Australian Government
National Mental Health Commission

National Mental Health Commission Submission to the Select Committee on Mental Health and Suicide Prevention

Contents

About the National Mental Health Commission

The Commission was established in 2012 and is an executive agency in the Australian Government Health Portfolio. The Commission is a listed entity under the Public Governance, Performance and Accountability Act 2013 with the Commission's purpose set out in clause 15 of Schedule 1 of the Public Governance, Performance and Accountability Rule 2014.

The Commission's purpose is to:

- Monitor and report on investment in mental health and suicide prevention initiatives
- Provide evidence-based policy advice to Government and disseminate information on ways to continuously improve Australia's mental health and suicide prevention systems
- Act as a catalyst for change to achieve those improvements. This includes increasing accountability and transparency in mental health through the provision of independent reports and advice to the Australian Government and the community.

Vision 2030 Blueprint for Mental Health and Suicide Prevention (Vision 2030)

Vision 2030 is a national blueprint for mental health and wellbeing in Australia. Initiated by the Minister for Health in 2017, its development has been by the Commission.

Vision 2030 casts a national direction for mental health and wellbeing in Australia. It is a long-term framework for a successful, connected and well-functioning mental health and suicide prevention system meeting the needs of all Australians, when and where they need. It explores a whole-of-system approach, considering each key stage from promoting mental and social health to responding to complex and severe mental illness. It brings together the community or sector context in which interventions are implemented with the macro-level factors enabling nationally consistent approaches.

As a key strategic reform policy project the content of Vision 2030 is reflected throughout this submission. Currently, the draft Vision 2030 framework is available on the Commission website. The Final Blueprint will be available in early 2021.

Submission Summary

The National Mental Health Commission (the Commission) welcomes the opportunity to provide information to the Select Committee on Mental Health and Suicide Prevention. This submission seeks to provide the Committee with information on key issues and priorities for the Committee to consider, linking this to the Commission's work and lines of inquiry detailed in the Committee's terms of reference.

While recent strategic reviews of the current mental health system have each been unique in scope and purpose, they consistently identify common concerns, priorities and actions to address long-standing issues in mental health care and suicide prevention in Australia. These issues are highlighted in the diagram below.

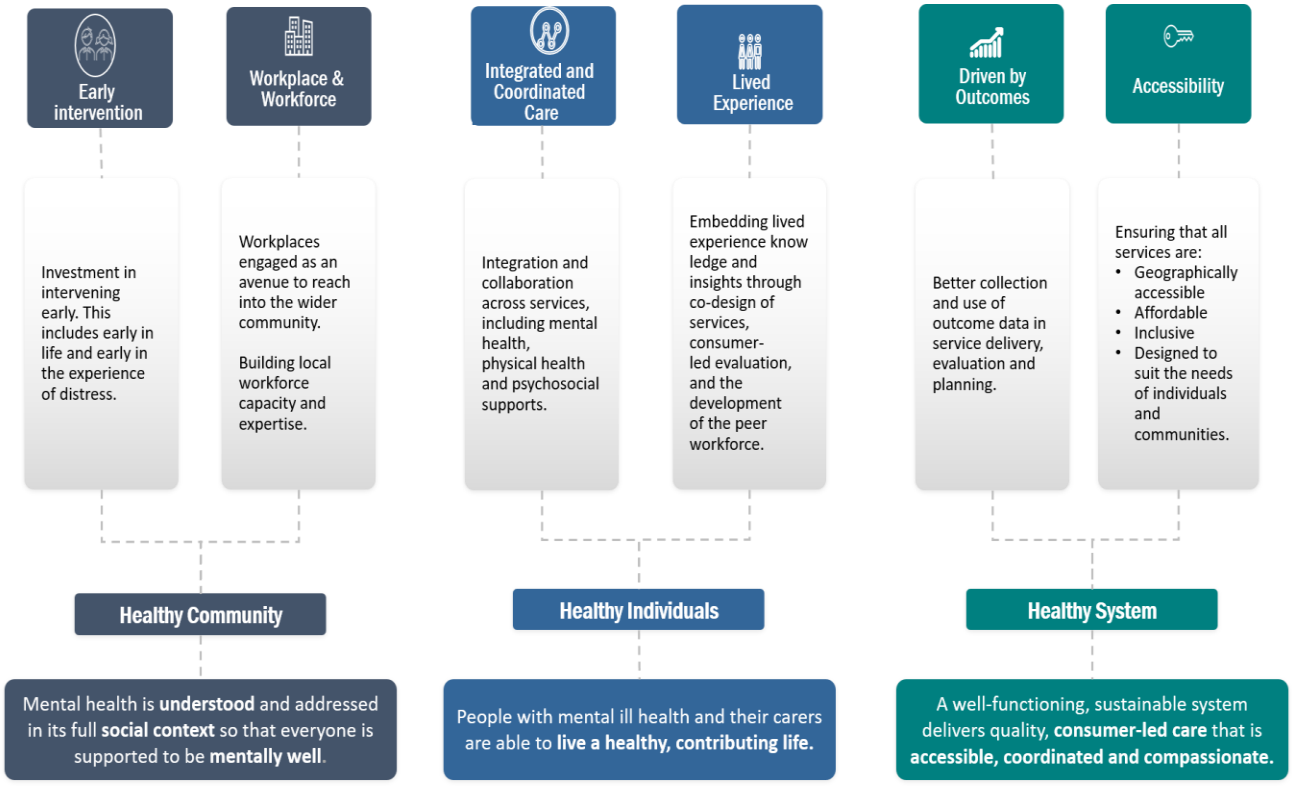

Figure 1 Mental Health Reform Priority Domains

From these priorities, the Commission considers the following issues to be critical gaps requiring further consideration from the Committee:

- **Workforce**; considering the national foundations and oversight needed to facilitate local capacity building.
- **Stigma and discrimination**; addressing national understanding of and attitudes towards mental health.
- **Accessibility particularly affordability**; creating a universally accessible system of resources and supports ensuring that everyone is able to access care when and where they need it.
- **Implementation of change**; considering the oversight, capacities, forces and resources require to implement reform recommendations in a sustainable way.

The Commission recommends the Committee consider the issues discussed in this submission during its inquiry and make recommendations for cultural, systemic and program change that address:

- The nine focus areas for workforce improvement identified as part of the Vision 2030 project, as detailed below in this submission.
- Implementation of national leadership structures to ensure workforce strategies and plans are actioned in a coordinated, timely and consistent way with national oversight.
- Identification of structural stigma and discrimination towards people with mental illness and legislative, policy and program developments to address this issue.
- Indicators to be included in a national attitudes survey to measure outcomes in achieving reduced stigma and discrimination.
- The recommendations made by the Productivity Commission and Victorian Royal Commission to address the 'missing middle' as well as formalised regional approaches to decision making, planning and commissioning.
- Significant reforms needed to improve affordability and accessibility and the stages process required to achieve sustainable funding change.

Key Issues for Consideration

Workforce

Vision 2030 identifies a robust, well-educated and resourced multidisciplinary workforce as a critical performance enabler to implementing a successful mental health and wellbeing system. A multidisciplinary workforce extends beyond the clinical disciplines to also acknowledge the contributions of a wide range of professionals across all types of care in the stepped care model including lived experience professionals.

As part of the development of Vision 2030, the Commission commissioned a report, 'Addressing Mental Health Workforce for the future.' The report identified a range of concerns including:

- A workforce facing critical shortages in some professions (e.g. psychiatrists) and aging professional cohorts in others (e.g. mental health nursing) that will result in significant gaps and deficits by 2030.
- Mal-distribution of the workforce, resulting in less accessible services, particularly for Australians living in rural, remote, and outer metropolitan regions.
- Ineffective recognition and use of the wide range of professionals providing support and treatment for mental ill health.

The report proposed nine focus areas for improvement for the future mental health workforce, including multidisciplinary service models and the expanded role of the peer and allied health workforces. These are:

1. Supporting the multidisciplinary workforce, including peer and lived experience workers
2. Enabling a multidisciplinary workforce to work to 'top of scope'[1] through development of competency-based frameworks and standards, increases capacity, satisfaction and efficiency
3. Improvements to mental health education and training, including the broader health and social service workforces and the mental health sector, starting with tertiary education
4. Expanding the role of social services (including education, policing, justice, and drug and alcohol services) and addressing the social determinants of health (safe and secure housing, financial security, improving living standards, participation in education, and employment.)
5. Taking an integrated and inclusive approach across all sectors and governments. Primary Health Services, Mental Health Services, Disability Services, Aged Care Services, and various social services all need to work collaboratively.
6. Improve staff safety and wellbeing to reduce stress and burn out.
7. Addressing culture, values, and attitudes in workforce development and training, standards and supports to reduce stigma and discrimination and increase early identification and compassionate support
8. Focus on growing and sustaining the rural and remote workforce.
9. Look at opportunities to improve access to services and a broader range of allied health providers using technology and e-Health.

Lived experience in the workforce.

The peer workforce has been growing internationally and within Australia over the last decade. While the total number of peer workers employed in Australia is not known, information available indicates that in 2016-17, there were 125 consumer peer workers and 42 carer peer workers (in full-term equivalents) working in state and territory specialised mental health services.[i] Many more are employed by non-government services providers, in policy and advocacy roles, and increasingly peer workers are providing private consultancy services.

There is a growing international evidence base that wellbeing and quality of life for those with a mental illness can be substantially enhanced when peer support is an integral part of their interventions[ii]. All jurisdictions in Australia have shown a commitment to the mental health peer workforce either through mental health plans and strategies, the development of a peer workforce or lived experience frameworks, or standards and guidelines. The growth and development of the peer workforce in Australia has also been recognised at the national level in the Fifth National Mental Health and Suicide Prevention Plan which has mandated the development of national Peer Workforce Development Guidelines, and the forthcoming National Mental Health Workforce Strategy which the Taskforce has identified the peer and lived experience workforce as one of its five priority areas.

The Commission is leading work on the Peer Workforce Development Guidelines which will provide formalised guidance for governments, employers and the peer workforce about the support

[1] Working to top of scope at the individual level means the workforce is able to fully use their knowledge and expertise and work efficiently, effectively and collaboratively within their scope of practice. At a systems level, it means optimising workforce capacity through maintaining best practice, developing new roles and ways of working, and ensuring there are adequate policy and environmental supports to enable these to succeed. (Te Pou, Scope it Right: Working to top of scope literature review – Mental health and addiction workforce).

structures required to sustain and grow a peer workforce. The draft Guidelines[2] are currently being completed.

Rural and remote communities and workforce

Regional, rural, and remote communities in Australia are at greater risk of mental ill-health and those living in remote areas are twice as likely to die from suicide compared to Australians in major cities.[iiiiv] And yet, they receive less mental health care, largely due to having less access to psychological care and mental health services.

People living in rural and remote Australia are not able to easily access mental health care in their local community. It is important to increase the skills of GPs and allied health providers currently working in rural and remote communities in relation to the provision of generalist mental health care as well as broaden the potential mental health workforce in rural and remote areas.
There are insufficient mental health providers in rural and remote areas,[3] but the generalist health professionals who do work there (e.g. GPs, nurses, allied health) rarely have the mental health training required to support the needs of their communities.[4]

Workforce issues for consideration:

- Actions to address the nine focus areas for improvement identified as part of the Vision 2030 project, as detailed above.
- Appropriate national leadership structures to ensure implementation of workforce strategies and plans in a coordinated and consistent way with national oversight.

Stigma and Discrimination

Australians affected by complex mental health issues still experience unacceptably high levels of stigma and discrimination. Mental ill-health and complex mental health issues can be exacerbated by shame, stigma and discrimination with devastating impacts to an individual, families and loved ones, and communities.

There are many forms of stigma in society, some are based on negative attitudes or beliefs, and others are due to a lack of understanding or misinformation.

The Productivity Commission mental health report[5] defines stigma and discrimination across three distinct levels:

- **Self-stigma** exists where individuals with mental ill health are socialised into believing that they are devalued.[v] This belief can then have behavioural consequences, such as the avoidance of social interactions, reluctance to seek help, and unwillingness to pursue housing or employment opportunities.[vi]
- **Social stigma** exists when community members' judge traits associated with mental illness to be contrary to community norms and behave in ways that are harmful to people with

[2] Guidelines due to be completed in early 2021.
[3] In 2018, 86.4% of psychiatrists (16.0 FTE/100,000), 76.5% of mental health nurses (93.2FTE/1000,000) and 83.2% psychologists (106.5FTE/100,000) were employed in major cities compared to (3.1FTE/100,000), (36.1FTE/100,000) and (25.5FTE/100,000) respectively in very remote areas.
[4] Using GPs as an example, only ~3% of registrars undertaking the advanced specialist training pathway with ACRRM chose the mental health stream, with only 1% of all ACCRM Fellows qualified in mental health via this stream.
[5] Chapter 8

mental illness. Social stigma may be expressed in an overt or a subtle way and may be anticipated or perceived rather than experienced.

- **Structural stigma** refers to the rules, policies and practices of social institutions that restrict opportunities for people with mental illness.[vii] Where policies disproportionately impact the lives of people with mental illness — even without having been intended to do so — this can be regarded as a form of structural stigma. Structural stigma can affect mental health through increased poverty resulting from discriminatory practices, systematic underfunding of mental health services and research, and coercive preventative measures.

The National Stigma Report Card prepared by SANE Australia[viii] identified 14 'Life Domains' where people living with mental illness reported most common levels of stigma and discrimination. These are:

1. Social media
2. Relationships
3. Employment
4. Healthcare services
5. Mental healthcare services
6. Housing and homelessness services
7. Mass media
8. Welfare and social services
9. Education and training
10. Financial and insurance services
11. Legal and justice services
12. Cultural, faith or spiritual practices and communities
13. Sports, community groups and volunteering
14. Public and recreational space.

All forms of stigma are associated with reduced quality of life, hopelessness, poor self-esteem, and reduced ability to function socially.[ix] Stigma is associated with a reluctance to seek diagnosis and treatment. It affects the way symptoms are communicated, which symptoms are reported, and compliance with prescribed treatment.[x] In turn, this can harm recovery prospects, particularly for people with severe mental illness.[xi] People labelled as 'mentally ill' are also less likely to benefit from available healthcare for physical health problems.[xii]

In 2019, the Commission facilitated a national consultation Connections Project. This project identified key issues and barriers to accessing mental health support. Stigma was the second most commonly identified barrier with 40% of all participants in Town Hall meetings discussing stigma and discrimination as a barrier. This was further supported by an online survey, which found:

- 63% of participants identified ‘fear of what may happen after seeking help’ as a barrier to accessing care
- 59% of participants identified ‘fear of being judged/worried about what people may think’ as a barrier to accessing care, and
- 55% of participants identified ‘feeling shame and embarrassment’ as a barrier to accessing care.

System and structural stigma and discrimination

Discrimination is a consequence or effect of stigma. It is the unjust or prejudicial treatment of a person or group of people because of their background or a personal characteristic. Discrimination

based, for example, on a person's psychosocial disability can be unlawful (*Disability Discrimination Act 1992* (Cth)).

The Productivity Commission report, Vision 2030, and the Commonwealth Department of Health's Australia's Long Term National Health Plan' identified this form of stigma and discrimination as one of three to be addressed through education and training, procedures and processes, and where necessary legislative reform. The Victorian Royal Commission has also made formal recommendations to address stigma and discrimination, including the initiation of legal claims, including test cases relating to systemic discrimination.[xiii]

The following settings need an immediate focus to address stigma and discrimination that exists within the structures and systems:

- Health Workforce[xiv]
- Community and social services including all aspects of policing and justice systems, employment, housing and child protection.
- Education and training settings.
- Taxation, banking, and finance industry.
- Retail and customer service contact points.
- Media and communications.
- Religious and spiritual organisations, systems, and workforce.
- Transport.
- Cultural communities, community and sporting institutions.

The Productivity Commission report identified and made recommendations for an immediate start to address systemic and structural stigma and discrimination in insurance and financial settings. Responding to these recommendations, the Australian Government announced in December 2020 the development of Australia's first National Stigma Reduction Strategy for all Australians who live with mental illness, enabling them to live long and contributing lives free from stigma and discrimination. The Commission is developing the National Strategy for delivery by the end of 2022. The Strategy will be co-designed with Australians who live with mental ill health and mental illness and those who represent and have contact with them in their everyday lives.

Stigma and discrimination issues for consideration:

- Acknowledge the responsibility of all levels of government and institutions to address structural stigma and discrimination on people with mental illness and consider legislative, policy and program developments to address this issue.
- Identify outcomes that could be included in a national attitudes survey to measure outcomes in achieving reduced stigma and discrimination.

Accessibility

"The most difficult challenge I've faced…is accessing appropriate therapy."

- Participant, Connections Town Hall meeting, 2019

Accessibility issues were the most commonly raised concern during the Vision 2030 Connections project consultation activities with half of all participants explicitly discussing accessibility.

The Commission heard that care is not always financially, geographically, or practically accessible for many Australians, and so individuals are often not able to access the services that are available to them. Services have limited availability to meet the needs of their community, and are not easily navigable or coordinated, making it difficult for a person to access care at the level they require and when they require it.

Financial concern was the most common accessibility issue raised. Services being unaffordable was raised by 1 in 5 Town Hall attendees and was considered an important barrier to care by 70% of survey respondents. Participants spoke of being denied treatment, delaying treatment, receiving less treatment than needed and being placed in financial distress because of the cost of services.

People with mental illnesses in the Australian community face a broad range of costs associated with their condition. These include the direct costs of their care, indirect costs associated with receiving treatment and a range of additional expenses and forgone benefits. People who experience mental ill health and mental illness are often unable to afford services that meet their needs, particularly if their needs fall in the mild to moderate stages along the spectrum.

Affordability of mental health care is a function both of the actual cost of the care and the resources available to the consumer. These differ from person to person and can be impacted both by income level and by other expenses required for daily living. An out-of-pocket cost that is affordable for a single person may be financially out of reach for someone on the same income with children, or someone with a chronic physical illness or disability that also requires regular treatment.

Those consumers who do access care often experience financial hardship in order to do so, which can compound the disadvantage they experience as a result of their illness. Often 'affordability' results in a compromise of quality of life or quality of care.

This lack of affordability is compounded by the social and economic experience of people with mental illness. People with mental illness are disproportionately represented among the unemployed and those on low incomes[xv]. This is especially so for people with severe and persistent disorders. Overall, more than 1-in-4 people making up the poorest one-fifth of Australians have current psychological distress at a high/very-high level, and this compares to about 1-in-20 in the richest one-fifth of Australians[xvi]. It is possible that social and economic policies outside those directly involving mental healthcare may be adversely impacting population mental health as well as contributing to the disparities in financial access to care.[xvii]

Beyond affordability there are also a range of other issues that impact the accessibility of services. This includes:

- **Lack of appropriate services:** individuals may not meet exclusion or inclusion criteria or find that the services available to them are not culturally safe or meet their needs in terms of identity or experience.

- **Limited service capacity:** This included long waitlists, not being available after hours, or not practically accessible within a geographic region.
- **Challenges entering care:** Services are not easily locatable, navigable or coordinated, making it difficult to enter care at the level required.
- **Location specific gaps in service:** There is no consistency to the services available across the spectrum of care with different gaps experienced in different locations.
- **Gaps in moderate-intensity services**: People commonly describe falling between public services provided in hospitals or the community. The complex range of health and social experiences means that people can fall through the service system gaps when their specific combination of needs cannot be met. Addressing the 'missing middle' requires a linked-up, stepped-care approach across the full range of health, psychosocial and social service supports, not just medical care.

Funding Models as a Lever for Accessibility

Funding mechanisms should be innovative and responsive, ensuring all core components of care, including clinical intervention, coordination, consultation, and support, are fully realised.
There are many changes, both small and large, that combine to create an environment of accessible and affordable mental health care. However, the establishment of appropriate, sustainable funding models is a crucial factor financial accessibility and universal access to core components of care.

Australia has seen substantial investment and changes in the mental health care system over the last five years. Significant Australian Government led reforms have established the National Disability Insurance Scheme (NDIS) and Primary Health Networks (PHNs), the co-commissioning for suicide prevention and more recently shared jurisdictional arrangements for pandemic planning.

Notwithstanding these recent changes, funding models employed in mental health care in Australia are largely traditional. In some settings this may be entirely appropriate, but in other settings such as primary care, it has created over servicing and inequitable access to care. Overall, mental health services are not funded in ways that reflect the extent or nature of mental illness within the Australian community, resulting in significant unmet need.[xviii]

Implementing Funding Model Change

There is no clear 'best' funding model that operates within mental health care. Funding model reforms are extremely challenging and require significant, sustained effort over years to prepare for, trial, transition and embed. More complex funding models also require detailed, accessible data on issues such as risk, cost, activity and outcomes.

Genuine funding model reform will require iterative development and agreements across all levels of government. Funding model reform should be developed around an agreed set of principles, align with broader healthcare system directions (e.g., value based care), and incentivise the efficient delivery of evidence based and outcome-focused care.

To facilitate this change, the following initial work should be considered to create the structures, strategies and administrative arrangements needed to drive funding model change:

→ Develop a **principles framework for funding reform** to guide the process of change
→ **Design governance frameworks** for new funding models and funding flows that ensure transparency in arrangements across jurisdictions and care continuums.
→ **Review current legislative arrangements** for governance, funding models, and payments in light of reform aspirations

- → Establish programs of funding that develop and support **collaboration**, **co-commissioning, co-design and coordination** from local to inter-jurisdictional and national levels.
- → **Evaluation** of key current and new investments and their impact on funding models and levels including MBS Better Access program and NDIS psychosocial support to identify opportunities for improvement.
- → **Substantial data collection for funding model realignment.** Complex blended models, e.g. for bundling require granular data to inform costs, resource use classification from prior utilisation patterns to predict pricing, data linkage between Commonwealth and States and clinical consensus of best practice across the jurisdictions. Accurate predictive modelling would be needed to create normative capitation pricing mechanisms and to evaluate these for risk of over or under-servicing.
- → **Capture opportunities for diagonal accounting** that could inform budget forecasts
- → **Implement models of value-based care** that combines investment with mental health outcomes instead of activity. Include where possible, opportunities to collect Patient Reported Outcome Measures (PROMS), Patient Reported Experience Measures (PREMS), evidence-informed care and clinical perspectives.

This should then be followed by planned stages of implementation through:

- → Testing innovations and new programs using trials, pilots and phased roll-out to scale or shadow pricing approaches
- → Considered and adaptable transition strategies for moving towards effective models in funding that increase funding in prevention and earlier intervention without compromising quality or availability of intensive or complex care
- → Whole of system evaluation and refinement of systems that includes interactions between funding models and achievement of outcomes.

Regional commissioning

The Productivity Commission report highlighted the need for structural changes to funding arrangements to drive service planning at a regional level. They noted a plethora of psychological services across Australia, funded by both the Commonwealth and jurisdictional governments. This has resulted in a complex web of different treatment options that is very difficult for consumers to navigate.

The Productivity Commission recommended the Commonwealth and jurisdictional mental health funding is pooled at a regional level to avoid duplication and maximise positive impact. The Commission supports a regional approach to commissioning. However, it acknowledges that a regional commissioning approach should include adequate and consistent national structures, standards and monitoring of outcomes to ensure consistency and quality in local funding arrangements.

Community-based services

The Commission's submission to the Productivity Commission's inquiry stated that the current funding model is imbalanced, with greater weight given to the primary and acute care services. Future commissioning arrangements need to strengthen funding across the stepped-care model, with increased investment in early intervention, psychosocial supports, and community-based services.

The Commission is also concerned that people who are deemed ineligible to access the NDIS or who choose not to test their eligibility cannot access the supports they need. The Commission supports the announcement that the National Psychosocial Support measure will assist people with psychosocial disability who are not eligible for the NDIS.

Medicare Benefits Schedule (MBS)

The Commission shares concerns raised in reform reviews, including the Productivity Commission Inquiry and Victorian Royal Commission, that the availability of MBS items for psychology and psychiatry is not clearly linked to evidence on their outcomes, effectiveness, and successful 'dosage' of treatment.

Further concerns relate to MBS items that currently do not facilitate multidisciplinary care or consumer or carer participation, both of these being core elements of effective care. The Commission supports the MBS taskforce recommendations for consumers to participate in discharge planning and community case conferences.

The Commission has also highlighted the need to improve mental health care for older people and has identified the need for MBS items that accommodate service providers to bill a higher rebate when attending residential aged care facilities.

Accessibility and Affordability issues for consideration:

- Consider the recommendations made by the Productivity Commission and Victorian Royal Commission to address the 'missing middle' as well as formalised regional approaches to decision making, planning and commissioning.
- Address the significant funding reforms needed to create the structures, strategies and administrative arrangements needed to drive funding model change that results in improved accessibility and affordability.

Implementing System Change

The current reform landscape comes after decades of iterative planning and strategy based on past reports and reviews. While there is strong enthusiasm from the community, government and mental health sector for the change current reforms will bring, there is a need to harness this enthusiasm towards implementing change.

Mental health is complex, and achieving change will require sustained implementation of actions across all aspects of the system. While some actions are already underway or have been implemented in individual jurisdictions or locations, other communities will require significant support to facilitate progress. Change must be appropriately led, incentivised and resourced.

Implementation needs to:

- → Create strong stakeholder partnerships that encourage active engagement and collaboration in the design and delivery of care;
- → Address challenges associated with the use of research to achieve more evidence-informed practice; and
- → Sufficiently resource ongoing quality improvement as part of all programs and services with particular focus on effectiveness, return on investment, scalability, and sustainability.

Reform Priorities for Action

In addition to Workforce and accessibility issues, the Commission has identified four further priorities, common across current mental health reform activities, which are relevant to the Committee's Terms of Reference:

- **Prevention and Early Intervention** including early in life and early in the experience of distress.
- **Workplaces** as an avenue to reach beyond the health system and into the wider community.
- **Integration and coordination** within mental health care and across mental, physical and social health.
- **Valuing and embedding lived experience knowledge** through co-design, consumer-led evaluation, partnership and inclusive leadership and oversight.
- **Driven by outcomes;** better collection and use of outcome data in service delivery, evaluation and planning.

Prevention and early intervention

It is essential to have a system which emphasises wellness; promotes good health, addresses the issues that contribute to poor mental health and maximises protective factors for everyone.

Supporting individuals in developing coping capabilities, problem-solving skills and resilience can promote more positive life experiences and capacity to self-manage challenges. A proactive approach to the general wellbeing of all Australians, built around the social, environmental, and socioeconomic determinants of health is key to reducing mental illness and preventing suicide.

Effective prevention and early intervention initiatives reduce the incidence, prevalence and recurrence of mental health disorders and reduce risk of harm for those with mental illnesses. However, many Australians do not or are not able to access supports when they first begin to struggle with their mental health, which can result in problems becoming more severe and less responsive to low-intensity treatments. Even when prevention initiatives are available, they are often disconnected from other components of care and can contribute to gaps and missed opportunities for early intervention.

The Productivity Commission inquiry identifies prevention and early intervention as a key area for reform with particular focus on social inclusion, stigma reduction and elevation of importance of psychological health and safety in workplaces. The Victorian Royal Commission also identified Prevention and mental health promotion as important strategies to improving mental wellbeing and reducing mental illness.

Vision 2030 identifies the core components of care needed to ensure that people who are 'at risk' are identified early and supported through targeted prevention programs. It draws on collaboration and coordination through whole-of-government approaches whereby a trained multidisciplinary workforce that extends outside of direct mental health services can deliver coordination of care including warm referral and linkage between other systems, services, or professionals.

Intervening Early in Life; National Children's Mental Health and Wellbeing Strategy (Children's Strategy)

Mental health struggles often begin during childhood. An estimated 50% of adult mental illness begins before 14 years of age.[xix] In 2015, anxiety, depressive disorders and conduct disorders accounted for three of the five leading causes of disease burden for children aged 5-14 years. Data from the Australian Child and Adolescent Survey of Mental Health and Wellbeing indicates that one in seven Australian children aged 4-17 years' experience mental illness with the most common types of diagnosed mental illness being: ADHD, anxiety disorders, depression, and conduct disorders.[xx]

There is evidence that poor mental health during childhood can lead to long term struggles. One study found that 50% of children with mental illness continue to struggle in adulthood; while the other 50% no longer warranted a diagnosis, their chance of functioning well was still less than that of people without a history of mental illness during childhood.[xxi]

Australia has to date not had an overarching strategy to guide action for supporting children's mental health and wellbeing. The Children's Strategy represents a significant opportunity to focus on a national approach and acknowledges the importance of early identification of mental illness or mental health issues in children long before adolescence.

When developing the Strategy, the Commission considered the recommendations of the Productivity Commission's inquiry report on the social and economic benefits of investing in mental health and also noted the considerable work being completed to revise and refresh the *National Framework for Protecting Australia's Children 2009-2020*, and the priority areas and actions in the *National Action Plan for Children and Young People*. The Strategy has also been developed in parallel and alignment with the Commission's work on the *Vision 2030 Blueprint* and aligns with the findings and advice from the Victorian Royal Commission's final report.

Consistent with a whole-of-government approach, the strategy extends beyond the health sector to focus on social determinants, including key issues of equity and access. The strategy considers the supports needed for parents and carers, and includes the need to work across health, education, and social services.

The draft Children's Strategy is publicly available, with consultations recently closed. The final strategy due for completion in mid-2021.

Workplaces

In considering the best way to promote prevention, early interventions, mental health literacy and building emotional resilience across the population it is crucial to design initiatives that reach people where they live, learn and work.

Workplaces can be the first point of contact for a broad cross-section of the community who may not have any interaction with the mental healthcare system. Equipping these environments with knowledge of early warning signs, appropriate referral pathways and the support required to enable recovery is critical to support the early identification and intervention of mental ill-health. There is emerging evidence regarding the effectiveness of workplace interventions for the prevention of bullying, stress, depression, and suicide as well as promotion of wellbeing, and stigma reduction.[ii]

The National Workplace Initiative[6] (NWI) is working to support the consistent implementation of emerging evidence-based approaches in the area of workplace mental health. The NWI is run by the Commission in collaboration with the Mentally Healthy Workplace Alliance, a group of national organisations collaborating to promote and create mentally healthy workplaces for all Australians. Members of the Alliance include peak organisations from business, union, mental health, workplace health and government sectors.

The NWI framework is built around three key pillars for action that cover the range of activities required to create a mentally healthy workplace:

- → Protect: Identify and manage work-related risks to mental health.
- → Respond: Build capability to identify and respond to support people experiencing mental ill-health or distress.
- → Promote: Promote mental health by creating work, work environments and cultures that are good for people.

Further information regarding the work of the NWI can be found on the Commission's website.

There is also a wide range of existing evidence-based frameworks for mentally healthy workplaces, from management systems like the National Standard of Canada for Psychological Health and Safety in the Workplace through to high-level frameworks such as the Thrive at Work or the Integrated Approach that can be reflected diagrammatically on a page.

Each of the Productivity Commission inquiry, Victorian Royal Commission and Vision 2030 support the importance of workplaces as key delivery mediums/locations of mental health care. This is especially so in considering the delivery of effective prevention and early intervention.

Integrated and coordinated care within and beyond the health system.

People are required to self-navigate what is a complicated mental health system at a time when they are already struggling. This process is even more difficult when a person requires multiple types of support – for example, seeing a psychologist for therapy, a psychiatrist for medication, and a social worker for housing support. Planning is also not always 'person-led'[2] and services are poorly connected between primary, secondary, and tertiary care. Due to a lack of coordination, people' fall between the cracks' of the mental health system, unable to access services to meet their needs before a crisis occurs.

The Commission supports integrated and coordinated care within and beyond the health system. This includes integration within services and the provision of coordinated care within mental health, as well as all governments beyond health portfolios working towards a common goal and taking a whole of government approach to mental health and wellbeing.

The Vision 2030 Blueprint addresses these challenges through a wellbeing approach to mental health providing an opportunity to develop the points of commonality between existing systems. The mental health system needs to be integrated with social systems such as housing, education, justice, suicide prevention and alcohol and other drugs to create pathways between entry points. Interventions should impact on adverse experiences including poverty, discrimination, family violence and adverse childhood events. This includes a focus on building protective factors as well as mitigating risk factors and a significant body of work emphasises the need for a life course

[6] The National Workplace Initiative is a $11.5 million investment by the Commonwealth Government to create a nationally consistent approach to mentally healthy work and workplaces in Australia.

approach[3] to understanding and tackling mental and physical health inequalities. Primary prevention, early intervention and optimisation of wellbeing should be available from the start of life for everyone. Furthermore, services should provide support across the spectrum of mental ill-health and operate in a collaborative way that shares information and data to provide a collective response to the individual.

These approaches are also supported by the Productivity Commission and the Victorian Royal Commission which each make recommendations supporting the prioritisation of the creation of a person-centred mental health system, reforms to improve people's experiences with mental health care in and beyond the health system, the removal of barriers to collaboration within different parts of the mental health system through information sharing and improvement of coordination and integration between health and other support services to help support recovery.

Valuing and integrating lived experience knowledge.

Over the last few years, the Commission has prioritised work to better understand and develop a national view of lived experience engagement and participation in relation to Australia's mental health and suicide prevention systems. Engagement and participation in practice, culture, and service delivery, which places the voice of lived experience at the centre of decision-making, is a key component of driving and leading change in mental health and suicide prevention.[iii]

For Vision 2030, the inclusion of qualitative experiential insights from people with lived experience, their families and other support people is crucial at all levels of policy and service development and delivery. Partnership with lived experience is one of the overarching principles of Vision 2030 emphasising the value of co-design and collaborative approaches. The principles in Vision 2030 also support informed decision-making and the implementation of lived experience rights and partnership as a core component of best-practice care. The Victorian Royal Commission and the Productivity Commission have also prioritised lived experience, the former through recommendations such as setting up initiatives led by people with lived experience and establishing lived experience leaders throughout the system and the latter through priority reforms which include a push for consumer and carer participation and advocacy in all aspects of the mental health system.[iv,v]

Measurement of outcomes

A number of data-related issues have been consistently raised by the sector and through review and reform activities such as the Productivity Commission inquiry. Issues identified include:

- → Information is not collected or distributed regularly, meaning decisions are often made based on old data.
- → Key gaps in Australia's population data, including data for some disorder types and high-risk community groups.[x]
- → Data collected shows the number of people accessing mental health services but often does not quantify people who are turned away from services or the length of time that people are waiting to access services.[xi]
- → No systematic outcome data being collated, meaning it is not possible to evaluate the effectiveness of programs or activities, including MBS-funded psychological therapies.
- → There is no current requirement for mental health programs or models to demonstrate effectiveness prior to being funded or delivered.

The Vision 2030 Blueprint promotes better use and collection of data, and consistent national monitoring and reporting for improved outcomes. Fundamental to outcomes and impact in Vision

2030 is the ability to measure, monitor and evaluate. Evaluation is an integral part of each component of the system as well as the way in which we view the system to ensure we are focused on translation and real-world effectiveness.

The measurement of outcomes approach is supported by the Productivity Commission, the Victorian Royal Commission, and the National Suicide Prevention Adviser's report to the Prime Minister. In particular, the Productivity Commission has addressed the need for an independent body to lead transparent evaluations of significant mental health and suicide prevention programs funded by governments and highlighted amongst a number of data actions, the collection of high-quality and fit-for-purpose data to inform decision making, evaluation, improved service delivery, and outcomes.[xii] Both the Victorian Royal Commission and the interim advice of the Suicide Prevention Advisor call for data and evidence to drive outcomes, including the development of outcomes frameworks.[xiii,xiv]

Terms of Reference - Additional Information

To support the work of the Committee the Commission provides the following additional information relevant to the Committee's terms of reference.

Current Reform activities, findings and reports

As the Committee is aware, there are several mental health and suicide prevention reform activities currently underway. In addition to those identified in the Terms of Reference the Committee may also wish to consider:

- Aboriginal and Torres Strait Islander strategies, including the National Partnership Agreement for Closing the Gap.
- Reform activities of the Royal Commission into Aged Care Quality and Safety
- The National Disability Insurance Agency (NDIA) reform and strategy work for NDIS participants with a psychosocial disability.
- The roll-out and evaluation of new innovative programs such as the Australian Government trial of eight Adult Mental Health Centres and residential eating disorder clinics.
- The work of the National Federation Reform Council's Vision for Australia's future mental health and suicide prevention system.
- The work of the Office of the National Commissioner for Defence and Veteran Suicide Prevention.
- National Mental Health and Wellbeing Pandemic Response Plan
- National Children's Mental Health and Wellbeing Strategy.

COVID-19 Pandemic and Mental Health

Almost all people affected by emergencies will experience some level of psychological distress. This will be mild and transient for most, while others will experience escalation of acuity or short-term mental distress. Some may suffer a long-term decline in mental health and wellbeing including those already living with mental illness as well as people with no prior history.[2]

Being in quarantine is associated with isolation, loneliness, loss of control, stress, frustration, anger, boredom, and inadequate information, with some evidence suggesting there may be long-lasting

psychological effects if these stressors are not minimised. People's experiences of self-isolation and quarantine are likely to differ depending on environmental, demographic, social, cultural, and individual factors.

Both the COVID 19 pandemic and the measures taken in response (including restrictions), have the potential for negative impacts on the mental health and wellbeing of Australians. Long-term Mental health outcomes continue to be expected to be impacted by both the mental health measures provided in response to current need, and those that target risk and protective factors.

The Commission has been drawing on a range of evidence to better understand how Australians are faring during the pandemic and has identified more than 100 mental health related research studies on COVID-19. Findings from surveys such as the ANU Poll, ABS Rapid Survey, the ABC's COVID-19 Monitor survey, and other datasets provide a picture of people's mental health in the early stages of the pandemic, during restrictions, and as physical distancing measures have been eased.

Findings of these studies indicate:

- During the course of the pandemic to date many Australians have experienced heightened anxiety, complex psychological distress, and mental illness. [xxii] This has improved nationally since August 2020[xxiii], although distress rates have been observed to increase with local restrictions, such as those experienced in Victoria.
- A number of social and emotional determinants of mental ill health have been significant affected by the pandemic, including financial distress, domestic and intimate partner violence.[xxiv]
- Younger people have been particularly affected by higher levels of distress[xxv xxvi xxvii xxviii] though this has not translated at this time to an observable increase in suicide at this time.[xxix, xxx]

The Commission has funded the ANU National Centre for Epidemiology of Population Health to conduct a research project: *Digging Deeper – Exploring the Effects of Coronavirus (COVID-19) Pandemic on Social Connectedness and Mental Health*. The project will review pandemic research within Australia and compare it to international data and previous pandemics/disasters while exploring the experience of and relationships between variables through the collection of additional qualitative data. The project will focus on the effects of quarantine and self-isolation on people's mental health and will dig deeper into people's experiences through qualitative interviews. The project is due to be completed in June 2021.

Impact on specific mental health conditions

The COVID-19 pandemic appears to have generated a marked increase in presentations of new and relapsing eating disorders. Researchers have highlighted that COVID-19 may trigger or exacerbate disordered eating behaviours.[xxxi,xxxii,xxxiii] An Australian study identified a significant proportion of participants with a self-identified eating disorder reported an exacerbation of restricting behaviours, binge eating, purging, and exercise behaviours within the initial stages of the pandemic.[xxxiv]

There are some indications that there may have been an increase in the acuity and severity of eating disorder presentations. Increases can specifically be seen in children and young people. Between September and October 2020, Victorian state data shows a 33% increase in child and youth contacts in community mental health services for eating disorders.

This increase in presentations and complexity has been accompanied by challenges in safe and effective treatment using technology to deliver eating disorders-specific treatments and supports.[xxxv] Concerns have been raised on the use of appropriate platforms, and how to adapt assessments and treatment modalities that would normally be conducted face-to-face, for example, weight checks and meal support.[xxxvi]

Impact on mental health services and their use

The COVID-19 pandemic has led to substantial changes in the delivery of mental health services, most notably the expansion of telehealth services. Australia's health system has embraced telehealth services as demand for mental health services continues to rise. Overcoming geographical barriers of face-to-face treatment by adopting new technologies and workflows is crucial to enhance access to services so that people receive the right care at the right time.[xxxvii]

During the course of the pandemic we have seen significant uptake in digital and telehealth for mental health concerns[xxxviii]. Since 16 March 2020, 12 million Medicare mental health services were delivered nationally, and 3.9 million of these services (32.5%) were delivered by telehealth. In Victoria, between September and October, the number of Medicare-funded mental health items increased by 31% compared to the same period last year and the proportion of MBS mental health services delivered via telehealth continues to be much higher for Victoria than New South Wales or the rest of the country and in August, 62% of MBS mental health services in Victoria were delivered by telehealth.

Despite the relatively reduced risk of COVID-19 in most parts of the country and easing of associated restrictions in most states and territories at this time, the use of mental health support services – both face-to-face, telehealth and crisis support services – remains high compared to previous years[xxxix].

The Pandemic has also raised awareness of the importance of caring for mental health. One in four (26%) people put more or much more priority on their mental health since March 2020. Of those who prioritised their mental health more since March 2020, over half (56%) did so because of the COVID-19 pandemic.

While a significant proportion of people are accessing mental health services, available data suggests not everyone who needs mental health support is getting it. According to the May ANU Poll,[xl] 10.8% of people reported needing mental health support during April-May 2020 however, only 75.3% of people who reported a need for mental health support actually sought help. Whilst in the July ABS RAPID survey 6% of people reported they needed to use a mental health or support service since March 2020 but did not take it up.[xli] People who reported difficulty accessing mental health support services were likely to report cost, isolating due to COVID-19 and dislike or fear of service as barriers to receiving care.[xlii] These barriers also extend to support services for experiences that increase risk of mental ill health, for example domestic and family violence services.

Pandemic Mental Health and Wellbeing Response Plan

The National Mental Health and Wellbeing Pandemic Response Plan (the Pandemic Response Plan) was developed in May 2020 and aligns with the priorities and recommendations identified in both the World Health Organisation and United Nation's advice on COVID-19 and mental health.[xliii,xliv] The Pandemic Response Plan identifies priority action areas incorporating a range of responses for short, medium, and long-term providing agreed 'guardrails' across all jurisdictions while recognising

the need for flexibility to best suit the demographics and needs presenting in each jurisdiction. It defines governance, coordination and implementation requirements including data collection and sharing across Australian jurisdictions to facilitate informed planning and decision making.

In responding to population mental health needs, the Pandemic Response Plan took a whole of government approach including consideration of relevant social determinants such as employment, housing, and social connectedness. Consideration was also given to the accessibility of appropriate mental health services across the spectrum of care, and it has led to substantial changes in the delivery of mental health services including telehealth services (for mental health services generally), online services (24/7) and a significant increase in use of help lines.

The Pandemic Response Plan includes three agreed priority immediate actions:

→ Better access to data,
The need for improved access to services within communities where people live learn and work (taking service to people), and
→ The urgent need for improved connectivity between services (clear referral pathways).

Once launched, responsibility for implementation transferred to the relevant jurisdictions, with oversight from MPHC and coordination support from the Commission. Actions under the Pandemic Response Plan have been reported to National Cabinet, to approve or endorse, as necessary, any collective actions. MHPC (or its ongoing equivalent) is to have oversight of receiving jurisdiction updates, and the identification and recommendation of any collective actions.

Natural Disasters and Mental Health

Natural disasters are increasing in frequency and severity with research indicating that they have a long-lasting impact on the mental health and wellbeing of those affected. According to the Australian Strategic Policy Institute in 2019, some 2.2 million people now live in places with high or extreme risk of bushfire. Many more people are indirectly affected, for example, during the 2019-20 Black Summer bushfires the Australian Academy of Health and Medical Science estimated that nearly 79% of Australians were touched by these fires, though direct experience or their close contacts.

It is widely acknowledged that bushfires and other disasters can erode the mental health of people living in affected communities with increased rates of mental distress occurring during, following and for a small proportion of people for several years after the event.[xlv] [xlvi] For people living with existing mental health concerns, the impact of bushfires and other disasters can lead to a worsening of existing conditions, often exacerbated by the disruption of usual sources of support. The post disaster environment may also cause relationship issues and evidence suggests rates of family violence can increase following bushfires and other disasters.[xlvii] There are many who may be particularly vulnerable to these effects including first responders and emergency workers, people who have experienced multiple disasters or other trauma, children and young people and cultural groups who do not feel safe or supported to access mainstream services.

The Commission is working collaboratively with national and jurisdiction disaster response sectors to develop the National Disaster Mental Health and Wellbeing Framework, due to be finalised by June 2021. The Framework will be Australia's first national cross-jurisdictional framework to guide action

and investment on mental health before, during and after disasters. The Framework will reduce service duplication, improve role clarity across different levels of government and sectors, and thus make it easier for people who need support to find it.

Emerging evidence-based approaches to effective early detection, diagnosis, treatment and recovery.

The core system principles in the Vision 2030 blueprint outline that all essential components of care should meet best practice standards, incorporate evidence-based treatment models, and be delivered by appropriately skilled and trained staff. This includes specific consideration of providing trauma-informed, culturally appropriate, and person-led care.

The Vision Blueprint supports the development of governance structures (such as national agreements) and system enablers (such as research and evaluation) that will support the effective and timely translation and integration of evidence-based approaches to mental wellbeing and mental ill health into the system at all levels of the spectrum of stepped care. This includes establishing an evaluation culture, underpinned by enforceable standards of practice and agreed national outcome measures. The overall outcome of this focus should be that anyone at risk of or living with a mental health issue has access to affordable, evidence-based care in their community.

There is currently a lot of work being undertaken across Australia within this research translation space through research institutions (for example, Orygen, the Matilda Centre, Black Dog Institute) along with the development of translation strategies and initiatives including the Victorian Collaborative Centre for Mental Health as proposed by the Victorian Royal Commission. This submission highlights a range of activities currently being undertaken in the area of emerging evidence-based approaches to workplace mental health and the work of the National Workplace Initiative. In addition, the Committee may wish to refer to the draft Children's Strategy for successful emerging evidence-based approaches in the area of children's mental health.

Digital and Telehealth

New technology is changing the way mental health services are delivered.[xlviii] With the introduction of new health technology tools like wearables, apps and devices, connecting to and integrating mental health services is increasingly attractive and efficient.

Digital mental health services have seen significant growth globally over the past decade.[xlix] These services are offering new and innovative ways for consumers and carers to access services. They provide an opportunity to significantly increase access to care by transcending geographic, stigma, privacy, and financial barriers.

In Australia, technological innovations in healthcare continue to expand across the continuum of care and services delivery. Digital platforms like the internet, smartphones, tablets, electronic medical records, electronic prescribing, secure communication software and national databases such as the My Health Record are starting to replace conventional monitoring and recording systems. Commonwealth funding to date has primarily focused on digital service delivery:

- The Australian Government commenced funding for The Telephone Counselling, Self Help and Web-based Support programs measure in 2006, which provides funding to several nationally available digital mental health services.
- In 2017, the Government launched Head to Health, a consumer-friendly digital mental health gateway to help people more easily access information, advice, and free and low-cost phone and online mental health services and support.
- Currently, the Commonwealth funds around 30 individual digital mental health or suicide prevention services than span the spectrum from health promotion to prevention and continuing care.[l]

Nationally, there has also been a decade-long focus on policy that supports digital mental health innovation. In 2012, the Australian Government developed the E-mental Health Strategy for Australia. Building on this the Department of health is leading work on the National Digital Mental Health Framework (NDMHF), an action under the Fifth National Mental Health and Suicide Prevention Plan. The NDMHF aims to provide an integrated and strategic approach to digital mental health service delivery within the broader context of Australia's mental health system.

Despite these significant developments, there are still challenges identified in the successful delivery of digital health services in Australia.

At present, uniform awareness of the broad range of digital mental health services is limited amongst the mental health workforce, despite platforms such as Head to Health which seek to identify services suited to specific patient needs. For many clinicians, digital mental health services are limited to applications. The Fifth Plan states that guidance and training tools are important in raising awareness of digital mental health services and reducing stigma.[li]

The market has also outpaced the government in innovation, production and disruption. This can create gaps between evidence-based practice in mental health care and the products available. Priorities to address this issue include; interoperability and standards, person-centric models, trust and privacy, co-design, equitable access, and legislative and regulatory reform.

Digital health and health informatics are seen as an integral part of the Vision 2030 framework, including digital service delivery, digital solutions for performance enablers, and innovation opportunities in enhancing emerging and disruptive technologies to solve complex problems. Reform should work towards a sustainable, scalable, and adaptable digital ecosystem that connects resources, information, and stakeholders across interoperable and standardised platforms towards a common goal in improving Australian's mental wellbeing and providing safe, quality care.

Effectiveness of Digital Mental Health Services

Research in the digital health space continues to develop and expand rapidly. In the last five years, over 200 articles on integrating technology into mental health treatment have been published.[lii]

Continued research and evaluation are important to understand the effectiveness of digital mental health services, including specific services and modes of delivery, for the general population and different cohorts. Examples of findings relating to specific programs or cohorts to date include:

- Digital mental health interventions in the workplace can improve employee psychological wellbeing and increase work effectiveness.[liii]

- Research to date indicates that digital mental health services can support the same outcomes as face-to-face services.[liv]
- Digital mental health services enable equal outcomes for Aboriginal and Torres Strait Islander,[lv] non-English speaking migrants,[lvi] and older cohorts.[lvii]
- Digital mental health services create an access point for carers to receive training, establish social networks with other carers, learn from peer and expert advice, and engage in interactive problem-solving.[lviii]

While evidence suggests digital services can have positive mental health outcomes, there are barriers to accessing services or ensuring their effectiveness in real-world implementation. For example:

- The digital divide or digital poverty and health inequalities where those who need care most are those least likely to be able to access digital options. This may be particularly true for older Australians, Aboriginal and Torres Strait Islander people, people from low socioeconomic backgrounds and rural and remote communities
- Concerns around privacy and confidentiality
- The efficacy of digital mental health and lack of matching between need and service offering
- Challenges with consumer and community literacy
- Limited meaningful inclusion of co-design with lived experience in the development.

Standards and Regulation in Telehealth and Digital Health Services

Mental health services are delivered within a complex system funded, overseen, and delivered by the Australian Government and States and Territories. Digital and telehealth have often developed in parallel to the face-to-face mental health care system rather than in an integrated way.

There are multiple agencies at the Commonwealth level with responsibility for funding and regulating digital mental health services, including the Department of Health, Australian Digital Health Agency (ADHA), the Therapeutic Goods Agency (TGA), the Australian Commission on Safety and Quality of Health Care (ACSQHC), and Primary Health Networks.

There are no registration or accreditation requirements for health practitioners specific to digital mental health services: Under the Health Practitioner Regulation National Law 2009, all health practitioners providing mental health services will be appropriately trained and qualified to do so. Digital mental health services that provide diagnosis or screening, monitoring, treatment, or therapy through information can be classified as Software as a Medical Device (SaMD) and thus subject to the TGA regulatory framework. It is somewhat unclear how to interpret this for interventions focused on early intervention, depression, symptom monitoring or suicide prevention.

No single view has emerged on what constitutes best-practice in this field. However, many lessons are being learned and evidence-based solutions being defined. This global experience and growing capability can potentially be leveraged in the Australian context – reuse over re-invent. In addition, this presents the opportunity for Australia to take a leadership role in this important field.

National Safety and Quality Digital Mental Health Standards (NSQDMHS)

NSQDMHS have been developed by the Australian Commission on Safety and Quality in Health Care and address key safety and quality risks for digital mental health service users.

It is important to create standards and structures to support consumer participation and co-design, the integration of services, systems and public health with private enterprise while maintaining safety, quality, and equitable access to care.

The development of the NSQDMH Standards is a significant step in providing safety and quality assurance for digital mental health service users and best practice guidance for service providers and developers. The Standards were released on 30 November 2020. The project's next phase will focus on developing an assessment framework for an independent audit of services.

International Digital Health Usage

Digital services frequently span international boundaries – offering supports regardless of geographic location, citizenship, or local healthcare arrangements. While this has positive implications for diversity, choice, and innovation in digital mental health care, it also poses significant legal and ethical challenges for providers and service users. For example:

- Privacy issues and data sovereignty
- Differences in professional standards and regulation of digital health services across jurisdictions
- Duty of care including notifying of risk of harm to self or others in an international context
- Integrating digital service offerings with local community-based services and acute care.

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