
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<tr>
<td>Homelessness services</td>
<td>174</td>
</tr>
<tr>
<td>Social housing</td>
<td>811</td>
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<tr>
<td>Employment support</td>
<td>520</td>
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<tr>
<td>Psychosocial supports — National Disability Insurance Scheme</td>
<td>638</td>
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<tr>
<td>Psychosocial supports — Australian Government non-National Disability Insurance Scheme</td>
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<tr>
<td>Psychosocial supports — State and Territory Governments</td>
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<tr>
<td>Education</td>
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<tr>
<td>Justice</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4 119</strong></td>
</tr>
</tbody>
</table>

*a* Expenditure converted to 2018-19 estimates using CPI inflator. This does not take into account growth in expenditure due to population growth in programs where funding is uncapped. Components do not necessarily sum to the total due to rounding. *na* Not available.

*Source: Productivity Commission estimates.*
Informal care of those with mental illness

Informal carers, such as family members, partners and friends, play a significant role in the care of people with mental illness in Australia (chapter 18). They can help and support a family member or friend with mental illness by coordinating their healthcare, providing emotional support, and assisting with day-to-day living. The total annual replacement cost for adult informal mental health carers in 2015 was $14.3 billion (Diminic et al. 2017). This represents the cost involved in replacing the caring tasks currently provided by informal carers with formal or paid mental health support services. In 2019, this represented an annual replacement cost of approximately $15 billion. Diminic (2017, p. 3) noted:

The intention is never for government to completely replace the care provided by mental health carers. Rather, a replacement cost analysis is a method used to quantify the economic value of informal care, and in turn highlight the importance of carers.

Cost of collecting taxes to provide services

Governments use a variety of taxes to collect tax revenue that ultimately funds mental health services and provides financial support payments to eligible people and families. The tax distribution process involves governments transferring revenue from taxpayers to mental healthcare and other service providers. Such transfers do not occur without a cost. These costs include the cost of administration that lie behind tax collection, the compliance costs that businesses and individuals face as they meet eligibility criteria, and the costs of distortions imposed when governments collect tax. The latter is known as the excess burden of taxation, or its ‘deadweight loss’ to society.

Estimating the cost of collecting tax revenue is, however, complex and beyond the scope of an inquiry that is focused on mental health. Some issues include:

- establishing the best methodology used to measure the excess burden of a given tax
- not all taxes create an excess burden. In the case of externalities, such as the negative health effects of smoking, taxing the sale of and lowering output of the externality producing good (in this case, cigarettes) is an improvement in welfare
- the difficulty of establishing the net effect on society for a given level of taxation when governments levy a range of taxes.

H.3 Government income support

The Australian Government provides a range of income support payments to assist people with mental ill health and their carers. These include the Disability Support Pension (DSP), Newstart Allowance, Youth Allowance, Carer Payment, 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 (table H.3).
Table H.3  
**Income support payments related to mental illness**  
2018-19

<table>
<thead>
<tr>
<th>Income support payment</th>
<th>Total cost</th>
<th>% mental health related(^a)</th>
<th>Cost attributable to mental illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability Support Pension</td>
<td>16.7</td>
<td>35</td>
<td>5.8</td>
</tr>
<tr>
<td>Newstart Allowance(^b)</td>
<td>9.7</td>
<td>26</td>
<td>2.6</td>
</tr>
<tr>
<td>Youth Allowance</td>
<td>0.9</td>
<td>11</td>
<td>0.1</td>
</tr>
<tr>
<td>Carer Allowance</td>
<td>2.3</td>
<td>32</td>
<td>0.7</td>
</tr>
<tr>
<td>Carer Payment</td>
<td>5.6</td>
<td>27</td>
<td>1.5</td>
</tr>
<tr>
<td>Carer Supplement</td>
<td>0.6</td>
<td>..</td>
<td>0.2</td>
</tr>
</tbody>
</table>

**Total income support payments related to mental illness**  10.9

\(^a\) DSP: primary medical condition is recorded as psychological or psychiatric. Carer Allowance or Payment: primary medical condition of the care receiver is recorded as psychological or psychiatric. Newstart Allowance and Youth Allowance: the jobseeker has a partial capacity to work and reported a mental illness.

\(^b\) The JobSeeker Payment replaced the Newstart Allowance and some other payments on 20 March 2020.

.. Not applicable

*Source: Productivity Commission estimates.*

The projected future lifetime cost for an average individual (aged 18–40 years) on DSP with a psychological or psychiatric primary medical condition at 30 June 2017 is estimated to be $614 000. On average, these individuals are expected to receive an income support payment, including the Age Pension, in 47 years or 91% of their future life (table H.4). In 2027, 85% of this group are expected to be receiving DSP, 6% are expected to not be receiving any income support payments, 2% are expected to be receiving a working age payment and 5% are projected to have passed away (Department of Social Services, unpublished data).

The projected future lifetime cost for an average individual (aged 18–40 years) on a working age payment (this does not include the DSP) with a primary psychological/psychiatric medical condition at 30 June 2017 is expected to be $355 000. On average, these individuals are expected to receive an income support payment, including the Age Pension, for the next 36 years or 61% of their future life (table H.4). However, when time in receipt of the Age Pension is excluded, on average, this group is expected to receive income support for about 19 years. In 2027, 32% of this group are projected to be receiving a working age payment, 37% are expected to not be receiving any income support payments, 7% are expected to be receiving a parenting payment, 5% a carer payment, and 7% are expected to be receiving DSP (Department of Social Services, unpublished data).
Table H.4  
Projected future lifetime costs and duration of income support for a person aged 18–40 years with a psychological or psychiatric medical condition

<table>
<thead>
<tr>
<th></th>
<th>Including Age Pension</th>
<th>Not including Age Pension</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average future lifetime cost</td>
<td>Future duration in income support</td>
</tr>
<tr>
<td>Disability Support Pension</td>
<td>$614,000</td>
<td>47 %91</td>
</tr>
<tr>
<td>Working Age payments (primarily Newstart or Youth Allowance (other)) b,c</td>
<td>$355,000</td>
<td>36 %61</td>
</tr>
</tbody>
</table>

a % of future lifetime on income support. b The Priority Investment Approach working age payment class is primarily made up of Newstart Allowance and Youth Allowance (Other) recipients, but also includes a small number of Partner Allowance, Sickness Allowance, Special Benefit, Widow Allowance, ABSTUDY (Apprentice), and Austudy (Apprentice) recipients. c The JobSeeker Payment has since replaced the Newstart Allowance and some other payments.

Source: Department of Social Services, unpublished data.

H.4  Effects of mental health on work

Participation

Mental ill-health reduces people’s participation in the workforce (figure H.1). Compared to the broader population, a lower proportion of people with mental ill-health are employed and a higher proportion of people are unemployed or are not in the labour force. A person’s level of psychological distress can also affect whether or not they are employed or in the labour force. Generally, as a person’s level of psychological distress increases, the less likely they are to be employed, for example.

To capture the effect of mental illness on participation in the workforce and productivity, the Productivity Commission modelled the cost of forgone output due to mental illness to be between $12.2 billion and $22.5 billion in 2018-19 (using the wage model outlined in appendix J).
Figure H.1  Mental ill-health affects people’s ability to participate in the workforce$^a$
People aged 15–64 years

Labour force status by mental health disorder

<table>
<thead>
<tr>
<th></th>
<th>Without mental health disorder</th>
<th>With mental health disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>80</td>
<td>62</td>
</tr>
<tr>
<td>Not in the labour force</td>
<td>17</td>
<td>32</td>
</tr>
<tr>
<td>Unemployed</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>

Labour force status by Kessler 10 category of distress level

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
<th>Very high</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>68</td>
<td>56</td>
<td>28</td>
<td>54</td>
</tr>
<tr>
<td>Unemployed</td>
<td>4</td>
<td>56</td>
<td>40</td>
<td>54</td>
</tr>
<tr>
<td>Not in the labour force</td>
<td>2</td>
<td>4</td>
<td>7</td>
<td>40</td>
</tr>
</tbody>
</table>

$^a$ The Kessler 10 is a 10-item questionnaire intended to measure psychological distress based on questions about anxiety and depressive symptoms. Low = scores of 10–15; Moderate = scores of 16–21; High = scores of 22–29; Very high = scores of 30–50.

Source: ABS (National Health Survey: First Results 2017-18, Cat. no. 4364.0.55.001; Microdata: National Health Survey, 2017-18, Cat. no. 4324.0.55.001).

There are two possible interpretations of what is captured in these estimates. At minimum, these costs include only the effect on people’s foregone income from reduced or no participation in the workforce due to their mental illness. For those employed, the consequence of missing days at work due to mental illness (absenteeism) or functioning less effectively (presenteeism) are temporary and not reflected in their income. At the other end of the spectrum, the costs could be interpreted to capture participation effects and lower productivity for those in employment. The implication is that the consequence of people being absent from their employment or not always being able to function effectively while at work has a permanent effect on their income (table H.5). In practice, the average effect of mental illness on participation and productivity will be somewhere on this spectrum.

Absenteemism

Some employed people with mental ill-health may require some time off from work to recover. Individuals with mental ill-health who are employed have a higher number of temporary absences than those without any mental disorders.

According to the ABS National Health Survey people with mental ill-health took an average of 10–12 days off work due to psychological distress — depending on the indicator used to
determine mental ill-health (ABS 2019). This calculation is based on a survey question that asks people if they were unable to work, study or undertake day-to-day activities because of feelings of distress in the last 4 weeks. If people were employed at the time of the survey and they had indicated they were unable to do any of the tasks listed, we have assumed they were unable to work. We have defined mental ill-health using both:

- the self-reported mental and behavioural conditions that are within the scope of this inquiry (chapter 1)
- a Kessler 10 score of 16 or greater, which corresponds to psychological distress levels of ‘moderate’ to ‘very high’. The Kessler 10 is a 10-item questionnaire intended to yield a measure of psychological distress based on questions about anxiety and depressive symptoms. Higher Kessler 10 scores are correlated with the existence of a mental health disorder.

Monetising the total number of days off work using average weekly earnings, it is estimated that the cost of days off work for people with mental ill-health to be $7.9 billion to 9.6 billion in 2018-19. These cost calculation take into account the effects of hours worked (full- and part-time) and gender.

**Presenteeism**

Mental ill-health can also affect a person’s ability to function effectively while at work. This is known as presenteeism. Symptoms such as fatigue, decreased concentration and poor memory can affect employee performance (chapter 7).

Using data from the ABS National Health 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 — depending on the measure of mental ill-health used. This calculation is based on a survey question that asks 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’, we assumed that they had functioned less effectively at work (ABS 2019).

Measuring presenteeism or an individual’s reduction in productivity on particular days is difficult as it is not easily observed. Measurement typically has been based on self-reported survey data collected from employees. However, questions relating to an employee’s output on these days is not asked in the ABS National Health Survey. Data from other presenteeism surveys cannot be easily used for this exercise as they report average productivity reductions across all employees with mental ill-health, not just those that who stated they had reduced productivity.

---

17 This estimate is based on the average number of days absent in the last 4 weeks scaled up to an annual estimate by a factor of approximately 12 — assuming that employees work for 48 weeks per year and take 4 weeks annual leave.
Consequently, it was assumed that workers with mental ill-health had lower productivity of 50% on days that they specified working less effectively. Based on this, approximately 7 to 9 days per worker with mental ill-health per year, on average, is lost because of presenteeism due to mental ill-health. Using average weekly earnings to monetise this cost, it is estimated that presenteeism as a result of mental ill-health to be in the range of $5.3 billion to $7.0 billion in 2018-19. These cost calculations take into account the effects of hours worked (full- and part-time) and gender.

### Table H.5  Estimates of labour market costs due to mental ill-health

<table>
<thead>
<tr>
<th>Loss due to:</th>
<th>Lower bound</th>
<th>Upper bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower participation and productivitya</td>
<td>12.2</td>
<td>22.5</td>
</tr>
<tr>
<td>Absenteeism</td>
<td>–</td>
<td>9.6</td>
</tr>
<tr>
<td>Presenteeism</td>
<td>–</td>
<td>7.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12.2</strong></td>
<td><strong>39.1</strong></td>
</tr>
</tbody>
</table>

a The lower bound estimate is based on assumptions that the costs captured include not working, working fewer hours and lower productivity for those in employment. Separate estimates for presenteeism and absenteeism are therefore not included. The upper bound estimate assumes the costs captured are attributed to not working or working fewer hours. Any effect of presenteeism and absenteeism is temporary and not reflected in wages. Separate estimates for productivity are, therefore, included in the overall total of the upper bound.

Source: Productivity Commission estimates.

### H.5  The cost of diminished health and reduced life expectancy

Mental illness affects a person’s life, in terms of the healthy years of life lost due to disability, and years of life lost due to premature death. This loss is gauged using an epidemiological measure known as disability-adjusted life years (DALYs) (chapter 2). This measure of diminished health is based on disability weights that attempt to capture the severity of the effects of ill-health on a scale from 0 (perfect health) to 1 (equivalent to death). Attribution of these weights are based on various international surveys of people in the general community. This allows the effect of a variety of health conditions to be compared or aggregated (AIHW 2019a).

The total consequence of mental illness for a population measures the gap between the actual health and an ideal health situation, where the entire population lives to an advanced age, free of ill-health. In 2015, Australians lost about 710 000 years of healthy life due to living with and dying early from mental illness (AIHW 2019a).

The years of healthy life lost can be converted into a monetary value using an estimate of the value of a statistical life year (box H.3). Using the Office of Best Practice’s estimate of
value of a statistical life year, the total cost of healthy life lost due to mental illness, suicide and self-inflicted injury is estimated to be $151 billion in 2019 (table H.6).

<table>
<thead>
<tr>
<th></th>
<th>Mental disorders</th>
<th>Suicide and self-inflicted injury</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years of life with disability</td>
<td>558 596</td>
<td>1 241</td>
<td>559 837</td>
</tr>
<tr>
<td>Years of life lost due to death</td>
<td>14 178</td>
<td>134 133</td>
<td>148 311</td>
</tr>
<tr>
<td>Disability adjusted life years (2015)</td>
<td>572 775</td>
<td>135 374</td>
<td>708 149</td>
</tr>
<tr>
<td>Cost of disability and premature death ($b) (2019)</td>
<td>122.0</td>
<td>28.8</td>
<td>150.8</td>
</tr>
</tbody>
</table>

Source: Productivity Commission estimates using AIHW (2019a) and OBPR (2019).

Box H.3 Valuing life: can it be done?

Valuing life is not without disagreement. Some believe life cannot be valued in monetary terms: the value of a person’s life is immeasurable. This principle is displayed in what would seem like a willingness by governments and other groups to spend an unlimited amount of money to rescue individuals from a dangerous situation that risks death or serious injury.

While placing a monetary value on life may not sit easy with many people, in an environment where resources are limited, choices need to be made on how these resources are allocated. In the absence of a value of life, decisions will still be made on where to invest in mental healthcare and its supports, implicitly making such valuations in the process. Calculating the value of life, despite the difficulties and limitations, to use in this decision-making process makes the valuation explicit, transparent and consistent with other decisions.

The value of a statistical life is an estimate of the financial value society places on reducing or avoiding the death of one person. By convention, it is assumed to be based on a healthy person living for another 40 years. It is known as a ‘statistical’ life because it is not the life of any particular person. An estimate of the value of life is, therefore, a tool for decision-making, not the value that is placed on any particular person.

There are a variety of methods used to value a life, but the ‘willingness to pay’ method is viewed as the most appropriate technique (OBPR 2014). Unlike other methods, such as the human capital model that captures the discounted value of future earnings, the willingness to pay method quantifies non-market preferences and values, such as quality of life, health and leisure (ASCC 2008; box H.4). For Australia, various studies have estimated that the value of a statistical life (using the willingness to pay method) ranges from $3 million to $15 million (OBPR 2014, based on a review by Abelson (2008)). Abelson (2008) concludes $3.5 million to be a plausible estimate for the value of a statistical life in 2007. For use in cost-benefit analysis, the Office of Best Practice Regulation has estimated the value of a statistical life to be $4.9 million in 2019.

The value of a statistical life year converts the value of a statistical person’s life over the next 40 years into an annual estimate. Having an annual value of life allows for the valuation of life years that are lost or gained that is less than 40 years. The Office of Best Practice Regulation has estimated the value of a statistical life year to be $213 000 per year in 2019.
H.6 Estimating the economic cost of suicidal behaviour

The Productivity Commission estimated the quantifiable economic costs of suicidal behaviour by estimating a range of direct and indirect costs associated with suicide deaths and non-fatal suicide behaviour in Australia. Suicide cost estimates indicate the magnitude of the suicidal behaviour as an economic and public health policy issue, and provide an economic context for efforts to reduce suicidal behaviour. Total costs associated with suicidal behaviour are estimated to be in the order of $30.5 billion each year.

The overall cost of deaths to suicide is estimated using a ‘willingness to pay’ approach similar to that used by Bureau of Infrastructure, Transport and Regional Economics in calculating the costs associated with road fatalities (BITRE 2009). This approach centres around use of a notional monetary value assigned to the ‘intangible’ quality of life that is lost due to suicide. This ensures that all suicide deaths are costed equally, and that the value of leisure time is taken into account (BITRE 2009; ConNetica 2010). A ‘human capital’ approach is used to value foregone output as a result of non-fatal suicide behaviour (box H.4).

As well as the intangible value assigned to years of life lost due to suicide, a range of other direct and indirect costs are estimated, using the costing framework developed by Kinchin and Doran (2017). Other indirect costs include:

- production disturbances — the short-term costs experienced by firms following suicide-related behaviour of employees (for both fatal and non-fatal suicide behaviour)
- human capital costs — the long-run costs, such as loss of potential outputs. Where non-fatal suicide behaviour results in an inability to work (full incapacity), human capital costs are calculated using the value of potential future earnings from time of injury to retirement age in Australia assuming a discount profile and productivity loss.

Human capital costs are calculated for people experiencing full incapacity due to non-fatal suicide behaviour, regardless of their employment status. Average wage rates were used to calculate lost productive output for employed people who experience ongoing incapacity to work. It is assumed that people who were not employed at the time of experiencing ongoing incapacity would have otherwise engaged in some productive activity that is not based on wages, such as caring for others or volunteering. The wage model outlined in appendix H was used to estimate average expected wages for employed and non-employed adults. Based on the assumption that about half of people not in employment would enter part-time work, it was estimated that the average expected wages of non-employed people was 81% of the average expected wages of people currently in employment.
Box H.4  Willingness to pay and human capital approaches to valuing human life

Willingness to pay

The willingness-to-pay (WTP) approach estimates the value of life in terms of the amount of money that people are prepared to pay to reduce risks to their own lives (this is the value to the individual prior to any negative outcomes). In other words, the WTP approach attempts to capture trade-offs between individual wealth and small reductions in risk. Conceptually, the advantage of the WTP approach is that it tries to reflect people’s preferences. The methods typically used to determine people’s preferences are studies of revealed preference (such as wage risk studies and studies of consumer behaviour) and stated preference surveys.

However it can be difficult to effectively capture people’s preferences, for several reasons.

- People participating in WTP surveys often have difficulties in valuing small differences in risks.
- Individuals often have different perceptions of risk.
- There are also differences in people’s willingness and ability to pay.

In using WTP to estimate costs associated with suicide, there is an implicit assumption that the value placed on an individual’s life is from the perspective of the community rather than the individual affected.

Human capital

The human capital approach estimates the expected value to society of forgone output on an ex-post basis. The output in this context refers to the forgone economic contribution to society from both workplace and household participation, from the age at which premature death occurs to the end of the expected natural life. Implicit in this approach is the concept of a ‘productive life’.

This approach has several advantages, in that it provides a transparent value that is relatively straightforward to estimate, while also reflecting age and gender differences in the loss of output.

However, there are a number of conceptual problems with the human capital approach.

- Given the focus on productive output as the indicator of value, this approach explicitly values the lives of working people above those who are not working.
- Similarly, it does not take into account the value that people place on their non-working (leisure) time, and the non-pecuniary benefits that people would have enjoyed if they were not working.

While there are conceptual problems in using the human capital approach to estimate costs of fatal suicides, it is considered a reasonable approach to quantifying the cost to society of the foregone outputs that result from non-fatal suicide behaviour.

Source: BITRE (2009); Mendoza and Rosenberg (2010).
Costs directly incurred as a result of fatal and non-fatal suicide behaviour include:

- the cost of medical treatment, which varies by according to the level of severity of the injury experienced
- administrative costs, including the costs of investigating an incident, travel to medical support and funeral costs (funeral costs are brought forward by suicide fatality)
- a range of other costs, including the cost of carers, aids, modifications, counselling and bereavement support for those affected by suicide fatalities.

The Productivity Commission used average costs estimated by Kinchin and Doran (2017) and inflated the costs to 2018 dollars using the CPI. Key assumptions and parameters are presented in table H.7, while average and total costs are summarised in table H.8.

<table>
<thead>
<tr>
<th>Table H.7</th>
<th>Summary of key assumptions and estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td><strong>Estimate</strong></td>
</tr>
<tr>
<td><strong>Suicide</strong></td>
<td></td>
</tr>
<tr>
<td>Years of life lost due to suicide</td>
<td>134 133</td>
</tr>
<tr>
<td><strong>Non-fatal suicide attempts</strong></td>
<td></td>
</tr>
<tr>
<td>Years of life lost due to disability</td>
<td>1241</td>
</tr>
<tr>
<td>Number of suicide attempts</td>
<td>78 319</td>
</tr>
<tr>
<td>Hospitalisation rate (per 100 000 people)</td>
<td>118.8</td>
</tr>
<tr>
<td>Proportion full incapacity</td>
<td>0.6%</td>
</tr>
<tr>
<td>Proportion short absence</td>
<td>99.4%</td>
</tr>
<tr>
<td>Employed</td>
<td>41%</td>
</tr>
<tr>
<td>Not employed</td>
<td>59%</td>
</tr>
<tr>
<td><strong>Productivity (% wage rate)</strong></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>100%</td>
</tr>
<tr>
<td>Non-employed</td>
<td>81%</td>
</tr>
<tr>
<td><strong>Other parameters</strong></td>
<td></td>
</tr>
<tr>
<td>Value of a statistical life year</td>
<td>$213 000</td>
</tr>
<tr>
<td>Costs inflated to 2018 dollars</td>
<td>7%</td>
</tr>
<tr>
<td>Population growth rate</td>
<td>20%</td>
</tr>
</tbody>
</table>
### Table H.8  Costs of suicide and non-fatal suicide behaviour

2018 dollars

<table>
<thead>
<tr>
<th></th>
<th>Suicide deaths&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Non-fatal suicide behaviour (full incapacity)</th>
<th>Non-fatal suicide behaviour (short absence)</th>
<th>Not requiring hospitalisation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Employed</td>
<td>Not employed</td>
<td>Employed</td>
<td>Not employed</td>
</tr>
<tr>
<td>Average intangible costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year of life lost</td>
<td>43.4</td>
<td>43.4</td>
<td>2.6</td>
<td>2.6</td>
</tr>
<tr>
<td>Costs ($)</td>
<td>9.2 m</td>
<td>9.2 m</td>
<td>562 514</td>
<td>562 514</td>
</tr>
<tr>
<td>Average indirect cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Production disturbance ($)</td>
<td>40 549</td>
<td>..</td>
<td>40 549</td>
<td>..</td>
</tr>
<tr>
<td>Human capital ($)</td>
<td>..</td>
<td>2.1 m</td>
<td>1.7 m</td>
<td>..</td>
</tr>
<tr>
<td>Average direct costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical ($)</td>
<td>2 593</td>
<td>2 593</td>
<td>13 354</td>
<td>13 354</td>
</tr>
<tr>
<td>Administrative ($)</td>
<td>7 501</td>
<td>7 501</td>
<td>2 811</td>
<td>2 811</td>
</tr>
<tr>
<td>Other ($)</td>
<td>123 884</td>
<td>123 884</td>
<td>85 532</td>
<td>85 532</td>
</tr>
<tr>
<td>Average cost per person ($)</td>
<td>9.4 m</td>
<td>9.4 m</td>
<td>2.3 m</td>
<td>1.8 m</td>
</tr>
<tr>
<td>Number of people</td>
<td>1 268</td>
<td>1 825</td>
<td>193</td>
<td>277</td>
</tr>
<tr>
<td>Total costs ($b)</td>
<td>11.9</td>
<td>17.1</td>
<td>0.6</td>
<td>0.7</td>
</tr>
</tbody>
</table>

<sup>a</sup> As years of life lost to suicide and self-inflicted injury data are from 2015, the number of deaths by suicide is also taken from that year.  
<sup>b</sup> Production disturbance costs are included only for those people who were employed at the time of their non-fatal suicide behaviour.  .. Not applicable.  

Source: Productivity Commission estimates.
References


ABS (Australian Bureau of Statistics) 2018, Microdata: Multi-Agency Data Integration Project, Australia, Cat. no. 1700.0, Canberra.

—— 2019a, National Health Survey 2017-18, Basic Confidentialised Unit Record File (CURF), Cat. no. 4324.0.55.001, Canberra.

AIHW (Australian Institute of Health and Welfare) 2017, National Social Housing Survey 2016 — Online and Supplementary Data Tables, Canberra.

—— 2019a, Australian Burden of Disease Study: Impact and Causes of Illness and Death in Australia 2015, Cat. no. BOD 22, Canberra.

—— 2019b, Mental Health Services in Australia – Specialist Homelessness Services, Canberra.

—— 2020a, Mental Health Services in Australia - Expenditure on Mental Health Services 2017-18 Tables, Canberra.


BITRE (Bureau of Infrastructure, Transport and Regional Economics) 2009, Cost of Road Crashes in Australia 2006, Research report, 118, Department of Infrastructure, Transport, Regional Development and Local Government, Canberra.

ConNetica (ConNetica Consulting Pty Ltd) 2010, Suicide and Suicide Prevention in Australia: Breaking the Silence, Lifeline Australian and Suicide Prevention Australia.


—— 2019, Mental Health: Key Statistics Fact Sheet, Canberra.


OBPR (Office of Best Practice Regulation) 2014, Best Practice Regulation Guidance Note Value of statistical life, Canberra.

—— 2019, Best Practice Regulation Guidance Note Value of statistical life, Canberra.


I Benefits and costs of improved mental health

This analysis looks at the health benefits that are likely to stem from the main Inquiry actions, and provides an indication of how much health improvements that result from the recommended actions are likely to cost. This serves several purposes — it demonstrates that the recommended actions provide relatively good value for money in terms of health returns for government expenditure and provides an indication of what actions give the biggest health returns for a given amount of expenditure.

A number of terms that are used throughout the appendix are defined in box I.1.

I.1 Benefits and costs framework

The benefits of improved mental health that were readily quantified are:

- improved employment prospects
- increased labour income (wages)
- improved health-related quality of life (in terms of quality-adjusted life years, or QALYs) (box I.2).

Estimating the expected benefits of the actions involved two steps:

- The relationship between mental health and wages, labour market outcomes, and health-related quality of life was quantified, using an econometric model based on representative population (HILDA) data. This model is described in detail in appendix J.
- The econometric results were combined with information from the existing mental health literature that describes the possible effect of policy changes on the mental health of people targeted by an action. This allowed the calculation of estimates of expected changes in employment, wages, and health-related quality of life. Information about possible health effects, costs and cost savings are outlined in appendix K.

This is a relatively straight-forward approach to estimating the health and labour market benefits that result from improved mental health. However, there are some important limitations to this approach.

- Spillover benefits are not fully captured in this model. For example, improving someone’s housing situation can facilitate better access to other services, which in turn is likely to improve overall outcomes (chapter 20).
Quantified benefits are limited to short-term benefits that directly result from improved mental health. This means that long-run benefits, such as the labour market benefits that result from improving the mental health and wellbeing of children are not estimated.

Box I.1 Definitions used in this discussion

**Increased costs/expenditures**
Increases in costs/expenditures refers to the additional annual government expenditures required to implement a recommended action, such as the Medicare costs associated with the increased use of group therapies.

**Cost savings**
Cost savings are expenditures that are offset by the implementation of an action. For example, increases in Medicare expenditures for group therapies are likely to be partially offset by a reduction in expenditures associated with individual therapies.

**Additional income**
The majority of actions are likely to result in improvements in the mental health of people affected (the target population). Consequently, improvements in mental health are likely to result in increases in employment and wages. The additional labour market income can then be aggregated as an indicator of the economic benefits associated with an action.

**Additional Quality-Adjusted Life Years (QALYs)**
Improvements in mental health are reflected in better health-related quality of life, measured in quality-adjusted life years (box I.2). Additional QALYs that are associated with the mental health improvements resulting from an action are aggregated as a measure of the benefits of that action.

**Net cost**
The net costs associated with an action are the increases in expenditures required to implement the action, minus any cost savings and additional incomes that may result from the action. Where the cost savings and additional incomes are greater than the costs, an action is considered to be *net cost saving* — the additional expenditures associated with their recommendation is more than completely offset by the expenditure savings and expected increases in aggregate income.

**Net cost per QALY**
The net cost per QALY is the average cost of an additional QALY gained by implementing an action. It reflects the likely effect of additional expenditure on mortality and morbidity associated with mental illness, and can be used to assess the value of that action relative to other forms of health expenditure. Where a group of actions are likely to be net cost saving, the net cost per QALY is less than zero. This means that not only is the action expected to result in net savings, but it is also expected to lead to improved health.
**Box I.2 What are quality-adjusted life years?**

In this analysis, the potential health benefit associated with a recommended action has been measured in quality-adjusted life years (QALYs).

QALYs provide a measure of the effect that illness — including mental illness — has on the quality of life experienced by people affected. The effect of an illness on quality of life is reflected by a ‘utility weight’ (derived from standard valuations), where a weight of 1 equates to perfect health, and a weight of 0 is equated with death. Certain health states can be assigned a negative value as they may be characterised by severe disability and/or pain that are regarded as worse than death (Whitehead and Ali 2010). QALYs can be calculated using questionnaires which cover general aspects of health. For example, a commonly used questionnaire is the SF-6D, which allocates a person to one of 18 000 potential health states using their responses to the questionnaire (Norman et al. 2014).

Economic evaluations can assess the value of interventions by calculating the cost per unit of health improvement. In our case, units of improved health are measured by improvements in QALYs. A successful intervention may reduce the duration a person has a mental illness, or the severity of that illness. This may be conceptualised as an increase in the utility weight that reflects a person’s health-related quality of life, in terms of QALYs. The health benefit in QALYs attributed to a recommended action is the determined by the difference in the utility weights associated with the action, and the time over which the difference persists (figure).

**Stylised increase in quality-adjusted life years associated with a recommended action**

The improvements in health can be measured as an increase in the number of QALYs experienced by the people affected. In the diagram above, the total health benefit attributable to a recommended action, measured in QALYs gained, is the area between the two curves. However, in the analysis presented in table I.1, it is assumed that benefits ‘decay’ after a single year, meaning that only the yellow health effects are counted. This is a conservative assumption, and the effects of this assumption are shown in table I.4.
In addition to possible benefits, many of the recommended actions have substantial cost implications. New programs have implementation and ongoing costs, but also result in cost savings as demand for other services is reduced. Costs considered include direct expenditures to government that are required to implement actions, and cost savings include government expenditures that are reduced as a result of a recommended action. Where possible, time and out-of-pocket costs to individuals are incorporated in estimates of costs and cost savings. As with benefits over the longer term, it is likely that there are reductions in government expenditures (cost savings) over the longer term that are not taken into account, meaning that cost savings are also likely to be understated.

**Cost effectiveness**

The expected costs of an action or suite of actions can be combined with estimates of the mental health benefits expected, to indicate priority areas for change. In this analysis, the cost per QALY is used as a measure of cost effectiveness — that is, for a given action or group of actions, how much is an additional QALY likely to cost, on average?

In order to assess whether this represents value for money, the costs per QALY estimates can be compared to benchmark values that indicate the opportunity costs with respect to the next best uses of funding within the healthcare system. However, there is considerable diversity in the benchmarks used for cost effectiveness:

- An early analysis of cost effectiveness in Australia found that the Pharmaceutical Benefits Advisory Committee was unlikely to reject medication when the cost of an additional life year was less than $42 000 (in 1998-99 dollars). This is around $96 000 in 2019 dollars.

- The Assessing Cost Effectiveness in Prevention study in 2010 assumed a threshold value of $50 000 per Disability-Adjusted Life Year averted as a decision threshold to determine whether or not an intervention was effective or not (Vos et al. 2010). This is around $64 000 in 2019 dollars.\(^\text{18}\)

- More recently, Edney et al. (2018) estimated the expected QALY gains from additional government health expenditure, finding that there is an opportunity cost of 1 QALY for every additional $33 000 of government expenditure (2019 dollars).

This provides three thresholds by which the actions included below may be assessed:

1. **Very cost effective** — cost is less than $33 000 per QALY.
2. **Cost effective** — cost is less than $64 000 per QALY.
3. **Marginally cost effective** — cost is less than $96 000 per QALY.

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18 This has been used as a cost effectiveness threshold in Australia for some time, and appears to be originally based on a threshold used in the United Kingdom by the National Institute of Clinical Evidence. They have traditionally used a threshold of between £20 000 and £30 000 as a threshold for cost effectiveness. This threshold appears to be a rule of thumb and has not been changed since 2004 (Claxton et al. 2013).
Calculating cost per QALY

To calculate the cost per QALY, the monetary values from the actions are combined into a net cost. The net costs included here are:

- additional annual expenditure associated with implementing an action
- any cost savings that are likely to be realised as a result of the implementation of an action
- any additional wages that result from improved mental health leading to changes in expected employment and labour productivity.

Costs and cost savings are simulated from triangular distributions, with the lower and upper bounds taken from the lower and higher cost estimates (appendix K). Changes in income and QALYs are simulated from their respective posterior distributions implied by the econometric model. It is assumed that these distributions are independent. The simulated values for cost, cost savings, and changes in income are then aggregated together to calculate a simulated value for net cost and net cost per QALY. This process is repeated 100,000 times to construct a distribution of net cost per QALY. Table 1.1 presents the 10th to 90th percentile of these distributions.

Grouping of actions

The report includes a large number of recommended actions over a broad range of policy areas, and there is potential for complementarities and substitution effects between the policy changes recommended. That is, the effects of some actions are likely to be greater if other changes are instituted, and other actions may have a smaller effect with other changes in place. It is not possible to model the interactions between actions due to a lack of information due to a lack of information about how this might play out.

There is a large scope for overlap and double counting of benefits in terms of improved mental health. This makes the presentation of aggregate benefits and cost savings difficult. For example, aggregating effects of healthcare changes with those associated with improvements in psychosocial supports is likely overstate benefits given likely overlap of benefits between those areas. This was a problem discussed at a roundtable discussion with a number of experts in early 2020, and it was agreed that the best approach was to ‘group’ actions so as to minimise overlap.

19 Drummond et al. (2015) noted that where evidence about a cost parameter is limited it is inappropriate to use a single value, and that distributions should be used to represent the uncertainty about possible mean values. Gamma distributions are commonly used to represent cost uncertainty but, as with a triangular distribution, require assumptions about shape. The decision to use triangular cost distribution was made so as to make better use of the higher and lower cost estimate information.
Other caveats

This analysis can only be considered indicative of the potential benefits and costs that are associated with actions in the final report. There are a number of caveats that need to be considered.

- The labour market model is based on an assumption that labour demand is completely responsive to labour supply. That is, it assumes that firms are able to create jobs to meet the increased supply of workers.

- Information about the mental health effects of some actions is limited. In cases where benefits have been estimated, the effect sizes which have been used to represent an improvement in mental health are based on standardising them for comparability. This is similar to what is done in meta-analyses, where multiple studies which use different scales are combined together.

- The evidence for the scalability of some actions is limited, with some actions requiring substantial scaling. For example, the benefits and costs of rolling out a national Individual Placement and Support (IPS) program have been estimated on the basis that 40 000 people will end up using these services. However, it is estimated that only 1800 people were using IPS employment support in mid-2018.

- There are many actions included in the report for which it was not possible to estimate expected costs and benefits. This includes instances where the Productivity Commission recommends reviews be undertaken, or where there is an absence of sufficient evidence to indicate possible costs and benefits. Similarly, actions that affect governance arrangements for the provision of services have not been quantitatively assessed.

I.2 Results

This analysis shows that there are a number of actions that governments can take that are likely to be cost effective in improving the health-related quality of life of people living with mental illness. There are also a range of actions that may also result in net cost savings and improvements in health (figure I.1)
Figure I.1 Cost-effectiveness of recommended actions

<table>
<thead>
<tr>
<th>Category</th>
<th>% of simulated outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare</td>
<td>100%</td>
</tr>
<tr>
<td>Carers and families</td>
<td>90%</td>
</tr>
<tr>
<td>Income &amp; employment support</td>
<td>80%</td>
</tr>
<tr>
<td>Housing</td>
<td>70%</td>
</tr>
<tr>
<td>Psychosocial supports</td>
<td>60%</td>
</tr>
<tr>
<td>Early childhood &amp; school</td>
<td>50%</td>
</tr>
<tr>
<td>Young adults</td>
<td>40%</td>
</tr>
<tr>
<td>Workplaces</td>
<td>30%</td>
</tr>
<tr>
<td>Social participation</td>
<td>20%</td>
</tr>
<tr>
<td>Suicide prevention</td>
<td>10%</td>
</tr>
</tbody>
</table>

Source: Productivity Commission estimates.

Assumptions about the persistence of mental health benefits resulting from actions have a substantial effect on estimates of total QALYs and cost-effectiveness. In this model, it has been assumed that all benefits ‘decay’ after a single year — in most cases this is a very conservative assumption, and suggests that the benefits in table I.1 should considered as understating likely effects. For example, if the assumption of full annual decay of benefits is replaced by an assumption that benefits decay by 50% each year (over 5 years with a 3% real discount rate), then the net cost per QALY for early childhood and school recommended actions decreases from $3000-$7000 per QALY to $1000–$3000 per QALY. The effects of persistence assumptions and discount rates on cost per QALY estimates are shown in table I.4.
### Table I.1  Estimated benefits and costs by action group

All benefits decay after one year

<table>
<thead>
<tr>
<th>Action group</th>
<th>Benefits</th>
<th>Costs</th>
<th>Net cost per QALY&lt;sup&gt;a,c&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Additional income&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Additional QALYs&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Additional costs&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Carers and families</td>
<td>124-245</td>
<td>4 390-6 390</td>
<td>160-189</td>
</tr>
<tr>
<td>Income &amp; employment support</td>
<td>42-90</td>
<td>240-430</td>
<td>108-286</td>
</tr>
<tr>
<td>Housing</td>
<td>8-21</td>
<td>920-4 780</td>
<td>740-940</td>
</tr>
<tr>
<td>Psychosocial supports</td>
<td>79-177</td>
<td>4 910-8 900</td>
<td>373-1 085</td>
</tr>
<tr>
<td>Justice&lt;sup&gt;d&lt;/sup&gt;</td>
<td>..</td>
<td>380-420</td>
<td>12-18</td>
</tr>
<tr>
<td>Early childhood &amp; school</td>
<td>46-86</td>
<td>29 300-52 860</td>
<td>260-260</td>
</tr>
<tr>
<td>Young adults</td>
<td>..</td>
<td>980-1 790</td>
<td>60-87</td>
</tr>
<tr>
<td>Workplaces</td>
<td>12</td>
<td>170-310</td>
<td>60-60</td>
</tr>
<tr>
<td>Social participation</td>
<td>22-44</td>
<td>420-760</td>
<td>4-6</td>
</tr>
<tr>
<td>Suicide prevention</td>
<td>3</td>
<td>50</td>
<td>63-194</td>
</tr>
</tbody>
</table>

<sup>a</sup> Changes in income and quality-adjusted life years (QALYs) are simulated from their respective posterior distributions implied by the model described in appendix J. Ranges for additional income, additional QALYs and net cost per QALY are the 5<sup>th</sup> and 95<sup>th</sup> percentiles.  

<sup>b</sup> Cost and cost savings for actions groups with only one action are based on the lower and upper bounds presented in appendix K. Where there is more than one action in an action group, cost and cost savings represent 5<sup>th</sup> and 95<sup>th</sup> percentiles based on simulated distributions. It is assumed that these distributions are independent.  

<sup>c</sup> Action groups are regarded as ‘cost saving’ if they are estimated as having a net cost less than zero.  

<sup>d</sup> Benefits were not able to be quantified for justice actions.

.. Not applicable. — Nil or rounded to zero.

### I.3 Cost and benefit inputs

The additional expenditures and expected cost savings associated with recommended actions are presented in table I.2. Details of the target population and the mental health benefits they receive are in table I.3. Detailed assumptions used in calculating likely costs associated with recommended actions are presented in appendix K.
<table>
<thead>
<tr>
<th>Actions</th>
<th>Cost increases ($m)</th>
<th>Cost savings ($m)</th>
<th>Description of costs included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to healthcare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased psychiatric advice to GPs</td>
<td>0.4–1.1</td>
<td>_a</td>
<td>Increased costs based on additional time required by psychiatrists, GPs, and paediatricians.</td>
</tr>
<tr>
<td>Encouraging more group psychological therapy</td>
<td>0.9–1.5</td>
<td>1.9–2.6</td>
<td>Increased expenditure from additional people using group therapy. Cost savings of substitution from individual to group therapy, for those already using services.</td>
</tr>
<tr>
<td>Increased access to psychiatry and psychological therapy by telehealth</td>
<td>3.3–6.5</td>
<td>11.1–31.1</td>
<td>Increased costs from additional people using telehealth. Cost savings from substitution of face-to-face initial assessments and removing additional rebates paid to psychiatrists for telehealth consultations.</td>
</tr>
<tr>
<td>Expanding supported online treatment options</td>
<td>47–69</td>
<td>7–22</td>
<td>Increased costs include provision for a review, an information campaign for culturally and linguistically diverse people, consumers, and health professionals, and the costs of providing online supported treatment. Cost savings are from the substitution to a lower-cost online treatment.</td>
</tr>
<tr>
<td>State and territory community ambulatory services</td>
<td>403</td>
<td>–</td>
<td>Increased expenditure for the provision of additional community ambulatory services for people aged over 18 years.</td>
</tr>
<tr>
<td>Bed-based services</td>
<td>426</td>
<td>–</td>
<td>Increased expenditure for the provision of additional long stay residential non-acute bed-based services.</td>
</tr>
<tr>
<td>Alternatives to emergency departments</td>
<td>2.6–4.1</td>
<td>3.3–5.8</td>
<td>Increased expenditure from expanding trials of mobile crisis services and safe haven cafés. Cost savings from a reduction in emergency department presentations.</td>
</tr>
<tr>
<td>Online navigation portal to support referral pathways</td>
<td>6–10</td>
<td>–</td>
<td>Increased expenditure from establishing HealthPathways portals for the three Primary Health Networks that do not already have it, and expanding the portal into areas beyond health across all Primary Health Networks.</td>
</tr>
<tr>
<td>Care coordinators and single care plans</td>
<td>176–413</td>
<td>–</td>
<td>Increased expenditure from having additional care coordination services and single care plans developed and reviewed. Costs and benefits associated with care coordinators and single care plans are excluded from aggregate healthcare calculations due to substantial overlap with community ambulatory services.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Actions</th>
<th>Cost increases ($m)</th>
<th>Cost savings ($m)</th>
<th>Description of costs included</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Carers and families</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family and carer inclusive practices</td>
<td>73–101</td>
<td>–</td>
<td>Increased expenditure from subsidising carer and family consultations and on family and family and carer workers in each region.</td>
</tr>
<tr>
<td>Support services for carers and families</td>
<td>87</td>
<td>–</td>
<td>Increased expenditure on family and carer support services.</td>
</tr>
<tr>
<td>Cost savings across carer actions</td>
<td>40–73</td>
<td></td>
<td>Reductions in the number of hospital admissions and emergency department presentations.</td>
</tr>
<tr>
<td><strong>Income and employment support</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cost savings are from reduction in use of healthcare services and reduction in Disability Employment Services costs which would have otherwise been incurred.</td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing security for people with mental illness</td>
<td>12–52</td>
<td>–</td>
<td>Increased expenditure for mental health training and resources for social housing workers and expansion of tenancy support programs.</td>
</tr>
<tr>
<td>Supported housing</td>
<td>230–807</td>
<td>147–540</td>
<td>Increased expenditure for providing additional supported housing places and meeting the gap for homelessness services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cost savings are reductions in health and other expenditures.</td>
</tr>
<tr>
<td>Housing after discharge from hospital or prison</td>
<td>15–94</td>
<td>25–333</td>
<td>Increased expenditure from care coordination and access to accommodation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cost saving are from reduction in use of healthcare services.</td>
</tr>
<tr>
<td>Homelessness services</td>
<td>278–393</td>
<td>67–132</td>
<td>Increased expenditure from homelessness services and long-term housing arrangements</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cost saving are from reduction in use of healthcare services.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Actions</th>
<th>Cost increases ($m)</th>
<th>Cost savings ($m)</th>
<th>Description of costs included</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychosocial support</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Filling the gap in demand for psychosocial support services</td>
<td>373–1085</td>
<td>–</td>
<td>Increased expenditures from providing additional psychosocial supports — expenditures are based on past programs — Personal Helper and Mentors Service (PHaMs) and Day to Day Living in the Community (D2DL).</td>
</tr>
<tr>
<td><strong>Justice</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving access to court diversion programs</td>
<td>46</td>
<td>–</td>
<td>Increased expenditures from ensuring that all magistrate courts have court liaison services, and the associated additional cost for mental health courts.</td>
</tr>
<tr>
<td>Increased support for police</td>
<td>15–23</td>
<td>12–18</td>
<td>Increased expenditures from scaling up co-responder models, based off similar programs in other states, nationally. Cost savings from reduction in emergency department attendances and reduced police time spent on mental health-related cases.</td>
</tr>
<tr>
<td>Additional mental health expenditure on prisoners</td>
<td>48–110</td>
<td>–</td>
<td>Increased expenditures so that the expenditure per prisoner is equivalent to the expenditure per person in the community.</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander prison expenditure</td>
<td>170</td>
<td>–</td>
<td>Increased expenditure are cost of establishing models, similar to the Winnunga Model of Care in the ACT, nationally.</td>
</tr>
<tr>
<td>Health justice partnerships</td>
<td>1.2</td>
<td>–</td>
<td>Increased expenditure from establishing health justice partnership trials in all Australian states and territories (based on the cost of cost of Mind Australia’s pilot in Victoria)</td>
</tr>
<tr>
<td>Legal representation at mental health tribunals</td>
<td>49</td>
<td>–</td>
<td>Increased expenditures are cost of increased legal representation for those appearing before mental health tribunals.</td>
</tr>
<tr>
<td>Individual non-legal individual advocacy services</td>
<td>13</td>
<td>–</td>
<td>Increased expenditures are cost of provision of non-legal advocacy services.</td>
</tr>
<tr>
<td>Advance directives, statements or agreements</td>
<td>22</td>
<td>–</td>
<td>Increased expenditures are cost of advance directive development support.</td>
</tr>
</tbody>
</table>
Table I.2 (continued)

<table>
<thead>
<tr>
<th>Actions</th>
<th>Cost increases ($m)</th>
<th>Cost savings ($m)</th>
<th>Description of costs included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perinatal mental health</td>
<td>18–23</td>
<td>–</td>
<td>Increased expenditures from: (1) raising awareness about screening (2) implementing screening (3) receiving care (for example, face-to-face with psychologist or online supported treatment).</td>
</tr>
<tr>
<td>Expanded provision of parent supports</td>
<td>6.8</td>
<td>2.2</td>
<td>Expenditures from the rollout of an indicated parent education program designed to prevent anxiety disorders in children. Cost savings from reduced healthcare costs (from treating anxiety).</td>
</tr>
<tr>
<td>Education support for the mental health of school-aged children</td>
<td>230</td>
<td>–</td>
<td>Increased expenditure of consistent improvements to wellbeing policies and practices in schools.</td>
</tr>
<tr>
<td>Young adults</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training for educators in tertiary education institutions</td>
<td>60–87</td>
<td>–</td>
<td>Increased expenditure from providing mental health training for staff at universities who have direct contact with students, based on the cost of a mental health first aid course.</td>
</tr>
<tr>
<td>Workplaces</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prioritising mental health in the workplace</td>
<td>49</td>
<td>67</td>
<td>Cost for employees to complete a universal, self-directed online mental health course. Cost savings through cases of depression avoided.</td>
</tr>
<tr>
<td>No-liability treatment for mental health related workers compensation claims</td>
<td>9</td>
<td>–</td>
<td>Increased expenditure from the medical costs that would have previously been rejected, but would be accepted under a no-liability system.</td>
</tr>
<tr>
<td>Social participation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National stigma reduction strategy</td>
<td>3.8–6.4</td>
<td>–</td>
<td>Increased expenditure on implementing a national anti-stigma campaign, based on comparable campaigns in the United Kingdom and Denmark.</td>
</tr>
<tr>
<td>Suicide prevention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Universal aftercare after suicide attempts</td>
<td>63–194</td>
<td>294</td>
<td>Increased expenditure of providing aftercare for people who have been hospitalised due to intentional self-harm. Cost savings from a reduction in medical, administrative, transfer, and other costs from suicide attempts.</td>
</tr>
</tbody>
</table>

a – Nil or rounded to zero. b There are likely to be a number of cost savings that result from the implementation of these actions, including reduced arrests, imprisonment and being held involuntarily in beds.
<table>
<thead>
<tr>
<th>Action grouping</th>
<th>Population affected</th>
<th>Effect size</th>
<th>Income ($ million)</th>
<th>Number of QALYs</th>
</tr>
</thead>
</table>
| Access to healthcare | 3 000-5 000 additional people using group therapy  
5 000-7 000 people using group therapy instead of individual therapy  
5 000-10 000 additional people accessing therapy by telehealth  
200 000-400 000 psychological therapy and psychiatry consultations via telehealth instead of face-to-face  
50 000 additional people — not currently accessing any other treatment — using online supported treatment  
100 000 people using online supported treatment instead of other treatment options  
84 000 people provided a full mix of community ambulatory services  
28 000 people accessing acute beds | An effect size averaging about 0.9 is shown in Burlingame et al. (2016) and Cuijpers et al. (2019) for group therapy. Each additional person accessing therapy has a 25% chance of improving.  
For those accessing therapy through telehealth, we assume an effect size of 0.8, in line with meta-analyses by Berryhill et al. (2019). Each additional person accessing therapy has a 25% chance of improving (Lambert, Hansen and Finch 2001).  
A meta-analysis of computer therapy by Andrews et al. (2018) suggested an effect size of 0.8 for online supported treatment.  
For ambulatory and bed based services, effect sizes are calculated using data on measures at admission and discharge from the AMHOCN (2019). | 501-718 10 280-15 280 | |
| Carers and families | 55 000 mental health carers with unmet needs  
7 500 care recipients with schizophrenia or psychosis  
200 800 children of parents with mental illness (COPMI) | The results of a range of interventions for families and carers suggests an effect size of 0.4 for carers (appendix K).  
A meta-analysis of family psychosocial interventions for schizophrenia (Pharoah et al. 2010) suggested an effect size of 0.79 for care recipients from schizophrenia or psychosis.  
Solantaus et al. (2010) suggested a child-focused psychoeducation discussion with parents has an effect size of 0.12 for COPMI. | 124-245 4 390-6 390 | |
| Income and employment support | 40 000 people with severe mental illness, of employment age | Synthesising the results of a range of IPS trials suggests an effect size of 0.08 for calculating health-related quality of life benefits (Burns et al. 2009; Drake et al. 1999; Kukla and Bond 2013; Michon et al. 2014).  
Labour market benefits are based on the secondary vocational outcomes (duration of employment, average hours worked, hourly wage) reported in Waghorn et al. (2014). | 42-90 240-430 | |

(continued next page)
<table>
<thead>
<tr>
<th>Action grouping</th>
<th>Population affected</th>
<th>Effect size</th>
</tr>
</thead>
</table>
| Housing         | Between 15 000-40 000 people:  
|                 | • have unmet needs for assistance to sustain a housing tenure  
|                 | • are in need of housing upon discharge from hospital or prison  
|                 | • require supported housing  
|                 | • have unmet needs for long term housing. | Additional QALYs are calculated using estimates from Aldridge (2015) and Connelly (2013). These papers suggested that a year of homelessness is associated with a loss of between 0.06-0.12 QALYs.  
|                 | • Flatau et al. (2007) reported a difference in employment rate of about 4.5 percentage points at the follow-up after their entry into support. It is assumed that recipients of IPS will be on minimum wage, and the number of hours and weeks worked is assumed to be the same as those who gain competitive employment under IPS from Waghorn et al. (2014). |
|                 |                     | Income ($ million) | Number of QALYs |
|                 |                     | 8-21 | 920-4 780 |
| Psychosocial supports | There is a gap of 154 000 people with severe mental illness who require psychosocial supports. | Muir, Meyer and Thomas (2016) conducted an evaluation of the Wellways Partners in Recovery program and estimated an effect size of 0.44 on the ‘managing mental health’ dimension. The number of hours and weeks worked is assumed to be the same as those who gain competitive employment under IPS from Waghorn et al. (2014). | 79-177 | 4 910-8 900 |
| Early childhood & school | • Around 11 100 students benefit from the rollout of an indicated parent education program designed to prevent anxiety disorders in children. | Reduced anxiety effects are drawn from Rapee et al. (2005). | na | 385-703 |
|                 | • There are 3.9 million students in primary and high schools across Australia (ABS 2020) who are expected to experience improved health-related quality of life from social and emotional learning programs.  
|                 | • 12 000 partners of new mothers, who are screened and identified to have a perinatal mental illness. | Sklad et al. (2012) conducted a meta-analysis on school-based universal social, emotional, and behavioural programs and found an effect size of 0.1 on follow-up outcomes for mental disorders.  
|                 | • For partners of new mothers, it is assumed that an even mix of face-to-face and online supported treatment is used, with an effect size of 0.9 (Burlingame et al. 2016; Cuijpers et al. 2019) and 0.8 (Andrews et al. 2018) respectively. | 46-86 | 29 300-52 860 |

(continued next page)
## Table I.3 (continued)

<table>
<thead>
<tr>
<th>Action grouping</th>
<th>Population affected</th>
<th>Effect size</th>
<th>Income ($ million)</th>
<th>Number of QALYs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young adults</td>
<td>• There are around 271 100 young adults who could benefit from teaching staff at TAFE and universities having improved access to adequate mental health training.</td>
<td>• A meta-analysis of the effects of workplace health promotion interventions by Martin, Sanderson, and Cocker (2009) identified an effect size of 0.05 on composite mental health measures.</td>
<td>—</td>
<td>980-1 790</td>
</tr>
<tr>
<td>Workplaces</td>
<td>• The introduction of no-liability treatment for mental health-related workers compensation, is expected to result in a total of around 8 000 people returning to work earlier than otherwise would have been the case. Because these claims are related to mental health, it is assumed that people in this group have a mental illness. • Around 10 000 people are expected to have health-related quality of life benefits from recommendations to prioritise mental health in the workplace.</td>
<td>• For no-liability treatment for mental health related workers compensation claims, it is assumed that the time spent reliant on workers compensation is reduced by 21% for people making a mental health claim (estimated using data from Safe Work Australia (2018) and Sampson (2015)). • The QALYS estimated are from prevented cases of depression resulting from prioritised mental health in the workplace, using an effect size of 0.23 from Stratton et al. (2017).</td>
<td>12</td>
<td>170-310</td>
</tr>
<tr>
<td>Social participation</td>
<td>• 1.2 million people with a diagnosed mental illness are expected to have health-related quality of life benefits of those, 850 000 people with a diagnosed mental illness are expected to have labour force benefits</td>
<td>There is a limited evidence about the magnitude of the effect on mental illness due to the endogeneity of mental illness and stigma, meaning that assumptions about likely mental health benefits are required. The assumed effect sizes are: • 0.01 for people with a severe mental illness • 0.005 for people with moderate mental illness • 0.001 for people with a mild mental illness.</td>
<td>22-44</td>
<td>420-760</td>
</tr>
</tbody>
</table>

(continued next page)
Table I.3 (continued)

<table>
<thead>
<tr>
<th>Action grouping</th>
<th>Population affected</th>
<th>Effect size</th>
<th>Income ($ million)</th>
<th>Number of QALYs</th>
</tr>
</thead>
</table>
| Suicide prevention | • There were 3 046 deaths due to suicide in 2018, where 2 380 were people aged 20-64 (ABS 2019) and there were 31 083 hospitalisations due to self-harm in 2017-18 (AIHW 2019).  
• Of those who would have completed suicide, or would be permanently incapacitated by their attempt, 37 cases are prevented.  
• A second effect is included for those who would have a short absence from work due to a suicide attempt, but are not permanently incapacitated. This can prevent about 6 150 short absences from work.  
• Kinchin and Doran (2017) estimated that 0.6% of suicide attempts result in full incapacity, and 99.4% lead to a short absence from work. Aftercare can lead to a 19.8% reduction in subsequent suicide attempts and a 1.1% reduction in the suicide rate (Krysinska et al. 2016). | | 3 | 50 |

\* Improvements in social and emotional wellbeing for preschool children are estimated in disability-adjusted life years (DALYS) averted and should not be added with QALY benefits.
Persistence of mental health benefits over time

The extent to which mental health benefits are likely to persist over time has a noticeable effect on the aggregate benefits, and therefore the costs effectiveness estimates. The results above present the benefits and costs that are expected to result from action groups, based on the assumption that the benefits ‘decay’ over a single year.

This is a conservative assumption in some respects — where people are provided with care that is likely to assist their return to recovery, it may be reasonable to expect the benefits to persist beyond a year. Where people require ongoing services in order to maintain a state of recovery, persistence of benefits is less likely. In the table below, estimated benefits and net costs per QALY are calculated using an alternative assumption about the persistence of benefits are assumed to decay by 50% each year, for a total of 5 years (by which time they are almost non-existent). This is an assumption used in other cost-effectiveness models in this literature (Mihalopoulos et al. 2011, 2012). Results are not presented for housing and psychosocial support services which are not assumed to have persistence effects.

Increasing persistence of benefits improves the cost effectiveness of all action groups. For example, assuming benefits decay by 50% each year, for a total of 5 years shifts the lower bound estimate for the ‘young adults’ action group from cost-effective to very cost effective, while the ‘access to healthcare’ action group becomes cost saving. The rate at which future benefits are discounted does not noticeably influence cost effectiveness.

<table>
<thead>
<tr>
<th>Grouped actions</th>
<th>1 year</th>
<th>5 years (50% decay in benefit, 3% discount rate)</th>
<th>5 years (50% decay in benefit, 7% discount rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to healthcare</td>
<td>$11–30</td>
<td>Cost saving</td>
<td>Cost saving</td>
</tr>
<tr>
<td>Carers and families</td>
<td>Cost saving</td>
<td>Cost saving</td>
<td>Cost saving</td>
</tr>
<tr>
<td>Income &amp; employment support</td>
<td>Cost saving</td>
<td>Cost saving</td>
<td>Cost saving</td>
</tr>
<tr>
<td>Housinga</td>
<td>47–199</td>
<td>..</td>
<td>..</td>
</tr>
<tr>
<td>Psychosocial supporta</td>
<td>45–136</td>
<td>..</td>
<td>..</td>
</tr>
<tr>
<td>Early childhood &amp; school</td>
<td>3–7</td>
<td>1–3</td>
<td>1–3</td>
</tr>
<tr>
<td>Young adults</td>
<td>40–76</td>
<td>21–40</td>
<td>22–42</td>
</tr>
<tr>
<td>Workplaces</td>
<td>Cost saving</td>
<td>Cost saving</td>
<td>Cost saving</td>
</tr>
<tr>
<td>Social participation</td>
<td>Cost saving</td>
<td>Cost saving</td>
<td>Cost saving</td>
</tr>
<tr>
<td>Suicide prevention</td>
<td>Cost saving</td>
<td>Cost saving</td>
<td>Cost saving</td>
</tr>
</tbody>
</table>

a Persistence of benefits is not assumed for housing and psychosocial support. .. Not applicable.

Source: Productivity Commission estimates.
References


—– 2020, *Schools Australia, 2019*, Cat. no. 4221.0, Canberra.


Burlingame, G.M., Janis, R.A., Seebeck, J.D. and Whitcomb, K.E. 2016, ‘Outcome differences between individual and group formats when identical and non-identical treatments, patients, and doses are compared: a 25-year meta-analytic perspective’, *Psychotherapy*, vol. 53, no. 4, pp. 446–461.


Mental health is an important aspect of an individual’s ‘human capital’ — the individual attributes such as knowledge and skills that affect people’s productivity, and the wages they earn if they are employed. For people already employed, improvements in mental health would be expected to result in higher wages. For people who are unemployed or not in the labour force, improvements in mental health are expected to increase the probability of gaining employment, as well as their income if they find employment.

Individuals are also likely to experience an improvement in their health-related quality of life as their mental health improves. The Productivity Commission has estimated how improvements in mental health are likely to increase the quality of life across the population expected to benefit from its recommendations and actions. These improvements in quality of life are measured in ‘quality-adjusted life years’ (QALYs).

This appendix outlines how the relationship between mental health, and labour market outcomes and health-related quality of life is quantified (sections J.1 and J.2). Results of this model are briefly presented in section J.3. The way in which the results of this estimation are used to calculate the potential benefits that may result from improved mental health is outlined in section J.4.

J.1 Estimating the effect of mental health on employment and wages

Mental health is associated with labour market outcomes such as employment and wages (Forbes, Barker and Turner 2010). People with mental ill-health are less likely to be employed, and if they are employed they are likely to earn less (figure J.1). For example, depression can lead to absenteeism and lower productivity (Waghorn and Lloyd 2005), and prolonged absenteeism can lead to a complete withdrawal from the labour market. The stigma associated with mental illness may also mean that employers do not hire someone with mental illness.

Friijters et al. (2014) provided examples of studies that have attempted to establish causal relationships between mental health and employment (Alexandre and French 2001; Chatterji et al. 2007; Ettner, Frank and Kessler 1997). These studies found that diagnoses of
psychiatric disorders and depression can reduce the probability of employment by 13–26% across different cohorts.

Figure J.1  People with mental ill-health are more likely to be unemployed or not in the labour force\textsuperscript{a} ...

... and, if they are employed, they are likely to earn lower wages\textsuperscript{a,b}

\textsuperscript{a} A mental component summary (MCS) score below 40 can be considered indicative of a mental illness (Kiely and Butterworth 2015). \textsuperscript{b} The hourly wage is calculated as current weekly gross wage across all jobs divided by hours per week usually worked across all jobs.

Source: Housing, Income and Labour Dynamics in Australia, wave 18.
In addition to mental health, there are a range of other human capital and sociodemographic factors that are likely to affect an individual’s labour force status and the wages they can expect. These include age, gender, education, marital status, work history, language and cultural background, geographical location and family composition (Cai 2010; Forbes, Barker and Turner 2010; Frijters, Johnston and Shields 2014).

**Reverse causality is a problem**

While the correlation between mental health and labour market outcomes is clear, it can be difficult to demonstrate the causal effects of mental health on labour market outcomes — mental health not only influences people’s ability to work, but their experiences at work can also influence their mental health. This is known as a ‘reverse causality’ or ‘endogeneity’ problem.

The model used in this analysis draws on the work by Frijters et al. (2014), who studied the effects of mental health on employment using an instrumental variable model (box J.1). They addressed the problem of reverse causality between employment and mental health by using ‘the death of a close friend in the last 3 years’ as an instrumental variable to control for the endogeneity between employment status, wages and mental health.

**Box J.1 What is an instrumental variable?**

Suppose we have a dependent variable Y and an independent variable X, where there is likely to be two-way correlation or reverse causality. It is not possible to establish the size of the effect of X on Y using standard regression approaches. Instrumental variables are an econometric method that can be used to resolve problems of reverse causality.

An instrument, Z, is a variable that is correlated with X, and correlated with Y — but only through its effect on X. In other words, the instrument should change X and only change Y through its effect on X, allowing for the identification of a causal effect.

For example, suppose that we are interested in the effect of hours of attendance at a tutoring program (X) on grades (Y). The relationship between these two are likely to exhibit reverse causality — more hours at the tutoring program is likely to lead to higher grades, and students with higher grades may attend for more hours. A potential instrument for the tutoring program could be proximity to the tutoring program (Z), which can be argued to affect the hours of attendance (X) directly, and to only affect grades (Y) through its effect on hours of attendance (X).

The choice of the instrument, Z, is crucial as it is up to the researcher to argue that the instrument affects X, but is only correlated with Y through its effect on X.
This ‘death of a close friend’ instrument is found to be correlated with mental health, but independent of labour market outcomes. A literature review conducted by Frijters et al. (2014) found that stressful life events can have substantial effects on mental health and can increase symptoms of depression. Data from the Housing, Income and Labour Dynamics in Australia (HILDA) survey supports these findings — people who have experienced the death of a close friend in the past 3 years are more likely to be in the left-tail of the distribution of mental health scores (figure J.2).

Frijters et al. (2014) also argued that the use of ‘death of a close friend’ as an instrument is more appropriate than using the ‘death of a relative’ or the ‘death of a spouse or child’. The authors suggest that it is conceivable that a person will take time off work to look after a terminally-ill parent or their spouse/child after these events, whereas it is less likely in the case of a terminally-ill friend.

Establishing the effect of mental health on wages and QALYs using an instrumental variable approach involves four stages.

The first stage involves establishing the relationship between the ‘death of a friend’ variable and mental health by estimating the linear regression:

\[
MH = \alpha_1 + X_1\gamma + \delta \times \text{Death of friend} + \epsilon_1
\]  

where MH represents a measure of mental health, \(\alpha_1\) is the parameter for the intercept, \(X_1\) is a matrix of independent variables, \(\gamma\) is a vector of parameters, \(\text{Death of friend}\) is the instrumental variable (a dummy variable indicating whether a close friend has died in the
last three months; 1=yes, 0=no), $\delta$ is the parameter associated with the instrument, and $\varepsilon_1$ is a vector of independently and identically normally distributed random variables with variance $\sigma_1^2$. Where statistically significant, the parameter $\delta$ denotes the relationship between the death of a friend and mental health.

The results of the first stage equation are used in several ways. The residuals are used in the second stage regression (multinomial logistic regression for employment outcomes) as part of a control function approach, and the fitted values are used in the third stage wage regression (linear regression) and the QALY regression (linear regression) as part of a two-stage least squares approach.

**Mental health and employment**

The second stage equation is a multinomial logistic regression, that controls for the endogenous variable (mental health) by including the residuals from the first stage as an explanatory variable. $L$ is a categorical variable for labour force status, where the model assumes that people can either be employed full-time, employed part-time, unemployed, or not in the labour force.

$$L = \text{Multinomial Logistic}(\alpha_2 + X_2\beta + \tau \times \text{MH} + \phi\hat{\varepsilon}_1)$$

where $\alpha_2$ is the parameter for the intercept, $X_2$ is a matrix of independent variables, $\beta$ is a vector of parameters, $\tau$ is the parameter associated with MH, $\hat{\varepsilon}_1 = \text{MH} - \bar{\text{MH}}$, which is the vector of residuals from the first stage equation, and $\phi$ is the parameter associated with the first stage residual. Because there are four categories, three sets of coefficients are estimated.

The predicted probability of each labour force status can be estimated using the results of this regression. Let $\hat{p}$ be the predicted probability of employment (summing up the predicted probability of working full-time or part-time) and $\hat{q}$ be the probability of not being employed (summing up the predicted probability of being unemployed or not in the labour force).

**Mental health and wages**

The third stage involves estimating a wage equation that seeks to explain the expected wage rate for each individual given their characteristics. Because wages are only observed for people who choose to work, this means that there is likely to be bias in the estimation procedure because those who are not employed are likely to be systematically different to those who are employed. For example, those that are not employed tend to have lower levels of education, a greater incidence of chronic illness and a longer experience of unemployment. Human capital theory suggests that, given their characteristics, these people would be expected to be less productive on average if they were employed than people who are currently working, and, as a result, earn lower wages.
One way to control for the bias is to use a control function approach (the Heckman correction is a prominent example of this). A third order polynomial is constructed from the predicted probability of not being employed ($\hat{q}$) from the second stage equation, taking into account the possibility of full-time and part-time employment. The polynomial is then included as additional predictors in the wage equation, alongside the fitted value of the measure of mental health from the first stage equation that controls for the endogeneity between wages and mental health.

$$\log(\text{Wage}) = \alpha_3 + X_3\theta + f(\hat{q})\theta_{CF} + \xi \times \text{MH} + \varepsilon_3$$ \hspace{1cm} [3]

where $\alpha_3$ is the parameter for the intercept, $X_3$ is a matrix of independent variables, $\theta$ is a vector of parameters, $f(\hat{q})$ is a third order polynomial constructed from the fitted probability of not being employed from the second stage, $\theta_{CF}$ is a vector of parameter associated with the probabilities of not being employed, $\xi$ is the parameter associated with the fitted value of the measure of mental health, and $\varepsilon_3$ is a vector of independently and identically normally distributed random variables with variance $\sigma_3^2$. The variable used for the exclusion restriction is unemployment history (the proportion of time spent unemployed since leaving full-time education) — that is, it is included in $X_2$ but not $X_3$.

### Mental health and quality-adjusted life years

The fourth stage of the model estimates the relationship between QALYs and mental health. Using the fitted values of the measure of mental health from the first stage equation, QALYs are regressed on mental health and other characteristics.

$$\text{QALY} = \alpha_4 + X_4\zeta + \kappa \times \text{MH} + \varepsilon_4$$ \hspace{1cm} [4]

where $\alpha_4$ is the parameter for the intercept, $X_4$ is a matrix of independent variables, $\zeta$ is a vector of parameters, $\kappa$ is the parameter associated with the fitted value of the measure of mental health, and $\varepsilon_4$ is a vector of independently and identically normally distributed random variables with variance $\sigma_4^2$.

### Unobserved heterogeneity

Another factor to consider is the unobserved heterogeneity (differences) across individuals. With linear models, this is commonly dealt with by including individual fixed effects within the model. However, with non-linear models (such as the multinominal logit model used here), the inclusion of individual-specific fixed effects typically leads to the incidental parameters problem (whereby the large number of additional parameters included biases the estimates of the covariance used in estimation). One way of dealing with this in non-linear models is to use conditional maximum likelihood estimation. However, a drawback with this approach is that the unconditional predicted probabilities cannot be recovered, which are important to the analysis.
A Chamberlain-Mundlak correlated random effects approach is used to account for individual heterogeneity. This requires a stronger set of assumptions than the individual fixed effects model regarding idiosyncratic shocks and unobserved individual heterogeneity. However, it affords considerable flexibility and allows for the identification of average partial effects and unconditional predicted probabilities (Wooldridge 2019).

**Bayesian methods**

Traditional, or frequentist, approaches to statistical inference typically calculate single ‘point’ estimates for each population parameter and the corresponding confidence intervals. Frequentist approaches assume that there are a ‘true’ set of underlying population parameters, and then construct an estimator, with errors resulting from finite sampling. Conclusions driven by a frequentist interpretation usually have a true/false conclusion resulting from statistical methods for testing hypotheses (Wagenmakers et al. 2008). As such, the probability assertions made under a frequentist approach are pre-sample. For example, a 95% confidence interval contains the true parameter value with a probability of 0.95 only before observing the data — after observing the data, the probability is either zero or one. However, confidence intervals are often incorrectly interpreted by many as a guide to post-sample uncertainty (Hoekstra et al. 2014).

Bayesian inference treats everything as random before it is observed, and everything observed as no longer random. Unobserved parameters can be therefore be constructed as probabilistic statements that are conditional on observed data. This is one of the distinguishing features of a Bayesian approach. Bayesian inference attempts to assign probabilities to different sets of parameters, given a higher weight if they are more likely to lead to the observed data (McElreath 2019). Prior probability distributions are first specified and are then updated with information arising from the data, given the assumed model structure. The resultant probability distribution (the posterior probability distribution) can be interpreted as the distribution of possible values that a parameter can take.

For this analysis, there is not likely to exist a single ‘true’ value quantifying the benefits of the reforms recommended. As a result, Bayesian inference is used to evaluate the outcomes for many different scenarios and to assign probabilities to the likelihood of occurrence. The end product is a distribution of potential benefits and their associated credibility intervals (for example, ‘for reform X, there is a Y% chance that the labour force benefits will exceed $Z million’).

To allow the analysis to be informed by the data, diffuse priors are used for the parameters in the model — that is, prior distributions with relatively large variances. The priors for the regression coefficients are that they are have a Normal (0, 10) distribution and that the standard deviations have an Inverse Gamma (0.5, 5) distribution.
How should parameter estimates be interpreted?

The posterior distributions from a Bayesian--estimated model are often simplified for presentation using summary statistics. The uncertainty associated with parameter values is often reported using the 5th and 95th percentiles of the posterior distribution — sometimes as a shaded area, sometimes as lines that indicate ranges. This can be interpreted as saying, ‘there is a 90% chance that the true parameter value lies in this range’.

J.2 Housing, Income and Labour Dynamics in Australia

The HILDA survey is a nationally representative household panel survey, conducted annually and contains information from respondents on a range of different areas including education, health, labour force status, and demography. As of May 2020, there were eighteen waves of data available, all but the first are used in the analysis undertaken here.20

Following Frijters et. al. (2014), the analysis is focused on the Australian population aged between 21–64 years. Summary statistics for individual level characteristics are presented in table J.1. Mental health is measured using the mental component summary (box J.2).

20 The first wave of HILDA does not include the instrumental variable.
Table J.1  **Sample means of key variables**\(^{a,b}\)

<table>
<thead>
<tr>
<th>Category</th>
<th>All respondents</th>
<th>MCS ≤ 40</th>
<th>MCS &gt; 40</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>0.826</td>
<td>0.654</td>
<td>0.857</td>
</tr>
<tr>
<td>Full-time employment</td>
<td>0.606</td>
<td>0.444</td>
<td>0.634</td>
</tr>
<tr>
<td>Part-time employment</td>
<td>0.221</td>
<td>0.211</td>
<td>0.222</td>
</tr>
<tr>
<td>Unemployed</td>
<td>0.033</td>
<td>0.062</td>
<td>0.028</td>
</tr>
<tr>
<td>Not in the labour force</td>
<td>0.141</td>
<td>0.283</td>
<td>0.116</td>
</tr>
<tr>
<td>Unemployment history</td>
<td>0.043</td>
<td>0.072</td>
<td>0.038</td>
</tr>
<tr>
<td>Mental component summary (MCS)</td>
<td>50.498</td>
<td>32.287</td>
<td>53.694</td>
</tr>
<tr>
<td>Physical component summary (PCS)</td>
<td>51.816</td>
<td>42.163</td>
<td>53.509</td>
</tr>
<tr>
<td>Utility weight (quality-adjusted life years)</td>
<td>0.683</td>
<td>0.347</td>
<td>0.742</td>
</tr>
<tr>
<td>Female</td>
<td>0.513</td>
<td>0.583</td>
<td>0.501</td>
</tr>
<tr>
<td>Age (single-year)</td>
<td>40.290</td>
<td>39.860</td>
<td>40.370</td>
</tr>
<tr>
<td>Highest qualification – University degree</td>
<td>0.318</td>
<td>0.259</td>
<td>0.329</td>
</tr>
<tr>
<td>Highest qualification – Diploma/certificate</td>
<td>0.327</td>
<td>0.331</td>
<td>0.326</td>
</tr>
<tr>
<td>Highest qualification – Year 12</td>
<td>0.158</td>
<td>0.164</td>
<td>0.157</td>
</tr>
<tr>
<td>Married</td>
<td>0.688</td>
<td>0.561</td>
<td>0.711</td>
</tr>
<tr>
<td>Divorced</td>
<td>0.089</td>
<td>0.148</td>
<td>0.079</td>
</tr>
<tr>
<td>Lives in regional area</td>
<td>0.295</td>
<td>0.304</td>
<td>0.294</td>
</tr>
<tr>
<td>Aboriginal or Torres Strait Islander</td>
<td>0.020</td>
<td>0.032</td>
<td>0.018</td>
</tr>
<tr>
<td>Non-English speaking background</td>
<td>0.170</td>
<td>0.155</td>
<td>0.173</td>
</tr>
<tr>
<td>Currently studying</td>
<td>0.045</td>
<td>0.049</td>
<td>0.044</td>
</tr>
<tr>
<td>Number of children between ages 0–4 years</td>
<td>0.229</td>
<td>0.203</td>
<td>0.233</td>
</tr>
<tr>
<td>Number of children between ages 5–14 years</td>
<td>0.415</td>
<td>0.403</td>
<td>0.417</td>
</tr>
<tr>
<td>Number of children between ages 15–24 years</td>
<td>0.305</td>
<td>0.310</td>
<td>0.304</td>
</tr>
<tr>
<td>Many friends</td>
<td>4.422</td>
<td>3.644</td>
<td>4.559</td>
</tr>
<tr>
<td>Death of a close friend in the past 3 years</td>
<td>0.167</td>
<td>0.209</td>
<td>0.159</td>
</tr>
<tr>
<td>Sample size</td>
<td>127 886</td>
<td>19 321</td>
<td>108 565</td>
</tr>
</tbody>
</table>

\(^{a}\) A mental component summary (MCS) score below 40 is considered indicative of mental illness (Kiely and Butterworth 2015). ‘Unemployment history’ is defined as the proportion of time a person has been unemployed since finishing full-time education. ‘Many friends’ is a value between 1–7 based on participants response to the question ‘I seem to have a lot of friends’, where 7 represents strongly agree and 1 represents strongly disagree. \(^{b}\) Waves 2 to 18 of HILDA are pooled for estimation.

*Source:* Housing, Income and Labour Dynamics in Australia, waves 2–18.
Box J.2  Measuring mental health using the mental component summary

The measure of mental health used for this analysis is called the mental component summary (MCS). The MCS is derived from responses to the Short Form 36 (SF-36) questionnaire, and transformed into a range from 0 to 100, with a mean of 50 and standard deviation of 10, with higher scores corresponding to better mental health (Ware and Kosinski 2001). The SF-36 is reflective of a range of health indicators over the preceding four weeks.

While the SF-36 does not include references to symptoms of specific diseases, the measures derived from it have been shown to be highly correlated with the frequency and severity of many health problems. The SF-36 is comprised of 36 questions relating to different aspects of an individual’s health-related quality of life. The 36 questions are used to derive eight subscales of health, each ranging from 0 to 100, that measure different elements of health: physical functioning; limitations in carrying out usual role due to physical problems; bodily pain; perception of general health; vitality; social functioning; limitations in carrying out usual role due to emotional problems; and mental health. The physical and mental health summary measures are produced by aggregating the most correlated of the subscales.

To check the validity of the MCS as a measure of mental health, the distribution of the MCS of people who have been previously diagnosed with long-term depression are compared with the corresponding distribution for those who have not been diagnosed with long-term depression (where long-term is defined as lasting or expected to last for at least six months). The figure below suggests that the MCS is strongly correlated with the diagnosis of depression, where people with lower MCS scores much more likely to have been diagnosed with depression.

While the draft report used an uncorrelated (orthogonal) factor solution to calculate the factor loadings to compute the PCS and MCS, the estimates presented here use a correlated (oblique) factor solution, as suggested by an expert roundtable.

Source: Ware and Kosinski (2001); Housing, Income and Labour Dynamics in Australia, wave 17.
**Health-related quality of life**

Health-related quality of life is measured in terms of QALYs. A QALY is the arithmetic product of life expectancy combined with a measure of the quality of life-years — as shown be a healthy utility weight — remaining. The time a person is likely to spend in a particular state of health is weighted by a utility weight, derived from the SF-6D instrument (Norman et al. 2014). A utility weight value of 1 indicates perfect health, while a health utility weight of 0 is conceptually equivalent to death. Certain health states can be assigned a negative value as they may be characterised by severe disability and/or pain that are regarded as worse than death (Whitehead and Ali 2010). In HILDA, the distribution of QALYs is left-skewed, with the majority of people having between 0.6–0.8 QALYs. (figure J.3).

If an intervention provided perfect health for one additional year, it would produce one QALY. Likewise, an intervention providing an extra two years of life at a health status of 0.5 would equal one QALY.

![Figure J.3](source: Housing, Income and Labour Dynamics in Australia, waves 2–18)

**Estimating parameters**

Before estimating the model, continuous variables are rescaled so that the posterior distributions can be estimated more efficiently. In most cases, this involves normalising the variables to zero mean with a unit standard deviation. Some variables are categorical variables that need to be interpreted relative to a baseline (table J.2).
Table J.2  **Categorical variables — baseline**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Relative to:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Multiple categories</strong></td>
<td></td>
</tr>
<tr>
<td>Age 21–24 years, Age 25–44 years</td>
<td>Age 45–64 years</td>
</tr>
<tr>
<td>Vic, Qld, SA, WA, Tas, NT, ACT</td>
<td>NSW</td>
</tr>
<tr>
<td>University degree, Diploma/certificate, High school</td>
<td>Did not graduate high school</td>
</tr>
<tr>
<td><strong>Binary categories</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>Married/de facto</td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td></td>
</tr>
<tr>
<td>Lives in a regional area</td>
<td></td>
</tr>
<tr>
<td>Aboriginal and Torres Strait islander</td>
<td></td>
</tr>
<tr>
<td>Non-English speaking background (NESB)</td>
<td></td>
</tr>
<tr>
<td>Currently studying</td>
<td></td>
</tr>
<tr>
<td>Death of a friend in the past 3 years</td>
<td></td>
</tr>
</tbody>
</table>

The Productivity Commission used the statistical package Stan (Carpenter et al. 2017) through an interface to the R programming language to rescale the posterior distributions.

For all but the simplest cases, there is no mathematical equation that defines the posterior distribution — this means that it needs to be estimated empirically. This estimation can be computationally difficult. Indeed it has only been possible to estimate complicated models in recent years, as computing power has increased. Stan uses an algorithm called Hamiltonian Monte Carlo to explore and sample from the posterior probability distribution. Statistical inference about the posterior distribution is conducted using these samples.
### J.3 Parameter estimates

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>SD</th>
<th>5th percentile</th>
<th>Median</th>
<th>95th percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 21–24 years</td>
<td>-0.112</td>
<td>0.011</td>
<td>-0.130</td>
<td>-0.112</td>
<td>-0.093</td>
</tr>
<tr>
<td>Age 25–44 years</td>
<td>-0.107</td>
<td>0.007</td>
<td>-0.119</td>
<td>-0.107</td>
<td>-0.096</td>
</tr>
<tr>
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<td>0.006</td>
<td>-0.049</td>
<td>-0.038</td>
<td>-0.028</td>
</tr>
<tr>
<td>Diploma/certificate</td>
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<td>0.006</td>
<td>-0.014</td>
<td>-0.004</td>
<td>0.005</td>
</tr>
<tr>
<td>High school graduate</td>
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<td>0.007</td>
<td>-0.029</td>
<td>-0.018</td>
<td>-0.006</td>
</tr>
<tr>
<td>Married/de facto</td>
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<td>0.189</td>
<td>0.199</td>
</tr>
<tr>
<td>Divorced</td>
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<td>0.009</td>
<td>0.022</td>
<td>0.036</td>
<td>0.049</td>
</tr>
<tr>
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<td>-0.046</td>
<td>0.005</td>
<td>-0.054</td>
<td>-0.046</td>
<td>-0.038</td>
</tr>
<tr>
<td>Qld</td>
<td>0.022</td>
<td>0.006</td>
<td>0.012</td>
<td>0.022</td>
<td>0.031</td>
</tr>
<tr>
<td>SA</td>
<td>-0.027</td>
<td>0.008</td>
<td>-0.040</td>
<td>-0.027</td>
<td>-0.012</td>
</tr>
<tr>
<td>WA</td>
<td>-0.011</td>
<td>0.007</td>
<td>-0.023</td>
<td>-0.011</td>
<td>0.001</td>
</tr>
<tr>
<td>Tas</td>
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<td>0.014</td>
<td>-0.031</td>
<td>-0.006</td>
<td>0.017</td>
</tr>
<tr>
<td>NT</td>
<td>-0.037</td>
<td>0.022</td>
<td>-0.073</td>
<td>-0.036</td>
<td>-0.001</td>
</tr>
<tr>
<td>ACT</td>
<td>0.006</td>
<td>0.015</td>
<td>-0.017</td>
<td>0.006</td>
<td>0.030</td>
</tr>
<tr>
<td>NESB</td>
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<td>0.065</td>
<td>0.074</td>
<td>0.083</td>
</tr>
<tr>
<td>Currently studying</td>
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<td>0.010</td>
<td>-0.079</td>
<td>-0.062</td>
<td>-0.045</td>
</tr>
<tr>
<td>Lives in a regional area</td>
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<td>0.005</td>
<td>0.030</td>
<td>0.038</td>
<td>0.046</td>
</tr>
<tr>
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<td>-0.057</td>
<td>-0.033</td>
</tr>
<tr>
<td>Unemployment history</td>
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<td>-0.020</td>
<td>-0.017</td>
</tr>
<tr>
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</tr>
<tr>
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<td>0.593</td>
<td>0.596</td>
<td>0.600</td>
</tr>
<tr>
<td>Children 0–4 years</td>
<td>-0.021</td>
<td>0.003</td>
<td>-0.026</td>
<td>-0.021</td>
<td>-0.016</td>
</tr>
<tr>
<td>Children 5–14 years</td>
<td>-0.031</td>
<td>0.004</td>
<td>-0.037</td>
<td>-0.031</td>
<td>-0.024</td>
</tr>
<tr>
<td>Children 15–24 years</td>
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<td>0.003</td>
<td>-0.031</td>
<td>-0.025</td>
<td>-0.019</td>
</tr>
<tr>
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<td>0.109</td>
<td>0.003</td>
<td>0.105</td>
<td>0.109</td>
<td>0.114</td>
</tr>
<tr>
<td>Female</td>
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<td>0.004</td>
<td>-0.100</td>
<td>-0.092</td>
<td>-0.085</td>
</tr>
<tr>
<td>Death of a friend</td>
<td>-0.058</td>
<td>0.005</td>
<td>-0.067</td>
<td>-0.058</td>
<td>-0.049</td>
</tr>
</tbody>
</table>

*a* Year-specific fixed effects are included in the model, but not shown here. *b* The covariates and outcome variable were standardised prior to estimation.

*Source:* Productivity Commission estimates using Housing, Income and Labour Dynamics in Australia.
<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>SD</th>
<th>5th percentile</th>
<th>Median</th>
<th>95th percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 21–24 years</td>
<td>0.035</td>
<td>0.007</td>
<td>0.024</td>
<td>0.035</td>
<td>0.048</td>
</tr>
<tr>
<td>Age 25–44 years</td>
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<td>0.053</td>
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<td>0.066</td>
</tr>
<tr>
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<td>0.101</td>
<td>0.106</td>
</tr>
<tr>
<td>High school graduate</td>
<td>0.103</td>
<td>0.004</td>
<td>0.097</td>
<td>0.103</td>
<td>0.109</td>
</tr>
<tr>
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<td>0.003</td>
<td>0.065</td>
<td>0.069</td>
<td>0.075</td>
</tr>
<tr>
<td>Divorced</td>
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<td>0.005</td>
<td>0.028</td>
<td>0.036</td>
<td>0.043</td>
</tr>
<tr>
<td>Vic</td>
<td>-0.029</td>
<td>0.003</td>
<td>-0.034</td>
<td>-0.029</td>
<td>-0.025</td>
</tr>
<tr>
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<td>-0.027</td>
<td>-0.022</td>
<td>-0.017</td>
</tr>
<tr>
<td>SA</td>
<td>-0.052</td>
<td>0.004</td>
<td>-0.059</td>
<td>-0.052</td>
<td>-0.045</td>
</tr>
<tr>
<td>WA</td>
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<td>0.028</td>
<td>0.034</td>
<td>0.040</td>
</tr>
<tr>
<td>Tas</td>
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<td>0.007</td>
<td>-0.040</td>
<td>-0.028</td>
<td>-0.016</td>
</tr>
<tr>
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<td>0.018</td>
<td>0.034</td>
<td>0.052</td>
</tr>
<tr>
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<td>0.007</td>
<td>0.088</td>
<td>0.100</td>
<td>0.112</td>
</tr>
<tr>
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<td>-0.072</td>
<td>-0.067</td>
<td>-0.062</td>
</tr>
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<td>0.010</td>
<td>0.020</td>
</tr>
<tr>
<td>Lives in a regional area</td>
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<td>-0.063</td>
<td>-0.059</td>
<td>-0.055</td>
</tr>
<tr>
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<td>0.043</td>
<td>0.055</td>
</tr>
<tr>
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<td>0.010</td>
<td>0.220</td>
<td>0.236</td>
<td>0.253</td>
</tr>
<tr>
<td>Experience squared</td>
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<td>0.009</td>
<td>-0.102</td>
<td>-0.088</td>
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</tr>
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<td>0.002</td>
<td>0.019</td>
<td>0.022</td>
<td>0.024</td>
</tr>
<tr>
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<td>0.002</td>
<td>-0.006</td>
<td>-0.003</td>
<td>-0.001</td>
</tr>
<tr>
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<td>-0.075</td>
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<td>-0.067</td>
</tr>
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<td>0.009</td>
<td>0.012</td>
</tr>
</tbody>
</table>

*a* Year-specific fixed effects are included in the model, but not shown here. *b* The covariates and outcome variable were standardised prior to estimation.

*Source:* Productivity Commission estimates using Housing, Income and Labour Dynamics in Australia.
Table J.5  Parameter estimates — QALY equation\textsuperscript{a,b}

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>SD</th>
<th>5\textsuperscript{th} percentile</th>
<th>Median</th>
<th>95\textsuperscript{th} percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 21–24 years</td>
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<td>0.013</td>
<td>0.013</td>
<td>0.033</td>
<td>0.056</td>
</tr>
<tr>
<td>Age 25–44 years</td>
<td>0.014</td>
<td>0.010</td>
<td>-0.002</td>
<td>0.014</td>
<td>0.032</td>
</tr>
<tr>
<td>University degree</td>
<td>0.018</td>
<td>0.006</td>
<td>0.008</td>
<td>0.018</td>
<td>0.028</td>
</tr>
<tr>
<td>Diploma/certificate</td>
<td>0.008</td>
<td>0.005</td>
<td>0.000</td>
<td>0.008</td>
<td>0.016</td>
</tr>
<tr>
<td>High school graduate</td>
<td>0.014</td>
<td>0.006</td>
<td>0.004</td>
<td>0.014</td>
<td>0.024</td>
</tr>
<tr>
<td>Married</td>
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<td>0.016</td>
<td>-0.056</td>
<td>-0.028</td>
<td>-0.005</td>
</tr>
<tr>
<td>Divorced</td>
<td>-0.020</td>
<td>0.007</td>
<td>-0.032</td>
<td>-0.020</td>
<td>-0.009</td>
</tr>
<tr>
<td>Vic</td>
<td>-0.004</td>
<td>0.006</td>
<td>-0.013</td>
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</tr>
<tr>
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<td>-0.020</td>
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<tr>
<td>SA</td>
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<td>0.007</td>
<td>-0.019</td>
<td>-0.008</td>
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<tr>
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<td>0.006</td>
<td>-0.027</td>
<td>-0.018</td>
<td>-0.008</td>
</tr>
<tr>
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<td>0.012</td>
<td>-0.040</td>
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</tr>
<tr>
<td>NT</td>
<td>0.051</td>
<td>0.017</td>
<td>0.021</td>
<td>0.050</td>
<td>0.079</td>
</tr>
<tr>
<td>ACT</td>
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<td>0.005</td>
<td>0.022</td>
</tr>
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<td>-0.010</td>
<td>-0.002</td>
<td>0.006</td>
</tr>
<tr>
<td>Indigenous</td>
<td>-0.003</td>
<td>0.013</td>
<td>-0.024</td>
<td>-0.003</td>
<td>0.018</td>
</tr>
<tr>
<td>Unemployment history</td>
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<td>0.003</td>
<td>-0.011</td>
<td>-0.007</td>
<td>-0.003</td>
</tr>
<tr>
<td>Experience</td>
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<td>0.019</td>
<td>0.007</td>
<td>0.038</td>
<td>0.071</td>
</tr>
<tr>
<td>Experience squared</td>
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<td>0.017</td>
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<td>0.003</td>
<td>0.031</td>
</tr>
<tr>
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<td>0.498</td>
<td>0.584</td>
<td>0.655</td>
</tr>
<tr>
<td>Children 0–4 years</td>
<td>0.007</td>
<td>0.003</td>
<td>0.002</td>
<td>0.007</td>
<td>0.012</td>
</tr>
<tr>
<td>Children 5–14 years</td>
<td>0.004</td>
<td>0.004</td>
<td>-0.002</td>
<td>0.004</td>
<td>0.011</td>
</tr>
<tr>
<td>Children 15–24 years</td>
<td>-0.001</td>
<td>0.003</td>
<td>-0.007</td>
<td>-0.001</td>
<td>0.004</td>
</tr>
<tr>
<td>Many friends</td>
<td>0.001</td>
<td>0.009</td>
<td>-0.014</td>
<td>0.002</td>
<td>0.015</td>
</tr>
<tr>
<td>Female</td>
<td>-0.016</td>
<td>0.008</td>
<td>-0.028</td>
<td>-0.017</td>
<td>-0.002</td>
</tr>
<tr>
<td>MCS</td>
<td>0.448</td>
<td>0.081</td>
<td>0.324</td>
<td>0.443</td>
<td>0.587</td>
</tr>
</tbody>
</table>

\textsuperscript{a} Year fixed effects are included in the model, but not shown here. \textsuperscript{b} The covariates and outcome variable were standardised prior to estimation.

Source: Productivity Commission estimates using Housing, Income and Labour Dynamics in Australia.
J.4 Calculating expected benefits of recommended actions

The econometric results were combined with information from the existing mental health literature that describes the possible effect of policy changes on the mental health of people targeted by a recommended action. This allowed the calculation of estimates of expected changes in employment, wages, and health-related quality of life. Information about the possible effects of the actions, and their associated costs is presented in appendix I.

Given the difficulties in implementing longitudinal models over numerous subpopulations and recommended actions, this analysis considers only the short-term benefits of improved mental health. For example, various actions recommended regarding early childhood and school may ultimately result in long-term improvements in labour market outcomes of the children affected. However, this model only considers the health improvements (in terms of QALYs) that these children experience, and the potential for their parents to have better labour market outcomes in the short term. As a result, the benefits presented here are likely to understate the overall potential benefits of the recommended actions.

The direct economic benefits of improvements in mental health may be thought of as consisting of two elements — increases in income and increases in employment.

The recommended actions are modelled as functions that transform the relevant pre-reform variables into post-reform variables:

$$MCS_i^{post} = f_j(MCS_i^{pre})$$

[5]

where $f_j$ is a function that indicates how the mental health of individual $i$ changes as a result of reform $j$. An individual’s MCS is typically increased by the relevant effect in order to indicate the expected post-reform mental health state of affected individuals.

The increase in employment (which includes both full-time and part-time employment) between pre- and post-reform is given by the expression:

$$\Delta Employed = \sum_i \hat{p}_i(MCS_i^{post}) - \sum_i \hat{p}_i(MCS_i^{pre})$$

[6]

The overall labour market benefits are calculated as the change in expected aggregate income. Changes in aggregate income can come from either a change in wages attributed to changes in mental health or a change in the probability of working full-time or part-time (and the associated average number of hours worked).

$$\Delta Income = \text{Weeks} \times \text{Hours}^{FT} \times$$

$$[\sum_i \text{Wage}_i(MCS_i^{post})\hat{p}_i^{FT}(MCS_i^{post}) - \sum_i \text{Wage}_i(MCS_i^{pre})\hat{p}_i^{FT}(MCS_i^{pre})] +$$

$$\text{Weeks} \times \text{Hours}^{PT} \times$$

$$[\sum_i \text{Wage}_i(MCS_i^{post})\hat{p}_i^{PT}(MCS_i^{post}) - \sum_i \text{Wage}_i(MCS_i^{pre})\hat{p}_i^{PT}(MCS_i^{pre})]$$

[7]
Similarly, interventions with an effect size which affect mental health are assumed to change a person’s MCS score, and change the utility weight used to derive their QALYs, using the parameter estimates from equation [4]. This provides an indication of the change in QALY, given a change in mental health, which can then be summed up over the population for which the intervention is applied to.

\[
\Delta \text{QALY} = \sum_i \text{QALY}_i(MSC_i^\text{post}) - \sum_i \text{QALY}_i(MSC_i^\text{pre})
\]  

[8]

Waves 2–18 of HILDA are used to estimate the parameters of the model following the procedure outlined in section J.1. In constructing the dataset used for the analysis, observations are dropped when an individual has not provided a complete set of responses to the questions used to construct the variables required for estimation. To estimate the benefits of recommendations, the latest wave of HILDA is used as it is expected, with population weights, to more closely reflect the current state of the Australian population.

The Bayesian approach to estimating the relationships between mental health and wages, labour force participation and health-related quality of life (QALYs) produces a distribution over the parameters rather than a single ‘point’ estimate. Using the output from the models described in section J.1 combined with a set of reforms yields a range and distribution of possible expected effects (box J.3). Benefits estimated using this approach are presented in appendix I.

**Box J.3**  
**Interpreting outputs from Bayesian statistical models**

Bayesian methods deliver parameter estimates spanning a range of possible values. The choice of which statistic to present in summarising the outputs requires judgment.

In this work, the median (50th percentile) is preferred as it represents outcomes with a reasonable chance of occurring and is not skewed, as the mean can be as a result of outliers. Uncertainty associated with an estimate is often indicated by presenting values from percentiles at the top and bottom of the span. The value at the 90th percentile, for example, can be interpreted as meaning that ‘there is only a 10% probability that the true parameter value is greater than this figure’. Values between the 5th and 95th percentiles can be interpreted as indicating that ‘there is a 90% chance that the true parameter value lies in this range’. This is sometimes referred to as a **credibility interval**.
References


K Detailed assumptions about benefits and costs

This appendix outlines detailed assumptions used in calculating benefits and costs made in each of the various ‘groups’ of actions for which results are presented in appendix I. This includes a brief description of the recommended actions for which benefits and costs are presented, as well as the key assumptions made in order to quantify these benefits and costs.

In some cases, the beneficial effects of the actions are modelled as the cumulative effect of a number of actions. Where this is the case, there are some actions for which only costs are specified, with the assumptions underlying the effects detailed separately.
K.1 Access to healthcare

Action  Increased psychiatric advice to GPs

The final report recommends that the Australian Government should introduce an Medicare Benefit Schedule (MBS) item for psychiatrists to provide advice to a general practitioner (GP) or a paediatrician over the phone on diagnosis and management issues for a patient who is being managed by the GP or paediatrician.

Costs

The additional time required by psychiatrists, GPs and paediatricians is expected to result in increased costs:

- It is assumed that 10 minutes is spent on each call.
- It is assumed that these changes will lead to an additional 3300-8000 GP and 500-2000 paediatrician calls to psychiatrists. (This is based on the estimated 1050 calls under the NSW Primary Health Network (PHN) GP Psychiatrist Support Line in 2019-20 (chapter 12), scaled up to a national level. In 2019-20, The NSW Support Line covered eight PHNs across New South Wales, constituting about 25% of Australia’s population).
- It is assumed that all calls are bulk billed, and that the MBS rebate paid to psychiatrist per call will be set at $66, using the average fee charged by psychiatrists for a consultation lasting for less than 15 minutes as a benchmark (Productivity Commission estimates based on MBS data).
- The (unreimbursed) cost of GP and paediatrician time is assumed to be $4 per minute (based on MBS fees and average consultation lengths).
- The total cost is estimated to between $400 000 and $1.1 million (2019 dollars).

Additional considerations

- The NSW GP Psychiatrist Support Line is currently costing the commissioning PHNs $500 000 per year in 2019-20, 2020-21 and 2021-22 (Productivity Commission estimate based on Coordinare, pers. comm., 27 May 2020). If these PHNs were to rely on the proposed MBS-funded services beyond this, it is likely that there would be additional cost savings.
- Cost estimates are highly sensitive to assumptions about expected use of this item.
**Action**  
**Encouraging more group psychological therapy**

Changes should be made to MBS rules to encourage more group therapy. This includes allowing group therapy with a smaller number of people and creating new group therapy Medicare items.

**Implementation**

- In 2019, about 7000 people received MBS-rebated group psychological therapy; the average number of sessions was 4.6; the average fee (rebate plus co-payment) was $53 (unpublished MBS data).

- It is assumed that the average fee for a 60 minute session is $53; for a 90 minute session it is $70 and for a 120 minute session it is $90. Existing sessions are assumed to remain at 60 minutes in length, 60% of additional sessions run for 60 minutes, 20% run for 90 minutes, and 20% run for 120 minutes. This implies an average fee per additional session of $64.

- It is very difficult to predict either:
  - the number of people who will receive group therapy as a result of these changes, who would not have received any therapy otherwise. It is assumed between 3000 and 5000 additional people receive therapy.
  - the number of people who will receive group instead of individual therapy as a result of these changes. It is assumed between 5000 and 7000 people receive group therapy.

**Effect**

- It is assumed that the group therapy is as effective as the individual therapy for those already receiving individual services (chapter 12), and improves the mental health of people who were not previously receiving services.

- Format equivalence between group and individual therapy, and an effect size averaging about 0.9 are shown in Burlingame et al. (2016) and Cuijpers et al. (2019). People in these studies tend to receive many more than 4.6 sessions on average. We assume that each additional person accessing therapy get 4.6 sessions on average, and therefore has a 25% chance of getting this effect size, roughly in line with estimates from Lambert et al. (2001) and Howard et al. (1986). The other 75% are assumed to have no improvement. This is estimated to result in an additional 33-61 quality-adjusted life years (QALYs) and $2.8-5.3 million in wages.

**Costs**

- For people who have not used previously accessed services, there is an average cost per person of $293 (4.6 sessions times $64 per session). For 3000 to 5000 people, total cost is estimated to be $900 000 to $1.5 million.

- For people already using services, substituting from individual to group therapy is likely to result in cost savings. In 2019, the average fee charged for individual therapy was $145, so the difference in cost (between individual and group) is assumed to be $81 per session. The cost saving per person switching from individual to group is estimated to be $373 (4.6 sessions times $81 per session). For 5000 to 7000 people, total cost saving is estimated to be $1.9 million to $2.6 million.

**Additional considerations**

The extent to which consumers will choose to access more group therapy after this change in policy is not clear, and cost estimates are highly sensitive to changes in demand. The changes are also likely to lead to an increase in the average number of sessions received.
Action  Increased access to psychiatry and psychological therapy by telehealth

The Australian Government should make permanent the MBS items introduced during the COVID-19 pandemic that allow people across Australia to access certain psychiatric and psychological services by videoconference (and telephone where videoconference is not available). These should replace other telehealth items for psychiatry and psychological services.

Population

- There were about 82,000 psychiatry and about 14,000 psychological telehealth consultations in 2019 (chapter 12). In 2019, roughly a quarter of the population had access to psychiatry by telehealth, and roughly 10% to psychology by telehealth.
- But in March 2020 alone, following the measures introduced in response to the COVID-19 outbreak, there were about 24,000 psychiatry consultations by telehealth, and about 30,000 psychological therapy sessions by telehealth (chapter 12).
- It is very difficult to predict either:
  - the number of psychological therapy and psychiatry consultations that will occur via telehealth instead of face-to-face, because of our changes (we assume 200,000 to 400,000 consultations switch)
  - the number of people that will access psychological therapy who would not have accessed it otherwise, because of our changes (we assume 5,000 to 10,000 people) — we assume that there is no change in the number of people accessing psychiatry, because psychiatrists are supply constrained (chapter 16).

Effect

- For people who are already receiving treatment, it is assumed that telehealth treatment has an equivalent benefit (chapter 12).
- For those who did not access psychological therapy previously, we assume an effect size of 0.8, in line with meta-analyses by Berryhill et al. (2019). People in these studies tend to receive many more than 4.5 sessions on average. We assume that each additional person accessing therapy get 4.5 sessions on average, and therefore has a 25% chance of getting this effect size, roughly in line with estimates from Lambert et al. (2001) and Howard et al. (1986). The other 75% are assumed to have no improvement.
- This is estimated to lead to an increase of between 49-90 QALYs and $4.1-7.9 million in aggregate labour income.

Costs

- People are assumed to save time getting to and from appointments and incidental costs (such as transport costs and lost income). We estimate these cost savings to be between $20–$60 per consultation (based on Anderson et al. 2016). Assuming 200,000 to 400,000 consultations are done via telehealth instead of face-to-face, we estimate the total cost saving to be between $4 million and $24 million.

(continued next page)
Action  Increased access to psychiatry and psychological therapy by telehealth (continued)

- We estimate a cost saving of $7.1 million associated with removing additional rebates paid to psychiatrists for telehealth consultations, assuming no increase in co-payments (chapter 12).

- For people that were not previously receiving any therapy, we assume 4.5 sessions on average and an average fee (rebate plus co-payment) of $145, in line with 2019 averages (unpublished MBS data). This implies a cost per person of $652 (4.5 sessions time $145). Assuming 5000 to 10 000 people in this category, we estimate a total cost of $3.3 million to $6.5 million.

Additional considerations

- It is difficult to estimate the increasing number of people who will choose to access psychological therapy via telehealth. The changes are also likely to lead to an increase in the average number of sessions received, as people find it easier to keep attending sessions if they are able to attend some via telehealth (though we have not accounted for this in our modelling). Given higher use of telehealth in the wake of COVID-19, cost savings from removing additional payments for psychiatrists could also be higher than $7.1 million.
Action  Expanding supported online treatment options

Funding should be expanded for services to accommodate up to 150 000 clients per year for supported online treatment as a lower intensity service for people with high prevalence mental health conditions. As part of this:

- Supported online treatment should have a strong evidence base and be offered to children, youth and adults. Services should cater for demand for services from people of culturally and linguistically diverse backgrounds.
- Funding should provide for information campaigns to increase awareness of the effectiveness, quality and safety of government-funded, supported online therapy.

Population

It is assumed that an additional 50 000 people with a mild mental illness who are not currently accessing treatment will use supported online treatment and 100 000 people will substitute towards supported online treatment from other treatment options.

Effect

- We assume an effect size of 0.8 for online supported treatment based on a meta-analysis by Andrews et al. (2018). People who substitute towards online supported treatment are assumed to have the same outcome as expected previously.
- Increased use of supported online treatments is estimated to result in an additional 1313-2390 QALYs and $108-210 million in aggregate labour income.

Costs

- The cost of reviewing an expansion of online supported treatment is assumed to require 5.4 full-time equivalent (FTE) employees, at a total cost of up to $400 000. This assumes a mix of public sector staff who will spend half a year conducting the review.
- There will be expenditures to run three information campaigns: one for culturally and linguistically diverse people, one for consumers and one for health professionals. Each campaign is assumed to cost $450 000.21
- The cost of providing online supported treatment via MindSpot are between $300-447 per client (Lee et al. 2017; Titov 2020).
- The total program is expected to cost between $47 and $69 million.
- Cost savings from substituting from care-as-usual are estimated to be between $7-22 million, using parameters from Lee et al. (2017).

Additional considerations

- Effect sizes for supported online treatment can be influenced by a range of factors, in particular people’s willingness and capacity to complete all modules of the treatment (adherence). By using a meta study, our results are not conditional on the circumstances or findings of one particular study. Of note, is that the median adherence rate in the meta study is similar to the rates of an Australian supported online treatment course (MindSpot).

(continued next page)
**Action**  Expanding supported online treatment options  

- Labour supply constraints may limit the uptake of online supported treatment.
- We estimate that supported online treatment services could be expanded by 150 000. This estimate are based on prevalence rates of mental illness and current treatment service usage, as well as recognising 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 ability of the sector to expand while maintaining quality treatment for consumers.

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21 A campaign for Head to Health was previously run from December 2018 to May 2019 to help promote Head to Health as a trusted online resource for digital mental health information and services. The budget threshold for that campaign was up to $450k (DoH, pers. comm., 17 January 2020).
Across Australia, State and Territory community ambulatory services fall short of population needs predicted by service planning tools. The final report recommends that Australian governments should increase funding for these services, in line with agreed commitments to rectify service shortfalls over time.

**Population**

- The National Mental Health Service Planning Framework (NMHSPF) provides benchmark estimates of the number of FTEs and costs required to provide the specified service mix of community ambulatory services. Care profiles associated with these service elements are identified, along with their population size. The benchmark number of FTEs required excludes FTEs from top-up care profiles, as these are additional services that are not assigned to a specific population. However, they are still taken into account in the gap analysis in chapter 12.

- It is assumed that the current 'real-world' mix of FTEs and services provided is proportional to the benchmarks for the services delivered to the care profiles in the NMHSPF.

- Data on the number of FTEs currently supplying community ambulatory services are from AIHW (2020c). This is compared against the benchmark estimates of FTEs from the NMHSPF to determine how many additional FTEs would be required to fill this gap for adults and older persons.

**Effect**

Effect sizes for each age group are calculated using data from the Australian Mental Health Outcomes and Classification Network (AMHOCN) for 2017-18 ambulatory services, using differences in the Kessler Psychological Distress Scale (K10+ LM) scores between admission and discharge (AMHOCN 2019). The K10 is highly correlated with the MCS (correlation coefficient of -0.8), meaning that changes in K10 are likely to be consistent with changes in the MCS. It is assumed that the benefits for older people will only consist of QALYs, while for adults, there will also be changes in the likelihood of employment and wages, if they are employed.

**Costs and benefits**

The results are estimated based on the NMHSPF assumption that 67% of clinical staff time is spent on consumer-related activity. However, the Productivity Commission estimates that in practice, only 29% of time is spent on consumer-related activity (chapter 12). An additional adjustment is added on top of the recurrent costs to cover capital costs (Rosenheck, Frisman and Neale 1994).

(continued next page)
Action  | State and Territory community ambulatory services (continued)

<table>
<thead>
<tr>
<th></th>
<th>Child &amp; adolescent (age less than 18)</th>
<th>Adults (age 18-64)</th>
<th>Older persons (age 65+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effect size for ambulatory services</td>
<td>na</td>
<td>0.91</td>
<td>0.96</td>
</tr>
<tr>
<td>Marginal cost per FTE</td>
<td>$156 118</td>
<td>$167 214</td>
<td>$170 139</td>
</tr>
</tbody>
</table>

Assuming 67% of clinical staff time spent on consumer-related activities

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of FTEs required to fill gap</td>
<td>1 063</td>
<td>1 271</td>
<td>1 118</td>
</tr>
<tr>
<td>Cost to fill gap</td>
<td>$165 million</td>
<td>$212 million</td>
<td>$190 million</td>
</tr>
<tr>
<td>Change in QALYs per additional FTE</td>
<td>na</td>
<td>2.02-3.68</td>
<td>2.71-4.94</td>
</tr>
<tr>
<td>Change in income per additional FTE</td>
<td>—</td>
<td>$157 390-304 486</td>
<td>—</td>
</tr>
</tbody>
</table>

Assuming 29% of clinical staff time spent on consumer-related activities

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of FTEs required to fill gap</td>
<td>5 233</td>
<td>12 453</td>
<td>3 567</td>
</tr>
<tr>
<td>Cost to fill gap</td>
<td>$817 million</td>
<td>$2.082 billion</td>
<td>$607 million</td>
</tr>
<tr>
<td>Change in QALYs per additional FTE</td>
<td>na</td>
<td>0.87-1.59</td>
<td>1.17-2.14</td>
</tr>
<tr>
<td>Change in income per additional FTE</td>
<td>—</td>
<td>$67 617-131 725</td>
<td>—</td>
</tr>
</tbody>
</table>

Assuming that 67% of clinical staff time is spent on consumer-related activity, if the FTE gap were to be completely filled for adults and older persons services, the costs are expected to be about $403 million. The benefits are estimated to be between $200-387 million in additional income and 5598-10 193 QALYs.

Additionally, 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 QALYs (not including benefits to children and adolescents), and an additional $650 million to $1.25 billion in income.

Additional considerations

- The benefits here are estimated assuming that the effects from treatment only persist for a single year. This can be seen as a conservative approach and may underestimate the true benefits from treatment, if the benefits were ongoing.
- It was not possible to estimate possible benefits to children and adolescents from increased access to community ambulatory care.
- The estimates of the workforce gap is based on the service mix set out in the NMHSPF. As the mental health system continues to evolve over time, the service mix will change to reflect the services that are being provided. In other words, what is perceived as optimal today is not likely to be optimal in the future.

(continued next page)
There are many types of community ambulatory services, but data from the AMHOCN which was used to calculate the effect sizes only contain a broad grouping for service settings described as ambulatory, which include ‘all other types of care provided to consumers of a public sector specialised community-based ambulatory mental health service’. This can hide the heterogeneity between the effectiveness of different types of community ambulatory services, as the analysis only focuses on the average effect across all community ambulatory services. For example, it could be the case that a particular type of community ambulatory service is more cost effective.

The calculation of benefits captures only direct benefits to consumers, and does not capture the broader or longer-term benefits that may arise from community ambulatory staff spending time on non-consumer-related activities, such as research or training.

In the AMHOCN, a ‘discharge’ collection occasion does not necessarily mean the person has entered recovery, rather it is an indicator that the episode of care has ended. For example, an ambulatory episode of care may end when a person is admitted to a hospital. However, based on the change in psychological distress scores between admission and discharge, it appears likely that most people who have been discharged have recovered.
**Action**  Bed-based services

Across Australia, non-acute bed-based services fall short of population needs predicted by service planning tools. The final report recommends that Australian governments should increase funding for these services, in line with agreed commitments to rectify service shortfalls over time.

**Implementation**

- There are two ways in which supplying an additional non-acute bed can be assumed to improve outcomes. An additional non-acute bed can either:
  - free up an acute hospital bed in cases where people in hospital beds are experiencing delayed discharge, allowing more acute patients to be treated
  - be used to treat additional non-acute patients who were not being treated previously.

- It is assumed that people who are experiencing delayed discharge will have the same outcomes when treated in a non-acute bed.

- Occupancy rates and average length of stay are based on inputs from the University of Queensland (2016) and AIHW (2020b), which together provide an indication of the number of additional patients who could be treated per additional bed provided.

- Using the NMHSPF, a ‘gap’ in the supply of non-acute beds is estimated (chapter 13).

**Costs and benefits**

Cost per bed were estimated using data on the recurrent cost per day from SCRGSP (2020c). An additional on top of the recurrent costs is made to cover capital costs (Rosenheck, Frisman and Neale 1994).

<table>
<thead>
<tr>
<th>Bed type</th>
<th>Average length of stay (days)</th>
<th>Occupancy rate</th>
<th>Cost per year ($)</th>
<th>Number of separations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long stay, residential</td>
<td>365</td>
<td>100%</td>
<td>236 541</td>
<td>1</td>
</tr>
<tr>
<td>Long stay, hospital</td>
<td>365</td>
<td>100%</td>
<td>398 001</td>
<td>1</td>
</tr>
<tr>
<td>Rehabilitation, residential</td>
<td>120</td>
<td>85%</td>
<td>201 060</td>
<td>2.6</td>
</tr>
<tr>
<td>Step up/step down, residential</td>
<td>14</td>
<td>85%</td>
<td>201 060</td>
<td>22.2</td>
</tr>
<tr>
<td>Acute, hospital</td>
<td>14</td>
<td>85%</td>
<td>—</td>
<td>22.2</td>
</tr>
</tbody>
</table>

**Effect**

Effect sizes for each age group are calculated using K10 scores from the AMHOCN for 2017-18 inpatient and residential services, using the difference between admission and discharge (AMHOCN 2019). It is assumed that the benefits for long stay beds (365 days) will only have QALY benefits. For those utilising rehabilitation and step up/step down beds, income is scaled down based on the time spent in a bed.

(continued next page)
Using the beds to move non-acute patients out of hospital

- Moving non-acute patients out of hospital can reduce the extent of delayed discharge, and allow for more acute patients to be treated. These are patients who could be discharged from hospital if appropriate accommodation or care were available. It is assumed that an additional 1800 residential beds are supplied in the community, and that non-acute patients treated in these settings will have the same outcome as being in hospital.

- For the additional acute patients who are not being treated, it is assumed that about 85% of these patients are of working age (AIHW 2020b) and will have both labour force and QALY benefits, while those not of working age will only receive QALY benefits.

- The average length of stay is assumed to be 14 days (for modelling convenience), with a 28 day readmission rate of 15%, and an occupancy rate of 85%. This implies a 14-day readmission rate of 8%, assuming independence of 14-day periods of recovery. Patients are assumed to have recovered if they are not readmitted within 28 days. These assumptions together suggest that about 28 000 patients can be treated per year.

- The cost of supplying the additional long stay residential beds is estimated to cost about $426 million. The benefits are expected to be between $128-166 million in additional aggregate labour income and an additional 2068-3766 QALYs.

Using the beds to treat non-acute patients who were not being treated

- The analysis is split into supplying additional hospital and residential beds, with a further split of residential beds into older adults and other. It is assumed that the real-world existing mix of non-acute beds is proportional to the mix of non-acute beds specified in the NMHSPF. This allows for a gap to be calculated for each bed type, the number of additional patients who can be treated, and hence the identification of the costs and benefits.

- While the AMHOCN has data on the outcomes for inpatient services in hospitals, the vast majority of the data are for acute episodes, which would not be an appropriate comparison. Instead, it is assumed that the effect size of a long stay hospital bed is half that of community residential services.

(continued next page)

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22 The probability of not being readmitted within 28 days is assumed to be 85%, or alternatively, there is some probability, $p$, such that the person will not be readmitted within 14 days. A person is not readmitted within 28 days if they are not readmitted in either of the 14 day periods. That is, $p$ satisfies $p^{2} = 0.85$, implying $p = 0.922$. Then $1 - p = 0.078$ is the probability of being readmitted within 14 days.
Action  Bed-based services (continued)

Additional considerations

- It would cost about $771 million to supply these additional non-acute beds. The benefits are expected to be between $24-48 in additional income and an additional 425-773 QALYs.

- While the results indicate that reducing the extent of delayed discharge (moving non-acute patients out of acute beds) may be a more cost effective measure in the short run. it is important to ensure that non-acute patients who are not currently treated have access to beds, as these people will usually have no other alternatives in seeking treatment for mental illness. Long stay residential beds are likely to be a more cost effective option compared to long stay hospital beds in the cases where the patient can be provided with a similar level of care.

- While the AMHOCN provides data on outcomes for different collection occasions, it does not provide an indication of the length of time a patient has spent within an episode. These results could be refined — for example, if a residential episode could be further disaggregated by length of stay, it would be possible to have separate effect sizes for long stay residential care and step up/step down care (which currently both use the same residential effect size).
**Action  Alternatives to emergency departments**

State and Territory Governments should provide more alternatives to hospital emergency departments (EDs) for people with acute mental illness.

**Population**

There are people who attend EDs for a mental health-related reason who could have been treated elsewhere. Treating these people elsewhere could lead to better outcomes and cost savings from a reduction in ED presentations. The estimated cost savings arise from two different populations, based on the method of arrival. Those who arrive by ambulance potentially have cost savings from mobile crisis services, while those who arrive via walking, private/public transport, community transport, or taxi could have cost savings from after-hours/peer-led services.

**Costs and cost savings**

- The cost per ED presentation for a serious mental illness is assumed to be $805 (2019 dollars) (IHPA 2017).

- Costs for mobile crisis services include increased expenditures as well as cost savings. It is assumed that, in the first instance, an additional five sites are trialled nationally.
  - For the Mental Health Acute Assessment Team (MHAAT), between 2015 and 2017, about 50% of mental health-related callouts resulted in patients bypassing EDs in favour of more appropriate care (WSLHD 2017), while a pilot trial in Victoria found 75% of attendances were diverted (Barwon Health 2019).
  - Cost data provided by NSW Ambulance suggested a cost of $600 000 per year, covering two ambulance and two mental health FTEs. The trial results indicate that 51.5% of shift time (or 5.7 hours per day) is spent on MHAAT cases, with an average of 3.9 cases per day. Using the proportion of shift time spent working on mental health-related cases as a lower bound on the cost, this suggests a cost between $1.5-3 million, and a cost saving between $2.9-4.3 million (2019 dollars).

- Safe haven cafés
  - An evaluation of the St Vincent’s safe haven café in Melbourne (PwC 2018) found that between 118 and 362 ED presentations could have been avoided per year. From the evaluation, the initial fixed cost was $124 175, and the annual operating costs (which includes wages, overheads, and goods and services) were $191 540 (2018 dollars). It is assumed that the fixed costs are equally spread over 10 years.
  - Establishing five safe haven café trials is estimated to cost $1.1 million. Across the trials, this implies total cost savings of between $470 000 and $1.5 million per year.

**Additional considerations**

- For mobile crisis services, limited service utilisation will limit cost effectiveness. This could be due to time spent waiting for new cases to arrive which are suitable for the team. As such, it is important for any additional sites to be located strategically in areas that historically have had higher rates of mental health-related attendances. It is essential that appropriate locations for diversions be available within the area (e.g., community mental health services). Similar considerations apply to safe haven cafés — the additional sites should located be in areas with higher rates of mental health-related ED attendances.

- These are other unquantifiable benefits, such as avoiding the distress potentially associated with going to an ED.
Action  **Online navigation portal to support referral pathways**
Commissioning agencies should ensure service providers have access to online navigation portal offering information on pathways in the mental health system.

**Effect**
This recommended action supports the implementation and effectiveness of other healthcare actions.

**Costs**
The HealthPathways portal model, which is already used by most PHNs, could be used to contain information on pathways within the mental health system. Increased expenditures will result from establishing portals for the three PHNs that do not already have it, and expanding the portal beyond the health sector to include schools and psychosocial supports, across all regional commissioning authorities.

Initial expenditures of $2.6-4.3 million are required to expand online navigation portals to include non-clinical services, and to establish portals in the three regions not yet covered by HealthPathways.

- **Startup costs** are based on the $282 400 to establish the HealthPathways portal in Mackay (Blythe, Lee and Kularatna 2019).
- **The cost estimates used in this report also take into account that an additional 20% ($1 750 880) and an upper bound estimate of an additional 40% ($3 501 760) may be needed to expand the coverage of portals across all regions.**

Ongoing annual costs are estimated to be about $3.4–5.7 million, and include:

- **the costs of the additional three portals,** based on the ongoing annual cost of $369 400 for the portal in Mackay
- **an additional lower bound estimate of 20% ($2 290 280) and upper bound of 40% ($4 580 560) in ongoing costs to manage the non-clinical content in the portal** (Blythe, Lee and Kularatna 2019).

**Additional considerations**

- These estimates are based on the implementation of HealthPathways in Mackay. Any regional differences in costs (such as wages) are not take into account.

- The Productivity Commission is not recommending that governments adopt any particular model for the online navigation platforms. A navigation platform that is different to HealthPathways is likely to have different costs.

- Additional changes to platforms over time, such as including the ability to make bookings with providers through the platform, will likely increase the cost of the platform, which is not accounted for in these estimates.
Action  Care coordination services and single care plans

Care coordination services and single care plans should be made available to people with severe and persistent mental illness who need them due to their complex health and social needs.

Population

- There are estimated to be about 354,000 people with severe mental illness and complex needs who require a care coordinator.
  - 64,000 of these people have the highest psychosocial needs, and are expected to receive these services from the National Disability Insurance Scheme (NDIS).
  - This leaves about 290,000 people who require a care coordinator.
- There are also 400,000 people who require high-intensity care, and are assumed to require a single care plan. This includes people with:
  - physical and/or substance use comorbidities in addition to their mental illness
  - moderate to severe mental illness who require psychosocial support services due to their mental ill-health, and are not receiving care coordination services (chapter 15).

Effect

These actions are in place to support the implementation and effectiveness of other healthcare actions.

Costs

- The NMHSPF includes a range of care profiles that require care coordination services, with the cost per person ranging from $56 to $1622, depending on the level of services required. It is assumed that people on the NDIS have the highest care coordination cost per person, while those who require a single care plan have the lowest costs. A plausible range of costs of between $475–1217 per person is assumed in estimating total expected care coordination costs. Total care coordination costs for the 290,000 adults requiring care coordination services outside the NDIS are estimated to range between $138–353 million.
- Single care plans are costed on the assumption that a care plan is developed and reviewed each year by a clinician, usually a GP. This is estimated to cost $189.35 per person (MBS Online). It is assumed that between 50% to 80% of people will have their care plan developed and managed by a clinician who will receive these rebates. This suggests a total cost of $38–61 million. Where the care plan is developed and managed by a worker who is not eligible for the MBS, for example, a psychosocial support worker, these activities are assumed to be part of their usual duties, and incurs no additional cost.

Additional considerations

- There is a lack of information about how many people already receive care coordination services or have single care plans outside of the NDIS. The actual number of people who require these services will be less than the estimated 290,000 and 400,000 people assumed. As a result the actual increase in costs will be also be lower than estimated.
- People receiving care coordination services will also require a single care plan. This is assumed to be included in the cost of care coordination services.
- Community ambulatory services include care coordination services. The cost of providing care coordination costs for these people are included in the costing of reforms to community ambulatory services.
K.2 Carers and families

<table>
<thead>
<tr>
<th>Action</th>
<th>Greater support for carers and families within mental healthcare and support services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A range of actions to benefit the carers and families of people with mental illness are presented in chapter 18, including:</td>
</tr>
<tr>
<td></td>
<td>- the promotion of family- and carer-inclusive practices in mental health services</td>
</tr>
<tr>
<td></td>
<td>- improvements to the responsibilities, planning and evaluation of carer and family support services in the community.</td>
</tr>
<tr>
<td></td>
<td>Family- and carer-inclusive practice requires mental health services to consider the needs of family members’ and carers’, and their role in contributing to the recovery of individuals with mental illness. The proposed action includes expanded access to rebated carer and family consultations, as well as increased accountability and capacity within state and territory mental healthcare services.</td>
</tr>
<tr>
<td></td>
<td>Improvements to carer and family support services in the community are assumed to fill unmet needs over time.</td>
</tr>
<tr>
<td></td>
<td>These actions are assumed to benefit carers and families in a single benefit that represents the cumulative effect of these proposed changes.</td>
</tr>
</tbody>
</table>

Population

There were almost 1 million carers of people with mental illness in 2018. Mental illness was the main condition of the care recipient for 414 000 (43%) of these mental health carers (chapter 18). However, not all carers require carer support services or interact with mental health services every year.

There are 96 000 primary carers who co-resided with person whose main condition was mental illness in 2018 (chapter 18) and it is estimated that 57% have unmet needs (table 18.4), suggesting that there are in the order of 55 000 carers who are assumed to benefit.

There are 4.4 million children and adolescents aged 4-17 (ABS 2019a). Of their primary carers, 4.6% reported that mental health problems had interfered with daily activities most or all of the time since the child was born (Johnson et al. 2019). Assuming one child per primary carer with mental health problems, there may be about 201 000 children of parents with mental illness who could benefit.

Costs

*Carer and family consultations without the care recipient present*

Between 6-15% of the people rebated under the MBS to see a psychiatrist, had a related non-patient consultation (unpublished MBS data, AIHW 2019e). If the same proportion was applied to all people using Better Access (1.25 million in 2017-18), between 79 000 and 192 000 additional people would have psychologist (or allied mental health) consultations without the care recipient present. 41% of these people would see clinical psychologists (at a cost of $86.15 per session), with the remainder seeing registered psychologists or other mental health professionals ($61.05 per session).23

23 MBS benefits do not include out of pocket costs, meaning that these costs are likely to be an underestimate.
Greater support for carers and families within mental healthcare and support services (continued)

The annual cost of MBS rebates for carer and family consultations without the care recipient present for psychologists and other allied mental health professionals would be between $9.6-23.3 million (2019 dollars). This is based on the assumption of an average of 1.7 sessions (based on unpublished MBS data).

Carer and family consultations with the care recipient present

Given that the MBS rebates clinical psychologists to provide any evidenced based therapy with the patient present, the cost associated with this action applies to sessions with registered psychologists and other allied mental health professionals, who are limited in the types of interventions they are subsidised to provide. It is assumed that the same proportion of people wanting a non-patient consultation — but excluded from doing so under current arrangements — would want a family and carer consultation with the patient present (6-15%). It might be expected that between 46 000 and 113 000 families would benefit from this action (59% of the population estimated above).

The annual cost of MBS rebates for carer and family consultations with the care recipient present would be between $4.0 and 9.7 million (2019 dollars). It is assumed that the average number of sessions is one (based on the single-session family consultation model, chapter 18) and that the MBS benefit is $86.15.

Family- and carer-inclusive practices in state and territory mental healthcare services

Improving capacity for family- and carer- inclusive practices within state and territory community and inpatient mental healthcare services is expected to require additional dedicated staff, which is estimated to cost between $59.5-68.3 million (2019 dollars).

Support services for carers and families in the community

Costs of providing carer and family support services that meet community need can be estimated using information from the NMHSPF and other cost assumptions. It is estimated that there is a need for an additional $153 million (2019 dollars) worth of these services in 2019-20, including:

- $17.0 million for individual and group based carer peer work delivered by specialised mental health community support services
- $101.6 million for day and flexible respite, and residential crisis and respite services
- $10.1 million for other carer support services
- $24.4 million for family support services.

The Survey of Disability, Ageing and Carers only provides information on the support needs of the subset of carers who are primary carers and reside with their care recipient There were 96 000 co-resident primary carers to someone whose main condition was mental illness in 2018. Of these carers, 55 000 carers (57%) reported unmet needs for support (based on a range of measures reported in table 18.4). Assuming this percentage is proportional to the amount of services required to support all carer and family needs, an approximate estimate of the additional funding needed to meet the unmet mental health needs of families’ and carers’ is $87.3 million per year.

(continued next page)
**Action**  Greater support for carers and families within mental healthcare and support services (continued)

The total costs of providing greater support for carers and families within mental health care and support services is estimated to be between $160 and 189 million (2019 dollars).

**Effects**

The costs outlined above cover a broad range of supports for families and carers. Families and carers who did not previously have access to support that met their needs are expected to benefit. However, the costs are not assessed against the benefits of a particular intervention, but rather, against a more general summary of possible effects on carers, care recipients, and children of parents with mental illness.

**Carers**

An effect size of 0.4 was estimated by combining effects from a selection of studies.

- Farhall et al. (2020) found that a family education program for carers of adults with serious mental illness has a mental health effect size of 0.3 for carers. This was based on the change in the total DASS score between time 1 and time 4 for the subsample considered in the study.

- McCann et al. (2013) reported results from a randomized control trial of bibliotherapy for carers of young people with first-episode psychosis. For those receiving the bibliotherapy intervention, there was an effect size of 0.44 (as measured by change in K10 between baseline and follow-up at 16 weeks).

- Chiocchi et al. (2019) found that a carer-led psychoeducational program for carers had an effect size of 0.89 between time 1 and time 5 (as measured by the Warwick-Edinburgh Mental Well-Being Scale).

- Hibbs et al. (2015) undertook a meta-analysis of interventions for carers of people with eating disorders and reported an effect size of 0.32 on carer distress (as measured by the GHQ, DASS, and The Hospital Anxiety and Depression Scale).

**Care recipients**

- A meta-analysis of family psychosocial interventions for schizophrenia (Pharoah et al. 2010) was used to construct an effect size for care recipients by synthesising the results across the studies. This suggests an effect size of 0.79 for care recipients. This is assumed only to benefit the 7500 care recipients with schizophrenia or other psychoses in SDAC of carers with unmet needs.

- The evidence base for the effect on the care recipient for other types of mental illness is limited and hence the benefits for these care recipients have not been included here.

**Children of parents with mental illness**

- Solantaus et al. (2010) found that a child-focused psychoeducation discussion with parents with depression has an effect size of 0.12 for children of parents with mental illness. Although, the effect size for the benefits for children of parents with mental illness was drawn from a study focused on parents with mood disorders, Reupert et al. (2012) demonstrated that significant effects extend to other forms of severe mental illness.
**Action**

Greater support for carers and families within mental healthcare and support services (continued)

<table>
<thead>
<tr>
<th></th>
<th>Population size</th>
<th>Effect size</th>
<th>Income</th>
<th>QALYs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carers</td>
<td>55 000</td>
<td>0.40</td>
<td>$124-245</td>
<td>1 602-2 917</td>
</tr>
<tr>
<td>Care recipients with schizophrenia or psychosis</td>
<td>7 500</td>
<td>0.79</td>
<td>—</td>
<td>431-785</td>
</tr>
<tr>
<td>Children of parents with mental illness</td>
<td>200 800</td>
<td>0.12</td>
<td>—</td>
<td>1 790-3 259</td>
</tr>
</tbody>
</table>

**Cost savings**

It is estimated that 29% of the care recipients who are expected to benefit have had an ED presentation in the past 12 months (Productivity Commission estimates using ABS 2020a). This means that there are potential cost savings from reduced ED presentations for about 7500 care recipients. However not all of these ED presentations will be avoided. A randomised controlled trial by Calvo et al. (2014) found that at the end of the group intervention, people in the psychoeducation group were 24 percentage points less likely to have had visited the emergency department. Combining this with the average cost of an ED presentation for severe mental illness ($805 per presentation), the cost savings from a reduction in ED presentations are $1.4 million.

Family psychosocial interventions for schizophrenia (Pharoah et al. 2010) and family interventions for early psychosis (Bird et al. 2010) can reduce the number of hospital admissions, compared with care as usual, by 26-49 percentage points. It is estimated that there were about 7500 hospital admissions by care recipients (Productivity Commission estimates using ABS 2020a). Assuming an average length of stay of 15 days in an acute bed (at an average cost of $19 548 per stay), reducing the number of hospital admissions could lead to cost savings between $38-72 million. This is likely to be a conservative assumption as it could be the case that multiple admission are avoided by the same care recipient.

**Additional considerations**

There are a number of other possible effects that need to be considered:

- Aggregate benefits to carers are likely to be underestimated. The population of carers who have unmet need and are likely to benefit from these reforms is an underestimate because carers who do not reside with their care recipient, are not primary carers, or are caring for someone who has mental illness but it is not their main condition are not included.

- The population of children of parents with mental illness with unmet needs is uncertain. All children of parents with severe and chronic mental illness have been included, but some of these families may not have unmet needs. Children of parents with severe but not chronic mental illness are not included in the population estimate, although some may have unmet needs.

- Other family and household members of people with mental illness who are not carers are also likely to experience benefits not quantified here.
K.3 Income and employment support

**Action**  Staged rollout of Individual Placement and Support

The Individual Placement and Support (IPS) model of employment support should be extended through a staged rollout to all State and Territory Government community ambulatory mental healthcare services.

**Population**

IPS participants are assumed to be working age, not employed, consumers of community ambulatory mental healthcare services with the most severe mental illness (receiving medium to long-term treatment). It is estimated that there are currently 68 100 people who are potential IPS participants, and that after a full rollout, 40 000 of these people will use IPS (Productivity Commission estimates, chapter 19).

**Effect**

*Health-related quality of life*

IPS is assumed to have a positive effect on participant’s health-related quality of life, thereby increasing their number of quality-adjusted life years. Assuming an effect size of 0.08, this suggests an additional 238-434 QALYs per year. The effect size is estimated based on pooling the estimates from several studies:

- Michon et al. (2014) evaluated the effectiveness of IPS for people with severe mental illness in the Netherlands. Mental health was measured using the Mental Health Inventory (MHI-5), and found an effect size of 0.17 for those with competitive employment at the end of the 30-month trial.
- Drake et al. (1999) evaluated the effectiveness of a supported employment for inner city patients with severe mental illness. Conducting a randomised control trial, mental health was measured using the BPRS (Brief Psychiatric Rating Scale) and an effect size of 0.16 was found for those who received IPS (compared to those receiving enhanced vocational rehabilitation).
- Kukla and Bond (2013) studied the effect of IPS on non-vocational outcomes including psychiatric symptoms and quality of life. These were measured using the Positive and Negative Syndrome Scale (PANSS), and found an effect size of 0.17 for those who received IPS compared to those that received a stepwise vocational model.
- Burns et al. (2009) studied a randomised controlled trial of IPS across six European countries, with participants allocated to IPS or the best alternative local vocational service. The authors did not find significant differences between the two groups, with an effect size of -0.051 based on using PANSS as the outcome measure.

*Employment*

Labour market benefits are based on vocational outcomes reported in Waghorn et al. (2014), which compared the effectiveness of IPS to current employment support programs for people with disability. The authors reported that, over a 12 month period, people receiving IPS were 19 percentage points more likely to be employed, work an additional 3.6 weeks, worked 5.1 hours less, and have a $2.50 higher hourly wage compared to the control.

(continued next page)
Action  Staged rollout of Individual Placement and Support (continued)

However, pre-existing differences in the employment rate between the two groups in the year preceding the study could bias these results. The employment rate was 11 percentage points higher in the treated group than the control (39% compared with 28%).

Given this, a range of 8-19 percentage points is assumed for the difference in the probability of gaining employment, leading to a change in expected labour income of $42-90 million (2019 dollars).

Costs

- The estimates of the total additional costs associated with a staged rollout of IPS are based on those identified in the evaluation of the national youth-focused IPS trial (KPMG 2019). The costs cited in the study include annual site expenses and a fidelity review. Across the range of sites evaluated in the review, the total cost per person ranges from $2692–7149, with a mean of $4449 (2019 dollars). Assuming an additional 40,000 people participate in IPS, total costs are likely to range from $108-286 million, with a mean of $178 million (2019 dollars).

- IPS is likely to result in substantial healthcare savings, ranging between $137-575 million, with an average cost saving of $329 million (2019 dollars). This translates to an average cost saving per person of $8230 (2019 dollars). This is based on several studies.
  - Shi (2011) found that on average, healthcare costs were reduced by $9581 over a 12-month period (2019 dollars).
  - Burns et al. (2007) found that the time spent in hospital was halved — equivalent to 15 days over a 12-month period. In Australia, the cost of a non-acute inpatient bed day is $929 (2019 dollars). This suggests that healthcare cost savings over a 12-month period are $14,380 per person (2019 dollars).
  - Heslin et al. (2011) found that costs of service use were reduced by $6853 (2019 dollars) over a two year period. These include healthcare costs, day care, education, and social care. This suggests that cost savings over a 12-month are $3427 per person (2019 dollars).

- There are likely to be further savings through people moving from Disability Employment Services (DES) into an IPS program. The cost of DES per person is estimated to be $4609 (2019 dollars) over a 12-month period (DSS 2019; LMIP 2018). Using Waghorn et al. (2014), it is estimated that introducing an IPS program would result in 26% of DES participants moving into an IPS program, and an aggregate cost saving of $49 million (2019 dollars).

Additional considerations

- It is assumed the total cost of running a program for adults is equivalent to running a youth-focused program.

- Studies used above have small sample sizes and this analysis assumes that there is no loss of benefit when the program is scaled up to service a national cohort. In actuality, the benefits are likely diminish as the size of the program increases.
Action  Staged rollout of Individual Placement and Support (continued)

- Some of the studies cited above are based on international evidence. When considering healthcare costs, the Productivity Commission has used purchasing power parities published by the OECD to convert costs from the units reported to Australian dollars. However, the proportion of employed participants in international studies was not adjusted to account for differences between international and Australian labour markets or health systems.

- Not all studies referenced above had statistically significant results (for example, Heslin et al. 2011). Estimates from Heslin et al. (2011) were included to so as not to upwardly bias the cost-savings estimates.
K.4 Housing

Action  Housing security for people with mental illness

There is a need to help people with mental ill-health stabilise their tenancies in both the social and private housing markets. State and Territory Governments should provide mental health training to social housing workers and, with support from the Australian government, increase the provision of tenancy support services to people with mental illness in the private housing market.

Population

- The number of social housing workers who should receive mental health training was estimated using the ABS Census of Population and Housing (2017). The Census reports that 16 628 people worked in ‘other residential care services’. This number has been adjusted to 2018-19 figures using population growth from the ABS Australian Demographic Statistics (ABS 2019a), giving 17 356 workers.
- There are an estimated 5503 people with a mental health problem, aged 10 years and over, with unmet need for assistance to sustain housing tenure in 2018-19 (Productivity Commission estimates based on AIHW unpublished data).

Costs

- Mental health training costs are estimated using a sample of 30 course listings (as of May 2020) for the 12 hour standard mental health first aid course (MHFA Australia 2020). This gives an average course cost of $262 per person with a range between $150 to $440. Assuming 17 356 workers are provided training, the average total cost is $4.5 million, with a range between 2.6-7.6 million.
- Tenancy support costs are drawn from Zaretzky and Flatau (2015), who estimate that the average cost of tenancy support to be $3199. This included support to maintain an existing social tenancy ($1402) and costs for general homelessness support to access/maintain a social housing tenancy ($6394) (2012 dollars). This gives an average total cost between $10-44 million (2019 dollars).

Additional considerations

- Mental Health First Australia training course fees vary for many reasons including individual Instructor qualifications and credentials, course venue, course location, course catering and course participant subsidies that may be available as a result of a community grant.
- Cost savings to government from avoiding eviction events are likely to be substantial. The Productivity Commission has not attempted to estimate the cost savings from these interventions (for example through fewer eviction events or escalation of mental illness episodes) as it is difficult to get estimates of the prevalence of such events and to predict the effectiveness of interventions in reducing such events. Zaretzky and Flatau (2015) estimated that average cost per eviction event was $11 075 (2019 dollars) based on data for the ACT, Tasmania, Victoria and WA. This represents a significant savings opportunity for government.
Action  Supported housing

Each State and Territory Government, working with housing support providers and with support from the Australian Government, should address the shortfall in the number of supported housing places for people with severe mental illness by providing a combination of long term housing options for people with severe mental illness who require integrated housing and mental health supports.

Population

It is estimated that between 9019 and 12 515 additional people required supported housing places in 2017-18. The ‘gap’ between current and required supporting housing was estimated using numbers of existing supported housing places (AIHW 2020c Table FAC.25) and an estimate of demand based on ABS population projections and the rate per 100 000 who need supported housing (ABS 2019a; Siskind et al. 2012).

Costs

Costs and cost savings are sourced from evaluations of the Housing and Accommodation Support Initiative (HASI) from Bruce et al. (2012) and Doorway (a private rental program) from Nous Group (2014). This suggests an average total cost of $484 million with a range between $230-807 million, and an average total cost saving of $320 million with a range between $147-540 million (2019 dollars).

Supported housing costs and cost savings

<table>
<thead>
<tr>
<th></th>
<th>HASI</th>
<th>Doorway</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average non-accommodation cost (2019 dollars)</td>
<td>$46 361</td>
<td>$13 498</td>
</tr>
<tr>
<td>Average accommodation cost (2019 dollars)</td>
<td>$18 096</td>
<td>$11 992</td>
</tr>
<tr>
<td>Average reduction in health service usage (2019 dollars)</td>
<td>$43 142</td>
<td>$16 274</td>
</tr>
</tbody>
</table>

a HASI accommodation costs are assumed to be equal to mean public housing costs per annum. Doorway accommodation costs are based on rentals in the private housing market.

Additional considerations

- Fixed costs of providing new public housing have not been included above.
- The population of interest is based on 2017-18 data. The Productivity Commission has not adjusted this value to obtain a 2018-19 value.
- The estimate of the number of people who require supported accommodation is based on Siskind et al. (2012), who found that 88 supported accommodation places per 100 000 population were required, consisting of supported public housing, supervised supported hostels, crisis accommodation, and residential rehabilitation. The lower bound on the estimate of supported housing places required (9019) only includes supported housing and supervised supported hostels, while the upper bound (12 215) contains all forms of supported accommodation discussed. This means that the upper bound will have an overlap with community residential non-acute beds, while the lower bound will not.
**Action**  
**Housing after discharge from hospital or prison**

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

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

**Population**

There are 3000 people who are in need of housing upon discharge from hospital or prison (chapter 20). This is based on an estimated 2000 people in hospital who are able to be discharged and 1000 people who are discharged from ‘institutional settings’ into homelessness (AIHW 2019c).

**Costs**

Costs and cost savings are estimated using data from the Transitional Housing Team (Queensland) (Siskind et al. 2014), Homeless Teams (Perth) (Gazey et al. 2019), and the National Partnership Agreement on Homelessness (NPAH) Housing Support Worker Mental Health (HSWMH) Program (Wood et al. 2016). The total costs presented here are estimated by scaling up the range of average program costs to meet estimated demand. This suggests an average total cost of providing services of $49 million with a range between $15-94 million and an average total health cost savings of $159 million with a range between $25-333 million, and an overall potential net benefit of $10-295 million.

<table>
<thead>
<tr>
<th>Costs and cost savings associated with housing support after discharge</th>
<th>Transitional Housing Team (Queensland)</th>
<th>Homeless Teams (Perth)</th>
<th>NPAH HSWMH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average cost per support period (2019 dollars)</td>
<td>$31 208</td>
<td>$5 134</td>
<td>$12 734</td>
</tr>
<tr>
<td>Average health cost savings per support period (2019 dollars)</td>
<td>$38 605</td>
<td>$8 397</td>
<td>$111 000</td>
</tr>
</tbody>
</table>

**Additional considerations**

- There are large variations between the cost and cost saving estimates across pilot programs considered in this analysis. The Productivity Commission has not attempted to adjust these costs based on the reach or scalability of each of the three studies considered.

- The pilot programs used to estimated costs focus on people discharged from hospital rather than prison. The cost of providing discharge support to people leaving prison is likely to differ, although there is a lack of evidence in this respect.

- Addressing the shortage in non-acute beds (discussed above) will also help to ensure people are not discharged into homelessness. Given the potential overlap in the people that are likely to benefit from these two actions the cost of improving discharge from hospital may be an overestimate.
Action  Homelessness services

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

- Housing First programs should target people who experience severe and complex mental illness, are persistently homeless, and are unlikely to respond to existing homelessness services.
- This would require governments to invest in homelessness services that make long term housing available specifically for these programs.

Population

- There are between 15 366 and 18 832 people with a current mental health issue who have unmet needs for long-term housing (AIHW unpublished).

Costs

- Accommodation costs are estimated using average accommodation costs for social housing ($18 096 per year) and private rental ($20 860 per year) (Productivity Commission estimates based on ABS (2019, Housing Occupancy and Costs, Cat. no. 4130.0) and SCRGSP (2020a, 2020b, unpublished data)). Total costs are estimated to be between $278-393 million per year. These estimates do not include the fixed costs of providing new public housing.
- Cost offsets from Zaretzky et al. (2013) are used to calculate the cost savings. They found an average cost offset of $1643 for men, $10 554 for women, and $4360 across both genders (2019 dollars). Total cost savings are estimated to lie between $67-132 million per year.

Additional considerations

- Cost offsets were not estimated for street-to-home clients owing to the a very small sample size, which is likely to have a materially significant impact on the average cost offsets.
- An eviction related cost-offset was not estimated, but evidence suggests that support results in a reduced probability of eviction from a public tenancy, resulting in a saving of just over $600 per client (Zaretsky et al. 2013).
Benefits across housing actions

Population

Across the housing actions above, each year there are about:

- 5500 people requiring assistance to sustain housing tenure
- between 9000 and 12 500 additional people who require supported housing
- 3000 people who are in need of housing upon discharge from hospital or prison (AIHW 2019c)
- between 15 300 and 18 800 people with a current mental health issue who have unmet needs for long-term housing.

Effect

- Aldridge (2015) surveyed 27 homeless services in London and found that a year of spent in homelessness was associated with a loss of 0.117 QALYs. In an analysis of the benefits of providing mental health services to homeless people, Connelly (2013) reported results from a similar (unpublished) study in Wisconsin, which suggested that access to homeless services to treat mental illness could increase QALYs by 0.12, but a more conservative assumption of 0.06 was used to account for cross-country differences. Using a QALY gain of 0.06-0.12 across the set of actions, suggests an increase of 1968–4776 QALYs.

- Homelessness prevention and assistance is also likely to increase the likelihood of people gaining employment. Flatau et al. (2007) reported a difference in employment rate of about 4.5 percentage points at the follow-up after their entry into support. The number of hours and weeks worked is assumed to be the same as those who gain competitive employment under IPS from Waghorn et al. (2014). Using these parameters and assuming minimum wages, total additional labour income is likely to range between $17-20.6 million (2019 dollars).

- The estimates of QALYs and income above are based on the assumption that the people affected across the different actions do not overlap. A conservative estimate may consider complete overlap — in which no more than between 15 300 and 18 800 people would experience a benefit. Under this more conservative population construct QALYs would increase by between 918-2256, and aggregate income would increase by between $7.9-$9.7 million.

Additional considerations

- Housing is fundamental to recovering from mental illness — without a place to live, it is difficult for people to receive support and recover. Further, as a key protective factor against mental ill-health, access to suitable housing is often a first step in promoting long-term recovery for people with mental illness (Giuntoli et al. 2018). Losing the psychological support associated with adequate housing can be detrimental to an individual’s sense of order, trust, continuity and security (Hulse and Saugeres 2008; Muir et al. 2018).

- Cost effectiveness should not be the only factor in choosing whether or not to provide housing services. Cost-benefit analyses can lead to the perception that reducing homelessness is only beneficial from a financial perspective, and that sufficient regard is not given to the social equity motivations for policy change (Please et al. 2013).

(continued next page)
Benefits across housing actions (continued)

- The benefits considered here assume a counterfactual where the person would have otherwise been evicted, homeless, or did not have treatment for their mental illness without the interventions in place. Where this is not the case, estimates may overstate the change in QALYs which arise from the intervention.

- Estimates of labour market income may also overstate the benefits from these housing policies. In their HASI evaluation, Bruce et al. (2012), did not find a significant improvement in the employment of people with supported housing.

- There are likely to be overlaps between the population who require supported housing and non-acute beds — hence, aggregating the benefits across the two actions will overestimate the benefits.

External estimates of the impact of homelessness on QALYs are used here because data on the population who require housing is scarce, with the link between QALYs, mental health, and housing even more so. This means that the estimates of the effects on QALYs reported here are not necessarily comparable with other estimates — for example, Aldridge (2015) used the EQ5D to measure QALYs, while the QALYs in HILDA are based on the SF-6D using Australian utility weights.
K.5 Psychosocial supports

Action  Filling the gap in demand for psychosocial support services

People who require psychosocial supports due to mental illness should receive them. Need for these supports should be determined through a functional assessment by a psychosocial support assessor.

Population

The NMHSPF estimates that about 290,000 people require psychosocial supports (Diminic, Gossip and Whiteford 2016). The Productivity Commission estimates that about 109,000 people currently receive psychosocial support, where 34,000 of these people are on the NDIS. Assuming that the cap for the NDIS (64,000 people) will be met at some point in the future and that the provision of supports outside of the NDIS remains constant, about 154,000 people are likely to be without requisite supports. The estimates of costs and effects presented here assume that 154,000 additional people receive psychosocial support.

Effect

- Muir, Meyer and Thomas (2016) conducted an evaluation of outcomes for Wellways Australia, and estimated an effect size of 0.44 on the ‘managing mental health’ dimension.
- The number of hours and weeks worked by those who gain employment is assumed to be the same as those who gain competitive employment under IPS from Waghorn et al. (2014).
- This suggests an aggregate increase in labour market income of between $79-177 million, and an increase in QALYs between 4912-8903.

Costs

- Costs are based on two previous psychosocial supports programs (Productivity Commission estimates based on DSS and DoH, unpublished)
  - Personal Helpers and Mentors Service (average cost per client of $7043)
  - Support for Day to Day Living in the Community (average cost per client of $2421).
- Given that it is likely that people with higher level needs are provided with psychosocial services under NDIS, it is assumed that two thirds of consumers will be provided with lower cost services, and the other third will be provided with higher cost services. This suggests a total additional cost of about $610 million with a range between 373-1085 million (2019 dollars).

Additional considerations

- There is considerable uncertainty concerning the estimates of benefits. Muir, Meyer and Thomas (2016) is an uncontrolled pre-post study, and the standard of evidence about the size of the effect is low due to the lack of randomisation. It is also likely that there would be overlap with other services areas, such as individual placement and support programs (above).

(continued next page)
<table>
<thead>
<tr>
<th>Action</th>
<th>Filling the gap in demand for psychosocial support services (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The estimation of the number of people who are supported outside of the NDIS (approximately 75 100) is based on:</td>
</tr>
<tr>
<td></td>
<td>- 2016-17 estimates of the number of people supported by Australian, State and Territory Government-funded programs (90-95 000 (DoH 2017))</td>
</tr>
<tr>
<td></td>
<td>- State and Territory recurrent expenditure on grants to NGOs for specialised mental health services in 2017-18 (AIHW 2020a, table EXP.3)</td>
</tr>
<tr>
<td></td>
<td>- Information about funding for NPS-T, NPS-M and CoS (DoH 2020)</td>
</tr>
<tr>
<td></td>
<td>- The number of people being supported on NPS-T (DoH, pers. comm., 1 May 2020)</td>
</tr>
<tr>
<td></td>
<td>- Unpublished acceptance rates data for Partners in Recovery, Personal Helpers and Mentors Service and Day to Day Living programs.</td>
</tr>
</tbody>
</table>
The beneficial effects of the various actions recommended made in the justice chapter could not be quantified because of limited quantitative evidence about the direct mental health benefits that are likely to result. However, that is not to say that there are no benefits expected from the actions. For example, while research shows that mental health court diversion programs improve access to mental health services and can also reduce recidivism rates (chapter 21), evidence on the quantifiable change in mental health outcomes is limited. As a result, this section only details how cost estimates in the justice chapter are calculated.

**Action**  **Improving access to court diversion programs**

State and Territory Governments have developed court diversion programs that ‘divert’ people with mental illness away from the criminal justice system. Mental health courts offer a different model and can operate alongside court liaison services. They provide a personalised, problem solving approach that differs from a mainstream court process. Court liaison services aim to identify people with mental illness who have been charged, intervening as early as possible, often pre-trial or during the trial process (Davidson 2015).

**Costs**

*Mental health courts*

Increased costs for mental health courts were estimated using program expenditure and funding data for states where mental health courts have been established — in Victoria, South Australia, Western Australia and Tasmania (although data could not be located for Tasmania). Queensland has a mental health court, but it specialises in matters relating to forensic patients.

- Victoria: was allocated $22 million (2017-18 dollars) over four years for its Assessment and Referral Court — about $5.5 million per year (MCV 2018).
- South Australia: was allocated $3.3 million (2019 dollars) in the state budget (South Australian Government 2019).
- Western Australia: reported expenditure of $4.2 million (2017-18 dollars) (State and Territory Government Survey).

There is lack of information about the population likely to benefit from increased coverage of mental health courts. For the purposes of deriving cost estimates, it is assumed that the number of referrals (and cost for mental health courts) double, giving an additional cost of $13.5 million (2019 dollars).

*Court liaison services*

- Assume that all courts will receive court liaison services, with expenditures scaling up proportionately. This suggests total additional costs are estimated to be $32 million (2019 dollars).
## Action  Improving access to court diversion programs (continued)

### Additional considerations

- This cost estimate aims to provide some indication of how much current expenditure would need to increase in order to expand the court diversion program by a certain amount. It does not estimate the additional expenditure required to meet unmet demand for court diversion programs owing to data limitations. Although anecdotal evidence suggests there is unmet demand for these programs (NSW MHC 2017; Soon et al. 2018; Victoria Legal Aid, sub. 818), reliable data to quantify this was unavailable.

- The cost of expanding court liaison services coverage to all courts is likely to be an overestimate. While the physical presence of court liaison services in courts is beneficial, these services do not need to be based in every court — services can be provided on request if needed (Davidson 2018).
Action Increased support for police

A systematic approach, where mental health expertise is incorporated at multiple stages of police response, should be implemented to support police responding to mental health related incidents. State and Territory Governments should implement initiatives that enable police, mental health and ambulance services to collectively respond to mental health related incidents.

Population

- It is assumed that PACER-style programs are rolled out nationally.
- In 2017-18 there were 20,372 mental health-related ED attendances via police or a correctional services vehicle (AIHW 2019b). But this number is an underestimate of the number of cases which involve police, as some of these cases may be recorded as arriving by ambulance.
- Using data on the number of police interactions for states where data is available and imputing for states where data is not available, it is estimated that police deal with 44,300 mental health-related cases per year (Henry and Rajakaruna 2018; Meehan and Stedman 2012; Victoria Police 2019; State and Territory Governments Survey).

Effect

Increased support for police is expected to reduce the number of cases sent to an emergency department, with some evidence that ED attendances could be reduced between 27-63% (Allen Consulting 2012; Scott 2000). This will result in cost savings that are detailed below.

Costs

- Costs associated with rolling out systematic co-response programs are calculated on the basis of cost data from Western Australia ($727 per case), and PACER ($478-673 per case) (Allen Consulting 2012; Henry and Rajakaruna 2018; WA Mental Health Commission, unpublished data). This includes the estimated costs of having mental health expertise located in police call centres and in co-response teams responding to mental health incidents on the ground.

  Based on estimates of police interactions (44,300 cases per year), it is estimated that the cost of increasing support programs for states which do not already have these programs is between $15-23 million (2019 dollars).

- Reduced ED attendances are likely to result in cost savings — ED attendances for a serious mental illness cost on average $760 (2017 dollars) per attendance (IHPA 2017). Using the lower bound on the number of mental health-related ED attendances, this suggests cost savings between $4.4-10.3 million (2019 dollars).

- Reducing the time that police spend on mental health-related cases is expected to result in cost savings. The Allen Consulting Group (2012) estimated that police spent 2.8 hours per case on average and that this could be reduced to 0.7 hours per case. They also estimated that the cost of police time as $65.37 per hour (2012 dollars). Based on estimates of police interactions (44,300 cases per year), the total cost savings are estimated to be $7.4 million (2019 dollars).

(continued next page)
Action  Increased support for police (continued)

Additional considerations

- These cost estimates do not account for cost-savings from replacing existing programs, and so are likely to overestimate the true cost.
- Use of Western Australia numbers as a benchmark may also lead to overstating of costs, as coverage in Western Australia was expanded recently to obtain greater geographical coverage.
- Data on the number of police interactions (with people experiencing a mental health-related incident) was not available for all jurisdictions. For states with missing data, the number of cases per year were imputed.
**Action**  
**Additional mental health expenditure on prisoners**

Mental healthcare in correctional facilities should be equivalent to that in the community and mental healthcare should be continued seamlessly as people enter and leave correctional facilities.

State and Territory Governments should ensure that:

- there is mental health screening and assessment of all individuals (sentenced or un-sentenced) by a mental health professional on admission to correctional facilities, and on an ongoing basis where appropriate
- mental health information obtained from screening and assessment is comprehensive enough to inform resourcing of mental health services in correctional facilities
- with consent from the individual, there is communication with any of their community based mental health providers to further inform mental health needs
- individuals in correctional facilities are able to access timely and appropriate mental healthcare, that is equivalent to that in the community

**Population**

The number of people in prison with mental illness was estimated using prisoner population data (SCRGSP 2019) and prevalence (of mental illness) data from State and Territory Governments and the AIHW prisoner health survey in table 16.1 (AIHW 2019d; JHFMHN 2019; State and Territory Survey; Victorian Government, sub. 483). It is estimated that there are about 17200 people with mental illness in prisons, nationally.

**Costs**

- Additional expenditure required to provide adequate care to people with mental illness in prison is calculated based on the Sainsbury Centre for Mental Health’s estimate that 11 FTE mental health workers per 550 male prisoners are required to provide prison mental healthcare that is equivalent to community services (Davidson et al. 2019).
- Funding required to meet this benchmark is based on information about the number of fully funded FTEs for mental health services currently in prisons by state from Davidson et al (2019), share of mental health expenditure as a proportion of total health expenditure (AIHW 2020a), and total health expenditure in prisons from (SCRGSP 2019).
- Mental health expenditures on prisoners nationally should be about five times greater (from $707 per prisoner to $3479) in order to meet this benchmark.
- This implies additional expenditure of $47.8 million (2019 dollars).
- However, when analysing at a state level and aggregating up, the estimate for additional expenditure is higher, at about $109.8 million (2019 dollars). This is because, at a state level, the required increase to meet the FTE benchmark can be much higher than the national average estimate (five times greater). For example, in New South Wales, the estimated increase required is over 10 times.

(continued next page)
State data on the number of fully funded FTEs for mental healthcare in prisons has several limitations. First, data had to be imputed for Victoria and South Australia. Second, the data is not directly comparable across states owing to different services delivery models. Third, data for some jurisdictions underestimate the number of FTEs. For example, in New South Wales psychology services are provided by Corrective Services (not Justice Health services), which was not included in the FTE count (Davidson et al. 2019). Additionally, in South Australia, visiting consultants provide mental healthcare are not included in the FTE count.

Current mental health expenditure in prisons is estimated on the basis of reported health expenditure in prisons and the assumption that 7.6% of health expenditure is on mental health (as is the case in the community) (AIHW 2020a). This might not be the case in practice and may differ across states and territories. Where mental health expenditure is less than 7.6% of all health expenditure, the amount of funding required to meet the FTE benchmark will be higher.

Prevalence data had to be imputed for Tasmania, the Northern Territory and the ACT.
**Action  Aboriginal and Torres Strait Islander prisoner expenditure**

State and Territory Governments should ensure Aboriginal and Torres Strait Islander people in correctional facilities have access to mental health supports and services that are culturally appropriate.

**Population**

The number of Aboriginal and Torres Strait Islander people in prison is about 12 000 nationally (SCRGSP 2019). The number of Aboriginal and Torres Strait Islander people in prison with mental illness was not estimated, as the Winnunga Model of Care aims to address health and mental health needs for all Aboriginal and Torres Strait Islander people detained in the ACT’s Alexander Maconochie Centre (Winnunga AHCS 2016).

**Costs**

- The cost of the ACT’s Winnunga Model of Care at the Alexander Maconochie Centre (Winnunga AHCS 2016) is estimated to be about $1.5 million (2017-18 dollars) per year, for about 110 Indigenous prisoners in 2018-19 (SCRGSP 2019). This implies an estimated cost per Indigenous prisoner of $14 332 (2019 dollars).

- Across Australia, there are about 12 000 Indigenous prisoners (SCRGSP 2019), implying a total additional cost of about $170.2 million (2019 dollars) if rolled out nationally.

**Additional considerations**

This recommended action is about ensuring Aboriginal and Torres Strait Islander people in correctional facilities have access to mental health supports that are culturally appropriate. However, the estimated cost is based on just one type of model that could be implemented. There are other models of care, such as South Australia’s Model of Care for Aboriginal Prisoner Health and Wellbeing (Sivak et al. 2017). Costs would differ based on the model of care implemented in each state.
**Action  Health justice partnerships**

State and Territory Governments should fund pilot programs of multi-site (rather than just single-site) health justice partnerships to:

- improve access to legal services for people with mental illness
- enable larger volumes of data to be collected, for more rigorous evaluation, to build the evidence base
- inform future policy and program development in this area.

State and Territory Governments should consult with relevant stakeholders to ensure a coordinated approach.

**Costs**

- Estimated using the cost of Mind Australia’s pilot in Victoria, which was $430,000 over two and a half years (2018 dollars) (LSBC 2019).

- Assuming that this can be scaled up across all other states and territories, the cost is about $1.2 million per year (2019 dollars).

**Additional considerations**

The cost of establishing pilot programs in other states and territories may differ from Mind Australia’s pilot in Victoria, which is funding a multi-site partnership between Mind Australia’s mental health services and about six community legal services (Mind Australia 2018; sub. 380).
Action  Legal representation at mental health tribunals

State and Territory Governments should ensure people appearing before mental health tribunals and other tribunals that hear matters arising from mental health legislation have a right to access legal representation. To ensure this, State and Territory Governments should adequately resource legal assistance services for this purpose — for example, through broader legal assistance funding or a specific legal assistance grant.

Population

Individuals who are or may be subject to compulsory mental health treatment, and expected to appear before mental health tribunals. However, the demand for legal assistance and representation would depend on the number of cases/hearings, not the number of individuals. There were about 52,000 mental health tribunal hearings conducted nationally in 2018-19.

Costs

- Legal representation costs were estimated using grant information provided by Victoria Legal Aid (to estimate a cost per case), and data on the number of hearings conducted by state and territory mental health tribunals (and other tribunals dealing with matters arising from mental health legislations), which were sourced from annual reports (ACAT 2019; NSW MHRT 2019; NT MHRT 2019; QLD MHRT 2019; SA DHW 2019; TAS MHT 2019; VIC MHT 2019; WA MHT 2019).

- In Victoria, a grant of legal aid is a set amount of funding per case that a legal practitioner can receive from Victoria Legal Aid on application. Under Victoria Legal Aid 2019 guidelines a grant of aid comprised: $752 (2019 dollars) for preparation, and $376 (2019 dollars) for appearance (VLA 2019). This sums to a total cost per case of $1128 (2019 dollars).

- Scaling this up across Australia, and assuming that 83% of people want legal representation (NSW MHRT 2019), the total cost is $48.6 million (2019 dollars).24

Additional considerations

- This is an overestimate as it does not account for existing expenditure on legal representation (for mental health tribunal hearings) by states and territories. The ‘gap’ in legal representation, across states and territories, could not be estimated from available data.

- The proportion of people who would want legal representation may differ across jurisdictions. The cost estimates presented here are based on the proportion of cases that involve legal representation in New South Wales which averaged about 80%, over the past five years.

- Data on the number of hearings could not be located for South Australia. The number of mental health orders was used as a proxy, which is an underestimate.

- Estimating costs based on a cost per case method has limitations, and Victoria Legal Aid advised it is not the most reliable approach (VLA, pers. comm., 8 May 2020). Instead, Victoria Legal Aid advised that a cost per Tribunal sitting day would be more reliable, as it reflects how resources are committed in practice. However, data on the number of Tribunal sitting days could not be located for all states. As a result, a cost per case method was used. A cost per Tribunal sitting day method led to cost estimates that were much lower for Victoria (where data on the number of sitting days was available) — less than half of what was estimated under a cost per case method. Therefore, the use of a cost per case method may overstate the actual cost.
**Action Individual non-legal advocacy services**

State and Territory Governments should ensure individual non-legal advocacy services are available for any individual detained under mental health legislation. In particular, services should:

- focus on facilitating supported decision making by individuals
- be adequately resourced to provide assistance to individuals who require it
- not replace legal advocacy services.

Where an individual is detained under mental health legislation, or agrees to mental health treatment in lieu of being detained under mental health legislation, the treating facility should notify non-legal advocacy services and the individual's family or carer.

**Population**

People who are subject to mental health orders (both inpatient and community orders), by state and territory. The demand for individual non-legal advocacy services will depend on the number of mental health orders made per year, not the number of individuals subject to them per year, as people can be subject to multiple mental health orders. There were about 29,900 mental health orders made nationally in 2018-19.

**Costs**

- The total cost of this action is estimated using expenditure data from Western Australia Mental Health Advocacy Service (2018) and the number of mental health orders in each state and territory sourced from various annual reports (ACAT 2019; NSW MHRT 2019; NT MHRT 2019; Queensland Health 2019; SA DHW 2019; TAS MHT 2019; VIC MHT 2019; WA MHAS 2019).

- About 66% of the Western Australia Mental Health Advocacy Service expenditure ($2.7 million) is on the cost of advocates and the chief advocate. Combining this with the number of involuntary treatment orders in Western Australia (4116), suggests an average cost of $446 per order (2019 dollars).

- Scaling this nationally, gives a total cost estimate of $13.3 million (2019 dollars).

**Additional considerations**

- This may overestimate actual cost as it assumes that all individuals subject to a mental health order would want individual non-legal advocacy services which may not be the case in practice. However, data are unavailable to establish the extent to which this may be the case.

- The cost of providing individual non-legal advocacy services may differ across states and territories, as they have different models of service delivery. For example, in New South Wales and Victoria, these services are delivered through parts of their state legal aid commissions. Whereas, in Western Australia, the service is provided through the Chief Mental Health Advocate, which is a statutory office.

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24 Although all individuals have the right to access legal representation, 83% of cases in New South Wales involved legal representation (NSW MHRT 2019).
Action  Advance directives, statements or agreements

Advance directives, statements or agreements enable consumers to state their preferences regarding future treatment and their recovery. This can include identifying preferred medications, or nominating carers and specifying the types of information to be shared with carers.

Population

There is limited data on the number of people who want or need an advance directive. The number of mental health orders from various state and territory annual reports is used as a proxy of how many people may need an advance directive (ACAT 2019; NSW MHRT 2019; NT MHRT 2019; Queensland Health 2019; SA DHW 2019; TAS MHT 2019; VIC MHT 2019; WA MHAS 2019).

This is because advance directives are often prepared by individuals who anticipate becoming subject to compulsory mental health treatment in the future. This suggests that about 29,900 people could need an advance directive.

Costs

- The Productivity Commission was advised by the Mental Health Legal Centre (MHLC, pers. comm., 11 March 2020) that the cost per advance statement (as they are called in Victoria) was about $750 (2019 dollars) under its MHLC Advance Statement Project — which was delivered by its lawyers through outreach services located at mental health facilities (MHLC 2019).

- This suggests a total cost of $22.4 million (2019 dollars), to provide support services nationally.

Additional considerations

- There are people who already have an advance directive, hence the costs presented here will be an overestimate.

- Cost estimates would vary depending on the type of support service provided (to help individuals complete advance directives). There are different ways to support consumers to complete advance directives, and the costs would differ depending on the approach. For example, support could also be provided through online resources and supporting workshops, as is the case in the ACT, which is likely to cost less than $750 per advance directive.
K.7  Early childhood and school

**Action  Perinatal mental health**

Increased availability of screening for perinatal mental illness for all parents of newborn children is expected to improve their mental health.

**Population**

Screening for perinatal mental illness is offered for 315,000 fathers and partners of new mothers (ABS 2019c). It is assumed that of these fathers and partners, 75% will engage in screening, and that 10% of those have perinatal mental illness (Paulson and Bazemore 2010). Of those who are identified as requiring treatment, it is assumed that half will seek and receive treatment.

**Effect**

- The 12,000 fathers and partners of new mothers who receive help experience a mental health benefit (instead of having a deterioration in mental health).
- It is assumed that an even mix of face-to-face and online supported treatment is used, with an effect size of 0.9 (Burlingame et al. 2016; Cuijpers et al. 2019) and 0.8 (Andrews et al. 2018) respectively.
- This is estimated to result in an additional 505-919 QALYs and $46-86 million in labour market income.

**Costs**

Improving perinatal mental health is expected to result in an additional $18-23 million in direct expenditure, including:

- a campaign to raise awareness about screening
- costs associated with implementing screening
- the cost of providing care, assuming that a mix of online supported and face-to-face treatments are used.

**Additional considerations**

- There is an implicit assumption that all fathers and partners of new mothers experiencing perinatal mental illness do not currently seek and receive help. Where they do seek treatment, the costs of that treatment should be deducted from the costs above so as to avoid double counting.
- There is limited literature regarding treatments and their effectiveness that is specific to new fathers (O’Brien et al. 2017). As a result, effect sizes are drawn from non-perinatal studies for general populations experiencing a mix of anxiety and depression. It is not clear in which direction this will bias results.
Expanded provision of parent supports

Parent education programs are part of a suite of measures recommended to improve the social and emotional development of preschool children. The expanded provision of parent education programs through a range of channels (including online platforms and child and family health centres) is expected to result in a range of mental health benefits for children. The intervention here indicates possible benefits and costs associated with the rollout of an indicated parent education program designed to prevent anxiety disorders in children. The anxiety program is an example of additional parenting supports that are recommended in action 5.2. It is expected that these results are indicative of benefits of additional parenting supports that may be expected more broadly.

Population

The intervention presented targets parents of preschool children at risk of developing anxiety. The initial population includes the 649,000 children aged 3 or 4 in 2019 (ABS Cat no. 3101.0). On the basis of an existing study (Mihalopoulos et al. 2015), it is assumed that:

- 95% of these children attend preschool
- 75% of preschools take part in screening
- 29% of parents return screening questionnaires
- 63% of parents agree to participate in the intervention
- 16% of children meet screening criteria.

It is estimated that about 11,100 children receive the intervention.

Effect

The intervention is expected to reduce anxiety among children, with the effectiveness results sourced from Rapee et al. (2005).

Percentage of children with at least one anxiety diagnosis

<table>
<thead>
<tr>
<th>Follow-up time</th>
<th>Intervention</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 months</td>
<td>50.8</td>
<td>63.5</td>
</tr>
<tr>
<td>24 months</td>
<td>37.8</td>
<td>68.4</td>
</tr>
<tr>
<td>36 months</td>
<td>39.5</td>
<td>68.8</td>
</tr>
</tbody>
</table>

In terms of health-related quality of life, improved social and emotional development for preschool children is estimated to result in between 385-703 disability-adjusted life years (DALYs) averted. Other health benefits included in this appendix are specified in terms quality-adjusted-life-years. Disability-adjusted are conceptually similar to QALYs, but are typically disease-specific and do not take into account comorbidities.

Costs

Costs of the intervention are taken from Mihalopoulos et al. (2015), and adjusted for inflation and change in population. Screening costs included one hour of preschool teachers time, costs of training teachers, and the processing of screening questionnaires. Intervention costs include up to six 1.5 hour group sessions. The costs of time and travel for parents are also included. The total cost is estimated to be about $6.8 million. Cost savings included the healthcare costs associated with treating anxiety and are estimated to be about $2.2 million.
### Action  
**Expanded provision of parent supports** (continued)

### Additional considerations

- Unlike other interventions considered, the benefits calculated include those that accrue over subsequent years. This is due to the fact that benefits appear to increase in the years after the intervention. In the year following the intervention, it is estimated that about 95 DALYs are averted.

- Benefits are likely to be underestimated, given that costings in Mihalopoulos et al. (2015) include consideration of a number of children who are given access to the course without actually meeting screening criteria. No benefits from these children are included here.
Action  Education support for the mental health of school-aged children

The mental health of school-aged children can be better supported by improving teachers' knowledge and understanding of child social and emotional development and wellbeing via the implementation of accredited programs in schools and improvements in pre-service education and professional development for teachers.

Population

3.9 million students in primary and high schools across Australia (ABS 2020b) are expected to experience improved health-related quality of life from improved social and emotional learning programs within schools.

Effect

Sklad et al. (2012) conducted a meta-analysis on universal, school-based, social, emotional, and behavioural programs and found an effect size of 0.1 (0.04-0.17) on follow-up outcomes for mental disorders. This is estimated to result in an additional 28,620-52,110 QALYs per year.

These recommended actions are likely to have ongoing positive effects for those benefiting, including improved educational outcomes. For example, using results from a random effects analysis of Longitudinal Study of Australian Children data by Khanam and Nghiem (2018), it is estimated that this effect is likely to result in an average improvement in NAPLAN of about 0.01 standard deviations for reading and writing and 0.005 standard deviations for spelling and numeracy.

Costs

Most of the actions for improving education support for the mental health of school-aged children involve repurposing of existing expenditures.

However, funding arrangements to support schools in identifying and addressing gaps in their ability to support the wellbeing of students will require some additional government expenditure. Based on similar schemes already existing in New South Wales and Western Australian, overall expenditure of $230 million would be required annually. However, all jurisdictions, as well as the Australian Government, already invest in wellbeing programs in schools, so the true figure is likely to be far less.

Additional considerations

There are a number of uncertainties associated with these estimates:

- The benefits estimated use health utility weights derived using the SF-6D instrument. This is likely to give uncertain results for children and adolescents. Health benefits calculated in this way are indicative only.
- These actions are likely to result in improvements in domains other than mental disorders (the basis for the health benefits above), including improvements in academic achievement, prosocial behaviours and social-emotional skillsets, all of which are likely to have ongoing, lifelong economic and health benefits for those affected.
- Many of the schools affected by the actions already have (or are required to have) social, emotional and behavioural programs. As a result, the benefits expected might be towards the lower end of the likely range of benefits.
K.8 Young adults

**Action** Training for educators in tertiary education institutions

Staff who have direct contact with students are to undertake training on student mental health and wellbeing.

**Population**

There are about 1.1 million people aged between 15-24 currently studying for a Certificate level III or above (ABS 2019e, Education and Work, table 22). For people aged between 15-24, it is estimated that about 24% experience some form of mental illness each year (IHME 2019). This suggests there are about 271 100 young adults who could benefit from teaching staff at TAFE and universities having improved access to adequate mental health training.

**Effect**

There is an absence of evidence about the direct mental health benefits that are likely to accrue to students as a result of training university staff. However, a meta-analysis of the effects of workplace health promotions by Martin, Sanderson and Cocker (2009) suggest that they may achieve a standardised mean difference of 0.05 in composite mental health measures. If a similar effect was to be achieved for students in tertiary institutions, this would result in an increase of between 982 and 1789 QALYs per year.

**Costs**

- Nationally, there are 33 600 Vocational Education and Training (VET) teachers in 2019, and there were 134 112 teachers and student facing staff in 2018 (AISC 2020; DESE 2018).
- Gulliver et al. (2018) estimated that 50% of teaching staff at universities and TAFE did not have access to adequate training. This number of staff requiring training is increased by 10% to allow for student-facing non-teaching staff who may also require training, suggesting that there are about 92 000 people who should undergo training. The average cost for a mental health first aid training course is estimated to be $262 (ranging between $150 to $440 per person) (MHFA Australia 2020). This gives a total cost of $26 million, ranging from between $14-41 million.
- There is also an opportunity in undertaking this training, as the time spent — 12 hours for the standard in-person mental health first aid training session — comes at the expense of other purposes. Wages for vocational education teachers and university lecturers and tutors (ABS 2019f, Employee Earnings and Hours, Data Cube 11) are used to calculate the opportunity cost of staff time spent training ($46.5 million).
- The total costs are estimated to be between $60-87 million (2019 dollars).

**Additional considerations**

- Expenditure on training VET and university staff is likely to yield benefits to students beyond the initial cohort considered here.
- The effect size above, although relatively small, is drawn from a workplace health promotion, and can only be considered as indicating possible outcomes.
### K.9 Workplaces

**Action** Prioritising mental health in the workplace

The mental health of employees is to be improved by changes that make mental health as important as physical health in terms of Workplace Health and Safety legislation, and through the development of employer codes of practice to assist employers in meeting their duty of care in providing a mentally healthy workplace.

**Implementation**

The actions of each employer required to achieve a mentally healthy workplace are specific to their workforce, and would likely involve a mix of interventions including job-redesign and in-person training. Given this, a number of assumption about how employers will act in order to achieve a mentally healthy workplace are required. For the purposes of estimating costs and benefits, it is assumed that select employers provide support for their employees to complete a universal, self-directed online mental health course (including time allocated during work hours).

**Population**

Medium-large firms (20 or more employees) that do not provide a mentally health workplace are the target of this intervention:

- Bailey, Dollard and Richards (2015) estimate that about 35% of employees work in a low ‘psychosocial safety climate’ (PSC).
- Given that there are about 7.2 million people employed in medium-large firms, there are about 2.5 million people who may benefit from this intervention (ABS 2019b).
- It is assumed that 5% of these people (125 000) take up the opportunity to complete the self-directed online mental health course.

**Effect**

Using effects from a meta-analysis of 23 controlled trials of eHealth interventions by Stratton et al. (2017), it is estimated that about 8% of people who undertook the online course are likely to avoid depression. Interventions considered in the meta-analysis included web and mobile-based mindfulness, cognitive behavioural therapy and stress reduction programs. This suggests an increase in QALYs between 170-308 each year.

**Costs**

The total additional costs associated with increasing the consideration given to mental health in larger workplaces where this is likely to be an issue is estimated to be about $48 million.

It is assumed that access to eHealth interventions have no marginal cost associated with accessing the course. The main cost to firms is the time required for employees to access the services during work hours. The average time spent on the interventions considered in Stratton et al (2017) was 7.5 hours. Given average hourly total cash earnings of $40.9 (ABS 2019f), this suggests average total costs of $307 per employee and total costs of about $39 million.

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An additional overhead cost of $328 per firm is included to account for administrative requirements. This value was calculated assuming that 8 hours of work (at an average wage rate of $40.9) is required to research and select the eHealth intervention most suited to the organisation and to communicate the roll out of the program to staff. Applying this cost to an estimated 30,000 medium or large size firms (ABS 2019b) implies a total overhead cost of $9.9 million.

Taking these measures is likely to result in substantial cost savings. The average cost per case of depression avoided in terms of lost productive time is estimated to be about $6578 (2019 dollars). This is calculated on the assumption that an employee with depression is expected to be absent from work between 10 and 12 additional days. A further 7 to 9 days of productive output is lost due to presenteeism (appendix H). Part-time and full-time employees have similar amounts of lost time due to absenteeism and presenteeism (ABS 2019g). Average hours and wages are sourced from Employee Earnings and Hours (ABS 2019f), and inflated to 2019 values.

Applying an assumed take-up rate of 5%, this suggests potential cost savings of about $67 million.

**Additional considerations**

- There are a range of interventions aimed at improving mental health in the workplace. As noted above, this modelling exercise is based on the assumption that a universal eHealth intervention is the only response implemented by workplaces.
- The target population is based on the assumption that the proportion of low PSC workplaces are evenly distributed among small and medium/large firms.
- Aggregate costs and benefits are highly sensitive to the assumed take up rate. If the take up rate was 10% (rather than 5%), then the additional expenditures ($87 million) and total cost savings ($218 million) would be doubled. The number of QALYs that would be gained would also be higher (340-615).
Action  No liability treatment for mental health-related compensation claims

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 self-insurers.

Population

The introduction of no-liability treatment for mental health-related workers compensation, is expected to result in a total of about 8000 people returning to work earlier than otherwise would have been the case in 2018-19. This includes 4700 people who have successful mental health-related claims for workers compensation, who had between a week and six months away from work. Because these claims are related to mental health, it is assumed that people in this group have mental illness. The other 3300 claims are for those workers with rejected claims who previously took extended leave (e.g. sick leave).

Effect

For no-liability treatment for mental health related workers compensation claims, it is assumed that the time spent on workers compensation is reduced by 21% for people making a mental health claim, as they can be treated earlier and return to work more quickly (estimated using data from Safe Work Australia (2018) and Sampson (2015)). This is expected to increase aggregate income by about $11.9-12.2 million.

Costs

Increased expenditure is expected to relate to healthcare costs which would not be incurred under the current workers compensation system, but would be accepted under the proposed system. For example if this policy had been in place for the 2018-19 financial year, it would have costed about $9 million per year. This estimate was based on information from various workers compensation schemes on the medical cost of accepted claims and involves a number of assumptions:

- the proportion of claims that result in an absence of work of less than six months is the same for rejected and accepted claims.
- the median healthcare cost is the same for both claims that are accepted and claims that are rejected.

In the 2018-19 financial year, this action would have resulted in a total of 3300 previously rejected claims (that resulted in up to six month of time off work) being accepted, and their medical costs being paid. The total additional cost is the product of the number of new claims and the median cost of a serious accepted claim (that resulted in up to six month of time off work).

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Action  No liability treatment for mental-health related compensation claims (continued)

Additional considerations

- Increased costs associated with no-fault liability must be regarded as a lower bound, as behaviours will change as policy changes, and people may become more likely to put in mental health claims. The incentive to do so can be argued to be low, as it only covers medical costs, and not income payments.

- It is assumed that those that those workers who are expected to be off work for six months or longer for mental health reasons will not receive a substantively greater benefit from access to no fault liability relative to the current policy arrangements, and so are excluded from cost and benefits calculations.

- The benefit estimates provide a lower bound as it assumes the only benefit from earlier access to medical care is an earlier return to work. The calculation does not include, for example, any increase in workplace productivity arising from better mental health.
K.10 Social participation

Action   National stigma reduction strategy

A National Stigma Reduction Strategy is modelled as a national campaign that seeks to reduce stigma towards people with mental illness that is poorly understood in the community.

Population

The introduction of a national stigma reduction campaign is expected to result in a health-related quality of life benefits to 1.2 million people with a diagnosed mental illness. Of those, 850 000 are expected to have labour force benefits.

Effect

Stigma is likely to negatively affect mental illness, with internalised stigma leading to poor adherence to treatment and increased severity of psychiatric symptoms (Livingston and Boyd 2010) and is argued to be a fundamental source of health differences for people with mental illness (Hatzenbuehler, Phelan and Link 2013). There is a limited evidence about the magnitude of the effect on mental illness due to the endogeneity of mental illness and stigma, meaning that strong assumptions about likely mental health benefits are required. The assumed effect sizes are:

- 0.01 for people with severe mental illness
- 0.005 for people with moderate mental illness
- 0.001 for people with mild mental illness.

Across the population, a successful campaign is expected to result in:

- an additional $22-44 million in labour income
- between 419-759 QALYs.

Costs

The campaign is expected to cost between $3.8-$6.4 million per year. Expected costs are based on similar campaigns in the United Kingdom (Henderson, Lacko and Thornicroft 2017) and Denmark (Bratbo and Vedelsby 2017) adjusted for differences in population size.

Additional considerations

- The potential benefits of a stigma reduction campaign can be considered indicative only, given that the mental health benefits are based on assumed effect sizes. However, the assumed effect sizes are conservative, meaning that minimal effect is required for a cost effective intervention.
- The cost estimates do not include reductions in healthcare expenditure that may result from improved mental health, meaning that actual costs per QALY may be lower than reported.
- While there is some evidence about the effectiveness of large-scale anti-stigma campaigns (Corrigan et al. 2012; Evans-Lacko et al. 2013b, 2013a), evidence as to their ability to effect lasting changes in public attitudes is mixed (Smith 2013).
K.11 Suicide prevention

**Action Universal aftercare after suicide attempts**

The provision of aftercare following a suicide attempt is likely to reduce subsequent suicide attempts and result in lower rate of suicide across the population. People that have attempted suicide should be provided with, or referred to, aftercare services. They should be provided with culturally-informed support prior to discharge or leaving the service, as well as proactive follow up support within the first day, week, and three months after discharge, when the individual is most vulnerable.

**Population**

There were 3046 deaths due to suicide in 2018, where 2380 were people aged 20-64 years (ABS 2019d) and there were 31 083 hospitalisations due to self-harm in 2017-18 (AIHW 2019a).

**Effect**

Kinchin and Doran (2017) estimate that 0.6% of suicide attempts result in full incapacity, and 99.4% lead to a short absence from work. Aftercare can lead to a 19.8% reduction in subsequent suicide attempts and a 1.1% reduction in the suicide rate (Krysinska et al. 2016).

These effectiveness rates for aftercare suggests that about 33 deaths by suicide could be prevented by providing those that attempted suicide with aftercare services. About 6150 suicide attempts are likely to be prevented including about 37 that would have resulted in permanent incapacity. It is estimated that the annual benefits are an increase in labour force income by about $3.2 million and about 50 additional QALYs.

**Costs**

Direct costs incurred involve increases in expenditure associated with the provision of universal aftercare for people who have been hospitalised due to intentional self-harm. Estimates of aftercare costs range from between $2000 to $6000 per person, with KPMG and Mental Health Australia (2018, p. 50) suggesting a cost of $4000 per person.

Using these estimates as lower and upper bounds, the cost of providing aftercare to all people hospitalised due to intentional self-harm is between $63-194 million.

There are expected to be cost savings from a reduction in medical, administrative, and other costs from suicide attempts (Kinchin and Doran 2017), as well as indirect and intangible cost savings associated with suicide deaths (appendix H). Total cost savings are estimated to be about $294 million dollars each year.

**Additional considerations**

Intangible cost savings are based on the ‘value of a statistical life’ approach to costing suicide deaths (appendix H).
References

   — 2019a, Australian Demographic Statistics, September, Cat. no. 3101.0, Canberra.
   — 2019b, Australian Industry, 2017-18, 31 May, Cat. no. 8155.0, Canberra.
   — 2019c, Births, Australia, 2018, December, Cat. no. 3101.0, Canberra.
   — 2019d, Causes of Death Australia 2018, Cat. no. 3303.0, Canberra.
   — 2019e, Education and Work, May 2019, November, Cat no. 6227.0, Canberra.
   — 2019f, Employee Earnings and Hours, May 2018, January, Cat. no. 6306.0, Canberra.
   — 2019g, National Health Survey 2017-18 TableBuilder, Cat. no. 4324.0.55.001, Canberra.
   — 2020a, Microdata: Disability, Ageing and Carers, Australia, 2018, Cat. no. 4430.0.30.002.
   — 2020b, Schools Australia 2019, Cat. no. 4221.0, Canberra.

ACAT (ACT Civil and Administrative Tribunal) 2019, Annual Review 2018-19, Canberra.

AIHW (Australian Institute of Health and Welfare) 2019a, Admitted Patient Care, 2017-18, Cat. no. HSS 225, Canberra.
   — 2019b, Mental Health Services in Australia – Hospital Emergency Services, October.
   — 2019c, Mental Health Services in Australia – Specialist homelessness services.
   — 2019e, Medicare-Subsidised GP, Allied Health and Specialist Health Care Across Local Areas: 2013–14 to 2017–18, Cat. no. PHE 254, Canberra.
   — 2020a, Mental Health Services in Australia – Expenditure on Mental Health Services 2017-18 Tables, Canberra.
   — 2020b, Mental Health Services in Australia - Overnight Admitted Mental Health-Related Care 2017-18 Tables, Canberra.
   — 2020c, Mental Health Services in Australia - Specialised Mental Health Care Facilities 2017-18 Tables, Canberra.


Blythe, R., Lee, X. and Kularatna, S. 2019, HealthPathways: An Economic Analysis of the Impact of Primary Care Pathways in Mackay Queensland, Australian Centre for Health Services Innovation, Queensland University of Technology, Brisbane.


Connelly, L. 2013, An economic evaluation of the homeless to home healthcare after-hours service.


—— and Mental Health Australia 2018, *Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform*.


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MHLC (Mental Health Legal Centre) 2019, Submission to the Royal Commission into Victoria’s Mental Health System, Submission, SUB.0002.0032.0106, Melbourne.


Mind Australia 2018, Media Release: Funding for Legal Assistance for People with Mental Ill-Health.


Victoria Police 2019, *Submission to the Royal Commission into Victoria’s mental health system*, SUB.0002.0029.0370, Melbourne.


Winnunga AHCS (Winnunga Nimmityjah Aboriginal Health Service) 2016, *Planning and Delivering Services to Address Entrenched Disadvantage in the Aboriginal Community*, Canberra.


