



Australian Government
Productivity Commission

Mental Health

Productivity Commission Draft Report Volume 2

October 2019

This is a draft report prepared for further public consultation and input. The Commission will finalise its report after these processes have taken place.

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An appropriate reference for this publication is:

Productivity Commission 2019, *Mental Health*, Draft Report, Canberra

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The Productivity Commission

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

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

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

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PART IV — Early intervention and prevention

17 Interventions in early childhood and school education

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

- Many mental illnesses emerge in childhood and adolescence, but children and young people are far less likely to access treatment and support.
- Addressing risk factors and symptoms early is a cost-effective approach to improving children's life-long outcomes.
- Educational institutions are already investing significant efforts in students' wellbeing — and can achieve much more with improved leadership, training and resourcing.

Successful intervention requires ...

As a priority:

- Expanded social and emotional wellbeing aspects of routine health checks in pregnancy and early childhood.
- Governments should work towards ensuring that every school has a designated wellbeing leader, who will coordinate whole-of-school and individual programs to support students at risk of mental ill-health.
- Expanded outreach services intended to support students with mental illness.

Additional actions required include:

- The COAG Education Council should develop a strategic policy on social and emotional learning in the Australian education system. This should include national standards for initial teacher education and professional development programs.
 - State and Territory teacher regulatory authorities should use the standards to accredit all providers, ensuring teachers are equipped with skills to support students social and emotional wellbeing.
 - Strengthen skills to support social and emotional development in the early childhood education and care workforce.
 - Nationally-consistent data on the wellbeing of school students should be collected, and used it to build an evidence base for future interventions.
-

Supporting the mental health and wellbeing of children and young people has been on the policy agenda for many years. But despite substantial efforts — including billions of dollars spent, countless hours of work by teachers and other education professionals, doctors, nurses, specialists and experts, and Australia being considered globally as a country with proactive, comprehensive early intervention and prevention measures — improvements in the mental health of children and young people have been limited.

One in seven children and young people are reported to have a mental illness, though the true prevalence is likely to be higher (chapter 2). Many mental illnesses emerge at a young age and can have substantial effects on the life trajectories of children and young people. For example, in year 3, children with mental illness are lagging in their learning outcomes by about 7 to 11 months compared with children who are not affected by a mental illness, and this gap expands 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).

The way children and their families approach and navigate the mental health system and obtain the assistance and support they require is markedly different from the adult population. Although they come in frequent contact with the health and education systems, children are less likely to receive a formal diagnosis and treatment within the mental healthcare system (Hiscock et al. 2019).

Most infants aged 0–3 years attend regular physical development checks offered by community health services. These checks often include some screening for mental health concerns of the primary care giver (usually the mother). But additional screening and support tools can be valuable in prevention of mental illness or early intervention where it is required.

The vast majority of children aged 3–18 years attend an education institution, commencing with early childhood education and care (ECEC) centres and progressing to compulsory education from about the age of 5. For many children, school is the place where their mental illness symptoms or risk factors are first identified, and school teachers and other staff play a central role in the recovery of children and young people with mental illness. Primary and secondary schools are also required to explicitly teach a social and emotional wellbeing curriculum. This curriculum is intended to promote mental health and reduce the risk of mental illness among children and young people.

This chapter makes draft recommendations to improve early detection of risk factors for mental ill-health, expand early intervention and enhance the efficacy of prevention and mental health and wellbeing promotion for children and young people delivered through the education system. Many of these recommendations are not new. Most recently, these issues were raised by the 2014 National Mental Health Commission (NHMC) review, but the reforms implemented in response have addressed a small part of the problem (box 17.1). Workforce training is one area where only minor improvements can be identified. The effects of reforms and other interventions will 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 17.1 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 2014e, 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 2015). In addition, the Government committed to:

- the development of a single integrated end-to-end school based mental health program. This has led to the development of the Be You initiative (box 17.2).
- 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 2019a; sub. 455).

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 2019c).

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 across the population. 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 Commission has made draft recommendations to:

- improve perinatal mental health services, through increased screening and better parenting support (section 17.1)
- enhance the social and emotional aspects of early childhood checks, with a specific emphasis on checks prior to starting preschool (section 17.2)
- strengthen the ability of ECEC centres and schools to deliver a meaningful social and emotional wellbeing curriculum by improving educator and teacher training and professional development, and by accrediting all wellbeing programs offered by external providers (sections 17.2 and 17.3)
- improve outreach and support services to students with mental illness (section 17.3)
- clearly define the roles and responsibilities of all involved in student wellbeing, including school psychologists and counsellors, and assist schools in building highly functioning student wellbeing teams (section 17.4)
- collect nationally consistent data on student wellbeing, and use this to inform policy planning and improve schools' implementation of a social and emotional wellbeing curriculum (section 17.5).

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

The experiences and environments of children in their early years are widely recognised as crucial factors that influence their physical and mental wellbeing throughout life. There are well-established processes to monitor and enhance the physical health of expectant mothers, new parents and infants. In more recent times, infant mental health has emerged as an area that attracts increasing interest from practitioners and policy makers, based on an understanding of the important role of infant mental health in lifelong mental wellbeing (RACP, sub. 488).

The definition of infant mental health is still a matter of debate among experts, although more formalised approaches to diagnosis and treatment are being developed and implemented. The Australian Association of Infant Mental Health refers to infant mental health as:

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 nd)

In other words, just like physical health and development, infants and young children develop social and emotional skills that are the cornerstone of future wellbeing (Zero to Three 2016). A complex combination of family factors and circumstances contributes to social and emotional development:

The family and family environment (which includes cultural practices/approaches, the physical and mental health of family members, intra-family relations, household wealth, occupational status, and housing conditions) are the main sources of the child's experiences, and therefore have a key influence on a child's social and emotional development. (NHMRC 2017, p. 2)

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. While there are jurisdictional differences in the services provided, periodic checks assess primarily the physical development of the child, but their scope has been expanded to include psychosocial screening for caregivers (Schmied et al. 2015). Jurisdictions have also increased their focus on infant social and emotional wellbeing, using different approaches. 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).¹
- 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 with families at risk (Centre for Excellence in Child and Family Welfare, sub. 211).
- strategies intended to tackle specific risks to infant mental health and wellbeing, such as fetal alcohol spectrum disorder (NT DoH 2018).

There is no adequate data to assess whether the increased focus on infant social and emotional wellbeing has had a substantial effect on young children and their families. In some cases, this is because the policies are relatively new. Governments should evaluate the extent to which these guidelines and services have changed the approach to the maternal and child checks from one that focuses on physical development to one that looks at the whole child and their family.

Improving infant wellbeing by supporting parents and families

The mental health of parents has a strong influence on the social and emotional wellbeing of infants and young children. Mental ill-health is common among pregnant women and new mothers and fathers. One in ten women experience depression during pregnancy, one in five women suffer from anxiety and one in seven women experience depression in the year following the birth of a baby (COPE 2017). New fathers are also more likely to experience

¹ 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'.

mental ill-health compared to the rest of the population (Karitane, sub. 324; Safe Motherhood for all, sub. 165; Price-Robertson 2015). 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).

The frequent interactions of families with healthcare providers in the perinatal period (pregnancy and the weeks following birth) offer a valuable opportunity to improve detection of mental illness and offer early intervention. Mental health screening of pregnant women and new mothers has been part of perinatal care for many years. Notably, such screening is not generally offered to new fathers and partners of new mothers (Karitane, sub. 324).

Clinical guidelines and government policy — at both the Australian and State and Territory Government levels — have been explicit about the expectation that screening of pregnant women and new mothers occurs routinely. However, there is no administrative data collected on the extent to which this screening does indeed occur. 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 2018q). 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).

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 2013b). It appears to have increased access to mental health services and reduced psychiatric hospitalisation (Chambers et al. 2016; Lee et al. 2019); however, it was defunded in 2013, and according to the Australian Nursing & Midwifery Federation (sub. 317), the lack of funding has limited the ability to build additional capacity in the workforce to address perinatal mental health concerns.

Since 2017, Medicare has changed its payments guidelines to require practitioners to offer mental health assessments as part of their obstetric checks (DoH 2017a). In addition, there is an expectation in all jurisdictions that maternal and child health nurses screen mothers for post-natal depression after a baby is born. Nonetheless, 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)

Healthcare providers report other difficulties in implementing universal screening, including lack of time and insufficient referral pathways. 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 as well as stigma (comment no. 6, people in a government or a government agency, interested persons).

Screening for perinatal mental illness, and supporting new parents to access treatment, is likely to have benefits for families and the broader community. The National Health and Medical Research Council (2017) found that the benefits of interventions for treating maternal depression in the perinatal period are likely to outweigh the costs. The costs of untreated perinatal depression and anxiety have been estimated at \$660 million over 20 years, which includes the healthcare costs to parents and children, who are at higher risk of developing a mental illness, lower productivity for parents and lower educational attainment for children (PWC 2012).

Realising the benefit of screening opportunities

The way screening policies are currently implemented appears to miss opportunities to both 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. They should also include fathers and partners in perinatal mental health screening.

As a first step, reliable data should be collected to establish the overall prevalence of perinatal mental illness. Such data should be included in the Perinatal National Minimum Data Set, and included in the monitoring framework to be overseen by the NMHC (chapter 25). Jurisdictional 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; increased 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; 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 (chapter 11). The Australian Government intends to implement a grant program, which will support (among other things) perinatal mental health promotion and training (DoH, sub. 556).

More broadly, 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 chapter 4), including ensuring 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.

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 NHMRC (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 both to universal programs, offered to all parents, and to interventions that target vulnerable groups, such as frequent home visiting by nurses. 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).

While a range of services are offered by government and non-government providers, they are often disconnected and there is a lack of cohesion in their approaches (NHMRC 2017). Further, even where services exist, they may not be reaching families in need of support (VicHealth and partners, sub. 131).

Supporting parents and improving their knowledge of children's social and emotional development can enhance prevention and early intervention (Zero to Three 2016). 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 (draft recommendation 17.2). Specifically for new parents, subsidised parenting education programs should be provided through public health centres that offer services to families with young children.² Funding for such programs can be provided through the same channels used to fund community mental health services (chapter 24 includes the funding models considered by the Commission).

² 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.

DRAFT RECOMMENDATION 17.1 — PERINATAL MENTAL HEALTH

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

In the short term (in the next 2 years)

- The Australian Institute of Health and Welfare should expand the Perinatal National Minimum Data Set, to include indicators of mental health screening, outcomes and referrals. This data should be reported by State and Territory Governments.
- State and Territory Governments should use the data to evaluate the effectiveness of health checks for infants and new parents, and adjust practice guidelines in accordance with outcomes.

In the long term (over 5 – 10 years)

- The National Mental Health Commission should monitor and report on progress towards universal screening.
 - State and Territory Governments should put in place strategies to reach universal levels of screening for perinatal mental illness for 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.
-

17.2 Mental health and wellbeing for preschool-aged children

As children grow, their engagement with the health system through maternal and child health checks becomes far less frequent, and attendance rates at health checks drop.³ The last government-funded health check is offered between a child's third and fourth birthday, depending on the jurisdiction (DHS 2019c).

This check offers another opportunity to identify potential risk factors that may affect mental health and wellbeing before a major life transition — starting school. Addressing difficulties identified at this age would give children a greater opportunity for a positive start to their education.

The Australian Government has attempted to achieve this in the past. In 2008, the Government introduced the Healthy Kids Check, funded by Medicare and delivered by GPs, which was offered to families of 4-year-old children around the time of their immunisation. One of the optional components of the check was questions on behaviour and mood. There was widespread criticism among experts of how the check was structured and attendance rates were low (Alexander, Brijnath and Mazza 2014). In 2012, the Government convened

³ In Victoria for example, attendance at health checks in the baby's first six months is over 90%. By 3.5 years of age, attendance declines to 63% (DET 2017).

an expert working group to develop the Enhanced Healthy Kids Check, designed for 3 year olds, which was intended to contain questions on social and emotional wellbeing. However, this version of the check was never rolled out, partly due to public criticism as the check was perceived by some as a mental health check for children (Oberklaid 2014). In 2015, the Healthy Kids Check was removed from the Medicare Benefits Schedule (Alexander and Mazza 2015).

Expanding the scope of existing health checks for 3- to 4-year-olds, which are currently conducted by maternal and child health nurses, to consistently encompass social and emotional development can result in risk factors being detected early and support offered to families and children as they prepare to start school. Achieving this requires relatively little change to existing practice — the guidelines required to conduct these checks have already been developed, as part of the preparation for the Enhanced Healthy Kids Check; a substantial proportion of the population already attends these checks with their local maternal and child health nurse, and in some cases, these checks already include questions on family wellbeing.

What is 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. Once risk factors are identified, families should be referred to parenting programs (draft recommendation 17.2) or GPs, depending on need. Maternal and child health nurses should also be able to access online information portals outlining pathways for intervention and the local services available to support families (chapter 10 discusses these in detail).

As pointed out by the Melbourne Children’s Campus Council (sub. 191, p. 3), community education and evaluation of outcomes (addressed in chapters 20 and 25 of this report) will be required if early detection of mental illness risk factors 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.

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 90% of 4 year olds participate in a preschool program (either standalone or in a long day care service) (SCRGSP 2018a).

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 the context of mental health and wellbeing, 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 Quality Framework (NQF) supports ECEC services in fulfilling these roles. 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 (Australian Children's Education and Care Quality Authority (ACECQA) nd). All ECEC services are assessed against these standards, and nearly 80% comply with or exceed the national standards (ACECQA 2019). Services are also required to complete and update a Quality Improvement Plan (ACECQA nd).

In addition, ECEC curricula are based on the national Early Years Learning Framework, which includes strong social and emotional wellbeing for children as one of its outcomes (DoE 2009).

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 schools, Be You (box 17.2). Over 2800 early learning centres have signed up to Be You since it was launched in late 2018 (Beyond Blue, pers. comm., 3 October 2019), representing about 25% of services. However, the uptake and implementation of any framework is subject to the decisions of individual centre (Mental Health Australia, sub. 407).

The NQF also mandates minimum qualifications for all staff in ECEC, and requires the presence of a qualified teacher in all long day care services (ACECQA nd). 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). However, past reviews have found a number of shortcomings in the delivery of ECEC training, including time frames that are too short to enable the development of sufficient skills and knowledge (ASQA 2015). The quality of qualifications can be variable:

[S]ome graduates from both [the university and vocational education and training] sectors are inadequately trained or skilled to work in early childhood settings. Stakeholders identified a lack of knowledge of child development, insufficient practical experience in early childhood settings and challenges engaging with diverse communities and families (Pascoe and Brennan 2017, p. 65).

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 qualifications, 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.

While there are no regulated professional development requirements for ECEC educators, many participate in a range of learning activities. Teachers are required to participate in professional development to maintain their registration (section 17.3). Many public and private providers offer professional development courses to ECEC staff, but there is limited monitoring of their quality (Siraj et al. 2017). For services struggling to attract staff and comply with legislated child-to-educator ratios, it can be challenging to allow staff sufficient time to participate in professional development. This was reflected in the evaluation of KidsMatter Early Childhood, the national early childhood mental health promotion, prevention and early intervention initiative (which has recently been rolled into Be You):

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

Therefore, during the period of the KMEC [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, KMEC 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 large centres providing long day care; the lack of time and the need to arrange alternative care for children were significant barriers to family day care educators improving their knowledge of child mental health (Davis et al. 2015).

Improving ECEC capacity requires coordinated action from governments

To build the capacity of ECEC services in this space and equip educators with the necessary skills will require action from several parts of government.

First, the Australian Children's Education and Care Quality Authority, which approves all ECEC qualifications, should review current training programs to ensure all pre-service training for ECEC includes a compulsory component on social and emotional development, commensurate with the level of the qualification. In particular, early childhood teachers should be taught to identify behaviours that may be of concern and work with parents to access support for the child and their family. Such a review should take into account the national guidelines for teacher qualifications (draft recommendation 17.3).

Second, ECEC staff should continue to build their knowledge and skills in this area. As part of their NQF quality improvement plans, all ECEC services should ensure that staff complete professional learning on children's social and emotional wellbeing. In some jurisdictions, services can access funding for backfilling positions when staff attend professional development programs (for example, VIC DET 2019a). Where this is not occurring, State and Territory Governments should allocate funding for backfilling. Organisations providing professional development programs should be accredited (draft recommendation 17.3).

Unlike teachers in schools, early childhood teachers do not always have access to external qualified mental health staff, such as psychologists. Early childhood services are not required to retain the services of a counsellor or psychologist or necessarily have access to either these service providers or other types of professionals such as nurses.⁴

Each ECEC service should have access to support and assistance from qualified mental health professionals, similarly to the support available to schools. State and Territory departments of education, as the regulatory authorities responsible for ECEC quality, should provide these, as an extension of their existing mental health and wellbeing programs in schools. Expanding the support services offered to parents through maternal and child health clinics (draft recommendation 17.2), as well as improving the accessibility of mental healthcare services (chapter 5), would create meaningful pathways that ECEC services can refer families to.

Early childhood interventions for vulnerable groups

One in 10 pre-school 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)
- personal trauma (experienced either by the child or their carer/family) (Mental Health Australia, sub. 407)
- 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 and in the child protection system⁵, and in particular Aboriginal and Torres Strait Islander children in out of home care (SNAICC, sub. 123; Victorian Aboriginal Children and Young People's Alliance, sub. 240).

⁴ 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 (DET 2019).

⁵ For example, Accoras, sub. 135; Berry Street, sub. 366; FCAV, sub. 114; PACYPC, sub. 291; Leonie Segal and Jackie Amos, sub. 468.

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). 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. Over many years, and in many developed countries, studies and trials have shown that early intervention for vulnerable children significantly improves outcomes. Early intervention usually takes the form of integrated education and therapeutic services, delivered by highly skilled staff. For example, one such program in Victoria for 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).

Scaling such programs to substantially increase the number of children attending is a very challenging task, 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, at risk children, and in particular infants and young children, access no health services at all (Guy et al. 2016).

Nonetheless, vulnerable children are increasingly attending ECEC services and preschools. For some groups, rates of attendance are higher than the rest of the population (SCRGSP 2019h). While not providing a universal solution, strengthening the ability of all ECEC staff to recognise factors that may put children at risk of a mental illness, as well as offering additional support to all ECEC services (draft recommendations 17.2 and 17.3) are likely to aid an improvement in social and emotional wellbeing for vulnerable children.

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 5 and 7). Children facing multiple risk factors associated with a family member having a severe mental illness will benefit from coordinated interventions — the proposed care coordinator model is described in chapter 10 and family therapies are discussed in chapter 13.

DRAFT RECOMMENDATION 17.2 — 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.

In the short term (in the next 2 years)

- State and Territory Governments should use existing guidelines to expand early childhood health checks, such that they assess children's social and emotional development before they enter preschool.
- State and Territory departments of education should ensure that all early childhood education and care services have ready access to support and advice from qualified mental health professionals.
- The Australian Children's Education and Care Quality Authority should review the pre service training programs for early childhood educators and teachers to ensure qualifications include specific learning on children's social and emotional development.

In the medium term (over 2 – 5 years)

- State and Territory departments of education, as the regulators responsible for early childhood education and care, should review the quality improvement plans of all services to ensure they include professional learning for staff on child social and emotional development.
- Where this is not already occurring, funding for backfilling should be made available to enable early childhood education and care staff to attend accredited professional development, to support their knowledge of child social and emotional development and mental health.
- State and Territory Governments should expand the provision of parent education programs through child and family health centres.

17.3 Supporting children and young people during their school years

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

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

A range of support programs for parents, partly or fully subsidised by governments, are offered by:

- healthcare providers (doctors, nurses, Aboriginal Health Workers and peer workers employed in the health system)
- non-health care services, including NGOs, 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)
- phonelines such as parentline (although their availability differs by jurisdiction (eMHprac 2019b))
- parenting classes such as the Positive Parenting Partnership (Triple-P) and many others.

Despite the number of services available, parents may still lack the information they require to support their child's mental health. 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).

Parenting 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 (NMHC 2019d).⁶

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, and are widely used in the provision of family support services, including 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).

⁶ 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 illness (NMHC 2019).

While well-designed and funded targeted interventions are important, universal parenting programs have also been shown to improve children's mental health and wellbeing. Universal programs can be very important for engaging vulnerable parents, by reducing the stigma attached to interventions and having a strong prevention focus (Stewart-Brown and Schrader-Mcmillan 2011).

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. As discussed in section 17.1, subsidised parenting education programs for new parents should be available through maternal and child health centres.

In addition, the Australian Government should expand the provision of evidence-based online parenting programs, through mental health portals such as Head to Health, and increase community and health professionals' awareness of such resources (chapters 6 and 10).

The changing role of schools

The role of the education system in society has changed markedly in the past few decades. Schools are now expected to not only teach numeracy, literacy and academic subjects, but they also play a major part in actively supporting their students' mental health and wellbeing. There are good reasons for this change:

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

Schools contribute to the mental health of their students in three key ways. First, they 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'.

Second, teachers and schools are a key part of the treatment and recovery of children with mental illness — discussed in more detail below.

Finally, schools are required to deliver a mental health and wellbeing curriculum to all their students, and support them through their schooling years. This ever expanding role of schools is reflected in numerous policy documents, funding initiatives, new programs and frameworks (figure 17.1).

In practice, schools need to navigate what has been described by stakeholders as a ‘crowded space’ of curricula, government programs, frameworks, service providers, NGOs and specialists of many kinds, and weave together an effective support system for their students (Bowles et al. 2017). One New South Wales secondary school worked with more than 13 separate programs and 31 agencies to coordinate the delivery of their wellbeing services (NSW Auditor-General 2019). This also increases the expectations placed 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 (Department of Education, pers. comm., 21 August 2019).

Like many other issues affecting mental health services, the problems relating to program delivery in the education system are well-known. Most recently, they were raised by the NMHC in 2014:

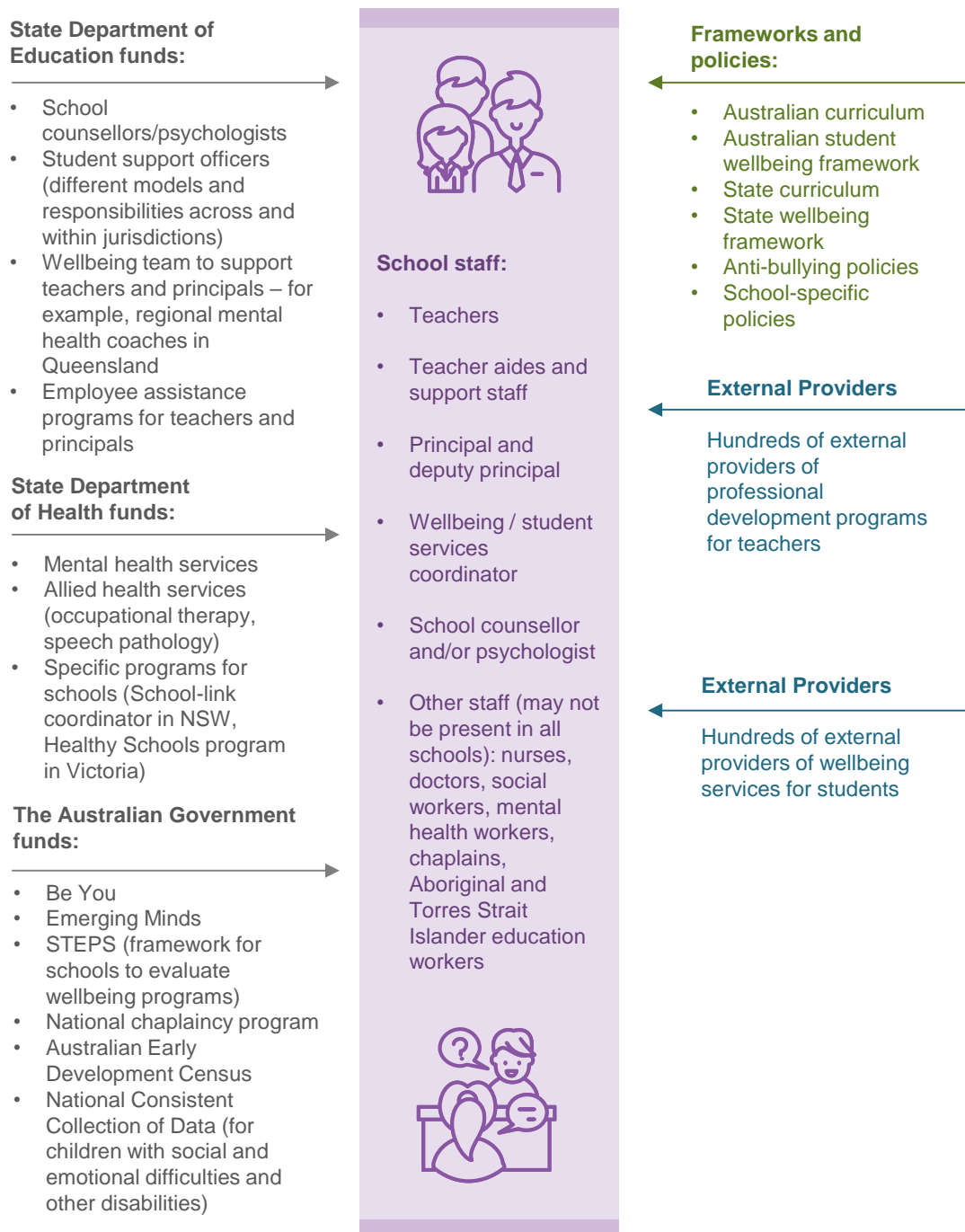
There is a range of preventive and early intervention programmes (Commonwealth, state and local community) across the education sectors addressing the mental wellbeing of young children and students. These focus more on those promoting resilience among school children rather than supporting those with emerging or established difficulties.

The problem lies in the plethora of initiatives, lack of consistent messaging and poor uptake across the country. There also are concerns about lack of comprehensive longitudinal evaluation of the impact of many initiatives, partly because they are not sustained over time. (NMHC 2014e, pp. 122–123)

The Australian Government has put in place two national initiatives to support teachers in delivering mental health and wellbeing programs in schools – Be You (Beyond Blue, sub. 275, box 17.2) and Emerging Minds (sub. 455, box 17.1). 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 coordination and planning
- 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

Figure 17.1 Crowded space — roles, responsibilities and policies in school wellbeing^a



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

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- 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, 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 recommendations below aim to address each of these gaps.

As submitted by ADHD Australia (sub. 295, p. 6), 'school is the place where the most damage can be done, but also where the greatest difference can be made'. Schools have the potential to deliver improvements in population mental health and teach children the skills they will need to support their own wellbeing as they grow. To achieve this potential, however, they require more practical assistance from governments, in the form of concerted investment in the ongoing training of teachers and in meaningful pathways to support for children and families who require it.

The curriculum and framework maze

As the attention paid to mental health in the education system has increased, so too has the number of policies and frameworks setting out the expectations of governments for the delivery of social and emotional wellbeing programs in schools. While each individual school develops its own learning plan, they are required to comply with the Australian curriculum, and the jurisdictional curriculum where applicable, and to take into account numerous frameworks, government policies and programs and other regulatory requirements (figure 17.1).

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. 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). 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.

Unlike the curriculum, which is compulsory, the Australian Student Wellbeing Framework is intended to offer schools principles for building 'positive learning environments'. In addition, every jurisdiction has developed its own framework for wellbeing.

While the basic philosophy behind all policies is the same — intervening early to build capacity and prevent mental ill-health — 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)

This creates challenges for teachers and principals, who need to manage the competing priorities imposed by various policies within very tight timeframes:

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

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

In response to the concern about multiple, overlapping programs, the Department of Health funded the development of a national mental health initiative — Be You — for all types of educational settings, from ECEC to secondary schools (box 17.2). Be You is an optional program, with about 68% of all schools participating as at October 2019 (Beyond Blue, pers. comm., 3 October 2019). It 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). While the Department of Health funds Be You, the Department of Education has invested in the development of an online student wellbeing hub, which includes similar materials for educators and schools (ESA 2019).

Addressing the curriculum requirements and responding to the needs of students and families has prompted many schools to create detailed programs for social and emotional learning (SEL), and build wellbeing teams, including 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 D). Some schools also engage with external providers to deliver suicide prevention programs (chapter 21).

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 17.3).

Box 17.2 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 several previous mental health 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 external providers of wellbeing programs. It also employs consultants that assist ECEC centres and schools both in creating and implementing wellbeing strategies, and following crises that affect the school community.

Participation in Be You is free. About 2800 ECEC centres, 6200 schools and 85 000 individual educators have joined the initiative (as at October 2019) (Beyond Blue, pers. comm. 3 October 2019).

Be You received funding from the Australian Government for four years. Beyond Blue (sub. 275, p. 10), which led the development of the program, has argued that governments should extend its funding: 'having 'unscrambled the egg', it is now critical that governments invest in Be You for the long haul, avoiding unnecessary duplication and focussing investments on complementary initiatives'.

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

[Be You] is an important initiative, however requires close monitoring and review of resourcing to support uptake and implementation across the Australian education sector. (Office of the WA Commissioner for children and young people, sub. 311, p. 21)

The rollout of this national program 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)

Box 17.3 Poor uptake, ineffective implementation — stakeholders' views on whole-of-school wellbeing programs

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

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

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

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

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

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

Associated problems include:

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

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). As there is only a limited evidence base to establish which programs are effective, 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, after providers have demonstrated their programs are based on evidence.⁷ To ensure consistent implementation of accreditation processes, the COAG Education Council should develop accreditation guidelines for the departments; this should form part of the COAG Education Council strategic policy development (draft recommendation 17.3). In addition, departments should use wellbeing outcome measures (section 17.5) 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.

Teacher training and professional development

The explicit expectation that schools play an increasingly large role in supporting the social and emotional wellbeing of students has imposed new demands on teachers. Even for those not directly involved in teaching SEL, 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. And while teachers are making a substantial effort, systemic shortcomings limit their ability to respond to student needs.

The need to improve teacher training in student mental health was raised by numerous stakeholders in this inquiry.⁸ 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. While there is an increasing focus on improving teachers' understanding of students' social and emotional development, 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:

⁷ This is similar to the approach applicable to programs that promote safe behaviours online and aim to address cyberbullying. These programs need to be accredited by the Office of the eSafety Commissioner before they can be delivered in schools (Office of the eSafety Commissioner 2018).

⁸ 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, sub. 16, 98; RRMH, sub. 97; Samaritans Foundation, sub. 121; VCOSS, sub. 478; Victorian Government, sub. 483; Youth Mental Health – North Metropolitan Health Services, sub. 99.

[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)

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 2018b).

Since 2011, all jurisdictions have been working towards the implementation of a nationally consistent approach to teacher registration. This has seen the introduction of national teacher standards, as well as national standards for the accreditation of ITE programs, both developed by the Australian Institute for Teaching and School Leadership, and agreed to by the COAG Education Council (AITSL 2018b, 2018a). 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 authorities 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 2018b). 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)

All teachers need a clear understanding of child and adolescent social and emotional development to allow them to respond effectively both 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 requires strengthening the implementation of the national standards for accreditation of ITE programs, so that all providers of initial teacher education include explicit instruction in child and adolescent social and emotional development, practical tools to support students' mental health and referral pathways to appropriate services when required. These requirements should apply to all teachers, including early childhood education teachers (draft recommendation 17.3).

This training would 'facilitate the development of capable and responsive education workforces, across early childhood, school and higher education' (Victorian Government, sub. 483, p. 11). It is not, however, intended to negate the need for specialised mental health workers within the education system (section 17.4).

Teachers' professional development

In order to maintain their registration, teachers must complete 20 hours of professional development activities each year (AITSL 2018b). For registered teachers, these hours of professional development offer an opportunity to expand their knowledge of the SEL curriculum and 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 (Australian Education Union (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 17.2) 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 authorities accredit professional development programs for teachers that include content in line with the school curriculum.⁹ In some States and Territories, departments review programs offered to teachers in public schools (for example, NSW Auditor-General 2019). In addition, Be You (2019b) has developed an online directory for professional development as well as programs for students, which it has assessed as being evidence-based.

To best equip teachers with the tools required to support student mental health and wellbeing, a more structured approach to professional development is required. 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, SEL 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. Accreditation processes should be based on national guidelines, to promote consistency across education systems (draft recommendation 17.3) Only professional development undertaken with accredited providers should be recognised for the purposes of teacher registration.

A national policy to support better teacher training and professional development

Improvements to pre-service training and professional development for teachers need to be based on a national policy, in line with the national approach to teacher standards. Introducing a national policy is intended to address two key issues, which lead to significant fragmentation and inconsistency. First, while the Australian Institute for Teaching and School Leadership (AITSL) standards can be interpreted as requiring pre-service teachers to learn about child social and emotional development as part of their ITE, there is limited national consistency in the implementation of the standards. Second, apart from the national requirement to complete 20 hours of professional development, there is no national consistency in the specific requirements teachers need to comply with and no consistent approach to assessing the quality of professional development activities.

The Council of Australian Governments’ (COAG) Education Council, as the national body that develops strategic policy on school education, early childhood and higher education, should be responsible for filling this policy gap. The Education Council should develop a national strategic policy on social and emotional learning in the Australian education system. This policy should include:

- a clear statement on the role of the education system in supporting mental health and wellbeing, and the role of schools in interacting with the mental health system

⁹ 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).

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- a commitment to cooperate with the COAG Health Council in the implementation of mental ill-health prevention policy, to prevent overlap and confusion
 - clear guidelines for the accreditation of initial teacher education programs and professional development courses for teachers, which must include social and emotional learning
 - similar guidelines for the accreditation of social and emotional learning programs offered to schools.

There are different approaches to developing the accreditation guidelines. The Education Council can choose to adopt the guidelines used in a specific jurisdiction (for example, the NSW requirement that initial teacher education programs include a mental health component) and implement those on a national scale. Alternatively, 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. Alternatively, the Education Council 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, the Commission sees benefit in tasking it with the development of the guidelines for accrediting initial teacher education programs and professional development, provided they are clear and unambiguous. This process mirrors current approaches to quality improvements in the teaching profession, where AITSL develops the national standards, which are endorsed by the COAG Education Council, and these are implemented by the jurisdictional teacher regulatory authorities.

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. 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.

To develop guidelines for the accreditation of SEL programs offered to schools, the COAG Education Council may need to convene an expert advisory panel. Several existing frameworks can be considered — 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 2019b).

DRAFT RECOMMENDATION 17.3 — SOCIAL AND EMOTIONAL LEARNING PROGRAMS 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.

In the short term (in the next 2 years)

- The COAG Education Council should develop a national strategic policy on social and emotional learning in the Australian education system. This policy should include:
 - a clear statement on the role of the education system in supporting mental health and wellbeing, and the role of schools in interacting with the mental health system
 - a commitment to cooperate with the COAG Health Council in the implementation of mental illness prevention policy, and a clear delineation of responsibility, to prevent overlap and confusion in policy development
 - guidelines for the accreditation of initial teacher education and professional development courses for teachers, which will include social and emotional learning. These guidelines should be developed by the Australian Institute for Teaching and School Leadership
 - guidelines for the accreditation of external social and emotional learning programs offered to schools. These guidelines could be developed by an expert advisory panel.

In the medium term (over 2 – 5 years)

- State and Territory departments of education should use the national guidelines to accredit social and emotional learning programs delivered in schools.
- State and Territory teacher regulatory authorities should use the national guidelines to accredit initial teacher education programs and professional development programs for teachers. 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.

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). In addition, teachers, principals and other staff in the education system often face substantial difficulties and time pressures in their roles (APACS, sub. 419; Australian Education Union (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 19.

School-based support for children with mental illness

Many mental illnesses emerge in childhood and adolescence, and some, such as eating disorders, tend to affect young people more than adults (box 17.4). Ensuring children with mental illness remain engaged in education is important to their recovery. These children have a legal right to education — as expressed in the *Disability Standards for Education 2005*, meaning that all schools are legally required to cater for children with mental illness (DoE 2018b).

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).¹⁰ 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 the student.¹¹ 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)

¹⁰ 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 2019b).

¹¹ 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 2017).

Box 17.4 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, sub. 329)). 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 [at] appropriate intervals students are expected to learn about 'body image and self-worth and their impact on mental health and wellbeing'. We believe [there] is significantly insufficient focus on this critical area of health and wellbeing.

Overall, HPE may not account for more than 10% of teaching hours (in NSW for example); not only is there limited time for education relating to body esteem and other risk and protective factors for eating disorders; they must also compete with other important health content.

Further, there has been no government funding for eating disorder prevention programs since 2011. Lack of funding is not the only challenge faced by schools:

Other perceived barriers to schools addressing this issue effectively include:

- Lack of confidence, in part because many adults struggling with their own body issues and feel unable to 'walk the talk' or provide an authentic voice
- Limited up-to-date evidence based and age appropriate accessible resources
- Insufficient professional development and support on the ground to deliver, particularly around the sensitive areas of eating disorders.

Currently, the national picture of how these issues are being addressed within our schools is incomplete and largely anecdotal. (Butterfly Foundation, sub. 424, part 2, p. 3).

The Australian Government announced it will increase Medicare funding for treating eating disorders from November 2019 and make additional investment in research and workforce development (DoH., sub. 556). However, stakeholders in the sector are concerned about the lack of available specialist services and insufficient data on prevalence and consumer pathways (Butterfly Foundation, sub. 424, part 1).

Given that all students have a legal right to education, governments need to 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 (as the most recent review was completed in 2015, and the standards include a requirement for five-yearly reviews) (DoE 2018b). 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. A review 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).

A 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 recommended the development of clear policies for how consultations should be conducted and documented (Urbis 2015a).

Numerous submissions to this inquiry have 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 by GPs and psychiatrists in some cases (chapter 10). This means, for example, that psychologists who treat children may need to forgo payment or bill their clients privately to attend consultations in 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 5). This report must include recommendations for future management of the patient's disorder, 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 10), 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.

Supporting 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. The Commission has heard from carers and parents about the substantial difficulties in finding help for their children:

[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. I.e. 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)

There are examples of outreach programs run or funded by State and Territory Governments, which 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 18). 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, Robert Davis, sub. 133; Australian Clinical Psychology Association, sub. 359). Ways to promote effective care coordination for those requiring care from a larger team of professionals are discussed in chapter 10.

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.

DRAFT RECOMMENDATION 17.4 — EDUCATIONAL SUPPORT FOR CHILDREN WITH MENTAL ILLNESS

The education system should review the support offered to children with mental illness and make necessary improvements.

In the short term (in the next 2 years)

- The Disability Standards for Education are due to be reviewed in 2020. The upcoming review should:
 - include specific consideration of the way the standards affect students with mental illness and their educational outcomes.
 - examine application processes for adjustments and consider any necessary improvements.
- MBS-rebated health professionals treating children should be required to include recommendations for parents/carers and teachers in their report to the referring medical practitioner.

In the medium term (over 2 – 5 years)

- The Australian Government should use data collected by schools as part of the National 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 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 referred to them, once the student's attendance declines below a determined level, and monitor their implementation.

17.4 The wellbeing and mental health workforce within schools

Beyond teachers and principals, there is a wide array of professionals whose role is to support the mental health and wellbeing of students. Depending on the jurisdiction, school-based 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 17.1). However, in all jurisdictions, various factors limit the ability of staff to contribute to improving student outcomes, including:

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

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, according to Australian Psychologists and Counsellors in Schools (APACS, sub. 419, p. 3), an uncoordinated approach to service delivery can carry risks:

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.

Insufficient services to respond to need

While there are school psychologists in every jurisdiction, there is a substantial difference in the ratios of psychologists to students in government schools. Information provided to the 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)

[M]any schools lack funding for wellbeing programs, and need more youth workers, nurses and counsellors. (VCOSS, sub. 478, p. 42)

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

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

Due to reporting policies and lack of confidentiality in most schools’ children resist seeing school guidance officers, who in the most part are psychologists not counsellors in the public-school system. Issues such as stigma and lack of confidentiality/privacy, many counselling rooms are situated in the main admin area close to the principal’s office, and where foot traffic is constant, there is a strong reluctance by students to use available services. Students are also aware their files are not confidential; principals and other teaching staff can access files and, in some schools, counsellors must share files and cases with teaching staff who have no training in mental health. Another roadblock for many students is that Guidance Officers (in the main psychologists) will automatically assess and diagnose students against the DSM5 or ICD with a mental illness before entering into a counselling process. This can have lifelong negative consequences. (ARCAP, sub. 337, p. 20)

Many young people the [Queensland Family and Child Commission] spoke to did not know who their school counsellor or guidance officer was or how to access them. ... Young people are concerned about school guidance officers and counsellors breaching their privacy and confidentiality should they raise mental health. This concern is stopping them engaging with support services. (QFCC, sub. 85, p. 5)

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 public 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 to others working 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 (QNMU, sub. 229; NSWNMA, sub. 246; ANMF, sub. 317).

A recent audit of the wellbeing services offered in New South Wales 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 (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).

Funding and policy overlap create confusion

State and Territory departments of education fund a very large range of policies intended to support school mental health and wellbeing services. 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 State Department of Education and Training but the initiatives are

implemented by primary health networks, which are funded by the Australian Government. According to the Primary Health Networks (sub. 377, p. 18):

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.

... [C]ase studies unveil the structural weaknesses in the healthcare system such as:

- the existence of multiple commissioning bodies (e.g. State governments and PHNs) and the subsequent risk of parallel and disjointed commissioning approaches for the same type of services, resulting in complex navigation pathways, possible duplication of some service offerings and service gaps.
- the State Department's rigid commissioning approaches including tight timelines and limited community and PHN consultations resulting in siloed rather than more integrated, flexible and tailored initiatives responsive to local needs.

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)

Leadership – the missing piece of the puzzle

In response to the increasing focus on student mental health and wellbeing, many schools have established wellbeing teams to coordinate their efforts and support staff; in some jurisdictions, state governments offer funding to government schools to create a leadership position that will oversee wellbeing programs. For example, the NSW Department of Education allocates funding for secondary schools to employ a Head Teacher Wellbeing, Victorian secondary schools receive funding for school welfare coordinators¹² and South Australian schools can employ school wellbeing leaders (NSW Auditor-General 2019; VIC DET 2019b; State and Territory Governments Survey).

In practice, however, the scope of these roles varies substantially between schools, and can include everything from bullying prevention to counselling. For example, in New South Wales, the Auditor General (2019, p. 17) found that:

¹² Eligible primary schools can employ primary welfare officers (VIC DET 2019b).

An appropriately skilled Head Teacher Wellbeing is essential to an effective team and requires adequate time away from classroom duties to perform the role. This role requires more consistent definition and identification of the time required to fulfil the role.

Recently, reforms introduced in the United Kingdom included ‘incentivising every school to identify a designate senior mental health leader to deliver whole of school approaches to promoting better mental health for students as well as staff’(APS, sub. 543, p. 16). This model was successfully trialled before roll-out and the evaluation showed substantial benefits within schools (box 17.5).

Box 17.5 The United Kingdom approach to mental health leaders

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
- 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).

The reforms were developed based on a trial conducted in 2015 across 255 schools. Each school designated a senior teacher, whose role was to liaise with local mental health services and lead the implementation of mental health and wellbeing initiatives in the school. This included acting as the first point of contact for teachers raising concerns about their students’ mental health and wellbeing. An evaluation of the trial showed a range of benefits, such as improvements in communication and referrals to mental health services. In addition:

It was also apparent that improvements to the mental health knowledge and awareness of school staff had contributed towards increased capacity and capability for preventative mental health and well-being support. Although it was less common for schools to report delivering ‘interventions’ per se, it was certainly the case that many were willing to engage in preventative work with young people, where the default response would have been to make a referral. (Day et al. 2017, p. 75)

While the appointment of a Designated Senior Lead is not compulsory, the UK Government is offering incentives to schools to participate in the program. Teachers designated as mental health leads will receive free training, and the role will be incorporated in the career pathways of teachers. The Government intends to offer the training to all schools by 2025 (UK Department of Health & Social Care and Department for Education 2018).

The Commission considers that all schools in Australia should employ a school wellbeing leader, who would be tasked with coordinating the work of the various professions that contribute to student mental health and wellbeing and overseeing the implementation of whole-of-school SEL programs, including relevant professional development for staff.

The Commission recognises that some schools already have a designated wellbeing leader carrying out these duties, and in others wellbeing coordinators are fulfilling part of this role.

Where government schools can demonstrate that a leadership role already exists and operates effectively, they would be able to use the funding for other activities intended to promote student mental health and wellbeing. Funding arrangements are discussed further below.

The role of a school wellbeing leader

A school wellbeing leader should be responsible for:

- coordinating the work of the school wellbeing team, which can include a school psychologist, counsellor, social worker, school nurse, chaplain, local Aboriginal community leader or health worker, peer workers and others. This should include clear definitions 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 working with school leadership and government agencies to find suitable funding
- acting as the 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
- ensuring plans to support students with mental illness are implemented, and there is appropriate consultation with their family and mental healthcare providers
- overseeing the implementation of whole-of-school wellbeing programs, including identifying the most suitable programs for the school community, developing the skill sets of teachers who will be delivering the programs, monitoring outcomes and supporting school staff to incorporate wellbeing practices in their day-to-day teaching
- developing and maintaining referral pathways to local community services, including community mental health services, parenting programs and support services for young carers.

A school wellbeing leader should be part of the leadership team of a school, and should have minimal (if any) classroom duties. They should have substantial knowledge of child social and emotional development and mental health. In school communities with a substantial proportion of Aboriginal and Torres Strait Islander or culturally and linguistically diverse families, relevant cultural capability would be essential. They should not be required to hold psychology qualifications, as their role would not involve counselling individual students.

A teaching background is essential, however, in enabling the school wellbeing leader to support other school staff members in implementing wellbeing initiatives. While many teachers may complete brief professional development courses, there is often limited follow up support (Orygen and headspace, sub. 204). Mentoring teachers and other staff members and supporting them in incorporating wellbeing practices in their daily work and identifying emerging mental health issues among students, should be a core part of the school wellbeing leader role.

Monitoring outcomes and using data to better understand student wellbeing, as well as any additional resources the school may require, should be another core responsibility for the school wellbeing leader. Currently, there are limited accountability structures around the delivery of mental health and wellbeing programs in schools. The school wellbeing leader should be accountable for improvements in wellbeing and accessibility of support services for students. Data collected in schools should be used by governments to evaluate the effectiveness of this policy initiative, and generate more insights into best practice in school-based mental health and wellbeing.

In the UK trial of mental health leaders in schools, access to training for school staff as well as ongoing monitoring and self-evaluation were identified as critical factors for success. Other key factors relevant included support from senior school management and clear referral pathways (Day et al. 2017). These factors will be equally important to success in Australian schools.

Funding the employment of school wellbeing leaders

Different funding arrangements apply across the education system, and this will affect the way the role of the school wellbeing leader would be funded. While both levels of government contribute to school funding, State and Territory Governments are mostly responsible for funding government schools, while the Australian Government is the major contributor to the funding of non-government (independent and catholic) schools. The Australian Government is in the process of reforming its school funding arrangements, such that they are consistently based on need and, in the case of non-government schools, reflect the ability of the school community to contribute to funding through school fees (DoE 2019d).

All State and Territory departments of education should be required to fund the creation of this role in all government primary and secondary schools. Smaller schools should employ a wellbeing leader on a part-time basis; alternatively, one position could be shared among schools. Larger schools may require additional resources, such as more counsellors or psychologists, but as the school wellbeing leader is seen as a senior management role, it is not envisaged that more than one leader would be required. The Commission will give more consideration to scale efficiencies, and make further recommendations on the structure of this role in its final report.

Where schools are able to show that they already have a full-time equivalent of a dedicated wellbeing leader and they are tracking the outcomes of wellbeing initiatives, they should be awarded the equivalent funding as a designated mental health and wellbeing budget.

In the case of non-government schools, there are arguments for and against the Australian Government (as a major funder of the sector) contributing funding to these positions. On the one hand, it can be argued that this is a role for the Australian Government as part of its overall responsibility towards non-government schools, and in a similar way that other wellbeing initiatives such as Be You are offered to all types of schools. On the other hand, non-government schools have developed their own approaches and wellbeing strategies, and

are often well placed to continue implementing them. It is likely that many non-government schools already have a leadership position in place to manage mental health and wellbeing initiatives and additional funding is not required.

The Commission estimates that the annual cost of employing school wellbeing leaders in government schools would be up to \$660 million. Actual expenditure is likely to be lower for two reasons. First, most jurisdictions have already allocated funding to similar initiatives as part of their education budgets (for example, head teachers wellbeing in New South Wales, wellbeing leaders in South Australia and regional mental health coaches in Queensland) and this funding could be redirected towards the employment of school wellbeing leaders. Second, this estimate is based on the assumption that a full-time wellbeing leader would be employed in all government schools with over 100 students.¹³ However, anecdotal evidence suggests that this is unlikely to be an efficient level, and full time leaders would only be required in larger schools, for example those with more than 200 students.

This estimate represents about 1.8% of State and Territory Government expenditure on schools.¹⁴ If funding is allocated to employing wellbeing leaders in non-government schools as well, the cost is estimated at \$975 million per year, or 2.2% of total government expenditure.¹⁵ However, the benefits of improved student wellbeing are likely to be substantial (chapter 26). The Commission is seeking further input on the mechanisms to fund the employment of wellbeing leaders in non-government schools, and existing state and territory government funding that could be redirected towards their employment in government schools.

¹³ In 2018, there were 4851 government schools with more than 100 students (ABS 2019). Wages for the proposed school wellbeing leaders were estimated based on the annual salary currently offered to head teachers in NSW, which is \$112 614 per annum. Adding superannuation and other employment costs, the expenditure per school wellbeing leader was estimated at \$136 000 (NSW Department of Education nd).

¹⁴ In 2016-17, expenditure on schools by State and Territory Governments totalled \$37 134 million (SCRGSP 2018a).

¹⁵ As above, this assumes the expenditure per school is \$136 000. In 2018, there were 7173 government and non-government schools with over 100 students (ABS 2019k). In 2016-17, total expenditure on schools by the Australian and State and Territory Governments reached \$43 731 million (SCRGSP 2018a).

DRAFT RECOMMENDATION 17.5 — WELLBEING LEADERS IN SCHOOLS

All schools should employ a dedicated school wellbeing leader, who will oversee school wellbeing policies, coordinate with other service providers and assist teachers and students to access support.

In the short term (in the next 2 years)

- State and Territory Governments should review existing programs that support school wellbeing initiatives, and establish which funding could be redirected towards the employment of school wellbeing leaders in government schools.

In the medium term (over 2 – 5 years)

- All schools should have a dedicated wellbeing leader. In larger schools, this should be a full-time position.
- Where government schools can demonstrate that they already employ a staff member in an equivalent position, and are delivering effective mental health and wellbeing programs, they should be able to access the equivalent funding to be used for additional investment in social and emotional wellbeing.

INFORMATION REQUEST 17.1 — FUNDING THE EMPLOYMENT OF WELLBEING LEADERS IN SCHOOLS

The Productivity Commission is seeking input on funding mechanisms for the employment of wellbeing leaders in schools.

- *What existing funding could State and Territory Governments redirect towards employing wellbeing leaders in government schools?*
- *To what extent should the Australian Government contribute to funding their employment in non-government schools?*
- *What would be the number of students enrolled in a school above which a full-time school wellbeing leader would be required?*

A team-based approach to school mental health and wellbeing

In some ways, the delivery of school-based mental health services mirrors the stepped care approach described in chapter 4. Schools implement universal, targeted and intensive interventions, depending on the needs of their students and school community and the curriculum requirements. There is no uniform model for successful delivery of mental health and wellbeing services within schools. As described above, schools often establish wellbeing teams, and their composition will vary from school to school, depending on need and available resources. What determines the success of wellbeing teams is often the commitment and shared understanding of their members. 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 17.5), 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.

In addition to school management and the school's wellbeing leader, wellbeing teams need to include mental health professionals:

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 students' individual needs, in-school support services can initially be delivered by a range of professions — counsellors, social workers, school nurses. The school psychologist would 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).

The education system is not a suitable setting for long-term treatment of mental illness, and practicing in schools can create substantial ethical challenges for psychologists; for example, around student confidentiality and sharing information with teachers and principals (APS 2018b). 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 intense services and they need to work with mental

healthcare professionals to support their students, but their role is not one of mental healthcare provision.

To fulfil their role as a gateway into the mental health system, school mental health and wellbeing teams should develop the school's relationships with local providers of mental healthcare services, such as headspace or other community mental health services. Depending on individual need, the school's wellbeing team should be able to refer students to any external services required, or draw on additional supports offered by the Department of Education.

School wellbeing leaders should monitor the effectiveness of the team they lead. This includes defining clear boundaries around the various responsibilities of team members, assessing whether the school has the right balance between the roles involved in supporting student health and wellbeing and establishing whether available resources match the needs of the school community.

Stakeholders have suggested that resources available currently are insufficient (Merri Health, sub. 120; APS, sub. 543). It is difficult to identify best practice around the numbers of counsellors or psychologists required to improve student outcomes. In the US, the National Association of School Psychologists recommends that ratios do not exceed one psychologist to 1000 students, but this may need to reach 500 or 700 in schools that aim to provide comprehensive prevention services, or whose communities have additional needs. Recommended ratios for counsellors and social workers are 1:250 and 1:400 respectively (NASP 2010, 2013). Nonetheless, the National Association of School Psychologists (2010, p. 10) argues that the 'ratio should be determined by the level of staffing needed to provide comprehensive school psychological services in accordance with the system's needs assessment'.

Departments of education should work with school wellbeing leaders 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. Overall, departments of education should aim to work towards best practice ratios of students to staff members.

Youth workers and peer workers can play a very important role in supporting the mental health and wellbeing of students (for example, VCOS, 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)

17.5 Are we on the right track? Assessing the effect of policy on the wellbeing of school-aged children

As is the case in the broader mental health system, the mental health and wellbeing of children is a topic where Australia is data rich but information poor (chapter 25). Beyond the headline indicators about mental illness among children and young people, which are often based on surveys that have been carried out several 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.

Large scale data collections are not used to their full potential

There is a wide choice of data collections that include metrics relevant to child mental health and wellbeing. 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 2019a). There are also a number of longitudinal studies, which follow groups of children as they grow and collect detailed data on their health (including mental health) and wellbeing.¹⁶

There are many other population health surveys run by governments; in some states, these cover a range of topics relevant to child mental health and wellbeing (for example, VIC DET 2019c; WA DoH 2018). The last national survey, Young Minds Matter, was run in 2013-14 (Telethon Kids Institute 2019). There are currently no plans to repeat the national survey.

Data from these surveys has been used in a very large number of publications, describing the mental health of Australian children, and the effects it has on their education and other outcomes. 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.

Schools also collect vast amounts of data on their students. Collections can be part of standardised testing, such the program for international student assessment (PISA) 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

¹⁶ Examples include the Longitudinal Study of Australian Children (LSAC), the Childhood to Adolescence Transition Study (CATS) and the NSW Child Development Study (AIFS 2019; Murdoch Children's Research Institute nd; UNSW Sydney 2018).

in the Wellbeing and Engagement Collection survey, which offers a very detailed view of children and adolescents' wellbeing (box 17.6).¹⁷

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, participation rates in the survey offered to public schools by the NSW Department of Education vary between 41% and 91% (NSW Auditor-General 2019).

Box 17.6 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 2018, more than 65 000 students from year 4 to year 9 took part in the survey, enabling comparisons between students in their primary and secondary school years. Results show 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 (2014e), 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 2014e, p. 101).

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.¹⁸

Some of the organisations running SEL programs in schools have commissioned individual evaluations of their work, which generally concluded that the programs delivered improvements to children's wellbeing (Slee et al. 2012; Stokes and Turnbull 2016). However, evaluations of the wellbeing policies rolled out across entire education systems have been rare. The Commission has been able to identify only two publicly available

¹⁷ 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 2018, table 4A.27).

¹⁸ The Commission has 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.

evaluation reports, one completed by the Victorian Auditor-General in 2010 and a 2019 report by the NSW Auditor-General.

Improving the use of data to assess child wellbeing: what should governments do

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. According to the 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.

Efforts to develop a national indicator for children's social and emotional wellbeing have been in train since 2006. Most recently, in its 2016 submission to the Productivity Commission's Education Evidence Base inquiry, the Australian Curriculum, Assessment and Reporting Authority stated that is 'collaborating with states and territories to explore measurement of student wellbeing and engagement' (ACARA 2016, p. 1).

The current national indicator for children's social and emotional wellbeing, published by the AIHW, relies on 2014 data from the Young Minds Matter survey (AIHW 2018c). This data is not comparable to past national surveys, or to more recent surveys conducted by other stakeholders, nor is it linked to information about government interventions. While some jurisdictions collect data as part of their population health survey, inconsistent definitions mean it cannot be used to construct a national indicator.

Research undertaken by the AIHW has concluded that responses to 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). The Strengths and Difficulties Questionnaire was included in the Young Minds Matter survey, but has not been run on a large scale since then.

Given that the AIHW has laid the groundwork for a national indicator that uses existing data collections to assess children's wellbeing, the Commission considers that 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 add the Strengths and Difficulties Questionnaire to their population health surveys, with data to be collected and published annually.

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).

Further, as recommended by the Commission in its Education Evidence Base inquiry (PC 2016a), the Australian Government should fund the Australian Institute of Family Studies to establish new cohorts of the Longitudinal Study of Australian Children (LSAC) at regular intervals. The LSAC uses different measures of mental health and wellbeing, which can paint a more comprehensive picture of children and young people's 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 LSAC should include questions about informal care provided by children and young people (chapter 13).

The collection of data is important, but what matters most is the use of this data to improve policy development and implementation. 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 Commission (2016a). Such an evidence base will 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.

State and Territory Governments should monitor the wellbeing of school-aged children, and the extent to which programs delivered in schools are effective in improving outcomes. This could be achieved by:

- the ongoing collection of population health data, as described in draft recommendation 17.6. Such data should routinely be used to inform and evaluate policy.
- the use of existing school surveys to develop school-based outcome measures. Each school's wellbeing policy should aim to deliver measurable improvements in wellbeing, and these should be benchmarked against schools with similar populations. Additional support should be offered to schools where wellbeing measures are declining, and results should be measured continuously to monitor improvement. Results should be aggregated by State and Territory departments of education, such that they are able to report on the effectiveness of the overall school system in supporting better health and wellbeing.
- school surveys should also be used to assess the efficiency and effectiveness of wellbeing programs offered by external providers.

DRAFT RECOMMENDATION 17.6 — DATA ON CHILD SOCIAL AND EMOTIONAL WELLBEING

Governments should expand the collection of data on child social and emotional wellbeing, and ensure data is used (and used consistently) in policy development and evaluation.

In the short term (in the next 2 years)

- the Australian Government should fund the AIHW'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 AIHW should work with Departments of Health to implement data collection. Data should be collected and reported annually.
- State and Territory departments of education should use existing school surveys to monitor the outcomes of wellbeing programs implemented in schools. These should be used to identify schools that require additional support to implement effective wellbeing programs.

In the long term (over 5 – 10 years)

- The Australian Government should fund the creation of an education evidence base, including an evidence base on mental health and wellbeing. This should include funding networks of schools to trial and evaluate innovative approaches.
- The Australian Government should fund the Australian Institute of Family Studies to establish new cohorts of the Longitudinal Study of Australian Children at regular intervals.

17.6 Quantifying the benefits of recommended reforms

There are strong economic arguments for investing in mental health programs targeted at infants, children and young people. Such investments can deliver benefits by:

- preventing mental illness from emerging or reducing its severity, which improves the wellbeing of the individual and their family, reduces the cost of treatment for the healthcare system and prevents productivity loss across a person's life.
- enhancing mental health across the population, which will contribute to higher levels of wellbeing, better educational outcomes, and later on, improved labour market outcomes and overall life trajectories (for example, through fewer incarcerations), higher income tax and GST contributions and less reliance on income support
- intergenerational benefits, as young people become adults and have their own families that experience less parental stress and a lower risk of child maltreatment, which contribute to better outcomes for children (McDaid 2011; McDaid, Park and Wahlbeck 2019).

Numerous studies have attempted to quantify the benefits of interventions to improve mental health and wellbeing for children and young people. Many such studies were conducted in

the United States, with broadly positive results; some have reported returns as high as \$32 for every \$1 invested in specific programs (WSIPP 2019).

Australian studies also reported positive returns on investment in prevention and early intervention across the population. Some estimates reached \$53 billion over the period to 2040, through increased productivity and participation, and saving across health, justice and social services (Urbis 2015b). Submissions to this inquiry emphasised that delaying intervention will offset some of the possible benefits:

Investing in the early years makes good economic sense. Research has demonstrated that investing in the formative years from pregnancy to three years is one of the most efficient and cost-effective ways to create the human capital needed for economies to grow. For every \$1 spent on early childhood development interventions, the return on investment can be as high as \$13.

These returns diminish every year that intervention is delayed. The short terms costs of investment in early years programs, are more than offset by the immediate and long-term benefits in terms of reduction in the need for special education and remediation, better health outcomes, reduced need for social services, lower criminal justice costs and increased self-sufficiency and productivity among families. (QMHC, sub. 228, p. 6)

In this chapter, the Commission has made a range of recommendations to support the mental health and wellbeing of children through the health and education systems. Each of these will carry its own specific costs, although some are likely to mostly require governments to shift their focus to improving current efforts, rather than invest in additional functions.

For example, improving teachers' knowledge of child social and emotional development (draft recommendation 17.4) has been shown to improve outcomes for students (Day et al. 2017; Sklad et al. 2012; Taylor et al. 2017). The costs involved are likely to be relatively low, given that there are already legislated standards for initial teacher education and requirements for ongoing professional development. Regulators would, however, need to ensure that course content is consistent, and provides teachers with evidence-based tools to support their students and deliver effective SEL programs.

The Commission has estimated the possible economic benefits of these recommendations, in terms of expected changes in labour force participation and income. Based on large scale analyses conducted overseas, we assumed that an improvement in the quality of SEL in schools will result in a minor improvement in population mental health for those with below average mental health (specifically, this was assumed to be 0.04 of a standard deviation (appendix F)).

The possible benefits of such a change are likely to be large, given that in the long term, they will apply to a large portion of the working population. Based on preliminary analysis, the possible improvements in mental health are likely to result in 43 000-59 000 more people in employment, and an increase in overall income of about \$4.3-5.6 billion. This includes income from people entering employment due to better mental health, switching from part-time to full-time employment, as well as increases in productivity across the workforce (chapter 26, appendix F).

18 Youth economic participation

Interventions for youth matter because ...

- The years of 18–24 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.
- 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.
- Many 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.

Successful intervention requires ...

- Tertiary education providers should be required to develop a mental health and wellbeing strategy that sets out how they will meet their regulatory obligations to their students in respect of mental health.
 - Tertiary education providers should also clarify the roles and responsibilities of teaching staff in supporting students' mental health and provide information and guidance to teaching staff to help them meet their responsibilities.
 - Guidance should be provided to non-university higher education providers and Vocational Education and Training providers so they can meet their regulatory obligations in regard to their students' mental health.
-

The years between 18 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. 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.

18.1 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. About 50% of adult mental health disorders start by the age of 14 years, with another 25% emerging between the ages of 14 and 24 years (Kessler et al. 2005).

Young adults experience higher rates of mental illness than the rest of the adult population. 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 18.1).

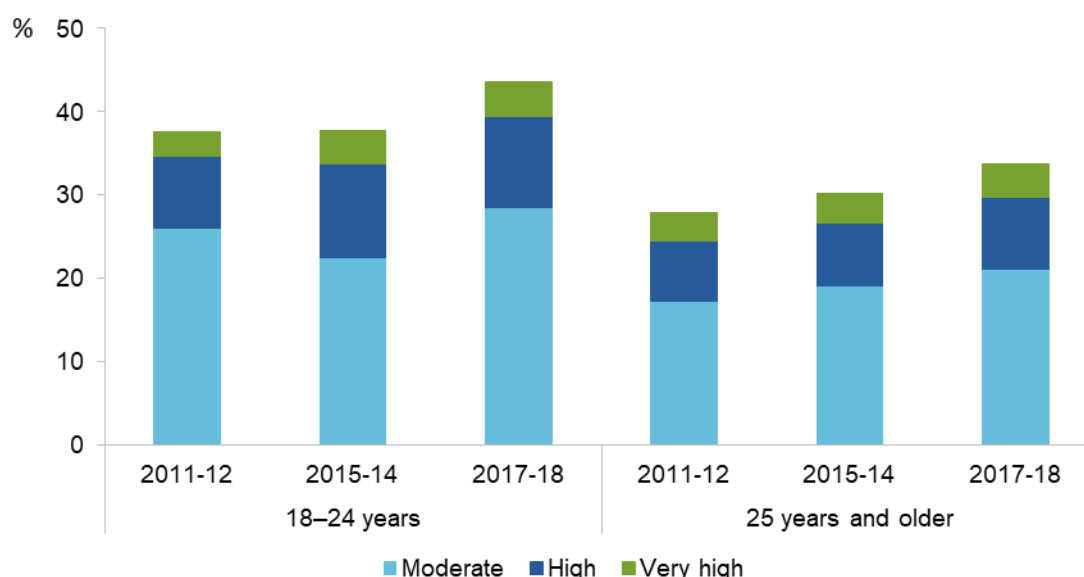
Similar to the general population, the proportion of young adults experiencing moderate or greater psychological distress increased between 2011–12 and 2017–18 — from 37.6% to 43.5% (figure 18.1). However, at least part of this increase could be due to increased awareness about mental health possibly leading to people being more likely to report feelings of distress.

The types of mental illnesses young people experience differ to the general adult population. Young adults have much higher rate of substance use disorders (12.7% of 16–24 year olds compared with 5.1% 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 2011b). 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 2019a).

Figure 18.1 Psychological distress in young adults over time^a



^a Graph excludes not asked and unable to be determined.

Source: ABS (Microdata: Australian Health Survey, National Health Survey, 2011–12, Cat. no. 4324.0.55.001; Microdata: National Health Survey, 2014–15 and 2017–18, Cat. no. 4324.0.55.001).

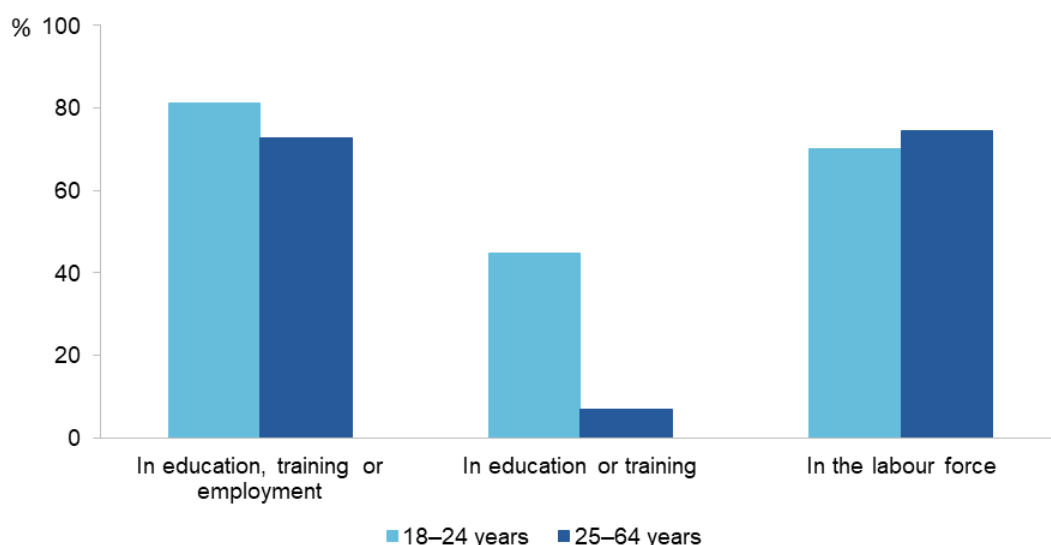
Among young people, those leaving out-of-home-care at the age of 18 years are particularly vulnerable. A Senate inquiry considered them to be some of the most disadvantaged groups of young people who were at greater risk of negative outcomes in terms of social outcomes, psychological functioning, financial status and educational and vocational achievements (Senate Community Affairs References Committee 2015). Young carers are another highly vulnerable group. About 12% of mental health carers in Australia are aged between 15 and 25 years (chapter 13).

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 both.

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 18.2).

Figure 18.2 **Adult economic participation^a**



^a Excludes not stated and unable to be determined.

Source: ABS (*Microdata: Census of Population and Housing, 2016*, Cat. no. 2037.0.30.001).

But there is a large group who struggle with the transition from secondary school into further studies or employment. For example, one study found 19% of 15–24 years olds seeking help for mental ill-health were not engaged in employment, education or training. Those not engaged are more likely to be male, older, and have a history of criminal charges, risky cannabis use, higher levels of depression, poorer social functioning, greater disability and economic hardship, and a more advanced stage of mental illness than those who are engaged (O’Dea et al. 2014).

While short spells not engaged are very common for young people (more than two thirds of all youth spend some time in neither education nor work), long spells of time not engaged are most common for young females and Aboriginal and Torres Strait Islander people (OECD 2016).

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 2019c).

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 2018a)

-
- 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). Employment has also been shown to have mental health-related benefits (chapter 19)
 - increased social participation (OECD 2017a, 2018a; 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.

Poor mental 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 20.2% of clients were disengaged from employment, education and training, compared with 10.7% of the comparable general population (Hilferty et al. 2015, cited in Orygen 2018b). This can have substantial negative consequences for their future wellbeing. Analysis of the 2007 Australian National Survey of Mental and Wellbeing showed that people with no post-school qualifications were more likely to have an affective disorder (Slade et al. 2009).

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 (sub. 204, p. 16) 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.

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 2017; 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 2017, p. 14).

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, 24.3% were employment costs, including reduced earnings due to lower education, and 7.0% were unemployment costs (Degney et al. 2012). The costs associated with mental ill-health are discussed further in chapter 3 and appendix E.

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.

18.2 Supporting people in tertiary education

Many young adults are studying at higher education or vocational education and training (VET) institutions (box 18.1).

While the focus of this chapter is on youth economic participation, many people who undertake tertiary education are aged 25 years and older (ABS 2019d). Given that the data and research in this area generally covers students regardless of age, and that the benefits of education, and the rationale for support 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 2017, there were over 1.5 million university students in Australia and, in 2018, there about 4.1 million undertaking VET studies (DoE 2018c; 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 18.1).

Box 18.1 The tertiary education sectors

Tertiary education in Australia is made up of two sectors: higher education and Vocational Education and Training (VET). These sectors often overlap, with some universities, particularly in Victoria, providing VET-level qualifications and some public and private VET providers also offering higher education qualifications (Norton, Cherastidham and Mackey 2018; Orygen 2017).

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 October 2019, there were 178 higher education providers operating in Australia, including 40 Australian universities, 1 Australian university of specialisation, 1 Australian university college, 2 overseas universities and 134 non-university higher education providers (TEQSA 2019a). The non-university higher education providers are a mix of for-profit and not-for-profit providers, generally specialising in one field of education, occupation, qualification level or type of student (Norton, Cherastidham and Mackey 2018).

The Australian Government is predominantly responsible for policy and regulation of the higher education sector. Higher education providers are regulated under the Higher Education Standards Framework. The Tertiary Education Quality and Standards Agency was established in 2011 as the higher education sector regulator. It registers providers and evaluates their performance against the Higher Education Standards Framework (DoE 2018d).

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. 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 2019g). 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 18.1 Characteristics of tertiary students

Proportion of all students in sector^a

<i>Characteristic</i>	<i>Higher education (2017)</i>	<i>VET (2018)</i>
	%	%
Sex		
Male	44.5	50.8
Female	55.5 ^b	45.1
Located in: ^c		
Major cities	79.8 ^d	59.2
Regional	19.1 ^d	26.7
Remote	0.9 ^d	2.5
Full-time	71.3	10.7 ^e
Aboriginal or Torres Strait Islander	1.3	3.4
With disability	6.4 ^d	4.1
At school	na	8.4
Apprentice or trainee undertaking off-the-job training	..	7.7
SEIFA quintile: ^e		
1 (most disadvantaged)	na	17.3
2	na	18.3
3	na	19.6
4	na	17.4
5 (most advantaged)	na	14.9
Low socioeconomic status ^d	17.6	na
International student	28.5	4.4 ^e

^a For VET data, each category includes a proportion of students of which their status is not known. ^b According to the data notes, students who have requested their gender to be recorded as neither male nor female are counted as female. ^c Does not include students who are located overseas. ^d Excludes international students. ^e Data are for 2017. ^f Quintile 1 is the most disadvantaged. **na** Not available. **..** Not applicable.

Source: DoE (2018a); 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 2019d). 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 28.5% in 2017 (DoE 2018c).

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 outcomes than the general population. For example, Cvetkovski, Reavley and Jorm (2012) analysed the 2007 wave of the Household, Income and Labour Dynamics in Australia survey, the 2007-08 National Health Survey and the 2007 National Survey of Mental Health and Wellbeing and found that tertiary students had a higher prevalence of moderate psychological distress, but the rate of high distress was similar to that of non-students. 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. They 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).

This is not unique to Australia. International studies have also found that tertiary students experience relatively high rates of mental ill-health (Eskin et al. 2016; Kramer et al. 2004; Said, Kypri and Bowman 2013; Steptoe, Tsuda and Tanaka 2007).

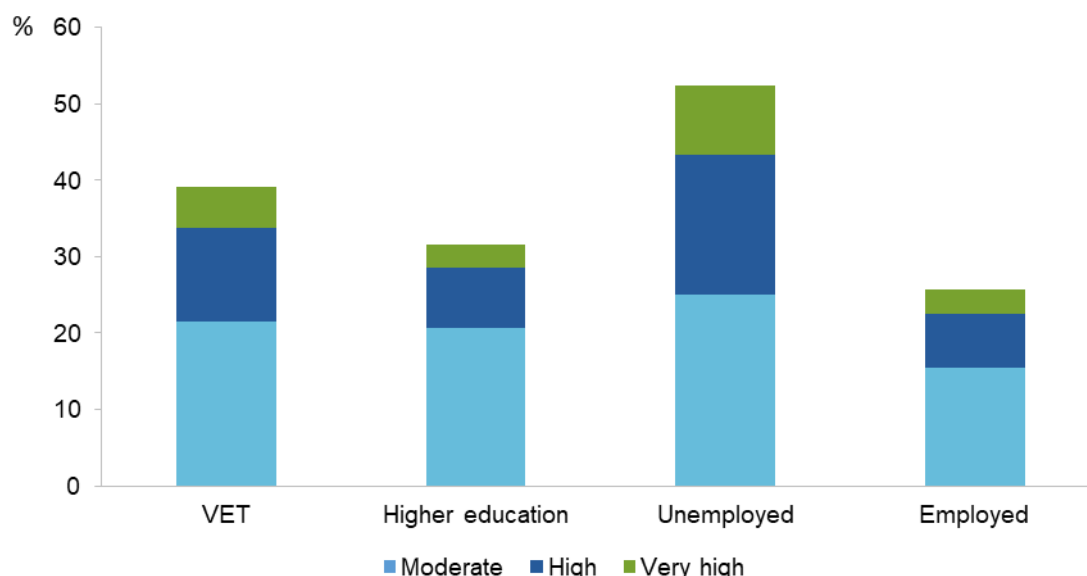
According to data from the Multi-Agency Data Integration Project (ABS 2019e), VET students appear to experience higher levels of psychological distress than university students. Both VET students and university students experience higher levels of distress than those in employment, but not as high as those that are unemployed (figure 18.3).

The prevalence of mental ill-health in university students could have increased in recent years. For example, counselling service managers at Australian and New Zealand universities have reported they have seen an increased demand for counselling, which many services are struggling to meet (Vivekananda, Telley and Trethowan 2011). Also, a submitter to this inquiry who is a TAFE teacher advised that they were encountering more and more students with anxiety (Name withheld, sub. 41). However, an increase could also be driven by more students seeking 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.¹⁹ In some cases, the results of these studies have been benchmarked against national data collections, enabling some comparison with the general Australian population.

¹⁹ Given participation in these surveys has been optional and they generally have low response rates, the results should be treated with caution.

Figure 18.3 Psychological distress by type of economic participation^a
People aged 16–65 years



^a Psychological distress is measured using the Kessler Psychological Distress Scale (K10) assessment.

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

The prevalence of mental ill-health varies between different groups of students

The prevalence of mental ill-health in tertiary students varies between different groups. There is evidence that mental ill-health might be more prevalent in:

- female students (Andrews and Chong 2011; Said, Kypri and Bowman 2013; Stallman 2010; Vivekananda, Telley and Trethowan 2011)
- full-time students (Stallman 2010)
- younger students (Cvetkovski, Reavley and Jorm 2012; Stallman 2010)
- undergraduate students (Andrews and Chong 2011; Said, Kypri and Bowman 2013)
- LGBTIQ students (Said, Kypri and Bowman 2013)
- students with disability (Vivekananda, Telley and Trethowan 2011)
- students on low incomes and those experiencing financial stress (Andrews and Chong 2011; Cvetkovski, Reavley and Jorm 2012; Said, Kypri and Bowman 2013; Stallman 2010)
- students living alone or off-campus (Cvetkovski, Reavley and Jorm 2012; Stallman 2010) and students who have relocated to study (King et al. 2011)
- students who also work (Cvetkovski, Reavley and Jorm 2012)

-
- students undertaking some areas of study, with one study finding that law, psychology and mechanical faculty students had higher rates of psychological distress than medical students (Leahy et al. 2010), and another finding that law students had higher rates of psychological distress than other tertiary students (Kelk et al. 2009)
 - students from a non-English speaking background (Vivekananda, Telley and Trethowan 2011)
 - students in regional and remote areas (Mulder and Cashin 2015)
 - Aboriginal and Torres Strait Islander students (Toombs and Gorman 2011).

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 not found that international students have worse mental health outcomes (Said, Kypri and Bowman 2013; Skromanis et al. 2018; Stallman 2010).

At least part of the mixed results related to international students may be due to cultural factors. International students might underreport 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 18.2).

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.

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 all respondents 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 stress levels and 16% severe levels of anxiety (North, Gross and Smith 2015).

Box 18.2 **Suicides among international students**

Suicides among international students have received significant attention in recent years. In 2019, a Victorian Coroner investigated the death of Zhikai Lui, an international student studying at the University of Melbourne in Victoria. The Victorian Coroner found that Zhikai Liu was likely depressed due to relationship issues, the difficulties he had understanding what was happening in his university classes and the language barriers he faced.

As part of the investigation, the Coroners Prevention Unit found that at least 27 international students had died by suicide in Victoria between 2009 and 2015. However, this is likely to be an underestimate as the Coroners Prevention Unit found, when reviewing the Victorian Suicide Register, in some cases they were unable to determine if the person was in Australia on a student visa or another type of visa. The Unit compared these students to a cohort of domestic students who had died by suicide and found that a lower proportion of international students had a diagnosed or suspected mental health issue, 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 of 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:

- 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 and how critical incident reports maintained by education providers may be brought together 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 with consulting with the education sector to further develop strategies to support international student mental health.

Source: Hunter (2019); Tehan (2019); Victorian Coroner (2019).

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).

Financial stresses

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.

Financial stress may be worsening over time, with a number of studies suggesting that higher education has become less affordable in recent years (Bradley et al. 2008; James et al. 2007 and Long and Hayden 2001, cited in Mulder and Cashin 2015).

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 2017). 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’.

Mental ill-health problems can affect 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 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:

- they can lead to difficulties with concentrating and studying, missing classes and disruptions to participation due the mental ill-health
- perceived and actual stigma, discrimination and fear of failure
- the effect of other issues associated with mental ill-health such as financial pressures (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 reported seeing counsellors, which may reflect the availability of counselling services on university campuses.

Data from a VET provider survey indicated that only 11.7% 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 (Orygen 2018b). This discrepancy indicates that many VET students may choose not to disclose their mental illness, and avoid seeking support and reasonable adjustments. In addition, while the proportion of students with disability enrolled in higher education has increased, only 6.4% of domestic higher education students report having a disability (table 18.1) and only a portion of these would have a mental illness.

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 problem.

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 2017).

Not unlike 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).

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 providing 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 2018b) (box 18.3).

Box 18.3 **Disability Discrimination Act and Disability Standards for Education**

The *Disability Discrimination Act 1992* (Cth) makes it unlawful to discriminate on the basis of disability (including mental illness) in areas such as education, employment, the provision of goods and services, and access to public buildings.

The Disability Standards for Education 2005 were created under the Disability Discrimination Act to clarify education providers' obligations and the rights of students with disability under the Act. The objectives of the standards are to:

- (a) to eliminate, as far as possible, discrimination against persons on the ground of disability in the area of education and training; and
- (b) to ensure, as far as practicable, that persons with disabilities have the same rights to equality before the law in the area of education and training as the rest of the community; and
- (c) to promote recognition and acceptance within the community of the principle that persons with disabilities have the same fundamental rights as the rest of the community.

The Standards are to be reviewed every five years, with the next review expected to take place in 2020 (chapter 17).

Source: *Disability Discrimination Act 1992* (Cth); Disability Standards for Education 2005.

In addition, all higher education and VET sector providers that are registered to educate overseas students must provide certain supports to these students under the *National Code of Practice for Providers of Education and Training to Overseas Students*. These include providing an age and culturally appropriate orientation program and providing or referring students to mental-health and disability related services (box 18.4).

Requirements for the higher education sector

The Higher Education Standards Framework (Threshold Standards) 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 18.4 Requirements of providers who educate overseas students

Under Standard 6 in the National Code of Practice for Providers of Education and Training to Overseas Students, education providers are required to provide a number of mental-health related supports including:

- giving overseas students an age and culturally appropriate orientation program that provides information about:
 - student support services available to assist overseas students to adjust to study and life in Australia and to assist with general or personal circumstances that are adversely affecting their education
 - emergency and health services
 - the provider's facilities and resources
- either directly providing, or referring overseas students to, services and programs, including counselling and mental health, general health, and disability support, at no additional cost to the student
- having a designated contact officer for overseas students, who must have access to up-to-date details of the registered provider's support services
- having a critical incident management policy.

Source: DoE (2018e).

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 the 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 (RTOs) 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. As an example, the University of Technology Sydney (sub. 474, p. 5) stated that adjustments for its students with mental illness commonly included:

- clarification of attendance expectations, procedures for absence and behavioural norms
- provision of a peer mentor
- flexible delivery methods such as online learning, blended learning and flipped classroom programs
- individual orientation to laboratories, workshops, studios and computer systems to reduce anxiety
- feedback on assignments given verbally in private rather than in writing
- additional time in exams, modified exam papers, alternative exam venues or take home exams
- postponement of assessments or suspension of enrolment without penalty if a student experiences a severe episode of their mental illness.

Higher Education Disability Support Program

The Higher Education Disability Support Program was established by the Australian Government to help support students with disability in higher education. 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 2019c).

KPMG conducted an evaluation of the Higher Education Disability Support Program in 2015. While KPMG concluded that the Disability Support Program is generally meeting its objectives, it noted some areas where it could be improved. In relation to mental health, KPMG found that:

- while more students with mental health issues and learning disorders are accessing university disability services, the bulk of funding under the program supports physical disabilities
- a lack of awareness of the implications of mental illnesses and understanding of how to support students amongst academic staff means that disability support workers spend a lot of time working with academics to raise awareness and develop learning plans. In addition, staff training was not eligible for funding under the Disability Support Program
- students with mental illness thought that students with more visible disabilities were better catered for
- higher education providers do not necessarily have the expertise to meet the needs of students with mental health issues (KPMG 2015).

KPMG argued that including staff training in the activities that could be funded under the Disability Support Program would improve the ability of the program to respond to changes in student needs and to better meet the needs of students with mental health and learning disorders (KPMG 2015). The Australian Government Department of Education has stated that it is progressing this recommendation to expand the use of funding to include staff training to better support students with mental illness (Department of Education, pers. comm., 27 August 2019). However, it remains unclear when this recommendation will be implemented.

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. 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, and 35% offered access to external counselling. About 25% of services reported that they do not offer any counselling at all (TEQSA 2019b). However, there is no complete information on which institutions have counselling services.

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 2017; Universities Australia, sub. 251).

Most students who access counselling services do so for common mental disorders, including depression and mood disorders and anxiety disorder. 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 2017).

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 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 in 2020 (Hunt 2018a; Orygen and headspace, sub. 204).

What needs to be done to improve support provided to tertiary students?

Given the high proportion of tertiary students who experience mental ill-health and the effect these problems 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.

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 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 need 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 ensure 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 institutions 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 also 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 number of students are approaching counselling services
- current students are more likely to have severe and complex needs than previously seen
- the student population is becoming more diverse, and these students often require a different approach (Andrews et al. 2010).

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. 2010). These guidelines cover a range of topics including the role, function and responsibilities of services, the typical activities and types of services provided, services standards, staffing — including staff levels, qualification and workloads — and risk management and occupational health and safety.

These guidelines also include a recommended staff to student ratio for counselling services of either one counsellor to 1000 or 3000 student population per campus, depending on the types of services the counselling service is expected to provide (Andrews et al. 2010). 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 these services. This includes ensuring that these services can meet the needs of a diverse cohort of students, including those who are Aboriginal or Torres Strait Islanders, from overseas, from culturally and linguistically diverse backgrounds and who are studying off-campus (draft recommendation 18.2).

There have been calls for tertiary education providers to develop partnerships with external service providers. Orygen (2017) 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 (Andrews 2019 IHEA, sub. 555; Inglis & 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 6). For example, Macquarie University provides an online delivered treatment course over 5 weeks for its students to provide practical skills for managing symptoms of stress, anxiety, worry, low mood and depression (Macquarie University 2018).

The use of online services could improve 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.

INFORMATION REQUEST 18.1 — GREATER USE OF ONLINE SERVICES

Should tertiary institutions play a more active role in promoting the use of online services for student mental health? To what extent could (and should) an increase in the use of online services in tertiary institutions be used to improve information on, and practical support for, the mental health of student populations?

Educators 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. 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).

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).

Tertiary education providers need to clarify the roles and responsibilities of teaching 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).

DRAFT RECOMMENDATION 18.1 — TRAINING FOR EDUCATORS IN TERTIARY EDUCATION INSTITUTIONS

In the short term (in the next 2 years)

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 teaching staff to undertake training on student mental health and wellbeing
- all tertiary education providers to make available guidance for teaching staff on what they should do if a student approaches them with a mental health concern and how they can support student mental health.

INFORMATION REQUEST 18.2 — WHAT TYPE AND LEVEL OF TRAINING SHOULD BE PROVIDED TO EDUCATORS

What type and level of training should be provided to teaching staff to better support students' mental health and wellbeing?

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. 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 18.2).

More generally, if there are barriers to international students accessing mental health services, these need to be addressed. Students from most countries²⁰ 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 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 2 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 2019i).

We have heard concerns during the inquiry about the ability of international students to access mental health services, even though they hold OSHC.

The Commission has been unable to ascertain which government department has responsibility for ensuring that international students have and maintain the necessary OSHC. 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). While the regulatory arrangements remain unclear and there is insufficient sharing of information between government agencies and service providers, the amount of taxpayer funds involved with respect to mental healthcare is likely to be comparatively small.

²⁰ 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 2019b).

Tertiary education institutions that choose to accept international students need to provide adequate services to students that meet their varied and diverse needs. One approach would be for tertiary education institutions (or groups of institutions) 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. It would be up to the tertiary institution to recover the costs of the insurance cover from their international students.

INFORMATION REQUEST 18.3 — INTERNATIONAL STUDENTS ACCESS TO MENTAL HEALTH SERVICES

The Productivity Commission is seeking more information on:

- *the difficulties international students face accessing mental health services, including any problems with the Overseas Student Health Cover and the merits of requiring tertiary institutions to take responsibility for ensuring their international students have sufficient healthcare cover*
 - *what reforms are required to improve the treatment of and support provided to international 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 in-house counselling services or 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 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.

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 initiative to support their students' mental health.

DRAFT RECOMMENDATION 18.2 — STUDENT MENTAL HEALTH AND WELLBEING STRATEGY IN TERTIARY EDUCATION INSTITUTIONS

In the short term (in the next 2 years)

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*, including information on their internal and external support and the partnerships with providers of external supports
- ensuring on-site 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.

In the medium term (over 2 – 5 years)

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 this information to tertiary education providers.

DRAFT RECOMMENDATION 18.3 — GUIDANCE FOR TERTIARY EDUCATION PROVIDERS

In the short term (in the next 2 years)

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 18.5).

Box 18.5 **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 now 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).

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).

In some workplaces, apprentices and trainees are ‘soft targets’ with limited potential to defend themselves. There is an imbalance of power and status experienced by apprentices and trainees and in some workplaces, new apprentices and trainees may be outranked both formally and informally by other workers. The bullying that sometimes results may be seen as 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 D.

A further pressure for trainees involves their contractual arrangements relating to their employment and training (box 18.5) — for example, the need to find another employer to continue and complete their training if their employer’s business fails. 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 19). 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 2019)
- 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 2019f)

- 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 2019a)
- supports provided by Group Training Organisations²¹, 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 18.6)
- 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).

Box 18.6 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

²¹ 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 2019c).

apprentices and found that informal and peer-based mentoring services are often more effective than formal mentoring arrangements. As well, we have heard that support from industry mentors has been effective in helping apprentices to complete their training. 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 19) will benefit apprentices and trainees and their mental health.

18.3 Support for youth to re-engage with 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 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, negative effects of medication and

difficulty with 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).

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 Commission considers that both of these program types are needed for improved educational outcomes and that each State and Territory should have clear, well-funded policy and interventions that support the roll-out of such programs.

Education support for young people experiencing mental ill-health

Australia has no structure for addressing incompleteness of school education in a consistent way. Schools are able to register frequent or long-term absences, but cannot track student who change 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 the 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, p. 43).

VET is an attractive pathway because it is more accessible than other post-school education programs. Completing a VET program also increases the likelihood of employment more for people with disability than those without (Polidano and Mavromaras 2010).

headspace Digital Work and Study Service

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 the young people participating in the service reported a work or study outcome, which increased to 72% for people who completed at least ten 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 14).

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 Department of Social Services stated that the initial results were promising, with 50% of the 879 participants achieving an education or employment placement (Henderson and Fletcher 2019). Although evaluation results have not been made public, Orygen and headspace (sub. 204, p. 43) noted that the program has a placement rate of young people into education or work of about 72% based on data it privately received from nine IPS sites. About 20% of people in the program are placed into education based on Commission estimates. In January 2019, the trial was extended by two years, with additional funding to extend the trial to 10 more headspace centres (chapter 14).

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).

Another NSW Government initiative is the Young People's Outreach Program within the Community Living Supports program that aims to increase social participation and inclusion more generally, with education part of its agenda (Mental Health Commission of NSW 2015). Other states run similar programs, for instance Western Australia funds the Individualised Community Living Strategy program.

General support for disengaged young adults

National, state-based and local programs also 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.

Flexible Learning Options

Flexible learning options (FLOs) are re-engagement programs that emphasise inclusivity for marginalised young people across Australia. They offer formal academic credentials and feature applied learning while providing comprehensive mental and emotional wellbeing support (Thomas and Nicholas 2018). They typically cater to 15–18 year olds but can extend to cohorts several years older. For instance, programs can be offered by TAFEs and Community Colleges either as part of their general education program or offered to specific groups of disadvantaged people.

The OECD (2016) noted that while some individual cases studies have proven promising, many flexible learning programs have not been subject to rigorous evaluation as to the their effect on participants.

National Disability Coordination Officer Program

The National Disability Coordination Officer Program is an Australian Government funded program that aims to improve access and participation in tertiary education and subsequent employment for people with disability. The program establishes a network of regionally based National Disability Coordination Officers who work with stakeholders (such as educational institutions, employment agencies, and bodies that provide relevant services to Aboriginal and Torres Strait Islander people) at the local level to reduce systemic barriers, facilitate smooth transitions, build links and coordinate services. Part of this program is raising awareness about the support services available to participants (DoE 2019e).

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 have young people re-engage 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 17.

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 would be expected to be improvements in participation of disengaged learners in achievement (as measured by completion or improvement in skill levels), progress to other types of study and an overall reduction in the population with Certificate III or above qualifications. However, these conclusions were for all disengaged learners across all age groups.

Trials have shown that a youth-focused IPS that provides support for young people with mental illness has been fairly successful in placing them in employment or education (Orygen and headspace, sub. 204). The IPS services model in general is considered to be effective in improving the employment outcomes of people with mental illness. Depending on the final outcomes of the trial, State and Territory Governments should include youth-focused services in their staged rollout of IPS services more generally (draft recommendation 14.3).

19 Mentally healthy workplaces

Interventions for 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 good 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.
- A number of recognised workplace risk factors — such as high job demands with little control, imbalance between effort and reward and a lack of organisational justice in the workplace — can create a poor psychosocial work environment.
- Hazards such as workplace bullying are increasingly an issue.
- The cost of workers compensation claims for work related mental health conditions is about three times the cost of other workers compensations claims and involves significantly more time off work.

Successful intervention requires ...

As a priority:

- Making psychological health and safety as important as physical health and safety in Workplace Health and Safety (WHS) arrangements.
- Providing clinical treatment for mental health related workers compensation claims, irrespective of liability, for a period of up to 6 months.

Additional actions required include:

- Developing codes of practices to assist employers, particularly small employers, better manage psychological risks in the workplace
 - Having WHS agencies and employers work together to collect and disseminate information on the effectiveness of workplace programs and interventions.
-

There are strong links between employment and mental health. Being employed can improve mental health and mentally healthy work places are important to maintain the good mental health of those who work there.

There are also strong economic reasons to encourage those with a 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 issues, improved productivity and lower compensation claims).

19.1 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 any existing mental health problems. Most studies have found that being employed supports good mental health and work, on balance, acts as a protective force — and while unemployment can be psychologically damaging, poorly designed workplaces can exacerbate mental health symptoms (Harvey et al. 2014). The benefits of employment on mental health are discussed in detail in chapter 14.

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 business in Australia is in the order of \$11 billion (PWC 2014) to \$12.8 billion each year (KPMG and Mental Health Australia 2018).

What is a mentally healthy workplace?

There is limited evidence of what actually 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 19.1).

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 19.1 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 control 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 mitigating these psychosocial risks. There is also the quality of the interpersonal relationships in the workplace and the leadership exhibited by supervisors and management.

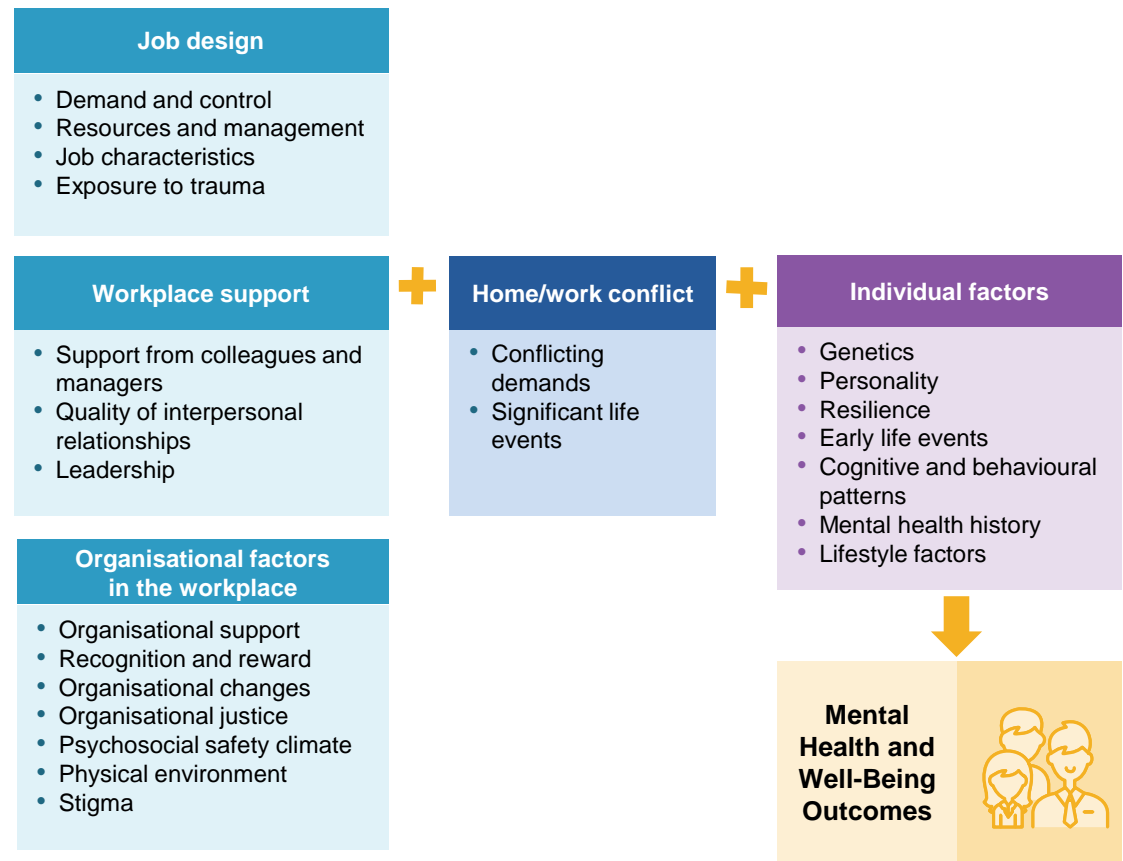
Research into organisational justice (the perceived fairness of rules and norms within an organisation in terms of the distribution of benefits and rewards and the methods and processes of how these rewards are distributed) has indicated that organisation factors relating to fairness and justice can 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: Safe Work NSW (2017) Harvey et al.(2012); Harvey et al. (2014); Beyond Blue (2018a).

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 19.1).

Figure 19.1 **Factors contributing to a mentally healthy workplace**



Source: Harvey et al (2014).

These outside risk factors include home/work conflict or the pressures at home, such as marital distress, domestic violence, caring for dependent children and older persons that can impact on levels of depression and anxiety as well as on 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).

While on balance employment is generally recognised as being protective to an individual's mental health, poorly designed work can exacerbate mental ill-health symptoms. Given the importance of a mentally healthy workplace to the mental health of an individual and the costs resulting from mentally unhealthy workplaces, governments 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
- the initiatives undertaken by business to improve the mental health of their workplace and address the potential costs of ill-health.

19.2 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, then 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 territories²². 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.

²² 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.

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 health issues 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, as required under 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 2010b). 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 requirements involving 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 19.1). 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 19.2).

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 more 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 D.

Box 19.2 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 physical and mental health.

In a workplace with a high PSC 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: Dollard et al (2012); Becher and Dollard (2016); Dollard and Bakker (2010); 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 to 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 issues.

Is there is a lack of focus in the WHS legislation and regulation?

Although there is a duty of care to the health and safety of employees under WHS legislation (including their mental health), specific reference to psychological health and safety is limited. The recent independent review of the model WHS laws in Australia noted the widespread view that psychological health was neglected in WHS codes and regulations (Boland 2018). This has resulted in some uncertainty and confusion for employers as to how they should meet their duty of care in regard to psychological health. It has also presented challenges for the broader interpretation and implementation of the legislation as well as for WHS regulators in dealing with enforcement or breaches associated with mental health (Safe Work NSW 2017).

The review of the model WHS laws in December 2018 recommended that new WHS regulations be developed that set out how to identify the psychosocial risks associated with psychological injuries and appropriate control measures to manage those risks. However, a number of employer groups argued that this would be overly prescriptive and instead proposed that guidelines rather than regulation be used (Boland 2018). In its submission to this inquiry, the Australian Chamber of Commerce and Industry said:

Blanket ‘one-size-fits-all’ approaches to psychological risk in workplaces are not effective and the emphasis should be on empowering and assisting workplace to effectively manage psychological risk relevant to their individual work contexts (sub. 365, p. 30)

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).

DRAFT RECOMMENDATION 19.1 — PSYCHOLOGICAL HEALTH AND SAFETY IN WORKPLACE HEALTH AND SAFETY LAWS

Psychological health and safety should be given the same importance as physical health and safety in workplace health and safety (WHS) laws.

In the short term (in the next 2 years)

The model WHS laws (and the WHS laws in those jurisdictions not currently using the model laws) should be amended to ensure psychological health and safety in the workplace is given similar consideration to physical health and safety.

- 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 similarly 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. 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, NSW 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 Psychological Health Guide to assist employers with meeting their duty of care under the model WHS laws (Safe Work Australia, sub. 256).

Guidance or regulation?

Some employers are seeking more than guidance in meeting their duty of care in regard to psychological health (Boland 2018). Unlike with physical health and safety, there are no specific regulatory requirements or practical examples of how to comply in the WHS laws. As 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.

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).

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.

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 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 issues (appendix C).

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. (The Western Australian Government recently introduced a code of practice for mentally healthy workplace 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 business would continue to be able to implement their own processes and procedures to meet their duty of care.

DRAFT RECOMMENDATION 19.2 — CODES OF PRACTICE ON EMPLOYER DUTY OF CARE

In the short term (in the next 2 years)

Codes of practice should be developed by Workplace Health and Safety authorities in conjunction with Safe Work Australia to assist employers meet their duty of care in identifying, eliminating and managing risks to psychological health in the workplace. Codes of practices should be developed to reflect the different risk profiles of different industries and occupations.

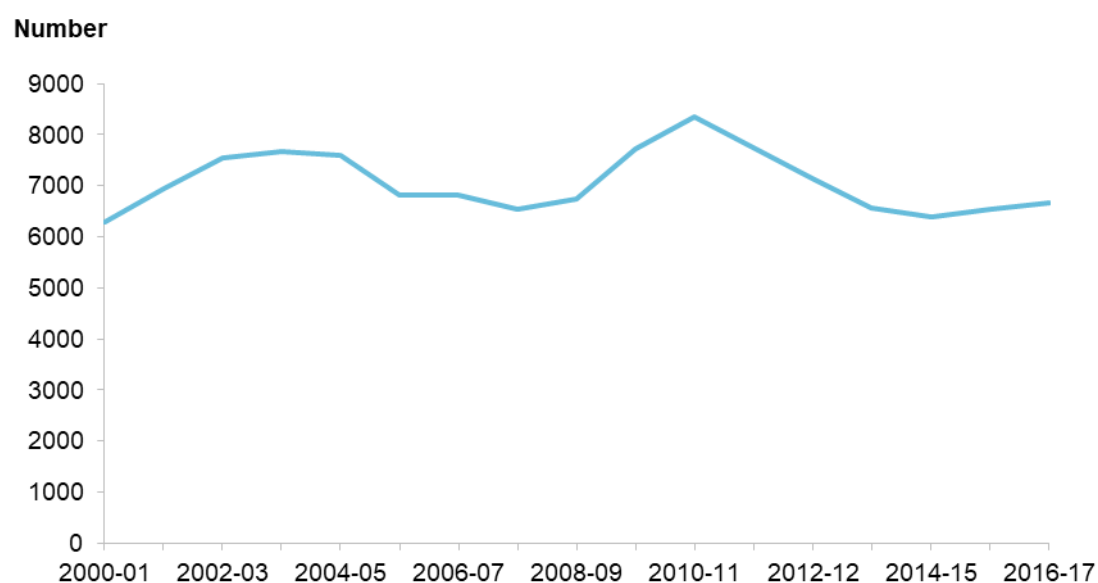
19.3 Workers compensation arrangements and workplace mental health

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 and involve more time off work. (Serious claims are those accepted claims that resulted in at least a week's absence from work). Between 2012-13 and 2016-17 the typical cost of a workplace related mental health claim was \$25 650 compared with \$10 600 for all other claims and the typical time of work was 16.2 weeks compared with 5.7 weeks for all other claims (Safe Work Australia 2018b, sub. 256).

The number of serious workers compensation claims caused by work place mental stress has fluctuated over the past 15 years at between roughly 6000 and 8000 claims per year (figure 19.2). However, the number of serious work-related mental health claims as a proportion of all claims has remained fairly stable at about 5 to 6 % of all claims over the past 15 years.

Figure 19.2 Serious accepted workers compensation claims caused by mental stress^a



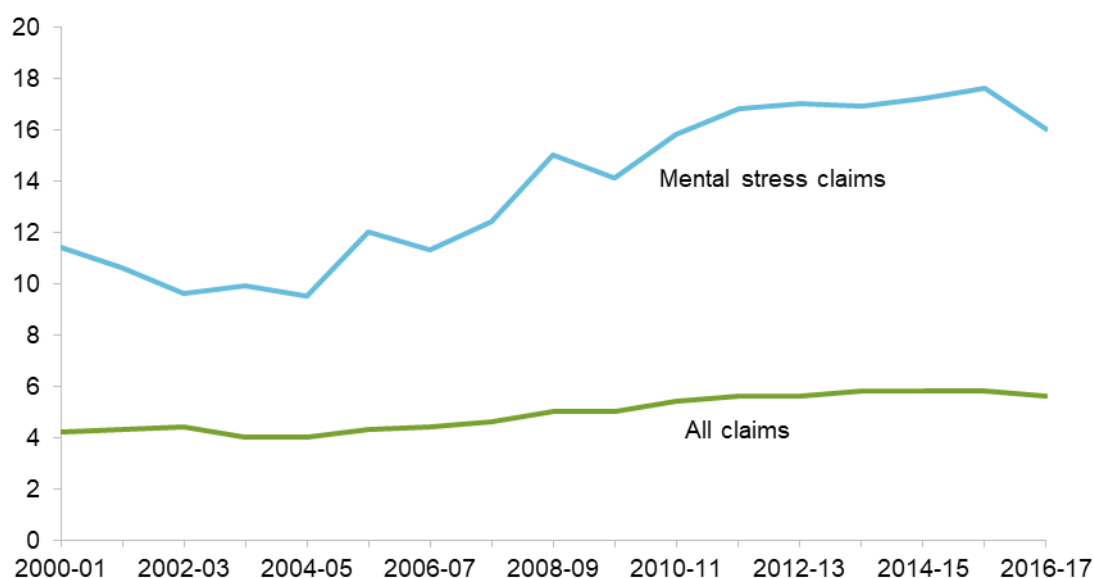
^a Serious claims are those that resulted in a least a week's absence from work. Data for 2016-17 is provisional.

Source: Safe Work Australia's National Data-Set for Compensation-based Statistics.

Although the number of claims caused by work place mental stress as a share of all claims has remained fairly stable over time, the time lost from work from these claims has been increasing (figure 19.3).

Figure 19.3 Time lost from work due to serious accepted workers compensation claims caused by mental stress^a

Median working weeks lost



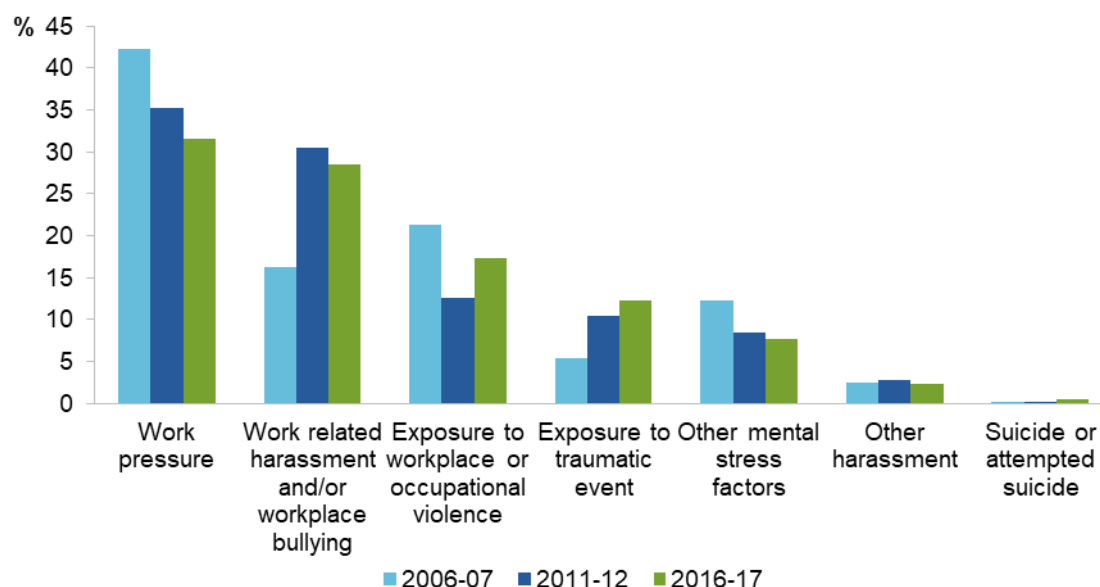
^a Serious claims are those that resulted in a least a week's absence from work. Data for 2016-17 is provisional.

Source: Safe Work Australia's National Data-Set for Compensation-based Statistics.

The most common cause of accepted mental health related workers compensation claims in 2016-17 was a result of work pressure, followed by work related harassment or bullying and exposure to workplace or occupational violence (figure 19.4). 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 (figure 19.4). Appendix F discusses workplace bullying in further detail.

Figure 19.4 Accepted workers compensation claims caused by type of mental stress, 2016-17

Share of total accepted serious mental health related claims in Australia^a



^a Serious claims are those accepted claims that resulted in absence from work of a single working week or more. Data does not include Victoria and is provisional for 2016-17.

Source: Safe Work Australia's National Data-Set for Compensation-based Statistics.

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 health care and social assistance and then education and training — reflecting the occupational share of claims (figure 19.5).

However, the data discussed above relate to those claims for workers compensation that were both lodged and accepted. Others may simply have not lodged a claim or had their claim rejected. Drawing on data provided by the State and Territory workers compensation schemes indicates that 35 to 45% of workers compensation claims related to mental health are rejected in comparison to between 6 to 10% of non-mental health claims. Data from the Australian Government's workers compensation scheme, Comcare, indicates rejection rates on average of nearly 60% for mental health related claims and 18% for non-mental health related claims. Workers compensation arrangements and mental health along with the various requirements for a claim to be accepted are discussed below.

Figure 19.5 Incident rate of serious accepted claims^a caused by mental stress, by industry^b

Claims per 1000 employees, 5 year average 2012-13 to 2016-17



^a Serious claims are those that resulted in a least a week's absence from work. Data for 2016-17 is provisional. ^b Public administration and safety includes police services, investigation and security, fire protection and other emergency services, correctional and detention services, regulatory services, border control and other public order and safety services.

Source: Safe Work Australia's National Data-Set for Compensation-based Statistics.

Workers compensation arrangements and workplace mental health

All employers are required to have workers compensation insurance. Workers compensation provides those workers suffering from 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 ACT, workers compensation is provided by private insurers underwriting the scheme (table 19. 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 administered by the Military Rehabilitation and Compensation Commission. The Productivity Commission's inquiry into the compensation

and rehabilitations 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 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 the 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.

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 workplace performance. 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 D.

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. 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, formally under a workers compensation claim, a clinician such as a psychologist treating the worker 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 childhood trauma.

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.

The difficulty of linking a mental health problem 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.²³

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)

Return to work following a psychological injury or mental illness

Time away from work can be detrimental to recovery. 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

²³ 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 laws claims made by employees. Most workers compensation schemes in Australia have limits on access to common law claims.

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. The difficulties around return to work are discussed further in box 19.3.

Box 19.3 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 colleagues further increasing tensions in the workplace (Ai Group, sub. 208).

DRAFT FINDING 19.1 — RETURN TO WORK IS 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 are more acute for smaller businesses operating from a single location, as unlike larger organisations that have multiple sites, the business is unable to provide return to work at a different location.

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 from 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 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 (see appendix D) (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 and should not be understated.

Some jurisdictions set a higher standard of contribution from employment for psychological injuries to be compensable than for physical injuries. For example, the Queensland scheme requires that for a non-psychiatric injury or psychological disorder employment is required to be ‘a significant contributing factor’, whereas for a psychiatric injury or psychological disorder the threshold is that ‘employment is the major contributing factor to the injury’ (*Workers Compensation and Rehabilitation Act 2003* Qld s32(1)). 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 35 and 45% 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).

DRAFT FINDING 19.2 — THE ROLE OF WORKERS COMPENSATION IN ADDRESSING MENTAL HEALTH

Workers compensation arrangements can most effectively deal with mental health claims and improve outcomes for employers and employees by providing for:

- early intervention
- early treatment
- successful return to work.

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 19.1). 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 and in Queensland claims experience does not apply to businesses with payroll less than \$1.5 million. However, the Queensland scheme does provide for premiums to move between 5 rating categories. These 5 categories range from 80% of the industry rate to 120% of the industry rate for these businesses based on their previous claims experience and premiums 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 businesses 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.

For those employers with premiums impacted by previous claims experience there is an incentive to deny liability, particularly for those claims where there may not be a clear causal link to employment. These incentives to deny liability can be strengthened where employers are faced with having their premium reflect their actual claim costs as well as an estimate of the future cost of these claims. For example, Victorian WorkCover includes claims lodged and paid over a particular period (usually three consecutive years) and a statistical case estimate²⁴ for the future costs of those claims in setting next year’s premium (Stipic 2018). 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.

²⁴ The statistical case estimate is based on a range of claims variables (diagnostic, compensation, demographic, medical and time factors of the claim) to predict claims outcomes (Konekt 2019).

Table 19.1 **Workers compensation schemes**

	<i>Scheme type</i>	<i>How are premiums set</i>	<i>Exemptions from claims history</i>
NSW	Hybrid (Private insurers operate as scheme agents on behalf of Icare)	Claims performance rate (CPR) is calculated by comparing the employers claims performance with other similar NSW businesses.	Previous claims do not affect premiums for those employers with an average premium less than \$30 000
Vic	Hybrid (Private insurers operate as scheme agents on behalf of WorkSafe Victoria)	Premiums are primarily set by the size of the remuneration, the industry and claims experience against the industry average. The larger an employer the more its experience impact on its premium.	Previous claims do not affect premiums for employers with rateable remuneration less than \$200 000. Premiums are set on an industry average
Qld	Government scheme (WorkCover operates the scheme and no private insurers are involved)	For employers with payrolls < \$1.5 million premiums are based on claims performance, industry claims performance and size relative to industry. Below \$1.5 million simplified model using categories relative to industry rate to set premiums	For those with payrolls less than \$1.5 million rating categories protects from large variances in premiums shifts due to expensive one-off claims For those over \$1.5 million claims history is taken into account
SA	Hybrid (Private insurers operate as scheme agents on behalf of ReturnToWork SA)	Based on remuneration, industry and claims experience in the previous year	Sole business operators and some small business pay a flat premium of \$200 in 2018-19
WA	Private^a	Based on remuneration, industry and claims experience in the previous year (discount and loading of up to 75% can apply depending on the risk profile)	There are no exemptions from claims history, but loadings are limited by the regulator
Tas	Private^b	Based on remuneration, industry and claims experience	No exemptions from claims history
NT	Private^c	Based on the industry type, claims history, payroll and number of employees	No exemptions from claims history
ACT	Private^d	Based on the industry type, claims history, payroll and number of employees	No exemptions from claims history
Cth	Government scheme (Comcare)	Based on the industry type, claims history, payroll and number of employees	Claims history is relevant

^a WorkCover WA sets recommended premium rates with the private insurers able to use their underwriting models to take into account claims experience. Insurers are able to apply a loading above 75% of the recommended premium and loading above that require WorkCover approval. ^b The Tasmanian WorkCover Board monitors premium rates at the scheme level, but is not able to influence the premiums charged by the licensed insurers ^c The NT legislation does not regulate minimum or maximum premiums or establish advisory premiums and insurers operate with commercial independence. ^d The ACT Government annually publishes suggested reasonable rates to guide private insurers.

Source: Safe Work Australia (2018a). State based workers compensation schemes.

Why exempt smaller businesses from claims experience in setting premiums?

The reason put forward to exempt small businesses²⁵ 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.

Consequently, 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 to employers to improve workplace health and safety, and create a more mentally healthy workplace—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. 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.

²⁵ 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 19.1).

Workers compensation schemes through their insurers collect a considerable amount of claims data. 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. Further opportunities to utilise this and other insurance data are discussed below.

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.

DRAFT RECOMMENDATION 19.3 — LOWER PREMIUMS AND WORKPLACE INITIATIVES

In the medium term (over 2 – 5 years)

Workers compensation schemes should provide lower 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 fire fighter 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.

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 introduced presumptive legislation for PTSD for all public sector workers including first responders and volunteer first responders (Courtney 2019; Skatsoon 2019).

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 19.2).

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 \$7500 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 2 years. The pilot program commenced in July 2019. For the pilot scheme there would be a monetary cap on medical expenses, with the only requirement that the expenses remain reasonable (Andrews 2018) (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.

A 2018 review of Queensland's workers compensation arrangements recommended that insurers cover the costs of a prescribed level treatment for workers claiming a potential psychological injury or mental illness on a 'no prejudice' basis until liability had been determined (up to a limited time). This was to ensure that workers received timely support and necessary treatment and to provide an appropriate incentive for insurers to meet reasonable claim decision times. Provision of these services was not intended to have any bearing on liability or acceptance of the claim. If the injury was work related the cost would ultimately be met by the employer (at least for large employers) through their claims history whereas if not work related, the insurer (being the Queensland Government's WorkCover) would have to meet the cost of the treatment. The Review called for these arrangements to be evaluated after having been in place for 2 years (Peetz 2018).

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, there is an issue as to who pays 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. Clearly, if the liability is denied and the payments received by the claimant have to be recovered, additional pressure will 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.

Table 19.2 Time requirements on determination of workers compensation claims and provisional or interim payments

NSW	The worker is entitled to receive provisional liability of up to 12 weeks compensation (for loss of income) and \$7,500 in medical expenses. If the claim is likely to exceed this period of time, the agent must determine whether to accept or reject the claim.
Vic	Agent has 28 days to accept or reject a claim. If the worker has not been advised of the decision by the 39th day after the claim was lodged with the employer, the claim will be deemed to have been accepted.
Qld	WorkCover Queensland has 20 days to accept or reject a claim, or must write to the worker (within 5 days of the 20 days) advising of its reasons for not making a decision, and advising that the worker can seek a review.
SA	The agent is required to make reasonable efforts to make a decision on the claim within 10 days. If this is not achieved, interim payments will be made.
WA	The insurer must advise the worker within 14 days that the claim has been accepted or is in dispute. If the worker does not receive final notification that the claim has been accepted or rejected, within a further 10 days, the claim is deemed to be accepted.
Tas	Payments are payable 'without prejudice' on lodgement of the claim. The employer, or their insurer, must advise the worker of the status of claim within 28 days of claim being lodged with the employer. If an employer wishes to dispute a claim, they must do so within 84 days
ACT	The insurer has 28 days from the time they receive the claim to make a decision to accept or reject the claim, otherwise the claim is deemed to be accepted.
NT	If a decision is not made by the Agent within 10 days of the employer receiving the claim, the claim is deemed to be accepted.
Comcare	No legislated time frame for claims decisions. The only requirement to make determinations accurately and quickly.

Source: Ai Group (2019), Safe Work Australia(2017).

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 or to determine liability can delay the treatment that would improve the likelihood of recovery and a successful return to work.

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 considerable 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 the access to similar treatment and may be limited to treatment through the public system.

There would also be considerable cost shifting on to employers and others. Removal of the employment related test would require employers to pay premiums to meet the costs of all health conditions affecting their employees, not just those that have arisen within the workplace or within their control. This would 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 mental ill health. 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 avoids 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 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 were ‘mentally healthy’ — not dissimilar to workers compensation premiums.

A role for the nominal insurer or similar?

Given that there are significant problems around removing the link between employment and liability, 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 type 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, while having the insurer meet costs for which they were not liable would raise premiums above a level that was actuarially fair.

Workers compensation schemes typically operate with a nominal insurer arrangement (or uninsured fund or default insurance fund) in place to provide a safety net for injured workers left without workers compensation arising from uninsured employers, bankrupt employers or insolvent insurers. The nominal insurer, as the ‘safety net’ insurer, would meet the costs of the treatment provided to these workers, although these costs would be passed on to all employers through their premiums given that the nominal insurer is ultimately funded by those businesses that are insured. Even though the employer would bear the costs of these arrangements to provide early intervention, they (along with the employee) would benefit from the arrangements through lower absenteeism, a quicker recovery and return to work and reduced presenteeism following return to work.

The increase in premiums in such an approach should be transparent rather than having the insurer absorb these costs and then shift these costs back on to employers as general increases in premiums. This could be achieved by including on the employer’s premium document or workers compensation account the explicit dollar amount levied on their premium to fund the nominal insurer. Self-insurers would be required to make similar provisions to meet these costs.

The increase in the annual premium costs required to fund the treatment for these workers would not be large. From data provided to the Commission, annual medical costs for the treatment of mental health claims that were later rejected (in those jurisdictions with provisional liability or similar arrangements) ranged from under 0.1% to about 0.6% of the annual written premium revenue collected. In two of these jurisdictions medical costs are capped (at \$5000 in Tasmania and \$7500 in New South Wales).

To limit the demand on the nominal insurer, these arrangements would not compensate for any loss of income until liability was determined, within a specified period of time.

A set period for treatment to improve return to work outcomes

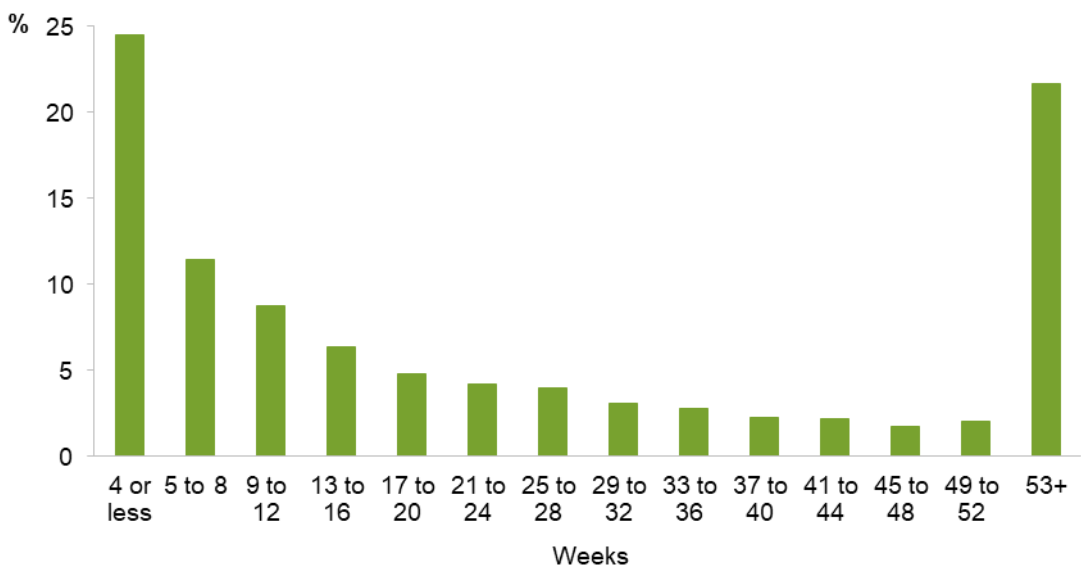
A problem with having the date of determination of liability as the ‘set date’ for clinical treatment is that this date may not align with an appropriate point in the employee’s treatment. If liability is denied, then the employee is likely to suffer a disruption of treatment unless they have their own funds or private health insurance that allows them to continue current treatment. This disruption can slow the employee’s recovery and may slow his or her 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 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 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 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 uninterrupted 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 (see figure 19.6).

Figure 19.6 Serious workers compensation claims for mental health related claims, by work time lost^a

Share of all mental health claims, 2012-13 to 2016-17



^a Serious workers compensation claims are accepted workers compensation claims for an absence from work for one working week or more. Data for 2016-17 are preliminary.

Source: Safe Work Australia’s National Data-Set for Compensation-based Statistics.

The six month period limit for treatment 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 clinicians will prefer to maximise the time.

The Commission’s preferred option to ensure early intervention and the provision of treatment to improve return to work outcomes is for the relevant workers compensation scheme to 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.

DRAFT RECOMMENDATION 19.4 — NO-LIABILITY TREATMENT FOR MENTAL HEALTH RELATED WORKERS COMPENSATION CLAIMS

In the short term (in the next 2 years)

Workers compensation schemes should be amended to provide clinical treatment 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.

To provide clinical treatment for the injured worker until they return to work or up to a six months and irrespective of liability raises the issue of ‘who pays’? Funding this treatment entirely through workers compensation insurance premiums would raise premiums from an actuarially fair level. Employers could — through their premiums — be paying for clinical treatment for employees even where the mental illness has been determined not to be work related which would be a significant departure from current practice and settled law.

Alternatively, governments could provide some of the funding. This would reduce premiums for employers, but comes with a risk of diluting employers incentives to maintain mentally healthy workplaces. A further option (as noted above) would be for governments to levy a tax on employers to fund the treatment based on the number of employees, the industry they operate in and their risk profile based on various metrics to indicate the relative mental health of their workplace — reflecting to a large extent the way in which workers compensation premiums are set.

The Commission is seeking further information as to how the provision of clinical treatment should be funded for workers with mental health related workers compensation claims for up to six months following lodgement of the claim and irrespective of liability.

INFORMATION REQUEST 19.1 — HOW SHOULD THE TREATMENT BE FUNDED

How should the clinical treatment for workers with mental health related workers compensation claims (irrespective of liability) be funded until return to work or up to a period of six months?

Estimate of the benefits of earlier return to work

Time away from work due to mental ill health is costly to the economy. Modelling of the impacts of early intervention and treatment for those claiming workers compensation for work related mental illness or psychological injury focused on the likely reduction in time away from work. Those who had been on workers compensation for an entire 12 months were considered likely to be permanently unable to work and were not included in the modelling to estimate the benefits. The modelling assumed that if early intervention and

treatment (based on treatment being provided through workers compensation until return to work or up to 6 months) halved the time a person with a work related mental illness or psychological injury was absent from work would produce an estimated benefit of \$121 million per year (appendix G).

19.4 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. 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 19.4).

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 issues and create a mentally healthy workplace. Along with the relevant unions, it 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.

There are also industry wide initiatives

There have also been industry wide initiatives, such as ‘Mates in Construction’ to address suicide by construction 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. Other business such as SMEC, provide employee assistance program (EAP) services, collaborate with Beyond Blue and other similar agencies to facilitate workshops and training, provide mental health training as part of their management training and sponsor a number of wellbeing events (sub. 365).

Industry associations are also involved in supporting their members to take initiatives to improve mental health in the workplace. For example, the Australian Chamber of Commerce and Industry 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).

Box 19.4 Mental health, elite athletes and professional sport

Survey research into elite athletes in Australia has suggested they experience common mental disorders such as depression at a higher rate than the wider community. As there are strong links between exercise and good mental health, it has also been suggested that elite athletes should experience lower rates of mental disorders than the rest of the community (Gulliver et al. 2015).

There are a number of factors that could increase the susceptibility of these athletes to mental disorders. For example, these athletes are typically required to relocate for their sport often when they are young and then can spend long periods away from home and family when competing at an elite level. There are also the expectations to perform at a certain level and pressure to win. Injuries in particular have been identified as being associated with depression in elite athletes (Gulliver et al. 2015).

There are specific risk factors for certain types of mental disorders, such as eating disorders. The prevalence of eating disorders is higher among elite athletes than the general population, higher in female athletes than male and more common among those involved in aesthetic sports relying on a lean physique, such as gymnastics and those where weight is critical, such as boxing and wrestling (Sundogot-Borgen and Torstveit 2009). Retirement from a professional career raises — particularly if premature as a result of injuries — further risks to mental health as these athletes may not have the skills, qualifications or experience even at a relatively young age to transition into another occupation. For some, the loss of public profile may also raise additional risks.

In looking at the job stress experienced by players in the AFL, Noblett et al. (2003) found that the most widely reported football specific stressors included poor performance, injury, the possibility of being de-listed and uncertainty as to 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 issues, 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 (ACA 2018).

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, Innovation and Science is currently reviewing the mental health management in the Australian Public Service to identify barriers to improving mental health management in the public service, 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 public service (Department of Industry, Innovation and Science 2019).

These initiatives and programs operate at different levels

These programs or initiatives are often referred to as interventions and operate at different levels. Primary interventions are delivered to all employees regardless of their current mental health or exposure to risks. These include strategies to improve job design and control, and to build organisational resilience through manager and leadership training and personal resilience through workplace health promotions and cognitive behavioural therapy (CBT). Secondary interventions target specific employees often at greater risk of poor mental 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 19.5).

Box 19.5 **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 and reducing stigmatising attitudes towards mental health and increasing their confidence in supporting those with mental health issues
- team work group support — developing awareness of mental health issues and confidence in teams to support colleagues with mental health issues
- 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
- mindfulness based interventions — to enable individuals to build awareness and understanding of themselves

(continued)

Box 19.5 (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 claim have remained relatively stable over the past decade (see section 19.3).

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 19.3).

Table 19.3 Workplaces approach to mental health in NSW

	<i>All business</i>	<i>Large (>200 FTE employees)</i>	<i>Medium (20-199 FTE employees)</i>	<i>Small (5-19 FTE employees)</i>
	%	%	%	%
Integrated and sustained approach	8.8	15.4	10.3	8.4
Effective action	13.6	15.4	13.0	13.7
Limited action	29.4	30.8	33.3	28.5
Intention	29.3	30.8	31.2	28.8
Basic awareness	19.1	7.6	12.2	20.7

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 in 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 focussed 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 19.7).

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 19.7 **Why organisations are not taking action on mental health in the workplace**



Source: Diversity Council of Australia (sub. 70).

Employer Assistance Programs

Employer 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 employers on a confidential basis and are often the initial point of contact for an employee seeking assistance for a mental health problem.

There is considerable variation as to the actual services EAPs are contracted to provide. In contracting in 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. 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 (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. What level of service and availability of service (24 hour availability, crisis response services) best meets the needs of the business and its workforce is a decision for that business.

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, turn over, 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.

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.

One approach 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 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. This may help to address the industry’s concerns around the reliability of services and its impact on the reputation of the industry.

DRAFT FINDING 19.3 — EMPLOYER ASSISTANCE PROGRAMS (EAPs)

Employer Assistance Programs (EAPs) are reported to be highly valued by at least some employers and employees. 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.

The services provided by EAPs, as well as concerns around the reliability of services and the reputation of providers, would be enhanced through further evaluation of their outcomes. To facilitate this, the EAP industry could:

- develop mechanisms to enable individual businesses and EAP service providers to evaluate outcomes for that business
- invest in research to improve external evaluation and benchmarking of best practice in the wider provision of EAP services.

Peer support networks

Peers 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 to 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.

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 19.5) (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 (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 19.6).

Box 19.6 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, for example. (sub. 216, p. 9)

While some employers recognised the benefits from investing in mental health, others simply took a short-term 'tick the box' approach to mental health. Rural & Remote Mental Health commented.

Some mining and resource companies have made significant investment in mental health in their workplace and, will over time, reap the rewards. However, there are other companies which recognise that it is a significant issue but take a short-term, limited investment approach that means they can 'tick the mental health compliance box'. (sub. 97, p. 24)

The use of some initiatives, while of short-term benefit could distract management from dealing with more serious issues.

... fruit boxes and yoga can be good for individuals and the culture of an organisation, but this can distract management and deflect actions and funding from more worthwhile and more efficacious actions on work-related factors and initiatives. Even resilience training can distract from more systemic issues. Some research show actions that can be effective, although many (even widely accepted programmes) have only short-term effect. (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 increases in back pain in the workplace 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 arm pain or RSI 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 risk 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:

Business 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)

Clearly, employers cannot be held entirely responsible for ensuring the mental health of their employees. 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.

19.5 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:

- A PwC study (PWC 2014) estimated a return to employers of \$2.30 for each \$1 spent on successfully implementing appropriate action to improve mental health in the workplace.
- KPMG (KPMG and Mental Health Australia 2018) estimated that the return on each \$1 invested in workplace interventions ranged from \$1.30 for interventions that improved job control to \$4.70 for return to work programs.
- A study commissioned by Safework Australia and published by the NSW Government (Yu and Glozier 2017) estimated a return of between \$1.50 and \$4 for each \$1 spent.

These type of studies have triggered an interest by policy makers and some employers to invest in strategies and programs to improve productivity and lower costs for employers and improve the wider mental health of the workforce (Mattke et al. 2007). Further details on the rate of return found by these studies are highlighted in table 19.4.

Table 19.4 Return on investment by type of intervention

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

^a The PWC study estimated the return on investment was 2.3 for all interventions. This was based on average of the individual return on investments result from implementing the appropriate actions in a combination of organisations, size and industry. Each action included in the analysis would achieve and 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 initiative and programs result from potential reductions in ‘presenteeism’ and the subsequent increase in productivity from the increased mental health and wellbeing of the workforce.

These studies have all found that in estimating the costs of mental ill health in the workforce, the most significant cost is ‘presenteeism’. It represents a significant share of the cost of mental ill health in the workplace. 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)
- the KPMG study found it 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 the PWC research it comprised 55% of cost of mental health conditions in Australia or \$6.1 billion of \$11 billion (PWC 2014)

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 19.7). 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 determined 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 E.

Box 19.7 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 individuals 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).

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 due (or presenteeism) 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 health issues across the community.

That said, other changes in workplace culture over time — such as the increased demand for in-café produced coffee (as opposed to self-made instant or brewed coffee available in the workplace) and travel to and from its offsite availability — are also likely to have had detrimental effects on productivity that are difficult to measure.

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. However, it appears that while employers in most cases were interested in investing in interventions and programs to improve mental health in the workplace, many

employers were confused and uncertain as to the actual initiatives and/or programs that would be effective and suitable for their workplace.

19.6 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 employees 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. This would enable these agencies to disseminate better information 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 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 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. 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.

Employers regardless of size, require information on how to effectively deal with mental health issues 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 requires extensive infrastructure, such as access to human resources departments or occupational health services that may not be available in small businesses. Ai Group (sub. 208) also noted that while large organisations had the resources and staff to support such interventions, this was not necessarily the case with small and medium sized enterprises. It also pointed out that small business owners themselves experienced considerable mental stress as the family's livelihood and financial security were often bound up in the business (sub. 208). Small businesses will require interventions that recognise their specific needs and the resources available to these enterprises to implement initiatives to protect the mental health of the employees and the business owner.

In December 2018, the Australian Government announced specific funding for mental health assistance for small business — the majority of this funding will be to expand the trial of Everymind's 'Ahead for business' program from New South Wales to a national level (Cash 2018a). The 'Ahead for business' program provides a website and app for small business owners to connect them with information, self-assessment tools, programs and interventions to manage business stressors and assistance for mental health issues (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 Employment, Skills, Small and Family Business 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 the 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.

DRAFT RECOMMENDATION 19.5 — DISSEMINATING INFORMATION ON WORKPLACE INTERVENTIONS

In the medium term (over 2 – 5 years)

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. They should then advise employers of effective interventions that would be appropriate for their workplace.

Changing leave arrangements to address absenteeism from poor mental health

There have been suggestions that including a number of 'mental health' days in an employee's personal leave or sick leave entitlement would improve workplace mental health and reduce absenteeism. Some consider that mental health days are just as important as recreation leave, traditional sick days or other paid leave and employees should be able to take an occasional day off to tend to their mental health and wellbeing (Heads up 2017). Of course, labelling a certain number of days per year of personal or sick leave as 'mental health leave' may discourage such leave due to the stigma attached to mental health and the unwillingness of employees to disclose to their employer that they needed a day off for mental health reasons.

Having a number of days of existing personal leave a year designated as ‘personal care days’ would allow employees some time off for self-care without having to disclose the explicit reason to their employer or ‘pull a sickie’ and have to fake an illness to have the time off. Categorising leave around a specific purpose can lead to an erosion of trust between employers and employees and having access to personal care leave on an undocumented basis would enable an employee to attend to their personal wellbeing without having to fabricate a physical illness or other reason.

A further view is that being able to take a day off for personal care may be a proactive approach to deal with issues and stress before they do have an impact on an individual’s mental health (Steen 2019). Such an approach may actually reduce overall absenteeism due to mental health in the longer term.

While being able to take a personal care day may allow employees to refresh or meet other personal care needs, it will not address any underlying reasons behind poor mental health linked to the workplace such as poor job design, work load or workplace conflict.

INFORMATION REQUEST 19.2 — PERSONAL CARE DAYS FOR MENTAL HEALTH

Would designating a number of days of existing personal leave as ‘personal care’ to enable employees to take time off without medical evidence to attend to their personal care and wellbeing improve workplace mental health and information on absenteeism due to mental ill-health? If so, what would be needed to make this provision effective?

Providing 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 pilot income in the event of loss of licence.

In the course of the inquiry, it was suggested that employees in certain occupations, such as emergency service workers and construction workers — where there was a higher risk of developing a work related psychological injury or mental illness — should be able to access additional income protection insurance that covers psychological injury or mental illness, on a group basis through their employer. This would potentially enable employees in these higher risk occupations to access insurance products for income protection at a lower price than purchasing a policy as an individual. The Commission notes a range of issues with the disclosure of mental illness and the coverage of insurance policies and these are discussed in chapter 20. We are seeking further information on any barriers to employers facilitating solutions for those employees who are at a particularly high risk of psychological injury or mental illness.

INFORMATION REQUEST 19.3 — BARRIERS TO PURCHASING INCOME PROTECTION INSURANCE

Are there any barriers to employers — in sectors where there is a higher risk of workers developing a work related psychological injury or mental illness — purchasing income protection insurance (including for loss of income relating to mental ill-health) for their employees on a group basis to enable their employees to access this insurance at a lower cost?

The workforce of the future

There is no data captured to assess the mental health of the current workforce. However, data from the 2007 National Survey of Health and Wellbeing (ABS 2008) covering the wider adult population aged 16 to 65 is often referred to as a proxy for the workforce indicating that almost half of adult Australians will experience a common disorder in their lifetime and each year about 20% of this age group are estimated to experience a mental disorder (chapter 2). Survey data collected for Beyondblue indicated that about 1 in 5 Australians (21%) had taken time off work in the past years 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 although prevalence rates decline over time (chapter 2). For school children, an estimated 25-30% require psychological support and addressing risk factors and symptoms early is considered to be a cost effective way to improve longer-term outcomes (chapter 17). Those in tertiary study, university and VET students, experienced poorer mental health outcomes than the general population (chapter 18).

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 the overall mental health of the workforce could decline in the future without further intervention.

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.

20 Social participation and inclusion

Interventions for social participation and inclusion matter because ...

- For those with mental illness, social participation and inclusion are important aspects of recovery and reduce the likelihood of relapse.
- Socioeconomic disadvantage is a major barrier to social participation, and is strongly associated with mental ill-health.
- Attitudes of other people influence how well people recover from mental ill-health. Stigma associated with mental illness limits social participation and inclusion, and can lead to discrimination, social exclusion and a reluctance to seek care.
- Aboriginal and Torres Strait Islander people are disproportionately affected by mental ill-health and social exclusion due to many factors, including persistent disadvantage, discrimination and racism, and intergenerational trauma.

Successful intervention requires ...

As a priority:

- Programs to reduce the stigma experienced by people with severe mental illness from health professionals should be incorporated into the initial training and the continuing professional development requirements of mental health professionals.

Additional actions required include:

- Anti-stigma campaigns can promote the social participation of people with mental illness that is poorly understood by the community.
 - Actions that support Aboriginal and Torres Strait Islander people to positively shape and control their futures are likely to improve social and emotional wellbeing.
 - Evaluate best practices for, and disseminate information on, a partnership between traditional healers and mainstream mental healthcare for Aboriginal and Torres Strait Islander people.
-

Our social interactions and feelings of inclusion are inextricably linked with our mental health and wellbeing:

Social inclusion, working and volunteering create purpose and human beings need purpose and social interaction to thrive. (Stefanie Roth, sub. 164, p. 14)

[t]he absence of meaningful relationships in a person's life will often make the notion that life is worth prolonging quite implausible. (Name withheld, sub. 482, p. 139)

For a person with mental illness, interacting with other people — with family, friends, work colleagues or in 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)

Indeed, social participation can guard against risk of mental illness for all people, and promote mental wellbeing more generally.

Positive peer social interactions can ... serve as a protective factor for children and young people as they grow. (Early Childhood Australia, 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* 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 20.1). When people have mental illness, the extent that 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 exclusion
- 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 20.1 What is 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 ideas 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 ideas.

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, and personal factors (such as age, personal history and cultural background), and the external physical and social environments in which they live (WHO 2013b, p. 5).

Social participation 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). The rights of individuals to make decisions about their own health are discussed in chapter 22.

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 and education and improve community life and work outcomes. However, strong social capital can result in 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 which includes traditional ideas of disadvantage such as income but 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:

... 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.

20.1 Barriers to social participation and inclusion

As well as the symptoms of mental illness that can directly impede social participation, the ability of people with mental illness to participate socially and feel included in society is limited by:

- the association between mental illness and social exclusion, including limited employment and housing opportunities and increased psychosocial stressors
- the persistence of stigma towards people with mental illness.

Disadvantage and stigma can also have profound effects on the ability of people who care for those with mental illness to participate socially.

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 15), employment and income support (chapter 14), youth economic participation (chapter 18), interactions with the justice system (chapter 16), access to primary, specialist and emergency healthcare services (chapters 6, 7 and 8) and psychosocial supports (chapter 12).

Social exclusion is strongly linked with poor mental health

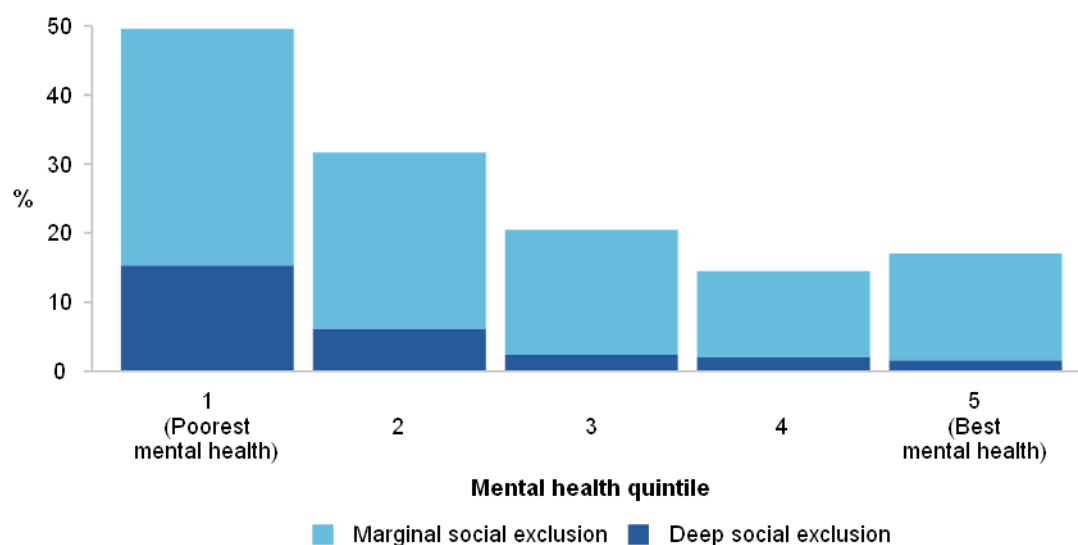
Persistent disadvantage limits people's ability to participate socially and economically — with people who experience limited opportunities for employment and education also experiencing increased social isolation and a lack of inclusion (cohealth, sub. 231). Poverty limits people's ability to meet their basic needs, leading to a lack of control over resources and personal wellbeing and safety. In this way, inequality is a source of psychosocial stress that contributes to poor mental health and social exclusion (Wilkinson and Marmot 2003).

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).

Social exclusion is strongly associated with mental ill-health in the broader population.²⁶ More people with poorer mental health meet criteria for social exclusion, with social exclusion decreasing as mental health increases (figure 20.1). Of the people considered deeply excluded, over 55% are in the bottom quintile for mental health.

• ²⁶ The Social Exclusion Monitor (SEM) is a method for estimating the extent of social exclusion in Australia, and can be used to identify people who are excluded and the extent of their disadvantage (Scutella, Wilkins and Horn 2009; Scutella, Wilkins and Kostenko 2009). Responses to a set of Household, Income and Labour Dynamics in Australia (HILDA) survey questions are used to construct 29 indicators across seven key life domains, including access to material resources; employment; skills and education; health and disability status; social connections; community; and personal safety.

Figure 20.1 Mental ill-health is associated with social exclusion^{a,b,c}
Percentage of people deeply and marginally socially excluded



^a Social exclusion is measured using the Social Exclusion Monitor (Scutella, Wilkins and Horn 2009; Scutella, Wilkins and Kostenko 2009). People with a social exclusion score greater than one are regarded as marginally excluded, while those with a score greater than two are considered deeply excluded. ^b Mental health is measured by Mental Health Component summary score quintile, which is derived from the SF-36 survey instrument. ^c Responses are population weighted.

Source: Housing, Income and Labour Dynamics Australia, wave 17.

Social exclusion is unevenly distributed across the population with:

- women experiencing slightly higher rates of exclusion than men
- people who have not completed year 12 (or equivalent) and those with a long term health condition more likely to be deeply excluded and in poor mental 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
- people who did not complete year 12 schooling having higher rates of exclusion than those who have completed post-school education (Scutella, Wilkins and Kostenko 2009).

With the exception of people aged over 65 years, all of these groups also have disproportionately high rates of poor mental health (figure 20.2).

DRAFT FINDING 20.1 — SOCIAL EXCLUSION IS ASSOCIATED WITH POOR MENTAL HEALTH

Social exclusion is strongly associated with poor mental health. People with mental illness are more likely to be socially excluded, and people facing social exclusion for other reasons are likely to subsequently experience poor mental health.

People likely to experience both social exclusion and poor mental 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 do not complete secondary school.

Access to material resources

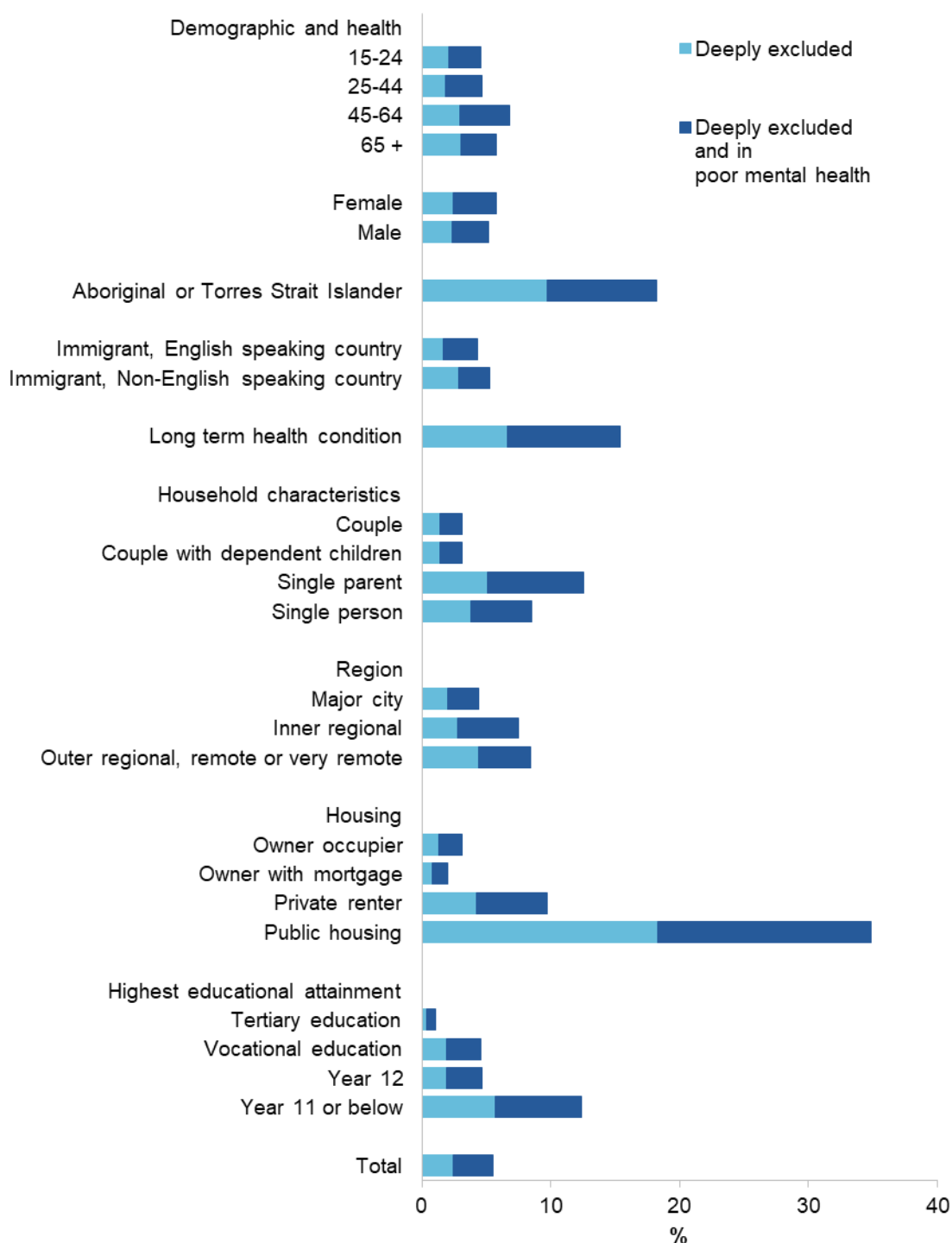
Economic participation through employment is likely to affect mental health directly, by providing opportunities for social interactions, and indirectly, by reducing financial stresses and increasing capacity for social interactions. Yet people with mental illness are less likely to be employed, and 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 2019g).

Access to material resources is an important determinant of social exclusion, with the relationship between socioeconomic status and poor mental health well established (Murali and Oyebode 2004; Wilkinson and Marmot 2003). Material disadvantage can limit access to services, consumable goods and transport, which can be a barrier to social inclusion and increase risk of mental ill-health:

Exclusion due to financial hardship may cause, maintain and reinforce mental illness (Kiely and Butterworth 2013, p. 665)

This is reflected in the fact that, among the poorest 20% of Australians — in terms of household equivalised disposable income — more than 1 in 4 people reported psychological distress at a high or very -high level in 2017 (figure 20.3). In contrast, people in the highest three income deciles have a much lower rate of distress, with around 1 in 10 people having high or very high levels of distress.

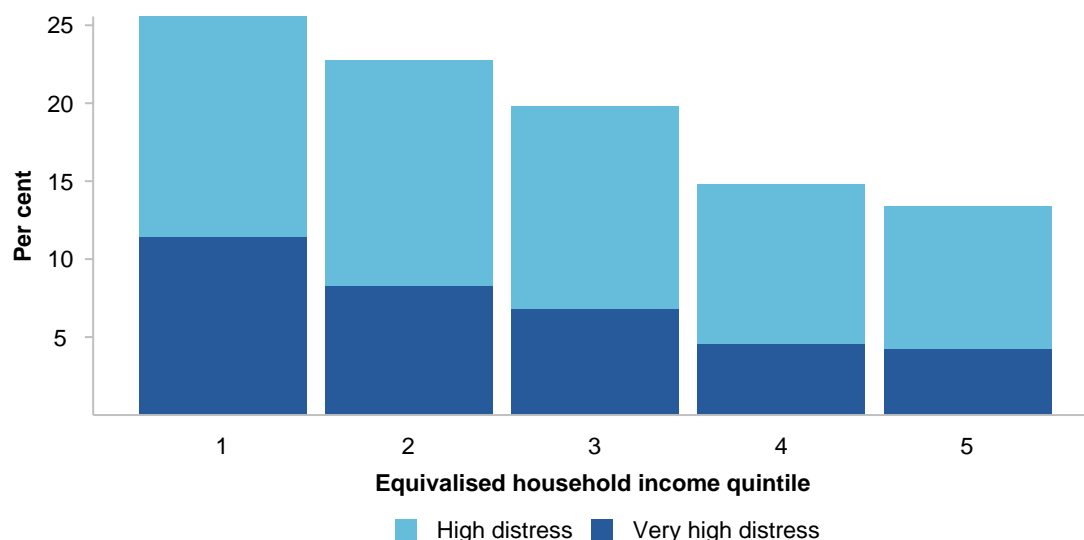
Figure 20.2 Social exclusion and poor mental health^{a,b,c}



^a Social exclusion is measured using the Social Exclusion Monitor. People with a social exclusion score greater than two are considered deeply excluded. ^b Mental health is measured by the Mental Health Component summary score, derived from the SF-36 survey instrument. People with a summary score in the lowest quintile are categorised as being in poor mental health. ^c Responses are population weighted.

Source: Housing, Income and Labour Dynamics in Australia, wave 17.

Figure 20.3 More people with lower incomes experience higher psychological distress^{a,b}



^a Psychological distress is measured using the Kessler 10 scale. ^b Equivalised income adjusts for household size and composition, accounting for larger households needing more resources to achieve the same standard of living as a smaller household (PC 2018c).

Source: Housing, Income and Labour Dynamics in Australia, wave 17.

People who do not have employment and rely on income support payments are more likely to have lower incomes. More than 55% of working-age households in which no person is in paid work are estimated to be in poverty. The major source of income for these households is likely to be income support payments. For working-age households with at least one person in paid work, it is estimated that about 5% experience poverty (PC 2018c).²⁷ These individuals and families are more likely to experience mental or behavioural problems than people in the paid workforce (table 20.1).

Income support may be associated with poor mental health, not just because people with mental illness are more likely to be unemployed or not in the labour force and therefore be in receipt of income support (chapter 14), but also because welfare dependency and social stigma towards welfare recipients can be demoralising (Kiely and Butterworth 2013). Lack of employment and dependency, as indicated by income support payments, can lead to intergenerational mental ill-health. 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 (Cobb-Clark, Dahmann, Salamanca and Zhu, sub. 57; Cobb-Clark et al. 2017).

²⁷ This is a relative measure of poverty, with a person being classed as living in poverty if their income is less than half of the median household equivalised income (PC 2018b). Single adult Newstart payments were around 30% of median equivalised household income in 2015-16 (Whiteford 2019).

Table 20.1 Income support recipients are more likely to experience mental illness^a

Selected mental illnesses/symptoms

	<i>Newstart Allowance</i>	<i>Disability Support Pension</i>
	Risk Ratio (95% confidence interval)	Risk Ratio (95% confidence interval)
Depression	3.31 (2.75-4.00)	5.99 (5.26-6.82)
Anxiety disorders	3.28 (2.59-4.17)	6.59 (5.60-7.77)
Panic disorders	3.64 (2.71-4.88)	7.77 (6.34-9.50)
Feeling depressed	3.45 (2.83-4.20)	4.13 (3.51-4.86)
Feeling anxious/nervous or tense	2.28 (1.88-2.76)	3.30 (2.85-3.81)

^a Risk ratios indicate risk of illness or symptoms for income support recipients relative to the risk for wage earners.

Source: Collie et al. (2019).

A number of submissions to this inquiry noted that low levels of income support impede help-seeking, and lead to social isolation and marginalisation (sub. 493; sub. 283; comment no. 34, consumers):

[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 ... 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)

While it is beyond the scope of this study to consider what levels of income support payments might affect mental illness, it is clear that:

- there is an association between socioeconomic disadvantage and mental illness that contributes to social exclusion
- that 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).

Income and employment support for people with mental illness is discussed in chapter 14.

Stigma and discrimination excludes people with mental illness

People with mental illness regularly cite the stigma that often accompanies mental illness as a central concern (Corrigan et al. 2003; McNair, Highet and Hickie 2002). 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. (Public Health Association of Australia, sub. 272, p. 11)

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 (box 20.2). The effects of stigma and consequent discrimination are reflected in many of the submissions to this inquiry, for example:

I have endured extensive social isolation at times because of the stigma that my illness attracts. (comment no. 17, consumers)

Stigma is identified by people with mental illness and their carers as one of the greatest deterrents to their full citizenship within our society ... Stigma stops people asking for help and getting the support and treatment they need. (MIFA, Sub. 343, pp. 27–28)

[A] depressing majority of employers do not comprehend mental health and disability as anything more than a potential liability, they want nothing to do with it, views are dated and backwards, talking about it is a career death sentence (comment no. 2, consumers)

Stigma is especially likely to affect people with severe mental illness:

Many people with serious mental illness are challenged doubly. On one hand, they struggle with the symptoms and disabilities that result from the disease. On the other, they are challenged by the stereotypes and prejudice that result from misconceptions about mental illness. As a result of both, people with mental illness are robbed of the opportunities that define a quality life: good jobs, safe housing, satisfactory health care, and affiliation with a diverse group of people. (Corrigan and Watson 2002)

The extent and nature of stigma will also vary with cultural and social characteristics. For example, in some cultures mental illness is thought to reflect poorly on family lineage, diminishing the social and economic prospects of both the person with the mental illness and their family members. These perceptions can make people less willing to seek help or have it known that they are experiencing mental illness.

We try to refer someone to Headspace, and they won't go. There is stigma associated. Or the perception that 'Headspace is a place that white people go. (CMY and MYAN, sub. 446, p. 10)

The issue of stigma was one that was constantly raised ... [r]ural communities have a culture of self-sufficiency and self-reliance which does not lend itself to openly seeking treatment when it might be required ... The lack of anonymity in small rural settings often creates barriers to access due to stigma and privacy. (QAMH, sub. 247, pp. 1–2)

[P]eople from [culturally and linguistically diverse] backgrounds face ... barriers ... in accessing mental health services ... including lack of knowledge or understanding about mental health services; stigma related to mental illness or seeking help; concerns about confidentiality; language barriers; cultural misunderstandings; previous unfavourable or negative experiences with health or other services; and concerns about being heard, understood or respected, especially in relation to their own explanation of their problem or issue. (DLGSC, sub. 78, p. 2)

Box 20.2 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* involves individuals with negatively stereotyped characteristics — such as mental illness — being 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, and refers to community members who judge traits associated with mental illness to be contrary to community norms, and behave in way that is harmful to people with mental illness. This may be expressed in an overt or a subtle way, and may be anticipated or perceived rather than actually experienced.
- *Structural stigma* refers to the rules, policies and practices of social institutions that result in restricted opportunities of people with mental illness (Corrigan 2004). Where policies disproportionately impact the lives of people with mental illness — even without intending 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; Zäske 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 (Zäske 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)).

Stigma is also likely to affect the mental health and wellbeing of children of different ages (chapter 17). 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 Council, 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)

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 made commitments 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 governments indicated that they would undertake a number of actions to reduce the stigma and discrimination experienced by people with mental illness. While a review of existing initiatives and evidence by an expert provider 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.

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).

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 and are to be completed by mid-2021 (COAG Health Council 2017b). This involves the Mental Health Principal Committee seeking 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.

The National Mental Health Commission is to release a report on the progress of the Fifth National Mental Health Plan in February 2020.

Social stigma and discrimination in the community

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). The level of stigma in the community associated with depression and anxiety has declined to some extent (Jorm, Christensen and

Griffiths 2006), although severe mental illness — such as schizophrenia and psychosis — remains poorly understood and highly stigmatised (Reavley and Jorm 2011).

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 and unpredictability along with 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 to the other disorders considered. Perceptions of dangerousness and desire for social distance was 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, with people more likely to know someone with mental illness and 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 dangerousness and unpredictability of people living with depression, depression with suicidal thoughts or schizophrenia.

Discrimination against people with mental illness

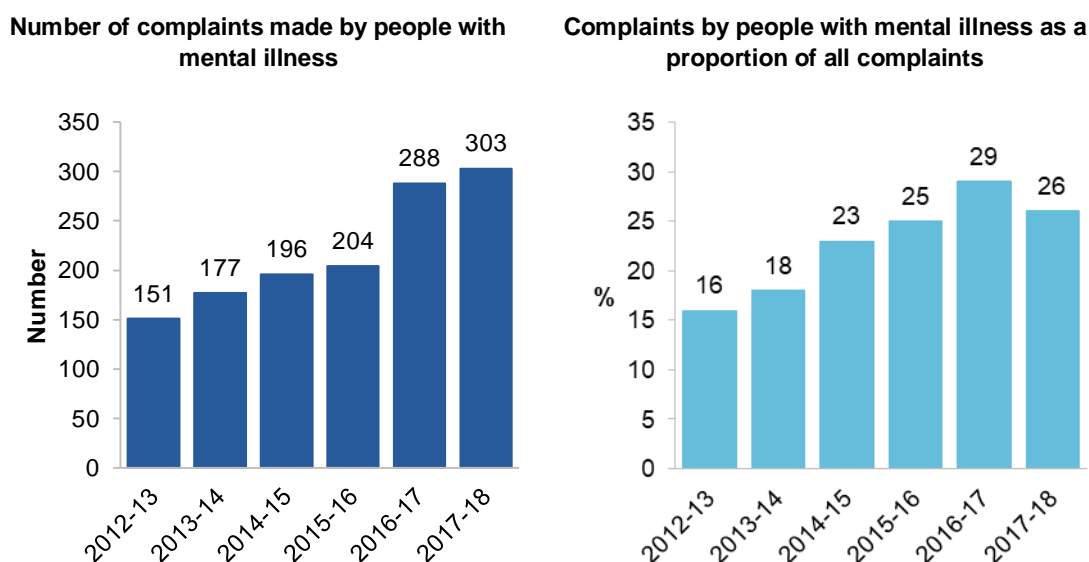
Stigmatising views of mental illness can lead to discriminatory and unfair treatment of people who experience mental illness.

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 are made to the Australian Human Rights Commission each year (figure 20.4). It is likely that the number of people experiencing discrimination on the basis of mental illness greatly exceeds the number of complaints made, and people with mental illness also experience discrimination that is not considered unlawful under the DDA (Kingsford Legal Centre, sub. 469).

It is usually up to individuals to seek to enforce their right to protection against discrimination (Victoria Legal Aid, sub. 500). This can be particularly difficult for people living with mental illness often with 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, is recognised in a number of submissions (Kingsford Legal Centre, sub. 469; Mental Health Legal Centre, sub. 315; Paul Salsano, sub. 545; Victoria Legal Aid, sub. 500).

Figure 20.4 Complaints by people with mental illness have increased over recent years

Complaints made under the Disability Discrimination Act



Source: Australian Human Rights Commission, Annual Reports, 2012-13–2017-18.

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 16.

Experiences of people with mental illness

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, around 11% of people reported being avoided or excluded, while about 14% reported that they suffered discrimination, including dismissive treatment or

a lack of understanding their people's illness, 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. Around 5% of people reported avoidance behaviours, and 7% reported discrimination, but nearly one in three reported being treated more positively.

Anti-stigma interventions

Interventions intended to reduce stigma at the population level are likely to achieve changes in attitudes and, to some extent, improvements in 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 through the provision of factual information that contradicts inaccurate stereotypes (such as the common misconception that people with schizophrenia are dangerous). The intervention 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 are also 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 of dangerousness among people with schizophrenia, and the misattribution of social phobia to 'personal weakness' require different approaches.

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’ (2018, p. 77). They 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 20.3). Both of these campaigns were well funded, included provision for both the campaign and the evaluation processes, and were long running.

Effective stigma reduction has the potential to improve the lives of people with mental illness. However, stigma reduction 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 (around \$38 million) over four years — stigma reduction campaigns are very difficult to assess in terms of their cost effectiveness, and there is an absence of literature in this area (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).

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 allow the development of a national campaign that targets stigmatising views of those with severe mental illness. A nationally coordinated strategy should trial different approaches in different areas in order 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 provisions 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, improves self-esteem, increases optimism about the future and improves capacity to deal with stigma (Bratbo and Vedelsby 2017).

Box 20.3 **Examples of successful anti-stigma campaigns**

Time to Change (United Kingdom; 2007-present)

Time to change is an ongoing campaign that seeks 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 with a mix of government and charity funding.

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, Evans-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 health care 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 if they experienced improved health.

Hjärnkoll (Sweden; 2010-2014)

Hjärnkoll was a government-funded program, which 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 and 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, health care professionals and social workers (Beldie et al. 2017).

Hjärnkoll is found to have positively affected the attitudes, mental health literacy and intended behaviour of the general public during the campaign period, with social contact being considered an effective approach to reducing stigma (Hansson, Stjernswärd and Svensson 2016). The campaign was also found to have a positive effect on the attitudes, mental health literacy and behaviour of police who had undergone training.

Stigma and discrimination in the health sector

People with mental illness report experiencing stigma and discrimination in their interactions with the health sector (box 20.4). This can manifest in the form of disrespectful or condescending behaviours, and health professionals changing their behaviours after finding out about a person’s mental illness (MHCA 2011), and it can have a significant effect on the recovery and wellbeing of people with mental illness. Stigma and discrimination by health professionals 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 to hospital in suicidal distress (chapter 21).

Box 20.4 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 Bipolar disorder] ... Some continue to deny the disorder is a mental illness and label the disorder as purely 'behavioural'. BPD may be described by some professionals as a nuisance in the mental health care system. (Aaron Fornarino, sub 17, p. 2)

Many of the health professionals that I sought care from or was referred to simply did not have the education and skills to provide care specific to the perinatal period. My family and I had to spend many days and hours trying to find the right professionals that would be able to help ... I felt the public system fobbed me off and labelled me as 'attention seeking' because of my circumstances. (comment no. 37, consumers)

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' (11.8%) 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.

While only a small proportion — around 10% — of those reporting discrimination felt that health professionals ignored their health concerns, 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 a mental illness, 'undermin[ing] diagnosis, treatment, and successful health outcomes' (Nyblade et al. 2019). This

‘systematic disregard for the physical health needs of people with mental illness’ may substantially contribute to the lower life expectancies of people with mental illness (Thornicroft et al. 2016, p. 1127) (chapter 9).

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 (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.

Stigma may persist between health professionals and people with mental illness because of the circumstances in which most contact between these two groups occur. When contact between the two groups typically happens, health professionals are in positions of relative power and people with mental illness are usually 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 say and do, are likely to lead to the greatest reductions in stigma (Knaak, Modgill and Patten 2014).

For 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 around 20 students living with and participating in a range of activities with around 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 clinical 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.

DRAFT RECOMMENDATION 20.1 — NATIONAL STIGMA REDUCTION STRATEGY

A national stigma reduction strategy can direct efforts to reduce stigma towards people with mental illness that is poorly understood in the community.

In the short term (in the next 2 years)

The National Mental Health Commission should develop and drive the implementation of a national stigma reduction strategy that focuses on the experiences of people with mental illness that is poorly understood in the community. The 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 distance, 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.

Australian Governments should recognise their commitments to reducing stigma and discrimination made under the Fifth National Mental Health and Suicide Prevention Plan, and should support the National Mental Health Commission in developing and implementing this strategy.

In the medium term (over 2 – 5 years)

Stigma reduction programs should be incorporated in the initial training and continuing professional development requirements of all mental health professionals, subject to periodic evaluation as to their appropriateness and effectiveness.

Stigma and discrimination in the insurance sector

Stigma by insurers toward people with mental ill-health has been raised as a concern during the inquiry.²⁸ Insurance gives people a way to financially protect themselves against a range 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 individual’s capacity to earn an income (chapter 19), 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 around 8500 people experiencing mental ill-health in the 12 months to June 2018 (FSC, sub. 535). As noted by Metlife (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 result in people with mental illness experiencing problems when seeking to access different types of insurance:

[E]mpirical evidence and anecdotal reports demonstrate that many people with a mental health condition experience significant difficulties in obtaining and claiming on different types of insurance products ... These difficulties occur across the general and life insurance industries for products such as travel insurance, income protection, total and permanent disability (TPD) and life insurance. (Beyond Blue 2017, p. 3)

Discrimination — whether lawful or unlawful — is a relatively common experience among people with mental illness seeking insurance. Around 22% of survey respondents who self-identified as being a ‘mental health consumer’ reported having an application for insurance declined due to mental health, with this number increasing to around 36% of those applying for life insurance and 45% of those seeking income protection insurance (MHCA and Beyond Blue 2011).

²⁸ Similar concerns were also raised with the recent Parliamentary Joint Committee on Corporations and Financial Services Inquiry into the Life Insurance Industry, the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (the Royal Commission) and the Senate Economic References Committee Inquiry into the Regulatory Framework for the Protection of Consumers in the Banking, Insurance and Financial Services Sector.

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 for people with a disability, including people with a mental illness, to insurance (box 20.5). However, these protections have exceptions which allow for differential treatment of people with mental illness. Concerns about insurance raised in relation to mental illness include the:

- way in which insurers understand mental illness and use information about mental illness
- manner in which insurance claims and dispute resolutions are handled
- broad access of insurers to the medical records of people with mental illness.

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.

Poor understanding of mental illness in the insurance sector is illustrated by practices such as the exclusion of all mental health-related conditions from policies. Beyond Blue suggest 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 ... [and that] 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 (Beyond Blue 2016, p. 4).

Further, 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). This is supported by the Public Interest Advocacy Centre (2017), who stated 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, sub. 239, p. 9). Blanket exclusions on mental illness from travel insurance have been shown to be an unjustified form of discrimination²⁹, although there is limited case law regarding discrimination against people with mental illness and no evidence that these exclusions are becoming less common.

²⁹ Ella Ingram v QBE Insurance (Australia) Ltd [2015] VCAT No H107/2014 (18 December 2015).

Box 20.5 **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

Which body provides legal remedies varies with circumstances. The Australian Human Rights Commission investigates alleged breaches of the DDA. The Australian Securities and Investment 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. 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 (Parliamentary Joint Committee on Corporations and Financial Services 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 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 where the product is offered by a life insurer.

Membership of these bodies can also be limited. For instance 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.

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, including people avoiding necessary treatment in order to meet insurer's requirements³⁰, 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, 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 seek to create a more nuanced industry understanding of mental illness, including the development of a life 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 Investment 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). Around 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, as opposed to 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).

³⁰ See, for example, Bainbridge, Selvaratnam and Clark (2018).

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 Industry Standard 21 in 2013, which 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 Standard No. 21, p. 5). Insurers who 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.

While the Standard is a positive move towards mental health awareness in the life insurance industry, the Standard has not been updated since being implemented. This inquiry provides an opportunity for it be reconsidered by the FSC. In particular, there is 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. This Standard is currently binding only on life insurance members of the FSC, but is in the process of being rolled out to superannuation funds and financial advisory group members.

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 health problems 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 implements maximum timeframes for assessing claims, and it appears that nearly 80% of the alleged breaches of the Code relate to time limits (LCCC 2018). There is no information provided about the proportion of breaches that are mental health-related.

Insurer access to clinical records

Insurer access to clinical records also 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, there are concerns about insurance companies seeking broad access to clinical information when deciding whether to provide cover or in assessing a claim. The Parliamentary Joint Committee on Corporations and Services (2018, p. 131) 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.

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 2018, vol. 2 p. 333). Other concerns arising from 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 avoid seeking treatment altogether — for fear of how an insurer might use that information (Parliamentary Joint Committee on Corporations and Financial Services 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 poor mental 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 clinical records of people seeking insurance. 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. 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 the release of consultation notes from GPs in the instance that they are unable to provide a general report, or a report about a specific condition, within the specified timeframe of four weeks.

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 effectiveness of the Standard should be reviewed by the Office of the Australian Information Commissioner after it has been operating for two years.

DRAFT RECOMMENDATION 20.2 — AWARENESS OF MENTAL ILLNESS IN THE INSURANCE SECTOR

In the short term (in the next 2 years)

- The Financial Services Council should update the mental health training requirements for insurers in Life Insurance Industry Standard 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 Life Industry Standard 21 to include all employees of covered insurers so as to ensure the industry as a whole has a better understanding of mental illness
 - publish data they receive on industry compliance with the Standard
 - rollout the Standard to superannuation funds and financial advisory group members.
- The Australian Securities and Investments Commission should evaluate 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 evaluation 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
 - has implemented standardised definitions of diagnosed mental illnesses that are used to assess risk
 - 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 these changes have not been achieved, regulatory changes to ensure that these changes are put in place should be recommended. This review should occur within two years.

- The Office of the Australian Information Commissioner 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.

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 2017b, p. iii)

The social and emotional wellbeing of Aboriginal and Torres Strait Islander people is discussed in section 20.3.

In Victoria, people who frequently experience racism are estimated to be almost five times more likely to have poor mental health, and around 2.5 times more likely to have poor physical health (VIC DHHS 2017b). 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. People who identify as LGBTIQ are more likely to experience mental illness than the rest of the population (chapter 2) and are twice as likely as others to be subject to violence or abuse, putting them at increased risk of depression, anxiety, substance abuse, self-harm and suicidal thoughts (Connect Health and Community, sub. 94). The high incidence of mental illness is ‘directly related to experiences of stigma, prejudice, discrimination and abuse’ suffered by these people (The National LGBTI Health Alliance, quoted in Mental Health Australia, sub. 407, p. 16). The Fifth National Mental Health Plan recognises that reducing stigma and improving the appropriateness of mental health care is critical for these people (COAG Health Council 2017a).

Stigma associated with involvement with the criminal justice system is also seen as a barrier to social and economic participation (chapter 16). 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).

Loneliness and social isolation

Loneliness is simply the difference between a person's desired and actual social relationships. 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).

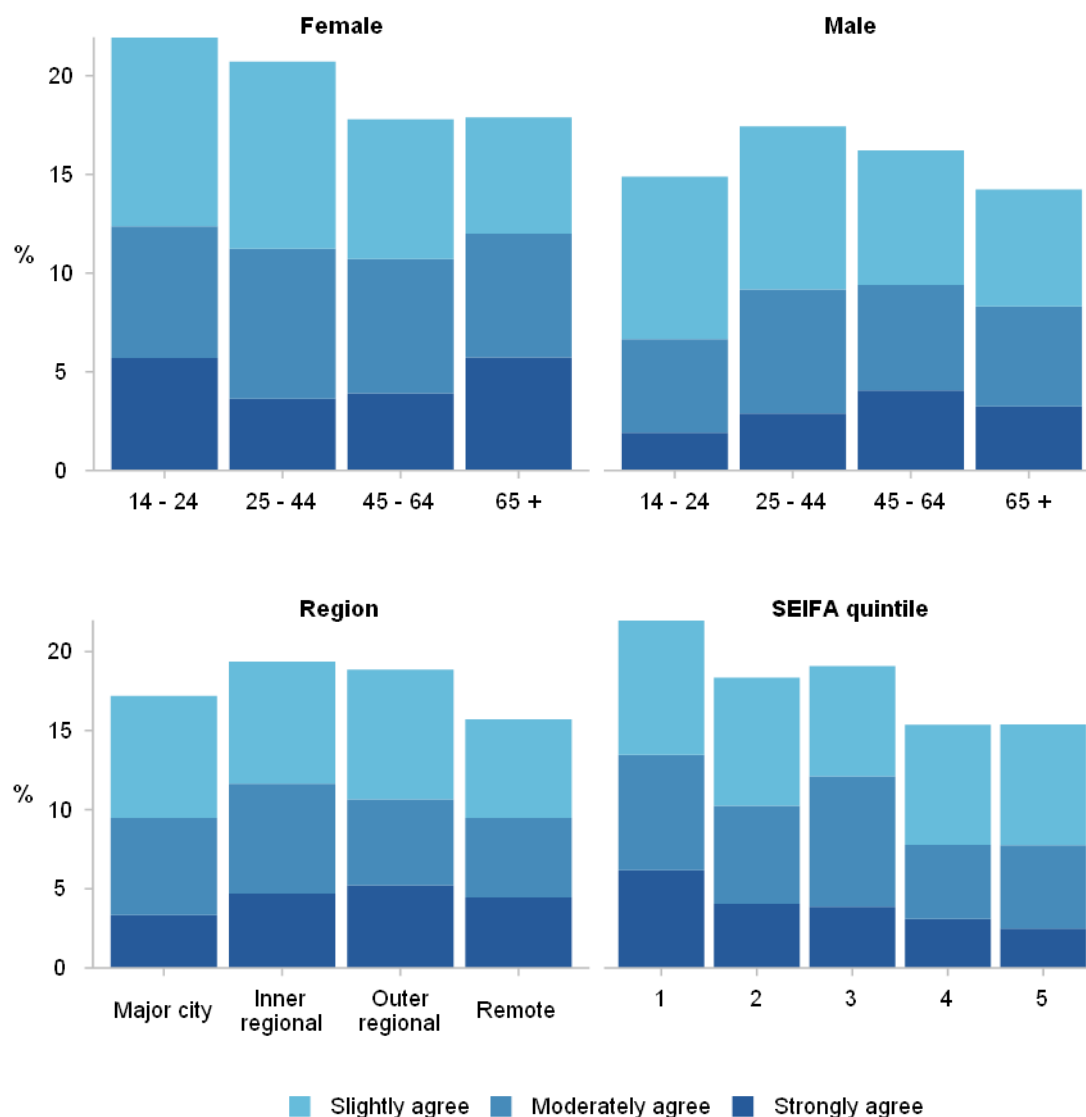
Around one in four Australian adults consider themselves to be lonely, and as many as half of all Australians feel lonely for at least one day each week (APS 2018a). Young people, particularly women, report high levels of loneliness, as do people who live in more disadvantaged regions (figure 20.5).

Loneliness is an increasing health concern because of its association with both physical and mental 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 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 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 income, high unemployment, poor access to transport and healthcare are likely to have higher levels of loneliness and are more likely to experience poor mental health (Tong et al. 2019).

The Housing, Income and Labour Dynamics in Australia survey shows clearly the association between loneliness and poor mental 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 20.6). 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 20.5 Loneliness in the Australian population^{a,b,c}
 % of people who agree with the statement “I often feel very lonely”

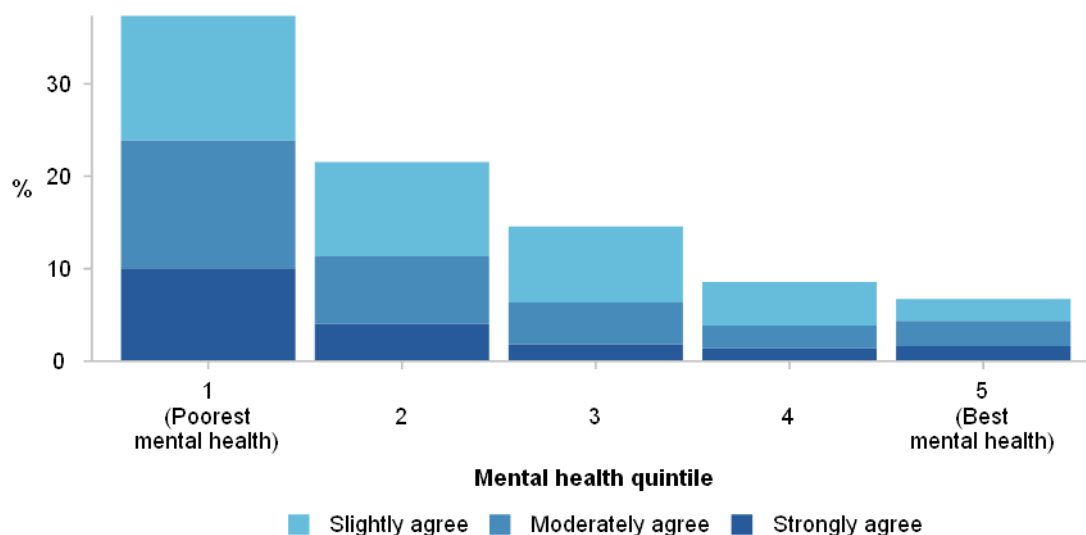


^a Survey respondents are asked to rate on a scale between 1 and 7 the extent to which they agree or disagree with the statement ‘I often feel very lonely’. A score of 1 indicates strong disagreement with the statement and a score of 7 indicates strong agreement. ^b Responses are population weighted. ^c SEIFA quintile indicates the relative advantage of the area in which people live. People living in lower quintile areas are more disadvantaged.

Source: Housing, Income and Labour Dynamics in Australia, wave 17.

Figure 20.6 Feelings of loneliness are strongly associated with lower levels of mental health^{a,b,c}

% of people who agree with the statement “I often feel very lonely”



^a Mental health is measured using the Mental Health Component summary score — a higher score indicates better mental health. ^b Survey respondents are asked to rate on a scale between 1 and 7 the extent to which they agree or disagree with the statement ‘I often feel very lonely’. A score of 1 indicates strong disagreement with the statement and a score of 7 indicates strong agreement. ^c Responses are population weighted.

Source: Housing, Income and Labour Dynamics in Australia, wave 17.

The association between loneliness and mental health is also reflected in the responses to this inquiry (College Of Sport and Exercise Psychologists, sub. 273; Friends for Good Inc, sub. 115; Mission Australia, sub. 487; On the Line, sub. 258; WayAhead, 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, the elderly, refugees and people with intellectual disabilities (Allianz Australia, sub. 213).

There is little evidence about what works to reduce loneliness

Despite loneliness being 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) categorises 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). Other interventions are likely to be less effective at reducing loneliness in the general population without access to these foundation services to identify people in need of support, and the types of support that they need (Friends for Good Inc., sub. 115).

Direct interventions provide people with opportunities for social engagement, either in the form of support 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 that provides access 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)

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 life of the carers, including stress and financial burden, employment insecurity and social isolation (chapter 13). 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, Loddon Mallee Mental Health Carers, sub. 52; Mental Health Carers Australia, sub. 489; Victorian Government, sub. 483). In particular, young carers can be disadvantaged in terms of their ability to participate in education and employment (EACH, sub. 227; Mind Australia Limited, 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 that are discussed in detail in chapter 13.

20.2 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. (National Mental Health Commission, 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. 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). Ensuring that communities are inclusive of people with mental illness can require government involvement, including:

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- 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 people with mental illness. In addition, people with mental illness may require support to ensure that they are able to participate socially.

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 the recovery process and ensure 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 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 20.6). 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)

Public libraries are one example of a community resource that allows for social interaction through group activities, provides contact points for health promotion, while also allowing 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, the purpose of which is for people within a community to meet and interact with each other (ALIA, sub. 185).

Box 20.6 **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 activities include health and wellbeing programs such as yoga, adult education and training, art and craft groups, computer training, English classes, self-help groups, children's activities and community lunches (Neighbourhood Houses Victoria, sub. 203). As well as serving as: 'soft entry points to mental health support':

[N]eighbourhood centres also provide a range of activities and supports for people who may not have a diagnosed mental health condition but are at risk of social isolation and other determinants of poor mental health. [They] offer programs and support groups to assist with health and wellbeing, community development, personal development, family support, employment support and financial counselling, as well as information on and referral to more intensive services such as housing. (NSW Council of Social Services, sub. 143, p. 11)

Arts and cultural events are seen to improve social participation and have beneficial effects on participants' mental health:

[C]reative expression and cultural activities can improve quality of life, self-esteem, resilience, social engagement and confidence, as well as reduce stress and stimulate an interest in further learning (Dept. of Communications and the Arts, sub. 82, p. 4)

[M]useums can bring benefits to individual and community health and wellbeing in their role as public forums for debate and learning, their work with specific audiences through targeted programmes, and by contributing to positive wellbeing and resilience by helping people to make sense of the world and their place within it (Dodd and Jones 2014, in AMaGA, sub. 113, p. 3).

[P]eople with disability indicated that going to arts events increases their wellbeing and happiness and makes for a richer and more meaningful life (ACT Government, sub. 210, p. 22)

Informal community groups and activities can also aid social participation and be valuable sources of support:

Many South Australians stated that loneliness and isolation is a key driver to seeking support from services, and that this need may be better met not only by NGOs but also by other sustainable community models of support. This support is often provided by informal community groups such as **faith groups, choirs, art groups, sporting groups and other communities of interest**, but may also be provided by more formal community centres. (SA Mental Health Commission, sub. 477, p. 8)

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 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).

For example, Melbourne City Council has recently employed a social worker to provide support for homeless clients who make regular use of their services (Topsfield 2019).

Physical environment

The physical environment in which people live can affect their social participation and mental wellbeing:

Access to well-designed public spaces that foster social interaction, [and] the ability to ... feel safe and secure, ... support better mental health and combat social fragmentation and isolation ... [W]ell-designed green spaces are key to encouraging social interaction, reduc[ing] chronic noise impacts, and provid[ing] restorative local environments. (Anglicare Australia, sub. 376, p. 11)

The physical neighbourhood and transport options are also recognised as important:

South Australians felt that ‘the way we plan our suburbs is critical to improving mental health outcomes’, and such plans may include community hubs, suitable public transport and green spaces to build stronger connections in the community. (SAMHC, sub. 477, p. 19)

As well as planning communities that foster connection, geography affects the accessibility of health services and people’s ability to access opportunities for social interaction.

[A]s much as we consider the role of clinical services, we need to understand how matters such as town planning practices influence health outcomes, whether people can use accessible public transport to get to where they need to be and whether people are able to find and keep somewhere safe to live, that meets their needs. (ACT Government, sub. 210, p. 3).

Public transport subsidies have been suggested as a way of reducing geographic isolation, and consequently facilitating social engagement of 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 and over has been found to reduce depressive symptoms and feelings of loneliness, and 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 point out that, rather than just the cost, it is the lack of public transport that affects social connectedness and access to health care (NT Mental Health Coalition Inc. 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)
- 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; NSW Council of Social Service, 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, submission to PC (2017g)). The act of volunteering may also result in mental health benefits, although much of the evidence is observational (Jenkinson et al. 2013) or anecdotal:

People living with mental illness, social isolation or vulnerability experience a greater sense of social inclusion and improved mental health by volunteering their time to community organisations, by receiving support from community-based volunteer ... organisations, or by participating in community groups. (VCA, sub. 417, p. 3)

[T]he experience of helping others provides meaning, a sense of self-worth, a social role and health enhancement (Volunteering Australia, submission to (PC 2019a)).

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 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 that need to develop skills for social interaction. Psychosocial supports are discussed in detail in chapter 12 and appendix B.

Centre-based services

Centres where people can ‘drop -in’ to access psychosocial support services when necessary also provide valuable opportunities for social participation and inclusion. They also can allow people living with mental illness to guide their own activities, form a community with peers, gain employment skills and interact socially (One Door, 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). They have a low barrier 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)

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, and may be affected by recent funding changes. Centres have previously been 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:

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. (sub 108, p. 16)

The provision of psychosocial supports and the NDIS are discussed in chapter 12 and appendix B.

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 (Centre for Social Impact Swinburne, 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 20.7). 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 Service, sub. 458). Other examples of WISEs include a smash repair service in North Melbourne (Mission Australia, sub. 487), a commercial cleaning service (Mental Health at Work, sub. 171), cafes (Friends of Callan Park, sub. 198), property and road maintenance, and traffic and grounds management services (WISE Employment, sub. 186).

Social enterprises can create opportunities between people with a 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 whilst 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).

WISEs are likely to be cost-effective approaches to improving the social participation of people with mental illness. Studies of the use of WISEs to encourage employment among the long-term unemployed have indicated that for every dollar invested, four dollars of savings in government services were likely. Savings are most likely to be realised in terms of reductions in income support payments and use of health services (Centre for Social Impact Swinburne, sub. 509). The effectiveness of social enterprises in providing skills and experience to people with mental illness will vary according to the diagnoses and levels of recovery of employees, and the return on investment will also vary according to the type of business (WISE Employment, sub. 186).

Box 20.7 **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 a lived experience of 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: Centre for Social Impact – Swinburne (sub. 509); Vanguard Laundry Services (sub. 458).

There are several options for assisting the development of WISEs in the community (Centre for Social Impact Swinburne, 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. Ongoing customer support is essential to the success of a WISE. 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 WISEs 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 seek 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 among people with psychosis have also been found to have a positive effect on social network 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 2014d) 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 12.

Social prescription

Social prescription is a way that primary care services can link patients 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, as well as those with mild or moderate depression (CHF, sub. 496; AIAA, sub. 472; Latrobe Health Advocate, sub. 364).

Social prescribing schemes can involve a variety of activities which 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). (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:

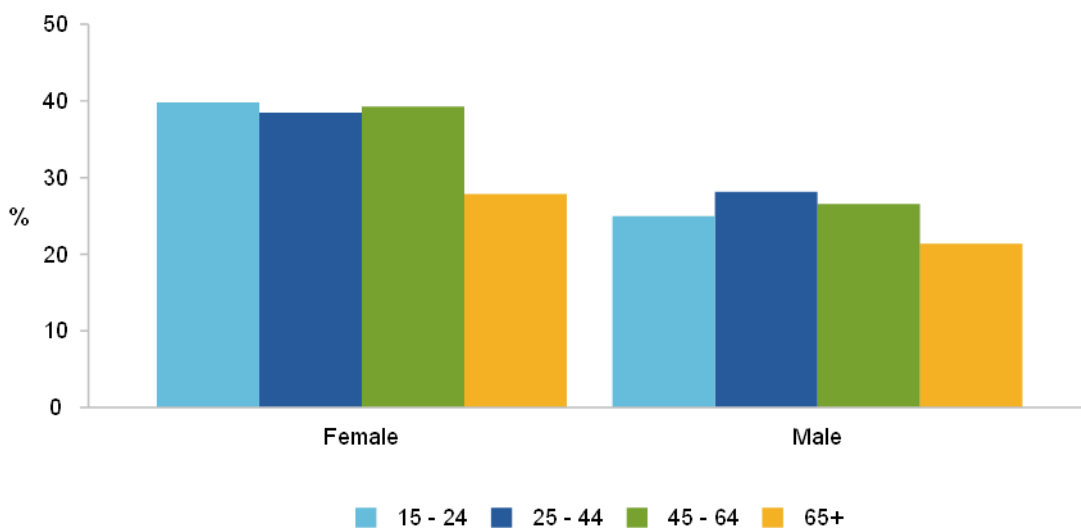
- GPs and other health workers may experience barriers to using social prescription either due to scepticism, patient expectations or a lack of adequate referral services.
- The take-up of social prescription will increase demand for community services. Any adoption of social prescription as a means of improving community mental health needs to include explicit provision for the funding of these services.

20.3 Improving social participation for Aboriginal and Torres Strait Islander people

Many Aboriginal and Torres Strait Islander people experience high levels of distress — for example, one in three adults report having experienced high or very high distress in a recent four week period (figure 20.7).³¹

Figure 20.7 Many Aboriginal people have high levels of psychological distress

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



^a Psychological distress is measured using a set of questions about negative emotional states experienced in the past 30 days. This measure is a 5-item subset of the Kessler 10 Psychological Distress Scale known as the K5. It is not a diagnostic tool, but an indicator of current psychological distress, where very high levels of distress may indicate a need for professional help.

Source: Tablebuilder, using National Aboriginal and Torres Strait Islander Social Survey 2014-15, ABS Cat no. 4720.0.55.002.

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 psychosocial stress often go hand in hand, and pose a concurrent risk to people’s health. Among other things, inadequate housing, a lack of employment, high rates of incarceration or insufficient education opportunities are sources of disadvantage for Aboriginal and Torres Strait Islander people that may lead to psychological distress (Zubrick et al. 2014). Entrenched poverty amongst Aboriginal and Torres Strait Islander people is recognised as a ‘significant

³¹ In contrast, around 13% of non-Indigenous adults reported high or very high levels of distress (AIHW 2017).

underlying factor’ that contributes to self-destructive behaviour, intentional self-harm and suicide (Milroy et al. 2017) (chapter 1).

The past 250 years of Australia’s history is replete with actions that have reduced social inclusion and wellbeing among Aboriginal and Torres Strait Islander people and undermined progress in early intervention and treatment for those who have mental illness. Experiences of racism are consistently associated with poor mental health (Paradies 2006; Paradies, Harris and Anderson 2008), something reflected in the submissions to this inquiry (AAL, sub. 151; AMSANT, sub. 434; The 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).

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 Australian 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) point 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 20.8).

Box 20.8 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 last twelve months.

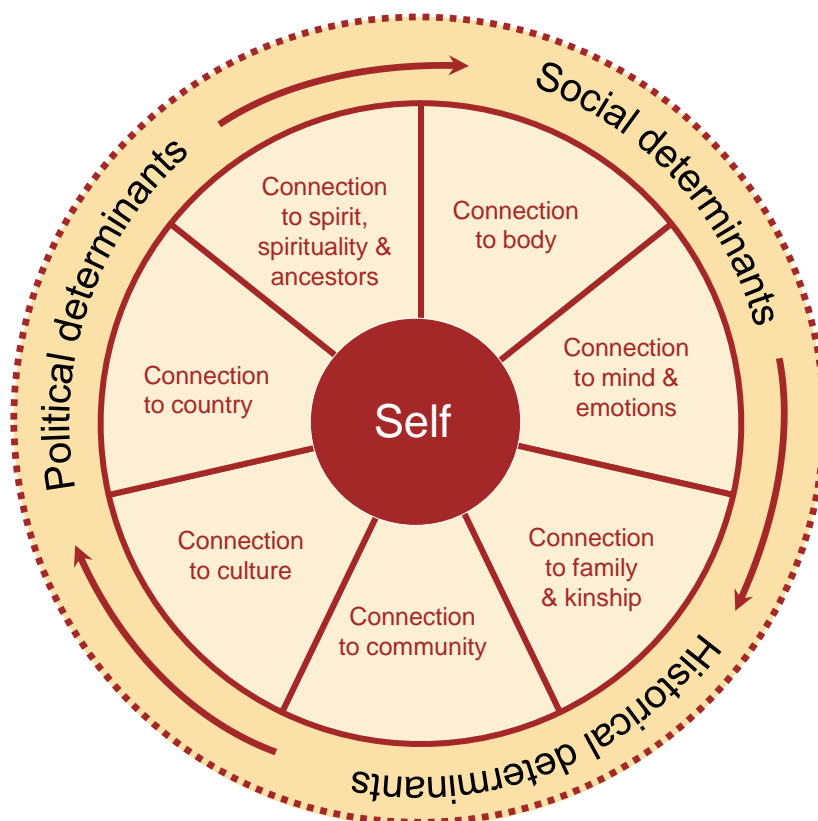
Source: Yap and Yu (2016a, 2016b).

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 (Gee et al. 2014) (figure 20.8).

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 20.8 **A model of Aboriginal and Torres Strait Islander Social and Emotional Wellbeing^a**



^a The concept of the individual in this model is viewed as being part of, and inseparable from, family and community (Gee et al. 2014).

Source: Australian Government (2017a); Gee et al. (2014).

The nature and importance of these connections and the way in which people engage with each domain can vary at a point in time and throughout their lives — people may experience health connections and resilience in some domains while encountering difficulties and a need for healing in others (Gee et al. 2014). Loss of cultural connection has been identified as an important factor in youth self-harm and suicide in Aboriginal and Torres Strait Islander communities (Silburn et al. 2014).

The importance of culture and empowerment

Culture and cultural identity — including spirituality, connections to country and language, and relationships with family and kin — are recognised as fundamental to social and emotional wellbeing (Beyond Blue, sub. 275). Ongoing cultural engagements, such as living on or returning to country, learning or speaking an Aboriginal language and participating in cultural activities are positively associated with subjective emotional wellbeing (Biddle and Swee 2012). For example:

When I'm on Country, or with my community, it reminds me of a time where colonisation didn't impact our culture and we weren't influenced by Western society. Being on Country is for me a form of self-preservation. It protects my mental health and puts things back into perspective ... It's because of my Country, my culture and my community, that I am able to be the proud Yuin/Kamilaroi woman I am today. (Jash 2019)

The importance of connections to culture and land is 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. (The 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. (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).

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), and the Kimberley region of Western Australia (home to the Maparn) (box 20.9).

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 Mental Health and Wellbeing* (discussed further in chapter 22) (Australian Government 2017a).

Box 20.9 **The Ngangkari of Central Australia**

The Ngangkari are the traditional healers in the Anangu Pitjantjatjara Yankunytjatjara (APY) lands in Central Australia. The Ngangkari have nurtured the physical, emotional and social wellbeing of their people for thousands of years, helping them to cope and be resilient against life's problems. The basis for traditional healing is an understanding that the spirit is inextricably linked to the body and emotions, with a pathway to healing provided through cultural activity and connectedness to country. Some methods of healing and treatment used by Ngangkari healers include the blowing breath method, spiritual healing, the suction method, massage and wound healing, and bone manipulation (Panzironi 2013, p. 171). There are many parallels between traditional healing and methods employed in counselling such as developing trust, being held in mind (spirit), developing shared understanding, meaning and use of metaphors (Australian Indigenous HealthInfoNet 2019).

Ngangkari healers sometimes work alongside western medicine practitioners in a complementary role. This has helped to encourage Aboriginal people to visit doctors when they otherwise would not have. Ngangkari and western medical care are often provided in parallel and positive outcomes for patients reaffirms the importance of 'providing a holistic and culturally appropriate health care to Aboriginal patients' (Panzironi 2013, p. 134).

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 to not only consider conventional outcomes but also 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 (PC 2019b), and this strategy should be used as a basis for the assessment.

DRAFT RECOMMENDATION 20.3 — TRADITIONAL HEALERS

Traditional healers have the potential to help improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people.

In the medium term (over 2 – 5 years)

- 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 indicate that suicide rates are strongly correlated with measures of cultural continuity and local control (Chandler and Lalonde 1998).³² 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)³³. The need for local solutions to address suicide among Aboriginal and Torres Strait Islander people is discussed in chapter 21.

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 2017a, 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 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’³⁴:

Proportionally, we are the most incarcerated people on the planet. We are not an innately criminal people. Our children are alienated from their families at unprecedented rates. This cannot be because we have no love for them. And our youth languish in detention in obscene numbers. They should be our hope for the future.

These dimensions of our crisis tell plainly the structural nature of our problem. This is the torment of our powerlessness. (Referendum Council 2017)

³² Local control was measured in terms of involvement in land claims and local government, and control of education, health services, cultural facilities and police and fire services (Chandler and Lalonde 1998).

³³ As well as self-determination and the need for local leadership, other priorities were: the social determinants of health, trauma, incarceration and justice, and culture and identity (Milroy et al. 2017)

³⁴ A constitutional convention that brought together 250 Aboriginal and Torres Strait Islander leaders who met in May 2017 at Uluru, on the lands of the Anangu people in Central Australia. This convention was convened by the Referendum Council, and was the result of a process to determine an acceptable path towards constitutional recognition of Indigenous Australians (Referendum Council 2017). At the convention, a majority of delegates resolved to support the establishment of a ‘First Nations Voice’ in the Australian Constitution, and a ‘Makarrata Commission’ to supervise a process of truth, reconciliation and agreement-making between the Australian governments and the Aboriginal and Torres Strait Islander peoples. These resolutions are known as the ‘Uluru Statement from the Heart’.

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 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. (Sinclair, Truth and Reconciliation Commission (Canada), 2015, p. 10)

In Australia, such reconciliation is an ongoing process that is hindered by a lack of trust (AH&MHRC, 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 of 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:

The RACP 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)

DRAFT FINDING 20.2 — 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 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.

21 Suicide prevention

Interventions for suicide prevention matter because ...

- The impacts 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 (such as medical costs and foregone wages) of suicides and non-fatal suicide attempts is estimated to be \$16 billion to \$34 billion each year.
- The unquantifiable social and emotional costs of suicide are likely to be much higher.

Successful intervention requires ...

As a priority:

- Universal access to aftercare support for people who have attempted suicide.
- Empowering Aboriginal and Torres Strait Islander organisations as preferred providers of local suicide prevention activities for their people, to better prevent suicide in Indigenous communities.

Additional actions required include:

- Clarifying which level of government is responsible for specific suicide prevention activities and expanding responsibility to take a whole-of-government approach.
 - Assessing the effectiveness of current trials at reducing suicide rates and implementing successful programs widely.
 - Improving access to, and the effectiveness of, mental health services.
 - Developing performance monitoring, reporting and evaluation frameworks to assess the effectiveness of suicide prevention efforts and apply lessons from suicide prevention trials.
-

Suicide is a stark and often-used indicator of the state of Australia's mental health. There is a strong link between poor mental health and suicide. This inquiry makes a range of recommendations to improve the mental health of Australians, which will support suicide prevention. However, explicit efforts to address suicide are needed to complement broader mental health reforms.

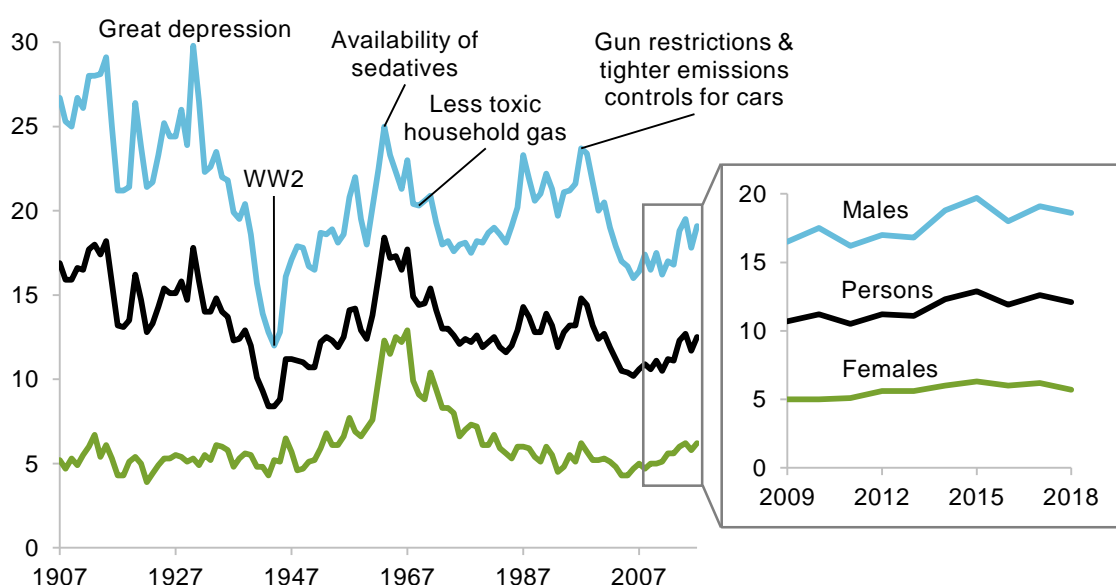
This chapter reviews trends in suicidal behaviour in Australia (section 21.1), examines its economic cost (section 21.2), and considers the research into what works in suicide prevention (section 21.3). Practical mechanisms to better empower suicide prevention efforts among Aboriginal and Torres Strait Islanders are also considered (section 21.4). Finally, the chapter examines the effectiveness of Australia's suicide prevention efforts and structural ways to improve its approach (section 21.5).

21.1 Suicide remains a significant issue in Australia

The suicide rate in Australia has varied over time (figure 21.1). But in the past decade, the number of people who lost their lives to suicide has grown significantly. In 2018, 3046 people lost their lives to suicide, an average of more than eight people per day. Under current trends, the number of people dying by suicide is estimated to rise to about 3800 people each year by 2030 (SPA 2019). Suicide rates in Australia sit within the top one-third of developed countries (figure 21.2).

Figure 21.1 Suicide rates have been variable^a

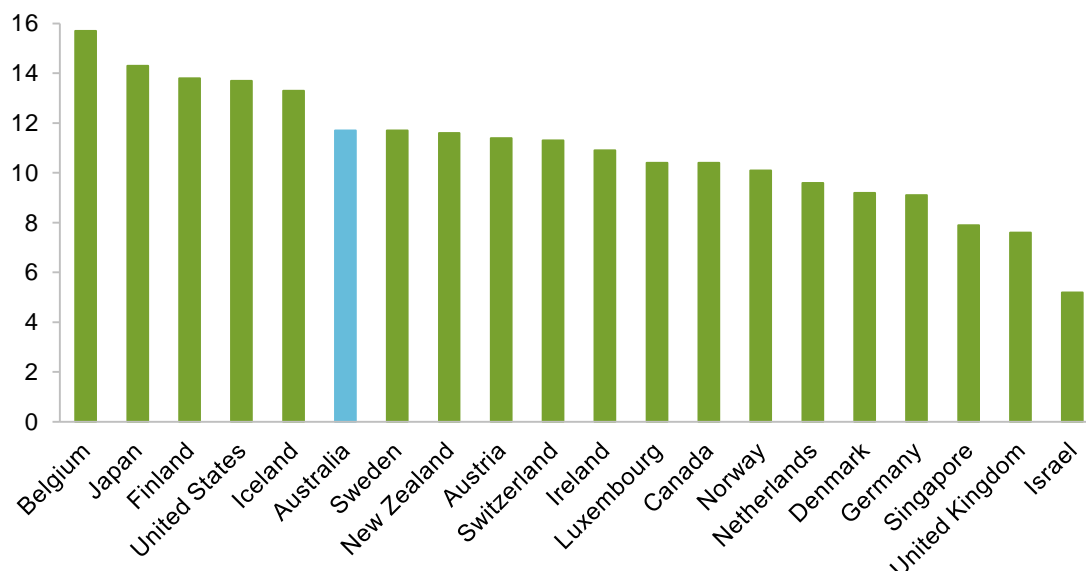
Age-standardised suicide rate per 100 000 people, 1907–2018



^a Descriptions show notable events that *may* be associated with changes in the rate of suicide deaths.

Source: ABS (*Causes of Death, Australia, 2018*, Cat. no. 3303.0); AIHW (2019g); Harrison and Henley (2014).

Figure 21.2 Suicide rates in developed countries^{a,b}
Age-standardised suicide rate per 100 000 people, 2016



^a Top 20 countries with available data ranked using the United Nations 2018 Human Development Index.

^b Estimates are adjusted for cross-country comparability and may differ from official national estimates.

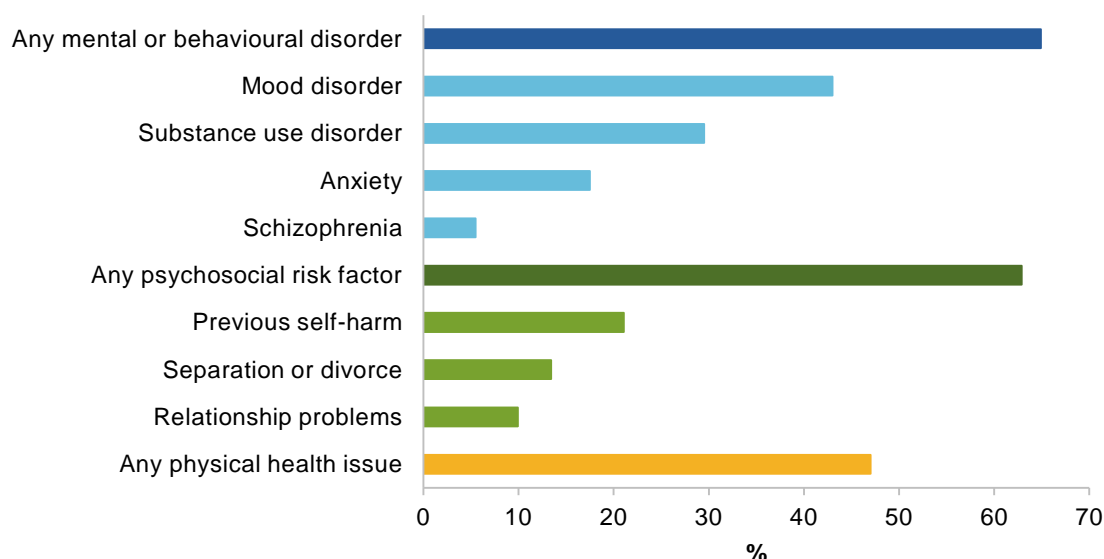
Source: WHO (2019b).

Mental illness is a key risk factor for suicide (Ferrari et al. 2014). Almost two-thirds of people who die by suicide had a diagnosed mental illness, including depression, substance use disorders and anxiety (figure 21.3). In 2007, about 72% of people who had suicidal thoughts, 78% who planned suicide and 94% who attempted suicide, experienced a mental disorder within the past 12 months (ABS 2008). Yet, most people who experience a 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 of 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 causes.

Many more people attempt suicide and even more have suicidal thoughts (ideation), than die by suicide. In 2007, 13% of the population had thought about suicide at some point during their lifetime, 4% had made a suicide plan and 3% had attempted suicide (Slade et al. 2009).

Figure 21.3 Proportion of suicide deaths associated with select causes^{a,b}



^a 2017. ^b Death may be associated with more than one risk factor.

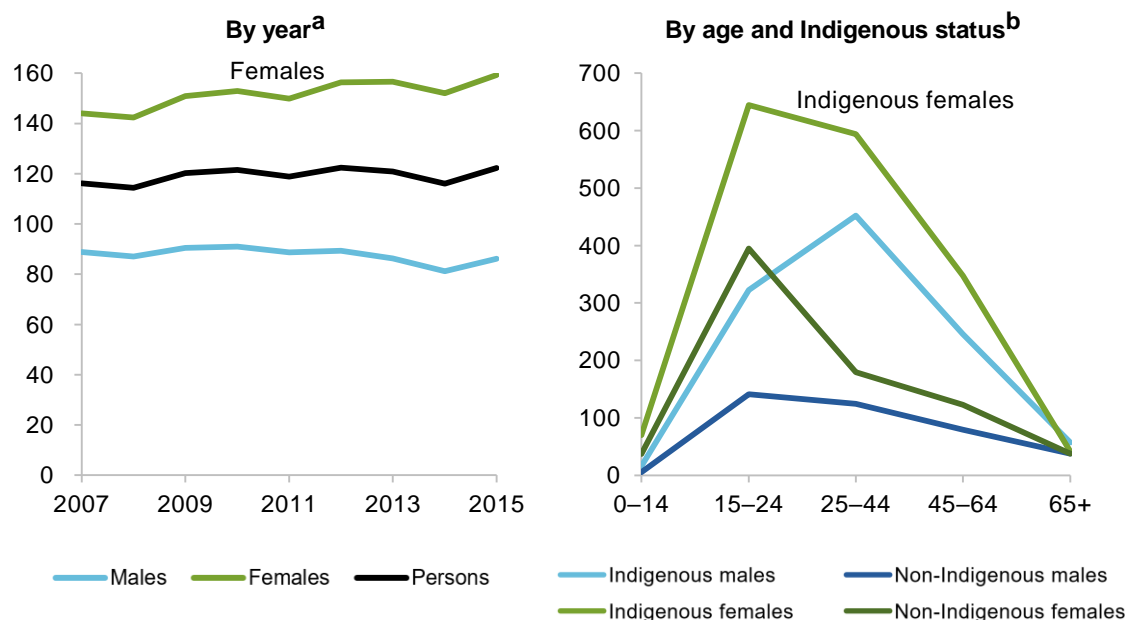
Source: ABS (2018b, 2019j).

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 in Australia is likely to be significantly higher than the number of suicide deaths (figure 21.4). In 2017-18, there were over 31 000 people hospitalised for intentional self-harm (AIHW 2019b); although ambulance data suggests this number may be a substantial underestimate of the scale of the problem. Turning Point (2019) found that ambulance data showed rates of self-harm among men (at least) that were almost three times higher than hospitalisation data. That is, not everyone who intentionally self-harmed was subsequently transported to, or admitted into, hospital, and some hospital presentations were not coded as intentional self-harm.

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, between 10 to 30 people attempt suicide (COAG Health Council 2017a; Kinchin and Doran 2017; Slade et al. 2009). This suggests somewhere between 30 000 and 90 000 people may have attempted suicide in 2018.

Figure 21.4 People hospitalised due to intentional self-harm

Rate of intentional self-harm per 100 000 people



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

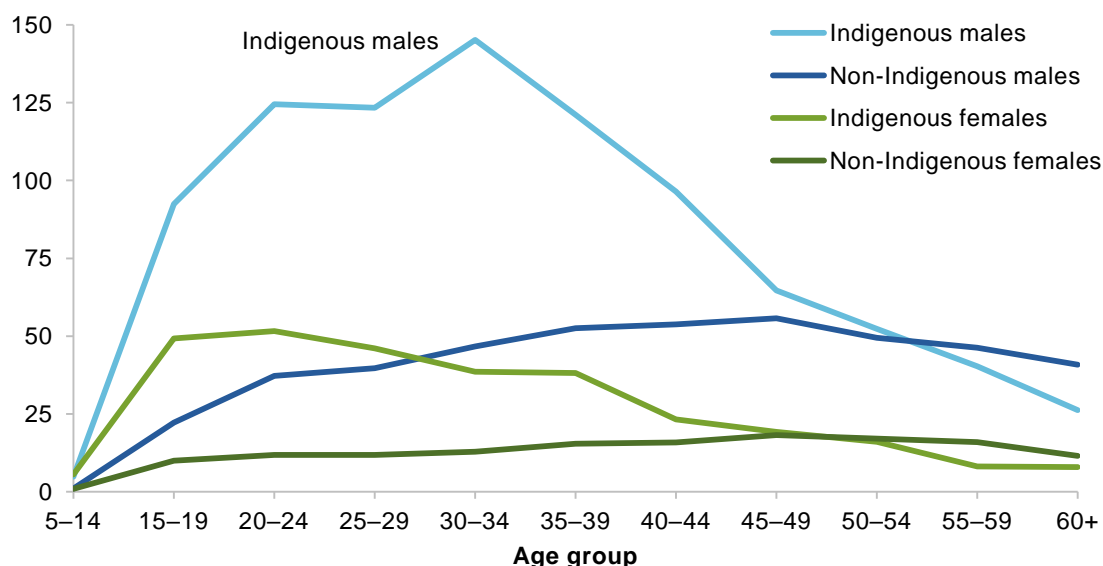
Source: AIHW (2018u, 2019h).

Some groups of people are associated with higher risk of suicide than others.

- About three quarters of people who die by suicide are male (figure 21.1). This may be because males choose more deadly means when attempting to take their own life (Tsirigotis, Gruszczynski and Tsirigotis 2011).
- 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 2019a).
- Aboriginal and Torres Strait Islander people are twice as likely as non-Indigenous people to die by suicide (ABS 2019a). This is largely attributable to young Aboriginal and Torres Strait Islander males who are at much higher risk of suicide (figure 21.5). Suicide is the fifth leading cause of death for Aboriginal and Torres Strait Islander people, compared with the twelfth cause for non-Indigenous people.
- Regional communities have a significantly higher rate than capital cities (figure 21.6) (chapter 2).
- While females are less likely to die by suicide, they tend to have far higher rates of hospitalisation due to intentional self-harm than males (figure 21.4). Aboriginal and Torres Strait Islander females have particularly high rates of intentional self-harm.

Figure 21.5 Young Aboriginal and Torres Strait Islander males are at particularly high risk of suicide^a

Age-specific suicide rate per 100 000 people, 2009–2018

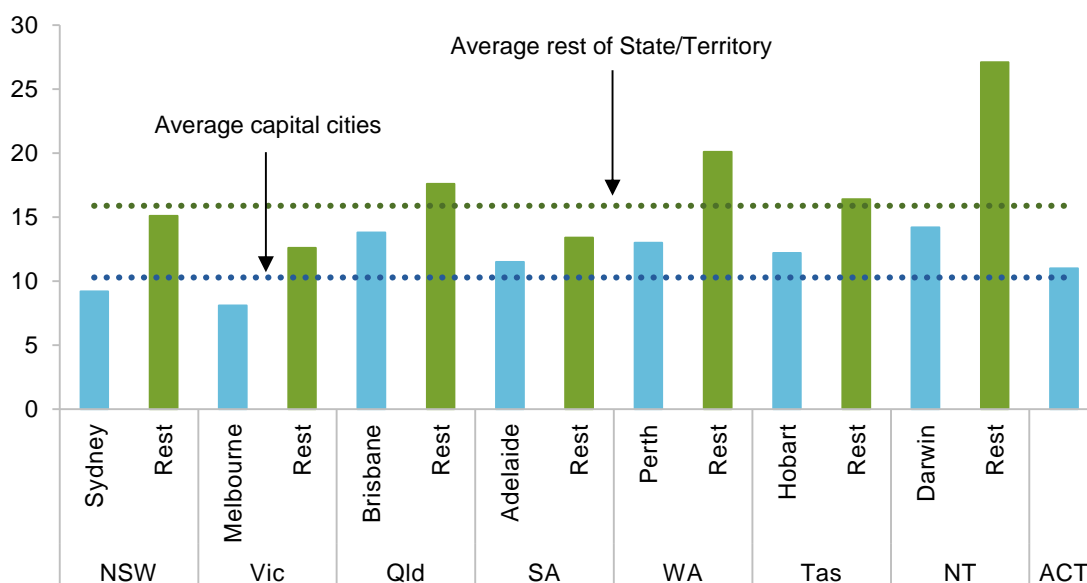


^a Data is for NSW, Qld, SA, WA and NT only.

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

Figure 21.6 Suicide rates are higher in regional areas^a

Age-standardised suicide rate per 100 000 people, 2018



^a Greater capital cities and rest of the State or Territory.

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

21.2 The cost of suicide is high

Suicide has a devastating impact on individuals, families and communities across Australia. Losing one's life is ultimately the greatest cost of suicide. But suicide can have a deep impact on those left behind. Of those left behind, about six people may be profoundly affected (Andriessen 2009). And the impacts can extend up to 135 people for each life lost (Cerel et al. 2019). These impacts were expressed by many inquiry participants:

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. (Lifeline Australia, sub. 87, p. 3)

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)

In rural communities, the ripple effect of suicide appears to be much stronger, reaching further into neighbouring communities, clubs, businesses and schools; far beyond the immediate family and circle of friends. (Foundation for Rural and Regional Renewal, sub. 195, p. 4)

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)

The social and emotional costs of people losing their lives through suicide are incalculable.

Many of the economic costs of suicidal behaviour can be calculated. The Commission has estimated some of the economic costs to help galvanise the community and governments to improve culture, policies and strategies to overcome this significant burden and encourage investment in effective suicide prevention activities. But ultimately, the non-monetary costs will more likely act as a call to action.

A handful of studies have estimated the economic costs of suicidal behaviour to Australia (box 21.1). Several international studies have estimated similar costs (McDaid 2016). Estimates vary considerably depending on the methodology used and the target population; for example whether they capture non-fatal suicide behaviour.

The costs of peoples' suicidal behaviour can be split into three broad categories (chapter 3).

- Direct costs — expenditure incurred by people and governments, such as the cost of medical, coronial and police services.
- Indirect costs — the lost productivity (such as wages) of an individual being unable to contribute to society, such as through paid work, volunteering or home responsibilities.
- Intangible costs — the social and emotional costs that are essentially unquantifiable, such as the pain and suffering associated with the loss of an individual.

Box 21.1 **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 \$6.73 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'.

The quantifiable economic costs of suicide and non-fatal suicide attempts were estimated to be in the order of \$16 billion to \$34 billion each year (table 21.1). This includes the average costs of:

- suicide deaths, which was between \$0.7 million to \$1.6 million per person
- non-fatal suicide attempts that leaves the person permanently incapacitated, which was between \$1.0 million to \$2.2 million per person
- suicide attempts resulting in a short absence from normal activity, which was just over \$1000 per person.

The vast majority of these costs are the result of lost future activity due to an individual's early death or their inability to return to work, education or household duties. These estimates are broadly in line with those reported by others (appendix E).

There were about 78 000 instances of people who had a non-fatal suicide attempt in 2018. That is, for every suicide death, about 26 people attempted suicide — this falls toward the higher end of the commonly agreed range of estimates of 10–30 people (section 21.1). The considerably larger number of suicide attempts drastically increases the cost of suicidal behaviour in Australia. It is estimated that the total cost of non-fatal suicide attempts was \$14 billion to \$29 billion each year (table 21.1).

Table 21.1 Costs of suicide and non-fatal suicide behaviour, 2018

	<i>Number of cases</i>	<i>Average costs</i>	<i>Total costs</i>
Suicide death	3 046	\$0.7 – \$1.6 million	\$2.2 – \$4.9 billion
Suicide attempt: full incapacity ^a	13 316	\$1.0 – \$2.2 million	\$14.0 – \$28.8 billion
Suicide attempt: short incapacity ^b	65 003	\$1 055 – \$1 225	\$0.07 – 0.08 billion
Total	81 365	–	\$16.3 – \$33.7 billion

^a Full incapacity means the individual is permanently unable to return to work. ^b Short incapacity means the individual requires a short absence from normal duties.

Source: Appendix E.

These estimates are conservative. For example, they do not include the cost of providing mental health services for people who have survived a suicide attempt (estimated in section 21.3). 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 2019o). 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).

The quantifiable cost of suicide is higher when the person who dies is a young person who has the majority of their life ahead of them (given the high cost of lost productivity). Kinchin and Doran (2018) estimated the average cost of a suicide death for a 15–24 year old was between \$2.1–3.1 million per person in 2014 — significantly higher than the Commission’s average estimate.

While the quantifiable cost of suicides is high, these costs cannot capture the enormity of the consequences of suicidal behaviour. In 2015, suicide was the 2nd leading cause of the total burden of disease for males, behind coronary heart disease, and the 15th leading cause for females (AIHW 2019c). Overall, suicide and self-inflicted injuries has remained the 8th leading cause of disease burden in Australia from at least 2003. The burden of disease is often measured in ‘disability-adjusted life years’ — the sum of the years of potential life lost due to premature mortality (such as suicide deaths) and years lived with disability (such as incapacity as a result of a non-fatal suicide attempt) (chapter 2).

In 2015, suicide and self-inflicted injuries cost Australians 135 373 disability-adjusted life years. The majority of this was caused by the years of life lost due to suicide deaths. In 2018, suicide accounted for 105 730 years of potential life lost, making suicide the leading cause of the number of years of life lost (ABS 2019a). This is largely because the median age at which someone dies by suicide is about 44 years old, considerably lower than other causes of death. On average, a person who dies by suicide loses almost 37 years of their expected life.

As illustrated by the economic costs above, the years lived with disability as a result of non-fatal suicide attempts can also be significant. The Mental Health Council of Tasmania (sub. 314, p. 12) noted that ‘approximately 17% of people who attempt suicide will incur a permanent disability from the attempt, limiting their potential to live a full, enjoyable and productive life’.

DRAFT FINDING 21.1 — THE COST OF SUICIDE AND NON-FATAL SUICIDE ATTEMPTS IS HIGH

Suicide and suicide attempts create enormous social and emotional impacts on individuals, families and the broader Australian community. The quantifiable cost of suicide and non-fatal suicide attempts in Australia is estimated to be \$16 billion to \$34 billion each year. The vast majority of these costs are due to lost productivity resulting from suicide deaths and permanent incapacity from non-fatal suicide attempts.

21.3 What works in suicide prevention?

Suicide prevention includes any activities that aim to reduce suicide deaths, attempts, plans and thoughts. There are many potential risk factors for suicide, and thus many potential methods of preventing suicide by reducing these risks. Therefore, it is important to rely on the available evidence to understand what works in suicide prevention so as to target activities that are likely to be most effective.

There are many risk factors for suicide ...

Suicidal behaviours are complex. Each person’s risk of suicide is different and there may be many contributing factors and causes.

Mental illness is a key risk factor for suicide, but there are many other potential risk factors. Social determinants, including trauma, abuse, discrimination, harmful use of alcohol and job or financial loss, can increase someone’s risk of suicide (figure 21.7). Some inquiry participants provided examples of how these risk factors impacted their loved ones:

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)

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)

Many submissions to this inquiry recognised that some groups are more vulnerable to suicide risk factors than others (for example, FASSTT, sub. 293; Justice Health Unit, sub. 339; OzHelp Foundation, sub. 294) (figure 21.7).

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. (Rural and Remote Mental Health, 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)

... but suicide remains difficult to predict

While the risk factors are known, 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). This may be partly because past studies tend to test risk factors in isolation (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 used machine learning to monitor user posts and identify those at greater risk of suicide from 2017.

There is scope for governments and researchers to improve the predictive ability of suicide risk assessments by investigating the application of artificial intelligence to existing administrative datasets, such as health records. These data-driven approaches can be a useful way 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 the screening tool. 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 proposed that the National Mental Health Commission (NMHC) be tasked with sponsoring relevant research into mental health and suicide prevention (chapter 25). Research to improve the ability to identify individuals at imminent risk of suicide should be high on its list of priorities.

Figure 21.7 Key suicide risk factors, vulnerable groups and interventions

Risk factors		Vulnerable groups	Interventions	
Society	Access to means	Previous suicide attempt	Mental health policies	Universal
	Inappropriate media reporting	Mental illness	Policies to reduce harmful use of alcohol	
	Stigma associated with help-seeking behavior	Aboriginal and Torres Strait Islander people	Access to health care	
Community	Disaster, war and conflict	Regional and remote Australians	Restrictions of access to means	
	Stresses of acculturation and dislocation	Fly-in Fly-out workers	Responsible media reporting	Selective
	Discrimination	LGBTIQ	Raising awareness about mental health, substance use disorders and suicide	
	Trauma or abuse	CALD		
Relationships	Sense of isolation and lack of social support	Refugees		
	Relationship conflict, discord or loss	Emergency responders	Interventions for vulnerable groups	Indicated
Individual		Comorbid physical and mental illness	Gatekeeper training	
	Previous suicide attempt	Male-dominated industries	Crisis helplines	
	Mental disorders	Homeless		
	Harmful use of alcohol	Prisoners	Follow-up and community support	
	Job or financial loss		Assessment and management of suicidal behaviours	
	Hopelessness		Assessment and management of mental and substance use disorders	
	Chronic pain			
	Family history of suicide			
	Genetic or biological factors			

Source: Adapted from WHO (2014a).

Evidence-based interventions

Interventions for suicide prevention are designed to reduce corresponding suicide risk factors. Given the many risk factors for suicide there are many types of suicide prevention activities. They generally fall into three categories (figure 21.7).

- *Universal* interventions target an entire population. For example, these interventions may involve improving access to health and mental healthcare, restricting access to the means of suicide, and raising awareness to reduce stigma.

-
- *Selective* interventions target vulnerable groups based on population characteristics, such as age, sex, culture or family history. 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 follow-up support after a suicide attempt or management of mental disorders.

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’) can reduce further attempts or deaths
- school-based awareness programs can reduce attempts and ideation
- restricting access to the means of suicide can reduce deaths (box 21.2) (Zalsman et al. 2016).

Australia has been reasonably successful at progressing interventions in some of these areas. For example, means-restriction is clearly an effective approach, and has been associated with reduced suicide rates in Australia in the past (box 21.2). However, it is difficult to take this intervention much further. It is also important to note that means-restriction does not target the underlying causes of suicide.

However, there is room to improve Australia’s efforts towards 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.

Improving peoples’ access to mental health services

Mental health services can be effective at reducing suicidal behaviour (Ougrin et al. 2015; Zalsman et al. 2016). This includes medications and psychological treatment (such as Cognitive Behavioural Therapy). However, mental health services can only be effective at reducing suicide if people can access these services when they are needed and the treatment is effective.

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). People may not access mental health services either because of a lack of appropriate services or because they choose not to seek help.

Box 21.2 Restricting access to the means of suicide

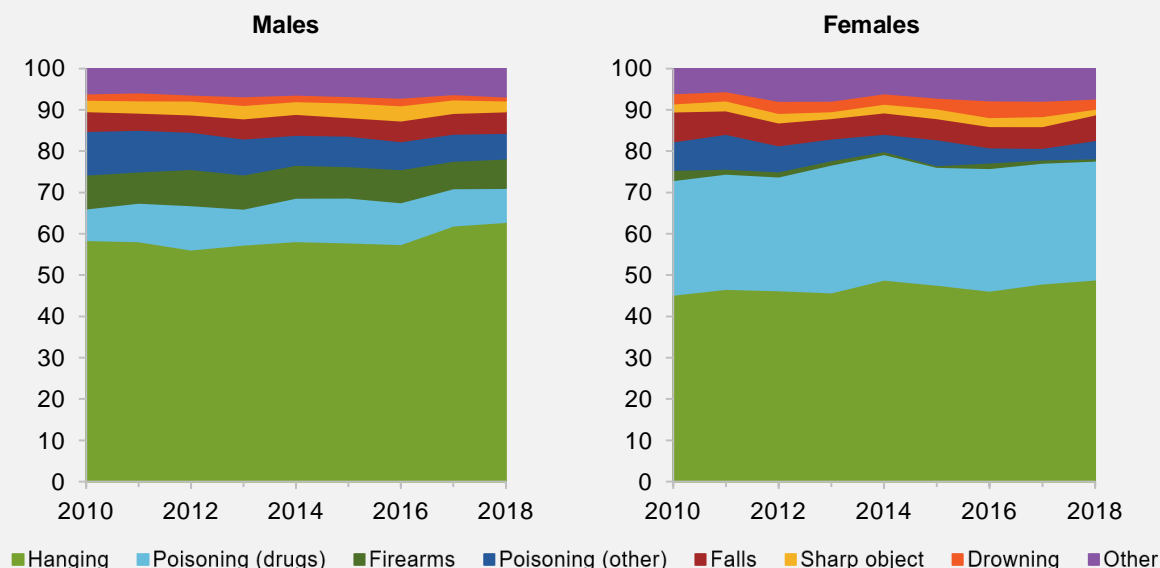
Difficulty in predicting suicide indicates that some interventions should restrict access to the means of suicide (Large and Nielssen 2010). Evidence suggests this can significantly reduce suicide deaths and attempts, particularly when the method is highly lethal and common, and that substitution to other means appears to be limited (Yip et al. 2012; Zalsman et al. 2016). Means-restriction can be effective because some suicide attempts are impulsive, occurring in moments of crisis (Layard and Clark 2014; WHO 2014a). This gives individuals contemplating suicide time for the crisis to pass and to receive support.

A systematic review of international studies by Mann et al. (2005) found that restricting domestic gas use led to a 19–33% reduction in annual suicide rates, restricting guns led to a 1.5–9.5% decline, and restricting barbiturates led to a 23% decline.

In Australia, means-restriction has been associated with a reduction in suicide rates in the past. For example, emissions controls, which greatly reduced the amount of carbon monoxide permitted in the exhaust gas of new motor vehicles, were associated with a significant decrease in poisoning by gas (Harrison and Henley 2014).

In recent years, the majority of suicide deaths in Australia have been caused by hanging and poisoning. It is not feasible to restrict the means of hanging due to the availability of different materials that can be used. Further, the vast majority of poisoning-related suicide deaths were caused by drugs that are either illegal or require a prescription (Henley and Harrison 2018). This makes it difficult to take means-restriction much further in Australia. Nevertheless, future interventions that can feasibly reduce access to means of suicide should be considered.

Proportion (%) of suicide deaths by gender and means, 2018



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

In some parts of Australia, there is a significant lack of available mental health services (chapters 2 and 5). 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 (CARC 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)

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)

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. (Queensland Alliance for Mental Health, 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 21.3).

Box 21.3 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 (Mental Health Council of Tasmania, 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 and headspace, 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)

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 8). There is also a evidence of stigmatisation among some hospital workers towards patients in mental health or suicide distress (box 21.3).

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 8).

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 5, 6, 7, 11 and 12).

Improving access to mental health services can prevent many suicide deaths and attempts, avoiding the associated social, emotional and economic costs. Krysinaka 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.³⁵ 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 2014e; Owens, Horrocks and Allan House 2002; WHO 2014a;

³⁵ The number of people in each category was based on the number of cases in table 21.2.

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 21.4).

Preventing deaths and attempts through aftercare reduces the associated social, emotional and economic costs of suicide. Kryszynska et al. (2016) estimated that adequate aftercare could reduce the prevalence of suicide attempts that reach an emergency department by about 19.8% and all suicide deaths by 1.1%. This could prevent about 5108 people from attempting suicide resulting in short incapacity, 1046 people from attempting suicide resulting in full incapacity, and about 34 people from dying by suicide.³⁶ Using the Commission's estimated costs, aftercare could be expected to reduce the economic cost of suicide and suicide attempts by \$1.1 billion to \$2.3 billion each year. This is largely driven by preventing the loss of economic activity produced by people whose suicide attempt would be likely to result in full incapacity.³⁷

³⁶ 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 2019a), 17% resulted in full incapacity and 83% in short absence (appendix E). 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 21.1). 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 (table 21.1).

³⁷ These costs are reasonably consistent with the Commission's separate labour market model, which estimated that aftercare could deliver about \$1.3 billion each year in lifetime earnings for the working age population and provide an additional 0.65 QALYs per person who might have otherwise died or become permanently incapacitated for those impacted (appendix F).

Box 21.4 **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 appropriate, 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 program which provides intensive support within 24 hours of hospital discharge, with support continuing for up to three months (DHHS 2019b). 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).

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 11).

This suggests that 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).³⁸ Therefore, aftercare could provide a long-term return on investment of \$5.82 to \$36.57 per dollar invested (about 6:1 to 36:1). Other studies have also estimated that aftercare can lead to a positive return on investment (KPMG and Mental Health Australia 2018). For example, McDaid, Park and Knapp (2017) estimated that psychosocial assessment for people presenting to hospital due to intentional self-harm could provide a return on investment over 10 years of about 39:1.

In 2014, the National Mental Health Commission (2014e) 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 2015, p. 17).

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

³⁸ 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).

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. (SA Mental Health Commission, 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 submissions identified the need for effective support for people who have attempted suicide (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, sub. 103; Suicide Prevention Australia, sub. 523; yourtown, sub. 511).

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)

There is a clear net benefit to providing universal aftercare for people who present at a hospital following a suicide attempt. Further, aftercare should extend to people presenting to any health or government service following a previous suicide attempt in order to reach and support as many people as possible.

School-based awareness programs

Stigma and negative attitudes about mental illness and suicide can discourage people from seeking help (chapter 20). There is significant stigma towards suicide in Australia — a survey found that over one-third of Australians thought suicide was ‘irresponsible’ (SPA 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, some school-based awareness programs 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). The Black Dog Institute (2018b, sub. 306, p. 29) has begun trialling the YAM program (evaluations are 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 1885 people from attempting suicide resulting in short incapacity and 386 people from attempting suicide resulting in full incapacity.³⁹ Using the Commission's estimated costs, school-based awareness programs could be expected to reduce the economic cost of suicide attempts by \$407 million to \$834 million each year. This may be an underestimate considering that students have their entire working life ahead of them, increasing the cost of foregone wages.

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.⁴⁰ However, these costs are likely 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 22:1 to 88:1.

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. This highlights the need to build rigorous outcomes-based evaluations into these programs to continue to build the evidence base and confidently direct government funding.

Educators have many competing priorities to meet within a limited timeframe. 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

³⁹ The number of people in each category is based on the number of cases in table 21.2.

⁴⁰ 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). The Commission 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 2019k). The Commission assumed that between 2 to 6 YAM instructors were needed for each school, yielding a range in the estimated costs.

accreditation of social and emotional learning programs offered to schools, such as those that can encourage help-seeking behaviour (draft recommendation 17.3).

DRAFT FINDING 21.2 — SCHOOL-BASED AWARENESS PROGRAMS CAN BE COST-EFFECTIVE

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 draft recommendation 17.3.

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 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 ‘gatekeeper’ training. Gatekeepers 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 health professionals and other gatekeepers (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). And studies have estimated that some gatekeeper training programs, such as 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 gatekeeper training requires further investigation.

Mental health and suicide prevention training for gatekeepers 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 gatekeepers, 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 16), teachers (chapter 17) and housing workers (chapter 15).

Another form of intervention with promise is ‘postvention’ programs — these are interventions targeting those bereaved 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.

Australian studies of the StandBy Response Service program found that clients were significantly less likely to be at risk of suicidality or experience mental health concerns, and that the intervention was likely to cost less than treatment-as-usual and improve quality of life (Comans, Visser and Scuffham 2013; Gehrmann et al. 2018). The Be You initiative also delivers postvention programs in schools to support the community after a suicide death (chapter 17). 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 (Thirrili Ltd, sub. 549). While these programs appear logical and hold promise, more research is needed to determine their effectiveness and cost-effectiveness (Jesuit Social Services, sub. 441; Orygen and headspace, sub. 204).

Interventions such as gatekeeper training and postvention programs are likely to be high on the list of research priorities for the NMHC (chapter 25).

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 Commission has made recommendations to improve mental health services and school-based programs elsewhere in this report.

DRAFT RECOMMENDATION 21.1 — UNIVERSAL ACCESS TO AFTERCARE

In the short term (in the next 2 years)

Australian, State and Territory Governments should offer effective aftercare to anyone who presents to a hospital, GP or other government service following a suicide attempt. Aftercare should be directly provided or referred, and include support prior to discharge or leaving the service, as well as proactive follow-up support within the first day, week and three months of discharge, when the individual is most vulnerable.

21.4 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 factors that can increase their risk of suicide (box 21.5). 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 21.5 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 identifies a number of risk factors which are disproportionately or exclusively experienced by Aboriginal and Torres Strait Islander people.

- 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. For example, 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 single 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.
- There is a strong element of impulsivity to many Indigenous suicide deaths.

Source: ATSISEPP (2016b); Dickson et al. (2019); Fogliani (2019); Thirili 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 (ATSISEPP 2016a; Healing Foundation 2018; WHO 2014a). For example, the Yarrabah community came together to respond to high rates of suicide through programs that empowered the community (box 21.6). 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 21.6 Suicide prevention in the Yarrabah community

In the 1980s and 1990s, the regional Aboriginal community of Yarrabah in 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 closure of 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 forward 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 men's group that focuses on men's healing and restoring cultural pride, connection and responsibility.

These programs led to several improved outcomes because they were led by, controlled by 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 21.7). In 2016, the *Aboriginal and Torres Strait Islander Suicide Evaluation Project* (ATSISPEP 2016a) evaluated what works for the prevention of suicide by Aboriginal and Torres Strait Islanders. The project 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) are the preferred providers of suicide prevention programs for Aboriginal and Torres Strait Islander people.

Box 21.7 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 21.5) 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, *The Fifth National Mental Health and Suicide Prevention Plan*, established an *Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee* (COAG Health Council 2017a). This subcommittee is 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 21.5).

In 2018, the 2nd 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 these programs.

Many submissions supported pursuing some or all of these recommendations (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; NT Mental Health Coalition, sub. 430; Orygen and headspace, sub. 204; Thirrili Ltd, sub. 549; VACSAL, sub. 225; WAAMH, sub. 416; WHV, sub. 318).

But implementation of these recommendations appears slow or non-existent.

Australia is yet to revise its *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* and develop an associated *Implementation Plan* (box 21.7). A revised strategy and dedicated implementation plan is warranted given relatively high rates of suicide in some Indigenous communities. The existing strategy was developed by the Australian Government. 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. To do so, the Council of Australian Governments (COAG) should develop a renewed *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* and associated *Implementation Plan*. This will mirror arrangements for the *National Suicide Prevention Implementation Strategy* under development (section 21.5).

Some 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, 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 initiatives and services that are sensitive to their experiences, culture and specific issues they face (chapter 4). The Commission supports a greater role for Indigenous organisations in suicide prevention as they are likely better placed to meet the needs of Aboriginal and Torres Strait Islander people.

However, this may not be feasible in all cases, 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 available 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 11). But in many cases, capable Indigenous organisations already exist and investing in their capabilities and capacity could give them the opportunity to take on this suicide prevention role.

Indigenous organisations should be the preferred providers of local suicide prevention activities for Indigenous communities. For these organisations — and other providers of programs or services for Aboriginal and Torres Strait Islander people — performance monitoring, reporting and evaluation requirements should be adapted to ensure they are appropriate and responsive to cultural needs.

DRAFT RECOMMENDATION 21.2 — EMPOWER INDIGENOUS COMMUNITIES TO PREVENT SUICIDE

In the short term (in the next 2 years)

- The Council of Australian Governments Health Council should develop a renewed *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* and associated *Implementation Plan* to guide suicide prevention activities in Indigenous communities.
- Indigenous organisations should be the preferred providers of local suicide prevention activities for Aboriginal and Torres Strait Islander people. For all organisations providing programs or activities into Indigenous communities, the requirements of performance monitoring, reporting and evaluation should be adapted to ensure they are appropriate and reflective of the cultural context.

21.5 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 (for example, the Victorian suicide prevention framework 2016–2025).

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 through grant rounds on an ad hoc basis across the country (AHA 2014). This process was not well coordinated with State and Territory Governments and akin to funding some training in one area and some bereavement support in another.

Australia's post-2015 move to a 'systems approach' holds promise

A 2014 review by the NMHC (2014f, p. 116) pointed to mounting international evidence indicating that a *systems approach* to suicide prevention is likely to be a more effective means of reducing suicide rates.

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.

A systems approach involves devolving decision making to the local community to tailor a local approach that implements 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 at reducing suicide rates (van der Feltz-Cornelis et al. 2011; Krysinska et al. 2016; Zalsman et al. 2016) (box 21.8). Several inquiry participants favoured a systems approach to preventing suicide (Connect Health & Community, sub. 94; ConNetica Consulting, sub. 450; Jesuit Social Services, sub. 441).

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, the Fifth Plan committed all governments to supporting PHNs and LHNs to follow a systems approach. From 2018, 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 2018b).

Currently, there are 30 local suicide prevention trials that generally follow a systems approach in Australia (box 21.9). 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 (box 21.9).

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 25), will need to assess if these evaluations provide adequate evidence that a systems approach is likely to be successful at reducing suicide rates. If so, this approach should be implemented across all Australian regions.

Box 21.8 **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 other outcomes, including a 51% reduction in homicide and 54% reduction in severe family violence.

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; 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 United Kingdom 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.

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 over time.

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 mistakes of the past.

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 has 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, creating a lottery based on the standards, personalities, qualifications and relationships of agencies in different regions.

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. 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 too. Many of the 30 regions trialling a systems approach to suicide prevention have been implemented separately from one another (box 21.8), making it difficult to compare experiences. And Lifeline Australia (sub. 87) expressed concern 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 COAG 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 over each tier of government to fund and deliver mental health services and suicide prevention activities (draft recommendation 22.1).

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 a 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 in their area. Therefore, 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 have responsibility over national leadership and coordination across all suicide prevention activities.
- The Australian Government should be responsible for suicide prevention activities that target the entire population and are likely to be 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 proposed National Mental Health and Suicide Prevention Agreement (draft recommendation 22.1) should be informed by, and consistent with, the *National Suicide Prevention Implementation Strategy* (the Strategy) under development to be signed by the COAG Health Council. 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 21.4).

The Commission also recognises that a whole-of-government approach is needed. While the health sector has taken a leadership role in suicide prevention, other government portfolios have a role to play within their direct scope of influence (Suicide Prevention Australia, sub. 523). The Australian Government has signalled the importance of this approach.

The government has also appointed a National Suicide Prevention Adviser to the Prime Minister to ensure a whole-of-government approach to addressing the priority area of suicide prevention. (DoH, sub. 556, p. 4)

This inquiry has recommended that the COAG Health Council should include other COAG Councils or portfolio Ministers in situations where cross-portfolio commitment is necessary to implement reforms (draft recommendation 22.2). To inform whole-of-government

responsibilities, the Strategy must be updated to extend beyond health portfolios to include priority actions for other portfolios, such as those concerned with families, communities and the justice system. Further, this inquiry has recommended that COAG Health Council agree on a set of targets that specify key mental health and suicide prevention outcomes that Australia should achieve (draft recommendation 22.4).

Performance monitoring and reporting

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 21.2). The NMHC currently reports on the progress of indicators detailed in the Fifth Plan.

However, this framework has little use 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 outcomes measure of 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 25). 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 develop strategies to fill existing data gaps.

The NMHC should incorporate indicators of population outcomes that measure the rate of suicide attempts and suicide ideation (table 21.2). In Australia, data recording suicide deaths are reasonably 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 21.9).

Existing performance frameworks for service delivery tend to lack measures related to suicide prevention. For example, the Australian Government Department of Health's (DoH 2018g) 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 21.2). In particular, there is a clear need for the NMHC to develop a consistent monitoring and reporting mechanism for State and Territory Government expenditure on suicide prevention activity (draft recommendation 25.4). Other measures can also be used to indicate the level of suicide ideation among service users and stigma or literacy across service providers (CRESP & 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 21.2 Existing and potential suicide prevention indicators^a

<i>Indicator</i>	<i>What does this measure?</i>	<i>Data source</i>	<i>Availability</i>
System-level outcomes indicators			
Rates of suicide	The number of suicides per 100 000 Australians	ABS Causes of Death	Available
Rates of suicide attempts	The number of suicide attempts per 100 000 Australians	AIHW Injury due to self-harm	Partial measure
Rates of suicide ideation	The number of people reporting suicide ideation per 100 000 Australians	ABS National Survey of Mental Health and Wellbeing	Available (decade-long intervals)
Service-level performance indicators			
Suicide of persons in inpatient mental health units	The number of suicides that occur in admitted patient specialised mental health services	State and Territory hospital data	Requires development
Rates of follow-up after suicide attempt/self-harm	Proportion of presentations to hospital for which there was a follow-up in the community within an appropriate period	Data linkage of State and Territory clinical mental health and patient administration systems	Requires development
Post-discharge community care	Proportion of discharges from an acute admitted specialised mental health unit for which there was a follow-up by a community mental health service within 7 days	State and Territory clinical mental health data systems	Available
Rates of suicide ideation in patients presenting to services	Level of suicidal ideation or behaviour experienced by patients presenting to services, before and after support	Suicidal Ideation Attributes Scale; Suicidal Behaviours Questionnaire-Revised	Requires development
Suicide stigma and literacy	Level of suicide-related stigma and literacy of service staff and the community, and proportion of service staff trained	Literacy of Suicide Scale; Stigma of Suicide Scale; Service admin data	Requires development
Expenditure on suicide prevention activities	Total expenditure on suicide prevention activities defined in a consistent way	State and Territory Governments	Requires development

^a Black text denotes existing indicators. Blue text denotes potential additional indicators.

Source: COAG Health Council (2017a); CRESPI & Black Dog Institute (2015); NMHC (2018a).

Box 21.9 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 and headspace, sub. 204).

However, there are efforts underway to improve data over time. Some States and Territories 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 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 participants recognised the need for proper independent and rigorous outcome evaluations of the effectiveness of suicide prevention activities (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). Some also recognised the need to develop Indigenous-specific outcomes measures for

evaluations of Indigenous-focused suicide prevention programs (CATSINaM, sub. 75; NT Mental Health Coalition, sub. 430).

Australia has the potential to become a world leader in suicide prevention research if our mechanisms for adequately evaluating programs can be improved. ConNetica Consulting (sub. 450, p. 17) suggested that the focus of suicide prevention research needs to shift from descriptive studies toward evaluating programs.

In the eight years, 2010 to 2017, a total of 36 grants and fellowships were awarded where suicide was the primary focus. These totalled \$10.68 million or just over \$1.322/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 had remained on descriptive epidemiological studies (34% in 2010–17 compared to 22% in 1999–2006). Significantly less attention was given to evaluating the efficacy of interventions in 2010–17 (30%) to the previous period (52%).

This inquiry has recommended that the NMHC lead and coordinate a national approach to evaluation in mental health and suicide prevention (chapter 25). This approach lays the foundation for evaluations to follow a set of best practice principles, such as planning evaluation at the start of program development and making them public upon completion.

In the short term, there is scope for governments to improve Australia's approach to suicide prevention by agreeing to and clarifying responsibilities for suicide prevention activities. In the medium term, the NMHC should assess evaluations of current trials to determine whether these approaches should be implemented across Australia.

DRAFT RECOMMENDATION 21.3 — APPROACH TO SUICIDE PREVENTION

Australia's approach to suicide prevention holds promise, but there are opportunities to improve going forward.

In the short term (in the next 2 years)

- The proposed National Mental Health and Suicide Prevention Agreement (draft recommendation 22.1) 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.

In the medium term (over 2 – 5 years)

- The National Mental Health Commission should assess evaluations of current trials that follow a systems approach to suicide prevention. It should consider whether the evidence shows if these approaches are likely to be successful at reducing suicide rates and behaviours in Australia. If so, this approach should be implemented across all Australian regions.

PART V — Pulling the reforms together

22 Governance

Stronger governance of Australia's mental health system matters because ...

- Unclear responsibilities between the two tiers of government prevent the system from operating effectively and efficiently to benefit the community.
- Strategic planning in mental health focuses on the health sector without adequately integrating other sectors.
- The mechanisms for holding jurisdictions accountable for mental health outcomes are weak and poorly developed.
- A lack of consumer and carer involvement in developing strategy, major programs and accountability processes lowers the quality of decision making and system performance.
- The absence of a robust culture of program evaluation impedes innovation and continuous improvement in system efficiency and effectiveness.

Successful reform requires ...

As a priority:

- The Council of Australian Governments (COAG) should set clear divisions of responsibilities in a new National Mental Health and Suicide Prevention Agreement.
- 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.
- The COAG Health Council should agree on a set of targets and specify key mental health and suicide prevention outcomes that Australia should achieve over a defined period of time.
- The Australian, State and Territory Governments should collaborate with consumers and carers in all aspects of mental healthcare system planning, design, monitoring and evaluation.

Additional actions required include:

- The National Mental Health Commission should have statutory authority to lead the evaluation of mental health and suicide prevention programs.
- COAG should develop a new whole-of-governments National Mental Health Strategy that aligns the collective efforts of health and non-health sectors to improve mental health outcomes.

Major reforms are needed to the governance arrangements that underpin Australia's mental health system to inject genuine accountability for system outcomes, to clarify responsibilities for program funding and delivery, and to ensure consumers and carers participate fully in the design of policies and programs that affect their lives.

This chapter is the first of four that recommend governance reforms to enable the mental health system to operate as consumers and carers expect — as a 'planned, unitary whole' (NMHC 2014e, vol. 1). It aims to improve public governance, which serves to direct and discipline decision making, and to support governments in implementing recommended reforms (box 22.1). Chapters 23 and 24 follow with reforms that clarify the responsibilities of both tiers of government. Clear responsibilities are crucial for realising authentic accountability. Chapter 25 concludes with reforms that promote accountability through an improved framework for monitoring and evaluating system performance.

Box 22.1 What is public governance?

Public governance is the framework of institutions, rules, arrangements, conventions, systems, processes and informal customs that guide how government manages its business. Most jurisdictions set down principles that shape their governance, such as: consistency, responsibility, accountability, fairness, transparency, participation, effectiveness and adherence to law. These echo 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. It:

- encourages closer coordination and integration of government services, a necessary condition for a more effective, efficient and equitable system
- promotes public trust in decision making
- assists governments to achieve the aims and actions to which they commit.

In the context of the mental health system, good governance serves to: clarify roles and responsibilities; give decision-makers power to deploy public resources to improve mental health; create incentives for system performance; facilitate engagement with non-government parties, including consumers and carers; monitor the use of services and outcomes; and maintain agreed levels of integrity and accountability.

Stakeholders in this inquiry have stated that existing governance arrangements lack effectiveness and have contributed to the mental health system failing the community:

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)

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)

These governance issues have accumulated over time, rather than abated. A combination of shared constitutional responsibility and vertical fiscal imbalance has seen the Australian Government emerge from having no mental health responsibilities to playing a dominant role, particularly since the mid-2000s. However, governance has not kept pace with decision making by both tiers of government and issues raised by past reviews still persist (box 22.2). The result has been underinvestment in mental health, in part, because neither tier of government is certain of how the other will respond to unilateral policy changes.

Box 22.2 Governance issues raised by past reviews

Dissatisfaction with federal funding arrangements prompted the first survey of the national mental health system in 1955, when mental health was a responsibility of State and Territory Governments. Although the Stoller Report viewed the extent to which the Australian Government should be involved as a political decision, it nevertheless suggested several roles: funding (possibly including prevention), monitoring and reporting, and distributing mental health knowledge (Stoller and Arscott 1955, p. 173).

The Burdekin Report (HREOC 1993) applied standards set by 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 be responsible for ensuring 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, p. 946).

The need to resolve governance issues on a wide front had become acute by the time of the National Mental Health Commission's (NMHC 2014c) review. Along with numerous other independent and governmental reviews, it identified fundamental shortcomings with the structure of the mental health system and Australia's record of 'poor implementation or the failure to sustain initiatives' (NMHC 2014f, p. 13). Many issues stemmed from governance failures. The NMHC recommended clarifying federal roles and strengthening accountabilities for outcomes.

In considering options for reforming mental health governance, the Commission adopted a whole-of-government approach. In particular, we looked wider than the arrangements outlined in the *Fifth National Mental Health and Suicide Prevention Plan* (the Fifth Plan). This was necessary because the numerous interdependencies between elements of the system mean that it was difficult, if not impossible, to promote genuine accountability by focussing on any one element.

22.1 Current governance arrangements

The Australian, State and Territory Governments individually share responsibility for aspects of mental health policy and collectively through the Council of Australian Governments (COAG).

COAG arrangements

There are two COAG strategies that outline the future direction of mental health policy at a national level:

- *National Mental Health Strategy*
- *National Disability Strategy*.

The National Mental Health Strategy

The COAG Health Council provides an intergovernmental forum for continued cooperation on mental health issues (COAG Health Council 2014b). It comprises Australian, State, Territory and New Zealand Government Ministers responsible for health, and the Australian Government Minister for Veterans' Affairs.

The framework that guides mental health reform is a set of documents badged as the National Mental Health Strategy. 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 COAG's strategic intent for Australia's mental health system by declaring its long-term aims and setting out its future direction. It provides context for and influence over the development of state and territory mental health plans (NT DoH 2019; VicHealth and partners, sub. 131). The COAG Health Council (2017a) will renew this National Policy during the life of the Fifth Plan to support the development of a sixth plan
- *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)
- *Fifth Plan* (COAG Health Council 2017b) and its associated *Implementation Plan* (COAG Health Council 2017b). The purpose of these national plans are to achieve the intent of the National Mental Health Policy through governments agreeing to collaborative actions over a 5-year period. In particular, the Fifth Plan commits governments to integrate the mental health system and to improve its transparency, accountability, efficiency and effectiveness
- four previous national plans in 1992, 1998, 2004 and 2009 (COAG Health Council 2017a, p. 1).

The Australian Health Ministers' Advisory Council is responsible for implementing the Fifth Plan and the National Mental Health Commission (NMHC) is responsible for monitoring and reporting on implementation of the Fifth Plan (COAG Health Council 2017a, p. 49) (figure 22.1). Other national bodies that contribute to mental health governance, but have a

wider health remit, include the Australian Commission on Safety and Quality in Healthcare and the Australian Institute of Health and Welfare (AIHW).

There are few formal arrangements under the Fifth Plan that link the COAG Health Council with other Ministerial Councils that relate to mental health (figure 22.1). While the Fifth Plan recognises the importance of a whole-of-government approach to improving mental health outcomes, it does not formalise this beyond:

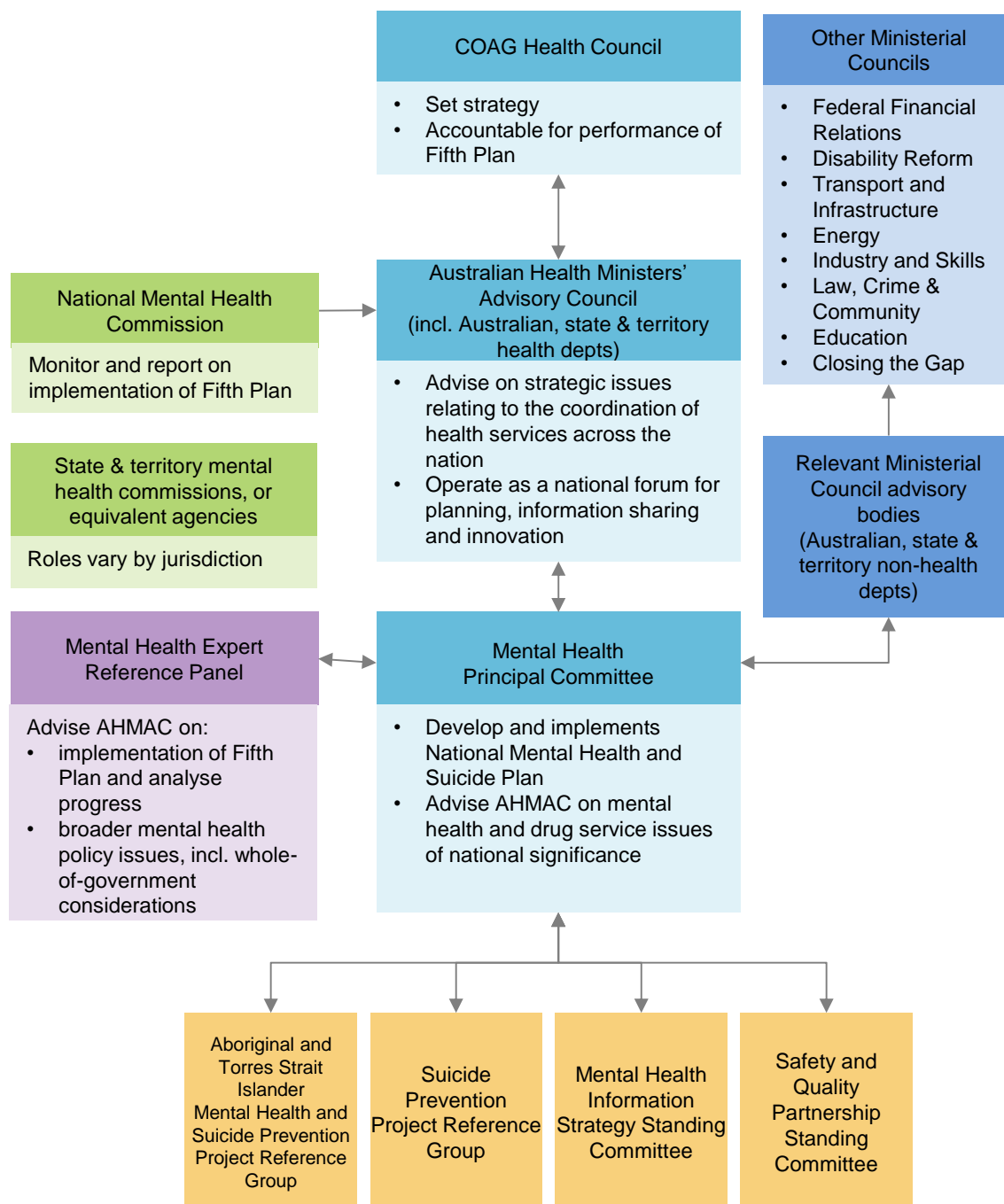
- requiring the Mental Health Principal Committee to meet regularly with relevant ministerial council advisory bodies on the implementation of the Fifth Plan and broader mental health policy issues that require whole-of-government consideration
- recognising the role played by Primary Health Networks and State mental health commissions (COAG Health Council 2017a, pp. v, 13).

The National Disability Strategy

The *National Disability Strategy 2010–2020* is a 10-year national plan for improving life for people with disability, their families and carers. It includes people 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 strategy lies with Ministers of disability and treasury portfolios through the COAG Disability Reform Council. A particular role of the Disability Reform Council that relates to mental health is advising COAG, as necessary, on the implementation of the *Principles to Determine the Responsibilities of the NDIS and Other Service Systems* (COAG 2015). The principles clarify service funding and delivery responsibilities of the NDIS vis-à-vis other service systems, which therefore creates an important interface with the mental health system (COAG 2018, p. 3).

Figure 22.1 Institutional governance arrangements under the Fifth Plan



Source: Adapted from the COAG Health Council (2017a, p. 13).

Australian Government roles and responsibilities

The Australian Government's principal role in the delivery of mental health services is to support primary care, which offers education and promotion as well as early intervention, treatment and referral (COAG 2012, p. 12). It also delivers some clinical and non-clinical community-based services, partners with non-government organisations (NGOs) to provide a range of community and social support programs that relate to mental health, and subsidises private specialist care. The Australian Government also has primary responsibility for delivering physical health services and for various other services and supports that are particularly relevant to some consumers and carers, including:

- employment (including the provision of employment services)
- income support for families, people with psychiatric and other disabilities and their carers
- funding of non-government school sectors
- veterans' affairs.

The Australian Government's functions in the mental health system primarily relate to national leadership, policy direction and funding. The Australian Government's response to the 2014 NMHC review declared that it will lead national mental health reforms and continue to fulfil its ongoing responsibilities for promotion, prevention and stigma reduction, supporting consumer and carer engagement, building the evidence base and monitoring system performance (DoH 2015).

There are no formal arrangements that guide how the Australian Government will act as a whole to improve population mental health and the social and economic participation of people with mental ill-health, with one exception. The National Indigenous Australian 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 2019h). Its focus areas, including those in conjunction with State and Territory Governments, include culture, education, employment, health and wellbeing, and land and housing.

The Department of Health is the lead agency for the Australian Government and has principal responsibility for mental health policy. The Fifth Plan highlights its role in providing funding and policy direction, and its central role in infrastructure of the mental health system through funding research and digital service delivery initiatives (COAG Health Council 2017a). The growing importance of mental health policy has seen the Australian Government Department of Health restructure in early 2019 to create a mental health division. The Australian Government also established the NMHC to play a leading role in the governance of Australia's mental health system.

State and Territory Government responsibilities

State and Territory Governments play a key role in the mental health system by providing hospital-based, specialised, clinical and community-based mental health services that target people with severe and persistent mental illness (COAG 2012, p. 12). They provide these services directly and through partnerships with NGOs. In addition, they play a role in mental health 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.

In recent years, New South Wales, Victoria, Queensland, South Australia, and Western Australia have established mental health commissions. Although they all share a common purpose, which is to drive reform and improve accountability in the sector, they all differ in their levels of independence and role. The mental health commissions in New South Wales and Queensland are broadly similar in so far as they exist to prepare strategic plans and to monitor and report on the implementation of those plans. The Western Australian Mental Health Commission is quite different as it is a commissioning agency, which purchases mental health services. Victoria's Mental Health Complaints Commissioner differs yet again as it is a regulatory agency with powers to deal with complaints relating to mental health services providers. In the Australian Capital Territory, Northern Territory and Tasmania, there are senior public servants with responsibility for mental health who are members of the COAG Mental Health Principal Committee.

International obligations

The Australian Government has ratified a number of United Nations conventions that explicitly identify people with mental ill-health and aim to protect their rights. The introduction of Australian legislation establishes much of the machinery of enforcement of Australia's international obligations. In particular, the *Convention on the Rights of Persons with Disabilities* (Article 25) obliges Australia to promote, protect and ensure that persons with mental impairments have the right to the enjoyment of the highest attainable standard of health. Other conventions that have influenced Australian mental health policy include the:

- *Optional Protocol⁴¹ 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*
- *Convention on the Rights of the Child.*

⁴¹ 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 and treaties, declarations are not intended to be legally binding by reason of 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 that (explicitly relate to mental health) include:

- 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).

Given the current governance arrangements described above, the Commission now turns to addressing those areas where it sees scope for improvements that will significantly improve the performance of the mental health system. This will involve reforms to many aspects of the existing governance arrangements, including by:

- codifying Australian, State and Territory Government responsibilities through a new National Mental Health and Suicide Prevention Agreement (section 22.2)
- strengthening the National Mental Health Strategy (section 22.3)
- enhancing consumer and carer collaboration (section 22.4)
- improving accountability (section 22.5)
- building an evaluation culture through the NMHC (section 22.6).

22.2 Codifying federal responsibilities

The lack of clarity about how both tiers of government share responsibility for mental health is an urgent issue that needs to be addressed. Blurred lines of responsibility for funding and service delivery confound efforts to improve system effectiveness and efficiency. From a governance perspective, unclear responsibilities also make it difficult for consumers and carers to hold governments individually accountable for mental health outcomes.

While there are areas of broad agreement (notably specialised mental health services in public hospitals), uncertainty surrounds other areas, such as the provision of clinical mental health services in the community, psychosocial supports and carer supports (chapter 23). Moreover, the apparent absence of responsibility and authority to fix gaps in the service system fundamentally compromises the effectiveness of the mental health system as a whole. The lack of clear responsibilities is similarly problematic in suicide prevention. (The Commission is proposing changes to some roles and responsibilities in chapter 23.)

A notable deficiency of the current arrangements is the lack of an intergovernmental agreement that codifies, in detail, clear responsibilities for the delivery and funding of mental health services and suicide prevention activities. While clarifying responsibility for service delivery is important, it is not sufficient to successfully realise the aims of the *National Mental Health Strategy*. This section makes recommendations to codify the responsibility of

each tier of government to fund and deliver mental health services and supports, and suicide prevention activities.

Existing national agreements

Australia currently has three national agreements/strategies relevant to mental health: the Fifth Plan (which is one of the documents comprising the National Mental Health Strategy), the National Health Reform Agreement and the National Healthcare Agreement. In the Commission's view, none of these provides sufficient clarity or detail to promote system performance, nor to assuage concerns about the ability of governments, jointly or severally, to be held accountable for mental health outcomes.

A fundamental shortcoming of the Fifth Plan is its lack of clarity about specific roles and responsibilities across all mental health-related services and suicide prevention activities. Further, while it aims to integrate mental health services and attendant supports, its approach is through an important, but nevertheless small segment of the system — the collaborative efforts of Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) (COAG Health Council 2017a, pp. v, 19). As such, the Fifth Plan is unable to catalyse broader system reform. It also lacks detail that would enable stakeholders to hold governments more accountable for outcomes.

The *National Health Reform Agreement* does not adequately support mental health either, which often depends on combining services and supports from health and non-health sectors to meet complex needs. Although it provides details about funding and delivery responsibilities and accountabilities, these relate to the healthcare system. This is largely because COAG structured it about the twin clinical pillars — public hospitals and primary healthcare. However, it does not refer to mental health services and supports provided in non-health sectors (such as education and housing).

The *National Healthcare Agreement* barely mentions mental health, aside from confirming that all governments are jointly responsible for funding mental health services.

The case for an intergovernmental agreement

Specifying funding commitments within the scope of an agreement is critical. 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)

Governments have not always considered funding separately from strategy. As originally conceived, the *National Mental Health Strategy* included Medicare Agreements, which set out the roles of the Australian, State and Territory Governments and defined the conditions for the transfer of federal funding to assist in the reform of mental health services (National Mental Health Strategy Evaluation Steering Committee 1997, p. 3). However, an explicit funding agreement has not supported the strategy since the *Third National Mental Health Plan* (2003–2008).

A new *National Mental Health and Suicide Prevention Agreement* (NMHSPA) would serve to clarify and codify, in detail, responsibilities for funding and delivering these services and supports. Of course, it is the collective actions and attitudes of people that count in directly improving mental health outcomes, particularly voluntary carers and care professionals. Nevertheless, a new Intergovernmental Agreement (IGA) is necessary to better align their collective efforts and to improve government accountability through clearer articulation of responsibilities and more transparent reporting of performance.

The enhanced transparency of IGAs offer multiple advantages over other national agreements (such as COAG strategies and statements of cooperation). An IGA would serve to strengthen the accountability of individual jurisdictions through:

- publicly declaring commitments made by all governments. Given the scale of mental health issues, it is critical that governments agree precisely on who is responsible for funding all aspects of the mental health system. In contrast to intergovernmental commitments made through reports and communiqués which do not always contain this specificity, IGAs permit the inclusion of detailed policy and/or operational matters
- clearly signalling to all government portfolios that the outcomes sought have head of government support. Mental health and suicide prevention have struggled to gain whole-of-government support because their inherent complexity means that they frequently straddle multiple portfolios and the role of the Australian Government is ambiguous, especially in the provision of community mental health services
- improving the accountability of State and Territory Governments, not just for mental health services and suicide prevention activities expenditure but, more importantly, for the quality, effectiveness and efficiency of the services delivered and the outcomes achieved.
- requiring all jurisdictions to report on mental health outcomes through public reporting (chapter 25).

In addition, there are benefits in placing the proposed NMHSPA on the same administrative footing as the *National Healthcare Agreement* and the *National Health Reform Agreement*. Successful implementation of these three agreements depends on administrators clearly understanding the specific requirements of each and having visibility of their wider interactions.

There is a strong case for suicide prevention to remain closely linked to the mental health system architecture. Mental illness and psychosocial risk factors are associated with the vast majority of

suicide deaths and there is clear evidence that access to mental health services can reduce this (chapter 21). Further, there is a parallel need to clearly define responsibilities and take a whole-of-government approach to suicide prevention activities.

Development of the intergovernmental agreement

Oversight of development

A key consideration for COAG is selecting a standing council to develop and implement the proposed NMHSPA. A standing council provides a permanent cross-jurisdictional forum for ongoing cooperation on shared responsibilities, ensures that responsibilities given to ministers in COAG agreements are met, and considers matters reported by relevant advisory groups. At issue is whether the COAG Health Council should be responsible, or a different body with a broader remit.

The COAG Health Council is the default option. It is already responsible for mental health, the *National Health Reform Agreement* and the *National Healthcare Agreement*. Retaining responsibility for mental health would enable it to maintain and strengthen obvious links between the physical and mental health systems. In addition, the Council is also responsible for developing the National Suicide Prevention Implementation Strategy (chapter 21).

However, many participants criticised mental health and suicide prevention planning for being too health centric (for example, Allan Fels, sub. 303; Relationship Australia, sub. 103; Roger Gurr, sub. 40; WentWest, sub. 445). As discussed throughout this report, attempting to address mental health issues or suicide without considering social determinants and other risk factors is ineffective, especially over the long term.

Another option is for COAG to create another standing council specifically for mental health with representation beyond health ministers alone. This would be consistent with the long-standing aim of the *National Mental Health Strategy* to improve cross-portfolio integration. In this regard, the Fourth and Fifth Plans explicitly recognise the importance of involving other Ministerial Councils in addressing broader mental health policy issues that require whole-of-government consideration.

However, there are potential downsides to creating a Standing Council on Mental Health. Most jurisdictions do not have mental health ministers which, presumably, would necessitate health ministers having to routinely participate in a second standing council. For the same reason, opening representation to all relevant portfolios would prove even more cumbersome. At best, it would provide broad, symbolic support for mental health. At worst, it risks stalling progress in mental health reform. A more manageable council could comprise selected portfolios, say, health and housing, given their strong interdependencies. However, it is far from clear that this arrangement would necessarily improve strategic decision making. In addition, there is a distinct possibility that health would play a dominant role, commensurate with its majority investment in mental health.

The Commission also considered whether mental health and suicide prevention should be a standing item on the COAG agenda for first ministers. However, mental health reform and suicide prevention planning, by nature, demands persistent commitment over the long term. Entrusting first ministers with long-term oversight of the proposed NMHSPA risks mental health and suicide prevention having to compete with more immediate issues of the day.

On balance, the Commission's preference is for the COAG Health Council to be responsible for developing the proposed *National Mental Health and Suicide Prevention Agreement*. Perceptions that health ministers may fail to recognise the importance of taking a whole-of-government approach can be countered by recognising that they have the most to lose by not doing so. As discussed earlier, shortcomings in the mental health system are most readily observed as pressures on the hospital system.

Consumer and carer collaboration

COAG should ensure that consumers and carers are key partners in the proposed NMHSPA. 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. It is important from the outset for COAG to embed people with lived experience in order to capitalise on their experiential knowledge and to empower them to take greater control over the policies that affect their lives. Section 22.5 discusses the underlying reasons for, and advantages of, enhancing consumer and carer participation.

Having the qualification of 'lived experience' (in addition to skills that are generally necessary in high-level policy forums) would be valuable in many aspects of the co-design process, in particular, to ensure that the proposed NMHSPA:

- results in a clear articulation of which tier of government is responsible for what
- adequately considers key linkages with non-health services and supports
- comprehensively and systematically considers what aspects of the agreement's performance should be monitored and reported, and how best to implement this
- provides advice on the governance arrangements for the proposed Regional Commissioning Authorities (if agreed)
- takes a long-term view of the effectiveness of mental health investments.

COAG should consult early with people with lived experience to determine the most effective approach to co-design the NMHSPA. Further, COAG 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), sub. 547, p. 5).

Cross-border agreements

A specific issue in relation to national agreements is how governments provide treatment across State and Territory borders.⁴² Mental health consumers have ‘the right to ... equal opportunities to access and maintain health and mental health care’ (Standing Council on Health 2012, p. 7). However, some participants raised concerns about service delivery across borders (Gateway Health, sub. 42; Rural Doctors Association of Australia, sub. 475).

The *National Health Reform Agreement* facilitates the provision of specialist mental healthcare services by one jurisdiction to residents of another. Where differences in service delivery lead to significant cross-border flows, the *National Health Reform Agreement* enables states and territories to establish cross-border agreements that estimate activity levels and allow both jurisdictions to contribute to planning of cross-border activity. It also sets out principles for cross-border hospital activities (box 22.3).

However, evidence suggests that the *National Health Reform Agreement* is not causing concerns. The Independent Hospital Pricing Authority, which has a role to investigate cost-shifting disputes and cross-border disputes (where cross-border agreements exist) as requested by health ministers, has never received any requests (IHPA 2019a). In addition, the Rural Doctors Association of Australia (sub. 475, att. A, p. 12) observed that:

People living in cross-border towns can have better access to health professionals and services on one side of the same town. This is generally not an issue with respect to acute medical services, but is problematic for all other levels of mental health care.

Box 22.3 Principles for cross-border hospital activities

The treatment of cross-border hospital activities will be governed by the following principles:

- the State where a patient would normally reside should meet the cost of services (exclusive of the Commonwealth contribution discussed below) where its resident receives hospital treatment in another jurisdiction;
- payment flows (both Commonwealth and State) associated with cross-border services should be administratively simple, and where possible consistent with the broader arrangements of this Agreement;
- the cross-border payment arrangements should not result in any adverse GST distribution effects;
- States recognise their commitment under the Medicare principles which require medical treatment to be prioritised on the basis of clinical need;
- both States should have the opportunity to engage in the setting of cross-border activity estimates and variations, in the context that this would not involve shifting of risk; and
- there should be transparency of cross-border flows.

Source: COAG (2011, pp. 25–26).

⁴² Forensic cross-border agreements that allow for exchange between states of individuals who are under forensic mental health orders are not considered here.

Instead, participants pointed to broader differences that inhibit consumers from realising equal opportunities to access to treatment and support in border areas. Gateway Health, a provider in border areas, observed a range of challenges that stemmed from inconsistent approaches.

A cross-border environment creates specific and complex barriers to integrated and effective approaches to treatment and recovery. The differences in state and federal legislative, policy and funding environments makes it very difficult to align work and program development, to measure outcomes, for clients to have equitable choice of services and service delivery, and can in fact rule some people ineligible for services they need. (Gateway Health, sub. 42, pp. 2–3)

A particular challenge arises where an acute care interface intersects with a jurisdictional interface. While discharge from hospitals and other specialist mental health services into community settings can ordinarily be a challenge, inter-jurisdictional differences can magnify these difficulties. The need to ‘systematise cross-border discharge planning for mental health’ was identified as a significant issue in one large cross-border area (Murray PHN 2018, pp. 14, 43).

In chapter 10, the Commission is recommending a system of care coordinators to overcome difficulties in moving between parts of the mental health system. In particular, for those admitted to hospital, care coordinators would be tasked with comprehensive discharge planning, to ensure continuity of care. Where this occurs across jurisdictional borders, care coordinators should also be responsible for arranging an appropriate handover to their counterpart.

DRAFT RECOMMENDATION 22.1 — A NATIONAL MENTAL HEALTH AND SUICIDE PREVENTION AGREEMENT

All stakeholder groups, including government, should know which tier of government is responsible for funding particular services and is accountable for mental health outcomes that are attributable to the provision of those services.

In the short term (in the next 2 years)

COAG should develop a National Mental Health and Suicide Prevention Agreement between the Australian, States and Territory Governments 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
- recognises the importance of separating funding and governance arrangements of mental health from those of physical health to strengthen the accountability of individual jurisdictions for mental health outcomes
- specifies the responsibility of each tier of government to fund and deliver particular mental health services and supports, and suicide prevention activities to ensure maximum separation in responsibilities and maximum coverage of consumer and carer needs
- introduces new funding and governance arrangements between both tiers of government for mental health services and supports, including the mechanism for establishing funding allocations
- includes consumers and carers as key partners in developing the agreement
- recognises the role of non-health supports in meeting consumer and carer needs, particularly psychosocial supports
- sets out clear and transparent performance reporting requirements
- sets out the governance arrangements for the proposed Regional Commissioning Authorities, if recommended and accepted by all governments.

The COAG Health Council should be responsible for developing and implementing the proposed National Mental Health and Suicide Prevention Agreement.

22.3 Strengthening the National Mental Health Strategy

Strategy shortcomings

The National Mental Health Strategy is failing. Since its introduction in 1992, the Strategy has led to a series of reforms of government-funded mental health services and supports. However, the outcomes can be summarised by two trends: strong growth in non-hospital mental health expenditure and services, but static mental illness prevalence rates. Aside from leadership, accountability and appropriate resourcing to ensure successful implementation, the National Mental Health Strategy lacks:

-
- a whole-of-government approach
 - coherence
 - the role of the private sector
 - a vision that is outcomes focussed.

Whole-of-government

The *National Mental Health Strategy* does not articulate how governments should approach service planning and integration across health and non-health sectors. While it acknowledges the importance of non-health sectors to mental health outcomes, it remains health centric insofar as the strategy enables collaborative action between health portfolios as agreed in national mental health plans. For example, while the *National Mental Health Policy* asserts that it ‘embeds a whole of government approach to mental health’ and that it ‘brings together a range of sectors’ (AHMC 2009, pp. i, 8), it is not clear how this will occur while other portfolios are not a party to the Strategy.

Coherence

The National Mental Health Strategy lacks coherence. The current practice of augmenting it with each new national mental health plan, rather than replacing previous ones, means that it now spans seven documents totalling over 300 pages. As the Strategy retains the priorities of past plans, it risks everything becoming a priority and little being accomplished.

Private sector

Various inquiry participants raised concerns that the *National Mental Health Strategy* does not adequately reflect the significance and role played by the private mental health sector (Anthony Jorm, sub. 45; Beyond Blue, sub. 275; Health Services Union, sub. 237; Youth Health Forum, sub. 404). The Private Mental Health Consumer Carer Network (Australia) summarised the issue:

The Network has raised many times that 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)

Some private sector service providers also expressed frustration with the lack of engagement with their sector in past mental health inquiries, which shape future strategies.

We note, that despite many inquiries into the poor state of mental health delivery since the early 1990s, little progress has actually been made. One of the reasons for that is that the private mental

health sector has largely been ignored when such inquiries have occurred in the past. (Independent Private Psychiatrists Group, sub. 473, p. 2)

A lack of collaboration in strategic planning by governments and their agents (such as PHNs) with the private sector could lead to suboptimal planning and resource allocation. There are examples where governments have undertaken mental health reforms involving the private sector in parallel with the national strategy rather than as components of the strategy. For example, the Australian Government has undertaken unilateral 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, the COAG Health Council has sought to strengthen its engagement with the private sector. In 2017, it 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.

Vision

There is no clear national vision for mental health. Although the *National Mental Health Policy 2008* declares that it ‘provides a strategic vision for further whole-of-government mental health reform in Australia’ (AHMC 2009, p. 1), there is little evidence that its development involved collaboration with non-health portfolios. This is consistent with the subject of the vision being the mental health *system*, rather than mental health *outcomes*.

There is also a disconnect between the national vision statement and those developed by individual State and Territory Governments (table 22.1). COAG defines the desired future state in terms of a better system, whereas State and Territory Governments have tended to use bolder language of desired outcomes, reflecting the buy-in from a wide range of stakeholders. While the vision statement in the *National Mental Health Policy* provides context, no jurisdictions refer to COAG’s vision in their strategic mental health plans.

Whole-of-governments strategy

In developing the new strategy, the COAG Health Council should ensure that it is a single, coherent document that outlines a comprehensive approach to improving mental health outcomes. This would enable all stakeholders to more easily align their own strategies with the national strategy, to better effect. The Commission notes that Australian Health Ministers’ Advisory Council has committed to renew the *National Mental Health Policy*, beginning with a review in 2018 (COAG Health Council 2017b). This is an ideal opportunity to permanently separate longer-term strategy from shorter-term action plans. It should include and be based on renewed aims and principles following the planned review of the existing *National Mental Health Policy*.

Table 22.1 State and Territory Government vision statements^{a,b}

<i>Jurisdiction</i>	<i>Vision statement</i>
New South Wales	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.
Queensland	A fair and inclusive Queensland where all people can achieve positive mental health and wellbeing and live lives with meaning and purpose.
South Australia	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.
Western Australia	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. To achieve a Western Australian community that experiences minimal alcohol and other drug-related harms and optimal mental health.
Tasmania	Tasmania is a community where all people have the best possible mental health and wellbeing.
Northern Territory	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.
COAG	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.

^a The ACT Government's Office for Mental Health and Wellbeing is currently developing a Territory-wide vision for mental health in the ACT. ^b Victoria does not have a specific 'vision statement' as such. Rather, its 10-year Mental Health Plan outlines its vision to improve mental health services and results for Victorians with mental illness (DHHS 2015).

Source: Australian Health Ministers Conference (2009); Northern Territory Department of Health (2019); NSW Mental Health Commission (2014); Queensland Mental Health Commission (2018); South Australian Mental Health Commission (2017); Tasmanian Government Department of Health and Human Services (2015); Western Australia Mental Health Commission (2011, 2018).

Further, COAG should take a long-term view in developing the new strategy. Given that poor outcomes have persisted over the life of the current strategy, a time planning horizon that is a generation in length — that is, 30 years — would be appropriate. Although this time frame is somewhat arbitrary, the Commission is suggesting it begin by clearly aligning stakeholder expectations and avoiding any proposition that governments can easily dislodge deep-seated mental health issues within a term of government, or worse, a 12-month funding period to organisations tasked with providing essential services and supports in this area.

Moreover, the COAG Health Council should redraft its vision statement to better balance the future state of mental health outcomes that consumers and carers desire with its level of ambition for national mental health reforms. This should serve to align the collective efforts of all stakeholders more closely.

The Commission appreciates the magnitude of developing a national strategy that is whole-of-government and the extensive consultation it would involve. While its co-design

must involve consumers and carers, applying this approach with all stakeholders would be beneficial, including the private sector, as noted above. Overwhelmingly, the evidence provided to this inquiry underscores the importance of:

- involving all jurisdictions and relevant portfolios
- ensuring that it covers all stakeholders
- ensuring its effectiveness and legitimacy by developing it through authentic collaboration.

The Commission considers that independent and transparent oversight is essential for successful implementation of the new national strategy. A range of measures would assist.

- The NMHC should be responsible for annual monitoring and reporting on the strategy's implementation.
- The COAG Health Council should
 - ensure that progress in implementing the strategy is independently reviewed and improvements recommended every five years.
 - continue to develop national plans every five years, as it currently does.

In addition, COAG should provide its Health Council with stronger guidance to consider cross-sector impacts on mental health. Specifically, there should be a clear expectation in its terms of reference to include other COAG Councils in policy discussions where it is necessary to cement cross-portfolio action beyond what could normally be achieved through working groups. This directive would send a strong signal that solving multi-jurisdictional and cross-portfolio issues can necessitate close collaboration at the highest levels. The terms of reference for the COAG Education Council contains a similar provision.

Where cross-portfolio commitment is necessary to implement substantial mental health or suicide prevention reforms, but a relevant COAG council does not exist, the Health Council should include responsible Ministers and Parliamentary Secretaries. This initiative would have cascading consequences for subordinate committees. As mentioned earlier, there are strong interdependencies between health and housing. Amending the COAG Health Council's terms of reference to promote such collaboration offers greater scope for a whole-of-governments approach to mental health and suicide prevention governance.

Integrating other national strategies

A significant weakness of the mental health system 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 people with mental ill-health.

There are also noticeable gaps in the current approach to strategic planning. For example, there is no contemporary national mental health workforce strategy; however, the Australian Government announced that it is developing a new strategy, which will be fundamental to improving access to quality services and supports (chapter 11).

Several consequences arise from this lack of strategic integration. First, the effectiveness of individual strategies may be diminished by not accounting for mental ill-health, given its relatively high prevalence. Second, the community forgoes the potential benefits from taking an integrated approach to solving mental health issues, many of which are characterised by a complex interdependence of various mental health determinants (chapter 1).

A wide variety of participants noted the importance of integrating mental health strategies with other strategies, including: the 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); National LGBTI Health Alliance (sub. 494); Relationships Australia South Australia (sub. 420); and Victorian Council of Social Service (sub. 478).

The challenge for Australian, State and Territory Governments is to view these agreements and strategies as interdependent and take a whole-of-government approach that aligns the collective efforts of all Australians to improve mental health outcomes. This is fundamental to ensure that all relevant portfolios from both tiers of government develop mutually reinforcing policies. The importance of concurrently addressing social determinants and advancing clinical treatments is now widely accepted, as reflected in the Commission's terms of reference.

COAG councils should ensure that all national agreements and strategies that affect mental health outcomes explicitly articulate how they contribute to meeting the aims of the *National Mental Health Strategy*. Moreover, it is unclear how government could expect the *National Mental Health Strategy* (existing or new) to be fully effective without the support of key enabling strategies, such as those that would cover workforce, data and program evaluation. Similarly, the new *National Mental Health Strategy* should include corresponding links to other strategies that support it.

National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023

The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023* (the Framework) (AHMAC 2017) is the national strategy dedicated to improving the social and emotional wellbeing and mental health of Aboriginal and Torres Strait Islander people. Its purpose is to guide and inform Aboriginal and Torres Strait Islander mental health and wellbeing reforms. The Framework was developed under the auspices of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group, along with significant

input from Indigenous communities. The Australian Health Ministers' Advisory Council endorsed the Framework in 2017.

The Framework forms an essential component of the national response to Aboriginal and Torres Strait Islander health (AHMAC 2017, p. 1). It responds to the high incidence of social and emotional wellbeing problems and mental ill-health among Aboriginal and Torres Strait Islander people by setting out a comprehensive and culturally appropriate stepped care approach to mental health, to help guide and support mental health policy and practice. Nine guiding principles underpin the Framework 'to emphasise the holistic and whole-of-life definition of health held by Aboriginal and Torres Strait Islander peoples' (AHMAC 2017, p. 3). The Framework applies equally to health services delivered by Aboriginal and Torres Strait Islander services as well as mainstream health services.

The Framework complements the overarching Fifth Plan with a dedicated focus on Aboriginal and Torres Strait Islander social and emotional wellbeing and mental health (AHMAC 2017, p. 5). Importantly, both support implementation of the *Gayaa Dhuwi (Proud Spirit) Declaration* (National Aboriginal and Torres Strait Islander Leadership in Mental Health 2015), which is a policy framework for embedding and supporting Aboriginal and Torres Strait Islander leadership within the mental health system. The aim of the Declaration is to achieve the highest attainable mental health outcomes by supporting Aboriginal and Torres Strait Islander people and the practitioners who work with them to access 'the best of both worlds' (National Aboriginal and Torres Strait Islander Leadership in Mental Health 2018, p. 5).

Many participants were concerned that governments had not yet fully implemented or operationalised the Framework (Beyond Blue, sub. 275, p. 27; Congress and Aboriginal and Torres Strait Islander Nurses and Midwives, sub. 75, p. 4; National Aboriginal Community Controlled Health Organisation, sub. 507, p. 2; National Aboriginal and Torres Strait Islander Leadership in Mental Health, Indigenous Allied Health Australia and Australian Indigenous Psychologists Association, sub. 418, p. 8; National Mental Health Commission, sub. 118, p. 2). In their view, this required an implementation plan and associated funding. The National Aboriginal Community Controlled Health Organisation explained that inaction by governments in actioning the Framework 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. Our health belongs in our hands. 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. We urge the Productivity Commission to recognise that the answers exist, but governments are long overdue in actioning 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) also recommended that an implementation plan for the 2017 National Strategic Framework be ‘developed, costed and implemented by the end of 2018 in partnership with Aboriginal and Torres Strait Islander health leaders and communities’.

In the Commission’s view, the Australian Government should resource and 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*. There is little benefit in not implementing a strategy that Aboriginal and Torres Strait Island peoples regard highly and that the Australian Health Ministers’ Advisory Council has endorsed. The rationale for this strategy as a complement to the Fifth Plan lies in the disproportionately high rates of psychological distress, mental illness and suicides (chapter 2) and associated social determinants — ‘a complex mix of intergenerational trauma, social disadvantage and exclusion, racism, and discrimination since colonisation’ (Queensland Mental Health Commission, sub. 228, p. 7).

Leadership

Effective leadership is central to realising systemic change in the mental health system (Mental Health Complaints Commissioner (Victoria), sub. 321; Latrobe Health Advocate, sub. 364; Relationships Australia South Australia, sub. 420; WentWest, sub. 445; Mental Health Commission of New South Wales, sub. 486). It ‘breathes life’ into governance, imbeds values and behaviours, and promotes interagency collaboration (Edwards et al. 2012; ‘t Hart and Uhr 2008). Effective leadership is also what many Australians want in their mental health system.

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)

A lack of leadership was a common perception among many participants. In their view, it contributed to poor integration, poor resourcing, poor access and absolved responsibilities (David Clark, sub. 205, p. 23; NSW Nurses and Midwives’ Association, sub. 246, p. 9; Rural Doctors Association of Australia, sub. 475, appendix A, p. 15). As the Mental Health Commission of New South Wales put it (sub. 486, p. 13):

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. These arise in funding and delivering the most complex set of health services (and arguably of all government services) and an array of supports from other portfolio responsibilities across three tiers of government. And, of course, the Constitution requires a shared model of ministerial leadership as the Commonwealth and the States share responsibility for mental health.

Australia is not alone in this regard and nor can the blame be laid fully with federation. New Zealand, for example, which is not a federation, faces similar concerns.

Across the spectrum of promotion or prevention, early intervention, primary care, specialist services and addiction services, people were concerned that a lack of direction and leadership means positive change is not sustained and good ideas are not implemented beyond the pilot stage. They also spoke of a lack of leadership and coordination in government services outside the health system, such as in the housing, police and corrections sectors, which clearly impact on mental health and addiction. (New Zealand Government Inquiry into Mental Health and Addiction 2018, p. 63)

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). While the Commission's recommendations in this chapter will strengthen the strategy and help improve accountability, a strategy cannot of itself drive improved outcomes. It requires effective leadership.

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. This will require, among other things, governments and other stakeholders to consider and develop the skills and experience necessary to drive the systemic and cultural changes that are required to improve population mental health outcomes so as to realise economic and social participation and productivity benefits over the long term.

DRAFT RECOMMENDATION 22.2 — A NEW WHOLE-OF-GOVERNMENT MENTAL HEALTH STRATEGY

A national strategy that integrates services and supports 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.

In the short term (in the next 2 years)

The Council of Australian Governments (COAG) should amend the terms of reference of the COAG Health Council to enable it to include other COAG Councils in policy discussions and decisions, or ministers responsible for portfolios that do not have a relevant COAG council, where this is necessary to cement cross-portfolio commitment to reforms directed at the social determinants of mental health and suicide prevention.

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.

The COAG Health Council should develop a new whole-of-government *National Mental Health Strategy* to improve population mental health over a generational time frame. In developing the new strategy, the COAG Health Council should:

- collaborate with relevant health and non-health portfolios of Australian, State and Territory Governments, consumers and carers, and the private sector
- redraft its mental health vision statement to better balance the outcomes desired by consumers and carers with the level of ambition it has for mental health reforms
- ensure that it is a single document that has the demonstrable support of consumers and carers, for whom it exists.

The National Mental Health Commission should be responsible for monitoring and reporting on the strategy's implementation annually.

The COAG Health Council should ensure that progress in implementing the strategy is independently reviewed and improvements recommended every five years.

The COAG councils should ensure that all national, and State and Territory agreements and strategies that affect mental health outcomes explicitly articulate how they contribute to meeting the aims of the *National Mental Health Strategy* and how they will demonstrate progress in meeting these aims. Similarly, the new *National Mental Health Strategy* should include corresponding links to other strategies that support it.

22.4 Enhancing consumer and carer collaboration

Consumers and their carers are an important source of information about the quality, effectiveness, accessibility and appropriateness of mental health services. They know what does and does not work for them 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). Their insights can also complement official statistics as an effective feedback channel to drive innovation and continuous improvement.

Enabling consumers and carers to participate more deeply in policy and planning can improve the performance of the mental health system. Among other things, their contributions can help to develop better goals, standards, programs, resources and monitoring regimes (Angelmar and Berman 2007, p. 142). Governments now regard their involvement in all planning steps as ‘vital ... to get the best results’ (Integrated Regional Planning Working Group 2018b).

Consumers and carers should *expect* to participate in the design of government policies and programs that affect their lives. Australian Governments codified this right in the *National Mental Health Policy 2008*, which states that people with mental ill-health:

... 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 2009, p. 12)

Two sets of national standards apply to consumer and carer participation: the National Standards for Mental Health Services (AHMAC National Working Group on Mental Health Policy 2010) and the National Safety and Quality Health Service Standards (ACSQHC 2017b). These apply at all levels: from individuals receiving clinical treatment to partnering with government in system planning, design, measurement and evaluation.

Governments (and other decision makers) can strengthen consumer and carer participation in system governance in two broad ways, by committing to consumer and carer collaboration, and strengthening systemic advocacy.

Committing to consumer and carer collaboration

Current participation in system governance

Many consumers and carers regarded their level of participation in system governance as inadequate to significantly improve policies. Despite long-standing policy directives, some 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 participants had the view 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 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)

Inadequate data limits rigorous analysis of this issue. While the Report on Government Services includes the number of paid mental health workers who are consumers and carers (SCRGSP 2018b, p. 2 of table 13A.23), this data does not indicate their participation in planning and policy design, nor whether this improves mental health outcomes. More data is expected to be developed. For example, the Australian Commission on Safety and Quality in Health Care began a process for collecting data against the second National Safety and Quality Health Service Standard ‘Partnering with consumers’ in 2019.

Increased opportunities suggest that consumers and carers are becoming more embedded in policy and planning. They now contribute to the COAG Health Committee (through the Mental Health Information Strategy Standing Committee, the Safety and Quality Partnership Standing Committee and the Mental Health Principal Committee). There is also consumer and carer representation on working groups established under the Fifth Plan.

Notwithstanding, there is considerable scope to improve collaboration. Many participants argued that governments should listen to the voices of lived experience and increase their involvement in the management and delivery of services (Community Mental Health Australia, sub. 449; David Clark, sub. 205). 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-design of policy frameworks to improve the governance and commissioning frameworks. In this regard, the National Mental Health Consumer & Carer Forum has a clear view on what constitutes acceptable participation, generally through a co-design or co-production role (box 22.4).

Box 22.4 Co-design and co-production

Consumers should expect to participate through a co-design or co-production role 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)).

Consumers and carers have a clear view about what ‘participation’ should mean. They distinguish traditional consultation and mere participation from ‘authentic partnerships’ that are underpinned by ‘early engagement, inclusivity, transparency, shared power and equity of knowledge’ (MHA 2017, p. 1). The National Mental Health Consumer & Carer Forum (2017) provides the following definitions and a 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’.

Challenges in fostering collaborative partnerships

For many consumers and carers, the general aim should be for collaboration that is:

... 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)

However, this can challenge the established way of doing things. It may require professionals to ‘let go’ and let administrative systems become more responsive, or for consumers and carers to think about mental healthcare in different ways (Foot et al. 2014). For example, although they may understand how the system worked (or did not) in their own situation and can identify gaps and shortcomings in access to services, some consumers 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).

Some PHNs and LHNs have applied the principles of co-design in regional planning (Integrated Regional Planning Working Group 2018b). In fact, the Department of Health expects PHNs to apply co-design processes in developing regional mental health and suicide prevention plans (DoH 2018d). To support this, the Integrated Regional Planning Working Group (2018b) identified common mistakes in engaging consumers and carers in planning and service design, namely:

- 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 of consumers and carers in implementation and review, particularly given the important role of consumers in supporting accountability.

Commission’s view

The Australian, State and Territory Governments should ensure they genuinely collaborate with consumers and carers in all aspects of system planning, design, monitoring and evaluation. At a minimum, governments should adhere to Standard 3 ‘Consumer and carer participation’ of the National Standards for Mental Health Services and Standard 2 ‘Partnering with consumers’ of the National Safety and Quality Health Service Standards. Target population subgroups should be included in collaborative opportunities.

Governments also need to be more transparent about the extent to which they routinely collaborate with consumers and carers about matters of system governance. Improved availability of data and information is necessary to monitor progress towards enhancing consumer and carer collaboration. Without this evidence, it is difficult for stakeholders to assess the extent to which consumers and carers are participating in the design of government policies and programs that affect their lives, and how this is changing over time.

COAG should instruct the NMHC to monitor and report on the extent to which Australian, State and Territory Governments collaborate with consumers and carers in governing the mental health system. This should cover the level and nature of their collaboration in key system activities (such as planning, designing, monitoring and evaluation) across both tiers of government. As part of its remit, the NMHC currently monitors major reforms that are underpinned by an emphasis on collaboration across systems and between governments (NMHC 2018b, p. 10). This monitoring should extend to illuminating the *processes* by which government developed these reforms and tracking how this may be changing over time.

Strengthening systemic advocacy

Speaking up for or taking action on behalf of groups of people who face common issues (that is, systemic advocacy), is an ‘integral enabler’ for an ideal mental health system (Mental Health Australia, sub. 407, p. 35). Although it is preferable for people with lived experience to participate in system governance themselves, in some instances, this is better undertaken collectively with the support of an advocate. Peak bodies, larger NGOs and some organisations that specialise in individual legal advocacy can be systemic advocates. They also play a role in supplying consumer and carer representatives who are able to collaborate effectively in system planning, design, monitoring and evaluation, as discussed previously.

Systemic advocacy differs from individual advocacy, which supports individuals to exercise their rights and promote, protect and defend their welfare and justice (chapter 16). However, the two are related as good linkages with individual advocates are necessary for systemic advocates to be most effective (Jenny Pearson and Associates 2009, p. iii). They 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).

Some inquiry participants submitted that governments were underinvesting in systemic advocacy (One Door Mental Health, sub. 108; Sarah Sutton, sub. 508; Victorian Government, sub. 483). Mental Health Carers Australia (sub. 489, p. 13) contended that there is a lack of resources for systemic advocacy precisely when mental health services at the national level are going through a period of profound change. Mental Health Australia (sub. 407, p. 36) observed that:

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.

Governments fund systemic advocacy for several reasons. First, it enables consumers and carers to influence the development of policies that affect their lives, albeit indirectly. In particular, it gives a voice to the disadvantaged and vulnerable who are ‘hard to reach’ to ensure their interests are represented in the policy process. Second, it is often a ‘source of

early warning about system failures’, thereby offering governments a ‘very cheap and reliable source of ongoing advice about system performance’ (Mental Health Australia, sub. 407, p. 36). Finally, governments see a role in mitigating the free rider problem, which limits funding options for consumers and carers.

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)

Further, the work of systemic advocates and the public discourse that follows serve to strengthen government accountability and spur improvements in areas of systemic failure. Naturally, public funding of systemic advocacy can be contentious within government as it risks these agencies criticising the policies or programs of the department or government that is funding them (Jenny Pearson and Associates 2009, p. vii). However, without systemic advocacy, there is undue reliance on governments to identify shortcomings in the performance of systems for which they are responsible. Moreover, in many instances these agencies can inform the development of government initiatives and play a role in helping to implement them by acting as a trusted conduit between their members and government.

There is little publically available data with which to assess whether systemic advocacy has been funded adequately. The annual Report on Government Services (produced by the Productivity Commission on behalf of the Steering Committee for the Review of Government Service Provision) publishes data on consumer and carer participation from the Mental Health Establishments National Minimum Data Set which it receives from the AIHW. However, this data does not represent their full range of participation. In particular, it excludes data on peak representative bodies. Further, there is scarce quantitative information about the benefits or returns to government expenditure on systemic advocacy in mental health. Nonetheless, a cost benefit analysis of independent disability advocacy found that it returns economic benefits that far exceed its economic costs (Daly, Barrett and Williams 2017, p. 5).

One test for funding adequacy is to identify material gaps in consumer and carer input into policy processes. This can be difficult to detect, but some participants pointed to issues at the national level in particular, 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 peak bodies in some jurisdictions (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)
- lack of resources limiting the ability to be a ‘strong voice’ (Mental Health Carers Australia, sub. 489, p. 13).

In the first instance, governments should help systemic advocates to more efficiently use public funds. More particularly, short government funding cycles have a negative effect on service delivery and support, as discussed for other parts of the mental health system elsewhere in this report (chapters 12, 23 and 24).

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)

The Commission has previously commented on the need for governments to avoid entering into contracts that are inappropriately short given the nature of the issues being addressed (PC 2010a, 2017c). Among other things, it creates difficulties for providers in attracting and retaining high-performing staff towards the end of the contract. For many NGOs in the human services sector, it can also dampen the interest and commitment of volunteers and donors. In turn, there are impacts on service users.

Short-term contracts can also be detrimental to service users because service providers spend too much time seeking short-term funding, which is a costly distraction from delivering and improving services. Short-term contracts can also be an impediment to service providers developing stable relationships with service users, hindering service provision and the achievement of outcomes for users. (PC 2017c, p. 24)

Increasing the term of contracts to better reflect the time required to achieve agreed outcomes would help. The Commission has previously recommended that the Australian, State and Territory Governments should increase the default terms for family and community services contracts to seven years (PC 2017c, recommendation 8.5, p. 48). However, in this inquiry, the Commission is recommending that the Australian, State and Territory Governments should, in the first instance, extend the default contract length for peak bodies that represent consumers and carers to a minimum five years to improve business planning and capability development. The Commission views this as an initial move towards consideration of longer time frames. It is inefficient to contract on a short-term basis with peak bodies that have an enduring role, yet expect them to develop a strong capability to provide high-quality advice.

In addition, governments should conclude renewal negotiations at least one year before contracts expire. This approach would enable peak bodies to operate more efficiently, including better managing risks of losing high-performing staff. Last minute indecision by government about future arrangements compounds business uncertainty.

An additional issue that requires addressing is the inability of stakeholders (and, in some instances, governments themselves) to assess the extent to which governments invest in systemic advocacy that exists to represent target population subgroups, in particular, consumers and carers.

All governments should disclose their total funding to peak bodies that represent mental health consumers and carers as part of their annual reporting. This is consistent with good governance practice according to the accountability statutes and policies under which all jurisdictions operate.

- In the case of the Australian Government, the NMHC should monitor and report on expenditure by relevant departments, including the Department of Health and the Department of Social Services, on funding for systemic advocacy in mental health that is provided by peak representative bodies.
- In the case of State and Territory Governments; this expenditure data should be added by the AIHW and included in the annual Report on Government Services (produced by the Productivity Commission on behalf of the Steering Committee for the Review of Government Service Provision).

DRAFT RECOMMENDATION 22.3 — ENHANCING CONSUMER AND CARER PARTICIPATION

Consumers and carers should have the opportunity to participate in the design of government policies and programs that affect their lives.

In the short term (in the next 2 years)

- The Australian, State and Territory Governments should ensure that they collaborate with consumers and carers in all aspects of mental healthcare system planning, design, monitoring and evaluation.
- COAG should instruct the National Mental Health Commission to monitor and report on total expenditure by individual jurisdictions on systemic advocacy in mental health that is provided by peak representative bodies.

In the medium term (over 2 – 5 years)

The Australian, State and Territory Governments should strengthen systemic advocacy by:

- extending the funding cycle length for peak bodies to a minimum five years to improve business planning and capability development
- concluding contract renewals at least one year before expiry
- reporting their total funding to peak bodies that represent mental health consumers and carers through the annual Report on Government Services.

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 that 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.

Lack of accountability was *the* major governance issue raised by participants. Many submissions from a wide cross-section of stakeholders pointed directly at this issue. However, concern by peak organisations dominated.⁴³ 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.

Monitoring, reporting and evaluation

Monitoring, reporting and evaluation — the chief means for promoting accountability — are discussed in chapter 25. Once governments commit to monitoring and measuring outcomes, the question emerges as to whether they should set specific targets.

Targets

Targets are a long-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' (COAG Health Council 2009, 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, p. 918). The Department of Finance (2015b, p. 29) suggested that 'targets are particularly useful when there is a clear expectation of the standard to which a purpose is to be fulfilled ... and comparison against such targets provides a clear and unambiguous result'. The Australian National Audit Office (2019, p. 12) likewise recommends 'when designing major policy initiatives, it is good practice to establish high-level outcome targets and robust mechanisms for monitoring and reporting against them'. In addition, some peak body participants supported targets for their ability to hold

⁴³ For example, Law Council of Australia (sub. 492), Mental Health Australia (subs. 407 and 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).

governments accountable for improvements in mental health service delivery (Australian Medical Association, sub. 387; Mental Health Australia, sub. 407).

There are also disadvantages in setting targets. Targets 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, p. 922). For example, measures of employment for the Australian population are readily available, while measures of mental health stigma are less so. Policymakers may focus effort on the former, when the latter may be a more significant driver of poor outcomes for those with mental ill-health. Another downside may be ‘gaming’, where efforts are made to improve the *statistic* being measured without actually improving the underlying quality of service that is meant to drive that statistic (Kelman and Friedman 2009, p. 924). For example, hypothetically, a target to reduce the rate of suicide could be improved by reporting suicides in other categories of mortality (such as drug- or drinking-induced deaths), even if the deaths were in fact suicides. The Commission is not suggesting that reporting of suicides statistics is deliberately gamed in this way, only that it is possible.

Australia’s experience

Australia has generally not adopted targets as a means of spurring mental health and suicide prevention reform, with one exception. The Prime Minister recently set a target of zero suicides in Australia, albeit without a date for achievement (Morrison 2019). COAG has considered targets on several occasions, but never adopted them. It prioritised setting targets within the first year of the Fourth Plan (COAG Health Council 2009, p. iii), but this did not happen. In 2013, the COAG Working Group on Mental Health Reform sought advice from its Expert Reference Group (ERG) (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 ERG (2013, p. 8) proposed 10 targets, but COAG never formally agreed to them. A subsequent attempt by the NMHC (2014e, p. 65) to secure agreement from COAG on a revised set of targets was similarly unsuccessful.

Notwithstanding COAG’s intentions, these initiatives raise questions. First, many of the targets set by the ERG (and adopted by the NMHC) could not be easily attributed to changes in practice — it was not clear what actions would best support the achievement of targets. For example, two of the NMHC’s targets were about improving employment rates for individuals with mental illness. Second, the ERG noted there were no data nor a ‘meaningful baseline’ for several indicators for which targets were set; setting a baseline was the starting point (ERG 2013, pp. 9, 11). Third, the proposed targets would not have formally placed responsibility for their achievement on particular parts of government. Finally, and in any case, the ERG proposed these targets at some distance from the many agencies (both public and private) responsible for service delivery. Highly devolved systems can mute the ability of high-level targets to permeate through the system. As Briscoe (2004, pp. 3, 6) puts it:

‘Local people need to feel the centrally imposed targets reflect sensible aspirations ... there are fundamental problems with the accountability of any target that is set centrally without proper reference to those on the front line.’

International experience

Many targets exist in mental health internationally.

- The *WHO Comprehensive Mental Health Action Plan* sets out specific targets, such as reducing the rate of suicide in countries by 10% by the year 2020 (WHO 2013c, Global target 3.2, p. 17).
- The New Zealand Inquiry into Mental Health and Addiction recommended targets to buttress policy objectives for clear policy changes. For example, it recommended a ‘suicide prevention target of 20% reduction in suicide rates by 2030’ as a component in its proposed suicide prevention strategy and implementation plan (New Zealand Government Inquiry into Mental Health and Addiction 2018, pp. 111, 181).
- Scotland’s *choose life* strategy set a target of reducing the country’s suicide rate by 20% (Scottish Executive 2002, p. 20). It was a single, national goal that was easily understood by all levels of the system and became a clear priority across health services, police, social services and community organisations (WHO 2018d, p. 10). According to the World Health Organisation (2018, pp. 10–11), a key ingredient of Scotland’s success in achieving this goal by 2017 (albeit several years later than expected) was a ‘sustained focus on suicide prevention actions and outcomes’.

A proper role for targets

International experience suggests that targets can play an important role in progressing system priorities, particularly if they are visible to frontline service delivery staff. They can help to motivate participants at all levels towards the purpose of that system. In the mental health system, this should be towards improving the wellbeing of those with mental ill-health and reducing the poor consequences of mental ill-health on the individual.

However, as discussed above, an exclusive focus on quantitative targets can lead to declines in outcomes that are not easily measured, or to efforts that improve measurements without improving service quality. The culture of governments and organisations responsible for delivering mental health services need to pre-empt unintended responses and mitigate them. Some approaches for limiting adverse effects include:

- adding measures for elements of the system that may face declines in effort in the face of primary targets (though this runs the risk of a proliferation of measures that reduce the benefit of focusing on a small number of core targets)
- adapting measures over time to reflect organisational learning about gaming

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- effective management that encourages system participants to draw on an intrinsic public service motivation to improve quality, directing participants' focus towards meaningful rather than superficial improvements (Kelman and Friedman 2009, pp. 940–941).

It is also 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. It is not surprising that governments may choose to avoid setting targets or evaluating policy measures that could result in political backlash (Anderson 2011, pp. 290–291). Mental Health Victoria (sub. 479, p. 15) similarly 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.

It is preferable to have targets and proper evaluation than to have a system that puts no effort into evaluation (Kelman and Friedman 2009, p. 942). Accordingly, rather than avoiding the setting of targets altogether, system participants should work together to put the success or failure of targets in context, and adapt and improve them to improve the overall quality of the system.

How should targets be set? The Fourth Plan (COAG Health Council 2009, p. 86) suggested that 'targets may be set on the basis of objective evidence, expert consensus, values or simple averages'. In practice, targets are set to reflect the expectations of stakeholders, though baseline results, benchmarks from other similar systems, or the overall trend of performance can be considered (Department of Finance 2015b).

Well designed and implemented targets could make a difference in improving Australia's mental health system. Even if monitoring and failure to meet targets can be uncomfortable for governments, this is no reason to avoid setting meaningful benchmarks to improve the mental health system.

COAG should agree on a set of realistic, stretch 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 reflect an appropriate balance of ambition and reality, it should develop a process for setting them that, among other things, involves collaboration with consumers and carers. Following this collaborative process, COAG should publish the targets and an explanation of how they were set.

DRAFT RECOMMENDATION 22.4 — ESTABLISHING TARGETS FOR OUTCOMES

Accountability for mental health outcomes should include measurement against predetermined performance targets.

In the medium term (over 2 – 5 years)

The COAG Health Council 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 reflect an appropriate balance of ambition and reality, it should develop a process for setting them that, among other things, involves collaboration with consumers and carers. Following this collaborative process, the COAG Health Council should publish the targets and an explanation of how they were set.

22.6 Building an evaluation culture through the NMHC

In chapter 25, the Commission finds that evaluation and research activities are not being fully used to deliver continuous improvement in mental health policies, programs and services. There is a lack of a culture for routine program evaluations and where evaluations and research are undertaken, they do not always provide practical knowledge and evidence. Moreover, where evidence is developed that can improve practice, it is not well communicated, translated or implemented.

This section considers what governance arrangements are necessary for building a stronger evaluation culture.

A national body to lead evaluation

The Commission considers that a national body should lead the evaluation of mental health and suicide prevention programs funded by the Australian Government, State and Territory Governments, and other programs that have strong links with mental health outcomes, including those in non-health sectors. Both tiers of government are responsible for programs that significantly affect the functioning of the mental health system and thus outcomes.

There are several reasons that support tasking of a national body.

- Tasking a body with leading evaluations nationally would ascribe accountability to this function. Unlike monitoring and reporting, no institution currently performs this role. This approach would help overcome disincentives for all governments to commit scarce funds to independent evaluations.
- A national body would engender consistency in evaluating programs with similar objectives that operate across multiple jurisdictions (for example, headspace).

-
- Having visibility of evaluation activity nationally would enable the body to identify priority areas, such as programs used by, or targeting, large numbers of consumers.
 - A body that is separate from policy and program funding, design and implementation would promote greater independence and objectivity. It could also promote transparency by publishing and sharing evaluation findings where privacy constraints do not exist.

There are additional advantages to this approach. The corporate knowledge a national body accumulates about what types of interventions are most effective and efficient would become a valuable resource for policy practitioners and stakeholders in all jurisdictions. In addition, the body would be well placed to facilitate linking policy and program delivery with research by: a) undertaking policy-relevant research to support strategic decisions about the mental health system; and b) working actively with researchers, funders, NGOs and policy organisations to bridge key research and information gaps identified in the course of evaluations.

To fulfil this role, the national body tasked with leading evaluation in mental health and suicide prevention would be responsible for the following specific activities:

- undertaking or commissioning program evaluations
- adopting and promoting rigorous evaluation quality control processes
- developing in-house evaluation capacity and capabilities
- sponsoring research into the performance of Australia's mental health system and developing the capacity to translate, communicate and implement findings and evidence in practice
- building co-operative partnerships between consumers and carers, research institutes, governments and mental health service planners and providers
- promoting a culture of evidence-based policy and program development.

Expanding the NMHC's functions to include program evaluations

The question arises as to whether a new body should be created to fulfil this role, or whether this should be given to an existing body. There is potentially much to the role. A robust culture of program evaluation benefits from expert input at all stages. It begins with the program design phase, where consideration is given to what data should be collected to enable a proper evaluation and how analysts will access that data, and continues through program implementation to a final evaluation following decommissioning.

The Productivity Commission considers that the best way to proceed is to authorise the National Mental Health Commission to perform this role for several reasons. First, the NMHC already has a mandate to work across all areas that impact mental health including education, housing, employment, human services and social support (NMHC, sub. 118, p. 1). It is widely acknowledged that improving mental health requires investments beyond the health sector, which implies a broader view of evaluation than health alone. Second, the

cost of expanding its role compared with inaugurating a new body is lower. Third, the NMHC is well established in the sector, having developed relationships with stakeholders including consumers and carers and state and territory mental health commissions.

In addition, 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 25). For example, monitoring progress can highlight areas of concern where evaluations and research may be prioritised.

While the NMHC is currently authorised to fulfil aspects of the evaluation function (box 22.5), it does not have a clear mandate for independent and transparent program evaluations as such. Nor does it have a cross-jurisdictional purview, a necessity given the scale of mental health-related activity that occurs in both tiers of government. An expansion of its current functions would require matching funding.

Consideration was given to whether the AIHW should be tasked with leading mental health evaluation as it is the leading health and welfare statistics agency in Australia. In the Commission's view, the AIHW's remit should not be expanded. First, it would be inconsistent for it to evaluate policy for mental health and not all health and welfare. Second, giving AIHW a policy evaluation role while the NMHC retained a policy advisory role may cause confusion with mental health roles and responsibilities between the two organisations.

Need for greater independence for evaluations

As with any body tasked with assessing performance, a sufficient degree of independence is vital. However, in considering what level of independence the NMHC should have, it is important to first define its meaning and context.

In its review of the NMHC, Deloitte (2017, p. 17) argued that the 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 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 Chief Executive Officer, who is the accountable authority, reports to the Minister.

Box 22.5 **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 also 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, aimed to position the NMHC as the independent governance pillar of the mental health system, 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:

1. develop, collate and analyse data and information to ensure a cross sectoral perspective is taken to mental health policy development and reform
2. build and maintain effective working relationships with stakeholders in Australia and internationally to inform the work of the Commission
3. provide independent and impartial advice to Government to improve mental health services and support within the Australian community
4. manage, administer and publicly release evidence-based information in order to promote mental health and wellbeing
5. review, analyse and promote research and best practice to support better treatment outcomes across the mental health sector
6. promote a person-centred approach to mental health care that engages and values the participation of people with lived experience, their families, carers and communities; and
7. undertake other relevant tasks as the Minister may require from time to time. (Order dated 27 September 2018 in Gazette C2018G00764)

However, in the Productivity Commission's view, these protections would not be adequate, even if the NMHC were to be tasked with evaluating Australian Government programs only — the intention is to broaden the NMHC's scope to include State and Territory Government programs. The NMHC needs to be able to provide independent advice on evaluation as an input to program design, carry out those evaluations and then publically report on its findings, including recommended improvements. Fulfilling these responsibilities presents the difficulty of commenting on the merits or otherwise of Australian, State and Territory Government policies, and raises perceptions about independence.

Accordingly, there needs to be a level of professional independence that goes beyond simply a lack of direct veto power by the Department of Health. At times, it is expected that the NMHC would evaluate programs that are championed by the Department and the Minister.

Here, the NMHC could face a situation where its public reporting was contrary to that of key stakeholders (such as the Department) and, potentially, political office holders.

As such, 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, all stakeholders 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.

In this regard, Mental Health Australia (sub. 544, p. 12) argued that NMHC should be positioned to provide independent evaluation that guides reform outside of political influence and process. A high-quality evaluation can only drive change if it is seen to be independent by all parties involved in that change — including both tiers of government. Such independence needs to endure beyond the goodwill and intentions of current office holders and staff.

Case for statutory authority

The NMHC should be a statutory authority in the view of some participants, such as Roger Gurr (sub. 40) and some stakeholders consulted by Deloitte (2017) for its review of the NMHC. Mendoza (2013, p. 49) 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.

Deloitte (2017, pp. 24–25) considered the case for statutory independence, but did not recommend changing its form. In its view, the strong rationale required by Government was not evident and the current arrangements offered sufficient independence. It contended that strengthening the NMHC's capacity and capability, and clarifying the roles and responsibilities of its Commissioners would address stakeholder perceptions about insufficient independence. However, this conclusion assumed no change to its functions.

The Australian Government Department of Finance (2018) indicated that statutory powers are particularly relevant for bodies that scrutinise public sector activities. For example, a statutory entity is generally appropriate where there is a need for the 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 fulfil an evaluation function, which 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 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 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, under the Commission's proposal, the NMHC should:

- continue to work closely with the ABS, AIHW and the Australian Commission on Safety and Quality in Health Care to minimise duplication in monitoring and reporting.
- 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

In the Commission's view, the NMHC should be established as an interjurisdictional body. This would enable it to work closely with both the Australian Government and State and Territory Governments to assist them in reforming policies and programs. State and Territory Governments deliver the bulk of clinical and psychosocial services, as well as a range of services and supports that directly affect mental health outcomes in sectors such as housing, justice and education. Interjurisdictional authority would also facilitate evaluation of the proposed Regional Commissioning Authorities (chapter 23), which would be State and Territory Government entities.

A range of interjurisdictional bodies exist under intergovernmental agreements in Commonwealth statutes, or in state and territory legislation. They 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. The nature of their interjurisdictional interactions varies according to their prescribed activities and processes. For example, the *Australian Institute of Health and Welfare Act 1987* (Cth) requires the Australian Government Minister to consult with each state health minister before giving a direction that relates to the AIHW's health-related functions (section 7). The Act also specifies that its Board shall consist of not more than three members nominated by state health ministers (section 9).

In addition to its statutory interjurisdictional independence, the COAG Health Council should communicate its support to the NMHC in taking on the proposed broad-ranging evaluation role. This support should, among other things, include a statement agreeing to a set of principles for undertaking the evaluation role, as outlined in chapter 25.

Governance arrangements

The following outlines the Productivity Commission's proposed governance arrangements for the NMHC as an interjurisdictional statutory authority.

Board

Given its proposed role, jurisdictions would be expected to be keenly interested in the appointment of Board members. In the Commission's view, the NMHC should be:

- governed by a Board of multiple persons, to mitigate any risk (real or perceived) that the NMHC becomes unduly aligned with the interests of any one jurisdiction
- granted full powers to act in the interests of the NMHC in fulfilling its statutory functions, including powers to appoint and remove a CEO.

The Commission also considers that the NMHC board should be skill-based, not representational. Board effectiveness depends on obtaining the right mix of skills, experience and attitude to successfully acquit board responsibilities. 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 will differ greatly, their first-hand experience will complement those of other board members. More particularly, their expert knowledge is an inherent characteristic that would, among other value-adds, help ensure the effectiveness of the NMHC board. For the same reasons, the Commission views the inclusion of one board position for an Aboriginal and Torres Strait Islander person as similarly important.

Accountability and engagement

As part of its annual planning cycle, the NMHC should prepare a rolling 3-year schedule of evaluations of mental health programs and programs that have strong links to mental health. This would ensure stakeholders, including all governments, have clear visibility of its intentions and to minimise duplicative effort. Broad consultation would continue to remain a hallmark of NMHC operations, including its work plan development. The Commission's intention is for governments to view the NMHC as a change agent for promoting effective and efficient policy that improves outcomes for consumers and carers, rather than as a potential critic of the performance of some programs. 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 consumer and carer peak bodies

- in consultation with key stakeholders, develop and publish a process for prioritising policy and program evaluations, including decision-making criteria.

DRAFT RECOMMENDATION 22.5 — 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 most efficiently and effectively.

In the medium term (over 2 – 5 years)

The National Mental Health Commission (NMHC) should have statutory authority to 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. The COAG Health Council should communicate its support to the NMHC in taking on the proposed broad-ranging evaluation role.
- The NMHC should be governed by a skills-based Board of multiple persons. 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 continue to work closely with 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.
- 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. To this end, the NMHC should:

- develop a consultation process and consult with, at a minimum, State and Territory Government health/mental health departments, the Australian Government's Department of Health, the Department of Social Services, the National Indigenous Australians Agency, and consumer and carer peak bodies
- in consultation with key stakeholders, develop and publish a process for prioritising policy and program evaluations, including decision-making criteria.

INFORMATION REQUEST 22.1 — GOVERNANCE ARRANGEMENTS FOR THE NMHC

The Productivity Commission is seeking views on the form the National Mental Health Commission should take as an interjurisdictional statutory authority and the nature of its governance arrangements to enable it to effectively lead evaluations of mental health and suicide prevention programs funded by the Australian Government, State and Territory Governments, and other programs that have strong links with mental health outcomes, including those in non-health sectors.

23 Federal roles and responsibilities

Changes to federal roles and responsibilities are necessary because ...

- Federal roles and responsibilities for mental healthcare and psychosocial and carer supports are not clearly defined.
- Neither the Australian Government nor State and Territory Governments face adequate incentives to invest in services for closing the gaps in the service system. Intergovernmental funding arrangements dissuade State and Territory governments from investing in community-based care.
- Recent efforts at incremental reform are impressive given these structural impediments, but their success is far from guaranteed and they have largely disregarded non-health services.

Successful reform requires ...

As a priority:

- Governments should work together to reform the architecture of the mental health system. The Commission has proposed two options for structural reform in funding:
 - the Renovate model, which is similar to the current arrangements and would see more responsibility for funding allocation sit with the Primary Health Networks
 - the Rebuild model (the Commission's preferred option), under which State and Territory Governments establish Regional Commissioning Authorities that take on the mental health responsibilities of Primary Health Networks, commission mental healthcare from Local Hospital Networks, and commission psychosocial and carer supports outside of the National Disability Insurance Scheme.

Additional actions required include:

- The Independent Hospital Pricing Authority should continue pursuing activity-based funding for community ambulatory mental healthcare services, but a review is needed to ensure that the proposed system is fit-for-purpose.
 - State and Territory Governments should take on sole responsibility for psychosocial and carer supports outside of the National Disability Insurance Scheme, supported by additional Australian Government funding.
-

Both the Australian Government and State and Territory Governments provide services for people with mental illness. Some are provided by one level of government. For example, the Australian Government provides all income support (chapter 14), while State and Territory Governments provide the vast majority of justice (chapter 16) and housing services (chapter 15). Others are provided by both levels, most notably healthcare (chapters 5–11), psychosocial supports (chapter 12) and carer supports (chapter 13). These areas of shared responsibility are marked by unclear roles and inefficient resource allocations. For consumers, the result is a fragmented experience with gaps and overlaps in services and poor continuity of care.

This chapter proposes new allocations of federal (Australian Government and State and Territory Government) roles and responsibilities for those services that straddle the federal divide, and changes to intergovernmental funding arrangements to support this. It culminates by proposing two options for structural reform of mental healthcare: the ‘Renovate’ and ‘Rebuild’ models. The Commission prefers the ‘Rebuild’ model, but is seeking further feedback from stakeholders on these options.

Chapters 12 and 13 describe most of the federal issues facing the provision of psychosocial and carer supports. Hence, the early part of this chapter focusses primarily on federal issues in healthcare arrangements.

23.1 Structural flaws in mental healthcare

The division in mental health care responsibilities between the Australian Government and State and Territory Governments has led to service gaps. The largest gaps affect people whose needs are too acute for primary mental healthcare, but not sufficiently acute to receive the specialised mental healthcare offered in the public system and who cannot access private psychiatric treatment (sometimes called the ‘missing middle’) (chapter 7). This is the boundary where government responsibilities change: the Australian Government funds primary mental healthcare and State and Territory Governments provide specialised mental healthcare in public hospital and community settings.

These gaps result from two key factors. First, the relevant government roles and responsibilities are unclear. Second, State and Territory Governments face incentives to direct resources towards acute care instead of providing more care in the community.

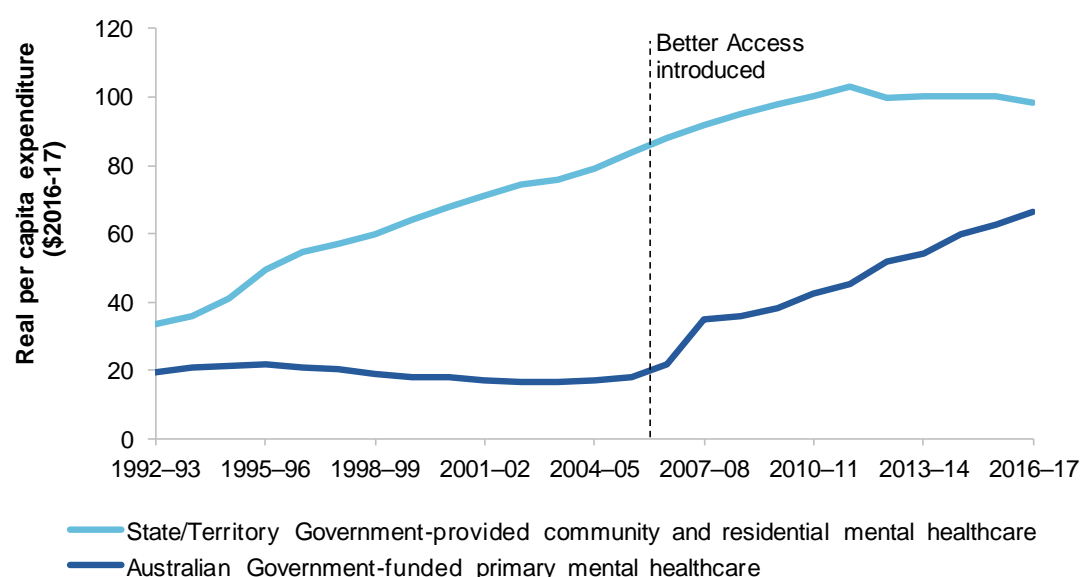
Unclear roles and responsibilities

Unclear roles and responsibilities are one cause of the service gaps for the missing middle. The Primary Health Network Cooperative (sub. 377, p. 15) notes that this group ‘are at risk of falling through the silos and divides of our health system’, while Rosenberg (2015) attributes the problem to neither level of government clearly having ownership of it.

Services that could fill the gaps have not grown. State and Territory Government expenditure on community mental healthcare services⁴⁴ (inclusive of Australian Government contributions) which could help the missing middle has not kept up with population growth in recent years (figure 23.1). The Australian Government has greatly expanded its direct funding of primary mental healthcare (figure 23.1), but this is mostly for people with less severe conditions (chapter 6). A recent review of the Primary Health Network (PHN) program noted:

Many stakeholders expressed concern that there is little evidence of the ‘missing middle’ in the stepped care approach being addressed through PHN commissioning, although it was acknowledged that the funding that would be required to address this gap has not been made available to PHNs. (PHN Advisory Panel 2018, p. 7)

Figure 23.1 Expenditure on community-based mental healthcare^{a,b}
By level of government, 1992-93 to 2016-17



^a Australian Government expenditure comprises expenditure on Medicare Benefits Schedule rebates to psychiatrists and allied health professionals, and Department of Health-managed national programs and initiatives. ^b State and Territory Government expenditure on community ambulatory mental healthcare services and residential mental healthcare services, inclusive of Australian Government transfers to State and Territory Governments.

Source: Productivity Commission estimates based on AIHW (2019o).

⁴⁴ Community mental health services comprise community ambulatory mental health services and residential mental health services.

Intergovernmental transfers encourage a focus on hospital-based care over community-based care

State and Territory Local Hospital Networks (LHNs) receive funding from the Australian Government to support their provision of mental health services in public hospitals and community mental healthcare services. This amounted to \$1.8 billion in 2018-19, or about one quarter of all State and Territory Government expenditure on specialised mental healthcare services in 2016-17 (the most recent year for which comparable data are available) (unpublished data from DoH).

These Australian Government transfers are governed by the 2011 National Health Reform Agreement (NHRA) (box 23.1), which specifies that they should:

- be provided directly to LHNs, which are separate legal entities of State and Territory Governments that manage public hospitals and other health services and are governed by service agreements with State and Territory Governments
- wherever practical, be calculated using an activity-based funding (ABF) formula, and block funding otherwise.⁴⁵ Currently, public hospital mental healthcare services (including mental health-related emergency department presentations) are funded via ABF, while community mental healthcare services and specialist psychiatric hospitals remain block funded. State and Territory Governments also contribute funding to LHNs, which many do using a variant on the payment model adopted by the Australian Government.

Under the NHRA, the Australian Government provides 45% of ‘efficient cost’ growth (defined as the national average cost growth) in eligible services, up to a cap of 6.5% growth of total Australian Government NHRA payments per year. The Independent Hospital Pricing Authority (IHPA) determines Australian Government transfers to LHNs on this basis.

Hence, ABF is used both as a way to pay LHNs (as healthcare providers) for the care that they deliver and to determine the size of the contributions that the Australian Government makes to State and Territory Governments for mental healthcare. These functions create different incentives, so we have analysed their effects separately.

⁴⁵ ABF is a payment model whereby service providers are paid according to the number and mix of patients that they treat. Other things equal, they will get paid more for treating a greater number of patients and for treating more complex patients. Block funding is a payment model whereby service providers receive a fixed grant irrespective of the volume of services that they provide and the patients to which they provide them.

Box 23.1 **The National Health Reform Agreement**

The 2011 National Health Reform Agreement (NHRA) sets out the framework through which the Australian Government provides funding to State and Territory Governments to deliver health services (overwhelmingly hospital services). A central principle of the agreement is that Australian Government funding for these services should be provided on an activity basis wherever practical, and a block-funding basis otherwise.

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 and are governed by service agreements with State and Territory Governments.

In 2016, the NHRA was amended to, among other things, introduce a 6.5% annual cap on Australian Government funding growth and to allow the national activity-based funding system to reduce payments in the event of hospital-acquired complications, sentinel events and avoidable readmissions.

The NHRA is due to expire in mid-2020. The Australian Government has proposed a new five year agreement that maintains the existing funding parameters. At August 2018, each State and Territory with the exception of Queensland and Victoria had signed a Heads of Agreement that this would form the basis of negotiations toward a new agreement (Biggs 2018).

Source: COAG (2011).

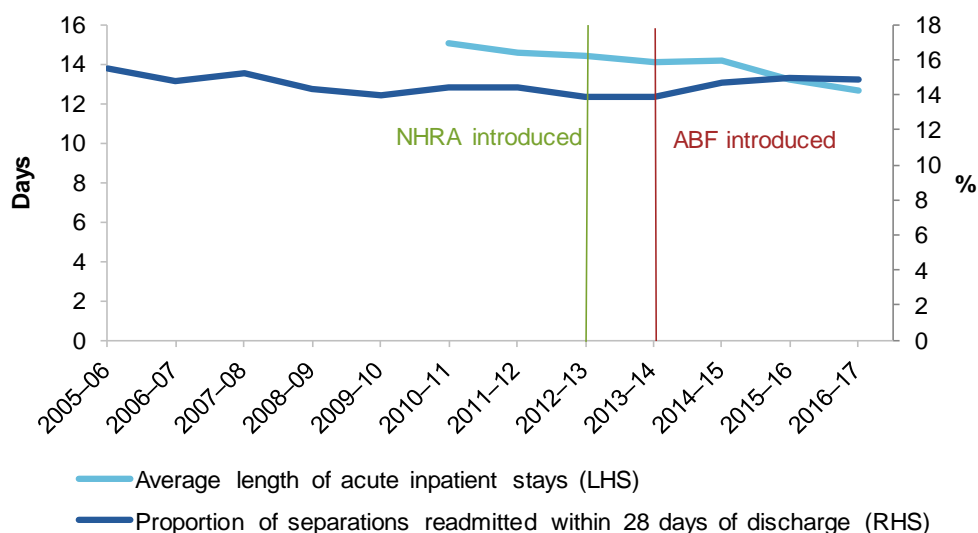
Activity-based funding as a means to fund public mental healthcare

The goal of ABF is to increase the technical efficiency of service provision. LHNs receive a payment for each patient they treat at a public hospital, and hence benefit by treating those patients at the lowest possible cost. The evidence is generally consistent with this. Empirical studies have consistently found that ABF leads to increases in hospital activity and/or decreases in length of stay (Ettelt et al. 2006; O'Reilly et al. 2012).

Increasing the technical efficiency of hospital-based mental healthcare is desirable. Shorter stays in hospital are less costly and, when adequate treatment and services are available in the community, consistent with achieving good outcomes for the consumer (chapter 8). The extent to which ABF for hospital-based *mental* healthcare has reduced lengths of stay is unclear. Across Australia, the average length of acute inpatient stays declined in recent years, but these declines were already underway prior to the introduction of the national ABF system (figure 23.2).

The flipside to this is that ABF may incentivise hospitals to skimp on quality of care by prematurely discharging consumers. The evidence for this is unclear. The proportion of mental health-related hospital separations that were followed by readmission within 28 days of discharge (a measure of care quality and premature discharge) rose slightly after the national ABF system was introduced, but, in 2016-17, remained below the level it was a decade prior (figure 23.2).

Figure 23.2 Performance indicators for acute mental healthcare services



Source: AIHW (2019i).

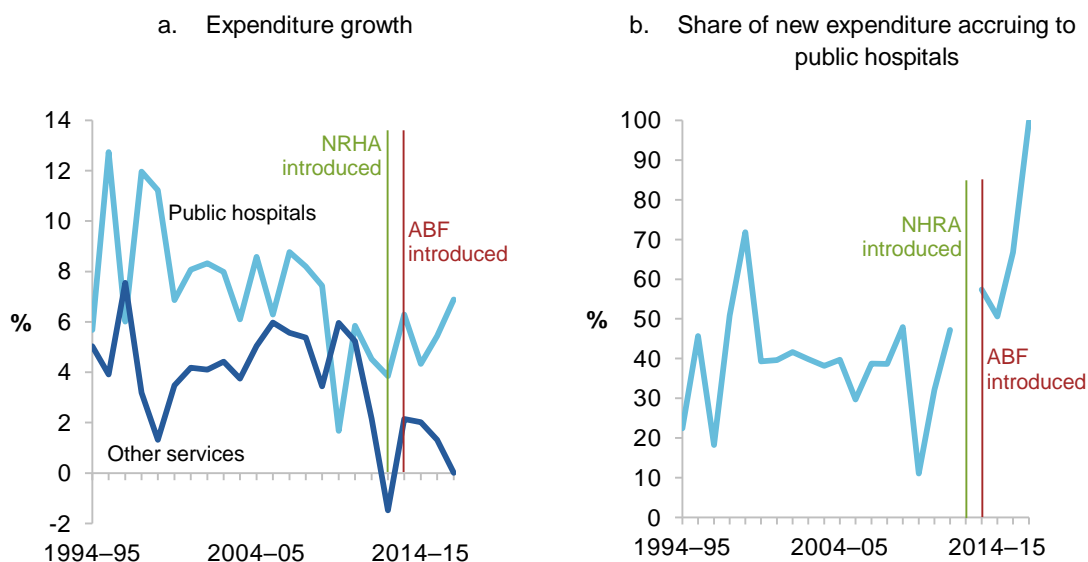
IHPA is currently developing adjustments to the ABF system that would penalise hospitals for avoidable hospital readmissions (among other quality metrics), and thereby reduce their incentives to skimp on care quality. Mental health-related avoidable hospital readmissions are not currently in the scope of this work. Given time, IHPA would ideally extend this work to mental health-related avoidable hospital admissions.

A clearer downside to the current arrangements is that ABF is *only* used for hospital-based mental healthcare and not community mental healthcare services (these are block-funded). This creates incentives for LHNs to shift care into hospitals rather than treat patients in community mental healthcare services (Fels, sub. 303 attachment; Wand 2014). Indeed, public hospitals have received a higher share of State and Territory Government expenditure on mental healthcare (inclusive of the Australian Government contributions) since the introduction of the NHRA and ABF for public hospital mental healthcare (figure 23.3). This is especially concerning as chapter 7 indicated that the larger gaps in State and Territory Government-provided mental healthcare services are in community mental healthcare.

The obvious way to rectify these poor incentives is to extend ABF to community mental healthcare. (IHPA is making strides in this direction for community ambulatory services, as discussed below.) If both hospital and community settings were subject to ABF there would be no incentive for LHNs to preference hospital-based care over community-based care.

Figure 23.3 Share of State and Territory Government specialised mental health expenditure accruing to public hospitals^{a,b}

Real recurrent State and Territory Government expenditure (inclusive of Australian Government contributions) on specialised mental health services



^a 'Public hospitals' are specialised psychiatric units or wards in public acute hospitals. Public psychiatric hospitals are counted within 'other services' as Australian Government contributions to these are not calculated using activity-based funding. ^b The share of new expenditure accruing to public hospitals is not shown for 2012-13 as expenditure on 'other services' declined in that year.

Source: Productivity Commission estimates based on AIHW (2019o).

Extending ABF to community-based settings would also create desirable incentives for technical efficiency at community mental healthcare services. There is some evidence that productivity is poor at community ambulatory mental healthcare services:

- The Commission has estimated that, in 2016-17 only about 29% of clinical staff time was spent on consumer-related activities at community ambulatory mental healthcare services across Australia — 21% with the consumer present and 8% without the consumer present.⁴⁶ This falls well short of the benchmark built into the National Mental Health Service Planning Framework that 67% of clinical staff time in these settings should be spent on consumer-related activities (including face to face care, writing notes, individual care planning and liaison).
- One jurisdiction supplied the Commission with a study of several community ambulatory mental healthcare services that indicated that 77% of clinical staff time was spent with consumers, but this was primarily due to a large volume of time spent on what was recorded as consumer-related activity for which the consumer was not present.

⁴⁶ This estimate was derived by comparing the total duration of care provided in community mental health services (unpublished data supplied by AIHW) with the number of full-time equivalent healthcare providers working in community mental health services (AIHW 2019d), assuming 44 productive working weeks per year.

According to the study, 21% of clinical staff time was spent with consumers present, which is very comparable to the Commission's Australia-wide estimate.

- Dr Olav Neilsson (sub. 37, p. 2) noted that:

[A] problem is the low productivity of community mental health centres. Case managers increasingly conduct reviews by telephone and spend only a small proportion of their time face to face with patients, in contrast to GPs and other private practitioners, who spend nearly all their work time with patients.

Hence, *in principle*, the Commission supports using ABF to fund hospital-based mental healthcare and extending ABF to community mental healthcare services.

In practice, implementing ABF for mental healthcare has proved challenging. An ABF classification system must group patients into clusters based on observable characteristics for which efficient treatment costs are similar. Classification systems are usually based around 'diagnosis-related groups', but diagnosis has less ability to predict treatment costs for mental healthcare than for other services (IHPA 2015). A further problem that arises for community-based care is defining an 'episode of care' — the unit of activity that the community mental health service would receive funding for — when it can be difficult to define when the episode formally starts and ends for a person with a long-term mental illness.

A poor classification system undermines the efficacy of ABF. While ABF should create incentives for technical efficiency *regardless* of the quality of the classification structure — LHNs still benefit from unilaterally reducing treatment costs — a classification structure that does not adequately match patients with efficient service delivery costs creates difficulties and poor incentives for providers. Volatility in margins (the difference between treatment costs and the price paid to the LHN) may undermine the viability of providing mental healthcare services. And, to the extent that the LHN is able to distinguish between higher margin and lower margin patients at the outset, it faces incentives to preference lower margin patients (Jacobs et al. 2019). Allan Fels (sub. 303, p. 2) argued that:

Whilst there is a good case for ABF 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.

IHPA currently uses a diagnosis-related groups-based ABF system for hospital-based mental healthcare, but is developing a new mental health ABF classification system known as the Australian Mental Health Care Classification (AMHCC) that does not use diagnosis-related groups as a classifying variable (box 23.2). If implemented, the AMHCC would change the way that ABF works for hospital-based mental healthcare *and* extend ABF to community ambulatory mental healthcare services. The AMHCC uses a new concept called 'phase of care' to establish episodes of care in each setting.

Box 23.2 **Structure of the Australian Mental Health Care Classification**

The Australian Mental Health Care Classification is a mental health-specific casemix classification developed by the Independent Hospital Pricing Authority. It has separate admitted setting and community ambulatory setting structures.

- 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 (HoNOS). These create 45 classes of admitted patients, each which are intended to have their 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 which are intended to have their own price per episode of care.

The Australian Mental Health Care Classification does not cover residential mental healthcare services.

Source: IHPA (2018).

However, there are several concerns about the AMHCC. One is the robustness of the ‘phase of care’ variable. 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). Another is 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 Burgess (a senior clinical advisor of IHPA’s Mental Health Working Group) advised the Commission that the study did not adequately isolate the treatment costs of individual consumers to produce comparable data across jurisdictions. Burgess’ overarching view is that the AMHCC is not fit-for-purpose at this time (pers. comm., 2 September 2019).

IHPA intends to implement the AMHCC as a funding mechanism from 2020-21, although this is likely to be on a ‘shadow pricing’ basis (IHPA, pers. comm., 9 July 2019). Some State health departments have suggested a cautious approach toward doing so. In 2018, Queensland Health submitted to IHPA that ‘it may be several years before the AMHCC is sufficiently robust for funding purposes’ (QLD Health 2018, p. 8), and the Victorian Department of Health and Human Services urged a cautious approach to implementing the AMHCC involving several further years of testing (VIC DHHS 2018b).

The Commission is not in a position to make a determination about whether the AMHCC is fit-for-purpose, but considers that there is sufficient concern among informed parties to warrant consideration of whether it needs revision. The Commission's 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 the variable can be refined to improve inter-rater reliability
- if a new costing study is required
- a revised timeframe for implementing the classification.

If this proposed review proceeds it may well delay the introduction of the classification system. We are concerned that community ambulatory mental healthcare services will remain block funded during that time. So the question arises as to whether there is a simpler funding methodology that captures some of the essence of ABF that could be used in the interim period.

An obvious approach is to draw on the fee-for-service payment model (chapter 7), and fund community ambulatory mental healthcare services on the basis of time spent treating patients. This is a form of funding on the basis of activity, but differs from ABF in that the unit of activity that is funded would be, say, an *hour* of care rather than an *episode* of care. Because the cost of providing an hour of care is much less variable than the cost of providing an episode of care, there would be no need for a complex casemix classification.

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 2019b). There may be value in further refining this funding model so as 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. IHPA should be well-placed to determine an appropriate set of parameters around such an interim model, and should liaise with Victoria about which aspects of its model are more and less successful.

**DRAFT RECOMMENDATION 23.1 — REVIEW PROPOSED ACTIVITY-BASED FUNDING
CLASSIFICATION FOR MENTAL HEALTHCARE**

In the short term (in the next 2 years)

The Independent Hospital Pricing Authority should review the Australian Mental Health Care Classification to determine:

- whether the structure of the Australian Mental Health Care Classification 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 the variable 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, the Independent Hospital Pricing Authority should consider developing a classification system for community ambulatory mental healthcare services based on hours of care provided.

Activity-based funding as a means to determine intergovernmental transfers

A significant benefit of the NHRA’s activity-based system of transfers is that it exposes the Australian Government to 45% of the costs of activity growth in public hospitals, and hence provides some incentives to improve the provision of primary mental healthcare (Duckett 2015). Moreover, the establishment of a national system of ABF governed by IHPA has increased the transparency and comparability of public hospital performance.

The flipside of this, however, is that State and Territory Governments do not receive the full fiscal benefit of efforts that they make to reduce avoidable hospitalisations, as these will result in reduced funding from the Australian Government. Mental Health Australia (sub 544, p. 17) highlighted that although the Victorian Government has established the ‘Hospital Admission Risk Program’, a NRHA-eligible program that substitutes hospital-based care for community-based care, such programs can be:

... perceived negatively by states and territories with reductions in hospital demand resulting in reduced hospital funding and the Australian Government appearing to benefit without making a contribution.

That said, these incentives are moderated by the 6.5% cap on the annual growth in Australian Government expenditure.

A more serious distortion would arise if not all State and Territory Government-provided mental healthcare outside of hospitals were deemed to be within the scope of the NHRA (primarily an agreement about hospital funding), as this would incentivise State/Territory Governments and LHNs to shift care to hospitals. This was the case with child and adolescent

community mental healthcare services until 2019-20 and older persons' community mental healthcare services until 2014-15 (box 23.3).

Box 23.3 Scope of mental healthcare services funded under the National Health Reform Agreement

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.

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 in the scope of the 2010 Public Hospitals Establishment Collection.

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:

- Adult integrated community mental health services
- Crisis assessment and treatment (including telephone-based services)
- Dual diagnosis services for patients with co-morbid conditions
- Home and community-based eating disorders programs
- Mental health hospital avoidance programs
- Mobile support and treatment services
- Perinatal infant mental health services
- Step-up step-down services
- Telephone triage services

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.

Sources: IHPA Pricing Framework for Australian Public Hospital Services (various issues).

These issues appear to be resolved. Queensland Health told us that all of its clinical mental healthcare services now fall within the scope of the NHRA (pers. comm., 2 September 2019), and IHPA has not received any further requests from State and Territory Governments to bring additional mental healthcare services within scope (IHPA, pers. comm., 28 August 2019).

23.2 Impacts of recent reforms

Recent efforts at reform have sought to work around the structural problems outlined above by integrating services from across the federal divide at a regional level. The first priority area of the Fifth National Mental Health and Suicide Prevention Plan (COAG Health Council 2017a) — *Achieving integrated regional planning and service delivery* — seeks to achieve this through neighbouring PHNs and LHNs working cooperatively to create unified regional mental health systems. This involves them (with the support of their respective

governments) undertaking joint regional needs assessments, developing joint regional plans, and examining new funding models (such as co-commissioning) that bridge the boundaries between PHN- and LHN-funded services. The Fifth Plan's implementation plan and supporting documentation provide further detail about this strategy and expected timeframes (box 23.4).

Overall, it is too early to determine how successful this approach will be at realising improved mental health outcomes. The remainder of this section notes some emerging trends.

Box 23.4 PHN–LHN integration activities

To support the first priority area of the Fifth National Mental Health and Suicide Prevention Plan, PHNs and LHNs are required to jointly undertake activities within specified timeframes, namely:

- from early 2018 — engage with local stakeholders toward implementing integrated regional planning and service delivery
- from June 2018 — undertake joint regional mental health needs assessments
- from mid-2020 — examine innovative funding models, such as joint commissioning of services and fund pooling for packages of care
- from late 2017 to mid-2020 — commission services according to joint regional mental health and suicide prevention plans
- mid-2021 — develop region-wide multi-agency agreements, shared care pathways, triage protocols, information-sharing protocols, and shared clinical governance mechanisms.

Source: Integrated Regional Planning Working Group (2018b).

Early successes

The earlier actions of the first priority area of the Fifth National Plan are mostly on track, according to the National Mental Health Commission (table 23.1). These relate primarily to stakeholder engagement and joint regional planning. Only a small number of PHNs are behind schedule on these actions.

Table 23.1 Progress of actions toward ‘Achieving integrated regional planning and service delivery’

Selected actions from the Fifth National Mental Health and Suicide Prevention Plan 2018 Progress Report

<i>Action</i>	<i>PHN progress</i>	<i>State/Territory Government progress</i>	<i>Australian Government progress</i>
1.1b — Development of joint regional mental health and suicide prevention plans	3 PHNs ahead of schedule, 3 PHNs behind schedule, 20 PHNs on track	1 State/Territory behind schedule, all others on track.	On track.
1.1c — Public release of joint regional mental health and suicide prevention plans	2 PHNs ahead of schedule, 8 PHNs behind schedule, 17 PHNs on track.	1 State/Territory behind schedule, all others on track.	On track.
2.2 — Engaging with the local community, including consumers and carers, community managed organisations, Aboriginal Community Controlled Health Services, National Disability Insurance Scheme providers, the National Disability Insurance Agency, private providers and social service agencies	2 PHNs complete, 4 PHNs behind schedule, 21 PHNs on track	1 State/Territory behind schedule, all others on track.	On track.
2.3a — Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) work towards data sharing to map regional service provision and identify areas of duplication, inefficiency and service gaps	5 PHNs ahead of schedule, 3 Behind schedule, 20 PHNs on track.	1 State/Territory behind schedule, all others on track.	—
2.3b — PHNs and LHNs utilise the National Mental Health Service Planning Framework and other planning tools to facilitate regional needs assessment and planning	3 PHNs complete, 1 PHN ahead of schedule, 4 behind schedule, 20 on track.	1 State/Territory behind schedule, all others on track.	—
2.5 — Develop joint, single regional mental health and suicide prevention plans and commissioning services according to those plans.	1 PHN ahead of schedule, 7 behind schedule, 20 on track	1 State/Territory behind schedule, all others on track.	—
2.7 — Developing 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.	5 PHNs behind schedule, 22 PHNs on track	1 State/Territory behind schedule, all others on track.	—
2.8 — Developing shared clinical governance mechanisms to allow for agreed care pathways, referral mechanism, quality processes and review of adverse events.	8 PHNs behind schedule, 20 PHNs on track.	1 State/Territory behind schedule, all others on track.	—

Source: NMHC (2018a).

Prospective weaknesses

There are several weaknesses inherent in relying on closer PHN–LHN integration to drive mental health reforms, namely:

- weak incentives to prevent hospitalisations
- co-commissioning arrangements remain novel
- PHN and LHN boundaries do not align
- non-health services have been neglected.

Weak incentives to prevent hospitalisations

The Australian Government does not have strong incentives to relieve the pressure on LHN-provided services, including hospitals, as they are a State and Territory Government responsibility. Does the same apply to PHNs, as Australian Government-funded entities?

The Australian Government does direct PHNs to prevent hospitalisations, but it is unclear that these directives have much ‘bite’. Reducing ‘potentially preventable hospitalisations’ is an objective in the PHN Program Performance and Quality Framework (DoH 2018g), but indicator measures do not specifically capture patients that were hospitalised due to mental illness (AIHW 2018p). Moreover, 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 2016d), the Mental Health 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.

LHNs, meanwhile, have few incentives to reduce avoidable hospitalisations because of the current ABF arrangements (section 23.1)

Co-commissioning arrangements face barriers

The Fifth Plan does not anticipate that PHNs will engage in co-commissioning arrangements until at least mid-2020. There are several types of co-commissioning arrangements (box 23.5). These arrangements are a key means through which PHNs and LHNs *could* break down budgetary silos. As such, the Commission has considered the likelihood of them being successful.

Box 23.5 **What is co-commissioning?**

‘Co-commissioning’ or ‘joint commissioning’ is a process by which multiple parties (usually PHNs and LHNs in the context of this inquiry) contribute to an investment. While the term is commonly used, it is not used consistently, and is rarely precisely defined.

According to the Memorandum of Understanding between the Victorian Department of Health and Human Services and the Victorian and Tasmanian Primary Health Network Alliance, there are three forms that co-commissioning may take:

- *Pooled commissioning*: where funding from multiple parties is combined to commission services, typically through a single contract. In this context, parties may have direct oversight of their individual investment, but the outputs and outcomes are shared.
- *Aligned or parallel commissioning*: where parties agree to use funding to achieve the same outcome, but do so in parallel. This could occur, for example, through separate contracts for each investment, typically representing discrete outputs or components of the commissioned service. In this context, parties maintain direct oversight of their investment, have separate outputs, but share the overall intended outcome.
- *Secondary commissioning*: where the ‘primary commissioner’ outsources the commissioning, or elements of it, to the ‘secondary commissioner’. The primary commissioner is responsible for the overall intended outcome and the secondary commissioner is responsible for the elements for which they are assigned.

Another definition is found in the Council of Australian Governments Bilateral Agreements on Co-ordinated Care Reforms (Council on Federal Financial Relations 2019), which note that co-commissioning:

Encompasses a variety of ways of working together, as locally appropriate, to make the best use of pooled or aligned budgets to achieve better outcomes for patients.

Some progress towards co-commissioning has occurred. For example, there are now several intergovernmental agreements and memoranda of understanding that aim to facilitate co-commissioning between PHNs and LHNs or State/Territory Governments.

- The Council of Australian Governments (COAG) Bilateral Agreements on Co-ordinated Care Reforms commit State and Territory Governments to working with the Australian Government on co-commissioning reforms. Several State and Territory Governments advised the Commission that they had made progress on these commitments.
- A Memorandum of Understanding between the Victorian Government Department of Health and Human Services, all Victorian PHNs and the Victorian and Tasmanian PHN Alliance commits the parties to support and undertake co-commissioning activities, but does not specify which future activities should be co-commissioned.

There have also been some examples of co-commissioning, including:

- the Victorian Government Department of Health and Human Services and the six Victorian PHNs co-commissioned a series of place-based suicide prevention trials across 12 locations in Victoria (Victorian-Tasmanian PHN Alliance 2019).

-
- the Victorian Government Department of Education and Training and the six Victorian PHNs co-commissioned the ‘Doctors in Secondary Schools’ program, which used a secondary commissioning model (led by PHNs) to provide primary healthcare in 100 Victorian secondary schools (VIC DET 2018).

These developments are positive. But there remain barriers to co-commissioning, as noted in past reviews and participants’ submissions to this inquiry.

First, co-commissioning involves transaction costs, which sets a minimum benefit threshold for adoption. Moreover, these transaction costs constitute a business risk to the extent that they are underestimated. A recent evaluation of the PHN program noted:

A key lesson learned has been that proper co-design and co-commissioning takes time and money to effectively engage and work with key stakeholders (such as LHNs, service providers, consumers, communities and a whole range of other stakeholders). (EY 2018, p. 46)

Second, cultural and process differences between PHNs and LHNs (or State and Territory Governments) also serve as a barrier to co-commissioning. WentWest (sub. 445, p. 36) said:

[A difficulty is] the strong hospital centric nature of [LHNs]. [LHNs] also have very different timelines, policies and processes to PHNs which makes collaboration more difficult.

And in relation to recent efforts to co-commission services with State and Territory Government agencies, the PHN Cooperative (sub. 377, p. 18) said:

These two case studies unveil the structural weaknesses in the healthcare system such as:

- the existence of multiple commissioning bodies (e.g. State governments and PHNs) and the subsequent risk of parallel and disjointed commissioning approaches for the same type of services, resulting in complex navigation pathways, possible duplication of some service offerings and service gaps.
- the State Department’s rigid commissioning approaches including tight timelines and limited community and PHN consultations resulting in siloed rather than more integrated, flexible and tailored initiatives responsive to local needs.

These cultural and process differences are not surprising, given that PHNs and LHNs are such different types of organisations. PHNs are private entities tasked with commissioning mental health services from a relatively small budget (approximately \$500 million for mental health services in 2018-19 (unpublished data supplied by DoH)). LHNs, meanwhile, are primarily public *providers* rather than *commissioning bodies*. They also receive considerably more funding than PHNs — almost \$5 billion for mental health services in 2016-17 (AIHW 2019o). Moreover, some LHNs may not be inclined to engage with PHNs because mental health services comprise a very small share of their service mix.

PHN and LHN boundaries do not align

There is rarely a one-to-one geographical correspondence between PHNs and LHNs, although their boundaries usually match up (box 23.6). WentWest (sub. 445) noted that this

is a barrier to further integration, a view expressed to the Commission by other PHNs during consultations early in the inquiry.

Box 23.6 Alignment of PHN and LHN boundaries

There are 31 Primary Health Networks (PHNs) and 147 Local Hospital Networks (LHNs) across Australia.

Outside of Victoria, PHN and LHN boundaries usually match up, although there are often multiple LHNs within a PHN. There are:

- 10 PHNs that correspond with a single LHN
- 11 PHNs that correspond with 2 LHNs
- 4 PHNs that correspond with 3 LHNs.

In Victoria, there is typically a single LHN for each hospital or health service (85 LHNs in total). 26 of these have significant mental health service delivery functions. These are not distributed evenly among the PHNs — there are between 1 and 7 hospitals or health services that provide mental healthcare within the 6 Victorian PHNs.

Source: Integrated Regional Planning Working Group (2018a).

To a certain extent, this issue is unavoidable. It would not be desirable to create additional PHNs, as an original rationale for creating PHNs was to rationalise the larger number of preceding Medicare Locals (61) to achieve more efficient scale (Horvath 2014). Nor does it seem judicious to force a wholesale amalgamation of LHNs purely to ensure a one-to-one correspondence with PHNs.

That said, the Victorian LHN arrangements differ markedly from those of each other State or Territory. To improve the scope for integration, there would be merit in the Victorian Government reviewing its LHN boundaries with a view to increasing compatibility with the Victorian PHNs.

Non-health services have been neglected

To date, efforts to promote integration at the regional level have been healthcare-centric. The first priority area of the Fifth Plan is largely silent on non-health services. The only action it suggests is that governments, PHNs and LHNs should:

... engage with the local community, including consumers and carers, community-managed organisations, [Aboriginal Community Controlled Health Services], [National Disability Insurance Scheme] providers, the [National Disability Insurance Agency], private providers and social service agencies. (COAG Health Council 2017a, p. 21)

Indeed, integration of Australian Government and State and Territory Government psychosocial support programs (outside of the National Disability Insurance Scheme (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.

23.3 What system design features do we want?

Chapter 1 outlined that Australia's mental health system should be people oriented and prioritise prevention and early intervention. Achieving these objectives takes more than efficient and effective funding arrangements, but they are vital enablers.

The task of reforming Australia's mental health funding arrangements to deliver on these objectives requires us to consider the *incentives* that decision makers face and the *information* they have at their disposal (box 23.7). In the Commission's view, the key issues to consider are the extent to which decision making should be centralised or devolved, the extent to which funding streams should be siloed or pooled, and how to generate an investment mindset among decision makers.

Centralised or devolved decision making?

Devolving mental health decision-making and purchasing activities to the regional level is often desirable. Australia is a large and diverse country, with regional variations in population density, socioeconomics 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 (PC 2017e). This was pointed out by WentWest (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.

Box 23.7 **When is funding allocated to its most productive use?**

Any decision to purchase a mental health service carries with it costs and benefits. Suppose that a ‘purchaser’ (a government agency, private health insurer or individual) chooses to purchase ‘service X’ (a mental health service). The costs of doing so are captured by the price paid for that service. The benefits of purchasing service X are:

- the improved mental health of the recipient of the service. This has a monetary dimension (increased workforce participation) and a non-monetary dimension (increased welfare and social participation, reduced demands on family members and carers).
- the benefits of reduced demand for ‘service Y’, which could be, for example, a more acute mental health service.

Funding is allocated to its most productive use when the group of services purchased yields the highest possible net benefit. However, there are several reasons why purchasing decisions may not accord with this principle:

- Incentive problems — purchasers do not bear all of the costs and benefits associated with their decisions and therefore do not take them all into account.
- Information problems — purchasers cannot conceive the full array of benefits and costs of purchasing a particular service. If, for example, a Primary Health Network does not know which mix of services would keep a consumer out of hospital, then it is unlikely to purchase the efficient set of services regardless of the incentives it faces.

Nevertheless, there are limits to how small these ‘regions’ should be and which decisions should be devolved to them, as some activities respond to ‘economies of scale’ (they are more efficiently delivered on a large scale) and/or ‘economies of scope’ (they are more efficiently delivered alongside other services). For example, it would be prohibitively costly to design an ABF classification for each region when a universal model would be adequate. And some services, such as telehealth and e-mental health (chapter 6), may require little (if any) adaptation to local contexts, but may benefit from considerable cost savings if deployed over a large population base.

Pooled or siloed funding?

Whether funds from multiple sources are pooled or siloed affects the incentives that act to allocate these funds efficiently. What matters here is the extent to which mental health services are, at least on some level, *substitutable* or *complementary* — so that the supply of one service impacts on the demand for another. As noted above, a PHN may face weaker incentives than otherwise to commission primary mental health care that keeps patients out of hospital (a substitute service for primary care, broadly conceived), because the costs of hospital-based care are borne through the LHN’s funding stream. In addition, the separation of PHN and LHN funding creates barriers to information flows, which hampers efforts to coordinate activity.

This problem is not limited to the health sector. Discussing the challenges of incentivising other sectors to invest in activities that improve mental health outcomes, McDaid, Park and Wahlbeck (2019, pp. 381–382) said:

One challenge in all contexts is that promoting and protecting mental health involve multiple sectors. These are issues for more than just mental health services or even health systems. Collaboration with external sectors can be problematic; improved mental health is not often a primary policy objective for these agencies. Thus, they may be reluctant to commit resources to mental health, even if compensated by health agencies for doing so. Fragmented funding and accountability structures are also likely to pose additional barriers to action. For instance, one sector may shoulder the financial responsibility for delivering a service, while another sector is perceived to make most of the gains (and avert costs) at some future point in time.

Likewise, the National Mental Health Commission (sub. 118, p. 25) said:

There are also structural barriers around portfolio-based funding and decision making by governments, which dis-incentivise spending in one portfolio when the economic return over time will accrue in a different portfolio area (and budget), or indeed a different jurisdiction altogether.

These problems are reduced when these funding streams are pooled and responsibilities are made clear. A single purchaser (or group of purchasers acting on a genuinely cooperative basis) could be more aware of the full scope of its purchasing decisions and face greater incentives to ‘internalise’ the costs and benefits of its decisions.

That said, there are administrative limits to pooling. From a practical viewpoint, decisions about which funding streams should be pooled (either explicitly or through separate decision makers operating in a unified manner) and which can remain siloed should be based on the extent to which the services they fund are substitutable or complementary, and also the impacts on economies of scope and scale in service delivery.

To illustrate, consumers of low-intensity mental health services are unlikely to present to emergency departments, so there is little efficiency to be gained from pooling funding for these services. And while rapid and secure access to public housing may reduce demands on mental healthcare and improved mental healthcare may reduce risks to public housing, this does not mean that funds for these services should be pooled as these areas involve specific specialised skills and administrative abilities.

An investment approach

It is important for the system’s design to incentivise decision makers to take a long-term view. Some mental health services or programs may take many years to generate sufficient benefits to render them cost-effective. This presents further informational and incentive problems. In particular, the long term nature of the payoffs makes them inherently

challenging to quantify, and advocates for a particular service face incentives to overstate its future benefits.⁴⁷

The Commission understands a challenge in a resource-constrained world is for decision makers to be seen to solve problems now, notwithstanding that a longer-term application of funds to other services may reduce expenditure in the future.

The problem of making long-term decisions under considerable uncertainty plagues many areas of policy making and has no easy solution. Approaches that may work involve:

- conducting high quality research into the future benefits and costs of particular programs and communicating this in an accessible way to policy makers and the community. This is a general principle that the Commission would support in all areas of policy making.
- seeking to assess the performance of decision makers on longer term outcomes.

Chapter 25 discusses the importance of reporting historical measures in monitoring and reporting frameworks. This allows assessment of performance over several years, which could incentivise decision makers to be more forward looking in their approach.

23.4 Changes to roles and responsibilities for psychosocial and carer supports outside of the NDIS

Chapters 13 and 12 highlight that both levels of government provide psychosocial and mental health carer supports to those not eligible for these supports under the NDIS.⁴⁸ For both psychosocial and mental health carer supports, there is no clear division between the types of supports that each level of government offers. This creates unclear responsibilities, leading to gaps and overlaps in service provision and inefficient service delivery.

With both levels of government offering such comparable services, there appears little hope that incremental changes to the current arrangements will clarify responsibilities. Instead, with some limited exceptions (discussed below), the Commission is proposing that one level of government take on responsibility for *all* psychosocial and mental health carer supports outside of the NDIS (including additional carer supports for carers of people with psychosocial disability that are receiving NDIS supports).

While it would be possible to have one level of government responsible for all psychosocial supports and the other responsible for all mental health carer supports, the Commission is in

⁴⁷ There may also be a double whammy — payoffs to a policy intervention that both accrue to a different portfolio and in the distant future. Knapp and Iemmi (2016) refer to this as a *diagonal accounting* challenge.

⁴⁸ Psychosocial 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. Carer supports includes services such as peer support, respite and psychoeducation.

favour of the same level of government being responsible for both. Psychosocial and carer supports have similarities (for example, a similar psychoeducation program may be provided to both carers and consumers) and are partially substitutable (as psychosocial supports substitute for informal care). For the reasons set out in section 23.3, it makes sense for these services to be funded by a single level of government, and within the same portfolio.

Which level of government should take on sole responsibility?

The Commission considered several criteria to decide which level of government should take on sole responsibility for psychosocial and carer supports outside of the NDIS.

First, psychosocial and mental health carer supports are well-suited to being devolved to sub-national administrative levels. As set out in section 23.3, decision makers ‘closer to the ground’ are generally better placed to make informed judgements about the types of services that should be funded. And there is no good reason *not* to devolve administration of these services — while chapter 12 highlights some issues with excessive administrative burdens faced at present, psychosocial and carer supports would not seem to feature the types of sophisticated administration (such as ABF classification systems) that yield substantial economies of scale.

This would seem to suggest that State and Territory Governments are most suited to delivering these services. But this may not be the case. The Australian Government:

- has recently devolved its provision of psychosocial supports to PHNs (section 23.2), which — in the larger States/Territories — have smaller catchments than State and Territory Governments
- intends to devolve its provision of carer supports to 16 Carer Gateway service areas (DSS 2019k), the boundaries of which match PHN boundaries. Again, in the larger States these will have smaller catchments than State Governments.

It is important to note that these new Australian Government approaches are relatively untested. Also, one option the Commission is proposing is that State and Territory Governments establish ‘Regional Commission Authorities’, to commission mental health services. These would be sub-state entities in the larger States. On the whole, the ‘closer to the ground’ criterion seems unhelpful in deciding which level of government should take responsibility for psychosocial and mental health carer supports outside of the NDIS.

Second, the Commission favours making the least disruptive change possible. Recent years have witnessed significant disruption to the provision of psychosocial and carer supports due to the ongoing rollout of the NDIS, so it is difficult to know which changes would be more or less disruptive at this time. That said, the Commission estimates that State and Territory Governments provided about 70% of psychosocial and carer support services prior to the

large-scale rollout of the NDIS.⁴⁹ This would suggest that it would be less disruptive for State and Territory Governments to take on existing Australian Government service delivery than the other way around.

Hence, the Commission's preferred option is for State and Territory Governments to take on responsibility for all psychosocial and carer supports. This necessitates intergovernmental transfers, as discussed in sections 23.5 and 23.6.

An exception

The Australian Government is establishing an 'Integrated Carer Support Service' to which it is seeking to transfer all of its carer support services (for mental health carers and other carers) (chapter 13). While the Commission is suggesting that many of the mental health carer supports within this service should transfer to State and Territory Governments, an exception to this is the Carer Gateway — a phone line and website service (chapter 13). It would be efficient for this phone line and website to continue to be a service entry point for all carers.

DRAFT RECOMMENDATION 23.2 — RESPONSIBILITY FOR PSYCHOSOCIAL AND CARER SUPPORT SERVICES

In the medium term (over 2 – 5 years)

State and Territory Governments should take on sole responsibility for commissioning psychosocial and mental health carer support services outside of the National Disability Insurance Scheme. The Australian Government should provide funding to support the new and expanded roles that State and Territory Governments are taking on, and continue to administer the Carer Gateway's service navigation and information services for all carers.

23.5 Two options for reforming mental health system architecture

The Commission is proposing two options for the future federal distribution of roles and responsibilities for mental healthcare and some associated changes to service delivery architectures. We intend to propose a single preferred option in the final report.

⁴⁹ Schess et al. (2018) estimated that, in 2014-15, the Australian Government and State and Territory Governments spent \$66 million and \$25 million respectively on mental health carer supports. In 2016-17, the Australian Government spent \$114 million on the psychosocial support services Partners in Recovery, Day 2 Day Living and Personal Helpers and Mentors (unpublished data from the Department of Social Services and Department of Health), while State and Territory Governments spent about \$400 million on psychosocial supports (exclusive of carer supports) (AIHW 2019c).

The first option, called the *Renovate* model, largely continues the path of recent reforms within the mental healthcare sector.

Under the second option, called the *Rebuild* model, State and Territory Governments would create ‘Regional Commissioning Authorities’ that commission nearly all mental healthcare and psychosocial and carer supports. At this stage, the Rebuild model is our preferred option.

The remainder of this chapter outlines these two models in more detail. Table 23.2 outlines how federal roles and responsibilities would differ between the two models.

Table 23.2 Roles and responsibilities under the Renovate and Rebuild models

Includes only services that would differ in funding and/or administration between the two options. Services highlighted in green are those for which service delivery responsibility sits with a different level of government between the two models.

	<i>Renovate model</i>		<i>Rebuild model</i>	
	<i>State and territory governments</i>	<i>Australian Government</i>	<i>State and territory governments</i>	<i>Australian Government</i>
Health	<ul style="list-style-type: none"> Public hospital and community mental healthcare services Place-based suicide prevention services (in concert with PHNs) 	<ul style="list-style-type: none"> Medicare Benefit Schedule-funded mental health services Commissioned primary mental health services (devolved to PHNs) Care coordinators (devolved to PHNs) Place-based suicide prevention services (devolved to PHNs, and in concert with LHNs) 	<div>Managed by Regional Commissioning Authorities</div> <ul style="list-style-type: none"> Public hospital and community mental healthcare services Commissioned mental health services Care coordinators Place-based suicide prevention services 	<ul style="list-style-type: none"> Medicare Benefit Schedule-funded mental health services (rebates for allied mental healthcare are linked to the size of the Regional Commissioning Authorities’ pools)
Psychosocial supports	<ul style="list-style-type: none"> Psychosocial supports (outside of the NDIS) 		<ul style="list-style-type: none"> Psychosocial supports (outside of the NDIS) 	
Carer supports	<ul style="list-style-type: none"> Carer supports (outside of the NDIS) 		<ul style="list-style-type: none"> Carer supports (outside of the NDIS) 	

DRAFT RECOMMENDATION 23.3 — STRUCTURAL REFORM IS NECESSARY

The Australian Government and State and Territory Governments should work together to reform the architecture of Australia's mental health system to clarify federal roles and responsibilities and incentivise governments to invest in those services that best meet the needs of people with mental illness and their carers. There should be greater regional control and responsibility for mental health funding.

INFORMATION REQUEST 23.1 — ARCHITECTURE OF THE FUTURE MENTAL HEALTH SYSTEM

The Productivity Commission has proposed two distinct models for the architecture of the future mental health system:

- *The Renovate model, which embraces current efforts at cooperation between Primary Health Networks (PHNs) and Local Hospital Networks (LHNs).*
- *The Rebuild model, under which State and Territory Governments would establish 'Regional Commissioning Authorities' that pool funds from all tiers of government and commission nearly all mental healthcare (Regional Commissioning Authorities would take over PHNs' mental health commissioning responsibilities and also commission more acute mental healthcare) and psychosocial and carer supports (outside the NDIS) for people living within their catchment areas.*

At this stage, the Rebuild model is the Commission's preferred approach.

How could the Rebuild model be improved on? Are the proposed governance arrangements appropriate? Should RCAs also hold funding for, and commission, alcohol and other drug services?

If you consider the Renovate model or another alternate approach is preferable, please describe why, and outline any variations you consider would be an improvement.

23.6 The Renovate model

The Renovate model does not propose further changes to intergovernmental roles and responsibilities other than the reallocation of psychosocial and carer support roles outlined in the previous section. In the area of mental healthcare, it follows the approach of the first priority area of the Fifth National Mental Health and Suicide Prevention Plan, by recognising that — short of more fundamental structural reform — the approach of pursuing regional integration between PHNs and LHNs is a superior option among imperfect alternatives.

Table 23.3 outlines these proposed roles and responsibilities. If the Commission were to recommend the Renovate model, we would recommend that these roles and responsibilities be clarified in a Council of Australian Governments National Mental Health and Suicide Prevention Agreement (chapter 22).

The remainder of this section outlines how intergovernmental transfers for mental healthcare, psychosocial supports and carer supports would operate under the Renovate model.

Table 23.3 Roles and responsibilities under the Renovate model

Italics denote changes to current governmental responsibilities

<i>Portfolio</i>	<i>State and territory government responsibilities</i>	<i>Australian Government responsibilities</i>
Health	Public hospital mental healthcare services and public community mental healthcare services	Medicare Benefit Schedule-rebated mental health services, commissioned mental health services and care coordinators (devolved to Primary Health Networks (PHNs)), e-mental health supports
Suicide prevention	Place-based suicide prevention services (in conjunction with PHNs)	Place-based suicide prevention services (devolved to PHNs, and in conjunction with LHNs), population-level suicide prevention services
Disability services	<i>Psychosocial and carer supports (outside of the NDIS)</i>	NDIS psychosocial and carer supports
Education (school and early childhood education and care (ECEC))	In-school services in public schools, parenting support in community settings, perinatal mental health screening and support for new parents, mental health information and backup for ECEC service providers	Funding for in-school services in independent and Catholic schools, online and phone-based parenting support
Education (tertiary)	Government funded vocational education and training (VET) student services	University student services and some VET student services
Employment support ^a		Conventional Disability Employment Services and jobactive employment supports
Justice	Justice services for mentally-ill offenders and victims	
Housing	Integrated supported housing, homelessness services, tenancy support services, housing first programs	NDIS long-term supported accommodation

^a The Commission is seeking further information on which level of government should administer trials of Individual Placement and Support employment supports (chapter 14).

Intergovernmental funding arrangements for mental healthcare

As roles and responsibilities for mental healthcare are unchanged under the Renovate model, the discussion of the pros and cons of the current system of intergovernmental transfers under the NHRA — to support State and Territory Governments' provision of public hospital mental healthcare services and public community mental healthcare services — in section 23.1 remains fully relevant in this context.

As set out in section 23.1, the principal argument in favour of maintaining an ABF system for intergovernmental transfers is that it provides incentives for the Australian Government to improve the quality of primary mental healthcare (to prevent people requiring more acute mental healthcare, for which the Australian Government foots part of the bill). These incentives would not exist if the Australian Government just provided block transfers to State and Territory Governments, as is the case under most intergovernmental funding agreements. For this reason, the Commission's preferred approach is to maintain the system in place under the National Health Reform Agreement. The Commission will consider further the issue of whether additional funding is required in its final report.

Intergovernmental funding arrangements for psychosocial and carer supports

As noted in section 23.4, the Commission is proposing that existing Australian Government responsibilities for psychosocial and carer supports be transferred to State and Territory Governments. This necessitates additional intergovernmental transfers to compensate State and Territory Governments for taking on additional responsibilities.

These services do not fall within the scope of existing intergovernmental transfers. The Commission considers that they would best be administered via a new National Mental Health Specific Purpose Payment, governed by the Commission's proposed National Mental Health and Suicide Prevention Agreement (chapter 22). The National Mental Health and Suicide Prevention Agreement should specify:

- the amount of funding to be provided to State and Territory Governments, including growth over the duration of the agreement
- the types of services within scope
- that State and Territory Governments must maintain the real value of their existing funding to these services.

23.7 The Rebuild model

The Rebuild model is a more ambitious reform proposal than the Renovate model. It calls for State and Territory Governments to create 'Regional Commissioning Authorities' (RCAs) that fund nearly all mental healthcare and psychosocial and carer supports (outside of the NDIS) for people living within their catchment areas. RCAs would hold pooled Australian Government and State and Territory Government funds, with which they would take over the PHNs' mental health commissioning responsibilities, and also commission mental healthcare services from LHNs. RCAs would report data back to the Australian Government for monitoring purposes (chapter 25). Mental healthcare would remain eligible for Medicare Benefits Schedule (MBS) rebates, but there would be arrangements in place to allow greater integration of MBS rebates for allied mental healthcare and RCA funds (chapter 24).

The model has the same focus on regional decision making as the Fifth National Plan (and the Renovate model), and advances the drive for regional integration by avoiding the ambiguities in roles and responsibilities and need for PHN-LHN cooperation inherent in the current arrangements. It echoes structures that others have proposed for Australia's health system or that have been used in other policy areas in Australia (box 23.9).

Box 23.9 Proposed reforms of Australia's health system similar to the Rebuild model

- Option 4 of the 2015 Reform of the Federation Discussion Paper describes a model for Australia's health system in which the Australian Government and State and Territory Governments jointly establish 'Regional Purchasing Agencies' that would receive pooled funding and purchase health services for individuals in their catchment regions (PM&C 2015b).
- Options 2a and 3a of a 2008 Options Paper commissioned by the National Health and Hospitals Reform Commission describe similar models for Australia's health system where State and Territory Governments (either by themselves, or jointly with the Australian Government) establish 'Health Funding Authorities' that receive pooled funding and purchase health services for individuals in their catchment regions. Under this model, the Medicare Benefits Schedule would remain in place as a national billing mechanism (Dwyer and Eagar 2008).
- A 2008 Roundtable Discussion Paper co-sponsored by the Australian Healthcare and Hospitals Association, the Mental Health Services Conference of Australia and New Zealand, and the PwC Health Actuarial and Advisory Practice proposed a model for funding mental healthcare where State and Territory Governments establish 'Regional Mental Health Funding Authorities' that hold pooled funding and commission all mental healthcare and psychosocial supports (Gurr, sub. 40, attachment 3).

For which services should Regional Commissioning Authorities be responsible?

The benefit of establishing RCAs is that they allow existing siloed funding streams to be pooled, remedying many of the incentive problems set out in this chapter. This begs the question: which services should they hold funding for? Section 23.3 set out the principle that it is most desirable to pool funding streams when: a) they fund services that are closely substitutable or complementary; and b) this would not lead to loss of economies of scale or scope. This section applies this logic to the task of considering which services should be funded by the RCAs.

Mental healthcare

The Commission's starting point is that the RCAs should hold all funding for mental healthcare, as this would improve continuity of care and create incentives for earlier intervention (as, for instance, a RCA could save on hospital care if it prevented the need for it). This would include the funding currently allocated to MBS-subsidised services; the PHN

Mental Health Flexible Funding Pool; and State and Territory Government spending (inclusive of Australian Government contributions) on public hospital-based and community mental healthcare.

However, there are good reasons for some services not to be commissioned by RCAs.

- The Commission sees merit in maintaining MBS rebates to mental health professionals for reasons of administrative efficiency. However, this opens up a federal divide and scope for cost-shifting to occur in the provision of allied mental healthcare (section 24). A simple solution — elaborated on in the next chapter — is to deduct MBS rebates for allied mental healthcare from Australian Government transfers for RCAs. However, the RCA would not control these funds — they would remain part of an unchanged Medicare system
- Also for administrative reasons, justice and forensic mental healthcare services (chapter 16) are ill-suited to being a RCA responsibility. They are provided to consumers detained in secure facilities who do not access the broad range of other mental health services, and thus require specialised models of delivery rather than tight integration with other mental health services (except when their consumers are transitioning back into the community).

Non-NDIS psychosocial and carer supports

Chapter 12 set out that psychosocial supports are generally *complements* to community-based clinical services (in that they improve the effectiveness of clinical services), and, hence, can substitute for assistance with day-to-day activities provided in hospitals. Similar logic applies to carer supports (chapter 13).

Other reviews have reached similar conclusions. A 2014 review recommended that, in England, separately commissioned healthcare and ‘social care’ (a broader term that encompasses, but is not limited to, disability supports) be brought within the purview of a single commissioner managing a single budget (Independent Commission on the Future of Health and Social Care in England 2014). And a recent Australian report suggested regional linkages between healthcare and psychosocial supports (Global Access Partners 2019).

Alcohol and other drug services

Chapter 9 outlined that several State and Territory Governments have integrated their planning and/or provision of alcohol and other drug and mental healthcare services, and that PHNs are responsible for commissioning both alcohol and other drug and mental healthcare services. Were RCAs to *not* take on responsibility for alcohol and other drug services, there would be a risk that integrated service delivery would become siloed. That said, the Commission has not investigated the provision of alcohol and other drug services as thoroughly as it has for mental health services.

At this stage (and if we were to recommend that governments adopt the Rebuild model in the final report), we see a reasonably strong case for RCAs taking on responsibility for alcohol and other drug services. This would include alcohol and other drug services provided by State and Territory Governments and those commissioned by PHNs. However, we are requesting further feedback on this issue.

How much funding is involved?

Based on 2016-17 actual expenditure on services within their scope, RCAs would hold approximately \$6 billion in funds (table 23.4).

Table 23.4 How much funding would Regional Commissioning Authorities hold?

Indicative annual estimates based on actual expenditure for 2016-17 and excluding MBS-subsidised mental healthcare^a

<i>Sector</i>	<i>Type of service</i>	<i>Estimated annual funding currently allocated to these services</i>
Healthcare	Public hospital-based mental healthcare	\$2.6 billion
	Community mental healthcare	\$2.4 billion
	PHN-funded primary mental healthcare	\$0.4 billion
Psychosocial supports		\$0.5 billion
Carer supports		\$0.1 billion
Total		Approx. \$6 billion

^a Under one of the options listed in chapter 24, RCAs would hold estimated prospective MBS rebates for allied mental healthcare, but these would be drawn from their regional pools in real-time.

Source: Productivity Commission estimates based on AIHW (2019o).

Which level of government should establish RCAs?

Either the Australian Government or State and Territory Governments *could* establish RCAs. But which level of government *should* do so?

There are some arguments in favour of the Australian Government establishing RCAs, but they have their limitations. First, it could lead to greater uniformity in RCA structure, which may render RCAs' performance easier to compare across jurisdictions. But this may come at the cost of experimentation with the alternative models of governance and implementation that would emerge organically under a state-based solution. In any event, as a significant funder of RCA activities, the Australian Government should use its influence to ensure that RCAs collect and report data on a nationally consistent basis, and could even dictate a particular governance structure if it desired. This occurred with the creation of LHNs, which State and Territory Governments were required to establish as a condition of the NHRA.

Second, it would reduce the imbalance between federal responsibilities and revenue-raising capacities (known as ‘vertical fiscal imbalance’), in turn reducing the need for intergovernmental transfers. Eccleston (2008) suggested this as a reason for the Australian Government taking over the management of public hospitals. That said, the quantum of funding at stake in this instance is not sufficient to make serious inroads into the existing vertical fiscal imbalance. Approximately \$9 billion was spent on specialised mental health services in 2016-17, while Australian Government transfers to State and Territory Governments totalled \$116 billion in that year (AIHW 2019n; PC 2018b).

On the other hand, there are several strong arguments in favour of State and Territory Governments establishing RCAs. First, they have a more entrenched role in providing mental health services, especially more complex acute mental healthcare services. Relatedly, having the Australian Government responsible for acute public mental healthcare services but not acute public physical healthcare would frustrate governance arrangements. LHNs would be accountable to State and Territory Governments for physical health services but accountable to the Australian Government for mental health services — especially challenging since both are routinely delivered in general wards of public hospitals. Meanwhile, the WA Mental Health Commission has effectively demonstrated that it is possible within current governance arrangements for a State Government entity other than a health department to commission public mental healthcare (discussed further in the following section).

Second, State and Territory Governments have primary responsibility for education, housing and justice services. These deliver specialised services that are not usually targeted at people with mental illness, and so they should remain outside the scope of the RCAs. However, it is essential that they are integrated with the services that RCAs would fund. For example, supported accommodation places (chapter 15) would be delivered in partnership between RCAs and State/Territory housing departments, with RCAs supplying the psychosocial and clinical supports and housing departments supplying the accommodation.

Hence, the Commission’s view is that State and Territory Governments should be responsible for establishing RCAs. With the scope of RCA activities and the level of government to which they would be responsible now established, table 23.5 sets out proposed roles and responsibilities under the Rebuild model.

Table 23.5 Roles and responsibilities under the Rebuild model^a

Italics denote changes to governmental responsibilities

<i>Portfolio</i>	<i>State and Territory Government responsibilities</i>	<i>Australian Government responsibilities</i>
Health	Public hospital mental healthcare services and public community mental healthcare services, <i>commissioned mental health services and care coordinators (devolved to PHNs)</i>	Administration of MBS-rebated mental health services, e-mental health supports
Suicide prevention	<i>Place-based suicide prevention services</i>	Population-level suicide prevention services
Disability services	<i>Psychosocial and carer supports (outside of the NDIS)</i>	NDIS psychosocial and carer supports
Education (school and ECEC)	In-school services in public schools, parenting support in community settings, perinatal mental health screening and support for new parents, mental health information and backup for ECEC service providers	Funding for in-school services in independent and Catholic schools, online and phone-based parenting support
Education (tertiary)	Government funded VET student services	University student services and some VET student services
Employment support ^a		Conventional Disability Employment Services and jobactive employment supports
Justice	Justice services for mentally-ill offenders and victims	
Housing	Integrated supported housing, homelessness services, tenancy support services, housing first programs	NDIS long-term supported accommodation

^a The Commission is seeking further information on which level of government should administer trials of Individual Placement and Support employment supports (chapter 14).

Governance of Regional Commissioning Authorities

Good governance arrangements would maximise the likelihood of RCAs successfully fulfilling their intended purpose (box 23.10) to the benefit of mental health consumers and carers. They would also provide comfort to the Australian Government and State and Territory governments that RCAs would improve mental health outcomes beyond what would otherwise be the case.

Organisational form

Should RCA functions be performed by a new State/Territory public entity, or by expanding the remit of an existing State/Territory public service body (such as a State/Territory department, or one of its executive agencies)?

Box 23.10 **Purpose, objectives and functions of Regional Commissioning Authorities**

Purpose

The purpose of RCAs is to create a seamless mental health system that offers continuity of service and fills gaps in service provision. RCAs would overcome gaps, duplication and discontinuities in care that would otherwise persist at the interface of Australian Government and State and Territory Government responsibilities.

Objectives

The objectives of the RCAs should reflect the aims of the National Mental Health Strategy (chapter 22).

Functions of RCAs

RCAs would have three functions, namely:

- **to conduct mental health planning** at a regional level
- **to administer pooled mental health funds** on behalf of the Australian Government, and State and Territory Governments
- **to purchase mental healthcare, psychosocial supports and carer supports** that best meet the needs of people living with mental ill-health and their carers who reside in their regions.

As noted previously, there are sound reasons for leaving this decision with individual State and Territory Governments. First, doing so would be consistent with the overall approach of giving States/Territories responsibility for mental ill-health treatment and recovery, and creating an authorising environment for them to commission services for maximum effect. Second, there are practical reasons for allowing State and Territory Governments to develop individual approaches that are tailored to their demographic needs and geographical dispersion. It is conceivable that RCA functions could be efficiently undertaken within existing government structures, especially for smaller jurisdictions. Third, it would allow for greater experimentation — a key advantage of a federal system of government.

On the other hand, there are advantages to a greater degree of uniformity in RCA structure. The costs of establishing RCAs would be non-trivial and these costs could be reduced through the use of template legislation which each State/Territory Government could tailor to meet their own situations. Moreover, uniformity could lead to greater comparability of RCA performance across jurisdictions, although the primary means for this is a rigorous performance reporting framework (chapter 25).

The creation of LHNs offers some precedent here. Under the NHRA, State and Territory Governments agreed to establish LHNs as separate legal entities that receive funds from both the Australian Government and State and Territory Governments and are responsible to State and Territory governments through service agreements. However, LHNs are providers rather than commissioners, so while this demonstrates that it is feasible for the Australian

Government to prescribe a governance structure, it does not necessarily offer a blueprint for RCAs.

Irrespective of their form, their legal underpinnings would need to enable RCAs to:

- receive and pool funds from the Australian Government and State and Territory Governments (this is elaborated on below)
- permit contracting with service providers and be able to enforce contracts, noting that some service providers (most notably LHNs) will be government entities
- be established cost effectively.

Another issue is extent to which RCAs would be independent from day-to-day Ministerial direction. Granting some independence to RCAs would allow them greater scope to make evidence-based decisions in the best interests of their regions, and is consistent with usual practice for organisations of their type. Countries with regional healthcare systems (such as New Zealand and England) generally grant some independence to their regional commissioning bodies, as has been the case for PHNs in Australia. Of course, RCAs would face clear monitoring and reporting requirements (chapter 25), and State and Territory Governments should establish mechanisms to appoint administrators in the event of serious malfeasance.

The Commission invites further feedback from stakeholders about RCA governance arrangements. At this stage, our preferred model is that RCAs should be established as separate legal entities under State/Territory law and at arm's length from Ministerial control (for example, they should have flexibility to allocate funding without ministerial intervention). Box 23.11 contains our views on ideal corporate governance arrangements at this stage. We also favour State and Territory Governments having flexibility in how they construct their RCAs and, hence, do not wish to propose a prescriptive model.

Making use of existing expertise

While RCAs would take on some of the roles currently performed by PHNs and State and Territory Government departments, these bodies have developed expertise in regional planning and commissioning mental health services that RCAs should harvest. To some extent this would likely happen quite organically, as some staff could transfer from existing bodies to the RCAs. And, as noted below, State and Territory Government health departments should provide assistance to RCAs in their State or Territory. But RCAs could also consider:

- developing strong relationships with PHNs, which would retain expertise in regional planning and primary care
- contracting PHNs to commission some primary mental healthcare or other services, if PHNs are better placed to do so. While this could appear superficially to be a reversion to the current arrangements, it would be quite different in that RCAs would still control the source of funds and that any such arrangement would be voluntary.

Box 23.11 Proposed corporate governance arrangements for Regional Commissioning Authorities

Governing boards

Boards (appointed by the State/Territory minister responsible for mental health) 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 also 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 be agile. 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 non-executive 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 will 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. This presents a risk that an LHN representative might, to some extent, govern on behalf of her or his LHN, rather than the RCA itself. In the Commission's view, RCAs should be able to determine the level of LHN service that is optimal for their region in a manner that is free of any influence from LHNs themselves. In relation to this issue, it is less clear whether a similar conflict of interest would necessarily attach to a representative of a Primary Health Network.

State and Territory Governments should be able to dismiss the board in the event of serious malfeasance.

Advisory councils

RCA boards should be supported by advice from advisory councils. To be effective, RCA boards would need to think carefully about the governance needs of a diverse range of stakeholders, including: consumers and carers, all three tiers of government and government agencies, providers (public, non-government 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.

The Commission does not intend to prescribe a minimum number of advisory councils, or nominate particular types. However, unlike board membership, it does not see any reason for RCAs to necessarily exclude representatives from LHNs or Primary Health Networks on their advisory councils. On the contrary, there may be significant value in regularly canvassing their views and experiences.

Relationships with housing, justice and education portfolios

As noted previously, RCAs would need to be integrated with the housing, justice and education portfolios to ensure that services that cross this interface are delivered as seamlessly as possible. RCAs should consider devising memoranda of understanding with each of these departments that clearly lay out responsibilities in these situations.

Also, spending by RCAs could lead to savings in these portfolios (and vice versa). For example, chapter 15 notes evidence that investing in further supported housing places would yield reductions in health service usage, and chapter 16 notes that early intervention programs (some of which would fall within the scope of standard RCA activities) would generate downstream savings to the justice budget. High quality communication between RCAs and other portfolios will be necessary to realise these cross-portfolio gains. In some States, mental health commissions could play a leading role in coordinating across portfolios, while in others, central agencies should do so.

Relationship with State/Territory health departments

While it would be a decision for State and Territory Governments, the Commission envisages that health departments would provide support to RCAs and oversee their activities. State and Territory health departments would also need to enter into agreements with RCAs that allow them to commission services from LHNs, which are governed according to service agreements with health departments (such an agreement is currently in place between the WA Mental Health Commission and the WA Department of Health (WA DoH 2017)). There would also need to be agreements in place that allow RCAs to commission services from LHNs, which are governed by service agreements with State/Territory health departments. These could mirror the agreement between the WA Mental Health Commission and the WA Department of Health.

A more complex issue concerns control over funding for capital works. Given the current gaps in mental health expenditure (chapters 7 and 8), the Commission expects that RCAs would seek to expand the provision of community mental healthcare services. But a recent performance audit of the WA Mental Health Commission (OAGWA 2019, p. 21) noted that its lack of control over capital funding limited its ability to shift care into community settings:

The [WA Mental Health Commission] purchases mental health services from providers. If the [WA Mental Health Commission] decides that it is willing to purchase a new service from [an LHN], the [LHN] needs to have the infrastructure in place to provide the service. If new infrastructure is required, the [WA Mental Health Commission] or the Department have to negotiate the capital funding required to build the infrastructure in order for the [WA Mental Health Commission] to be able to purchase the service. This is a consequence of the organisational structure, where the Department controls the infrastructure used to provide mental health services and [WA Mental Health Commission] is responsible for determining the service mix and purchasing services to deliver the desired service mix.

... The [WA Mental Health Commission's] delivery of the [Western Australian Mental Health, Alcohol and Other Drug Services Plan's] initiatives is dependent on ad-hoc funding, based on individual business cases. This approach has resulted in patchy implementation of the Plan, and prolonged reliance on higher-cost hospital services.

It would not be feasible for RCAs to hold a comprehensive capital works budget because hospital-based mental health services are usually provided in general hospitals, including in general wards. Instead, the Commission considers that RCAs should have clear agreements with their governing health department about the distribution of capital works funding.

Intergovernmental funding arrangements

Relative to the Renovate model and current arrangements, the intergovernmental funding arrangements that would underpin the Rebuild model would function quite differently.

First, there would need to be a greater *volume* of transfers, as PHN mental health responsibilities would shift to the State and Territory Government level.

Second, several factors suggest that intergovernmental transfers for services within the scope of the RCAs (mental healthcare and psychosocial and carer supports) should be designed differently.

- Intergovernmental transfers are the primary means by which the Australian Government can comfort itself that State and Territory Governments will establish RCAs that are fit-for-purpose. While the Commission favours giving some flexibility to State and Territory Governments to experiment with RCA governance arrangements, the Australian Government should make its funding conditional on RCAs reporting high quality and comparable performance data (RCA reporting requirements are proposed in chapter 25).
- As noted previously and elaborated on in the next chapter, the Commission favours linking the volume of MBS rebates for allied mental health in each region to the corresponding RCA's funding pool. In practice, this would be achieved by varying Australian Government transfers to RCAs in line with MBS outlays.
- Under the Renovate model, the Commission favours maintaining the NHRA's system of activity-based transfers to maintain the Australian Government's existing incentives to provide primary mental healthcare to a high standard (section 23.1). But under the Rebuild model, State and Territory Governments would take responsibility for much primary mental healthcare, so this justification no longer holds. As a result, there are considerable benefits to returning to a system of block intergovernmental transfers. This would mean that RCAs would face the full fiscal costs and benefits of any decisions they make that reduce demand for more acute (and expensive) mental healthcare — providing a stronger incentive to focus on earlier intervention than would otherwise exist.

National Mental Health and Suicide Prevention Agreement funding

Taking this into account, the Commission is proposing a new intergovernmental funding source that would be governed by the proposed National Mental Health and Suicide Prevention Agreement (chapter 22). This payment would pool:

- existing Australian Government payments to State and Territory Governments for mental healthcare services under the NHRA, with the exception of forensic mental health services. The NHRA (or its future equivalent) would be amended to remove these services from its scope
- the existing PHN Mental Health Flexible Funding Pool (including funding for additional PHN-funded services recommended by this inquiry)
- Australian Government payments to State and Territory Governments for psychosocial and carer supports, as set out under the Renovate model.

In relation to this payment, the National Mental Health and Suicide Prevention Agreement should specify:

- the amount of funding to be provided, including growth over the life of the agreement
- the types of services that RCAs are expected to fund
- that State and Territory Governments must make transfers to RCAs that are not less than their expenditure on in-scope services that would be expected under current arrangements.

Allocation to Regional Commissioning Authorities

The National Mental Health and Suicide Prevention Agreement funding should be distributed between State and Territory Governments on a weighted per-capita basis. These weights should take account of exogenous factors that influence the costs of providing services in each State/Territory — such as rurality and age of the population and the proportion of the population that are Aboriginal or Torres Strait Islander. The Commonwealth Grants Commission should advise the Department of Health on this funding distribution.

A further consideration is whether the Australia Government should seek to distribute the funding directly to RCAs or to State and Territory Governments and allow them to allocate it between RCAs as they see fit. The Commission is still considering this issue.

Activity-based funding and the role of the Independent Hospital Pricing Authority

To be clear, the Commission is *not* proposing that LHNs are no longer paid via ABF for mental healthcare in public hospitals, and nor are we proposing that IHPA should not continue to develop a viable ABF classification for mental healthcare in community ambulatory mental healthcare services. Rather, the Commission envisages that RCAs would

receive block grants from the Australian and State and Territory Governments, and pay LHNs for mental healthcare services on an ABF basis. This arrangement mirrors aspects of the English health system, among others.⁵⁰

Hence, the Independent Hospital Pricing Authority would maintain its critical role in developing and refining a mental health ABF classification, but it would be RCAs that use this for funding purposes.

⁵⁰ In the English National Health System, Clinical Commissioning Groups receive block funding but some commission acute mental healthcare on an ABF basis.

24 Funding arrangements

Changes to funding arrangements are necessary because ...

- Efforts to prevent the shifting of costs on to the Medicare Benefits Schedule (MBS) are partial in scope and hamper flexibility for commissioning agencies to pursue alternative ways of paying for mental healthcare services.
- Primary Health Networks (PHNs) are required to commission headspace centres, but the rationales for this are weak and inconsistent with the flexibility they otherwise have.
- Private health insurers and life insurers are not permitted to fund community-based healthcare, creating unnecessary limitations on funding.

Successful reform requires ...

- The Australian Government should relax requirements for PHNs to direct funds to headspace centres.
 - The Australian Government should tie the funding that commissioning agencies (PHNs or the Productivity Commission's proposed Regional Commissioning Authorities, as the case may be) receive to the volume of MBS rebates for allied mental health services paid in their regions. It should relax restrictions that prevent commissioning agencies from co-funding MBS-subsidised providers.
 - As part of the next renegotiation of the National Housing and Homelessness Agreement, the Australian Government should consider additional funding to State and Territory Governments for delivery of housing and homelessness services for people with mental illness.
 - The Australian Government should review the regulations that prevent private health insurers from funding community-based mental healthcare.
 - The Australian Government should permit life insurers to fund mental health treatments for their income protection insurance clients on a discretionary basis.
 - The Australian Government should establish a Mental Health Innovation Fund to trial innovative system organisation and payment models, and permit commissioning agencies pay MBS-subsidised allied mental health professionals in different ways as part of these trials.
-

This chapter recommends reforms to funding arrangements that complement those proposed elsewhere in this report, especially chapter 23. It seeks to:

- consolidate the Commission’s plan for a flexible and regionally controlled mental health system (chapter 23)
- ensure that intergovernmental funding arrangements in non-health sectors support the Commission’s proposed reforms in those sectors, particularly housing (chapter 15) and education (chapter 17)
- enable private health and life insurers to fund more mental healthcare where it is in the community’s interest, and with adequate protections in place.

24.1 Primary mental healthcare funding

Closer integration of funding streams

At present, primary mental healthcare (chapter 5) is funded in two ways:

- allied mental healthcare and mental health-specific general practice are listed on the Medicare Benefits Schedule (MBS)
- Primary Health Networks (PHNs) commission primary mental healthcare services.

These mechanisms fund services that, for consumers, often appear very similar (Bassilios et al. 2016). The MBS subsidises the Better Access program, while many PHNs fund variants on what was formerly the Access to Allied Psychological Services program. The difference is that the PHN-commissioned services plug ‘gaps’ where the MBS rebate mechanism fails to incentivise providers to offer services. (A similar situation would arise if governments were to adopt the Rebuild model (chapter 23), except that Regional Commissioning Authorities (RCAs) would take on the PHNs’ commissioning responsibilities.

PHNs are not permitted to provide additional funding to MBS-subsidised clinicians (and, by default, neither would RCAs be). 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. PHNs and the majority of headspace centres interpret this clause as meaning that clinicians who receive a salary from headspace or a PHN cannot provide services that receive MBS rebates (headspace, pers. comm., 8 July 2019). These restrictions serve to prevent PHNs from engaging in cost shifting by, for example, providing some funding to providers in their catchments, but encouraging them to bill their services to the MBS.⁵¹

⁵¹ Conceptually, this cost shifting behaviour could be desirable. Were the Commission confident that the social return from each MBS-rebated service was sufficiently high, then any mechanism that expanded access to the MBS would be desirable. However, this is not the case. The Commission found that MBS-rebated services are not ideal in every circumstance (chapter 5). Moreover, while the MBS is formally an

While the Commission supports attempts to prevent cost shifting, the MBS restrictions have negative consequences. Consider a regional PHN or RCA whose catchment has an undersupply of MBS-subsidised clinicians. Given the desirability of a fee-for-service payment model for some types of mental healthcare and the administrative efficiency of the MBS payment mechanism, it may be that a hybrid model offering clinicians a modest salary to relocate to the region but having them bill their services to the MBS is a more cost-effective way to fund primary mental healthcare than the options currently available to PHNs. Likewise, for a PHN or RCA whose catchment has a shortage of bulk billing or low cost MBS-subsidised psychologists, providing a salary or additional payments to MBS-subsidised clinicians in exchange for them lowering their out-of-pocket fees may be more feasible than commissioning a rival lower cost service. In any event, if cost shifting were not a concern, there would be merit in allowing PHNs/RCA's the flexibility to use these hybrid payment mechanisms should they wish to do so. There would be no difference in clinical care from the consumer's perspective.

In addition, the current restrictions are ineffective in preventing all forms of cost shifting that can arise from the siloing of PHN/RCA and MBS rebates. A PHN or RCA need not pay a salary or co-payment to an MBS-subsidised clinician to encourage them to practice in a particular region. For example, 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). These MBS rebates were billed for services provided by in-house clinicians who were not permitted to receive a salary or other co-funding from the PHN under the Health Insurance Act. Nonetheless, if headspace centres do not require clinicians to pay 'market rates' for their tenancy and/or administrative support the centre is effectively subsidising the MBS-subsidised clinician. Moreover, were a PHN to not fund a given headspace centre, the MBS-subsidised clinicians working within that headspace centre conceivably may not have practiced in that PHN's catchment region.

One might counter this argument by saying that the Australian Government, which does bear the costs of the MBS, required PHNs to fund headspace centres knowing that these centres would increase the volume of services billed to the MBS, and so these additional MBS payments do not amount to cost shifting. This point has some merit. However, the current arrangements also incentivise an inefficient *mix* of services within headspace centres — overuse of MBS-subsidised clinicians relative to salaried clinicians, as the PHN pays only for salaried clinicians.

A way to minimise inefficient cost shifting and other perverse incentives and also grant PHNs/RCA's the flexibility to co-fund MBS-subsidised providers is to adjust the size of each PHN's/RCA's mental health funding pool in line with the volume of MBS rebates for mental health services billed in its catchment. This would make PHNs/RCA's bear the costs of any additional MBS rebates that their service funding decisions induce, and thereby enable the Australian Government to safely lift the MBS restrictions. It would also:

uncapped funding stream, registration requirements for doctors and allied mental health professionals effectively cap service volumes. This justifies a more judicious approach.

-
- encourage greater integration between PHNs/RCAs and existing MBS-subsidised clinicians, as PHNs/RCAs would effectively be funding MBS-subsidised providers
 - provide PHNs/RCAs with stronger incentives to educate local GPs (the gatekeepers to MBS-subsidised mental health clinicians) and consumers about low cost services, such as e-mental health therapies, because directing consumers with lower needs away from higher cost MBS-rebated services would save them money.

Options for linking MBS and PHN/RCA funding

The Commission is proposing two options for linking the size of each PHN's/RCA's mental health funding pool to the MBS rebates for mental health services billed in its catchment. We are seeking further feedback from stakeholders on the pros and cons of these options.

Linkage based on projected use of MBS-rebated services

One option is to have a coincident reconciliation of PHNs'/RCAs' pools and MBS subsidies. This would require a projection of prospective MBS rebates for eligible mental health services (over, say, one year). This total funding pool (existing PHN/RCA funds plus projected MBS subsidies) would be held by the PHN/RCA, but MBS subsidies would be deducted as services are used. PHNs/RCAs would also receive near real-time data about these deductions.

For PHNs, this arrangement would bring some risks. PHNs would effectively be funding services over which they have limited control. If the prospective MBS rebates were greater than expected for reasons outside a PHN's control, that PHNs could struggle to meet its obligations to contracted providers. The Commission's proposed expansion of the Better Access program (draft recommendation 5.5) could amplify this risk in the short term. Demand for MBS-rebated services has proved difficult to estimate in the past. For example, Better Access was projected to cost \$538 million in the first five years at the time of its introduction, but actual outlays were \$1.8 billion (Rosenberg and Hickie 2019b).

There are several ways of mitigating these risks.

- Allowing adequate time for the impacts of other reforms on use of MBS-rebated services to be properly understood before implementing the linkage.
- Committing to provide additional funding at short notice to any PHN that experiences budgetary issues to ensure continuity of service and business certainty for PHNs. This would, of course, need to be accompanied by auditing of PHNs with action taken if mismanagement were found to be the source of the problem.

For RCAs, these risks would be more manageable. Their co-funders, State and Territory Governments, would be able to provide additional funding were MBS payments greater than expected. If necessary, State and Territory Governments could adjust the volume of their own contributions to guarantee several years of funding for RCA commissioning.

Linkage based on past use of MBS-rebated services

Another option is to introduce a lag to the process, so that the size of each PHN's/RCA's funding pool is related to the historical volume of MBS rebates in their region (box 24.1). This arrangement would be substantially simpler and less risky to operationalise, as it would negate the need to forecast prospective MBS rebates.

For PHNs, this option would also be consistent with recent policy changes by the Australian Government to provide certainty of funding three years ahead, which has increased PHNs' scope to provide longer-term contracts to providers (NMHC 2019c). However, it would only be effective at making PHNs internalise the costs of increased MBS rebates if they are able to consider the future budgetary impacts of their decisions. Hence, while the Commission is leaning toward a linkage based on past use of MBS-rebated services, it is seeking further feedback from stakeholders about which is likely to be the better arrangement in the PHN context.

Box 24.1 Linkage based on past use of MBS-rebated services — a worked example

Linkage based on past use of MBS-rebated services is best understood by way of example. Suppose that:

- there is only one PHN
- the Australian Government decides to determine how much funding it will allocate to the PHN based on the volume of MBS-subsidised allied mental healthcare billed in the PHN's region in a prior period, say, three years prior.

Then the linkage would proceed as follows. At the start of 2018-19, the Australian Government would inform the PHN that the maximum amount of funding it could receive for its Mental Health Flexible Funding Pool 2021-22 would be, say, \$100 million. Suppose also that in 2018-19, actual MBS rebates for mental healthcare in the PHN's region were \$30 million. At the end of 2018-19, the Australian Government would inform the PHN that the size of its Mental Health Flexible Funding Pool in 2021-22 will be \$70 million.

For RCAs, linkage on the basis of past use of MBS-rebated services is relatively less appealing given that:

- the arrangement would need to be specified in the proposed National Mental Health and Suicide Prevention Agreement (chapter 22), which would necessitate the agreement having a long lifespan in order to generate the desired incentives for RCAs
- as noted above, State and Territory Governments could adjust the volume of their own contributions to guarantee several years of funding for RCA commissioning.

Scope of the linkage arrangement

The MBS-rebated services most suited to being linked to the size of PHN/RCA mental health funding pools are those that most closely substitute for PHN/RCA commissioned services (this principle was established in chapter 23). In particular:

- *allied mental health professionals* (MBS rebates should be linked in) — these services are currently funded both via the MBS (47% of mental health-related MBS rebates in 2016-17 (AIHW 2019n)) and by PHNs, and would be funded by RCAs. Hence, these services should be incorporated into the linkage arrangement for both the Renovate and Rebuild models
- *psychiatrists* (MBS rebates should not be linked in) — these services are currently subsidised via MBS rebates (29% of mental health-related MBS rebates in 2016-17 (AIHW 2019n)) but not generally by PHNs. Therefore, there is not a strong case for inclusion under the Renovate model. And, while RCAs would provide funding to public psychiatry, MBS rebates also fund these services in private hospitals, which are outside the scope of RCA arrangements. Hence, there is not a strong case for inclusion under the Rebuild model either.
- *GPs* (MBS rebates should not be linked in) — GP services are currently subsidised via MBS rebates (24% of mental health-related MBS rebates in 2016-17 (AIHW 2019n)), do not receive funding from PHNs in relation to the provision of mental health services, and would not receive funding from RCAs. Nor are the services that they provide through MBS-rebated mental health items especially substitutable with PHN/RCA-funded services. For example, GPs occupy a unique gatekeeper role that has no PHN/RCA-funded equivalent.

Removal of restrictions on co-funding MBS-subsidised providers

With the incentives for cost-shifting removed, the Commission favours relaxing the restrictions in the *Health Insurance Act 1973* that prevent PHNs (and would prevent RCAs) from co-funding MBS-subsidised allied mental health professionals.

There are also other potentially desirable payment arrangements that the current restrictions prevent. State and Territory Governments (including Local Hospital Networks (LHNs)) are not usually permitted to provide additional funding to MBS-subsidised clinicians under the current rules.

Under the Renovate model, it would be desirable for State and Territory Government funds to be directed to MBS-subsidised clinicians where this reduces avoidable hospitalisations or enables services to meet demand in a region. In relation to services delivered by MBS-subsidised allied mental health professionals, this can be solved by allowing State and Territory Governments to provide additional funding for these services on the condition that this is governed by an agreement with the relevant PHN.

A further complication is that, of the suite of MBS-rebated services, out-of-hours GP services may be particularly useful at preventing mental health-related presentations at emergency departments (chapter 8). As the Commission is not suggesting that funding for these services be linked to PHN/RCA mental health funds, PHNs/RCAs should not be automatically relied on to determine whether the State/Territory Government should be able to co-fund the service in question.

A pragmatic solution (under the Renovate model) would be to allow State/Territory Governments to co-fund these services with the agreement of the PHN, but the Australian Government (which *would* bear the additional costs) should issue guidance to PHNs on the circumstances under which they should allow or disallow these requests.

Distribute PHN funding on a needs basis

If governments were to adopt the Rebuild model, the Commission has suggested that the Commonwealth Grants Commission recommend how Australian Government funding for RCAs is allocated between the RCAs. This is consistent with the recommendations of the previous section as the methodology would take account of the volume of MBS rebates that each RCA catchment receives. The overall aim would be to further geographic equity by taking account of exogenous factors that influence the cost of providing services, such as the remoteness and age of each region's population and their need for culturally appropriate services.

For the Renovate model, the same principles should apply when determining the allocation of PHN mental health funds among PHNs. In order to achieve an equitable geographic spread of services, the distribution of PHN mental health funds must neuter the sharp geographic inequities in the distribution of MBS-subsidised clinicians, which is a consequence of clinician preferences and the MBS payment model (box 24.2).

The current method of distributing the PHN Mental Health Flexible Funding Pool (box 24.3) goes some way toward achieving geographic equity. To demonstrate its impacts, the Commission has ranked PHN catchment regions by level of *need* for primary mental health funding (with higher need reflecting higher costs of service delivery), and examined the total amount of mental health funding each receives on a per-capita basis (figure 24.1). Generally speaking, the distribution of the PHN funding is sufficient to cancel out inequities in the distribution of the MBS rebates, and *total* per-capita funding is higher in areas of greater need.

Nevertheless, there is scope for improvement. The existing methodology (box 24.3) is somewhat ad-hoc. It only partially accounts for the quantity of MBS rebates that each PHN catchment region receives, and does not apply a needs-based weighting scheme when doing so. As a result, per-capita funding does not uniformly increase with need.

The Commission's preferred funding model would be to apply a transparent and evidence-based weighting scheme to determine a target *overall* (MBS and PHN) allocation

to each region, and then apply this according to the methodology used to link MBS and PHN mental health funding in each region.

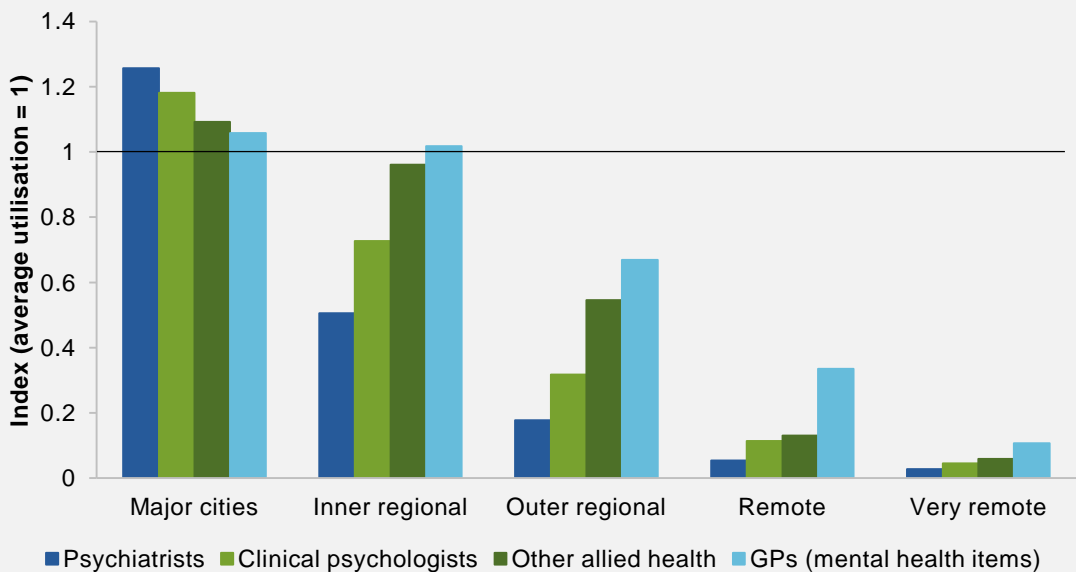
Box 24.2 Geographic inequities in the distribution of MBS-rebated mental health services

Total funds paid under MBS rebates disproportionately benefit urban areas, as consumer utilisation of all provider types decreases sharply with remoteness. This is a consequence of the MBS payment model. Providers are paid a uniform rebate, have autonomy in choosing where to locate, and can charge consumers an out-of-pocket payment if they desire. Hence, they tend to favour locations that:

- allow them, by virtue of income levels in a region, to charge higher out-of-pocket payments for their services. Typically, this will drive providers toward wealthier areas
- meet their own preferences (in relation to amenities and the costs of living and doing business) (Fels, sub. 303).

Medicare Benefits Schedule funding disproportionately benefits urbanites

Relative utilisation of MBS rebates by remoteness of consumer for selected healthcare professionals, 2007–2011



Source: Productivity Commission estimates based on Meadows et al. (2015, table 2).

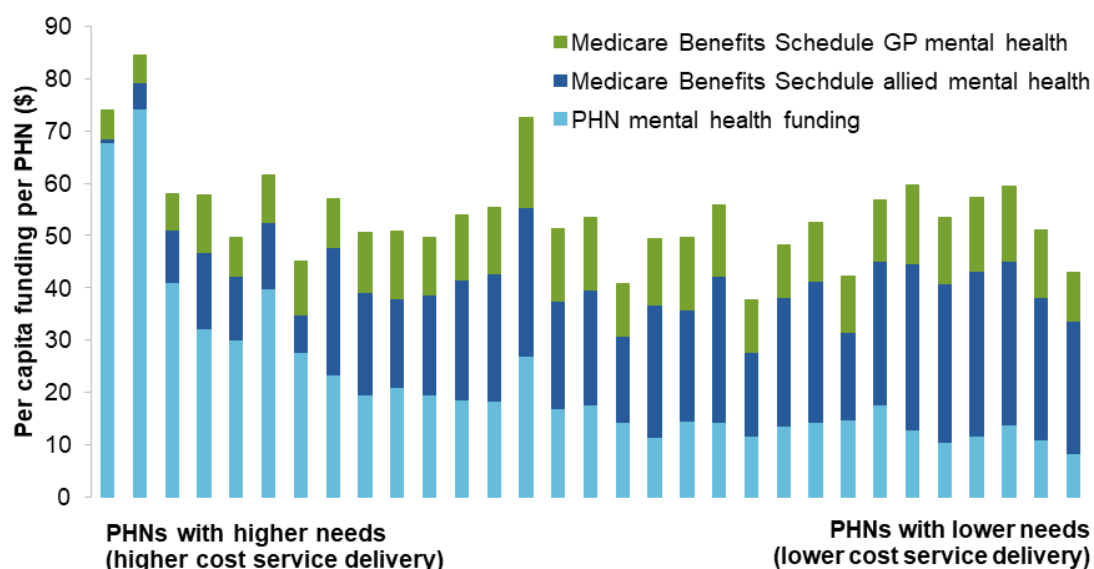
Box 24.3 How PHN mental health funds are distributed

At present, the Primary Health Network (PHN) Mental Health 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 rebate
 - 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 weighting schemes or a similar weighting scheme.

Source: DoH (pers. comm., 9 October 2019).

Figure 24.1 **Distribution of mental health funding among PHN regions^{a,b}**
Estimated 2017-18 funding, by PHN



^a MBS subsidies are based on 2016-17 expenditures inflated to match growth in expenditure on the relevant MBS items to 2017-18. ^b PHN needs are ranked according to the adjustments that the Independent Hospital Pricing Authority's national non-admitted activity-based funding prices make for Indigeneity and remoteness.

Source: Productivity Commission estimated based on IHPA (2019b) and unpublished data supplied by the Department of Health.

DRAFT RECOMMENDATION 24.1 — FLEXIBLE AND POOLED FUNDING ARRANGEMENTS

MBS-rebated and regionally commissioned allied mental healthcare should be funded from a single pool, and commissioning agencies should be able to co-fund MBS-rebated allied mental health professionals. State and Territory Government agencies should be permitted to co-fund MBS-rebated out-of-hours GP services where this will reduce mental health-related emergency department presentations.

In the short term (in the next 2 years)

The Australian Government Minister for Health should issue a direction in relation to section 19.2 of the *Health Insurance Act 1973* (Cth) that allows State and Territory Government agencies to provide additional funding to MBS-rebated out-of-hours GP services, with the agreement of PHNs. 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.

In the medium term (over 2 – 5 years)

MBS rebates for allied mental healthcare should be explicitly linked to commissioning agencies' (PHNs or RCAs) mental health funding pools, so as to create a single budget from which all primary allied mental healthcare would be funded.

Once this linkage has been established, the Minister for Health should issue a direction in relation to section 19.2 of the *Health Insurance Act 1973* (Cth) that:

- allows commissioning agencies (PHNs or RCAs) to provide additional funding to allied mental health professionals whose services receive MBS rebates
- allows other Australian, State and Territory Government agencies to provide additional funding to MBS-rebated allied mental health professionals with the agreement of commissioning agencies (PHNs or RCAs).

INFORMATION REQUEST 24.1 — REGIONAL FUNDING POOLS

The Productivity Commission is seeking further feedback on its proposals for implementing draft recommendation 24.1.

If the Commission were to adopt the Renovate model:

- *What would be the pros and cons of our proposal to implement this recommendation by linking PHN mental health funding with projected MBS-rebates for allied mental healthcare?*
- *What would be the pros and cons of our proposal to implement this recommendation by linking PHN mental health funding with past MBS-rebates for allied mental healthcare?*
- *Do you have another proposal for how draft recommendation 24.1 might be implemented?*

If the Commission were to adopt the Rebuild model, our preference would be to link RCA mental health funding with projected MBS-rebates for allied mental healthcare. Is there any reason that funding linkage should be undertaken on a different basis?

24.2 Restrictions on regional funding pools

At present, about 40% of the PHNs' Mental Health Flexible Funding Pool covers centralised commitments, with about 32% devoted to headspace (including the headspace youth early psychosis program) and about 8% devoted to mental health programs for Aboriginal and Torres Strait Islander people. The remaining 60% is allocated at the PHNs' discretion (Primary Health Network Advisory Panel 2018). If governments were to adopt the Rebuild model (chapter 23), these services would fall within RCAs' scope.

This approach of hypothecating some funding for certain purposes was initially implemented as a transitional mechanism to ensure service continuity, but there are indications that it is becoming a permanent fixture of the PHN mental health program. The Australian Government's response to the 2014 review of the National Mental Health Commission said that PHNs would be provided with a 'flexible' funding pool, and made no mention of a quarantining of funding for particular purposes (DoH 2015). 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 nd, 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 2019d). While a decision to maintain the existing controls for a longer timeframe could be interpreted as a lengthening in the transition period, the

commitments to new centres amount to a tacit policy change of recentralising some control of PHN primary mental health programs.

Is this hypothecated funding justified?

The Commission's framework set out in section 23.3 suggests two possible grounds for centralising control of PHN funds. First, it could be the case that providing the centrally committed services in one PHN's region is beneficial to another PHN's region (this is called a positive 'spillover' or 'externality'). While the PHN in question would have no reason to consider these spillover benefits in its planning, the Australian Government would. There may be some validity to this point in relation to headspace, by virtue of its use of branding. A recent academic paper suggested that headspace's value partially derived from its consistent national branding:

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)

This branding effect could suggest that one PHN's choice to fund a headspace centre increases the value of headspace centres in other PHN catchments by further promoting the headspace brand. But to the extent that the value of having a headspace centre in a given location derives from the national media attention afforded to headspace rather than people moving around and becoming familiar with centres in other parts of Australia, these spillovers may be modest.

A second potential justification for centralising control of some PHN funds is that Australian Government is privy to information about valuable ways to use this funding that the PHNs are not. PHN capabilities are certainly not perfect — 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 a commensurate diminution in their progress. (Primary Health Network Advisory Panel 2018, p. 4)

That said, the Commission has not been presented with any evidence that suggests that the Australian Government is better placed than PHNs to make decisions about whether to fund headspace centres. In any event, if the Australian Government has these concerns, it is not clear why they would apply to headspace and not the services that PHNs choose to commission.

Some exceptions in favour of hypothecation

One exception to the arguments above relates to mental health programs for Aboriginal and Torres Strait Islander people. The Australian Government may be justifiably concerned that some PHNs would lack adequate cultural understanding and awareness to commission these programs were they not required to do so. For this reason, the Commission sees merit in maintaining the hypothecation of funding for mental health programs for Aboriginal and Torres Strait Islander people.

Another exception arises if a PHN is provided additional funding to undertake a trial of a particular activity.

The path forward

In light of these considerations, the Commission considers that the Australian Government should immediately cease hypothecating portions of the PHNs' Mental Health Flexible Funding Pool for headspace services (including the headspace youth early psychosis program). It should be a decision for PHNs whether, and to what extent, to fund headspace centres in their region, in preference to other services. And, were governments to adopt the Rebuild model, there should be no requirement that RCAs commission headspace centres either.

In making this recommendation, we are cognisant that the control that headspace National exerts over headspace centres may limit the scope for PHNs to adapt headspace centres as they see fit. headspace operates through a franchise model — individual headspace centres are operated by independent organisations, while headspace National ensures adherence to the headspace model. Meanwhile, for other PHN-commissioned services, PHNs perform this quality assurance role.

DRAFT RECOMMENDATION 24.2 — REGIONAL AUTONOMY OVER SERVICE PROVIDER FUNDING

In the short term (in the next 2 years)

The Department of Health should cease directing PHNs to fund headspace centres, including the headspace Youth Early Psychosis Program, and other specific service providers. PHNs should be able to continue funding headspace services or redirect this funding to better meet the needs of their local areas as they see fit.

In the medium term (over 2 – 5 years)

There should be no requirements that commissioning agencies (RCAs or PHNs) have to fund particular service providers.

24.3 Changes to intergovernmental funding arrangements

Earlier in the report, the Commission recommended substantial increases in funding for State and Territory Government housing and education programs (chapters 15 and 17). As set out in chapter 23, the Commission's view is that the Australian Government should fund a substantial contribution toward any significant increases in expenditure on State and Territory Government-provided services, given its access to more efficient tax bases and greater scope to grow those bases.

Intergovernmental transfers for housing and homelessness services

In chapter 15, the Commission proposed an increase in funding to housing and homelessness services — a State and Territory Government responsibility — of \$450 million–\$1.2 billion per annum. Of this, about \$100–\$600 million would be for additional mental health care 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 health care (and other government services) that would be primarily captured by State and Territory Governments, it nevertheless involves a significant upfront increase in expenditure. For the reasons set out above, the Australian Government should provide at least the majority of the additional funding.

The Australian Government provides funding to State and Territory Governments to deliver housing and homelessness services according to the 2018 National Housing and Homelessness Agreement. This funding amounted to \$1.7 billion in 2018-19 (COAG 2018b).

In its current form, the National Housing and Homelessness Agreement does not provide scope to substantially increase Australian Government funding to housing and homelessness services. Unlike the National Health Reform Agreement, which links increases in Australian Government transfers to growth in State and Territory Government expenditure on a defined set of services (chapter 23), transfers under the National Housing and Homelessness Agreement are indexed to wage growth.

There are two ways that the Australian Government could increase its funding to housing and homelessness services. It could provide another payment to State and Territory Governments in addition to the National Housing and Homelessness Agreement, or it could renegotiate the terms of the existing agreement with a view to expanding the quantum the transfers under the agreement.

The Commission prefers the second option as housing is an area necessitating ongoing funding security. If agreed by all parties to the agreement, as part of the next negotiation for the National Housing and Homelessness Agreement, the Australian Government should

consider an increase in the total State and Territory Government funding for housing and homelessness services in order to meet ongoing stable housing needs of those people with mental illness, as outlined in draft recommendation 15.2.

DRAFT RECOMMENDATION 24.3 — THE NATIONAL HOUSING AND HOMELESSNESS AGREEMENT

In the medium term (over 2 – 5 years)

As part of the next negotiation of the National Housing and Homelessness Agreement, the Council of Australian Governments should increase the quantum of Australian Government funding for State and Territory Government-provided housing and homelessness services. State and Territory Governments should use this additional funding to expand their provision of housing and homelessness services for people with mental illness.

Intergovernmental transfers for school-based services

The Commission is proposing a significant expansion of school-based mental health services (chapter 17). As with existing school funding arrangements, State and Territory Governments would be responsible for administering funding for these services at public schools.

In this case, State and Territory Governments should fund these services out of their existing budgets, rather than the Australian Government. Several State and Territory Governments already fund similar initiatives, and some could redirect funding from existing programs that aim to deliver similar outcomes, but whose scope and scale is at times insufficient to support student mental health and wellbeing across the entire population. For example, the NSW Government funds public schools to employ ‘head teachers — wellbeing’, but this funding could be redirected toward employing school wellbeing leaders (chapter 17).

24.4 Toward more innovative payment models

So far, this chapter has not taken an especially long-term view of development of innovative payment models for mental healthcare. This reflects the relatively paucity of research and data (both in Australian and abroad) about the relative merits of more sophisticated ways of paying providers of mental health services. But it is worth considering ways in which the healthcare system can support the development of innovative payment 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 a *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 a patient (as is the case under activity-based funding (ABF; chapter 23)), LHNs could instead receive a quarterly payment for each patient within their care and have flexibility to provide care in their preferred setting. This would strongly incentivise the LHN to *prevent* avoidable hospitalisations, whereas the ABF approach can *encourage* hospitalisations (chapter 23).

That said, capitation payment models are not a panacea. They can encourage ‘underservicing’ (PC 2017e). And they are 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). Given the challenges of developing an ABF casemix classification for mental healthcare (chapter 23), a capitation casemix would probably not be feasible for some time.

Rigidities in the existing system

In this chapter, the Commission has laid out a path toward a mental health system that utilises greater regional decision making. Are there barriers that prevent regional decision makers (PHNs, LHNs, or RCAs, as the case may be) from pursuing innovative payment models for mental health services? If so, what can be done about them?

While the Commission considers the MBS to be the most suitable way to fund most primary mental healthcare at this time, it is nevertheless a rigid system. Several stakeholders raised the possibility of granting PHNs the option of ‘cashing out’ MBS payments — administering this funding through a means of their choosing (Deakin Health Economics sub. 156; RANZCP sub. 385). And the Western Sydney PHN has previously proposed primary mental healthcare funding arrangements that place a greater emphasis on regional commissioning (WentWest 2015). There is merit to these proposals, provided that the PHN or RCA in question has demonstrated good performance in the past and there are strong accountabilities.

As regards more acute care, a distinction should be made between the Renovate and Rebuild models. Under the Renovate model, payment models are somewhat locked-in as the Australian Government makes direct payments to LHNs on an ABF basis (chapter 23). However, there is scope under the National Health Reform Agreement for the Australian Government to convert an existing ABF funding stream to block funding should a State or Territory Government indicate that it wishes to trial an innovative funding model (IHPA 2019c). 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 patients with chronic and complex health needs (VIC DHHS 2017a).

While this aspect of the National Health Reform Agreement is positive, it would be more efficient for the Independent Hospital Pricing Authority to take the lead in devising these models rather than State and Territory Governments.

Under the Rebuild model, there would be scope for payment model innovation in more acute care as RCAs would have some discretion over the way that they pay for LHN-provided services.

Trials and evaluations are needed

Only carefully designed and evaluated trials would indicate which new approaches would work. But trialling and evaluating a new way of doing things is costly and risky. A concern is that PHNs, State and Territory Governments and/or RCAs would be unwilling to take on these risks when they could wait for one of their counterparts to do so. This motivates a role for the Australian Government in providing additional funding to support trials, on the proviso that they are independently evaluated to a high standard and the findings are made publicly available.

There is precedent, both in the mental health sector and in the health system more broadly, for the Australian Government playing such a role. Within the mental health sector:

- the 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 establishment 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 (Eagar et al. 2005). These trials were evaluated.

As for the broader health system, the Australian Government has recently established a ‘Health Innovation Fund’. Under this arrangement, NSW and WA 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). NSW and WA are required to report performance data and provide an evaluation of these projects to the Australian Government.

The Commission sees an ongoing role for trials and evaluations, regardless of whether it recommends that governments adopt the Renovate or Rebuild model in its final report. This would be best served by a designated Mental Health Innovation Fund that could support ambitious trials on the scale of the National Mental Health Integration Program.

DRAFT RECOMMENDATION 24.4 — TOWARD MORE INNOVATIVE PAYMENT MODELS

In the long term (over 5 – 10 years)

The Australian Government should establish a Mental Health Innovation Fund to trial innovative system organisation and payment models. Commissioning agencies (PHNs or RCAs) could apply for additional funding to trial new models under the proviso that they have them independently evaluated and share the findings.

As part of these trials, and with appropriate governance arrangements in place, commissioning agencies (PHNs or RCAs) should be permitted to cash-out Medicare Benefits Schedule rebates for allied mental health professionals in their regions and administer this funding through a means of their choosing.

24.5 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 around 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 24.4). It is outside the scope of this inquiry to consider the merits of this policy, and the Commission has not formed a view on whether it would be desirable to substantially change the scope of PHI (for example, to cover all primary mental healthcare). Nor has the Commission examined the appropriateness of the subsidies and tax breaks that consumers receive for taking out PHI, or the thorny 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 24.4 **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 (MBS) 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 MBS rebates (including psychology).

Regulatory environment

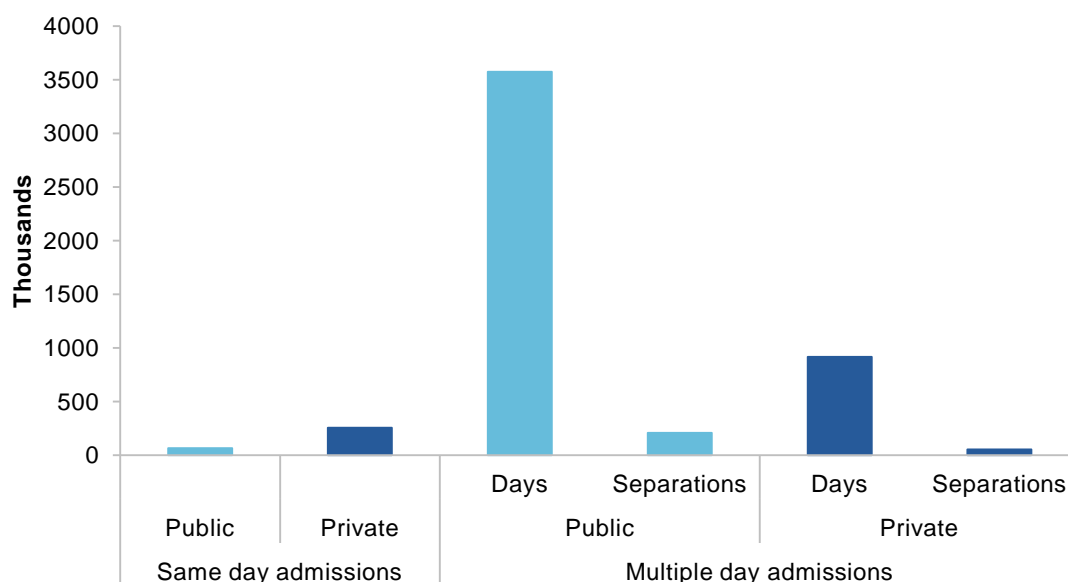
The private health insurance market is tightly regulated.

- 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 (to incentivise people aged under 30, 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, with private hospitals generally servicing a population with less acute mental health conditions. In 2016-17, private hospitals provided 80% of mental health-related same day admissions, but only 20% of multiple day admissions and 20% of multiple-day care (figure 24.2). 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 24.2 Public and private hospital admissions and days of care
 Number of mental health-related public and private hospital admissions and days of care, 2016-17



^a The counts of 'separations' indicate the numbers of multiple-day episodes of care completed. For example, if a patient is admitted for a three day period, this will be recorded as three days of care and one separation.
 Source: AIHW (2019z, 2019x).

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, given that private health insurers face strong incentives to prevent hospitalisations among their insureds, the Commission considers that the regulatory framework should ideally:

- permit (but not require) private health insurers to fund services outside of hospitals that could prevent their hospital cover holders from requiring hospitalisation
- 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 limited 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 hospital that are eligible for MBS rebates (irrespective of whether the rebate is claimed or not). But there are exceptions for services that:

- are designated as 'hospital substitutes' (under the Private Health Insurance (Health Insurance Business) Rules 2018 (Cth), s.10). As Bupa ANZ 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. (sub. 485, p. 10)

There are no mental health-related items currently designed as hospital substitutes.

- 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 ANZ 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. (sub. 485, p. 10)

Some private health insurers have aimed 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 ANZ both argued for changes to 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 ANZ (sub. 485), proposed that additional MBS-rebated mental health services be deemed ‘hospital substitutes’ (therefore permitting PHI co-funding). It would appear that these approaches could produce similar results, and hence the Commission does not have a preference between them.

In addition, Bupa ANZ 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 the 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. (sub. 485, p. 11)

Some efforts at reform are currently afoot. 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 2018e)

The Private Health Ministerial Advisory Committee was unable to provide the 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 2018m).

The Commission supports the objectives of this Working Group, but would welcome further transparency. The Australian Government should extend the work into a larger and more public review of the regulatory framework.

DRAFT RECOMMENDATION 24.5 — PRIVATE HEALTH INSURANCE AND FUNDING OF COMMUNITY-BASED HEALTHCARE

In the short term (in the next 2 years)

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.

24.6 Life insurance

Life insurers, which provide income protection insurance products, are currently not permitted to fund mental health services 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 illness among their insureds, lest it lead to insurance claims in the event that they become unable to work. For these reasons, MetLife Insurance (sub. 443) and the Financial Services Council (sub. 535) argued that life insurers should be permitted to fund mental health treatments.

This issue was considered at a 2018 Parliamentary Joint Committee inquiry into the Life Insurance Industry (Parliamentary Joint Committee on Corporations and Financial

Services 2018). That inquiry declined to recommend regulatory changes on the basis that it had not had adequate time to properly consider the issue and because of concerns raised by Beyond Blue that clinicians who are funded by life insurers may be pressured to inappropriately recommend that a patient return to work.

The Commission acknowledges these concerns, but considers that appropriate regulation and ethical convictions on the part of clinicians should be sufficient to manage the issue. For example, the life insurance industry code of conduct could be amended to prevent life insurers making payments to clinicians on the basis of the number of patients that they are able to have return to work or otherwise pressuring clinicians to engage in such behaviour.

With these issues managed, the Commission sees a strong case for permitting life insurers to fund mental health treatments on a discretionary basis.

DRAFT RECOMMENDATION 24.6 — LIFE INSURERS AND FUNDING OF MENTAL HEALTHCARE

In the short term (in the next 2 years)

The Australian Government should permit life insurers to fund mental health treatments for their income protections 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.

25 A framework for monitoring, evaluation and research

Monitoring, evaluation and research matter because ...

- Governments and service providers need to be accountable to the public in their decision making.
- Decision making by governments, service providers and consumers can be informed by quality monitoring, evaluation and research.
- Monitoring, evaluation and reporting can be used to promote innovation and continuous quality improvement, and ultimately improve outcomes for people with mental illness and their carers.

Successful reform requires ...

- Improve monitoring and reporting of outcomes, social determinants and impacts of mental ill-health at regional levels. This would increase transparency and enable comparisons on a consistent basis.
 - Ensure that data needed for making system improvements and for improving the decision making capacity of consumers is collected, translated into useful information, and published. This should include data at the service provider level.
 - Strengthen national leadership, guidance and the coordination of mental health program evaluations and the promotion of research activities necessary for continued improvement of policies, programs and services.
-

Monitoring, reporting and information arrangements have supported decision making and policy design in mental health since the *National Mental Health Strategy* commenced in 1992. Decision makers rely on a wide range of data and information to develop mental health and suicide prevention reforms and policies, and to decide which programs and services to fund. A robust evidence base is necessary to ensure that the mental health system is improving outcomes for consumers and carers, and using taxpayers money effectively and efficiently.

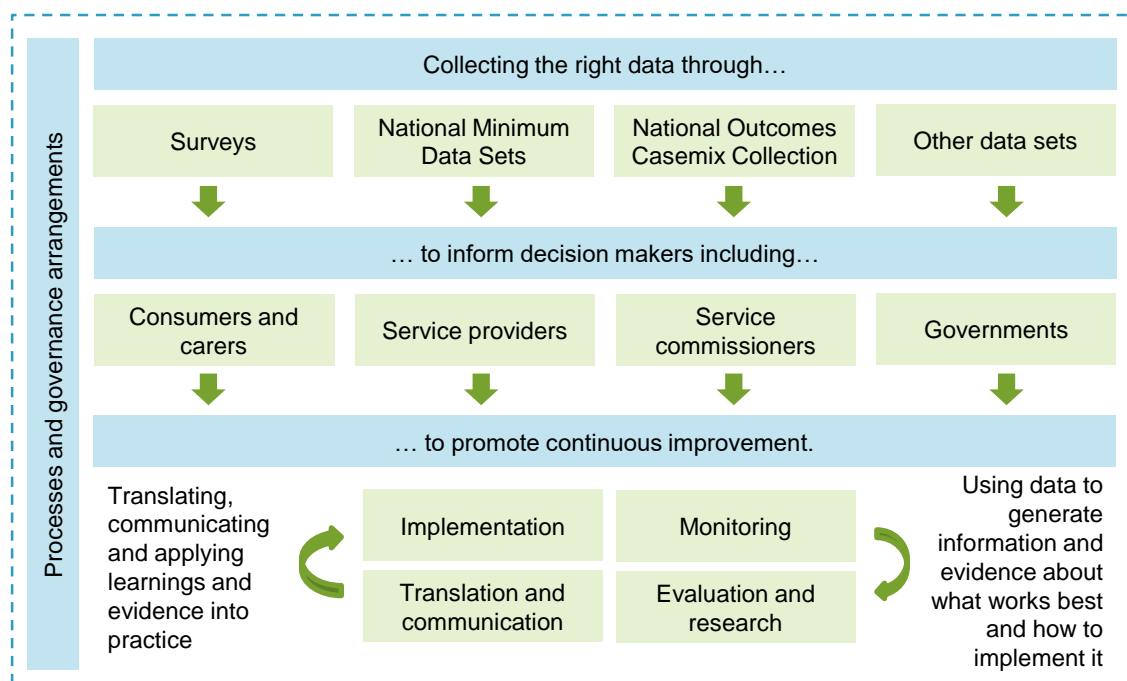
... information on [the prevalence of mental disorders, the costs of mental ill-health, treatment outcomes and service quality] is crucial if policy makers are to commit greater resources to mental health care, to prioritise areas of greatest need, and make sensible decisions about effective and efficient care for mental ill-health. A better information infrastructure will be the foundation of stronger mental health systems. (OECD 2014b, p. 19)

However, many inquiry participants and past reviews highlighted the limitations of the current arrangements for monitoring, evaluation and research (AIHW, sub. 370; CHF, sub. 496; Mendoza et al. 2013; NMHC 2014e, vol. 1; sub. 118). The costs of inadequate data and information to guide decision making and promote accountability can be significant. It can lead to government expenditure on ineffective and costly interventions that reduce public confidence in the mental health system (AHMC 2009; COAG Health Council 2009). Data collection must be cost effective and governments must avoid collecting data that would be rarely used.

Currently, there is no overarching framework that guides and unifies monitoring, evaluation and research in mental health and related sectors, despite the considerable amount of activity that occurs. As a consequence, some aspects are likely being 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 Commission is proposing a high-level framework that sets out how improved processes and institutional arrangements could better support monitoring, evaluation and research, that aims to generate the right *information* to drive continuous improvement and promote accountability (figure 25.1). The framework is based on a set of key principles (box 25.1).

Figure 25.1 **Proposed framework for monitoring, evaluation and research**



Source: Adapted from PC (2016a).

Box 25.1 **Key principles for guiding monitoring, evaluation and research**

The Commission's proposed framework for monitoring, evaluation and research (figure 25.1) is based on the principles of being:

- fit-for-purpose — data collected should be used to inform decision makers at all levels of the mental health system (including consumers and carers, governments, service planners and commissioners and providers)
- supporting continuous improvement — information from monitoring, evaluation and research should be used to support continuous improvement in mental health outcomes
- independent — bodies undertaking monitoring, evaluation and research should be independent from the responsible policy and program areas
- transparent — monitoring, evaluation and research should be made publicly available through appropriate, ethical and collaborative consent processes
- person-centred — monitoring, evaluation and research should ultimately aim to improve outcomes for people with mental ill-health and their carers. Monitoring should include patient reported experience measures and patient reported outcome measures where possible
- culturally appropriate — bodies undertaking monitoring, evaluation and research should consider different cultural needs that may impact 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 Commission has applied this framework to analyse current issues facing the mental health system and proposed reforms to:

- data collections and processes (section 25.1)
- monitoring and reporting activities (section 25.2)
- evaluation (section 25.3)
- research (section 25.4).

25.1 Data collection and use

In order to effectively undertake monitoring, evaluation and research, the right data needs to be collected. This includes investing in data that is of high quality. The *ABS Data Quality Framework* sets out dimensions for assessing data quality, such as relevance, timeliness, accuracy and consistency (ABS 2009).

Over time, Australia has developed the capacity to collect a considerable amount of mental health data to support decision making and promote accountability. All of the National Mental Health Plans have prioritised data development and management activities since COAG introduced the *National Mental Health Strategy* in 1992.

This section describes the existing data landscape, highlights areas where data is underutilised, where gaps exist and identifies and recommends reforms to address such issues.

Data landscape

There is a large amount of data collected and reported at the national level in mental health relative to other areas of health and welfare (AIHW, sub. 370). Currently, major data collections (table 25.1) comprise:

- National population surveys — providing information on population outcomes and the characteristics of people with mental health problems, including the *ABS Survey of Mental Health and Wellbeing* (1997, 2007) (ABS 2008), child and adolescent mental health surveys (1998, 2014) (Telethon Kids Institute 2019) and surveys of low prevalence (psychosis) disorders (1998, 2010) (Morgan et al. 2011).
- Five mental health national minimum datasets (NMDS) — including State and Territory data and more recently Primary Health Networks (PHN) data. Reporting on NMDS is mandatory, but can allow exclusions for some service providers. For example, it is optional for non-government organisations (NGOs) to provide data for the residential mental healthcare NMDS.
- A National Outcomes and Casemix Collection (NOCC) — collecting outcomes data from State and Territory public sector specialised mental health services (box 25.2).

- Other health datasets — including admitted patient and emergency department data collections, Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) payments data and wider health workforce data.

Table 25.1 Major data collections in mental health

Survey data	
ABS National Survey of Mental Health and Wellbeing (1997, 2007)	Prevalence of selected mental disorders, demographics, medication, comorbidity, employment and education characteristics of people aged 16–85 years
ABS National Health Survey (pre-2000, 2004-05, 2007-08, 2011-12, 2014-15, 2017-18)	Psychological distress, various mental health conditions, demographics, medications, comorbidity, employment and education characteristics of people aged 15 years and older
Low prevalence (psychosis disorder) surveys (1998, 2010)	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 impact of illness including on functioning
Child and adolescent surveys (1998 and 2014)	Prevalence of selected mental disorders, severity, impact on schooling, service use of people aged 4–17 years
National Minimum Data Sets (NMDS)	
Mental health establishments	Expenditure and activity (for example, bed and staff numbers) for public sector specialised mental health- services
Admitted patient care	Same day and overnight admitted mental healthcare
Residential mental healthcare	Care in residential mental health services. NGO services receiving government funding is optional
Community mental healthcare	Community or ‘ambulatory’ mental health services
Primary mental healthcare	Activity and outcomes data of primary mental healthcare services commissioned by primary health networks
Outcomes and casemix collection	
National Outcomes and Casemix Collection (NOCC)	Consumer outcomes data from public sector specialised mental health services
Other datasets	
Medicare Benefits Schedule and Pharmaceutical Benefits Scheme	Administrative payments data
National Health Workforce Dataset	Registration and survey data collected through the registration process for registered health practitioners
Your Experience of Service (YES) survey	National consumer and carer experience surveys implemented in New South Wales, Victoria and Queensland
Mental health seclusion and restraint non-admitted patient National Best Endeavours Data Set (NBEDS)	Seclusion and restraint events at the hospital level for public sector specialised mental health hospital acute service units, including short stay mental health units

Box 25.2 **National Outcomes and Casemix Collection**

The Australian Government Department of Health funded the establishment of the Australian Mental Health Outcomes and Classifications Network (AMHOCN) in 2003 to develop outcomes measurement and casemix concepts in mental health. AMHOCN comprises three organisations that provide collection services, research and analysis and training and secretariat services:

- Strategic Data Pty Ltd — responsible for managing data routinely collected by clinicians in State and Territory specialised public mental health services. This data is known as the *National Outcomes and Casemix Collection* (NOCC)
- the University of Queensland — responsible for analysis, research and development of the NOCC data
- the Health Education and Training Institute — responsible for training and service development in relation to the NOCC data.

The NOCC comprises a range of clinician and consumer rated outcome measures. Different measures apply for different target age groups and service settings, and were selected following literature reviews, consultations with stakeholders and empirical trials.

Clinicians providing specialised public mental health services are *mandated* by the Australian Government to assess consumers presenting for care using the relevant clinician-rated outcome measure. Clinicians are also expected to use consumer-rated measurement tools, although this is not mandatory. Around 85% of all specialised public mental health services submit outcomes data. In contrast, the submission rate for consumer self-reported measures range from 10% to 69% across jurisdictions.

Data from these assessments are collected at the local level, collated by State and Territory Governments, and then submitted to AMHOCN. The Australian Government envisioned AMHOCN to support benchmarking activity, enabling services to access regular reports on performance relative to similar services to drive a quality improvement cycle.

Source: AMHOCN (2019c); DoH (2011); Burgess, Pirkis and Coombs (2015).

The Australian, State and Territory Governments are continuing work on initiatives to improve data collection, including jointly under the auspices of the COAG Health Council. The Mental Health Information Strategy Steering Committee (MHISSC) advises the Mental Health Principal Committee of the Australian Health Ministers' Advisory Council on the development and implementation of mental health information initiatives (box 25.3). Recent developments include the Your Experience of Service (YES) 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, and the Seclusion and Restraint NBEDS, which aims to monitor restrictive practices in hospitals and mental health units. These datasets can — and should — be used to inform service improvement and promote accountability. For example, the Victorian Mental Illness Awareness Council recently used this data to rank Victorian hospitals on seclusion rates to inform the public and hold hospitals accountable (VMIAC 2019).

Box 25.3 Mental Health Information Strategy Steering Committee

The role of the Mental Health Information Strategy Standing Committee (MHISSC) is to provide expert technical advice and, where required, recommend policy for consideration by the Mental Health Principal Committee of the Australian Health Ministers' Advisory Council. The MHISSC brings together jurisdictional mental health data representatives and key stakeholders including consumers, carers, clinicians, peak bodies and key organisations.

The Committee provides a national collaborative forum for the development and implementation of national initiatives in mental health information, national monitoring and reporting in mental health services, facilitate communication and collaboration for mental health information, and provides expert technical advice and recommendations for the information requirements of the National Mental Health Strategy.

Source: AIHW (2018j).

Optimising data to get more information

A lot of data currently collected in the mental health system is not being used to inform decision making to improve outcomes for consumers and carers. This is despite the high costs and burden associated with data collection.

Data collection can be costly and burdensome

Establishing and maintaining data collections can be complex, timely and costly for both those collecting data and governments. The Victoria 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'.

In practical terms, this can mean long delays between the timing of activities on the ground and when governments and service providers have information available to inform program improvements for consumers. For example, it took five years to develop the YES survey instrument and it is yet to be implemented in all States and Territories (AMHOCN 2019d). As a result, nationally consistent data on consumer experiences of care is still developing almost 10 years from its inception.

Forming nationally consistent datasets adds an additional element of complexity, requiring data to be collected from 'disparate state-based assortment of mental health services' (Holloway, Alam and Griffiths 2012) — State and Territory Governments often use data definitions and structures that are not consistent with each other. Moreover, maintaining national datasets can be time consuming, with time lags from data collection to reporting of approximately two years for some national mental health datasets (AIHW 2019n).

The complexities of data collection typically means additional resources and systems are required to ensure datasets are of high quality and are maintained over time. MindSpot (sub. 178, p. 7) said:

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.

Recognising the need for data collections to be of high-quality data, the Australian Government has funded the *Practice Incentives — Program Quality Improvement Incentive*, under which GPs are eligible for additional payments if they submit data on Improvement Measures to PHNs (DoH 2019n).

Data is collected, but not used

Despite recognition of the need for high quality data and incentives to support this, much of the information gathered from Australia's mental health data is of poor quality (Rosenberg and Salvador-Carulla 2017).

Data has value when it can be transformed into information that assists decision making. Many inquiry participants highlighted that data alone does not provide valuable insights and information. 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.

There are many instances where resources are allocated to collecting and storing data, but the data is not used to inform decision making. The National Mental Health Commission (sub. 118, p. 32) reported that 'more can be done to improve the collection and value of mental health data'. The Department of General Practice's (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'.

The Independent Private Psychiatrists Group (sub. 473, p. 2) also highlighted the poor use of the 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.

Other service provider representatives similarly noted the lost opportunities to derive benefits from 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).

Constraints imposed on the access and use of data for research and analyses are significant barriers to use of health data in Australia. The Commission's *Data Availability and Use* inquiry found that data access issues can be caused by privacy legislation and a 'culture [in health] that prioritised the protection of data, over promoting its use to improve program design and service delivery' (PC 2017a, p. 538). An example of where privacy legislation has prevented data access and use is the Medicare Consumer Directory (the largest administrative dataset in primary care), where government itself cannot use the data it collects (PC 2017a).

Another constraint on the use of collected data is that it may not be fit-for-purpose. Too often, data is collected without adequately considering how it will be used to create information of value in the decision making of Governments, providers or consumers.

INFORMATION REQUEST 25.1 — UNDER-UTILISED DATASETS

The Productivity Commission is seeking further information about what specific datasets are being under-utilised, the reasons why specific datasets are being under-utilised including examples of existing barriers, and what potential solutions can be practicably implemented to improve use of specific datasets.

Data linkage

Another significant weakness of the existing 'evidence base' is that many datasets sit in isolation from one another. 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 can provide more comprehensive information from existing datasets. It is the process of matching records on the same individual contained in different data sources, so that when combined more insights can be gathered about those individuals (PC 2017a).

For example, the Australian Government's Multi-Agency Data Integration Project (MADIP) provides insights into the employment status of sub-groups of people with mental illness who use MBS-rebated mental health services. From linking datasets, MADIP can demonstrate that individuals with less education, who were unemployed and were living in regional areas were less likely to be prescribed talking-based therapies, and more likely to be prescribed medication (NMHC, sub. 118).

Data linkage has consistently been highlighted in reviews of the mental health system as providing significant potential for improved information analysis (KPMG and Mental Health Australia 2018; NMHC 2014e; Nous Group 2018c). Many inquiry participants also highlighted the potential of data linkage in mental health (AIHW, sub. 370; MHCT, sub. 314; NSW Government, sub. 551). Broadly, more extensive use of data linkage in mental health could enable assessment of:

- consumer and carer outcomes that may be realised over a long period of time
- the relationship over time between use of services in one sector (such as psychosocial supports) and outcomes in another sector (such as health)
- the social determinants or predictors of mental illness
- an individual's access to services and pathways of care as their condition and circumstances change.

The extent of dataset linkage necessary depends on what information is needed. If the aim is to evaluate the outcomes of specific interventions, 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). Alternatively, if the aim is to address knowledge gaps around social determinants and consumer pathways of care, multiple datasets including health, housing, justice, tax and education may be required (KPMG and Mental Health Australia 2018). Many inquiry 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; Primary Health Networks, sub. 377).

However, there are both impediments to data linkage and some necessary protections. 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 be key impediments to greater use of data linkage (PC 2017a). The Commission's inquiry on *Data Availability and Use* found that data linkages in health are particularly restricted due to legislation (PC 2017a). For example, MBS and PBS data is not allowed to be linked routinely. The NMHC (sub. 118) observed that access to MADIP is granted on a project-by-project basis, which limits access to routine and ongoing analysis.

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 (2019b, p. 27) said that 'changes in sampling methods, methodologies and gaps in data collection can reduce the Victorian Government's ability to link data [in mental health]'.

The Australian, State and Territory Governments should task MHISSC to develop a strategy to support data linkage in mental health. The strategy should consider what data should be prioritised for linkage, barriers preventing linkage priorities from occurring and advise on solutions to address them.

DRAFT RECOMMENDATION 25.1 — A DATA LINKAGE STRATEGY FOR MENTAL HEALTH DATA

In the medium term (over 2 – 5 years)

The Australian, State and Territory Governments should task the Mental Health Information Strategy Steering Committee with developing a strategy to improve data linkage in mental health including:

- identifying high-priority data linkage projects
- assessing the barriers to implementing such projects
- advising on solutions to address them.

Addressing data gaps

Many inquiry participants identified data gaps as a hand brake on efforts to improve mental health system performance (for example, AIHW, sub. 370; NMHC, sub. 118; MHCN, sub. 245). Data gaps limit opportunities for data use to inform policy, program, service decisions and consumer decisions. The existence of data gaps in mental health and suicide prevention are well documented.

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. There should be transparency and accountability for the full range of care and support services funded or provided by Australian governments, from state and territory services and community managed organisations to private care and emerging areas, such as digital health and the NDIS. 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 most limiting data gaps relate to:

- prevalence data that are outdated
- mental health services provided by GPs and private providers (psychologists and psychiatrists)
- some population sub-groups
- non-health sectors.

Prevalence data is outdated

Although the Australian Government announced in August 2019 that it will re-establish the *ABS National Survey of Mental Health and Wellbeing* (NMHC 2019a), this data is now over 12 years old, with the last survey dated 2007. The survey is the main source of data on the prevalence of mental illness in Australia, therefore it is important that the response rate is maximised — evidence suggests people with mental illness are over-represented as non-responders (Torvik, Rognmo and Tambs 2011). Inquiry participants said the survey should have been re-established earlier and criticised its infrequency (FSC, sub. 535; Institute for Health Transformation, sub. 156; VicHealth and Partners, sub. 131).

The Commission acknowledges the Australian Government's announcement to conduct an updated survey, but is of the view that the Australian Government should ensure the survey be conducted *routinely*. It should be conducted no less frequently than every 10 years, to provide routine data on population prevalence, service use and outcomes. The survey design should enable consistent comparisons across time. The survey was funded by the Australian Department of Health, to an amount of \$5.7 million (DoHA 2007).

Collecting routine data on prevalence, service use and population outcomes including the impact of mental ill-health on daily functioning is important. It enables data to be collected on people who experience mental ill-health but who may not access mental health services. For example, the 2007 survey found 65% of people with a mental health problem did not access mental health services. As such, it is essential for planning and monitoring purposes, including by the non-government sector.

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 no. 312, p. 25).

The national survey should adequately represent population sub-groups. Some sub-groups have diverse needs and may be more vulnerable to mental illness. For example, the rate of depression among LGBTIQ Australians is three times higher compared to the general population (Senate Select Committee on Health 2015). Although it is necessary to track population outcomes for these groups for planning and monitoring purposes, there is a lack of data.

Furthermore, not all mental illnesses were included in the previous survey (for example, psychotic disorders and eating disorders were excluded), limiting scope for the survey to provide a comprehensive picture of mental health and wellbeing in Australia.

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.

One criticism of the previous *National Survey of Mental Health and Wellbeing* was the low response rate. Low response rates may lead to biased survey samples, undermining the validity of the survey. The response rate in 2007 was 60% at the national level (ABS 2008), lower than the *National Health Survey*, which was 76% (ABS 2019i). The ABS has not published reasons behind this. However, 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 them, social anxiety and lack of willingness to participate.

The ABS should consider methods to improve response rates of people with mental illness, ensure population sub-groups are adequately represented and that there are opportunities for linking the survey data to other datasets.

DRAFT RECOMMENDATION 25.2 — ROUTINE NATIONAL SURVEYS OF MENTAL HEALTH

In the long term (over 5 – 10 years)

The Australian Government should support the ABS to conduct a National Survey of Mental Health and Wellbeing no less frequently than every 10 years.

The survey design should enable consistent comparisons across time, and aim to routinely collect information on:

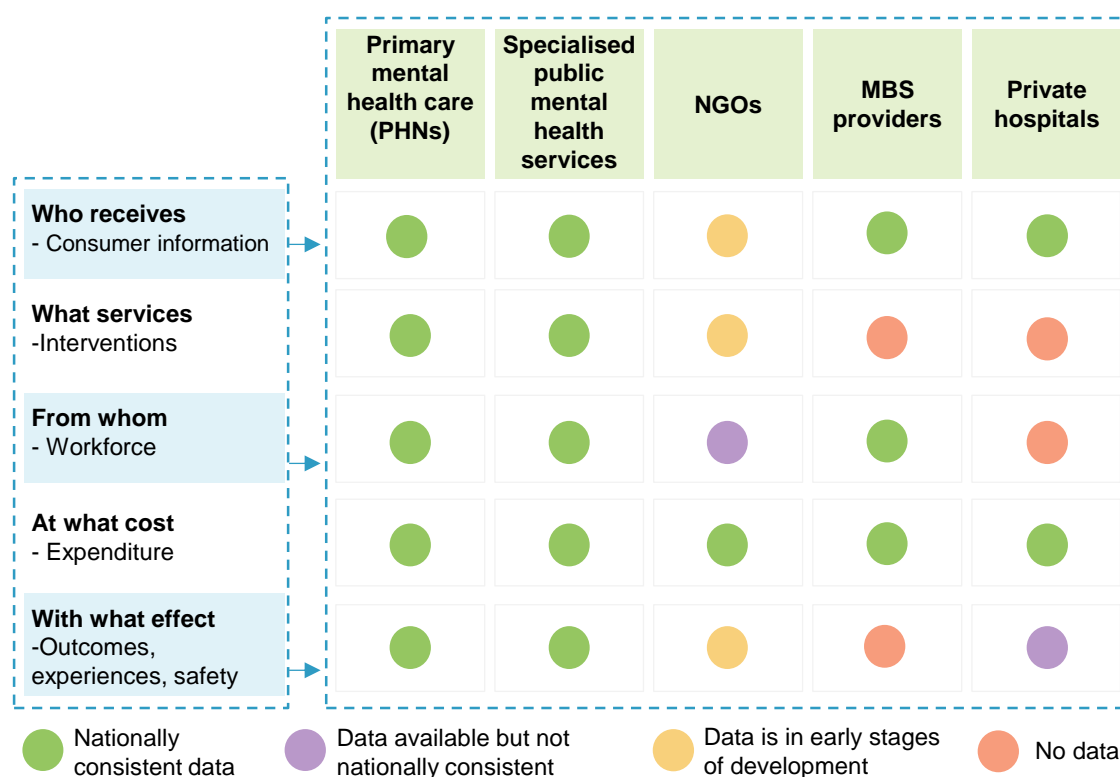
- prevalence of mental illness
- service use by people with mental illness, and
- outcomes of people with mental illness and their carers.

The survey design should ensure that it adequately represents vulnerable population sub-groups who may have diverse needs. Opportunities for linking the survey data with other datasets should be considered.

Mental health services

Despite much data being collected in mental health, data gaps exist in some key areas of service provision (figure 25.2). In particular, there are significant gaps in data collected on NGOs, private providers and GPs. These gaps prevent stakeholders from assembling a comprehensive view and analysing the sector's inputs, activity, outputs and outcomes.

Figure 25.2 Data gaps in areas of mental health service provision^{a,b}



^a There can be inconsistencies in data collected by service provision areas. For example, consumer information collected by MBS providers may not align with what PHNs collect. ^b A 'No data' label has been allocated to show that no ongoing, nationally consistent, consolidated collection of data exists.

Source: Productivity Commission analysis based on AIHW unpublished data.

MBS-rebated service providers

A lack of outcomes data, particularly for MBS-rebated mental health services was a key issue raised by consumers, peak bodies and service providers (box 25.4). MBS-rebated service providers (GPs, psychologists and psychiatrists) deliver mental healthcare to a large proportion of people seeking support. In 2018, 1.26 million consumers received MBS-rebated psychological therapy (chapter 5). While MBS data provides some information on activity, data on what services are provided and associated outcomes are limited. It would be desirable for services to be funded only if their effectiveness — preferably through outcomes data — can be evaluated. The lack of outcomes data and evaluation for MBS-rebated mental health services that cost approximately \$1.2 billion per year is concerning (AIHW 2019m).

The Mental Health Reference Group undertaking the MBS Review recommended outcomes measurement be built into the MBS and the Better Access program in particular (MBS Review Mental Health Reference Group 2018).

Box 25.4 **A lack of outcomes data — participants' views**

Inquiry participants raised concerns that data collected is focused on activity, but not outcomes.

There is significant focus in the health sector on measuring service delivery and activity, but less on outcomes and experience. Too often, organisations settle for proxies when instead a patient-centred system should be focused on what consumers want and get from the health system. Too often, data are collected to meet government reporting requirements rather than to drive reform or improve safety and quality. (CHF, sub. 496, p. 34)

... there is currently too much focus in the mental health system on generating activity, rather than improving individual and community outcomes. Work is undertaken by various bodies to measure processes and governance, however, with often too little to focus on quality care, evidence-based practice and outcomes. (RANZCP, sub. 385, p. 19)

... 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 (Jorm, 2018). 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 Australian Government spent \$1.2 billion on benefits for Medicare-subsidized (MBS) mental health-specific services [AIHW] ... 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).

NGOs and the NDIS

There is little data collected on NGO activity and performance, a sector that has grown strongly. As noted in chapter 12, the proportion of total expenditure on specialised mental health services spent on grants to NGOs has increased significantly from \$42 million in 1992–93 to \$424 million in 2016–17.

The Australian, State and Territory Governments have begun to address data gaps in the NGO sector, but data gaps remain nationally (Schess et al. 2018). In 2011, the AIHW commenced the Mental Health Non-Government Organisation Establishments National Minimum Data Set project to collect nationally consistent data on NGO establishments (DoH 2013c). Collection was due to rollout nationally in 2015, but has instead become a national best endeavours dataset, with only Western Australia and Queensland implementing the NMDS. It is unclear why the collection did not expand nationally, but the Commission was informed that implementation issues contributed to it. For example, NGOs may not have adequate information technology infrastructures to collect the data (MHA 2015).

The result of having the NGO data reduced to a national best endeavours dataset means nationally consistent data on NGOs is not available. Multiple inquiry participants highlighted this as a data gap (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 lack of data relating to NGO providers also limits the potential to improve the services they deliver under the NDIS. Data on individuals with psychosocial disabilities who are eligible for the NDIS is collected but it has not been made available for mental health monitoring and reporting. The NMHC (sub. 118, p. 31) said that:

... the NDIS is a major reform that directly impacts people with psychosocial disability. 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.

It would be beneficial for mental health monitoring and reporting agencies to access data associated with services delivered to NDIS mental health consumers — ideally, this would include data on access, activity and outcomes. Such data could be used to inform planning decisions and support improvement of outcomes for those accessing psychosocial supports.

Population sub-groups

There are limited data for population sub-groups of interest; for example, there is limited data on the degree to which Aboriginal and Torres Strait Islander people access general population mental health services and the extent to which their outcomes improve (NMHC 2014e). The AIHW (sub. 370, p. 6) also highlighted the lack of data for specific population sub-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.

Data that is collected on population sub-groups is of varying quality. For example, the quality statement for the National Community Mental Health Care Database acknowledges that further improvement to quality is required (AIHW 2017b). It states 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.

The Australian, State and Territory Governments should develop and fund strategies to address these known data gaps and limitations where it is cost effective and statistically valid to do so. This would unlock the potential for data to inform decisions around key areas of mental health service delivery and planning, and promote greater transparency and accountability. Action 24 in the Fifth Mental Health and Suicide Prevention Plan requires governments to update the National Mental Health Information Priorities, providing strategic priorities for information development over the next decade (COAG Health Council 2017a). MHISSC is responsible for delivering on this, with work currently underway (RANZCP 2019c).

DRAFT RECOMMENDATION 25.3 — STRATEGIES TO FILL DATA GAPS

High-quality and fit-for-purpose data should be collected to drive improved outcomes for consumers and carers.

In the medium term (over 2 – 5 years)

- 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. The priorities should consider data gaps identified in this inquiry, in particular for mental health services provided by general practitioners, private providers and non-government organisations, and vulnerable population sub-groups.

In the long term (over 5 – 10 years)

- The Australian, State and Territory Governments should develop and adequately fund strategies to address identified data gaps and information priorities. 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 consumers.

Non-health sectors

There is a dearth of data on mental health outcomes and activity in non-health areas, despite known expenditures. Gaps in data across non-health areas have been highlighted in many chapters of this report. In particular:

- chapter 16 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
- chapter 17 found that large volumes of data is collected by schools on their students, but it remains difficult to compile a clear picture of children's and young people's mental health and wellbeing
- chapter 18 reports the absence of a regular, national data collection on the mental health of tertiary students in Australia and stakeholders argue that data on the mental health of tertiary students is insufficient
- chapter 21 establishes that data recording suicide attempts and ideation are incomplete. And, although data recording suicide deaths are reasonably well reported, it tends to lack information about individual characteristics, such as health and mental health experiences, employment and family circumstances.

25.2 Monitoring and reporting

Monitoring is essential in any approach that aims 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 monitoring and reporting of the mental health system has been long acknowledged by governments, with a lot of monitoring activity occurring in mental health (Nous Group 2018b). However, commentators have said monitoring activities are sub-optimal, providing little information about the state of the mental health and mental illness in Australia (Mendoza et al. 2013). This section analyses existing monitoring and reporting arrangements, proposes reforms to rationalise and strengthen it, improve transparency and drive improvements in service quality.

Current arrangements

Roles and responsibilities

The NMHC 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 can influence the social determinants of mental health, such as education, housing, employment, human services and social support (NMHC 2017c, sub. 118). COAG (2017a) also tasked the NMHC with monitoring and reporting on the implementation of the Fifth Plan under the *National Mental Health Strategy*, including annual progress in implementing agreed actions and key performance indicators (KPIs).

The AIHW conducts national monitoring and reporting on public mental health services (AIHW 2019n). It produces an annual web report (*Mental health services in Australia*) and an accompanying hard copy report (*Mental health services: in brief*), which provide an overview of key statistics and related information in mental health (AIHW 2018k). In particular, it monitors KPIs for State and Territory mental health services, and trends in MBS and PBS activity. AIHW's reporting is constrained by the availability of comparable national data, with most data sourced from NMDS.

The Steering Committee for the Review of Government Service Provision also reports annually on the Australian, State and Territory Governments' management of mental health and mental illness through the *Report on Government Services* (SCRGSP 2019i). This focuses on State and Territory specialised mental health services, and mental health services subsidised under the MBS. These metrics cover aspects of equity, efficiency and effectiveness.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) reports on the variation of some mental health activity (based on MBS, PBS 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),⁵² remoteness and socioeconomic status.

State and Territory Governments also 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 WA Mental Health Commission monitors and reports on population outcomes and key indicators using data from the ABS, AIHW, WA Department of Health and its own data (WA MHC 2018). 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 2019w). It was developed in 2005 to facilitate a culture of continuous quality improvement in mental health service delivery (figure 25.3). 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 impacts of illness on functioning (tiers 2 and 3).

However, 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 (AIHW 2013). Further, KPIs under tier 1 are reported annually, but indicators under other tiers are not reported at all.

As such, there is scope to extend the coverage of monitoring activities to cover social determinants and the impacts of mental illness on outcomes. There is considerable and growing evidence that explains how social determinants can greatly impact mental health (WHO 2014b). And, conversely, mental ill-health affects the lives of individuals in different ways and to varying extents (Lawrence et al. 2015), including functioning at school or work and with family and friends. Monitoring activities could also track the impact of mental ill-health on other outcomes related to functional dimensions of health and recovery (Mental Health Australia, sub. 538). For example, the impact of illness on a person's ability to engage and participate in certain activities.

⁵² Statistical Area Level 3 is an ABS statistical area with population between 30 000 and 130 000 people

Figure 25.3 National Mental Health Performance Framework, 2020

Health service performance (tier 1)				
Accessible People can obtain health care at the right place and right time, taking account of different population needs and the affordability of care	Appropriate 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 (PROMs & PREMs).		Continuity of care Ability to provide uninterrupted and integrated care or service across program, practitioners and levels over time. Coordination mechanisms work for mental health consumers, carers and health care providers. Care and support is holistic and includes psychosocial and physical dimensions.	
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 (PROMs). 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 workforce 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 health care or the environment in which health care 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)				
Environmental Factors Physical, chemical and biological factors such as water, food and soil quality	Health Behaviours Attitudes, beliefs, knowledge and behaviours such as patterns of eating, physical activity, smoking and alcohol consumption	Personal biomedical factors Genetic-related susceptibility to disease & other factors such as blood pressure, cholesterol levels and body weight.	Personal history Factors such as experience of trauma	Socio-economic Factors Income, employment, housing, education and social inequalities
Health status and outcomes (tier 3)				
Deaths Age or condition specific mortality rates	Health conditions Prevalence of disease, disorder, injury or trauma or other health-related states	Human Function Alterations to body, structure or function (impairment), activities (activity limitation) and participation (restrictions in participation)	Wellbeing Measures of physical, mental, social and emotional wellbeing of individuals	

Source: AIHW (2019w).

Rationalising national reporting

Much monitoring and reporting activity is undertaken in mental health, with multiple government agencies contributing. Inquiry participants called for some rationalisation.

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)

In the Commission's view, 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).

However, the Commission is proposing greater clarity around roles and responsibilities, namely that:

- the NMHC should lead monitoring and reporting of the performance of the mental health *system* (all areas that impact on mental health including employment and social services), including progress against reforms (under plans and strategies).
- the AIHW should lead monitoring and reporting on the performance of mental health *services* (such as specialised mental health providers, NGOs, GPs and private providers).

The NMHC, AIHW and other Australian Government agencies (principally, the Steering Committee for the Review of Government Service Provision and the ABS) could where possible, seek to 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

A whole-of-government approach to monitoring and reporting on mental health outcomes has not been achieved in practice. This is a significant shortcoming, given the significance of social determinants and impacts of mental ill-health on human functioning. Notably, although the NMHC's monitoring role extends to areas beyond health that influence mental health outcomes, it is limited by data availability and access to it.

At present, the 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. (NMHC, sub. 118, p. 31)

Further, where mental health related data is collected by non-health portfolios, it is unclear to what extent they are used to improve policy, evaluation programs or improve services. For example, chapter 17 highlights that, although schools collect wellbeing measures, the data is inconsistently reported, and school results could only be compared directly in Victoria. This could be in part because mental health is not seen as a key area of responsibility of non-health portfolios. There is scope to strengthen monitoring activities in areas beyond health.

Strengthening the NMHC's non-health focus

In the Commission's view, the NMHC should be responsible for leading monitoring and reporting on system performance and reforms, focusing on analysis and commentary (rather than collecting). 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 impacts of mental ill-health on functioning (such as ability to participate in education and work) and reporting on mental health related expenditure in non-health areas.

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 (draft recommendation 22.2). Further, giving the NMHC statutory independence (draft recommendation 22.8) would likely strengthen its monitoring capability. Although the primary motivation is to support proposed 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. A number of participants supported a more independent NMHC to strengthen its monitoring role (CHF, sub. 496; Mental Health Australia, sub. 544).

Monitoring system outcomes

A person-centred approach rather than a system-centred approach could be taken to decide what outcomes are monitored. In doing so, this would help ensure the mental health system is working toward improving outcomes that are meaningful for people with mental ill-health and their carers. Tracking progress towards outcomes rather than inputs or outputs is necessary in determining if strategic goals, rather than delivery goals are being achieved (New Zealand Treasury 2008).

The Contributing Life Framework offers a broad set of outcomes that captures the type of lives people with mental illness wish to attain (box 25.5). The framework was developed in consultation with consumers and carers, identifying areas that are important to consumers' abilities to lead a contributing life (DoH 2013c). Inquiry participants highlighted the importance of supporting people with mental illness lead a contributing life.

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)

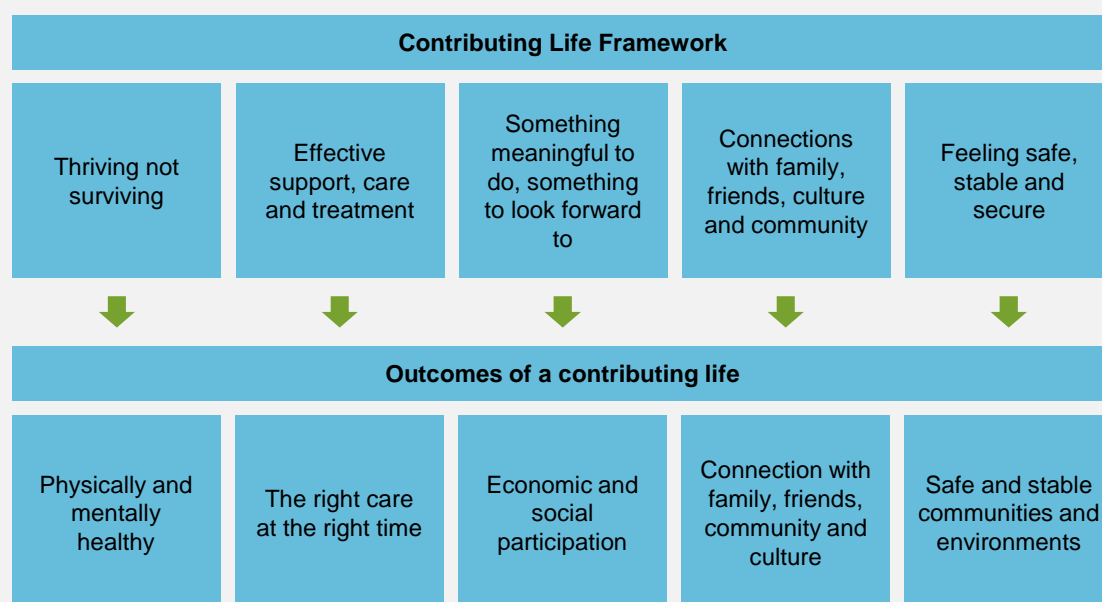
The National Mental Health Commission's concept of a 'contributing life' is insightful in describing what a good life looks like and is based on extensive consultation with people with lived experience. (MHCSA and LELAN, sub. 360, p. 8)

Box 25.5 Outcomes of a contributing life

The Contributing Life Framework offers a whole-of-life perspective on mental health and states that measuring success must centre upon people's quality of life and determinants such as access to housing, education and meaningful employment and leading a life free from discrimination. The NMHC 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).

For the purposes of national monitoring and reporting, the Commission mapped the five elements to the contributing life framework to five outcomes sought by people with mental ill-health and their carers.



Source: Productivity Commission analysis based on NMHC (2013).

In the Commission's view, the NMHC should monitor progress against outcomes derived from the Contributing Life Framework. The Commission sees the NMHPF as being overly health-focused and more applicable to health interventions. For example, the outcomes under tier 3 of the NMHPF (figure 25.3) is limited to objective 'health outcomes'. Monitoring a broader set of outcomes derived from the Contributing Life Framework reflects what is meaningful to consumers and ensures the framework is applicable beyond health.

To operationalise this new approach, indicators for measuring progress against each outcome area would be chosen. Often, a set of indicators is necessary as no single indicator can capture improvements in an outcome area. A set of criteria would be applied to guide selection of indicators that would be effective in measuring progress towards agreed outcomes (box 25.6).

Box 25.6 **Criteria for selecting indicators**

The Commission's *National Disability Agreement Review* developed a set of criteria that provide a comprehensive basis for considering the key issues relevant to the selection of performance indicators. The set was informed by a global review of literature on performance reporting and indicators. The same set of criteria could be relevant for the selection of indicators for monitoring and reporting on mental health outcomes, namely:

- validity — the indicator should be clearly linked to, and validly capture, one of the agreed Contributing Life Framework outcome areas
- unambiguous — the indicator should be clear in meaning and interpretation
- direction — the indicator should be specified such that an increase or decrease represents a clear improvement or deterioration in performance
- attributable — the activity measured should be capable of being influenced (although not necessarily fully controlled) by government policy
- avoids unintended consequences — the indicator should avoid creating perverse incentives that give rise to undesirable or unwanted actions
- credible — an indicator should be meaningful to people mental illness and their carers and families (that is, relevant to those with lived experience)
- data availability — data should currently be available for an indicator, or where there are not, the costs and benefits of collecting relevant data should guide judgment about collection. The selection of performance indicators should not simply be driven by considerations of what data is currently available
- frequent and timely — data availability should synchronise with required reporting frequency, and be available in a timely manner so that the data is relevant for decision making.

The Commission proposes a set of indicators in table 25.2 to track progress of mental health reforms against the Contributing Life Framework outcomes and suicide prevention. Although they provide an example of how monitoring against outcomes could be done in practice, the Commission recommends that broader consultation with stakeholders, sector experts and service providers collecting data be undertaken to inform a final set of indicators.

The NMHC should also consult with Aboriginal and Torres Strait Islander representatives to determine what social and emotional wellbeing outcomes and indicators could be monitored. Aboriginal Medical Services Alliance NT (AMSANT, sub. 434, p. 15) said that ‘there are currently no national KPIs to measure [social and emotional wellbeing]’ for Aboriginal and Torres Strait Islander people. The Commission recognises that an established model of social and emotional wellbeing outlines domains or outcomes that are important to Aboriginal and Torres Strait Islander people (chapter 20). It may be the case that NMHC undertakes additional monitoring under this model.

Table 25.2 Proposed list of indicators to measure progress against outcomes

<i>Outcome</i>	<i>Proposed indicator</i>
Physically and mentally healthy	Rates of understanding of mental health problems and mental illness in the community Rates of use of licit and illicit drugs that contribute to mental illness in young people Perinatal mental illness screening Rates of smoking, alcohol use, obesity and diabetes
The right care at the right time	Student wellbeing data Rates of contact with primary mental healthcare by children and young people Mental health related ED presentations Co-payments and other out-of-pocket expenses
Economic and social participation	% of tertiary education providers with whole-of-institution mental health and or wellbeing strategies/frameworks Number of mental health claims, cost and period until return to work Participation rates by young people aged 16-30 with mental illness in the labour force: General population Social exclusion rates
Connection with family, friends, community and culture	Stigma in schools Stigma in workplaces Stigma in health sector Stigma in community
Safe and stable communities and environments	% of people with mental illness in unsuitable housing Progress against the gap in supported housing places Prevalence in prisons and juvenile detention centres Number of police mental health crises calls
Suicide prevention	Rate of suicide deaths Suicide attempts Suicide ideation

INFORMATION REQUEST 25.2 — PROPOSED INDICATORS TO MONITOR PROGRESS AGAINST CONTRIBUTING LIFE OUTCOMES

The Productivity Commission is seeking information on what additional indicators should be considered to monitor progress against Contributing Life Outcomes and whether routine data is available for the Commission's proposed indicators.

Monitoring mental health expenditure

Monitoring expenditure on different interventions is necessary for assessing their effectiveness and efficiency relative to alternative allocations. This information is critical for decision makers seeking to improve mental health outcomes by reallocating resources more efficiently.

Routine reporting of expenditure on mental health across all sectors (health and non-health) would be beneficial for several reasons. First, it would enable a more complete view of governments' response to mental ill-health to be monitored over time. In this regard, 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'. 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. 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 25.3).

The NMHC should expand routine reporting of mental health expenditure to cover all relevant sectors. This could include *direct* expenditure that aims to support individuals with mental ill-health, and/or prevent mental ill-health. Effectively, this would provide a 'stocktake' of mental health related programs across multiple government portfolios. The NMHC could also consider reporting *proportions* of expenditure where its relation to mental ill-health can be clearly identified. An example is expenditure on the Disability Support Pension, where recipients identify the primary condition (such as a psychological or psychiatric disability) for receiving support.

The NMHC should determine which sectors could be in scope. There is a *prima facie* case to include expenditure directly attributable to mental health matters from health, social and human services, housing, education and training, employment and justice portfolios. These sectors are linked closely with mental ill-health, as discussed throughout this report and in some instances are not being reported on. For example there is currently no consistent reporting of State and Territory suicide prevention expenditure and activity (chapter 21). It may also be informative to report on private sector expenditure such as out-of-pocket expenses.

The NMHC should decide on the frequency of reporting following broader consultation. Again, determining the optimum frequency involves weighing expected costs and benefits. In the Productivity Commission's view, reporting of mental health related expenditure may not need to be conducted every year, as in the ordinary course of events, it is not likely that aggregate expenditure will change frequently. And, to the extent that it does, it is likely that interim expenditure values could be estimated based on announced changes.

However, it is likely cooperation between multiple government portfolios is necessary to collect appropriate data, and that pre-conditions are formalised to encourage cooperation. Options used elsewhere in government to encourage data sharing between multiple portfolios includes Memorandums of Understanding agreements, letters of exchange and head of agency/ministerial agreements (PC 2017a). The Commission is seeking information on whether formal mechanisms are required to support the NMHC undertake its proposed monitoring and reporting role, and if so, what mechanisms would be preferred.

INFORMATION REQUEST 25.3 — DATA SHARING MECHANISMS TO SUPPORT MONITORING

The Commission is seeking information on whether formal mechanisms would be required to support the National Mental Health Commission to undertake its proposed monitoring and reporting role in mental health and suicide prevention. If formal mechanisms would be required, what mechanisms would be preferred?

Monitoring implementation of reforms

Reporting on the progress of mental health reform is important to track whether commitments made in mental health plans and strategies are being honoured (COAG Health Council 2017a). This includes monitoring progress against action items and against outcomes for consumers and carers that the reforms aim to achieve. The NMHC was tasked with delivering annual progress reports on the implementation of the Fifth National Mental Health and Suicide Prevention Plan and performance against its indicator set.

The Productivity Commission believes this is an important component in national monitoring and reporting, and is of the view that the NMHC should continue its role in monitoring progress against mental health reforms under the National Mental Health Strategy.

DRAFT RECOMMENDATION 25.4 — STRENGTHENED MONITORING AND REPORTING

Monitoring and reporting should be more focused on outcomes for consumers and carers and broadened beyond health portfolios.

In the short term (in the next 2 years)

- The National Mental Health Commission (NMHC) should conduct monitoring and reporting on mental health and suicide prevention outcomes, activity and reforms across portfolios. This should include monitoring and reporting on:
 - outcome areas derived from the Contributing Life Framework for people living with mental illness, their carers and suicidal behaviour annually
 - mental health and suicide prevention expenditure (including in non-health sectors), with the frequency of reporting to be determined by the NMHC
 - 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 representatives and sector experts in finalising the set of indicators to monitor progress against outcomes.
- The NMHC should consult with stakeholders and sector experts to identify what expenditure across which sectors should be reported on.
- The NMHC should continue to monitor and report on progress against mental health reforms under the National Mental Health Strategy.

Transitioning to regional monitoring

Performance monitoring at the regional level

Although data is often available at a jurisdictional level, this is rarely the case for regional areas, which can be a barrier to improving the service experience for consumers and carers. The Primary Health Networks (sub. 377, p. 13) highlighted this:

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.

Governments have been working to improve data availability at local 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 (by Statistical Area Level 3). It is also developing a single ‘portal’ for a range of datasets (possibly including Medicare, PBS, hospital and community mental health services) to support local mental health planning activities (DoH 2018d).

There is scope to report service performance at a regional level as data systems already support this. Currently, performance is largely reported at a State, Territory or national level. Although the *Atlas in Healthcare Variation* reports provide some information at a Statistical Area Level 3, it is limited to information on access to mental health treatments, such as number of mental health treatment plans and antidepressant medicines dispensed (ACSQHC 2018a).

There are two key reasons to transition towards monitoring and reporting at regional levels. First, as service planning and commissioning are increasingly done at the regional level, so too should monitoring and reporting activities. Reporting State and Territory level data lowers transparency and thus accountability. The PHN Advisory Panel, 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. (PHN Advisory Panel 2018, p. 9)

Second, reporting jurisdictional-level data inhibits efforts to improve the provision of mental health services. In particular, it can limit the ability of planners and researchers to compare the performance of providers by controlling for factors beyond their control, such as various demographic and social determinants.

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. 49)

The Productivity Commission's proposed national network of Regional Commissioning Authorities (RCAs) represents an opportunity to strengthen monitoring and reporting at a regional level (chapter 23). Under the *Rebuilding Model*, RCAs would be responsible for meeting various mental health reporting requirements in much the same way that PHNs currently do, for example, by contributing to the Primary Mental Health Care NMDS.

In the event that governments agree to establish RCAs, indicators could be selected to monitor RCA performance. A framework developed by Leginski et al. (1989) outlines the type of data required for strong performance monitoring in mental health (box 25.7). It states that a framework should be able to answer the following: *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 has used it to develop its *National Mental Health Information Strategy* (New Zealand Ministry of Health 2005), and the Australian Government used it to guide development of mental health National Minimum Data Sets (NMDS) (AIHW 2004).

Box 25.7 **The Leginski et al framework for monitoring in mental health**

The Leginski et al. 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: It can be summarised as covering the following aspects.

- Who receives? — the who refers to the clients served by the organisation and data collected would include demographic and clinical characteristics of the mental health consumers.
- What services? — the 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? — the whom refers to service characteristics and details of the staff, for example the professional training, demographic characteristics and salary. Whom should apply to the full organisation and not only those directly involved in providing the services.
- At what cost? — expenditures of the mental health service. Note that cost is primarily driven by two other areas: the what and the whom.
- With what effects? — the effect refers to the outcome or benefit 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.

Sources: Leginski et al (1989); New Zealand Ministry of Health (2005).

In this regard, the KPIs developed for PHNs set a good example. The following PHN performance domains remain relevant and could be used to monitor RCA performance.

- Access to services — ability of people to obtain services at the right place and right time irrespective of income, geography and cultural background (*who* receives *what* from *whom*).
- Efficiency of service delivery — extent to which services are delivered and desired results achieved with the most cost-effective use of resources (at what *cost*).
- Appropriateness of services — services provided are relevant to consumers' needs and based on standards.
- Effectiveness of services — extent to which services achieve desired outcomes (and with what *effect*).

The Commission has proposed some indicators of RCA performance against these domains (box 25.8). However, the Australian, State and Territory Governments should consult with stakeholders, including consumers and carers, before finalising the indicators.

For example, consultation with Aboriginal and Torres Strait Islander representatives could be considered to ensure monitoring activities are culturally appropriate. Inquiry participants raised concerns that current reporting requirements are not. The National Aboriginal Community Controlled Health Organisation (NACCHO, sub. 507, p. 6) stated that:

Requesting client fully informed consent to report mental health information is necessary but could jeopardise the relationship of trust between clients and the ACCHO. The use of screening tools that are not specified in clinical guidelines was also mandated, infringing on the ACCHO's clinical autonomy.

Box 25.8 Proposed indicators of RCA performance

<i>Performance domains</i>	<i>Proposed indicators</i>
Access to services	Proportion of regional population who can access RCA commissioned services by service type Number of mental health related hospitalisations Number of potentially preventable hospitalisations for individuals accessing GP services
Efficiency of service delivery	Average cost of RCA commissioned services by service type
Appropriateness of services	Proportion of youth population who can access RCA services Proportion of RCA-commissioned mental health services delivered to the regional Aboriginal and Torres Strait Islander people where the services were culturally capable Proportion of people referred to RCA-commissioned services due to a recent suicide attempt or because they are at risk of suicide followed up within 7 days of referral Average duration in seclusion
Effectiveness of services	Consumer-rated outcomes, clinician-rated outcomes or consumer and carer experience measures for population receiving RCA-commissioned services Proportion participating in the labour force Proportion with a homelessness flag

Notwithstanding, the Australian, State and Territory Governments should authorise the AIHW to report all data relating to the performance of service providers at a regional level — PHNs or RCAs (as the case may be) in addition to existing reporting at a State and Territory, and national level. Reporting at regional levels already occurs in health more broadly. For example, the AIHW reports on the *healthy community indicators* (not specific to mental health) at a PHN level. Regional data can be aggregated to a state and territory or national level.

In addition, the AIHW should ensure this data is readily accessible to the public, including a historical time series, to maximise their 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 more accessible.

DRAFT RECOMMENDATION 25.5 — REPORTING SERVICE PERFORMANCE DATA BY REGION

In the short term (in the next 2 years)

- The Australian, State and Territory Governments should authorise the Australian Institute of Health and Welfare (AIHW) to report all data relating to the performance of mental health and suicide prevention services at a regional level, as defined by commissioning agencies (PHNs or RCAs), 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 their 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 more accessible.

Standardising reporting requirements

As mental health service planning and commissioning increasingly occurs at a regional level, the Australian, State and Territory Governments should provide national guidance to standardise reporting requirements. This is necessary to facilitate comparisons on a consistent basis for planning and research purposes.

Currently, PHNs are developing 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 2016c), the framework does not provide guidance on a standardised approach.

The emergence of individual approaches is 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 12). Jesuit Social Services highlighted the administrative burden of meeting multiple sets of reporting requirements:

... 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. (sub. 441, p. 20)

For the reasons discussed above, data from service providers that are collected inconsistently across different regions prevents comparative analyses to inform service planning.

DRAFT RECOMMENDATION 25.6 — STANDARDISED REGIONAL REPORTING REQUIREMENTS

In the short term (in the next 2 years)

The Australian, State and Territory Governments should provide commissioning agencies (PHNs or RCAs) with guidance and support to enable them to implement standardised monitoring and reporting requirements for commissioned services, with minimal undue regulatory burden.

Monitoring can improve service quality

Monitoring and reporting undertaken at a service provider level can promote accountability and drive improvements in service quality by: informing consumer choice and driving self-improvement among providers (PC 2017c); and by driving improvements in service quality through benchmarking analysis.

Publishing data at a service provider level

The limited availability of most mental health data at a service provider level severely impedes the extent to which data can be used to inform consumer choice and drive self-improvement among providers (PC 2017c). Notably exceptions to this include the recently established National Seclusion and Restraint NBEDS, which provides seclusion rate data across Australia, at a hospital level (AIHW 2019t). The Productivity Commission's *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services* inquiry recommended increased reporting of data at the service organisation level to support patient choice and encourage self-improvement by hospitals, specialists and allied health professionals (PC 2017c).

The Fourth National Mental Health Plan aimed to start monitoring and reporting activity at the service provider level by establishing transparent web-based reporting to compare similar services around Australia (COAG Health Council 2009). This goal was not achieved and not explicitly included in the Fifth Plan.

Monitoring and reporting 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 organisations across domains such as waiting times, recovery rates and outcome improvement rates (box 25.9). Clarke et al. (2018) found that publishing this data has improved transparency, enabled identification of sources of local variability in mental health outcomes, and facilitated improvements.

Published data at the service provider level can be a source of information for service providers to compare themselves with others to self-improve, and provide information to consumers and carers inform 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 2017c).

The suggestion of publishing data at a provider level often invokes initial claims that this will lead to mistrust of the relevant providers, that consumers will 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).⁵³

Box 25.9

England’s My NHS monitoring and reporting

England’s My NHS was launched in September 2014 to gather data from across the National Health Service (NHS) into one place so professionals and the public can easily compare the performance of health and care 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.

In relation to mental health services, My NHS 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:

	People waiting < 6 weeks	Recovery rate	Reliable improvement	Reliable recovery rate
Service provider A	100%	62%	72%	62%
Service provider B	95%	65%	76%	58%
Service provider C	100%	58%	68%	57%
Service provider D	100%	52%	71%	51%

Sources: National Health Service (2016, 2019).

⁵³ 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).

But transparent provision of data at the service provider level is an essential ingredient in creating a people-oriented mental health system and improving service outcomes for those for whom services exist — the consumers.

Benchmarking analyses

Another way that monitoring and reporting can support improvements in service quality is through benchmarking analysis. Benchmarking aims to drive a quality improvement cycle by enabling services to access regular reports on performance relative to similar services.

For example, the Australian Government Department of Health funds a program called MedicineInsight, which gathers data from 650 GPs 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, there is currently limited use of data to benchmark mental health services in Australia. For example, a review of AMHOCN found that, while it had substantially improved outcomes measurement, it had not yet lived up to its initial vision of supporting benchmarking activity (DoH 2011).

Various forms of benchmarking are undertaken in healthcare more broadly. For example, clinical quality registries (CQR) exist for some forms of healthcare (such as joint replacement) to systematically monitor quality by routinely collecting, analysing and reporting health-related information (ACSQHC 2014) (box 25.10). The information is used to identify benchmarks, significant outcome variance and inform improvements in healthcare quality. There are no CQRs in mental health, but this was listed as a 'clinical domain priority' in the Australian Government's Draft National Clinical Quality Registry Strategy (DoH 2019g).

Benchmarking analyses are relatively mature in some states, where central health authorities exist specifically for this purpose. For example, the System Information and Analytics Branch in NSW Health has a primary role to support data and information needs of the state's health system (NSW Health 2017d). 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 at the local hospital network and state government level (AHMAC MHSC 2009; NSW Health 2018b).

Some private providers compare staff performance with relevant benchmarks within their own practice to support service quality improvements. A proportion of these also publish their results to demonstrate accountability to clients for measureable outcomes and for use by other practices. For example, Benchmark Psychology (2018) publishes annually measures of effectiveness for each (de-identified) psychologist against best practice targets, which they set themselves.

Box 25.10 Clinical quality registries in Australia

A clinical quality registry (CQR) is a specific type of clinical registry which systematically measures and monitors the quality (appropriateness and effectiveness) of healthcare, within specific clinical domains (for example, mental health, musculoskeletal disorders and stroke). CQRs routinely collect, analyse and report health-related information, including longitudinal data (ACSQHC 2014).

Information collected from CQRs can be used to inform improvements in healthcare quality and safety within those domains. In addition to improved patient 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 has been no guiding, overarching Australian strategy to optimise the contribution of CQRs to improved outcomes for patients and ensure that returns on investment are maximised, although a national strategy is in development (DoH 2019g). Moreover, there is a lack of registries for 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)

A 2016 economic evaluation of Australian CQRs demonstrated an economic case for the establishment of registries. The assessment of five well-established CQRs (prostate cancer, trauma, intensive care, dialysis and transplantation, joint replacement) found that each of the five registries led to a significant net positive return on investment, with the benefit-to-cost ratios ranging from 2:1 to 7:1. The study also noted that potential issues such as low coverage, inadequate reporting and inadequate collection of information about patient outcomes would limit the effectiveness of some CQRs (ACSQHC 2016a)

The Consortium of Australian Psychiatrist-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 was able to evaluate outcomes based on a nationwide patient registry to identify that a reduction in psychiatric beds had likely caused a higher mortality rate amongst patient being treated for severe mental illness.

Service providers have revealed their support for making NOCC data available at an organisational level to facilitate enhanced benchmarking (DoH 2011). The Australian Psychological Society (sub. 543, p. 36) also 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 implementation of this outcome measurement system would enable on-going evaluation of the Better Access initiative but also has the potential to be expanded to evaluate other treatment programs. (sub. 543, p. 36)

Benchmarking analysis in mental health can have positive impacts 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 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, further work to address known barriers to implementation is necessary before the benefits of national benchmarking can be realised. A key issue is data quality (AHMAC 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 Commission has concluded that national benchmarking and public monitoring and reporting at the service provider level would improve service quality and outcomes for consumers and carers. Australian, State and Territory Governments should actively address barriers to implementing service provider public reporting and benchmarking.

DRAFT FINDING 25.1 — MONITORING AND REPORTING AT THE SERVICE PROVIDER LEVEL

Monitoring and reporting at the provider level can improve transparency and accountability, and potentially service quality, through:

- publishing data that informs consumer choice and drives self-improvement
- benchmarking analyses, where services are able to regularly compare their performance relative to similar services, that prompt discussions and information sharing.

However, there are several challenges including data limitations and risks of unintended consequences, such as gaming.

Governments would need to address these before the potential benefits of a national approach to monitoring and reporting of service providers were to be realised.

25.3 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 informs evaluation and research priorities by revealing where weaknesses or problem areas lie, 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 refers to the systematic process of collecting and analysing information to enable an assessment of an activity, project, policy or program (PC 2019b). 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 consumers and carers.

Current arrangements

Currently there is no national body tasked to undertake or coordinate program evaluations in mental health.

Some State Governments have developed their own evaluation capability. Notably, the WA Mental Health Commission established a Performance, Monitoring and Evaluation team to manage WA datasets and undertake system evaluations (WA MHC nd). In addition, it employed a full-time evaluation officer to support the State's *Suicide Prevention 2020* strategy (WA MHC, sub. 259). The role includes coordinating external evaluations, and evaluating projects and the overall strategy.

However, participants noted that Australia generally has a lack of routine program evaluation and evidence gathering on mental health to inform funding allocations and program improvements. 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 current lack of program evaluations. First, the 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, the incentives may be weakened by factors such as potential political risks. Such programs may be seen as an accepted part of service delivery, with strong opposition to any proposed changes from evaluations (Anthony Jorm, sub. 45).

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 NSW, sub. 486)
- do not provide meaningful findings due to funding constraints (One Door Mental Health, sub. 108)
- are not prioritised — funding for evaluation is usually the first casualty when negotiating costs (Anglicare Victoria, sub. 312).

The NMHC should lead evaluations nationally

While the lack of evaluation could be addressed at a State and Territory level, this would be a second-best solution. It would be unlikely to lead to nationally consistent datasets and make it difficult to compare programs between jurisdictions. 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 evaluation to an independent national body would address many of the shortcomings associated with the current approach. A national body could ensure national 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 health system and the community as a whole.

For these reasons, the Commission has proposed in chapter 22 that a national body — the NMHC — be specifically responsible (and incentivised) to undertake program evaluations to assist in strengthening governance of the mental health system nationally. The proposal is that the NMHC’s functions be expanded to include program evaluations of programs funded and delivered by the Australian, State and Territory Governments.

The NMHC would have to commit to a set of guiding principles for conducting program evaluations. At a minimum, these principles should be based on those listed in box 25.11 to ensure that evaluations are robust, reliable and relevant. These principles should be set and agreed by the COAG Health Council, in consultation with relevant stakeholders.

Box 25.11 Possible principles for program evaluations by the NMHC

In chapter 22, the Productivity Commission has proposed that the NMHC be responsible for evaluating mental health programs funded and delivered by the Australian, State and Territory Governments. At a minimum, the NMHC should adhere to the following principles.

- Consumer and carer participation — 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.
- Professionally defensible methodologies — appropriate approaches and methods should be used to generate robust, reliable and relevant evaluations.
- Transparency and accountability — evaluations should be made public upon completion. There should also be transparency and accountability around how policy makers and program funders/managers respond to evaluation findings.

The proposed recommendations in this chapter are intended to complement the *Indigenous Evaluation Strategy*, which would be relevant to evaluations of mental health and suicide prevention programs for Aboriginal and Torres Strait Islander people. This work is particularly important, given that inquiry participants highlighted the lack of quality evaluations for mental health and suicide prevention programs for Aboriginal and Torres Strait Islander people (NMHC, sub. 118; Aboriginal Health and Medical Research Council, sub. 206).

DRAFT RECOMMENDATION 25.7 — PRINCIPLES FOR CONDUCTING PROGRAM EVALUATIONS

In the short term (in the next 2 years)

The COAG Health Council should agree to a set of principles by which the National Mental Health Commission would undertake its evaluation function, as set out in draft recommendation 22.5. These principles should be set in consultation with relevant stakeholders.

Cost-effectiveness evaluations

Cost-effectiveness evaluations are necessary to support government decision-making on what mental health interventions 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 2012).

Cost-effectiveness evaluations consider the relative health benefits per unit of expenditure for each consumer treated. Measures of cost effectiveness are critical if health services are to provide the highest value of services to consumers within their limited budgets. Estimating the cost-effectiveness of different interventions or services are a key element for translating clinical research into practical programs.

Cost-effectiveness is different to clinical effectiveness. An intervention may be effective at a clinical level (for example, leading to significant benefits per patient treated), but may have low cost effectiveness due to its high cost per patient. 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.

The UK National Institute for Health and Clinical Excellence (NICE) considers economic evidence to formulate its guidelines (box 25.12). NICE guidelines are evidence-based recommendations for health and social care, with several guidelines existing 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).

Box 25.12 **The UK National Institute for Health and Clinical Excellence and its role in 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. Its roles include producing evidence-based guidance and advice for health, public health and social care practitioners.

NICE uses the best available evidence to develop recommendations to improve health and social care. Its guidance can take several forms including the development of NICE guidelines that cover clinical, social care, public health and medicines practice. NICE guidelines make evidence-based recommendations including for preventing and managing certain conditions, planning broader services and interventions.

Multiple NICE guidelines have been developed for mental health and suicide prevention including but not limited to guidelines for:

- depression in children and young people
- generalised anxiety disorder and panic disorder in adults
- common mental health problems
- preventing suicide in community and custodial settings.

Gyani et al. (2013) found that consumers who received NICE-recommended treatments for depression were more likely to recover than those who did not.

Sources: National Institute of Health and Clinical Excellence (2014, 2019); Gyani (2013).

DRAFT RECOMMENDATION 25.8 — REQUIRING COST-EFFECTIVENESS CONSIDERATION

In the medium term (over 2 – 5 years)

The Australian Government should consider the expected cost-effectiveness of all mental health programs or interventions *before* funding is provided. 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.

25.4 Research

Research generates reliable information on which to base decisions and policies. Importantly, it can shed light on the importance of causal mechanisms, such as: what causes mental ill-health, what are its impacts and why interventions do or do not work. 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 program evaluations may inform how 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).

Current arrangements

Roles and responsibilities

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, 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) is the major competitive funding body for mental health research in Australia (Econtext 2014). In the 2018-19 budget, the Australian Government announced it will provide \$125 million over 10 years to the *Million Minds Mental Health Research Mission*, which will be administered by the NHMRC (2019).

Encouraging practical mental health research

Some inquiry participants considered that existing mental health research fails to address ‘real world’ problems (box 25.13). This was seen as hampering the design and delivery of best-practice treatments and services which, in turn, prevents consumers and carers from leading a more contributing life. For example, research on prevention, early detection and whole-of-life support for mental illness have the potential to improve outcomes, but appear under-represented compared to research on single interventions and clinical trials (Econtext 2014).

The NMHC has argued that the current array of mental health research activities in Australia has limited relevance for improving policies, system design and clinical services (NMHC 2014b). Mental health funders, research institutions (such as universities) and researchers have a variety of objectives that extend well beyond simply the design of new health interventions or the evaluation of existing interventions. To the degree that existing research priorities are inconsistent with the priorities of policy makers, practitioners and consumers, there may be a role for influencing these priorities through targeted research.

Where ‘practical’ research does exist, governments and service providers have not been making the best use of it to improve treatments and services. Econtext (2014) pointed to a lack of capacity within governments and among service providers to assess and apply the results of research. This too is hindering system and service improvements. 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.

Box 25.13 Selected participant views about 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 Limited, 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. (Western Australian Association for Mental Health, 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)

The NMHC is developing a national research strategy to improve treatment outcomes, as stated in Action 28 of the Fifth National Mental Health and Suicide Prevention Plan (COAG Health Council 2017a). It has established a steering committee of consumers and carers, State and Territory Government representatives, research funding bodies and prominent researchers to develop the strategy, which is anticipated to be completed by the end of 2020 (NMHC 2019c). The Productivity Commission considers that a national research strategy is necessary to address the issues raised above. In addition to the research strategy, the NMHC could continue to sponsor relevant research in mental health and suicide prevention.

Establishing a clinical trials network

In addition to developing a national research strategy, improvements to existing research activity could also be made. Currently, fragmentation and poor coordination of clinical trials in healthcare generally and mental health specifically, are a source of duplication and other inefficiencies.

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 patient 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 developed 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 would require researchers to allocate more time coordinating with clinicians and other experts. Research efforts can also be duplicative, creating inefficient use of resources. For example, there are concerns of duplication in suicide prevention research (SPA 2018; The Black Dog Institute, sub. 306).

To address these deficiencies, other areas of healthcare have developed clinical trials networks. These are organised groups of clinicians and researchers who share research infrastructure, enabling them to collaborate to conduct multiple 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 associated with designing, conducting and analysing trials (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 ACSQHC (2017a) found 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, the ACSQHC 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, the ACSQHC found networks returned a net benefit, estimating a \$5.80 return for every \$1 invested (ACSQHC 2017a).

Despite the net benefits of clinical trial networks, there is no national network for mental health in Australia (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 ANZ (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 could 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).

The Australian Government should fund the establishment of a national clinical trials network in mental health. This would improve the efficiency of clinical trials in mental health, improve the translation of research into practice and drive better outcomes for consumers and carers through higher quality care. In developing this network, there should be consultation with relevant bodies who work in this area including NMHRC and ACTA.

DRAFT RECOMMENDATION 25.9 — A CLINICAL TRIALS NETWORK SHOULD BE ESTABLISHED

In the short term (in the next 2 years)

The Australian Government should fund the establishment of a national clinical trial network in mental health and suicide prevention. In developing this network, the Australian Government should consult with bodies that work in this area including the National Medical and Health Research Centre and the Australian Clinical Trials Alliance.

26 Benefits of reform

Mental health reform matter because ...

- A better mental health system would improve people's quality of life, and their economic and social participation
- Economic growth would follow from a healthier and more productive population.

Successful reform requires

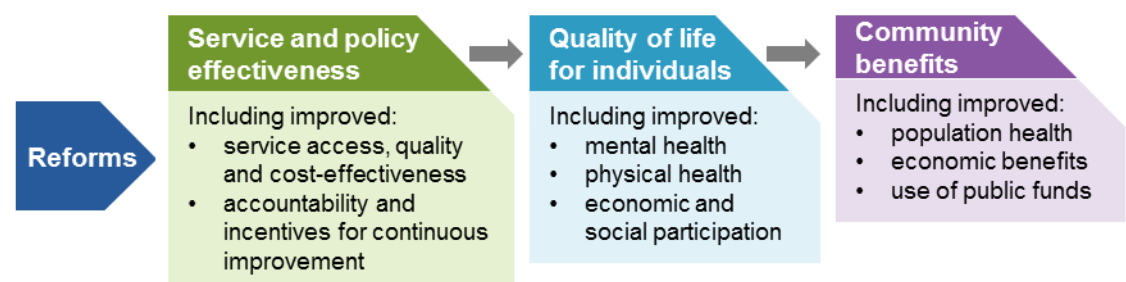
- Implementation should occur in stages. For some recommended reforms, implementation can commence in the short term, deploying existing resources and improving the efficiency of current programs. In other cases, the benefits of reform would take longer to be realised or additional evidence is required to show expected net benefits.
 - Cooperation and commitment by all levels of government, service providers and workplaces is essential for success.
-

Through the lens of participation and contribution, this inquiry examines how people with, or at risk of, mental ill-health can be enabled to reach their potential in life, have purpose and contribute to the lives of others. This benefits individuals — but it also enhances the wellbeing of carers, families and the whole community through more rewarding relationships with family and friends; more opportunities for carers; a greater contribution through volunteering and community groups; a more productive workforce; and an associated expansion in national income and living standards (figure 26.1).

A community is more inclusive and resilient when it is able to view mental ill-health in the same way as it views other health conditions — as preventable and treatable — and has compassion and respect towards the people affected by mental ill-health. Effective, accessible services can achieve early intervention and prevention, which would reduce the number of people who become unwell or die prematurely. As the mental health of the population improves, people would not require intensive support services as often, would be able to contribute more to the economy and community and have better quality of life.

If the Commission’s reforms are implemented, the benefits would be substantial. For this draft report, the benefits of some key proposed reforms have been modelled. The results show that the benefits likely to emerge as a result of these reforms could add up to the equivalent of between 4.6 and 6 years of healthy life per 1000 working-age people. This is expected to add an estimated \$8.8 to \$11.5 billion per year to Australia’s economy in the long term, as a result of increased employment and productivity (appendix F). This is equivalent to 0.5–0.6% of GDP (based on the June 2018 GDP level) (ABS 2018h). This estimate does not include an expansive range of other benefits from improved mental health, such as the social and emotional benefits of less time spent unwell and increased social participation, as these cannot be readily quantified.

Figure 26.1 **How mental health reforms benefit the whole community**



The Commission recognises that recovery from mental illness and staying well requires more than just a focus on healthcare and recommends ways to improve mental health as part of education, justice, housing and employment policies. The package of reforms that the Commission is proposing is summarised in chapter 4. The reforms aim to:

- create a person-oriented system that is responsive and sensitive to the needs and preferences of consumers and their carers and families
- increase the focus on prevention, early detection and intervention for people affected by mental ill-health
- remove the barriers to accessing mental health care — by addressing service gaps and workforce shortages, and providing clear gateways and pathways into and across the mental health system
- strengthen the foundations of the system, including more efficient funding arrangements and a new governance and monitoring framework to better support continuous improvement.

These reforms would translate into practical outcomes for people with mental ill-health, their carers and their families (figure 26.2). The reforms would reduce health inequality, especially for those in the community who have, in the past, found it difficult to access care that meets their needs.

This chapter describes the benefits of the proposed reforms and outlines what the reforms deliver for different people in the community and for governments. First, the results from the Commission’s model of the health and economic benefits of reforms are discussed (section 26.1). Benefits of reforms for different parts of the community are discussed in section 26.2. Looking beyond the numbers, the benefits to individuals are described in section 26.3. An implementation plan is outlined in section 26.4.

Figure 26.2 What do reforms mean for people with mental ill-health, carers and families?

Mild mental ill-health and those at-risk	Moderate mental illness	Severe mental illness
<p>Timely and culturally appropriate access to group therapy and clinician-supported online treatment options</p> <p>Early intervention, including effective social and emotional wellbeing support in early childhood education and schools</p>	<p>Greater access to mental health services in the community</p> <p>Better experiences in EDs and more peer and clinician led after-hours alternatives</p> <p>Practical application of mental health strategies by all employers and tertiary training providers</p>	<p>Improved access to:</p> <ul style="list-style-type: none"> • specialist mental health treatment • psychosocial supports • care coordination • effective employment support • supported housing • homelessness services • child and adolescent beds • peer workers • legal aid and advocacy services.
All mental health consumers, carers and families		
Less health inequality across different parts of the community	More appropriate assessment processes for income and employment support services	
Reduced stigma associated with mental illness	Family-focussed and carer-inclusive delivery of services	
Continuous improvement of services over time	More services to support carers	
More involvement in policy design	Effective suicide prevention programs	

26.1 Estimating the health and economic benefits of reforms

The Commission modelled the benefits of some key recommended reforms, to estimate their effects on labour market outcomes, wages and improved health-related quality of life. The preliminary results from the modeling are reported in table 26.1 and details about the methodology are described in appendix F.

The model uses existing evidence about how particular reforms might improve mental health and data from the Household, Income and Labour Dynamics in Australia (HILDA) survey to simulate the effects on the people likely to receive additional support (figure 26.3).

HILDA provides detailed information on how the lives of approximately 15 000 Australians have changed over the past 17 years, including their physical and mental health.

In this model, mental health is considered one aspect that affects an individual's likelihood to be employed and their productivity at work (Forbes, Barker and Turner 2010). For those already in employment, improvements to productivity are likely to increase their expected wage. For those not already in employment, improved mental health would increase their likelihood of employment and their expected wage if they were to be employed.

Figure 26.3 Estimating the benefits of reform

Summary of methodology in appendix F



To model how reforms improved people's health-related quality of life, the Commission used a measure called quality-adjusted life-years (QALYs) (box 26.1). A QALY equal to one means that someone is in perfect health for a year, and health-related quality of life is poorer as values reduce toward zero. A value of zero is equivalent to death and values less than zero reflect very severe disability or pain.

Table 26.1 **Estimated health and economic benefits of selected proposed reforms^a**

Reform category	Number of people benefiting	Quality-adjusted life-years		Wage income		Employment ^g	
		Total increase	Increase per 1000 people	Total increase (\$ million)	Increase per person (\$)	Total increase in employed persons	Increase in employment (%)
Improved social and emotional learning in early childhood and school education	6 308 682	33 445 - 42 912	5 - 7	4 266 - 5 569	676 - 883	43 132 - 58 515	0.7 - 0.9
Stigma reduction	2 398 643	11 971 - 15 342	5 - 6	1 340 - 1 761	559 - 734	16 631 - 22 670	0.7 - 0.9
Additional psychosocial supports	179 134	10 604 - 13 615	59 - 76	1 368 - 1 798	7 639 - 10 035	16 686 - 21 879	9.3 - 12.2
Additional community ambulatory mental health services	75 000	10 146 - 13 009	135 - 173	1 138 - 1 478	15 177 - 19 711	12 382 - 16 001	16.5 - 21.3
Expanded Individual Placement Support program ^{c,d,e}	50 000	..	..	104 - 109	2 072 - 2 186	16 667	33.3
Additional Youth Individual Placement Support places ^{c,d,e}	1 000	..	..	3	2 993 - 3 108	550	55
Expanded use of supported online treatment	50 000	1 482 - 1 903	30 - 38	196 - 255	3 925 - 5 108	2 023 - 2 713	4 - 5.4
Carer benefits from improved services for consumers ^c	42 536	..	..	111 - 162	2 602 - 3 817	2 113 - 2 973	5 - 7
Additional non-acute beds ^b	20 000	927 - 1 188	46 - 59	108 - 143	5 424 - 7 127	1 262 - 1 689	6.3 - 8.4
Changes to workers compensation for mental health related claims ^{c,f}	12 000	..	..	119 - 124	9 900 - 10 322	–	–
Improved aftercare for those who attempted suicide	1 074	692 - 700	645 - 652	54 - 55	50 003 - 51 132	823 - 835	76.6 - 77.8
Total	..	69 268 - 88 670	..	8807 - 11 458	..	112 268 – 144 492	..

^a Benefits from reforms are annual, and are described as a range (5th percentile to 95th percentile). Median results are reported in appendix F. ^b Non-acute beds refers to both subacute and non-acute beds. ^c Quality-adjusted life-years have not been estimated for reforms where there is no assumption of improved mental health directly resulting from the reform. ^d For Individual Placement Support (IPS) programs, the increase in employed persons does not have a range since the assumption for the change in employment is derived from an evaluation (rather than being modelled). ^e The small number of people benefiting from Youth IPS means that the estimated benefit in income is relatively small. A range is not presented for this estimate. ^f No additional employees gain employment as a result of these reforms.

^g Increase in employment for those directly benefiting from reform. .. Not applicable.

Source: Appendix F.

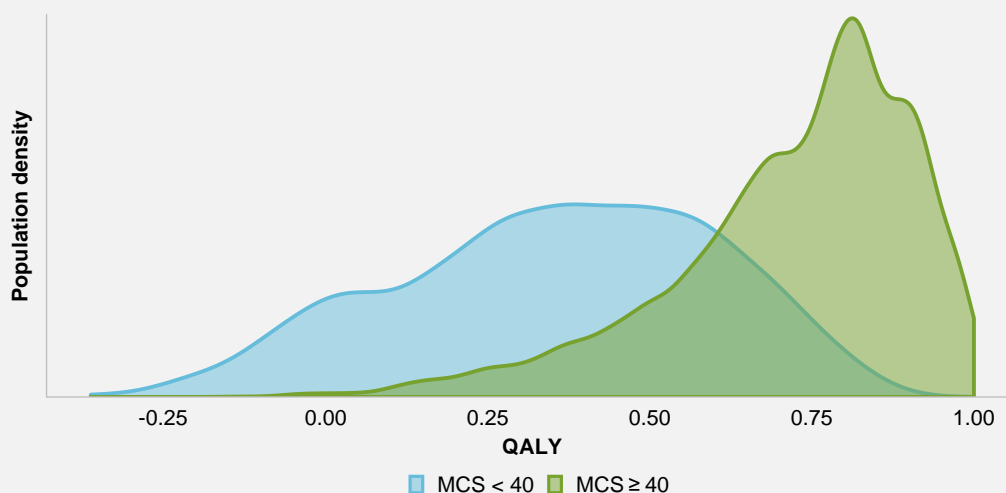
Box 26.1 Measuring health-related quality of life

The HILDA survey derives a measure for quality-adjusted life-years (QALYs) by combining a person's answers to the following physical and mental health related questions.

- During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (such as visiting friends, relatives, etc.)?
- How much does your health now limit you in: vigorous activities such as running, lifting heavy objects, participating in strenuous sports; and moderate activities, such as moving a table, vacuum cleaning, bowling or playing golf?
- How much does your health now limit you in bathing or dressing yourself?
- During the past 4 weeks, were you limited in the kind of work or regular daily activities as a result of your physical health?
- During the past 4 weeks, did you accomplish less than you would like as a result of any emotional problems (such as feeling depressed or anxious)?
- How much bodily pain have you had during the past 4 weeks?
- During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?
- How much of the time during the past 4 weeks have you: felt nervous; had a lot of energy; felt down?

The figure below shows that people with poor mental health experience much lower overall health than those without mental ill-health. Poor mental health in this case is defined as having a mental components summary (MCS) score of less than 40. The construction of the MCS is described in appendix F.

Distribution of QALYs in 2017 over the populations of people with and without mental ill-health:



Source: Melbourne Institute (2019); Productivity Commission estimates using HILDA (appendix F).

Unsurprisingly, the benefits of reform vary with the nature of the interventions — early intervention in schools increases future wages by a relatively small amount per person, but affects a large group of people. Greater access to specialised mental health services would substantially improve the quality of life for a smaller number of people (table 26.1).

The effects of the early childhood and school education reforms were assumed to have improved the mental health of 6.3 million working-age people (with below average mental health) by a small amount. Improved child social and emotional wellbeing support in schools and early education would result in 43 132 to 58 515 more people being employed as adults and they would earn an additional \$4.3 to 5.6 billion in income. This represents a 0.3% to 0.5% increase in the number of employed persons (ABS 2019c).⁵⁴

Several other results reported in table 26.1 were for interventions that applied to smaller groups of people with varying degrees of mental ill-health. While these groups may be smaller, the estimated benefit of these reforms to the individuals affected are considerable. For example, increasing the supply of community ambulatory mental health services would lead to 135 to 173 additional years of healthy life per 1000 people affected and increasing the supply of non-acute bed-based services would lead to 46 to 59 additional years of healthy life per 1000 people affected. Of the 75 000 people assumed to gain access to community ambulatory mental health services, between 17% and 21% gain employment and the group would likely earn an additional \$1.1 to \$1.5 billion in wages per year.

The reforms to workers compensation are assumed to halve the time spent on workers compensation and absent from work due to a mental health condition. The economic benefits of less time out of work for this group is about \$121 million, which is shared among the workers, their employers and the employers' insurers.

For carers, the Commission modelled how employment and productivity would increase if fewer carers chose to provide regular care as a result of increased supply of mental health services. More specifically, the Commission modelled how employment outcomes would change if formal services increased to the point where 35% of the carers of people with moderate mental ill-health no longer chose to provide regular informal care. Results showed that 5% to 7% could enter the workforce and the wages of the whole group would increase by between \$111 to 162 million (table 26.1).

The economic benefits of mental health reform are not just enjoyed by the people who receive the interventions and their families. First, a more productive and engaged workforce benefits employers too, through reductions in absenteeism and presenteeism as well as higher output. Second, increased productivity and employment and an additional \$8.8 to \$11.5 billion earned in wages per year has flow-on effects for economic growth. Third, increased employment and income also increase the tax base and tax revenue for governments and reduce expenditure on income support payments.

⁵⁴ ABS Cat. No. 6202.0, June 2019.

Benefits could not be modelled for all draft recommendations. In some cases, this was because the reforms aim to improve processes or system architecture, where benefits are diffuse. In other cases, draft recommendations propose the use of trials to expand the evidence base about the effectiveness of particular policy interventions. This chapter focuses on total benefits, without deducting the estimated cost of reforms. Where known, preliminary estimates of costs are discussed in section 26.4. The Commission is still refining calculations of the costs and benefits of implementing some of its proposed reforms, and will include those in the final report.

Further, the benefits described in table 26.1 represent additional income, employment and health benefits for a single year. The Commission did not model the cumulative effects over people's entire life. The modelled benefits would be much larger when summed over a lifetime, given that people receiving interventions that reduce or prevent mental ill-health earlier in life, can participate and thrive in the community for longer periods of time. Therefore, the Commission is proposing that changes that support mental health in the first 25 years of life be prioritised (chapters 17 and 18).

DRAFT FINDING 26.1 — MODELLED BENEFITS OF SOME KEY PROPOSED REFORMS

Improvements to people's mental health increases their likelihood of employment and their expected income, while also improving their health-related quality of life. In the long-run, the economic benefits from some key proposed reforms are likely to be between \$8.8 to \$11.5 billion dollars per year.

26.2 Reforms that benefit the whole community — by responding to people's needs

In designing its proposed reforms, the Commission focused on creating a mental health system that is person-oriented, where people with mental ill-health and their carers can access the services most suited to their needs, and navigate between services without falling through cracks. Such a system would also prioritise prevention and early intervention, given the substantial benefits these interventions can offer individuals and the community (chapter 4).

Many of the reforms modelled in table 26.1 increase access to services, which would also reduce health inequality. The stepped care model underpins the Commission's recommendations, including additional community mental health services and psychosocial supports (draft recommendation (DR) 5.9). Implementing these changes is likely to preventing people from experiencing more severe symptoms of mental illness, which would reduce unnecessary hospitalisations and increase the efficiency of the health system.

In addition, the Commission is recommending ways to increase access to clinician supported online treatment (DR 6.1). This would increase access to mental health care for people who face barriers due to physical distance from services, time constraints given their other activities, or anticipated stigma. 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 11). Of particular relevance is DR 11.7, which would assist in making employment in remote areas more attractive for health professionals by reducing professional isolation, increasing opportunities for professional development, and improving the scope to take leave.

Stigma associated with mental illness can discourage individuals from seeking treatment. There can be significant stigma associated with many culturally and linguistically diverse communities, which may compound the effects of stigma associated with mental illness. A national stigma reduction strategy would address different aspects of stigma and would build the evidence base for effective anti-stigma activities (DR 20.1).

People who experience socioeconomic disadvantage are at greater risk of mental ill-health. The Commission is recommending that, subject to successful trials, tailored employment support services for people with mental illness should be expanded (DR 14.3). Greater access to services for people with mental illness following discharge from hospital would help governments to meet a proposed commitment of zero exits into homelessness from inpatient care (DR 15.2).

The vast majority of mental health services that are currently provided in Australia take a ‘one-size-fits-all’ approach to service provision, one that does not always cater to the needs of individual consumers. Cultural and language differences can create substantial barriers for people who are seeking to access the support and care they need for their mental health. The person-oriented approach taken in this inquiry would benefit all Australians, including those whose needs do not align with a mainstream approach (chapter 4).

Aboriginal and Torres Strait Islander people experience mental ill-health at far higher rates than other population groups and face barriers to accessing services that meet their needs. The social and emotional wellbeing of Aboriginal and Torres Strait Islander people is strengthened by overlapping connections to culture, country, spirituality and ancestors, body, mind and emotions, family and kinship as well as community (chapter 20).

Policies and services intended to support the mental health of Aboriginal and Torres Strait Islander people must align with relevant concepts of wellbeing. The Commission’s draft report recognises this explicitly in several ways, including a recommendation to 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* (DR 22.2). An evaluation — informed by the views of Aboriginal and Torres Strait Islander people — of programs that use traditional healers to complement conventional mental health services would help mental health services to increase connection to culture (DR 20.3). The Commission’s reforms also empower Aboriginal and

Torres Strait Islander communities to prevent suicide through self-determination and local leadership (DR 21.2).

The Commission's mental health reforms proposed at all levels of the justice system would benefit people in correctional facilities who have a diagnosed mental illness (chapter 16). In particular, the provision of culturally capable, trauma-informed mental health services both in correctional facilities and upon release would improve the wellbeing of Aboriginal and Torres Strait Islander people and in time, may contribute to reducing over-representation of Aboriginal and Torres Strait Islander people in the justice system.

Greater use of peer workers is one way to increase access to mental health workers who have an understanding of people's different values, preferences and cultural needs across a wide range of community groups. The Commission is recommending reforms related to peer workers, including by educating other health professionals about how peer workers can improve outcomes for people with mental illness (DR 11.4).

Reforms that incorporate the consumer and carer voice will contribute towards more responsive services. These include reforms to improve collaboration with consumers and carers in all aspects of mental healthcare system planning, design, monitoring and evaluation (DR 22.4) and the proposed increase to advocacy services for people subject to involuntary treatment (DR 16.7).

26.3 Looking beyond the numbers

The economic and health benefits of the reforms that the Commission estimated are significant (section 26.1). However, it is difficult to fully appreciate all the ways that the proposed reforms could affect people's lives by looking at the numbers alone. The stories that follow are fictional, but demonstrate how the Commission's draft recommendations could improve access to a range of supports for each individual, their carers and family. The vignettes describe the effects of reforms for people with mild, moderate or severe mental illness and with varying needs for psychosocial and other supports.

Reduced barriers to treatment for mild mental health problems

2.3 million people experience a mild mental health problem each year (chapter 1).

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 improved, he does not feel like himself. He no longer looks forward to social events and 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 Commission's proposed reforms, he:

- understands that a lot of people feel the way he does, as a result of the national stigma reduction strategy's public information campaign (DR 20.1)
- learns about the benefits of clinician supported online therapy as a result of the public information campaign and enrolls in a service (DRs 6.1 and 6.2)
- feels comfortable enough to speak to his GP at his next check-up and the GP encourages him to keep in contact about how he finds the online therapy. Angelo chooses to forward the outcomes data from the online treatment to his GP (DR 6.1).

He values clinician supported online therapy because it is discreet and he can use it from home in the evening. He begins to feel better and able to participate more 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.

Services that support people to achieve their goals

Kim is 24 years old and recently left a traumatic domestic relationship. She is working nights at a local pub to make ends meet for her and her young son. She feels anxious and sometimes struggles to cope with the various 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 would again like to try to gain a post-school qualification to improve her job and financial security. This time, when she is unable to complete a module in the online vocational training course in which she's enrolled, the staff at the training provider are equipped to provide her with the support she needs to finish her qualification (DRs 18.1 to 18.3).

Kim's GP uses the online service navigation platform to help her access therapy that would work best for her (DR 10.2). She chooses to see a psychologist over videoconference because it is affordable and appointments fit flexibly around her family, work and study commitments (DR 5.7).

65% of students, aged 16–25 years reported high levels of psychological distress (chapter 18).

Better support for teachers and students

Nick is a high school teacher who is passionate about his job and trusted by his students. One of his Year 9 students who previously had been a very good student is no longer participating in class and has trouble concentrating. When he asks the student about this, she opens up about some problems she has been having and that she has been self-harming. Nick does not know what to do to get help for her.

12% of girls and 4% of boys aged 12 to 17 years self-harmed in the previous 12 months (chapter 2).

As a result of the Commission's proposed reforms:

- the teacher can seek the advice of his school's wellbeing leader (DR 17.5), who speaks with the student and puts her in contact with a mental health professional.
- social and emotional wellbeing programs in which the student participates throughout her schooling are effective and evidenced-based (DR 7.6), and provide her with a greater understanding of mental health and that effective treatment is available
- Nick learns more about social and emotional development and wellbeing as part of his professional development requirements (DR 17.6), which better prepares him for these issues in the future.

Mentally healthy workplaces are productive workplaces

Jade is a nurse at a small regional hospital. She works closely with patients recovering from mental illness and drug and alcohol misuse. Her work is highly valued by patients and co-workers. She often feels stressed and is not sure how much longer she will continue in this line of work.

The nature of the work is challenging but Jade has been able to manage the risks to her wellbeing in the past when she was well-supported by her employer. Challenges that nurses face include exposure to the trauma and suffering of others, making difficult decisions about balancing people's safety and their independence, and she has been the victim of verbal abuse.

Jade's workplace has had issues with staff retention, recruitment and turnover, which has contributed to a loss of skills and a reduced staff-to-patient ratio. She therefore 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 as she would like to recharge and spend time with family.

As a result of the health, governance, funding and monitoring reforms, gaps in funding for regional services improve over time. Reforms to the mental health workforce would help Jade's workplace reduce staff turnover (DRs 11.1 and 11.7) and make it easier to recruit new mental health nurses (DRs 11.3 and 11.6).

In addition, the Commission's proposed reforms result in workplaces taking workplace mental health risks as seriously as physical health and safety risks (DRs 19.1 and 19.2). Jade's employer now has a better understanding of what they can do to support staff, and jobs are 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

There were 22 000 nurses working in mental health in 2017 (chapter 11).

Health and welfare support workers are more likely than others to make a serious work-related mental health claims (chapter 19).

psychological injury are used to lower workers compensation scheme premiums (DR 19.3).

As a result of these changes, Jade plans to stay on at her workplace. 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 reduced.

Better mental health can improve physical health too

About 684 000 people will need psychosocial support in 2019 (chapter 12).

Almost 1 million people in Australia provided regular support to someone with a mental illness in 2015 (chapter 13)

Adel is 40, has a psychosocial disability from his mental illness and diabetes. He often feels lonely because he does not work or study, and finds it difficult to form friendships. His 63 year old father, Nasir, provides him with significant emotional and practical support, such as cooking his meals and helping him to manage his diabetes. Nasir is finding it increasingly difficult to continue this role as he is getting older and has health issues of his own.

As a result of the Commission's reforms, Adel's GP uses the online service navigation platform to find him psychosocial supports in the local area (DR 10.2). A more effective monitoring and reporting framework provides feedback on service effectiveness that keeps providers responsive to consumer needs (DRs 25.3 to 25.5). Services become more effective over time as the funding cycle for these services becomes more stable (DR 12.1).

Adel's psychosocial support service acts as a gateway to the broader community and helps improve his capacity to manage his health and everyday activities. They encourage him to engage with a community mental health service for the first time in years. This treatment, combined with the social connections that he formed over time volunteering at a community garden, really help his recovery. Once his mental illness is better managed, he starts to take a more proactive role in managing his diabetes.

It took time for Adel to build trust with the psychosocial support service and the community mental health care service, and throughout this transition Nasir continued to provide him with a significant level of support. The mental health service has adopted more carer-inclusive practices — one practical thing they did that helped was obtaining Adel's consent to share information about his medication with Nasir to enable him to better support his son at home (DR 13.3).

Care that considers the needs of the whole family

Michelle lives with borderline personality disorder and has three children under the age of 14. Her eldest child oversees the housework, provides emotional support to her mother, helps the other children with their homework, and sometimes misses school as a result of these responsibilities.

As a result of the Commission's proposed reforms, Michelle would have improved access to mental health care that meets her needs. Her treating physician receives support to improve the knowledge and skills needed to provide care that considers the needs of the whole family (DR 13.3).

Michelle receives psychosocial support for her everyday support needs, which reduces the caring responsibilities of her child (DR 23.2). Her children participate in young carer support services available in the area (DR 23.1), which helps them understand

About 5% of children aged 8 to 14 years provided care to a family member with mental illness or who were using alcohol or other drugs in 2014 (chapter 13).

borderline personality disorder better and provides opportunities to connect with children in similar situations.

Several studies have found that young carers are at risk of poorer educational outcomes than their non-carer peers (chapter 13). More tailored support for families affected by mental illness would help young carers to achieve their goals.

Coordinated access to a range of supports for people with complex needs

Over 5000 people with mental health issues could benefit from greater access to tenancy support services, particularly those living in the private rental market. (chapter 15).

Tom is 32 and lives in a regional town. He has lived with a mood 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.

There is a private psychology clinic in town but he cannot afford the treatment he needs and the waitlist is long. 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.

As a result of the Commission's proposed reforms, there would be more mental health care options for people in regional areas. There would be greater incentives for psychiatrists to provide psychiatric assessments by videoconference and provide timely advice to GPs (DRs 5.2 and 7.2). There are more peer workers employed locally (DR 11.4), and he finds increased hope for recovery after receiving support from a peer worker who has lived experience of a mood disorder.

Identifying and building on Tom's strengths help 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 (IPS) employment support service (DR 14.3). The IPS service is integrated with his mental health care 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 (DR 15.1).

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 (ED). The discharge plan was comprehensive but did not make adequate arrangements for coordinating his mental health care in the community or for somewhere to live.

Alex has 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 and soon becomes unwell again. The police are called to respond to unusual behaviour but, as a result of the Commission's reforms, this time would be different.

- The police would have access to real-time information from mental health professionals (DR 16.1). This time, a mental health worker assists the policeman and paramedics who attend to Alex.

800 000 people in Australia live with severe mental illness (chapter 1).

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- There are more alternatives to the ED, and Alex is assessed by a clinician at an after-hours service while a peer worker gives him support (DR 8.1).
 - Once admitted to hospital, Alex is assigned a care coordinator who takes responsibility for organising the services in his discharge plan and ensuring there is continuity of care (DR 10.4). 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 (DR 10.3).
 - Importantly, his care coordinator is able to find him housing that integrates with mental healthcare and support to maintain his housing (DR 15.2).

26.4 Effective implementation is key to realising the benefits of reform

Implementing the Commission's reforms would require additional expenditure but would produce savings in some areas over time

The Commission's package of reforms includes proposals that would result in better use of existing expenditure; reform options that can improve mental health with little additional recurrent expenditure; and a range of cost-effective interventions that should be expanded or trialled. Whether or not a particular intervention to improve mental health is cost-effective depends both on the efficacy of the intervention and the cost of alternatives. The benefits of an intervention should be measured broadly, and include the health and economic benefits that accrue to the individual who receives a service, their carers and family; and the savings to taxpayers from reduced demand for other services in the future.

For example, the Commission proposes to build on existing expenditure on care coordination service, to ensure that people with severe mental illness and complex needs have access to a care coordinator. There are many existing programs that provide care coordination; however, due to lack of planning, some people may have more than one care coordinator, while others who need the service are missing out. The Commission proposes that local commissioning authorities audit the services provided in their area, with a view to streamlining services. Expenditure could then be redirected towards providing more consistent services to people who need them (DR 10.4).

Additional government funding is not needed for some proposed reforms. For example, extending the length of contracts for psychosocial services from 1 year to a minimum of 5 years (DR 12.1) is unlikely to carry substantial costs. Other reforms have limited costs, but are likely to deliver substantial benefits, such as providing employers with codes of practice to help them meet their duty of care for mental health in the workplace (DR 19.2).

In some cases, the Commission anticipates that its proposed reforms would involve an increase in government spending in the short and medium term. For example, the Commission proposed an increase in Australian, State and Territory Government funding for housing and homelessness services of \$450 million to \$1.2 billion per year (chapter 15).

Of this, about \$100–\$600 million would be for additional mental healthcare and psychosocial support services for people living in integrated supported housing and housing programs for people transitioning out of institutional care. The remainder would be administered by State and Territory Governments’ housing departments. The draft recommendation to employ a wellbeing leader in every government school may impose a cost of up to \$660 million per year on State and Territory Governments, although some funding could be redirected from existing programs (DR 17.4).

However, additional expenditure would lead to substantial benefits (section 26.1) and reduce the costs to Australia of poor mental health. The costs of mental ill-health and suicide on people with mental ill-health and the broader community is large and pervasive — in the order of \$43 to \$51 billion in 2018-19 (chapter 3).

Further, it is not known how much additional funding is needed because some funding can be redirected from existing expenditure over time — fiscal savings are expected through several mechanisms. First, there are the specific reforms that we have proposed that would improve efficiency. Second, governments can achieve better outcomes with each dollar spent over time by gathering better information about ‘what works’ and improving incentives for continuous improvement. Third, providing access to appropriate mental health care in line with the stepped care model would reduce expenditure on acute health services and social services over time.

Savings from spending existing expenditure better

There is considerable scope for governments to use existing mental health funding to deliver better outcomes for people. For example, the Commission is recommending that additional payments for psychiatrists to use videoconferencing be removed (DR 7.2), and this may save \$15 million per year, which could be reallocated (chapter 7).

The Commission’s monitoring, reporting and funding reforms would encourage services to provide more effective treatment. The treatment people receive is not always consistent with best practice (chapter 1). Andrews et al. (2004) found that switching from typical treatments to optimal treatments in Australia would almost double the cost-effectiveness of treatment.

Although \$424 million was spent on psychosocial supports in 2016-17, there is little known about the consumer outcomes being achieved from this expenditure (chapter 12). Moreover, both levels of government provide similar psychosocial supports, which begets gaps and overlaps in service provision and inefficient service delivery. To rectify this, the Commission is proposing that State and Territory Governments take on sole responsibility for commissioning psychosocial supports (DR 23.2).

About \$2 billion was spent on community ambulatory mental healthcare services in 2016-17. The way they are funded (block funding) does not drive productivity, and incentivises Local Hospital Networks to preference more expensive hospital-based care (chapter 23). The proposed review of the Australian Mental Healthcare Classification puts community

ambulatory mental health services on a pathway towards activity-based funding that would improve efficiency and take pressure off hospitals (DR 23.1). In future, funding would be conditional on evidence that mental health programs and interventions are cost-effective (DR 25.8).

Similarly, schools invest a lot of effort in improving social and emotional learning each year and are faced with choosing from a crowded and overlapping list of programs. Little is known about the effectiveness of many of these programs. Schools would provide better and more cost-effective social and emotional wellbeing programs once these programs are accredited to ensure their quality (DR 17.6).

The Commission is recommending a range of trials and evaluations to improve the evidence-base (DRs 5.5, 13.3, 14.3, 17.9, 20.1). In addition, the Commission has proposed that the National Mental Health Commission lead and coordinate evaluations nationally and sponsor relevant research in mental health and suicide prevention (DR 22.5). Existing public expenditure would be allocated more effectively as the evidence about ‘what works’ (and what does not) guides better decision-making and contributes to continuous improvement.

Addressing unmet demand for community services reduces demand for more expensive alternatives

Governments should ensure that all Australians have access to the level of mental healthcare care that most suits their treatment needs, in line with the stepped care model (DR 5.9).

Given the latest evidence about the effectiveness and cost-effectiveness of low-intensity services and clinician-supported online treatment options for people with mild mental ill-health, the Commission is recommending ways to increase the take-up of these services (DRs 5.6 and 10.1). Group therapy, for example, is a third the cost of individual therapy but works at least as well for many conditions (chapter 5). In addition, headspace centres would be encouraged to provide services in line with the stepped care model (DR 5.3).

Chapter 7 describes the potential savings on acute services if gaps in the stepped care model were filled for people with mental health care needs that can be met in the community. It costs much more to manage a patient in an acute hospital bed than in community residential care. Costs are lower still for non-bed based services provided in the community.

There are significant avoidable costs associated with the delayed discharge of people from hospital because of insufficient supported housing places, community ambulatory services, and non-acute bed-based services. Surveys suggest that about 30% of mental health inpatients could be discharged if appropriate alternatives were available. This translates to more than 2000 people stuck in hospital beds. Every person able to be moved from an acute public inpatient bed (daily cost of \$1212) to a community residential care with 24-hour staff (daily cost of \$530) is a saving in the health system and potentially improved quality of life for the person involved (chapter 7).

When more people can access appropriate treatment in the community, they are less likely to present at an ED or require an acute hospital beds. For example, additional step-up, step-down services in New South Wales were expected to reduce hospitalisation rates by 16%, shorten length of hospital stays by 7 days, and reduce the risk of ED presentations by 40% (MHCC 2018, p. 13). Additional provision of these services was estimated to pay for itself over time, yielding savings of \$9480 per person per year (MHCC 2018, p. 13).

In the short term, the reduced demand for acute care may not lead to reduced expenditure. Rather, patients who are currently missing out on care — because they are not being admitted, or are being discharged early — would be provided with the care they need. In the longer term, this saving could be realised as a reduced need to increase bed numbers.

A healthier population would lead to reduced demand for some services over time

A significant proportion of current healthcare costs are associated with treatment for people living with severe and complex mental ill-health (chapter 3). Providing people with the support they need would result in a healthier population that needs fewer acute health services and fewer social services, such as homelessness and justice services. Earlier intervention and prevention of mental ill-health would require additional expenditure in some government portfolios but would deliver benefits in other parts — sometimes in the near term, but more often, many years later. For example, an increased focus on mental health in schools and workplaces would reduce the likelihood that mental health problems occur or worsen.

Addressing unmet needs for supported housing is expected to reduce hospitalisations and associated health expenditure. For example, the Housing and Accommodation Support Initiative in New South Wales was found to reduce hospital usage of participants and the savings almost completely offset the non-accommodation costs of the program (chapter 15). The Commission is recommending governments increase the number of supported housing places that integrate housing, tenancy support services and mental health services (DR 15.2).

Adequate aftercare for people who have attempted suicide, including discharge planning and follow up support, is an effective way to prevent future suicide deaths and attempts (chapter 21). This prevents immeasurable suffering and tragedy and in addition, prevents the loss of economic activity attributed to people whose future suicide attempt would be likely to result in death or full incapacity. In this way, and after taking into account program costs, aftercare could provide a long-term return on investment of \$5.82 to \$36.57 per dollar invested (chapter 21).

Some interventions provide a net benefit to tax payers. Reforms that improve the effectiveness of school-based early intervention and prevention programs (DRs DR 17.3 and 17.6) are likely to benefit taxpayers. The National Mental Health Commission analysed the expected costs and benefits incurred in delivering a range of interventions aimed at preventing mental illness, including anxiety and depression. In all cases, the benefit of interventions was found to outweigh the costs. In particular, interventions focusing on

preventing anxiety in children and young adults, and postnatal depression, were shown to substantially reduce healthcare costs and lost productivity (NMHC 2019e).

Programs that prevent discharge from hospital into homelessness have also been shown to produce strong returns on investment for tax payers (chapter 15). For example, the Royal Perth Hospital Homeless Team reduced hospital use by about \$7900 per patient and the average cost of the program was about \$850 per patient. The Commission estimated that these types of programs could deliver a net benefit to tax payers of between \$21 million to \$276 million each year.

Implementation timeframe

Effective implementation will be crucial if the benefits of the Commission's proposed reforms are to be more than theoretical. Intergovernmental cooperation is required because of the complexities of the mental health system. Although fiscal costs may be borne by one tier or area of government, the fiscal benefits are often enjoyed by both tiers of government and by multiple agencies. The reforms have the potential to reinforce each other — improvements to mental health are likely to increase if health reforms are pursued while making progress on access to housing and psychosocial supports.

Having a well-considered implementation timeframe and reform priorities would also improve chances of success (figures 26.4 and 26.5). Given fiscal and other constraints, reform in the mental health system will require Governments to make choices as to priorities, not just within the mental health system but across all areas of public expenditure.

Recognising these constraints, the Commission has suggested priorities based on:

- reforms that could be implemented quickly, often deploying existing resources, to bring about immediate benefits for those already experiencing mental illness. These are typically interventions that have a sound evidence base indicating that they are cost effective and can deliver significant benefits either to a small group in the population or community-wide. They involve comparatively little disruption to other parts of the community, a redirection of existing funding or relatively small additional expenditure.
- reforms that should be started in the short term, but with the understanding that benefits, while potentially substantial and widespread, may not be evident for many years. In some cases, these reforms may require agreement between multiple governments, multiple parts of a government, or additions to the workforce needed to deliver the relevant services.
- reforms that are likely to be beneficial, but where further evidence and evaluation is needed. In these cases, the Commission has recommended trials to determine the future direction of policy.

The final report will contain more guidance on implementation, including prioritising and sequencing the reforms.

Figure 26.4 **Implementation timeline for the Australian Government**
Proposed timeframes for commencing reforms

Priorities for the next 2 years	Start later
<p>Early help for people Reduce stigma amongst health professionals</p> <p>Provide aftercare following a suicide attempt</p> <p>Indigenous communities are empowered to deliver local suicide prevention activities</p> <p>Improving mental healthcare Care coordinators for consumers with the most complex care needs</p> <p>Expand clinician-supported online treatment options</p> <p>Navigation platforms for mental health referral pathways</p> <p>Improving surrounding services Encourage growth in long-term supported accommodation to meet the needs of people with severe and persistent mental illness in the NDIS.</p> <p>Participation education and work Increase the appropriateness of job plans for those people with mental illness who are using employment services</p> <p>Provision of no-liability medical treatment for mental health related workers compensation claims</p> <p>Funding and commissioning reform COAG to set clear funding responsibilities, determine outcomes targets and set data collection, monitoring & evaluation arrangements</p> <p>Expedite National Strategic Framework for Aboriginal & Torres Strait Islander Peoples' Mental Health & Social & Emotional Wellbeing</p> <p>Include consumers and carers in all mental health program development</p>	<p>Early help for people Assess lessons from suicide prevention trials</p> <p>Evaluate best practices for partnerships between traditional healers and mainstream mental healthcare</p> <p>Improving mental healthcare Strengthen the peer workforce</p> <p>Help GPs access advice from psychiatrists</p> <p>Incentivise family-focused & carer-inclusive care</p> <p>Single care plan with electronic sharing of information</p> <p>Participation education and work Staged rollout of Individual Placement & Support programs to job seekers with mental illness</p> <p>Reduce barriers to income support for mental health carers</p> <p>Safe Work Australia along with WHS agencies to work with employers to collect & disseminate information on effectiveness of workplace programs & interventions</p> <p>Funding and commissioning reform National Mental Health Commission to have statutory authority</p> <p>Link regional mental health funding to volume of regional MBS rebates</p> <p>Use data collections to improve services and choices for consumers</p>

Figure 26.5 Implementation timeline for State and Territory Governments
Proposed timeframes for commencing reforms

Priorities for the next 2 years	Start later
<p>Early help for people</p> <ul style="list-style-type: none"> All schools to have a wellbeing leader Incorporate social & emotional wellbeing checks into existing physical development checks for 0 to 3 year olds Reduce stigma amongst health professionals Provide aftercare following a suicide attempt Indigenous communities are empowered to deliver local suicide prevention activities <p>Improving mental healthcare</p> <ul style="list-style-type: none"> Care coordinators for consumers with the most complex care needs Determine regional needs for acute & non-acute beds & ambulatory services Navigation platforms for mental health referral pathways Provision of child & adolescent mental health beds separate to adults Provide peer-led and after-hours alternatives to ED <p>Improving surrounding services</p> <ul style="list-style-type: none"> No exits into homelessness Meet the gap in supported housing and homelessness services for people with severe mental illness Standards of care in correctional facilities to be equivalent to care in community, and ensure culturally capable mental health care in correctional facilities Mental health expertise to support police & paramedics <p>Participation education and work</p> <ul style="list-style-type: none"> Effective outreach for disengaged school students Provision of no-liability clinical treatment for mental health related workers compensation claims Amend WHS laws to elevate the importance of psychological health & safety <p>Funding and commissioning reform</p> <ul style="list-style-type: none"> COAG to set clear funding responsibilities, determine outcomes targets and set data collection, monitoring & evaluation arrangements Expedite National Strategic Framework for Aboriginal & Torres Strait Islander Peoples' Mental Health & Social & Emotional Wellbeing Include consumers and carers in all mental health program development 	<p>Early help for people</p> <ul style="list-style-type: none"> Expand parent education programs Strengthen skills in workforces of early childhood education and care, and schools to support child social and emotional development <p>Improving mental healthcare</p> <ul style="list-style-type: none"> Strengthen the peer workforce Incentivise family-focused & carer-inclusive care <p>Improving surrounding services</p> <ul style="list-style-type: none"> Develop disability justice strategies to ensure rights of people with psychosocial disabilities are protected in interactions with justice system Advocacy services for those subject to involuntary mental healthcare Improve rigour of mental health screening in correctional facilities Expand tenancy support services to private housing <p>Participation education and work</p> <ul style="list-style-type: none"> Staged rollout of Individual Placement & Support programs to job seekers with mental illness WHS agencies to work with employers to collect & disseminate information on effectiveness of workplace programs & interventions <p>Funding and commissioning reform</p> <ul style="list-style-type: none"> Link regional mental health funding to volume of regional MBS rebates Take policy responsibility for non-NDIS psychosocial and carer supports

PART VI — Supporting material

A Inquiry conduct and participants

This appendix describes the stakeholder consultation process undertaken for the inquiry and list the organisations and individuals who have participated.

Inquiry terms of reference

The terms of reference for the inquiry — reproduced at the end of the appendix — was received from the Treasurer on 23 November 2018. The inquiry was advertised in *The Australian* on 5 December 2018.

Consultations and input to the inquiry draft report

The Commission released an Issues Paper on 21 January 2019 to assist interested stakeholders in preparing their submissions and comments. There were 564 submissions received by the Commission prior to the release of this draft (table A.1). All public submissions are available on the inquiry website. The Commission also provided facilities on the inquiry website for interested stakeholders to lodge a brief comment. A total of 191 comments were received prior to the release of this draft (table A.2, figure A.1)

Throughout the course of the inquiry to date, we have had separate discussions with businesses, business groups, government agencies, academics and other individuals across Australia in 18 towns and cities (table A.3).

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 has convened via teleconference on three occasions to date and was used as an avenue through which to gather together information on mental health programs and supports delivered by State and Territory Governments.

What's next?

The Commission welcomes further contributions to the inquiry from interested individuals or groups. Public hearings have been scheduled to be held in Brisbane, Broken Hill, Canberra, Geraldton, Launceston, Melbourne, Perth, Sydney and Rockhampton during November and December 2019. Additional public hearings will be scheduled in South Australia and Northern Territory for early 2020.

Submissions and comments on this draft report close on **Thursday 23 January 2020**.

The final report for the inquiry will be provided to Government by 23 May 2020, and is required under the *Productivity Commission Act 1998* (Cth) to be tabled in parliament and released publicly within 25 parliamentary sitting days thereafter.

Table A.1 Public submissions received

<i>Participant</i>	<i>Submission no.</i>
Dianne Wynaden and Karen Heslop	1
Matthew Macfarlane	2
Bob and Barnaby Eden	3
Port Macquarie Community College	4
Michael Troy	5
Justin Kenardy	6
Name withheld	7
Name withheld	8
Name withheld	9
Name withheld	10
Supportive Residents and Carers Action Group inc	11
Robert Parker	12
Name withheld	13
Angela Martin	14
Vikein Mouradian	15
Name withheld	16
Aaron Fornarino	17
Ron Spielman	18
Medical Consumers Association (MCA)	19
Michael O'Donnell	20
Jessica Houston	21
NorthWest Area Mental Health Services	22
Name withheld	23
Name withheld	24
Woden Community Service	25
Brin Grenyer and Ely Marceau	26
Association of Australian Medical Research Institutes (AAMRI)	27
Penelope Knoff	28
Jigsaw Queensland Inc	29
Hope Community Services Ltd	30
Name withheld	31
Name withheld	32
Stephen Brown	33
Merridee & Nicholas de Jong	34
Terry Deacon	35
Meg Polacsek	36
Olav Nielssen	37
Name withheld	38
Coronial Reform Group (CRG)	39
Roger Gurr	40
Name withheld	41
Gateway Health	42

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Table A.1 (continued)

<i>Participant</i>	<i>Submission no.</i>
John Mills	43
Niall McLaren	44
Anthony Jorm	45
Sax Institute	46
Blue Knot Foundation	47
John Pink	48
Private Mental Health Consumer Carer Network (Australia)	49, 547, 550
Wendy Laupu	50
John Herbert	51
Loddon Mallee Mental Health Carers Network (LMMHCN)	52
Anglicare NT	53
Eating Disorders Victoria (EDV)	54, 329
Bullied Teachers Support Network	55
Windana	56
Deborah Cobb-Clark, Sarah Dahmann, Nicolas Salamanca and Anna Zhu	57
Name withheld	58
State and Territory Alcohol and Other Drug Peaks Network	59
Australian and New Zealand Academy for Eating Disorders Inc (ANZAED)	60
Darren Jiggins	61
Canberra Mental Health Forum	62
Name withheld	63
Mindgardens Neuroscience Network	64
Martha Henderson	65
Name withheld	66
Name withheld	67
Ronald Duncan	68
Life Engineering TM	69
Diversity Council Australia (DCA)	70
Richard Taylor	71
Peter Heggie	72
Ingrid Ozols	73, 80
BPD (Borderline Personality Disorder) Community	74
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)	75
Grant Family Charitable Trust (GFCT)	76
St John of God Health Care and Community Services	77
Western Australian Department of Local Government, Sport and Cultural Industries (DLGSC)	78
Name withheld	79
Name withheld	81
Department of Communications and the Arts	82
Jodie Gale	83
Clive Kempson	84

(continued next page)

Table A.1 (continued)

<i>Participant</i>	<i>Submission no.</i>
Queensland Family and Child Commission (QFCC)	85
Paul Gray	86
Lifeline Australia	87
Marathon Health	88
EFT Australia Pty Ltd	89
Karen Donnelly	90
Exercise and Sports Science Australia (ESSA)	91
Brian Haisman	92
Michael Carman Consulting	93
Connect Health & Community	94
Uniting Vic.Tas	95
Australasian Sleep Association	96
Rural and Remote Mental Health (RRMH)	97
Name withheld	98
Youth Mental Health, North Metropolitan Health Service	99
SleeplessNoMore – (Eyrie Pty Ltd)	100
The Florey Institute of Neuroscience and Mental Health	101
Western Australian Network of Alcohol and Other Drug Agencies (WANADA)	102
Relationships Australia	103
Name withheld	104
Department of Developmental Disability Neuropsychiatry	105
Moonee Valley City Council	106
Outback Futures	107
One Door Mental Health	108
Name withheld	109
Australian Unity	110
Legal Aid NSW	111
breakthru	112
Australian Museums and Galleries Association (AMaGA)	113
Foster Care Association of Victoria (FCAV)	114
Friends for Good Inc	115
Queensland Advocacy Incorporated (QAI)	116
EML	117
National Mental Health Commission (NMHC)	118
Anne-Marie Elias	119
Merri Health	120
Samaritans Foundation	121
Name withheld	122
SNAICC-National Voice for our Children (SNAICC)	123
Siblings Australia	124
Social Ventures Australia (SVA)	125
Michelle Smith	126

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Table A.1 (continued)

<i>Participant</i>	<i>Submission no.</i>
Better Place Australia	127
Inner South Family and Friends	129
SANE Australia	130
VicHealth and Partners	131
Becoming Us	132
Robert Davis	133
Prevention United	134
Accoras	135
Name withheld	136
Dean Harvey	137
Alicia Halls	138
The Painter – The Writer Gallery	139
Australian Chronic Disease Prevention Alliance (ACDPA) and Quit Victoria	140
Occupational Therapy Australia (OTA)	141
Karen Holmes	142
NSW Council of Social Service (NCOSS)	143
Melbourne Disability Institute	144
Council to Homeless Persons (CHP)	145
Community Life Batemans Bay Inc (CLBB)	146
Brian Shevlane	147
Centre for Mental Health Research (CMHR)	148
Peter Viney	149
Annette Valentine Eriksen	150
Aborigines Advancement League (AAL)	151
East Metropolitan Health Service (EMHS)	152
InnoWell Pty Ltd	153
Museum of Contemporary Art Australia	154
Top End Association of Mental Health Incorporated (TeamHEALTH)	155
Deakin Health Economics, Institute for Health Transformation	156
National Centre for Epidemiology and Population Health (NCEPH)	157
Kim Devlin	158
Trinity Ryan	159
James Alexander	160
Mental Health Carers ARAFMI Illawara	161
Katherine Vavasour	162
Name withheld	163
Stefanie Roth	164
Safe Motherhood for All Inc	165
KYDS Youth Development Service (KYDS)	166
Peter Blackwell	167
Glenn Morrow	168
Peter Tregear	169

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Table A.1 (continued)

<i>Participant</i>	<i>Submission no.</i>
Sydney Treatment Alternatives Advocacy Group	170
Mental Health at Work	171
Painaustralia	172
Patricia Sutton	173
Brave Therapy	174
NPS MedicineWise	175
Hobsons Bay City Council	176
Australian Services Union (ASU)	177
MindSpot	178
Peer Participation in Mental Health Services Network (PPIMS)	179
Name withheld	180
Douglas McIver	181
Star Health Group Ltd	182
Carers NSW	183
Speech Pathology Australia	184
Australian Library and Information Association (ALIA)	185
WISE Employment	186
Eastern Health – Murnong Adult Mental Health	187
Patricia Baird	188
Pain NT	189
Anglicare Sydney	190
Melbourne Children's Campus Council	191
Carolyn Davis	192
Healing Foundation	193
Grow Australia	194
Foundation for Rural and Regional Renewal (FRRR)	195
Shelter Tasmania	196
Montelukast (Singulair) Side Effects Support and Discussion Group	197
Friends of Callan Park (FOCP)	198
Community Services Industry Alliance (CSIA)	199
Shelter WA	200
AMAZE	201
Catholic Social Services Australia (CSSA)	202
Neighbourhood Houses Victoria	203
Orygen, The National Centre for Excellence in Youth Mental Health and headspace, National Youth Mental Health Foundation (Orygen and headspace)	204
David Clark	205
Aboriginal Health and Medical Research Council (AH&MRC)	206
Name withheld	207
Australian Industry Group (Ai Group)	208
Mentally Healthy Workplace Alliance	209
ACT Government	210
Centre for Excellence in Child and Family Welfare	211

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Table A.1 (continued)

<i>Participant</i>	<i>Submission no.</i>
Navitas	212
Allianz Australia	213
Mental Health Coordinating Council (MHCC)	214
Jane Bradbear	215
SuperFriend	216
Mindseye Training and Consulting	217
Australian Longitudinal Study on Women's Health	218
Jayne Wells	219
ReachOut Australia	220
Early Childhood Australia	221
Private Healthcare Australia (PHA)	222
Vegan Australia	223
Mental Health First Aid Australia	224
Victorian Aboriginal Community Services Association Limited (VACSAL)	225
The Matilda Centre	226
EACH	227
Queensland Mental Health Commission (QMHC)	228
Queensland Nurses and Midwives' Union (QNMU)	229
Victorian Small Business Commission (VSBC)	230
cohealth	231
Dietitians Association of Australia	232
Australian Salaried Medical Officers' Federation (ASMOF)	233
Curtin Student Guild	234
Kimberlie Dean	235
David Coghill, Jemimah Ride and Kim Dalziel	236
Health Services Union (HSU)	237
Consult Australia	238
Maurice Blackburn Lawyers	239
Victorian Aboriginal Children and Young People's Alliance	240
Change to Council of Australian Postgraduate Associations (CAPA)	241
Local Government Association of SA (LGASA)	242
Food and Mood Centre	243
Fighters Against Child Abuse Australia (FACAA)	244
Mental Health Carers NSW (MHCN)	245
NSW Nurses and Midwives' Association (NSWNMA)	246
Queensland Alliance for Mental Health (QAMH)	247
Police Federation of Australian (PFA)	248
Danielle B	249
Launch Housing	250
Universities Australia	251
National Disability Services (NDS)	252
FND Australia Support Services Inc	253

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Table A.1 (continued)

<i>Participant</i>	<i>Submission no.</i>
Neami National	254
Child and Adolescent Health Service (CAHS)	255
Safe Work Australia (SWA)	256
Actuaries Institute	257
On the Line	258
Western Australian Mental Health Commission	259
Consortium of Australian Psychiatrist-Psychologists	260
Robert Jaensch	261
Paul Vittles	262
Parks Clinics	263
Penington Institute	264
Thorne Harbour Health and Rainbow Health Victoria	265
Working Well Together	266
Australian BPD Foundation	267
Victorian Disability Services Commissioner	268
Foundation for Alcohol Research and Education (FARE)	269
Australian Council of Social Service (ACOSS)	270
Positive Life NSW	271
Public Health Association of Australia (PHAA)	272
College of Sport and Exercise Psychologists	273
R U OK?	274
Beyond Blue	275
University of Sydney Disability Action Plan Committee	276
Linda Mulquin	277
Commission for Children and Young People (Victoria)	278
Northern Community Legal Centre (NCLC)	279
The Matilda Centre for Research in Mental Health and Substance Use	280
Stroke Foundation	281
Social Alchemy	282
National Social Security Rights Network (NSSRN)	283
Institute of Public Accountants	284
Name withheld	285
Petra van den Berg	286
Greg Franklin	287
Alcohol and Drug Foundation	288
Asia Pacific Centre for Work Health and Safety	289
Australian National Office of the Citizens Commission On Human Rights	290
Public Advocate and Children and Young People Commission (PACYPC)	291
Australian Association of Psychologists Inc (AAPi)	292
Forum of Australian Services for Survivors for Torture and Trauma (FASSTT)	293
OzHelp Foundation	294
ADHD Australia	295

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Table A.1 (continued)

<i>Participant</i>	<i>Submission no.</i>
Angelo Virgona	296
ACT Mental Health Consumer Network	297
Healthy Minds Education & Training	298
HCF	299
Plumtree Children's Services	300
Australian Music Therapy Association (AMTA)	301
Department of Jobs and Small Business (DJSB)	302
Allan Fels	303
Mental Health Professionals Network (MHPN)	304
Australian Education Union (AEU) NSW Teachers Federation	305
Black Dog Institute	306
Justice Action	307
Centre for Disability Research and Policy	308
BrainStorm Mid North Coast	309
WayAhead Mental Health Association NSW Ltd	310
Office of the Commissioner for Children and Young People WA	311
Anglicare Victoria	312
Australians for Safe Medicines	313
Mental Health Council of Tasmania (MHCT)	314
Mental Health Legal Centre (MHLC)	315
Family Life	316
Australian Nursing and Midwifery Federation (ANMF)	317
Women's Health Victoria (WHV)	318
Life After Scams Ltd	319
Australian Private Hospitals Association (APHA)	320
Mental Health Complaints Commissioner (Victoria)	321
Criminal Bar Association of Victoria	322
Royal Far West (RFW)	323
Karitane	324
Inala Primary Care	325
Relationships Australia Victoria (RAV)	326
Sydney Youth Orchestras (SYO)	327
Top End Women's Legal Service Inc	328
Flourish Australia	330
Mark Porter	331
Heart Support Australia (HS-A)	332
NT Shelter	333
Batyr	334
Beyond a Joke Ltd	335
Central Australian Aboriginal Congress	336
Australian Register of Counsellors and Psychotherapists (ARCAP)	337
Emma-Kate Muir	338

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Table A.1 (continued)

<i>Participant</i>	<i>Submission no.</i>
Justice Health Unit	339
Pippa Ross	340
Wei-Chia Tseng	341
The Future of Work Institute	342
Mental Illness Fellowship of Australia (MIFA)	343
Perinatal Anxiety & Depression Australia (PANDA)	344
Two Wings Psychology	345
JusTas Inc	346
Michelle Hickman	347
Anne Mill	348
Deborah Garden	349
Noona Hinterland Psychology	350
Vikki Prior	351
Peter Kent	352
National Rural Health Alliance	353
Lidia Di Lembo	354
Name withheld	355
Shona Tudge	356
Name withheld	357
Matthew Fitzpatrick	358
Australian Clinical Psychology Association (ACPA)	359
Mental Health Coalition of South Australia (MHCSA) and the Lived Experience Leadership & Advocacy Network (LELAN)	360
Royal Flying Doctor Service (RFDS)	361
Heads of Department and Schools of Psychology Association (HODSPA)	362
Legal Aid ACT	363
Latrobe Health Advocate	364
Australian Chamber of Commerce and Industry (ACCI)	365
Berry Street	366
Bronwyn Hartnett	367
Effie Zafirakis	368
Carolyn Milner	369
Australian Institute of Health and Welfare (AIHW)	370
Name withheld	371
Carers Australia	372
Bob Riessen	373
Australians for Mental Health (AFMH)	374
Australian Small Business and Family Enterprise Ombudsman	375
Anglicare Australia	376
Primary Health Networks	377
Medicines Australia	378
Karen Hancock	379
Mind Australia Limited	380

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Table A.1 (continued)

<i>Participant</i>	<i>Submission no.</i>
ACON	381
Unions NSW	382
Wesley Mission	383
Centre for Emotional Health	384
Royal Australian and New Zealand College of Psychiatrists (RANZCP)	385
Royal Australian College of General Practitioners (RACGP)	386
Australian Medical Association (AMA)	387
Jenny Corran	388
Institute of Private Practising Psychologists (IPPP)	389
Melissa Raven	390
Mental Health Carers Tasmania (MHCTas)	391
Name withheld	392
Melissa Noonan	393
Brotherhood of St Laurence (BSL)	394
General Practice Mental Health Standards Collaboration (GPMHSC)	395
Wellways Australia	396
Name withheld	397
Jobs Australia (JA)	398
Anonymous Parent	399
Stop Organised Rape and Torture of Children	400
Jessica Klausen Psychological Services	401
Innervate Pain Management	402
Victorian Alcohol and Drug Association (VAADA)	403
Youth Health Forum (Consumers Health Forum of Australia)	404
NSW Small Business Commissioner (NSWSBC)	405
Lorna MacKellar	406
Mental Health Australia	407, 538, 544
Northern Territory Council of Social Service (NTCOSS)	408
NSW Mental Health Review Tribunal	409
NT Legal Aid Commission (NTLAC)	410
Employee Assistance Professionals Association of Australasia (EAPAA)	411
Volunteering Australia	412
Families and Friends for Drug Law Reform	413
The Pharmacy Guild of Australia	414
The Chamber of Minerals and Energy of Western Australia (CME)	415
Western Australian Association for Mental Health (WAAMH)	416
Volunteering and Contact ACT (VCA)	417
National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH), Indigenous Allied Health Australia (IAHA) and Australian Indigenous Psychologists Association (AIPA)	418
Australian Psychologists and Counsellors in Schools (APACS)	419
Relationships Australia South Australia (RASA)	420
Australian Kookaburra Kids Foundation (AKKF)	421

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Table A.1 (continued)

<i>Participant</i>	<i>Submission no.</i>
Joe Calleja	422
NovoPsych Pty Ltd	423
Butterfly Foundation	424
Name withheld	425
Colleen Hunt	426
Caring Fairly	427
GV Development Clinic	428
Society for Industrial and Organisational Psychology Australia (SIOPA)	429
NT Mental Health Coalition	430
Australian Universities Anti-Bullying Research Alliance (AUARA)	431
Australian Association of Social Workers (AASW)	432
Youth Law Australia (YLA)	433
Aboriginal Medical Services Alliance NT (AMSANT)	434
Christine Wade	435
Jade Weary	436
Caroline Dowling	437
Hunter Rise Associates	439
Just Reinvest NSW	440
Jesuit Social Services	441
Stephen Brown	442
MetLife Insurance Limited (MetLife)	443
Australian Rural Health Education Network (ARHEN) Mental Health Academy Network	444
WentWest	445
Centre for Multicultural Youth (CMY) and Multicultural Youth Advocacy Network (MYAN)	446
Institute of Clinical Psychologists (ICP)	447
Johnson & Johnson Australia	448
Community Mental Health Australia (CMHA)	449
ConNetica Consulting	450
Early- and Mid-Career Researcher (EMCR) Forum and Australian Brain Alliance EMCR Network	451
Australian Council of Trade Unions (ACTU)	452
John Pullman	453
Christine Newton	454
Emerging Minds	455
NSW Young Lawyers Human Rights Committee	456
Northern Territory Primary Health Network (NT PHN)	457
Vanguard Laundry Services	458
Business SA	459
AusPsy	460
Carers Victoria	461
Sharon Hulin	462
Catholic Health Australia (CHA)	463
Cabrini Outreach	464

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Table A.1 (continued)

<i>Participant</i>	<i>Submission no.</i>
Centre for Rural and Remote Mental Health (CRRMH)	465
Name withheld	466
Amy Wilson	467
Leonie Segal and Jackie Amos	468
Kingsford Legal Centre (KLC)	469
HelpingMinds	470
Australian City Mental Health Alliance	471
AIA Australia (AIAA)	472
Independent Private Psychiatrists Group	473
University of Technology Sydney	474
Rural Doctors Association of Australia (RDAA)	475
National Mental Health Consumer and Carer Forum (NMHCCF)	476
SA Mental Health Commission (SAMHC)	477
Victorian Council of Social Service (VCOSS)	478
Mental Health Victoria	479
Aftercare	480
Leanne McGregor, Vikki Prior and Camille Fitzgerald	481
Name withheld	482
Victorian Government	483
New South Wales Council for Civil Liberties (CCL)	484
Bupa ANZ	485
Mental Health Commission of New South Wales	486
Mission Australia	487
Royal Australasian College of Physicians (RACP)	488
Mental Health Carers Australia (MHCA)	489
Australian Red Cross Society	490
Australian Human Rights Commission (AHRC)	491
Law Council of Australia	492
ACT Disability Aged & Carer Advocacy Services (ADACAS)	493
National LGBTI Health Alliance	494
National Association of Practising Psychiatrists (NAPP)	495
Consumers Health Forum of Australia (CHF)	496
Patrick O'Connor	497
Tasmanian Government	498
Call to Mind	499
Victoria Legal Aid	500
Australian College of Mental Health Nurses (ACMHN)	501
Tandem	502
Stephen Brown	503
Richard Burnell	504
Ian and Rhonda McNees	505
Lou Brown, Carlie Lidonnici and Christine Jordan	506

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Table A.1 (continued)

<i>Participant</i>	<i>Submission no.</i>
National Aboriginal Community Controlled Health Organisation (NACCHO)	507
Sarah Sutton	508
Centre for Social Impact Swinburne (CSI-S)	509
Name withheld	510
yourtown	511
The Help Centre Psychology	512
Name withheld	513
Doctors Against Violence Towards Women	514
Maria Lohan	515
Australasian College for Emergency Medicine (ACEM)	516
Mental Health Community Coalition ACT (MHCC ACT)	517
Joyce Noronha-Barrett	518
Adelaide Psychological Services	519
Colin Jevons	520
Name withheld	521
Association of Counselling Psychologists (ACP)	522
Suicide Prevention Australia	523
Mental Health Australia, Federation of Ethnic Communities' Councils of Australia (FECCA) and National Ethnic Disability Alliance (NECA)	524
Loretta Woolston	525
David Bell	526
Australian Rehabilitation Providers Association (ARPA)	527
Michael Derrick	528
Kate Ives	529
Coming soon	530
drummond street services	532
Collective Conscious	533
Godwin Grech	534
Financial Services Council (FSC)	535
NeuralDx Ltd	536, 546
Council of Small Business Organisations Australia (COSBOA)	537
Quattro Investment Pty Ltd	539
City of Port Phillip	540
Laurence West	541
GenIMPACT Centre for Economic Impacts of Genomic Medicine	542
Australian Psychological Society (APS)	543
Paul Salsano	545
Ramsay Health Care	548
Thirrili Ltd	549
NSW Government	551
Tim Heffernan	552
Spiritual Health Association	553
WeParent	554

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Table A.1 (continued)

<i>Participant</i>	<i>Submission no.</i>
Independent Higher Education Australia (IHEA)	555
Department of Health (DoH)	556
First Step	557
<i>Coming soon</i>	558
Julie Couzens	559
Rebecca Sferco	560
Autism Aspergers Advocacy Australia	561
Name withheld	562
Name withheld	563
Name withheld	564

Table A.2 Emailed comments received

<i>Type of respondent</i>	<i>Number of public comments</i>
User or Consumer of mental health services or supports	64
Carers or family members	34
Mental health workers and providers	40
Other interest persons	53

Figure A.1 **Submissions and comments received**

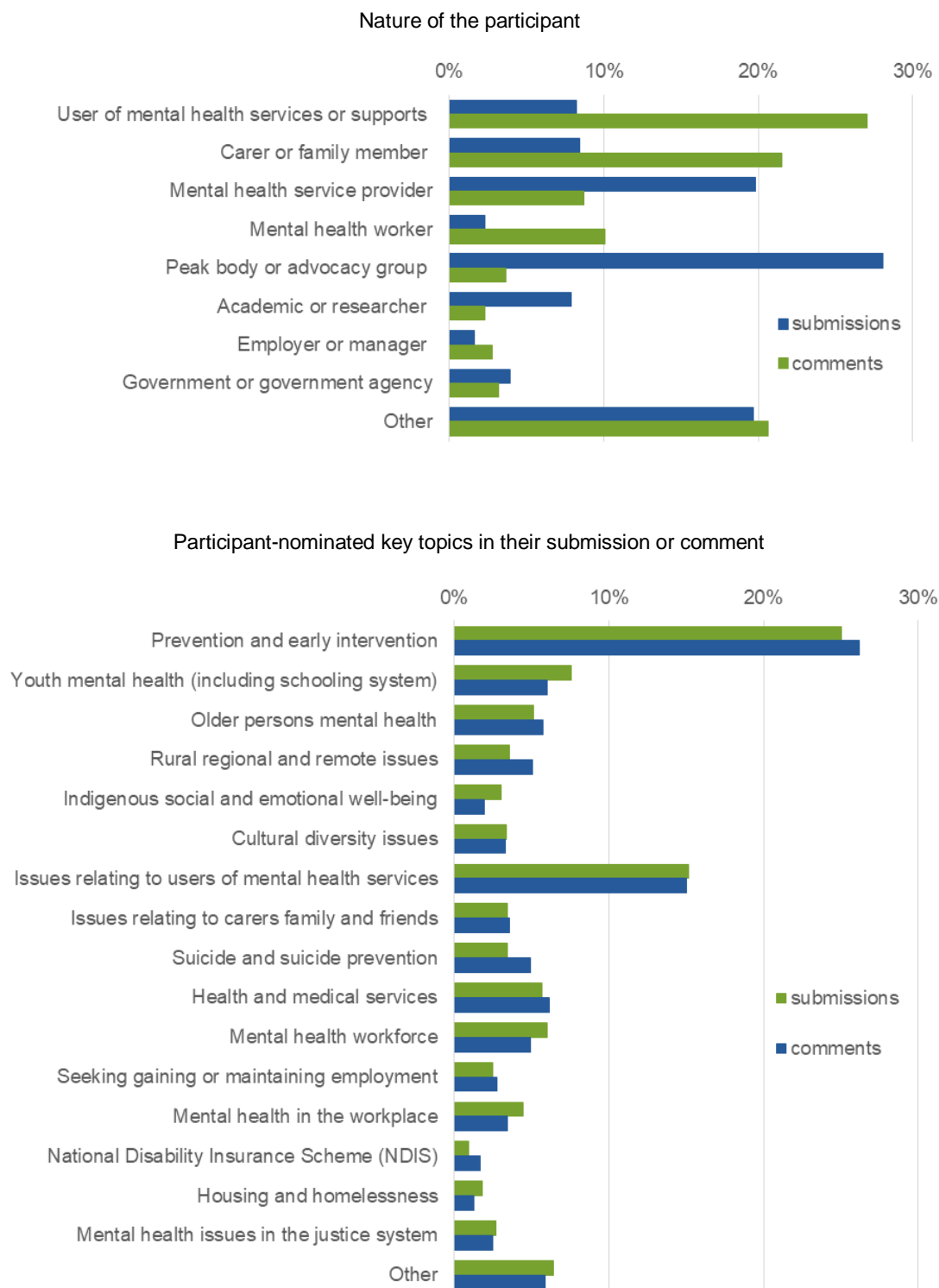


Table A.3 Consultations

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 Finance
Australian Government Department of Health
Australian Government Department of Health and Human Services
Australian Government Department of Human Services
Australian Government Department of Jobs and Small Business
Australian Government Department of Prime Minister and Cabinet – Indigenous Affairs
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
Bendigo Community Health Services
Bendigo Health
Beyond Blue

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Table A.3 (continued)

Bill Buckingham
Black Dog Institute
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 Aboriginal Congress
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)
Darling Downs and West Moreton Primary Health Network
David Butt
Delmont Private Psychiatric Hospital
Directors of Student Services of Australia and New Zealand
Disability Advocacy Service
Dr Edward Koch Foundation
Eileen Baldry
Emma Donaldson
Education First Youth Foyer
Evaluate Consulting Pty Ltd
Everymind
Faculty of Education and Arts, University of Newcastle
Forensicare
Foyer Oxford
Genia Janover
Geoff Waghorn
Gateway Health
Gippsland Primary Health Network
Grand Pacific Health
Grant Sara

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Table A.3 (continued)

HC Innovations
headspace
headspace Toowoomba
headspace Wollongong
Healing Foundation
Helen Milroy
Illawarra Shoalhaven LHD
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 Ogloff
Jane Gunn
Jane Pirkis
Jennifer Taylor
Jenny George – Converge International
Jesuit Social Services
Joe Coyne
Justice Health Unit – Melbourne School of Population and Global Health, University of Melbourne
Latrobe Health Advocate
Leonie Segal
Lesley Russell
Lifeline Central Australia
Lisa Wood - School of Population and Global Health, University of Western Australia
Liza Brock
Loddon Mallee Mental Health Carers Network
Lynette Pierce
Marathon Health
Margaret Grigg
Marilyn Campbell
Martin Hensher
Martin Knapp – Department of Health Policy, The London School of Economics and Political Science
Maureen Dollard
Matt Tyler
MBS Review Taskforce
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 Carers Tasmania
Mental Health Commissions
Mental Health Complaints Commissioner
Mental Health Coordinating Council

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Table A.3 (continued)

Mental Health Council of Tasmania
Mental Health Information Strategy Standing Committee
Mental Health Victoria Mentally Healthy Workplace Alliance - CEO Steering Group
Mental Illness Fellowship of Australia
Mike Woods
Millbrook Rise
Mind Australia
MindSpot
Mission Australia
Murdoch Children's Research Institute, The Royal Children's Hospital
Murray Primary Health Network
Murrumbidgee Local Health District
Murrumbidgee Primary Health Network
National Aboriginal Community Controlled Health Organisation
National Disability Insurance Agency
National Employment Services Association
National Mental Health Commission
National Mental Health Consumer and Carer Forum (NMHCCF)
National Social Security Rights Network
National Suicide Prevention Project Reference Group
National Suicide Prevention Taskforce
National Workforce Centre for Child Mental Health
Neami Wollongong
Nicola Reavley
Nolan House (Albury Wodonga Health)
North West Melbourne Primary Health Network
Northern Queensland Primary Health Network
NPY Women's Council
NSW Department of Premier and Cabinet
NSW Family and Community Services
NSW Health
NSW Mental Health Commission
NSW Police Mental Health Intervention Team
NT Aboriginal Medical Services Alliance
NT Association of Alcohol and Other Drug Agencies
NT Council of Social Services
NT Department of Chief Minister
NT Department of Education
NT Department of Health
NT Department of the Attorney-General and Justice
NT Mental Health Coalition
NT Mental Illness Fellowship of Australia
NT Primary Health Network
Office for Mental Health and Wellbeing

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Table A.3 (continued)

One Door Sydney
One Door Wagga Wagga
Orygen
Outback Futures
OzHelp
Pandsi
Peer Participation in Mental Health Service Network
Peggy Brown
Philip Burgess
Primary Health Network Tasmania
Qantas
QBE Insurance
Qld Alliance for Mental Health
Qld Department of Housing and Public Works
Qld Health
Qld Office of the Chief Psychiatrist
Queensland Department Communities, Disability Services and Seniors
Queensland Mental Health Commission
Recovery Camp
Regional and Rural Mental Health Services
Regional Australia Institute
Relationships Australia
Relationships Australia South Australia
Richardson and Lyons
Rivendell Clinic (North West Private Hospital)
Rod Astbury
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
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
School of Public Health – University of Queensland

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Table A.3 (continued)

Sebastian Rosenberg
South Adelaide Local Health Network
South East Melbourne Primary Health Network
Specialist Aboriginal Mental Health Service
St. Charles Borromeo Primary School
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
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 Health and Human Services
Victorian Mental Health Complaints Commissioner - Advisory Council
WA Association for Mental Health
WA Child and Adolescent Health Service
WA Department of Communities
WA Department of Health – Mental Health Unit
WA Department of Premier and Cabinet
WA Magistrate
WA Mental Health Commission
WA Primary Health Alliance
Wellways
WISE Employment

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.

J. FRYDENBERG

Treasurer

[Received 23 November 2018]

B Income and employment support

This appendix provides further detail on:

- the current income and employment support system — including key payments such as the Disability Support Pension (DSP), the Newstart and Youth Allowances, and key employment programs such as jobactive and Disability Employment Services (DES)
- mechanisms for streaming income support recipients into employment support programs (the Job Seeker Classification Instrument (JSCI) and the Employment Services Assessment (ESAt))
- the Individual Placement and Support (IPS) model of employment support
- mutual obligation requirements (MORs) for employment support program participants.

B.1 The income and employment support system

Income support payments

Income support payments have different sized cohorts, payment rates and eligibility criteria (table B.1).

Table B.1 Comparison of key income support payments
June 2018

	<i>Newstart Allowance</i>	<i>Youth Allowance (job seeker)</i>	<i>Disability Support Pension</i>
Cohort of interest	115 700 recipients deemed to have a mental illness	6 500 recipients deemed to have a mental illness	258 000 with a primary psychological or psychiatric disability
Estimated cost for cohort of interest ^a	\$1.5 billion	\$61 million	\$5.7 billion
Productivity Commission estimate of cohort of interest ^b	309 000 recipients with any mental health condition	28 000 recipients with any mental health condition	494 000 recipients with any mental health condition
Estimated cost for Productivity Commission estimate of cohort of interest	\$4.1 billion	\$259 million	\$10.9 billion
Total number of recipients	728 000	94 000	757 000
Payment rate if single, aged over 18, no children, no other income source	\$559.00	\$455.20	\$850.40 (if aged over 21)
Eligibility criteria	<ul style="list-style-type: none"> • Aged 22-pension age • Unemployed and looking for full-time work • Willing to complete activity requirements • Income and assets test (individual and partner) 	<ul style="list-style-type: none"> • Aged 16-22 • Unemployed and looking for full-time work • Willing to complete activity requirements • Income and assets test (individual, partner and parent) 	<ul style="list-style-type: none"> • Aged 16-pension age • Have a permanent disability that reduces their potential work capacity to less than 15 hours a week over at least the next two years (box B.1) • Willing to complete activity requirements (if under 35 years) • Income and assets test (individual and partner)

^a Productivity Commission cost estimates based on the total cost of provision apportioned to the relevant proportion of recipients for 2018-19. ^b Productivity Commission estimates of the proportion of separate payment recipients with any mental health condition from the National Health Survey 2014-15, apportioned to the number of total recipients in June 2018.

Source: ABS (*National Health Survey 2014-15 Tablebuilder*, Cat. no. 4364.0.55.001); Arthur (2017); DHS (2019f, 2019g, 2019i); DJSB (2019); DSS (2018f, 2019t); unpublished data from DSS and DJSB.

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 (e.g. permanently blind or terminally ill) are generally eligible if they meet age, residency and income and asset requirements (box B.1). All other applicants must have their eligibility determined through a range of criteria (as well as the meeting the same age, residency and income and asset requirements as manifest applicants).

Box B.1 **Disability Support Pension eligibility criteria**

The DSP 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 between 16 and 66 years (those over the retirement age 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 by a Job Capacity Assessor (which assess 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.

Table 5 of the Impairment Tables is used to assess the functional capacity of applicants with a mental illness (e.g. self-care and independent living, interpersonal relationships and concentration and task completion, among others (table B.3).

Source: ANAO (2017); DHS (2019b).

Impairment tables

The functional capacity of DSP applicants is assessed against 'impairment tables'. Applicants must score at least 20 points across the impairment tables as part of the eligibility assessment for the payment. Applicants who score 20 points or more over multiple tables (but do not score at least 20 on a single table) are deemed to not have a severe impairment. These applicants must complete a Program of Support — 18 months of participation in an employment support program (like jobactive or DES), before being eligible for the DSP. This is not a requirement for those who score over 20 on a single table.

Impairment table five assesses the impact of a psychological or psychiatric condition on an applicant's functional impairment (table B.2).

Table B.2 Summary of functional capacity assessment for Disability Support Pension applicants with a primary psychosocial impairment^a

<i>Activity</i>	<i>None (0 points)</i>	<i>Moderate (10 points)</i>	<i>Severe (20 points)</i>	<i>Extreme (30 points)</i>
Self-care and independent living	The person lives independently and attends to all self-care needs without support.	The person needs some support to live independently and maintain adequate hygiene and nutrition.	The person needs regular support to live independently.	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.
Social/recreational activities and travel	The person goes to social or recreations events regularly without support and/or travels alone to new environments.	The person goes out alone infrequently and/or will often refuse to travel alone to new environments.	The person travels alone only in familiar areas.	The person is unable to travel away from own residence without a support person.
Interpersonal relationships	The person has no difficulty forming and sustaining relationships.	The person has difficulty making and keeping friends or sustaining relationships.	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.	The person has extreme difficulty interacting with other people and is socially isolated.
Concentration and task completion	The person has no difficulties concentrating on most task and/or is able to complete a training or educational course or qualification in the normal timeframe.	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.	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	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.
Behaviour, planning and decision-making	There is no evidence of significant difficulties in behaviour, planning or decision-making.	The person has difficulty coping with situations involving stress, pressure or performance demands, has occasional behavioural or mood difficulties.	The person's behaviour, thoughts and conversation are significantly and frequently disturbed.	The person has severely disturbed behaviour which may include self-harm, suicide attempts, unprovoked aggression towards others or manic excitement.
Work/training capacity	The person is able to cope with the normal demands of a job which is consistent with their education and training.	The person often has interpersonal conflicts at work, education or training that require intervention or changes in placement or groupings.	The person is unable to attend work, education or training on a regular basis over a lengthy period due to ongoing mental illness.	The person is unable to attend work, education or training sessions other than for short periods of time.

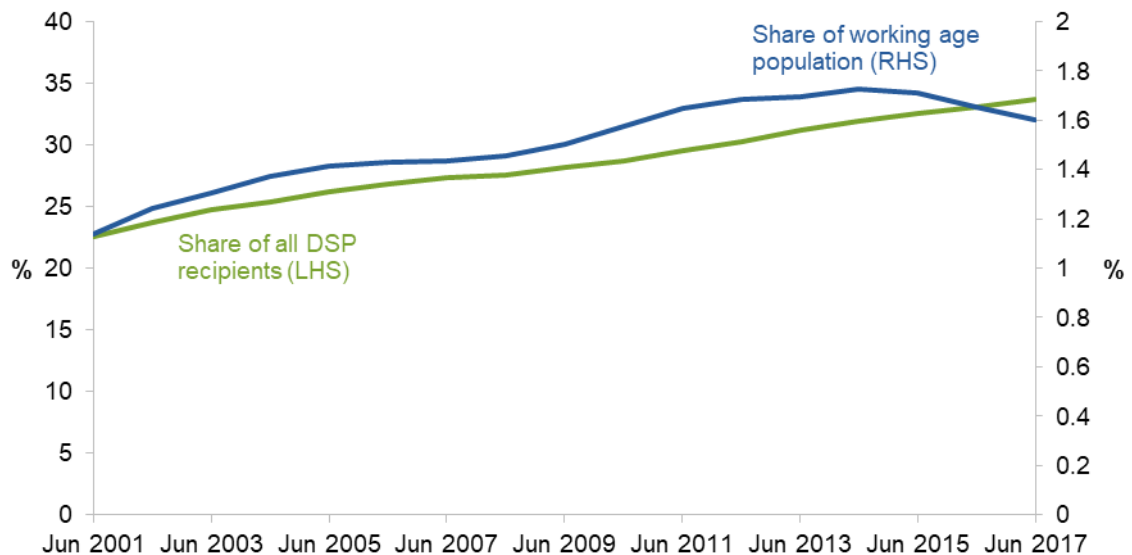
Source: Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011.

Disability Support Pension population and trends

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 1.6% by 2017 (figure B.1). And between 2001 and 2017, the share of DSP recipients with a primary psychological or psychiatric condition increased from 23% to 33%. 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 B.2).

Figure B.1 Mental illness-related Disability Support Pension recipients

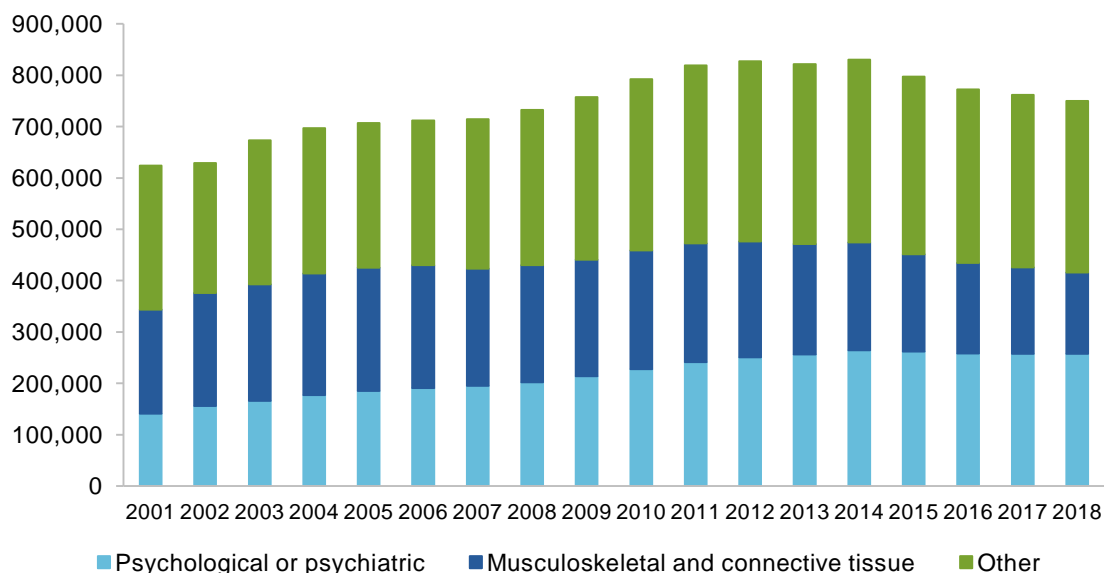
Share of working age population and DSP recipients receiving the Disability Support Pension due to psychological or psychiatric disability



Source: Productivity Commission estimates based on based on ABS (*Australian Demography Statistics*, Dec 2017, Cat. no. 3101.1); data.gov.au (various issues of DSS Payment Demographic Data); DSS (2013).

Figure B.2 DSP recipients by major condition

Number and share of recipients by common impairment types, 2001-2018



Source: data.gov.au (various issues of DSS Payment Demographic Data); DSS (2013, 2016c).

This 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 (OECD 2015b). The OECD (2015b) 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)
- work becoming more psychologically demanding, reducing the ability of people with a mental illness to remain in work.

Payment rates

Table B.3 Disability Support Pension fortnightly payment rates

<i>Individual characteristics</i>	<i>Maximum payment rate</i>
<i>Under 21 with no children</i>	
Single, under 18, live at home	\$379.00
Single, under 18, independent	\$585.00
Single, aged 18-20, live at home	\$429.60
Single, aged 18-20 and independent	\$585.00
A member of a couple, aged or under 20	\$585.00
<i>21 or over, with/without children, or under 21 with children</i>	
Single	\$850.40
Couple (each)	\$641.00
Couple (each, separated due to ill-health)	\$850.40

Source: DHS (2019g).

Newstart Allowance

Newstart Allowance is the general income support payment for unemployed jobseekers between the ages of 22 and 66 (retirement age) (DHS 2019f).

Recipients receive different payments rates dependent on individual characteristics (table B.4).

Table B.4 Newstart Allowance fortnightly payment rates

<i>Individual characteristics</i>	<i>Maximum payment rate</i>
Single, no children	\$559.00
Single, with a dependent child/children	\$604.70
Single, aged 60 or over, after 9 continuous months on payment	\$604.70
Partnered (each)	\$504.70
Single principal carer granted an exemption due to carer commitments ^a	\$780.70

^a Including foster caring, non-parent relative caring under a court order, home schooling, distance education or large family

Source: DHS (2019f).

Youth Allowance

The Youth Allowance is income support for students and job seekers.

- *Student* recipients must meet the following criteria:
 - aged 18 to 24 and studying full-time, or
 - aged 16 to 24 and undertaking a full-time Australian Apprenticeship, or
 - aged 16 to 17 and independent or required to live away from home to study (DHS 2018f).
- *Job seeker* recipients must be aged 16 to 21 and looking for full-time work (DHS 2018f).

This payment is also activity-tested but recipients may receive an exemption (for study or training, temporary incapacity or illness).

Job seekers and students receive the same payment rates but rates are dependent on other individual characteristics (table B.5).

Table B.5 Youth Allowance fortnightly payment rates

<i>Recipient characteristics</i>	<i>Maximum payment rate</i>
Single, no children, under 18, live at parent/guardian's home	\$249.20
Single, no children, under 18, not living at parent/guardian's home	\$455.20
Single, no children, over 18, live at parent/guardian's home	\$299.80
Single, no children, over 18, not living at parent/guardian's home	\$455.20
Single with children	\$596.50
Partnered, no children	\$455.20
Partnered, with children	\$499.90
Single, job seeker, principal carer and exempt from activity requirements	\$780.70

Source: DHS (2019i, 2019j).

Employment support

The Australian Government's two key employment support programs are jobactive — the general employment services program — and DES, for jobless people whose main barrier to employment is a disability (table B.6). Participation in jobactive or DES is compulsory for job seekers who receive income support payments and have been assessed as able to actively look for work (most Newstart and Youth Allowance recipients, and some DSP recipients aged under 35) (ANAO 2017).

Table B.6 Comparison of key employment support programs
March 2019

	<i>jobactive</i>	<i>Disability Employment Services</i>
Cohort of interest	84 800 participants deemed to have a mental illness	89 500 participants have a primary psychological or psychiatric disability
Estimated cost for cohort of interest ^a	\$193 million	\$323 million ^b
Total number of participants	631 000	226 000
Program streams	A (14%), B (34%) and C (51%)	Disability Management Services (43%) and Employment Support Services (57%)

^a Estimated from the total cost of provision and the proportion of recipients with a mental illness for 2018-19.

^b May include other non-DES disability employment services (valued at approximately \$35 million).

Source: data.gov.au (DSS Payment demographics data – March 2019); DJSB (2019, sub 302); DSS (2019t); LMIP (2019a, 2019b), unpublished data from DSS and DESSFB.

In addition, there are a range of smaller employment support programs (box B.2).

Box B.2 Specialised employment support programs

Transition to Work is a work readiness program for young people aged 15 to 21 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 (Australian Government 2015).

Time to Work is a national voluntary in-prison employment service 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 service provider when their sentence ends (DJSB 2018b).

The **Community Development Program** is an employment support service for remote communities across Australia. The program focuses on helping participants to build work relevant skills through compulsory participation in community projects or Work for the Dole (PM&C 2019b). The majority of participants have moderate to extreme barriers to employment, exacerbated by high entrenched unemployment in many communities (PM&C 2019a).

The Department of Employment, Skills, Small and Family Business 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. Stream A participants received the new program first (July 2019), with Stream B and C starting the trial in November 2019 (DESSFB 2019a).

The current streams of jobactive will remain intact. Stream A participants (Digital First) 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 (DESSFB 2019a).

Stream B participants (Digital Plus) 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 services provider and participate in complementary services (e.g. Career Transition Assistance or PaTH Internships) (DESSFB 2019a).

Stream C participants (Enhanced Services) 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 service provider. Services include connecting a participant with training and education or work experience, career mentoring, counselling, job placement and post-placement support (DESSFB 2019a).

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 (e.g. 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 (DESSFB 2019a).

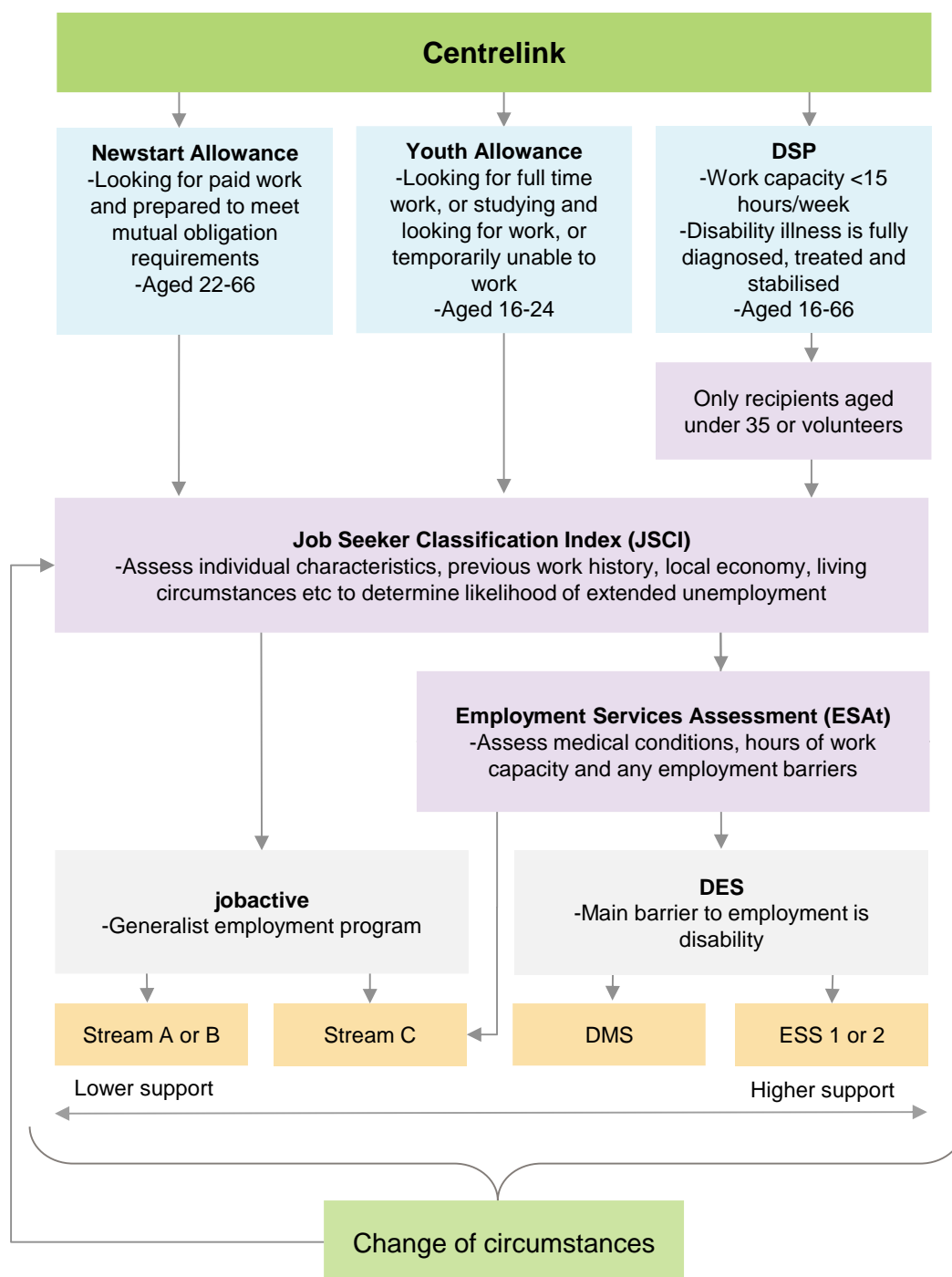
B.2 Mechanisms for sorting income support recipients into employment support programs

The Department of Human Services (branded as Centrelink) applies the Job Seeker Classification Index (JSCI) and the Employment Services Assessment (ESAt) to stream Newstart Allowance and Youth Allowance recipients between jobactive and DES employment support programs (figure B.3).

There are also streams within jobactive and DES (figure below). Participants considered to have a low risk of remaining unemployed over the long term are referred to Stream A or B of jobactive, whilst 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 (e.g. worsening or improving health, moving to a town with different employment opportunities, becoming homeless).

Figure B.3 Employment and income support pathways^{a,b}



^a Participants considered to have a low risk of remaining unemployed over the long term are referred to Stream A or B of jobactive, whilst participants who need more assistance are referred to Stream C. ^b DES participants are split between Disability Management Services (DMS) and two levels of Employment Support Services (ESS). DMS provides job search support only, whilst ESS provides job search support and on-going 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); DHS (2018d, 2018f, 2019e); DSS (2018h).

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?
- Are there any other factors which you think might affect your ability to work, obtain work or to look for work that we haven't already discussed?

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)? (Not all participants who disclose a medical condition or disability will be asked what the condition is. If participants 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.)

This assessment places participants with a 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 ESAt.

The Employment Services Assessment

The ESAt is a more thorough assessment process for participants deemed to have multiple or severe barriers to employment. It is undertaken by an allied health professional and face-to-face in about 80% of cases (OECD 2015b). 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 the participant's barriers to work (related to disability, injury or illness, among others) and their work capacity in hour bandwidths (e.g. 0-7, 8-14, 15-29) (Australian Government 2019a). Those for whom a disability is deemed to be their

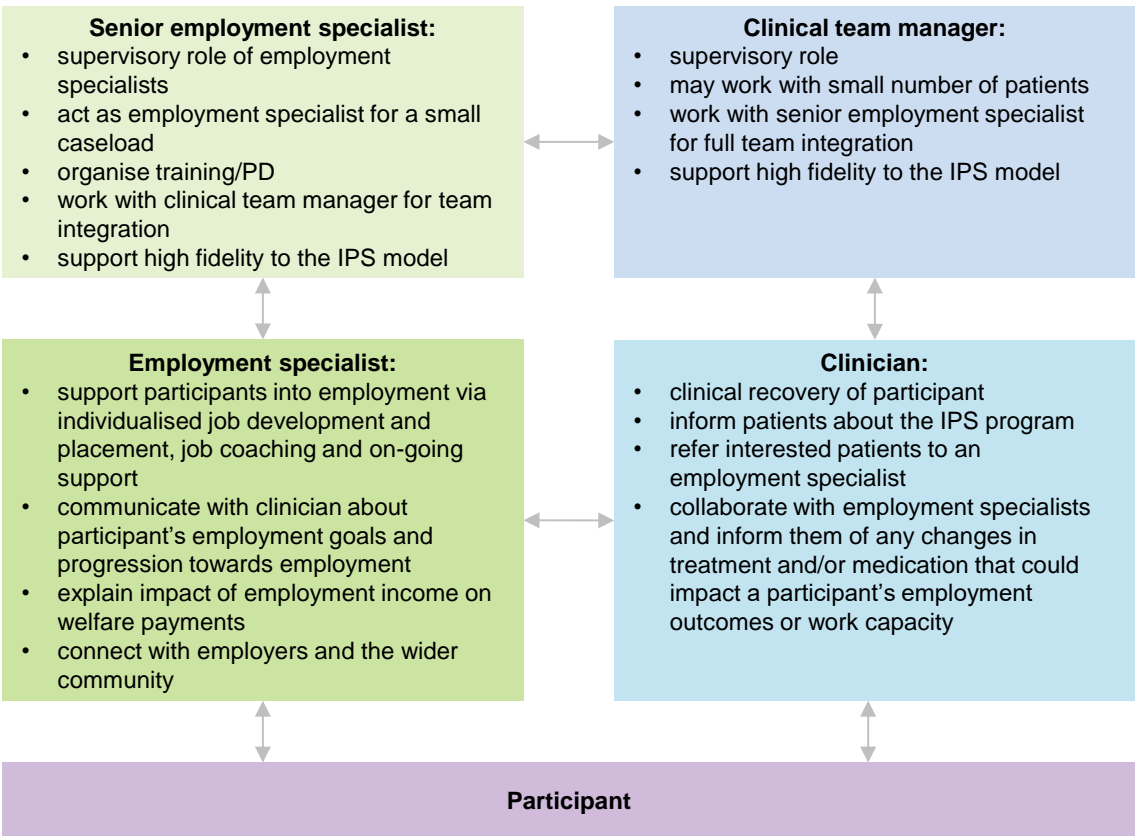
main barrier to employment are placed in Disability Employment Services and other participants are placed into Stream C of jobactive.

B.3 Individual Placement and Support

How the Individual Placement and Support model works

The success of the IPS model is strongly based on the integration of clinical and employment support for participants (chapter 14). Figure B.4 sets out a standard model for integration.

Figure B.4 **Roles and responsibilities under the Individual Placement and Support model^a**



^a The grey arrows in the diagram represent lines of communication.

Source: Centre for Mental Health (2018); Gilbert & Papworth (2017); Rinaldi et al. (2008).

Monitoring fidelity to the Individual Placement and Support model

Fidelity scales measure how closely IPS programs follow the theoretical IPS model by assessing a program's staffing, organisation and services (Becker et al. 2015). Each assessment criteria is ranked on a scale of 1 to 5, with a higher score representing more fidelity to the model (table B.7). A score of 74 or above out of 125 is necessary to 'pass' and be labelled an IPS program (Centre for Mental Health 2018).

Table B.7 Summary of assessment criteria for Individual Placement and Support fidelity^a

<i>Staffing</i>	<i>Organisation</i>	<i>Services</i>
<ul style="list-style-type: none">• Caseload size• Employment services staff only provide employment services• Employment services staff are vocational generalists	<ul style="list-style-type: none">• Integration of rehabilitation with mental health treatment through team assignment• Integration of rehabilitation with mental health treatment through frequent team member contact• Collaboration between IPS and Government employment and income support staff• Vocational unit is comprised of 2 full-time employment specialists and a team leader• IPS unit is led by a supported• Zero exclusion criteria• Executive team support for IPS	<ul style="list-style-type: none">• Work incentives planning• Employment specialists assist clients with disclosure• Ongoing, work-based vocational assessment• Rapid job search for a competitive job• Frequent employer contact and high quality of employer contact• Diversity of job types and employers• Individualised job search• Time unlimited, individualized follow-along support• Assertive community engagement and outreach by integrated treatment team

^a As per Supported Employment Fidelity Scale (Australia and New Zealand Version 2.0 (2011)).

Source: Waghorn and Lintott (2011).

To generate a score for each criteria, interviews are conducted with staff, participants, families or teachers. Internal and external meetings may also be observed. As well as providing a fidelity score, evaluations also offer recommendations for improvement (Becker et al. 2015).

In Australia, IPS Works — a technical support service operating within the Western Australian Association for Mental Health — conducts most IPS fidelity reviews (IPS Works 2019).

B.4 Mutual Obligation Requirements

What are Mutual Obligation Requirements?

Newstart and Youth Allowance recipients must complete Mutual Obligation Requirements (MORs) to continue to receive payments. MORs are completed through participation in employment support programs, like jobactive and DES. MORs are listed in a Job Plan and generally include completing job searches (capped at 20 jobs per month) and meeting Annual Activity Requirements (Australian Government 2019g). Participants also must attend all Department of Human Services and provider appointments and attend or act upon any job interviews or job referrals from providers (Australian Government 2019g).

Job Plans are set by a participant's employment support provider in accordance with guidelines from the Department of Social Services (DES participants) or Department of Employment, Skills, Small and Family Business (jobactive participants). When setting MORs, providers should consider a participant's age, work capacity, childcare obligations, past employment history, cultural factors and any barriers to employment (e.g. mental illness), as well as the strength of the local job market (Australian Government 2019g). Participants in the Community Development Program (run by the Department of Prime Minister and Cabinet; box B.2) have the most MORs, with participants required to complete annual activity requirements for 44 weeks of the year, as well as job search requirements (PM&C 2018).

Annual activity requirements are added only to a Job Plan for *jobactive* participants who have received the Newstart or Youth Allowances for more than 12 months. Continuous participation in activities are required for 6 months of the year, with hourly participation requirements determined by a participant's age. Generally, recipients participate in Work for the Dole (a program providing participants with 'work-like' activities to improve employability), but other activities can be completed (including volunteer or part-time work, and vocational training).

The new employment services model will change MORs to be counted on a points-based system. More intensive activities (e.g. job interviews and job search) receive more points, but other approved work focused activities will also contribute to fortnightly targets.

The Targeted Compliance Framework

Participants who do not meet their mutual obligation requirements (MORs) accumulate demerit points and are penalised by having their payment reduced or suspended. Penalties are administered based on a compliance framework, which was updated in July 2018 for jobactive and DES participants. DSP recipients have a different compliance framework where providers can opt to send a report of non-compliance to the Department of Human Services if participants fail to meet MORs (DSS 2018h).

A key goal of the new framework was ensuring participants cannot ‘game’ the income support system, and the framework is expected to generate savings of \$205 million by 2022 (Thomas 2017).

Under the new framework, participants are split into zones based on how many demerit points they have. Participants with no demerits are the Green Zone. After receiving a demerit, participants enter the Warning Zone where each failure to meet a MOR leads to a payment suspension and further demerits. No financial penalties apply in either of these zones. If a participant receives three demerits over six months, their activity requirements will be reviewed. If a fourth point is earned, a Centrelink assessment will assess whether they should change support programs or enter the Penalty Zone. In this zone financial penalties are incurred for additional failures, ranging from the loss of 50% of a fortnightly payment (one failure) to the cancellation of four weeks of payments (three failures). Meeting all MORs for three months resets demerits to 0 (DSS 2018b).

Further changes include the provision that if a participant does not accept a suitable offer of work, their payment will be cancelled for four weeks, and participants with a dependency on alcohol or drugs can meet some or all of their MORs by receiving medical treatment (and this dependency should be taken into account if these participants fail to meet other MORs) (Thomas 2017).

Approximately 43% of the jobactive caseload held at least one demerit that resulted in a payment suspension between September and December 2018 (EERC 2019), despite estimates finding less than 12% of participants consistently fail their MORs (Cash, Porter and Tudge 2017; DJSB, sub 302, p. 4; DSS 2019m). Almost 462 000 financial penalties were applied to participants between July 2015 and November 2018, and Indigenous Australians were more likely to receive penalties than other groups (EERC 2019).

Complaints against Mutual Obligation Requirements and the Targeted Compliance Framework

Some submitters 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 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 jobseekers, detracting from their well-being and their stability, generating barriers to employment. (JA, sub. 298, 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)

C Employment and mental health

Poor mental health and mental illness impacts on participation in employment in two major ways. For those in employment with an untreated mental illness or poor mental health, it can impact on their productivity, whereas for those outside the workforce it often acts as a barrier to gaining and maintaining employment.

C.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. 2016a; Waddell and Burton 2006; Waghorn and Lloyd 2005; Woodside, Schell and Allison-Hedges 2006).

Employment, in addition to income, provides a sense of identity and purpose, a sense of structure and social connectedness. Studies have found that 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 is critical to an individual's recovery (FCDC 2012).

A report prepared for the World Health Organisation (WHO) and the International Labour Organisation (ILO) 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 impact on an individual's mental health. The negative impacts associated with unemployment include lower self-esteem, reduced social contact and poverty. There are strong links between unemployment and poor mental health that are often exacerbated due to the related problems of social exclusion and poverty resulting from unemployment (Walsh and Tickle 2013). Those out of work often become dependent on social security and/or other family members and are restricted in their ability to play an active role in the community.

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 analyses of the relationship between depressive symptoms 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 leads to poorer 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). In relation to gender, 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). By age, those who are middle-aged or older tend to have higher expenses, increasing the financial stress caused by unemployment, exacerbating the negative impact on mental health. Older groups may be less affected by job loss the closer they are to retirement. However, there is some evidence high unemployment is associated with worsening mental health for youth who are wanting to, but cannot enter the workforce (Buffel, van de Straat and Bracke 2015).

As to being in employment, 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 health problems 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.

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 was a challenge that need to be addressed from both sides — improving mental health by improving employment outcomes and reducing barriers to employment for those with a 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)).

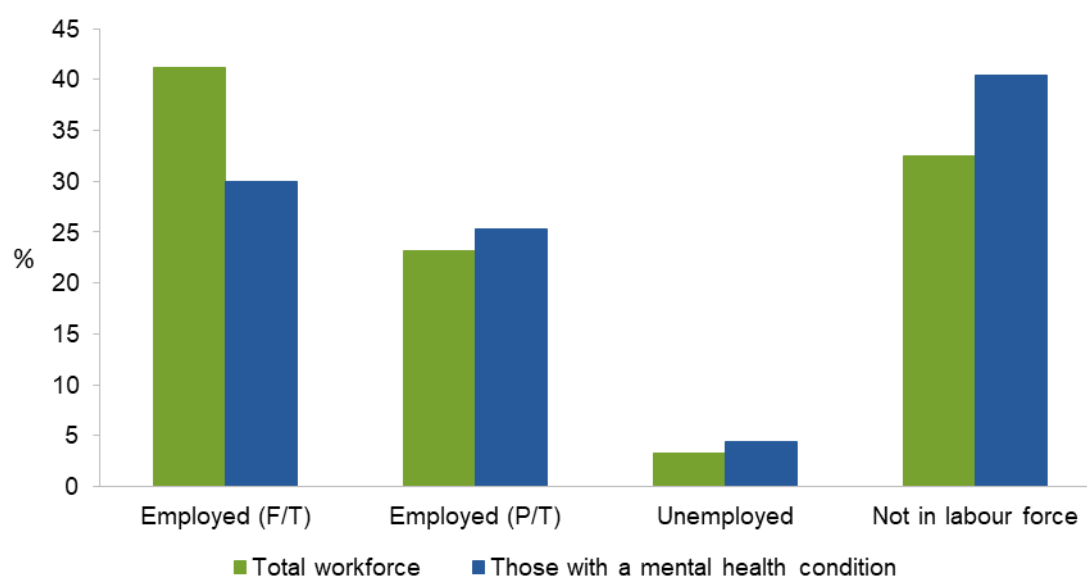
Although employment is associated with better mental health than unemployment and shifting from unemployment to employment improves mental health, there is some evidence that jobs with poorly designed work and a poor work environment can exacerbate mental health symptoms (Harvey et al. 2014). A study 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 actually result in a decline in mental health compared to unemployment. The issues around mental health in the workplace are discussed in detail in chapter 19.

C.2 Employment outcomes for those with a mental illness

Employment outcomes for people with a mental illness are worse than for the wider population. In 2017-18, 55% of working age Australians with a mental illness were employed, compared with 64% of all working age Australians (ABS 2019). This is reflected in the share of people with a 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 a mental illness employed on this basis was slightly above that of the wider working age population (figure C.1).

Figure C.1 **Labour force status of those with a mental illness**

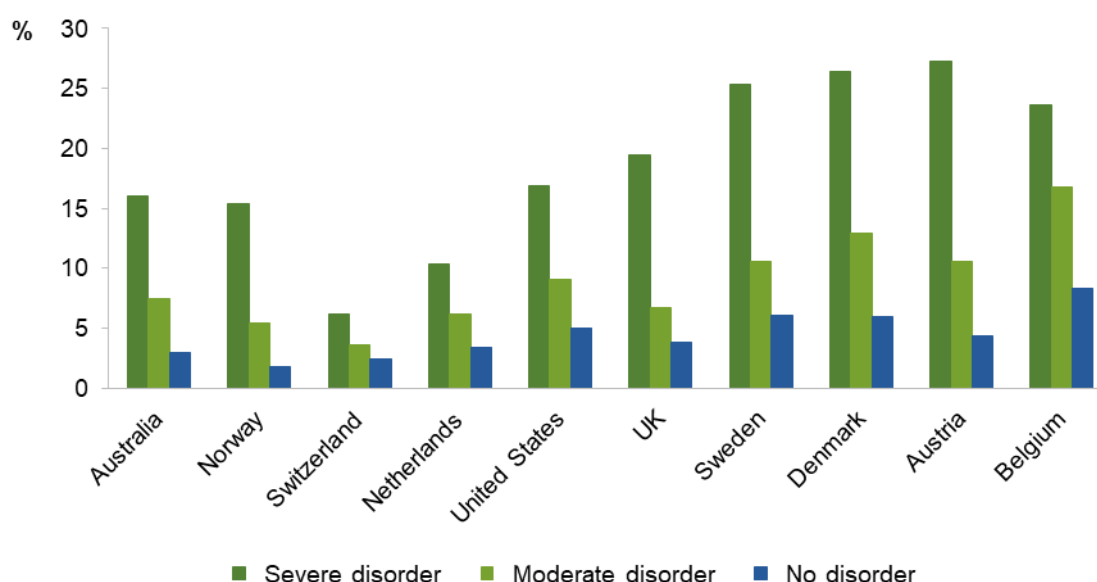
Australian labour force compared to those with any mental condition (aged 16 to 64 years), 2017-18



Source: ABS (2019).

In comparison to other countries, the unemployment rates for those people with a moderate mental disorder in Australia is about two and half times that for those with no disorder. For those people with a severe disorder it is more than five times the rate of those without a disorder. Switzerland and the Netherlands, have the smallest differences in the rate of unemployment between those people with a severe or moderate disorder and those without a disorder. In all countries, unemployment rates are higher for those people with more severe mental disorders (figure C.2).

Figure C.2 Unemployment rates by severity of mental disorder, selected OECD countries
2015



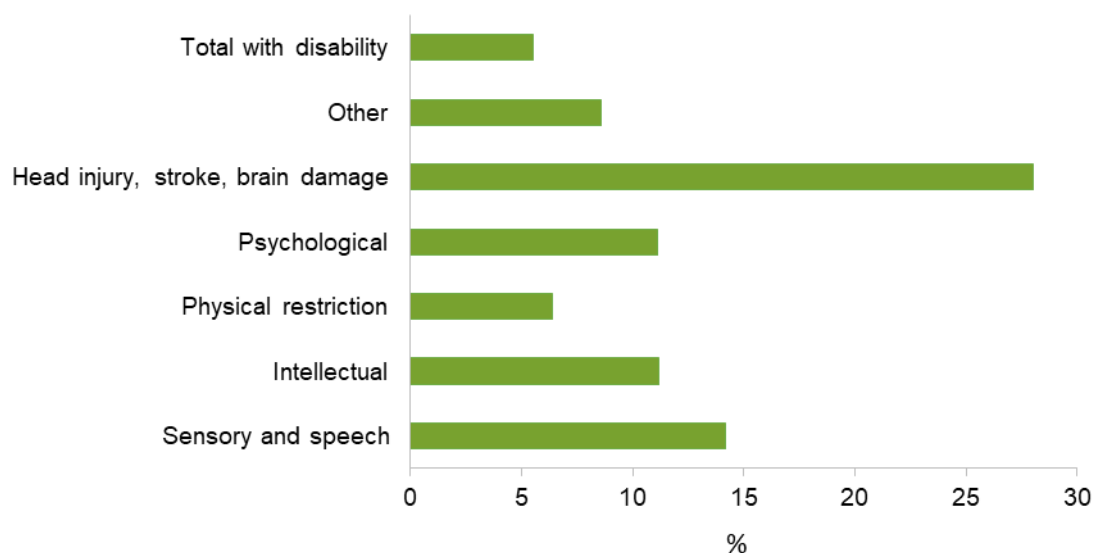
Source: OECD (2015b).

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 C.3).

There is also considerable variation in employment outcomes for those of working age with different reported mental health conditions (figure C.4). For example, a higher proportion of those with schizophrenia related conditions (76%) are not in the labour force compared to between 40 and 50 % of those with most other mental illnesses.

In regard to unemployment rates (unemployment being defined as actively seeking work), those with a bipolar disorder experienced unemployment rates significantly higher than those with other mental illness. For most reported mental illness the rate of unemployment was between 4 and 5%, except for attention deficit hyperactivity disorder (ADHD) where the rate was 8% (figure C.4).

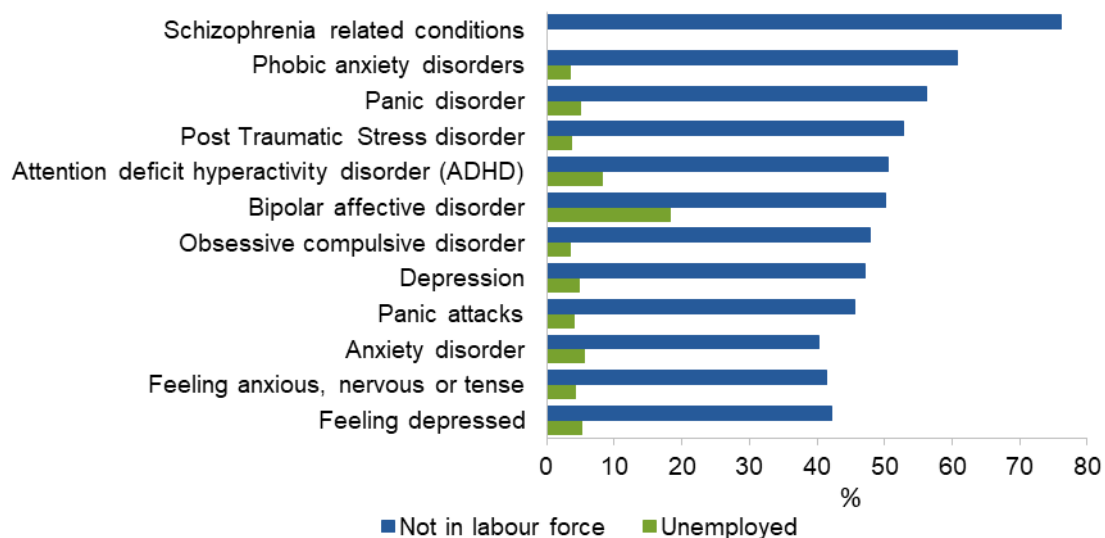
Figure C.3 **Unemployment rate by disability type**
2012



Source: ABS Cat. no. 44433.0.55/006, Disability and Labour Force Participation, 2012 (released February 2015).

Figure C.4 **Unemployment and not in labour force by type of mental illness**

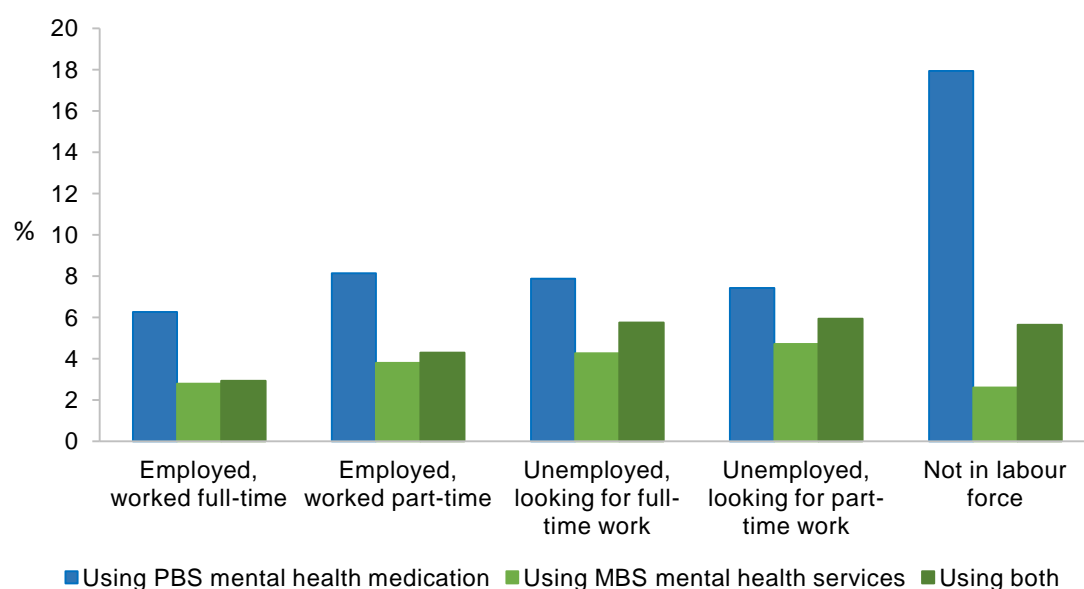
Selected mental illness (aged 16 to 64 years), 2017-18



Source: ABS (2019).

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 a mental illness. In examining the use of MBS mental health services and PBS mental health medication, part-time workers and unemployed people use mental health MBS services and PBS medications at a higher rate than full-time workers. For those not in the labour market, the use of mental health PBS medications is more than 2.5 times the rate of the rest of the population (figure C.5).

Figure C.5 Use of MBS mental health services and PBS mental health medication by labour force status



Source: PC estimates based on MADIP data.

The poorer employment outcomes for people with a mental illness is often considered to be due to the employment barriers facing those with a mental illness.

The barriers to employment facing those with a mental illness

Most people with mild to moderate mental illness manage their life without experiencing negative impacts in regard to employment (chapter 14). Others, particularly those with more severe mental illness, face a number of barriers to gaining and retaining a job. These barriers relate either to the individual, at the community level or within the wider mental health system (figure C.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 impacts 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).

Those individuals with a mental illness may also face educational disadvantage, poor physical health and homelessness providing further barriers to employment.

Figure C.6 Barriers to employment



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 a mental illness.

The stigma associated with mental illness is considered to be a significant barrier to both obtaining and maintaining employment for those with a mental illness. Vic Health and partners 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 (sub, 131, p. 10).

As a result, people with a mental illness in seeking employment 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 a 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 those in employment with a 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 and some carers to dissuade those with a mental illness from seeking employment due to concerns that the stress of work may exacerbate their mental illness (FCDC 2012; Rinaldi et al. 2008).

Low clinical, employer and self-expectations can discourage those with mental ill-health to seek out employment. A self-fulfilling prophecy may exist: clinicians (who often see their patients when they are most unwell) expect the patient will struggle with the demands of a workplace, patients are not encouraged to join the workforce and those that 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

Those with a 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 14 examines in detail the barriers facing those with a mental illness and makes a number of recommendations to improve the effectiveness of the employment support provide to those people with a mental illness.

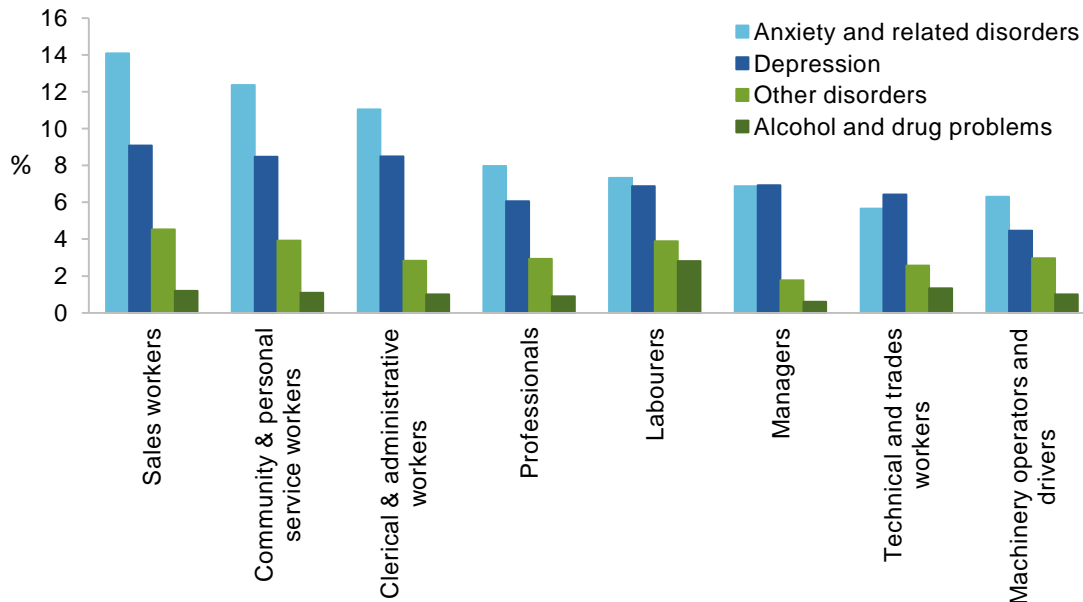
C.3 The mental health of those in the workforce

The mental health of those in employment and the impacts of the workplace on their mental health is discussed in chapter 19.

Mental illnesses tend to be more prevalent in certain occupations and industries. These tend to be in people-facing service occupations. By industry, those workers who have had or have

a particular mental health condition are lowest in agriculture and mining and highest in accommodation and food services (figure C.8).

Figure C.7 Prevalence of mental illness by sector^a



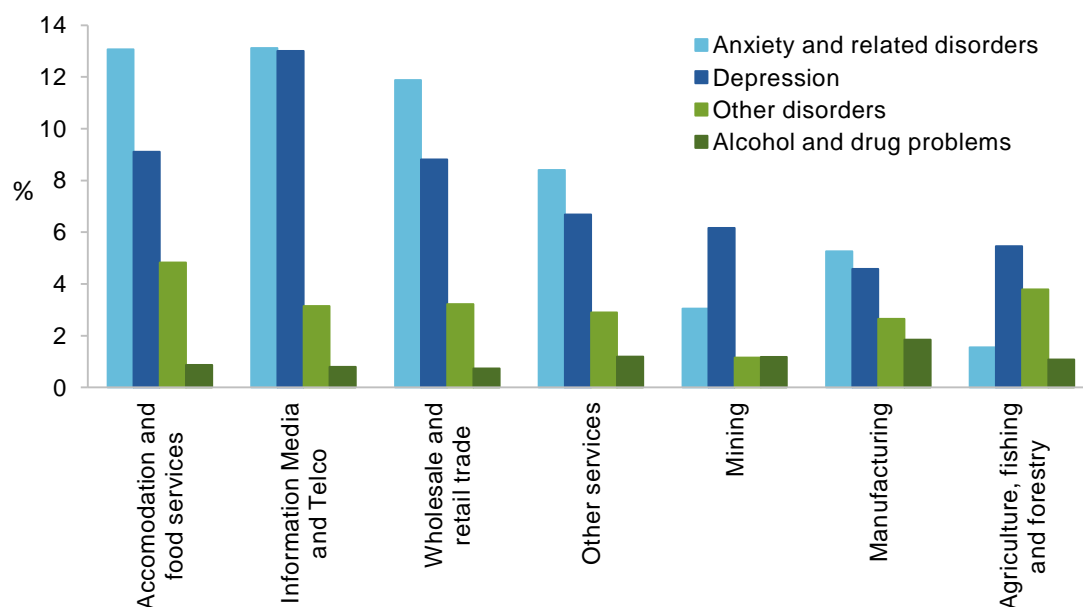
^a Share of people employed in each sector who have had or have various mental conditions.

Source: ABS (2019).

By occupation, those working in sales and community and personal services are more likely to have had or have a mental health condition (figure C.7). However, these occupational categories do not separate out those high risk occupations such as police, emergency service workers and correctional officers who (as discussed in chapter 19) are relatively more likely to develop a worker related mental illness or psychological injury.

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 has 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 2018a).

Figure C.8 Prevalence of mental health conditions by occupation^a



^a Share of people employed in each sector who have had or have various mental conditions.

Source: ABS (2019).

Are there differences between full-time and non-full-time employment on mental health?

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 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 (TAW) in Europe indicated that TAW 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 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 C.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 the mental health of women or men. 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).

While not focused specifically on mental health, a study using data from the Household, Income and Labour Dynamics in Australia (HILDA) survey examined job satisfaction to determine if non-standard employment arrangements, particularly casual employment, were inferior to more traditional arrangements (Wooden and Warren 2004). This study found that workers on fixed term contracts were more satisfied with their job than other workers, both permanent and casual. There were lower levels of job satisfaction for those working as casuals, but were restricted to those working as full-time casuals and the effects were greater for men. The study pointed out that the overwhelming majority of casual jobs were part-time and held by women, whereas men working full-time hours on a casual basis were less than 5% of all employees (Wooden and Warren 2004).

D 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 those who are bullied when younger, there are often problems adjusting to school and other adverse impacts that can continue into adult life.

Bullying is generally defined as aggressive behavior intended to harm or disturb that occurs repeatedly over time and 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. It has been seen as behavior that begins in the school playground and often continues into the workplace. This appendix focuses on bullying in those environments.

D.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; 20% of young people under 18 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 (Wozencroft et al. 2015).

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 those who witness bullying. Those 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. 68)

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, due to 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 2019a).

In 2015, the Australian Government established the office of the children's e-safety commissioner, to improve the safety of children online and reduce cyberbullying (Department for 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 safety commissioner received about 400 complaints of serious cyberbullying from young people under the age of 18. 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 & 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 & Griffiths 2018). SEL programs are part of the Australian curriculum and implemented in all schools – chapter 17 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 & 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 (Rigby & Johnson 2016). Chapter 17 discusses the issues of education policies and teacher training in detail.

D.2 Workplace bullying

Bullying in the workplace — as well as in other situations and through the social media platforms — has become a widely acknowledged cause of mental harm. It has also been increasing as a cause of work related mental stress (figure D.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 D.1).

How prevalent is it?

There has been wide variation in the estimates of the prevalence of bullying in Australia, 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.

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 %) when 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) regulation (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 (see box D.1).

As reported prevalence rates have increased, the number of accepted workers' compensation claims for workplace bullying and harassment have also increased — increasing from about 15% of all accepted workers compensation claims for mental stress related injuries in 2006-07 to just under 30% in 2016-17. However, workplace bullying and harassment although increasing continues to rank behind work pressure as a cause of accepted mental stress claims (figure D.1).

Box D.1 **What is and what is not workplace bullying**

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 19.

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.

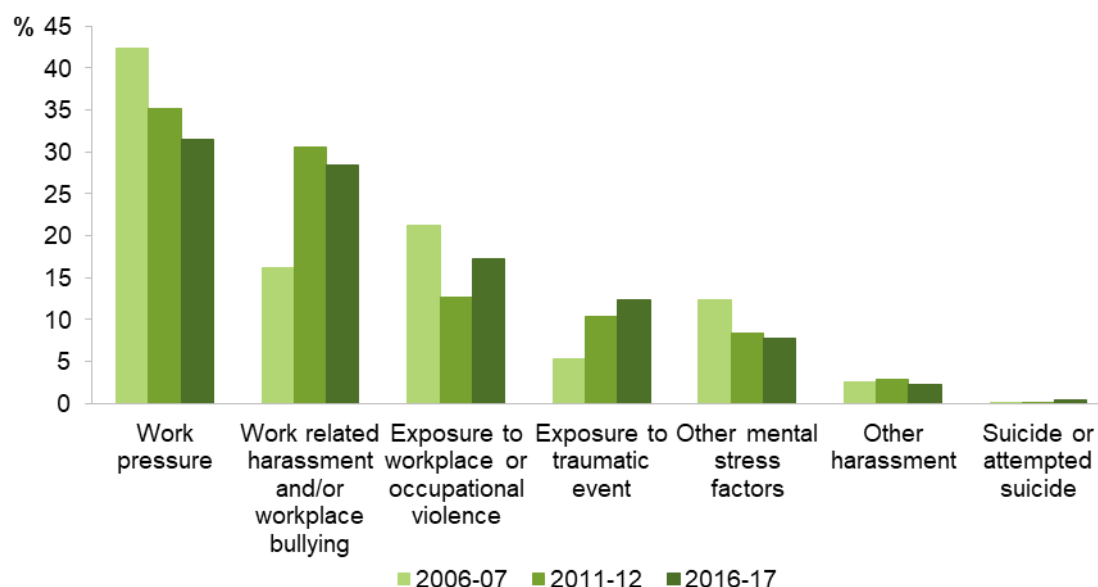
Bullying versus harassment

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*, *Racial Discrimination Act 1975* and the *Disability Discrimination Act 1992*) 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).

Figure D.1 Accepted workers compensation claims, by type of mental stress

Share of total accepted serious claims in Australia, selected years^a



^a Serious claims are those accepted claims that resulted in absence from work of a single working week or more. Data does not include Victoria and is provisional for 2016-17.

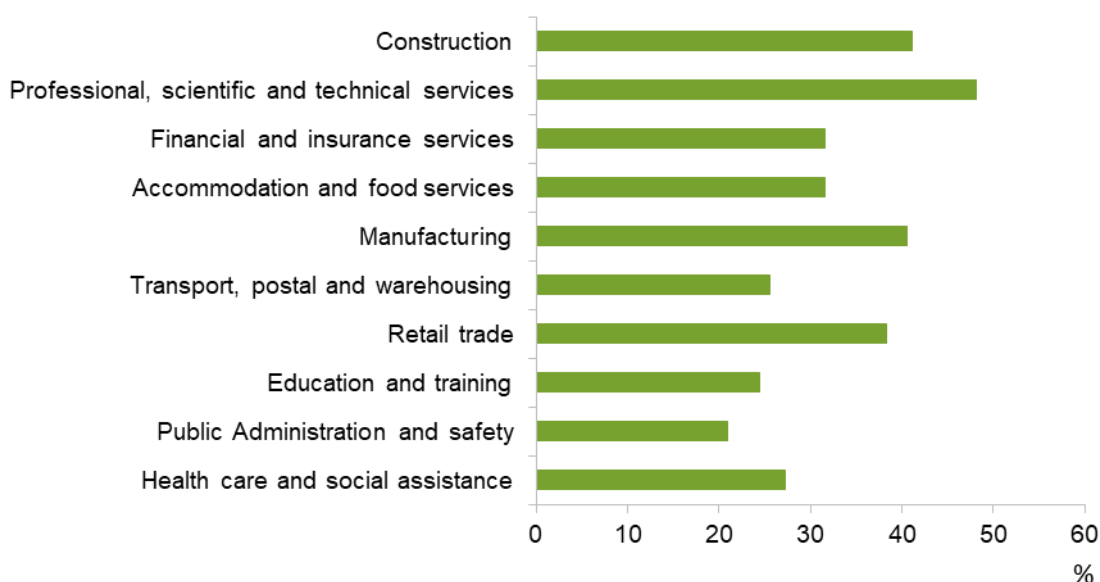
Source: Safe Work Australia's National Data-Set for Compensation-based Statistics.

By industry, workplace bullying and harassment (as a share of all serious claims caused by mental stress) was most significant in the professional, scientific and technical services, construction and manufacturing industries (figure D.2).

Workplace bullying is found in all workplaces. For example, the Law Council of Australia 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 (sub. 492, p. 29).

The Victorian Auditor General's report on bullying and harassment in the health sector found that while its prevalence was not conclusively known, a recent survey suggested it was widespread in the Victorian health sector. For example, a 2013 Victorian Public Sector Commission survey reported 25% of health agency employees reported experiencing bullying and 39% of surgeons who responded to a Royal Australasian College of Surgeons' Expert Advisory Group survey reported experiencing bullying and 19% harassment (Victorian Auditor-General 2016).

Figure D.2 Workplace harassment/bullying as share of all serious claims caused by mental stress, selected industries 2016-17^{a, b}



^a Data for 2016-17 is provisional and does not include claims data from Victoria. ^b Serious claims are those that resulted in a least a week's absence from work.

Source: Safe Work Australia's National Data-Set for Compensation-based Statistics.

The estimated costs of bullying and what drives it?

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 2010b).

Despite the very significant difference between the lower and upper estimates, 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 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).

What drives it?

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 19). 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).

Also, particular workplaces or industries may have certain behaviours or initiation rituals entrenched in their cultures that may appear or be intended to be nothing more than practical jokes on the new starter or young apprentice, but can easily morph into bullying behaviour or even physical assault.

WHS agencies across Australia provide guidelines to employers and employees on preventing and dealing with bullying to meet their obligations under the relevant WHS and legislation.

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 in WHS legislation as to bullying, there is the 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 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 (PC 2010b).

A study of 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 those 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 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)

The Australian Industry Group (Ai Group) 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 (sub. 208).

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 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 whether or not the established policies 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 (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.

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 the 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
- regular monitoring of behavior by an employer or principal
- compliance with an employer’s bullying policy
- the provision of information, additional support and training to workers
- review of 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 (Victorian Auditor-General 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 19.

E Calculating the cost of mental ill-health and suicide in Australia

This appendix calculates the cost of mental ill-health and suicide in Australia. It outlines our framework, noting the different types of costs and the people and organisations that bear them. It then proceeds to quantify, primarily in dollar terms, each category using data from the Australian, State and Territory Governments, estimates from literature and the Commission's own assessments. Our aggregate estimate of the cost of mental ill-health should be considered a preliminary estimate as we believe we will be able to refine it, with better information from inquiry participants and other sources.

E.1 Measuring the cost of mental ill-health and suicide

Mental health determines people's capacity to lead contributing 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 fail to achieve some, or all, of these important elements of life. This results in lost opportunities and costs.

Many, if not all, in the community bear these costs to some extent, including people with lived experience of poor mental health and their families and friends, governments (through current and future tax payers), employers and insurers. The nature of these costs varies considerably (figure E.1).

- Resources expended on healthcare and other services and supports are relatively visible. It includes time and effort spent by family members and friends in caring and supporting people with mental ill-health.
- Lost opportunities and lower living standards are less visible than resources expended. They manifest in terms of young people spending less time in education which inhibits their ability to develop their skills and talents. Mental ill-health also affects people's work outcomes (such as having reduced hours of work, not being able to work, or being less productive when at work). As a result, people with mental ill-health often have lower incomes and employers bear the cost of employees being absent from, or less productive at, work in terms of lower output. The education and labour market outcomes of carers are also affected.
- Social and emotional costs can also be somewhat hidden. Mental ill-health can reduce the range of life experiences and enjoyment of endeavours undertaken, can add tension

and stress to relationships, and in some cases can lead to premature death. Some carers experience a deterioration in their own physical and/or mental health.

Beyond these impacts that mental ill-health imposes on various parties, the community as a whole loses from not having the unique and valued contribution of a group of its people. And this group is not small, accounting for about 20% of the population each year. (chapter 2).

It is not necessary to quantify the cost of mental ill-health and suicide to know that it imposes damaging and costly impacts on the lives of these people, their family and friends, governments, business and collectively as a society. We have heard the lived experience in submissions, brief comments and consultations during this inquiry. We have also heard from those who work in the sector, who are committed to achieving better outcomes for those with mental ill-health and their families and friends.










There are challenges in estimating the cost of mental ill-health and suicide, 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, incomprehensible or objectionable.

Nevertheless, there are benefits in quantifying the dollar value of the full range of costs of mental ill-health and suicide (box E.1). The Commission quantified, where possible, each category using Australian, State and Territory Government data, estimates from research literature and the Commission's own assessments. These estimates are primarily derived from aggregate or population values. For example, the total expenditure by governments on mental healthcare or the total number of days absent from work due to mental ill-health.

A cost-of-illness study can be conducted from several different perspectives, and depending on the perspective, will include slightly different data. The focus of our study is on the community perspective, including various costs for all members of society. But we are also interested in the costs to various parties and highlight these costs when necessary. For example, transfer payments such as income support are outlined as a cost to government (or taxpayers) (section E.4).

But knowing the cost of mental ill-health is only one piece of information in the policy decision making process, and needs to be supplemented with other analysis, such as cost-effectiveness and cost-benefit analyses, to determine where resources should be allocated (chapters 5 to 21). Decision making should also be informed by the lived experience of those with mental ill-health and their carers.

Figure E.1 **Costs of mental ill-health to the community^a**

Resources expended on human services	Reduction in incomes & living standards	Social & emotional costs
Healthcare  Expenditure on diagnosis, treatment & recovery	Lower economic participation  Individuals & carers spend less time working or in education	Lower social participation  Less contact with family & friends, lower community involvement
Other services & supports  Expenditure on education, employment, housing, justice & social services	Lost productivity  People produce a lower rate of output when at work	Pain & suffering  Diminished health, reduced emotional resilience, increased distress & premature death
Informal care  Time and effort provided by family & friends to support individuals	Cost of collecting taxes to provide services  Taxes alter prices, change behaviours & lowers output	Stigma & discrimination  Reduced rights, limited choices & poor treatment by others

^a Financial 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. The cost of collecting taxes to fund transfer payments, and publicly funded human services, are included because this is a cost to the whole community.

Box E.1 **Why is measuring costs important?**

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

- provide 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
- help 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 E.1). Understanding this helps to identify the types of solutions and interventions that may be needed
- ensure all types of costs are considered so that sufficient resources are invested to avoid these costs as much as possible
- identify 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.

E.2 Mental healthcare expenditure

Government expenditure on healthcare

Governments spend a substantial amount on mental healthcare services each year. Total Australian, State and Territory Governments direct recurrent expenditure on mental health related services was estimated to be \$10.4 billion in 2018-19 (table E.1). State and Territory Government outlays on mental healthcare accounts for about two-thirds of this total government expenditure, consisting primarily of expenditure in public hospitals and community healthcare.

Despite the substantial size of the outlays, this estimate should be considered conservative. That is, while some health service expenditure captured in the Medicare Benefits Schedule, Pharmaceutical Benefits Scheme and hospital activity can be formally identified as mental health related, not all services that relate to mental health are included due to the way health service information is collected at the source (DoH 2019i). An example of under attribution is the amount assigned to mental health from the Medicare Benefits Schedule. It is projected that the Australian Government spent approximately \$1.3 billion for Medicare subsidised mental health specific services in 2018-19 (table E.1). The Australian Government expenditure related to Medicare is considered to be an underestimate as it captures only those Medicare Benefits Schedule numbers associated with mental health. It does not capture mental health services under standard Medicare Benefits Schedule items, such as a standard consultation with a general practitioner that deals with mental health issues.

Furthermore, there is also unaccounted expenditure on suicide prevention programs. The Australian Government spent almost \$50 million on suicide prevention under its National Suicide Prevention Program in 2017 (AIHW 2019o). 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 reported in any state or territory (AIHW 2018b) (chapter 21). Some expenditure on suicide prevention programs operating through schools is captured in the education expenditure component (see below).

Publicly-funded treatment services for misuse of alcohol and other drugs are largely funded by State and Territory Governments, while some are funded by the Australian Government (Ritter et al. 2014). National data collections, however, do not include the expenditure of publicly-funded treatment for misuse of alcohol and other drugs. Research publications have a broad range of estimates of the cost of treatment in this area. Based on the estimates by Ritter et al. (2014) and data from the Australian Department of Health, the Commission estimates the healthcare costs of substance use disorders to be \$1.1 billion in 2018-19.

Table E.1 Estimated mental healthcare expenditure
2018-19^a

	\$b
<i>Australian Government</i>	
Medicare	1.3
National programs and initiatives	1.0
Pharmaceutical Benefits Scheme	0.5
Alcohol and other drugs services	0.3
Other	0.4
Australian Government total^c	3.6
<i>State and Territory Government</i>	
Public hospitals (admitted patients)	2.7
Community mental healthcare services	2.2
Alcohol and other drugs services	0.8
Other ^b	1.1
State and Territory Government total^c	6.9
<i>Individual out-of-pocket expenses^d</i>	0.7
<i>Private health insurers</i>	0.5
<i>Workers compensation insurers</i>	0.5
Total	12.1

^a Expenditure converted to 2018-19 estimates using the health index of the CPI inflator. This does not take into account growth in expenditure due to population growth in programs where funding is uncapped.

^b Includes grants to non-government organisations. ^c Components do not necessarily sum to the total due to rounding errors ^d Only includes out of pocket expenses for Medicare and Pharmaceutical Benefits Scheme items.

Source: 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 cost can represent the full cost of a service or a shared payment, over and above any amount paid by the Australian Government (via Medicare) or a private health insurance fund (AIHW 2018g). Potential examples of out-of-pocket costs include:

- the gap between the fee for a general practitioner 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

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- the cost of private prescription medicines (those not under the Pharmaceutical Benefits Scheme)
 - the gap between the fee for a psychologist or psychiatrist consultation and the amount rebated by a person's health fund and/or Medicare
 - the full cost of a psychologist consultation not covered by Medicare, for example, after a consumer has exhausted their Medicare entitlement
 - the gap between the fee for private hospital in-patient treatment and the amount rebated by the person's health fund
 - the cost of traveling to and from appointments.

Data on the out-of-pocket costs of consumers of mental healthcare is limited. 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.

Of the mental health services that the Australian Government subsidises via Medicare, such as services from a general practitioner, individuals also contributed an estimated \$0.3 billion in 2018-19 (AIHW 2019o). Based on Pharmaceutical Benefits Scheme data, the total patient contribution for mental health prescriptions in 2018-19 was \$0.4 billion (Commission estimates based on ABS 2019c). Based on this administrative data, out-of-pocket costs for consultations and medication (that had an associated government subsidy) for people with mental ill-health was \$0.7 billion in 2018-19 (table E.1).

Information on out-of-pocket costs has also been collected by survey or estimated based on available data and a range of assumptions. For example, data from an international survey of adults regarding expenditure on medical services indicates that Australian households with a person experiencing mental illness had an average expenditure of A\$1350 per year in 2013 (Callander, Corscadden and Levesque 2016). An Australian study estimated the total out-of-pocket cost of high prevalence mental health disorders to be A\$168 million in 2013-14, based on the estimated cost of consultations and medication (Lee et al. 2017).

Out-of-pocket costs have a direct impact on access to healthcare with a sizable proportion of Australians reporting that they do not visit a general practitioner and/or did not get recommended care because of the cost. An estimated 44% of Australians with mental ill-health stated that they skipped healthcare treatment because of the cost. People with depression, anxiety and other mental health illnesses were 7.7 times more likely to skip treatment than people who were not living with any health condition, after adjusting for age, gender and education attainment (Callander, Corscadden and Levesque 2016). (Access barriers to treatment, including costs are covered in chapter 6).

Private insurance costs

Private health insurers also fund mental healthcare. In 2016-17, insurers spent \$0.51 billion on mental health services (AIHW 2019o). The Commission has predicted this to be approximately \$0.54 billion in 2018-19 (table E.1).

Similarly, workers compensation insurers fund mental healthcare for work related claims (chapter 19). According to SafeWork Australia, over 7000 Australians are compensated for work-related psychological claims each year, equating to \$0.43 billion paid in workers compensation (averaged over the period of 2012-13 to 2016-17) (Safe Work Australia, sub. 256). The cost of workers compensation is ultimately borne by the insured employers.

E.3 Expenditure on other services and supports

In addition to direct expenditure on mental healthcare, governments also have a range of programs and services that help support people, such as housing, education and employment services. However, as only some of these services are used as a direct result of a person's mental ill-health, assumptions are necessary to attribute expenditure (box E.2).

Homelessness services

The Australian, State and Territory Governments provide many forms of housing support (chapter 15). This includes financial assistance, social housing, affordable housing, homelessness services and tenancy support services (aimed at helping people maintain or move between tenancies).

In 2017-18, total net recurrent expenditure on homelessness services was \$905 million. 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 (SCRGSP 2019k). Government and non-government specialist homelessness service providers deliver a range of services to clients — including supported accommodation, counselling, advocacy, links to housing, health, 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 2016-17, 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 (17% of all clients). Based on this data, it is estimated that homelessness services provided as a result of a person's mental ill-health was \$155 million in 2018-19 (table E.2).

Box E.2 **Attributing expenditure on services and supports to mental ill-health**

For specialised mental healthcare services and supports, 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% aggregate expenditure.

People using these support services may or may not have a 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. 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 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. For example, a person with a mental illness may state that they are accessing public housing because of their low income. However, this low income may result from not being able to maintain continuous employment due to mental ill-health — but not expressed as the motivating factor for accessing the service.
- *Use the ‘population attributable fraction’.* This calculates the proportion of people accessing services as a result of a mental illness. It does so by combining the relative probability of accessing support services and with a mental illness and netting out the probability of accessing services in the rest of the population who do not have a mental illness.
- *Assume that every person with a 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.

Table E.2 Estimated government expenditure on other services and supports attributable to mental ill-health
2018-19^a

<i>Service or support area</i>	<i>\$m</i>
Homelessness services	155
Social housing	854
Employment support	517
Psychosocial supports	748
Education services	889
Justice	2 486
Total	5 648

^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 errors.

Source: Commission estimates.

Social housing

In 2017-18, State and Territory Government net recurrent expenditure on social housing was \$4.1 billion (SCRGSP 2019j). 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 (chapter 15).

In 2016, across the various types of social housing, the following proportions of households reported that they had utilised mental health services in the last 12 months:

- public housing (20%)
- State owned and managed Indigenous housing (14%)
- community housing and Indigenous community housing (24%) (AIHW 2017d).

As eligibility for social housing is primarily based on income, not all people accessing social housing with a mental illness will be doing so because of their mental disorder. However, a person's mental health impacts on their ability to complete schooling, undertake further education, and their ability to participate in the labour market, all of which has flow on effects to their income. However, 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 last 12 months (SCRGSP 2019j). Based on this, approximately \$854 million of social housing was estimated to be related to mental health costs in 2018-19 (table E.2).

Employment support

The Australian Government funds employment services to help eligible jobseekers find and maintain employment (chapter 14). Employment services providers are contracted to deliver a range of programs. The two major employment services programs are:

- **jobactive:** 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 (Australian Government 2019a)
- **Disability Employment Services (DES):** a specialist service that assists people with disabilities find employment. In 2018-19, total expenditure on DES was \$0.8 billion (Australian Government 2019b).

In jobactive, approximately 13% of participants had a mental illness (the Department of Jobs and Small Business, sub. 302). Based on this proportion, approximately \$193 million of employment services expenditure was attributed to mental ill-health in 2018-19. However, this is likely to be an underestimate as it relies on self-disclosure by the jobseeker that they have a mental illness, something that they may not be inclined to do given the potential discrimination that could result (chapters 14 and 20).

Some people with a mental illness are eligible for specialist disability employment services because of their mental health disorder. In March 2019, about 40% of DES clients were eligible for assistance because of disability due to mental ill-health (DES 2018). In 2018-19, approximately \$323 million of expenditure on DES is estimated to be attributable to mental illness.

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. 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 (chapter 12).

Funding for psychosocial supports is a complex web, weaving together a combination of different funding streams (chapter 12). State and Territory Governments have primary responsibility for funding, delivering and/or managing specialised mental health services, including psychosocial support services.

The Australian Government is a minority funder of psychosocial services, holding responsibility only for the oversight and funding of a range of services and programs that are primarily provided or delivered by private practitioners or NGOs (chapter 12). The Australian Government funds four major psychosocial support programs:

- **Partners in Recovery**

-
- Personal Helpers and Mentors
 - Day-to-Day Living
 - Mental Health Respite: Carer support

Funding for Partners in Recovery, Personal Helpers and Mentors and Day-to-Day Living is transitioning to the National Disability Insurance Scheme, while the carer support program is to be replaced by another program, the Integrated Carer Support Service (chapters 12 and 13).

As outlined in chapter 12, total expenditure on psychosocial supports (approximated by specialised mental health service grants to non-government organisations) was estimated to be \$424 million in 2016-17. This expenditure on these psychosocial supports programs is captured in expenditure on healthcare (section E.2).

In addition, the Australian Government also provides psychosocial supports for people with a mental illness through the National Disability Insurance Scheme (chapter 12). Allocated funding for these supports was estimated to be \$1.4 billion in 2018-19. Approximately 52% of these funds are actually spent in each year (chapter 12). Given this, the cost of the National Disability Insurance Scheme support for people with a mental illness was estimated to be about \$0.7 billion in 2018-19.

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 17 and 18). 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. These cover the full spectrum 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 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 a 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, the Commission is unable to provide an estimate of the overall cost of these activities.

State and Territory Governments provided the Commission with expenditure estimates on some standalone education programs that had a specific mental health focus. While this data is not comprehensive nor collected in a way that lends to aggregating, these programs represented about \$0.9 billion in expenditure in 2018-19 (table E.2). The Commission has requested further information from inquiry participants regarding these costs (chapter 3).

Justice

The costs related to managing people with mental ill-health in the criminal justice system are difficult to determine. Based on the data available, the Commission has calculated a population attributable fraction — of approximately 15% — to apportion the amount of criminal justice expenditure that was attributable to mental ill-health. Based on expenditure in the justice system of \$16.1 billion, approximately \$2.4 billion was attributable to mental ill-health in 2017-18 (\$2.5 billion in 2018-19) (table E.2 and chapter 16).

Informal care of those with a mental illness

Informal carers, such as family members, partners and friends, play a significant role in the care of people with a mental illness in Australia. They help and support a family member or friend with mental ill-health 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 — in what is claimed to be the only published attempt to establish the value of the care delivered (Diminic et al. 2017). This represents the cost involved in replacing all of the caring tasks currently provided by informal carers with formal or paid mental health support services. In 2018, this represented an annual replacement cost of approximately \$15 billion. The authors noted that:

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. (Diminic et al. 2017, p. 3)

This annual replacement cost estimate does not include the emotional cost or adverse physical impacts on the carer of their caregiving (chapter 13).

Cost of collecting taxes to provide services

Governments use a variety of taxes to collect tax revenue which ultimately funds mental health services (sections E2 and E.3) and provides financial support payments to eligible people and families (section E.4). The tax distribution process involves governments transferring revenue from taxpayers to mental healthcare and other service providers. Such transfers do not occur without costs. 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, most importantly, the costs of distortions imposed when governments collect tax.

The cost of distortions arise because taxes alter the (relative) price of goods or services, which changes both behaviours and output. The goods and services affected could be those that people buy to consume (such as a meal at a restaurant) or the inputs businesses use (such as hiring staff or purchasing machinery). When these goods and services are taxed the price increases, and people and businesses purchase less of them (for example, people eat out less often or businesses employ fewer staff). The reduction in output is the cost of distortions imposed when governments collect tax — 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 ill-health. Some of the 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 impacts of smoking, taxing the sale of and lowering output of the externality producing goods (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.

E.4 Government income support

So far, this appendix has focused on costs of mental health. Our cost framework, as outlined in figure E.1, is inextricably linked to the output or income that we earn from products made and services delivered, as individuals, businesses and a community. And where there is not a monetary estimate, we have attempted to put an economic value on this (for example, section E.8).

Income support payments (such as the Disability Support Pension (DSP)) are not included in this cost framework because they are transfers between different members of the community. That is, income support payments change the person who has that money to spend, not the output of the community (as measured by GDP). Consequently from an economy-wide perspective, income support payments are not viewed as an economic or resource cost.

Nevertheless, from a fiscal perspective, income support payments represent a substantial outlay that must be funded. This is something that will become increasingly harder to do in the context of an ageing population. Therefore, the capacity to reduce the prevalence or the severity of mental ill-health 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 (chapter 14). The McClure review (2015) recommended reducing future liabilities associated with long-term income support dependence by targeting investment to build peoples' self-reliance. Using this investment approach, the Australian Government is trialling innovative methods, since 2016, to tackle the complex policy issue of long-term income support dependency (DSS 2019s).

The Australian Government provides a range of income support payments to assist people with a mental illness and their carers, including the DSP, Newstart Allowance, Youth Allowance, Carer Payments, Carer Supplement and Carer Allowance (chapters 13 and 14.).

In 2018-19, \$9.7 billion in income support payments were estimated to be related to mental illness (table E.3). The DSP accounted for about 60% of these mental health related income support payments.

Table E.3 Income support payments related to mental ill-health
2018-19

<i>Income support</i>	<i>Total cost (\$b)</i>	<i>% mental health related^a</i>	<i>Cost attributable to mental illness (\$b)</i>
Disability Support Pension	16.7	34	5.7
Newstart Allowance	9.7	16	1.5
Youth Allowance	0.9	7	0.1
Carer Allowance	2.3	32	0.7
Carer Payment	5.4	27	1.5
Carer Supplement	0.6	32	0.2
Total income support payments related to mental illness^b			9.7

^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 has a psychological/psychiatric medical condition recorded (any medical condition). ^b Converted to 2018-19 estimates using CPI inflator.

Source: Commission estimates.

The projected future lifetime cost for an average individual (aged between 18 and 40) 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 E.4). In 2027, 85% of this group are expected to be receiving DSP, 6% are expected

to not be receiving any welfare payments, 2% are expected to be receiving a working age payment and 5% are projected to have passed away (DSS unpublished data).

Table E.4 Projected future lifetime costs and duration of income support for a person aged between 18 and 40 and with a psychological or psychiatric medical condition

	<i>Average future lifetime cost</i>			<i>Future duration in income support</i>		
	<i>including Age Pension</i>			<i>not including Age Pension</i>		
	\$	Years	% ^a	\$	Years	% ^a
Disability Support Pension	614 000	47	91	494 000	32	62
Working Age payments (primarily Newstart or Youth allowance (other)) ^b	355 000	36	61	241 000	19	33

^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.

Source: DSS unpublished data.

The projected future lifetime cost for an average individual (aged between 18 and 40) on a working age payment (but not DSP) with a psychological/psychiatric primary 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, in 36 years or 61% of their future life (table E.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 welfare payments, 7% are expected to be receiving a parenting payment, 5% carer payment, and 7% are expected to be receiving DSP (DSS unpublished data).

E.5 Impacts of mental health on work

The lost opportunities experienced by those with mental ill-health to work productively and fruitfully carry great costs for the individual (lost income) and the community more broadly (in terms of lost output or reduced productivity).

The impact of mental ill-health on productivity and output can be significant, as the effects of mental ill-health fall mainly on people during their working lives, as opposed to the impact of most other health issues which commonly affect older individuals (OECD 2014b). The high prevalence of physical health problems that coexist with mental ill-health (either contributing to the mental ill-health or as a consequence of it) can further impact on the work

capacity of people with mental ill-health (chapter 19). Productivity losses are the cost of production that is lost when people with mental ill-health alter their work patterns as a result of their condition. People may work less than they otherwise would, either being employed less or not at all, being absent more often (absenteeism) or being less productive while at work (presenteeism), or they may retire or die prematurely. These may be temporary changes to work patterns or they may be permanent (CREST 2016).

Traditionally, lost productivity has focused on paid work. However, there is increasing recognition that people's unpaid output, through roles such as caring for children or relatives, household tasks, and volunteering, also make important contributions to society (Access Economics 2009; CREST 2016). While desirable to value the non-market output lost due to mental ill-health, we have not calculated an estimate due to data limitations.

The Commission has adopted a human capital approach to valuing the productivity or output losses due to mental ill-health, using the hourly wage derived from average ordinary weekly full-time earnings to value lost time.

Mental health and employment participation

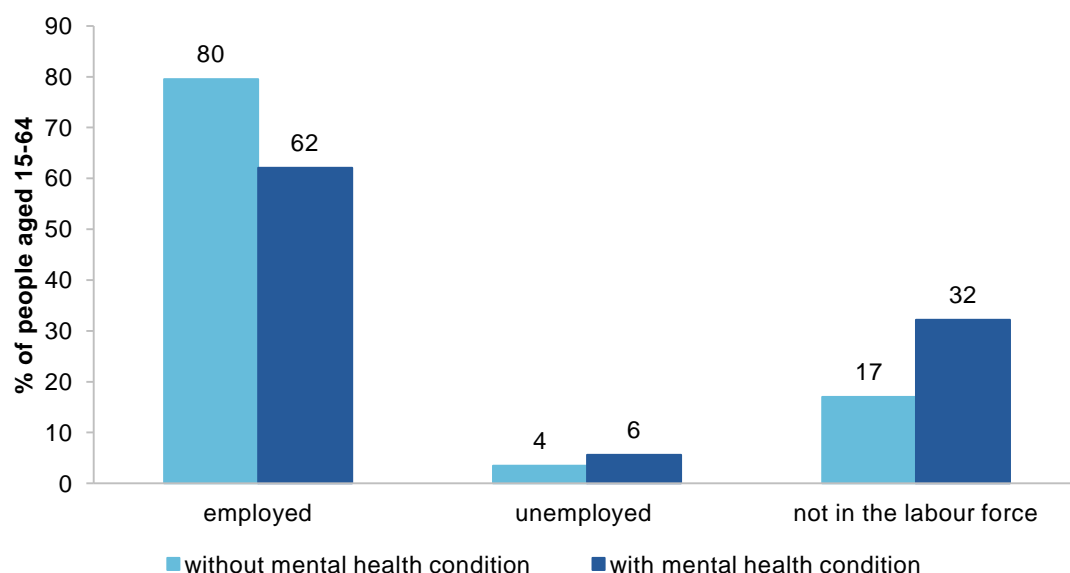
Mental ill-health reduces people's ability to participate in the workforce. They are less likely to be employed and more likely to be unemployed or not in the labour market (figure E.2). The effects are greater the higher the level of mental distress reported, for example:

- approximately three in five people of working age with a mental health disorder were employed, compared with about four in five people of the same age without a mental health disorder (figure E.2, panel A)
- just over half of working age people with high levels of psychological distress (as measured by the Kessler 10 questionnaire) and only 39% of those with very high levels were employed compared with 68% of those with low or moderate levels of distress (figure E.2, panel B)
- people aged 15-64 years with a mental health disorder were more likely to be unemployed than people without a mental health disorder (figure E.2, panel A)
- almost one in three people aged 15–64 years with a mental health disorder were not in the labour force, almost double the rate of those without a mental health disorder (figure E.2, panel A).

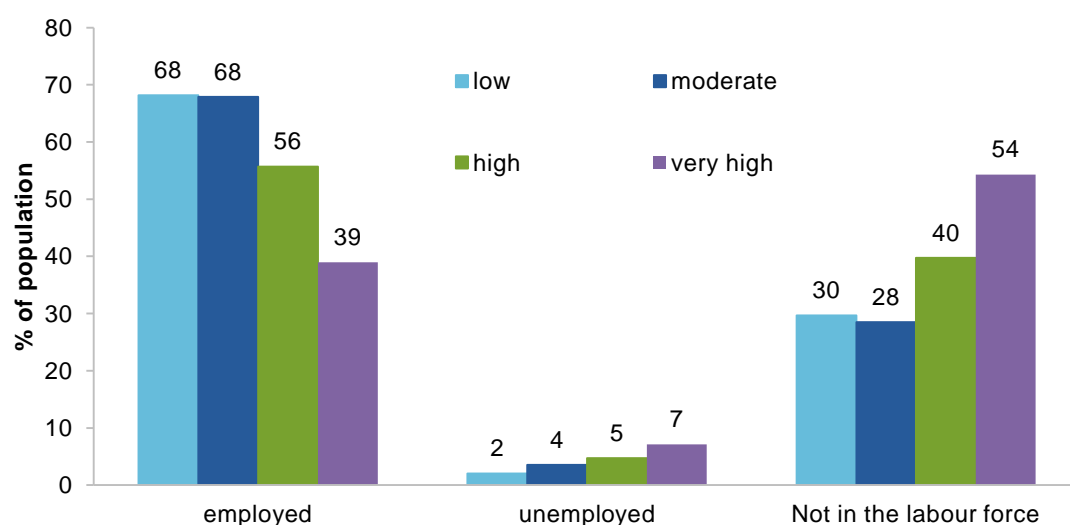
To capture the effect of mental ill-health on participation in the workforce and productivity, the Commission modelled the cost of forgone output due to mental ill-health to be between \$9.9 billion and \$18.1 billion in 2018-19 (using the wage model outlined in appendix F). This estimate assumes that those who are employed will work the average number of hours of those currently working. It captures the increased participation and improved productivity from reduced presenteeism but it does not capture the effects of reduced absenteeism.

Figure E.2 Mental ill-health affects people's ability to participate in the workforce

Panel A: Labour force status by mental health disorder



Panel B: Labour force status by Kessler 10 category of distress level



Source: ABS (National Health Survey: First Results 2017-18, Cat. no. 4364.0.55.001), ABS (National Health Survey 2017-18, TableBuilder, Cat. no. 4324.0.55.001).

Absenteeism from paid employment and people with mental ill-health

For people with mental ill-health who are employed, the condition can adversely affect work performance through absence from work. Individuals suffering from mental ill-health who

are employed are more likely to have temporary absences than those without any mental disorders.

According to the ABS National Health Survey people with mental ill-health took an average of 10-13 days off work due to psychological distress — depending on the indicator used to determine mental ill-health (ABS 2018b). 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 assumed they were unable to work. The Commission has 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 categorised 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 \$10.9 to 13.5 billion in 2018-19 (table E.5).

These are considerably higher than previous estimates of absenteeism due to mental ill-health. For example, KPMG and Mental Health Australia (2018) (KPMG study) estimated that the cost of workplace mental ill-health to Australia in 2015-16 attributed to absenteeism to be \$2.6 billion. This study uses the same estimation approach to the Commission but different survey data. The KPMG study used survey data from the World Health Organisation Health and Work Performance Questionnaire while ours is based on the ABS National Health Survey. Prior to the final report, the Commission will further investigate the differences in approaches and the effects on absenteeism.

Presenteeism and mental health

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, impaired attention, decreased concentration and poor memory can affect employee performance.

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 16 to 20 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 cut down at work (ABS 2018b).

Measuring presenteeism or an individual's reduction in productivity on the days they cut down is difficult as it is not easily observed or measured. Measurement typically has been based on self-reported survey data collected from employees. Goetzel (2004) found, in a meta-analysis of presenteeism studies in the United States, that workers with mental ill-health had lower productivity than their counterparts, on average, of about 15.3%. That is, on days of reduced productivity, workers delivered about 85% of their normal output. Based on this, approximately 3 days per worker 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 reduced productivity as a result of mental ill-health to be in the range of \$2.4 to \$3.4 billion in 2018-19 (table E.5).

The Commission's estimates of presenteeism are lower than other estimates. For example, PwC (2014) estimated that presenteeism due to poor mental health costs Australian employers \$6.1 billion annually. The KPMG study estimated the cost to be \$9.9 billion in 2015-16. The PwC study used a different estimation approach to the Commission's. In particular, this study assumes a reduction in productivity of 50 per cent. This assumption has a material impact on the total costs calculated. As noted above, the KPMG study used survey data from the World Health Organisation Health and Work Performance Questionnaire. Productivity losses due to presenteeism are calculated from the survey data. Employees are asked to estimate their usual job performance and job performance over the 4 weeks. Chapter 19 examines the methods used to estimate presenteeism in these studies.

Table E.5 Estimates of labour market losses due to mental ill-health^a
2018-19

<i>Loss due to:</i>	<i>Lower bound (\$b)</i>	<i>Upper bound (\$b)</i>
Decreased participation and productivity	9.9	18.1
Absenteeism and presenteeism	13.3	16.9

^a The numbers in each row are estimated using different methodologies and cannot be added to give a column total.

Source: Commission estimates.

E.6 Estimating the economic cost of suicidal behaviour

The Commission estimated the quantifiable economic costs of suicide by aggregating the direct and indirect costs associated with suicide and non-fatal suicide attempts in Australia. This was done by extending the methodology used by Kinchin and Doran (2017) who estimated the cost of suicidal behaviour in the Australian workforce. The Kinchin and Doran framework used six categories of direct and indirect costs applied to three categories of severity resulting from suicide attempt (box E.3). Where the authors estimated the direct and

indirect costs for *employed* Australians, the Commission extended this methodology to *non-employed* Australians.

It is important to note that the economic costs of suicidal behaviour estimated in this section overlaps with other costs estimated in this chapter to some degree, and therefore cannot be aggregated with other costs.

Box E.3 Costing framework

Kinchin and Doran (2017) applied a costing framework that identifies six categories of direct and indirect costs for employers, workers and the government as a result of suicidal behaviour.

- **Production Disturbance Costs** — the short-term impacts on firms until production is returned to pre-incident levels, including the value of lost production and staff turnover costs.
- **Human Capital Costs** — the long-run costs, such as loss of potential outputs. For example, for full incapacity or fatality, 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.
- **Medical Costs** — the cost of medical treatment.
- **Administrative Costs** — the costs of investigating an incident, travel to medical support and funeral costs (funeral costs are brought forward by suicide fatality).
- **Other Costs** — the cost of carers, aids, modifications, counselling and bereavement support for those affected by suicide fatalities.
- **Transfer Costs** — the deadweight costs on society as a result of redistributing public sector resources to care for incapacitated persons, measured as the value of taxation receipts foregone.

These cost categories are applied to three levels of severity that may result from suicidal behaviour.

- **Short absence** — a minor work-related injury or illness, involving less than five working days absence from normal duties, where the worker was able to return to full duties.
- **Full incapacity** — a work-related injury or disease, which results in the individual being permanently unable to return to work.
- **Fatality** — a work-related injury or disease, which results in death.

See Kinchin and Doran (2017) for a detailed explanation of the underlying methodology used to calculate each cost category.

Table E.6 provides an overview of the assumptions used in the model. The Commission retained the assumption used by Kinchin and Doran that 37% of people who died by suicide were employed and 63% were not employed. However, the Commission revised this assumption for people who engaged in non-fatal suicide behaviour by using the proportion of people who attempted suicide that were employed in the 2007 National Survey of Mental Health and Wellbeing. This led to a slight difference — 41% of people who engaged in non-fatal suicide behaviour were assumed to be employed and 59% not employed. Further, the Commission retained the assumption used by Kinchin and Doran that 17% of people

who engaged in non-fatal suicide behaviour resulted in full incapacity and 83% resulted in a short absence. The final estimates of the number of suicide deaths and attempts in 2018 are presented in table E.6.

Table E.6 Summary of key assumptions and estimates
2018

<i>Description</i>	<i>Estimate</i>	<i>Source</i>
Suicide deaths		
Number of suicide deaths	3 046	ABS (Causes of Death, Australia, 2018, Cat. no. 3303.0)
Proportion employed	37%	Kinchin and Doran (2017)
Proportion not employed	63%	Kinchin and Doran (2017)
Non-fatal suicide attempts		
Number of suicide attempts	78 319	ABS (National Survey of Mental Health and Wellbeing, 2007, Cat. no. 4326.0), updated using population growth rate
Proportion full incapacity	17%	Kinchin and Doran (2017)
Proportion short absence	83%	Kinchin and Doran (2017)
Proportion employed	41%	ABS (National Survey of Mental Health and Wellbeing, 2007, Cat. no. 4326.0)
Proportion not employed	59%	ABS (National Survey of Mental Health and Wellbeing, 2007, Cat. no. 4326.0)
Productivity (% wage rate)		
Employed	100%	Productivity Commission estimates
Non-employed (higher bound)	81%	Productivity Commission estimates
Non-employed (lower bound)	0%	Productivity Commission estimates
Inflation rates		
Costs inflated to 2018 dollars	7%	ABS (CPI, June 2019, Cat. no. 6401.0) inflation rate from June 2014 to June 2018
Population growth rate	20%	ABS (Australian Demographic Statistics, December 2018, Cat. no. 3101.0) inflation rate from June 2007 to June 2018

Table E.7 Estimated number of suicides and suicide attempts
2018

	<i>Short absence^a</i>	<i>Full incapacity^b</i>	<i>Fatality</i>
Employed	26 717	5 473	1 137
Not employed	38 286	7 843	1 909
Total	65 003	13 316	3 046

^a Short absence means the individual requires a short absence from normal duties. ^b Full incapacity means the individual is permanently unable to return to work.

Source: Productivity Commission estimates.

Calculating the costs of suicidal behaviour to employed people was reasonably straightforward. The Commission used average costs estimated by Kinchin and Doran and inflated the costs to 2018 dollars using the CPI (consistent with the authors).

However, calculating the costs of suicidal behaviour to non-employed people was less straightforward. In particular, the majority of the economic costs of suicidal behaviour are attributable to lost productivity resulting from premature death or long-term injury. This is more easily attributable for employed Australians, because average wage rates can be used to calculate lost productivity. This becomes more difficult when calculating lost productivity of non-employed Australians because their contributions to society cannot be as easily calculated using wages foregone. However, this does not mean that an employed person carries greater or lesser value to society than a non-employed person.

Therefore, the Commission estimated a range in the costs of suicide and suicidal behaviour to non-employed people using lower and higher bound estimates of costs.

The lower bound cost estimates presents the extreme case where non-employed Australians who engage in suicidal behaviour do not become employed through the remainder of their lifetime. Therefore, the estimate excludes production disturbance costs, human capital costs, transfer costs and some 'other' costs.

- Production disturbance costs were excluded because people who are not employed do not impose any short-term productivity impacts on a workplace.
- Human capital costs were excluded because people who are not employed will have zero future earnings.
- Transfer costs are measured as the value of taxation receipts foregone, which will also be zero if the person is not employed and does not pay income tax.
- Other costs excluded were the cost of counselling and time off work for work colleagues affected by a suicide death, because the person in question is not employed. That said, the estimate still includes the cost of bereavement services for an average of six people affected by a suicide death.

The higher bound cost estimates presents an alternative case that assumes non-employed people engage in some productive activity that is not based on wages, such as caring for others or volunteering. The Commission estimated that the productive activity of non-employed Australians was 81% of the wage that employed Australians earn.⁵⁵ Therefore, the higher bound cost estimates include 81% of the average production disturbance, human capital and transfer costs for non-employed Australians.

⁵⁵ The Commission used its wage model (appendix G) to estimate an average wage rate of \$34.01 per hour for employed Australians and \$27.68 per hour for non-employed Australians (under an assumption that half of non-employed people will move into full-time work and the other half into part-time work). Therefore, the average wage of non-employed Australians (\$27.68) is 81% of the average wage rate for employed Australians.

The average and total costs of suicidal behaviour by employment status are shown in table E.8. This shows that the vast majority of costs are the result of lost productivity resulting from suicide deaths or full incapacity. Table E.9 shows the results if the total cost of suicidal behaviour is averaged across both employed and non-employed Australians. Therefore, the Commission estimated that the total cost of suicide and suicide attempts in Australia was \$16.3 billion to \$33.7 billion each year. The Commission's estimated range for the average cost of a suicide death is similar to other studies in Australia and overseas (figure E.3).

Table E.8 Costs of suicide and non-fatal suicide behaviour
By cost category and employment status, 2018 dollars

	Average costs (\$ thousand)			Total costs (\$ million)		
	Employed	Not employed		Employed	Not employed	
		Lower	Higher		Lower	Higher
Suicide deaths						
Production disturbance	41	0	33	46	0	63
Human capital	1 508	0	1 227	1 715	0	2 343
Medical	3	3	3	3	5	5
Administrative	8	8	8	9	14	14
Other	124	92	124	141	175	236
Transfer costs	117	0	95	133	0	181
Total	1 799	102	1 489	2 046	195	2 843
Suicide attempts resulting in full incapacity						
Production disturbance	41	0	33	222	0	259
Human capital	2 148	0	1 748	11 756	0	13 711
Medical	13	13	13	73	105	105
Administrative	3	3	3	15	22	22
Other	86	86	86	468	671	671
Transfer costs	117	0	95	639	0	745
Total	2 407	102	1 978	13 174	798	15 513
Non-fatal suicide behaviour resulting in short absence						
Production disturbance	*	0	*	9	0	11
Human capital	0	0	0	0	0	0
Medical	1	1	1	23	33	33
Administrative	*	*	*	1	1	1
Other	0	0	0	0	0	0
Transfer costs	0	0	0	0	0	0
Total	1	1	1	34	35	46

* Cost is non-zero, but rounded to zero.

Source: Commission estimates.

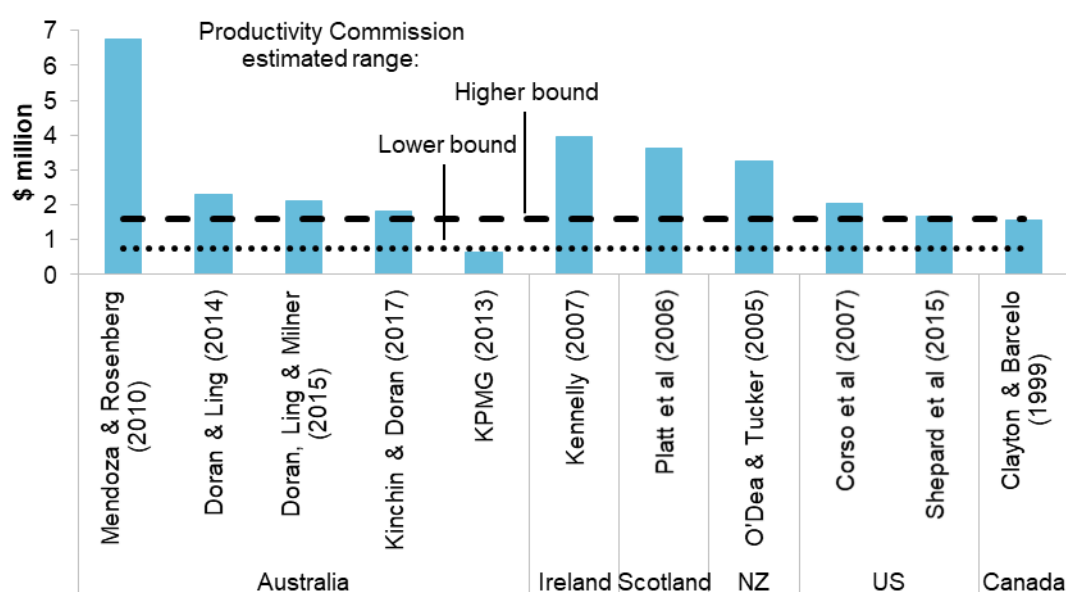
Table E.9 Costs of suicide and non-fatal suicide behaviour
2018

	<i>Number of people</i>	<i>Average costs</i>	<i>Total costs</i>
Suicide death	3 046	\$0.7 – \$1.6 million	\$2.2 – \$4.9 billion
Suicide attempt: full incapacity ^a	13 316	\$1.0 – \$2.2 million	\$14.0 – \$28.8 billion
Suicide attempt: short absence ^b	65 003	\$1 055 – \$1 225	\$0.07 – 0.08 billion
Total	81 365	–	\$16.3 – \$33.7 billion

^a Full incapacity means the individual is permanently unable to return to work. ^b Short absence means the individual requires a short absence from normal duties.

Source: Commission estimates.

Figure E.3 Average cost of a suicide death in Australia and overseas
2018^a



^a Average costs converted (using Purchasing Power Parity) and inflated to 2018 Australian dollars.

Source: Doran, Ling and Milner (2015); Kinchin and Doran (2017); McDaid (2016).

Sensitivity analysis

Results show that the vast majority of the costs of suicidal behaviour to Australia are attributable to people who engage in non-fatal suicidal behaviour resulting in full incapacity. This is because many people are expected to attempt suicide in any given year, and a significant proportion (17%) of these are assumed to result in full incapacity. This suggests that changes to this assumption are likely to lead to significant differences in the cost of suicidal behaviour.

The Commission produced a sensitivity analysis of the proportion of people engaging in non-fatal suicidal behaviour resulting in full incapacity. The analysis estimated the cost using the assumption that 7% and 27% of non-fatal suicidal behaviour resulted in full incapacity (table J.5). The results of the analysis show that if just 7% of suicide attempts result in full incapacity, the total cost of suicidal behaviour is between \$8.1 billion to \$16.8 billion. And in the case that 27% of suicide attempts result in full incapacity, the total cost of suicidal behaviour is between \$24.5 billion to \$50.5 billion.

These results suggest that efforts to reduce the risk that suicide attempts will result in full incapacity can significantly reduce the total cost of suicidal behaviour.

Table E.10 Change in total costs are sensitive to proportion of suicide attempts resulting in full incapacity
2018

	<i>Number of people</i>	<i>Total costs</i>
7% of suicide attempts resulting in full incapacity		
Suicide death	3 046	\$2.2 – \$4.9 billion
Suicide attempt resulting in full incapacity ^a	5 482	\$5.8 – \$11.8 billion
Suicide attempt resulting in short absence ^b	72 837	\$0.08 – 0.09 billion
Total	81 365	\$8.1 – \$16.8 billion
17% of suicide attempts resulting in full incapacity		
Suicide death	3 046	\$2.2 – \$4.9 billion
Suicide attempt resulting in full incapacity ^a	13 316	\$14.0 – \$28.8 billion
Suicide attempt resulting in short absence ^b	65 003	\$0.07 – 0.08 billion
Total	81 365	\$16.3 – \$33.7 billion
27% of suicide attempts resulting in full incapacity		
Suicide death	3 046	\$2.2 – \$4.9 billion
Suicide attempt resulting in full incapacity ^a	21 146	\$22.2 – \$45.6 billion
Suicide attempt resulting in short absence ^b	57 173	\$0.06 – 0.07 billion
Total	81 365	\$24.5 – \$50.5 billion

^a Full incapacity means the individual is permanently unable to return to work. ^b Short absence means the individual requires a short absence from normal duties.

Source: Productivity Commission estimates.

E.7 Opportunity to invest in education and skills development is hindered

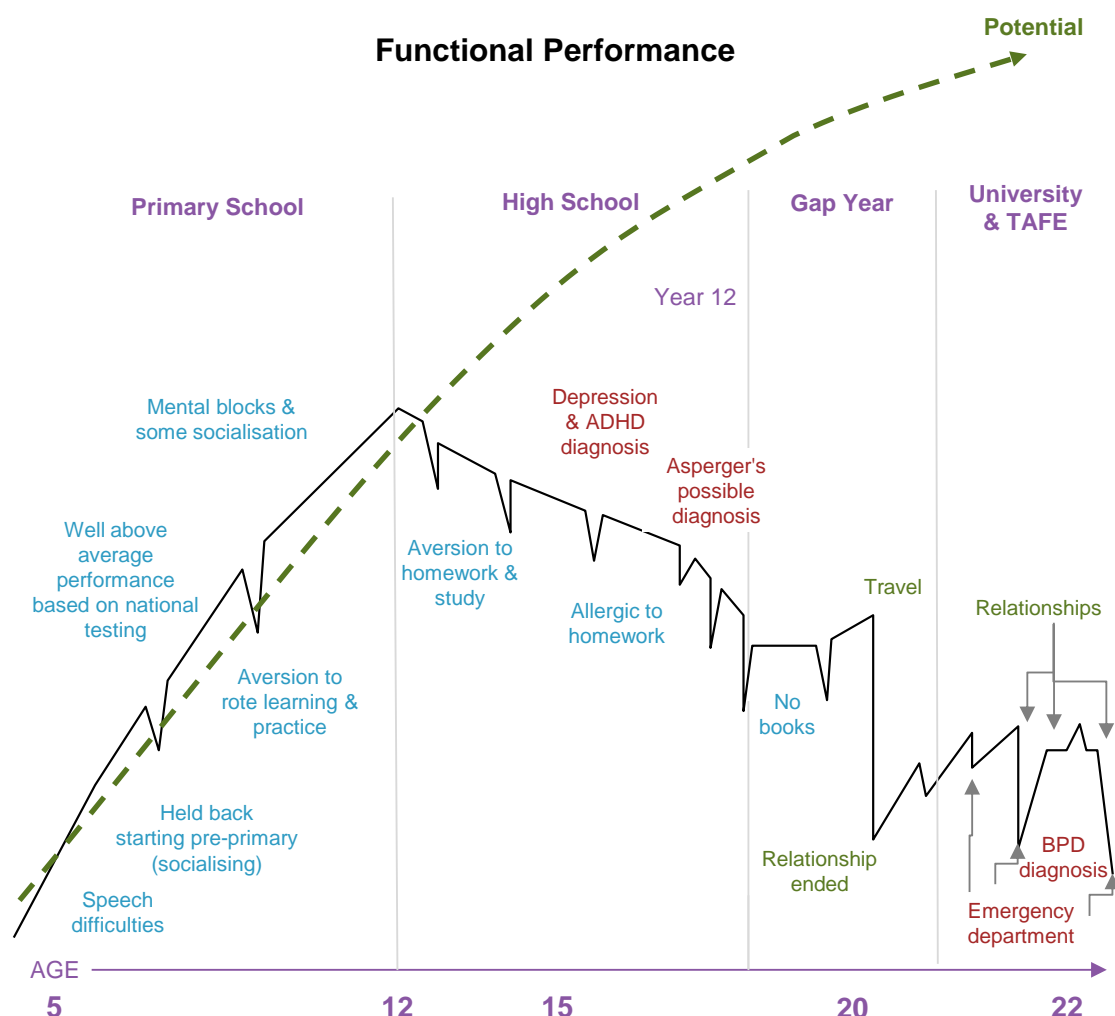
Young people missing the opportunity to fully develop their skills and talents, while at school and in post-school education due to mental ill-health, creates long-term losses. These losses arise from reduced regularity in school attendance, difficulties performing consistently in a school learning environment, and leaving formal education early due to

mental ill-health. Some of the future labour market impacts of these lost educational opportunities will be captured in the analysis above. But this analysis is just a snapshot of one year. A cost-of-illness study is unable to convey the full picture of how these costs can change a young person's life trajectory (figure E.4). In his submission, Mr Davis powerfully expressed how mental ill-health changed his daughter's learning path:

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 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. (sub. 133, p. 5)

This section looks to paint a picture of the effects of mental ill-health on learning and skills development for young people, and the implications for that young person's life path. Our evidence base for this cost analysis is broader than the monetary cost used in other parts of this appendix. Instead, it draws upon a range of evidence sources, both quantitative and qualitative, but most importantly the lived experience of young people with mental ill-health. While this analysis sits outside our cost-of-illness estimate, it is another important piece of information used to advise our reform agenda.

Figure E.4 Life's trajectory: the lived experience of one young person



Source: adapted from Mr. Robert Davis, sub 133.

Disruption of the post-school transition for those with mental ill-health

The years between 18 to 24 are an important transition point in a person's life. Many people in this age group are transitioning from school to tertiary education and/or work. But it is also a time when mental health problems first emerge, disrupting this transition process for those people with mental ill-health (chapters 2 and 18). In particular, this group may not complete high school and fail to find employment or enrol in further education or training.

- Approximately 19% of 15-24 year olds were 'not in employment, education or training' with mental ill-health (O'Dea et al. 2014). This is almost twice the rate found among the general population of youth in Australia. Furthermore, being 'not in education, employment or training' at the age of 16 is a predictor for being 'not in employment,

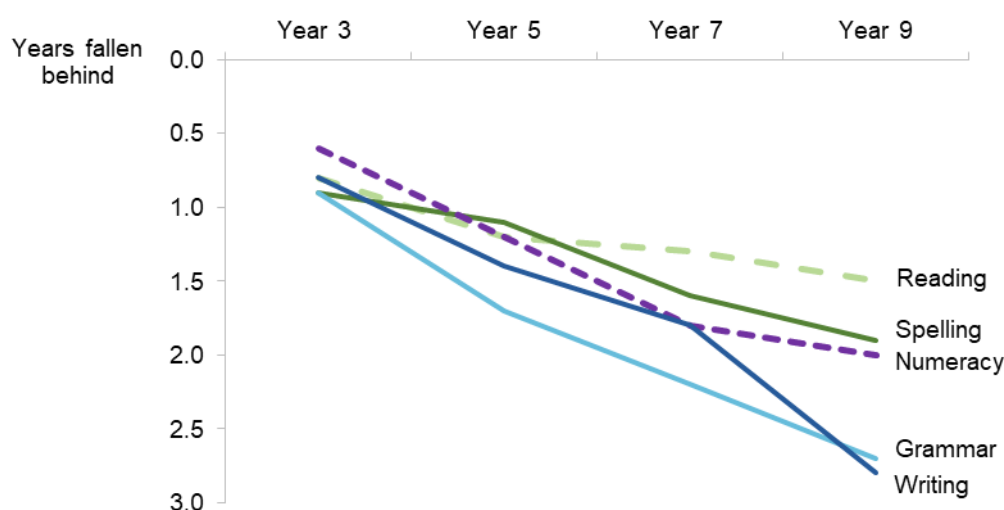
education or training’ at the age of 18 years, and it is also a strong predictor of chronic unemployment in adulthood (O’Dea et al. 2014).

- According to the 2007 National Survey of Mental Health and Wellbeing, 25% of people who had not completed school had an anxiety, mood or substance use disorder in a given year compared with 20% of people who have completed school (DoH 2009a).
- The National Mental Health Commission (2014e) stated that ‘31.5% of people living with psychosis complete high school, compared with 53.0% in the general community’ (p. 21).

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, several years behind their peers (1.5-2.8 years) (figure E.5). Students with mental disorders have more absences from school. 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 E.5 Students with mental ill-health progressively fall behind in school

Average years fallen behind in schooling, by test domain and year level^a



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

Source: Goodsell et al. (2017).

For those young people with mental ill-health that 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:

- 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’ (that is, days that students were unable to work, study, or manage daily activities specifically because of psychological distress) in the past month.
- For respondents to the 2016 National Tertiary Student Wellbeing Survey who had failed at least one subject to date, almost half stated that health problems had affected their academic progress (National Union of Students and Headspace 2016). Australian and international research have found that increased mental health problems and higher levels of psychological distress are associated with lower academic achievement (Stallman 2010).
- Karmel and Nguyen (2008) found that mental illness had a relatively larger impact on completion rates than other disability types. Polidano and Mavromaras (2010) found that students with a mental illness drop out of vocational education and training at a greater rate if they are unable to find help.

Even starting tertiary level study and not completing a qualification is undesirable outcome. It can create or reinforce a sense of failure in students, bring an end to otherwise positive social interactions, and result in students wasting their own resources (in time and effort, as well as money). Taxpayer funding for such students is also spent but not put to the best use. Students who do not complete their tertiary studies receive minimal financial benefit from units that they have completed. Instead many leave with ‘debt and regret’ (PC 2019d).

Not participating in education and work, during the formative years of 18 to 24, strongly influences a person’s economic and social participation and outcomes later in life. These include lower employment rates and incomes, reduced health and wellbeing and decreased social participation (chapter 18).

E.8 The cost of diminished health and reduced life expectancy

Mental ill-health effects 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 impact of a variety of health conditions to be compared or aggregated (AIHW 2019c).

The total impact of mental ill-health 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 over 600 000 years of healthy life due to living with and dying early from mental ill-health (AIHW 2019c).

The years of healthy life lost can be converted into a dollar value using an estimate of the value of a statistical life year (box E.4). Using the Office of Best Practice's estimate of value of a statistical life year, the cost of healthy life lost due to mental ill-health is estimated to be \$130 billion dollars in 2018-19.

Box E.4 Valuing life: can it be done?

Valuing life is not without disagreement. Some believe life cannot be valued in dollar 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 dollar 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.

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 which 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). For Australia, various studies have estimated that the value of a statistical life (using the willingness to pay method) ranges from \$3 m to \$15 m (OBPR 2014 based on a review by Abelson (2008)). Abelson (2008) concludes \$3.5 m 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 \$4.2 million in 2014.

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 \$182 000 per year in 2014.

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