

Contributing lives,
thriving communities

Report of the National Review of Mental Health Programmes and Services

Volume 2

Every service is a gateway
Response to Terms of Reference

30 November 2014



Australian Government
National Mental Health Commission

About this Review

This document is Volume 2 of the four-volume report of the National Review of Mental Health Programmes and Services. All volumes can be downloaded from www.mentalhealthcommission.gov.au. A complete list of the Commission's publications is available from our website.

A number of electronic fact sheets and a summary document are available on our website.

The quotes in this publication come from people and organisations in Australia who participated in the Commission's Call for Submission process.

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Throughout this report when we have named people and organisations in quotes or case studies we have gained their prior permission. When people did not respond to our request for permission the quote was de-identified.

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Introduction

The work of the Review of Mental Health Programmes and Services has required a dual perspective to chart a clear way forward.

The first perspective is one of broad system reform, focusing upon Commonwealth-state and territory relationships, funding and financial aspects of health system infrastructure (such as the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme) and national structures to deliver programmes (the new Primary (and Mental Health) Networks and Hospital Networks or equivalent). This work is the remit of Volume 1.

The 25 recommendations in Volume 1 start with a call for a Commonwealth commitment to leadership in mental health, suicide prevention and Aboriginal and Torres Strait Islander peoples' mental health and social and emotional wellbeing. They then step through how the national governance, system programmes and service platforms need to be recast to deliver improved lives for people living with a mental health difficulty and their families and the people who care for them, support their recovery journey, reduce the burden of illness and achieve greater benefit and outcomes for Commonwealth investment in mental health and associated services and supports. The directions recommended in Volume 1 are therefore overarching.

The second perspective is focused on the individual programmes, communities and heads of consideration specifically identified in the Terms of Reference. This includes an account of the mental health-related programmes funded by the Commonwealth. It is necessarily confined to those programmes where information was available and where the greatest opportunity for system improvement was possible. As such, Volume 2 is not an audit of all Commonwealth and state and territory mental health-related programmes. Without detailed information from states and territories, any accounting for programmes was only possible for Commonwealth-funded programmes. Initially, states and territories did not make available to the Commission any data that was not already in the public domain in regard to their mental health programmes and services. Subsequently, a request was lodged with the Mental Health and Drug and Alcohol Principal Committee of the Australian Health Ministers' Advisory Council (AHMAC), seeking state and territory data at the regional level. All jurisdictions agreed to the release of the data, with the Australian Capital Territory withholding approval until it was part of an overall COAG national data request.

Of Commonwealth agencies, a specific analysis was undertaken on the mental health-related programmes of the Departments of Health, Social Services and Prime Minister and Cabinet. This assessment was informed by available programme evaluation reports, financial data, submissions received from people with lived experience and their supporters and, more broadly, submissions from the mental health sector and individual organisations. The Departments of Veterans' Affairs and Defence were excluded from detailed analysis given their delivery of services to a circumscribed group. Additionally, the mental health programmes of the Department of Veterans' Affairs are under review through a separate process.

Our approach

This programme analysis in Volume 2 is not intended to be comprehensive or forensic – there was not adequate data made available to the Commission to undertake that level of work and the duration of the Review was limited. The Minister, in February 2014 when tasking the Commission to deliver the report within a specific set of Terms of Reference, requested that this be a confidential report to Government. In turn, this request directly influenced the way the consultation on the Review was undertaken.

“I expect that the Commission’s work on this review, including its reports, will be kept confidential throughout the process. This is consistent with the Commission’s function as an executive agency in my portfolio, undertaking work as part of the Commonwealth government.”

This was a more limited process than that previously undertaken by the Commission. Nonetheless, the Commission drew upon the advice and concerns raised by people over the first two years of its engagement with the community, and extensively used the information and comments made in submissions to the Review. References to these contributions can be seen throughout the report.

The Review took a whole-of-life perspective in its analysis of programmes, assessing where synergies exist or fail to support a person, their families and carers to lead a contributing life. In this volume the issues raised, deficiencies identified and emerging approaches are presented to inform how the 25 recommendations are considered by the Commonwealth Government, and in the longer term, assessment of how those directions will be translated into an implementation strategy.

Volume 2 therefore brings together analysis of programmes in terms of their individual performance, sector contribution and implications for people with lived experience and their supporters in one document. It specifically addresses each Term of Reference, as noted in the chapter overview below.

In Volume 2 we acknowledge the place of people with lived experience and their families and supporters as being central to the way programmes are designed, managed and funded. This report acknowledges the need for centrality of people and their families and supporters in the governance structures established to implement the direction of the Review, and in the consideration of how any impacts arising from change need to be mindful of unintended consequences upon people’s lives and opportunities for their recovery and to lead a contributing life.

The recommendations of this Review are framed on the understanding that any implementation must be achieved within existing resources. The Commission considers that there is currently substantial investment in the mental health of Australians, but that this investment is not necessarily being spent on the right things – those services which prevent illness, keep people well, support recovery and enable people to live contributing lives.

Overview of Volume 2

Volume 2 of the Report of the Review of Mental Health Programmes and Services presents the findings of the Review with respect to each Term of Reference.

In **Chapter 1** we emphasise the need for changes to the way mental health programmes and services are governed, funded, targeted and delivered, taking into account the current fiscal climate and policy context. **Chapter 2** outlines the comprehensive approach we have taken to collecting evidence from a wide range of sources and stakeholders, and details some of the challenges we faced in doing so.

We begin our detailed findings against the Terms of Reference by emphasising that the guiding principle for reform must be to improve the lives and outcomes of people who experience mental illness. Chapters 3 to 6 focus on the quality of this lived experience for the diversity of people and communities which make up Australian society today.

Mapping Terms of Reference to Volume 2 Chapters

Terms of Reference focus	Chapter
This Review will examine:	
Existing mental health services and programmes across the government, private and nongovernment sectors. The focus of the Review will be to assess the efficiency and effectiveness of programmes and services in supporting individuals experiencing mental ill-health and their families and other support people to lead a contributing life and to engage productively in the community.	Chapter 1: Case for change Chapter 2: Methodology
Programmes and services may include those that have as a main objective:	
The prevention, early detection and treatment of mental illness	Chapters 9 and 10
The prevention of suicide	Chapter 6
Mental health research	Chapter 8
Workforce development and training	Chapter 7
Reduction of the burden of disease caused by mental illness	Cross-chapter issue
The Review will consider:	
The efficacy and cost-effectiveness of programmes, services and treatments	Chapter 9
Duplication in current services and programmes	Chapter 9
The role of factors relevant to the experience of a contributing life such as employment, accommodation and social connectedness	Chapter 3
The appropriateness, effectiveness and efficiency of existing reporting requirements and regulation of programmes and services	Chapter 9
Funding priorities in mental health and gaps in services and programmes, in the context of the current fiscal circumstances facing governments	See Volume 1
Existing and alternative approaches to supporting and funding mental health care	Chapter 10
Mental health research, workforce development and training	Chapters 7 and 8
Specific challenges for regional, rural and remote Australia	Chapter 5
Specific challenges for Aboriginal and Torres Strait Islander peoples	Chapter 4
Transparency and accountability for outcomes of investment	Chapters 9 and 11

NOTE: Analysis of specific Commonwealth programmes is throughout the chapters, as is relevant to each Term of Reference.

Chapter 3 gives our assessment of how well programmes and services are supporting people to live contributing, productive lives in ways which are appropriate to their experiences, circumstances and needs.

Chapter 4 focuses on the particular challenges faced by Aboriginal and Torres Strait Islander (ATSI) peoples in accessing appropriate supports for their mental health and social and emotional wellbeing. **Chapter 5** examines service access challenges for people living in regional, rural and remote areas. One of the signs that we have failed to support people is the rate of people attempting to take their own life or dying by suicide, and **Chapter 6** examines what might be done to address this issue more successfully.

In Chapters 7 to 10 we address those Terms of Reference related to system infrastructure, financing and governance. One crucial element of the infrastructure supporting mental health services and programmes is workforce planning, distribution and training. This is addressed in **Chapter 7**, while suggestions for improving the way research supports frontline services are made in **Chapter 8**.

Chapter 9 makes a case for new models of governance and accountability which will form the foundation for greater efficacy and cost-effectiveness in our mental health services and programmes. We propose that these models can be the basic scaffold for overcoming current inefficiencies, duplicated activity, unmet need and lack of accountability for the outcomes of investment.

We finish our analysis of the mental health system with **Chapter 10**, which considers how alternative approaches to optimising service collaboration and provide services can secure person-centred pathways. This includes how technology can be used to improve mental health supports, delivering both better access and efficient use of resources. It also provides an overview of the potential of regional funding and social investment models.

Finally, **Chapter 11** outlines an implementation plan comprising short, medium and longer-term steps to achieve a mental health system which both improves the quality of experience and outcomes for people experiencing mental illness and provides an improved return on investment for governments.

This is a strategy for people of all ages, and throughout this document we will use the word 'people' to encompass infants, children, young people, working-age adults and older people, as well as Aboriginal and Torres Strait Islander peoples and those from culturally and linguistically diverse (CALD) backgrounds. However, issues for Aboriginal and Torres Strait Islander peoples are specifically addressed and acknowledged, respecting their culture and history.



Chapter 1: The case for change

The case for change

This chapter outlines the case for changing the way we support the mental health of all Australians.

In the first half we provide the key arguments against continuation of the status quo. Australia's patchwork of systems has led to a poor situation, where people experiencing mental illness do not receive the support they need and where governments get a poor return on their substantial investment. This situation arises from a combination of problems with the status quo. It creates unmet need, is socially and economically damaging, sustains inequality and does not support recovery.

In the second half of the chapter we outline the basic foundations upon which we have built the rest of our assessment of programmes and services. These include:

- emphasis on the contribution of people with a lived experience of mental health difficulty (and the families and carers who support them)
- the need for strong Commonwealth leadership
- the need for an early intervention approach
- recognition of the whole-of-life impacts of mental illness
- the need for a joined-up, whole-of-government response.

Why another review?

Our Review is not the first attempt to set a new direction for mental health programmes and services. Mental health services in Australia have had a national reform agenda since the first National Mental Health Plan in 1993.

Against this background, this Review is both timely and ambitious. The Terms of Reference of the Review explicitly provide for a whole-of-person, whole-of-life approach to mental health support. Accordingly, we have undertaken a cross-portfolio assessment of the strengths and weaknesses of the mental health system and made proposals for a whole-of-government recalibration at the federal level. The Review's focus is (as determined by the Minister):

' ... to assess the efficiency and effectiveness of programmes and services in supporting individuals experiencing mental ill health and their families and other support people to lead a contributing life and to engage productively in the community.'

This Review has taken a 10-year horizon in its consideration of how best to reprioritise and reorient Commonwealth investment in mental health programmes and services to get the best outcomes for people, their families and supporters and the most return on investment for the community.

The current mental health picture illustrates the complexity, the range of individual and system-level issues and the inequalities of life outcomes despite active Commonwealth and jurisdiction investment and policy focus in mental health as a national priority. This Review is specifically concerned with Commonwealth Government programmes and the opportunities to apply evidence-based approaches to yield greatest opportunities for all Australians to lead mentally healthy lives.

This Review was an election commitment of the current Commonwealth Government. It therefore represents the priority placed on analysing programmes and services to identify how the government can best support people to live a contributing life.

The policy environment

The Review of Mental Health Programmes and Services comes at a time when there is much change in the mental health sector through government reforms such as the National Disability Insurance Scheme and the introduction of new Primary Health Networks, as well as impacts from the Review of Australia's Welfare System and the current processes for the White Paper on Reform of the Federation. This Review occurs at the end of the Fourth National Mental Health Plan and at a time when the Mental Health Commissions of Western Australia, New South Wales and Queensland have undertaken mental health system strategic and planning reviews.

Review of Australia's welfare system (McClure)

The Commission met with and submitted a paper to the Reference Group tasked with reviewing Australia's welfare system to identify improvements to ensure the social support system is sustainable, effective and coherent and encourages people to participate in the workforce. As part of this submission the Commission outlined: flexible income support options that recognise the episodic nature of mental illness; encouraging people with any capacity to work or volunteer so that they benefit from that participation; and increasing partnerships with employers (including raising the profile of their significant role in the recovery process).

The Commission considers that tiered working age payments need to be flexible enough to respond to the episodic nature of mental illness (when people are unable to work), and sufficient enough to ensure that people with a psychosocial disability do not fall straight back onto the mental health system for additional support. Any change needs to be flexible enough to deal with the unintended consequences of poor choices by individuals who are aiming for recovery, but are stuck in a binary process.

Effective welfare reform requires recognition of the capabilities of people living with a mental illness, and not simply their diagnosis. Functional impairment refers to limitations experienced due to mental illness, where people may not be able to carry out certain functions in their daily lives. These can include interpersonal interactions and relationships, participation in community, social and civic life, education, training, and employment. Symptoms of mental illness may impact on an individual's sleep, energy, attention, memory and emotion.

A diagnosis of mental illness does not necessarily mean a permanent level of psychosocial disability, and the need for formal support can be episodic or decrease over time. People are not always affected to the extent they cannot participate, achieve recovery or live a contributing life. Alternatively, when a person's level of functioning does shift, it may also shift their capacity to participate, including in employment.

Flexibility is needed to respond to these changing circumstances.

The needs of carers and families also need to be taken into account in welfare reform. The role of being a carer has a profound impact on the lives of many. If that role changes because the circumstances of the person they are caring for changes, carers will need support to enable them to adapt their lives; often they may have been de-skilled or isolated because of the support they have contributed over extensive periods. Many carers may not have been able to work or advance their educational opportunities.

A separate formal assessment of their own goals and life opportunities would assist families and carers in planning for a changed future and help them access and retain employment.

White Paper on Reform of the Federation

The White Paper reform process is primarily aimed at addressing duplication and overlap between different levels of government and reducing waste and inefficiency, while maintaining the strengths of the Federation.

The Commonwealth Government's objective in launching the Terms of Reference for this White Paper is to clarify roles and responsibilities for states and territories so that they are, as far as possible, sovereign in their own sphere. The Commonwealth has stated its task is to take a leadership role on issues of genuine national and strategic importance, but that there should be less Commonwealth intervention in areas where states have primary responsibility.

This broad intent is highly consistent with the directions identified in this Review, and we have been mindful of these intentions while crafting our recommendations.

The introduction of Primary Health Networks

As part of the 2014–15 Budget the Commonwealth Government announced the formation of new Primary Health Networks (PHNs) to replace the existing 61 Medicare Locals. They are to become operational from 1 July 2015.

They will focus on networking health services across local communities so that people, particularly those needing coordinated care, have the best access to a range of health care providers, including general practice, community health services and hospitals. This will be achieved by working directly with GPs, other primary health care providers, secondary care providers and hospitals.

General practice and primary health care comprise a highly relevant building block at the regional level for people living with mental health difficulties, as the care coordination envisaged for the PHN is designed for people requiring help from multiple providers. PHNs will also have the flexibility to work with other funders of services and purchase or commission locally relevant services for groups of people at risk of poor outcomes.

The Government has flagged a role for the networks in trialling innovative ways of funding integrated health service delivery models. Again, this is very timely for the coordinated implementation of reforms recommended by this Review.

The rollout of the National Disability Insurance Scheme (NDIS)

The NDIS is still in its formative years. The 2014 annual report of the National Disability Insurance Agency¹ reports on the extent of the trialling of the scheme to date. In the past 12 months, trials have taken place for people in regions in New South Wales, Victoria and South Australia and across Tasmania. Launches are planned for parts of Western Australia, the Australian Capital Territory and the Northern Territory. There were 6434 participants eligible for the scheme, with 5414 having an approved plan by the end of March 2014.

The Australian Government must ensure Aboriginal and Torres Strait Islander people with qualifying mental health conditions are able to access the NDIS in an equitable fashion. This means ensuring providers are able to work in a culturally competent manner.

The NDIS is a major structural reform for people with disabilities. It must meet the needs of people living with mental health difficulties and their families and carers, and also avoid further disenfranchising them from generalist and specialist services.

Aboriginal and Torres Strait Islander mental health and related reform

At the time of the writing, there are a number of unimplemented or unreleased strategic responses to Aboriginal and Torres Strait Islander mental health and related issues. Any work from this Review needs to be considered in the context of, and reference to, these existing strategies. They include:

- The unimplemented National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013, which was released in May 2013 and has \$17.8m pledged against it.
- A review and implementation strategy for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 in partnership with Aboriginal and Torres Strait Islander health leadership bodies which is under way, but implementation is yet to begin. The plan is not focused on mental health, though it does propose some action in relation to mental health and social and emotional wellbeing.
- A National Aboriginal and Torres Strait Islander People's Drug Strategy which is in development.

Perhaps the most important strategic response is the National Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing Framework ('the Framework') that is being developed.

This unusual conjunction of unimplemented and overlapping strategic responses provides a unique opportunity to develop a dedicated, overarching national Aboriginal and Torres Strait Islander mental health plan which is based on the Framework but maintains the priority focuses of the individual strategies.

This would allow for a coordinated implementation of all four strategic responses and would maximise efficiencies. It could also support the Indigenous Advancement Strategy and the COAG Closing the Gap targets and framework.

Missed opportunities

While Australia has been world-leading in terms of setting national policy directions on mental health, opportunities to take advantage of these solid foundations have been lost due to poor implementation or the failure to sustain initiatives.

Since the first National Mental Health Plan was launched in 1993, research and policy development around the world means that we now know about innovative and efficient modes of delivering mental health care effectively. We are also increasingly informed by a human rights-focused approach to delivering mental health support, which emphasises strengths as much as psychosocial disability.

Developments in information and communication technologies, pharmaceuticals, clinical models of care, the peer workforce, personally controlled budgets and non-clinical recovery 'wraparound' services have led to major improvements to the experience of using mental health services in many countries.

Australia leads the world in the development of new technologies and models of care to support mental health, but too often this has not been translated to large-scale and coordinated improvements in access to mental health supports on the ground. To date, we have not achieved the right mix of services and investment to avoid poor outcomes.

The problem is not a lack of knowledge about what works. It is a problem of failing to harness this knowledge to guide strategic investment and the design of a consistent level of support across the country.

Fundamental problems with the status quo

The status quo means neglecting Australians in need

This failure to harness knowledge, as well as learning from previous reform attempts, has led to a situation where the help you can access for a mental health difficulty depends on where you live, who you know, how much money you have and the extent to which you can self-advocate.

In many places we have ended up with what is effectively a new ‘institutionalisation in the community’, where people experiencing mental illness live in the community but do not live well. They receive fragmented help or no help at all, and become stuck in a vicious cycle of poor health and limited life chances. They are moved between disconnected silos of intervention, including hospital wards, patchy support systems in housing, education and employment, and overstretched community and nongovernment services. Because these silos only support part of the person, whole-of-life needs are neglected and overall quality of life does not improve.

With almost one in two Australians likely to experience some form of mental illness in their lifetime, we are facing a mental ill-health epidemic which is causing needless suffering, crises and premature deaths, and which is burdening the nation with billions of dollars in avoidable costs.

We cannot know with any accuracy the degree to which people who may need to access mental health supports actually receive them. The most up-to-date estimate of the treatment rate for mental disorders in Australia indicates that in 2009–10, 46 per cent of people with a 12-month mental disorder received an intervention for that illness.²

This means that over half of those who have experienced mental illness in the past year are not accessing treatment. Others may receive inappropriate or ineffective care. This is despite extensive Commonwealth expenditure across the mental health sector of \$9.6 billion, of which \$5.7 billion is in income support. It includes a deemed estimated \$1 billion a year to the states and territories for mental health activity in hospitals under the National Health Reform Agreement (2011).

The public and private mental health systems are not providing the levels of support needed or paid for. At June 2014, 47.2 per cent of the population had some form of private health insurance, and for the 12 months to June 2014, \$22.3 million was paid for psychiatric/psychological ancillary services to private health insurance members.³

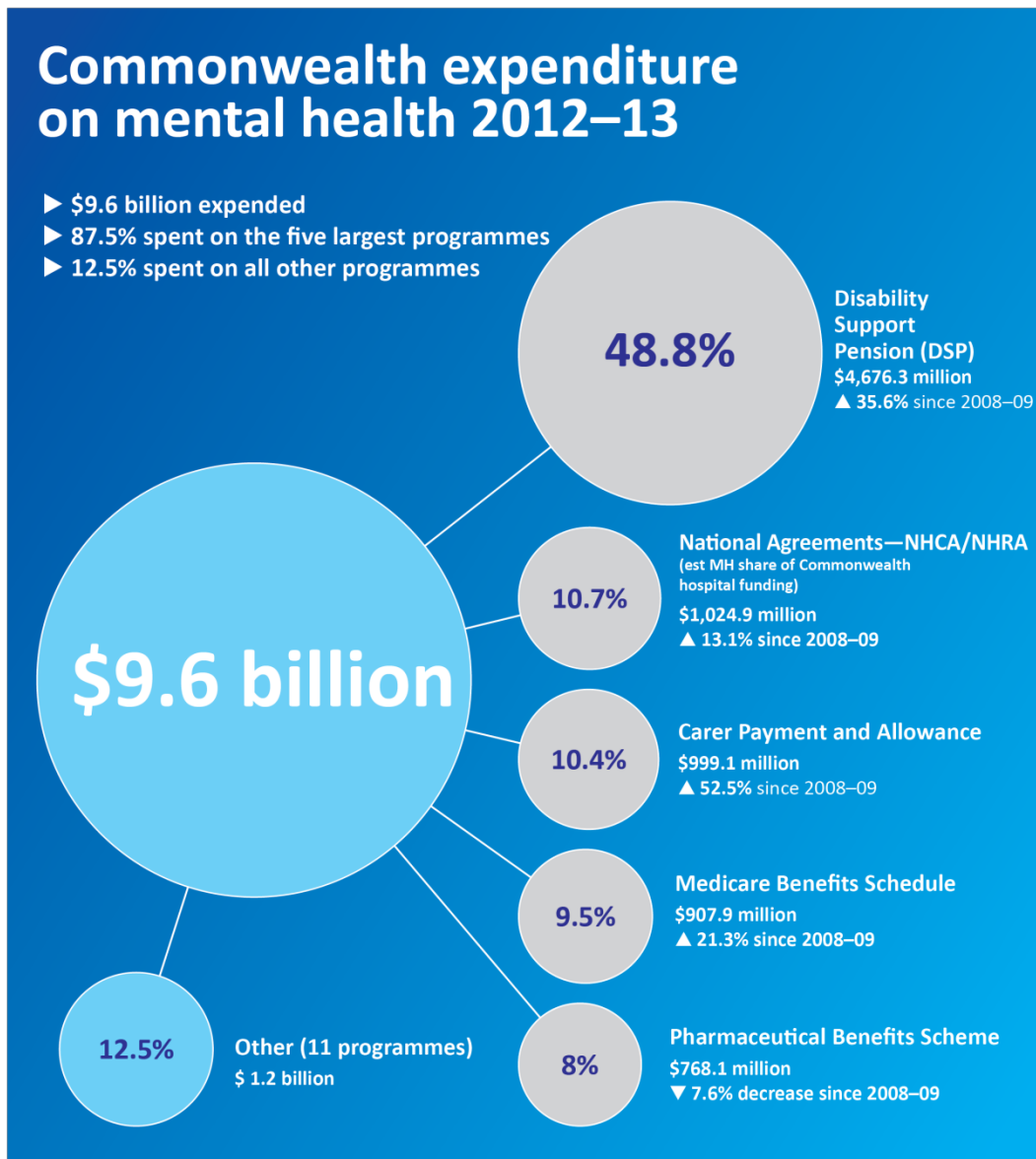
However, we were told by individuals and industry that even people with private health insurance are finding it increasingly difficult to get the care they need and that private care is often highly disjointed, with poor continuity and lack of linkage back into the community. Private health insurers promote mental health as an ‘opt out’ saving to young people. Yet young people are more likely to have a mental health episode than any other health problem, for which they often do not opt out (for example, heart disease or cancer). This is a good example of private health insurers passing the risk off to the Commonwealth, states and territories and to individuals and families. Private health insurers should not be able to exclude mental health treatment from their insurance packages.

Information on the mental health of Aboriginal and Torres Strait Islander peoples is confronting, with significantly worse outcomes than other Australians across key indicators, as outlined in Chapter 4. We refer to this in shorthand as the ‘mental health gap’ and it is perhaps the clearest evidence we have that the mental health system is not meeting the needs of this group.

The status quo provides a poor return on investment

Commonwealth investment is currently reactive and tipped toward acute mental illness and people experiencing crises (Figure 1.1). This focus on the people already in need of assistance, who may also be suffering related social and economic impacts, such as a lost job or family breakdown, is inefficient. We need to move towards a proactive, person-centred investment that averts the risk of crises. The Commonwealth mental health programme funding data gathered by the Commission illustrates that while the Department of Health is presumed to be the major funder of mental health supports, in fact the major funder is the Department of Social Services, by providing income support for people who are living with the consequences of deteriorating mental health and psychosocial disability.

Figure 1.1 Commonwealth expenditure on mental health



Source: concept designed by The National Mental Health Commission with expenditure information from Commonwealth agencies 2014

Table 1.1 shows a breakdown of the main programme streams making up the Commonwealth’s mental health expenditure. The Commonwealth spent \$9.6 billion on mental health programmes in 2012–13, which included:

- \$5.7 billion a year for disability and carer support payments
- a deemed estimated \$1 billion a year for mental health activity in hospitals funded under the National Health Reform Agreement – an estimate unknown prior to this Review.

Table 1.1 Commonwealth Mental Health Expenditure, 2008–09 to 2012–13 by Major Programme Stream (constant prices \$ millions)

MAJOR PROGRAMME STREAM	2008–09	2009–10	2010–11	2011–12	2012–13	5 YR (%) CHANGE
Mental health programmes and services: clinical and non-clinical ⁽¹⁾	3,116.3	3,235.1	3,358.5	3,533.2	3,737.4	19.9
Mental health support and programmes ⁽²⁾	4,106.0	4,330.7	4,772.1	5,345.9	5,675.4	38.2
Mental health system improvement ⁽³⁾	188.8	104.9	106.8	111.7	125.1	-33.7
GRAND TOTAL	7,411.2	7,686.7	8,259.1	9,026.5	9,577.5	29.2

Source: 15 Commonwealth departments’ estimates of expenditure on mental health received by the Review. February 2014.

Notes:

- (1) Direct expenditure on: GPs, community health; hospitals, medications; supported housing, care coordination
- (2) Indirect expenditure on: Carer Payment and Allowance, DSP
- (3) Direct expenditure on: research, workforce development, education and training

For ease of analysis, the Review grouped Commonwealth expenditure into three main streams (Table 1.1). These streams are:

- mental health programmes and services: clinical and non-clinical which comprises Medicare-subsidised mental health services; Pharmaceutical Benefits Scheme mental health-related medications; Commonwealth funding to public hospital mental health services; Commonwealth-funded community mental health programmes; and supported housing, care and coordination
- mental health support programmes: indirect expenditure on Carer Payment and Allowance, and Disability Support Pension
- mental health system improvement: direct expenditure on mental health research, workforce development, education and training.

The top five programmes by expenditure account for 87.5 per cent (\$8.376 billion) of all expenditure in 2012–13 (see Table 1.2) — \$7 of every \$8 spent. Overall expenditure has grown at an average of 6.6 per cent a year between 2008–09 and 2012–13 and is forecast to continue its strong growth.

Many of these programmes are essentially providing funding to compensate for system failure –the failure to support people early and avert or reduce illness and disability. Much Commonwealth spending is attempting to ameliorate the compounding disadvantage resulting from lack of early and appropriate support for emerging mental illness. If future growth in costs is to be curbed, the key focus has to be on these programmes and the necessary changes ‘upstream’ in the system to prevent the need for much of this spending in the first place. Currently, Commonwealth investment is fundamentally unbalanced.

Table 1.2 Top Five Programmes by Expenditure in 2012–13 (constant prices \$ millions)

PROGRAMME	2008–09	2009–10	2010–11	2011–12	2012–13	5 YR (%) CHANGE
Disability Support Pension (DSP)	3,449.7	3,664.0	4,031.5	4,471.6	4,676.3	35.6
National Health Reform Agreement (est. mental health share of C’wealth hospital funding)	906.3	952.8	967.6	1,003.4	1,024.9	13.1
Carer Payment and Allowance	656.3	666.7	740.7	874.3	999.1	52.2
Medicare Benefits Schedule	748.4	814.8	871.7	862.6	907.9	21.3
Pharmaceutical Benefits Scheme	831.6	830.4	827.5	842.0	768.1	-7.6

Source: Designed by The National Mental Health Commission (2014) with submitted expenditure information from Commonwealth agencies

The Review was only able to identify Commonwealth mental health and related grants that were specifically targeted to Aboriginal and Torres Strait Islander people to a value of \$123.1 million in 2012–13. This expenditure was on the SEWB Programme delivered by Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services) and Tier 2 of the Access to Allied Psychological Services (ATAPS) programme.

Other than these dedicated programmes, Aboriginal and Torres Strait Islander peoples are reliant on general population mental health services and programmes. However, the degree to which they are accessed by Aboriginal and Torres Strait Islander people or are contributing to better mental health outcomes is largely unknown.

The status quo creates high personal, social and economic costs

The social and emotional costs of a fragmented and crisis-driven mental health system and the unmet mental health need are significant – for individuals, their families and carers and for Australia as a whole. For people with severe or chronic illness and their support people, the status quo can mean getting caught in cycles of prolonged illness and dependency, lifetime discrimination and ongoing psychosocial disability. For some this leads to poverty, isolation and marginalisation and, in some instances, homelessness. We hear that for many people who can get access to help, it often happens too late. They often experience repeated readmissions to inpatient services because of the lack of support for their whole-of-life needs. People who live with more prevalent illnesses, such as anxiety and depression, can continue to struggle to retain employment or find services early when they know their mental health is deteriorating. It is often challenging to access the kind of support to maintain individuals (and their families) in their current accommodation, work and education.

The economic cost of our inadequate approach to mental health in Australia is enormous. Estimates vary but range up to \$28.6 billion a year in direct and indirect costs,⁴ with lost productivity and job turnover costing a further \$12 billion a year⁵ – collectively \$40 billion each year. The OECD estimates that the average overall cost of mental health to developed countries is about four per cent of GDP (including intangible costs such as the costs of reduced wellbeing, emotional distress, pain and other forms of suffering).

The high rates of mental health problems reported among Aboriginal and Torres Strait Islander peoples underpin a range of other problems and disadvantage. This includes higher rates of chronic disease, unemployment, family breakdown, alcohol and other drug use, smoking, the (unacceptably high) rates of incarceration, violence and school truancy, and the continuation of deep and entrenched poverty in some communities.

The failure to address mental health effectively impacts not only on those with a mental health issue, their families and other support people, but also on the wider community.

The status quo is inequitable

Over time, Australia's mental health system has evolved from primarily a state and territory government-operated system to a mix of state and territory, Commonwealth and nongovernment organisation (NGO) programmes and services. However, there has not been an effective national strategic vision to guide change and clearly define roles.

As a result, we have a system that duplicates services to some population groups and geographic areas while underservicing others. Without a national mental health service planning framework, we cannot stop duplication in the public sector and start to see where the nongovernment and private sectors can be more effective.

A range of factors influence whether people have access to the right support for mental illness, including where they live, how much they earn, and their cultural and linguistic background. For Aboriginal and Torres Strait Islander peoples, and people from culturally and linguistically diverse (CALD) backgrounds, this additionally includes whether supports and services are culturally competent. Whether the person has support from family or carers is also a major factor in gaining access to a fragmented system.

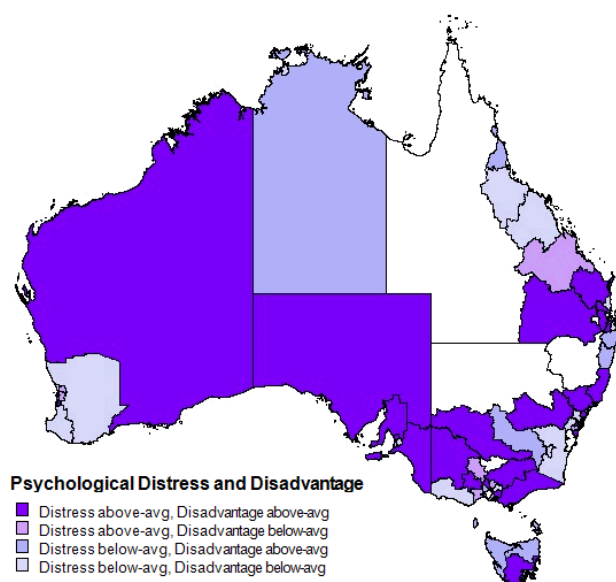
To maintain the status quo is to maintain the current inequity. We know that many groups are not getting fair access to services and programmes.

- Aboriginal and Torres Strait Islander communities do not enjoy the same access to mental health services as other Australians. In part, this is because of a lack of dedicated Aboriginal and Torres Strait Islander mental health services, or otherwise culturally competent services. These work with cultural differences, including being guided by the holistic concept of health that includes the health of family, community and culture as well as mental and physical health. Further, a lack of focus on primary mental health care, including promotion, prevention, early detection and treatment in primary health care settings, leads to significantly higher per capita levels of expenditure on acute inpatient care – the most expensive part of mental health treatment.
- For people in remote and very remote areas, there is poor access to specialist psychiatric care in hospitals, due to a concentration of facilities in larger population centres. The hospitalisation rate for people receiving specialist psychiatric care in major cities is almost twice as high as the rate for people who live in remote and very remote areas.⁶ Furthermore, people living in remote and very remote areas have high rates of hospitalisation without specialist care.⁶ This suggests you have less access to specialist care if you live in a remote or very remote area, which has implications for service choice, treatment and service outcomes.

Similarly, in all jurisdictions with major cities that reported data in 2011–12 (New South Wales, Queensland, Western Australia and South Australia – Victoria and ACT did not supply data), people in major cities had greater usage rates of community mental health services than those in outer regional, remote or very remote areas. (See the jurisdictional data made available to the Commission by the Mental Health Drug and Alcohol Principal Committee of the Australian Health Ministers' Advisory Council (AHMAC) in Volume 3). People living in major cities have greater access to specialist clinicians, with almost three-and-a-half times the per capita number of full-time psychiatrists, almost double the per capita number of mental health nurses, and almost three times the per capita rate of registered psychologists compared to remote/very remote areas,⁷ yet levels of psychological distress are highest in non-remote areas.⁸ This is an example of people with the greatest need having the least access to support.

- People living in socio-economically disadvantaged areas are more than twice as likely to experience high levels of psychological distress as those living in the least disadvantaged areas, as depicted in the map below (Figure 1.2). Some areas have both higher disadvantage and higher psychological distress; some areas have lower disadvantage and lower psychological distress; and other areas have a combination of higher/lower disadvantage and psychological distress. Yet the proportions of people who access Department of Veterans' Affairs (DVA) or Medicare Benefits Schedule (MBS) mental health items are roughly the same across all levels of disadvantage.¹²
- Higher rates of chronic physical illness and metabolic syndrome are experienced by people with severe and complex mental illnesses. For example, the life expectancy of people with schizophrenia can be up to 23 years less than the Australian average.¹³
- Education access and outcomes are poorer for people with severe and complex mental illness. People who experience psychosis have a greater chance of not completing Year 12, with 32 per cent completion, compared to 53 per cent for the general community.¹⁴

Figure 1.2 Psychological distress and socio-economic disadvantage in Australia



Source: Australian Bureau of Statistics. National Health Survey 2011–12, cat. no. 4364.0. Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia, 2011, cat. no. 2033.0

The way forward

The evidence clearly shows the status quo is unsustainable. It is time for a fundamental rethink, with recognition that current practices mean that the most severely ill individuals, their families and other support people experience needlessly prolonged and sometimes lifetime psychosocial disability from their illness. The most vulnerable communities experience high rates of suicide and many people live in the community without the adequate interventions and supports to reduce the burden of their illness and keep their families intact. By continuing current practices we are contributing to the mental ill-health epidemic and consigning Australia to an intergenerational burden of disease.

We need to have a clear and sustained implementation strategy, focusing on fewer but more important things to achieve reform across portfolios to help people with a mental illness sustain a contributing life. This requires all jurisdictions to sign up to a reform agenda with clear nationally agreed expectations and outcomes, which includes reporting back and being accountable to people who use mental health services and the wider community.

If Australia gets it right, we can reduce the social and economic burden of mental illness, improve the lives of people living with a mental illness and at the same time gain enormous economic benefits from increased participation and productivity in education, employment and the community.

That requires a realignment of mental health systems and services—of directions, roles and responsibilities—and a realignment of Commonwealth funding incentives to drive the right outcomes, based on evidence of what works.

The crucial role of people with a mental illness, families and support people

People with lived experience of mental health issues, their families, friends and supporters, should be involved in the governance and leadership structures which make decisions about the things that affect their lives. This has been called for in previous National Mental Health Plans. It is a basic principle which underpins all directions in this Review.

Full and meaningful participation by people living with mental illness and the people who support them is a fundamental component of a quality, high-performing system. They have much to contribute to improved leadership in mental wellbeing, at policy, planning and service delivery levels. They have told us they want services based on principles of recovery, human rights, peer involvement and workforce development; funding of services and programmes that are outcome-driven rather than reporting outputs only; and services which are evidence-based and in the long term will deliver savings in dollars, productivity and quality of life.

The commitment to participation of people with lived experience and their support people is one of the best ways to ensure that governments' significant investment is hitting the mark. It increases the accountability and transparency of decision-making, and it enables the integration of lived experience and expertise into policy, planning and funding decisions.

Leadership role for the Commonwealth Government

The Commission has encountered no dispute about the need for clarification of roles and responsibilities between governments. The picture has already been painted of different levels of government, different agencies within governments and organisations working in isolation and creating impenetrable barriers to access for individuals when they most need it.

Many strategies of the Commonwealth have not served to enhance integration and coordination around the needs of individuals, their families and carers; indeed, new silos have been created.

The Government has committed to a review of the operation of the Federation through a White Paper process, which is due to be released before the end of 2015. In the interim, work can commence on clarification of current roles and responsibilities to reduce confusion and overlap, improve cost-effectiveness and enhance access to essential supports and care.

In its accepted national leadership role, it is clear that the Commonwealth should have responsibility for national policy directions (in partnership with the states and territories and other stakeholders), as well as for national programmes (including funding of organisations which operate on a national basis), national education and communications, payment of benefits to individuals, standards, guidelines and research. There is also a case for this leadership role to include time-limited incentives for system change.

An emphasis on early intervention

Young people today who are first being diagnosed with a mental illness want a life where they can manage their illness and continue on their life journey. We know that mental illnesses typically develop in a person's life from mid-to late-adolescence. Great opportunity lies at this point in a young person's life. Keeping them mentally well and supported with the right interventions can keep them in school, allow them to complete their education and remain connected with family, their community and in employment.¹⁵ Evidence shows that keeping families healthy and resilient can reduce the future risk of mental health problems.¹⁶

We know from evidence and expert advice that there are proven interventions to support young people living a contributing life (see Chapter 3).

A whole-of-life, whole-of-government approach

We know that when early supports and interventions are not available, especially for severe and complex mental illness, people often endure ongoing cycles of illness. This can result in dislocation from family and friends and being squeezed out of education, work and housing, resulting in poverty and, in some situations, poor social consequences. We know, for example, that people living with a mental illness are overrepresented in prison numbers. Many also live with co-existing physical health problems or problems with alcohol and other drugs.¹⁷ Aboriginal and Torres Strait Islander peoples live with the highest suicide rates and a bleak outlook on almost any indicator of social and emotional wellbeing.

We also know that the answers from evidence to turn things around do not lie in more beds, more pharmaceuticals or more specialist medical appointments alone. They lie in keeping people engaged with community, culture and education, happy and healthy families and thriving children. A re-engineered system would provide accessible treatments at the GP or local health centre which keep people at home, maintaining links with work, family and community and rarely using hospital-based treatment. For people with a mental health difficulty, it is about having services available when things are not going well, housing and income support, and employer incentives to work with people to get a job and keep it through the ups and downs of their life.¹⁸

This has been the fundamental approach of this Review – a whole-of-life, community and inter-sectoral view. This is about what evidence shows is proven to improve the mental health of individuals and of the community. It is about which evidence-based approaches can underpin a system focused on improving health outcomes for people and their families and supporters, through the delivery of effective, efficient and available programmes. It takes an inclusive approach across programmes and supports and the wider community.

The strategy proposed in Volume 1 can only succeed via an inclusive approach. This means working with people with lived experience of mental health difficulties and their families and supporters to ensure that the redesign process meets their contributing life needs, and does not inadvertently produce unwanted consequences.

A dedicated focus on Aboriginal and Torres Strait Islander mental health

The Review has been charged with identifying the specific challenges for Aboriginal and Torres Strait Islander peoples' mental health in the context of the broader Terms of Reference. The Review finds that a major overarching challenge is that the mental health system has adapted to the needs of this group in an ad hoc manner.

Further, for Aboriginal and Torres Strait Islander peoples, mental health need is far greater than the services and programmes currently available. Significantly more services and programmes are required, and a greater emphasis is needed on cost-effective mental health promotion, prevention, early detection and treatment within primary health care settings rather than expensive and inefficient hospitalisation and other specialist treatment for otherwise preventable conditions.

Compounding all the above, the Review identified significant limitations with policy implementation and monitoring. Because of this, system level reform is needed to provide additional and dedicated services and programmes that address greater mental health need and cultural differences in an integrated manner.

The Review proposes making Aboriginal and Torres Strait Islander mental health a national priority and that this should be supported by agreeing to include an additional COAG Closing the Gap target specifically for mental health. Critically, dedicated national Aboriginal and Torres Strait Islander mental health policy, service and programme design is needed because mainstream options are, in general, limited and not appropriate for Aboriginal and Torres Strait Islander people. As noted previously, the current moment provides a unique window of opportunity for achieving such a plan.

A principles-based approach

The following description highlights how a principles-based approach can assist in determining priorities and directions, policy decisions and funding priorities.

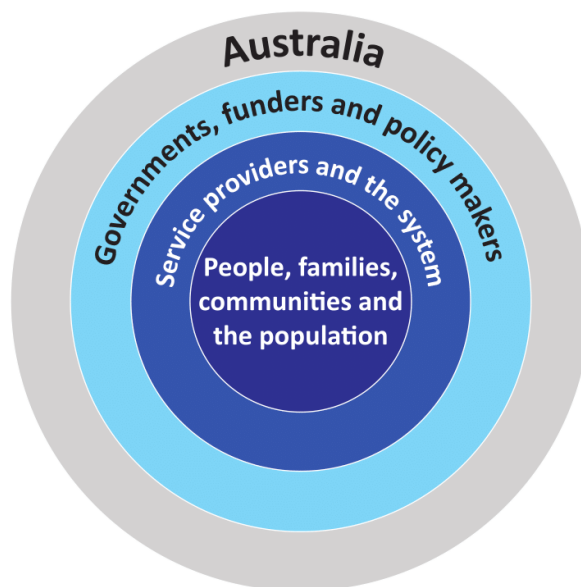
Principles

The importance of establishing principles is to agree to a set of desirable features which help decision-makers assess whether a new policy or investment proposal is aligned to desired directions, and whether an existing policy, programme or service is on-track to achieve the best results from the mental health system.

In particular, they serve to focus the system on what matters – the needs of people, their families, communities and the overall health and wellbeing of the Australian population.

These principles are both aspirational and practical. They recognise a desirable approach to better mental health outcomes, but do so within the context of the environment and the system within which mental health programmes and services are provided, including current and forecast fiscal circumstances.

They take into account a range of perspectives, central to which are the interests of people, their families and communities; the service system; governments as funders and policy makers; and the overall interests of Australia as a thriving, productive nation.



For people, families and communities:

- A contributing life which requires mental and physical health and wellbeing, work/life balance, education and skills, social connections, personal security, subjective wellbeing, housing, jobs and earnings
- People are empowered and involved—nothing about me without me
- Programmes and services are person centred/person rated, family and carer inclusive
- Focus is on self-care and recovery
- One story, one care plan, one key contact
- A single electronic health record: joined up around the individual
- Access is fair and equitable—to health, housing, education and training, employment, human services and social support

For the population:

- A mentally healthy nation and mentally flourishing communities
- A Life Course approach—a healthy start to life, healthy adolescence, adulthood and retirement, and dignified aged care
- A stigma-free and mentally healthy society which promotes respect and reduces discrimination
- Culturally sensitive and responsive
- Accessible, effective and efficient services and programmes
- Mainstreaming, where mental health is not separate or different, but part of everyone's business including in health, welfare, housing, employment, education and justice
- Keeping mentally healthy and supporting

For service providers:

- Interventions, programmes and services are evidence-based
- Streamlined and coordinated services and programmes
- Services organised around the individual, their families and other support people
- Providers funded to support recovery
- Mental health and physical health are integrated
- Build scale, capacity and competence, eliminate local duplication and confusion
- Interventions tailored to need (efficient and sufficient to get the job done)
- Ongoing funding is based on evaluation of results and outcomes

For the system:

- Promote the mental health of the Australian community
- Prevent the development of mental disorder and reduce the impacts on individuals, families and communities
- Focus on prevention, early intervention and recovery: invest in “upstream” services to reduce demand for “downstream” services like acute care and crisis management
- Assure the rights of people with mental illness
- Whole of system/whole of government—mental health crosses all of the pathways which lead to a contributing life
- Integrated care pathways help guide people through the system
- Work towards eliminating seclusion and restraint
- Encourage peer and community involvement
- Programmes and data collections centre on the pathways of individuals and population groups
- Research linked to strategy rather than investigator driven, with a focus on the factors that contribute to a contributing life

For governments, funders and policy makers:

- Commonwealth, state and territory roles and responsibilities are clear and agreed
- Programmes complement (rather than compete with) the private sector and NGOs
- Funding is person- focused not service-oriented. Reward providers for making people healthier, rather than simply paying them to provide more services.
- The focus is on outcomes, results and value for money, not activity and programmes
- Where there are shared responsibilities, Federal and State funds should be pooled to provide integrated packages of care for people
- Bundle up payments for those who access multiple providers
- Programmes and services are designed and de

For Australia:

- **Accountability**—governments measure and support what works, not just what can be counted, and shareholders (all of us) get value for our dollar
- **Affordability**— recognition of fiscal restraint and finite resources requiring prioritising of expenditure
- **Effectiveness**—scarce resources are used cost-effectively to achieve identified objectives
- **Efficiency**—investments in programmes and services result in the highest net benefit to the community (they maximise net benefits)
- **Participation**—the emphasis is on participation in employment, education, training and the community
- **Productivity**—return on Investment (ROI) identified in reduction in downstream/ lifetime costs

Source: concept designed by The National Mental Health Commission 2014

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Chapter 2: Methodology

This chapter describes the methodology used to collect evidence as the basis of our findings and recommendations. We describe what we did, why we did it, and some of the challenges we faced. We also discuss how these challenges imposed restrictions on the type and extent of information it was possible to collect and the impacts upon the Review.

Collection of evidence

This Review built on the two years of consultation undertaken in development of the Commission's two National Report Cards on Mental Health and Suicide Prevention in 2012 and 2013. The focus of the Review process was to first document the picture of Commonwealth mental health-related programmes and services – bringing some data together for the first time. From this the process we moved on to discrete pieces of work to inform our work on the Terms of Reference.

The collection of evidence proceeded in four phases.

First, to gain a 'helicopter view' of current patterns of spending on mental health supports at a national level, we requested information about mental health-related Commonwealth programme expenditure and activity from 29 Commonwealth departments and agencies.

Second, to supplement this national view with more detail about spending and service delivery at a state and territory level, we requested information about mental health-related activity and investment by state and territory governments.

We also wrote to more than 300 nongovernment organisations around Australia which are funded to deliver mental health-related Commonwealth programmes. Analysis of the 65 responses from this sector provided us with a partial line of sight into how these programmes are working on the ground, funding arrangements and reporting requirements.

Third, we sought to complement the 'helicopter view' with a 'grass roots view'. We wanted to understand more about what it is like to work within or use mental health programmes and services. We issued a public call for submissions via an online survey which was open for three weeks between 24 March and 14 April 2014. The Commission wrote to more than 530 stakeholders and encouraged them to promote the call for submissions to their networks and to consult with and reflect the views of their members and other constituents in their submissions.

Fourth, we sought expert advice on each Term of Reference. We commissioned eight groups of experts in their fields to research and advise upon the key issues named in the Terms of Reference.

Sources and types of evidence

Source	Type of evidence
Information received and analysed by the National Mental Health Commission	
Commonwealth departments and agencies	For 140 mental health-related expenditure items (including programmes) across 16 departments and agencies information about: Mental health expenditure for 2008–09 to 2012–13, programme descriptions, eligibility criteria, grants to nongovernment agencies (DSS, DoH, PMC only), and evaluations (completed or projected)
State and territory departments and agencies	AIHW-held mental health establishments data disaggregated at state and territory level and remoteness categorisation Summary of top 5 issues for mental health reform

Source	Type of evidence
State mental health commissions	'Top 5' issues for mental health reform (Queensland, NSW and WA Mental Health Commissions)
Nongovernment organisations	<p>From 65 nongovernment organisations in receipt of programme monies we received information about:</p> <p>Funding from Commonwealth and additional sources in 2013–14, annual reports, service evaluations, summary of top 5 issues for mental health reform</p>
Written submissions from the public	<p>Online survey responses to the call for submissions from:</p> <p>236 organisations, 621 individual consumers and carers, 861 individual professionals</p> <p>Independent (non-online) submissions from more than 100 organisations and individuals</p>
CEO consultations	Face-to-face meetings with 134 key stakeholder organisations and individual experts
Expert advice to the Review	
Australian Bureau of Statistics	<p>Data from across ABS collections has been used to inform the Review. Information about people and the lives they are living was sourced from the ABS household survey collections, including the 2007 National Survey of Mental Health and Wellbeing and the 2011–12 National Health Survey. Analysis of this information provided data on all Australians as well as sub-groups of the population, such as those living in regional or remote areas and those who were not in the labour force. The 2012–13 National Aboriginal and Torres Strait Islander Health Survey provided important data.</p> <p>The ABS produced the Mental Health Service-Census Integrated Data Set as part of a special project for the Review. For the first time, it brings together data from the 2011 Census of Population and Housing with mental health-related items from the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS). This data set provides insights into mental health programmes by enabling questions to be answered, for the first time, about the characteristics of people who access government-subsidised mental health-related services and medications.</p>
Australian Institute of Health and Welfare	<p>The Mental Health Establishments National Minimum Data Set (MHE-NMDS) was accessed by the Australian Institute of Health and Welfare, on behalf of the Commission, to inform an analysis of a range of data (service activity, workforce levels, expenditure) at state and territory level and below. Data for seven states and territories was provided.</p> <p>The institute also provided analysis of data from across the AIHW collections and expert advice on the sources and use of mental health data generally.</p>

Analysis of evidence

Public consultation

To bring the voice of people with a lived experience of mental illness to the Review, the Commission held a public call for submissions over March and April 2014. A very enthusiastic response was received from across Australia, with more than 1800 individuals, professionals and organisations submitting their views on the mental health system. The response represents good coverage of all geographical areas of the country, including rural and remote areas, and a balance of consumer/supporter and professional responses (621 and 861 respectively). These responses were read and then systematically analysed by Term of Reference theme. A paper outlining the methods and high-level findings is included in Volume 3 of this report.

Qualitative information also was sought through formal requests to funders and service providers for data and information, face-to-face meetings with consumers and carers, service providers and professional representatives, and the investigation of a range of research, evaluations and reviews. It also should be noted that the Commission spent its first two years consulting extensively and building evidence from around Australia, especially from people with lived experience of mental health problems, their families and supporters. This evidence always will be at the heart of our advice and reports.

Information on expenditure and activity

The Commission examined evidence from publicly available government reports, state and territory data sets, research papers, literature and Commonwealth agency responses (specifically submitted for the Review) to assist in its analysis of mental health programmes and services. We sought information across the public, private and nongovernment sectors as well as on specific issues under the Terms of Reference such as regional, rural and remote mental health and challenges for Aboriginal and Torres Strait Islander peoples.

Specific data analyses were commissioned from the Australian Bureau of Statistics (ABS). A first-ever linked data set of mental health items of the MBS and PBS with the 2011 Census of Population and Housing was undertaken by the ABS in conjunction with the Department of Health (with project funding from the Commission). This new data set enables the analysis of the circumstances and characteristics of people experiencing mental ill-health as they interact with the health system. It was constructed in October 2014, with initial analysis available to the Commission on 28 October 2014 for consideration in the Review.

Information on state and territory mental health funding and service provision

In the absence of state and territory public mental health service data at the sub-jurisdictional level, a direct data request was made to the Mental Health, Drug and Alcohol Principal Committee (MHDAPC) of AHMAC for the use of state and territory data held by the Australian Institute of Health and Welfare (AIHW).

In response to our request, MHDAPC approved an ad hoc sub-jurisdictional analysis of the Mental Health Establishments National Minimum Data Set (MHE-NMDS) to be undertaken by the AIHW. Seven jurisdictions – New South Wales, Queensland, Victoria, South Australia, Western Australia, Tasmania and the Northern Territory – approved the provision of data for the purposes of this analysis to inform the Review. The ACT advised that its data is ready to be released to the NMHC once the NMHC has a mandate from COAG or the COAG Health Council to review state and territory mental health services.

Expert advice to the Review

Our detailed analysis was supported by eight projects (initiated with researchers and consultancies) to obtain expert advice on the specific requirements of the Terms of Reference. This work contributed greatly, along with other sources of advice, to the Review.

These projects were broadly divided into two streams.

Stream 1: Projects to provide advice on particular elements of the mental health service system.

- Economic analysis and cost of mental health investment scenarios.
- Future workforce capability requirements of the mental health system.
- Innovative technologies in e-mental health.
- Prioritisation of mental health research.
- Factors influencing primary mental health care integration with physical health care, social supports and specialist mental health services.

Stream 2: Projects to explore particular target or priority communities and issues.

- Challenges for rural, regional and remote Australia.
- Gaps and challenges for Aboriginal and Torres Strait Islander wellbeing.
- A study of people's experiences of support following a suicide attempt (already commissioned at the time of the Review's commencement).

Challenges in collecting evidence

In conducting the Review we came across multiple barriers to accessing existing information which would have greatly assisted in our analysis process. The gaps in evidence which resulted placed limitations on the scope of what we were able to investigate.

Gaps in data on Commonwealth investments

Although we received a high level of cooperation and a significant amount of expenditure data from Commonwealth agencies, we discovered that there are many areas where no or insufficient data is collected. Some areas which we found were lacking in data were the mental health workforce and locating data that could be disaggregated into regional, rural or remote locations. Some jurisdictions did not provide programme data at a level of detail sufficient to identify the mental health component of larger programmes. This situation contributed to limiting the assessment of mental health programmes in specific areas and assessing the extent of duplication of services between Commonwealth, state and territory governments. Additionally, it was hard to determine the burden of red tape across these government-funded services or whether investment was the result of evidence-informed planning.

Limited cooperation from states and territories

Despite repeated efforts over the course of the year, we were unable to obtain timely information from the jurisdictions about what they fund and deliver. We were referred to existing publicly available information, but received permission from states and territories to access AIHW-held Mental Health Establishments data very late in the Review process.

This gap in evidence meant we largely were unable to gauge levels of unmet need or to compare service access and provision across regions. We do not know whether an apparent gap in Commonwealth programmes is in fact met elsewhere by state or territory-funded programmes. However, we were able to use information from 65 nongovernment organisations which responded to the Commission's request for information on mental health programmes and services funding to provide a more complete picture of how funding arrangements are working on the ground.

Lack of whole-of-life outcomes data

The lack of a consistent national outcomes data collection framework made it difficult for us to assess the efficacy and cost-effectiveness of services and programmes. There is little information about outcomes which are not just meaningful in terms of clinical improvement (there are many validated scales for measuring this) but also in terms of a person's quality of life and their participation in education, work and their community. This is despite several key Commonwealth programmes having comprehensive evaluations. Where there are gaps in programme-specific information on effectiveness, the Commission has made specific recommendations about how this could be addressed with more consistent approaches to evaluation.

Challenges with Aboriginal and Torres Strait Islander data

Severe data limitations have greatly hindered the Review's capacity to identify the mental health-related expenditure on vulnerable groups, including Aboriginal and Torres Strait Islander peoples. Mainstream primary mental health care is an important source of services for this group. However, little is known about how Aboriginal and Torres Strait Islander people are using the system and whether it is effective for them. There is certainly only limited information about the volumes of their MBS and PBS use. Another gap identified was in Aboriginal and Torres Strait Islander peoples' use of general population suicide prevention services.

Lack of access to National Mental Health Services Planning Framework

One of the greatest challenges we faced was our inability to access the National Mental Health Services Planning Framework (NMHSPF). This severely limited the Review's assessment and findings in regard to an optimum mix of services and supports and gaps in services. Under the Fourth National Mental Health Plan, the Commonwealth Department of Health provided \$2 million to the New South Wales and Queensland Governments to develop this Framework in collaboration with all jurisdictions.

The Framework establishes targets for the mix and level of the full range of mental health services, at a population level, based upon best available evidence to support and treat the mental health needs of people across the lifespan. The methodology—which models costs based on holistic packages of care for different types of mental health need—is already in use in Western Australia for statewide population-based planning. Aaron Groves, Principal Clinical Planner to the project, states that the Framework gives an 'evidence-based blueprint' for mental health services, including:

- the detail for the mix and level of services including taxonomies and facility guidelines
- the detail for the mix and level of services including standards, care packages and pathways and information on costing; for example, cost benchmarking, cost weights, and activity-based funding models.¹

Given the strengths of the framework, its utility to this Review would have been significant, had it been made available to the Commission. Accordingly, the analysis was restricted to an assessment at the programme level, rather than the optimal mix of services and treatments. This is an inefficient use of the \$2 million project budget for the framework and of the time and resources national stakeholders contributed to the associated extensive consultation process. The Commission understands that the framework is being refined through a process of practical application and evaluation at a local level. This process should be completed as soon as possible so that Version 2 of the framework can be released and a national standardised and evidence-based planning approach for mental health can be realised. This forms part of a recommendation of this Review.

Despite these limitations, the overall quantity and quality of data available to undertake the task allocated to us by the Government was sufficient to inform sound findings.

Given the limitations outlined above, however, the Review makes recommendations for improving data collection and reporting to assist in any implementation phase consequent to this Review.

References

1. Groves A. Presentation to WAAMH Forum, 30 October 2013. The Western Australian Ten Year Mental Health Services Plan: Development Update. 2013. waamh.org.au/assets/documents/reports/resources/waamh-forum-aaron-groves.pptx (accessed 18 November 2014).

Chapter 3: Achieving a contributing life

People living with a mental health difficulty, their families and carers all need access to programmes and services to support them to lead a contributing life. In turn, each person should also have the opportunity to access the services and supports they require to sustain their recovery journey. A person-centred approach to how programmes are designed and delivered is a key factor in providing both effective and appropriate interventions to achieve these twin goals.

This chapter outlines evidence about what truly person-centred programmes and services would include and the need to listen to the voices of people with a lived experience of mental health difficulties and their families and supporters. We then present evaluation evidence of specific initiatives which demonstrate the value—for people with lived experience and taxpayers alike—of addressing mental health alongside social and economic factors. The essential tailoring of services and programmes to a person’s individual life experiences and circumstances is examined, acknowledging that for Aboriginal and Torres Strait Islander peoples this means culturally appropriate services.

Term of Reference

The role of factors relevant to the experience of a contributing life such as employment, accommodation and social connectedness (without evaluating programmes except where they have mental health as their principal focus)

Three dimensions of a person-centred approach

People with a lived experience, carers and professionals have told us that our current systems of mental health support are often fragmented. This has been confirmed by our analysis of the Mental Health Services-Census Data Integration Project. Services and programmes often seem to deal with one isolated issue, not considering that each person seeking help has their own interests, strengths, preferences and needs. This becomes a problem because of the interrelated nature of mental health needs and the rest of a person's life, including their personal history, physical health and their social, cultural and economic circumstances. This is particularly pertinent for Indigenous Australians and their history, where culture has been affected by European settlement and the effects have been passed down through generations. Dealing with mental health symptoms in isolation is inefficient and ineffective, because other parts of a person's life may exacerbate the symptoms or, conversely, may be a source of support for good mental health.

The Commission has found that there are three key dimensions of effective person-centred programmes and services. The first is listening to evidence from people with a lived experience of mental illness and their carers about what helps or hinders them in maintaining or helping their recovery. There was broad consensus across submissions to the Review about what supports a good experience and outcome (from using a programme or service), and we will summarise these below.

The second dimension is the need for programmes and services to be sufficiently flexible to support people to increase their social engagement and economic productivity while at the same time improving their mental health. We were presented with evidence of well-evaluated approaches to increasing stability of housing, participation in employment, and reducing the number of people with a mental illness in the justice system. This dimension includes people and their families and supporters being able to access a variety of self-help options wherever possible as a way of building resilience and avoiding a crisis. These initiatives not only demonstrate effectiveness in terms of whole-of-life outcomes, but are also highly cost-effective for funders.

The third dimension of effective person-centred programmes and services is ensuring that their design and delivery is underpinned by the principle that each person seeking help brings with them their own circumstances and experiences, some of which may present specific mental health challenges (including stage of life, gender, sexuality and cultural background) or may be associated with increased mental health risk (such as intellectual disability, chronic illness and substance abuse). To be truly person-centred, services and programmes must be individually tailored to different life experiences and circumstances. A one-size-fits-all approach is the direct opposite of the principle of person-centredness.

Listening to the evidence from people

What is happening now

There was a startling level of consensus among people and organisations which formally submitted evidence to the Review that people with a lived experience and their supporters' expectations and needs are often not being met by services and programmes. Evidence from personal testimonials by people with lived experience of mental illness and their supporters, as well as from professionals and organisations, highlighted experiences of mental health supports which were, in their terms, often disturbing and sometimes tragic.

The characteristics of services and programmes which people have told us contribute to a poor experience or unsatisfactory outcome (or both) for people that use them and their supporters are wide-ranging. The focus here is on the themes which emerged most frequently from these responses.

Services and programmes which produce poor experiences and outcomes are those where:

- people feel they are not being taken seriously
- people are dropped or dismissed by services or professionals
- people are harmed more than helped by their experience of support
- people are excluded from accessing the support they need
- people are seen as collections of symptoms, not as whole people
- people do not know what help is available.

This picture is highly concerning but also offers important clues as to how the design and delivery of services and programmes could be improved in future. We also received evidence of aspects of mental health supports which commonly make for a positive experience of help seeking and positive whole-of-life outcomes. This is an opportunity to listen to these voices, which clearly tell us what works and what does not, and to build on the good and try to eliminate the inadequate.

Key findings

Our findings about positive experiences and outcomes are that there are five key ingredients to providing an experience of mental health support which feels therapeutic and person-centred, rather than dismissive and demeaning.

Effective person-centred services and programmes are those which are:

- **personalised:** people can access support which is tailored to their preferences and their whole-of-life needs
- **consistent:** people can access a consistent professional or team of supports they feel they can build trusting relationships with over time, and who have the skills, knowledge and approach which matches their needs
- **respectful:** people can access a professional or support team who demonstrate genuine care, listen without judgement and are willing to work alongside them to achieve their hopes and aspirations
- **capacity building:** people can access sufficient affordable support to enable them to cope sustainably over the long term
- **integrated:** people can access non-clinical supports and clinical supports as part of a spectrum of services which collaborate around a person and their family to address mental health and their current circumstances at the same time.

Creating equal opportunities and investing to save

The National Mental Health Commission developed the concept of ‘a contributing life’ in 2012 to emphasise that people with an experience of mental illness want the same thing as everyone else — to have an opportunity to fulfil their potential and to pursue their hopes and goals. It also reflects the fact that just because a person experiences mental illness, it does not mean they are unable or unwilling to contribute to the social and economic wellbeing of the communities in which they live.

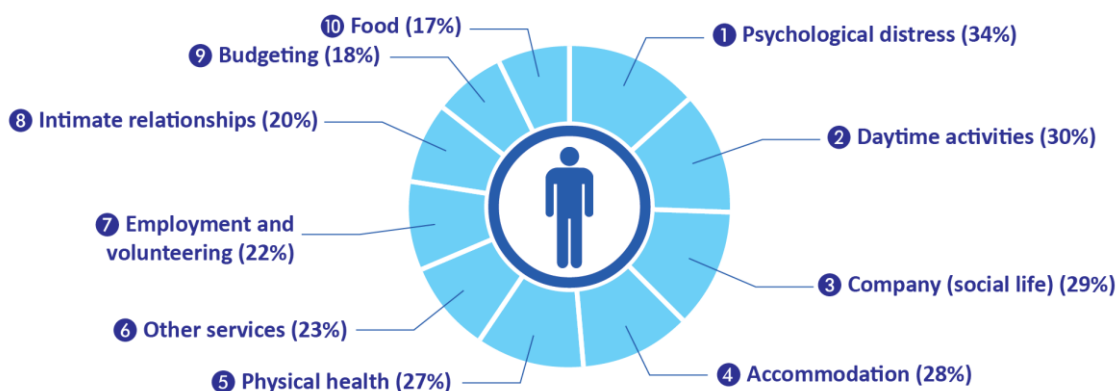
The Commission’s experience during the past three years of consultation with people with a lived experience of a mental illness, their families and supporters has confirmed the relevance of the contributing life idea as a guiding principle for the delivery of mental health services and programmes. People living with mental health problems do not want to be thought of as victims or passive recipients of ‘care’.

They want to contribute to their communities and harness their talents and strengths. They deserve the same opportunities to access education and employment as the wider community, and have the same right to a safe and stable place to live. A contributing life is enriched by close connections to family, friends and culture. This includes supports for mental and physical wellbeing as well as something meaningful to do each day.

The contributing life concept helps us understand that mental wellbeing is about so much more than medical or even psychosocial ‘treatments’ delivered by health care institutions.

If we look at what people with severe mental health problems say about what they need in terms of support, we can see that it is not only (or even mainly) help for the symptoms of mental illness itself that is required. As an example, the diagram below illustrates the self-reported needs of people seeking assistance from the Partners in Recovery programme in South-Western Sydney. They rated support for daytime activities, social connections and accommodation almost as highly as reduction in their psychological distress.

Figure 3.1 Top 10 needs of people referred to PIR Western Sydney to June 2014



Source: Based upon graphic from Partners In Recovery - One Year On – A Community Update, PIR South-Western Sydney

What is happening now

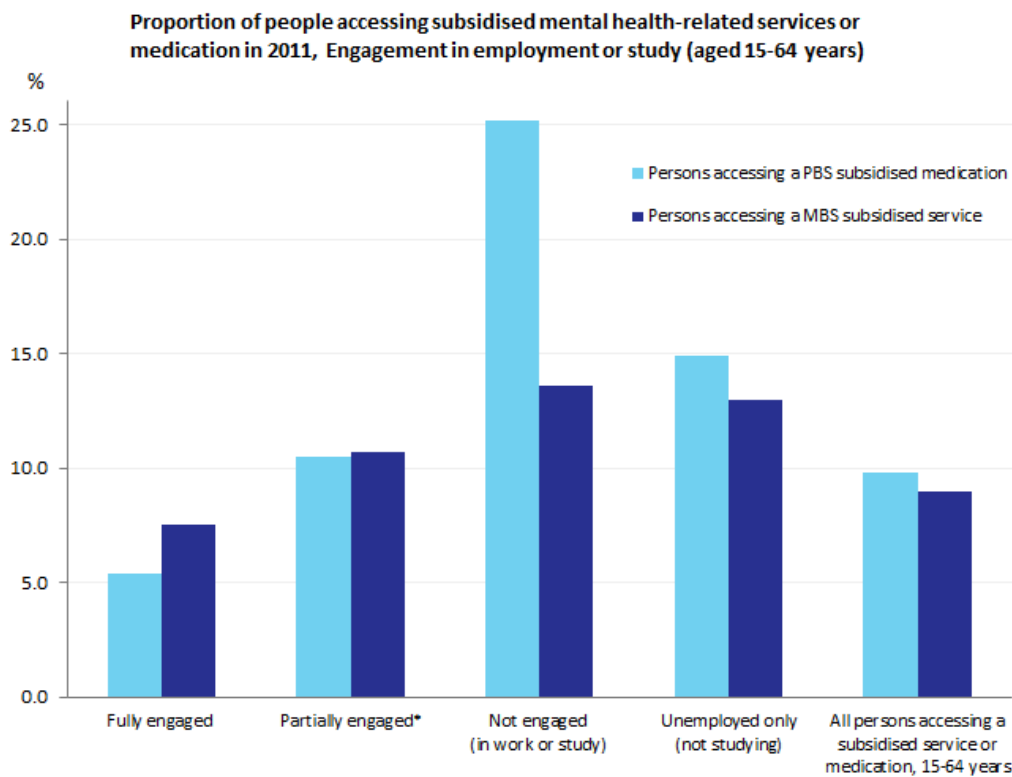
We know that many people living with a mental illness have fewer opportunities than the general population to participate socially and economically in the community. The proportion of people with a mental health condition in Australia who are not in the labour force is more than one-and-a-half times that of the general population (32 per cent compared to 21 per cent).¹ This is partly because our inflexible welfare support system can trap people permanently on benefits even though their functioning is only impaired episodically. We have seen access to the Disability Support Pension for psychosocial disability rise by 76 per cent over the past 10 years.² At June 2013 only 14.6 per cent of DSP recipients from the previous year (June 2012) exited to be non-recipients of other Commonwealth allowances. The remaining 85.4 per cent of people exited the DSP due to death (21.6 per cent) or moved onto another Commonwealth allowance (63.9 per cent).³

The interim McClure Report into Australia’s welfare system proposed changes to benefits to allow flexibility in the system, where people who want and are able to work can do so without jeopardising their chances of receiving a benefit should they fall ill in the future.⁴

A further factor contributing to low employment rates is a pattern of disadvantage which begins in school. For young people living with psychosis, only 31.5 per cent will finish high school.⁵ We know through the Mental Health Services Census Data Integration Project that the likelihood of using subsidised mental-health-related medication is more than twice as high among people of working age whose highest educational attainment is Year 11 or below (14.5 per cent accessed subsidised mental health medications in 2011) compared to those with a Bachelor’s degree (of whom 6.4 per cent accessed subsidised mental health medications).⁶ Lower levels of educational attainment have a significant effect on overall life chances and future employment.

We know that having something meaningful to do can help people recover from mental illness. Through the Mental Health Services Census Data Integration Project, as shown in Figure 3.2, we know that people not engaged in work or study were five times as likely to use a PBS-subsidised medication as those who were fully engaged. Similarly, people who were not engaged in work or study were almost twice as likely to access a MBS-subsidised service as those who were fully engaged.

Figure 3.2 Proportion of people accessing subsidised mental health-related services or medication in 2011



Source: Australian Bureau of Statistics Mental Health Services-Census Integrated Data Set, 2014

Such unequal opportunities are reflected in high rates of mental illness among people who are homeless or in contact with the justice system. During 2012–13 there were 46 037 specialist

homelessness clients across Australia with a current mental health problem.⁷ During the five years to 2010, the number of occasions of service provided to people who were homeless or at risk of homelessness because of a mental health problem grew by five per cent each year.⁷

In 2012, almost two in five people entering prison reported they had a history of mental illness.⁸ In one Queensland study, at least one mental health condition was detected in 72.8 per cent of male and 86.1 per cent of female Aboriginal and Torres Strait Islander prisoners.⁹

These statistics all reflect restricted opportunities for employment, education, stable housing and income generation. They show the extent to which our current patterns of investment are failing to support people to live contributing lives, and are therefore failing to support productive communities. Specific challenges for Aboriginal and Torres Strait Islander people and the delivery of culturally competent services will be explored in Chapter 4.

Harmonisation of legislation and practice in mental health

There remain significant variations in mental health legislation throughout Australia, as well as in the practical application of those laws. The varied provision for Community Treatment Orders is one such example.

A move to provide greater harmonisation would aim to simplify laws between states and territories and reduce the regulatory burden for individuals, businesses and community organisations, while ensuring protection of public health and legal rights.

In accordance with the Australian Government's Guide to Regulation (www.cuttingredtape.gov.au), work on harmonisation could consider questions including:

- what is the problem to be solved?
- why is government action needed?
- what policy options can be considered?

Options for agencies which could act as independent facilitators of the approach to harmonisation include the National Mental Health Commission or Australian Law Reform Commission.

'I just want to emphasise that people with mental health issues are a part of the community and that our lives matter.

Not only that, but by denying people like me the chance to have a stable life, with stable housing and a reduction in poverty-related stress, you are also denying our kids and loved ones relief from those stresses.

No matter how hard I try to shelter my child, the reality is that our children are affected by these problems and are more than likely going to present with mental health issues of their own because they are growing up in difficult environments with very little support (my 10 year old daughter was referred to a support programme over 6 months ago and we have had no follow up).

My child has already lost one parent to suicide and I worry that the constant financial pressure I live under will eventually leave her without me too.

I want a chance to live a meaningful life, I want a chance to live a life that is more than just hand to mouth survival I want my child to grow up hopeful and eager to explore all that the world has to offer, but I'm a mentally ill single mum who just survives on the poverty line.'

Submission from a person with lived experience

Key findings

There is strong evaluation evidence that effective strategies do exist for keeping people and families on track to contribute to the social, cultural and economic life of the community. These strategies take a whole-of-life approach to mental health by tackling some of the social and economic determinants and consequences of ill-health alongside the mental illness itself.

We now have an important opportunity to bring well-evaluated approaches, such as those presented below, to more people. We need to take a whole-of-life approach to intervening early, before a person's ability to live a contributing life starts to fall apart. There are opportunities for early intervention outside of the health system, in homelessness services, the education and justice systems and by working with families to give children a healthy start to life.

Lack of investment in these areas will lead to continued Commonwealth expenditure for assistance, such as the Disability Support Pension and Carer's Payment/Allowance. We know these are areas of investment that aid neither personal autonomy nor economic productivity.

Whole-of-government joint planning and investment, both within governments and between governments, to support people across multiple areas of their life will help to achieve equal life opportunities for people experiencing mental illness. Such a joined-up approach is also vital to reducing long-term health costs and the need for costly inpatient treatment.

Accommodation and community support

In 2011 it was estimated that more than 100 000 Australians were classified as being homeless on Census night. More often, Australians are living in marginalised housing such as shelters, overcrowded households and unsustainable accommodation.

Stable, safe and secure accommodation is the foundation from which people can build a contributing life and recover from mental illness. The relationship between housing and mental health is reciprocal. Poor housing can have a negative impact on mental health and

wellbeing. Lack of support and care in the community can lead to people living with mental illnesses losing their accommodation. Additionally, the symptoms of mental illness can lead to financial insecurity, relationship and employment breakdown and in turn onto initial and continued homelessness.

While the closure of many large psychiatric institutions was welcomed, the state response in providing alternatives – community-based services, acute response teams, housing, support into education and employment – was woefully slow. The impact of the lack of available support in the community still is seen today in the numbers of people who remain socially isolated and are living each day experiencing very poor physical and mental health. This can lead to an increase in hospital admissions, neighbourhood disputes, police and ambulance call-outs and eventually tenancy breakdown – a devastating outcome for the person and a huge cost on health and social services.

We need to do more work to understand the impact of housing programmes which have enabled people to lead contributing lives. We know good models exist – and they have the evidence to support their outcomes. One size does not fit all; we need a variety of choices to suit individual circumstances, sometimes for families or individuals, sometimes group and shared arrangements, and at the core of the design is integrated health and social service care.

Importantly, the provision of housing is not the same as the provision of accommodation. People can be given a house – but they may need help to fully engage with their local community.

Barriers also occur where claims of privacy interfere with the ability of mental health support workers to discuss client issues with housing providers. These barriers need to be broken down. Housing providers need to be included as part of the team and understand when there are mental health issues impacting on a person's functional capability. Adelaide's Common Ground provides a good example of an integrated accommodation and care provider and is described in the following case study.

Case Study

Adelaide's Common Ground was designed to respond to concerns that transitional accommodation in fact created its own problems in terms of the psychological impact of instability. The fact that it was not permanent meant people could not settle and feel secure about their future. People could get a house but no support, and with no guarantee over the longer term. That instability impacted on the ability of people to live stable lives.

Initially Common Ground battled with the disconnection between being a housing provider and dealing with mental health support services, but now it operates as a team.

Common Ground operates on the basis of bringing together everything a person needs: a home, a neighbourhood and a community, with the local mental health service providing inreach services to clients, and visiting services such as GP and dental services (there are dental chairs on site and dental volunteers are so numerous that they have extended the service to all homeless people).

Accommodation is provided on a permanent basis – it is not time limited, so there is no threat of instability. But as people recover – their lives change, they get a job, relationships, reunite with their children – Common Ground has found that they self-select out. The average stay is four or five years: after that, people want to live independently, or move in with someone.

Common Ground in Adelaide has two apartment buildings and is developing a third, funded by a mixture of Government funding, philanthropy and debt underwritten through the use of a private company's balance sheet.

Its message:

- Don't institutionalise.
- Respect the fact that this is the home of the residents.
- Treat people as equals and adults.
- Housing is essential but on its own it does not solve the problem.

"Every service is a gateway" – Maria Palumbo, CEO, Common Ground, 18 September 2014.

Housing First

There is substantial evidence from Australian and international sources that secure housing can yield great benefits for mental health and life chances. The Housing First Model is one example of an 'invest to save' model, underpinned by the idea that if people have stable housing first, they are more likely to be in a position to achieve their health, social and productivity goals and less likely to use hospital and crisis accommodation services. In Canada, specialist housing teams partnered with private landlords to offer clients a choice of housing location, and a community treatment team provided around the clock clinical care. An investment of \$110 million kick-started the programme in several sites and was highly cost-effective. For every \$10 invested, \$21.72 was saved in reduced use of public services by these frequent users.¹⁰

In Australia the Housing First Model has been used in different forms in different parts of the country, with a mix of approaches using public housing or purpose-built developments, such as the Common Ground approach.

An evaluation of the Housing and Accommodation Support Initiative (HASI) programme in NSW (a partnership between Housing NSW, NSW Health and local NGO accommodation support providers) found that more than one-third of participants were in hospital or unstable accommodation when they started the programme. Participants had a 59 per cent decrease in the average number of days spent in a mental health inpatient hospital per year, including a decrease in admissions of 24 per cent.¹¹ It is estimated (as Table 3.1 shows) that this model of care avoided costs of around \$30 million for the participants in 2009–10.

Table 3.1 Estimated cost of mental health inpatient hospitalisations, annualised for two years before and during HASI, applying 2009–10 costs

	Before HASI (\$)	During HASI (\$)	Cost avoided (\$)
Average cost per person per year (n=197)	47 425	19 508	27 917
Average cost per admission	5462	1821	3641
Total cost per year for all HASI consumers (n=1076)	51 029 192	20 990 070	30 039 122

Source: NSW Health, Admitted Patient Data Collection in the State HIE July 1999 – June 2009, in Bruce J, McDermott S, Ramia I, Bullen J, Fisher K. Evaluation of the Housing and Accommodation Support Initiative (HASI): Final report. Sydney: NSW Health, Housing NSW and Social Policy Research Centre, 2012.

Note: Estimated from mental health inpatient hospitalisation data Table 6.1. Cost data from NSW Health: acute admissions adjusted average bed day cost \$867 2009–10 (adjusted to include overhead and indirect costs), average length of stay 15.2 days.

Justice reinvestment and court diversion

Another invest-to-save approach, justice reinvestment, has been successfully applied in some areas of Australia. This initiative diverts a proportion of funds for correctional services into communities with high crime rates, and shows promise in reducing imprisonment rates in Aboriginal and Torres Strait Islander communities.¹² It is important to remember that imprisonment can be a consequence of trying to deal with a mental illness with insufficient or inappropriate support.

A recent cost benefit analysis by the National Indigenous Drug and Alcohol Committee has shown long-term savings for court diversion programmes prison costs can be as high as \$111 458 per offender.¹³

Flexible pathways through education and training

The largest ever survey of Australia's youth about their mental health, conducted this year by Mission Australia and the Black Dog Institute, indicates that more than one-fifth of teenagers aged 15-19 meet the criteria for a 'probable serious mental illness'. Unfortunately, many of these young people report that they often find it difficult to seek information, advice and support. Early childhood services, schools and tertiary and further education institutions are uniquely placed to spot problems early, to foster cultures which do not stigmatise mental illness, and to provide adequate signposting to sources of help. However, research shows that teachers often feel overwhelmed by their educational and student welfare responsibilities, and so they must be adequately supported with training and resources if they are to fulfil a mental wellbeing support role.

This role is vital because young people experiencing mental ill-health are disproportionately represented among those who have disrupted educations or drop out of school early, and who subsequently fall into 'NEET' (not in education, employment or training) status. There is clear

evidence of the link between level of educational attainment and quality of life indicators such as level of income.

Building adequate flexibility into the education system at all levels is important to ensure that illness is never a barrier to achieving academic, sporting, vocational or creative potential. This is key to avoiding wasted talent and reduced productivity. Traditional models of education do not suit everyone, and Australians experiencing mental illness should have access to alternative (and innovative) pathways through school, tertiary and vocational education and training. To assist with this, flexible and affordable adult education and training must be supported.

Mental fitness was a term raised with the Commission on a number of occasions during the Review – on the basis that mental fitness combined with physical and social and emotional fitness results in overall wellbeing. Education and training settings provide good opportunities to promote and enable good mental fitness.

Employment

Creating flexible opportunities for participation and employment

Employment is a fundamental part of a contributing life. Participation in the right employment, with the right support, can bring personal fulfilment and economic stability. It is a major factor in enabling stable relationships and maximising individual productivity. It gives people something meaningful to do, builds personal satisfaction, creates connections and helps with their financial stability.

Work is a key to good mental health and recovery. The approach to employment should be to increase the levels of participation of people with mental illness in employment in Australia to be comparable with best practice examples in other OECD countries. At the moment, Australia falls well short of that.

Mental illness can have a significant impact on a person's capacity to work. The fluctuating and episodic nature of mental illness means that people may be able to function at high levels for extended periods, but then may need time off.

It is known that many people receiving the Disability Support Pension (DSP) want to work, but the incentives between the DSP and employment services do not line up. For example, the benefits for an individual and society of getting someone into volunteering appear obvious: this often is the best place to start for someone with a psychosocial disability and may then lead on to greater workforce participation. The same is true with getting someone into one or two hours of work a week.

But neither of these examples is regarded as participation in terms of counting towards the benchmark hours or star ratings employment agencies are paid to achieve. There is no incentive to assist individuals into fewer hours of work than contribute to the star ratings – let alone into volunteering.

The following quote shows the value of recognising these types of participation. It comes from Brian (not his real name), who has had a mental health condition for more than 20 years. As he was only able to maintain casual employment of 4.5 hours per week, Brian is not recognised as reaching the current employment threshold and is therefore required to continually exit and reenter formal employment programmes. The employment agency which supports Brian has continued to support him, but this assistance is not reflected in their star rating for employment outcomes.

‘One of the most important things I see is I’ve stuck with it. They look forward to seeing me. Two mornings a week I have to get up and am expected to be there. I have to get up and get out of the house. I feel responsibility to turn up and clean that shop when I am expected there. I’ve never missed a day. It just feels more normal. You feel like you are participating in life like every normal human being.’

‘Brian’, Participant in Epic Employment Service

The system needs far greater flexibility in what is recognised as ‘participation’. It should be related to a person’s assessed ability to participate, not rigid cut-off points. The important objective is to get people started – get them into a job, keep them in a job, and over time support them where appropriate to progress into longer working hours.

A further complication occurs when job seekers with an employment agency which loses its contract mid-way through their programme are transferred to another provider. Job applicants with a mental health difficulty will again be required to meet with new staff, develop new working relationships and be asked to discuss their personal circumstances and difficulties with a new worker. It can take some job seekers with mental health issues several months to develop strong working relationships with their employment service providers, and being forced to change providers can be an extremely stressful process. The progress made by their previous employment service (e.g. contacts with employers) is lost and the job seeker then needs to start all over again.

The Commission strongly endorses the view put forward by the McClure Review Interim Report that consideration should be given to how approaches such as individual placement and support can be expanded to assist people with mental health conditions to gain and maintain employment. Individual placement and support operates by placing an employment specialist within a mental health service. It aims to provide support so that people with mental health conditions not only get into jobs, but are then supported to stay in a job.

The Commission concurs with the view expressed in the McClure Review Interim Report:

‘The broader social support system should work in tandem with the income support system to assist those most in need. This includes well-functioning employment services, housing assistance, child care, and early intervention and integrated services for people and families with complex needs, such as homelessness, mental health conditions and drug or alcohol addiction. Reform needs to take account of recent developments such as the system of lifelong care and support for people with disability being introduced through the National Disability Insurance Scheme, the expansion of paid parental leave and the opportunities offered by new technology. It should also take account of effective interventions to support people who are vulnerable in the labour market, such as people with mental health conditions and people with disability.’

The Commission has continued to work with the McClure Review on the issue of ‘permanent impairment’ and what this means in terms of the often episodic and persistent nature of severe mental illness, and the widespread philosophy of recovery. The final report of the McClure Review is yet to be released. The Commission confirms its view that tiered working age payments need to be flexible enough to respond to the episodic nature of mental ill-health when people are unable to work and sufficient enough to ensure that people with a psychosocial disability do not need to fall back on the mental health system for additional support.

In particular, the welfare system needs to respond to the capability of people rather than their diagnosed illness.

Encouraging employers to create mentally health workplaces

Employers already play a significant role in mental health – but most are not aware of it and they could do more.

The majority of Australian adults spend most of their waking hours at work. The workplace plays an important role in wellbeing – keeping the well healthy and supporting the unwell.

However, it is estimated that one in six Australian workers is affected by a mental health condition each year, and that Australian businesses lose six million working days per year due to depression.¹⁴

Australia is faring poorly compared to its OECD peers in terms of creating real opportunities for people with any form of disability to participate economically and socially. This is evident in the growth of reliance on our welfare system. Although stigma has reduced greatly for problems such as depression and anxiety, it remains a problem in relation to some more severe conditions. Discrimination—and fear of it if illness is disclosed—persists for all types of mental illness.

'I think that people with mental health problems need to be given greater support in finding a job. There should be more funding set aside for reverse marketing clients to employers and also building a network of employers who are interested in giving opportunities to people with mental health problems and other disabilities. Government should take the lead and be proactive in employing people with disabilities.'

Saying you are an equal opportunity employer is not enough.'

Submission from a person with lived experience

The greatest barrier to people with existing mental health problems gaining or maintaining work is lack of workplace support. However, like the other invest-to-save initiatives outlined in this section, support in the workplace has been shown to be highly cost-effective for businesses, with an average return on investment of \$2.30 for every \$1 spent on workplace mental health.¹⁵

Mentally healthy workplaces provide flexibility and understanding to people who may need to provide care for someone close to them who is living with a mental illness. They not only work to support people who are already in the workplace but also encourage people experiencing a mental health problem to apply for positions.

Flexible work arrangements and other measures to encourage people with a mental illness into the workforce need to be developed jointly by the Commonwealth and business/industry, so that people have meaningful opportunities to work and employers have the incentives to make this happen. The following figures should be incentive enough: the direct financial impact of mental health conditions for Australian employers is about \$10.9 billion every year, largely due to absenteeism and 'presenteeism'.¹⁵ Governments and businesses alike have the opportunity to reduce these costs by supporting mentally healthy workplaces.

The Mentally Healthy Workplace Alliance (see case study below) is an example of the foundations currently being laid to partner with employers to maintain and improve employee mental health. However, there is still a long way to go.

Case Study: Mentally Healthy Workplace Alliance

The Commission began investing in workplace mental health as a catalyst for the establishment of the Mentally Healthy Workplace Alliance. This is a national coalition of business, community and government leaders which has so far developed practical resources for all business and industry sectors to help them create mentally healthy workplaces.

The Alliance has also partnered with *beyondblue* in the Commonwealth-funded initiative HeadsUp, to raise awareness of the issue and provide direction for improved practices.

These and other initiatives will help employers retain and support staff, increase productivity, reduce discrimination and ultimately help people with a lived experience of mental ill-health gain and retain meaningful employment.

Tailoring support to each person's life circumstances and needs

The first section of this chapter demonstrated what consumers and carers believe makes for effective person-centred support, while the second section outlined some cost-effective initiatives which tackle whole-of-life determinants of mental health across traditional sector boundaries such as housing and employment. This final section illustrates the importance of tailoring person-centred support to a person's individual life experiences and circumstances.

We know that certain social, economic and other life circumstances are associated with particular mental health challenges or support requirements.

- We know that a person's age, family situation, cultural background, gender and sexuality can affect their experience of mental wellbeing and mental illness, as well as the types of support they may find helpful and appropriate.
- We also know that particular life experiences have considerable impact on – and can be impacted by – a person's mental health, and therefore need to be considered at the same time. These include intellectual disability, substance misuse and chronic physical illness or disability.
- We know that for Aboriginal and Torres Strait Islander people, specific issues such as sense of self, connection to land and belonging have a huge intergenerational impact.

A person-centred approach to supporting a person's whole-of-life needs encompasses a general principle that supports should be tailored to the person, rather than the other way around. This tailoring process means considering the range of preferences and needs of the full diversity of Australia's population.

While the previous sections of this chapter have suggested overall principles for providing effective whole-of-life supports to anyone experiencing mental illness, the focus of this section is to illustrate some of the considerations which are often lost when services and programmes take a 'one-size-fits-all' approach.

We do not claim here to present a comprehensive picture of each community's particular needs, but seek to emphasise that person-centred mental health support requires two things:

- recognition and consideration of each person's circumstances and experiences
- addressing each person's interrelated needs holistically.

The examples of particular circumstances and experiences we outline below are primarily drawn from submissions provided to us by organisations, professionals and members of the public.

Specific life circumstances

The particular challenges for Aboriginal and Torres Strait Islander People are addressed in Chapter 4. The discussion below highlights some of the needs of people with different circumstances in the community.

Families and caregivers

For a person experiencing mental health difficulties, family or ‘family of choice’ (close supporters who are not relatives) plays an important part in day-to-day support and in the recovery process. For programmes and services, tailoring support to a person in the context of their close support network is vital. Although these supporters can be a valuable resource for professionals to work alongside, to fulfil this role they often require specific information and support for themselves.

Several Commonwealth programmes have attempted to consider the needs of families and carers of people with severe mental illness, and to acknowledge the lost income a caring role might entail. The Carer Allowance and Carer Payment accounted for almost \$1 billion of Commonwealth spending in 2012–13, while the Targeted Community Care (Mental Health) Programme dedicated \$57.2 million to respite services for carers.

These programmes are welcomed by many carers and uptake has greatly increased in recent years, with combined spending on the three carer programmes increasing from \$723.4 million in 2008–09 to \$1 billion in 2012–13. The growth in carer payments should not be an area of criticism. Many people have contributed for a long time as unpaid carers. The fact that more of them are entitled to support payments to fulfil this role should be celebrated as an example of justice being achieved. The pressures of a caring/supporting role are evident. The Department of Social Services estimated that at June 2013, of the 256 380 Disability Support Pension customers who had a primary medical condition, 11 256 (4.4 per cent) had a previously recorded episode of Carer Payment.

However, submissions we received from carers’ organisations and from hundreds of individual supporters indicate that in addition to funding for carer support, major cultural change needs to happen in terms of the system’s treatment of carers. Such a shift would mean:

- ensuring a person’s preferences in terms of which caregiver(s) they want involved in their support ‘team’
- routine assessment of a person’s family or social support circumstances
- routine consideration of carers’ information and specific support needs, including employment options
- ensuring the preferred caregiver(s) are meaningfully involved and consulted.

Infants, children and young people

The adoption of a family-focused rather than individually focused model of care and support is especially important for early intervention in mental health and behavioural problems for infants, children and adolescents. Many childhood difficulties are closely related to developmental and attachment problems, and for this reason, best practice models of care include caregivers from the start.

This is the model traditionally operated within mainstream paediatric services in Australia. However, submissions to the Review informed us that it is not the norm within child and adolescent mental health services. It has been put to the Commission that such an approach can increase the short-term cost of treatments, and can be more time-consuming than individual support, but that the long-term benefits are greater over a child's lifetime and more effective in stopping intergenerational problems.

The way systems of support currently are set up makes it difficult for services to deliver family-focused models of care. For example, activity-based funding only accounts for treatment of the individual young person. However, we do have examples of well-evaluated models to build upon, such as the federally funded 'Children of Parents with a Mental Illness' (COPMI). This is an attempt to offer early intervention support for young people whose parents have a mental illness. This is aligned with their parent's treatment, recognising that between 41 and 77 per cent of people whose parent has a mental illness will go on to develop a mental illness themselves.¹⁶ The scheme has proven successful in terms of increasing professional awareness about considering family context and training the mental health workforce to deliver whole-of-family approaches to a person's mental health. Furthermore, early childhood worker and teacher training can include the identification of mental health problems in infants and children as a way to intervene early with families and children at risk of developing problems.

A case study describing a promising approach to collecting national data on the wellbeing of young people (the Middle Years Development Index) is described on the following page. The Commission proposes the systemic introduction of the MDI as an action to help achieve one of our recommendations in Volume 1.

Older people

A life course approach to mental health is not just about early intervention for young people, but also relates to an early intervention ethos for mental health needs at all stages of life. Older people can face particular difficulties with mental health. These can be related to age discrimination, bereavement, social isolation, increasing susceptibility to chronic disease and the transition from work to retirement. Men aged over 85 are the most likely of any age group to take their own lives,¹⁷ and elder abuse is prevalent but remains a largely hidden problem – a Western Australian study calculated that an average 4.6 per cent of people aged over 65 are victims of abuse or neglect.¹⁸

Respondents to our call for submissions told us that mental health care for older people—let alone early intervention—is a big gap in systems of support in many areas of Australia. Nearly 35 per cent of all aged care home residents experience depression or anxiety at any one time.¹⁹ Older people with depression and anxiety are poorly served, as they currently have low access to non-medical MBS items for mental health interventions. The Mental Health Services-Census Data Integration Project shows that in 2011, 0.2 per cent of people aged over 75 accessed MBS items provided by clinical psychologists, compared to 1.5 per cent of people aged between 15 and 64.²⁰

Older people with more severe illnesses also are poorly served. According to a submission to the Review from the Royal Australian College of Psychiatrists, there is 'reduced access for older people to state community, acute inpatient and non-acute inpatient care, almost total absence of supported community residential mental health care, and increased utilisation of 24-hour 'community residential' care that is largely within residential aged care facilities.' This lack of service access for older people is especially worrying as the first cohort of 'deinstitutionalised' people with more severe and chronic mental illness are now reaching old age.

Case Study: Using data to drive effective change – at school, region and national level

The Review received many submissions highlighting innovative practice beyond service interventions or programmes which have the capacity to reform approaches at all levels. One such initiative, aimed at children in the middle years of schooling, is the work being done by the Fraser Mustard Centre, a collaboration between the Telethon Kids Institute and the South Australian Department of Education and Child Development, on the application of a Middle Years Development Index (MDI) in Australia. The measurement tool is a companion to the Australian Early Development Index (AEDI) for children starting school and is based on work done in Canada.

Experiences in the middle years, ages 6 to 12, have critical and long-lasting effects. They are powerful predictors of adolescent adjustment and future success. During this time children undergo important cognitive, social, and emotional changes that establish their lifelong identity and set the stage for adolescence and adulthood.

A child's overall health and wellbeing affects their ability to concentrate and learn, develop and maintain friendships and make thoughtful decisions. It is important to understand and be informed on how children are doing at this stage of development.

The MDI is a population-level, self-report survey for children aged 8-14 which covers non-academic factors relevant to learning and participation. Like its younger prototype, the AEDI, which measures development at age of school entry, it provides important school-level, as well as small-area, regional and state-level data to guide identification of at-risk groups and clusters, as well as informing overall research and national level policy.

The MDI survey includes 76 questions related to the five areas of development that are strongly linked to wellbeing, health and academic achievement:

- social and emotional development
- connectedness
- school experience
- physical health and wellbeing
- constructive use of after-school time.

These factors and domains tell an important story about young people's mental health and wellbeing and will form an important part of the policy analysis underpinning future work in this area. The index identifies groups of students as thriving, medium to high well-being and low health and well-being, allowing interventions to be targeted at the students and families in highest need.

The index is being trialled in South Australia in more than 200 schools. The next step is to gain government support at national level (Commonwealth and state/territory) to realise its potential as a national level census for guiding policy and interventions at all levels.

Submission from the Menzies School of Health Research (and others)

Women

Women face particular mental health issues related to their gender, as well as challenges to receiving appropriate support for a mental illness. Challenges particular to women include mental illness related to pregnancy, childbirth and early motherhood, as well as trauma related to childhood sexual abuse and domestic violence.

The Commonwealth has funded support for women in the perinatal and early motherhood period through the National Perinatal Depression Initiative, including via ATAPS Tier 2 funding for perinatal mental health administered by Medicare Locals. Specialist statewide perinatal and mother and baby services also provide support in many jurisdictions, but in general there is only limited access to services for women in the perinatal period.

We have heard that when women seek help for a mental health problem, they can encounter service provision which is inappropriate at best and re-traumatising at worst. Inpatient mental health facilities are singled out as particularly inappropriate, where bedroom corridors and common spaces are shared with men in most units. This can leave women feeling vulnerable and recreate earlier trauma. Almost half of the women in a recent Victorian survey reported they had experienced some form of sexual assault while in a mental health unit.²¹ This is unacceptable. Guidance on providing gender-sensitive services and sexual safety is available in some states and could usefully be adopted at a national level.

The idea of trauma-informed services, where the planning and design of supports takes account of the fact that a majority of people experiencing severe mental illness have suffered some form of physical, sexual or psychological trauma in the past, has been around for a long time. However, this philosophy of care has yet to be translated into a reality in many mental health services.

Men

Men are three times more likely to die by suicide than women,²² but are less likely to seek help for depression or anxiety. Our linkage of MBS and Census data for 2011 show that during that year, 8.7 per cent of Australian females accessed any MBS-subsidised mental health-related service, compared to 5.6 per cent of men.²⁰ We know that men living in rural and remote areas are particularly likely to take their own life and particularly unlikely to seek professional help.²³ Barriers to help-seeking among men have been identified as partly related to the perceived role of men in Australian society.²⁴ Services targeted at men, such as The Older Men's Network in Queensland, use men's interests and contributions to the community as vehicles for talking about mental health and making use of peer support.

Lesbian, gay, bisexual, transgender and intersex people

Violence and discrimination are the key risk factors for the relatively poorer health of lesbian, gay, bisexual, transgender and intersex (LGBTI) people. Discrimination and abuse lead to higher drug and alcohol use, mental health issues and other risky behaviour. Research suggests that LGBTI people are at increased risk of a range of mental health problems, including depression, anxiety disorders, self-harm and suicide.²⁵

Despite this risk, same-sex attracted people, intersex and transgendered people still are not routinely identified in national minimum datasets nor in census statistics. This makes their need less visible and the impact of initiatives tailored to their particular mental health challenges difficult to determine. We understand that the National LGBTI Health Alliance is currently consulting on the inclusion of LGBTI-related data in health research and national data sets. This is a first step to providing sexuality and gender-sensitive mental health supports.

Aboriginal and Torres Strait Islander peoples

For Aboriginal and Torres Strait Islander peoples, the current package of mental health services and programmes is ineffective at the system level because of problems at the service and programme level. Reasons include:

- How individual services and programmes are designed; in particular, that they do not work within a broader context of social and emotional wellbeing as understood by Aboriginal and Torres Strait Islander people and that requires consideration not only to the mental health of individuals, but to their broader wellbeing and that of their families, communities and cultures. This is referred to as cultural competence.
- How the services and programmes work together. In short, they do not ensure a connected transition through the mental health system for Aboriginal and Torres Strait Islander peoples and, in particular, between the primary mental health components (mainly funded by the Commonwealth) and specialist clinical services components (mainly delivered by the states and territories).

These gaps lead to significantly higher per capita levels of expenditure on acute inpatient care, the most expensive part of mental health treatment. This is discussed further in Chapter 4.

Culturally and linguistically diverse communities

People who have an experience of immigration to Australia or who have fled traumatic home circumstances as refugees have specific mental health experiences and needs which must be accounted for if support is to be effective. Not only do experiences of migration often exacerbate or create mental distress,²⁶ but people can find the response of Australian mental health supports inappropriate to their needs. People from culturally and linguistically diverse communities may understand mental phenomena in a different way to communities with Anglo-Saxon origins, and intervention can only be useful if providers are informed about and sensitive to these differences. Language barriers can be significant and many services do not offer assessment or therapy in the consumer's own language. Commonwealth and state and territory programmes do not always make allowance for the cost of interpreters.

As a result of these challenges, many people who begin to have mental health difficulties may not approach formal services until they have deteriorated to the point of crisis. They then may have a bad experience of acute services which deters them from seeking help in the future, creating a vicious cycle.

There are several examples of efforts to change this pattern which could be built upon. National organisations such as the Forum of Australian Services for Survivors of Torture and Trauma (FASTT and its jurisdiction-based members) and Mental Health in Multicultural Australia (MHIMA) engage in advocacy work and help local services provide support which feels appropriate and approachable. Transcultural Mental Health Services operates a statewide specialist consultation and capacity building service in NSW, Queensland, Victoria and WA to mental health services. These have been positively evaluated.

People with interrelated needs

Some life experiences and non-psychiatric health difficulties are closely associated with increased likelihood of developing mental illness. This section uses a selection of these to show how our current mental health policies and supports often fail to address commonly interrelated needs in a holistic way.

Physical health and medications management

The interrelationship between poor physical health and mental health is evident and can require treatment from a wide variety of medications. Managing medications can pose a challenge for many people with a lived experience of mental illness and their carers.

In Volume 1 the proposal to involve pharmacists in the care team was to formally address this complexity and aid the success of the person's care plan.

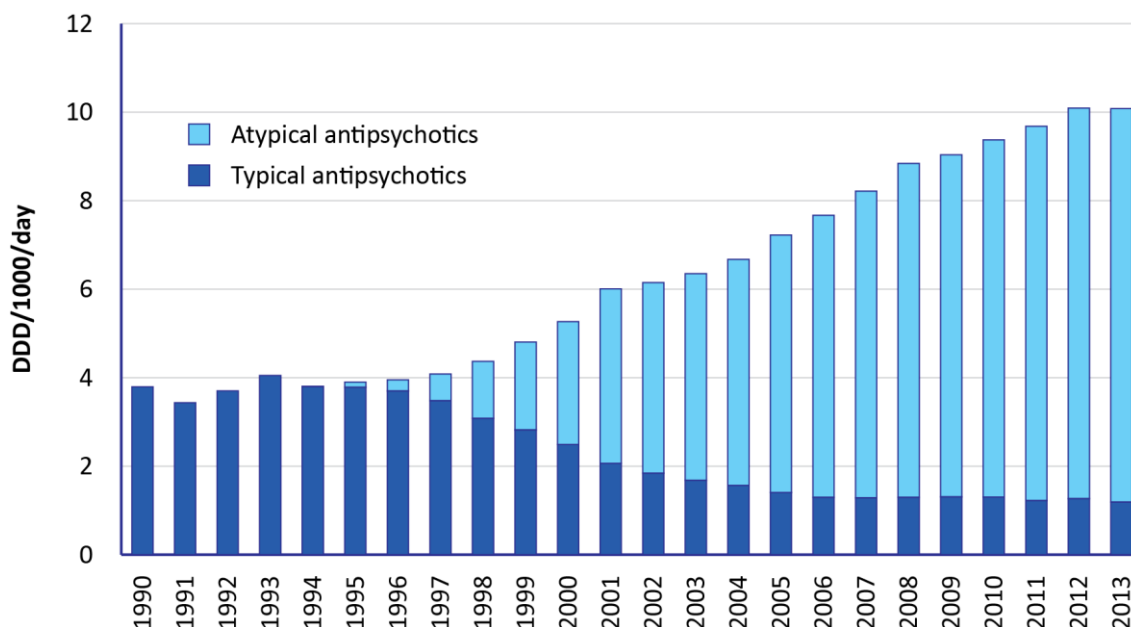
Medications are an essential component of treatment for many people with mental ill-health. However, best practice approaches note that the prescribing of pharmaceuticals should never be done in isolation of the broader model of whole-of-person care. As identified in Volume 1, use of medications should be considered as part of an overall care plan for people with mental health challenges, and never in isolation of the broader consideration of person-centred care.

Antipsychotic medications

Use of antipsychotic medications has more than doubled since 1990 (see Figure 3.3), and “[t]here are concerns that [this] rate of growth of antipsychotic use is higher than increases in prevalence”.²⁷

Some use is likely to be for off-label indications or indications not yet considered for cost-effectiveness by the Pharmaceutical Benefits Advisory Committee (PBAC). There is also concern that antipsychotic drugs may be replacing benzodiazepines to help with sleep disorders.

Figure 3.3 Antipsychotic use, 1990–2013

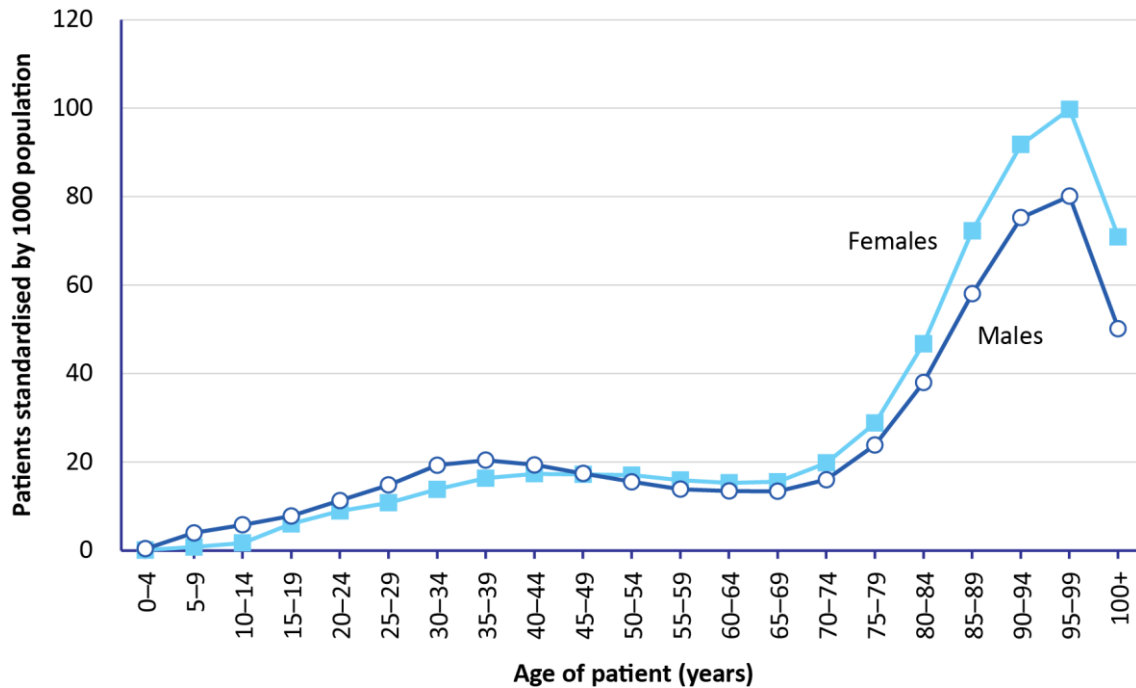


Source: Roughhead L. Presentation to Safety and Quality Partnership Standing Committee. 11 July 2014.

Note: “[...] DDD [Defined Daily Dose] is a unit of measurement and does not necessarily correspond to the recommended or prescribed daily dose (PDD) [...] Sales or prescription data presented in DDDs per 1000 inhabitants per day may provide a rough estimate of the proportion of the study population treated daily with a particular drug or group of drugs. As an example, the figure 10 DDDs per 1000 inhabitants per day indicates that 1% of the population on average might receive a certain drug or group of drugs daily.” (from *Introduction to drug utilization research*, World Health Organization, 2003).

The use of antipsychotics also has skyrocketed for elderly people. A person in their 80s is three times more likely to be taking antipsychotic medication than if they were in their 30s, 40s or 50s (see Figure 3.4). This indicates that medications are being used to manage behaviour for older people – a growing area of concern in relation to chemical restraint. In Volume 1, the Commission proposes that an independent group of experts be appointed to review the safety and efficacy of the use of medications as a means of restraining the behaviour of elderly people in their homes, including in residential aged care facilities (an action under our recommendations). This would build on the existing work of Alzheimer’s Australia on this issue.

Figure 3.4 Age-standardised rates of initiation of atypical antipsychotics, 2011



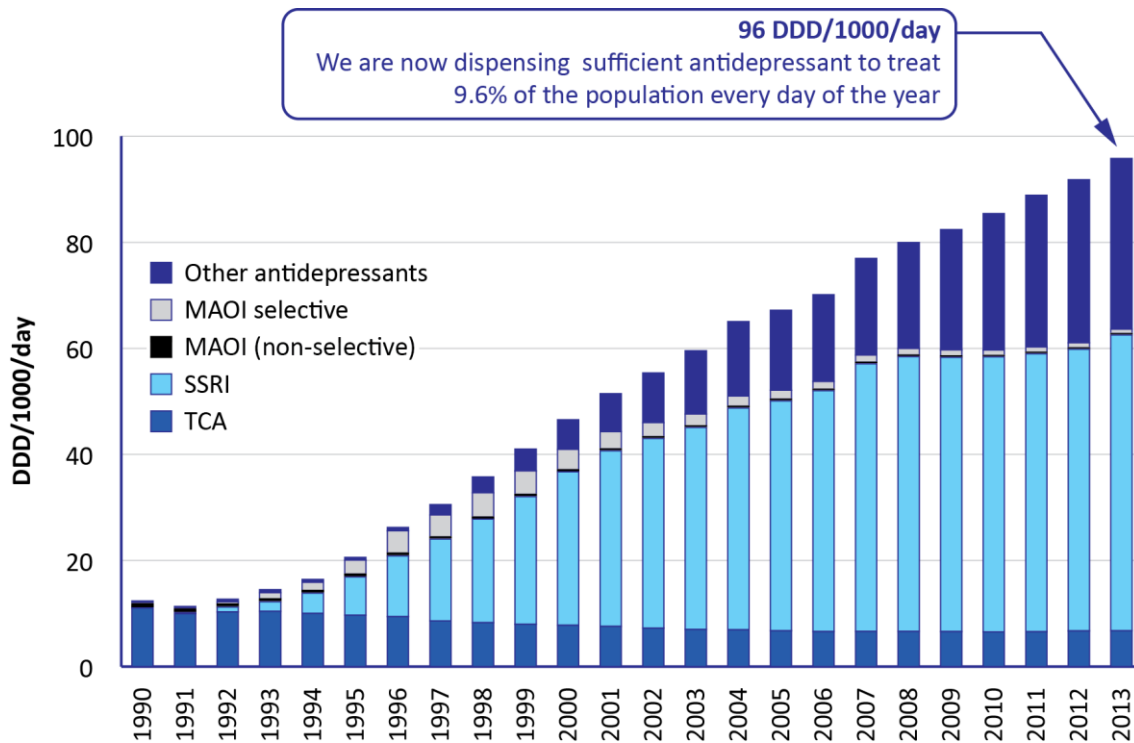
Source: Roughead L. Presentation to Safety and Quality Partnership Standing Committee. 11 July 2014.

In addition, the use of antipsychotics in children is increasing. The Commission questions whether this is being done with informed consent about the potential long-term side-effects and potential adverse impact of use of antipsychotics in children.

Antidepressant medications

Use of antidepressants has increased by 500 per cent since 1990 (see Figure 3.5).

Figure 3.5 Antidepressant use, 1990–2013



Source: Roughead L. Presentation to Safety and Quality Partnership Standing Committee. 11 July 2014.

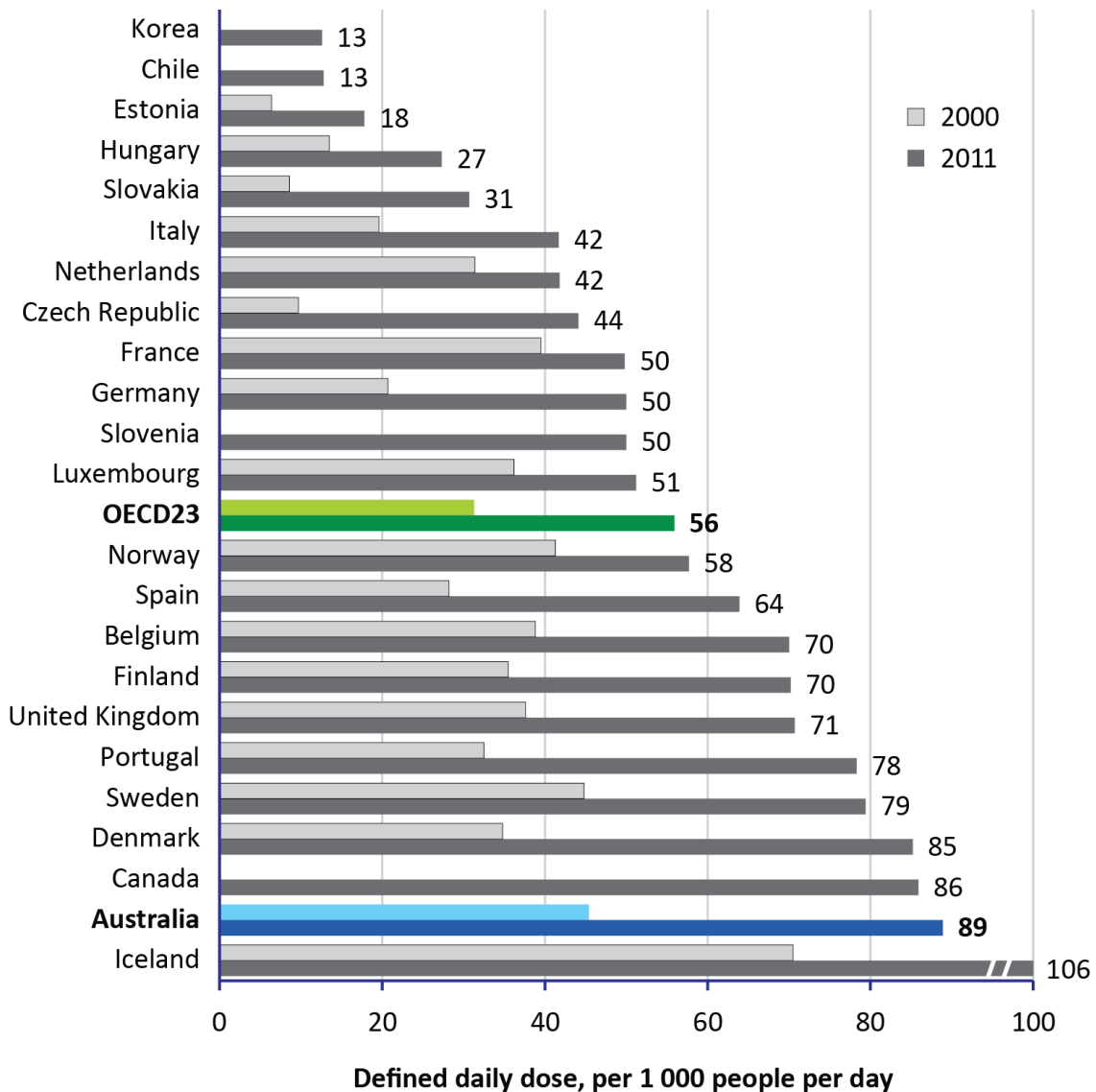
Note: “[...] DDD [Defined Daily Dose] is a unit of measurement and does not necessarily correspond to the recommended or prescribed daily dose (PDD) [...] Sales or prescription data presented in DDDs per 1000 inhabitants per day may provide a rough estimate of the proportion of the study population treated daily with a particular drug or group of drugs. As an example, the figure 10 DDDs per 1000 inhabitants per day indicates that 1% of the population on average might receive a certain drug or group of drugs daily.” (from *Introduction to drug utilization research*, World Health Organization, 2003).

In 2011 Australia ranked second-highest in an OECD comparison of antidepressants consumption, behind only Iceland²⁸ (see Figure 3.6). However, it should be noted that this comparison does not include the United States, which saw the rate of antidepressant treatment nearly double between 1996 and 2005.²⁹

The total volume of antidepressant use is suggestive of overuse, but the evidence on this is lacking. There is an important need to evaluate the best way to use antidepressants as a part of an integrated person-centered care plan. The major prescribers of pharmaceuticals for people with a mental health issue are GPs, who rightly are responsible for whole-of-person care. However, they could do with greater support, particularly when it comes to patients with multiple morbidities who may be on a range of medications, some of which may be contraindicated.

This particularly is the case for people with mental ill-health where there often are multiple co-morbidities and therefore multiple medications. This is complicated further by the fact that mental and physical health records can be kept in separate records so that knowledge of the complete history of medications is not always available to the treating practitioner.

Figure 3.6 International comparison of antidepressants consumption



Source: [OECD Health Statistics 2013](#)

Note: “[...] DDD [Defined Daily Dose] is a unit of measurement and does not necessarily correspond to the recommended or prescribed daily dose (PDD) [...] Sales or prescription data presented in DDDs per 1000 inhabitants per day may provide a rough estimate of the proportion of the study population treated daily with a particular drug or group of drugs. As an example, the figure 10 DDDs per 1000 inhabitants per day indicates that 1% of the population on average might receive a certain drug or group of drugs daily.” (from *Introduction to drug utilization research*, World Health Organization, 2003).

The Australian Medical Association and the Pharmaceutical Society of Australia are working on models which will enable a team-based approach where pharmacists work within general practice and assist in reducing prescribing errors, medication-related problems and adverse events.

The Commission proposes changes which will facilitate a greater integration of pharmacists as key members of the mental health care team.

More broadly, the Commission considers that the high levels of use of pharmaceuticals within the mental health system warrant system-wide evaluation. A review of cost effectiveness and efficacy should be undertaken, with results being used to determine the best approach to the

use of pharmaceuticals as part of a total package of care for people in the mental health system.

This includes a potential public education campaign to aid people experiencing mental ill-health in understanding that use of a mental health medication may not always be the best option.

Childhood trauma and later adult mental health

Childhood trauma in the form of abuse, emotional maltreatment and neglect outside of normal conduct can have a wide range of adverse outcomes for a child or young adult.³⁰ Researchers have found that childhood trauma can adversely affect key regions of a child's developing brain, which may leave them more vulnerable to a range of mental health issues in later life, including post-traumatic stress disorder (PTSD), anxiety and mood and adjustment disorders.³¹ A history of childhood trauma also has been found to predict whether a child ends up having contact with the mental health system,³² with some studies suggesting that people with a serious mental illness have prevalence rates of physical and sexual abuse between 37 and 47 per cent.³³ However, it is also apparent that not all children who experience trauma go on to develop mental health issues in later life.³⁴

In a 2010 review of the prevalence of child abuse and neglect in Australia, the Australian Institute of Family Studies cites a range of Australian studies with prevalence estimates for various forms of childhood abuse between 5 and 11 per cent.³⁵ In the case of witnessing family violence, the institute concludes that the best available evidence suggests that the prevalence rate for this form of childhood trauma is higher; somewhere between 12 and 23 per cent.³⁵

In particular, trauma and mental health problems in Aboriginal and Torres Strait Islander children are often undetected, or frontline staff and services do not know how to intervene effectively. Instead, a child might be placed in the 'too-hard basket' because of aggressive behaviour and low educational attainment, rather than this being understood as distress.

AIHW statistics on notifications of suspected child abuse and neglect made to state and territory authorities are another source of information on the potential level of childhood trauma in Australia. In 2012–13 there were nearly 273 000 notifications of suspected abuse or neglect involving more than 184 000 children – a rate of 35.5 per 1000 children in Australia.³⁶ (Not all of these children will have been maltreated, as state and territory authorities are required to act when children also are at risk of being harmed.)

There has been a variety of policy and service responses to the later impacts of childhood trauma. Specific models of care have been designed to meet the needs of people who have experienced trauma in their early life — typically referred to as Trauma-Informed Care and Practice (TICP).³⁷ Other efforts have taken a prevention approach by offering parenting programs to high-risk groups; for example, the Triple P (Positive Parenting Program). Research on this program concludes that participant parents report being less stressed and depressed, and for their children there are reduced rates of child abuse, reduced foster care placements and decreased hospitalisations from child abuse injuries.^{38, 39} Media-based advertising campaigns to raise awareness about child abuse and neglect also have proven effective.⁴⁰

Nationally, at a policy level, the public health model for children and maltreatment is the dominant model of child protection, as seen in the National Framework for Protecting Australia's Children 2009–2020 (COAG, 2009). This document does address the increased risk of poor health and wellbeing, both in childhood and later life.

During the past decade there has been rapid progress in the understanding of the effects of exposure to traumatic life experiences on subsequent psychopathology in children. Changing adult and primary caregiver behaviour can increase mental health and wellbeing development in children. In order to meet this challenge, we need to think in more integrated and innovative ways to ensure infants and children have improved chances of good mental health and wellbeing in later life.

Intellectual disability and mental health

Intellectual disability often co-occurs with mental health problems,⁴¹ but the two usually are treated in isolation. Often the mental health needs of a person with an intellectual disability go unrecognised. There are a limited number of professionals with knowledge of how mental health problems can manifest in this group of people. An Australian study which followed people with an intellectual disability for 14 years found that during the entire period, only 10 per cent of those who also had a mental illness received access to an intervention for that illness.⁴² Addressing problems in isolation in this manner does not improve overall quality of life because the difficulties posed by other problems continue.

‘Communication between the mental health and disability sector is often very poor ... generic mental health services are reluctant to become involved with a person with [intellectual disability and mental health problems]. The conclusion drawn by these services ... is that “it’s not mental health, it’s behavioural.” Consequently, services advocate that this group is not their concern, despite evidence to the contrary.’

Submission from Queensland Centre for Intellectual and Developmental Disability (QCIDD)

Multiple research groups dedicated to intellectual disability research, as well as several professional peak bodies, submitted recommendations to the Review for improved service responses to these co-occurring needs. These included a cross-agency agreement for collaborative working—including a shared care plan—between disability and mental health services; a national network of medical and allied health professionals who have expertise in intellectual disability and mental health to act as a consultancy to ‘mainstream’ mental health services; mandatory basic training in intellectual disability for frontline health workers and mental health professionals; measures within mental health organisations to address inequity of access for people with an intellectual disability; improved epidemiological data collection and linkage; and greater research into the experiences and needs of people with co-occurring intellectual disability and mental illness.

Specialist intellectual disability services and professionals are lacking across Australia, but we have received evidence of promising approaches being used on a limited scale. In South Eastern Sydney and Illawarra Local Health District, for example, multi-disciplinary teams with expertise in all areas of intellectual disability health, including mental health, have been established and driven by local clinicians with an interest in intellectual disability. Such comprehensive integrated approaches to intellectual disability health need to be recognised and encouraged at a national level.

Substance misuse and mental health

The service silo approach is repeated when responding to the needs of people who experience both substance misuse and mental illness. In the case of co-occurring substance use, the existence of one problem often excludes a person from help for the other problem, a practice related to separate funding streams and policy development.

Drugs and alcohol can exacerbate or induce mental illness, while self-medication to escape the effects of mental illness can lead to drug or alcohol addiction. The combination creates up to a 20-year reduction in life expectancy⁴³ compared to the general population, and is associated with homelessness and prison experience as well as poor outcomes on a range of physical health indicators (including being twice as likely to become a smoker).⁴⁴

The ‘no wrong door’ philosophy of support for these interrelated needs suggests that wherever a person seeks help, they should receive a holistic service which addresses their needs concurrently. This philosophy is not translated into practice, however. Only one in seven people with a substance misuse disorder and a mental health problem receives support for both problems.⁴⁵

Where to from here – implications for reform

Based on the evidence we have collected for this Review—from personal testimonials to formal evaluations—we can identify three key principles for reform to achieve person-centred mental health services and programmes.

- Listening to the voices of people with lived experience, their families and other support people is integral to the effort to make programmes and services person-centred. People who use these programmes and services usually know what helps and what harms – and their message to us has been consistent and clear. It is simple: respect us, work with us, inform us and see our potential.
- Cross-sectoral and interdisciplinary planning and working, from the national policy level down to the individual professional level, is essential both to improving whole-of-life outcomes and to making cost-effective investment in mental health. Without collaboration across traditional silo boundaries, we can only treat the person as a collection of separate ‘problems’ rather than a whole person with hopes, strengths and aspirations. This is not what they want, and it is not what the taxpayer wants.
- Recognising and appropriately responding to each person’s individual circumstances requires tailoring support to be sensitive to their past and present experiences and challenges. It also requires an understanding that interrelated needs have to be considered as a package – tackling one without the others will not improve overall quality of life.

Without cross-portfolio planning and by continuing to work through problems in silos we will make little progress in supporting people with a lived experience of a mental illness and their families to lead contributing lives.

Actions

- **Employment:** develop partnerships between governments and businesses to ensure that meaningful employment is equally accessible, whether someone has a mental health difficulty or not. Bring Australia up to the standard of the OECD countries which have high rates of employment for people with disabilities. Support carers into employment at the same time as the people they are caring for are being supported into employment.
- **Education:** ensure that schools, universities and colleges are supported to build a mentally healthy and open culture which discourages discrimination and supports help-seeking, and to recognise when a student is struggling with their mental health. Flexible pathways through education which ensure that mental illness is no barrier to achieving academic, sporting or vocational potential require further development. Integrate existing programmes within education to better target outcomes in this sector to ensure that the current service gap for children with emerging or established difficulties is closed.
- **Children:** support the resilience and wellbeing of children through engagement with new parents, preschools and primary schools to maximise development. Support adults to increase mental health literacy and resilience.
- **Housing:** build on the success of initiatives such as Housing First and Adelaide's Common Ground, recognising that initial expenditure will be more than offset by savings in use of crisis and inpatient services.
- **Justice system:** scale-up court diversion and justice reinvestment schemes to ensure that people whose criminal behaviour is prompted by a struggle with mental illness and/or addiction are diverted to therapeutic rather than custodial interventions.
- **Personal supports:** ensure that consumer-identified family or other informal caregivers are given the information and support they need to fulfil their role and stay healthy themselves. Opportunities to prevent intergenerational effects of mental illness also be recognised.
- **Interrelated needs:** explore opportunities for joint care planning between mental health and intellectual disability services, and between mental health and substance use services, to provide a truly 'no wrong door' holistic response to people with concurrent needs.
- **Interrelated needs:** increase community awareness of and action on evidence about what occurs to children before they are born and how their early years can affect their health, mental health and wellbeing and opportunities later in life, to support a focus on prevention.
- **Aboriginal and Torres Strait Islander peoples:** Dedicated, national Aboriginal and Torres Strait Islander mental health planning and service and programme design is needed because mainstream mental health policy, service and programme design is, in general, not appropriate for Aboriginal and Torres Strait Islander peoples and does not support an effective patient transition through the system.
- **Specific mental health challenges:** support the development of gender-sensitive inpatient units, expand training and development to ensure truly trauma-informed mental health services, and ensure that gaps in knowledge about and services for LGBTI communities and older people are addressed.

Confronting the myths

Myth	Reality
Mental health is not my issue: it concerns other people but doesn't impact on me or my family	This is a mainstream issue—mental health is not something that is lurking in the shadows: it impacts on all of us and we need to get used to dealing with it as a day to day part of our lives, our schools, our workplaces, and our society
The mental health sector is highly divided on what needs to change: it is characterised by deeply held divided views about what needs to change	Those in the mental health sector, particularly consumers and carers, generally agree on the directions for change—it is not a divided sector as some make out, the policy directions are clear, it is simply the implementation (strategy execution) which has been lacking, with the result that we have a highly fragmented and unfair system
It is not possible to identify those who may develop a mental illness	Future predictors of potential future mental health problems often show up very early as behavioural problems in children, and again often are identifiable among adolescents and young people. Early identification enables early intervention to prevent future illness and resultant complications.
If you develop a mental illness, it is with you forever	Mental ill-health is not a lifetime sentence: Much mental ill-health can be prevented and treated. People do recover. Treatment and support can reduce the onset and impact of more severe mental illness.
Mental illness is genetic	Like physical illness, there are some genetic factors which put people at more risk than others for some mental illnesses. However the right environment, early intervention and treatment can prevent, delay or diminish illness.
People with a mental illness are dangerous	Very rare. Most people with a mental health problem operate within the community, go to school and work with others, and want the same things out of life as everyone else does.
Mental health is not a problem for my workplace	Mental health issues are costing employers in the vicinity of \$11 billion each year. Given one in six people in employment will experience a mental health issue every year, and almost one in two over their lifetime, then even small businesses are likely to employ people with a mental health issue. Without proper support, this can result in high levels of absenteeism, presenteeism, and overall lost productivity, as well as workers compensation claims. But there is help available to support employers, employees and workmates.

Confronting the myths

Myth	Reality
Mental health is too hard—it can't change	The mental health system can change and improve—it is not “all too hard”, it has changed in the past and continues to change, and there are countless people who are ready and willing to champion the change.
Mental and physical health are totally separate issues and should be treated as such	There is considerable overlap in many factors which impact on wellbeing—both physical and mental. In addition, many people with complex chronic conditions often have a mixture of mental and physical health problems. As physical health worsens, the odds of having mental illness increase. There is overwhelming evidence for integration of approaches to physical and mental health—to overall wellbeing.

Source: concept designed by The National Mental Health Commission 2014

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Chapter 4: Aboriginal and Torres Strait Islander peoples' mental health

This chapter addresses the urgent and evident need to deliver better outcomes for Aboriginal and Torres Strait Islander peoples to improve their social and emotional wellbeing.

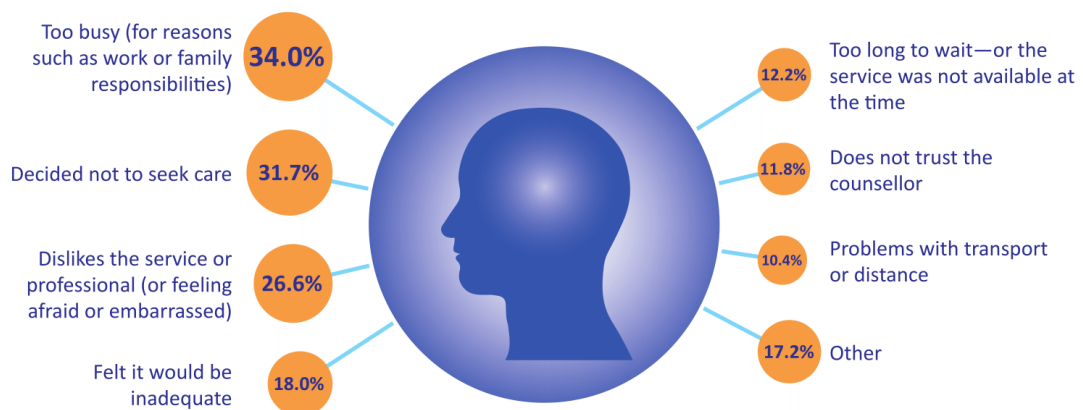
Term of Reference

Specific challenges for Aboriginal and Torres Strait Islander people.

Aboriginal and Torres Strait Islander Health and Wellbeing

- 10 years** The **LIFE EXPECTANCY** for Aboriginal and Torres Strait Islander people is still around **10 YEARS LOWER** than for other Australians
- 2.7 times** Aboriginal and Torres Strait Islander adults are **2.7 TIMES MORE LIKELY TO HAVE HIGH/VERY HIGH DISTRESS LEVELS**, compared with their non-Indigenous counterparts
- 38 per cent** Of all Aboriginal and Torres Strait Islander people aged 15 years and over, **38.1% HAD EXPERIENCED AT LEAST THREE 'LIFE' STRESSORS** in the previous 12 months. For example, death of a family member, serious illness, or inability to get to work.
- 27 per cent** In 2012, **27 PER CENT OF THE ADULT PRISON POPULATION** were Indigenous
- TWICE as high** From 2001–2010, **SUICIDE RATES** amongst the Aboriginal and Torres Strait Islander population were around **TWICE AS HIGH** as they were amongst the non-Indigenous population

In 2012–13 Aboriginal and Torres Strait Islander people reported that they did not go to a counsellor despite reporting the need to see one because...



Sources: National Aboriginal and Torres Strait Islander Health Survey 2012–13, Prisoners in Australia, 2012, Australian Bureau of Statistics (unpublished)

This chapter considers the challenges for Aboriginal and Torres Strait Islander peoples' mental health. It documents the mental health gap which underlines the necessity for COAG and the Commonwealth to commit to include, under Closing the Gap, an indicator for mental health and prepare a national Aboriginal and Torres Strait Islander peoples' mental health plan. This would be developed in consultation with Aboriginal and Torres Strait Islander people and national advisory committees.

What is happening now

Around three per cent of the Australian population (approximately 670 000 people) identify as being of Aboriginal or Torres Strait Islander origin (2011 Census)¹ and they fare badly on most high-level outcome indicators such as life expectancy, mortality, educational attainment and other measures of wellbeing.²

The recently released sixth report in the Overcoming Indigenous Disadvantage (OID) series measures the wellbeing of Aboriginal and Torres Strait Islander Australians. The report highlights that outcomes have worsened in some areas:²

- For the period 2008–2012, the rate of deaths from suicide for Aboriginal and Torres Strait Islander Australians was twice the rate for non-Indigenous Australians.
- Suicide rates were highest for Aboriginal and Torres Strait Islander people aged 25–34 years (39.9 deaths per 100 000 population), around three times the rate for non-Indigenous Australians of the same age. There was no difference in rates between Aboriginal and Torres Strait Islander and non-Indigenous people aged 45 years and over.
- From 2004–05 to 2012–13, the hospitalisation rate for intentional self-harm increased for Aboriginal and Torres Strait Islander Australians by 48.1 per cent, while the rate for other Australians remained relatively stable. The rate for Aboriginal and Torres Strait Islander Australians increased from 1.7 to 2.7 times the rate for other Australians.
- The adult imprisonment rate increased 57 per cent between 2000 and 2013. Juvenile detention rates increased sharply between 2000–01 and 2007–08 and have fluctuated since at around 24 times the rate for non-Indigenous youth.

The OID report also presents a picture on related indicators where no change—that is, no improvement—has occurred.

- On education standards, there was virtually no change in the proportions of students achieving minimum standards for reading, writing and numeracy from 2008 to 2013.
- There remained relatively high rates of family and community violence, with no improvement between 2002 and 2008.
- There was little change in alcohol and substance use and harm over time.
- Relatively high rates of disability and chronic disease have not improved.

On some indicators, such as life expectancy and child mortality, there has been progress in Closing the Gap. Educational attainment and employment indicators have improved, but remain well behind those of non-Indigenous people.

The Review commissioned research and consultation and sought advice on the needs of Aboriginal and Torres Strait Islander peoples and the current state of play in the system. The consultants worked closely with the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory group to the Commonwealth and with the National Aboriginal and Torres Strait Islander Leadership in Mental Health group that advises the mental health commissions of Australia. They also consulted subject matter experts and key stakeholders, conducted a literature review, stakeholder interviews and a review of Aboriginal and Torres Strait Islander-related submissions.

Highlights of that report showed:

- There is a significant mental health gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous people—with higher rates of psychological distress, hospitalisation for mental illnesses and deaths from intentional self-harm reported.³
- Stressful life events are experienced at high rates. In the 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey, (AATSIHS) 73 per cent of respondents aged 15 years and over reported that they, their family or friends had experienced one or more stressful life events in the previous year.⁵ That is 1.4 times the rate of non-Indigenous people. Stressful life events can include serious illness and accidents, the death of a family member or close friend, divorce or separation and not being able to get a job.⁶ Stressful life events and psychological distress are linked: experiencing between 1.9 and 2.6 overlapping stressful life events is associated with mild or moderate psychological distress, and between 3.2 and 3.6 events is associated with high or very high psychological distress.⁷
- Psychological distress levels are rising. In 2012–13, 30 per cent of respondents to the Australian Aboriginal and Torres Strait Islander Health Survey over 18 years of age reported high or very high psychological distress levels in the four weeks before the survey interview.⁵ That is nearly three times the non-Indigenous rate. In 2004–05, high and very high psychological distress levels were reported by 27 per cent of respondents, suggesting an increase in Aboriginal and Torres Strait Islander psychological distress rates over the past decade.⁵

But despite having greater need, Aboriginal and Torres Strait Islander people experience lower access to needed mental health services. Among the 27 per cent of those adults who reported high/very high levels of psychological distress in the NATSISS 2008, 38 per cent were unable to work or carry out their normal activities for significant periods of time because of their feelings.

In part this is because of the way general population services and programmes are designed. In particular, they do not work within a broader context of social and emotional wellbeing as understood by Aboriginal and Torres Strait Islander people, often referred to as cultural competence.

Further, such services do not ensure a connected transition through the mental health system for Aboriginal and Torres Strait Islander peoples and, in particular, between the primary mental health components (mainly funded by the Commonwealth) and specialist clinical services components (mainly delivered by the states and territories).

A lack of focus on primary mental health care, including promotion, prevention, early detection and treatment in primary health care settings, leads to significantly higher per capita levels of expenditure on acute inpatient care; the most expensive part of mental health treatment.

Aboriginal and Torres Strait Islander people are proportionally over-represented in mental health-related hospitalisations, with specialised psychiatric care accounting for 4.9 per cent of these hospitalisations in 2012–13. They had a hospitalisation rate that was over double that of non-Indigenous people (12.7 and 6.3 per 1000 population respectively).⁴

Current national approaches to addressing these gaps and poor outcomes

The National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes contributed approximately \$1.6 billion over four years, which included, among other health measures, the Indigenous Chronic Disease Package. The cost savings in addressing mental health, as part of an overall approach to chronic disease, are yet to be quantified here. The agreement expired in June 2013.

The COAG Roadmap for National Mental Health Reform 2012-22 committed to ‘Improve the mental health and social and emotional wellbeing (SEWB) of all Australians’⁹. This was recognition, at the highest level of governments, that the concept of SEWB underpinned any pathway to improving outcomes for Indigenous people. The SEWB concept acknowledges the importance of employment, housing and education to wellbeing.¹⁰ It committed governments to taking a whole-of-government approach at Commonwealth and state and territory levels.

At the time of writing, there are a number of unimplemented or unreleased strategic responses to Aboriginal and Torres Strait Islander mental health and related issues.

- The unimplemented National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013 was released in May 2013 and has \$17.8 million pledged against it.
- In July 2014 the Australian Government announced a review and implementation strategy for the Aboriginal and Torres Strait Islander Health Plan 2013-2023, in partnership with Aboriginal and Torres Strait Islander health leadership bodies. While the review phase is under way, implementation is yet to begin. The plan is not focused on mental health, although it does propose some action in relation to it.
- A National Aboriginal and Torres Strait Islander People’s Drug Strategy is in development.

Perhaps the most important strategic response is the National Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing Framework (the Framework) that is currently in development.

This unusual conjunction of unimplemented and overlapping strategic responses provides a unique opportunity to develop a dedicated, overarching national Aboriginal and Torres Strait Islander mental health plan based on the Framework, but that maintains the priority focuses of the individual strategies.

This would allow for a coordinated implementation of all four strategic responses and would maximise efficiencies. It also could support the Indigenous Advancement Strategy (as referred to below) and the COAG Closing the Gap targets and framework.

The draft National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2014-19 identified key action areas at system level. These were further prioritised as the ‘top five’ issues by the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG).

These top five issues were articulated as follows:

- strategies to promote the healing and wellbeing of communities, families and individuals

- promoting mental health and social and emotional wellbeing across the life course, with a focus on younger age groups
- prevention strategies to detect and manage risks to mental health
- clinical and culturally appropriate treatment of mental health problems and mental illnesses
- promoting the social and emotional wellbeing of those with ongoing and severe mental illnesses to assist with recovery and relapse prevention.

Other national frameworks and plans, which are either endorsed or in the process of early implementation, are:

- The Indigenous Advancement Strategy (IAS) streamlined more than 150 individual programmes and activities into five broad-based programmes to make it easier for organisations delivering important services in communities. The total Indigenous-specific funding through the Prime Minister and Cabinet portfolio is \$8.5 billion.
- The Indigenous component of the National Suicide Prevention Strategy (NSPS). Commonwealth initiatives for suicide prevention totalled \$68.8 million in 2012–13. Expert advisers engaged by the Commission found in their analysis that around 12.7 per cent of this allocation (\$8.7 million) targeted the needs of Aboriginal and Torres Strait Islander people.

Key findings

We found that the high rates of mental health problems reported among Aboriginal and Torres Strait Islander peoples encompass a range of other challenges and disadvantage. This includes higher rates of chronic disease, unemployment, family breakdown, alcohol and other drugs abuse, smoking, and high rates of imprisonment and crime victimisation.

Further, the burden of mental health problems and mental illness is far greater than existing services and programmes can realistically address. The current suite of services and programmes is neither cost-effective nor efficient at the macro, or system, level because of problems at service and programme level.

This is partly due to the design of individual services and programmes. In particular, they do not work within a broader context of social and emotional wellbeing (SEWB) as understood by Aboriginal and Torres Strait Islander people and that requires consideration, not only of the mental health of individuals, but of their broader wellbeing and that of their families, communities and cultures.

Coordination and collaboration—how services and programmes work together— is lacking. There is no connected journey through the mental health system for Aboriginal and Torres Strait Islander peoples and, in particular, between the primary mental health components (mainly funded by the Commonwealth) and specialist clinical services (mainly delivered by the states and territories).

Compounding the above problems, the Review identified significant limitations with policy implementation and monitoring. Dedicated, national Aboriginal and Torres Strait Islander mental health planning and service and programme design is needed because mainstream mental health policy, service and programme design is, in general, not appropriate for Aboriginal and Torres Strait Islander people. The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2014-2019* provides the basis for such planning and service and programme development.

The Review findings are presented below in five areas, reflecting where action is required:

- social and emotional wellbeing
- underlying disadvantage which has direct connection to the mental health status of Aboriginal and Torres Strait Islander people
- mainstream services capability and accountability for service delivery to Aboriginal and Torres Strait Islander people
- effectiveness of dedicated services and programmes for Aboriginal and Torres Strait Islander people
- limitations with policy implementation and monitoring.

Social and emotional wellbeing

Social and emotional wellbeing (SEWB) is critical to Aboriginal and Torres Strait Islander mental health service and programme delivery.

For Aboriginal and Torres Strait Islander people, as for non-Indigenous people, the SEWB concept acknowledges the importance of employment, housing and education to wellbeing.¹⁰ Additionally, it takes into account:

- the unique historical events and present day social determinants faced by Aboriginal and Torres Strait Islander people
- cultural differences, in particular the unique structures and belief systems underpinning family, community, culture and cultural practice, relationships to country and spirituality (including ancestors).¹⁰

It is a 'whole-of-life' perspective on wellbeing that includes mental health, but is not limited to it, or equivalent to it. However, for Aboriginal and Torres Strait Islander peoples' mental health, SEWB is critically important for two reasons.

First, as a source of resilience.¹¹ Resilience is important because Aboriginal and Torres Strait Islander peoples experience adverse childhood events and stressful life events at higher rates than non-Indigenous people. Further, these stressful and traumatic life experiences tend to occur concurrently and have a cumulative impact.¹⁰ For Aboriginal and Torres Strait Islander people, mental health promotion and a good deal of prevention is about strengthening SEWB to provide the resilience needed to cope with the unique and greater rates of stressful life events they face.

Second, because as with Aboriginal and Torres Strait Islander health in general, a 'whole-of-person' approach that includes working with cultural needs should underpin mental health service and programme delivery for Aboriginal and Torres Strait Islander people. This includes, but is not limited to, ensuring mainstream mental health practitioners, services and programmes are culturally competent and culturally safe.

Underlying disadvantage and co-morbidities influencing mental health status

Mental health problems and mental illness are connected to other forms of Aboriginal and Torres Strait Islander disadvantage. There are high costs associated with these.

Chronic disease

Much of the current national focus around Aboriginal and Torres Strait Islander disadvantage is drawn to the impacts of chronic disease.

Research over the past decade suggests a chain of causation may be present between mental health conditions (in particular, serious psychological distress) and chronic disease. The 2014 'Reeve Study' correlated data from the 2004–05 ABS *National Aboriginal and Torres Strait Islander Health Survey* and the 2004–05 ABS *National Health Survey*¹² to make some significant findings as to what was required to close the diabetes gap.

Among other findings, it found an association between people who self-reported diabetes and those who reported the forced removal of relatives. It described the finding as 'consistent with emerging evidence that serious psychological stress contributes to a range of health problems and may be involved in the development of risk factors for metabolic syndrome, including raised blood glucose'.¹²

Regardless of the causal link, mental health conditions must be considered as significant co-morbidities with chronic disease that can prevent the effective treatment of chronic disease and are associated with increased exposure to risk factors for chronic disease.¹³

Employment

Among the 27 per cent of Aboriginal and Torres Strait Islander adults who reported high and very high levels of psychological distress in 2008, 38 per cent were unable to work or carry out their normal activities for significant periods of time because of their feelings.¹⁴

These findings are echoed by studies in the general population. In particular, a 2013 review by the Mental Health Commission of NSW cited the evidence for the costs and impacts on the economy and productivity due to mental ill-health. This reported that high psychological distress increases work absenteeism and decreases employee performance at work by 6.1 per cent, resulting in a net productivity loss of 6.7 per cent.¹⁵ A 2010 report estimated that psychological distress produces a \$5.9 billion reduction in Australian employee productivity per annum.¹⁵ This is further explored in Chapter 3. This is in addition to the billions of dollars spent annually on mental health services and programmes, including those on Aboriginal and Torres Strait Islander peoples.

Alcohol and other drugs

High alcohol consumption and at-risk drinking can have harmful short and long-term effects on a person's physical, social and mental health and safety.¹⁶ Conversely, alcohol and other drug use can lead to mental health problems and mental illness.

Of great concern is what could be referred to as 'daily binge drinking'. The COAG Reform Council 2012 report on Closing the Gap targets reported that approximately 14 per cent of Aboriginal and Torres Strait Islander men and 12.7 per cent of non-Indigenous men aged 15 and over were drinking an average of more than five standard drinks per day in 2011–12.¹⁷ A significantly larger proportion of Aboriginal and Torres Strait Islander men (8.1 per cent) than non-Indigenous men (6.1 per cent) were drinking more than seven standard drinks per day.¹⁷

While figures for Aboriginal and Torres Strait Islander peoples are not available, in 2004–05 the annual economic cost of alcohol and illicit drug misuse to Australian society was estimated at \$55.2 billion.¹⁸ Leading researchers Collins and Lapsley found that alcohol misuse cost society \$15.3 billion and illicit drugs cost \$8.2 billion, while alcohol and illicit drugs acting together accounted for a further \$1.1 billion.¹⁸ If the costs to Aboriginal and Torres Strait Islander peoples are roughly calculated by use of a 2.5 per cent population measure (as estimated in the 2006 Census) the costs would amount to \$675 million.

Alcohol and other drugs measures and services

The Central Australian Aboriginal Congress, in its Review submission, provided evidence that alcohol supply reduction measures were particularly cost-effective in the primary and secondary prevention of mental illness. In particular, in Alice Springs:

- there has been a ten per cent decrease in alcohol consumption, which has prevented a large number of hospital admissions, including admissions for assault
- as a result, children are less exposed to the type of violence and trauma, which the Californian Adverse Early Childhood study has demonstrated leads to the development of mental illness, especially depression in later life.

Significant gaps were identified in the availability of drug and alcohol services, including detoxification and rehabilitation facilities, treatment programmes and services to support clients with dual diagnoses. This was particularly so in rural and remote communities.

There was strong support for integrating drug and alcohol services alongside primary mental health and social and emotional wellbeing services to support comprehensive primary health services delivered within Aboriginal Community Controlled Health Services.

Submission from the Central Australian Aboriginal Congress

High rates of imprisonment

Twenty-seven per cent of the adult prison population is Indigenous¹⁹—drawn from just three per cent of the overall population.¹ Of particular concern is the significant over-representation of Aboriginal and Torres Strait Islander youth within juvenile detention centres, where they represent 54.7 per cent of juvenile detainees (approximately 460 people).²⁰ Further, Aboriginal and Torres Strait Islander young people aged 10 to 17 years were 28 times more likely to be in detention than non-Indigenous people that age, and 16 times more likely to be under community-based supervision in 2012–13.²⁰

As noted in the Commission's 2012 Report Card, a 2008 survey in Queensland found most male (72.8 per cent) and female (86.1 per cent) Aboriginal and Torres Strait Islander prisoners had suffered from at least one mental health condition in the preceding 12 months;⁸ and 12.1 per cent of males and 32.3 per cent of females with post-traumatic stress disorder (PTSD).⁸ In turn, mental health conditions are associated with high incarceration rates. A 2009 survey of NSW prisoners reported that 54.9 per cent of Aboriginal men and 63.3 per cent of Aboriginal women reported an association between drug use and their offence.²¹ In the same sample group, 44.5 per cent of men and 51.9 per cent of women self-reported they had been assessed or treated for an emotional or mental health conditions.²²

In a recent Senate Legal and Constitutional Affairs References Committee report, *Value of a justice reinvestment approach to criminal justice in Australia*, released in June 2013²³, the economic costs of imprisonment were estimated at:

- \$226 per day for an adult prisoner (\$82 490 per annum)
- \$624 per day for juvenile detention detainee (\$227 760 per annum)
- \$77 per day for community custody (\$28 105 per annum).

Further attention is required by mainstream services to the mental health needs of Aboriginal and Torres Strait Islander people in custodial care. A justice reinvestment programme for these detainees should be introduced to reduce the risk of reoffending and minimise future custodial

care outlays. Such a programme is an excellent example of an “invest to save” approach. Reducing recidivism is good for people and for taxpayers. It could also be extended to more youth mental health services in Aboriginal and Torres Strait Islander communities.

Mainstream services capability and accountability

There are four broad categories of service accessed by Aboriginal and Torres Strait Islander people seeking support for their mental health. These are:

- community-based Indigenous Primary Health Care Organisations (IPHCOs) and Aboriginal Community Controlled Health Services (ACCHS), largely funded by the Commonwealth
- mainstream general practice and primary health care services
- specialist clinical mental health services
- specialist non-clinical mental support services.

It is not possible to identify what proportion of the approximately \$9.6 billion spent by the Commonwealth on the above mental health programmes and services in 2012–13 (in addition to state and territory contributions) is reaching Aboriginal and Torres Strait Islander people.

The principal organisational types favoured for Commonwealth funding under the mainstream mental health programme design rules are:

- individual clinicians (e.g. MBS for psychologists)
- Medicare Locals (e.g. the Access to Allied Psychological Services programme)
- a combination of Medicare Locals or nongovernment organisations (e.g. Partners in Recovery and Personal Helpers and Mentors programme).

Several of these programmes cannot routinely or accurately advise what proportion of Aboriginal and Torres Strait Islander people use their services, despite the high level of need of this population group. For example, the level of use of MBS psychology services by Aboriginal and Torres Strait Islander people is not known.

However, it is clear that the greater levels of need described above are reflected in higher per capita levels of expenditure on acute inpatient care, the most expensive part of mental health treatment.

The ratio of Aboriginal and Torres Strait Islander per capita hospital expenditure in 2010–11 compared with other Australians was:

- 2.68 to 1 for all mental health and behavioural disorder hospitalisations (\$336 per capita Aboriginal and Torres Strait Islander people; \$125 per capita non-Indigenous)
- 1.65 to 1 for anxiety and depression hospitalisations (\$53: \$32)
- 3.97 to 1 for alcohol dependence and other harmful use (\$37: \$9)
- 2.58 to 1 for self-inflicted injuries, an indicator of attempted suicide (\$19:\$7).²⁴

headspace

One area where there is some clarity around service usage is in relation to headspace services. Youth mental health services and programmes are of great importance to Aboriginal and Torres Strait Islander people, with 64 per cent of the population under 30 years of age. Data provided by headspace shows that approximately seven per cent of all headspace-serviced clients for the period June to December 2013 identified as Aboriginal and Torres Strait Islander. The following description is an abridged excerpt from the [headspace website](#) (2014):

Yarn Safe

For this project, headspace worked with a group of Aboriginal and Torres Strait Islander young people from across Australia and the Indigenous-specific advertising agency, Gilimbaa, to develop this campaign.

The campaign's aims are to increase the awareness of headspace as a place for Aboriginal and Torres Strait Islander young people to seek information, help and support. Common themes emerged from the workshop, including:

- The lives of Aboriginal and Torres Strait Islander youth and the issues they are facing are many and varied, complicated and serious.
- Mental health issues are having dramatic and devastating effects on communities across the country, from cities to remote areas.
- There is shame around asking for help.
- There is stigma around the language used in mental health.

Key themes emerged around critical areas related to health and wellbeing:

- identity
- culture
- relationships
- responsibility
- stress and pressure
- alcohol and other drugs
- family
- racism
- community

Aboriginal and Torres Strait Islander people will have an ongoing need to access specialist mental health services funded and operated by state and territory public health services. As such, the application of the 'one-size-fits-all' approach should be avoided as it is wasteful use of resources and unable to meet the needs of Aboriginal and Torres Strait Islander people.

In particular, there is a need for more training in delivering culturally competent and culturally safe services. This training needs to include clinicians in general practice, other primary health care settings and specialist mental health services. Training should be extended to workforce categories that support the care of Aboriginal and Torres Strait Islander people, including medical clinic receptionists, hospital admission staff, orderlies and pharmacy staff.

An important issue identified in submissions to the Review and in commissioned research was how mainstream services and programmes work together to ensure a connected journey through the mental health system for Aboriginal and Torres Strait Islander peoples. In particular, coordination between the primary mental health components (mainly funded by the Commonwealth) and specialist clinical services components (mainly delivered by the states and territories) was lacking.

Effectiveness of dedicated services and programmes

In contrast to mainstream mental health services, the Review was able to identify Commonwealth mental health and related grants that were specifically targeted to Aboriginal and Torres Strait Islander people to a value of \$123.1 million in 2012–13.²⁵ In addition to some smaller programmes, the main recipients of these funds are as follows:

- the Social and Emotional Wellbeing (SEWB) Programme delivered by Indigenous Primary Health Care Organisations
- the Access to Allied Psychological Services (ATAPS) programme.

Social and Emotional Wellbeing Programme delivered by Indigenous Primary Health Care Organisations (IHPCOs)

There are 260 Indigenous Primary Health Care Organisations (IPHCOs) funded by the Commonwealth to provide health services in the community for Aboriginal and Torres Strait Islander people and the majority are Aboriginal Community Controlled Health Services. These deliver primary health and mental health services, particularly those with GPs. As in the wider community, GPs are usually the first health service visited by a person with a health concern, including a mental health issue.

The IPHCOs also deliver what was known until recently as the Social and Emotional Wellbeing Programme. This comprises:

- *Link Up Services* – These provide family tracing, reunions and counselling for members of the Stolen Generations (\$12.7 million in 2012–13 for 20 grants). Link Up services aim to work closely with SEWB counselling services and other organisations to assist clients to reunite with their families, culture and community, and restore their social and emotional wellbeing wherever possible. Link Up services are either stand-alone organisations or are positioned within a larger organisation such as ACCHOs.²⁵
- *SEWB Counselling Services* – These were previously funded as Link Up counsellors, Bringing Them Home (BTH) counsellors and mental health workers (\$18.6 million in 2012–13 for 116 grants). These services provide counselling support for Aboriginal and Torres Strait Islander peoples, prioritising members of the Stolen Generations. Priority is given in the following order:

- people from the first generation who were directly impacted
- members of families and communities from which children were removed
- second, third, fourth and subsequent generations.²⁵

These services are under stress because of the limited availability of other services to respond to the SEWB and mental health needs of Aboriginal and Torres Strait Islander people. Thus, in 2012–13, the programme provided support to 17 700 clients. But of these, almost half (47 per cent) were other than first, second, third, fourth or subsequent members of the Stolen Generations.²⁶

- *Additional programme activity* – This includes: *Workforce Support Units* that support the SEWB workforce, including counsellors, Link Up caseworkers and substance use workers (\$5.2 million in 2012–13 for 11 grants); *Support for the National Sorry Day Committee and the National Stolen Generations Alliance*; and *funding for National coordination and support*, which provides a range of projects to support SEWB services (\$3.6 million in 2012–13 for 16 grants).²⁵

Funding provided for the above is summarised in Table 4.1.

Table 4.1 Resourcing for SEWB stolen generations counselling, 2012–13

Programme Component	Number of Services	Realised Demand	Recurrent Funding 2012–13 (\$m)
SEWB Counselling	116 grant recipients	17 725 clients (2012-13)	18.539
Workforce Support Units	11 grant recipients	Not applicable	5.218
Link up services	20 grant recipients	Not available	12.672

Sources: PM&C grant allocations spreadsheets, AIHW On-line Services Report, 2014, p.76.

The Review was impressed with the model for a SEWB team provided by the Aboriginal Medical Services Alliance Northern Territory (AMSANT), which underpins our support for wider uptake of the SEWB team model.

Access to Allied Psychological Services (ATAPS) programme

The ATAPS programme targets people diagnosed with a mild to moderate mental health disorder who may not have their needs met through MBS-subsidised services.

Under the original programme, consumers, including Aboriginal and Torres Strait Islander people, were eligible for 12 allied health sessions per calendar year, with the option for a further six sessions on review by the referring GP. It primarily supports treatment of high-prevalence mental health disorders such as anxiety and depression.

Between July 2003 and June 2010 the ATAPS programme was not targeted to meet the needs of Aboriginal and Torres Strait Islander peoples. In this period, 115 General Practice Networks delivering ATAPS programmes generated 6745 GP Mental Health Treatment Plans for Aboriginal and Torres Strait Islander people. This is an average of 863 GP Mental Health Care Plans generated for Aboriginal and Torres Strait Islander people each year over the life of the ATAPS programme.²⁵

While welcome, the first ATAPS was not functioning at a level to meet the needs of Aboriginal and Torres Strait Islander peoples. The 2012–13 AATSIHS reported that up to 30 per cent of

respondents had high to very high psychological distress.⁵ The number of places falls far short of the potential number of Aboriginal and Torres Strait Islander people requiring assistance.

In the 2010–11 Budget, ATAPS was substantially increased, in part to ensure that it performed better in relation to meeting Aboriginal and Torres Strait Islander mental health needs. A two-tier scheme was introduced for ATAPS, with Aboriginal and Torres Strait Islander-specific components. These include components for:

- *Culturally competent mental health services.* This is designed to deliver culturally appropriate mental health services to Aboriginal and Torres Strait Islander people. Cultural competence training is provided by the Australian Indigenous Psychologists Association as a part of this component of the programme.
- *Culturally competent suicide prevention services.* For these services, exceptions are made to the standard ATAPS eligibility requirements with the objective that a person at risk of suicide should be able to access allied mental health services rapidly. A person does not need a completed Mental Health Treatment Plan, for example, as they do for other ATAPS programmes. There is no limit to the number of consultations a person at risk of suicide can have in any one year (although a typical intervention period is expected to last two months). Allied mental health service providers are required to have completed training in providing culturally acceptable suicide prevention counselling to Aboriginal and Torres Strait Islander peoples to qualify as providers for these services.²⁷

The ATAPS Tier 2 Aboriginal and Torres Strait Islander components offer the following benefits.

- The approach was developed in partnership by the Department of Health and Ageing and its (then) Aboriginal and Torres Strait Islander Mental Health Advisory Group.
- There are dedicated funds for services for Aboriginal and Torres Strait Islander people within the overall programme which reflect both population size and relative need.
- It built on partnerships, captured in formal agreements, between what were Medicare Locals (now moving to Primary Health Networks) and ACCHS. In particular, these agreements address the vital issue of service accessibility and standards. Further, they recognise the greater accessibility and better health outcomes associated with ACCHS.

About \$36.5 million has been specifically allocated under ATAPS Tier 2 over five years from 2011–12, to provide mental health and suicide prevention services to Aboriginal and Torres Strait Islander people.

A recent analysis by the University of Melbourne found low service uptake by Aboriginal and Torres Strait Islander people (2097 clients in 2012–13) and suggested an average session cost of an ATAPS Tier 2 Aboriginal and Torres Strait Islander service of \$483, compared to the average Tier 1 (overall population) cost of \$170.²⁵

Comparisons should be made with caution. Certainly, the high costs of establishing such ATAPS Tier 2 services (including the cultural competence training of practitioners) must be taken into account and, conversely, the relatively low uptake of the ATAPS Tier 2 programme by Aboriginal and Torres Strait Islander people may be one explanation for the high per-session cost.

Further, low uptake of ATAPS Tier 2 programme may be due to poor promotion among Aboriginal and Torres Strait Islander communities. Despite this, the model of service is seen as having great potential by Aboriginal and Torres Strait Islander experts consulted by the Review team, particularly for the fact that it sets out to provide culturally competent services.

Other programmes

- *Suicide prevention services.* Commonwealth initiatives for suicide prevention totalled \$68.8 million in 2012–13. Around 12.7 per cent of this allocation (\$8.7 million) targeted the needs of Aboriginal and Torres Strait Islander peoples in addition to the mental health funds discussed previously.²⁵
- *Mental Health Services in Rural and Remote Areas (MHSRRA) programme.* This provides funding for mental health professionals in more than 200 rural and remote communities across Australia that would otherwise have little or no access to MBS-subsidised mental health services. Two ACCHSs are funded under the MHSRRA programme: Wuchopperen Health Service, located in Cairns, and Nganampa Health Council, located in far northeast South Australia. In 2012–13, Wuchopperen received approximately \$640 000 and Nganampa received approximately \$375 000 (both GST exclusive).²⁸
- *The Mental Health Nurse Incentive Programme (MHNIP).* This was introduced in 2007 to provide support to people with severe mental disorders during periods of significant disability. The programme provides non-MBS incentive payments to eligible organisations such as community-based general practices and private psychiatrist practices, which engage mental health nurses to assist in the provision of coordinated clinical care for people with severe mental disorders. Three IPHCOs currently participate in MHNIP.

Using dedicated Aboriginal and Torres Strait Islander services in a strategic way

The Review identified \$123.1 million of Commonwealth grants that were specifically targeted to Aboriginal and Torres Strait Islander mental health in 2012–13, including \$56.4 million for substance abuse programmes. There are minimal funds for prevention and early intervention services. Overall, the Review has emphasised the need to rebalance the mental health system towards relatively inexpensive mental health promotion and prevention and away from expensive services. For Aboriginal and Torres Strait Islander people the involvement of Indigenous organisations to ensure culturally sensitive and capable delivery is essential. These are best delivered by IPHCOs and ACCHS.

Greater consideration needs to be given to how IPHCOs and ACCHS can be positioned in relation to mainstream programmes (both public sector and NGO grants), reflecting the high level of need of the population they serve. The use of Aboriginal-controlled community-based organisations is an effective mechanism for getting services to Aboriginal and Torres Strait Islander people.

An additional funding approach would be to build on what is being proposed in the Review and identify a proportion of all mainstream mental health programme funds as a specific funding pool for Aboriginal and Torres Strait Islander primary mental health. This pool would then be allocated to ACCHS using population-based resource allocation formulae incorporating relative needs indices and allocated and delivered through a regionally based model.

Limitations with policy implementation and monitoring

Mainstream mental health policy, service and programmes in general have not been designed with sufficient consideration of the needs of Aboriginal and Torres Strait Islander people in mind. This is due partly to the greater burden of mental health problems and mental illness among them, and also to the cultural and experiential differences that underpin the 'mental

health gap'. The need for tailored services that work within the SEWB context and take into account cultural differences is well established.

The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2014–19* provides the basis for such planning and service and programme development. This should be developed and implemented along with the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*, the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013* and the *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy*. A coordinated implementation process for all four is not only necessary to close the mental health gap, but such a process will avoid duplication and be more efficient.

There also are significant limitations in monitoring the effectiveness of services and programmes in reducing mental health problems and mental illness among Aboriginal and Torres Strait Islander people. The quality of data remains limited and poor. This means services and programmes cannot be held to account for better Aboriginal and Torres Strait Islander mental health outcomes.

Where to from here – implications for reform

Our commissioned research highlighted that broad action was required in seven domains.

- Leadership and good governance
- Promoting productivity and participation
- Developing a strong market
- Infrastructure support
- Smart use of technology
- Innovative workforce
- Research

Leadership and good governance

The accountability of leadership for the delivery of quality mental health services to Aboriginal and Torres Strait Islander people, and the development of appropriate targets and indicators, needs consideration at three levels of governance: community providers, mainstream services and policy implementation.

- *Services in the community* – Indigenous-led organisations (IPHCOs/ACCHOs) to be encouraged and accountable for the continuing development of mental health and social and emotional wellbeing services in their communities, broadly through existing funding and renewed services agreements with government, taking into account services outside health (the regional model).
- *Mainstream mental health services* – In general, accountability for the quality of care they deliver to Aboriginal and Torres Strait Islander people and for improved mental health outcomes through agreements and performance reporting at regional level. There should be additional obligations placed on NGOs and other mainstream organisations funded to provide mental health services to report on their levels of engagement with Aboriginal and Torres Strait Islander people and communities and the cultural responsiveness of the services.
- *Policy, programme design and implementation* – the Commonwealth Aboriginal and Torres Strait Islander-led ministerial advisory group Aboriginal and Torres Strait

Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG) provides a platform for ongoing advice to the Australian Government on Aboriginal and Torres Strait Islander programmes and services.

Promoting productivity and participation

Promoting Aboriginal and Torres Strait Islander workforce participation is guided by the new *Indigenous Advancement Strategy* (IAS). The 2011 Census results show that health services (including, but not limited to, mental health services) currently employ 14.6 per cent of employed Aboriginal and Torres Strait Islander people. Health services are thus the single biggest 'industry' source of employment, which has expanded by almost 4000 places since 2006.²⁹

Health services, including ACCHS, also provide pathways to employment for community members through internships and 'in-house' training. This reduces welfare dependency and connects individuals, families and communities to the wider economy. Flow-on benefits include the enabling of healthy norms and routines for community members and their families. Investment in ACCHS has a multiplier effect in communities beyond the critical improvements in health they deliver.

Developing a strong market

The market for the delivery of mental health services to Aboriginal and Torres Strait Islander people has features of market failure. It lacks competition for a range of reasons related to geography, the specialist nature of some services, and a strong user preference by a significant proportion of the population to access community-controlled service providers.

In this situation it is important for the Commonwealth Government to have a clear view of its intentions and expected outcomes from the investment of resources that seek to redress the market failure (including funding, regulatory frameworks and programme interventions). Mechanisms must be put in place to monitor the effectiveness of those interventions (because there is limited competition to moderate outcomes).

Infrastructure support

There is a strong consensus among Aboriginal and Torres Strait Islander mental health experts consulted through the Review that IPHCOs/ACCHS provide value for money and a foundation for good practice for developing primary mental health services.

Case Study: Statewide Specialist Aboriginal Mental Health Service

The Western Australia Statewide Specialist Aboriginal Mental Health Service (SSAMHS) is attached to mainstream specialist mental health services. The service works with IPHCOs and ACCHS to not only ensure that their patients journey smoothly across the mental health system according to their needs, but also that they receive cultural support, including access to traditional healers and the support of their families and community. In recovery, the service helps connect people to community services and programs. Again, the focus is on the needs of the 'whole person' in a SEWB context.

An evaluation of the services has recently been completed but is yet to be released. Anecdotal reports suggest the services are significantly more successful than mainstream services in meeting the needs of Aboriginal and Torres Strait Islander peoples in WA.

Further uptake of the approach will be subject to consideration of the WA SSAMHS evaluation and developing a costing model to assess resource and funding requirements at jurisdictional level and/or regional levels.

Indigenous organisations (ACCHOs and AMS) have the potential to be the building block for future primary mental health service development. This addresses the market limitations by acknowledging the scope of the existing market and emphasising the need for mainstream services to improve their cultural responsiveness to the needs of Aboriginal and Torres Strait Islander people. The Western Australia Statewide Specialist Aboriginal Mental Health Service is a good example.

Smart use of technology

Smart technology will provide opportunities to strengthen the mental health service system to Aboriginal and Torres Strait Islander communities, but at present the use of innovative technology is limited. Examples of new clinical tools under development with a specific Indigenous emphasis include:

- the e-mental health portal
- *R U Appy*, a mobile application focused on supporting clients to strengthen SEWB
- *iBobbly*, a mobile application focused on supporting clients experiencing suicidal ideation.

Opportunities exist to promote coordinated care for Aboriginal and Torres Strait Islander people through greater use of information in electronic health records. Stakeholders interviewed during the Review saw potential for technology to enable connections to be maintained with family when Aboriginal and Torres Strait Islander people travel from a remote community to metropolitan or regional areas for acute mental health treatment.

Technology also has potential as a tool to enable family input into processes for care planning and discharge planning.

It is important that any overall strategy continues to support the development of a range of culturally appropriate electronic tools to improve access to care, and to support clinicians' work in culturally appropriate ways with clients.

Innovative workforce

Significant work is needed to develop the mental health workforce supporting the SEWB and mental health needs of Aboriginal and Torres Strait Islander people. In particular, there is a need for a skilled Aboriginal workforce within the mental health system.³⁰

Workforce development in this area should address the five professions that contribute significantly to the mental health workforce: mental health nursing, occupational therapy, psychiatry, psychology and social work. There is no comprehensive data on the proportion of the professional groups listed above with an Indigenous background. Anecdotally, the levels are low.

'I think it [lack of cultural awareness] stops you from having a really meaningful conversation that really matters.'

*Participant in Centre of Research Excellence in Suicide Prevention interview
Care After a Suicide Attempt Project (NMHC, unpublished, 2014)*

From an undergraduate training perspective, some progress has occurred in medicine, where Aboriginal enrolments have reached 2.5 per cent of the student population. Similar levels have not been achieved in other health undergraduate courses.³⁰

Workforce development plans should include the following strategies.

- Identify current capacity and identify future workforce needs. We understand little has been done to date in this area, although under the *NSW Mental Health and Wellbeing Policy*, NSW Health required at least one Aboriginal mental health worker to be employed per 1000 Indigenous people in the catchment area.
- Strengthen opportunities for Aboriginal and Torres Strait Islander health workers to attain advanced qualifications by strengthening educational pathways from the Vocational Education Training sector to the university sector.
- Strengthen Aboriginal and Torres Strait Islander participation rates in tertiary courses and in the mental health workforce. This will involve health professional associations and education providers taking greater responsibility for increasing the level of Aboriginal and Torres Strait Islander students undertaking their courses and entering the profession. The medical profession is demonstrating good practice in supporting the training and mentoring of Aboriginal and Torres Strait Islander medical students. The Djirruwang Program through Charles Sturt University is considered a programme of merit supporting increased participation of Aboriginal and Torres Strait Islander people as mental health practitioners in mainstream mental health services.

Research

Only a minimal amount of Aboriginal and Torres Strait Islander-specific research in mental health has been undertaken to date. Much of this is documented in *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*, published by the Commonwealth in June 2014.

While the knowledge and experience of clinicians has an important role to play in strengthening services, greater effort is required to undertake applied research projects and facilitate partnerships between service delivery organisations and research institutions.

Support was expressed in submissions to the Review for strength-focused research aimed at identifying effective approaches for:

- building SEWB and resilience
- interventions across the life stages
- protective and risk factors in responding to Aboriginal and Torres Strait Islander suicide
- interventions for particular population groups, including people who have borderline personality disorders
- interventions to assist high needs families where one or both parents have mental illness, and healing interventions.

It is important that Aboriginal and Torres Strait Islander experts and stakeholders lead in the above research.

The Commission acknowledges that these actions need to be funded from within existing resources and therefore their timing will be subject to realisation of whole-of-system efficiencies. The Commission considers that the mental health of Aboriginal and Torres Strait Islander people should be considered the first priority for investment when efficiencies and savings are realised.

Actions

The Review recommends five areas to transform the mental health outcomes for Aboriginal and Torres Strait Islander peoples, and create an effective and efficient system capable of meeting need.

1. Make Aboriginal and Torres Strait Islander mental health a national priority

In Volume 1, the Review proposes making Aboriginal and Torres Strait Islander mental health a national priority and that this should be supported by agreeing an additional COAG Closing the Gap target specifically for mental health. Critically, dedicated national Aboriginal and Torres Strait Islander mental health planning and service and programme design is needed because mainstream mental health policy, service and programmes are often not culturally appropriate for Aboriginal and Torres Strait Islander people. This work would support a dedicated national Aboriginal and Torres Strait Islander mental health plan.

In doing this, it is important that Australian governments work with a credible Aboriginal and Torres Strait Islander leadership and stakeholder partnership mechanism for mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drugs use prevention. The basis of this should be the Aboriginal and Torres Strait Islander Mental health and Suicide Prevention Advisory Group.

There are several components to advancing Aboriginal and Torres Strait Islander social and emotional wellbeing:

- Establish mental health as a priority within the COAG Closing the Gap framework and within the Indigenous Advancement Strategy.
- Additional costs could be offset by the significant reductions in the costs associated with addressing chronic disease, unemployment, family breakdown, alcohol and other drugs abuse, smoking, and high rates of imprisonment in Aboriginal and Torres Strait Islander peoples. In part this could occur through a justice reinvestment programme.

Achievement of this will require activation of existing frameworks for national Aboriginal and Torres Strait Islander mental health planning and service and programme design over the next 12 to 18 months through the implementation of:

- the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2014–2019
- the National Aboriginal and Torres Strait Islander Health Plan 2013-2023
- the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013
- the National Aboriginal and Torres Strait Islander Peoples' Drug Strategy.

This will require assessment of what funding from mainstream programmes could be diverted into the new approach to offset costs. This must be subject to the outcome of individual programme reviews. All such planning must occur in partnership with Aboriginal and Torres Strait Islander peoples and under the guidance of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG).

Monitoring implementation of this new approach and ensuring accountability of government departments and jurisdictions for progress will be essential.

In considering the funding needs of this approach within current fiscal circumstances, the following points should be considered;

- Suicide prevention expenditure should be quarantined.
 - Funding allocated to implement the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and the National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2014–2019.
 - Wherever possible, existing expenditure should contribute to supporting IPHCOs/ACCHS Mental Health and SEWB Teams and also specialist Aboriginal and Torres Strait Islander mental health services.
- Further attention is required by mainstream services to the mental health needs of Aboriginal and Torres Strait Islander people in custodial care. A justice reinvestment programme for detainees should be introduced as a cost-effective way to reduce the risk of reoffending and minimise future custodial care outlays. It also could be extended to more youth mental health services in Aboriginal and Torres Strait Islander communities.

2. Integrated Mental Health and SEWB Teams

- Require mental health and SEWB teams to be established in all government-funded IPHCOs and ACCHS, as part of renewed service agreements.
- Mental health services to be fully integrated within these services as a part of their existing comprehensive primary health care service package. This will enable the early detection and expanded treatment of mental health problems and some mental illness in relatively inexpensive community and primary health care settings. Such mental health and SEWB teams also could help support recovery in community settings.
- The integrated teams will provide access to:
 - medical care, including pharmacotherapies and preventive health care and health checks to promote, maintain and treat physical health
 - structured interventions using evidence-based therapy

- social and cultural support, including access to housing, support with issues of cultural identity and support from local Aboriginal people via Aboriginal health workers and Aboriginal mental health workers.
- With links to:
 - community mental health
 - alcohol and other drugs services
 - primary health care
 - access to a psychiatrist
 - mainstream services.

Workforce requirements for introducing integrated teams can be informed by planning work undertaken by the Aboriginal Medical Services Alliance Northern Territory (AMSANT).

The integrated teams would implement models of care/clinical pathways for:

- community mental health – screening, treatment, support
- alcohol and other drugs
- chronic illness support
- SEWB promotion/community strengthening.

3. Invigorate culturally responsive and accountable mainstream mental health services

- Provide incentives and place accountability requirements on mainstream services to improve their contribution to delivering better mental health outcomes for Aboriginal and Torres Strait Islander people, including strategies such as:
 - frameworks for policy approaches
 - quality and professional standards with organisations such as RACGP, Australian Practice Nurses Association and service accreditation standards agencies such as the Australian Commission on Quality and Safety in Health Care (ACSQHC)
 - targets and key performance indicators in funding agreements
 - partnership agreements being established at a local level between the leadership of mainstream services and the IPHCOs/ACCHS
 - clinical pathways development in partnership with local ACCHOs/AMS for mental health consumers, defining how the services will support them in their journey from primary care to acute care and the provision of ongoing care for people with a chronic mental illness
 - professional development programs delivered to support mainstream staff develop cultural competencies.

4. Sharpen role of dedicated Aboriginal and Torres Strait Islander services

- Refocus the role of dedicated Aboriginal and Torres Strait Islander services to support Aboriginal and Torres Strait Islander people’s journeys across the mental health system.

Additional effort is needed to facilitate the journey of Aboriginal and Torres Strait Islander people into and through the specialist mental health service system, and in particular from primary mental health care settings into mainstream specialist mental health services and programmes.

Each state and territory has a different infrastructure and mix of services, so the most appropriate responses will vary. Some jurisdictions could choose to establish specialist

Aboriginal and Torres Strait Islander mental health services along the lines of the Western Australia Statewide Specialist Aboriginal Mental Health Service (SSAMHS) model.

Irrespective of the precise approach, all Aboriginal and Torres Strait Islander people admitted to a specialist (mainstream) mental health service should be in the target group for this service and the following features/capabilities should be standard:

- ensuring each referred/admitted person is linked from IPHCOs/ACCHS to the mainstream service and back again on discharge
- cultural support during admission
- access to traditional healers and healing services
- maintaining links to family
- facilitation of access to community support on return to community.

5. Aboriginal and Torres Strait Islander mental health workforce development

- Develop a National Aboriginal and Torres Strait Islander mental health workforce strategy to support the changes in service delivery proposed and enable all services (specialist and mainstream) to be more culturally responsive and better able to work with Aboriginal and Torres Strait Islander peoples.

Key components of the strategy should include:

- identifying current capacity and future workforce needs
- increasing opportunities for Aboriginal and Torres Strait Islander health workers to attain advanced qualifications by strengthening educational pathways from the Vocational Education Training sector to the university sector
- Increasing Aboriginal and Torres Strait Islander participation rates in tertiary courses and in the mental health workforce, involving health professional associations and education providers taking greater responsibility for increasing the level of Aboriginal and Torres Strait Islander students undertaking their courses and entering the profession. (The medical profession is demonstrating good practice in supporting the training and mentoring of Aboriginal and Torres Strait Islander medical students)
- Developing specialist Aboriginal mental health courses such as the Djirruwang Programme through Charles Sturt University. This is a three-year Bachelor of Health Science (Mental Health) degree and has curricula based on workplace learning, university learning, placement learning and development of mental health competencies.

The Commission presents this report on the basis of it being implemented from within existing resources: it confirms the view that where efficiencies and savings are realised through a whole-of-government approach, the first priority for reinvestment should be Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing.

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Chapter 5: Regional, rural and remote Australia

This chapter discusses the unique circumstances that shape mental health and wellbeing in regional, rural and remote communities. It acknowledges the variation of experience and circumstances across areas of Australia, the service deficit faced by people in more remote areas in particular, and the need for local, place-based responses.

Term of Reference

Specific challenges for regional, rural and remote Australia.

Rural, regional and remote Australia

The availability of specialised mental health care in hospitals and Medicare-subsidised mental health services is significantly worse in more remote areas of Australia than in major cities.

MAJOR CITIES

For every 1000 people, there were

6.5

hospitalisations for mental health reasons with specialised psychiatric care, but

3.5

without specialised care.

For every 100 people

8 

received MBS-subsidised mental health services

Each of these people received

5.2

consultations

REMOTE/VERY REMOTE

For every 1000 people, there were

3.5

hospitalisations for mental health reasons with specialised psychiatric care, but

8.2

without specialised care.

For every 100 people

3 

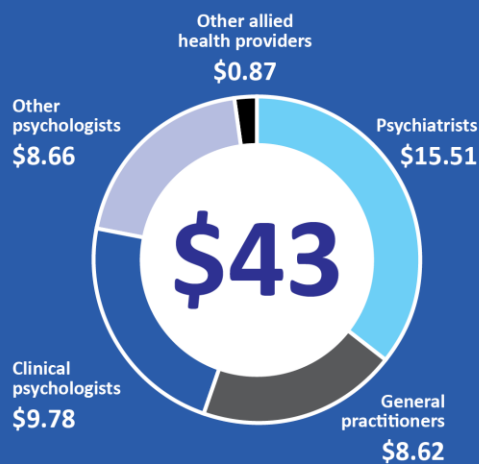
received MBS-subsidised mental health services

Each of these people received

3.0

consultations

In major cities, the per person Medicare funding for mental health services was \$43.44



In remote and very remote areas the per person Medicare funding for mental health services was \$7.46



Source: Australian Institute of Health and Welfare 2014. Mental Health Services in Australia. Canberra: AIHW.

People living in regional, rural and remote areas of Australia make up 30 per cent of the population. But they do not get anywhere near 30 per cent of funding and services for mental health. The problems facing people living in regional and, particularly, more remote areas of Australia in accessing quality mental health services are severe and require immediate attention. Further, this inequity compounds the mental health challenges facing the significant numbers of Aboriginal and Torres Strait Islander people living in these areas. Given the persistent difficulty in expanding face-to-face services and workforces in these areas, we need innovative, local ways of mitigating this situation in the short term, while adopting a long-term focus to improve quality and outcomes. These should be locally targeted to take into account community-specific issues.

What is happening now

People in regional, rural and remote Australia face unique circumstances that shape mental health and wellbeing. As remoteness increases, communities are increasingly affected by environmental extremes (such as flood, fire or drought) and economic variability. Fewer mental health specialists are available when people need to access assistance for mental health concerns and people generally need to travel over greater distances to deliver or receive care.

Throughout this chapter, when discussing data related to geographical areas of Australia, we generally use the remoteness categories used in the Australian Statistical Geography Standard (ASGS). 'Regional, rural and remote' is used as a general term to describe areas outside major cities.

Local differences need to be recognised

Regional, rural and remote Australia often is simply differentiated from metropolitan areas, and seen as possessing strengths in resilience and a sense of community. However, our information and research shows there is no single stereotypical community experience of mental health in regional, rural and remote Australia. Communities are differentially affected by many factors. These include:

- specific circumstances of local Aboriginal and Torres Strait Islander communities
- social isolation, particularly for specific social, cultural and employment groups
- exposure to environmental factors and economic restructuring, particularly for farming communities
- distance from major cities and services
- economic and contributing life factors, such as access to a secure job and home, a good education and quality health and mental health care.

Even in communities of similar sizes and remoteness, many different conditions can affect mental health. For example, remote Aboriginal communities and mining communities share the challenge of isolation but differ in almost every other aspect, such as family structures, economic position, culture and connection to land.

This means that 'one-size-fits-all' solutions for these areas will not work.¹ These factors must be considered in local responses to improve mental health of communities and individuals. Although greater external resourcing is required, we also need to leverage the strengths of communities and the technologies and resources already present.

In the absence of local data to pinpoint demand for services in particular communities, the following general trends give an impression of important distinctions between geographically defined categories. Evidence submitted to the Review and COAG Reform Council reporting shows that, in general, people in regional, rural and remote areas face higher levels of socio-economic, environmental, behavioural and physical health risks associated with mental ill-health than those who live in major cities.² While there is no clear evidence that the prevalence or severity of mental illness is any greater in regional, rural and remote areas, or that geography alone affects perceived need for specific types of mental health services by people with a lifetime mental health disorder, this data may be unreliable.^{3,4}

Submissions to the Review reported the high prevalence of mental illness and suicide as a key challenge for regional, rural and remote areas, in addition to concerns about stigma and anonymity acting as barriers to seeking help for mental health problems.⁵

There are also marked differences between outer regional, remote and very remote areas, and inner regional areas, which are usually more urban and closer to major cities.

- Outer regional areas record the highest prevalence of persistent and deep exclusion in Australia,⁶ and rural and remote areas often have poorer education, literacy, income, employment⁷⁻⁹ and housing opportunities.¹⁰
- In a submission to the Review, the National Rural Health Alliance suggests these areas also are often affected more severely by natural disaster; these areas may be more socially isolated.¹¹
- These factors can lead to depression and may contribute to the higher levels of suicide in rural and remote areas of Australia.¹² At higher risk are males, young people, Indigenous people and farmers.^{12,13}

Service provision declines with distance

The evident lack of services for people in regional and, particularly, more remote areas is a significant barrier to improving mental health outcomes. Submissions to the Commission identified insufficient and inaccessible supports for mental health difficulties and mental health workforce shortages as two key concerns.

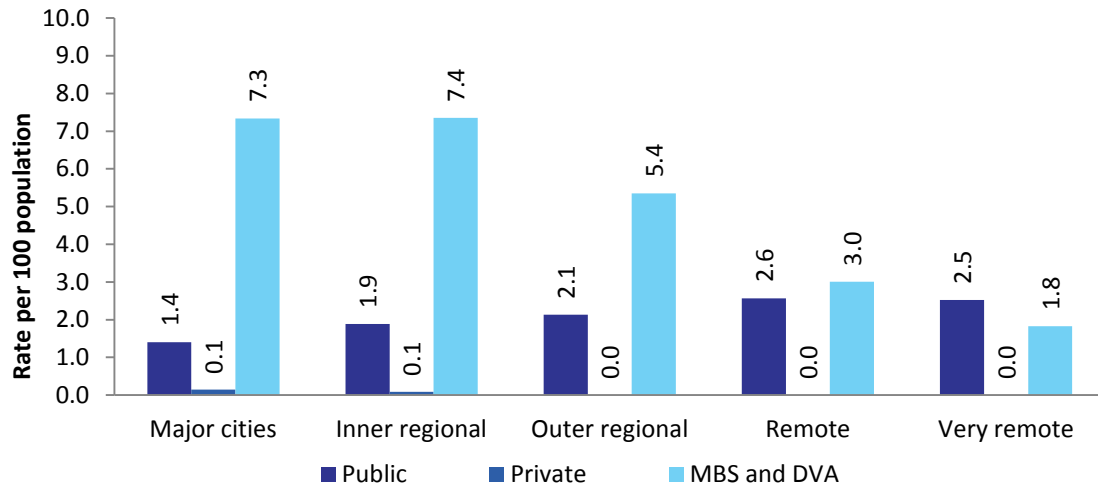
This was supported by the Commission's analysis of state and territory data from the Mental Health Establishments National Minimum Data Set, provided with agreement by all jurisdictions bar the ACT. The Commission analysed the patterns of specialised mental health expenditure, beds, full-time equivalent staff and service activity of contributing jurisdictions. The analysis revealed that for most jurisdictions, resources, facilities and services were disproportionately concentrated in major cities, followed by inner regional and outer regional areas. For more detail, see the Australian Institute of Health and Welfare's report on this data in Volume 3.

'My view is that funding should be reprioritised toward remote communities, and a distinction made between "rural" and "regional" locations. Some "regional" locations are in fact within 60 kilometres of a major city or town of over 250 000 people. Truly remote or regional locations are often 1000 kilometres from a city or town. The difference in resource provision between these locations is profound, leading to undetected mental health problems in remote communities, without access to highly qualified treatment services.'

Submission from a clinical psychologist

The data shows reliance on public mental health services increases by remoteness (see Figure 5.1)¹⁴

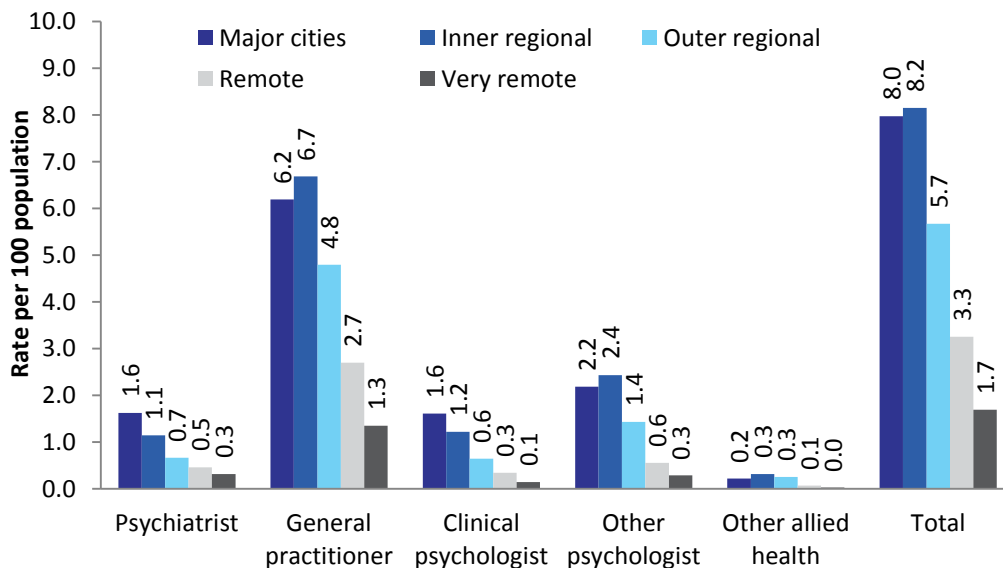
Figure 5.1 Percentage (rate per 100) of population using clinical mental health services, by service type and remoteness, 2010–11



Sources: State and territory (unpublished) community mental health care data, Private Mental Health Alliance (unpublished) Centralised Data Management Service data, Department of Health (unpublished) MBS Statistics, Department of Veterans' Affairs (unpublished) Treatment Account System data, Australian Bureau of Statistics (unpublished) Estimated Residential Population, 30 June 2010.

The percentage of people receiving mental health services provided by psychiatrists and clinical psychologists is generally less the more you move away from major cities (see Figure 5.2).¹⁵

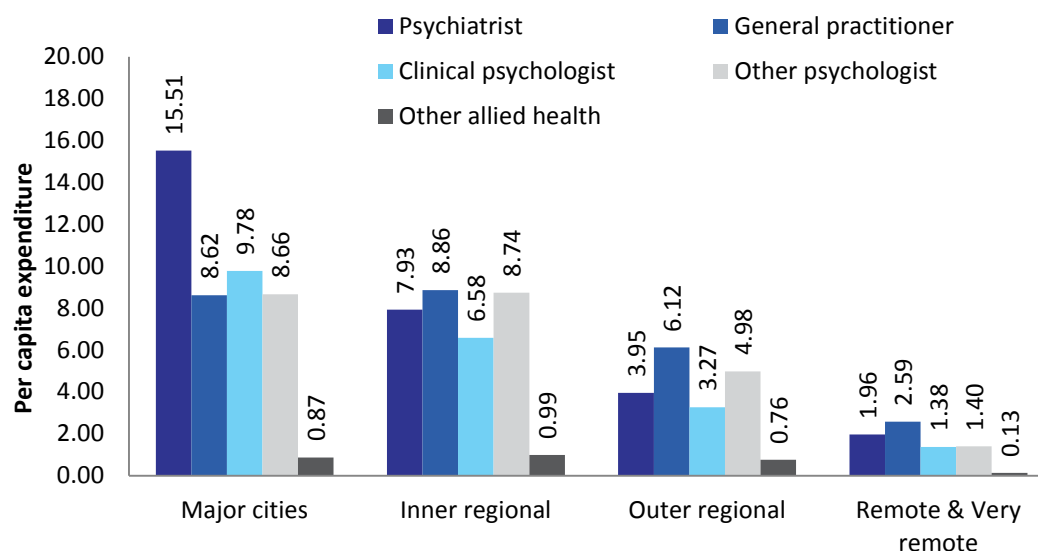
Figure 5.2 Percentage (rate per 100) of population receiving Medicare-subsidised mental health services, by provider type and remoteness area, 2012–13



Sources: MBS Statistics, Department of Veterans' Affairs (unpublished) Treatment Account System data; Australian Bureau of Statistics (unpublished) Estimated Residential Population, 30 June 2010.

Per capita, the overall mental health-specific MBS expenditure declines with remoteness (see Figure 5.3)^{16, 17}

Figure 5.3 Per capita mental health-specific MBS expenditure (\$) by provider type and remoteness area, 2012–13



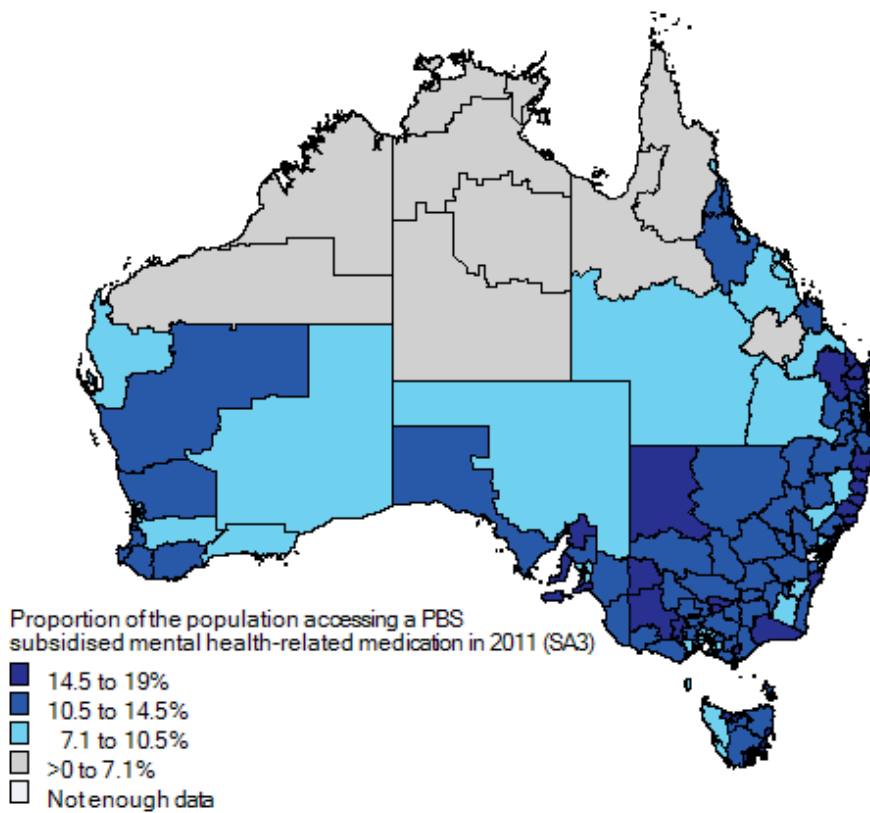
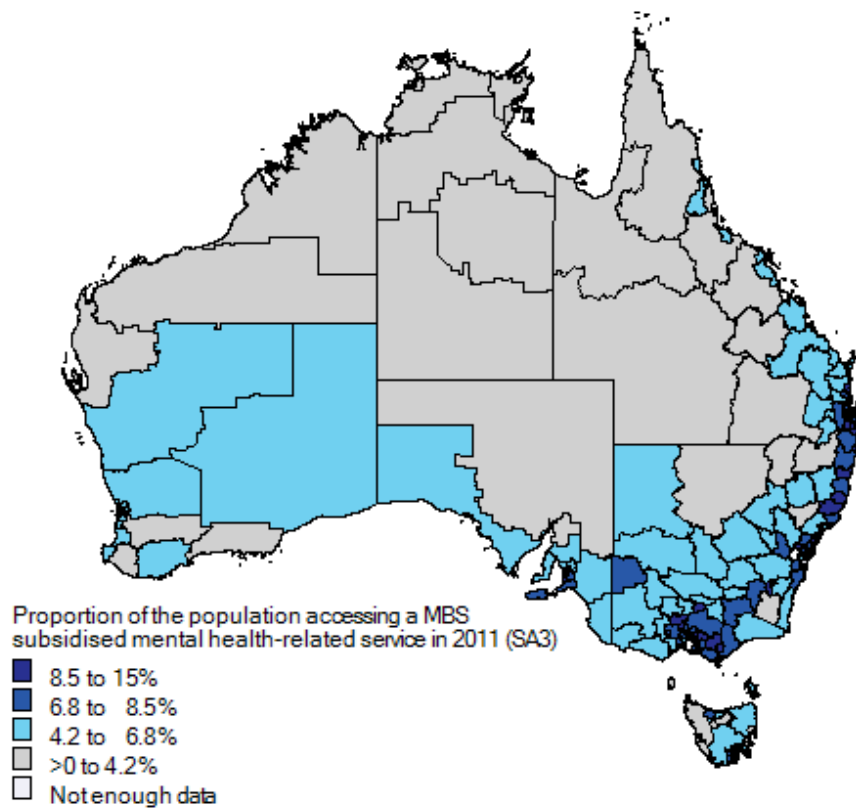
Source: Mental health services in Australia, Medicare-subsidised mental health-related services 2012–13.

Again, it is important to distinguish inner regional from outer regional, remote and very remote areas in this analysis. Aside from the lower availability of psychiatrists and clinical psychologists, the profile of mental health services available in inner regional areas more closely resembles the situation in major cities than outer regional, remote and very remote areas. In fact, the number of people in inner regional areas receiving MBS-subsidised mental health services is actually greater than in major cities,¹⁶ largely due to Medicare-subsidised services from GPs and other psychologists. People admitted to hospitals in inner regional areas are almost as likely to receive specialised psychiatric care as people in major cities, but people in remote areas are around 50 per cent less likely to access this care.¹⁸

The limited supply of specialist professionals and services means that it is harder for people in more remote areas to know about and access professional services, even if they want to. As a result, promotion, prevention, early diagnosis and intervention services that could address mental illness are hampered and delayed, which can result in serious crises. At a NSW Mental Health Commission forum, participants reported that people may resort to de facto ‘mental health services’, including police and/or expensive and often traumatising emergency evacuation over long distances (including by air).¹⁹

In inner and outer regional areas, there was comparatively higher access to PBS-subsidised mental health-related medication than MBS-subsidised mental health-related services in 2011. Figure 5.4 shows that areas with higher rates of access to MBS services tended to be in major cities, whereas areas with higher rates of access to PBS medication tended to be in regional areas.

Figure 5.4 Mental health-related MBS and PBS access comparison, 2011



Source: Mental Health Services-Census Integrated Dataset, 2011

It should be noted that remote and rural areas are under-represented in this data (and in other MBS/PBS data presented in this chapter) for a number of reasons related to use of MBS/PBS subsidised mental health-related services and medication (including GPs being less likely to direct bill under Medicare in remote areas, greater presentation as public inpatients in hospitals, and potential use of other subsidised programmes like Aboriginal Health Services and services not recorded as mental health-related items). People in outer regional and remote areas also were more likely to access PBS-subsidised mental health-related medication without accessing an MBS-subsidised mental health-related service in 2011; and of those who did access a service, people in outer regional and remote areas were more likely to access a GP service only. Further analysis using the data made available in the new Mental Health Services-Census Data Integration project will reveal more about local patterns of MBS and PBS usage.

Key findings

Losing local services

The transience of services, initiatives and workforce is a common complaint in regional, rural and remote areas. As policy changes are implemented, there is a risk that the accumulated experience of mental health services in regional, rural and remote areas will be lost. Submissions to the Review reported that too often programmes are given inadequate funding for the additional costs of service delivery in regional, rural and remote areas. For example, funding allocations often fail to factor in time and money spent travelling to where people live. Submissions also suggested that there is often a failure to adapt service models to operate outside major cities.

There are three specific and immediate policy reforms needed to take into account the specific needs of regional, rural and remote areas.

The National Disability Insurance Scheme (NDIS) rollout needs to be adapted for more remote areas. In these areas, agencies funded by Commonwealth programmes often are the only organisations with expertise in recovery support and psychosocial rehabilitation. People with severe mental illnesses currently receiving services from these agencies may be left without access to appropriate supports if they are ineligible for the NDIS and the agencies' programme funding is discontinued. For example, in the PHaMs (Personal Helper and Mentors) programme (in which more than 40 per cent of sites are in non-metropolitan areas), initial advice from the Hunter trial suggests around 70-80 per cent of PHaMs participants will not be eligible for NDIS Tier 3 packages.²⁰ However, advice from the Mental Health Coordinating Council confirmed that no PHaMs clients have been identified to date as disadvantaged through Tier 3 ineligibility due to a 'guarantee of service' through to June 2016. People depending on other programmes and services including Partners in Recovery, Day2Day Living and Support for Families and Carers may be similarly affected in such a transition.

The move to new Primary and Mental Health Networks (PMHNs) also needs to ensure the smooth transition of care-based models developed by Medicare Locals to suit particular geographical areas.²¹ The successful Mental Health Services in Rural and Remote Areas (MHSRRA) programme is one such example. This programme needs to be integrated with the new PMHNs and its focus on the implementation and management of services provided via local organisations retained, as well as its flexibility to be able to tailor services to local needs.²²

Workforce supply issues also need to be urgently addressed. Over the years, rural incentive programmes for professionals have had limited success. Regional, rural and remote areas remain unattractive for people to move to (for numerous reasons) and expansion of the current workforce mix for mental health care will require ongoing efforts.²³

Potential solutions through developing technology and community capacity

Throughout this Review, two solutions have been repeatedly advocated to overcome the persistent challenges to improving mental health in regional, rural and remote areas.

The first is improving access to services using technology. It is now possible to provide much-needed assistance and interventions in real time by telephone or over the internet. Issues raised during the Review included the extension of the current MBS item for telepsychiatry to include psychologists, mental health nurses, occupational therapists, social workers, GPs, nurse practitioners, practice nurses and Aboriginal health workers. This could help to reduce rates of hospitalisation and out-of-area hospital transfers and enable 24-hour emergency access to required services and advice. E-mental health services need to be promoted more strongly and embedded as a routine form of treatment and referral pathway.

The second solution is to train community members to provide services and supports in these areas. Evidence submitted to the review by the National Rural Health Alliance suggested skilling-up local community members may enable the development of a health promotion and recovery support workforce. Their life experience, expertise and local knowledge could be utilised to break down stigma, promote mental health literacy, encourage the use of formal specialist services and assist with suicide prevention. This could complement the development of a more formal peer workforce in non-metropolitan communities. Together, these could support existing mental health and community care services, as outlined in the following example:

Case Study: Farm-link

The Farm-link programme (now the Rural Adversity Mental Health Programme) involved educating and equipping frontline community members likely to interact with 'at-risk' population groups in mental health and mental health first aid practice. The aim was to improve access and responsiveness of mental health services to the needs of people who live and work on farms. The programme also contributed to the identification and establishment of mental health service development interventions in target communities.

The model leveraged existing community-based resources to develop intervention and treatment strategies, adapted to the particularly self-reliant and stoic help-seeking behaviour patterns of the rural communities. The ability to cultivate local knowledge, local people and local experience were the attributes most critical to the program's success. Another key attribute was the establishment of cross-agency networks and links with community organisations that allowed integration of approaches. The importance of programme development over an extended period was also highlighted, with relationship building something that required sustained engagement over time.

Adapted from Perceval, Fuller & Holley (2011)²⁴

Where to from here – implications for reform

Addressing the mental health needs of regional, rural and remote Australia requires an understanding of the specific challenges for these areas and an innovative approach to addressing them — one which maximises available local resources and adopts a regional or community-specific approach.

Addressing workforce concerns while finding alternatives

Every attempt should be made to rectify the alarming shortfall in traditional workforces outside major cities and inner regional areas of Australia. Expert advice²¹ to the Commission has included the following options:

- better utilising the primary mental health workforce (e.g. nurses, allied health professionals and particularly GPs)²⁵ to complement the services of psychiatrists, psychologists and mental health nurses (see Chapter 7 for further details)
- supporting appropriate mental health training and professional development of the generalist health workforce
- using technology to provide workforce education and support to deliver cost-effective service enhancement
- continuing to invest in improved recruitment, incentives and retention practices, especially where they have been shown to be effective, but also targeting socio-economically disadvantaged areas that are underserved by the current system.

These options need to be accompanied by more innovative parallel measures to meet community need. Expert suggestions include:

- technology to be used wherever possible in local service delivery, whether for face-to-face consultations with specialists or e-mental health interventions
- national leadership to ensure national coverage of telepsychiatry and expanded similar services for other professions, and to develop appropriate national guidelines for their use
- e-mental health services require greater promotion in regional, rural and remote communities
- there should be investment in improving the capacity of community members, especially those with a personal experience of mental illness, to provide peer and/or mental health first aid services and supports to augment the existing workforce (the following case study includes elements of this approach).

The Commission is concerned that there are no rural loadings under the Better Access programme, despite other rural loadings being common (for example, for GPs, practice nurses and mental health nurses). The Commission considers a similar loading is warranted under Better Access to attract allied health professionals (including psychologists) to rural and remote areas.

Case Study: the mining, resources and construction industries

The Australasian Centre for Rural and Remote Mental Health's Wellbeing and Lifestyle Survey (currently 1000+ workers) runs across several remote sites in Western Australia. It continues to identify all the significant risk factors directly related to work, split lifestyle and separation from family and friends. Risk factors include, but are not limited to:

- length of swings and shifts
- pressure from senior management
- stigma associated with mental health in the workplace
- remoteness of living circumstances and social isolation
- missing special events such as birthdays and anniversaries
- relationship stresses with partners, children and parents
- financial pressures.

These and other factors show that mental distress ranges from one in four to one in three workers. This is a significantly higher incidence than the national average of one in five. These factors contribute to mental health problems and, in extreme cases, suicide. Compromised mental health has a deleterious impact on both safety and productivity.

The ACRRMH's Minds in Mines program has been established as a social enterprise, promoted to the industry as providing a significant economic benefit. Estimates from commissioned research are that for every dollar spent on mental health programmes there is an average potential return of more than five times the investment in the mining industry.

Minds in Mines is evidence-based. The centre's Wellbeing and Lifestyle Survey and programme evaluations enable the specific risk factors in each company/site to be identified and addressed, thereby increasing safety and productivity.

It provides practical mental health strategies for resource workers and their families, and educates the workforce about mental ill-health to reduce associated stigma. It encourages workers to take responsibility for their own mental health and to seek help early. This reduces the inevitable reliance on employers and/or government services in times of acute distress.

Minds in Mines includes, but is not limited to:

"Onboarding" – an induction handbook for Australian mining, resource and remote construction sites: the handbook addresses all aspects of work, family and health.

Toolbox Talks – a series of talks which addresses a comprehensive range of issues directly related to mental health in the workplace and at home.

Passports to Mental Health in Mining, Resources and Remote Construction – essential, readable and designed to fit into a personal protective equipment (PPE) shirt pocket.

Mental Health Crisis Management Workshop – designed specifically for superintendents, supervisors, OH&S reps, emergency crew, shift bosses and managers to enable them to respond to mental health issues in their crews and the consequences of critical incidents.

Submission from the Australasian Centre for Rural and Remote Mental Health

Developing a coordinated regional approach, within a national framework

Other sections of this report discuss the importance of integrated service delivery, colocated, multi-sector care and increased availability of sub-acute care and other alternatives to hospitalisation. This is especially true in regional, rural and remote locations, given the lack of access to services, particularly specialist mental health services. Similarly, the overall focus on promotion, prevention and early intervention needs to consider these locations, given the low mental health access and literacy in these areas, and the frequency and impact of adverse circumstances that can create a need for services.

A nationally agreed conceptual framework is needed to guide mental health service delivery and its governance in regional, rural and remote Australia. This would promote regionally and locally relevant models and pathways for stepped and integrated care. Funding could be directed to regional level entities (such as the new PMHNS) which would take responsibility for planning and commissioning services on behalf of, and in consultation with, regional populations.

As well as incorporating local input, governments should continue to work with communities experiencing high levels of adversity and distress to build their capacity to assist those most vulnerable and at risk. Further research on the determinants of mental health in regional, rural and remote Australia, effective service delivery models and location-specific gap analysis and needs assessments are fundamental to ensuring that programmes invest in what each community needs. The Commission-led data linkage project can provide population-level information of the use of MBS and PBS services across geographic areas of Australia and across different population groups.

Understanding and addressing the broader factors affecting mental health

Beyond the mental health system, the contributing life factors that most affect mental health in regional, rural and remote Australia need to be addressed, including poverty and unemployment, lack of educational opportunities and adverse environmental conditions. The potential, and ongoing, mental health issues which often co-evolve with such disadvantage may be addressed through supply side initiatives proposed to the Commission, including:

- providing vocational training and counselling services
- promoting increased regular physical exercise
- providing information to address demand side issues of ‘desire for care’ in the face of adverse circumstances and events.

Ultimately, addressing these concerns requires answering the question posed by one stakeholder: *“How do we create a sense of hope and opportunity in these places?”*²¹

Actions

- Develop a regional model of service delivery based around the proposed Primary and Mental Health Networks (PMHN).
 - PMHNs to be tasked with working on behalf of, and in consultation with, local communities on the integration and coordination of place-based mental health and suicide prevention plans, including purchasing services and monitoring performance.
 - Models developed by Medicare Locals to suit particular geographical areas and existing programmes (including MHSRRA and ATAPS programmes) should be smoothly transitioned to PMHNs to enable services to be delivered to areas of need.
 - The National Mental Health Services Planning Framework to be used to support PMHNs to take such an approach. Location-specific gap analysis and needs assessments will be fundamental to ensuring that PMHNs invest in what each community needs, including specific needs of Aboriginal and Torres Strait Islander communities. The Commission-led data linkage project can provide population-level information on the use of MBS and PBS services.
 - Require PHMNs to be responsible and accountable within their jurisdictions for improved Aboriginal and Torres Strait Islander mental health outcomes. This includes developing partnership and other innovative funding and service delivery relationships with Indigenous Primary Health Care Organisations (including Aboriginal Community-Controlled Health Services) in their jurisdictions to support the mental health and social and emotional wellbeing teams and specialist mental health services proposed in this Review.
- Implement a range of changes to the Commonwealth's Better Access programme to address workforce shortages impacting on service access.
 - Limit access to benefit payments for new registered psychologists (not clinical psychologists) to more remote areas of the geographical classification.
 - Examine cashing out Better Access benefits for registered psychologists from fee-for-service arrangements and distribute funds on a weighted population basis to regional purchasers to purchase psychological services on a salaried or sessional basis.
 - Examine the introduction of provisions requiring access to benefits payments under Better Access being dependent on all new allied health professionals providing a significant proportion of their services (i.e. 50 per cent in the first five years) to more remote areas of the geographical classification.
 - Examine the provision of incentives for allied health professionals to more remote areas through targeted scholarships for postgraduate study, support of professional development and mentoring, and financial and relocation inducements.
- Further develop pathways for stepped and integrated care, incorporating:
 - adoption of technology enablers; for example, support for face-to-face consultations with specialists through expansion of telehealth MBS items beyond telepsychiatry
 - the use of e-mental health interventions
 - using remote or online flexible delivery for the education and training of professionals
 - promotion of e-mental health services to regional, rural and remote communities.

- Invest in improving the capacity of community members, especially those with a personal experience of mental illness, to provide peer and/or mental health first aid services and supports to augment the existing workforce.
- Add a rural loading to the Better Access programme weighted similarly to those for the Practice Nurse Incentive Programme.
- Conduct further research on the determinants of mental health in regional, rural and remote Australia and effective service delivery models.

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Chapter 6:

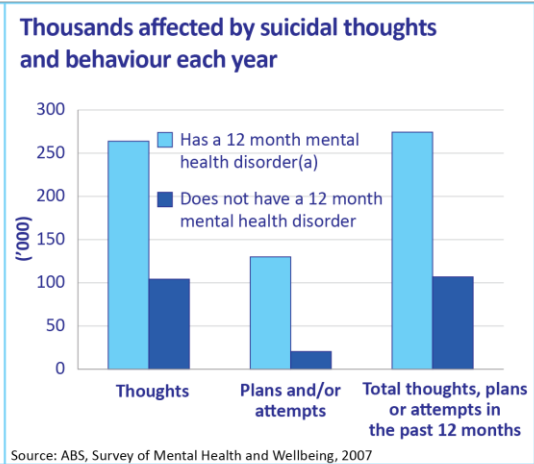
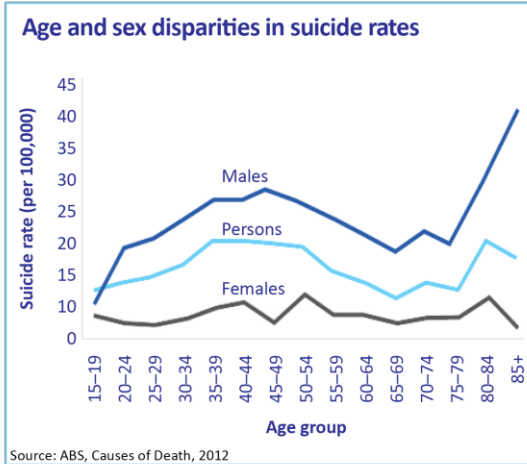
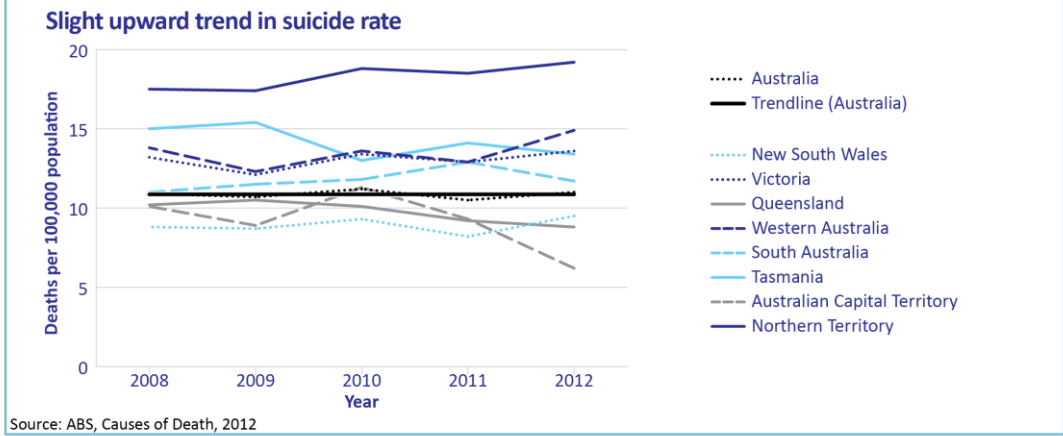
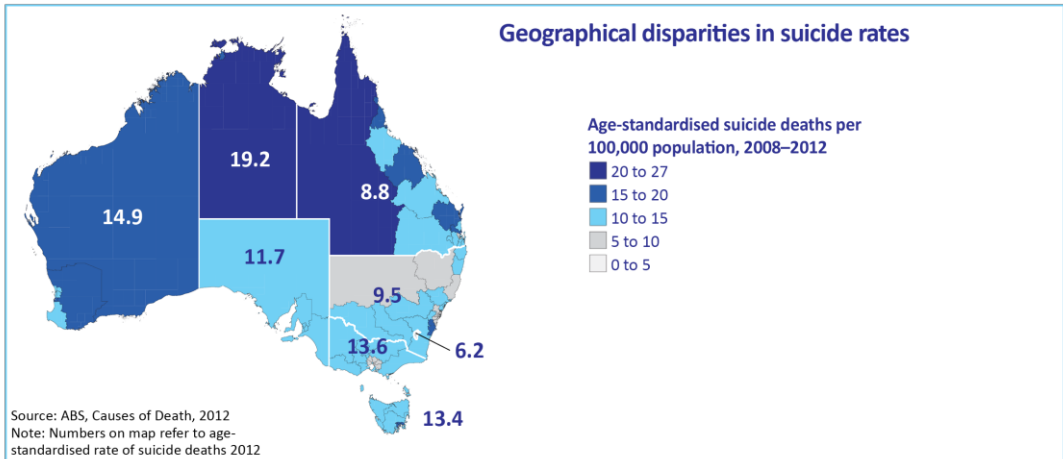
Suicide prevention

Suicide and suicide attempts have a significant impact on Australian families, communities and society as a whole. Suicide prevention is much broader than mental health. A complex interaction of social, economic, personal and situational variables may lead to a person's suicide and may or may not include mental illness. Therefore, suicide prevention is not the same thing as prevention and treatment of mental illness. In this chapter, we examine what is happening now and opportunities for the future in suicide prevention.

Term of Reference

The prevention of suicide

Suicidal behaviour in Australia



What is happening now

In 2015 Australia will mark 20 years since the development of its first national suicide prevention strategy. In the mid-1990s, Australia was seen as a world leader in suicide prevention policy, but the picture is very different now. According to a recent comparison of suicide prevention efforts globally, Australia's suicide rate is higher than that of New Zealand, Canada and the United Kingdom.¹

This chapter focuses on the broad issues in suicide prevention rather than talking about the needs of specific groups. Suicide prevention programmes are discussed in Chapter 9.

Trends in Australian suicide statistics paint a sad and frustrating picture. In 2012 more than 2500 people died by suicide,² while in 2007 an estimated 65 000 Australians attempted to end their own life.³ The absolute number of deaths has increased each year since 2006, while rates have remained almost static at close to 11 deaths per 100 000 population.² Remarkably, in terms of total years of life lost each year due to premature deaths across the Australian population, suicide ranks third after cardiovascular disease and cancer, diseases which cause far greater numbers of deaths.⁴

Suicide is the leading cause of death among the most economically productive age group (between 15 and 44 years), and males die by suicide three times more frequently than females.²

People from Aboriginal and Torres Strait Islander communities, as well as people living outside of major cities, are more likely to die by suicide, compounding existing disadvantage.⁵ For the former, the overall suicide rate was twice the non-Indigenous rate between 2001 and 2010.⁶ Around 100 Aboriginal and Torres Strait Islander deaths by suicide per year took place over that decade.⁷ In 2012, 117 suicides were reported. Rates of reported hospitalisations of Aboriginal and Torres Strait Islander people for self-harm rose by 48 per cent between 2004–05 and 2012–13.⁸ The compounding disadvantage experienced by Aboriginal and Torres Strait Islander peoples is discussed in Chapter 4.

The human suffering associated with the lead-up to a suicide or a suicide attempt for the person concerned, and in the aftermath for bereaved families and friends, has been called the 'hidden toll' and is not easily quantified.⁹ The direct and indirect costs to Australia's economy from suicide, including lost productivity and tax revenue, have been estimated to be \$1.7 billion each year.⁴ This estimate only includes deaths by suicide. Other estimates have put the figure at close to 10 times that when non-fatal suicidal behaviours are taken into account.¹⁰

Continuing with the status quo, where numbers of suicides continue to rise year on year, clearly is acceptable. More people die by suicide than die on our roads or from skin cancer.²

A key risk associated with the current set-up of support systems, which needs to be addressed before almost anything else can be done to improve suicide prevention efforts, is the lack of available data about suicidal behaviours and how the health and welfare systems respond to them. There is not enough information available in a timely way about particular communities' vulnerability to suicide, and it therefore is difficult to target tailored interventions for at-risk groups. For example, the Commission has heard from submissions to the Review that the farming community is at increased risk of suicide because of twin pressures over which they have little control: the role of agriculture in local and national economies, and extreme climatic events like drought and flood. However, we cannot confirm this because routine data is not collected about the occupation of people who die by suicide.

Our review of suicide-related data collections nationally¹¹ revealed that we do not know any of the following on a national level:

- accurate numbers of deaths by suicide or suicide attempts
- numbers of people presenting to emergency departments with suicidal thinking, plans or attempts
- types of support accessed by, or offered to people, with suicidal thinking or behaviours
- types of support which people find helpful in preventing suicidal thinking or behaviour, or in the aftermath of an attempt
- outcomes of specific initiatives to prevent or address suicidal behaviour
- Aboriginal and Torres Strait Islander use of general population suicide prevention services.

A recent evaluation of the 49 projects operating under the National Suicide Prevention Programme/Taking Action to Tackle Suicide package concluded that, although the projects appear to meet their own objectives, it is difficult to determine whether they are having a material impact on suicidal behaviour. This difficulty is compounded by the lack of outcome measurement built into the projects.¹² As such, we do not know whether Commonwealth money is being spent effectively or efficiently, nor whether alternative arrangements such as fewer, larger projects, or different models of service provision might offer better outcomes.

Given that many suicides are highly preventable and that we know a lot about the complex mix of social, economic and psychological factors contributing to these deaths, our current approaches to suicide prevention are clearly not having sufficient impact. The Commonwealth Government, as a substantial funder of prevention initiatives and as the coordinator of prevention strategy and policy, must now provide a timely response to this issue.

Key findings

Listening to the experiences of those affected by suicide can offer us important insights into how to improve the effectiveness of our suicide prevention efforts. For this Review, the Commission set out to collect and look for patterns in these experiences through a public call for submissions and a set of interviews and surveys of people who have attempted suicide and their caregivers.

The Commission found a consistent and highly concerning story emerging of major deficiencies in the response received by many of those seeking help for suicidal thinking, attempts or bereavement. It seemed that people who encountered caring attitudes or received effective care and follow-up when seeking help put this down to 'good luck'.

'I've been to emergency before. I hurt my back, not even fractured and saw a doctor. I had an asthma attack and saw a doctor. But acutely suicidal and feeling incapable of keeping myself safe, and I never saw a doctor. In fact I was told that there wasn't one available! I don't want a big fuss but the feeling of being trivialised at such a moment is so distressing!'

Submission from a person with lived experience

The suicide-related stories submitted to the Review—by people with lived experience, caregivers, and professionals alike—exhibited a clear pattern of negative experiences. Three stand-out features of these stories were as follows.

First, there was a common belief that services and supports would only be offered to people who had already made an attempt on their life, to the extent that multiple respondents reported deliberately attempting suicide out of desperation for professional support. This was related to a perception that there is no 'middle ground', in terms of help for acute suicidality, between inpatient hospital care and no support.

Second, there was a strong feeling of being dismissed by health professionals, particularly those working in emergency departments, when seeking help for suicidal thinking or self-injury, and being sent home with no follow-up despite explicit plans for suicide. Many respondents reported feeling that they were not being taken seriously.

'[I was told that] my daughter "must leave by Sunday, we need beds for ... next week," ... they are emptying beds again, very sick people discharged so that very sick people may be admitted ... hours after discharge and in despair, [she took her own life].'

Submission from a support person

Third, even when help is offered, there may be either a long wait before it can be accessed or it is not followed up or completed to ensure the same crisis does not happen again. People commonly feel 'dropped' from the system, particularly after discharge from inpatient services at a point when they do not feel well enough to be out of hospital and where they have not received therapeutic intervention while in hospital.

These themes are backed up by data linkage work in New South Wales which found that of people who were admitted to a public hospital following a suicide attempt, only one in 10 received treatment in a specialist psychiatric unit during the course of their hospital stay, while less than two-thirds received mental health support of any kind following their attempt (whether as an inpatient or outpatient).¹¹

Together, this evidence provides an overwhelming case for a radical rethink of responses to help-seeking. We know that a previous suicide attempt is the most reliable predictor of a subsequent death by suicide. How the system responds to people who think about suicide or make an attempt therefore must be a central plank of suicide prevention efforts. The following published research finding is one indication that this opportunity is currently being missed.

'... around 40 per cent of rural men who died by suicide had seen a mental health professional in the three months prior to their death ... [this] indicates a need to consider factors such as the adequacy and appropriateness of available mental health services, the type of support provided, the intensity and level of care, and whether available services match well to rural men's specific characteristics and needs.'

Adapted from McPhedran & De Leo (2011)¹³

Suicide prevention programmes

A cluster of separate projects are funded under the National Suicide Prevention Programme and the Taking Action to Tackle Suicide Package. A number of helplines also are funded under these initiatives.

While these programmes have been found to be largely effective, they have tended to be conducted as separate initiatives rather than as a coordinated whole, and future efforts need

to be better coordinated and targeted, particularly to vulnerable groups and hot spots, and with collective action within communities.

These programmes need to accelerate their efforts in a coordinated way and build the evidence base for further development. 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.

Where to from here – implications for reform

There is a great opportunity to improve service and professional responses by listening to peoples' views about what helps or does not help when they are feeling suicidal. Consumers, caregivers and professionals reported to the Commission that there are two principles above all others which can help to prevent suicide on an individual level.

First, being able to access consistent therapeutic care from trusted professionals is essential. This support or treatment needs to be sufficient both to address the complexity and severity of a person's difficulties and to allow them to build a sustainable capacity to avoid any future crises.

Second, people told the Commission that if a crisis cannot be averted, empathic understanding from health professionals and first responders, which acknowledges emotional as well as physical distress, is crucial. Even simple kindnesses from health professionals can make a huge difference to a person's recovery.¹¹

'The support of weekly sessions with a psychologist has ... kept me ALIVE [and] stopped me requiring hospital support ... it has started me on the road to being employable, rather than unable to function ... it has stopped me passing my issues onto my kids.'

Submission from a person with lived experience

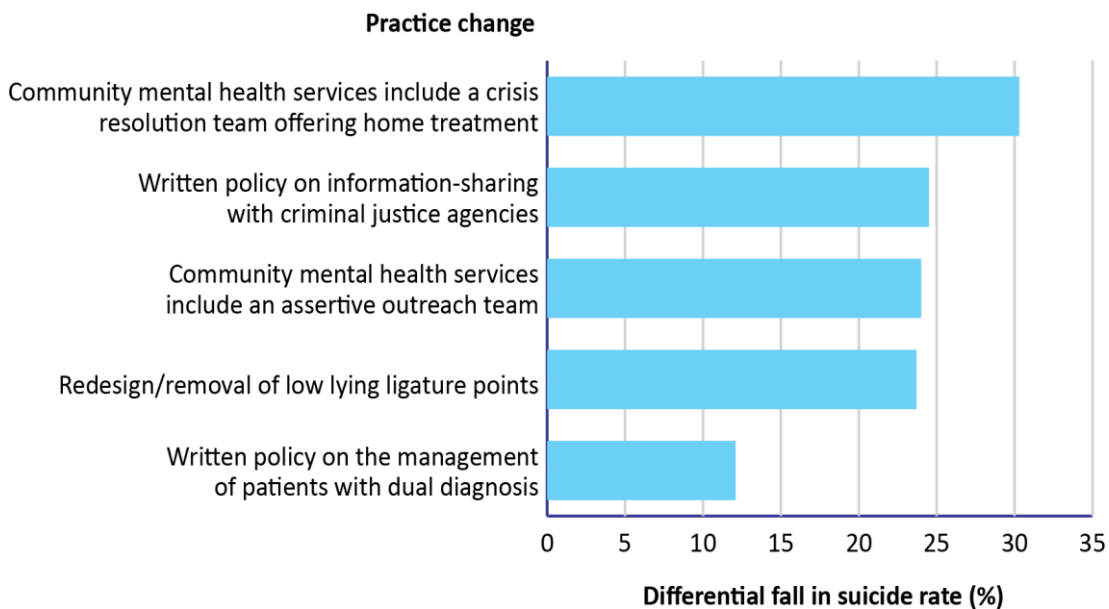
Many suicide prevention efforts are focused on 'universal' interventions such as anti-stigma and awareness campaigns which aim to encourage people to have 'difficult conversations' about suicidal thoughts and to help more people feel comfortable seeking help. Australia has had success in restricting access to means of suicide (for example, through firearms legislation) and in responsible media reporting of suicide, as well as in targeted intensive case management in some areas.

These are good starting points. However, the research for this Review indicates that when people do seek help, they too often are fobbed off or fall through cracks in the system of supports. It is important that if we encourage people to seek help, effective help is readily available.

There is promising evidence that systemic approaches to prevention which encompass coordinated, multi-sectoral initiatives within specific communities have had success in bringing rates of suicidal behaviour down. These include programmes run by the US Air Force, the European Depression Initiative and communities in Norway and Denmark which employ a 'chain of care' model. These all emphasise an integrated system of support activities ranging from general awareness-raising and 'gatekeeper' training to crisis follow-up and continuity of care.¹¹

Recent evidence from England also infers that a coordinated multi-component approach to suicide prevention is an effective way to bring suicide rates down, this time among a specific population of people who access specialist mental health services.¹⁴ Figure 6.1 illustrates the types of practice and policy changes associated with the biggest differential reduction in suicide rates among people using mental health services which implemented the changes, compared to those for people using services which did not. It is interesting to note that most of these changes involve promoting joint work across sectors and between hospital and community services.

Figure 6.1 Five practice changes associated with the greatest differential falls in suicide rates between implementing and non-implementing mental health organisations in England, 2004–2011



Source: UK National Confidential Inquiry into suicide and homicide by people with mental illness

Finally, dedicated, culturally appropriate campaigns are required for Aboriginal and Torres Strait Islander communities. Suicide has a particularly devastating impact on small, interconnected Aboriginal and Torres Strait Islander communities, and ‘suicide clusters’ are not uncommon. Research suggests the importance of strengthening culture and social and emotional wellbeing in preventing suicide among Aboriginal and Torres Strait Islander peoples, particularly young people. Culturally appropriate suicide prevention services, and the opportunity to be counselled by an Aboriginal and Torres Strait Islander person if required, are important in preventing Aboriginal and Torres Strait Islander suicide. Culturally appropriate postvention services are also important.

Actions

The research undertaken into suicide prevention for this Review, including the collation of existing evidence and the new evidence emerging from our consultation with stakeholders, points to two principal directions for change.

Firstly, future efforts in suicide prevention should focus on improving the quality of service responses to people who seek help for suicidal ideas or behaviours, and to those who are concerned about them. Such an improvement would involve the following:

- Access to adequate services, ensuring that the number of subsidised therapeutic interventions is able to be tailored to the complexity and severity of individual need. This is much cheaper than artificially curtailing the number of sessions and leaving a person 'lost' to the system and without professional support.
- In training, emphasising therapeutic communication and other 'soft skills' such as empathic understanding in the training of first responders and health professionals who are likely to encounter suicidal people.
- A 'no wrong door' approach, ensuring that no person who is expressing suicidal ideas or who has attempted to take their own life is turned away from any service at which they seek help.

Secondly, the Commission has identified a need to take advantage of existing research evidence which shows that a systemic, community-based approach to suicide prevention is likely to be the most effective at bringing suicide rates down.¹⁵ First steps in testing a whole-of-community approach would involve the following.

- Establishing agreed national minimum data sets for suicide prevention, to include outcome measurement and collection of baseline data.
- Initiating systemic, multi-level and multi-sectoral prevention models in particular Australian communities in collaboration with key stakeholders in those communities.^{16 17}

Thirdly, aim to close the gap in rates of suicide between Aboriginal and Torres Strait islander peoples and other Australians, including by providing services able to work effectively with Aboriginal and Torres Strait islander peoples in a culturally competent manner and by supporting community-developed and controlled suicide prevention programmes focusing on strengthening culture and social and emotional wellbeing in Aboriginal and Torres Strait Islander communities.

It is critical to promote evidence-based suicide prevention services following the report of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project. To date, the evidence suggests that community-focused and led interventions are the most effective in working to prevent suicide among community members.

Finally, implement the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013*, with—at least—existing funding commitments maintained and with Aboriginal and Torres Strait Islander mental health and suicide prevention leaders and stakeholders – such as the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG) – within the broader context of the development and implementation of a dedicated national Aboriginal and Torres Strait Islander mental health plan.

Case study

The following story was submitted to the Review by the relative of a man who died by suicide. It starkly illustrates how gaps in services and failure to follow up a call for help in a timely way can have tragic consequences, and how those who are bereaved can struggle to receive support.

‘My only sibling, my 19 year old brother, was reported to hospital triage by his regular GP just five days before his suicide. He died waiting for an appointment that was booked for three days after his death (8 days post initial request by GP for Crisis Team to attend). He had a problem that was completely solvable – he was struggling to come out as gay. This struggle is unsurprising given ... the fact that there are absolutely no support services for LGBT youth in this part of the country. The closest headspace centre is 1hr 20mins away, and my brother did not have his driver's license. Ultimately, there was no support for his specific issue anywhere near him, and there was no support for him when he faced crisis.

The support for those bereaved by suicide is non-existent in [my part of the country]. I have to drive 1.5-2 hours to the closest support group, ... When I became suicidal myself (which is apparently common for the suicide bereaved), the suicide call back service lines were often busy, as was Lifeline, *beyondblue* and a couple of the other support lines. I had already used most of my 10 psychologist visits available under Medicare when [my brother] died.

My brother's death was completely preventable, but he needed specialist assistance, and when that was not available, he needed urgent assessment and treatment. The system failed him.

I spend my nights having night terrors [...]. I have other symptoms too, and these symptoms tend to get better when I am able to see my psychologist more frequently. As long as I can only see her about once a month, I might not get better. Ultimately, the symptoms I experience prevent me from taking on full time roles in the fields I am trained in. Surely it would be better for the government if I could access around 20 visits under "Better Access" per year which would likely help me to recover to the extent that I could work full time.

Surely it is also better for the government if mental health triage perform their roles according to the guidelines rather than their limited funding. Of course, my brother will never work or pay taxes, but I'm sure the Coroner's inquest into his death that we have applied for will cost more than it would have to provide these services to him and save his life.’

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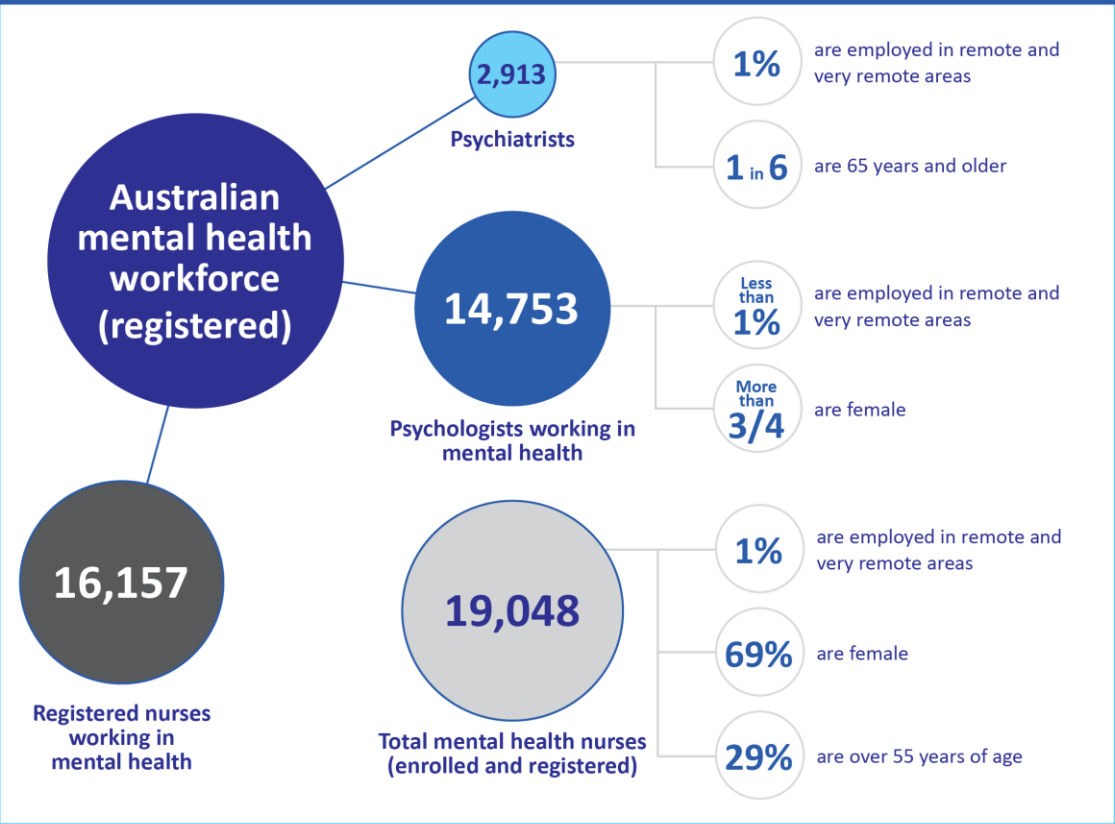
Chapter 7: Workforce development and training

In this chapter we address the Term of Reference on workforce development and training needs of the sector, and what is required to deliver on the system reforms aimed at improving access and outcomes. Action is required both in traditional specialist professions working in the mental health sector and for generalist workers requiring up-skilling and competencies to manage issues in the full range of settings.

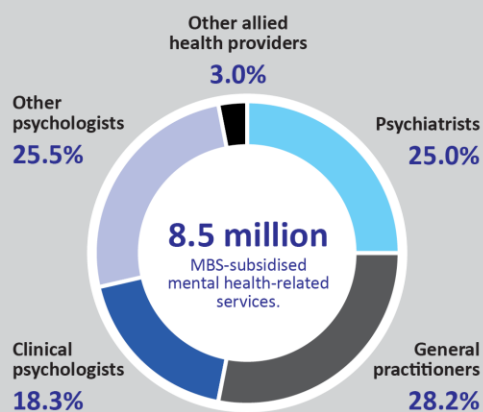
Term of Reference

Mental health research, workforce development and training

Australian mental health workforce

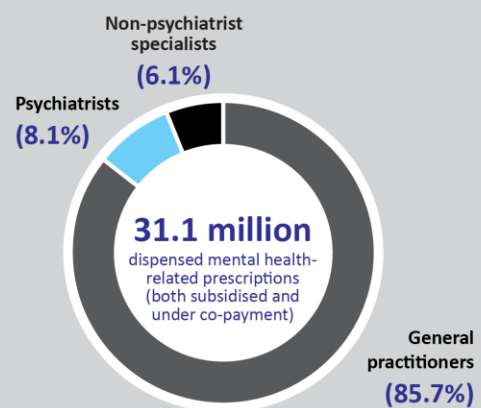


Medicare-subsidised (MBS) mental health-related services, by provider type, 2012–13



Australian Government expenditure in 2012–13 **\$874 million**

Mental health-related subsidised prescriptions, by prescribing practitioner, 2012–13



Australian Government expenditure in 2012–13 **\$788 million**

Sources: 2014 Mental Health Services in brief, AIHW, 2014. AIHW National Health Workforce Data Set 2012

What is happening now

The mental health workforce is broadening, moving from a clinical and medical-based workforce, including allied health, to one that encompasses the welfare and community sector and the growing peer workforce. This is a reflection of the move from hospital-based services to those in the community, the shift again into the nongovernment sector, and recent Commonwealth programme priorities to roll out personal support services.

National data collections have not kept pace with these changes, and so our picture is skewed towards the registered professions of psychiatrists, mental health nurses and registered psychologists. Generally we can only point to change and growth in the broader community and welfare sector, including:

- Employment for counsellors has increased strongly over the past five years and rose moderately in the past decade. Employment for counsellors to November 2018 is expected to grow moderately, from an estimated 21 700 in 2013 to 22 900 in 2018¹.
- Employment for health and welfare service managers rose very strongly in the past five years and over the past decade. Employment for health and welfare services managers to November 2018 is expected to grow very strongly, from an estimated 19 200 in 2013 to 23 800 in 2018².
- Employment for carers in the aged and disability sector rose very strongly in the past five years and over the past decade. Employment for carers in the aged and disability sector to November 2018 is expected to grow very strongly, from an estimated 127 000 in 2013 to 167 900 in 2018³.
- Employment for nursing support and personal care workers rose very strongly in the past five years and over the past decade. For this group, employment growth is expected to be very strong to November 2018, from an estimated 97 400 in 2013 to 110 900 in 2018⁴.

While these workforce groups do not exclusively work with people with a mental illness, they may work with people with psychological distress and/or psychosocial disability or work within the social and welfare sector managing the delivery of such services. They provide psychological support and therapies, health care, personal care and social assistance. The message is clear – this sector is growing and it is not all reliant upon professionals with a university education. Services are being delivered in peoples' homes and communities, not solely hospitals and health services.

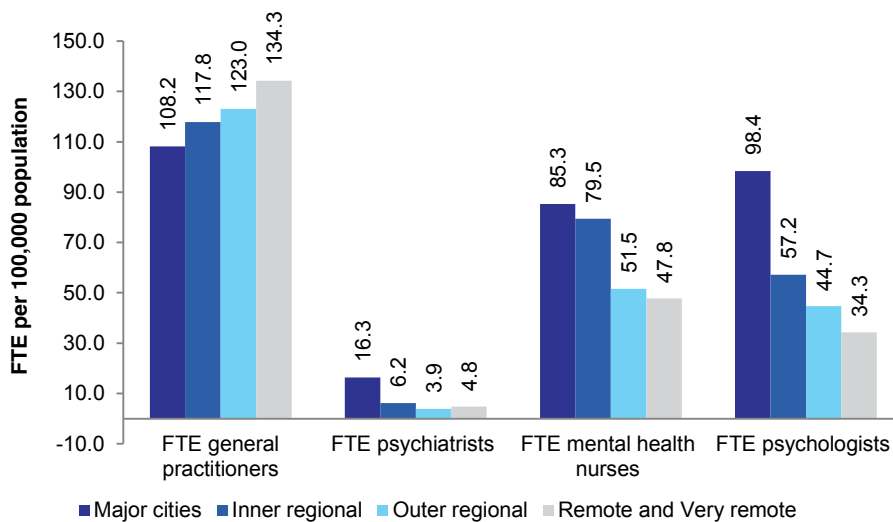
A number of allied health workforce groups may have a role in a person-centred mental health team, depending on the holistic needs of the person. These professionals include dietitians, occupational therapists, pharmacists, physiotherapists, psychologists, social workers and speech therapists. The regional team coordination model provides an opportunity for the best mix of professionals to work together in flexible ways, around the person's care plan.

The role of the mental health peer workforce is important in this evolving workforce environment. In one survey of 305 respondents, 51 per cent of peer workers reported they worked in the nongovernment sector, 17 per cent in public hospitals and 11 per cent in Commonwealth-funded mental health programmes or services.⁵ As an example, the nongovernment organisation Richmond PRA employs a large number of peer workers in services, including the Personal Helpers and Mentors (PHaMs), Housing and Accommodation Support Initiative (HASI), and Day to Day living (D2DL) programmes. While the numbers of people employed as carer and consumer workers is small, recognition of these groups and the role they have in a recovery-based mental health team is increasing.

The traditional mental health workforce

The role of the ‘traditional mental health workforce’ continues to play a large role and is essential to the success of Commonwealth programmes and services. General practitioners are essential in primary mental health care, in managing the person’s overall health needs and as gatekeepers for triaging and referral onto specialist assessment by psychologists or psychiatrists. While the specialist mental health workforce decreases on a population basis the further the distance from urban areas, the provision of GPs has the opposite trend. This has real implications for how people with a mental health difficulty who live in remote and very remote areas interact with the health system in seeking services and supports (Figure 7.1).

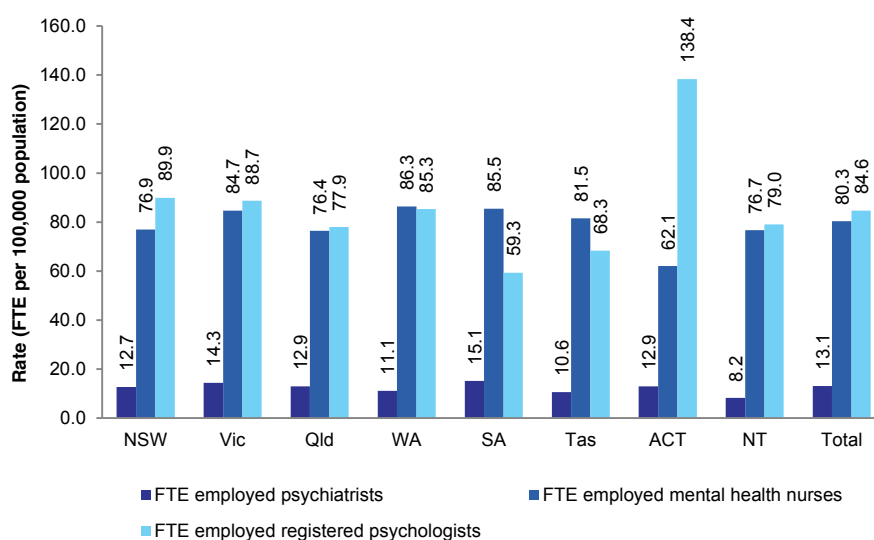
Figure 7.1 Employed (full-time equivalent) general practitioners, psychiatrists, psychologists and mental health nurses, by remoteness, 2012



Source: AIHW National Health Workforce Data Set 2012

Access to the mental health profession is not equitable; there is wide variation in the numbers of workforce groups across states and territories (Figure 7.2). In 2012 there were 8.2 psychiatrists per 100 000 people in the Northern Territory, with almost double that at 15.1 in South Australia.⁶

Figure 7.2 Employed full-time equivalent staff by profession type, states and territories, 2012



Source: AIHW National Health Workforce Data Set 2012

Professional workforce groups

The mental health workforce can be found in many settings, such as:

- community health services or hospitals
- residential settings providing housing support or personal support services
- schools and universities
- government social service and welfare agencies (e.g. Centrelink)
- business and industry workplaces
- criminal justice and corrections systems
- online (internet) or hotline (telephone).

Data across all of these settings and workforce groups is not readily available to allow assessment of the breadth of mental health work practice or workforce group types. This is a limitation to the Review’s assessment of the distribution, role and availability of individual workforce groups. Accordingly, the following discussion has a health focus.

The range of professional groups involved in providing mental health programmes and services in Australia includes ‘*mental health nurses, psychiatrists, general registered nurses, enrolled nurses, general and other medical practitioners, occupational therapists, social workers, psychologists, Aboriginal mental health workers, Aboriginal health workers, mental health workers, consumer (peer support) and carer workers*’.⁷

Of these, mental health nurses, psychiatrists and mental health workers are treated as being fully employed in mental health services, due to their specialist training. The remaining groups are considered to have opportunities to work both in mental health and other areas.

We know that, per capita, major cities have almost four times as many psychiatrists, double the number of mental health nurses and three times as many psychologists as remote areas.⁶ The workforce characteristics of these three groups are presented in Table 7.1.

Table 7.1 Registered psychiatrists, mental health nurses and psychologists, 2012

Group	Number (est.)	Characteristics	Distribution
Psychiatrists	2913	Average age 53 years, with about 70% over 45 years and more than 1 in 6 aged 65 years or over; almost 65% male.	More than 85% work in major cities, 9% in inner regional areas, and less than 1% in remote and very remote areas.
Registered nurses (working in mental health)	16 157	n/a ²	n/a
Registered and enrolled nurses (working in mental health)	19 048	Average age for mental health nurses (enrolled/ registered) 47 years, with over a quarter aged over 55 years. Almost one-third male.	75% of the mental health nursing workforce (enrolled and registered) in major cities, 18% in inner regional areas, and 1% in remote and very remote areas.
Psychologists (working in mental health)¹	14 753	For all registered psychologists, average age was 46 years; 25% are aged 55 years and over. More than 75% are female.	For all registered psychologists, 82% work in major cities, 12% in inner regional areas, and less than 1% in remote and very remote areas.

Source: AIHW National Health Workforce Data Set 2012 and Human Capital Alliance Report on Workforce Requirements.

Notes:

¹ In 2012 there were 22 404 registered psychologists. Not all registered psychologists work in mental health services as defined by HWA. This figure is an estimate calculated using the distribution of psychologists by work setting (Health Workforce Australia [2014]: Australia's Health Workforce Series – Psychologists in Focus)

² The National Health Workforce Data Set 2012 collects information on the characteristics of registered and enrolled nurses combined. There is no separate characteristic data available for registered nurses only.

Workforce distribution is a significant issue for regional and remote populations. This was identified in submissions to the Review as a barrier to optimal outcomes for consumers and supporters. The skewed distribution of the registered workforce directly contributes to inequitable access to mental health professional services and interventions in rural and remote communities. The ageing of the workforce is leading to staff vacancies on teams.

Health Workforce Australia (HWA) identified shortages in mental health nurses as being of most concern. Using the “comparison” supply and demand projections for registered mental health nurses (assuming constant graduate supply, no change in skilled migration rates and higher wastage rates after 2016) there is a projected 36 per cent shortfall to 2025. In comparison, a projected shortage of psychiatrists was estimated at eight per cent to 2025. No projections were undertaken for psychologists.⁸

Mental health nurses are important members of the mental health workforce. The recent evaluation of the Mental Health Nurse Incentive Programme (MHNIP) shows it is highly valued,⁹ and the Commission's consultations have confirmed that view. However, there are limited incentives for nurses to undertake additional mental health training.

Short-term challenges for the workforce include:

- resolving the current and potential future shortfalls in mental health nurses, psychiatrists and key allied health professions
- supporting training of generalist health workers such as allied health professionals and frontline workers on mental health-specific skills through additional opportunities for training in the Certificate IV in Mental Health or Mental Health First Aid.

Workforce pressures

Work undertaken for the Review highlighted that the traditional mental health workforce is under pressure, as many mental health nurses and psychiatrists move into pre-retirement age. Despite this, services remain reliant upon traditional face-to-face service provision from these groups.¹⁰

What doesn't help is when professionals treat you more like a number than an individual person [...]. There is a substantial lack of understanding in the health care system towards mental health. On multiple occasions I have felt as though I was entirely misunderstood, and have been treated poorly due to the stigma attached to my diagnosis (borderline personality disorder).

Submission from a person with lived experience

In 2014 we have no clear line of sight on projected workforce needs outside psychiatrists, mental health nurses and clinical psychologists, yet Commonwealth programmes are investing in more personal support and psychosocial interventions to keep people well in the community (including PHaMs, PIR, D2DL).

Approaches to the mental health workforce need to broaden and become sufficiently flexible to work across differing locations and through different models, to deliver efficient and effective services.

Action to reduce discrimination demonstrated by health workers also is needed, as it has been found to be a factor in people not seeking help, or poor interactions that result in people not returning to a service.¹¹ The Review has identified the need for professional groups who come into frequent contact with people with a mental health difficulty to improve their understanding of mental illness, and in doing so contribute to a better outcome for the person. This is especially important in particular workforce groups such as nursing, as well as groups in non-health workplaces such as the education sector. Half of all lifetime cases of psychiatric disorders start before 14 years of age.¹² Evidence suggests it is possible to prevent or ameliorate social and emotional problems that impact on educational outcomes using school-based interventions.¹³ These approaches rely upon health professionals working collaboratively in these environments. We know that in 2007 more than 2000 psychologists worked across Australian school systems.¹⁴

Key findings

Volume 1 of the Review concentrates on broad system reform with a focus on funding of health system infrastructure and national structures to deliver programmes. These reforms identify specific workforce supply and demand strategies requiring action in the next two years. There also are training requirements for workforce categories where improved supply and access is dependent on specific training or retraining. Workforce data sets are essential to support evaluation and future policy development in this area.

Reform in early childhood and teacher training, which is needed to support the focus on improving mental wellbeing in infants and children, is also covered in Volume 1, with a number of key actions to be completed by 2017.

The workforce comparison supply and demand projections undertaken by HWA demonstrate that without change in graduate supply and service delivery, demand for mental health nurses will substantially exceed supply by 2025.⁸ Workforce shortages also are apparent in the nongovernment mental health sector, albeit without the focus on nurses and psychiatrists. High staff turnover rates, staff supply shortages and challenges in recruiting staff with adequate experience remain concerns.¹⁵

We require new approaches to how we both define the ‘mental health workforce’ and shift the focus from a medical and health professional basis to a broader one that includes social and personal support workers.

If workforce approaches do not change, current training, recruitment and retention strategies will not meet current or future demand for mental health services.⁷

Workforce education needs to change, so that contemporary evidence-based practice is embedded across the mental health system to provide an effective service system. If generalist and emergency workers do not have their mental health literacy and understanding improved, clients will turn away from services due to poor or stigmatising experiences. This has flow-on effects of failure to access the right type of supports when first needed to avoid progression of illness and the consequent need for more acute interventions.

The workforce is much more than a delivery mechanism of health interventions and treatments. Workers have opportunities to provide evidence-based care, to engage positively with the person and their family and carers and to keep the person engaged with services or supports in their own homes, in school, at work or in training.

If services continue to be provided under current structures and the mental health workforce continues to be developed along current lines, mental health services will never meet the needs of the Australian population.⁷ Stakeholders have argued that more of the same will not work,¹⁶ and despite efforts and resources being applied to recruitment and retention of the mental health workforce, these will be insufficient to meet ongoing workforce requirements.⁷ Particularly in small towns or across the community-managed sector, mental health training of existing workers could expand their scope of practice, or reform their current practice, to reflect more contemporary approaches for improved outcomes.¹⁷

The longer-term challenge is to refocus the sector to more demand-driven approaches and on working more flexibly across professional groupings. This includes moving to a greater role for the primary health sector and expanding access to lower resource-intensive services such as e-mental health. In turn, this will free up existing specialist workforce capacity, enabling these trained professionals to provide direct care for people experiencing more acute mental ill-health. Increased numbers of mental health nurses and psychiatrists are needed in the face of potential shortfalls as well as development of other workforce categories, such as peer workers.

Considerable potential for new workforce groups and work practices

The necessary workforce and work practice shifts go beyond the mental health workforce and traditional face-to-face interventions. We need a mental health-competent primary health care sector, a flexible and resourced community health sector and opportunities for individuals to be supported in ways that suit them better in accessing support and treatment.

- There is a need for an expanded role at the frontline for mental health identification, management and referral to personal supports or specialist services. The Primary Health Care (PHC) workforce includes GPs, practice nurses, allied health professionals,

Aboriginal health workers, nurse practitioners and peer support workers. The PHC sector will need to develop and enhance its competence in mental health promotion, prevention, early intervention, medication management and referral to specialist services.

- Welfare and frontline services that are not in the mental health sector need workers to develop mental health competence to enable them to ensure appropriate and safe services for individuals with mental ill-health.
- Improved mental health competencies of teachers and educators would extend their capacity to identify and refer people needing mental health support to mental health skilled workers and services. This is an important role in assisting people to get to the right interventions when they need them early on.
- A professional peer workforce comprises workers who have a lived experience of mental health, either as an individual or as a carer of someone who has experienced mental ill-health. Peer workers currently work across a range of service settings and perform a variety of roles. These include providing individual support, delivering education programmes, providing support for housing and employment, coaching, and running groups and activities. The benefits for people with a mental illness of having a peer support worker as part of their mental health team have been found to include reduced hospitalisation rates and longer periods of living within the community.¹⁸

Developing the Aboriginal and Torres Strait Islander mental health workforce

A key strategy in attracting Aboriginal and Torres Strait Islander people to use mental health services and improve mental health outcomes is to increase the number of Aboriginal and Torres Strait mental health workers within the community-managed mental health sector.¹⁹ This would support the changes in service delivery proposed and enable all services (specialist and mainstream) to be more culturally responsive and better able to work with Aboriginal and Torres Strait Islander peoples.

It is a priority to ensure that culturally appropriate services are available, especially given the higher incidence of mental health difficulties and high or very high psychological distress experienced by Aboriginal and Torres Strait Islander peoples.²⁰ Expansion of this workforce is illustrated in recent efforts in NSW by the Mental Health Coordinating Council, which supported 32 trainees and four existing workers to complete the Aboriginal Careers in Mental Health (ACIMH) course. The ACIMH is an evaluated programme demonstrating a significant positive impact on employment and support of Aboriginal staff.²¹

Aboriginal and Torres Strait Islander people, particularly those unable to access Indigenous Primary Health Care Organisations (including Aboriginal Community-Controlled Health Services) are generally reliant on GPs for primary mental health care. Evidence suggests that this is the case for approximately 50 per cent of the Aboriginal and Torres Strait Islander population. MBS-subsidised GP health assessments are a potentially useful tool for screening and detecting high or very high levels of psychological distress among Aboriginal and Torres Strait Islander patients and for then connecting them to programmes like ATAPS or Better Access for treatment or ongoing referral.

Because of the critical importance of GPs to Aboriginal and Torres Strait Islander primary mental health care, the Review believes that all new GPs should be required to undergo training in delivering culturally competent professional services to Aboriginal and Torres Strait Islander people. Relevant professional bodies should work to ensure all GPs complete such training eventually.

Where to from here – implications for reform

Declining mental health nurse numbers are the most immediate threat to specialised mental health service workforce capacity and should be the primary short-term focus, alongside parallel strategies to increase the peer workforce. The supply of mental health nurses can be increased by training general registered nurses to become mental health nurses (using incentives such as low-cost qualification and scholarships). Transferring nurses from the general to the mental health workforce will have a limited impact on the general registered nurse population but will dramatically improve the supply of mental health nurses. Combining elements of the Practice Nurse Incentive Programme (PNIP) and to the Mental Health Nurse Incentive Programme (MHNIP) has the potential to create attractive incentives for the employment of mental health nurses in general practice.

There also are opportunities to address the productivity of the current workforce. While investment in e-mental health, tele-mental health and self-management technologies is already occurring, there is a need to train and appropriately deploy psychiatrists, psychologists and mental health nurses to make best use of these cost-effective measures. Such approaches could be addressed through a review of training programmes.

Addressing other workforce resources is another approach to filling immediate shortfalls in supply. The psychology workforce holds great potential for a rapid and sustained response to demand; however, more information is needed on the actual supply of clinicians currently working in mental health services. Based on the information this yields, there is opportunity to explore how best to utilise four-year trained psychologists through provisional registration and associated limits on scope of clinical practice, such as the use of psychology assistants.

In the longer term, and in addition to increasing the overall numbers of mental health nurses and peer workers, the shortage in current workforce groups employed in mental health services requires a shift to a more flexible workforce, driven by consumer demand, and trained and distributed on the basis of competencies rather than professional categories. The mental health workforce of the future will involve an increasingly diverse mix of people, operating in teams and focused on responding to mental illness as early as possible. The workforce also will need to encompass whole-of-life approaches, including mental health and social supports across health, human services and social services sectors.

New models of care to support greater effectiveness in the community mental health and acute care sectors will require the workforce to be able to be better integrated and form into teams more easily. These new models would see workforce groups change the way they provide services to enable greater reach. One example would be for psychiatrists to be used as consultants across services in the community, providing their expertise as inreach to primary health care workers, in addition to having community mental health specialists support primary health care teams. This will allow greater reach of expertise. Incorporation of e-mental health interventions into practice also would improve reach, particularly in rural and regional Australia.

The primary health care sector needs to be more involved as the locus of care changes from inpatient (centralised) treatment settings to being provided in community collaborative settings. This means increasing the capacity of GPs, practice nurses, practice managers and others to work with people with a lived experience of mental health. The role of the general practice workforce, in particular, will need to be a focal point to assist in improved access to services, reduction of stigma, identification of mental health issues and management of mental health and physical health comorbidity.

Mental health peer workers are needed, particularly for those people with severe and complex mental illness. This group is a key component of recovery-oriented mental health services and also can play an important role in suicide prevention. In addition, other mental health support people will need to have mental health literacy competence to support individuals with a mental health issue to adopt a recovery-based pathway.

Work practices will include a greater integration of face-to-face and e-mental health practices. Self-help will need to be routine, while remote monitoring of people with a mental illness is expected to become common practice. The ongoing development of e-mental health also provides significant opportunities for education and training of the mental health workforce.

Workforce development and planning actions will need to be reoriented from discipline-based teaching processes to broader capability-based learning experiences. Mental health training, including suicide prevention training, also needs to be incorporated into the training and professional development of first contact staff such as hospital emergency department staff, ambulance officers, police and welfare officers, as well as in education.

Support for the development and wellbeing of children and resilient and mental health-literate adults needs to be increased through engagement with new parents, early childhood services, preschools and primary schools to maximise child development. Integration of existing programmes to better target outcomes in the education sector will ensure that the current service gap for children with emerging or established difficulties is closed.

Specialists working in “physical” health disciplines also need training and development on how to recognise the mental deterioration of patients.

Actions

- Increase the number of mental health nurses by 1000 by retraining general registered nurses as mental health nurses (using incentives such as recognition of prior learning and service, low-cost qualification pathways and scholarships).
- Improve productivity of the current workforce by training psychiatrists, psychologists and mental health nurses to make best use of e-mental health, tele-mental health and self-management technologies.
- Increase the supply of the skilled specialist workforce by exploring opportunities to use four-year trained psychologists, through provisional registration and associated limits on scope of clinical practice, such as the use of psychology assistants.
- Develop a more flexible workforce, driven by consumer demand and trained and distributed on the basis of competencies rather than professional categories; and encompass whole-of-life approaches, including mental health and social supports across health, human services and social services sectors.
- Increase the reach of the professional workforce expertise by using groups as consultants across services in the community, both through technology solutions and by providing direct assistance to primary health care teams.
- Embed the primary health care sector as the locus of care in community collaborative settings, particularly the role of general practitioners in improving access to services, reducing stigma, identification of mental health issues and management of mental health and physical health comorbidity.
- Embed the role of peer workers within the mental health team, particularly for those with severe and complex mental illness, as a key component of recovery-oriented mental health services.

- Reorient workforce development and planning from discipline-based teaching processes to broader capability-based learning experiences. Incorporate mental health training, including suicide prevention training, into the training and professional development of first contact staff such as hospital emergency department staff, ambulance officers, police, welfare officers, and in education.
- Include in continuing professional development training on recognition of clinical deterioration – both mental deterioration of people with a physical illness and physical deterioration of people with a mental illness.

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Chapter 8:

Mental health research

This chapter examines the current prioritisation of different types of mental health research in Australia and proposes a change to align research priorities with the priorities of practitioners, consumers and supporters.

Term of Reference

Mental health research, workforce development and training

Australian research into mental health is considered to be world-leading. However, there is a disconnect between the 'mental health system' (of policy and delivery) and the 'research system'. This section examines the rationale behind mental health research and the steps towards a strategic prioritisation of mental health research to match policy, service and consumer priorities.

What is happening now

Context

The term 'mental health research' refers to a wide spectrum of work carried out by academics, clinicians, governments and people with a lived experience of mental illness, across a wide range of disciplinary and methodological areas. The spectrum covers everything from basic science (laboratory) research into the biological causes of mental illness, clinical research into potential treatments (including drug interventions), investigation of potential and existing models of system design and service delivery, and social science-based approaches to the consumer experience of mental illness and of interventions and services.

Our findings against this Term of Reference are a synthesis of three main sources of evidence: first, stakeholder interviews with 12 leading researchers, clinicians and consumer/carer representatives; second, a review of published literature, including international examples of good practice in research; and third, views about the state of mental health research in Australia which were formally submitted to the Review.

The findings in this section are presented in the context of two recent developments for health research in Australia – the McKeon Review¹ and the Australian Government's announcement early in 2014 of a Future Fund for medical research.² The Commission understands that as at the end of November 2014, the Government has not yet determined how funds under the Future Fund will be disbursed. We are concerned that mental health receives its 'fair share' of research funding, especially given that \$73.8 million of mental health savings in the 2013–14 budget will be directed to the fund from the deferred establishment of Partners in Recovery organisations and non-indexation of mental health programme grants.³

With regard to the McKeon Review, the Commission has found that our proposals for the future development of mental health research in Australia broadly align with (and build on) its directions for health research more generally.

An aspect of mental health research which is sometimes excluded from this spectrum is the evaluation of existing programmes and services, but it was clear that both interviewees and submissions to the Review perceived evaluation as a key role that research can play in improving experiences and outcomes for consumers and supporters, by informing service and programme design and delivery as well as accountability.

The status quo

University-based mental health research in Australia, especially in the areas of genomics and e-mental health, is considered to be of an excellent standard and to punch above its weight on the world stage. However, the size of this research sector is small in absolute global terms and has been referred to as a 'cottage industry'. This means that in order for the work of Australian researchers to have a noticeable impact on mental health programme and service reform, it

needs to be strategically prioritised, aligned with policy and practice challenges and efficiently translated into practice.

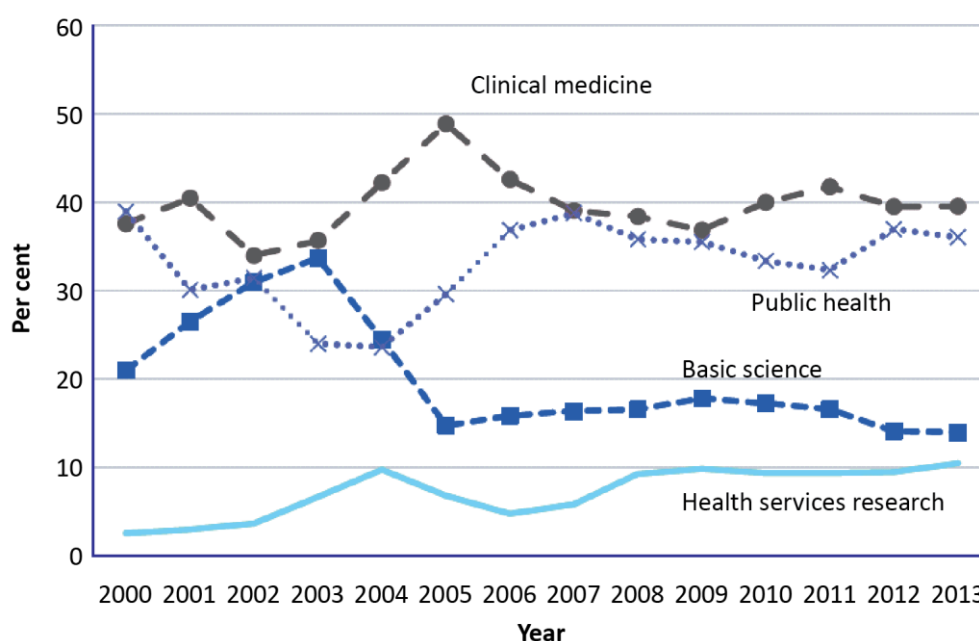
Due to the breadth of issues and disciplines involved, governance and oversight of publicly funded mental health research in Australia is divided at a national level between the National Health and Medical Research Council (NHMRC) and the Australian Research Council (ARC). ARC data suggests that an average of \$15.2 million of funding was provided each year between 2010 and 2014 to mental health-related research. NHMRC reports that its annual funding of mental health research has increased tenfold between 2000–01 and 2013–14, from \$7 million per year to \$70 million per year.⁴ Beyond this, many nongovernment organisations fund and oversee mental health research using public or private income, including Rotary Health and *beyondblue*.

Funding priorities

Detailed breakdowns of recent trends in mental health research spending by topic have been difficult for the Commission to determine using the information provided by the two research councils. The available NHMRC funding data shows that despite the growth in total mental health expenditure, funding dedicated to mental health research presently comprises 8.6 per cent of its total funding of health and medical research in 2013 – less than might be expected from the burden of disease (BoD) attributable to mental health (the 2010 Global Burden of Disease study found mental disorders contributed 12.9 per cent of the total BoD and 22.3 per cent of the non-fatal BoD).⁵

Approximately 40 per cent and 35 per cent of NHMRC mental health funding is allocated to clinical and public health research respectively, 15 per cent to basic science and 10 per cent to health services research, as shown in Figure 8.1.⁴ Beyond this, it is difficult to determine more detailed funding information due to opaque categorisation of research.

Figure 8.1 NHMRC mental health-related funding by broad category



Source: eContext Report on Strategic Priorities for Mental Health Research prepared for the National Mental Health Commission 2014

To supplement this data, evidence supplied to the Review by those working within and alongside the mental health research sector indicates that certain types of research appear to be under-prioritised. Basic science research and clinical research into single interventions under laboratory conditions are considered to be comparatively well funded.

In comparison, ‘real world research’ appears to be neglected. This includes, but is not limited to, cross-disciplinary investigations into combinations of supports which take account of the complex nature of mental illness and other social and economic difficulties, including lost productivity, cost-effectiveness research, and research into the design of optimal models of care delivery. In addition, while developing innovative treatments is seen as important, assessing the effectiveness of current investments—such as acute inpatient care—is seen as a priority for the development of mental health research in the future.

In particular, there is a need to establish best practice in Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention services and programmes. To that end, it is important to establish and fund a body under Aboriginal and Torres Strait Islander leadership to pursue these research priorities.

Key findings

The evidence collected for this Review reveals a consensus among diverse stakeholders that there are a number of significant problems with the status quo in mental health research. The most prominent are as follows:

- There is a major disconnect between the research sector and the mental health services and supports sector. Researchers need to give greater consideration to the needs of practitioners, consumers and carers, while planners and providers of services do not always take account of available research and evaluation findings.

- There is no national mechanism for prioritisation and oversight of mental health research to ensure it is aligned with policy priorities and the challenges faced by frontline practitioners.
- Career progression for researchers is driven by peer regard and does not encourage increasing the impact of their research on services and programmes.
- The lack of nationally consistent tools and infrastructure for collecting data about efficacy and cost-effectiveness significantly hampers research into which mental health and associated interventions work, and for whom.
- There is a need to strengthen the evidence base for Aboriginal and Torres Strait Islander mental health, suicide prevention, and related services and programmes. The ongoing Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project provides a model for the development of this evidence base under Aboriginal and Torres Strait Islander leadership.
- There is no mechanism to involve consumers, frontline practitioners and informal supporters systematically in prioritisation and conduct of evaluations and research.

There are two key risks of continuing with this status quo in mental health research:

- Commonwealth investment is not prioritised towards research which has the greatest potential to improve the experiences and outcomes of consumers and carers.
- Commonwealth investment in and planning of programmes and services is insufficiently informed by the findings of evaluations and research.

There are significant opportunities to build on the current strengths of Australian mental health research. These could be realised by adopting a systemic approach which recognises successful research and effective service delivery as interdependent. Until now, efforts to strategically prioritise mental health research have relied on 'soft levers' such as the NHMRC's research priority area statements. These levers traditionally encourage change in the behaviour of researchers, but do not acknowledge the role of policy makers in the successful use of research findings.

The options for change proposed below rely on the implementation of such a systemic approach, requiring reform both in how research is produced and how it is used. This means:

- increasing the connectedness of the research and broader mental health systems
- increasing the ability of the broader mental health system, including the community, to leverage local and international research.

Where to from here – implications for reform

Rebalancing the mental health research portfolio to ensure it supports consumer outcomes as well as value for money for taxpayers could usefully be based on the following principles.

Excellence: maintaining the current world-leading standards of research, while balancing current emphasis on investigator-driven research with greater attention to priority-driven research.

Responsiveness: delivering research that mental health programmes and services need to drive improvement, especially regarding complex interventions, non-clinical supports, models of clinical care, early intervention and consumer pathways.

Partnership: a wide range of stakeholders, including people with a lived experience of mental illness and their supporters, are involved in setting research priorities.

Relevance: improving the whole-of-life experience of consumers and supporters, including the experience of programmes and services, underpins research.

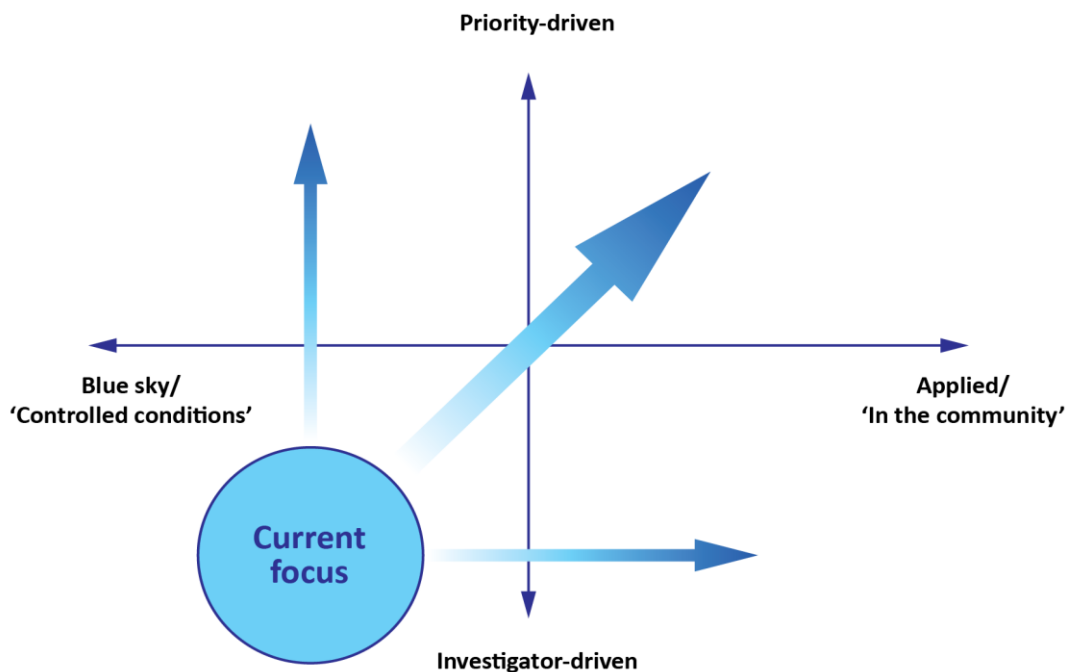
Connectedness: specific mechanisms exist to connect the research and service systems, including translation and dissemination of research for ease of use, and evaluation is embedded in the planning and operation of services.

Evidence: measures to implement improvement are evidence-based where possible, and ongoing evaluation means inappropriate interventions are ceased.

Accountability: robust mechanisms exist to ensure research bodies are publicly accountable for the investment made in them.

Figure 8.2 describes the desired change in future prioritisation of mental health research..

Figure 8.2 Current and desired focus of mental health research



Source: eContext Report on Strategic Priorities for Mental Health Research prepared for the National Mental Health Commission 2014

Actions

- Establish a sense of urgency for change in mental health research priorities from mostly investigator-led to mostly driven by the needs of policy makers, services, clinical professionals, consumers and carers. This might be achieved through a consultation document developed by a core group of key stakeholders.
- Establish a tangible national mechanism for consensus-building about future strategic prioritisation of mental health research, such as a National Mental Health Research Strategy.
- Generate quick wins to demonstrate the value of greater connection between research and service sectors. For example:
 - introduce a 'researcher in residence' model as a way of embedding evaluation within the core business of service provision

- create an Australian mechanism for involvement of consumers and caregivers in the design and conduct of research, along the lines of UK models
- conduct an audit of current mental health data collection across Australia, including a gap analysis of data requirements
- investigate current data linkage platforms and how to improve these/scale them up – focusing on using them to assess the impact of complex, cross-sectoral supports on social and economic engagement
- establish a body under Aboriginal and Torres Strait Islander leadership to establish best practice in Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention and alcohol and other drug use prevention
- Develop a single national data set which serves the needs of researchers, policy makers and service providers for quality improvement, accountability and evaluation purposes. This should be developed in consultation with consumers and caregivers and piloted extensively with services.
- Make it easier for policy makers and people working in frontline services to access and use research evidence and evidence of good or promising practice.
- Establish a ‘what works’ and ‘best buys’ internet portal, including Australian and international evidence about the efficacy, effectiveness and cost-effectiveness of mental health models of care and interventions.
- Create ‘hard’ incentive structures to encourage research focused on service and consumer priorities:
 - filter research grant applications through a panel of frontline professionals, consumers and supporters (once scientific and ethical validity have been established)
 - establish funds to encourage ‘new’ researchers with innovative ideas rather than funding research based exclusively on track record and publications
 - build research activity into continuing professional development requirements for frontline practitioners and ensure this time is funded
- Ensure strategic prioritisation of research activity is embedded in the everyday operating principles of research funding bodies, universities and service providers:
 - success for researchers to be measured in terms of policy and practice impact rather than exclusively peer-regard and numbers of publications
 - all government-funded projects incorporate time and funding for evaluation.

Case Study: the Cancer Australia model of research prioritisation

‘A more strategic approach to research and health care delivery, and to integrating research and care, has been taken in respect of cancer. It is evident in the Australian Government’s National Cancer Plan, which led to the creation of Cancer Australia, a Commonwealth Government agency created by statute.

One of the notable features of the Cancer Plan is that it brings together elements of research, health care delivery, workforce development and patient support ... there is merit in considering whether the Cancer Plan model would work effectively for mental health research.

The National Mental Health Commission is well placed to play a leadership role in integrating research into mental health services and programmes. The advantages of such an integrated approach include:

- data collection which serves clinical, research and performance reporting needs
- clinical interventions, standards and guidelines which have an evidence base
- community education and prevention measures which have a basis in research and are subjected to rigorous assessment of effectiveness
- research which is directed to areas of need and seeks to answer the questions that are relevant to health care providers and people experiencing mental illness
- identification of ineffective and inefficient practices and interventions
- integration of KPIs and performance measures for research conducted in mental health services and programmes with existing KPIs and performance measures.

Research Australia submits that Australia needs to take a more strategic and integrated approach to mental health, and calls for the development of a National Mental Health Plan which integrates service delivery and support for people who experience mental illness and their families with research, performance reporting and increased community awareness of mental illness and mental health.’

Submission from Research Australia

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Chapter 9: Governance and accountability

This chapter addresses the overarching Terms of Reference for the Review which relate to how programmes are delivered, how people are supported and how the system can improve performance.

Terms of Reference

The efficacy and cost-effectiveness of programmes, services and treatments

Duplication in current services and programmes

The appropriateness, effectiveness and efficiency of existing reporting requirements and regulation of programmes and services

Transparency and accountability for the outcomes of investment

System governance

This chapter undertakes a broad assessment of programmes and services, taking both a system perspective and a closer view of the larger areas of programme funding.

As the previous chapters have shown, we presently are stuck in a “lose-lose” situation where neither people using mental health services nor taxpayers get a good deal from the mental health system. This infers that it is necessary to undertake a fundamental rethink of the basic scaffold upon which the system is built. Governance and reporting frameworks, driven by the Commonwealth, form this scaffold.

In this chapter we assess the efficacy and cost-effectiveness of current investment patterns, and some of the negative ramifications of current governance strategies, including duplicated services and inappropriate reporting. It focuses on the largest mental health-related programmes to draw out findings of greatest impact for people and government.

The efficacy and cost-effectiveness of programmes, services and treatments

How we have interpreted this Term of Reference

The Commission took a person-centred approach to considering the efficacy and cost-effectiveness of programmes and services. Our starting point was the assumption that high-level governance strategies and financing decisions need to begin with the individual. If a system does not allow a person seeking help to have their mental health needs met it is poorly designed and cannot be considered as either effective or efficient.

The efficacy and cost-effectiveness of current overall investment patterns and programme spending have been the main focus. It has been beyond the resources of this Review to evaluate the efficacy or cost-effectiveness of specific clinical treatments.

The Review identified that over the past five years, the Commonwealth has led 140 programmes that focused on mental health across 16 agencies. Some had funding attached, while others were National Agreements or mental health partnerships. This group of programmes, according to advice from Commonwealth agencies to the Review, encompassed direct payments to states and territories for hospital mental health services, welfare payments to people and carers related to a psychiatric impairment or disability, programmes for the Australian Defence Force and returned soldiers, and non-clinical psychosocial support services.

This Review has focused on the 108 Commonwealth programmes/services that provided mental health and psychosocial supports in the community (that is, outside of hospitals) during 2012–13. These are summarised in Attachment A to Volume 1.

What is happening now: efficacy and cost-effectiveness of programmes and services

An assessment of efficacy or cost-effectiveness usually requires some kind of outcome information against which levels of investment can be compared. However, it is a well recognised failing of the mental health system in Australia that there is a lack of outcomes measurement, collection and use of data on a nationally consistent level. The Commission has reviewed a number of evaluations of Commonwealth programmes (some of which are years out of date) which commonly identify that although they are succeeding against many of their objectives, programmes are under-achieving against access goals, especially where the target population is not adequately reached by the programme, or where availability is inconsistent in different geographical areas.

The variability of local management approaches, fidelity to models or local circumstances beyond the control of a service provider (such as workforce shortages in rural and remote areas) imply that efficacy could be improved through a greater emphasis on design and service planning to reflect local or regional circumstances, involvement of communities in regional programme development, and flexibility in model design to accommodate different workforce mix or mode of delivery (face-to-face, phone, videoconference or online). These findings are considered in recommendations on programmes and rural and remote issues.

The following is a brief synopsis of high-level findings about the largest Commonwealth programmes which provide direct clinical and non-clinical support for people experiencing mental health difficulties. Key data about each programme, including expenditure during 2012–13, is given in the summary table attached to this chapter of the report.

headspace: the National Youth Mental Health Foundation

Headspace provides clinical services for people aged 12 – 25 who need help across the areas of mental health, employment, drug and alcohol use, relationships and school. This initiative was established specifically to respond to the major deficit that existed at that time in accessing primary care-based services for young people during the period of onset of major mental disorders.

Since 2007 the emphasis has been on building a national network of shop-front services in local communities, distributed widely across the major regions of Australia. The headspace programme was most recently evaluated in 2009. Despite continued significant investment in the programme since then, the next assessment of its effectiveness is not due until early in 2015. The Government has committed to expand to a total of 100 headspace services by 2016.

The 2009 evaluation reported that:

- it took an average of seven months for new services to open and longer to provide a full complement of services
- the implementation approach for headspace does not significantly vary in terms of geographic location
- regular reviews of effectiveness are needed to ensure that headspace is reaching out to marginalised groups, including economically disadvantaged people, refugees and Aboriginal and Torres Strait Islander communities.

To date there is little systematic data available from headspace directly (or through independent evaluations) on a range of important issues: the impact of the establishment of headspace services on local service pathways; whether the services have increased access for young people in the regions served (or simply diverted young people from other pathways); provided greater access for those with limited access to standard care (by geographical, diagnostic or socio-demographic characteristics); improved the quality of clinical assessment of young people with emerging mental disorders (e.g. through earlier and better access to skilled general practitioners, clinical psychiatrists or specialist psychiatrists); or linked effectively with functional recovery services in education or employment participation. Currently, only service participation data has been reported at the national aggregated level.

While headspace has been enthusiastically received by many communities, there also have been clear indications that problems can arise due to a lack of local planning, along with duplication of, and competition with, other community, private and state government services in some regions. There is concern that a one-size-fits-all, shop-front-style approach does not fit well with expressed service integration needs of some communities, or meet the needs of young people from many diverse groups, including those with more complex or ongoing difficulties.

In some submissions to the Review, people reported their experiences of working with and using headspace services. These often indicated that a regional planning approach to headspace would be beneficial. The objective would be to ensure that headspace:

- complements and collaborates with, rather than duplicates, existing youth-focused services which may already exist
- provides tailored services to meet the needs of the local area (including, for example, access to public transport, distance, demographics and other services available).

The Review found some duplication in relation to the national administration of programmes that operate at a local level, such as in the case of headspace. There are significant gaps in programme evaluation and monitoring. Many contracts and funded programmes that draw significantly on Commonwealth resources do not require the routine collection and reporting of outcomes data. In the case of headspace, \$411.7 million over five years from 2013–14 has been committed to the national programme, with a 20 per cent increase in funding from 2012–13 to 2013–14. Despite this investment, its contracts do not include requirements for continuous evaluation or reporting of outcome data, and the most recent evaluation now is five years old. It should be emphasised this is not unique to the headspace programme; in fact, this is all too common.

Partners in Recovery

Partners in Recovery (PIR) is in the early stages of implementation and its continuing rollout will be affected by the transition from Medicare Locals to Primary Health Networks. Findings of an evaluation of existing sites, which is under way, is awaited.

In the meantime, the Commission notes the Government's stated intention to divert PIR monies into the NDIS. It is considered that any decision on the future of PIR needs to be informed by the formal evaluation and earlier advice in this report which recommended a re-consideration of rolling up all of the programme into the NDIS. It has been suggested that transferring PIR-funded services that are attached to individuals currently in receipt of those services when *they* are eligible under the NDIS should be considered. Evidence submitted to the Review emphasised that these decisions also should be informed by the following considerations.

- There is a clear need for integration mechanisms which help people who use mental health services and their carers navigate a complex and often opaque system of supports, and which encourage greater collaboration to provide a wraparound combination of supports tailored to each person. Whether this comes in the form of PIR support workers (who help guide people through the system) or another integration approach, consumers and professionals alike heavily emphasised the need for a more joined-up system of supports.
- There is some concern that existing (state and territory-funded) care coordination services are being duplicated by PIR in some areas. As is the case with headspace, this points to the need for any service of this type to be introduced only after local needs and service provision analysis has been undertaken.
- Many consumers and carers receiving PIR support are positive about the difference it has made to their lives. Some carers report that some of the burden of trying to navigate the system has been lifted from them. Providers also report they have found PIR helps them to link with other service providers so that a more holistic service can be provided.

Targeted Community Care including PHaMs

Like PIR, Targeted Community Care (TCC) programmes, including Personal Helpers and Mentors (PHaMs), are likely to be affected by the rollout of the NDIS.

A 2011 evaluation of the programme found positive outcomes for participants in terms of wellbeing and connection with services, personal coping and problem solving, increased confidence and a reduction in acute episodes of illness. However, the evaluation did not include a significant sample from rural and remote areas, where TCC initiatives are often a core element of mental health service delivery.

For particular communities and nongovernment agencies which receive PHaMs funding for services in regional, rural or remote areas, any proposed rolling up of services into the NDIS could present a significant loss of service provision, as well as loss of expertise in delivering services to a particular community. People who use mental health services have told the Commission that they value PHaMs, in particular, because of its emphasis on support for non-clinical interventions which help people focus on their strengths and have potential to improve quality of life. Many people find it helpful to have the support of a peer worker who understands their experience, and to have a programme that does not solely rely upon diagnostic criteria for eligibility (that may act as a barrier to entry).

Mental Health Nurse Incentive Programme

A formal evaluation of the Mental Health Nurse Incentive Programme (MHNIP) identified that the programme has improved the lives of participants and is a highly cost-effective model for providing community-based services. This programme has been reported to reduce hospital admissions, increase social connections for participants and strengthen mental health expertise in primary care.

A number of concerns were raised in submissions to the Review about the current freeze on this programme and the apparent red tape for providers in accessing further sessions. Some MHNIP services have ceased as a result. The Commission is concerned that if sessions are capped at current levels, without options for redesign that include regional planning in line with access to projects such as ATAPS and Better Access, the momentum and headway made throughout the first few years of this programme will be lost.

Another key risk to this programme is the potential shortage of mental health nurses. Workforce projections discussed earlier in this report indicate a shortage of approximately 1000 nurses nationally, which could be reduced with scholarship incentives and wider adoption of double major nursing degrees, with mental health as one of the majors. Continuation and enhancement of the programme should take this into consideration, as well as opportunities to use the programme to continue to create incentives to improve recruitment and retention of mental health nurses and grow the workforce.

Better Access to GPs, Psychiatrists and Psychologists under the MBS

The Better Access to Mental Health Care Initiative (Better Access) has achieved its objective of increasing the population's access to therapeutic interventions for mental health difficulties. Clinical outcomes relating to symptom reduction for depression, anxiety and stress have been positively reported in the Better Access evaluations, but wider quality of life outcomes are not assessed.¹

Clients who received services under Better Access from clinical psychologists, social workers, occupational therapists and registered psychologists were almost universally satisfied with the care they received.¹ In submissions to the Review, professionals said the initiative overall has minimal red tape.

While the Commission agrees that Better Access has indeed resulted in better access to mental health support among the general population, the Review has uncovered several failings in the current implementation of the initiative. These were identified in evidence submitted by people using and providing services under Better Access, as well as in evidence arising from the Mental Health Services-Census Data Integration project which linked MBS and 2011 Census data.

Overall, there is a failure within the Better Access scheme to achieve a match between supply and needs. These perceived failures include:

- unequal distribution of service provision: the number of sessions does not match well with the clinical presentations, when a more differentiated, individualised approach would enable a better match of services and individual needs. There is a need to improve access by Aboriginal and Torres Strait Islander peoples, including by providing culturally competent professional services and monitoring their use of the programme.
- professional entitlements: for no clear reason, some allied health professions are excluded from the MBS subsidy entitlement under Better Access. Professional groups which can usefully form part of a multi-disciplinary mental health team include neuropsychologists, counselling psychologists and speech pathologists.
- session entitlements: a large number of negative comments were received relating to the 2012 reduction of the maximum number of MBS-subsidised sessions in a calendar year from 18 to 10. This new maximum entitlement is considered by providers and consumers to be too low for people with anything more than mild depression or anxiety. For people with greater need the reduction is counter-productive, as incomplete treatment can result in deterioration. KPMG modelling for the Review supports this. The modelling identified that provision of optimal care through Better Access can lead to better client and investment outcomes and less treatment required later on. This is especially the case for high prevalence conditions, such as anxiety and depression.

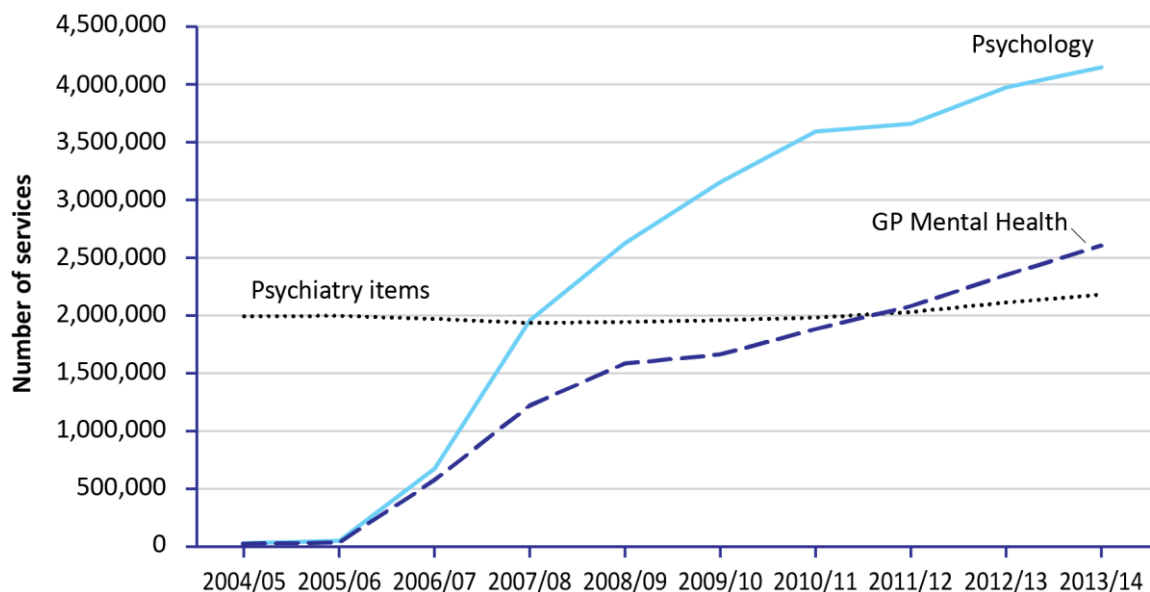
- clinical advisers consulted for the modelling project suggested that optimal care requires more than the current cap of 10 services. For someone with severe and complex mental illness, this ranges from 18 sessions for the clinical scenario related to schizophrenia to 50 sessions for the case study related to adolescent anorexia (25 services for the young person and 25 services for the family).²

The growth in Better Access has been quite dramatic.

Figure 9.1 shows:

- For psychiatrists there has been little change.
- GP use of Better Access has increased dramatically, although most GP consultations in relation to mental health occur within standard consultation items: the growth seen here relates to specific GP items such as GP Mental Health Treatment Plans.
- Use of psychological therapies and focused psychological strategies has skyrocketed. This reflects the fact that services provided by psychologists, social workers and occupational therapists were not included on the Medicare Benefits Schedule prior to 2005–06.

Figure 9.1 Number of Better Access items, 2004–05 to 2013–14



Source: Commonwealth Department of Health, 2014

A range of options for reform of Better Access is proposed at Recommendation 13 in Volume 1 of this report. This includes a number of actions. Action 9 proposes that current disparities in benefits payment between registered psychologists, social workers and occupational therapists be removed. Better Access currently has fees and payments for allied health professionals set at three levels.

The highest is for clinical psychologists, which reflects their higher level of training and the role they play in providing individual psychological therapies.

The clinical psychologist benefit is about 40 per cent higher than that for registered psychologists and 60 per cent higher than for social workers and occupational therapists – registered psychologists, social workers and occupational therapists all provide Focused Psychological Strategies.

There also is a 13 per cent differential between the benefit for a registered psychologist (\$70.65) and that for social workers and occupational therapists (\$62.25).

The Commission can find no obvious reason to justify this differential. Moreover, this appears to be a peculiar quirk of Better Access, because no such differential exists within ATAPS or DVA.

The Commission also considers there is a simple solution to resolve this issue.

Table 9.1 shows that in 2012–13, registered psychologists provided 2.179 million services, occupational therapists 0.048 million services and social workers 0.202 million services (Other was 0.005 million) – a total of 2.434 million services.

The benefits paid for this group were \$205 million.

Table 9.1 Medicare-subsidised mental health-related services, by provider type, 2012–13

Provider type	Services	Benefits paid (\$'000)	Fees charged (\$'000)
Psychiatrists	2 136 042	290 211	363 720
General practitioners	2 408 612	187 557	198 960
Clinical psychologists	1 558 063	191 114	226 946
Other psychologists	2 179 161	185 775	232 170
Other allied health providers (total)¹	255 129	19 698	24 113
<i>Occupational therapists</i>	48 123	N/A	N/A
<i>Social workers</i>	202 280	N/A	N/A
<i>Other mental health workers</i>	4726	N/A	N/A
All providers	8 537 007	874 355	1 045 909

Source: Mental health services in Australia, AIHW

Note:

1. Other allied health providers (total) includes occupational therapists, social workers and other mental health workers.

This means that registered psychologists provided about 90 per cent of all services provided, and accounted for 93 per cent of the benefits paid.

If social workers and occupational therapists attracted benefit payments at the same level as registered psychologists, the cost would have been an additional \$1.8 million.

A one per cent increase in fees and benefits under Better Access for these three groups (leaving aside clinical psychologists) would cost \$2.05 million, hence the \$1.8 million differential equates to about 0.9 per cent of an across-the-board increase.

The Commission proposes that, on the next indexation of Better Access items, the first 0.9 per cent for registered psychologists, occupational therapists and social workers should be applied to align MBS benefits for social workers and occupational therapists with those for registered psychologists.

Any indexation remaining above that 0.9 per cent then should be applied equitably to the Better Access items.

The Commission also considers that the number of sessions offered under Better Access should be based on clinical need and outcomes, rather than a pre-designated number of sessions.

Better Outcomes in Mental Health: Access to Allied Psychological Services

The continuing and detailed evaluations of the Access to Allied Psychological Services (ATAPS) programme have shown that it results in improved overall outcomes for participants.

However, concerns were raised in stakeholder submissions to the Review that the administration and structure of the programme is creating unnecessary access barriers. Given the administration of the ATAPS programme is to be transitioned to the new Primary and Mental Health Networks, there is an opportunity to consider its effectiveness in reaching marginalised groups, in particular:

- people from low socio-economic backgrounds (the average copayment for the programme is \$18.15)
- Aboriginal and Torres Strait Islander people (only 3500 of the more than 350 000 referrals made to the programme were for Indigenous people, despite the programme's specific priority to reach this community).

'I think there are some fantastic online resources that young people can access for support with mental health problems. Sites like ReachOut.com, eHeadspace, Kids Helpline Online, *beyondblue* and the Butterfly Foundation, who provide information, referrals and services such as online counselling. I have used all of these services when I didn't feel able to speak to anyone in person. They were a great help to me, and meant I didn't need to disclose my mental health condition to friends and family until I was ready.'

Submission from a person with lived experience

Submissions to the Review also cited professional credentialing requirements and stringent eligibility criteria as creating inflexibility in the scheme, where money may be allocated but no appropriate professionals are available to fill vacant provider positions. This is particularly the case in disadvantaged communities.

Consideration also should be given to whether the programme would work more effectively if delivered through a less fragmented administrative structure, rather than through two tiers specifically and separately targeting a wide range of groups, including bushfire-affected communities, children, people who are homeless, women with perinatal depression, suicide prevention and Aboriginal and Torres Strait Islander people. Broadbanding of ATAPS funding, instead of having any tiers or target groups, may be a good place to start. A further option would be to transfer Indigenous-specific spending associated with ATAPS to existing primary health care models that work within social and emotional wellbeing frameworks and are already in place in Indigenous communities.

Teleweb programme

Services funded under the Teleweb initiative (Telephone Counselling, Self Help and Web-based Support Programmes) are a vital national service to increase access to mental health information, counselling and suicide prevention.

People with lived experience of mental health difficulties and their families and carers reported to the Review that they found seeking help online and on the phone less confronting than approaching a service provider in person.

There is concern that these projects are funded in a “scattergun” way and that the myriad of support services available online and on the phone can be confusing for people to access and navigate. This is discussed in more detail in Chapter 10. It is an important area where access to help for people in remote areas can be increased in a cost-effective way. This type of assistance also helps to overcome barriers to seeking help, such as stigma or lack of privacy in small communities.

The promise of these approaches cannot be fully realised without streamlining them. As things stand there is a risk of duplication and inefficiency in this area. It has been difficult for the Commission to get a sense of outcomes for investment for grants under these projects due to the limited information available on this funding stream’s efficacy as a whole.

Efficacy and cost-effectiveness in the nongovernment sector

During 2012–13 three Commonwealth agencies allocated mental health funds to 542 nongovernment organisations (NGOs) under 64 programmes. Specifically:

- the Department of Health funded 55 programmes, with grants to 213 organisations
- the Department of Social Services funded six programmes, with grants to 196 organisations
- the Department of the Prime Minister and Cabinet funded three programmes, with grants to 133 organisations.

The Commission invited 310 nongovernment organisations to share information for the Review about their most recent Commonwealth programme funding arrangements. Responses were received and analysed from 65 organisations.

Although this is a small sample, the analysis demonstrated that the NGO sector is diverse and that most often, such organisations cannot be classified as exclusively providing ‘mental health’ services or supports. Commonly, organisations cater to a wide range of interrelated needs and their activity within mental health cannot be assumed from the amount received specifically as a grant.

Fragmentation of funding

A large number of NGOs receiving funding for mental health programmes and services also offer many other avenues of assistance, such as aged care services, domestic violence and family support. This was particularly the case for rural NGOs which offered a range of support services in their local area. Forty-eight of the 65 agencies (74 per cent) that responded to our request for information about their functions and programmes advised us that they provided a range of services in addition to offering specific mental health support.

Of the 65 organisations we reviewed in detail:

- 32 (approximately half) received less than \$2 million in 2013–14 for mental health-related programmes and services
- 20 received funding of less than \$1 million in 2013–14 for mental health-related services and programmes
- Six reported that they received funding of between \$5 million and \$10 million per annum.

Because of the small size of many of the grants they receive, and the wide variety of sources and potential sources of funding, NGOs are vulnerable to burdensome administrative requirements associated with each funding stream. For small organisations, this can significantly impact on the time made available for direct service delivery. Problems experienced in this sector with duplicated reporting requirements and accountability as identified through both programme evaluations (where they exist) and submissions to the Review are outlined below.

Duplication in current programmes and services

The Review has identified that in regard to Commonwealth-funded mental health-related programmes and services, the greatest potential for duplication lies between those psychosocial services and supports provided by the Departments of Health and Social Services. Duplication between Commonwealth, state and territory services could not be assessed (other than illustrated through the case studies cited below), as no state or territory government provided data that identified mental health programmes and services to a level that enabled any comparison to be undertaken.

The Commission examined whether there are programmes which either have similar or identical objectives, which target similar communities or population groups, or which in practice are achieving the same outcomes for consumers.

The example of suicide prevention activities is provided to illustrate how and why such duplication can occur.

Suicide Prevention Programmes

In 2012–13, \$42.2 million was invested through the National Suicide Prevention Programme (NSPP) by the Department of Health. In addition, the Department of Social Services (DSS) has contributed funding to local communities at high risk of suicide and to those areas where there are suicide clusters. At the same time, states and territories have suicide prevention plans that are funded. Joint planning, co-design and co-commissioning (at both Commonwealth and Commonwealth-state levels) appear to be limited. Some initiatives are showing local results, but fragmentation of funding and delivery undermines efficiency (and effectiveness) of the investment and the economic benefit to individuals, their families and the broader community. Suicide prevention should be promoted as a whole-of-government and whole-of-community endeavor that stretches beyond the domain of mental health. It needs to be supported by robust data to assist local and regional planning and help better understand the nature of suicides – for example, whether they are from Aboriginal and Torres Strait Islander communities, farming communities, culturally and linguistically diverse communities, fly-in-fly-out workers, or people who identify as lesbian, gay, bisexual, transgender or intersex (LGBTI).

A nationally consistent and coordinated approach to suicide prevention activities would be promoted by taking the following steps.

- **Consolidation of effort:** planning and administration of the NSPP and other Commonwealth suicide prevention funding could be streamlined. We note that current NSPP contracts end in late 2014. This provides an opportunity for consolidation of suicide prevention efforts nationally.
- **Clear roles and responsibilities:** separation of roles between the Commonwealth (for national strategic direction and priorities) and regional or local areas (for service

delivery, coordination and integration) can provide a platform for more effective, co-designed service delivery, integrated governance and reduction in duplication of roles.

- **Accountability:** contracts should require that specific outcomes be reached and should include incentives for providers to prove their efficiency and effectiveness. Performance reporting should be streamlined and aligned to national priorities and targets. Where goals and targets are not achieved, the Commonwealth should be prepared to reduce funding or defund organisations and initiatives.
- **Longer funding terms:** longer-term contracts for suicide prevention activities would assist projects with recruitment, expansion and sustainability where programmes demonstrate high performance.
- **Time and care:** it is worth spending time and care to reach agreement with and between the states and territories on a nationally driven and coordinated approach. This is essential to fulfilling community expectations about reductions in suicide rates, especially given that rates have slightly increased in recent years.

Inefficient programme development

The Commonwealth does not have a clear strategic framework across the range of its investments. Expenditure is not guided by a clear relationship to system outcomes and coordination and balance of investment across sectors is limited. This is compounded by siloed governance and eligibility and reporting structures that perpetuate separate service systems and reduce the capacity for whole-of-system planning. Those seeking information or assistance are often left to navigate a complex and fragmented service system on their own.

As things stand, opportunities for rationalisation or alignment of smaller programmes into a cohesive approach are lost, as are opportunities to prioritise achievement of whole-of-life outcomes rather than duplicated reporting of activity. Duplication is not only a measure of waste, but of opportunity foregone to drive improvements and productivity across the system.

Commonwealth mental health programmes are poorly linked to each other and to state mental health service systems. In particular, the increase in programme funding resulting from the COAG National Action Plan on Mental Health of 2006 has failed to drive practical solutions which would link effective recovery-based community support with clinical treatment to produce a wraparound and tailored range of supports for people who need them. The new funding has not created incentives or pathways to support people to access the coordinated care they need. It has provided focused support and interventions that generally have been found to be efficacious (where evaluations exist).

For example, headspace is seen as a worthy initiative, but it is nevertheless an example of the Commonwealth entering into areas of direct service provision which were previously the domain of the states and territories. Although headspace has been a “game changer” in terms of adolescent mental health, the need for each headspace centre to integrate and coordinate with state services has been under-emphasised and under-achieved. This was a common theme in submissions to the Review. With the development of the Youth Early Psychosis Programme (YEPP), which includes an acute service component, this is even more essential; to ensure a continuum of care, these centres need to be closely designed and implemented in association with state community and hospital-based services.

Mechanisms to achieve a “joined-up” system, which promotes a continuum of care and support, and makes best use of evidence-based pathways, need to be introduced. The quote below illustrates the impact of no overarching framework to guide investment in Commonwealth programmes.

‘There is no clear relationship between Commonwealth-funded programs. There is no publicly available simple schema that shows the target population and the program to support this group.

It was suggested ... that a mapping exercise should occur, so we are able to better target need, services and funding. To our knowledge this has not occurred.

As such, we continue to run the risk of duplication and patchwork services.’

Submission from the Australian College of Mental Health Nurses

Reducing duplication while retaining NGO expertise

Commonwealth funding of NGOs to deliver programmes presents another opportunity for improved coordination and strategic planning. There would be obvious administrative cost savings from rationalising NGO funding to reduce transaction costs and duplication of reporting. However, care needs to be taken in smaller communities, where local NGOs are often intimately acquainted with the needs of the communities they serve.

The proposal for a regional financing and governance model, recommended in Volume 1, promises to support both increased efficiency and improved tailoring of NGO services to meet local need. It involves considering the effectiveness and level of development of a local NGO “market” to support choice and retain regional expertise in programmes. This approach includes agencies such as the Red Cross and the Royal Flying Doctor Service, which fly into remote communities and develop local expertise, though they would not be regarded as being local on-the-ground organisations.

The introduction of a local NGO ‘market’ also needs to be sensitive to the impacts upon sustainability of that local market. For example, Share and Care Community Services, an NGO operating in Western Australia, reported to the Review that it received only a small proportion of funds in 2013–14 which were explicitly assigned to mental health, yet on investigation it provides a range of other services such as housing support, children's services, community relief, domestic violence, men's lodge, meals on wheels and home and community care. Rationalisation of mental health-specific grants into a larger organisation can risk the loss of the holistic model of community-wide support (which includes services not specifically labelled 'mental health'). Opportunities for local organisations to form consortia or other approaches to build networks of sustainable NGO markets is regarded as one solution.

Diversity of provision is also found in large national organisations. For example, Anglicare Victoria provides a spectrum of services to support families and children, while Anglicare NSW is more targeted towards supporting older people and community care.

The Commission also recognises that some NGOs have expertise in working with a particular group of people and this cannot be determined by looking at funding. Such specific focus organisations include Oz Help Foundation (providing services to workers in regional and remote communities), the Butterfly Foundation (eating disorders) and Peer Support Australia (support for young people). The issue of clustering of NGOs in a community, where outcomes for people, services and funding are not always transparent, is illustrated in the following case study submitted to the Review.

“We know that in some regions there are too many visiting services with overlapping and sometimes competing roles who do not collaborate or work closely with either the primary health care service or each other. This leads to inefficiencies, miscommunications and a lack of a patient and family-centred approach. It also takes up a huge amount of Primary Health Care (PHC) time and does not employ or involve local Aboriginal people who know the community and can provide sustainable, culturally appropriate care.

In Central Australia there are a number of mental health services:

- Frontier Services
- The Mental Health Association of Central Australia (MHACA)
- Royal Flying Doctor Service (RFDS)
- Central Australian Mental Health Service (CAMHS)
- TEAMhealth
- MOSplus

And some communities have their own resident counsellor or Social and Emotional Well Being (SEWB) service.

There are a few problems with this model of service delivery.

Some communities get most or all of these services. Some get little or none. There is serious inequity in service delivery.

In communities where a number of services visit, services often see the same clients, but do not share information amongst themselves, creating duplication of effort.

Services rarely (if ever) use PHC medical records.

Most of these services are a visiting service. Hence if primary health staff are not aware of which service is seeing their patients, let alone what the care plan may be, it is almost impossible for them to provide ongoing support, let alone respond appropriately in a crisis.

This lack of communication also results in ‘body part’ medicine where the whole of a person’s health is not addressed. For example Wurlli-Wurlinjang Health Service comments that “Clients who are under the care of mental health services are often lost to medical care and follow-up. People with psychoses, for example, might be getting their medications from mental health care services and not attending medical services for follow-up of the medical conditions that may exist along with their mental health problem and also reviewing the possible medical implications of taking their medications.

Having multiple providers results in a fractured mental health service. It would be better to have one inter-connected system.”

Submission from Aboriginal Medical Services Alliance Northern Territory

Rationalising funding streams or streamlining reporting requirements would assist with the 'mental health' money received for Commonwealth programmes. A sector-wide approach is needed. In addition, grant money also may be received from states and territories or other sources for aged care services and the like, so streamlined reporting and funding arrangements would have to be considered across traditional (state versus Commonwealth) boundaries if they were to meaningfully reduce reporting duplication and red tape burdens on the NGO sector. Bundling of programme funds on a regional basis could be one avenue to refocus resources to reflect local needs and drive performance and outcomes across the range of programmes delivered in that community. In turn, this approach would support better coordination, integration and easier pathways for people to negotiate to get the services they need.

Gaps in programmes and services

While duplication was identified in the evidence submitted to the Review, gaps in service provision were more commonly cited.

As the Commission was unable to obtain a clear view of the types and level of services provided by states and territories in particular geographic areas, it is difficult to determine whether apparent gaps in Commonwealth-funded provision are, in fact, filled by other services.

The most obvious gaps and inequalities – which were confirmed by our linkage of Medicare and Census data as well as substantial research evidence – have been identified elsewhere in this report, especially in relation to restricted service provision for people living in regional, rural and remote communities.

In identifying other types of unmet mental health needs in Australia, assessment of submissions to the Review made by people with lived experience of mental health difficulties, their families and carers, professionals and stakeholder organisations has been undertaken. Although it is acknowledged that claims about insufficient services are likely to be influenced by the vested interests of any individual or organisation, a number of patterns to responses infer that gaps exist beyond vested interests. Gaps were either a lack of supports targeted at particular difficulties, or a lack of supports which people find relevant and appropriate. The major ones are a lack of:

- services which recognise intergenerational trauma and the continued impact of colonisation on people of Aboriginal or Torres Strait Islander background.
- service provision which effectively addresses interrelated health needs concurrently. (Particular examples commonly cited were intellectual disability with mental health problems, and substance misuse with mental health problems.)
- provision of services which effectively address interrelated health, social and economic needs concurrently. Particular examples were gaps in services for prisoners and ex-prisoners and people from an economically disadvantaged background.
- affordable specialist support for severe and complex mental illness. Borderline Personality Disorder and eating disorders often were mentioned.
- culturally appropriate services, with interpreters, for people of culturally and linguistically diverse backgrounds, including recent immigrants and refugees.
- services informed about the impact of trauma, abuse and neglect in the origin and continuation of mental health difficulties, and the potential role of services in exacerbating this impact.

Reporting requirements and regulation of programmes and services

Service providers and professionals recognise reporting as an essential aspect of system regulation and service and programme accountability. Evidence provided to the Review showed that reporting is considered appropriate when reported information:

- does not just go one way (or is submitted and never heard of again) – it actually is used and becomes part of a system of feedback
- can be used to assist in planning and for quality improvement efforts, both by the reporters and the authorities requesting the information.

However, there are many circumstances in which reporting currently is not considered a productive activity, including where:

- reported information is not used by the authority requesting it
- multiple funders and agencies request similar information, resulting in duplication of effort by organisations and professionals
- reporting requirements can be subject to manipulation, have perverse consequences or have a detrimental effect on the quality of care delivered to consumers.

Suggested steps to improve the effectiveness and efficiency of reporting for regulation and accountability purposes include: focusing data collection on clinical and whole-of-life outcomes as well as activity, streamlining reporting requirements by rationalising funding sources and assessment/referral pathways and developing consistent, user-friendly data collection tools which can be standardised nationally. The necessity of reform in this area is nowhere more eloquently presented than in the following case study provided by Neami National.

'Neami National is a specialist psychiatric rehabilitation and recovery support provider with service delivery sites across five states. The organisation receives funding through 33 funding streams: three federal departments, sixteen through state government bodies and fourteen through PIR consortia. Like most non-government organisations we struggle with the wide range of accountabilities, reporting requirements and quality standards which are largely uncoordinated and idiosyncratic to each funding stream. Acquittals can be monthly, quarterly or annually with different reporting frameworks, certification requirements and templates. In 2014 we were required to provide 28 separate audited acquittals in addition to 17 requiring management certification only.

Program reporting is another area where there can be huge discrepancies in data and interpretation of terms. For example, each funding program has different definitions of what is considered direct and indirect hours. For example some programs include travel to a client's home as a component of the direct service delivery, others define this as indirect and some do not accept this as a legitimate cost. Quality accreditation is another area of complexity. Neami is required to report to at least ten quality frameworks, all running on their own timelines with distinctive requirements and costs associated.

There are many opportunities available to streamline these arrangements at program design stage but unfortunately there is rarely sufficient liaison between the funding body and the field, or across jurisdictions to secure arrangements which could promote efficiency and support evidence based decision-making or analysis.

Partners in Recovery is a useful example. It has been left to each consortium to choose the database it will use. This means that there is no capacity for our organisation to bring this data together as an organisation as some of the databases in use do not have interfacing capacity with other systems. What this means for us is needing to set up duplicate data capture arrangements.

In the case of the NDIS, Neami is active in two of the pilot sites and is funded to provide Disability services in another state. We have to register for the NDIS and as a disability provider in three states. We are also then required to meet the range of accountability and quality standards in the three states including three separate quality audit processes against the same standards, on different time cycles. Coordination of the auditing process and agreement at a national level to fully recognise a national approach to disability standards accreditation would be far more efficient.

These obligations result in high transaction costs and the need to dedicate precious funds to back of house administration functions at the expense of more direct care workers.'

Neami National

Transparency and accountability for investment outcomes

True accountability for investment was interpreted by those submitting evidence to the Review as being wider than just accountability to funding bodies; accountability to people with a lived experience of mental illness and to the community also is considered vital.

However, at present, true accountability for the outcomes of investment is hampered by a number of factors, including:

- lack of agreement on mandatory outcome indicators
- lack of data infrastructure and tools for collecting outcome information
- current focus on activity and activity-based funding.

Mechanisms which respondents view as promoting proper accountability for outcomes include:

- allowing time and funds for proper evaluation
- involvement of consumers and supporters in service planning and evaluation
- being conscious of accountability, to both stakeholders and the community
- collecting longitudinal and experiential outcome information
- scaling up existing tools for effective evaluation.

Accountability to funding agencies, and hence the public, requires a commitment to regular programme evaluation. This Review has uncovered an inconsistent approach to evaluation and the subsequent public reporting of findings.

The need for nationally consistent outcome data collection

The first step in ensuring accountability for outcomes is the development of a tool which is consistently used to show what outcomes a service or programme is achieving. This does not exist at present. We know a lot about how much of each activity is being done across the country. However, this does not provide information on whether the activity is having a beneficial impact on people experiencing mental health difficulties.

This failure to focus on outcomes also means that at a population level we do not know, for example, how many people attempt suicide each year, because we do not collect this information at the point of service – whether that is an ambulance, hospital emergency department or police. Initiatives are under way in some parts of the country to undertake real-time monitoring of suicides and suicide attempts by using standardised ambulance and police reporting forms. These innovative practical and tested approaches need to be scaled up and implemented across the country. Further discussion on this is found in Chapter 6.

A nationally consistent outcomes collection would require joint development by the Commonwealth, states and territories. Rather than adding to the existing reporting burden, this would replace existing forms of reporting. In the regionalised approach to planning and delivering mental health supports proposed in this Review, all the providers in a region would be responsible for delivering on outcomes specified in a nationally consistent indicator set. These outcomes would apply regardless of funding stream, so that reporting would focus on what is important to people and national goals, rather than be structured around compliance with imposed administration standards. Not only would this encourage collaboration to achieve jointly the best *overall* impact on mental health, but it would free up regional authorities to tailor the means of achieving this impact to the local context.

Such a collection (based on outcomes) would include a small number of performance targets for regions to achieve. Particular targets and indicators which the Commission believes would support monitoring of whole-of-life consumer and carer outcomes are described in detail in this report. As such, consumer and carer involvement in designing outcome measures and reporting will ensure that these are meaningful to both individuals and programme evaluation.

In conducting this Review, the Commission has tried to remediate the lack of person-centred outcome collection by taking a consumer pathways approach to assessing efficacy and cost-effectiveness (described earlier in this chapter). We also have secured new person-centred data by sponsoring a project to link, for the first time, mental health-subsidised services under the MBS and PBS with the Census. This new and unique data set, the 'Mental Health Services-Census Data Integration Project', enables assessment of the socio-demographic characteristics of people using mental health services at a population level across geographical locations. Some initial findings are discussed in Chapter 3.

Linking NGO performance to national goals

A key factor limiting our analysis of the effectiveness and efficiency of the NGO sector, as well as duplication within the sector and with government programmes, has been the lack of a consistent approach to reporting on outcomes of investment. Government investors in the NGO sector generally do not apply a considered approach to monitoring the outcomes of investment that have a view beyond their own portfolios.

NGO reporting needs to be reconsidered to inform a nationally agreed framework for outcomes across NGO sector investment to ensure that:

- NGOs are achieving evidence-based outcomes
- NGOs are made responsible for better mental health outcomes for vulnerable groups, including Aboriginal and Torres Strait Islander peoples. Developing partnerships between NGOs and Indigenous Primary Health Care Organisations (including Aboriginal Community-Controlled Health Services) is one way to build capacity for dedicated culturally competent services.
- outcomes can be qualitatively and quantitatively measured
- outcomes tie in with nationally agreed goals about what mental health programmes and services should be achieving. Volume 1 recommends a suite of targets and indicators, including a reduction in suicide and suicide attempts, improved experiences of care and outcomes, a healthy start to life, having access to a stable home and participating in education and employment.

Opportunities to streamline NGO funding exist, but this should occur within the context of a regional and location-specific planning approach that takes into account local needs and existing service infrastructure and frameworks.

Where to from here – implications for reform

The Review has gathered evidence which shows that current arrangements are not working for people living with a mental illness, their families and supporters, and are also inefficient and ineffective from the perspective of governments.

‘Australia’s mental health system is trapped in multiple inefficiencies of cost and efficacy, in large part because of the sheer complexity of funding, levels of government, departments, delivery points and pathways. Successive well-intentioned governments have responded to this by new initiatives which only serve to create new levels of complexity onto those which already exist. [...] Further, funding must focus on the person’s recovery ahead of existing organisational, professional or governmental preferences.’

Submission from SANE Australia

It is not enough simply to report on what is wrong with the status quo. We need to restructure our siloed, separate data collections that are oriented around agencies, professions and services, to be more effectively grouped and clustered around individuals to identify and implement high-value investment opportunities. For example, in New Zealand the social services sector has implemented a linked and proactive approach to using reporting to give real time data for programmes and services to use and respond to.³ This has meant that ‘early warning’ signals (such as multiple notifications to child protection agencies) indicating a high likelihood of later use of and engagement with social services, welfare and justice systems are identified. People showing patterns of high service use are then offered assistance at a stage when interventions can be more meaningful, successful and cost-effective.

The work undertaken by the social services sector in New Zealand has empowered system decision-makers with the evidence to implement more effective responses. This has involved the use of ‘big data’ or cross-portfolio, person-focused data collection to track outcomes and more effectively predict the likely return on investment for particular interventions. This return on investment reflects not just savings for government, but better outcomes for individuals through earlier, more effective and evidence-based interventions.

The Commission has considered submissions to the Review and suggestions presented during consultations. We propose three key strategies for changing the way funding priorities of mental health programmes and supports are identified and the way they are structured and governed. These strategies are:

- assessing efficacy and cost-effectiveness using a person-centred consumer pathways approach
- implementing a regionally controlled funding and governance model
- establishing a holistic stepped care model of service delivery within a highly integrated system of supports.

Together, these strategies form solutions to the difficulties currently faced which result in skewed investment, fragmented systems of support, suboptimal consumer and carer experiences and outcomes, unnecessary red tape and opaque accountability.

Increasing cost-effectiveness using a consumer pathways approach

To keep deliberations focused on the aspects of system design which translate into optimal consumer and carer experience and outcomes, the Review commissioned a cost-modelling simulation of a series of theoretical optimal consumer pathways. Based on common clinical scenarios, the modelling encompassed consideration of life-course costs across health and non-health domains of the person's life, and assessed the cost and implications of different interventions and supports along the way. The difference between the current situation and optimal care pathways also was determined. The scenarios are outlined in the table below and cover a broad range of diagnoses, functional impairments and age groups. They are not meant to be representative, but rather illustrative of how service and clinical pathways could be altered to achieve better outcomes, and how much this would cost.

SET OF CLINICAL SCENARIOS

8 year-old male with mild anxiety experiencing poor interaction with peers, and whose mother is suffering moderate depression and is recently divorced (mother's scenario was also modelled).

14 year-old female with severe anorexia nervosa, and a body mass index (BMI) of 15 for the past two years.

28 year-old female experiencing post-natal depression (PND) after birth of first child. She has experienced episodes of suicidality, and is at high risk of hospitalisation.

32 year-old female suffering post-traumatic stress disorder (PTSD) as a result of her son being involved in a motor vehicle accident, which left him with severe injuries. She is experiencing flashbacks and is unable to adequately care for her son.

36 year-old female with bipolar disorder who is obese and suffering Type II diabetes. She has experienced four episodes of mania in the past two years, all resulting in hospitalisation.

45 year-old male, homeless for past five years; chronic schizophrenia.

55 year-old female suffering from acute anxiety (panic attacks) brought on by a restructure at work. It is impacting her ability to work.

Source: KPMG Cost Modelling Report (unpublished) 2014

This cost modelling, undertaken by KPMG, identified options to improve outcomes and save system costs in two key ways:

- by improving current service provision, or investment in 'optimal' care pathways
- by investing differently to emphasise care and support options that reduce the likelihood that a person's mental illness will increase in severity or simply not improve.

Investment in optimal care also should be accompanied by investment to promote mental health and prevent mental illness. This could target specific groups defined by age or other criteria or involve greater investment in targeting specific settings, such as mental wellness in the workplace.

Four strategies for optimising cost-effective pathways and maximising outcomes based upon the set of scenarios were:

- treating people early
- increased emphasis on primary and community care
- improving coordination of and access to psychosocial supports
- better sub-acute care.

Key findings

The implications of each of these strategies, if they were to be adopted, are outlined below.

Treating people early

Modelling of optimal care confirms that treating people early improves health outcomes. KPMG modelling found, for example, that annual improvements in health for a person living with bipolar disorder accessing optimal care can be up to 34 per cent.² Alongside this finding was that treating people with bipolar disorder early led to an estimated saving of \$653 000 over nine years. Under the same scenario, early treatment realised an estimated saving of \$316 000 over nine years for a person living with schizophrenia. These savings are primarily generated by the avoidance of expensive treatments and indirect costs associated with more severe and complex mental illness.

This work provides positive directions for how, at a population level, such service reinvestment could yield health and social benefits for the person and their support network, and economic benefits to the community and government.

The modelling undertaken for the Review identified some other implications of a generalised early intervention approach: that increasing access to GPs, psychologists and psychiatrists can lead to improvement in health and reduce future costs; that the effectiveness of optimal care is affected by the ease of access and treatment pathways, and that optimal care includes access to supports other than health alone. The provision of housing with support is also identified as key for people with severe and complex mental illness. In the modelling of the pathway for a person with schizophrenia, stable housing was identified as crucial to enabling access to other services.

The role of housing in supporting good mental health has been demonstrated in programme evaluations of some state-supported housing programmes. This is detailed in Chapter 3.

Increased emphasis on primary and community care

Based upon the information provided by clinical consultants to support KPMG's modelling, optimal care consists of providing more primary and community care services to people, regardless of the severity of their illness. This included more GP and psychologist visits, but also additional community care services that could substitute acute care directly.

Since the first National Mental Health Plan, the percentage of state and territory mental health spending allocated to community-based clinical services has grown nationally from 23 per cent of mental health spending in 1992–93 to 40 per cent in 2011–12.⁴ However, without access to the National Mental Health Service Planning Framework, the Commission has no benchmark to assess whether this level of investment is adequate.

The evidence suggests that the substitution of inpatient care with community-based care is both clinically appropriate and cost-effective. For example, modelling optimal care for a person with severe post-natal depression suggests that the number of days in a mother-baby unit within a hospital could be reduced by more than half, if it were substituted for a combination of increased GP, psychologist and psychiatrist visits, visits from community mental health teams (CMHT), group therapy and day-patient services.²

Improving coordination of and access to psychosocial supports

The level of complexity associated with mental illness requires a multifaceted response to improving health outcomes, including health and community care, informal care, housing, substance misuse treatment, job training and education.

These services are delivered across a range of government portfolios and therefore investment in optimal care must be developed within a strategy that coordinates a broad range of programmes, planners and funders at a regional level. Working in regions allows services to be responsive to local needs.

Planning mental health care locally also requires commitment to all services, and not 'cherry picking' services, which is likely to reduce the potential improvements significantly in health and therefore lead to a waste in resources if complementary services are not accessible.

Maximising the benefits of psychosocial supports also requires taking an approach that looks at their role across the spectrum of severity of mental illness, and does not pin service categories to particular diagnoses. KPMG modelling undertaken on clinical pathways for schizophrenia suggests that stable housing is a crucial element for enabling improved access to other services (such as receiving visits from an acute care team at home), adherence to health care and improved health outcomes.²

Better sub-acute care

While primary and community care is important to prevent or avert the progression of mental illness, there always will be the need for services for people experiencing acute mental illness. This includes step up/step down and sub-acute options. This is identified in the KPMG study, where clinical advisers suggested that improvements in mental health require access to sub-acute services not currently available. For example, modelling clinical scenarios on anorexia and schizophrenia identified the reduced need for acute inpatient service by increasing sub-acute care services.²

In 2009 the National Health and Hospitals Reform Commission (NHHRC) noted that many parts of Australia have limited or poorly developed sub-acute care services, which created problems for the acute care sector and resulted in reduced patient outcomes. Subsequently, the Commonwealth injected \$2.1 billion to increase sub-acute services under two National Partnership Agreements with the state governments. Under these agreements a component of sub-acute funding was directed to sub-acute mental health and specialist mental health services for older people. The impact of these investments cannot be commented upon due to the lack of data provided to the Review at state and territory level, specific to the mental health component. However, sub-acute services need to be available to the community as identified above, to provide access to optimal clinical pathways.

Other social and economic benefits of optimal care

The KPMG study found that benefits from optimal care also impact on a number of government portfolios. Modelling has shown that improved mental health has wide social and economic benefits, including the following:²

- increased productivity, which is expected to reduce the dependence on income support, increase taxation revenue for the Federal Government and increase payroll taxation for state governments.
- decreased need for social housing, which is expected to reduce the expenditure of departments which provide social services at a state and Commonwealth level.

- reduced contact (from people with a mental illness) with the judicial system. This will in turn reduce the costs of policing and the justice and prison systems.
- reduced need for informal care. This has a flow-on effect to carer income support payments and increased taxation revenue through higher participation rates.

Given that governments will receive the benefits from optimal care, there is an incentive to contribute to the cost of providing it.

This is one of the important turning points in any serious reform of mental health.

Where to from here

A cross-portfolio response to improve how programmes are delivered is necessary to ensure funds are directed well and activity is reported once, then used for evaluation and programme improvement. People and their supporters who are reliant upon programmes to meet their needs in a clinical and cost-effective way deserve this, as does the community.

This will require the development of a governance framework that can account for the competing demands for funds across portfolios, while ensuring the system is consumer-driven. This is a recommendation of the Review in regard to the implementation strategy of its directions. A governance structure is required that both reflects agency representation and participation of people with lived experience of mental illness and their carers, and is essential to drive change that acknowledges the risk of harmful unintended consequences at a portfolio and personal level.

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Commonwealth programmes - the Commission's overview

Our Approach

In January 2014 the Commission wrote to every Commonwealth and state government department requesting information on the programmes they funded or led over the past five years that had a mental health focus.

We identified four main Commonwealth departments which fund mental health programmes – Health, Social Services, Prime Minister and Cabinet and Veterans' Affairs.

In 2012–13 the combined expenditure of mental health-related payments and programme funding was \$9.6 billion. We found 140 different types of programmes, payments, grants and mental health partnerships, which were reported by 16 Commonwealth agencies over the past five years.

The landscape of Commonwealth funding is confusing.

A number of projects are funded under some items in our taxonomy, such as within the umbrella of the National Suicide Prevention Programme, while other funding was for a discrete programme (for example, headspace).

The Teleweb measures give grants to a range of agencies to manage a number of helplines to various groups of people, including Adults Surviving Child Abuse and Kids Helpline.

Other grants are for the delivery of a particular programme, such as Partners in Recovery, or services to a particular population.

This was problematic for our analysis. The Department of Defence, for example, reported programme expenditure of \$26.9 million in 2012–13; however, this was not broken down into separate projects or programmes.

Overall the Commission was underwhelmed at the level and currency of programme evaluations, despite, in some circumstances, a significant amount of Commonwealth investment. As a principle, a culture of evaluation of Commonwealth funding needs to be embedded in programme design and funded as a specific element of administration.

Of the top 20 items of Commonwealth expenditure reported in 2012–13, not all were programmes delivered to people which could be evaluated for efficacy and efficiency.

- Two items were payments to people and families (the mental health proportion of the Disability Support Pension and the Carer Payment and Allowance).
- The Pharmaceutical Benefits Scheme accounted for more than \$750 million of expenditure in 2012–13.
- Two items were payments under the National Agreements to hospitals (share of Commonwealth funding and funding for sub-acute beds).
- Payments for private health insurance rebates for mental health-related costs were estimated at \$105 million.

These items, along with National Health and Medical Research Council grants, accounted for almost \$8 billion (or 82 per cent) of Commonwealth expenditure in 2012–13.

The remaining programmes which were in the 'Top 20' items of expenditure were MBS items claimed under the Better Access initiative, the Targeted Community Care Programme (PHaMs

and Mental Health Respite Carer Support), ATAPS, headspace, the Mental Health Nurse Incentive Programme and the Social and Emotional Wellbeing Programme. Also included in the top 20 were Partners in Recovery, the National Partnership on Mental Health and the National Suicide Prevention Programme.

Commonwealth grants to these programmes accounted for approximately 12 per cent or \$1.2 billion of expenditure.

The Commission has had to rely on existing evaluations and any other related evidence to inform its views on programmes and services. It is acknowledged that some programme streams have a specific focus and target population about which the respective department has expertise, such as the Department of Defence and the Department of Veterans' Affairs.

Should Government support the recommendations of this Review, it is envisaged that closer consultation with these and other departments will be undertaken in 2015. It is noted that the Department of Veterans' Affairs has recently established a mental health review committee, and the Commission awaits that committee's findings. The Commission supports the continuation of the mental health programmes of these two agencies.

The Department of Health funds a number of small national programmes for discrete services and the Commission confirms its support for these programmes. An example of a small national programme is the service for survivors of torture and trauma.

Other programme elements are provided to support mental health system advancement, such as funding national decision-making, quality and standards, data to inform system outcomes and performance and a national consumer and carer organisation. These programmes should remain in place and be included in any forward considerations of implementing the reform agenda as identified in this Review report.

In Table 9.2, the Commission has focused its analysis on the programmes which are delivered to people and their families and which comprise the greatest investment for the Commonwealth.

Table 9.2 Commonwealth Programmes – The National Mental Health Commission’s View

Programme	Description	Continue?	Change?	The Commission’s view is
Access to Allied Psychological Services (ATAPS) Department of Health	<p>This programme enables GPs to refer patients to mental health professionals for low-cost, evidence-based mental health care delivered in up to 12–18 sessions. Funds are currently held by Medicare Locals. ATAPS mental health professionals include psychologists, social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers with specific mental health qualifications.</p> <p>2012–13 allocation: \$74.1 M</p> <p>Evaluation? Yes</p>	Y	Y	<p><i>With the introduction of Primary Health Networks the ATAPS programme will need to be reformed to fit within the new remit of the networks. Given the number of programmes that target psychological and personal supports to people with mental health difficulties, it is appropriate that these population-driven programmes should be rolled up together as pooled funds to meet the needs of local communities. The Commission considers that ATAPS funding should form part of this pooled funding approach.</i></p>
Better Access Department of Health	<p>Under this initiative Medicare rebates are available to patients for selected mental health services provided by GPs, psychiatrists, psychologists and eligible social workers and occupational therapists.</p> <p>2012–13 allocation: \$635 M in benefits paid</p> <p>Evaluation? Yes</p>	Y	Y	<p><i>Better Access has improved access to psychological treatment in the community and has been a positive initiative. More work needs to be done to ensure it is targeted to those most in need and rolled up into regional models to address community needs in an integrated way.</i></p> <p><i>Concern has been raised about the number of sessions available and the efficacy of the GP MH Care Plan. The Commission proposes amending Better Access to enable a simple referral and additional sessions for people with higher or more complex disorders.</i></p>

Programme	Description	Continue?	Change?	The Commission's view is
Youth Early Psychosis Service (formerly EPPIC) Department of Health	<p>The Youth Early Psychosis Programme (formerly Early Psychosis Prevention and Intervention Centres (EPPIC)) offers an integrated and comprehensive mental health service to meet the needs of people aged 15-24 with a first episode of psychosis.</p> <p>2012–13 allocation: \$11.9 M</p> <p>Evaluation? No. The Department of Health in the process of commissioning an evaluation to be completed by 2016</p>	Y	Y	<p><i>This Review reconfirms the priority for early intervention for young people, especially when mental health problems first appear and when serious mental illness is developing.</i></p> <p><i>The EPPIC programme should continue and be reviewed in the light of the findings of the 2016 evaluation and progress of other reforms arising from this Review regarding regional planning and delivery of services, especially for young people. Introduction of pooled funding within a regional framework, should consider the inclusion of (YEPP) programme funding.</i></p>
headspace Department of Health	<p>Funded under the Youth Mental Health Initiative Programme, and managed by the National Youth Mental Health Foundation, headspace offers specific services for people aged 12–25 who need help across some of the areas of mental health, employment, drug and alcohol, relationships and school. Allied health, GP and psychiatry services in this setting are funded through the Better Access Initiative.</p> <p>2012–13 allocation: \$63.7 M</p> <p>Evaluation? Yes (2009); new evaluation currently under way</p>	Y	Y	<p><i>headspace has rapidly expanded and an evaluation is currently being undertaken by the Social Policy Research Centre (UNSW) and is due in 2015. Changes to this programme should take into account the evaluation.</i></p> <p><i>Submissions to the Review highlighted a lack of local planning and duplication of current services in some headspace locations. There is concern that a one-size-fits-all approach does not meet the needs of people from diverse groups. The Commission recommends that this programme continues but local headspace services are transitioned into a regional model to better integrate and complement other services also targeting the same population group and to better meet the needs of local communities.</i></p>

Programme	Description	Continue?	Change?	The Commission's view is
Mental Health Nurse Incentive Programme (MHNIP) Department of Health (funding allocation) Department of Social Services (grant waiting list management)	<p>This programme provides a non-MBS incentive payment to community-based general practice, private psychiatrists and Aboriginal and Torres Strait Islander Primary Health Care Services to engage mental health nurses to provide clinical care for people with severe and complex mental disorders in their practice or service.</p> <p>2012–13 allocation: \$35.4 M</p> <p>Evaluation? Yes</p>	Y	Y	<p><i>The Mental Health Nurse Incentive Programme has shown positive outcomes for participants, who also increased their social participation. Concerns have been raised about the programme's design – including being capped at current funding levels rather than service levels, the transparency of the waiting list for grant allocations (especially the reallocation of funding where an approved grant holder may be underspending their grant and not providing the level of service for that community and equity of access for marginalised groups.)</i></p> <p><i>The Commission considers redesign options for this programme under Recommendation 21.</i></p>
Mental Health Services in Rural and Remote Australia (MHSRRA) Department of Health	<p>MHSRRA provides funding to nongovernment health organisations such as Medicare Locals, Aboriginal Medical Services and the Royal Flying Doctor Service to deliver mental health services by social workers, psychologists, occupational therapists, mental health nurses, Aboriginal health workers and Aboriginal mental health workers. MHSRRA funds the provision of mental health services in rural and remote communities that would otherwise have little or no access to mental health services, including in areas where access to Medicare-subsidised mental health services is low.</p> <p>2012–13 allocation: \$15.9 M</p> <p>Evaluation? Yes</p>	Y	Y	<p><i>With the introduction of Primary Health Networks to replace Medicare Locals, this programme will need to be reformed to fit within the new remit of the networks.</i></p> <p><i>The well documented lack of mental health professionals in rural and remote Australia, the undersupply of Aboriginal and Torres Strait Islander trained mental health workers and the comparatively lower access to Medicare-subsidised services (especially GPs and specialist clinicians) provides a strong case for continuation of MHSRRA. This is supported by the evaluation of the programme, where local communities responded that the level of MHSRRA services could be expanded. Organisations reported that they would like to do more community development and health promotion work to target harder to reach groups; for example, Aboriginal and Torres Strait Islander communities, probation and parole groups and farmers. The variation across rural and remote communities was intrinsic to the local design and delivery of the programme.</i></p> <p><i>To ensure that local community needs and context are reflected in the design and delivery of MHSRRA, the Commission considers that transferring MHSRRA funds into a regional pool will enable funds to be more efficiently allocated and programmes more tailored to local circumstance and community characteristics.</i></p>

Programme	Description	Continue?	Change?	The Commission's view is
National Depression Initiative (<i>beyondblue</i>)	<p>beyondblue is the national initiative to raise awareness of anxiety and depression, providing resources for recovery, management and resilience.</p> <p>2012–13 allocation \$16 M</p> <p>Evaluation? Yes</p>	Y	N	<p><i>National mental health promotion and awareness should remain the responsibility of the Commonwealth. The Commission supports the continuation of beyondblue as a national initiative.</i></p>
National Perinatal Depression Initiative (ATAPS and <i>beyondblue</i>) Department of Health	<p>The National Perinatal Depression Initiative aims to improve prevention and early detection of antenatal and postnatal depression and provide better support and treatment for expectant and new mothers experiencing depression.</p> <p>Australian Government funding under this initiative is being distributed to states and territories as well as ATAPS to build the capacity of divisions of general practice to better support women with perinatal depression and <i>beyondblue</i> to support implementation, including raising community awareness about perinatal depression, and developing information and training materials for health professionals who screen and treat new and expectant mothers for perinatal depression.</p> <p>2012–13 allocation: \$11.1 M</p> <p>Evaluation? Partial</p>	Y	Y	<p><i>The lack of a comprehensive evaluation limits an objective and detailed view of this programme.</i></p> <p><i>This programme has two components –</i></p> <ul style="list-style-type: none"> <i>a community programme supporting women with perinatal depression</i> <i>a national component to raise awareness of perinatal depression in the community and to develop information and training materials for health professionals.</i> <p><i>It is proposed that the community component be transferred to a regional funding entity such as the new Primary Health Networks, to better integrate and roll out perinatal initiatives along with other ATAPS and local health services for new parents and infants.</i></p>

Programme	Description	Continue?	Change?	The Commission's view is
National Suicide Prevention Programme (NSPP) Department of Health	<p>Funding for suicide prevention activities across the Australian population and for specific at -risk groups including men, Indigenous people, people in rural and remote Australia, people bereaved by suicide, people with a mental illness, and young people. The NSPP also provides funding to other Commonwealth-funded mental health programmes, including Access to Allied Psychological Services (ATAPS) and MindMatters, for the inclusion of suicide prevention specific activities under these initiatives.</p> <p>2012–13 allocation: \$23.0 M</p> <p>Evaluation? Yes</p>	Y	Y	<p><i>Funding of a range of suicide prevention programmes is a cluster of separate programmes under the Health Department (National Suicide Prevention Programme and Taking Action to Tackle Suicide, as well as Access to Allied Psychological Services) and the Department of Prime Minister and Cabinet in regard to Aboriginal and Torres Strait Islander interventions under the SEWB programme.</i></p> <p><i>Additionally, the Commonwealth also funds a number of helplines for people who are in distress (Lifeline, Men's Line, Kids Helpline). Helplines need to be seen as part of the larger suicide prevention efforts, to also provide evidence-based approaches and streamlined access. The Commission considers that helplines need to be streamlined to ensure people in distress and crisis get one-on-one support when they call, and can be linked in to local services for additional in-person support.</i></p> <p><i>It is evident from available data that suicide rates are no longer decreasing. We need to accelerate efforts in a coordinated and targeted way, and to reconsider how to best to roll out evidence-based interventions. It is agreed by stakeholders that we also need a more robust and timely collection of attempted suicide and completed suicide figures, so funds are better used and better outcomes are achieved – more lives are saved. The Commission considers that clear targets are required to set a system goal and recommends a 50 per cent reduction on suicide attempts and suicides over the next 10 years.</i></p> <p><i>Given the different programme streams that fund suicide prevention and postvention supports, and the imperative that approaches need to be better designed and targeted to the specific needs and vulnerabilities of communities, it is recommended that these programmes be rolled up into a regional model.</i></p>
Partners In Recovery (PIR) Department of Health	<p>Coordinated support and flexible funding for people with severe and persistent mental illness with complex needs.</p> <p>2012–13 allocation: \$65.8 M</p> <p>Evaluation? Currently under way</p>	Y	Y	<p><i>PIR has shown promise in some areas where it has been rolled out and submissions to the Review highlighted the value and positive impact of the programme. It is currently being formally evaluated, and the Commission understands that early findings have identified variability in quality across sites.</i></p> <p><i>The issue of the transfer of PIR to the NDIS is considered to erode the existing benefits to individuals in receipt of quality services. The Commission is concerned that new inefficiencies will arise when current eligible clients will not be covered by the NDIS and so will lose their supports and compromise the advances they have made. A more efficient approach for the person and the system would be to re-engineer the programme so that funding is integrated into a regional pool, with improved coordination and service delivery efficiencies and better targeting of local population and individual needs.</i></p>

Programme	Description	Continue?	Change?	The Commission's view is
Social and Emotional Wellbeing Programmes Department of the Prime Minister and Cabinet	<p>The objective of the Social and Emotional Wellbeing Programme is to enhance existing service delivery to Aboriginal and Torres Strait Islander communities, prioritising members of the Stolen Generations, through flexible models of service delivery and national coordination and support.</p> <p>2012–13 allocation: \$47.78 M</p> <p>Evaluation? Yes</p>	Y	Y	<p><i>There is no longer a discrete mental health/social and emotional wellbeing programme. All funding has been rolled into the new flexible outcome-based structure. This includes a safety and wellbeing stream. The grant round for 2014–15 is currently under way with applications closed but decisions yet to be made. The Commission's view is that an additional target should be added to the COAG Closing the Gap programme to reduce early deaths and improve wellbeing.</i></p>
Support for Day to Day Living in the Community Department of Health	<p>A structured activity programme providing funding to improve the quality of life of individuals with severe and persistent mental illness by offering structured and socially based activities. This initiative recognises that meaningful activity and social connectedness are important factors that can contribute to recovery.</p> <p>2012–13 allocation: \$13.9 M</p> <p>Evaluation? Yes</p>	Y	Y	<p><i>This programme has been found to be highly effective for those interviewed in the evaluation as it provides a wide range of activities which improved the quality of life of participants. This was also reflected in the small number of submissions to the Review that the Commission received on this programme. The Commission considers that this programme should stay at its current funding levels and be transferred to be administered by a regional body, where pooled funding for programmes can be planned and allocated on local needs in an integrated delivery service framework.</i></p>
Taking Action to Tackle Suicide (TaTs) Department of Health	<p>The TaTs package provides further support for suicide prevention through universal and population-wide approaches and through community-led responses, including infrastructure for suicide hotspots and prevention activities and helplines.</p> <p>2012–13 allocation: \$19.2 M</p> <p>Evaluation? Partial (as part of NSPP)</p>	Y	Y	<p><i>Programmes need to continue under this initiative for target groups and special populations. All programmes run under this initiative should be evaluated rigorously and there is a need for a central point of planning with the NSPP. Funding for hotspots needs to be flexible and allocated to communities for local-specific solutions, administered by a regional model.</i></p>

Programme	Description	Continue?	Change?	The Commission's view is
Targeted Community Care Programme – Personal Helpers and Mentors (PHaMs), Mental Health Respite: Carer Support (MHRCS) & Family Mental Health Support Services (FMHSS) Department of Social Services	Three separate programmes are funded under the umbrella of the TCC programme, to assist people and their families in the community by providing day-to-day support to manage the impact of living with a mental illness through PHaMs, Mental Health Respite and Family Mental Health Support Services. 2012–13 allocation: \$180.8 M Evaluation? Yes	Y	Y	<p><i>The evaluation of this programme identified positive outcomes for people, their families and carers by improving access to daily support, increasing options for respite for carers and families.</i></p> <p><i>The Commission is concerned at the proposal to roll these programmes up into the NDIS, as this will leave some people without the services they are currently entitled to and affect the sustainability of some smaller organisations. As the largest single programme of supports for people with a mental illness and their families (other than income support), changing access will have the greatest impact upon current recipients. As such, given that components of the NDIS as they apply to people living with a mental health-related disability have not been clarified, now is the time to reconsider the rolling up of this programme into the NDIS. We should identify ways to ameliorate the episodic and longer-term impacts of disability arising from mental illness.</i></p>
Department of Veterans' Affairs Mental Health Programmes Department of Veterans' Affairs	These programmes provide education, advice and assistance for veterans and their families to recognise the signs of mental health problems and to act to improve and maintain mental health. 2012– 13 allocation: \$167 M Evaluation? Yes	Y	Y	<p><i>In recent years there has been a shift in the types of people being supported by DVA to an emerging cohort of younger members of the ADF and ex- service personnel from recent conflicts. The Commission recognises that serving and former members of the ADF and their families and supporters should have access to timely and efficient mental health care, and that access is not prevented by levels of red tape and bureaucratic processes.</i></p> <p><i>The Commission looks forward to the findings and advice from the Prime Ministerial Advisory Council on Veterans' Mental Health to support real change in this area.</i></p>

Chapter 10:

Alternative approaches

This chapter considers alternative approaches to optimise service collaboration and develop person-centred pathways. It outlines how mental health care and supports could be organised, how technology could be optimised and how funding could be allocated, to deliver population and person-centred mental health programmes and supports.

Term of Reference

Existing and alternative approaches to supporting and funding mental health care.

Supporting and funding mental health care involves collaborative efforts across the domains of service and support sectors, optimising new service platforms and effective funding allocation mechanisms for achieving improved mental health and reduced psychosocial disability. These issues are addressed in this chapter in the context of existing and alternative approaches to supporting and funding mental health care.

A new model of care delivery: integrated stepped care

We have received substantial evidence from all over the country that Australia's mental health supports are fragmented across services and programmes, which each have their own remit and eligibility criteria. This has negative implications not just for the experiences of consumers and their supporters, but also for professional practice and for the overall efficiency of spending on mental health.

'As family members we are worn out trying to be Sherlock Holmes trying to find out anything about anybody in the professional mental health field and what they are like (that are already few and far between) when we start out. Since we have next to no information on how good someone is ... in my case my family member had already seen someone they felt didn't really care and couldn't wait to wrap up exactly at the 40min bell. How does that make any young adult feel or a distraught exhausted family member who is disgusted that there is no decent 'system' to assist with help and guidance on any of this.'

Submission from a support person

Services and programmes are fragmented because of a diversity of funding sources as well as siloed operations within a sector or specialty. There are no incentives for organisations or professionals to work together in the interest of the person with multiple needs, meaning that both duplication and service gaps remain unchecked. People who use services have trouble navigating the disjointed array of supports available, fall through the gaps between services, and are not followed up after being turned away or discharged from a particular service.

All of this means that services respond not only to the needs and preferences of the people they are supposed to serve, but to the needs and preferences of funding and governing bodies. The person has to fit to the rigid service structure, rather than a combination of supports flexibly fitting around the needs of the person.

Our proposal for a regional primary and mental health network service delivery model, whereby services are commissioned for a defined population according to the assessed needs of that population, is one step towards ensuring that the focus is on improving outcomes overall, however that is achieved.

The way services could operate under such a regional network model would encourage collaboration and communication across service boundaries, provided that each organisation was judged on the performance—in terms of mental health outcomes—of the whole integrated system of services in that geographical area, rather than solely on their own levels of activity.

The following sections outline options for a model of care which is oriented around primary care-level mental health supports. These are linked closely with other supports in an integrated stepped care approach – stepping through care services as required by your mental health needs, rather than automatically being referred to a specialist as the first step (unless clinically warranted).

Matching support to need

Primary care, and especially the general practitioner, is most often the first port of call for someone who has decided to seek help for a mental health difficulty.

Currently, GPs usually refer on to specialist public or private mental health services if they consider their practice cannot provide the necessary expertise to manage a person's difficulties. This means that many people who could usefully be helped by non-GP interventions at community or primary care level end up in expensive specialist services.

Where a service is not tailored to level of need, less complex options of GP care or specialist mental health professional intervention may help some people. This approach, however, will be an unsuitable choice for others. It is also an inefficient way to organise services.

A more responsive way to structure mental health supports is to use a stepped care model which assesses the current level of functional impairment and need of the person seeking help, and matches this to a suitable combination and intensity of support(s). The system allows them to 'step up' or 'step down' easily. So, for example, for people with mild, reactive or discrete mental health issues, the first line of support could be referral for exercise classes and computerised Cognitive Behavioural Therapy (CBT), which is supervised online. If this first-line support does not achieve the desired outcome for the person, consideration could be given to 'stepping up' to psychological therapy.

On the other hand, if a person is living in fraught circumstances where they are experiencing psychotic symptoms, are recently unemployed and have nowhere to live, under a stepped care approach they would be more appropriately referred for a holistic assessment of mental health, social and economic support requirements. This does not mean that they will always require similar levels of support long-term. When their needs for support diminish, they could 'step down' to be seen by a multi-disciplinary team in primary care, assisted by specialist input from a psychiatrist consulting to the primary care team.

'The employment of locally respected, community-based, non-clinical Support Facilitators (e.g. Partners in Recovery) or Case Managers has already demonstrated that the case load of mental health clinicians/practitioners can be alleviated by preventing clients entering or re-entering the system by assisting them to manage their daily issues such as housing, finances, work-related issues, physical health and medication, etc. This ensures that there is a continuum of service and a targeted, appropriate level of support that fills the existing gap between an early intervention and intensive, acute or crisis clinical care.'

Australasian Centre for Rural and Remote Mental Health

Options for service integration

Integration of supports and services brings together people and organisations that represent different sectors or specialties, to align relevant practice and policy, and to improve access to and quality of support for consumers. Integration goes further than opening channels of communication and promoting collaborative or inter-professional practice. It means coherence across policies and legislation, developing cross-sectoral partnerships and agreements, as well as joint administrative, planning and funding arrangements.

Integration therefore occurs at different levels. The Review considers that using the proposed Primary and Mental Health Networks will provide the regional architecture to support integrated care and achieve the benefits for its communities from more efficient and tailored care and support. At the regional level, integration can occur between mental health and physical health supports, between mental health services that provide support at different levels of intensity or specialty and between primary health services and community supports across sectors.

Integration of mental health supports and physical health supports at the primary care level makes sense, given what we know about the interrelated nature of mental and physical wellbeing. Specifically, it would benefit people whose mental illness has arisen in tandem with a severe or chronic physical illness or disability, as well as people who are at risk of developing poor physical health as a side-effect of their lifestyle or mental health medication.

Such integration would not simply mean individual GPs continuing to attend to both physical and mental health needs (although this is essential), but would extend to referral to a multi-disciplinary team of nutritionists and dieticians, pharmacists, gyms or personalised exercise programmes, many of which could be collocated in primary health centres.

Vertical integration between services delivering different intensities of mental health support—encompassing primary, secondary and tertiary health care professionals and organisations—provides a clear pathway for a person as their clinical support requirements change over time. In such a model, specialist mental health teams could provide consultation and supervision to primary care-based teams.

At present, the Mental Health Nurse Incentive Programme provides a mechanism for embedding specialist mental health professionals in the primary care context. ‘Mental Health Hospital @ Home’ in South Australia is another example of integrating community and hospital level services to keep people at a lower level of stepped care (and out of hospital). Acute level care is offered to people in their own home.

Integration between primary health services and community-based supports across the many different sectors is designed around a person’s needs, such as where a person experiencing mental illness may need to access housing or personal support, in addition to their mental health treatment support. This type of integration allows the whole-of-life, holistic support of a person and their family. Meaningful integration of this type could provide for individual support facilitators, such as currently employed under *Partners in Recovery*, to help the person navigate the system. A greater level of integration could also involve pooled funding, regular joint meeting, and joint care planning between multiple agencies involved in a person’s support.

Another avenue for cross-sectoral integration would be through collocation of different agencies under one roof. Young consumers have told us that they value the range of services available in the ‘one stop shop’ set-up at *headspace* centres (including physical and mental health care, vocational and employment advice and substance use services).

The Faculty of Health, Queensland University of Technology, provides a multi-disciplinary health clinic which is described in the case study below. This illustrates how primary care-level clinics can reduce fragmentation of services by catering for physical health, mental health and lifestyle needs, as well as providing a range of levels of support from basic outreach and screening to partnership with specialist eating disorder services and support for family members.

‘The Faculty of Health operates a multi-disciplinary health clinic, which provides outreach health check services to vulnerable, high-risk groups such as the homeless and Indigenous people. These outreach services are low-stigma because they offer health checks across the spectrum - including optometry and podiatry, for example. The School of Psychology and Counselling, through its postgraduate student programs, provides a mental health screen as part of the health check and is able to assist with referral or brief consultation when this is indicated.

The School of Public Health and Social Work has developed and established the Interdisciplinary Family Based Treatment Clinic at the QUT Health Clinic, which engages with Psychology and Counselling, Nutrition and Dietetics, Nursing and Sports Exercise and a General Practitioner who specialises in Eating Disorders to deliver services for sufferers of eating disorders and their families. We have partnered with the Eating Disorders Outreach Service, Queensland Health, to provide training to our students and wider health services community in Self-Guided Cognitive Behavioral Therapy for Bulimia Nervosa and Binge Eating Disorder, and Skills-Based Learning Group for Carers and Families Affected by Eating Disorders.’

Submission from Faculty of Health, Queensland University of Technology

Steps towards integrated supports

Rolling out integrated mental health models is essential to leverage efficiencies from separate service providers or sectors, or even different providers within the one service. It is essential to achieving the mental health and wellbeing outcomes for people living with a mental health difficulty, their families and support people.

The practical steps to implement integration need to be based upon a clear set of principles. The World Health Organization (WHO) considers that a well-integrated mental health system emphasises the importance of life-course approaches, public mental health and whole-of government approaches to planning, funding and delivering services.¹ In practical terms, the literature suggests the following as necessary to underpin primary care-based integrated mental health.

Supporting people

- A ‘no wrong door’ approach to people seeking help for mental health difficulties, where they can access a tailored combination of supports wherever they first ask for assistance.
- A requirement for involvement of people with lived experience in the planning and implementation of integrated primary mental health care, reflecting practices in Aboriginal Community Controlled Health Services.

- A greater knowledge of the cross-sectoral multiple health needs of a person, and the mental health ramifications of different life experiences and events, to support further integration.

Workforce

- Increased levels of interprofessional training and education to improve awareness about potential for collaboration and about what each profession can offer.

Using technology

- Integration requires appropriate technology to enable effective referral pathways and shared electronic care records

Financial incentives

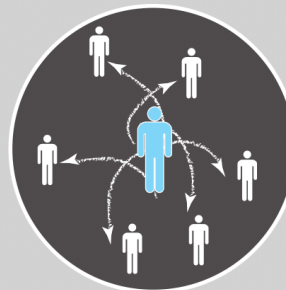
- A system of financial incentives for stepped care practices and structures, such as the recommended pooling of funding streams for commissioning at regional level by Primary Mental Health Networks in Volume 1.
- Incentives for collocation of multiple agencies as one-stop-shops for wraparound mental, physical, social and lifestyle supports to encourage integration.

The next two sections address the issues of technology and financial incentives.

Seeing change through personal experience

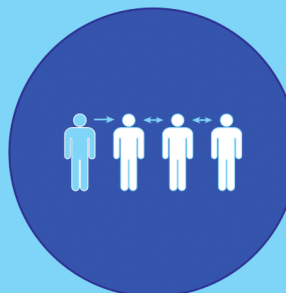
Today

- Every new person I see asks me the same questions all over again
- I never get to see the same people even though I'm having the same things done again and again
- I'm confused about what options are open to me and how I'll deal with my conditions over the next few years
- No-one takes overall responsibility for helping me
- Different staff don't seem to talk to each other



Future

- ▶ I only have to give my name and address once, and everyone I interact with knows what I've covered with other staff
- ▶ I have a plan to look after myself, which I really feel in control of
- ▶ The nurse at my practice just called to remind me that my early check is due next month, and I know to call my care coordinator if I find things are getting worse
- ▶ My pharmacist checks that I'm taking my medication because she notices if I haven't picked up my regular prescription
- ▶ If I need something my care coordinator can organise it straight away—I don't have to wait for another assessment



Source: concept designed by The National Mental Health Commission 2014

Opportunities to use technology for better mental health

Australia is a world leader in using information and communications technology, particularly e-mental health interventions, to improve mental health.² This area presents one of the greatest opportunities to improve the efficiency and outcomes of mental health programmes and services. Using these technology-based approaches to their full potential would be a cross-cutting change.

‘Online services work well in terms of mental health because they are anonymous for the user. ReachOut.com for example, I find its online forums can be great fun and a great help. They offer fun games and such, helpful tools and advice when needed. And multiple people can help you with your issues without you needing to repeat yourself over and over again. KidsHelpLine is also helpful, it provides professional support and is also free, which is a good thing as younger kids who need it can use it without needing money.’

Submission from a person with lived experience

In this chapter the term *e-mental health* is considered to include a range of elements, and as such is an overarching concept defined as –

“...that form of e-health concerned with mental health... e-mental health services provide treatment and support to people with mental health disorders through telephone, mobile phone, computer and online applications, and can range from the provision of information, peer support services, virtual applications and games, through to real-time interaction with trained clinicians.”³

The discussion also touches upon telehealth, e-health records and other technology-based approaches (such as telephone helplines and online support services).

Investing in the use of technology, and not in bricks-and-mortar services alone, aligns well with the overarching principles we have articulated in this report. Smart use of technology has the capacity, if planned and implemented well, to:

- put the individual at the centre of the response to mental health concerns, enabling choice and delivering a customised pathway for each person’s needs
- enable self-management of care as well as personal control of who sees each individual’s data, to enable a ‘tell it once’ experience
- better meet demand for mental health information and contact, freeing up highly valuable clinical resources by reallocating demand to the most cost-effective and appropriate modality for the need
- make use of proven, evidence-based resources to help reduce the progression to mental ill-health
- reduce the severity of conditions through the introduction of self-managed care in between face-to-face sessions
- increase availability of mental health services for people when they need it, especially segments of demand (e.g. rural and remote, or vulnerable populations) currently underserved by clinics.

For Aboriginal and Torres Strait Islander peoples, the use of the single care plan and e-health record by dedicated specialist support services to help connect patient transitions needs to be culturally appropriate.

What is happening now

The benefits of e-mental health

E-mental health provides access to services at low cost and in flexible, non-stigmatising and private ways for people with mental health difficulties. This is particularly important for people with high-prevalence, low-severity disorders, who are over-represented in the group not currently receiving treatment.⁴

E-mental health can assist in improving the mental health of those population groups that have limited access to services. Planning and service delivery may improve as a result of online data collection and information management.⁴

E-mental health services also reduce demands on the workforce, ensuring that clinicians use their skills for more complex care, and provide access to information, clinical practice guidelines and professional education and support resources.⁴

Current status of Australian services and programmes

The possibilities presented through innovative technologies are enormous, and the knowledge and use of these possibilities is expanding quickly. Australia's e-mental health services have grown up rapidly. First generation e-mental health services were funded under the Teleweb measure, and were often standalone e-mental health solutions providing web services directly to the community (e.g. Kids Helpline, MoodGYM, This Way Up and MyCompass).² From one perspective, these represent the building blocks of the e-mental health system, given their strong evidence base.²

We are now at the second generation of e-mental health. E-mental health services are beginning to be linked to primary care and face-to-face services. Some are already established on IT platforms and provide specialist programmes for adults and youth (such as virtual clinics). Others leverage existing connections within organisations; for example, integrating e-mental health services with general practice referrals.² Project Synergy, which is currently in development through a \$5 million three-year government grant, will provide links for young people to virtual clinics for university students and virtual psychiatric clinics for young people and further links with face-to-face services.^{2,4}

More traditional support services such as helplines still play a significant role in Australia, and are increasingly integrated with online support services. These support services provide anonymous and accessible options that people can access without having to leave the privacy of their homes. As examples, Lifeline provides telephone support to 820 000 callers per annum in addition to online counselling to 40 000 clients, while eheadspace provides telephone support to 40 000 young people each year, as well as online counselling via web-enabled chat.⁴ Telehealth plays a more limited role in mental health service delivery, with MBS-subsidised telehealth consultations in mental health limited to psychiatrists. Major Commonwealth Government involvement in mental health-related technology includes the initiatives outlined in Table 10.1. However, this is not a solely government-funded sector.

Table 10.1 Major Commonwealth programme involvement in mental-health related technology, 2012–13

Initiative	Description	Funding details
Teleweb programme	Provides evidence-based telephone and online mental health programmes for individuals with common mental health disorders and those in psychosocial crisis; both generalist lines (e.g. Lifeline) and specialist lines (e.g. QLife for the LGBTI community)	Department of Health grants to telephone counselling, self-help and web-based support programmes. \$11.4 million 2012–13
Personally Controlled Electronic Health Record (PCEHR)	A secure online summary of an individual's health information. The individual controls what goes into it and who is allowed to access it.	Department of Health \$81.3 million 2012–13
Project Synergy	A technological solution currently being developed which allows data to be captured and stored across multiple services. The project will enable young people to experience a seamless user journey through mental health services.	Department of Health Project commenced 2013–14. Total project costs \$5 million over three years. \$2.5 million 2013–14
Mindhealthconnect	An information aggregation website which provides content from leading health-focused organisations in Australia.	Operated by Health Direct Australia. No specific allocation with operational costs of \$3.6 million p.a.
Telehealth MBS item (telepsychiatry)	Provides access to specialist video consultations under Medicare to eligible rural and remote areas in Australia so patients do not need to travel to major cities for care.	Department of Health Benefits payments. \$3.5 million 2012–13
E-mental health strategy for Australia	A strategy that sets out a long-term vision for developing a respected, evidence-based, accessible, professionally recognised and integrated e-mental health service environment, building on the current funding for a small number of proven and successful online mental health and telephone crisis support services.	Department of Health strategy to coordinate e-mental health service and improve access. No specific funding allocation.

Sources: Commonwealth Budget Papers 2012–13; Annual Report of the Personally Controlled Electronic Health Report 2012–13, MBS payment data Department of Health, Department of Health Budget estimates, 2013–14

Different forms of e-mental health solutions have the potential to address needs across the spectrum of mental health care and support.

- Mobile applications and information websites can support the whole population to self-manage their own wellbeing.
- Self-directed online interventions and web-enabled chat can support individuals with moderate needs and augment face-to-face care for people with complex needs.

In this manner, e-mental health increases reach and frees up time to use clinical treatment for those people with very complex needs, such as eating disorders, major depression and anxiety, drug and alcohol addictions and psychoses. This stepped care approach via e-mental health is illustrated in Figure 10.1.

In submissions to the Review, people and organisations recognised a number of benefits of using technology in mental health services, including:

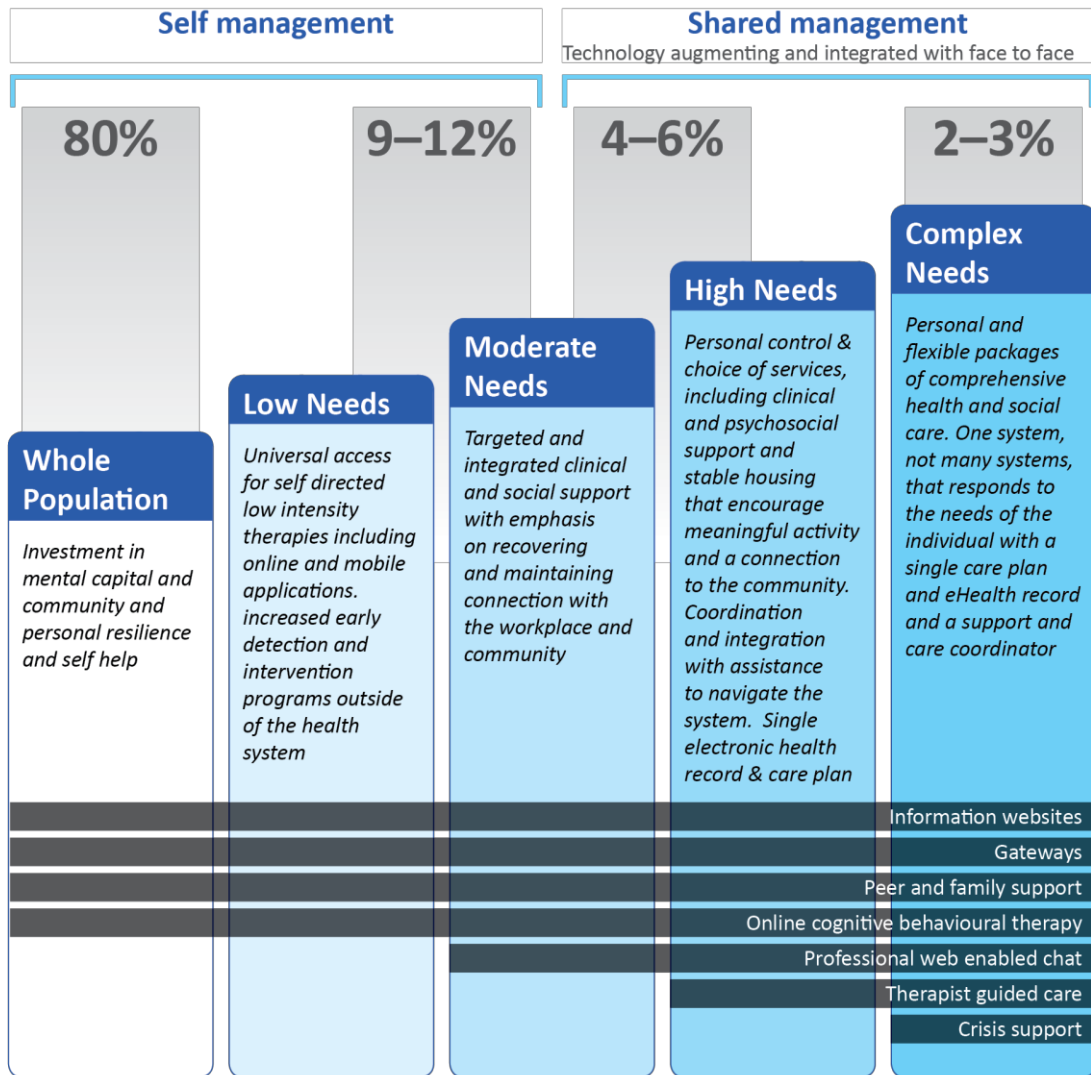
- Increased reach and accessibility of services, overcoming access issues related to stigma, privacy, geography and other circumstances.
- Offering social and peer support for consumers and caregivers.
- Disseminating information and sharing knowledge.
- Aiding professional networking, training and continuing professional development.
- Increased efficiency and effectiveness in provider roles.

They also saw a number of challenges, including:

- A lack of integration and coordination with existing services.
- Some ethical issues and lack of accountability in services delivery.

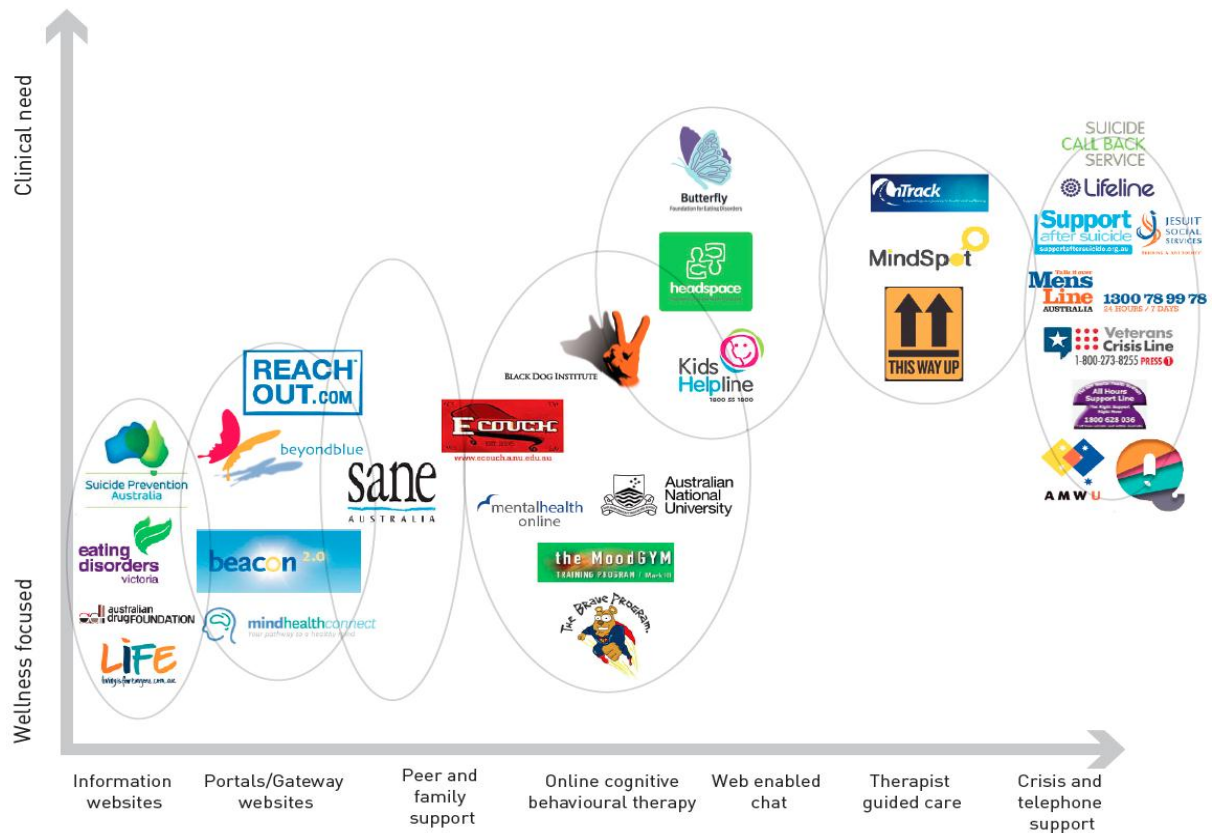
Some populations still find these resources difficult to access (e.g. in remote areas without reliable internet)

Figure 10.1 Stepped care, with e-mental health service matched to individual need and integrated with other services



Sources: Adapted from The Case For Mental Health Reform in Australia: a Review of Expenditure and System Design, Medibank Private and Nour Group, 2013

Figure 10.2 Illustrative examples of the current e-mental health landscape in Australia

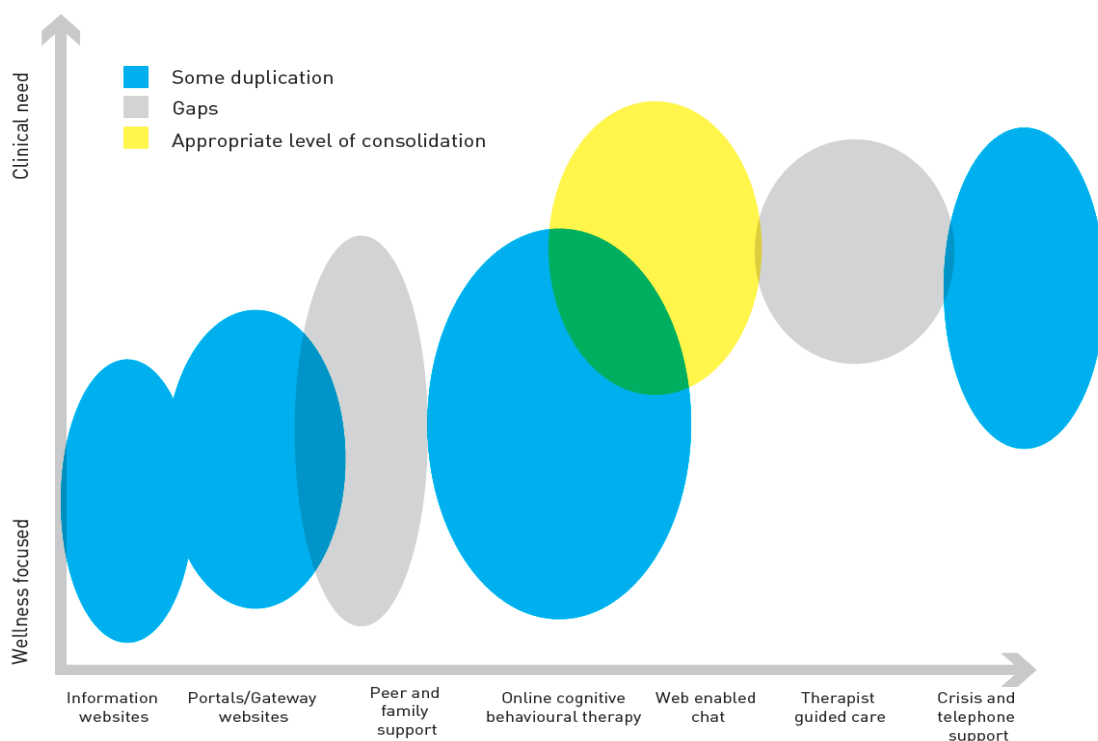


Source: Young and Well Cooperative Research Centre (2014): Advice on Innovative Technologies in e-Mental Health: Briefing Paper for the National Mental Health Commission (Unpublished).

From a consumer perspective, the system can be confusing. Figure 10.2, above, maps e-mental health services in Australia, showing the range of providers and services they offer.

Pathways through this map can be difficult. Currently telephone helplines are not integrated, they do not have common standards and there are limited referral pathways. There are various levels of duplication of target client groups and potential to be accessing the ‘wrong door’ by users. Figure 10.3 shows where duplication and gaps occur. There is duplication in information websites, portals/gateway websites, crisis and telephone support, and gaps in peer and family support and therapist-guided care.

Figure 10.3 Areas of duplication and gaps in the Australian e-mental health landscape



Source: Young and Well Cooperative Research Centre (2014): Advice on Innovative Technologies in e-Mental Health: Briefing Paper for the National Mental Health Commission (Unpublished).

Key findings

There are three key priorities requiring attention to realise the potential benefits of technology in mental health:

- integration of e-mental health with other services
- reorganisation of the e-mental health sector
- continuing use of other technologies and enablers.

Integration of e-mental health with other services

E-mental health is linked closely with primary mental health care services and should eventually be seen as a part of a wider integrated care model that enables people to access support at a level, time, and place that suits their needs.

Commissioned research for the Review from the Young and Well Cooperative Research Centre (YAW CRC) concluded that integration was the most important short-term priority for the use of new and emerging technologies in mental health.⁴ Their work proposed that e-mental health should be the lead modality for frontline response and early stage self-management.⁴

E-mental health services integrated with primary care can be used as an adjunct to face-to-face treatment or as a guide for treatment sessions, ensuring high-fidelity, evidence-based care and building the capacity of practitioners. For example, better integration between general practice and e-mental could include:

- feedback to GPs on progress of e-mental health referrals, and avenues to contact the consumer periodically to check progress
- screening in GP practices with direct transfer to e-mental health service provider for treatment or recovery services

- crisis and emergency support to those who have severe and complex mental health problems or urgent needs
- a relay connection activated by the technology back to the GP (nominated by the consumer), for individuals who have not responded to 'stepped care' at various points.²

'Online cognitive behavioural therapy for adult anxiety disorders and depression has been an invaluable adjunctive tool in my work as a clinical psychologist in private practice. These courses provide a means for patients to access relevant, complementary information to that which we cover in session. It also allows excellent ongoing monitoring of patient symptoms via automated online questionnaires. Adjunctive use of these online programmes enables me to deliver more specialised and personalised instruction when meeting with private patients.'

Submission from a clinical psychologist

Integrating e-mental health into a fully functional mental health system of stepped care offers one of the greatest invest-to-save opportunities for government in mental health. A 2014 report prepared by the e-mental health Alliance⁵ concludes that delivery of e-mental health is both cost-effective and cheaper to provide than care as usual, particularly for depressive and anxiety disorders. There is significant return on investment from e-mental health services, which leads to improvements in both cost-benefit ratios and sustainability of care.⁶ For example, a social return on investment study of Lifeline Online Crisis Support Chat service estimated a return of \$8.40 for every dollar invested in this service.⁴ A cost-utility analysis of clinical trial data from the myCompass programme for depression and anxiety shows that the programme can be delivered in a cost-effective manner, with a cost per quality-adjusted life year (QALY) gain of \$3508. This is approximately one-fifth the cost of treatment with antidepressants and a tenth the cost of recommended treatment with a psychologist to achieve the same QALY gain.⁴

Reorganisation of the e-mental health sector

Despite Australia's global leadership in e-mental health technology and research, the e-mental health sector is not a unified one. It needs intra-domain, inter-sectorial rationalisation and mechanisms for integration with other mental health services and expansion.²

For this Review, it was difficult to identify any overarching design, guidance or role specification for current services, allowing organisations to build what services they want, based on perceived need, often with government funding. There is no public register of what has been publicly funded or how effective it is, or widely available quality or accreditation standards to ensure consumers are getting evidence-based online help. Finally, there is no overarching technical framework to guide interoperability between products, so data is rarely shared and used in aggregate to help individuals.

Continuing use of other technologies and enablers

Tele-health continues to offer a potential solution to gaps in services. Research suggests that tele-mental health can be an effective mode of delivery, and is no less effective than in-person care. Randomised clinical trials have found comparable treatment outcomes for patients who received treatment via videoconference compared to in-person delivery, with favorable results even for challenging mental health problems, such as PTSD.⁴ Submissions to the Review frequently mentioned extending the use of telephone counselling and internet sessions to

increase access to service providers as another important element of incorporating technology into the integrated care system.⁷ Multiple professionals, organisations and consumers perceived the provision of psychological services through telephone or online services to be an effective use of resources, and recommended to the Review that Medicare rebates for consultations that occur via this method be expanded to professionals other than psychiatrists.

Many Australians also reported in their submissions to the Review that telephone helplines act as a valuable support for them to address mental health concerns. However, technology usage patterns have changed significantly, and the use of telephone helplines is complemented by the increased uptake of online counselling via web-enabled chat and a clear need for peer and family support online.⁴ The operation of hotlines and online help could be enhanced by providing direct triage to consumers to steer them towards providers of expertise and advice in the particular subject area, to reduce confusion about the services on offer to them.

Internationally, governments are increasingly considering some form of coordination and integration to ensure easy access and consistent quality across helplines and their websites. In the UK, a coordinated and integrated approach is being driven by a central agency which has seen improvement to services through the development of guidelines for operation. In New Zealand, the Ministry of Health has commenced a procurement process to develop and purchase an integrated national telehealth service to provide advice, support, assessment of symptoms, triage, treatment, preventive (educational) and curative aspects of health care services. It will be free of charge to users and available 24 hours a day, seven days a week either by telephone, text messaging or online.⁴

Where to from here – implications for reform

The next generation of e-mental health services is now required. The sector, including both providers and funders, needs to collaborate on how to:

- consolidate services in the main services domains (such as health promotion, prevention and early intervention, crisis support lines, treatment and recovery)
- promote cross-connection across these domains
- introduce screening and continuity of care solutions
- integrate with face-to-face services
- promote integrated treatment services.

This next generation will move on from the current system of stand-alone services with some areas of integration, to one that integrates across services and sectors, taking up the opportunities that e-health can provide. The decisions for the sector are not only about the capacity of the technology, but the evolution of clinical models and the simplification of consumer pathways. This will enhance coverage of services to people, assist GPs in their primary care role and connect people to face-to-face services when they need them.

An integrated system will require functionally appropriate e-health records to enable genuinely integrated care to become a reality. There are concerns about the current Personally Controlled Electronic Health Record (PCEHR), including its low uptake, the limited additional functional benefit beyond digitising the paper system, and slow improvement timeframes. Our research advice forecasts that emerging technologies will progress to individuals' data from multiple sources "talking to each other" through interoperability. This would contain real-time data and history, which individuals can use to gain a holistic perspective of their mental health and wellbeing, and which they can choose to share with professionals if they so wish to support their face-to-face care.⁴

Other mechanisms will include requirements around responsiveness (online case management to guide people through the system and keep them online across systems, not just as part of an internal programme), registration, a standardised adaptive screening tool to be used across all e-mental health domains,² standards and interfaces for interaction between system components, and accreditation mechanism that gives users and clinicians confidence in using e-mental health interventions as part of an integrated care system.⁴

The rapid growth and the complexity of this sector require appropriate leadership to develop a consolidated transformative plan for integration between e-mental health and face-to-face services.

Continuing use of other technologies and enablers

Apart from an integration strategy for the sector, specific reforms to the MBS could support more effective use of technology and more quickly address access barriers.

New MBS items for telehealth services, beyond the current item for telepsychiatry, would provide an opportunity to address shortfall in face-to-face services in areas outside major cities.⁴ This could be extended to include professional groups are able to provide MBS-subsidised services under Better Access.

On telephone and online support services, the strategic direction is in creating a ‘joined-up’ model of crisis support helplines, with each helpline playing its part according to its expertise. This would reduce duplication, increase efficiency and enable collaborative work.

Aboriginal and Torres Strait Islander peoples

For Aboriginal and Torres Strait Islander peoples, culturally appropriate helplines and websites should be developed with Aboriginal and Torres Strait Islander mental health and suicide prevention leaders and stakeholders – such as the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG). Given that Aboriginal and Torres Strait Islander peoples have the highest suicide rates, it is important that crisis support be able to work in a culturally competent manner with Aboriginal and Torres Strait Islander people and other clients from vulnerable groups, and particularly those presenting with suicide ideation. For such crisis support, Aboriginal and Torres Strait Islander counsellors and counsellors from other vulnerable groups should be available at all times if required.

Actions

- A new Commonwealth agenda for developing a consolidated, integrated approach within the e-mental health sector is needed.
- Commonwealth and state and territory governments and private sector to work collaboratively on a financing model for the inclusion of e-mental health technologies in the overall mental health system.
- A reform blueprint be developed that builds on the current e-mental health strategy, for the digital transformation of the sector and its participants.
- In parallel, implement a sector-led framework for research, design, development and roll-out of new interventions, which must integrate with other systems and close system gaps.
- Transform how the e-mental health sector is funded through innovative business and funding models for sustainability.

- Within the e-mental health sector, establish a number of consolidated domains, each under the leadership of a current e-mental health provider with proven expertise. Re-tender all associated national e-mental health functions.
- Adopt an 'ecosystem' approach to the development and integration of e-mental health services, including systems to collect data for usage in service planning and research.
- Support innovative research in e-mental health through greater partnering with the private sector. The establishment of an E-mental Health Research Centre think tank that builds on the investment of the NHMRC, its Centres of Excellence and programme funding would be a vehicle for research coordination and priority setting and serve a clearing house function.
- In light of the above, assess the place of mindhealthconnect in supporting further development of the preferred model of integration.
- Prioritise training for general practitioners and other primary care professionals on e-mental health interventions to enable greater integration.
- Ensure the applicability of the PCEHR for mental health, especially e-mental health, incorporating user perspectives and an examination of interactivity with the most-used e-mental health interventions.
- Examine cost-effectiveness, including cost offsets through reductions in use of other system areas, for MBS-subsidised mental health-related telehealth items to include allied health professionals, such as psychologists, social workers and occupational therapists.
- Create a coordinated, better integrated model of telephone and online support services, including for crisis support and seamless pathways to online and offline information, education, biometric monitoring and clinical intervention.

Investing for social change

What is happening now

Social investment is a relatively recent development through which loans from businesses (usually to the nongovernment and not-for-profit sectors) can be used to achieve a combination of economic and social objectives. It has been popularised by philanthropists in the UK and USA. These schemes are on the rise in a number of countries but their application in Australia has been limited.

It is recognised that there are a number of initiatives in this area and there are companies operating to achieve a social purpose as well as financial gain in Australia. Similarly, the private sector is moving towards investing more strategically in social causes that align with its business objectives and can demonstrate social and financial outcomes.

Social investment in mental health is an avenue where real social outcomes can be achieved. As an emerging financial model for the sector, it has great relevance to emerging organisations. For example, young leaders in mental health starting up new peer services could be linked in with the social investment sector. Together with other business and corporate expertise, this collaboration would leverage the lived experience, enthusiasm and expertise of young people to work in mental health, thereby improving meaningful engagement with their peers on issues of mental health and wellbeing.

Social Ventures Australia (SVA) and Impact Investing Australia are two organisations that are leading national developments in this area.

SVA estimates that it has generated \$45 million of investment from philanthropists within its first 12 years of operation.⁸ It has supported a number of innovative partnerships with nongovernment organisations and has been able to leverage private investment to match government funding for some initiatives.

The Queensland Social Enterprise Project (QSEP) started in 2006 as a \$90 000 per annum project with joint funding from Brisbane City Council, PricewaterhouseCoopers (PwC) and Social Ventures Australia. By the end of 2012 the project had worked with 57 social enterprises, created almost 500 jobs and 110 employment pathways for people who were seriously disadvantaged in the labor market.⁸

NSW is currently conducting its first trial of Social Benefit Bonds, which is a financial investment that pays a return based on outcomes rather than outputs. The aim of the programme is to intervene early with families who are expecting a child or have one child at least under six years old who is at risk of harm, as determined by the NSW Department of Family and Community Services. The structure of the programme is illustrated in Figure 10.4.

Figure 10.4 NSW Social Benefits Bonds project structure



Source: The Benevolent Society – Social Benefit Bonds

Key findings

Evidence of which models work and do not work and the ability to measure outcomes remains a challenge and is in its infancy in Australia. Many companies which invest in social enterprises prefer to provide capital where there is less risk than investing in the outcomes for programmes; for example, by funding a building or a simple project.

The Commission notes that social enterprise schemes can be complex and can take considerable time to develop and negotiate, particularly when it comes to looking at independent outcome measurement.

However, these schemes do not replace government expenditure — government remains the ultimate funder, but the incentive for the programme to succeed is transferred onto providers.

Development in this area has a real potential to increase cross-sectoral collaboration to lead to more opportunities for people with a mental illness and their families.

Actions

- Seed fund a small demonstration project to explore models of social enterprise involvement in the mental health sector. This would require these steps:
 - identify priority areas where there potentially are clear, measurable outcomes
 - identify potential partners, social enterprise companies and financial institutions
 - facilitate linkages with NGOs and other service providers which may be interested in entering into consortia arrangements of some type
 - go to market with a clear set of objectives and seek innovative and creative responses on how to achieve those objectives.

Case study: Ngaimpe Aboriginal Corporation – The Glen

The Glen in Chittaway (Central Coast, NSW) is a residential rehabilitation centre set up in 1995 for men suffering from drug and alcohol addiction. It is one of only six specialised Indigenous drug and alcohol rehabilitation centres in NSW and provides a safe place to get a chance at breaking the cycle of moving in and out of jail. In September 2014 The Glen was awarded the NSW 2014 *Mental Health Matters* Award for Aboriginal Social and Emotional Wellbeing. In a 2013 study by the University of Wollongong, 70 per cent of clients were found to be free of addiction one month after leaving The Glen.

As a small non-government organisation, it has had to supplement its government funding with alternative sources. In 2013–14 The Glen received \$1.04 million of funding from the Commonwealth and State Government bodies. It receives little to no private funding.

The largest barrier to success of The Glen is funding pressures. To mitigate this barrier The Glen is partnering with other rehabilitation centres on the Central Coast to create a consortium and eliminate some shared services to provide efficient and effective use of government funding. Since 2011, The Glen has also partnered with Bunnings on a work experience programme to assist clients. Additionally, it has recently published a funding prospectus to seek philanthropic funding from private sources.

Investing through regional funding models

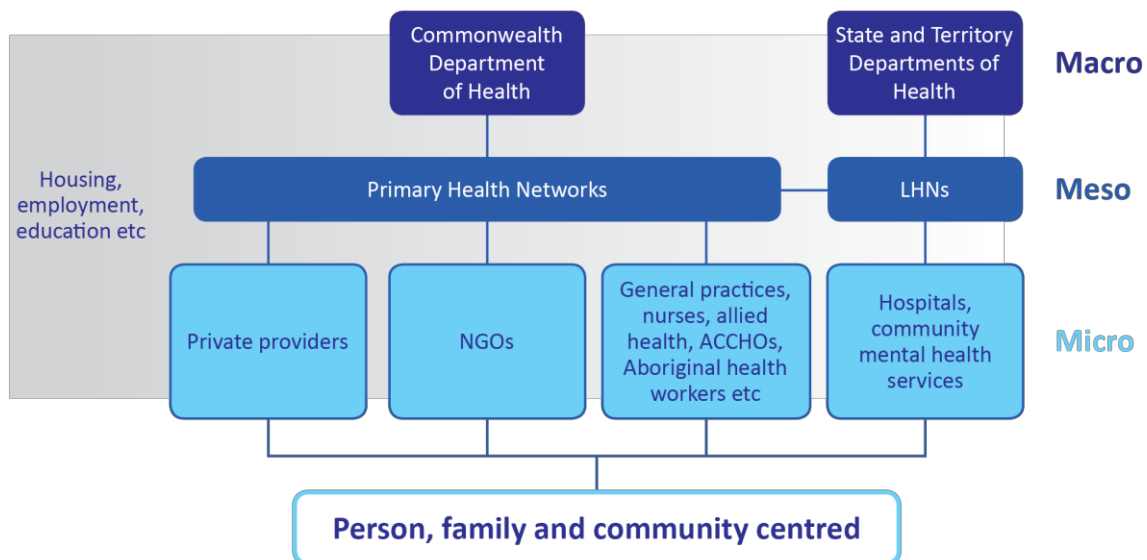
What is happening now

Regional funding models can be used to shift the model of care in Australia from one focused on supply to one focused on the needs of individuals and local communities.

Instead of an often remote funder of service providers for local-level services—in isolation of each other—a regional funding model aims to pool funds at a regional level. This would enable regional planning and purchasing of services (including commissioning new services where none exist) and local services to be wrapped around the needs of people, families and communities. Such an approach is therefore highly applicable to the mental health sector.

A regional funding model involves three levels:

1. Macro – Commonwealth and state governments set high-level policy directions and outcomes, agree performance measures and accountabilities and provide funding on a weighted population basis.
2. Meso – regional entities (in this case, Primary and Mental Health Networks and Local Hospital Networks) receive pooled funding, undertake needs assessments for their local communities (including identification of local priorities and gaps in services), and plan and purchase/commission services to be delivered to meet those needs as determined by local priorities, with accountabilities and performance requirements tied to purchasing agreements.
3. Micro – service providers deliver the services purchased to achieve performance requirements (e.g. accessibility, continuity of care, effectiveness, efficiency and sustainability, responsiveness, safety).



Source: Commonwealth Department of Health, July 2014

Regional funding models are designed to support integrated primary and mental health services, and integrated care pathways between primary and secondary level services.

Key findings

The provision of integrated primary (and mental health) care, as compared to models of episodic treatment, has not kept pace with the need for integration associated with the rise in chronic disease and comorbidities. Chronic diseases account for 54 per cent of preventable hospitalisations.⁹ Importantly, patients with chronic diseases become increasingly expensive to care for once their health becomes more complex and irreversible complications develop, but those complications often can be delayed, reduced or avoided. These are predictable risks. The health system needs to be geared and oriented to prevent and minimise them rather than simply to respond when incidents occur.

Around the world, governments are responding to the increase in non-communicable diseases (NCDs) by developing stronger, more integrated general practice and primary health care systems which focus on early actions designed to protect and promote the health of their populations. This includes a focus on primary prevention (for those at risk), secondary prevention (for those who have developed chronic conditions), chronic disease management within the community, and initiatives to reduce avoidable hospitalisations.

There is considerable evidence from both developed and developing countries that countries with primary care-oriented health systems achieve better health outcomes, at lower cost and with greater equity in health, than do countries with a higher focus on specialist and acute care.^{10, 11} However, reorienting the Australian systems towards strong, integrated community-based care will require redesign of systems, structures and incentives.

Integration and reorientation of primary health care will enable better management of predictable risks, to reduce the impact of avoidable morbidity and mortality and thus reduce future growth in health costs.

Aboriginal and Torres Strait Islander mental health – reinvestment for change

For Aboriginal and Torres Strait Islander peoples, this whole-of-government preventative emphasis requires a consideration of employment, access to education and community safety – the current priorities of the *Indigenous Advancement Strategy* (IAS). A broader approach to social and emotional wellbeing (SEWB) is required, based on empowerment and addressing identity, physical health, family, culture and community.

The systemic change proposed in this Review will require a rebalancing of funding towards SEWB promotion, prevention and primary health care and away from hospitalisation for preventable mental health conditions and from reinvestment from other areas – for example, reinvesting at least some of costs of imprisonment of Aboriginal and Torres Strait Islander people into mental health services over time. We know that the cost of delivering some specific services for Aboriginal and Torres Strait Islander peoples is higher on a per capita basis when compared to other Australians, and savings from improved efficiencies could also be reinvested. For example, hospital admissions for ‘mental health and behavioural disorders’ cost \$336 per capita for Aboriginal and Torres Strait Islander people compared to \$125 per capita for non-Indigenous people.¹² The level to which these costs may reflect the greater overall poor physical health of Aboriginal and Torres Strait Islander peoples is unknown, and would need to be considered in any cost review.

A redirection of funds is also required to support the systemic changes to Aboriginal and Torres Strait Islander mental health services and programmes proposed in this Review. In particular, such savings could help fund the mental health and social and emotional wellbeing teams and dedicated specialist services proposed in the recommendations. Such redirection

should be managed in such a way as not to have a disproportionate or unequal impact on Aboriginal and Torres Strait Islander people already experiencing mental illness – recognising that in the short term, they will continue to rely more heavily on hospital services for the treatment of mental health conditions than other Australians. That is, until increased levels of primary health care have been in place long enough to take effect.

Change may also require assessment of what funding from mainstream programmes could be diverted into the new approach to offset costs. This must be subject to the outcome of individual programme reviews. All such planning is to occur in partnership with Aboriginal and Torres Strait Islander peoples – preferably under the guidance of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG) or some other credible Aboriginal and Torres Strait Islander-led mental health body. Within a reconsideration of programme funding and programmes in general, given the scale of issues and the size of the mental health gap, support for programmes that target the specific needs of Aboriginal and Torres Strait Islander people should continue. Further, there should be an assumption that—until evidence and evaluation is in place to say otherwise—having any programme or service in place is better than having none.

Where to from here – implications for reform

Future primary and mental health models require:

1. Access to comprehensive primary health care involving multi-disciplinary teams (nursing, allied health, pharmacists, Aboriginal Health Workers, personal carers, etc.).
2. Strong focus on prevention, tailored according to level of risk of hospitalisation or readmission, including services to improve patient self-management.
3. Partnership between the primary and acute sectors, including co-design of programmes: target avoidable hospitalisations and reductions in readmission and emergency department attendance rates, and measure success, including dollar savings to the acute sector.
4. Effective care coordination, both in periods of chronic illness and in crises/acute episodes.
5. Seamless transfer between the primary, acute and community and aged care settings, with agreed clinician-driven care pathways and handovers involving GPs, specialists, nurses, allied health professionals and other carers.

Actions

New funding models are required, especially to support those with complex needs. This could involve more of a blended payment model, involving a mix of fee-for-service (particularly for those with episodic needs), population-based payments and payments for performance, particularly for those with complex needs. For those at high risk of acute care, and those at risk of becoming higher risk, bundled payments which can be used to purchase services to support them to stay in the community, in housing, in employment and education—to live a contributing life—also should be available.

New integrated service delivery models are needed. Primary and mental health teams can provide frontline support by wrapping services and support around people, their families and support people. When functions and responsibilities go beyond the capacity of their services (for example, complex care coordination, wider public health and regional/population level services) they in turn require the support of the meso-level organisation to wrap support around them.

Agreement to roles is necessary. There are six key roles which regional primary health organisations can play to support frontline services.

1. Plan for the needs of populations and organise the myriad of services around them. Represent population (including regional) needs in dealing with traditionally more powerful interests in the acute health system.
2. Use data-driven processes to drive benchmarking, performance measurement and improvement.
3. Promote value for money interventions based on translation of evidence into practice.
4. Align financial incentives between the primary health care system and acute, sub-acute and aged care services, including strategic investment of capital.
5. Support widespread use of a single care plan and an electronic health record with care team and patient access and interaction.
6. Workforce planning, training and retention of team members who are supported to work together at the top of their scope of practice as defined for their separate disciplines, with agreed handover arrangements.

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Chapter 11:

Implementation of a better mental health system

This chapter outlines the steps for implementation to set the foundation for long-term change to improve outcomes for people and productivity of the system. A new National Mental Health Agreement is proposed between the Commonwealth and the states and territories, to give effect to new funding packages supported by defined roles and responsibilities in a cross-portfolio, inter-governmental model, embedding a person and carer-centred approach.

Strategic Intent

This Review has identified a programme for redesign, realignment and rebalancing of funding of mental health programmes. It requires national leadership to redistribute funding across portfolios, from hospital-based services to primary and community care, and to adopt a set of national targets and indicators to measure and report upon progress.

The strategic intent of the recommendations is to realign the programme delivery mechanisms of government to better align with evidence-based treatment pathways. We want to adopt person, family, and carer-centred programme design, reinvest mental health funds saved through earlier treatment and mental wellbeing promotion, and integrate effort and investment for local communities.

This will be achieved by pursuing the following strategic directions:

1. Set clear roles and accountabilities to shape a person-centred mental health system.
2. Agree and implement national targets and local organisational performance measures.
3. Shift funding priorities from hospitals and income support to community and primary health care services.
4. Empower and support self-care and implement a new model of stepped care across Australia.
5. Promote the wellbeing and mental health of the Australian community, beginning with a healthy start to life.
6. Expand dedicated mental health and social and emotional wellbeing teams for Aboriginal and Torres Strait Islander people.
7. Reduce suicides and suicide attempts by 50 per cent over the next decade.
8. Build workforce and research capacity to support systems change.
9. Improve access to services and support through innovative technologies.

The Commission acknowledges that structural change is required to harness the dollars invested in mental health to drive performance and outcomes for people who are living with a mental health difficulty and the people who support them. Structural change is also required for governments to meet community needs within resources, and to manage risk over the forward budget period. Implementation over 10 years will enable the structures of reform to be discussed and agreed, and immediate priorities and longer-term actions to be scoped and implemented.

The recommendations require *national leadership*, to deliver *person and carer-centred* programmes and achieve *strengthened communities* with good mental health and wellbeing:

1. Set clear roles and accountabilities to shape a person-centred mental health system

- Rec 1. Agree the Commonwealth's role in mental health is through national leadership and regional integration, including integrated primary and mental health care.
- Rec 2. Develop, agree and implement a *National Mental Health and Suicide Prevention Agreement* with states and territories, in collaboration with people with lived experience, their families and support people.
- Rec 3. Urgently clarify the eligibility criteria for access to the National Disability Insurance Scheme (NDIS) for people with disability arising from mental illness and ensure the provision of current funding into the NDIS allows for a significant Tier 2 system of community supports.

2. Agree and implement national targets and local organisational performance measures

- Rec 4. Adopt a small number of important, ambitious and achievable national targets to guide policy decisions and directions in mental health and suicide prevention.
- Rec 5. Make Aboriginal and Torres Strait Islander mental health a national priority and agree an additional COAG Closing the Gap target specifically for mental health.
- Rec 6. Tie receipt of ongoing Commonwealth funding for government, NGO and privately provided services to demonstrated performance, and use of a single care plan and e-health record for those with complex needs.

3. Shift funding priorities from hospitals and income support to community and primary health care services

- Rec 7. Reallocate a minimum of \$1 billion in Commonwealth acute hospital funding in the forward estimates over the five years from 2017–18 into more community-based psychosocial, primary and community mental health services.
- Rec 8. Extend the scope of Primary Health Networks (renamed Primary and Mental Health Networks) as the key regional architecture for equitable planning and purchasing of mental health programmes, services and integrated care pathways.
- Rec 9. Bundle programmes and boost the role and capacity of NGOs and other service providers to provide more comprehensive, integrated and higher-level mental health services and support for people, their families and supporters.
- Rec 10. Improve service equity for rural and remote communities through place-based models of care.

4. Empower and support self-care and implement a new model of stepped care across Australia

- Rec 11. Promote easy access to self-help options to help people, their families and communities to support themselves and each other, and improve ease of navigation for stepping through the mental health system.
- Rec 12. Strengthen the central role of GPs in mental health care through incentives for use of evidence-based practice guidelines, changes to the Medicare Benefits Schedule and staged implementation of a Medical Home for Mental Health.
- Rec 13. Enhance access to the Better Access programme for those who need it most through changed eligibility and payment arrangements and a more equitable geographical distribution of psychological services.
- Rec 14. Introduce incentives to include pharmacists as key members of the mental health care team.

5. Promote the wellbeing and mental health of the Australian community, beginning with a healthy start to life

- Rec 15. Build resilience and targeted interventions for families with children, both collectively and with those with emerging behavioural issues, distress and mental health difficulties.
- Rec 16. Identify, develop and implement a national framework to support families and communities in the prevention of trauma from maltreatment during infancy and early childhood, and to support those impacted by childhood trauma.
- Rec 17. Use evidence, evaluation and incentives to reduce stigma, build capacity and respond to the diversity of needs of different population groups.

6. Expand dedicated mental health and social and emotional wellbeing teams for Aboriginal and Torres Strait Islander people

Rec 18. Establish mental health and social and emotional wellbeing teams in Indigenous Primary Health Care Organisations (including Aboriginal Community-Controlled Services), linked to Aboriginal and Torres Strait Islander specialist mental health services.

7. Reduce suicides and suicide attempts by 50 per cent over the next decade

Rec 19. Establish 12 regions across Australia as the first wave for nationwide introduction of sustainable, comprehensive, whole-of-community approaches to suicide prevention.

8. Build workforce and research capacity to support systems change

Rec 20. Improve research capacity and impact by doubling the share of research funding for mental health over the next five years, with a priority on supporting strategic research that responds to policy directions and community needs.

Rec 21. Improve supply, productivity and access for mental health nurses and the mental health peer workforce.

Rec 22. Improve education and training of the mental health and associated workforce to deploy evidence-based treatment.

Rec 23. Require evidence-based approaches on mental health and wellbeing to be adopted in early childhood worker and teacher training and continuing professional development.

9. Improve access to services and support through innovative technologies

Rec 24. Improve emergency access to the right telephone and internet-based forms of crisis support and link crisis support services to ongoing online and offline forms of information/education, monitoring and clinical intervention.

Rec 25. Implement cost-effective second and third generation e-mental health solutions that build sustained self-help, link to biometric monitoring and provide direct clinical support strategies or enhance the effectiveness of local services.

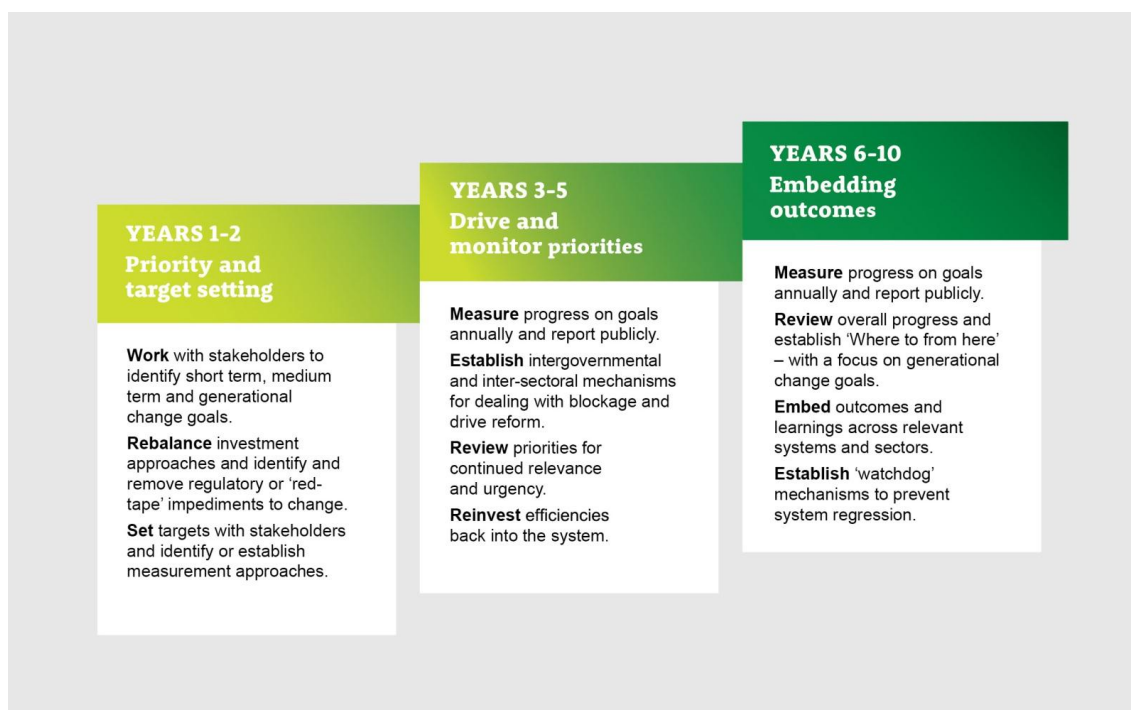
A logic model to guide implementation

This Review is the first step in restructuring mental health programmes and services. With government support, the next step is taking the recommended directions and engaging in a national conversation. This should be inclusive of people living with mental health difficulties (and their carers and families), state and territory governments, mental health experts, professionals and the sector more broadly.

This consultation and development phase provides an opportunity for testing of the recommendations against a wider set of information (as the Review was limited by lack of access to state and territory programme data, for example) and input from those impacted by the new directions. Together with government agencies across the health and human services portfolios, this initial phase will develop a cross-portfolio programme strategy to inform the 2015–16 budget cycle. In support of this, the Review has identified initial priorities or action for the next two years as outlined in Volume 1.

These initial steps are to be taken within an overall programme logic of three stages. What is needed is a planning model to give effect to the changes at various levels, and to plan these over the course of 10 years, so that priorities and targets can be agreed, system performance

driven and monitored, and outcomes measured and reviewed to ensure effort is sustained. The following logic model could guide implementation.



Source: concept designed by The National Mental Health Commission 2014.

Principles to underpin change

A high-performing quality mental health system needs to be built around a shared vision for change, which is developed by people with a lived experience, their families and carers.

What is important is the guiding principles to underpin implementation:

- strong, decisive leadership and good governance
- productive populations and communities and contributing individuals
- a strong market which promotes choice, availability of treatment and supports that are effective
- an infrastructure that supports good practice and drives value for money decisions and results
- world-leading smart use of technology
- team-led work practices
- world-leading research that translates into practice

Accountability mechanisms and governance

Redesign at the national level requires four things:

1. Agreed national targets and indicators for reform.
2. Monitoring and evaluation mechanisms, with public reporting.
3. Collaborative and inclusive consultation structures.

4. Agreed roles and responsibilities, and strong governance to manage risk and performance.

The initial step, after Government endorsement of the Review, is to establish accountability and governance mechanisms. Given the cross-portfolio, person and family/carer-centred approach and stakeholder engagement required for this national redesign of mental health, the first six months will:

- develop and agree programme KPIs, monitoring and evaluation processes for success
- establish governance structures including people with lived experience, their family and supporters, expert advisers, government and sector representatives
- develop a detailed, staged implementation strategy across governments and across sectors, with evaluation points for strategy recalibration
- prepare a costed 2015–16 budget proposal, with an indicative 10-year outlook.

What success looks like

The Key Performance Indicators for implementation are:

- a. Agreement between Commonwealth and state and territory governments on roles and responsibilities in mental health.
- b. A compact with stakeholders including consumer and carer groups, and NGO and private providers, on directions for change.
- c. Commitment by all governments on targets for achieving better outcomes in mental health and reducing numbers of suicides.
- d. New national accountability and transparency arrangements to improve accountability of policy makers, planners, purchasers and providers to consumers and carers.

Immediate priorities years 1 to 2

The Review's recommendations set directions to commence in the first two years of the strategy, as outlined in Volume 1.

This is a strategy for people of all ages, where we use the word 'people' to encompass infants, children, young people, working-age adults and older people as well as Aboriginal and Torres Strait Islander peoples and those from Culturally and Linguistically Diverse (CALD) backgrounds.

The programme for the first two years of reform (attached) sets out a staged implementation. It commences with Government endorsement of the Review and establishing accountability and governance.

This initial stage needs to be paralleled by a process to establish an agreed picture of success, interim governance structures for regional programmes, a parallel evaluation process for those major mental health programmes which have none, an evaluation of the administrative barriers of and between programmes, and a strategy for optimising existing technology and platforms for mental health online help and supports.

Regional models of delivery and governance

The reform framework is built on a regional model with integrated service delivery at the level of the individual. Future Commonwealth funding models will be supporting integration, avoiding duplication and allowing collaboration between programmes and services.

This will require major changes to the governance model at the delivery level, which will need to be negotiated with providers. It is envisaged this will be a major role for the proposed Primary and Mental Health Networks (PMHNs). It may also require contract incentives for local planning and collaboration.

The need for evaluation to guide programme directions

A number of key national programmes involving significant expenditure of approximately \$250 million have not been comprehensively evaluated or evaluated recently (including these allocations in 2012–13: National Perinatal Depression Initiative - \$11.0 million, the National Suicide Prevention Programme - \$23.2 million, Taking Action to Tackle Suicide - \$87.6 million), as well as headspace with an allocation of \$63.8 million and PIR with an allocation of \$62.5 million (both of which are currently being evaluated).

Comprehensive evaluation should accompany significant national investment. Evaluations should consider outcomes for people and whether both needs and service accessibility requirements are met; as well as cost effectiveness. Evaluations should consider whether programmes are providing a return on investment, are relevant to local needs and groups and are avoiding duplication with other programmes and services.

Access barriers to programmes and services

The Review has identified a range of access barriers to programmes and services, including caps on service delivery independent of need, and eligibility requirements that may hinder recovery. Although these can be addressed in any major restructuring, it is important that change does not disadvantage groups or individuals.

Maximising use of technology

Seeking help online and on the phone has been endorsed by consumers as an accessible point of service. The evidence backs the effectiveness of these programmes. However, the range of support services available online and on the phone can be confusing for people to access and navigate.

An e-mental health agenda is building among providers that sees its future as being integrated into the Australian mental health service model as the first step of service delivery (as appropriate) in a stepped care model.

Streamlining these services, with particular emphasis on crisis support, will need to take into account emerging technologies and best practice in communications, as well as the sector's work in developing capacity, and the cost impacts upon users for download and internet connection. It is a medium-term project requiring dedicated planning resources.

One area of potential expansion for e-mental health tools is in improving access to care for, (and to support clinicians to work in culturally appropriate ways with), Aboriginal and Torres Strait Islander people. Clinicians need workforce development programs to equip them in the smart use of new technology. In particular, opportunities exist to promote better transitions across the health system for Aboriginal and Torres Strait Islander peoples through the use of e-health records. Communication technologies can also help people maintain connections with family and community when travelling from a remote or very remote area to receive treatment.

Establishing longer-term goals and targets

What is happening now

Public accountability and reporting against commitments made by governments is an important lever in the federal arrangements where accountability for outcomes is shared between levels of government.

The model under national agreements and partnerships has been for governments to agree on a small number of high-level national targets to drive change. One of the most successful reform areas for this approach has been in the area of Indigenous disadvantage. Six targets were set by COAG in 2008 for Closing the Gap in Indigenous Disadvantage which have been consistently pursued over time, reported on annually and have driven systems change through government policy and investment decisions.¹

While there has been agreement for many years (and across successive Mental Health Plans) on the need for a similar approach in mental health, there has not been agreement on what those targets should be. The most recent substantial work in this area was the report of the COAG Expert Reference Group (ERG) on National Targets and Indicators for mental health reform. The ERG was set up to advise on a set of ambitious and achievable national, whole-of-life, outcome-based indicators and targets for mental health that would be understood by the community and drive systemic change. The ERG proposed a set of 14 targets; the Commission considers that, while all are important, a subset of the 14 will provide for a better focus on systemic change and performance. The Commission therefore proposes eight targets to address the key themes of this Review report.

Proposed eight targets

1. Healthier start to life: Increase the proportion of young children and new parents receiving support for mental health development and wellbeing, mental fitness training and resilience, at home, in the community and through the education and care system.
2. Improve life expectancy of adults with a mental illness to achieve parity with adults without a mental illness. This means better physical health, with measures that focus on smoking and screening for physical and dental health issues.
3. Increase the proportion of the population of people with a lived experience of a mental illness and their families and carers in safe, affordable, appropriate and stable accommodation to meet their mental health support needs.
4. Increase participation: reduce the rate of 16-25 year olds Not in Employment, Education or Training (NEET).
5. Timely access, care and treatment: Increase the proportion of people with mental health difficulty, families and carers who report timely access to the supports and services they need by 10 per cent each year.
6. Recovery and quality of life: Improve employment rates of adults over 18 with a mental illness and their families and carers.
7. Increase the proportion of people with a lived experience of mental illness, families and carers who report an improved and positive experience of mental health-related services and supports.
8. Reduce suicides and suicide attempts by 10 per cent in four years and 50 per cent in 10 years – supplementary target to Closing the Gap on suicide rates of Aboriginal and Torres Strait Islander people.

Data development needs of the sector

Throughout the Review, the Commission has been hampered in its analysis by the lack of a coherent framework for the collection, analysis and use of data. There are significant and well-used data collections to support operational activity and population planning. Notwithstanding this investment, there are significant gaps and overlaps in the data needed at various levels of the system. Many collections do not ‘talk to each other’.

This means that for vulnerable populations in particular it is not possible to say whether resources are being efficiently and effectively targeted. For many Aboriginal and Torres Strait Islander people, for example, the mental health system requires them to rely on general population (‘mainstream’) services and programmes. However, we do not know the degree to which they are accessing these services, nor whether they lead to improved outcomes.

Data to support accountability and outcomes reporting

The proposed high-level goals and national targets for mental health reform will require timely access and robust data to report both on population status (high-level outcomes) and on service performance goals. This includes outcomes ratings provided by people with mental illness and carers.

Accountability frameworks at national, state and territory and provider-funder level will need to have coherent outcomes reporting and timely data to support them. Reduction of duplication and red tape in this accountability is essential.

Transparency and public accountability by way of reporting on outcomes is also an area where a coherent framework is not obvious to the public, the media or stakeholders. Important work and partnerships have been developed by the Commission with the two leading national statistics bodies—the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS)—which will be foundational in achieving improvement in this area.

The next National Survey of Mental Health and Wellbeing is due in 2017. This will be the third iteration of the survey (following previous surveys in 1997 and 2007) and is important as a key source of information to inform progress on the performance target agenda in relation to mental health conditions in Australians aged 16-85 years on a longitudinal basis.

Better understanding of data about people using mental health services

A very important project being conducted by the ABS in conjunction with the Department of Health, initiated and financed by the Commission, is the Mental Health Services Census Data Integration project. The project for the first time integrates data items from the Medical Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS) and the 2011 Census.

Unlike previous separate data sets, this provides information about the people accessing the Medicare-subsidised elements of the service system through a process of data linkage. It will enable improved planning at population, service and individual levels when more is known about the relationship between the circumstances and characteristics of people experiencing mental health issues and how they interact with the health system.

Directions over the longer term

The Review has identified system and structural changes required to reshape how programmes are delivered and funding allocated to improve outcomes for people and their families and carers. These are essential to redesigning the overall architecture of a mental health system, and are identified for planning and implementation in the first two years of the reform programme.

For the medium and long term—three to 10 years— this chapter outlines programme priorities for consideration. These include proposed actions for change for specific priority groups and service needs, as identified under the Terms of Reference:

- challenges for Aboriginal and Torres Strait Islander peoples' mental health
- supporting suicide prevention
- addressing regional, rural and remote mental health
- issues for workforce training and development
- directions for research

The following table outlines areas for action from the mid-to-long-term policy directions. These priorities were informed through the Review's consultation process and by commissioned advice.

Aboriginal and Torres Strait Islander Peoples' Mental Health

Years 3-5: Set the foundation for long-term change

Policy priority: Evaluate progress with establishing mental health and social and emotional wellbeing teams.

Implementation steps:

Working with the National Aboriginal Community Controlled Health Organisation and other stakeholders:

- After a year's operation, establish the optimal service model for mental health and social and emotional wellbeing teams.
- Audit existing delivery by teams and identify gaps.
- Identify workforce needs (both supply and training needs).

Policy priority: Dedicated Aboriginal and Torres Strait Islander services support Aboriginal and Torres Strait Islander individuals' journeys across the mental health system.

Implementation steps:

Working with leaders and stakeholders in Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention:

- Support state and territory governments to facilitate the journey of Aboriginal and Torres Strait Islander people into and through the specialist mental health service system, and in particular from primary mental health care settings into mainstream specialist mental health services and programmes.
- State and territory governments assess the evaluation of the Western Australian Statewide Specialist Aboriginal Mental Health Service model for potential adaptation to their jurisdictions.

Years 5-10: A vision for change

Policy priority: General population mental health, suicide prevention, and alcohol and other drug use prevention professionals (including general practitioners) are culturally competent and services are culturally safe. Such professionals and services are accountable for better Aboriginal and Torres Strait Islander mental health, suicide prevention, and alcohol and other drug use prevention outcomes and closing the mental health gap.

Implementation steps:

Working with leaders and stakeholders in Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention:

- All relevant professional associations agree pathways to ensure their membership has undertaken cultural competence training within five to 10 years.

Years 5-10: A vision for change

- Relevant professional associations and education providers ensure that all graduates have undertaken cultural competence training within five to 10 years.
- Australian governments, through collaborative COAG processes, develop Aboriginal and Torres Strait Islander cultural safety standards for all general population mental health services and programmes, including those provided by NGOs.
- Progress in the above is benchmarked against standards developed by professional associations and education providers.
- Australian governments, through collaborative COAG processes, develop service and programme accountability mechanisms to ensure they play their part in closing the mental health gap. These could include area targets and assessments of equitable resource allocation against agreed levels.

Policy priority: Train and employ the Aboriginal and Torres Strait Islander workforce needed to close the Aboriginal and Torres Strait Islander mental health gap.

Implementation steps:

Working with leaders and stakeholders in Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention:

- Australian governments, through collaborative COAG processes, identify minimum mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention personnel requirements per population catchment area.
- Australian governments, through collaborative COAG processes, strengthen opportunities for Aboriginal and Torres Strait Islander health workers to attain advanced qualifications by strengthening educational pathways from the Vocational Education Training sector to the university sector.
- Relevant professional associations and education providers increase the numbers of Aboriginal and Torres Strait Islander students undertaking mental health and related training and entering the mental health professions and workforce. Progress is benchmarked against standards developed by professional associations and education providers.

Policy priority: A sound evidence base for Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention services and programmes.

Implementation steps:

Working with leaders and stakeholders in Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention:

- Australian governments, through collaborative COAG processes, designate a national body, with Aboriginal and Torres Strait Islander leadership, to establish best practice in Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention services and programmes.

Supporting Suicide Prevention

Years 3-5: Set the foundation for long term change

Policy priority: Evaluate and implement whole-of-community approaches to suicide prevention.

Implementation steps:

- Evaluate the first wave (12 regions) across Australia of whole-of-community approaches to suicide prevention and begin to roll out nationally.
- Integrate e-mental health supports into clinical services, so hospital staff and GPs are able to refer people to appropriate sources of formal and informal online support.
- Establish a case worker system for people who have made a suicide attempt, such that workers are routinely assigned to everyone who presents to the ED after an attempt. This person would help the consumer navigate available supports and ensure they do not fall between gaps in services. This should be supported by a mandatory assertive follow-up system which is planned with the person.

Policy priority: Roll out suicide prevention training nationally for all frontline staff who are likely to come into contact with people experiencing a mental illness or a substance use disorder.

Implementation steps:

- Ensure that training for all health and welfare professionals includes principles of therapeutic communication and recognition of emotional distress when encountering people experiencing suicidal thoughts or behaviours.
- Ensure that health and welfare services adhere to a 'no wrong door' approach to people who are reaching out for help. No-one should be turned away without follow-up or referral, and no-one should feel dismissed or that their distress is trivialised.
- Routinely survey the experiences of people and their caregivers who have sought help for suicidal thinking or behaviour—particularly in relation to the attitudes they encounter—and link financial or other incentives for organisations to the result.

Years 5-10: A vision for change

Policy priority: Review outcomes and design of the first wave (12 regions) of whole-of-community approaches to suicide prevention.

Implementation steps:

- Fund and evaluate the systemic prevention initiatives in communities in order to build an evidence base for effective suicide prevention in the Australian context, and to inform the next wave of investment.
- Adhere to a nationally consistent data collection for suicide and suicide attempts.
- Roll out proven approaches nationally.

Addressing Rural, Regional and Remote Mental Health

Years 3-5: Set the foundation for long term change

Policy priority: Build workforce and community capacity to respond to mental health concerns in regional, rural and remote Australia.

Implementation steps:

- Ongoing promotion, implementation and evaluation of recruitment, retention and incentivisation mechanisms to engage people in both generalist and specialist mental health career pathways in regional, rural and remote Australia, targeting in particular:
 - areas and communities that need it most, such as socio-economically disadvantaged areas or areas recovering from natural disasters that are underserved by the current system
 - areas where there is evidence to suggest the efficacy and sustainability of recruitment and retention strategies
- Up-skill local community members (e.g. who complete a Mental Health First Aid-type course) to further extend effective workforce coverage, including in vulnerable industries or communities.
- Targeted community capacity-building via funded projects within a regional framework using existing NGOs and networks.
- Support and promote mental health champions through a regional, rural and remote mental health leadership initiative.

Policy priority: Renewed focus on research, data collection and analysis of suicidal behaviour and mental health determinants, needs and services in regional, rural and remote Australia.

Implementation steps:

- Conduct further research and evaluation on how other related workforces (including allied health workers, non-mental health nurses, social workers, occupational therapists, peer workers) may assist in augmenting traditional mental health workforce categories in regional, rural and remote areas.
- Conduct research and data analysis to develop a more precise understanding of the mental health needs and outcomes in regional, rural and remote populations in Australia.
- Conduct targeted research to better understand how rural and remote cultural paradigms affect help seeking and suicidal behaviours, particularly during heightened times of personal, social, and/or economic adversity.
- Pilot new evidence-based funding and administrative approaches in a number of regional, rural and remote communities to enable integrated service delivery for people experiencing mental illness.

Years 5-10: A vision for change

Policy priority: A cross-sectoral approach to creating and maintaining mentally healthy communities in rural, regional and remote areas is embedded in service planning and delivery principles.

Implementation steps:

- Develop regional governance models that harness the full resource capacity of government and community-based services in an integrated way.
- Governments to engage more proactively with the private sector to ensure that key investors in rural, regional and remote economies are also investing in the mental health of their workers and communities.

Issues for Workforce Training and Development

Years 3-5: Set the foundation for long term change

Policy priority: Maximise workforce potential by using the specialist mental health workforce more effectively.

Implementation steps:

- Improve links between general practice and psychiatrists to provide greater reach of specialist services, through development of mental health services and consultancy-type arrangements between the two groups.
- Increase the use of self-help and online (e-mental health) services for people with lower levels of mental ill-health by providing a platform that provides advice on effective, evaluated e-mental health services.

Policy priority: Increase the effective use of the psychologist workforce in mental health services.

Implementation steps:

- Undertake a study of the psychology workforce to estimate current and future supply, and improve rates of registration and retention within mental health services.

Priority policy: Increase the number of peer workers in mental health services nationally.

Implementation steps:

- Promote the accredited vocational training for peer work to persons with a lived experience of mental ill health and consider entire workplace-based options to encourage take up of training.

Years 5-10: A vision for change

Priority policy: Improve broader workforce mental health assessment capabilities across sectors, including education, justice and housing.

Implementation steps:

- Develop and provide training to all non-mental health workforce groups which have significant contact with persons with mental illness.
- Include population health training (e.g. Mental Health First Aid) in mental health for all frontline workforces as a mandatory requirement.
- Implement changes in courses based on revised curricula.

Directions for Research

Years 3-5: Set the foundation for long term change

Policy priority: Establish a mental health outcomes National Minimum Data Set.

Implementation steps:

- Develop a single national data set which serves the needs of researchers, policy makers and service providers for quality improvement, accountability and evaluation purposes. This should be developed in consultation with consumers and caregivers and piloted extensively with services.

Policy priority: Make it easier for policy makers and people working in frontline services to access and use research evidence and evidence of good or promising practice.

Implementation steps:

- Establish a 'what works' and 'best buys' internet portal, including Australian and international evidence about the efficacy, effectiveness and cost-effectiveness of mental health models of care and interventions.

Policy priority: Create 'hard' incentive structures to encourage research focused on service and consumer priorities.

Implementation steps:

- Establish a panel of frontline professionals, people with a lived experience and supporters to provide advice on grant applications (once scientific and ethical validity have been established).
- Establish funds to encourage 'new' researchers with innovative ideas rather than funding research based exclusively on track record and publications.
- Build research activity into continuing professional development requirements for frontline practitioners and ensure this time is funded.

Years 5-10: A vision for change

Policy priority: Strategic prioritisation of research activity is embedded in the everyday operating principles of research funding bodies, universities and service providers.

Implementation steps:

- Success for researchers to be measured in terms of policy and practice impact rather than exclusively peer regard and numbers of publications.
- All government-funded projects incorporate time and funding for continuous cycles of summative and formative evaluations.

A role for the National Mental Health Commission

Track record as a catalyst for change and improvement

The Commission considers that governments, taxpayers and people with a lived experience of mental health difficulties and their families and carers all benefit from having an independent Commission which is able to stand at arm's length and provide a window into how the system is performing.

The National Mental Health Commission has established a high level of support and respect for its role in providing independent advice and performance reporting on the Australian mental health system.

The Commission views itself as a catalyst for improving the mental health system and establishing a collective for change in attitudes and behaviours of Australians about mental health issues. Through its unique mandate as an independent agent for change, the Commission brings together leaders and organisations from across the country to accelerate improvements which result in better health outcomes for the community.

The Commission walks with, but at arm's length from, stakeholders – governments, service providers and people and their supporters. It has a particular focus on adopting an inclusive approach—that people with lived experience and families and carers are essential in any discussions that affects them—that they are heard, listened to and have their needs and preferences reflected at all levels of the mental health system.

The Commission was established to increase accountability and transparency in mental health through public reporting and to provide independent advice to Government.

Engagement with people remains at the heart of the Commission's operations.

To date the Commission has released two Report Cards under the title *A Contributing Life*—in November of 2012 and 2013—containing 18 recommendations, and has led a number of projects arising from those recommendations.

This includes projects on:

- what enables a contributing life
- how to work towards elimination of seclusion and restraint
- establishment of the Mentally Healthy Workplace Alliance to support employers to recruit and retain people with mental health problems, and to recognise the value of good mental health in the workplace
- development of competencies and materials for a Certificate IV in Peer Work
- care and prevention after a suicide attempt.

The Commission also has produced Spotlight Reports to shine a light on areas of importance.

- Mental health research and evaluation in multicultural Australia
- Can we talk...about mental illness and suicide?
- Mental Health Report Card supporting paper on Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing
- Engaging young people in the development of a National Report Card on Mental Health and Suicide Prevention
- International Benchmarking of Australia's Mental Health Performance.

Going forward

To be of ongoing value to government, people and the sector, the Government can direct the Commission to lead, collaborate, advise and report on directions and changes required in mental health, with the capability to identify and monitor progress made over time.

This includes clarity about the aspirations for mental health and suicide prevention, including what will be different, backed by evidence to demonstrate what improvements can be observed.

To achieve this, the Commission recommends that, just as occurred with mental health commissions created as catalysts of change in Canada and New Zealand, Australia's National Mental Health Commission should be given a finite period to fulfil its objectives, with the ongoing need for the Commission to be subject to external evaluation.

Elsewhere in this report, the Commission has advised that this is a 10-year reform journey, with changes implemented on a stepped approach – where short-term priorities need to be achieved to establish a platform upon which medium-term priorities can be built, and which in turn enables longer-term priorities to be achieved.

In particular, while strategy directions and priorities have been identified in this report, there remains considerable work to be undertaken in a range of areas to build the platform for ongoing reform, and which can be facilitated by the Commission as an independent catalyst. Inclusive consultations on the Review's directions are required prior to advancing.

It therefore is proposed that the Commission is given a 10-year time horizon (2015-2024) to match the proposed reform journey, with an initial five-year timeframe (2015-2019) and with the ongoing role of the Commission subject to Government consideration of an external review of its performance in Year 4 (2018).

As a priority, the Commission will develop a new Strategy and Action Plan for approval by Government, inclusive of a set of Key Performance Indicators (KPIs) to be used in the proposed external evaluation to measure the Commission's achievements against its agreed objectives.

The Commission's initiatives and projects will be led by experts who bring a variety of perspectives and experience to the table.

The Commission recognises the valuable specialised and expert contributions to its work made by people who have a first-hand experience of a mental health issue or are a family member or support person. Where the Commission forms advisory groups or committees to assist its work priorities, provide advice or inquire into particular matters, these sub-groups will be jointly chaired by a Commissioner or other expert, and a person with lived experience of mental health issues, either personally or as a family member or support person.

There will need to be a high level of engagement between the Commission and the states and territories, and with state mental health commissions, particularly on data and information to assist in the Commission's reporting and advising role. Consultations will seek to identify opportunities for joint initiatives that align with the Strategies and Actions Plan and with state plans and priorities.

The Commission also will have strong formal and informal relationships with nongovernment organisations (NGOs) and various peak groups impacting on mental health and wellbeing.

Accountability and governance

As is highlighted throughout this report, many of those things which prevent mental ill-health and enable a contributing life lie outside the formal health system, in areas such as housing, education, employment, welfare and justice.

Hence it is important that the Commission is seen to transcend the formal health system and to take a whole-of-government, whole-of-community, whole-of-life, whole-of-system approach.

Accordingly, the National Mental Health Commission should be given an initial five-year mandate (2015-2020) as a catalyst for change, with extension of that mandate subject to government consideration of the outcome of an external review of effectiveness in the fourth year (2019).

References

1. COAG Reform Council. Indigenous Reform 2012-13: Five years of performance. Sydney: CRC, 2014.

Glossary and Abbreviations

Glossary

Term	Definition
Aboriginal and Torres Strait Islander person	A person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander.
Activity Based Funding	Activity Based Funding (ABF) is a system for funding public hospital services where the health service providers (hospitals) are funded based on the activity they undertake: with that activity being treating patients. Australian Governments agreed to implement ABF under the National Health and Hospitals Reform Agreement 2012.
Affective disorder	<p>Affective disorders are a set of mental illnesses, also called mood disorders, which are characterised by dramatic or extreme changes to a person's mood.</p> <p>The main types of affective disorders are depression, bipolar disorder and anxiety disorder.</p>
Anxiety disorder	An anxiety disorder is characterised by persistent and excessive worry, where the feeling is so distressing it can make it hard for a person to cope with daily life or take pleasure in activities. A person with an anxiety disorder will feel distressed a lot of the time for no apparent reason.
Access to Allied Psychological Services (ATAPS)	<p>This programme enables predominantly general practitioners (GPs) to refer patients with high prevalence disorders (e.g., depression and anxiety) to mental health professionals for low-cost evidence-based mental health care (most commonly cognitive behavioural therapy, or CBT). This care is typically delivered in up to 12 (or 18 in exceptional circumstances) individual and/or 12 group sessions.</p> <p>ATAPS is rolled out in two tiers, with Tier 1 targeting the broader population and common interventions and Tier 2 targeting harder to reach or more complex groups such as Aboriginal and Torres Strait Islanders, people in remote communities and people who are homeless.</p>
Better Access Programme	The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative (Better Access) commenced in November 2006. Under Better Access, psychiatrists, GPs and psychologists (and appropriately trained social workers and occupational therapists) provide mental health services on a fee-for-service basis subsidised through Medicare. These services offer access to short-term psychological therapies through private providers.

Bipolar disorder	Bipolar Disorder is an illness that results from an imbalance of chemicals in the brain, which can cause extreme fluctuations of mood from the heights of mania (elevated mood which may be out of character for the person), to the depths of depression (persistent low mood). The disorder is characterised by people experiencing repeated episodes of changes in mood and activity levels.
Borderline personality disorder	People with Borderline Personality Disorder (BPD) frequently experience distressing emotional states, difficulty in relating to other people, and self-harming behaviour. Symptoms can include deep feelings of insecurity, persistent impulsiveness and confused and contradictory feelings.
Burden of disease	Burden of disease is a measure used to assess and compare the relative impact of different diseases and injuries on populations. It quantifies health loss due to disease and injury that remains after treatment, rehabilitation or prevention efforts of the health system and society generally. One measure of burden of disease is disability-adjusted life years ('DALYs'), which estimate years of life lost due to premature death, as well as years of healthy life lost due to disability from disease and injury.
Carer or supporter	A person who has a support role for someone living with a mental health difficulty. They may be a family member, friend or have another close relationship with the person. Also referred to as a 'support person'.
Chronic disease	A diverse group of diseases, such as heart disease, cancer and arthritis, which tend to be long-lasting and persistent in their symptoms or development. Although these features also apply to some communicable diseases (infections), the term is usually confined to non-communicable diseases.
Contributing life	A term first used in the Commission's 2012 National Report Card on Mental Health and Suicide Prevention, which means - A fulfilling life where people living with a mental health difficulty can expect the same rights, opportunities and health as the wider community. It is a life enriched with close connections to family and friends, supported by good health, wellbeing and health care. It means having a safe, stable and secure home and having something to do each day that provides meaning and purpose, whether this is a job, supporting others or volunteering.

Cognitive impairment	Any characteristic a person has that acts as barrier to the cognitive (or thinking) process. Can be used to describe poor mental function, confusion, forgetfulness and other mental impairments.
Comorbidity	The presence of one or more disorders (or diseases) in addition to a primary disease or disorder.
Day to Day Living in the Community (D2DL)	An Australian Government-funded structured activity programme aimed at improving the quality of life for individuals with severe and persistent mental illnesses by offering structured and socially based activities. The initiative recognises that meaningful activity and social connectedness contribute to people's recovery.
Depression	A mood disorder where people can experience prolonged feelings of being sad, hopeless, low and inadequate, with a loss of interest or pleasure in activities and often with suicidal thoughts or self-blame.
Discrimination	Prejudicial action or distinguishing treatment of a person based on their actual or perceived membership in a certain group or category of people. This may take overt (intentional and obvious) or subtle (unintentional or embedded in social structure or process) forms. Discrimination can also include acts that are unlawful under the Australian <i>Disability Discrimination Act 1992</i> .
Diversion schemes	Programmes which seek to rehabilitate people who have committed a crime by focusing on the causes of a person's offending rather than punitive action. This can take many forms, such as the person receiving a police caution, participating in group conferencing or a court-approved programme.
Dual diagnosis	Term used to describe experiencing co-existing mental illness and substance use problems.
Early intervention	Term used to describe intervening early. In the context of mental health it is used to describe a coordinated approach to assisting a child, young person or adult through the early identification of risk factors and the provision of timely treatment for problems which can alleviate potential harms caused. It is a term widely used in both mental health and childhood development.
Early Psychosis Youth Programme (EPPIC)	Programme to identify and treat the early symptoms of psychosis in young people.

Epidemiology	The population-level study of the distribution and determinants of health-related states or events (including disease), and the application of this study to the control of diseases and other population and public health problems.
Family and support people/supporters	“Family and support include family members, partners, friends or anyone whose primary relationship with the person concerned is a personal, supportive and caring one.” A national framework for recovery-oriented mental health services: Policy and theory (2013)
First responders	Term used to describe those who first intervene or respond to a crisis; for example, paramedics, police and fire-fighters.
Forensic services	Mental health services that work with people who are mentally unwell and who have been in contact with the criminal justice system. Facilities can include prisons, education courses, therapy, prison hospitals and forensic hospitals and services.
headspace	Established by the National Youth Mental Health Foundation, headspace offers specific services for people aged 12-25 who need help across the areas of mental health, employment, drug and alcohol, relationships and school.
Incarceration	Putting a person in jail, imprisonment.
Juvenile justice	The corrective system for young offenders aged 10–17 years.
Jurisdiction	The geographical area over which an authority extends. In the Review report this is used to refer to states, territories and the Commonwealth.
Justice system	Term describes the whole law enforcement system. This can include policy, law reform, policing, courts, tribunals, penalties, fines, prison, corrections and parole, legal assistance and victim support.
Involuntary treatment	Refers to a person being treated for their illness without their consent, either in hospital or in the community. This may occur when mental health problems or disorders result in symptoms and behaviours that lead to a person's rights being taken away or restricted for a period of time.
Medicare Locals	Medicare Locals are primary health care organisations established under the Australian Government’s National Health Reforms to coordinate primary health care delivery and manage local health care needs and service gaps.

Medications	Mental health-related medications typically refers to five selected medications groups as classified under the Anatomical Therapeutic Chemical Classification System (World Health Organization), namely anti-psychotics, anxiolytics, hypnotics and sedatives, anti-depressants and psycho-stimulants and nootropics.
Mental Illness	Disturbances of mood or thought that can affect behaviour and distress the person or those around them, so the person has trouble functioning normally. They include anxiety disorders, depression and schizophrenia.
Mental health literacy	Knowledge and beliefs about mental illness which can impact problem recognition, mental illness management and prevention.
Mental health issue	Broader term used to describe mental health problems, which may or may not be in the context of life circumstances. If these issues are not addressed this may result in disadvantage or continued dependence on mental health treatment.
Mental Health First Aid (MHFA)	Mental Health First Aid (MHFA) is the help provided to a person who is developing a mental health problem, or who is in a mental health crisis, until appropriate professional treatment is received or the crisis resolves. MHFA courses teach mental health first aid strategies in evidence based training programmes.
Mental Health Nurse Incentive Programme (MHNIP)	This programme provides a non-MBS incentive payment to community-based general practices, private psychiatrist services, Divisions of General Practice, Medicare Locals and Aboriginal and Torres Strait Islander Primary Health Care Services which engage mental health nurses to assist in the provision of coordinated clinical care for people with severe mental disorders
Mentally Healthy Workplace Alliance	A national collaboration between the National Mental Health Commission, business, government and the mental health sector. The Alliance aims to create mentally healthy workplaces across Australia, in small and large business across all sectors.
Model of care	A model of care defines the way health services are delivered. It outlines the group or series of services which are required for the optimum treatment of a person or population group for a specific injury or illness, those required across the stages of treatment and across the stages of care (from acute through to non-acute and rehabilitation) whether that be provided in the community or hospital/ facility or by different services.

National Disability Insurance Scheme	Newly introduced national disability insurance scheme which provides individualised support for eligible people with permanent and significant disability, their families and carers.
NEET	Acronym used to describe a young person who is 'not engaged in education, employment or training'.
OECD (The Organization for Economic Co-operation and Development)	The Organization for Economic Co-Operation and Development is a global organisation with membership from 34 countries which works to promote policies that aim to improve the economic and social well-being of people around the world.
Obsessive compulsive disorder	A form of anxiety disorder where repeated and unwanted thoughts and impulses disturb and dominate a person. Often involves rituals such as excessive hand washing, checking and counting, which in turn cause anxiety if such actions are prevented or out of control.
Participation	The act of taking part or sharing in something.
Partners In Recovery (PIR)	Partners in recovery or PIR is an Australian Government programme which aims to better support people with severe and persistent mental illness with complex needs and their carers and families, by improving collaboration and coordination. Initial funding was to support 24 000 people through this programme.
Person with lived experience of a mental health difficulty	To ensure that our language in the Review report is clear both to people who recognise the term 'consumer' and those who do not identify with an established mental health consumer movement, the Commission prefers to use the term 'people with a lived experience' to describe people experiencing mental health difficulties, their families and support people.
PHaMs (The Personal Helpers and Mentors Programme)	An Australian Government-funded programme which aims to provide increased opportunities for recovery for people whose lives are severely affected by mental illness. The programme takes a strengths-based recovery approach and assists people 16 years and over whose ability to manage their daily activities is impacted because of a severe mental illness.
Prevalence	The proportion of people in a population found to have a condition at a certain point in time. It is arrived at by comparing the number of people found with a condition to the number of people studied. Prevalence is usually expressed as a fraction or percentage.

Psychiatric disability	<p>Psychiatric disability is the consequence and impact of a mental illness on the affected person's ability to function and is a term used in the Australian <i>Disability Discrimination Act 1992</i>. Psychiatric disability may be intermittent and associated with symptoms of schizophrenia, affective disorders, anxiety disorders, addictive behaviours, personality disorders, stress, psychosis, depression and adjustment disorders.</p> <p>The Commission, however, prefers the term 'psychosocial disability' to describe the type of disability as it affects the daily functioning of a person and to recognise the broader social disadvantage and effects of mental illness on people.</p>
Psychosis	<p>A more severe degree of mental disturbance where people can often experience fixed, false beliefs known as delusions. As a group of illness, psychoses are less common forms of mental illness.</p>
Qualitative research	<p>A research approach which aims to gather an in-depth understanding of human behaviour and experience. It makes use of methods such as focus groups, in-depth interviews and ethnography.</p>
Recovery	<p>The National Framework for Recovery-oriented Mental Health Services: Policy and Theory (2013) states "There is no single definition or description of recovery. Starting with the initial assumption that personal recovery is different for everyone, it is defined within this framework as 'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues'".</p>
Recidivism	<p>Term used to describe people relapsing into crime, also termed reoffending.</p>

<p>Remoteness area (Regional, Rural, Remote)</p>	<p>Each state and territory is divided into several regions based on their relative accessibility to goods and services (such as general practitioners, hospitals and specialist care) as measured by road distance. These regions are based on the Accessibility/Remoteness Index of Australia (ARIA) and defined as Remoteness Areas by either the Australian Standard Geographical Classification (ASGC) (before 2011) or the Australian Statistical Geographical Standard (ASGS) (from 2011) in each Census year.</p> <p>Remoteness Areas currently are classified into five categories: Major cities, Inner regional, Outer regional, Remote and Very remote. The category Major cities includes Australia's capital cities, with the exceptions of Hobart and Darwin, which are classified as Inner regional and Outer regional respectively.</p> <p>The new Modified Monash Model categorises metropolitan, regional, rural and remote areas according to both geographical remoteness and town size. The system was developed to recognise the challenges in attracting health workers to more remote and smaller communities. Further details can be found at the DoctorConnect website.</p>
<p>Restraint</p>	<p>When somebody's movements are restricted by the use of straps or belts (physical restraint) or sedation (chemical restraint).</p>
<p>Schizophrenia</p>	<p>A group of serious mental disorders where people can experience imagined and disordered thoughts, often with problems of behaviour, mood and motivation and a retreat from social life.</p>
<p>Seclusion</p>	<p>When someone is confined in a specific room from which they cannot freely leave.</p>
<p>Sentinel events</p>	<p>A relatively infrequent, clear-cut event that occurs independently of a patient's condition; it commonly reflects hospital system and process deficiencies and results in unnecessary outcomes for the patient.</p>
<p>Sexual orientation</p>	<p>Personal quality that inclines people to feel romantic or sexual attraction to persons of the opposite sex or gender, the same sex or gender or to both sexes and more than one gender.</p>
<p>Specialist mental health service</p>	<p>Services with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental illness or a disability arising from their illness.</p>

Stigma See also Discrimination	<p>A negative opinion or judgement held about certain people by individuals or society. Stigma against people with a mental illness involves inaccurate and hurtful representations of them as violent, comical or incompetent. This can be dehumanising and makes people an object of fear or ridicule.</p> <p>If these propositions are acted upon, these actions are discriminatory – see Discrimination.</p> <p>Stigma can occur in the media in the form of reports that refer to inaccurate stereotypes, sensationalise issues through unwarranted references to mental illness, misuse medical terminology or use demeaning or hostile language.</p> <p>Self-stigma is the acceptance of prejudiced perceptions held by others.</p>
Structural discrimination	Term used to describe discrimination at the institutional level; for example, workplace practices. See also Discrimination.
Substance misuse	Term used to describe use of a substance which is illegal or inconsistent with medical guidelines.
Substance use disorder	A disorder of harmful use and/or dependence on either legal or illegal substances, including alcohol, tobacco and prescription drugs.
Suicide	Deliberately ending one's own life.
Suicide attempt	A non-fatal self-directed injury or behaviour with the intent to die. A suicide attempt may or may not result in injury.
Suicidal behaviour	Term used to describe behaviours and thoughts that people have to deliberately harm themselves.
Suicidal ideation	Persistent, intrusive thoughts of wishing to be dead, or deliberate planning or actual attempts to take one's own life.
Support person	<p>"Family and support include family members, partners, friends or anyone whose primary relationship with the person concerned is a personal, supportive and caring one."</p> <p>A National Framework for Recovery-oriented Mental Health Services: Policy and Theory (2013)</p>
Targeted Community Care (Mental Health) Programme (TCC)	The TCC Programme aims to assist people with mental illness and their families and carers. Its objective is to implement community mental health initiatives to assist people with mental illness and their families and carers to manage the impact of mental illness – through PHaMs, Mental Health Respite and Family Mental Health Support Services

Twelve-month disorder	People who have experienced symptoms of a mental or physical disorder in the past twelve months.
Twelve-month prevalence	Term used to describe the prevalence of a mental or physical disorder in the population over the past 12 months. See also Prevalence.
Underemployment	Refers to an employment situation that is insufficient for the person, or jobs that are inadequate with respect to training or potential economic benefits.

Abbreviations

ABF – Activity Based Funding
ABS – Australian Bureau of Statistics
ACT – Australian Capital Territory
ADHD – Attention Deficit Hyperactivity Disorder
AIHW – Australian Institute of Health and Welfare
ATAPS – Access to Allied Psychological Services
CALD – Culturally and Linguistically Diverse
COAG – Council of Australian Governments
D2DI – Day to Day Living in the Community
DVA – Department of Veterans Affairs
FTE – Full time equivalent
GDP – Gross Domestic Product
GP – General Practitioners
IPS – Individual placement and support
LGBTI - Lesbian, Gay, Bisexual, Transgender and Intersex
MBS – Medical Benefits Schedule (also known as Medicare)
MHNIP – Mental Health Nurse Incentive Programme
NEET – Not Engaged in Employment or Training
NDIS- National Disability Insurance Scheme
NGO – Non Government Organisation
NMHC – National Mental Health Commission
NHS – National Health Survey
NSW – New South Wales
NT – Northern Territory
OECD – The Organization for Economic Cooperation and Development
PBR – Payment by results
PBS – Pharmaceutical Benefits Scheme
PTSD – Post Traumatic Stress Disorder
PHAMS – Personal Helpers and Mentors
PND – Post Natal Depression
QLD – Queensland
SA – South Australia

SIDS – Sudden Infant Death Syndrome

TAS – Tasmania

VET – Vocational Education Training

VIC – Victoria

WA – Western Australia