Contributing lives,
thriving communities

Report of the National Review of Mental Health Programmes and Services

Volume 1

Strategic Directions
Practical Solutions 1–2 years

30 November 2014

Australian Government
National Mental Health Commission

About this Review

This document is Volume 1 of a four-volume report of the Commission's review of national 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 for the national review report are available on our website.

Many of 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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We also acknowledge the support of Commonwealth agencies and state and territory departments which provided detailed information of funded programmes and services, and shared data and insights into mental health service provision in Australia.

We thank the Australian Institute of Health and Welfare, along with the Australian Bureau of Statistics for their support and assistance with management and analysis of data and information, and contributions to the development of the Review report.

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.

About the Commission

The Commissioners and respective appointment dates are:

Professor Allan Fels AO (Chair) – 1 January 2012

Mrs Lucinda Brogden – 9 April 2014

Mr David Butt (Chief Executive Officer) – 13 January 2014

Ms Jackie Crowe – 1 January 2012

Professor Pat Dudgeon – 1 January 2012

Ms Nicole Gibson – 24 September 2014

Professor Ian Hickie AM – 1 January 2012, reappointed 9 April 2014

Mr Rob Knowles AO – 1 January 2012

Hon Dr Kay Patterson – 9 April 2014

The Chair and Commissioners thank the Commission's staff for their outstanding efforts and commitment in developing this Final Report of the National Review of Mental Health Programmes and Services.

"…mental health is probably the hidden epidemic in our community. Something like one in five Australians will have an episode of mental ill-health in any one year; it's something that is happening everywhere, but it's so often unrecognised and it's so often untreated."

Prime Minister Tony Abbott

17 October 2014

Remarks at the Black Dog Institute Zoo2Zoo Ride, Sydney

Australian Government

National Mental Health Commission

To the Minister for Health and Minister for Sport

Dear Minister

On behalf of the Commission, we commend to you this Final Report of the *2014 Review of Mental Health Programmes and Services*.

This report gives you clear guidance on practical solutions for change that address our Terms of Reference. The Commission has taken a whole-of system, whole-of-Government and whole-of-life perspective to this work. Throughout our consultations, the Commission has found a strong commitment to mental health reform to deliver better outcomes for people who need mental health supports and programmes.

The work of the Review has found there is an extraordinarily high degree of consensus as to the directions needed to create a system which promotes good mental health and wellbeing and a contributing life. Practical steps now need to be taken.

We would like to acknowledge the contributions of all those we consulted. Indeed, the strength of these contributions was no better illustrated than in the 1,800 submissions we received through our public call for submissions. Overall, the Commission received well over 2,000 submissions.

You will find in this report immediate priorities for action, a programme to start implementation now and a set of measures to guide change. Very importantly, the Commission is proposing that these changes should occur within existing resources. While there is significant expenditure on mental health it is not necessarily being spent on the right things—those services which prevent illness, keep people well, support recovery and enable people to lead contributing lives.

The recommendations of the Review have implications for a number of portfolios which go beyond health. In particular, the Commission reinforces the point that many programmes and services which enable people to live a contributing life sit in areas such as housing, employment, education, welfare and justice.

The Review includes a particularly strong focus on the social and emotional wellbeing of Aboriginal and Torres Strait Islander people, given the very high burden of mental ill-health and suicide in this population.

We have every confidence that the adoption of the recommendations in this report will result in transformational reform of the mental health system, promote significant innovation, particularly at a local level, and enable people, their families and communities to thrive.

Thank you for this opportunity to contribute to the Government's agenda on mental health and suicide prevention. We value the opportunity to walk with Government and the mental health sector—particularly people with lived experiences, their families and other support people—to work collectively to achieve our vision that all Australians achieve the best possible mental health and wellbeing.

Sincerely

Allan Fels AO

Chair

30 November 2014

David Butt

Chief Executive Officer

30 November 2014

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Terms of Reference

This Review will examine existing mental health services and programmes across the government, private and non-government 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.

Programmes and services may include those that have as a main objective:

- the prevention, early detection and treatment of mental illness
- the prevention of suicide
- mental health research, workforce development and training
- the reduction of the burden of disease caused by mental illness.

The Review will consider:

- The efficacy and cost-effectiveness of programmes, services and treatments.
- Duplication in current services and programmes.
- The role of factors relevant to the experience of a contributing life, such as employment, accommodation and social connectedness (without evaluating programs except where they have mental health as their principal focus).
- The appropriateness, effectiveness and efficiency of existing reporting requirements and regulation of programmes and services.
- Funding priorities in mental health and gaps in services and programmes, in the context of the current fiscal circumstances facing governments.
- Existing and alternative approaches to supporting and funding mental health care.
- Mental health research, workforce development and training.
- Specific challenges for regional, rural and remote Australia.
- Specific challenges for Aboriginal and Torres Strait Islander people.
- Transparency and accountability for outcomes of investment.

Summary of recommendations

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 Plan* 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 eHealth 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—PMHNs) as the key regional architecture for equitable planning and purchasing of mental health programmes, services and integrated care pathways.

Rec 9. Bundle-up 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 Medical Homes 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 Health 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 existing and future allocations 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.

Executive summary

This Review

The four volumes of this report present the findings of the *National Review of Mental Health Programmes and Services*. The Review responds to the specific Terms of Reference provided by the Commonwealth Government early in 2014.

This first volume contains immediate recommendations and priorities for action over the next 1–2 years. It builds the platform for further changes which have been identified in the second volume as goals to be achieved over the longer term of 3–10 years.

In conducting this Review, the Commission's primary areas of focus have been the efficiency and effectiveness of Commonwealth services and programmes, as well as overall investment and spending patterns. The Commission did not evaluate specific clinical treatments and could not evaluate state and territory-funded programmes, services and systems.

The Review has been informed by the *Contributing Life Framework*—a whole-of-person, whole-of-life approach to mental health and wellbeing. Accordingly, we have undertaken a cross-portfolio assessment of the strengths and weaknesses of the mental health system as a whole.

Our approach recognises the interaction between mental health and personal characteristics (such as genetic make-up, age, family situation, cultural background, gender and sexuality) and social, economic and other life circumstances. These life factors include employment, housing and chronic physical illness, and related factors such as alcohol and substance use and past experiences of trauma or abuse.

While a whole-of-government perspective has informed our thinking, it was beyond the scope of this Review to make specific recommendations across all of these areas. Instead, our objective was to identify proposals for a whole-of-government system recalibration at the federal level that ultimately would improve the lives and opportunities of people who experience mental illness as well as their families and other support people.

Our findings

The Review's findings clearly show that Australia's patchwork of services, programmes and systems for supporting mental health are not maximising the best outcomes from either a social or economic perspective. Many people do not receive the support they need and governments get poor returns on their substantial investment. Total mental health spending by Commonwealth, state and territory governments is about $14 billion per year. This is without taking into account the hidden costs of mental illness as measured by lost productivity, both for those with a mental illness and those impacted by that illness, including families and other support people.

At a service level, we found there are many examples of wonderful innovation and that effective strategies do exist for keeping people and families on track to participate and contribute to the social and economic life of the community. The key feature of these strategies is that they take a person-centred, whole-of-life approach.

We found no real evidence that specific Commonwealth-funded services or programmes were not adding value or that they should be defunded due to lack of impact. However, it is notable that in a number of cases the information available to make this assessment was limited. In particular, there was a lack of state and territory information at the programme and regional

levels, and about nongovernment organisation (NGO) performance. Of data that was available, most focused on activity, rather than the achievement of outcomes.

Strikingly, however, it is plain that there is significant inefficiency and overall the system as a whole could not be judged as cost-effective.

We found some areas of duplication (for example, online and telephone supports), services where lack of flexibility means access is not necessarily matched to need (such as Better Access), and substantial gaps in services, especially in supporting at-risk populations and consistency of supports across different geographical areas.

Of critical concern is the dire status of the mental health and wellbeing of Aboriginal and Torres Strait Islander people. Indigenous people have significantly higher rates of mental distress, trauma, suicide and intentional self-harm, as well as exposure to risk factors such as stressful life events, family breakdown, discrimination, imprisonment, crime victimisation and alcohol and substance misuse. Service and system responses to these poor outcomes are inadequate, and have generally not been designed with the particular needs of Aboriginal and Torres Strait Islander people in mind.

Nationwide, resources are concentrated in expensive acute care services, and too little is directed towards supports that help to prevent and intervene early in mental illness. Of total Commonwealth spending of $9.6 billion, 87.5 per cent is in demand-driven programmes, including income support, and funding for acute care. This means that the strongest expenditure growth is in programmes that can be indicators of system failure—those that support people when they are ill or impaired—rather than in areas which prevent illness and will reap the biggest returns economically and 'future proof' people's ability to participate and live productive, contributing lives.

Problems experienced by people with mental illness often are dealt with in isolation, with structural, cultural and practice barriers to integrated, wraparound supports leading to system inefficiencies and poorer mental and physical health outcomes for individuals.

Red tape places undue burden on service providers—particularly in the community sector—which are required to manage multiple programmes and contracts with different data collection and reporting requirements, placing pressure on programme administration and diverting resources away from frontline service delivery.

The Review found inefficiency due to issues such as lack of economies of scale, and multiple organisations needing to provide back-office support services. But by far the biggest inefficiencies in the system come from doing the wrong things—from providing acute and crisis response services when prevention and early intervention services would have reduced the need for those expensive services, maintained people in the community with their families and enabled more people to participate in employment and education.

In fact, there is evidence that far too many people suffer worse mental and physical ill-health because of the treatment they receive, or are condemned to ongoing cycles of avoidable treatment and medications, including avoidable involuntary seclusion and restraint.

These challenges are compounded by a mental health workforce under pressure, with services experiencing shortages, high rates of turnover and challenges in recruiting appropriately skilled and experienced staff. Too frequently, the voices of people with lived experience, their families and support people are ignored, misheard and undervalued.

Our ability to identify key challenges and pursue emerging opportunities is limited by poor information design and management. Across the system, information about mental health services is incomplete, inconsistent and often inaccessible, including no nationally consistent approach to outcomes measurement, collection and use.

Our use of evidence is impeded by research priorities predominantly driven by investigators instead of the needs of people with mental illness, service providers and policy-makers. Findings are not consolidated or communicated, meaning examples of success often are not scaled-up or translated into practice.

The case for reform

Overall, the findings of this Review present a clear case for reform. The status quo provides a poor return on investment for taxpayers, creates high social and economic costs for the community, and inequitable and unacceptable results for people with lived experience, their families and support people.

The Commonwealth bears significant financial risk as a consequence of this imbalanced system. This Review identified that 60 per cent (approximately $5.7 billion annually) of Commonwealth expenditure on mental health is through the income support system, predominantly through the Disability Support Pension. The income support system also is the area of greatest growth in spending on mental health and currently is projected to remain so.

The largest health portfolio programmes are the Medicare Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS) and payments to the states and territories for hospital-related activity. Expenditure in all of these areas is essential to support the health and wellbeing of the population: however, the current balance is wrong and the Commonwealth is not necessarily accessing interventions which could be described as the “best buys” for the considerable amounts it is spending. Certainly the MBS and PBS in particular support treatment and secondary prevention responses to developed risk factors, while funding for hospitals and emergency departments provides responses to crises and acute illnesses. However, a “best buy” approach would shift the pendulum in Commonwealth expenditure towards primary prevention, early intervention and a continuous pathway to recovery.

Managing these costs effectively and sustainably requires a carefully designed programme of practical reforms that rebalance the system to reduce demand for services in the first place and improve the range and appropriateness of support options. This will deliver better mental health outcomes for individuals and promote economically and socially thriving communities.

Our recommendations

In this report, the Commission proposes new system architecture to **redesign, redirect, rebalance, repackage** and ultimately **reform** the approach to mental health in Australia.

Central to this is a person-centred approach where, through an integrated stepped care model, services are designed, funded and delivered to match the needs of individuals and particular population groups. This model includes the continuation of national programmes designed to support the wellbeing of the Australian population, with a particular focus on those most at risk, supported by pooled funding arrangements controlled at a regional level to respond to local need. This model will promote flexible, person-centred services for people with lived experience, their families and other support people, while at the same time achieving better value for money for governments.

Our report also is underpinned by the definition of roles and responsibilities of the Commonwealth in mental health, including through a new National Mental Health Agreement with the states and territories.

The Commission has adopted a principle that there should be no net reduction in overall investment in mental health. At the same time, the Commission is proposing that its recommendations be implemented within existing resources. There is a significant level of expenditure within mental health but it needs to be spent on the right things. So if, as we recommend, there needs to be more money spent on prevention, early intervention and community-based services, then those funds have to come out of somewhere else within the system. There needs to be a rebalancing, and our recommendations advise on how to do that.

Over the next two years, the Commission proposes a process of transformational change, guided by 25 recommendations across the following nine 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.

Over the next 10 years, the Commission proposes further reforms which build on the initial reforms to create a quality, high-performing mental health and suicide prevention system so that all Australians achieve the best possible mental health and wellbeing.

About this Review

Throughout this year, the aim of the Commission has been to fulfil the Terms of Reference set by the Government and in particular "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."

Specifically, we have not written a new National Mental Health Plan or Strategy for Australia. Rather, we have been asked to advise on whether Commonwealth programmes and services are being leveraged to maximise impact and achieve the greatest public value in enabling a contributing life for people experiencing mental ill-health.

The Review has been framed in the context of the fiscal constraints faced by all Australian governments. The Commission does not propose any overall reduction in current and forecast spending on mental health. Our recommendations propose redirecting existing resources rather than new funding, with resources to be used cost-effectively to leverage better outcomes.

The Commission has considered the Terms of Reference in the context of the ***Contributing Life*** framework: the right of all Australians to lead a full, contributing life, to flourish and to participate in their community. This includes population groups with a greater burden of mental ill-health and disadvantage and which, as a result, need specific attention: Aboriginal and Torres Strait Islander people; people living in rural and remote regions; those who are marginalised due to their sexuality, gender, cultural background or their job; people who have difficulties with alcohol or other drugs; and people living with an intellectual disability.

The Commission makes special mention of the very high burden of mental ill-health for Aboriginal and Torres Strait Islander people in relation to social and emotional wellbeing, access to culturally appropriate treatment when needed, and action to prevent suicides, suicide attempts and self-harm. The Commission considers that, within overall existing resources, where funds are freed up or saved from efficiencies in whole-of-government spending on mental health, the first priority for additional investment should be to improve the life opportunities and outcomes for Aboriginal and Torres Strait Islander people.

This Review comes at a time of significant review activity in the mental health sector. The *Fourth National Mental Health Plan* expired this year, with an expectation that there will be a fifth. Many states and territories are in the process of preparing or have recently released plans on mental health. Outside of government, organisations in the nongovernment and private sector have produced their own analyses. The Review also has been conducted within an environment where many other reviews across government will have a bearing on mental health, including the initiation of the *Federation White Paper* and the *McClure Review of the Welfare System*.

Our approach

This Review builds on the foundations of the extensive consultations and research done in the development of the Commission's two National Report Cards on Mental Health and Suicide Prevention (2012[1], 2013[2]). The Commission has considered data and information from Commonwealth agencies, states and territories, and the nongovernment and private sectors. It has carried out detailed research on a number of Terms of Reference, including the specific challenges for Aboriginal and Torres Strait Islander people and people living in rural and remote areas, sought and received submissions, consulted and undertaken extensive reviews of available evidence. Given the specialist role of the Department of Veterans' Affairs (DVA)

programmes, the Commission excluded these from the work of the Review. However, the Commission is of the view that in principle the directions proposed in this Report can be applied to DVA programmes and services.

The Commission has identified a significant quantity of good evidence to inform the Review. We also have encountered data gaps and inadequate and inappropriate data. Overall the Commission was underwhelmed at the level of programme evaluations available, given the significant investment of Commonwealth funds. Hence in critical areas, and for vulnerable populations, 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 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.

A fundamental principle emerging from this Review is that a culture of evaluation needs to be embedded as core to Commonwealth programme design, funded as a specific element of programme implementation. States and territories also need to be held accountable through public reporting of data and performance at both jurisdictional and regional levels.

Data quality has limited our capacity, but not our commitment to consider how we can shine a light on where efficiency and effectiveness of Commonwealth investment at the national level can bring real change and improvements for people at the personal level.

Our Report—Contributing lives, thriving communities

The Review's Final Report to Government is presented in four volumes.

- **Volume 1:** ***Strategic directions, practical solutions 1–2 years***

  This volume sets out high-level findings, our strategic directions, recommendations and practical actions for pursing transformational change **over the next two years**.

- **Volume 2:** ***Every service is a gateway: response to Terms of Reference***

  This volume presents findings against the Review's Terms of Reference, provides the evidence behind these findings and sets out a **10-year implementation agenda**.

- **Volume 3:** ***What people told us: analysis of submissions to the Review***

  This volume provides an overview of key findings received in the generous public response to the call for written submissions to the Review.

- **Volume 4:** ***Supporting papers***

  This volume is a collection of work undertaken throughout 2014 in support of the Review.

Overview of mental illness in our community

Rates and impacts of mental illness and suicide

Each year, it is estimated that more than 3.6 million people (aged 16 to 85 years) experience mental ill-health problems[3]—representing about 20 per cent of adults. In addition, almost 600,000 children and youth between the ages of four and 17 were affected by a clinically significant mental health problem.[4] Over a lifetime, nearly half of the Australian adult population will experience mental illness at some point—equating to nearly 7.3 million Australians aged 16 to 85.[3] Less than half will access treatment.[3]

There are an estimated 9,000 premature deaths each year among people with a severe mental illness.[5] The gap in life expectancy for people with psychosis compared to the general population is estimated to be between 14 and 23 years.[6]

In 2012 more than 2,500 people died by suicide,[7] while in 2007 an estimated 65,000 Australians attempted to end their own life.[3] Suicide is the leading cause of death among people aged between 15 and 44 years old,[7] and is more likely among men, Aboriginal and Torres Strait Islander people and people living outside of major cities[8] (see further in Volume 2).

Our work has identified that many people with mental ill-health face compounding disadvantage—particularly Aboriginal and Torres Strait Islander people, people living in rural and remote regions, those who are marginalised due to their sexuality, gender, cultural background or their job, people who have difficulties with alcohol or other drugs, people living with an intellectual disability and people who experienced childhood trauma.

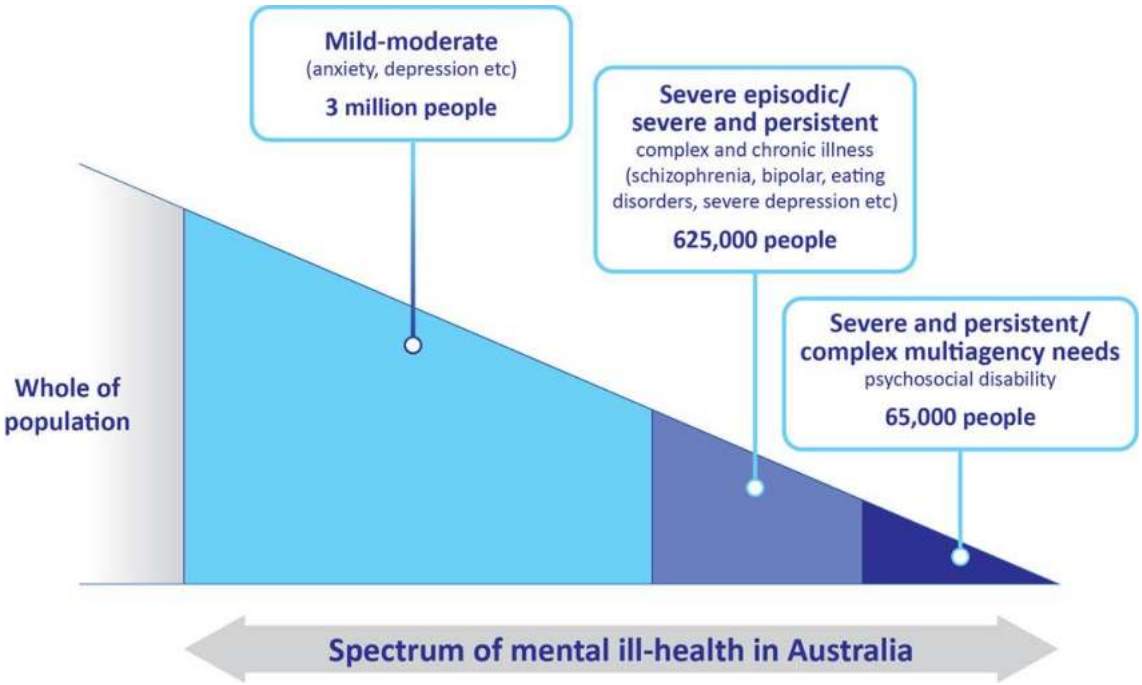
The mental health needs of Aboriginal and Torres Strait Islander people are significantly higher than those of other Australians. In 2011–12 nearly one-third (30 per cent) of Aboriginal and Torres Strait Islander adults (aged 18 years and older) had *high* or *very high* levels of psychological distress, almost three times (2.7) the rate for other Australians.[9] Nationally, there were 22.4 suicides per 100,000 Aboriginal and Torres Strait Islander people during 2012, more than double the rate of 11.0 for other Australians.[7] Aboriginal and Torres Strait Islander people aged 15 years and older report stressful events at 1.4 times the rate of non-Indigenous people.[9]

The concept of 'mental health' for Aboriginal and Torres Strait Islander people is tied inextricably to the concept of *social and emotional wellbeing* (SEWB). This is a broader perception than *mental health.* It places holistic wellbeing within the person's experience of their family, culture and history:

> 'The concept of mental health comes more from an illness or clinical perspective and its focus is more on the individual and their level of functioning in their environment. The social and emotional wellbeing concept is broader than this and recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual. Social and emotional wellbeing problems cover a broad range of problems that can result from unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination and social disadvantage.'[10]

It is important to recognise that the experience of mental ill-health ranges across a wide spectrum, as illustrated in Figure 1. The most common mental illnesses are depression, anxiety or a substance misuse. Less prevalent are chronic and complex conditions, such as severe depression, schizophrenia, bipolar disorder and eating disorders, as well as severe and persistent psychosocial disability, including those with complex multi-agency needs.

Figure 1 Annual distribution of mental ill-health in Australia



Those with severe mental illness can be classified broadly within three further groups, with overall numbers of people being about 690,000 (3.1 per cent of the population):

- **Subgroup 1—Severe episodic**—individuals who have discrete episodes, interspersed with periods of remission (about two-thirds of the overall severe population).
- **Subgroup 2—Severe and persistent illness**—individuals with chronic mental illness that causes major limitations on functioning (i.e. very disabling) and is chronic without remission over long periods. This group represents about one-third of the overall severe population.
- **Subgroup 3—Severe and persistent illness with complex multiagency needs**—this group represents those with the greatest disability among the severe population and who require significant clinical care (including hospitalisation), along with support to manage most of the day-to-day living roles (e.g., housing support, personal support worker domiciliary visits, day program attendance). This group is relatively small (approximately 0.4 per cent of the adult population or 65,000 people) and is likely to be the focus of NDIS Tier 3 individual support packages.

Many people with experience of mental illness do not seek support for their condition, with rates of help-seeking and treatment much lower than prevalence in the community. Latest statistics suggest about 46 per cent of people with a mental ill-health problem seek help each year.[11]

People with mental illness experience poorer outcomes across a range of domains.

- People with a psychotic illness have diabetes at a rate three times that of the general community, and half have metabolic syndrome as a side-effect of their prescribed antipsychotic medications, increasing their risk of cardiovascular disease and diabetes.[12]
- Of people experiencing mental illness, 20 per cent use alcohol excessively or have a drug addiction.[13]

For social and economic outcomes for people with mental illness:[12, 14]

- 37.6 per cent (or 67.3 per cent with severe mental illness) are unemployed or not in the labour force, compared to 22.3 per cent of people without mental health conditions.
- 38.1 per cent are in full-time employment compared to 55.3 per cent of people without mental health difficulties.
- 31.5 per cent of people living with psychosis complete high school, compared to 53.0 per cent in the general community.
- 20.9 per cent are in households in the lowest income bracket, compared to 15.6 per cent of people with no mental illness.
- 26 per cent of people with a mental illness have government pensions and allowances as their main income, increasing to 85 per cent of people living with a psychotic illness, compared to 21.6 per cent for people without mental illness.

Mental health outcomes are even worse for Aboriginal and Torres Strait Islander people, who:

- use mental health disability services at double the rate of non-Indigenous Australians[15]
- have suicide rates twice as high as non-Indigenous people.[7]

These disparities are compounded by socio-economic and regional factors (as outlined in Volume 2). For example, for people living in outer regional or remote Australia in 2007 and who had a mental health condition, 23 per cent had arthritis, 19.3 per cent had asthma and 6.5 per cent had diabetes[14]—rates that are potentially higher than people with mental illness living in cities or inner regional areas.

Poorer outcomes for people with mental illness also are reflected in the justice system.

- Of the 29,000 people in prisons in Australia in 2012,[16] it is estimated that 38 per cent had a history of mental illness—a rate almost twice that seen in the general population.
- In New South Wales, the annual number of police incidents involving people with a mental health problem increased by 25 per cent, from around 22,000 in 2007–08 to around 30,000 in 2011–12.[17]
- Across Australia over the 11 years from 1989–90 to 2010–11, 42 per cent of people shot by police had a mental illness.[18]

Across the nation there were:

- 1,514 state and territory specialised mental health care facilities in 2011–12[19]
- 31.1 million prescriptions for mental health-related medications dispensed, of which 23.7 million were PBS-subsidised prescriptions in 2012–13[20]
- 1.96 million Australians (9.2 per cent of the population) who received public and private mental health services in 2011–12.[21]

Commonwealth expenditure

The Review identified 140 programmes from 16 Commonwealth agencies that have been funded at some stage in the past five years. Of these programmes, 53 had associated Commonwealth expenditures in 2012–13, whereas the remaining 87 were unfunded.

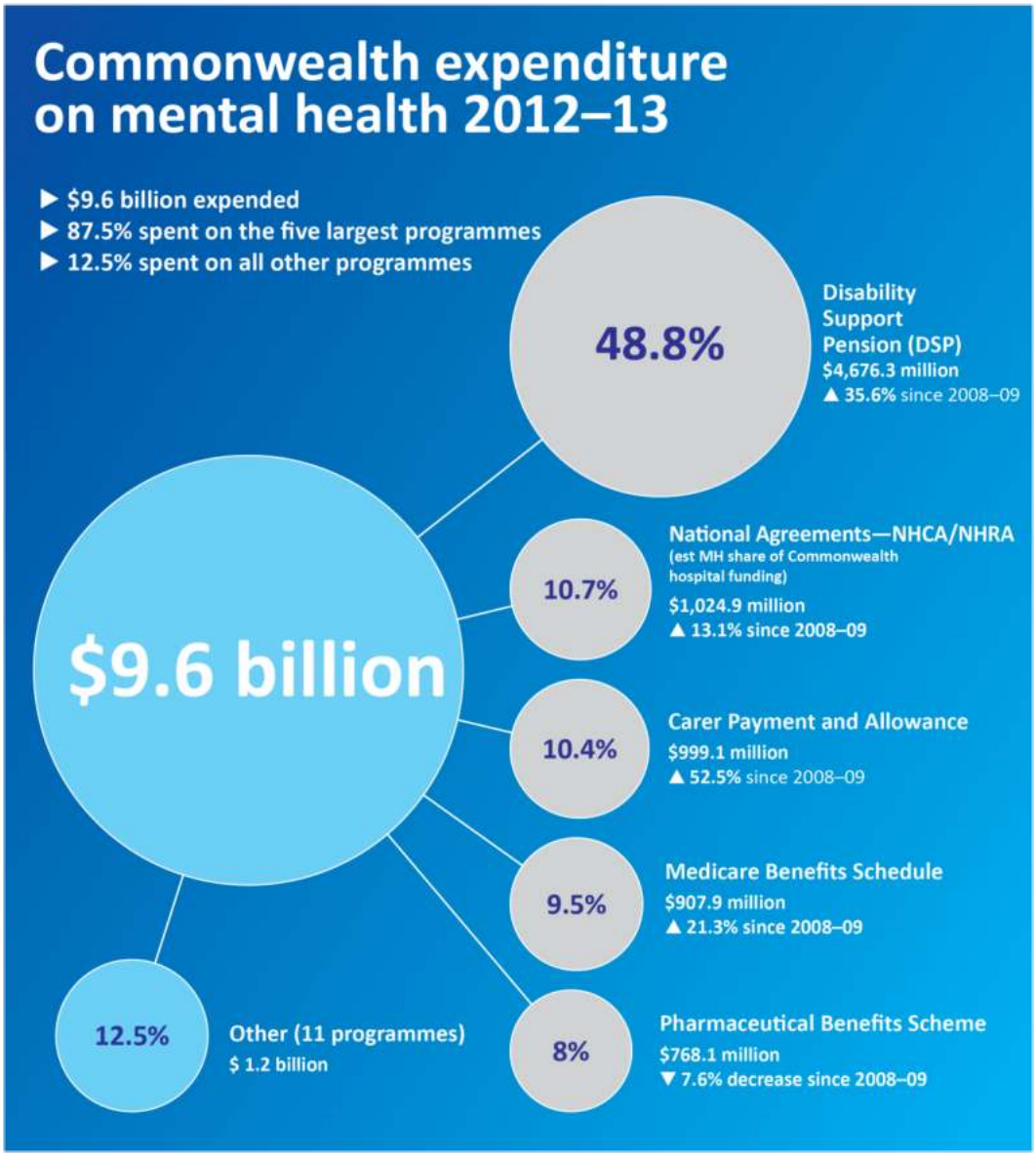
Based on information requested and received by the Commission from 16 Commonwealth agencies, in 2012–13 these 16 agencies spent almost $10 billion on mental health and suicide prevention programmes.

As illustrated in Figure 2, in 2012–13, the 16 agencies spent:

1. $8.4 billion (87.5 per cent) on **benefits and activity-related payments** in five programme areas:
   - Disability Support Pension (DSP) $4,700m
   - National Health Reform Agreement (Activity Based Funding—ABF) $1,000m
   - Carer Payment and Allowance (CP) $1,000m
   - Medicare Benefits Schedule (MBS) $900m
   - Pharmaceutical Benefits Scheme (PBS) $800m
2. $533.8 million (5.6 per cent) through **programmes and services with Commonwealth agencies and payments to states and territories:**
   - DVA and Defence programmes ($192.3m)
   - Private Health Insurance Rebate for mental health-related costs ($105.0m)
   - Payments to states and territories for specific programmes (perinatal depression, suicide prevention, National Partnership Agreement Supporting Mental Health Reform) ($169.0m)
   - National Health and Medical Research Council (NHMRC) research funding ($67.1m).
3. $606 million allocated by the Department of Health (DoH), the Department of Social Services (DSS) and the Department of the Prime Minister and Cabinet (PM&C) on **programmes delivered by NGOs**.
   - DoH spent $362 million on 55 grant programmes, including payments to 213 NGOs, representing 11 per cent of total mental health-related expenditure from this department.
   - DSS spent $180 million on six grant programmes, including payments to 196 NGOs, representing three per cent of total mental health-related expenditure from this department.
   - PM&C spent $64 million on three grant programmes, including payments to 133 NGOs (the proportion of total mental health-related expenditure that this represented was not available).

In 2012–13 these three departments ran 64 programmes with total funding of $606 million allocated to 542 organisations. These grants ranged from the highest of $69.4 million (headspace) and $29.5 million (beyondblue) down to numerous much smaller amounts below $1.0 million.

Figure 2 Commonwealth expenditure on mental health



These figures show that 87.5 per cent of Commonwealth funding on mental health is through five major programmes. That equates to $7 out of every $8 spent by the Commonwealth on mental health.

Four of these are demand-driven programmes providing benefits to individuals. The fifth major area of expenditure is an estimated $1 billion per year provided to the states and territories under the 2011 National Health Reform Agreement (NHRA) for treatment of patients with a mental health issue in the public hospital system, including an estimated $280 million for patients in stand-alone psychiatric institutions.

Commonwealth funding to public hospital mental health services was estimated by identifying the agreed proportion of block funding for mental health services under the NHRA in 2012–13, and applying this proportion retrospectively to funding under the National Health Agreement for 2008–09 to 2011–12. This deemed Commonwealth funding was split further into acute inpatient care and non-admitted (specialised ambulatory clinical services) components, based on information provided by states and territories through the National Minimum Data Set on Mental Health Establishments.

The Review identified Commonwealth mental health spending specifically targeted to Aboriginal and Torres Strait Islander people of $123.1 million in 2012–13. This spending is mainly through the Social and Emotional Well-Being Programme delivered by Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services) and the Access to Allied Psychological Services (ATAPS) programme. In addition to these dedicated programmes, Aboriginal and Torres Strait Islander people access general population mental health services and programmes, although in what proportions—and leading to what outcomes—is largely unknown.

Other costs

The states and territories spend an estimated $4.5 billion on mental health programmes, services and supports.[22] This expenditure is predominantly in hospitals and specialised community mental health services. It includes around $300 million for NGOs.[22]

Other areas of direct expenditure on mental health are through individuals' out-of-pocket expenses and other private contributions, such as through Medicare co-payments, private health insurance and purchase of fee-for-service supports.

There also is significant indirect expenditure associated with mental health, such as through employment services, NewStart payments and supports through state and territory-run education, justice and family services systems.

Economic and social costs to Australia

The economic cost of mental ill-health to Australia is enormous. Estimates range up to $28.6 billion a year in direct and indirect costs,[23] with lost productivity and job turnover costing a further $12 billion a year[24]—collectively $40 billion a year or more than two per cent of GDP. 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).[25] In Australia, this would equate to more than $60 billion, or about $4,000 a year for each person who lodges a tax return. The OECD states:

> "The costs of mental ill-health for the individuals concerned, employers and society at large are enormous (…). Most of these costs do not occur within the health sector. Mental illness is responsible for a very significant loss of potential labour supply, high rates of unemployment, and a high incidence of sickness absence and reduced productivity at work. In particular, mental illness causes too many young people to leave the labour market, or never really enter it, through early moves onto disability benefit. Today, between one-third and one-half of all new disability benefit claims are for reasons of mental ill-health, and among young adults that proportion goes up to over 70 per cent."[26]

The World Economic Forum (WEF) predicts that mental illness costs will more than double by 2030 and this dwarfs the cost of any other non-communicable disease (NCD).[27] In a study on The Global Burden of Non-communicable Diseases—cardiovascular disease (CVD), cancer, chronic respiratory diseases, diabetes and mental illness—the WEF noted that, in addition, there would be "a huge global loss in output", with mental health conditions having the greatest impact on productivity, followed by CVD: combined, mental health and CVD will account for almost 70 per cent of lost output.

"Two points are key here:

- First, in economic terms, NCDs matter significantly. At the national level, treatment expenses can be high and the loss of labour due to chronic disease can make a substantial dent in a country's productive capacity. Ongoing improvements in economic wellbeing can be seriously impeded by widespread chronic disease.
- Second, the human and economic burdens of NCDs can both be contained by devoting resources directly or indirectly to prevention, screening, treatment and care. In other words, health spending is not predominantly consumption. A large portion of health spending is appropriately viewed as investment—one that yields a handsome rate of return."

"The key premise of this report is that expressing the burden of NCDs in dollar terms—not just human terms—gives economic leaders the ability to consider the effects of NCDs in terms that they most often use. And the evidence is clear: NCDs impose a substantial economic burden today, which will evolve into a staggering economic burden over the next two decades."

"A final thought: Economic policy-makers are naturally concerned about economic growth. The evidence presented in this report indicates that it would be illogical and irresponsible to care about economic growth and simultaneously ignore NCDs. Interventions in this area will undeniably be costly. But inaction is likely to be far more costly."[27]

Mental illnesses are the leading cause of the non-fatal disease burden, and account for about 13 per cent of Australia's total burden of disease (645,300 of 4,987,400 Disability Adjusted Life Years—DALYs). This means that of the non-fatal disease burden (i.e. years of healthy life lost through illness and disease) in Australia, 24 per cent were lost through the effects of mental illness. Anxiety and depression, alcohol abuse and personality disorders accounted for almost three-quarters of this burden.[28]

Finally, there are significant and often unquantifiable personal costs associated with mental illness for individuals and their families and other support people. For Aboriginal and Torres Strait Islander people, there is evidence to suggest that mental ill-health is contributing to the unacceptably high rates of incarceration, unemployment, unsafe communities, school truancy and the continuation of deep and entrenched poverty in some communities. This also applies to other people who are socio-economically disadvantaged.

The significance of these direct and indirect costs means that mental ill-health impacts not only the individual, their families and other support people, but also the standard of living of every Australian and our communities more broadly.

Financial risk

The Commonwealth's role in mental health creates significant exposure to financial risk. As a major downstream funder of benefits and income support, any failure or gaps in upstream services means that as people become more unwell, they consume more of the types of income supports and benefits which are funded by the Commonwealth.

Those risks also fall back on state and territory crisis teams, emergency departments (EDs) and acute hospital services—so it is in the best interests of the Commonwealth and the states and territories to work together to both achieve the best outcomes for individuals and communities and minimise costs to taxpayers.

Ironically, much risk comes from within governments—portfolios working in isolation of each other, aiming to minimise their exposure and their costs without taking into account the downstream costs to their fellow agencies and the overall costs to their government.

For example, many of the services required to keep people well and participating in their homes and the community lie outside the formal health system. This includes areas such as accommodation, education, employment and family and community services. Yet a breakdown in housing or relationships for an individual can pitch them into crisis, resulting in ED presentations and extended periods of hospitalisation and acute care. This means that agencies within governments, as well as agencies across governments, need to work together, collaborate and coordinate to manage overall costs and risks.

The Commonwealth's five major programmes are focused on funding activity and include outlays in areas which, in many ways, can indicate system failure. Very importantly, as they involve payments of pensions and health-related benefits, these largely are areas which constitutionally are Commonwealth responsibilities (*Australian Constitution, s51*). The one exception is the payment to the states and territories for hospital care.

If future growth in costs is to be managed, the key focus has to be on these programmes.

Placing further restrictions on access to these programmes may produce short-term savings but is likely to result in more severe needs in the longer term, and thus exacerbate the need for more complex support, rather than decrease system-wide demands. Once again, a significant element of this demand will fall back on Commonwealth-funded programmes such as the DSP, carers' payments, MBS and PBS, as well as on the acute system.

The risk management strategy which is most likely to be effective in relation to all these programmes is to stop people needing access to them in the first place. Spending a higher proportion of funds from within existing resources on keeping people well and in the community by focusing on prevention, early intervention and recovery can help tackle both the growth in costs and overall expenditure.

Overview of findings

Efficiency

This Review identified a number of issues that suggest the mental health system is not operating efficiently. Current funding and structural incentives drive efficiency for some programmes but not others. Allocative efficiency—which refers to the mix and distribution of services across areas of need—is not supported across the system as a whole. Further, the dynamic efficiency of the system, which refers to flexibility and responsiveness to changing demands, is poor. As a result, current arrangements are driving the wrong behaviours and the best positive outcomes are not being achieved.

> "There is nothing more efficient or effective than something that changes a person's life".
>
> ***Janet Meagher AM, former National Mental Health Commissioner***

However, our findings around efficiency are limited by the absence of consistent measurement of mental health outcomes associated with specific programmes. There is nothing efficient about funding activity-based programmes when there is no way of measuring the impact of those programmes, including for vulnerable groups like Aboriginal and Torres Strait Islander people. Without outcomes information, there is no way of truly knowing whether we are maximising the return on our investments and whether our efforts are directed in the right places and delivering the desired objectives.

Improving the efficiency of the mental health system is critical. Like other OECD countries, Australia is facing a fiscal environment where it is increasingly difficult to maintain the levels of growth in health expenditure experienced over the past 20 years. In order to reduce future growth in health costs, emphasis needs to be given to whole-of-system solutions that allow integration of care focused upon strengthening primary health care and reducing expensive admissions to hospital.

This reflects the reality that population demand for health services is increasingly moving from a transaction-based system focused on single diseases and acute care, to one focusing upon individuals living with chronic conditions for a significant proportion of their lives.

Given its system of multiple jurisdictions and multiple funding streams, Australia faces significant barriers to achieving such a reduction in expenditure. Fiscal tightening gives strong incentives for all jurisdictions to work together on initiatives that redirect resources away from income support and acute care for those with complex chronic conditions and into programmes which keep people out of hospital, reduce complexities caused by their illnesses and circumstances, and support them to live fulfilling lives in the community.

System-wide efficiency

At a system level, we found that the greatest source of waste is not inefficient operation of organisations or payment systems, but rather is in funding and doing the wrong things. That means that if there were a stronger system of care and support to prevent illness and keep people well and participating in the community, there would be far less expenditure on the medical and hospital system.

The evidence collected and economic analysis carried out as part of the Review shows that intervening early, and providing the right interventions at the right time, can save enormous costs throughout a person's lifetime.

The Independent Hospital Pricing Authority found that in 2011–12 there were 108,235 hospital separations for mental diseases and disorders, with a total cost of $1.1 billion and average cost of $10,248. This is double the average cost of a general admission at $4,812. The average $10,000 spent on one person's hospitalisation of nine days could enable a community mental health service to provide support to a person for a full year.

For example, for people with complex needs, such as a person with severe bipolar disorder, optimal care (based upon greater GP contact, increased support from community mental health teams and continued access to care coordination and psychosocial supports) can yield savings over nine years of $323,000, with about half of that saving being directly to the states through reduced acute care costs (admissions) (noting previous advice about Commonwealth financial contributions to acute care) and about one-third to the Commonwealth. Much of that saving occurs in years one to three, although health savings also occur in the later years as health status improves.[29] Up to two per cent of people will develop bipolar disorder at some time in their lives.[30] While it is not possible to extrapolate this model to all Australians with bipolar disorder, it gives an example of the types of efficiencies which can be made by ensuring the right intervention at the right time.

This inefficiency is particularly noticeable in relation to Aboriginal and Torres Strait Islander people, where per capita hospital expenditures are higher than for other Australians, including spending rates of:

- 2.68 to 1 for all mental health and behavioural disorder hospital separations ($336 per capita Aboriginal and Torres Strait Islander people; $125 per capita non-Indigenous)
- 1.65 to 1 for anxiety and depression hospital separations ($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).[31]

At present our programmes and services across sectors are not set up to promote early intervention. For example, sometimes people need to inflict serious physical harm to gain access to support; even then, sometimes that care and support is not made available.

The idea of late intervention in physical health conditions (such as cancer, heart disease, COPD) is plainly unacceptable, with obvious costs and unnecessary harm to individuals. However, in mental illness, late intervention is too often the norm. This is due to two factors:

- low rates of help-seeking and treatment for mental illness, including delaying or avoiding treatment due to stigma, stress and other related factors, as well as anosognosia or lack of awareness of illness
- low prioritisation of mental illness within the system as compared to physical illness.

These are symptoms of a crisis-driven system. Critically, this system is trapped in a vicious cycle of underinvestment in effective services, leading to higher demands on more expensive and reactive modes of care and demand-driven safety net programmes.

Efficiency of programmes and services

As noted above, our findings around efficiency at a programme level are constrained by the information that was available to the Review.

Within this constraint we found that overall, the larger demand-driven programmes supporting mental health—namely income support, the MBS and PBS—generally are efficient. They are tightly targeted and supported by efficiencies of scale, systems and infrastructure. These programmes feature allocative inefficiencies, such as inadequate access to MBS benefits as a result of poorly distributed workforces in rural and remote areas. There also are dynamic inefficiencies: to change eligibility criteria and programme guidelines requires lengthy formal processes which limit the ability to respond to changing needs in the community, or on an individual basis.

These larger programmes generally provide payment for activity—payment of pensions, providing prescriptions, or particular types of GP consultations—rather than the achievement of outcomes. This means that it is unclear whether the investment is delivering the desired mental health objectives overall.

As an example, the use of antipsychotics has more than doubled since 1990, even though the prevalence of psychosis has not changed.[32]

In addition, in 2011 Australia ranked second-highest in an OECD comparison of antidepressants consumption, behind only Iceland[33] (see Figure 3). 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.[34]

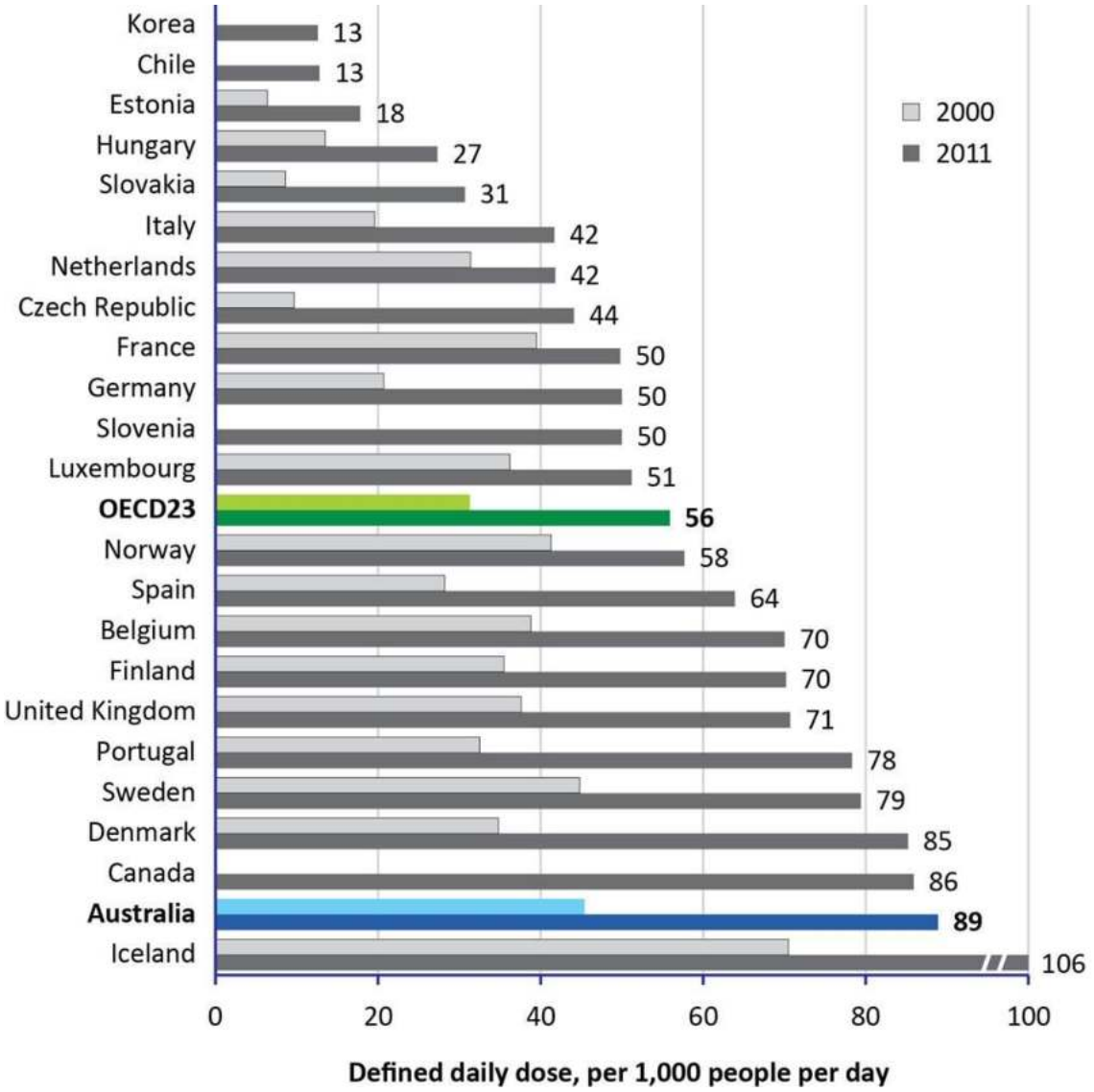
This does not necessarily present a negative picture: it instead might reflect better access to mental health services compared to other countries. But in order to know whether that is the case, we would need much better information on outcomes of people who use these psychological medications, as well as on the efficacy of alternative treatments and opportunity costs.

Many smaller mental health programmes originally were designed to address identified service gaps. However, they have not always been framed within an overarching strategy and the end result is a collection of often siloed programmes that are relatively costly for both government and providers to administer, increase red tape for providers and cause confusion and complexity for people with lived experience, their families and support people.

Overall, this Review identified that services and programmes:

- often are not well linked or integrated
- are administered by separate Commonwealth departments
- are delivered through short-term funding arrangements, which limits operational certainty, workforce stability and continuity of service delivery
- do not explicitly enable service coordination and integration
- often target similar population groups and/or provide similar types of supports
- lack outcome-based evaluation data and accountability mechanisms
- do not appear to be planned for or designed with integrated whole-of-government, whole-of-life outcomes objectives in mind.

Figure 3 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 1,000 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 1,000 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).

Effectiveness

Effectiveness refers to whether the intended outcomes of programmes, services and treatments are being achieved. There are two important elements of assessing effectiveness—first, identifying the outcomes being pursued, and second, the availability of information against which to measure whether those outcomes have been achieved.

We found that effective strategies do exist for keeping people and families on track to participate and contribute to the social and economic life of the community. The key feature of these strategies is that they take a person-centred, whole-of-life approach. Our findings against specific services and programmes are outlined in detail in Volume 2.

Overall, we found no real evidence that specific Commonwealth-funded services or programmes were not adding value or that they should be defunded due to lack of impact.

However, our ability to make specific findings about the full suite of Commonwealth-funded mental health programmes was limited by the information available to make this assessment.

This has particularly hindered the Review's capacity to identify expenditure on vulnerable groups, including Aboriginal and Torres Strait Islander people. Mainstream primary mental health care is an important source of services for this group. However, little is known about Aboriginal and Torres Strait Islander people using the system (including MBS and PBS use, and general population suicide prevention services) and whether it is effective for them.

Data was not always readily accessible, consistent or comparable, and most funding arrangements we considered did not require the consistent measurement, collection and reporting of mental health outcomes.

The Commonwealth's major programmes reward volume of activity and funding of one-off patient interactions, with no accountability for effective achievement of outcomes.

- The MBS underwrites the volume of people seen by GPs, specialists, private nurse practitioners and some allied health professionals.
- The PBS subsidises the cost of listed drugs delivered on an individual basis when people with complex comorbidities often require a multitude of (potentially contraindicated) drugs.
- Activity-Based Funding (ABF) for hospital services, used under the NHRA, rewards hospitals for the volume of people treated on a cost-weighted basis. (This approach will apply until the end of 2017, when the Commonwealth contribution to the states and territories will be linked to movements in the consumer price index (CPI) and population growth).

An activity-based approach to mental health services works well in some respects. Paying on a through-put basis may be appropriate, particularly when dealing with episodic illnesses or elective surgery. However, in general, the current system is oriented to support the 'undifferentiated' patient, providing siloed funding that fails to account for vastly different needs of people on the basis of risk, symptoms or diagnoses, different client needs due to levels of functional impairment or the need for culturally appropriate and competent services delivery.

While a move to outcomes reporting and performance assessment should be pursued vigorously, there are issues in measuring effectiveness, especially system-wide impacts. Further, the information infrastructure to do so is relatively under-developed, particularly in comparison to the formal health system, where improvements in physical health and functioning can be identified and counted more easily.

We identified that the effectiveness of some programmes (such as the Mental Health Nurse Incentive Programme or MHNIP) is limited by regulatory barriers, while programme requirements often are rigid and inflexible, potentially stymying innovation and integrated multi-disciplinary support by limiting fundholding arrangements. For example, headspace cannot access the MHNIP to employ mental health nurses. Similarly, Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services) cannot hold Access to Allied Psychological Services (ATAPS) funding even though one of the target populations under the programme is Aboriginal and Torres Strait Islander people. These types of access barriers decrease timely and appropriate support, including through community-based services.

At a system level, we found that effectiveness of services and programmes is impacted negatively by poor policy design, which in turn contributes to poor implementation and outcomes, often despite the best intentions of experienced and dedicated people on the ground. Policy and programme design is not guided by a consistent and consolidated framework, with decisions not coordinated across government.

Significant structural barriers exist which act as a disincentive for government agencies to work together and to come up with co-designed and shared solutions. For example, insecure housing for a person with severe mental illness is a risk factor that can pitch them into crisis, and lead to ED presentations or extended periods of hospitalisation and acute care. The logic would be for an agency responsible for housing to work with the mental health system in the design and delivery of programmes which keep people housed, supported and stable within the community, and thereby reduce pressure on the acute system. However, under existing government arrangements this would come at a cost to the housing agency, because the savings to the health system either would be seen as fortuitous or would be used to meet demand from more patients.

A much stronger focus on co-design of programmes, and of measuring and sharing efficiencies, is needed across and between governments.

Duplication

The largest areas of duplication between the Commonwealth and the states and territories appear where there is a lack of clarity of roles and responsibilities: community mental health services and non-clinical community support services, where too often both levels of government make decisions about programmes and services without proper engagement, planning and co-design of services.

A large part of this problem comes about because the Commonwealth does not have a clear strategic framework across the range of its investments, nor does it have such a clear framework with the states and territories. Expenditure is not guided by a clear relationship to system outcomes, and coordination and balance of investment across sectors is limited.

As a result, opportunities for rationalisation or alignment of smaller programmes into a cohesive approach are lost, as are the opportunities to consolidate outcomes for people. Duplication is not only a measure of waste, but of opportunity foregone to drive improvements and productivity across the system.

This is compounded by siloed and duplicative governance, eligibility and reporting structures which perpetuate separate service systems and reduce the capacity for whole-of-system planning. People often are left to navigate a complex and fragmented service system on their own, without a clear pathway through that system.

Commonwealth mental health programmes are not linked to each other or to state and territory mental health service systems. In particular, the increase in programme funding resulting from and since the *COAG National Action Plan on Mental Health 2006–2011* has had limited success in driving practical solutions which link effective recovery-based community support with treatment and broader support for people who need it most. The new funding has not created pathways to support people to access the coordinated care they need. More detailed information about specific programmes is available in Volume 2 of this report.

We 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 also is anecdotal evidence of duplication in activity between some Commonwealth and state government programmes (for example, in suicide prevention), and lack of links between housing, disability support and health in provision of services. This has resulted in sub-optimal use and distribution of available resources.

Gaps

There are substantial gaps in the mental health service landscape. Access to a system of continuing care is patchy, with gaps in both step-up and step-down services to match the full spectrum of need in our community. Other gaps identified in this Review include a lack of focus on mental health in alcohol and other drugs services, the justice system, workplace supports, technologies and stepped care options.

The Commission received considerable feedback about the emerging and growing "missing middle" in mental health. While the Commonwealth has parachuted various siloed programmes into the mental health system, the states and territories have been pulling back their community-based mental health services, resulting in a growing gap between what GPs do and what services are provided in hospitals. The "missing middle" is causing enormous system failure, with people falling through the gap between GPs and primary health care on the one hand, and emergency departments and hospitals on the other hand.

The Commission also heard on many occasions that, due to the withdrawal of state services from specialised community mental health services, people in many areas now need to be in crisis or subject to a community treatment order to gain access to assistance. Many state services also have moved away from being direct service providers and instead have taken on case management roles, meaning that the clients they used to treat now are referred to Commonwealth-funded programmes such as Better Access, ATAPS and headspace. These programmes were not designed to support people with severe mental health problems.

There are gaps in the availability of services at different times (especially over weekends when private practitioners often are not available) and locations. A particular finding of the Review is around the substantial inequities in geographic accessibility of mental health services and supports.

There are significant gaps in programme evaluation and monitoring processes. Many contracts and funded programmes that draw significantly on Commonwealth resources do not require the routine collection and reporting of outcomes data. For example, $411.7 million over five years from 2013–14 has been committed to the national programme, headspace, 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. The second evaluation is under way and will report in early 2015. It should be emphasised this is not unique to the headspace programme: in fact, it is all too common. This means government has very little surety that scarce public dollars are being spent in the most efficient and effective way.

The level of investment for particular population groups when compared to risk and need appears to be highly variable. For example, while there has been significant and vital investment in adolescent mental health through headspace (and significant further investment planned through the headspace Youth Early Psychosis Programme or hYEPP), there has not been a corresponding investment for children, even though there is overwhelming evidence about the lifetime benefits of investing in the birth to 12 year-old age group.

Many issues which go on to develop into mental health problems in adolescence can be identified, prevented and managed if picked up earlier in childhood. The proposed health check for three-year-old children is one element of such an approach but needs to be considered as part of a broader strategy. Likewise, the investment for adults with severe and persistent conditions is wrongly aligned to acute and crisis services, rather than to community support. Australia also seems poorly prepared to deal with issues of ageing and mental health, and in particular how to support elderly people to remain mentally healthy and participating in the community.

There also are gaps in the provision of specialised supports or programmes for other at-risk population groups, including Aboriginal and Torres Strait Islander people, people in rural and remote areas, people who identify as lesbian, gay, bisexual, transgender or intersex, and people who endure discrimination or are marginalised and suffer poor mental health as a result. This includes people from culturally and linguistically diverse (CALD) communities as well as people who have particular mental health needs, such as people with intellectual disability, people with childhood experience of trauma or people caught in the criminal justice system. These gaps were highlighted in submissions to the Review.

For Aboriginal and Torres Strait Islander people, these service and programme gaps can be summarised as:

- a significant gap in community-based social and emotional wellbeing promotion, prevention activity and primary mental health care enabling the prevention, early detection and treatment of mental health problems at an early stage
- culturally competent general population mental health services
- ensuring patient transitions from family and community to primary and specialist mental health care, and then back into the community
- a lack of Aboriginal and Torres Strait Islander specialist care to support transitions and ensure culturally appropriate services that accommodate cultural difference—for example, by supporting access to traditional healers, or working with families.

There are serious concerns about the potential gaps which might grow under the NDIS. While those who are eligible for the top tier (Tier 3) in the system are expected to be provided with better, wrap-around supports (in non-clinical areas), people currently supported by mental health services may be left significantly worse off if they are not assessed as having a 'permanent disability' and therefore do not qualify for Tier 3. There needs to be a significant Tier 2 package in place to ensure people are supported and do not end up falling back on the mental health system. There also are related issues about support for carers of people who are eligible for the NDIS.

The unanswered questions about mental health and the NDIS cannot wait until the scheme is implemented. Re-engineering to fix the problems will be too difficult and ineffective, and for too long, people with a mental illness have borne the brunt of patch-up jobs. At a minimum, support for people who currently access existing programmes must be maintained until this issue is resolved.

Red tape, transparency and accountability

For people with lived experience, their families and support people, red tape has a real impact on their lives, as they often have to tell their story over and over to the various different providers of services they receive. One mechanism to assist with this is the Personally Controlled Electronic Health Record (PCEHR). The PCEHR will be able to include summaries of

health system-related services such as medical and psychological assessments, mental health plans, treatment and counselling services, as well as specialist and hospital-related services, diagnostic information and medications. At a later stage, inclusion of the broader array of psychosocial supports that enable people with a severe mental illness to lead a contributing life should be considered.

We found that red tape is placing an undue burden upon service delivery organisations. Many receive funding through multiple programmes, leading to complex and time-consuming administrative functions being carried out, to both run the business and to meet contract requirements. Commonwealth contracts and reporting requirements drive inefficiencies, with organisations reporting through multiple and misaligned frameworks, geographical boundaries, timeframes and processes. These complex arrangements are placing pressure on programme administration and diverting efforts away from frontline service delivery for people and families in need.

These arrangements place particular burdens on NGOs, including those that provide mental health and other types of social services, as well as Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services). While Commonwealth funding through programmes delivered by NGOs comprises less than 10 per cent of total mental health expenditure, addressing the complexity and uncertainty of these arrangements will be critical if 'upstream' funding is to be increased and administered efficiently in future.

There is a need to strike the right balance between public reporting to ensure accountability for outcomes and the use of taxpayers' resources, and the resources organisations can reasonably dedicate to this reporting. Data that is provided should be reported once and used often—but too much data currently provided is not used strategically or to inform future policy decisions.

In this report we recommend reporting against targets at national, state and regional levels. At the same time there needs to be a reduction in red tape and unnecessary reporting. Hence accountability against a consistent set of targets should replace other reporting requirements—it should not be additional. In this way we can achieve a net reduction in red tape and regulation, while reporting on the things that really matter—outcomes and results.

Specific challenges for Aboriginal and Torres Strait Islander peoples' mental health

The Terms of Reference asked the Commission to consider the specific challenges for Aboriginal and Torres Strait Islander peoples' mental health.

As outlined in further detail in Volume 2, the evidence on the mental health and wellbeing of Aboriginal and Torres Strait Islander people is confronting. That there are significantly worse outcomes than other Australians across key indicators is perhaps the clearest evidence we have that the mental health system does not meet the needs in our communities.

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

Further, the burden of mental health problems and mental illness is far greater than the current offerings in 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 partly is 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. This not only requires consideration of the mental health of individuals, but also of their broader wellbeing and the wellbeing 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 people 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).

Compounding these 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. 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.

More detailed findings on the specific challenges for Aboriginal and Torres Strait Islander people in mental health are outlined in Volume 2, under five key areas where action is most needed, namely:

- 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.

Mental health challenges for people in rural and remote areas

On almost any indicator, people living outside of metropolitan areas experience inequity both in terms of their health and in getting access to the right services: lower life expectancy, lower access to Medicare-funded services which diminishes with increasing remoteness, reduced health workforce distribution, and lower rates of mental health service access, with access to psychological services significantly less than in major cities. The impact of these inequities is particularly significant for Aboriginal and Torres Strait Islander people living in these areas.

In rural and remote areas, issues in mental health are compounded by reduced access to infrastructure, communications and costs to access services. The Commission has learned from submissions to the Review that discrimination due to mental illness is a factor which affects whether a person seeks services in their town. For some, anonymity is important and they will travel to the next town or regional centre to get the support they need. This presents another barrier to them getting timely access to the type of supports they need. The impacts of drought, bushfires and hard economic times also add to the distress of families and communities in these areas.

The Review found that:

- mental health services in rural and remote areas are transient, face significant workforce shortages and in many cases are decreasing despite high demand
- programmes are given inadequate funding for the additional demands and costs of service delivery in regional, rural and remote areas
- access to services could be improved by wider use of technology and increasing community capacity.

Mental health research, development and training

This Review revealed a number of significant problems with mental health research.

- There is a major disconnection between the research sector and the mental health services and supports sector. While the research sector is driven insufficiently by the needs of the population and of practitioners, there also is not a clear pathway for the translation of research into practice.
- 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 recognise and prioritise the impact of 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 what mental health and associated interventions work for whom.
- There is no mechanism to systematically involve people with lived experience, frontline practitioners and informal supporters in prioritisation and conduct of evaluations and research, and in research translation.

There are two key risks of continuing with the 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 people with lived experience, their families and support people.
- Commonwealth investment in and planning of programmes and services is insufficiently informed by the findings of evaluations and research.

However, 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 National Health and Medical Research Council's (NHMRC) 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 outlined in this report rely on the implementation of such a systemic approach, requiring reform both in how research is produced and in 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.

Summary of findings

The past few decades have seen considerable changes in mental health and suicide prevention policy, systems and services, featuring:

- deinstitutionalisation and the closure or downsizing of many large-scale dedicated psychiatric institutions
- greater mainstreaming of services and attempts to fully integrate them across sectors and around people's needs
- an acceptance that the health system is just one part of the picture: housing, employment, education, justice and welfare play a significant part in people's recovery and ability to live contributing lives
- growing private and nongovernment sectors
- increasing recognition of the rights of individuals and the need for least restrictive treatments
- a growing recognition of the greater and different social and emotional needs of Aboriginal and Torres Strait Islander people, and the need for community-based and controlled services
- the involvement of people and their families and other supporters in planning and making decisions about the care and support they want and get, and providing feedback
- greater community understanding of mental health, mental illness and suicide, and a greater willingness to talk about issues and seek help.

The need for mental health reform has had long-standing bipartisan support. Yet as a country we lack a clear destination in mental health and suicide prevention. Instead of a "mental health system"—which implies a planned, unitary whole—we have a collection of often uncoordinated services that have accumulated spasmodically over time, with no clarity of roles and responsibilities or strategic approach that is reflected in practice.

The preceding section highlights that despite the many past improvements and innovations, there remain significant gaps in services and variable results for people and families.

In summary, we found:

- While there has been significant progress in mental health reform over the past three decades, Australia still has a long way to go in designing and delivering a quality, high-performing mental health and suicide prevention system.
- Funding often is siloed, limiting innovation and the smarter use of existing funds to provide appropriate person-centred care and slow forecast growth in expenditure.
- New programmes too often are conceived to plug gaps in the status quo, without integration and the big picture in mind, both for the general population and for specific population groups, in particular Aboriginal and Torres Strait Islander people.
- The mental health system does not make value-for-money choices the easiest choices.
- The system measures activity and the volume of services rather than the added value to people through improved outcomes.
- The system is driven by supply (what providers provide), rather than by demand (what people want and need).
- People and families are expected to find and navigate services in the absence of clear guidance and support, with complexity of services presenting a barrier to access.
- People with lived experience, their families and support people are not afforded the same range of choices and options and timely access as those afforded to people with cancer or other physical diseases.

- The challenges of the patient transition across the health system for Aboriginal and Torres Strait Islander people are a critical area that needs attention.
- Access to services often is dependent on where you live, or what (or who) you know.
- Many people are excluded from the mental health system, including Aboriginal and Torres Strait Islander people where services are not culturally competent.
- There is a lack of:
  - integration and coordination—service providers, as well as governments and their various agencies, often are operating in silos, in isolation of each other and of the broader system. Indeed, contractual arrangements can encourage this, with structural barriers preventing more collaborative approaches
  - capacity and flexibility—many small providers providing often vital but only small parts of a comprehensive service, with what flexibility they have impeded by stringent reporting and funding requirements
  - transparency and accountability for what is paid for: government and taxpayers have little visibility of whether people are getting better for the big investment we make
- Costly backroom operations take money from frontline services, with a lack of scale contributing to higher total overhead costs.
- Mental health services through the public hospital system significantly contribute to the accelerating cost curve for health care when options are available to reduce avoidable hospitalisations.
- The system is out of balance— the pendulum needs to swing away from crises, acute care and maintenance on income support and towards wellbeing, prevention, early intervention and integrated primary and mental health care.
- There is a mixed focus on recovery across all services.
- People and families repeatedly say they need a range of supports that help them to get well, stay well, live independently in the community and contribute to society and the economy.

What we need is systems reform. We need to:

- **redesign** the system to focus on the needs of individuals, and their families and other supporters, rather than on what providers do
- **redirect** Commonwealth dollars as incentives to purchase value-for-money, measurable results and outcomes, rather than simply funding a myriad of programmes to produce more and more activity
- **rebalance** expenditure away from those things which indicate system failure and invest in those things which are known to work— prevention and early intervention, recovery-based community support, stable housing, and participation in employment, education and training
- **repackage** and bundle funds being spent on that small percentage of people with the most severe and persistent mental health problems and who are the highest users of the mental health dollar. Purchase integrated packages of services which support them to lead contributing lives and keep them out of avoidable high cost care
- **reform** our approach to supporting people and families to lead fulfilling, productive lives so they not only maximise their individual potential and reduce the burden on the system but also can lead a contributing life and help grow Australia's wealth.

"If we look at the data, the business case for this decade of change is not only morally and socially compelling, it is economically fundamental."

Jennifer Westacott, Chair, Mental Health Australia[35]

FROM: WHERE WE ARE NOW

➢ **Stigma persists**

➢ **People with lived experience, families and support people have a poor experience of care**

- A myriad of sources of information and advice
- Distressed individuals having to provide the same information to multiple organisations
- Vulnerable people left to navigate a complex and fragmented service system
- Families and support people excluded from consultations and planning
- Limited choice
- Specialist services where the clients have to come to them

➢ **A mental health system that doesn't prioritise people's needs**

- The Commonwealth's main programmes focus on generating activity: not necessarily on making anyone better
- A high level of unmet need, with many people not seeking necessary support. A person's mental health and circumstances may deteriorate and become more complex.

➢ **A system that responds too late**

➢ **A mental health system that is fragmented**

- Fragmentation of services
- A myriad of providers, many of them with limited capacity and poor economies of scale
- A myriad of siloed funding streams and programmes focused on providers
- Highly variable access to quality services largely depending on the "luck" of where people live—or their income—leading to great variation in services provided and the outcomes achieved
- Poor planning, coordination and operation between the Commonwealth and the states and territories, resulting in duplication, overlap and gaps in services

➢ **A system that does not see the whole person**

- People being discharged from hospital and treatment services into homelessness, or without adequate discharge planning
- High rates of 16–25 year olds with a mental health condition who are 'Not in Education, Employment, or Training' (NEET)
- Poor physical health among those with severe and persistent mental health problems
- High rates of unemployment among adults with a mental illness and their support people

➢ **A system that uses resources poorly**

- A fragmented mental health workforce where many clinicians work in isolation of each other, and do not operate at the top of their scope of practice
- The greatest level of funding goes into high cost areas such as acute care, the criminal justice system, and disability support, indicating that the system has failed to prevent avoidable complications in people's lives
- Research is carried out in isolation of mental health strategic objectives, with a haphazard approach to evidence translation into practice

TO: WHERE WE WANT TO BE

➢ **Widespread public knowledge and understanding**

➢ **People with lived experience, families and support people encounter a system that involves them in decisions, is easily navigable and provides continuity of care**

- People, families, businesses, schools, etc. know where to go to get practical information and advice
- Provide once, use often: people with a mental health condition a priority group using e-health records
- Clear pathways provided for individuals and their support people, with care coordination and case management for those who need it
- Families recognised and included as vital members of the care team
- Enhanced choice of providers
- Specialists reaching out into the community

➢ **An outcomes-focused mental health system**

- A focus on funding outcomes, to achieve value for money for individuals and society. Commonwealth funding to be focused on providing incentives to achieve outcomes, rather than on simply generating activity
- More people getting the services they need, when and where they need them, with enhanced access and participation in services which aim to keep people mentally healthy, improve participation and focus on recovery

➢ **Access in the right place at the right time**

➢ **A mental health system that wraps around the person**

- Integration of services around the needs of individuals, with increased use of pathways and management plans which cover the continuum of needs of the person e.g. primary and community based care, housing, employment, and acute care when necessary
- Integration of providers around the needs of individuals and communities: larger provider organisations or networked providers providing integrated services and economies of scale
- A person focused approach, where funding is wrapped around support for the individual and their families
- Greater consistency in access to services which meet safety and quality standards
- Clarification of roles and responsibilities between the Commonwealth and the states and territories, with shared policy development, system design, implementation and monitoring and reporting.

➢ **A system that responds to whole-of-life needs**

- No one is discharged from hospitals, custodial care, mental health or drug and alcohol related treatment services without an appropriate discharge plan which provides for necessary supports and includes regular follow-up
- Increased productivity, participation and economic impact: continuous improvement measured by reductions in the NEET rate
- Reductions in risk factors resulting in high morbidity and premature mortality of people with a mental illness (e.g. reduced smoking rates and obesity levels)
- Improved financial position for individuals, families and support people, better economic participation and productivity

➢ **A proactive, strategically aligned system**

- A team based approach where the person, their family and support people are at the centre of the team, and the various members work together in providing support and services, with an enhanced role for peer workers. No one works alone, or in isolation
- Shifting the centre of gravity of funding away from the acute, crises end, towards prevention, early intervention and community services which reduce the onset of illness, complications and crises
- Research is priority driven in accordance with targets and objectives, with clear pathways for translation into practice

Future approaches and funding priorities

The ultimate goal of the recommendations from this Review is to create a person-centred system where the mental health and wellbeing of individuals enables them to lead contributing lives and participate as fully as possible as members of thriving communities.

All our recommendations and actions are designed to collectively impact in leading us to that destination.

On the basis of our findings, it is clear that we need to **redesign, redirect, rebalance, repackage** and **reform** our approach to mental health.

This Review is framed on the basis of making change within existing resources. The Commission considers there is substantial funding within the mental health system but that it is not distributed efficiently, effectively or fairly.

The overall impact of our poorly planned and badly integrated 'system' in mental health is a massive drain on people's wellbeing and participation, and on Australia's productivity and economic growth. Given the fiscal circumstances faced by all Australian governments, it is imperative that every dollar spent in mental health and other systems that support mental health is spent well. Therefore, a key focus in this Review has been to consider and advise on how the Commonwealth can maximise value for the taxpayer's dollars by using its resources as incentives to leverage desirable and measurable results and outcomes.

To achieve fundamental system change, we propose changes to improve the longer-term sustainability of the mental health system based on three key components:

1. Person-centred design principles
2. A new system architecture
3. Shifting funding to more efficient and effective 'upstream' services and supports.

A person-centred approach

A person-centred mental health system is one where services are designed around the needs of people, rather than people having to organise themselves to find their way around what the system provides.

It shifts the locus of control away from providers and towards meeting the needs of users. That does not mean that people make all the decisions about their care and support, but rather that they are involved in decision-making at all levels of planning, designing and delivering services —"nothing about us without us".

A person-centred system needs to be designed to have the person and their individual needs at the centre, with services then wrapped around them—increasing as need increases, and decreasing as need decreases.

Figure 4 illustrates an example of the design of a person-centred approach.

The first priority of such a system is to enable each person and their family to look after themselves. For most people, from birth until death, the most important resources they have to build and sustain good mental health and overall wellbeing are themselves and the people around them. Conversely, if those relationships are unhealthy or potentially even traumatic, this has an adverse impact on wellbeing. This is particularly so for infants and children.

Much resilience and wellbeing can come from life within a local community through social contacts and participation in schools, employment, clubs and other socialising occasions. Many people engage in social media and go online to either communicate with others or to seek out information (with an increasing move towards seeking help online).

Mental health starts with where we live, learn, work and mix, usually long before the signs of illness. The opportunities for people to have contributing lives, to participate and be productive—and many of the solutions—belong in our families, neighbourhoods, schools and workplaces. This recognises the centrality of the individual, the importance of family, friends and other support people, the role of local communities and community participation, and the ripple effect as need spreads out into different (and often increasingly expensive) layers of the system and society.

If a person becomes distressed or ill, they can benefit through connecting with the formal mental health system, with their first contact often being with a GP or practice nurse. As needs increase or change, new members are added to the care team—for example, psychologists and other allied health professionals, Aboriginal health workers, non-clinical service providers, psychiatrists and community mental health services.

For some people the care team needs to be extended to provide broader supports; for example, with relationship or financial counselling, and supporting people with accommodation, education, training and employment or by providing income support payments.

When required, hospital care should be accessible in a timely manner, with the hospital focus being on treatment and recovery. The hospital's goal should be to provide safe, high-quality care and to assist people to return home, with their families and other support people, or into step-down care. People never should be discharged into homelessness and in particular there should be intensive follow-up for people discharged after a suicide attempt or self-harm.

Very importantly, the hospital's highly specialised expertise should be used to support care in the community. The availability of this specialised knowledge, particularly where psychiatrists and other specialised professionals spend physical time in primary health care, can assist the primary health care team to provide safer, more effective care, and to take on increasing responsibility for more complex care.

A person-centred approach means that, as a person's acuity and functional impairment increase, the care team will expand to include different members. As acuity diminishes and functional capacity is improved, the team will contract.

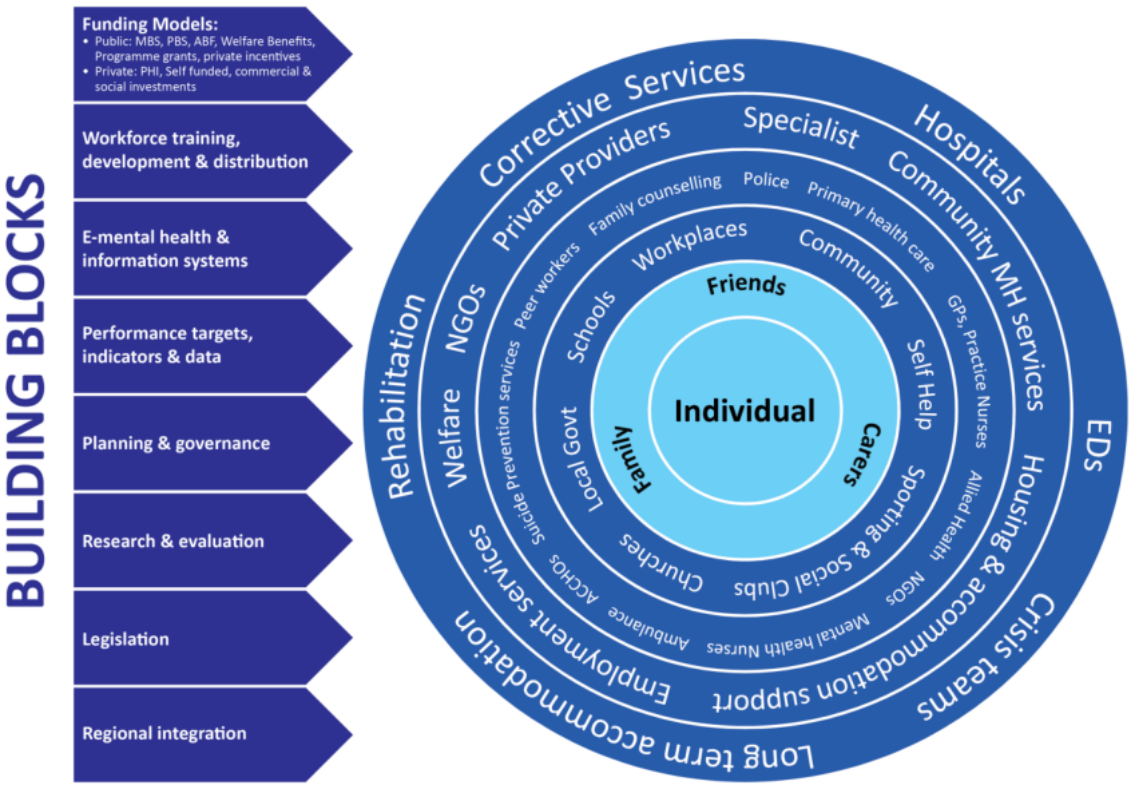
That means people are not transferred from one team to another but remain connected throughout, to a general practice, an Indigenous Primary Health Care Organisation (including Aboriginal Community Controlled Health Services) or a community mental health service, and with that ongoing core relationship with the family and other support people.

An ideal, person-centred mental health system would feature more clearly defined pathways between health and mental health. It would recognise the importance of non-health supports such as housing, justice, employment and education, and emphasise cost-effective, community-based care.

As identified in Figure 4, wrap-around care and support is enabled by strong building blocks which align resources to support individuals, their families and communities. This includes:

- governance models which engage with people with lived experience, their families and support people and enable them to participate at every level in planning, commissioning and monitoring of services
- funding models (which, if properly designed, can drive the right behaviour)
- the right workforce to provide equitable access and to do the job in the most efficient and effective way
- e-mental health and information technology to link people and services and promote self-care and wellbeing
- research and evaluation to translate evidence into practice
- measurement of results to ensure transparency and accountability and to feed into planning
- regulatory frameworks to protect and promote safety and quality for people but which otherwise should be light touch
- regional planning and organising to be responsive to the diverse local needs of the different communities across Australia.

Figure 4 A person-centred approach with systems and resources as enablers



System architecture

The person-centred approach described above fits within a population-based model, where system design begins with a focus on the needs of the entire Australian population, and on particular population groups on the basis of needs and risks.

A population approach involves segmenting and stratifying population groups according to risks and needs.

Services and supports then can be designed and implemented to provide value-for-money interventions according to individual risk which respond to the characteristics of mental illness and different population groups, and can be tailored to the specific needs and circumstances of individuals, their families and supporters. This includes a focus on the spectrum of interventions encompassing promotion, prevention, early intervention, treatment and recovery approaches, which allows for both population and individual interventions.

As Figure 5 shows, the main features of such an approach are:

- population interventions to support the whole community to look after and protect their mental health and wellbeing
  - for today's 23 million Australians
- initiatives that prevent mental illness and intervene early (at any age or stage of life) to stop lifelong disadvantage or chronicity of illness and support people most at risk
- measures that support people's recovery from mental illness in the community, through accommodation, participation in education, sport and other community activities, and in the workforce
  - high prevalence disorders such as anxiety and depression affect about three million people or up to 18 per cent of the adult population each year
- keep people living with chronic, persistent conditions sustained in their homes or with appropriate housing and support, and keep them out of acute care unless necessary. Strategies focus on reducing avoidable readmissions and ED presentations, and providing rapid responses to crises, e.g. medications management, housing instability or homelessness, domestic violence and relationship problems.
  - low prevalence, complex and chronic illnesses such as schizophrenia and bipolar disorder affect about 600,000 people or two to three per cent of the population.[36] Of this group around 60,000 people are severely disabled because of their illness[i]

A population approach better matches available resources to identified need, placing particular emphasis on population groups which are at higher risk or where there are special needs:

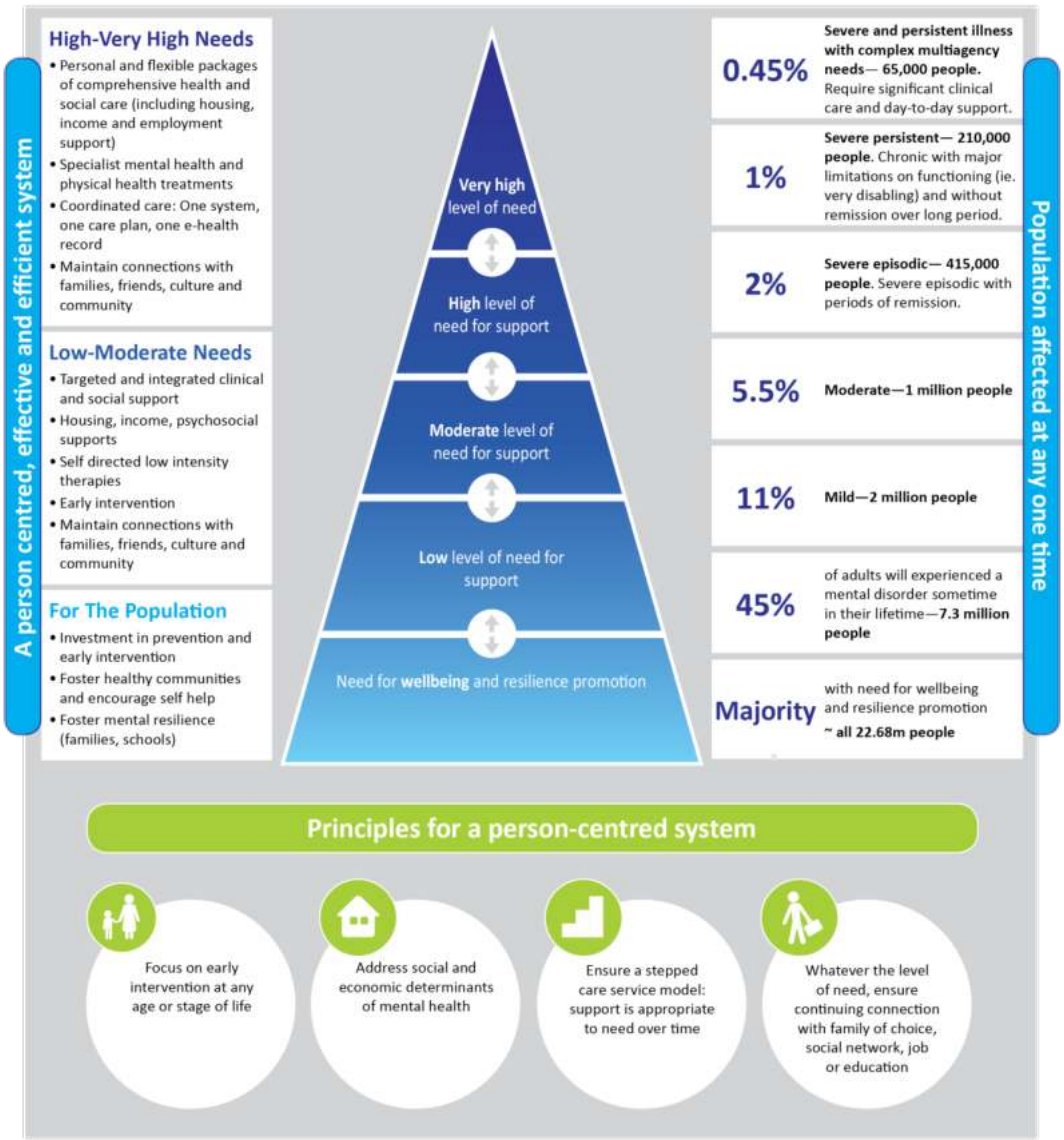
- **Family and child health**: recognising the lifelong health and economic benefits of care and support prior to and during pregnancy, and in early years of child development.
- **Youth and young adults**: recognising the early onset of mental illness and that a contributing life is possible if support and treatment is provided early.
- **Adults:** recognising that the greatest burden of mental illness falls on those with persistent and chronic mental health (and often related physical health) complications.
- **Older people**: particularly those with a mental illness who live in residential aged care facilities or access Home and Community Care (HACC) services. These people often are

[i] As reflected elsewhere in this Report, this figure has been updated to 690,000 (3.1 per cent of the population) since the unpublished November 2014 Report, based on Department of Health advice.

poorly diagnosed, treated and supported. Their frailty and comorbidity often masks their mental health conditions, and there are poor incentives for many mental health providers to visit and practice in aged care homes.

This approach shifts groups of people towards 'upstream' services—population health, prevention, early intervention, recovery and participation—and thereby reduces 'downstream', costly services—ED presentations, acute admissions and avoidable readmissions. This approach is illustrated below.

Figure 5 Population-based architecture



The realignment of system architecture as recommended in this report involves a cross-cutting and interdependent approach with two other closely related aspects:

- A stepped care framework that provides a range of help options of varying intensity to match people's level of need. Stepped care relates resource usage more directly to individual and population need. It begins with a focus on self-care and individual and community wellbeing, and advances through various steps of resourcing based on stratification of risk and need.
- Integrated Care Pathways (ICPs) for mental health to provide for a seamless, evidence-based and efficient pathway through the mental health system.

A clear objective of these approaches to system architecture is to ensure interventions are:

- effective: scarce resources should be used cost-effectively to achieve identified objectives
- efficient: decisions on what programmes and services we invest in result in maximising net benefits to the community
- evidence-based: decisions need to be based on evidence, and that in turn means services need to be able to collect meaningful information about what difference they are making to people's lives.

The mental health system needs to be redesigned to provide integrated, end-to-end support for individuals, regardless of when and where the system is accessed, to deliver better quality and outcomes which are demonstrably cost-effective. It should be underpinned by a strong focus on prevention, early intervention and support for recovery that is not just measured in terms of the absence of symptoms, but in the ability to lead a contributing life.

A stepped care approach supports Australians to take greater responsibility for their own mental and physical wellbeing. A new service paradigm is needed to support that choice and responsibility. Significant advances occurring in e-mental health provide the opportunity to encourage a society where self-help is more fully integrated in the system, and that people know where to go and how to get access to the specific information and support they need. It does not obviate the need for face-to-face care when necessary, but it does reduce the need for expensive services for those things which people can do for themselves, or with their families or other support people. That creates efficiencies but also enables cost-effective use of the time and skills of clinical and other professionals—and frees up the valuable personal time of individuals.

The Commission considers that one of the most fundamental elements of the stepped care approach lies in the general practice and primary health care sector and that a fundamental design feature for reform involves integrating physical, mental, social and emotional health and wellbeing within primary health care.

There is international evidence that national health care systems with strong primary care infrastructures have healthier populations, fewer health-related disparities and lower overall costs for health care, than do than those countries with a higher focus on specialist and acute care.[37] The World Health Organization (WHO) has called for mental health to be integrated into primary health care.[38] "Integration of mental health into primary health care not only gives better care: it also cuts wastage resulting from unnecessary investigations and from inappropriate and non-specific treatments."[39]

The current development of 30 Primary Health Networks across Australia provides the ideal opportunity to build on that infrastructure and better target mental health resources to meet population needs on a regional basis. These new entities will be the meso-level organisations responsible for planning and purchasing services on a regional basis.

Regional entities could work in partnership and apply targeted, value-for-money interventions across the whole continuum of mental wellbeing and ill-health to meet the needs of their communities. This would enable a stepped care approach, with the aims of:

- promoting mental health and wellbeing
- reducing risk factors
- preventing mental ill-health
- reducing or delaying the onset of mental ill-health experiences
- managing and supporting people in the community as much as possible
- providing timely access when needed to hospital and other acute services
- managing the handover from hospital back into the community, step-down care and rehabilitation, aged care and palliative care
- reducing adverse events, waste and duplication.

Stepped care services would range from no-cost and low-cost options for people with the most common mental health issues, through to options to provide support and wrap-around services for people with severe and persistent mental ill-health to live contributing lives in the community.

To support this approach, evidence-based ICPs for mental health would need to be developed and supported by PMHNs (Commonwealth) and Local Hospital Networks or equivalent (states and territories). In developing these pathways, priority should be given to pathways relevant to mental health conditions with the highest contribution to service utilisation.

This approach also aims to address the over-emphasis in the system on health 'treatments' that are applied when mental illness has progressed, even though there were opportunities to intervene early, as described in our chapter on *A Contributing Life* (see Volume 2).

Shifting funding to rebalance the system

The Commission has considered the roles of investors in the mental health system, and the potential to maximise return on investment by taking a system-wide approach to rebalancing. This goes beyond the purview of health and health-related agencies and includes the roles of employment, education, social service agencies, housing agencies, NGOs and the private sector.

A fundamental design principle arising out of this Review is that the Commonwealth should use its resources as incentives to leverage measurable results and outcomes, and shift the focus of the entire mental health system to prevention, early intervention, primary health care, and—importantly—to recovery.

Our proposed system architecture is designed to move funding away from separate, siloed payment arrangements for primary, secondary and post-acute services, to a focus on promotion and prevention for the population in general and those at risk in particular, and to Integrated Care Pathways for those in need, to encourage the best and most efficient use of resources.

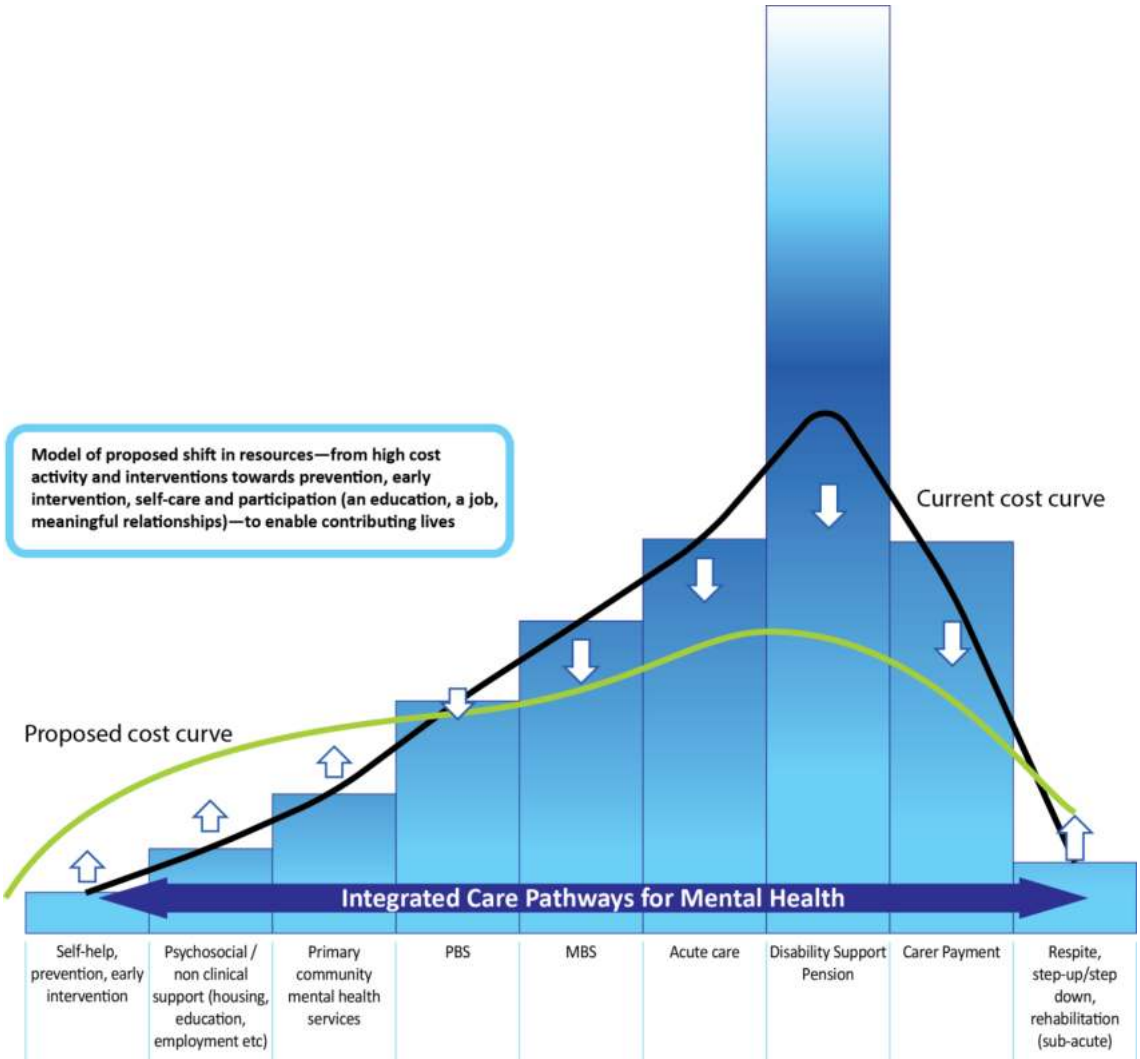
Shifting resources to 'upstream' services in turn will reduce the need for growing expenditure on 'downstream' services such as pharmaceuticals, hospitals, EDs and income support. Over

time, these arrangements are expected to decrease the growth in overall expenditure, while at the same time reallocating resources across the entire continuum of care (Figure 6).

For high users of the mental health system, a system of voluntary enrolment and bundled payment models should be available. Voluntary enrolments through general practice and ACCHSs would provide the extra support this group needs by enabling a more cost-effective and coordinated approach to the provision of wrap-around and whole-of-person supports.

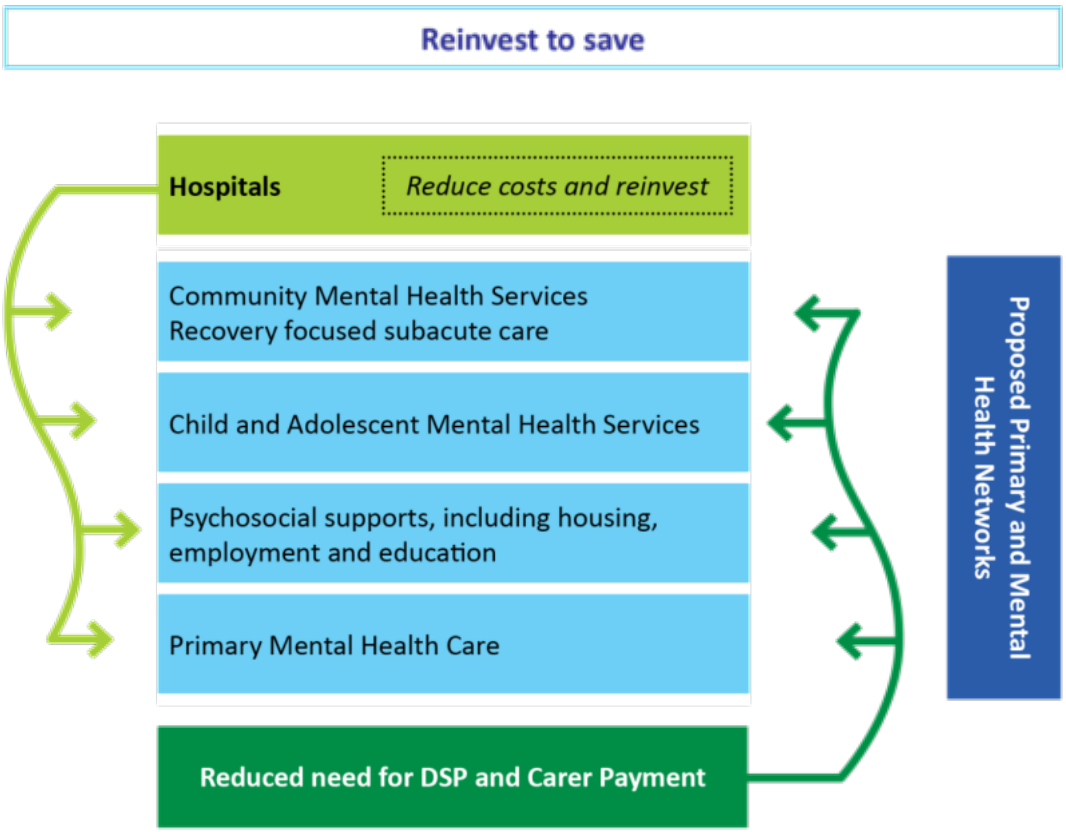
For those with very high needs, or at risk of developing very high needs, as identified under the risk segmentation and stratification approach, PMHNs could work with LHNs (or equivalent) to bundle funds from both their budgets (as well as cashing out of MBS and PBS payments) and purchase packages of care which can be used to keep people well and in the community.

Figure 6 Model of proposed shift in resources



The result of the Commission's work, based on modelling and data we received, would entail a slowing rate of increase in DSP and Carer Payment costs, and in the costs of acute care and crisis management. This would provide an opportunity to redistribute these savings through regional integrators, which would identify the 'upstream' system elements that will be most effective in their communities, to reduce avoidable hospitalisations and keep people participating in the community, with the overarching principle of reinvesting to save (Figure 7).

Figure 7 Reinvesting to save through regional integrators



Our strategic intent

The principle underpinning all our recommendations and actions is that people—those with lived experience, their families and other support people, carers, population groups with specific needs and the broad Australian population—need to be involved in decisions that affect them, from the services available locally to the development of national policy.

We also reconfirm the importance of supporting Aboriginal and Torres Strait Islander social and emotional wellbeing as an overarching strategic priority which sits across all directions identified in this Review.

Our strategic intent as an outcome of this Review is that all Australians achieve the best possible mental health and wellbeing through a person and family-centred approach which enables people to live contributing lives, communities to thrive and Australia to prosper.

Our strategic directions

To move from where we are now to where we want to be, we propose our strategic intent be progressed through actions **over the next two years**. The Commission proposes 25 recommendations across the following nine strategic directions, as follows:

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.

What this means

1. This Review is not proposing that more money should be spent on mental health at this stage, but rather that the overall mental health funding bucket should be maintained and spent on more effective things. We need to make changes within existing resources.
2. People with lived experience, their families, carers and supporters should be engaged in formal and informal ways which enable their involvement in decision-making at all levels of the mental health system.
3. The Commonwealth should take a leadership role on national issues on the one hand, and regional integration of programmes and services on the other.
4. End the confusion and waste about who does what at federal, state and territory levels through development of an Intergovernmental Agreement on roles and responsibilities.
5. Agree a new National Mental Health and Suicide Prevention Plan—the Fifth National Mental Health Plan—with the states and territories, in consultation with the broad mental health sector.
6. Include an evidence-based framework which resolves roles and responsibilities for promotion and prevention in mental health and suicide prevention.
7. Tie a substantial percentage of any funding in any replacement plan to a shared agreement with state and territory on priorities, reporting on performance and increased transparency and accountability.
8. Resolve the confusion about access to the NDIS for people with a psychosocial disability, their families and carers, and resolve what happens for people and carers who currently get support and are going to get less support if they are left outside the NDIS.
9. Adopt national targets and indicators to measure how Australia is performing in improving mental health and wellbeing, and pursue them relentlessly, vigorously and consistently over the next decade.
10. Agree a specific mental health and social and emotional wellbeing target under the Closing the Gap strategy for Aboriginal and Torres Strait Islander people.
11. Shift money from payments to hospitals and income support to grow community-based psychosocial, primary and community mental health services.
12. Support the states and territories as the system managers for public hospitals, but encourage them to team up with Commonwealth-funded agencies on models of hospital avoidance and psychosocial support which keep people with their families and contributing within the community.
13. Empower Primary and Mental Health Networks (PMHNs) as the Commonwealth's key architecture for regional integration of services and programmes.
14. Work with and fund organisations which have a national or supra-regional role, but don't directly fund regional/local organisations which provide services to local communities.
15. Bundle up existing programme funding, from a range of different programmes which operate at a local/regional level, into a small number of flexible funds, supplemented by funds shifted from state and territory payments for hospital services to community and primary services.
16. Allocate those flexible funds to PMHNs on a weighted population basis, with a high weighting for Aboriginal and Torres Strait Islander people, and with a small number of high-level indicators to measure performance.
17. Empower PMHNs to commission services from a smaller number of larger providers (or larger consortia of providers) which can provide comprehensive, integrated and whole-of-person services and demonstrate efficiency and effectiveness.

18. Fund on the basis of performance—withdraw funding from those organisations which do not achieve targets, and reward those which demonstrate high performance; for example, through use of longer term contracts.
19. Introduce a new model of stepped care, with a strong emphasis on self-help and individual resilience, supported by e-mental health systems and applications.
20. Strengthen the role of GPs in assessment, triaging and management in mental health, and introduce incentives for better care and more accountability through Mental Health Medical Homes and changed Practice Incentive Payments (PIP) for quality mental health care.
21. Develop bundled payment models, including care coordination and case management, for those who are high users of services, and very importantly for those who are at risk of becoming high users.
22. Provide better access to psychologists and other allied health professionals and pursue options to improve regional equity.
23. Introduce incentives to include pharmacists as key members of the general practice and primary health care team.
24. Require better coordination and integration of services among different siloed providers to enable a healthy start to life for children.
25. Initiate a special investigation into the costs to society of childhood trauma and abuse, of the best ways to prevent abuse, and how best to support those living with the impact of childhood trauma.
26. Task the Commission with resolving the evidence base for a national approach to reduce stigma and discrimination and to advise on what works, and what provides a return on investment.
27. Establish dedicated mental health and social and emotional wellbeing teams at all Aboriginal and Torres Strait Islander community controlled health organisations.
28. Use existing funds from suicide prevention programmes to fund 12 local communities across Australia as the first wave in leveraging local community action on suicide prevention.
29. Double the funding for mental health research from within existing resources to match the burden of disease, and ensure it is applied to making a difference in service delivery and improving people's lives.
30. Combine elements of the Mental Health Nurse Incentive Programme and the Practice Nurse Incentive Programme to create incentives for general practices to employ mental health nurses.
31. Develop the Mental Health Peer Workforce so that peer workers are available to be with those in need, particularly when people are discharged from hospitals.
32. Ensure all frontline workers are trained to recognise and manage mental health issues, and in particular with people who may be at risk of suicide.
33. Enforce, through funding agreements, improvements so that people can get emergency access to the right telephone lines and internet support, which are linked to triaging and transfer systems. Different telephone systems need to be clearly connected and each element's role clearly defined, both for workers within the system and for the general public.
34. Shift funding to create incentives for e-mental health solutions which support biometric monitoring and direct clinical support strategies.

1. Set clear roles and accountabilities to shape a person-centred mental health system

What success looks like

- Agreement is reached (and documented in a new Intergovernmental Agreement) between federal, state and territory governments on roles and responsibilities in mental health.
- People with lived experience, their families and support people are engaged and involved in setting strategic directions—"nothing about us without us".
- They, their families and support people, service providers and communities are engaged in development of a new *National Mental Health and Suicide Prevention Plan*.
- People with lived experience and carers are supported to participate in national, state and regional consultations and engagement.
- All governments have committed to sustained and coordinated action to achieve targets for better outcomes in mental health and reducing numbers of suicides.
- New national accountability and transparency arrangements are introduced to improve accountability of policy makers, planners, purchasers and providers to people with lived experience, their families and support people.
- Australian governments agree on responsibilities for Aboriginal and Torres Strait Islander mental health and are held accountable for improved outcomes.
- All governments provide timely and accurate data to enable transparent reporting, measurement of results and improved planning.
- Communication and sharing of best practice solutions between stakeholders.
- There is a smooth transition for people with lived experience, their families and support people, as well as an integrated approach, between the mental health system and the National Disability Insurance Scheme.

Key recommendations

Recommendation 1:

Agree the Commonwealth's role in mental health is through national leadership and regional integration, including integrated primary and mental health care.

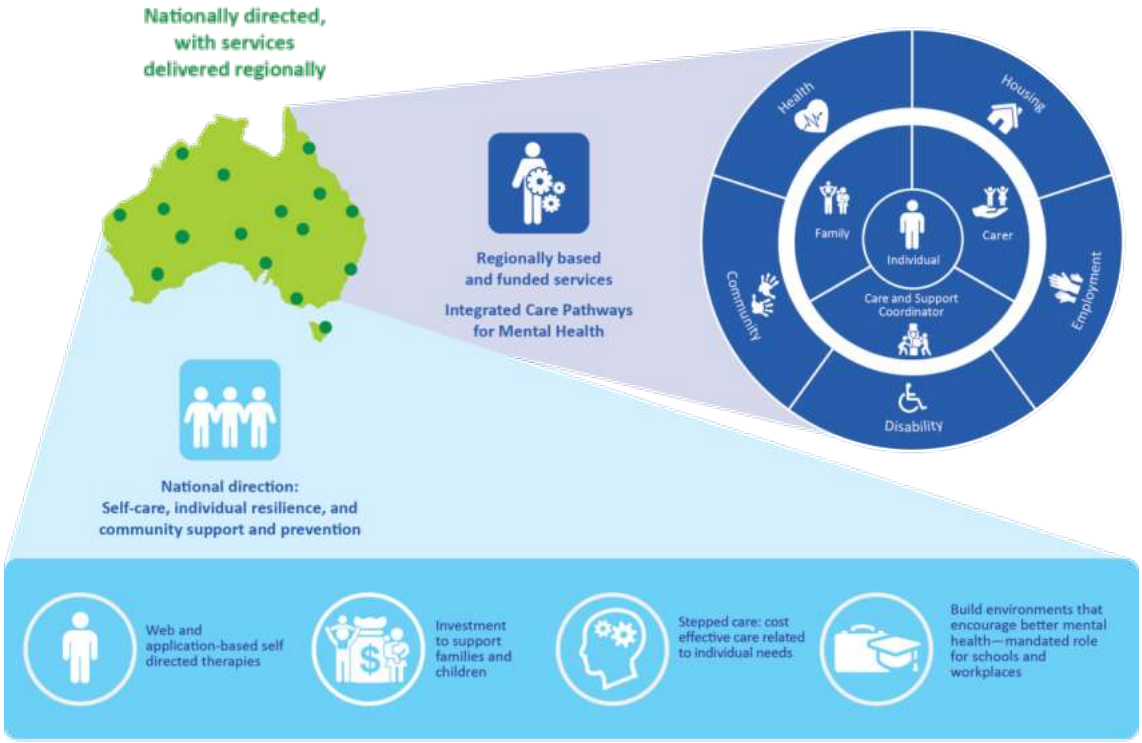
How this will be achieved

1. The Commonwealth to confirm its primary roles in mental health as being in national leadership of those things where a national approach is efficient and effective, and in enabling regional integration around the needs of people, their families and communities (as shown in Figure 8). This includes:

    - leading national mental health policy direction
    - working with organisations that operate nationally or across regions

- supporting better mental wellbeing through its other national roles in areas such as communications, standards, guidelines, research, and payment of benefits to individuals (including through MBS and PBS), and employment, education, and social services
- ensuring that Aboriginal and Torres Strait Islander people are benefitting in an equitable manner (including with reference to their greater mental health needs) through MBS-subsidised mental health care, including that provided by GPs, and by access to PBS-subsidised mental health medications
- providing pooled funding to promote regional integration of services around the needs of individuals, their families and communities through primary and mental health networks.

Figure 8 The Commonwealth's role: National leadership with regional integration



Adapted from The Case For Mental Health Reform in Australia: a Review of Expenditure and System Design, Medibank Private and Nous Group (2013)

Issues:

- On the roles of the Commonwealth and states and territories, John Feneley, the NSW Mental Health Commissioner, has noted: "both [levels of government] provide some community-based services often with little joint planning. This results not in a 'system' of services or even a system at all but rather a lumpy patchwork which is not only difficult for individuals, their families and carers, and even professionals to navigate but also results in poorer outcomes for individuals."[40]
- The Commission considers that the roles and responsibilities of the Commonwealth on the one hand, and the states and territories on the other, should be agreed and documented through a new Intergovernmental Agreement.

- The Commission is aware that this Review is being completed while the process for development of the White Paper on Reform of the Constitution still is under way. The Commission has not attempted to pre-empt the outcome of the Federation review process. However it is considered that the directions outlined in this report are not inconsistent with the directions identified in the Federation White Paper process, for example:
  - the Commonwealth continues to take a leadership role on issues of genuine national and strategic importance, but with less Commonwealth intervention in areas where states and territories have primary responsibility
  - reduce and end, as far as possible, the waste, duplication and "second guessing" between different levels of government
  - achieve a more efficient and effective federation, and in so doing, improve national productivity
  - make interacting with government simpler for citizens.
- A consistent message from stakeholders throughout the Review has concerned the lack of clarity in Commonwealth, state and territory roles. This adversely affects service users' ability to navigate their way to the service or support they need. This has been echoed by service providers.
- Clarifying Commonwealth and state and territory roles is important to the efficient delivery and planning of mental health programmes and investment. The Commonwealth has started a range of initiatives in the area of severe mental illness (especially since the *COAG National Action Plan on Mental Health 2006–2011*). This unintentionally caused confusion among service users and providers, enabled more opportunities for cost shifting from state to Commonwealth programmes and created overlap and gaps in services. For example, there is evidence that the Commonwealth has established new funding programmes to augment services in various locations (at times without proper consultation, local planning and engagement with state-funded or local services). Once the services are established, the states have withdrawn or cut back their services—Better Access, ATAPS and headspace increasingly perform as providers of services on referral from state services.
- A question asked on many occasions during the Review was, "If the Commonwealth and states can't be sure about their respective roles and responsibilities, then how is a person with mental health difficulties or provider expected to know where to go?" If the Commonwealth takes on a defined role and responsibility, it then needs to occur in a transparent, planned way, with proper accountability.
- In its national leadership role, the Commonwealth should:
  - have responsibility for national policy directions (in partnership with the states and territories and other stakeholders). This includes the development and negotiation of a new *National Mental Health and Suicide Prevention Plan (the Fifth National Mental Health Plan)*
  - fund organisations which operate on a national basis or across regions. For clarity, if a programme or service deals with a single organisation working across all of Australia (e.g. beyondblue) or multiple regions (e.g. Programme of Assistance for Survivors of Torture and Trauma), it should be managed nationally
  - oversee functions which involve national education and communications strategies, payment of benefits to individuals, standards, guidelines and research

- establish a regional integration role to provide pooled funding for local level mental health services via Primary and Mental Health Networks (PMHNs), which in turn would be responsible for consulting, planning and contracting services to meet the needs of their local populations
- take overall responsibility for Aboriginal and Torres Strait Islander primary mental health care through its funding of Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services); through Primary and Mental Health Networks; through MBS-subsidised mental health services provided by general practitioners, and through the PBS.

- The importance of local organisations' knowledge, expertise and established relationships with the local community is acknowledged. A move to regional planning and delivery does not mean that programmes currently delivered at a regional level will disappear, nor that their clients will be disadvantaged. Instead programmes, contracts and performance will be managed regionally. Regional integrators will be required to consult and plan locally, and have the opportunity to drive improvements and efficiencies in service delivery, including fewer silos, greater integration (including with physical health programmes) and a person-centred, whole-of-person approach. Involving Aboriginal and Torres Strait Islander communities as partners in these activities will be critical to their success.
- The Commonwealth should continue to take lead responsibility for integrated primary and mental health services. This area of responsibility has both national aspects (e.g. Medicare Benefits, PBS) and regional aspects (e.g. Primary (and Mental) Health Networks, payments to NGOs for both clinical and non-clinical services). The Commonwealth's leadership in this area is fundamental in enabling the shift of people and resources away from acute care and pensions to mental wellbeing and participating lives.
- As the acknowledged system managers for the public hospital system, the states and territories should have primary responsibility for funding and providing public hospital related mental health services.
- The states and territories may choose to contract out some or all of their service delivery responsibilities, potentially using PMHNs as a pooling and funding mechanism (bigger bang for the buck by combining with Commonwealth funds). There are a number of NGO and private organisations which are expanding their range of services into areas such as step-up/step-down care, rehabilitation and community-based treatment.

The community-based and family oriented approach taken by Ballarat Heath Services has resulted in some remarkable outcomes for its community. The Acute Inpatient Bed Occupancy rates stood at 63.3 per cent for adults and 60.7 per cent for aged care, when the average across Victoria was 91 per cent. The case loads for clinicians were in the order of 8–12 people and the re-admission rate was 11 per cent.

- The states and territories must take responsibility for the clinical care coordination of people with severe and persisting disorders such as schizophrenia and bipolar disorder. Most of these people are connected to the state and territory mental health system with case managers/care coordinators (often at times on community

treatment orders under mental health legislation) and a smaller number are treated by private psychiatrists (increasingly with the help of mental health nurses).

- The states and territories should be responsible for the delivery of the Aboriginal and Torres Strait Islander specialist mental health services proposed in this Review. A model of great promise for these services is the Western Australian Statewide Specialist Aboriginal Mental Health Services (SSAMHS). These work within the State mental health system but were funded initially through the COAG National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes.
- The Commission considers that a mechanism needs to be established between stakeholders to exchange information on best practice. A substantial agenda of change requires a coordination mechanism as well as a communicator to interface and explain the changes to the network of people with lived experience, their families and support people, and nongovernment provider groups. The Commission is positioned well to use its existing strategies and established partnerships with these groups.
- A further contributing role for the Commission is in the conduct of national projects to support reform directions, where no mechanism or body currently exists to fulfill these objectives. For example, over the past two years the Commission has led projects on developing mentally healthy workplaces, seclusion and constraint and peer worker training, among others. There is a considerable body of work arising from this Review and where the Commission can be a catalyst for change.
- Aboriginal and Torres Strait Islander mental health leadership, stakeholder and advisory bodies (such as the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group) should partner with and advise the Commonwealth in relation to the systemic change for better Aboriginal and Torres Strait Islander mental health outcomes proposed in this Review.

Recommendation 2:

Develop, agree and implement a National Mental Health and Suicide Prevention Plan with states and territories, in collaboration with people with lived experience, their families and support people.

How this will be achieved

1. The Commonwealth to lead development of a new *National Mental Health and Suicide Prevention Plan*, based on the directions identified in this report.
2. Engagement with, and input from, states, territories, people with lived experience, their families and support people, NGOs, the mental health sector and the community.
3. Clear reporting requirements and accountabilities to be set out to include:
    - funded organisations to be held accountable for their outcomes—no outcome, no funding
    - a substantial percentage of funding (say 10 per cent) to be tied to timely reporting against a national minimum data set—payment to be applied as an incentive rather than as a penalty; that is, not paid unless and until data has been received
    - governments to be held accountable by an independent agency (such as the Commission).

4. Overarching principles and objectives to include:
    - commitment of endorsing parties to whole-of-government (i.e. cross-portfolio) and interjurisdictional efforts to better mental health outcomes
    - targets and indicators for mental health outcomes including Aboriginal and Torres Strait Islander mental health outcomes
    - roles and responsibilities of all stakeholders in progressing towards the objectives and outcomes of the plan, including in terms of policy and programme development, funding, service delivery, monitoring and evaluation
    - roles and responsibilities for achieving better Aboriginal and Torres Strait Islander mental health outcomes, including responsibilities for the additional services proposed in this Review
    - reporting requirements, including through independent evaluation and monitoring of the plan
    - governance arrangements for the administration of the plan, including processes for endorsement (e.g. for bilateral negotiations between Commonwealth and individual states/territories) and implementation
    - cross-portfolio and intergovernmental links, including objectives for development of the primary and community mental health sector, and defined optimal roles and responsibilities for Commonwealth, state and territory governments, as well as for community-managed and private sector organisations, in achieving more sustainable mental health outcomes
    - Aboriginal and Torres Strait Islander mental health outcomes to be monitored to support accountability across the federal system.
5. The plan to set out the preconditions for hospital funding related to mental health supports. In return for ongoing Commonwealth funding for mental health services provided through the acute hospital system, the plan should require:
    - the routine sharing of Australian and international evidence-based and “best practice” services and treatments for psychiatric illness
    - a person-centred treatment approach that is comprehensive and integrated across all service elements
    - authentic participation by people with lived experience, their families and support people
    - quality improvement that is seamlessly incorporated into all aspects of the service to improve patient and organisational outcomes
    - action on the link between physical health and mental health to reduce current unacceptable rates of clinical deterioration
    - promotion of healthy communities
    - long-term reductions in Aboriginal and Torres Strait Islander peoples’ use of hospitals for preventable mental health conditions, with savings redirected to Aboriginal and Torres Strait Islander primary mental health care.
6. Include in the plan a national framework for the promotion of mental health and wellbeing and the prevention of mental ill-health, to be applied across systems, services and communities.

Issues:

- Existing mechanisms for addressing national reform priorities, on matters that cut across Commonwealth and state and territory responsibilities in mental health, are

limited. The existing *Fourth National Mental Health Plan* expired this year, while the *Roadmap for National Mental Health Reform 2012–2022* provides little in the way of specific actions and has been roundly criticised by stakeholders.

- Aboriginal and Torres Strait Islander mental health and suicide prevention needs dedicated planning and additional resources if better mental health outcomes are to be achieved.
- It is proposed that a national framework for the promotion of mental health and wellbeing and the prevention of mental ill-health should be included under the Agreement to (a) clarify roles and responsibilities and (b) pull together evidence of effectiveness and efficiency of promotion and prevention programmes.
- This should include a mapping of all current funded programmes—federal, state and territory—to identify gaps and duplication across service settings.
- It should include national priorities for action based on need, the evidence for effectiveness and potential or proven return on investment.
- A component of the framework should include building the capacity of the sector and of local communities to apply the evidence in their work, education centres and in their communities, and to evaluate effectiveness and return on investment of programmes and services.
- A core role for the Commonwealth in the next five years will be to champion a new vision for change and oversee reform implementation.
- Given the $9.6 billion annual investment by the Commonwealth in mental health programmes and supports, the potential for real impact from a clearly managed and coordinated reform process can be substantial.
- Ongoing Commonwealth funding to states and territories under any future hospital funding agreement should be based on agreement to, and evidence of, a model of care which aims to achieve better outcomes and delivers accessible, effective, accountable, efficient care, including the following elements:
  - clinical treatment provided in the client's own environment
  - family involvement and participation
  - emphasis on recovery from mental disorder
  - enable independence from mental health services
  - routine delivery of evidence-based treatments
  - involvement of the GP and broader primary health care team
  - 'best practice' health outcomes
  - a rigorous programme of internal clinical auditing
- While the previous Australian Health Care Agreements (hospital funding agreements between the Commonwealth and states and territories) included relatively minor penalties for lack of provision of vital performance data, the current *National Health Reform Agreement* involves an agreement on reporting against a *National Minimum Data Set*, but provides no incentives or penalties for not producing that data. For example, data on Victorian community mental health services has not been reported since 2010–11 due to service level gaps resulting from protected industrial action.

- The Commission found the ability to access state data an ongoing barrier to being able to fulfil its Terms of Reference in relation to examining existing mental health services and programmes across the government, private and nongovernment sectors. Accordingly the Commission considers a financial incentive needs to be included in any new agreement on the timely provision of data.

Recommendation 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 allows for a significant Tier 2 system of community supports.

How this will be achieved

1. Have the money follow the individual. If someone who currently is supported by mental health programmes goes into the NDIS, then the funds being spent on supporting that individual should go with them, but no more.
2. Do not cash out existing mental health and other associated programmes (e.g. carer and respite programmes) into the NDIS until there is evidence as to eligibility for people with a psychosocial disability, and clarity about ongoing support for those who are eligible for Tier 2 support.
3. Establish a trial NDIS rollout site specifically for people living with mental illness, to test the feasibility of current arrangements and to inform the development of arrangements more appropriate to the nature of mental illness.
4. Incorporate people with lived experience and carers in sector consultation and communication in a revised NDIS approach for people living with mental health difficulties.
5. Conduct a modelling exercise to determine a) how clinical mental health supports will interface with the NDIS and b) how non-clinical support programmes other than the NDIS will need to develop around it to ensure that people not eligible for higher levels of support under the NDIS will not lose currently successful and familiar supports.
6. Include respite for carers in the NDIS package arrangements as support for people with a mental illness or psychosocial disability.
7. All carers involved in the planning process for the NDIS are offered a separate professional assessment of their own goals and support needs that is formalised and nationally consistent.
8. Reforms flowing from the *McClure Review of Australia's Welfare System*[41] include flexible support for carers to gain and retain employment as the people they currently care for are supported into employment.

Issues:

- The NDIS represents an unprecedented opportunity to access support for people with a disability arising from mental illness.
- It is designed as a flexible mechanism to plan for and fund an individual's non-clinical support, with the aim of increasing social and economic participation.

- The Productivity Commission's estimate was that, when the NDIS is fully operational, about 57,000 people with psychosocial disability will be using NDIS plans. However, in practice it is not yet clear how many people will be eligible, nor in particular how many of them will be eligible for Tier 3 or Tier 2 support packages. Anything below Tier 3 support may result in people with persistent and severe psychosocial disability who currently are eligible for support through the mental health system having a lesser service than they do now.
- Given that funds from programmes such as Personal Helpers and Mentors (PHaMs) and Partners in Recovery have been designated as "in scope" for the NDIS, if the funding goes into the NDIS and the people do not, then there will be proportionately less funding in the mental health system to achieve the "continuity of service" guarantee to which all governments have committed.
- There is potential for the NDIS model to be an empowering one for people living with severe mental illness, because it gives a level of choice and control over funding and support which generally is not currently available. The NDIS also has potential to enable people to access educational, recreational and social opportunities which they otherwise may not have.
- This means the uncertainties surrounding the application of the NDIS for people living with a mental illness and psychosocial disability need to be resolved.
- Under section 24 of the *National Disability Insurance Scheme Act 2013*, a person with a mental health disorder meets the disability requirements if the person has "one or more impairments attributable to a psychiatric condition", "the impairment or impairments are, or are likely to be, permanent" and "the person is likely to require support under the National Disability Insurance Scheme for the person's lifetime" (among other conditions). This potentially is problematic for people with severe impairment but with episodic illness, particularly where the emphasis in mental health is not on permanent impairment but rather on recovery and leading a contributing life.
- Likewise, the level of service available under Tier 2 NDIS-funded community-based supports is yet to be determined, as is the level of support available for carers when the person they support accesses the NDIS.
- There remains great uncertainty about the design and implementation arrangements, and these need to be resolved. A trial specific to people with psychosocial disabilities would appear a sensible way to do so.
- The logic of Tier 2 should be that it is of sufficient capacity to support people whose psychosocial disabilities are not sufficiently "permanent" or profound to live productive lives in the community and reduce their risk of entering Tier 3 due to worsening disability. If this were to be the outcome, then it would be a major achievement for the people involved, their families and support people and for the outcomes of the system.
- Sufficient funding needs to be available to ensure a significant Tier 2 system of community supports, including carers, regardless of whether these are funded through the NDIS or continued through state, territory and Commonwealth funding arrangements.
- Until this is resolved, the only funding which should be going from mental health and associated support programmes into the NDIS should be that attached to any

individual who is deemed eligible for the NDIS. This means programmes and dollars do not transfer—people and dollars do.

- The needs of carers also need to be taken into account in system design, communications and consultations. The role of being a carer has a profound impact on the lives of many people. If that role changes, carers need support to enable them to change their lives—often they have been de-skilled or isolated because of the support they have contributed over extensive periods, with many of them not having been able to work or advance their educational opportunities.
- A separate formal assessment of their own goals and life opportunities would assist carers in planning for a changed future, as would support to enable them to access employment and remain in employment.
- Aboriginal and Torres Strait Islander people with qualifying mental health conditions need to be able to access the NDIS in an equitable fashion. This means ensuring providers are able to work in a culturally competent manner.

2. Agree and implement national targets and local organisational performance measures

What success looks like

- Agreement on national targets and transparency about progress in achieving them over time.
- Agreement on a new Closing the Gap Target on Mental Health.
- Agreement on state, territory and regional KPIs, tied to ongoing funding.
- Aboriginal and Torres Strait Islander mental health is recognised as a national priority supported by a dedicated national Aboriginal and Torres Strait Islander mental health plan.
- NGOs and others receiving government funding have measurable performance targets, with achievement of targets tied to ongoing funding.
- Increased transparency and accountability for results and outcomes.
- A person with a lived experience to tell their story once, not many times: a shared case record and a single care plan links providers into a person-centred approach.
- There is "no wrong door" into mental health and related services.

Key recommendations

Recommendation 4:

Adopt a small number of important, ambitious and achievable national targets to guide policy decisions and directions in mental health and suicide prevention.

How this will be achieved

1. The Commonwealth to endorse eight mental health and suicide prevention targets (see Figure 9) as the key priorities to pursue over the next decade.
2. The Commonwealth to agree with state and territory governments (on a bilateral or multilateral basis) on the eight recommended targets.
3. In consultation with people with lived experience, their families and support people, states and territories, NGOs, the private sector and other mental health stakeholders, as well as data and outcomes measurement experts, the Commonwealth should lead a process to develop and/or confirm appropriate indicator measures to support the eight agreed targets.
4. The Australian Bureau of Statistics should incorporate the endorsed indicators into the 2017 National Survey of Mental Health and Wellbeing to provide baseline and contextual information.
5. The Commonwealth to establish and maintain additional collection processes that support ongoing monitoring of progress against the targets through the National Mental Health and Suicide Prevention Plan.
6. Build formal evaluation mechanisms into all existing and future programmes.

7. Develop with stakeholders standard KPIs and benchmarks for contracting with provider organisations, including measures of access, effectiveness and quality. As far as possible, these KPIs should contribute to achievement of national targets and key performance indicators (individual funding agreements may relate to one or more of the national targets).
8. Agreement to the national targets and indicators should be achieved within 12 months, with reporting commencing within 24 months.
9. Application of organisational targets and indicators aligned to national targets should be included in contractual arrangements by no later than July 2016.

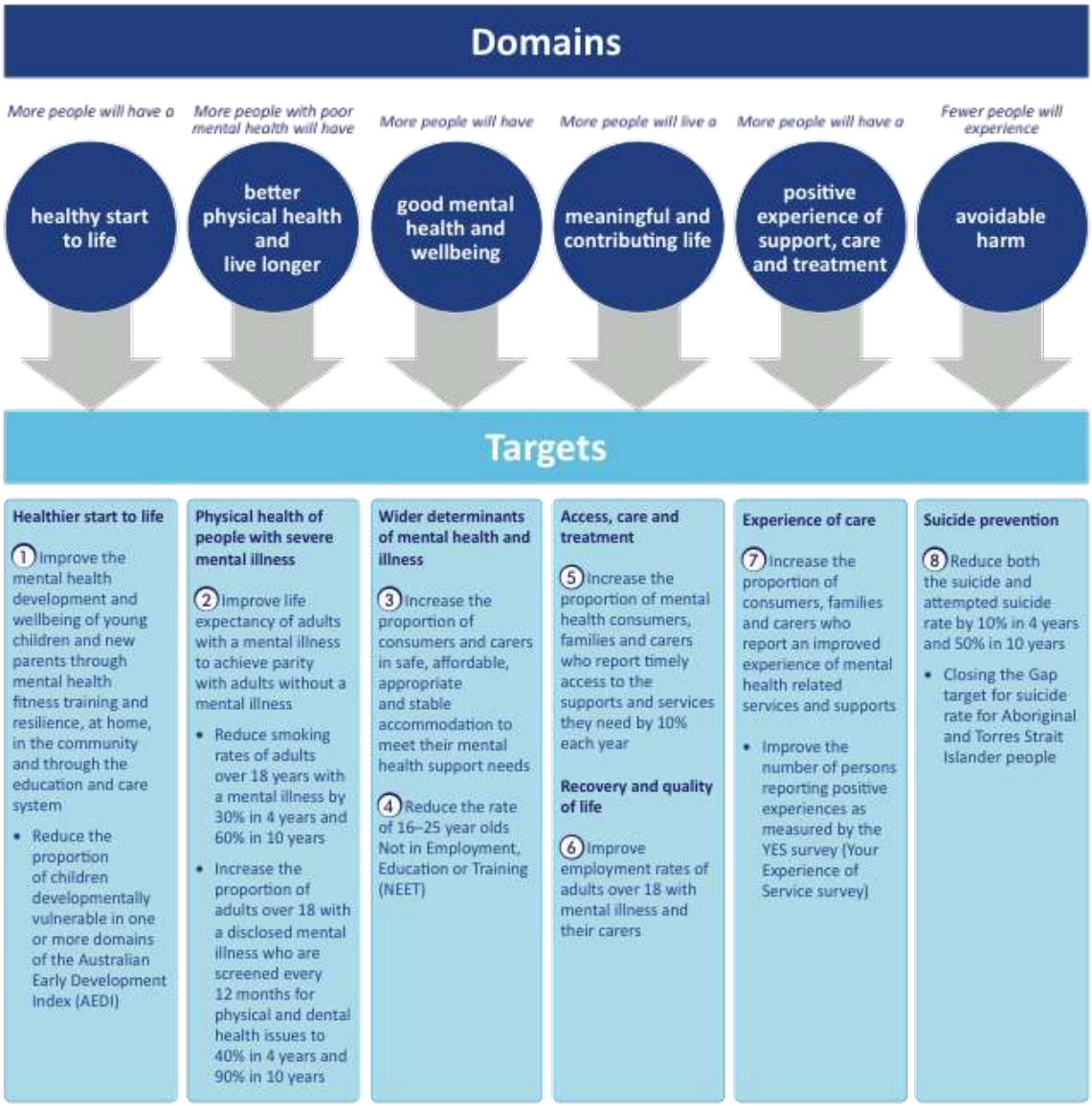
Issues:

- Agreeing and publicly reporting on a small number of very important national targets can be an effective lever to drive change. This has been demonstrated with the six targets set by COAG in 2008 for *Closing the Gap in Indigenous Disadvantage*—those targets have been consistently pursued over time, and have driven systems change through Government policy and investment decisions.
- 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 2013 Report of the Expert Reference Group (ERG) on National Targets and Indicators for the COAG Working Group on Mental Health Reform.[42] The ERG was set up by governments to advise on a set of ambitious and achievable national, whole-of-life, outcome-based indicators and targets for mental health that will be understood by the community and drive systemic change.
- After an extensive consultation process, the ERG proposed a set of 14 targets to COAG. Those targets have not yet been agreed.
- The Commission considers that, while all targets recommended by the ERG are important, a smaller set of seven of the 14 will provide for a better focus on systemic change and performance. This is not to downplay the importance of the other seven targets but rather to seek the agreement of governments to a smaller set of high-priority targets which should be pursued relentlessly and consistently over the next decade. As progress is made, targets may be added or refined.
- None of the 14 targets addresses the issue of a healthy start to life, beginning with maternal and child health, strong families and supporting communities and education systems—a key issue coming from stakeholders, submissions, and the evidence base, and therefore a key theme of this Review report.
- The Commission therefore proposes an eighth target and considers this should be refined over the coming months, with indicators to be developed as a priority.
- Aim to have agreement to targets and indicators in place within 12 months, with reporting commencing within 24 months.
- A target-oriented approach, with reputational and financial incentives for all levels of government, could be supported by appointment of an agency to independently monitor implementation and outcomes and to be a clearing house for the

dissemination of best-practice examples of innovation and implementation and evaluation.

- The Commission also recognises the need for targets and indicators to be linked at all levels of the system—national, state and territory, regional, service level, and individual level—but that different targets and indicators also are required for services and individuals.
- Services and programmes should be evidence-based and regularly evaluated to ascertain ongoing effectiveness and to feed into overarching funding priorities and policy decisions.
- Incentives and disincentives should be established by connecting continuing funding to agreement and achievement on targets and indicators, as well as regular provision of relevant data to enable measurement of progress. The Government should have access to the data that shows whether programme dollars are getting to those who need them, whether it is getting what it paid for and whether the community is getting value for money.
- It is essential that the views of people with a lived experience, their families and support people about what is important to them also are taken into account, measured and reported upon.
- 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 the prevalence of mental health conditions in Australians aged 16–85 years on a longitudinal basis.

Figure 9 Eight national targets



Recommendation 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

How this will be achieved

1. Establish a credible Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention leadership and stakeholder partnership mechanism.
2. Working with the above body, COAG:

- agrees that Aboriginal and Torres Strait Islander mental health and closing the mental health gap is a national priority within the Closing the Gap Framework
- develops and agrees a mental health specific target for Closing the Gap
- establishes a coordinated process for developing a dedicated, national Aboriginal and Torres Strait Islander mental health plan
- identifies medium and long-term savings to be made from closing the mental health gap (i.e. from lower imprisonment rates, better physical health, increasing employment and reducing unnecessary hospitalisation for mental health conditions)
- identifies medium and long-term savings to be made from decisively shifting its approach to Aboriginal and Torres Strait Islander mental health, suicide and alcohol and other drug use to promotion, prevention and early detection
- develops a reinvestment-based funding strategy for closing the mental health gap over the next decade, based on the above two assessments, that includes the additional services proposed in Recommendation 18
- agrees to a national approach to closing the mental health gap that is included in the *National Indigenous Reform Agreement*.

3. The Federal Government makes closing the mental health gap an underpinning element of the Indigenous Advancement Strategy.

Issues:

- Dedicated national Aboriginal and Torres Strait Islander mental health planning and service and programme design is needed because general population mental health policy, service and programme design may not be appropriate for Aboriginal and Torres Strait Islander people.
- This is because of (a) the greater burden of mental health problems and mental illness among Indigenous Australians, (b) the cultural and experiential differences between Aboriginal and Torres Strait Islander people and non-Indigenous people that underpin the 'mental health gap' and (c) the need for tailored services that work within the SEWB context and take into account cultural differences.
- 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 People' Drug Strategy* (under development).
- 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.
- Programme success also requires improved support for Aboriginal and Torres Strait Islander families, and culturally competent services available to communities.
- Public and regular reporting on progress is required to ensure accountability and performance evaluation against targets.

Recommendation 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 eHealth record for those with complex needs.

How this will be achieved

1. Consult with peak consumer and carer bodies, including Aboriginal and Torres Strait Islander bodies and the National Aboriginal Community Controlled Health Organisation, to seek engagement and buy-in on the approach to use of a single care plan.
2. Adopt an 'opt-out' model of voluntary participation in the use of a single e-health record, in line with that recommended in the Review of the Personally Controlled Electronic Health Record.[43] Ensure privacy and security of records including understanding of how the privacy and security works for people with lived experience and practitioners.
3. Introduce into contracts from 1 July 2015 a requirement for service providers to move to a single care plan during 2015–16 for those with complex needs. The plan would need to be agreed to by the person, inclusive of the family, and signed up to by the care team.
4. Services would need to report on an indicator of progress in moving to a single care plan throughout 2015–16, with funding in future years put at jeopardy by suboptimal performance against the indicator.
5. Enable sharing of information for optimal care of the person, irrespective of whether that involves workers from a state-funded service, an NGO or a housing provider, for example. A person-centred approach works to a single care plan and requires different agencies to share information. Locally this means each worker can speak to others confidentially.
6. Use existing technologies to support providers to offer person-centred services. This could mean having a confidential central portal for personal information to be shared between government agencies to assess eligibility for services. People then would not need to keep providing the same sets of data and personal information to different agencies.
7. Information sharing to support the person and ensure they get the best care should not be undermined by unnecessary red tape. Health, nongovernment and other social services/agencies need to sign up to sharing protocols as part of funding contracts.
8. Over time, integrated care and support should extend beyond the health system into the full range of services and supports required to enable people to live contributing lives. For example, research shows that when vocational support is linked to treatment services, people with a mental illness who stay in work or return to work have better outcomes. A single care plan, therefore, might include an employment provider, or housing services, for example.

Issues:

- The growing evidence from people with complex needs (mental health, chronic disease and psychosocial disability needs) is that in addition to managing their own mental health, they need to navigate the myriad of health providers and services supporting them—GPs, specialists, psychologists, housing workers, employment support and personal supports. Families and support people therefore can become default care coordinators.

- The coordination of a person's overall care is an important factor in ensuring the best possible mental health outcomes. This is particularly true for people who are dealing with a number of different service providers in relation to their overall mental health and wellbeing.
- Cost modelling has identified that for people with complex needs, such as a person with severe bipolar disorder, optimal care (based upon greater GP contact, increased support from community mental health teams and continued access to care coordination and psychosocial supports) can yield savings over nine years of $323,000, with about half of that saving being directly to the states through reduced hospital admissions and about one-third to the Commonwealth. Much of that saving occurs in years one to three, although health savings also occur in the later years as health status improves.[29]
- While effective evidence-based interventions are available for people with chronic illnesses and mental health conditions, access to such service approaches are reported as being suboptimal. Studies consistently highlight the importance for those with complex needs of integrated care models, based around the use of a single care plan and supported by a single e-health record.
- Where services take responsibility for people with severe mental illness with complex needs they need the non-clinical and clinical care to be coordinated. The clinical services should provide optimal treatment to reduce symptoms and disability as much as clinically possible. For those individuals with persisting disability (despite optimal clinical treatment) and no privately paid support the publicly funded NGO services should support this individual to live in the community. For people with complex needs, there should be a single care plan which clinical services, government and nongovernment services and any other providers are signed up to.
- People with complex mental health needs are among the highest priority for use of a single e-health record. This is particularly so given the high rates of undiagnosed/late diagnosed and poorly treated physical health complications for those with mental ill-health problems.
- The 2007 National Survey of Mental Health and Wellbeing found that 11.7 per cent of Australians aged 16–85 years—1.9 million people—had both a mental disorder and a physical condition.[3] This means many of them will have multiple service providers, be on multiple medications and probably have more than one health record.
- The use of a single e-health record gives public sector, NGO and private providers a vehicle to enable a whole-of-person approach to the care and support of people with complex needs.
- Clinical deterioration has been recognised as a serious quality and safety issue within the Australian health system.[44, 45] Recently, the Australian Commission on Safety and Quality in Health Care (ACSQHC) expanded its work in this area to auspice a specific Scoping Review on *Recognising and responding to deterioration in mental state*, which was published in July 2014.[46]

Recognising and responding to deterioration in mental state

The poor identification of clinical deterioration among people with a mental illness frankly is unacceptable, given what we know about quality and safety in health care. This applies as much to the clinical deterioration of a person's mental state as it does to the clinical deterioration of the physical health of a person with a mental illness.

Much of this appears to come back to a lack of confidence or knowledge about how to recognise mental deterioration. For example, a person in an acute hospital may have multiple comorbidities which may include a mental ill-health problem. But because the hospital's role is about the patient's physiology, the patient is unlikely to ever undergo an assessment by a psychiatrist, mental health nurse or psychologist.

Likewise, there are similar risks about deterioration and adverse outcomes for patients in psychiatric wards and specialised hospitals, where their physical deterioration will go undiagnosed.

One private psychiatric hospital (anonymous) advised the Commission that the major reason for transfer from their hospital to the public sector was not because the hospital could not manage the complexity of the patient's mental health issues but because of physical deterioration.

"Recognising and Responding to Clinical Deterioration in Acute Health Care" is one of the 10 National Safety and Quality Health Service Standards, which are a critical component of health service accreditation.

In its Scoping Review, the ACSQHC recognised that "ensuring that patients whose clinical condition deteriorates in hospital receive appropriate and timely care is a key safety and quality challenge. This challenge applies equally to physiological deterioration and deterioration in mental state."[46]

The Scoping Review proposes that the link between physical health and mental health be embedded in the National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration which was endorsed by Health Ministers in 2010. It also proposes that the key adverse events associated with deterioration in mental state should be identified and that nationally agreed sets of markers, pathways and protocols should be developed. It also calls for support for practice development to improve skills and confidence in recognising and responding to deterioration in mental state, support for research, evaluation and clinical innovation to enhance early recognition and response, and to better manage the potential for adverse outcomes. The Scoping Review also proposes recognition, rewards and showcasing of clinical excellence and innovation in preventing, recognising and responding to deterioration in mental state in acute settings.

The Commission endorses these actions.

3. Shift funding priorities from hospitals and income support to community and primary health care services

What success looks like

- Programme funding is doubled to enable the nongovernment sector to provide more whole of person, family-centred, wrap-around services.
- Funded organisations demonstrate performance against clear objectives and key performance criteria which are aligned with national priorities.
- People gain improved access to services in the community which support their wellbeing, reduce avoidable hospitalisations and enable them to live contributing lives.
- Funded organisations develop whole-of-person approaches, build capacity, achieve economies of scale and begin to expand the services they offer into more extensive clinical services.
- A whole-of-person approach and improved service integration leads to better mental health and wellbeing outcomes in regional, rural and remote communities.
- Young people experiencing psychosis, their families and supporters know how to, and are consistently supported to, maintain physical health and minimise risks associated with their treatment.
- Primary and mental health networks take a whole-of-person approach in preventing both physical and mental illness and keeping people out of hospital.
- Rural and remote areas are funded on a more equitable basis to provide better access to services.
- Multi-purpose services have developed capacity to extend their care offering to include more integrated mental health services.
- Indigenous primary health care organisations (including Aboriginal Community Controlled Health Services) build capacity with mental health and social and emotional wellbeing teams.

Key recommendations

Recommendation 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.

How this will be achieved

1. Establish a clear plan and budget for migrating Commonwealth funding priorities over time from hospitals and acute services to prevention, early intervention and community and primary health care.
2. With the impending end of the *National Health Reform Agreement* in 2017, shift Commonwealth funding which is currently tied to hospitals away from acute care and crisis management—the role of the states and territories—and in particular away from support for stand-alone psychiatric institutions.

3. Plan and budget to redirect and reinvest an additional $100 million from 2017–18—to be increased by $50 million a year over each of the following four years to $300 million by 2021–22—from the forward estimates to expand hospital avoidance services and build the financial capacity of primary and mental health networks to plan and purchase evidence-based packages of care which reduce demand on state and territory acute and crisis mental health services. This means:

Table 1 Proposed staged redirection of funds

Year	$m
2017–18	$100
2018–19	$150
2019–20	$200
2020–21	$250
2021–22	$300
Total	**$1000**

4. Work with states and territories that wish to participate on initiatives that redirect resources away from crisis and institutional care for those with complex severe and chronic conditions and into programmes which keep people out of crisis, reduce the impacts caused by their illnesses and support them to live contributing lives.
    - Pathways of care which cross the continuum of care (including primary, acute and post-acute care) should be developed, costed and implemented for patients with common complex conditions to increase integration and shift the focus of treatment and support.
    - Introduce pooled funding arrangements between the Commonwealth and states and territories for that small percentage of people who are high users of acute care, or who are at risk of becoming high users of acute care and who usually have comorbidities: establish individual budgets for those assessed as high need and purchase services which enable people to remain with their families and friends, and to lead contributing lives.
5. This phased approach, beginning with relatively small steps in 2017–18, and moving to full implementation by 2022–23, provides time and opportunity for states and territories to plan for system changes which ultimately will reduce the pressure on their hospital systems and provide better health outcomes for the community.
6. Make elements of any future hospital funding agreement at risk dependent on state demonstration of achievement of a number of requirements (such as no overall increase in acute mental health beds, more flexible models of care including community and sub-acute options, downsizing of stand-alone psychiatric institutions).
    - Use pricing signals to increase flexible accommodation and support options as alternatives to stand-alone and outdated long-stay psychiatric institutions.
    - Use contract performance indicators to drive service integration across the hospital and community sectors, and between the public, private and nongovernment sector.

7. Confirm efficiency targets, so that at the midpoint of reform (Year 5), savings and subsequent reinvestment from across all portfolios is identified, along with reinvestment in mental health programmes that have been shown to drive improved outcomes for people and efficiency of government expenditure. These anticipated savings could be accrued through reductions in areas such as acute hospital care, medication prescribing as an initial clinical response and reduced requirements for income support.
8. A redirection of funds also is required to support the systemic changes to Aboriginal and Torres Strait Islander mental health services and programmes proposed in this Review. Such redirection should be managed so as not to have a disproportionate or unfair impact on Aboriginal and Torres Strait Islander people already experiencing mental illness—recognising that in the short term Aboriginal and Torres Strait Islander people 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.

Issues:

- Current funding incentives are driving the wrong outcomes—the incentives are wrong. We need to turn them around and correct the imbalance in the system. The majority of Commonwealth funding is being used at the wrong end of the pendulum—it treats people when they become sick and supports them to stay sick, endlessly cycling through the system and through life.
- People with more severe conditions are ending up in hospital when what they needed was more services and support, including non-clinical supports such as housing, employment and education, to reduce functional impairment and assist with recovery.
- Australia still spends a disproportionate amount of its budget on hospital treatment—and particularly on treatment in stand-alone psychiatric hospitals.
- The Commonwealth currently pays more than $1 billion a year to the states and territories under the National Health Reform Agreement (NHRA) for treatment of patients with a mental health issue in the public hospital system. This includes an estimated $280 million for patients in stand-alone psychiatric institutions. That agreement ends in 2017. The Commonwealth has advised that it plans to negotiate a new hospital funding agreement that will not include growth based on Activity Based Funding (ABF); rather it will include an indexation factor.
- Accessing treatment when it is needed is important—it is essential—but hospital admissions often can be seen as evidence of the failure of the system to keep people well and in the community. The centre of gravity in Commonwealth mental health funding needs to shift upstream, to prevention, primary health care, early intervention and recovery. Conversely, unless action is taken now to change the system and the current incentives, hospitals will continue to absorb an increasing amount of funding and people will continue to end up in crisis when it could have been avoided.
- Costing analysis demonstrates that the earlier a person engages with appropriate clinical treatments and support, the better the health and life outcome for the person, and with a realised financial benefit to overall Commonwealth programmes and to state acute and crisis funding through reduced need for costly acute services and supports with associated higher employment rates and tax revenue.

- Outcome evidence demonstrates the benefits of early intervention to strengthen resilience, avert illness, reduce psychosocial disability and support recovery at:
  - a young age, supporting mothers and babies
  - at early onset of illness, supporting adolescents and families
  - when mental ill-health recurs, supporting people across all age groups and circumstances.
- Throughout the Review, feedback was provided that Australia's level of investment in community-based services is both poor and inequitable and that further investment in psychosocial support and community mental health services will prevent, delay and reduce mental ill-health, keep people out of more expensive hospital and crisis care and help with their recovery.
- The data received by the Commission from Commonwealth agencies suggests that Commonwealth and state and territory governments spend just under seven per cent of their mental health budgets on NGO services: about $900 million.[22, 47] While comparisons are difficult to make, international commentary suggests that over time an increasingly larger share of resources should be moved into this sector.
- In its Mental Health Action Plan 2013–2020,[48] the World Health Organization sets as one of its four objectives "to provide comprehensive, integrated and responsive mental health and social care services in community-based settings." It states that the plan "focuses on a prioritized set of conditions and, importantly, directs its capacity building towards non-specialised health care providers in an integrated approach that promotes mental health at all levels of care."
- The Mental Health Strategy for Canada, *Changing Directions Changing Lives*[49] sets as a recommendation to "increase resources and capacity for a range of community mental health services that serve people of all ages."
- There is a trend among many governments around the world (and indeed at state level in Australia) to reduce their role in direct service provision, and instead to operate as policy makers, planners and funders, with the private sector—not for profits and for-profits—taking on expanding roles as service providers.
- The cessation of the *National Health Reform Agreement* from July 2017 is an opportunity for the Commonwealth, states and territories to plan and budget for a change in direction—to support an approach which will result in better health outcomes for the community and will reduce pressure on the state and territory hospital systems by reducing expensive avoidable hospital admissions. It also will assist states in their processes of deinstitutionalisation as bigger and more comprehensive psychosocial support services will be built up in the community.
- Incentives are created to develop fund pooling arrangements between the states and territories and the Commonwealth for that top few per cent of people who are high users of hospitals and other high cost services, or who are at risk of becoming high users. Through fund pooling, the Commonwealth, states and territories can combine their resources and purchase individual packages of care which keep people out of crisis and acute care, manage their comorbidities and support them to live contributing lives. There is international evidence that fund pooling and purchasing of packages of care is both cost-effective and achieves better outcomes. A similar

approach has been taken under the National Disability Insurance Scheme (NDIS), although the NDIS does not include cashing out of clinical services.

- A phased approach is essential to give states and territories time to design and develop new system architecture for their mental health services.
- The timing of this change also works in well with the establishment of primary and mental health networks. By the time the NHRA expires, the networks will have been in place for two years and will have had the time to build capacity to plan for and manage an increase in resources and responsibilities.
- In addition, by that stage the move to contestability among NGOs and to larger, more flexible funding buckets will be well advanced, so that NGOs will have been developing the capacity to manage further injections of funds. The private sector also may have taken a larger role in this area.

Recommendation 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.

How this will be achieved

1. Rename PHNs as Primary and Mental Health Networks (PMHNs) to give proper recognition to mental health as an area requiring special focus, a priority for government and the community, and a core function of the work of the new networks.
2. Task PMHNs with responsibilities as core system and service integrators of both physical and mental health services for people with mental health problems, and as facilitators and purchasers of mental health and suicide prevention services and programmes.
3. Encourage PMHNs to develop mechanisms to regularly engage with people with lived experience and service providers, involving inclusion of mental health clinicians and people with mental health difficulties on their formal advisory bodies—Clinical Councils and Community Advisory Committees—and establishment of a specific mental health advisory group.
4. In recognition that a small number of national performance indicators are to be used to monitor and assess performance of PMHNs, include an indicator on access to primary health care services as being a fundamental need at the local level.
5. PMHNs should build on what exists and what works in frontline service delivery by engaging with local services, people with lived experience, their families and support people, and research and evidence bases: existing arrangements which make a positive contribution to mental health outcomes should be supported.
6. Where change occurs, there needs to be a smooth, seamless transition for service recipients.
7. Confirm which mental health programmes, or elements of programmes, should be included in the bundled-up flexible funds, as well as which characteristics of those programmes need to be retained as fundamental building blocks and key community-based priorities for larger pooled mental health funding. This includes identification of

those elements which could be included in the design of Integrated Care Pathways (ICPs) for mental health.

8. Set as a priority the development of ICPs for mental health, in consultation with Local Hospital Networks, people with lived experience, their families and support people, and other stakeholders, to enable people with a psychological illness to safely and seamlessly navigate the system with a continuous focus on recovery.
9. Adopt the Healthy Active Lives (HeAL) Programme[50] as the standard intervention framework for people with psychosis on antipsychotic medications, to support their physical health and wellbeing, and enable young people experiencing psychosis to have the same life expectancy and expectations of life as their peers who have not experienced psychosis.
10. In recognition of the early stage of development of the PMHNs, and the desire not to overload them in the initial establishment period, existing programmes should be rolled over in 2015–16, with that year to be used to plan and establish the smaller number of broader, more flexible programmes, and with those programmes to commence from 1 July 2016.
11. Quarantine the mental health budget as a specific line item in the PMHN budget.
12. Accelerate the finalisation and release of Version 2 of the National Mental Health Services Planning Framework and make this publicly available to support PMHNs in their roles as regional planners and purchasers.
13. To assist with location-specific gap analysis and needs assessments (which will be fundamental to ensuring that PMHNs invest in what each community needs), use the Commission-led data linkage project as a further input to provide population-level information on use of MBS and PBS services, linked to ABS census data.
14. Explore opportunities for flexible mental health funding through existing Multipurpose Services and ensure mental health is built in as an essential priority for future MPSs.
15. Require PMHNs to be responsible and accountable within their jurisdictions for improved Aboriginal and Torres Strait Islander mental health outcomes.

Issues:

- Given the appalling physical health and premature deaths of people with severe mental health difficulties, and the high levels of comorbidity involving both physical and mental health,[51] it is logical that primary physical and mental health should be integrated.
- The development of Primary and Mental Health Networks places mental health where it needs to be—a multidisciplinary primary health care approach which looks at the needs of the whole person, not simply at separate diseases or body components.
- An important message from this Review is that the primary health care sector, the NGO sector and the private sector all should play a bigger role in enabling better mental health and wellbeing.
- A clear direction is that physical and mental health (and likewise physical and mental health systems) should not be seen as separate, but rather as interdependent and mutually integral in protecting, promoting and achieving overall wellbeing.

- It follows that the regionally based Primary and Mental Health Networks should take responsibility for both physical and mental health and wellbeing. This also is a practical approach in that a number of regional mental health programmes already are funded through Medicare Locals and with the transition to PHNs these programmes are expected to transition as well.
- The Commission considers the future regional role and structure of mental health as fundamental to the design, development and introduction of the PHNs, with a regional approach to the planning, commissioning and delivery of mental health services being core to mental health change. Mental health and suicide prevention services and programmes need to be a part of mainstream services, but in such a way that the separate identity and accountability for mental health outcomes is maintained and enhanced.
- The Review has identified that access and availability often is determined by where a person lives, and is predetermined by programme constraints and funding arrangements, rather than the person's individual needs, diagnosis or circumstances.
- The Commission is aware that the intent is to establish a small number of KPIs reflecting outcomes that are aligned with PMHN priorities to be used to monitor and assess performance at a national level. Accordingly the Commission considers that a KPI on access to primary mental health care is appropriate.
- *Treatment rates for mental illness* is a measurable indicator on the proportion of the population accessing primary mental health care programs, disaggregated by program stream and including identification of Aboriginal and Torres Strait Islander access. To be meaningful, the indicator should include hospital attendance information (given that in many rural and remote areas people go to hospital to see a GP rather than to private practice) as well as ATAPS and MHNIP activity as being alternatives to MBS-subsidised items. This approach also needs to include local benchmarking of access.
- The Commission recognises that PHNs (or PMHNs) will be new organisations and that in the initial stages it will be important to not overload them as they become established and put in place their corporate arrangements. However, the prevalence of mental illness within our society means that it is simply not possible to plan for integrated primary health care without taking into account mental health.
- A core priority for PMHNs should be the establishment of Integrated Care Pathways (ICPs) for mental health, developed in consultation with state and territory services, other service providers, and people with lived experience, their families and support people. ICPs should be designed and used to provide the most effective care for people with a psychological illness and enable them to seamlessly navigate through the system, with a continuous focus on recovery.
- Bundling up of programmes provides for greater flexibility and responsiveness to local needs. Integration also provides potential for greater efficiency and effectiveness to achieve better value for money for the users of services and taxpayers.
- As 2015–16 will be the first year for PMHNs, it is proposed that existing contracts for programme funding which will flow to PMHNs should be rolled over in the first year, with a focus on health care service continuity and a smooth transition.
- In moving to such a system, it is important to ensure that those things which currently work are not lost in transition. This is not about reinventing the wheel but rather

about building on what works, while improving efficiency and effectiveness of programmes and services so that more on-the-ground services can be provided.

- Very definitely, it is not about taking away necessary frontline services from those who are accessing services now—it is about ensuring they are person-centred and integrated around the needs of individuals, their families and other support people.
- Thus it will be important to confirm in contracts with PMHNs the key design characteristics of services and programmes which need to be retained and built upon, as well as any community-based national priorities for larger pooled funding.
- Recent data from Western Australia shows that the gap in life expectancy for people with psychosis compared to the general population is estimated to be between 14 and 23 years.[6] They have nearly twice the rate of obesity, three times the rates of diabetes, smoke at a rate two to three times higher, and they have high blood cholesterol levels at five times the rate of the general population.[12]
- People with schizophrenia also tend to seek treatment late and access fewer services than the general population.[52-54] On a daily basis, care is being compromised by the unequal status and treatment of mental health compared with physical health conditions.
- The HeAL Declaration is an internationally recognised tool, initiated by Australian psychiatrist Dr Jackie Curtis, which aims to put mental and physical health on a par through a programme which responds to the physical risks experienced by young people experiencing psychosis due to the physical complications caused by their treatment.[50]
- The programme has been implemented in a number of countries including the UK, Canada, Italy, Japan, and Norway, and is used to varying degrees across Australia.
- HeAL should be adopted as the standard across Australia in PMHNs and LHNs for managing the physical health risks of young people experiencing psychosis.

Recommendation 9:

Bundle-up 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.

How this will be achieved

1. Agree to establish a smaller number of larger regional programmes, to be managed regionally by Primary and Mental Health Networks.
2. Determine which programmes should be managed at a regional level, and the number of bundled programmes which should be created.
    - While one option is a single programme, this may not be the best approach to achieve government policy directions.
    - Another option is for programmes focused on individuals such as PHaMs and Day to Day Living to be bundled into one programme, while programmes focused on clinical services such as ATAPS and Mental Health Services in Rural and Remote Areas (MHSRRA) could go into another.

- Other options are for programmes to be based on population groups—for example, child and adolescent mental health—or on specific models of care, such as support for integrated care pathways between the primary and secondary levels of care.

3. Move planning and management of the new programme structure and related existing contracts to a regional level. This would enable improved integration, responsiveness, efficiency and effectiveness: a small number of larger and more flexible programmes, with broader, more comprehensive objectives, fewer outcome indicators and reduced red tape, overlap and reporting requirements.
4. Consider providing industry assistance funding, to enable skills training and facilitate 'backroom' efficiencies (and potentially mergers) between NGOs, on the basis that organisations provide a business case demonstrating that resultant efficiencies can be used to either repay those costs or enable provision of more services.
5. On a staged basis, move to contestability for these fewer but larger programmes, with one of the objectives being to contract with a smaller number of larger NGOs, consortia or private providers with increased capacity to manage and to ensure a larger proportion of expenditure reaches frontline services.
6. Determine the future governance and contract arrangements for headspace National.
7. Consolidate headspace National and the National Centre for Youth Mental Health to achieve efficiencies.
8. Reduce red tape and tendering costs by enabling contracts of up to five years, subject to risk rating and demonstration of performance—the better the performance, the longer the contract (and vice versa).
9. Ensure contracts include specific accountabilities for better mental health outcomes for Aboriginal and Torres Strait Islander people and development of partnerships with Indigenous primary health care organisations including Aboriginal Community Controlled Health Services.
10. Contracts should require expertise and cultural sensitivity to the communities being supported—for example, people from Culturally and Linguistically Diverse backgrounds (CALD) and Lesbian Gay Bisexual Transgender and Intersex (LGBTI) people—or the specific issue being addressed; for example, expertise in eating disorders.
11. Support young mental health leaders to establish peer services to help young people develop leadership and business skills, including through grant and social enterprise funding, and expert advice in corporate, business, financial and governance requirements to enable them to successfully compete for funds and operate sustainable not-for-profit businesses.

Issues:

- While findings of this Review revealed mixed progress on formal evaluations of a number of programmes, none of the available evidence or feedback from stakeholders suggested that any programme was not adding value. That is, there is insufficient evidence to suggest that any specific programme should be defunded due to lack of impact.
- What the Review has identified is a range of factors inherent in the current programme structure which are having an impact on how they operate collectively.

- From a provider perspective, concerns were raised about red tape and compliance costs that draw resources away from front-line services. Issues included:
  - the input nature of a number of programmes
  - the nature and volume of reporting
  - different programmes, different agencies and different levels of government requiring different reporting at different times and frequencies
  - different geographical boundaries that contribute to complexity and cost, with providers recasting reports to fit within boundaries of different programmes and levels of government.
- Concerns also were raised about the lack of clarity in Commonwealth and state and territory roles, including that the Commonwealth's direct funding of local service providers has been without proper consultation, local planning and engagement, and has created even greater uncertainty for people with lived experience and providers, and even more confusing pathways for people with lived experience.
- Therefore, it is not so much that the evidence on the effectiveness and efficiency of individual programmes necessitates changes, but rather that a systems change is warranted, particularly on the basis of the factors experienced by people with a lived experience of mental ill-health.
- Programmes which could have their non-national funding components rolled up into larger regional programmes include:
  - Support for Day-to-Day Living in the Community
  - Better Access Education and Training
  - Visiting psychiatric services through the Medical Specialist Outreach Assistance Programme (MSOAP)
  - Youth Early Psychosis Programme (YEPP) (formerly Early Psychosis Prevention and Intervention Centres—EPPIC)
  - headspace
  - Partners in Recovery (PIR)
  - Access to Allied Psychological Services (ATAPS)
  - Elements of the National Perinatal Depression Initiative and the National Suicide Prevention Programme
  - Personal Helpers and Mentors (PHaMs)
  - Mental Health Respite for Carers
  - Family Mental Health Support Services
  - Infrastructure for Suicide Hotspots
  - Mental Health Services in Rural and Remote Areas (MHSRRA).
- The Commission proposes that, at this stage, the Mental Health Nurse Incentive Programme (MHNIP) should remain outside of these arrangements. The reasons for this are explained at Recommendation 21.
- The intent of this bundling into a smaller number of bigger programmes is not to close programmes or reduce access to services, but rather just the opposite: it is to improve integration of frontline services, enhance effectiveness, efficiency and economies of scale, and channel a greater share of funding into frontline services.

headspace: the National Youth Mental Health Foundation

- headspace provides clinical services for people aged 12–25 who need real help across the areas of mental health, employment, drug and alcohol use, relationships and school difficulties. This initiative has been established specifically to respond to the major deficit that existed previously in access to 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 shopfront-based services in local communities, distributed widely across the major regions of Australia. The Government has committed to expand to a total of 100 headspace services by 2016.
- 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, shopfront-oriented 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.

Funding model

- The current headspace funding model is an unusual arrangement in that it involves a funding contract from the Commonwealth Department of Health to an intermediary in headspace National in Melbourne, which in turn subcontracts with local headspace services subject to a range of terms and conditions—in effect, a franchise model. There are no other Commonwealth mental health contracts structured in this way.
- More than $400 million has been committed to headspace over the five years from 2013–14.
- headspace National (i.e. the national office as distinct from the contracts with local service providers) is being funded $41.2m over the six years to June 2015, or $8.6m in 2013–14, for headspace core activities associated with national oversight of headspace, including setting up local sites, community awareness, a Centre of Excellence run on its behalf by Orygen (the National Centre of Excellence on Youth Mental Health—separate to the new initiative funding of $18 million over the next four years from the Federal Government), training and education and other specific activities such as indigenous and homelessness strategies.
- This arrangement enabled the roll-out of the headspace model in what originally was a new and emerging sector. It has been claimed that the centralised contract management and implementation support by headspace National has enabled strong support for the fidelity of the headspace model and for monitoring of that fidelity.

- On the other hand, the overly centralised control of the headspace model and rigid management requirements imposed on local headspace services has resulted in the development of headspace services which often operate as a silo to other mental health services, and indeed to the broader service sector. headspace clinical and regionally located services are not a population-based model. They are a specific service which sits within a broader system which is focused on meeting the needs of a particular population, but they also sit outside most of the pre-existing private, community or state government-based systems.
- If the principles proposed in this report were to be applied to headspace in the same way as is being proposed for other programmes, the department would not fund headspaces via an intermediary, but rather would provide a flexible payment to PMHNs which includes funding for local headspaces. It is emphasised that this in no way should be seen as a threat to the ongoing existence and role of the headspace services; they would continue to expand in number and service capacity but under a contract with the PMHN, supervised by the Federal Department of Health, rather than with headspace National.
- In fact, the arrangement proposed here could result in additional funding for local headspace centres, depending on the priority as determined by regional population health models, the local community and the PMHN.
- The advantage of such an arrangement is that local communities could co-invest in the initiative, benefit from greater integration and coordination between headspace services and other established services (including health, private, community, social and academic services) in the local area, and that headspace could be effectively located within a population-based approach to mental health and wellbeing. PMHNs would be responsible for ensuring local headspace services are flexible and responsive to local need, work in partnership with other relevant services (e.g. state child and adolescent mental health services) to provide a comprehensive local response, and have an assigned role in integrated care pathways through the primary and acute care sectors. It also enables streamlining and reduces potential for duplication.
- Under such an arrangement, while the national organisation no longer would be the direct contract manager for the individual headspace services, it could continue to have a direct relationship with individual headspace services in national initiatives such as development of standards, models of care, standardised evaluation, participation in clinical trials, participation in systematic health services evaluation, translation of research into practice, sharing of best practice, branding, workforce development and consultancy support, particularly for new headspaces.

Guaranteeing the headspace model

- The challenge is to ensure that under any changed arrangements headspaces continue to operate in fidelity with the headspace model and that the national system of youth mental health care flourishes and delivers better outcomes to young people while improving efficiency. It is essential that the important gains that have been made are not dissipated under a different and more regionally responsive contracting model.
- In effect, the question becomes: what is the optimal way of contracting services in ways that maintain the fidelity of the model and give authority for a national organisation to monitor and take corrective action to ensure that fidelity is maintained, while giving the flexibility at a local level to enable greater integration and networking of services around the holistic needs of the target population?
- There is a range of options which could be considered, including:

- maintain the status quo (which would not respond to the issues raised in this Review)
- introduce greater flexibility and local engagement and integration requirements into contracts with local headspaces, and reducing the role of headspace National in becoming involved in local decision-making
- contract direct from headspace National to PMHNs, and from the PMHNs to local headspaces
- a three-way contract between the department, headspace National and PMHNs, with clear accountabilities identified and agreed between the parties
- the department to contract with PMHNs, which in turn contract with local headspaces. headspace National develops national policies, guidelines and an annual purchasing framework to be implemented through contractual arrangements with the department as funder, the PMHNs as planners and commissioners, and headspaces as providers.

- To achieve efficiencies and get more funds to frontline services, the Government should look at consolidating headspace National with Orygen's National Centre for Youth Mental Health (which recently received an additional $18m from the Commonwealth). This would have the advantage of reducing duplication between the two nationally funded operations, as well as capitalising directly on the research and evaluation expertise of Orygen (and thereby require a much greater degree of academic and public reporting of the outcomes of this novel service initiative).

Recommendation 10:

Improve service equity for rural and remote communities through place-based models of care

How this will be achieved

1. Primary and Mental Health Networks, in partnership with Local Health Networks, should conduct comprehensive mapping of mental health services, programmes and supports available in regional, rural and remote areas through Commonwealth, state and territory and local governments, private and not-for-profit sectors.
2. As appropriate, this mapping exercise also should be used to support the development of mental health and social and emotional wellbeing teams operating in rural and remote Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services) and specialist mental health services.
3. Include services that are mental health-specific, delivered through health and other non-health portfolios, e-mental health and other phone and online services, as well as broader services which contribute to the physical health of those with a mental illness.
4. As an urgent priority, develop a regional mental health and suicide prevention strategy, based on the mapping of local services and application of the National Mental Health Services Planning Framework.
5. Coordinate initiatives to improve both the physical and mental health outcomes of people with mental illness, including, for example:

- integrated, multi-disciplinary approaches—new models and ways of thinking, funding and working
- tailored prevention and early intervention strategies
- building links between mental health and primary and subacute/acute care
- making improvements in referrals (with an emphasis on supported referral) and other aspects of service coordination.

6. Build on the Multipurpose Service Programme model as important local infrastructure to integrate and collocate mental and other health services in rural communities, supported by telehealth services.
7. Address the impact of isolation on young people, particularly those in remote areas who have limited opportunities to socialise, through both social media and the development of inreach and outreach opportunities with others.

Issues:

- Location matters for the mental health of approximately 30 per cent of Australians who live outside our major cities. But there is no agreed national approach to mental health service delivery in regional, rural and remote areas and for ensuring a fair and equitable share of resources.
- We know there is a significant shortfall in mental health-specific services in areas outside major cities and inner regional areas, and this deficit tends to worsen with remoteness. Compared to remote/very remote areas, per capita, major cities:
  - Have almost four times as many psychiatrists, three times as many registered psychologists and twice as many mental health nurses
  - Receive around six times more in Medicare subsidies for mental health services ($43 compared to $7)
  - Are twice as likely to provide specialist psychiatric care to people admitted to hospital for mental health reasons.[55]
- About one in four Aboriginal and Torres Strait Islander people live in remote and very remote areas. This recommendation should be closely developed with the overall systemic approach to improving Aboriginal and Torres Strait Islander mental health proposed in this Review.
- Due to diversity between regions, a 'one-size-fits-all' approach cannot be applied across regional, rural and remote Australia. Nor can assumptions be made about the availability of services in one area on the basis of those in another. Local circumstances need to be considered, including current service availability, prevalence of mental health concerns, and demographic, environmental, socioeconomic, cultural and other factors.

- Work undertaken for the Commission in the course of this Review concludes that "access to the advice of specialist mental health professionals in emergency situations, 24 hours a day, seven days a week and year round, is now possible— no matter how remotely a person might live….when specialist mental health and recovery support professionals and services cannot be present on the ground, it is now possible to provide the necessary assistance and interventions in real time via telephone or over the internet via computers, iPads and other hand-held devices."[56] The Commission has considered telehealth and e-mental health later in this report and agrees on the vital need for development and integration of e-mental health services, but that there should be a particular focus on people living in regional, rural and remote areas.
- Multipurpose Services (MPSs) are integrated health and aged care services that provide flexible and sustainable service options for small rural and remote communities. The Federal Government provides aged care funding which is combined with state and territory government funding for health services and infrastructure to bring a flexible mix and range of aged care and health services together under one management structure. This gives small communities which are having difficulty supporting a range of independently run services the opportunity to develop a more coordinated and cost-effective approach to service delivery.
- Currently there are 174 MPSs across Australia providing services to communities with populations within the range of 1,000 to 4,000 people.
- MPSs are important hubs within rural communities: PMHNs and LHNs should work together on opportunities to collocate other services with them, including mental and other primary health care services.
- Social isolation is a major factor impacting on the mental health of young people, particularly in more remote areas—for example, where distance education is used. Social media is an important way for young people to connect, and for them accessing online information is the norm. Services should look for ways of communicating with socially isolated young people, as well as connecting peer groups, both online and through face-to-face opportunities to meet.

4. Empower and support self-care and implement a new model of stepped care across Australia

What success looks like

- Online and self-help services are available and being accessed.
- Self-help, peer-based and online services are fully integrated with more traditional existing services, with a mental health workforce trained to optimise access.
- More people with mental ill-health problems are encouraged to seek appropriate care.
- General practice and the broader primary health care team are supported as the frontline response on prevention and early intervention.
- Integrated care pathways and guidelines for mental health are widely used in primary health care, and between primary and secondary care.
- Projected growth in acute hospital funding has been curbed.

Key recommendations

Recommendation 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.

How this will be achieved

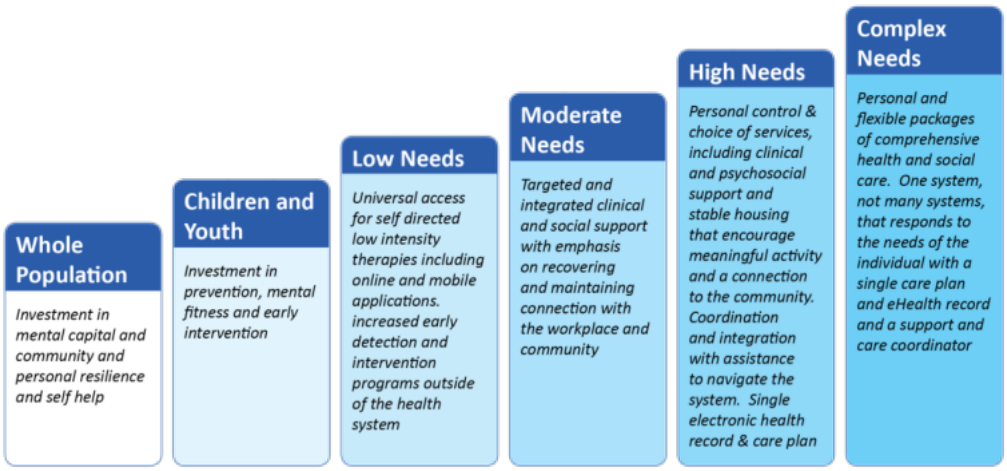
1. Agree a system of stepped and integrated care as a fundamental building block for the mental health system.
2. Promote self-help and building resilience as a first-line response to achieving wellbeing and reducing mental distress.
3. Drawing on the expertise of the mental health and community sectors—including e-mental health providers—to develop, disseminate and promote a suite of resources and supports for self-help and online services, and evidence of effectiveness of these supports.
   - This could include a 'Mental Fitness Ready Reckoner' for people, their families and other support people to explain psychological distress and mental health.
   - Distribution should be through various channels including social media, eHealth and telehealth, as well as through general practices, pharmacies, community centres, Centrelink offices, schools and workplaces.
4. Task the Mentally Healthy Workplace Alliance (the Alliance) with mental health safety and wellbeing, self-help, and with reducing stigma and discrimination in the workplace.
5. Promote mental health first aid training and other evidence-based programmes for workers who are likely to come into contact with people with mental illness, including those in human services (including Centrelink and employment service agencies), justice, health, education systems and human resources, as well as in early childhood, to encourage more mental health aware approaches, and reduce unintentional discrimination.

6. Build on existing opportunities and events such as Mental Health Week and R U OK? Day to promote mental wellbeing, resilience and reduced stigma and discrimination.

Issues:

- A key finding of this Review is for resources in the mental health system to be allocated according to need, to eliminate waste and promote efficiency, ensure safety, enhance quality, and improve access for people to the right services, at the right time and in the right place. The system should operate efficiently and effectively, to guard against both under-servicing at higher levels of need and over-servicing at lower levels of need.
- A stepped care model aims to provide a match between need and supply. Stepped care services need to range from no and low-cost options for people who are generally healthy, may be mentally distressed, or at low risk, to options which provide support and wrap-around services for people with severe and persistent mental ill-health to live contributing lives in the community.
- Just as the level of need for services and support travels along a continuum, from no and low need to high needs, so too should the level of supply move from low to high, as should the associated costs. But far too often this is not the case and people enter into a medical model of care that may have been avoidable with the right early steps.
- This report deals elsewhere with other elements of the stepped care approach, including building capacity for children and youth, changes to primary health care, and regional funding models. This particular recommendation is focused on self-directed and supported care, particularly for those with no or low needs (self-management should occur at all levels of the model). To assist in explaining the concept, the illustration of a stepped care model is repeated below (Figure 10).

Figure 10 Stepped care, where services are matched to individual need



Adapted from The Case For Mental Health Reform in Australia: a Review of Expenditure and System Design, Medibank Private and Nous Group (2013)

- An emphasis on support for self-management of people who are mentally distressed, or with mild or moderate high prevalence needs, aims to provide people with a first option to access alternatives to medical and pharmaceutical treatments such as online

self-help, childhood and youth education and support, and family and community resilience building.

- Providing individuals, families and communities with the tools they need to safely and confidently use self-care and take preventive steps to look after their own wellbeing also can reduce pressure on other parts of the system and free up resources to be used to treat more people.
- In many cases, these approaches will prevent people from needing services in the first place, which in turn will enable more efficient and appropriate allocation of existing resources. Time is a precious resource, for both providers and people with lived experience and their families and supporters. An approach which promotes online interventions at the click of a mouse (not a prescription or other more intensive intervention) gives people and providers back their time.
- Importantly, the ultimate objective is to help people to avoid the experience of mental illness, and the personal and financial costs this often entails.
- The community needs better information and understanding about what options are available for managing mental ill-health problems, including how to access information, self-care and self-delivered services, online and telephone supports, and improved skills among families and communities to support each other. It also includes greater awareness of how to maintain good mental health, including through mentally healthy work practices and workplaces, family and community engagement and physical exercise.
- To encourage take-up of these options, they require information on effectiveness, particularly in relation to self-care and online services as alternatives to medication or one-on-one professional support. This information needs to be credible, reliable, coordinated and consistent, to ensure that alternative care and support options are (rightly) perceived as legitimate.
- Encouraging greater knowledge and appreciation about recovery from mental illness also can promote community resilience and address issues of stigma and discrimination.
- Stigma is associated with poorer physical and emotional health, as well as poorer employment outcomes. It can discourage individuals from disclosing their illness and from seeking help, both of which are important steps to gaining assistance in managing symptoms and preventing the development of a more serious experience of mental illness. In this way, stigma presents barriers to service access, creates additional distress and mental ill-health and ultimately drives up system costs.
- The Commission previously advised governments about the need for targeted anti-discrimination initiatives, beginning with those who come into frequent contact with people with mental health problems and their families and support people, as well as those among whom discrimination is the greatest.
- As part of the approach to promotion of self-care, the opportunity should be taken to respond to issues of stigma and discrimination which break down resilience, create additional distress and mental ill-health and drive up system costs.
- Funding for this initiative could be sourced from existing national programmes.

- The Mentally Healthy Workplace Alliance is a national coalition of business, community and government leaders which so far has developed practical resources for all business and industry sectors to help them create mentally healthy workplaces. The productivity cost to Australia of mental ill-health is estimated at $12 billion a year: it is something that impacts on virtually all businesses at some time.
- The alliance has partnered with *beyondblue* in the Commonwealth-funded national initiative HeadsUp, to raise awareness of workplace employment issues and provide direction for improved practices, including tools to enable businesses to assess and plan for mentally healthy workplaces.
- Involvement of the alliance can assist employers to recruit, 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.

Recommendation 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 Medical Homes for Mental Health.

How this will be achieved

This recommendation comprises four key elements:

a. The promotion of the use of evidence-based guidelines which support a stepped care approach.
b. Changes to the Practice Incentives Programme (PIP) to promote quality mental health services in general practice.
c. Inclusion of a mental health assessment in Medicare Benefits Schedule (MBS) health assessment items.
d. Establish a first phase rollout of Medical Homes for Mental Health, beginning in four diverse regions.

Stepped care and evidence-based guidelines

1. Seek confirmation of best practice guidelines for mental health as expert guidance on assessment, treatment, monitoring and referral, including on meeting the particular needs of Aboriginal and Torres Strait Islander people.
2. Promote the guidelines to GPs and the broader primary health care team, including information on alternative pathways of care and support based on severity of need, including functional impairment. This approach could include (subject to further expert advice):
   - as a first-line response, access to self-help such as Internet self-help programmes and information, mobile applications and low intensity counselling services (including family counselling) for people with mental distress, and mild and moderate mental ill-health difficulties (see Recommendation 25)
   - backed up where needed with proven psychological services
   - medication being considered as a second or third-line response to clinical need, other than where medically indicated at an earlier stage.

3. Further, this could include providing general practice with alternatives to medication prescriptions such as:
   - Blue prescriptions with information on peer-reviewed and evidence-based online sites such as online psychotherapy.
   - Green prescriptions with information on how to access other programmes, including exercise, diet, lifestyle changes and mindfulness strategies.

Practice Incentive Programme (PIP) payments for Mental Health

4. Bundle a number of the existing PIP payments into a single, larger payment which encourages holistic, quality general practice, including mental health quality indicators such as use of best practice guidelines (to be determined in consultation with stakeholders, including people with lived experience, their families and support people and relevant professional colleges).

MBS Health Assessment items

5. Change the descriptors for MBS health assessment items to ensure that claiming for them includes a requirement for GPs to undertake an assessment of the mental health/social and emotional wellbeing of the patient.
6. Promote mental health and social and emotional wellbeing assessments as a part of the MBS-subsidised health checks for Aboriginal and Torres Strait Islander children, adults and over-55s.

Staged implementation of Mental Health Medical Homes

7. Pool existing funding from programmes supporting people who experience serious mental illness and develop new funding and administrative approaches in a number of PMHNs, including at least one with regional, rural and remote communities to keep people out of hospital and functioning capably within the community.
8. Work with the dedicated Aboriginal and Torres Strait Islander specialist services to ensure patient transitions across services.
9. Design the first phase in consultation with stakeholders.
10. Develop a funding pool from efficiencies in the forward estimates identified across mental health (e.g. PBS, hospitals, DSP, carer payments), and a transparent, built-in share of any future planned increases in MBS fees and rebates.
11. Introduce incentive payments for general practices to take on responsibility for the coordination of care for people with more severe mental illness:
    - voluntary enrolment with a general practice
    - a single care plan linked to a single patient electronic health record which all providers need to sign up to
    - assignment to a primary mental health treatment team
    - assignment to a care coordinator or case manager who will support the individual to navigate the system.
12. Focus initially on clinical services for mental and physical health, supported by PMHNs to incorporate liaison with community service providers including in housing, justice, education and employment, for example. Over time, and depending on the scale of the practice, the practice could take on these responsibilities as well.

13. Develop a virtuous circle in mental health investment: undertake an assessment of likely downstream costs of enrolled patients (using an actuarial assessment of a practice population or based on past individual experience), track and forecast savings over time, and use those savings to increase the funding pool to enable higher payments to general practice and further increase capacity.

Issues:

- Much of the responsibility for providing mental health care sits with primary health care providers—GPs, nurses, allied health professionals, Aboriginal health workers and community health workers. This reflects both the treatment preferences of many Australians and the availability and affordability of health care services.
- For many people, episodic treatments supported by episodic payments through the MBS are absolutely appropriate, effective and efficient. But treatment for more severe mental ill-health can be complex and time consuming.
- Aboriginal and Torres Strait Islander people, particularly those unable to access Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services) generally are 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. As such, the ability of GPs to provide a culturally competent service is critical to how the mental health system responds to greater Aboriginal and Torres Strait Islander mental health needs.
- In Australia, there is relatively high use of antidepressant and other medications, of acute care and crisis services, and relative under-use of other forms of cost-effective supports.
- GPs have a central role in connecting people with lived experience, their families and support people to the right services.
- However, GPs' referral options currently are restricted by a limited range of service types, low capacity within existing services to take on new clients, and MBS rebates being available for some services but not others.
- To address these barriers, changes are needed in relation to:
  - MBS items: specifications and rebate values
  - referral guidelines
  - GP education: to increase awareness of the range and effectiveness of mental health service options
  - funding for services: to increase the diversity, availability and capacity of stepped care options in mental health services

Stepped care and evidence-based guidelines

- Introduce reforms and incentives which match services to different levels of need, from no or low cost/low intensity supports and interventions to higher level clinical and non-clinical support for those with higher needs, with changes required to support availability of new service/referral options within the Medicare Benefits Schedule (MBS), Better Access programme and the Pharmaceutical Benefits Scheme (PBS).
- This approach is based on strong evidence about a stepped, integrated approach:

- the *beyondblue*-developed/NHMRC-endorsed Clinical Practice Guidelines: Depression in adolescents and young adults[57] state:
  - "SSRIs (antidepressant medication) are not recommended for treating young people with mild depression" - Good Practice Point 19
  - "Prescription of the selective serotonin reuptake inhibitor (SSRI) fluoxetine should be considered for acute, short-term reduction of depressive symptoms in adolescents with moderate to severe major depressive disorder, where psychological therapy has not been effective, is not available or is refused, or if symptoms are severe." (emphasis added)—Recommendation 5

- In Tolkien II, Andrews et al[58] describe "optimal" treatment for various mental health disorders—for mild and moderate depression, both steps 1 and 2 involve general practice plus information/internet education and treatment. Neither step involves the prescribing of antidepressants.
- This approach also is consistent with evidence of other countries which make extensive use of guidelines; for example, the UK's National Institute of Health and Clinical Evidence (NICE) guideline on Common Mental Health Disorders[59] involves a three-step model using pathways where medication is not proposed at Step 1, and is just one of a number of options at Steps 2 and 3.
- The concept of green and blue prescriptions, as alternatives to the standard medications prescription pad for GPs, comes from both overseas experience and some innovative approaches in Australia.
- Many people visiting a GP expect to be given something before they leave, and that something is often a prescription. This also is impacted by the fact that GPs are time-poor, with Medicare benefits based on timed fee-for-service items.
- In New Zealand, green prescriptions were introduced 14 years ago through a partnership with general practice as a means of supporting health professionals to provide written advice to patients on being physically active, as part of the patient's health management. Research shows that green prescriptions have been an inexpensive way of increasing physical activity, improving diet and improving quality of life.[60, 61] They also have proven to be highly popular with the public.[62]
- The introduction of blue prescriptions formalises the practice of some doctors who provide patients with a list of web addresses where they can access self-help and information services. Providing printed blue prescriptions which list evidence-based websites would provide another alternative for GPs and a useful service for patients.

Practice Incentive Programme (PIP) payments for Mental Health

- Around 5,400 general practices participate in the Practice Incentives Programme (PIP) each year with funding budgeted at $253 million in 2014–15 ($290 million in 2015–16). The PIP:
  - provides a key reform instrument for changing the way general practice is delivered and delivering on government health priorities
  - is a key driver for general practice accreditation

- Replacing some of the existing PIP payments with a quality incentive which includes mental health within existing resources would be a no-cost option but would represent good use of the programme to promote quality practice. Again, this could include incentives for continuous improvement in the use of evidence-based practices, including guidelines and pathways of care.

MBS Health Assessment items

- The MBS includes a number of health assessment items. There are four age-based items which are described in the schedule as follows:
  - a Healthy Kids Check for children who are aged at least three years and less than five years of age, who have received or who are receiving their four-year-old immunisation
  - a health assessment for people aged 45–49 years who are at risk of developing chronic disease
  - a Type 2 diabetes risk evaluation for people aged 40–49 years with a high risk of developing Type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool
  - a health assessment for people aged 75 years and older.

  Other health assessment items include:
  - a comprehensive medical assessment for permanent residents of residential aged care facilities
  - a health assessment for people with an intellectual disability
  - a health assessment for refugees and other humanitarian entrants.
- A separate item, with separate descriptions, is available for Aboriginal and Torres Strait Islander health assessments.
- The guidelines allow, but do not require, the undertaking of a mental health check as part of a health assessment. The Commission considers that they should.
- 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 patients and for then connecting them to programmes like ATAPS or Better Access for treatment, or otherwise ongoing referral.

Staged implementation of Mental Health Medical Homes

- We know the majority of people with mental illness can recover with appropriate treatment and support.[63] We also know that for some people, such as about 20 per cent of people with schizophrenia where their illness is more persistent, it has a greater effect upon their ability to lead their daily lives and they need additional support.[64] In such instances, the more a person's illness is persistent and their needs complex, the more service providers they tend to have. Navigating the system becomes more complex and they have to retell their story repeatedly to different providers.
- Complexity means they are more likely to have physical health comorbidities—for example, diabetes and heart disease. Providers who support a person's mental health may be different from those who support their physical health problems. And the different providers often will not know of the existence of or details of other

treatments. This is particularly a problem where people are on multiple medications where adverse side-effects may occur.

- Many people find the complex treatment pathways daunting and stressful and do not seek the support and treatment they need. A number fail to comply with medication requirements. Some people may have problems in day-to-day living; for example, with housing, their relationships, their education, their employment, or potentially with police and the prison system.
- For people who tend to experience disjointed and uncoordinated health care the trial of a Patient Centred Medical Home (PCMH) model has the potential to enable significant improvements in integration and coordination around the needs of the individual.
- To increase the focus on the quality of care and improve outcomes, bundled payments could be introduced for these high users of the health system. These payments could be paid prospectively, on an enrolled population basis, and could be priced to provide care coordination and services targeted to improve outcomes and reduce avoidable health system utilisation.
- Such bundled payments could be actuarially assessed (on a population risk basis rather than an individual basis) and could include redirected ABF payments from the Commonwealth, state and territory governments, and payments from the MBS, PBS and Home and Community Care (HACC).
- Bundled payments could be provided where practices (including general practices and Aboriginal Community Controlled Health Services) take on proactive management of eligible enrolled patients to develop a care plan, engage a multi-disciplinary team, actively manage health care to prevent hospitalisations and care for people in the community.
- Existing fee-for-service arrangements not included in the bundled payment would be retained for general practice.

Recommendation 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.

How this will be achieved

1. Amend Better Access to enable the option of a simple referral from a GP to an allied health professional (AHP) (as is now possible with psychiatrists and paediatricians), but only on the basis that at the initial session the AHP undertakes an assessment and develops a care plan with the person, which is then provided to the GP for review and endorsement or amendment.
2. Limit use of the GP Mental Health Care Plan items, other than for people who do not improve from the first-line response, are assessed at their initial attendance as severe or who have low prevalence disorders.
3. For severe or complex disorders, enable an extra six Better Access sessions of psychological treatment as clinically determined (a total of 16 in any one year).

4. For people with more severe conditions, where the GP assesses they are likely to require more than the initial six sessions with an allied health professional, GPs should be encouraged by the guidelines and supported in practice to initially refer to an endorsed and registered clinical psychologist (for example, by provision of easily accessible information about the different qualifications of psychologists available for referral within their local area).
5. Extend eligibility for Better Access to include neuropsychologists.
6. Consider extension of Better Access to other allied health professionals who contribute to the health and wellbeing of people with mental health problems where they undertake appropriate mental health training. For example, speech pathologists are engaged in mental health teams in some parts of Australia but not in others: they play an important role in mental health, particularly in prevention and early intervention for children.
7. Note that this is not proposing an increase in the number of sessions and the overall budget for Better Access, but rather a broadening of the mix of professionals able to provide focused psychological strategies within the available sessions.
8. Examine the potential efficiency of extending Better Access to nurses with postgraduate qualifications in mental health as an alternative to expansion of the Mental Health Nurse Incentive Programme (MHNIP).
9. Realign MBS benefits levels between allied health professionals: on the next indexation of MBS items weight the first component of the increase to align MBS benefits for social workers and occupational therapists with those for registered psychologists, with any remaining elements of indexation then being distributed equitably across Better Access items (current differential is about 12 per cent or $8: parity would take up the first 0.9 per cent of any future indexation increase and cost $1.8 million).
10. Consider ways to ensure Aboriginal and Torres Strait Islander people access Better Access, including by providing culturally competent professional services through the programme.
11. From January 2016, limit access to Better Access for newly registered psychologists who are not endorsed (i.e. do not have an additional qualification and advanced training, such as clinical psychology, as recognised by the Psychological Board of Australia) to communities outside the Major Cities classification as identified under the Modified Monash Model, as recently adopted by the Commonwealth Government.
12. From January 2017, 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 people who reside in regional, rural and remote areas.
13. Examine cashing out Better Access benefits paid for services provided by registered psychologists who do not have an additional endorsed qualification and distributing those funds on a weighted population basis to regional purchasers for psychological services on a salaried or sessional basis.
14. Examine incentives for allied health professionals to work in regional, rural and remote areas through targeted scholarships for post-graduate study, support of professional development and mentoring and financial and relocation incentives.
15. Use future indexation of Better Access benefits to introduce a Better Access rural loading.

Issues:

- In line with the stepped care approach outlined above, these changes are designed to better match care with need; for example, by reducing the level of care provided for those with low-level need (e.g. GP Mental Health Management Plan) and by making additional services available for those with more severe and complex needs.
- The proposed extension of Better Access sessions to neuropsychology is considered a logical inclusion of a group which provides important psychological services.
- Considering other allied health professionals as members of the care team recognises that others do play important roles in the care and support of people with a mental health problem. For example, speech pathologists play an important role in mental health teams in some parts of Australia, but their inclusion is patchy. Their role is particularly relevant for many young children where speech and language problems lead to distress, isolation and an inability to communicate with parents, educators, and friends, and can result in high levels of mental ill-health (a child with a speech problem is five times more likely to end up with a mental health problem than the general population, and many children presenting with early psychosis also have speech and communications problems).
- Inclusion of additional allied health professionals would require confirmation that they have specific skills and training in mental health.
- The realignment of the MBS items for registered psychologists, social workers and occupational therapists provides a simple solution to a long-standing inequity in the system. There is no such differential under DVA or ATAPS arrangements and the Commission considers there should not be one under Better Access.
- The remaining issues are aimed at enabling a more equitable distribution of allied health professionals in regional, rural and remote areas, particularly for psychologists, who are poorly distributed outside of metropolitan areas.
- Thirty per cent of the Australian population lives in rural and remote areas. If rural Australia is to receive its fair share of services, it needs to receive a fair share of funding.
- Because access to Better Access is dependent on provider availability rather than service demand, people in rural and remote communities are less able to use services under this programme due to a lack of workforce presence in their areas.
- Although Mental Health Services in Rural and Remote Areas (MHSRRA) has helped improve the workforce situation, and Access to Additional Psychological Services (ATAPS) has directed resources towards high community need, the service deficit in rural and remote locations remains significant. The lack of psychiatrists and psychologists is particularly acute.
- Exposure to rural and remote professional practice during education is inadequate, and rural professional practice is not presented as an attractive path for career development and progression.
- The lack of rural incentives under Better Access appears to be an anomaly when compared with other programmes where there is a rural loading—for example, for GPs, practice nurses and mental health nurses.

Recommendation 14:

Introduce incentives to include pharmacists as key members of the mental health care team.

How this will be achieved

1. Allocate a substantial percentage of the new *6th Community Pharmacy Agreement* as reward payments to pharmacists who work as partners in the primary mental health team. The reward payments would be paid as incentives for pharmacists to participate as part of the primary mental health team, including contributing to a single care plan, initial and regular contact with the client to ensure compliance with medication use, and overall medication management review as a part of their cycle of care.
2. Include pharmacists under the existing Practice Nurse Incentive Programme payment arrangements which enable general practices and AMSs to be paid for employing practice nurses and Aboriginal health workers, as well as a range of allied health professionals.

Issues:

- Pharmacists play an important role in primary mental health, but not in isolation of the primary mental health team, nor as replacements for the central roles played by GPs.
- The Australian Medical Association and the Pharmaceutical Society of Australia recently announced that they are working together on the development of a model to better support a more integrated role for pharmacists to work in GP clinics as part of the primary care team.[65] They announced there was strong interest from many members of both organisations for such an arrangement, which could enhance patient care in areas such as improved use of medicines, reduced adverse drug events and better coordination of patient care.
- The Commission supports changes which will maximise the potential of non-dispensing pharmacists to work with doctors and other health practitioners to meet health needs, relieve the strains on the health budget and improve the health outcomes of people with lived experience, their families and supporters.
- Pharmacists need to be a part of an integrated approach, working with GPs who are providing continuous follow-up care, and with other members of the multi-disciplinary team.
- The *6th Community Pharmacy Agreement* is due to commence in mid-2015. This provides an ideal opportunity to put in place incentives that recognise and reward the role of community pharmacists in the treatment team.
- Mental health provides considerable scope for pharmacists to exercise their skills in the medication management cycle. It enables a move away from simply dispensing pharmaceuticals to a long-term sustainable role for pharmacists as key multi-disciplinary team members.
- What the Commission is proposing here is not new. It builds on what pharmacists already do in medication management reviews, and uses an existing programme—the Pharmacy Agreement—to provide incentives for pharmacists to operate within general practice. However, it provides a particular focus on mental health and the mental health team, recognising that people with severe mental ill-health issues often are on multiple medications, have multiple physical comorbidities such as diabetes

and heart disease and are among the most vulnerable people managed in general practice.

- In addition, the Commission is proposing that the PNIP should be extended beyond its current suite of health workers to include pharmacists. This would be done within existing arrangements and existing resources; for example, the cap on total payments to practices would remain in place, with pharmacists providing an alternative to engagement of other professionals for which practices are eligible to be paid under the programme.
- Currently general practices in urban areas of workforce shortage, as well as Aboriginal Medical Services and Aboriginal Community Controlled Health Services can apply for support through the PNIP to employ or otherwise retain the services of an allied health professional instead of, or in addition to, practice nurses or Aboriginal health workers. Allied health professionals eligible to participate in the PNIP are audiologists. chiropractors, diabetes educators, dietitians/nutritionists, exercise physiologists, occupational therapists, orthoptists, orthotists/prosthetists, osteopaths, physiotherapists, podiatrists, psychologists, social workers and speech pathologists.
- The fact that pharmacists are not included in this list appears to reflect a typecasting of their role. In addition, the Commission proposes that a cost-benefit assessment should be undertaken on extending the entitlement beyond areas of workforce shortage to include all general practices, Aboriginal Medical Services and Aboriginal Community Controlled Health Services.

5. Promote the wellbeing and mental health of the Australian community, beginning with a healthy start to life

What success looks like

- There is widespread understanding of mental health and mental ill-health as being a mainstream issue for everyone—that it impacts on all of us and we need to deal with it as a day-to-day part of our lives, our schools, our workplaces and our society.
- Australia supports a healthy and safe start to life for our children and teenagers.
- People, families and other support people are well educated about proven self-management strategies.
- Primary and secondary schools have introduced mental awareness and mental fitness training as core components of their curricula.
- Trauma informed principles are embedded in training for mental health professionals.
- GPs regularly refer patients to evidence-based online self-management strategies and lifestyle programmes.
- Significant reductions are achieved in the rates of suicide and suicide attempts among young Aboriginal and Torres Strait Islander people.
- Drastic reductions occur in the rate of detention among Aboriginal and Torres Strait Islander people aged 10–17 years.

Key recommendations

Recommendation 15:

Build resilience and targeted interventions for families with children, both collectively and with those with emerging behavioural issues, distress and mental health difficulties.

How this will be achieved

1. Identify as a national priority for primary and mental health networks the mental health and wellbeing of children, adolescents and young adults, including Aboriginal and Torres Strait Islander people.
2. Funding for regionally provided services to be provided as flexible funds to regional entities as proposed in this Review, but to be earmarked as a programme of expenditure on children, adolescents and young adults.
3. Programme redesign and prioritisation to be recast as appropriate to reflect regional integration and evaluation within this new model.
4. Co-design and co-create, with local health networks, local councils, NGOs, the private sector, early childhood services, schools, workplaces, clubs and community organisations a system-wide framework for child and adolescent mental health, with integrated models of care and care pathways.
5. Ensure links with maternal and child health services as fundamental to an integrated approach.

6. Include a coordinated response to eating disorders as a priority within the existing headspace model.
7. Provide information locally and through online services on evidence-based programmes such as Positive Parenting Partnership (Triple P) and Every Parent.
8. Conduct a national study into the scaling up of Triple P, including workforce implications and the potential to roll the programme out by using the workforces of other organisations under contract to PMHNs.
9. Prevent onset of mental ill-health through school-based programmes.
10. Support the roll-out of KidsMatter and MindMatters through primary and secondary schools as part of a broader mental fitness and wellbeing agenda within schools.
11. PMHNs to work with local communities and potential private supporters on scoping development of local 'Childspaces', or children's wellbeing centres, for vulnerable children, not as separate services but to be integrated with early childhood and other services, funded by programmes such as Better Access and potentially with local community funding support.
12. Ensure measurement of child development vulnerability with the Australian Early Childhood Development Index.
13. Establish a pathway for broad introduction of the Middle Development Index for students in Years 4 to 9 as the next stage in measuring, identifying and responding to child development issues.

Issues:

- A life courses approach to prevention, early intervention and recovery recognises that different age groups will have different needs, and those needs will change as we go from birth, through to childhood, adolescence, adulthood, and older age.

> "Inpatient psychiatric services for children are the best places to learn to be sick—there has got to be a different way."
>
> **Dr Steve Hambleton, former National President, Australian Medical Association, 24 April 2014**

- Of all these stages, there is overwhelming evidence about the importance of infancy, childhood and the teenage years in determining a person's life opportunities and outcomes. The burden of mental health problems among children is significant, even among very young children.
  - An estimated 14 per cent of children and adolescents aged 4–17 (i.e. almost 600,000 children) have a clinically significant mental health problem and many of them were at increased risk for suicidal behaviour.[4]
  - Mental ill-health starts even younger. In the US, the prevalence of socio-emotional and behavioural problems in a representative sample of one and two-year-old children is 11.6 per cent.[66]
  - Fifty per cent of lifelong mental health problems start before the age of 14.[67]

- Experiences during the early years, including in utero, have lifelong effects on children's later achievements, social adjustment, mental and physical health and life expectancy.[68]

- At the 2011 Census, individuals under 15 years of age comprised 35.9 per cent of the total Aboriginal and Torres Strait Islander population, compared with 18.3 per cent of the non-Indigenous population.[69] Families are pivotal to the wellbeing of Aboriginal and Torres Strait Islander children.[70] Aboriginal and Torres Strait Islander families can be structured differently to non-Indigenous families, with child rearing managed more collectively.[70] These differences must be accounted for in responses to support families and Aboriginal and Torres Strait Islander child mental health. The youth justice example below, based on AIHW data,[71] provides an illustration:

  - It is well established and accepted that investment in the early years of childhood has long-term benefits for the individual, their family and the community as a whole. If left untreated, mental health problems in childhood have the potential to set the scene for a lifetime of difficulty.

Focus on young Aboriginal and Torres Strait Islander people in detention

On any given night, nearly half of those aged 10–17 years in juvenile detention will be Aboriginal and Torres Strait Islander young people. Over the four-year period (June quarter 2009 to June quarter 2013) the level of Aboriginal and Torres Strait Islander over-representation among young people in detention increased from 25 to 28 times the non-Indigenous rate.

The impact of incarceration at an individual, family and community level is significant. For those entering custody for the first time, this in itself can be traumatic. Being in custody removes young people from their family and puts them into an environment that does not support them achieving the age-appropriate developmental tasks needed for early adulthood. Those recurrently incarcerated risk institutionalisation. The early involvement of young people in the criminal justice system also puts them at much higher risk of further involvement as adults.

  - Because mental ill-health is an illness of the young (unlike many other illnesses which peak in middle and older age), there is a strong economic argument for a return on investment in these early years.
  - In recent years, Australia has made increasing investments in the mental health of adolescents and young adults, particularly through the development of headspace services in almost 100 locations across Australia. headspace has provided an important service for those aged 12 to 25 and has received international recognition.
  - There remains a critical gap for children aged from birth to 12 years, both for the child and for parents who need to be supported to maximise their child's development and wellbeing.
  - The approach proposed involves local, planned and coordinated community action on child development and wellbeing, and is as much about parenting and the mental health of adults as it is about children.
  - Local planning should consider child development at every phase and cover social, emotional and behaviour vulnerabilities, and should involve a partnership approach

with state and local government services such as child and adolescent mental health services, maternal and child health and school nurses.

- The approach should include universal support for all children and targeted, more intensive support for vulnerable children.
- The Commission proposes further scoping on the development of children's wellbeing centres ('Childspaces') to deliver evidence-based, cost-effective practice for infant and child mental health. These centres would involve one-stop-shops for delivering core services critical to the care of children in infancy and childhood. They would bring service providers together in places where children and families go—early childhood services, schools, housing and homelessness services, employment services and financial support services. Services would provide assessments for children and families, and either provide services directly or link them with other service providers.
- Plans should include guided access to evidence-based online programmes such as Triple P (Positive Parenting Partnership).
- PMHNs also should look at innovative ways to identify the workforce to support children and adolescents; for example, through local community organisations, as well as from the workforce of organisations which are funded to provide other local services.
- For rural and remote areas, the approach should include building social networks for children and for parents, particularly those in more remote areas e.g. children who participate in school by distance.
- Identification of need and achievement of outcomes should be measured using the Australian Early Development Index (AEDI). The AEDI provides communities with information about the early development of children from the ages of 0–5 years.
- In late 2013, schools in South Australia and Victoria trialled the Middle Years Index (MDI) which is a self-report instrument for students between Years 4 and 9 (8–14 year-olds). The MDI was developed in Canada and, like the AEDI, provides communities and parents with information on the vulnerability of children so that local community and individual responses can be identified and implemented.
- The MDI is completed at school by students, and at $2 a student comes at a relatively small cost to the AED Census.
- Governments should work together on introduction of the MDI into schools as an important means of measuring child health and wellbeing, and identifying need for intervention.

Recommendation 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.

How this will be achieved

1. Establish collaborative structures to design and develop the framework.
2. Agree on responsibilities at federal, state and regional levels.

3. Develop options for a study into the cost to society of childhood trauma and of best investments to reduce the impact of childhood trauma by a body such as the Productivity Commission or the Australian Institute of Family Studies, to include:
   - Lifetime mental health care
   - Lifetime health care
   - Suicide
   - Attempted suicide care
   - Drug and alcohol abuse
   - Juvenile justice
   - Forensic
   - Welfare costs
   - Productivity losses
   - Special education costs
   - Vulnerable groups, such as Aboriginal and Torres Strait Islander people
4. Use the outcomes of the study to implement an evidence-based national framework approach focusing on key outcomes for people, transparency and accountability.
5. Adopt in the proposed 'National Research Strategy' a component dedicated to build evidence about how to mitigate the ongoing mental health, health, suicide and suicide attempts effects of child maltreatment, and ensure research is linked to practice.
6. The variety and scope of children's exposure to violence, crime and abuse suggest the need for better and more comprehensive tools in clinical and research settings for identifying these experiences and their effects.
7. Introduce collection of prevalence data available in Australia on adults who are diagnosed with a mental health condition who have been victims of child maltreatment. Connect this to the *Footprints in Time—Longitudinal Study of Indigenous Children*.

Issues:

- "Numerous studies demonstrate that around two-thirds of both inpatients and outpatients in the mental health system have a history of childhood sexual and/or physical abuse. When emotional abuse and neglect are added to the mix, the percentage experiencing some form of adverse/traumatic childhood becomes even higher. The single most significant predictor that an individual will end up in the mental health system is a history of childhood trauma, and the more severe and prolonged the trauma, the more severe are the psychological and physical health consequences." Professor Warwick Middleton, Chair, The Cannan Group, Director Trauma and Dissociation Unit, Belmont Private Hospital.[72]
- The Commission expresses its serious concern about the serious impact of childhood trauma and maltreatment on children, families and society overall.
- In one long-term study, as many as 80 per cent of young adults who had been abused met the diagnostic criteria for at least one psychiatric disorder at age 21. These young adults exhibited many problems, including depression, anxiety, eating disorders and suicide attempts.[73]

- More support is needed for children who grow up in the most at-risk families and for parents to give their children the best possible care. Children need to be helped to be as mentally healthy and have the best wellbeing possible by encouraging healthy behaviours from pregnancy onwards.
- In Australia the public health model for children and maltreatment is currently the dominant model of child protection, as can be seen in the *National Framework for Protecting Australia's Children 2009–2020* (COAG, 2009). This document does not 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.[74] As understanding grows in addressing infant, child, youth and caregiver functioning in the physical, behavioural, social and cognitive areas, one of the great challenges of our generation will be: how to create personal mental health and wellbeing, not just national sickness and treatment services.
- In order to meet this challenge, more integrated and innovative approaches are needed on how to empower primary health care givers and communities to assist infants and children to have improved mental health and wellbeing to decrease usage of health and mental health services, decrease distress, suicide attempts and suicides, and improve lifetime outcomes.
- "Failure to acknowledge the reality of trauma and abuse in the lives of children, and the long-term impact this can have in the lives of adults, is one of the most significant clinical and moral deficits of current mental health approaches. Trauma in the early years shapes brain and psychological development, sets up vulnerability to stress and to the range of mental health problems." Professor Louise Newman, Psychiatrist, Director, Centre for Developmental Psychiatry and Psychology, Monash University.[72]

Recommendation 17:

Use evidence, evaluation and incentives to reduce stigma, build capacity and respond to the diversity of needs of different population groups.

How this will be achieved

1. Explore evidence-based approaches to reduce stigma and discrimination, and low cost options on how to permeate those approaches throughout the community.
2. Engage employers, schools, community organisations and workplaces to take part in local initiatives which improve both mental health understanding and behaviours and reduce stigma and discrimination.
3. Improve cultural responsiveness by supporting the widespread adoption of the *Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery* as a tool to help organisations identify what they can do to enhance their cultural responsiveness.
4. Require PMHNs to partner with state-wide transcultural mental health services in New South Wales, Queensland, Victoria and Western Australia in planning and developing responses to local community needs, and with PMHNs in other states and territories to identify (or help to develop) alternative mechanisms.

5. Adopt clear and explicit equity-oriented targets for people from Culturally and Linguistically Diverse (CALD) backgrounds from multicultural communities to include in government funding agreements.
6. Extend the National Mental Health Commission's Seclusion and Restraint Project to look at the specific factors which result in seclusion and restraint for vulnerable people (for example, communication problems).
7. Seek agreement from the professional colleges for obstetricians, paediatricians, psychiatrists and general practitioners so that the needs of and options for transgender and intersex people are included in training and continuous professional development, including an emphasis on the personal right to choose.
8. Establish guidelines about how to manage the birth of an intersex baby which emphasise that, except in the case of medical emergencies, intersex children should not be operated on to remove ambiguous reproductive or sexual organs and that as far as possible any surgical intervention should await the ability of the individual to be involved in decisions about gender identity.
9. Appoint an independent group of experts 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.
10. PMHNs and LHNs should work together to identify local clinicians to champion a multi-disciplinary team approach to coexisting intellectual disability and mental health.
11. Develop clear integrated care pathways for people with mental illness and a substance use disorder to bring together the too-often uncoordinated approach between mental health and substance use services.

Issues:

- Focusing on the needs of different population groups requires a person-centred approach where programmes and services 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 that match the person's needs
  - **respectful:** people can access a professional or support team that demonstrates genuine care, listens without judgement and is 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 social or economic circumstances at the same time.
- People in all circumstances in life have a right to expect a just and fair approach which reflects these principles.
- There are differences in need and experience between different population groups; for example, men and women face different risks to their mental wellbeing.

- Emphasis needs to be applied to the needs of population groups where there are particular gaps and barriers to achieving a contributing life.
- These issues are covered in more detail in Volume 2 (Chapter 3). The various groups include (but are not limited to):

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,[75] but people can find the response of Australian mental health supports inappropriate to their needs. They also can face problems of seclusion and restraint in the mental health system because of issues such as language barriers and culturally different approaches to mental health and wellbeing.

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. Research suggests that LGBTI people are at increased risk of a range of mental health problems, including depression, anxiety disorders, self-harm and suicide.[76]
- The birth of an intersex child is often treated by health professionals as a 'psycho-social emergency', with a strong focus on early medical intervention. Except in the case of actual health emergencies, this is not the case, yet premature medical intervention has potential lifetime repercussions on the mental health of individuals.

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 face particular difficulties with mental health related to age discrimination, bereavement, social isolation, increasing susceptibility to chronic disease and the transition from work to retirement. The fact that a person grows older is not sufficient reason to accept that mental ill-health is a necessary consequence of age. Nor should it be acceptable that admission to a residential aged care facility is reason enough to use chemical restraints to manage older people's behaviour.

Intellectual disability and mental health

- Intellectual disability (ID) often co-occurs with mental health problems,[77] but the two are usually treated in isolation. Often the mental health needs of a person with ID go unrecognised and there are a limited number of professionals with knowledge of how mental health problems can manifest in this group. Specialist intellectual disability services and professionals are lacking across Australia, but the Commission 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 ID health, including mental health, have been established and driven by local clinicians with an interest in ID.

Substance misuse and mental health

- There remains a strong service silo approach in response 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. It is time for local leaders to end the existing service divide.

Other areas for action:

- **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.
- **Housing**: build on the success of Housing First initiatives and recognise that initial expenditure will be more than offset with 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 family or other informal caregivers identified by people with lived experience 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 should 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.
- **Community awareness**: increase community awareness of current research on 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.
- **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.

6. Expand dedicated mental health and social and emotional wellbeing teams for Aboriginal and Torres Strait Islander people

What success looks like

- Access is improved to:
  - Mental health and social and emotional wellbeing teams in Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services).
  - Aboriginal and Torres Strait Islander specialist mental health services.
- General population mental health services are accountable for better Aboriginal and Torres Strait Islander mental health outcomes.

Key recommendations

Recommendation 18:

Establish mental health and social and emotional wellbeing teams in Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services), linked to Aboriginal and Torres Strait Islander specialist mental health services.

How this will be achieved

1. Start with the context provided by the implementation of Recommendation 5: the establishment of Aboriginal and Torres Strait Islander mental health as a national priority, the establishment of a credible leadership body and dedicated national planning to improve Aboriginal and Torres Strait Islander mental health outcomes and close the mental health gap.
2. Each IPHCO/ACCHS to have an integrated mental health and SEWB team providing links to: community mental health, alcohol and other drugs; primary health care, access to a psychiatrist and links to mainstream services.
3. Work with the states and territories on services and systems required to be put in place to facilitate the transition 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.
4. Ensure through contractual performance requirements that general population mental health services are accountable for better Aboriginal and Torres Strait Islander mental health outcomes.
5. Train and employ the Aboriginal and Torres Strait Islander workforce needed to close the Aboriginal and Torres Strait Islander mental health gap.

Issues:

- Mental ill-health is so prevalent and such a high priority among Aboriginal and Torres Strait Islander people that it needs to be integrated as a core part of a holistic approach to care and support.
- Mental health services need to be expanded and fully integrated within IPHCOs and ACCHS as a part of their existing comprehensive primary health care service package. 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 AHWs and Aboriginal mental health workers.
- An effective approach will require strong links and partnerships between the Commonwealth, states and territories. This will be particularly important for those who require specialist services and therefore require easily navigable pathways through the system.
- While approaches will vary according to local circumstance, for all Aboriginal and Torres Strait Islander people admitted to a specialist (mainstream) mental health service the following features/capabilities should be standard:
  - ensuring each referred/admitted patient 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
  - maintain link to family
  - facilitation of patient access to community support on return to community.
- The delivery of primary mental health services to Aboriginal and Torres Strait Islander people outside of IPHCO/ACCHS settings and mainstream specialist mental health services and programs needs to be culturally competent and culturally safe. In the development of the National Mental Health and Suicide Prevention Plan, governments should consider ways to make such services more accountable for delivering better mental health outcomes for Aboriginal and Torres Strait Islander people. These may include:
  - Development of quality and professional standards with organisations such as RACGP, Australian Practice Nurses Association and the Australian Psychological Society.
  - Setting targets and key performance indicators in funding agreements as a way of holding mainstream service providers accountable for the development of culturally responsive services.
  - Partnership agreements being established at a local level between the leadership of mainstream services and the IPHCOs/ACCHS.
  - Requirements to develop Aboriginal mental health service plans and/or professional development strategies.

- Developing clinical pathways in partnership with the local IPHCOs/ACCHS for mental health patients defining how the services will support patients in their transition from primary care to acute care and the provision of ongoing care for people with a chronic mental illness.
- Ensure professional development programmes are being delivered to support mainstream staff develop cultural competencies.

- Planning between the Commonwealth, states and territories, and at regional and local levels, needs to identify the future demand for services and the workforce required to meet that demand.
  - Opportunities need to be identified 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 should set a target for the numbers of Aboriginal and Torres Strait Islander students undertaking mental health and related training and entering the mental health professions and workforce. Progress should be benchmarked and reported against standards developed by professional associations and education providers.
  - Scholarship and traineeship programmes should specify a special weighting for Aboriginal and Torres Strait Islanders to enter into the mental health workforce.
  - Relevant professional associations and education providers develop specialist Aboriginal and Torres Strait Islander mental health courses based on models of good practice such as the Djirruwang Programme (UNSW) and roll them out nationwide.

7. Reduce suicides and suicide attempts by 50 per cent over the next decade

What success looks like

- Community partnerships co-create solutions at a local level for suicide prevention.
- Suicide rates fall by 10 per cent in four years and 50 per cent in 10 years.
- Suicide attempts fall by 10 per cent in four years and 50 per cent in 10 years.
- A national multi-level system and evidence-based model of suicide prevention is in action in 12 regions in Australia in 12 months, and extended across Australia in five years.
- Assertive follow-up of people after discharge from an emergency department or other public hospital service after a suicide attempt is standard practice, with public reporting of the number and clinical outcomes of people supported.
- All health (community, public and private) organisations which come into contact with potentially suicidal people work to a target of "zero suicides in our care", and report annually their data on suicide attempts and completed suicides while people are in their care.
- Novel e-health based suicide prevention strategies are made available nationally and locally.

Key recommendations

Recommendation 19:

Establish 12 regions across Australia as the first wave for nationwide introduction of sustainable, comprehensive, whole-of-community approaches to suicide prevention.

How this will be achieved

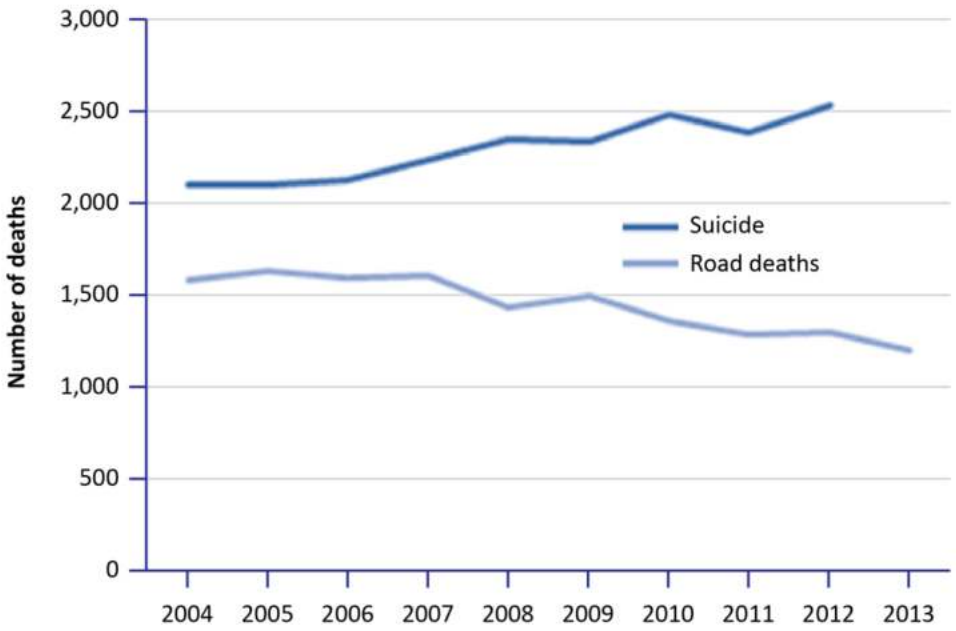
1. Use funds from within the National Suicide Prevention Programme and the Taking Action to Tackle Suicide (TaTs) Programme for funding regional initiatives as the first stage in implementing an evidence-based comprehensive whole-of-system approach to suicide prevention.
2. Work with state and territory governments, people with lived experience and other key stakeholders in the development of a National Suicide Prevention Framework which is based on Australian and international evidence of what works.
3. Invite business cases consistent with the framework from regional partnerships, possibly based on Regional Development Australia regions, on co-created models of suicide prevention.
4. Use Commonwealth funding as incentive funds to leverage local contributions: encourage models which demonstrate buy-in from local communities through inclusion of contributions (either in dollars or in kind) from partners, including local councils, business, clubs and community organisations.
5. Progressively roll the model out across Australia over five years.

6. Establish nationally consistent routine data collections for suicides and suicide attempts and what services people are accessing, to allow monitoring and evaluation of the outcomes of the investment.
7. Work with states and territories to establish a national protocol whereby when hospitals discharge a patient from an inpatient service or after a suicide attempt they:
    - ensure the person is discharged into a safe and supportive environment and that involved family or support people are assisted in how to support the person
    - offer every person the support of a mental health peer worker trained in this area and/or case manager to support them
    - provide intensive follow-up services for the following 30 days (or as best practice evidence indicates), with financial incentives for the extended pathway.
8. Promote as standard practice that all frontline staff likely to come into contact with vulnerable people—for example, in health, welfare, police, ambulance, justice and education—undergo mandatory training on suicide identification and prevention, and that their organisations set as performance targets "zero suicides in our care."

Issues:

- The annual road toll has fallen from 3,798 deaths in 1970 to 1,192 in 2013.[78] In contrast, Australia's suicide rate has not changed dramatically over the past 10 years.
- There were 2,535 suicide deaths in 2012[7]—seven a day, approximately double the road toll (Figure 11).

Figure 11 A comparison of deaths by suicide and the road toll in Australia



Source: ABS cause of death, 2012; Department of Infrastructure and Regional Development, Road deaths Australia 2013

- The National Suicide Prevention Programme is too fragmented, lacks sufficient focus and operates from too small a resource base to achieve a meaningful impact on these rates. It is not working effectively and a new approach is needed.

- Each year an estimated 65,000 Australians attempt to take their own life.[3] We know that suicide attempts are a large cause of health-related disability as well as being one of the main predictors of subsequent attempts and of later suicide deaths.
- Suicide rates are particularly high among Aboriginal and Torres Strait Islander people. Nationally there were 21.4 suicides per 100,000 Aboriginal and Torres Strait Islander people, more than double the rate of 10.3 for other Australians. Aboriginal and Torres Strait Islander people report stressful events at 1.4 times the rate of non-Indigenous people.[9]
- People who attempt suicide are not receiving sufficient support and follow-up to help prevent further attempts. This is a missed opportunity to reduce suicide rates.
- The risk is particularly high in the period following discharge from hospital or an emergency department after a suicide attempt.
- People are still being turned away or discharged to no support when they have an expressed and known suicidal intent and are at the highest level of risk. It is difficult to identify any other health condition where a person with a history well known to the services, with a clear and urgent need for healthcare, would not be admitted (if need be, involuntarily, due to their state of mind).
- There is no consistent and agreed data collection mechanism for suicide attempts and support received prior to or following a suicide attempt.
- Overseas models of suicide prevention which rely on a multi-component, whole-of-community approach have been shown to produce real reductions in suicidal thinking, attempts and deaths.[79]
- These models tend to involve strong top-down approaches with broad and comprehensive involvement at a local/regional level, with effective local coordination.
- There are excellent examples of suicide prevention throughout Australia but too often these operate in isolation of the broader system and wider community.
- The Commission proposes the urgent development of a national framework to connect what works, to build momentum, encourage creativity, and collectively guide investment in activities to make the greatest possible impact on suicide in Australia. The framework should promote an evidence-based approach while supporting diversity to allow for local and cultural strengths to be recognised in planning and implementation.
- The approach proposed involves an intensive concentration on suicide prevention as a local community priority. On development of the national framework, and in partnership with state and territory governments, the Commonwealth should use its resources as incentives to promote a comprehensive community response to suicide prevention.
- Initially funding from within existing resources would be made available through a competitive commissioning model for up to 12 regions—six urban, four regional and two remote—with an emphasis on those areas where there are high rates of suicide and suicide attempts, or where communities are under increasing stress (e.g. drought-affected communities).

- Potentially the approach could build on the existing 55 Regional Development Australia partnerships which are made up of local leaders who work with all levels of government, business and community groups to support development of their regions.
- Decisions on who leads the approach would need to be decided locally but ultimately selection criteria should be weighted towards applicants demonstrating a multifaceted approach involving commitment from a wide range of stakeholders, including local government and community leaders.
- The consortia would need to include those who come into direct contact with vulnerable people; e.g. health, police and ambulance services and Aboriginal and Torres Strait Islander services, as well as PMHNs and LHNs (or equivalent).
- Selection criteria also should include engagement from the broader community which demonstrates commitment at a local level to co-create solutions and take collective action, and should identify any contributions in dollars or in kind to the programme, to leverage off Commonwealth (and state and territory) funding.
- Proposals also should demonstrate that communities have the capacity to respond to crises with appropriate interventions and that individuals in a crisis situation have access to emergency mental health care, including through telephone helplines or the internet.
- The programme should be rolled out progressively across Australia, with research and evaluation of outcomes built into the contracting model.

8. Build workforce and research capacity to support systems change

What success looks like

- People get access to more integrated, whole-of-person services which are wrapped around their needs.
- The management of programmes is more efficient, effective, streamlined and responsive to the needs of clients.
- The workforce regularly deploys evidence-based treatment.
- Integrated care pathways, linking primary and secondary care, as well as community and step-down care, increasingly are used to guide patients through the mental health system.

Key recommendations

Recommendation 20:

Improve research capacity and impact by doubling the share of existing and future allocations 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.

How this will be achieved

1. From 2015–16 tie research funding to a National Mental Health Research Strategy to be developed by the Commission in consultation with stakeholders, and with research linked to strategic priorities in mental health, rather than being largely investigator-driven.
2. The strategy should:
    - Require participation of people with lived experiences, their families and other support people in all Commonwealth-funded mental health research planning, design and action.
    - Include applied research in the area of Aboriginal and Torres Strait Islander mental health to understand better what interventions work as a research priority.
    - Canvass both experiential and applied research that has the potential to generate innovative interventions and service models that are both efficient and cost-effective.
    - Develop evidence about what works in areas which have the potential to realise the greatest public value; for example:
        - infant trauma
        - child and adolescent health
        - mental health and aged care
        - stigma and discrimination
        - medications use, including metabolic syndrome
        - mental health for vulnerable groups e.g. people from culturally and linguistically diverse backgrounds, Lesbian Gay Bisexual Transsexual and Intersex (LGBTI) people
        - suicide and suicide prevention.
    - Include consideration of interventions across the domains of:
        - promotion

- prevention and early intervention
- crisis intervention and suicide prevention
- treatment
- recovery and support

3. Resources for this recommendation could be made available by:
   - redirecting a proportion of NHMRC funding into a pool which is distributed on the advice of a specific Mental Health Research Committee
   - the Commission convening an annual forum to both catalogue outcomes, and then establish immediate and longer term priorities for research
   - using the Medical Research Fund to target translational research in mental health that is strategically aligned with the directions specified under this reform package.
4. Drawing on existing and developing frameworks and classifications in mental health, conduct a scoping study to investigate data linkage platforms for complex, cross-sectoral aspects of delivery and design of services and supports for people with mental illness.

Issues:

- Although mental health accounts for about 13 per cent of Australia's total burden of disease, the Commission estimates that mental health research receives only 8.6 per cent of all health research funding.[80] Of this funding, most is spent on investigation of clinical interventions, which does not help to determine the effectiveness or cost-effectiveness of complex, multi-faceted programmes and services.
- Success as a mental health researcher is primarily based on peer regard rather than potential or actual real-world impact. As a result, research priorities are investigator-led rather than led by the needs of people with lived experience, supporters and the wider mental health system.
- Mechanisms are needed to strategically align mental health research funding priorities with the needs of policy makers, services, professionals, people with lived experience and supporters.
- Frameworks currently under development—such as the DSS Data Exchange, the National Mental Health Service Planning Framework and the Australian Mental Health Care Classification—would provide a solid basis from which the proposed scoping study could be progressed.

Recommendation 21:

Improve supply, productivity and access for mental health nurses and the mental health peer workforce.

How this will be achieved

1. Pay a proportion of the Mental Health Nurse Incentive Programme (MHNIP) funding as a loading on top of the Practice Nurse Incentive Programme (PNIP) to attract more mental health nurses into general practice.

2. Retrain registered general nurses as mental health nurses: in the short term the projected shortage of mental health nurses in 2016 of just over 1,000 (or approximately seven per cent of the workforce demand) is best reduced by a stop-gap training intervention that can deliver supply quickly.[81] The only way that is possible is to train current registered nurses to become mental health nurses, which in theory requires only one year. Transferring 1,000 nurses from the general to the mental health workforce will have limited impact on the general registered nurse population (less than 0.5 per cent) but will dramatically impact on the number of mental health nurses.
3. End the freeze on the MHNIP as an identified priority for more equitable access to mental health services.
4. Commit to at least maintaining the existing level of funding for the programme: when funding permits, it should grow from its allocation of $41.7 million in 2014–15 to $72 million a year to enable an equitable distribution of funds for the target population.
5. Examine the cost-effectiveness of including extension of Better Access to nurses with postgraduate qualifications in mental health.
6. Extend MHNIP eligibility to include residential aged care facilities and Multipurpose Services.
7. Promote the uptake of the programme by Indigenous Primary Health Care Organisations including Aboriginal Community Controlled Health Services, including opportunities for MHNIP-funded nurses to be a part of the proposed mental health and social and emotional wellbeing teams.
8. Remove the requirement for GPs to write a mental health care plan for referral to mental health nurses under MHNIP where a comparable health plan has been prepared by a specialist mental health professional.
9. Enable PMHNs to contract directly with mental health nurses instead of through an "eligible organisation" to provide greater flexibility across multiple settings.
10. Train practice nurses to develop their mental health skills and provide scholarships which enable them to train to become mental health nurses.
    - Practice nurses should be trained to take more responsibility for people with moderate and episodic illness and to assist in meeting the gap which is arising from the looming shortage of mental health nurses.
11. Build the capacity of the primary health care sector to significantly and pragmatically increase service access to a greater proportion of persons with a mental health problem and improve the delivery of mental health promotion and the likelihood of earlier intervention. Develop the mental health competence of GPs and collaborative teams to provide them with appropriate support services and decision-making tools to assess and manage the mental health needs of their patients.
12. PMHNs and LHNs should work together to create a primary health care mental health consultancy team in each LHN to support general practices, provide second opinions, support assessment practice and provide opportunistic training of GPs and practice nurses.
13. Include a mandated amount of mental health curricula content and assessed mental health competencies for undergraduate nurse preparation.
14. Develop a more generalist workforce to provide services in areas of greatest need.

- Continue promotion, implementation and evaluation of recruitment, retention and incentive mechanisms, in both generalist and specialist mental health career pathways. This should target particular areas and communities that need it most (e.g. socio-economically disadvantaged, recovering from natural disasters)
- Expand rural health education initiatives to include a focus on supporting the generalist workforce to respond to mental health emergencies as well as working with people with comorbidities, and conduct further research and evaluation of how health and welfare workers may augment traditional categories.

15. Establish National Mental Health Peer Workforce Development Guidelines for use in a range of settings including: agreed definitions, key roles and functions, guiding principles and a code of ethics, national capabilities for peer workers and supervisors (including diversity), principles for employment and reasonable adjustment, training and support, practical resources, supervision, coaching and mentoring and a dissemination/ implementation approach.
16. Develop a national mental health peer workforce data set, data collection and public reporting approach across employment sectors to measure progress and support evaluation.
17. Grow the Aboriginal and Torres Strait Islander workforce in social and emotional wellbeing: set a target of growing the workforce at least proportionate to their three per cent presence in the population.

Issues:

- Just as with the mental health system overall, the mental health workforce needs to be demand-driven. Demand for workforce is derived from the work performed, which in turn is determined by demand for services.
- There is an immediate priority to address current shortfalls in supply: in particular the mental health nurse workforce numbers constitute the most immediate threat to both short and long-term service ambitions. The projected shortage of mental health nurses in 2016 of just over 1,000 (or approximately seven per cent of the workforce demand) is best reduced by a stop-gap training intervention to deliver supply quickly.[81]
- The Commission also supports ending the freeze on the MHNIP programme, indexing sessional payments and aiming for a long-term commitment in the regional funding arrangements for PMHNs.
- Even though it is called an incentive payment, the MHNIP in fact is a fee-for-service payment—a full payment for sessions of services provided. The PNIP, on the other hand, is a true incentive payment: it provides a contribution towards the cost of employment of a practice nurse.
- In 2013–14 about 300 FTE mental health nurses provided services to about 45,000 people with severe mental health problems at a cost of about $100,000 per nurse.[82]
- The PNIP, which had a budget of $330 million in 2013–14, involves payments to eligible general practices, Aboriginal Medical Services and Aboriginal Community Controlled Health Services, of an incentive to offset the costs of employing a practice nurse. This incentive is up to $25,000 for each nurse, with a cap of $125,000 for each practice, and a rural loading of up to 50 per cent. About 4,100 practices receive funding.

- It is proposed that a proportion of the MHNIP budget should be reallocated as a substantial payment on top of the PNIP payments as an incentive to be able to attract mental health nurses into general practice.
- Not all of the MHNIP should be paid in this way. There are other services which are eligible for the MHNIP payment but not eligible for the practice nurse payment. In addition, there is widespread inequity in use of the MHNIP.
- The 2012 MHNIP evaluation found broad support for the programme with the model of care—involving flexible, one-on-one clinical treatment and support provided by credentialed mental health nurses working with eligible medical practitioners—receiving strong endorsement from GPs, psychiatrists and mental health nurses, as well as people with lived experience, their families and other support people and relevant peak bodies.
- The evaluation identified scope for improvement in a number of areas, including addressing current inequity in the distribution of MHNIP services across jurisdictions (this was an application-based programme where those who applied first were funded, and when the programme was capped other "eligible organisations" could not get access, so the inequity now is built in to existing arrangements).
- The current inequitable distribution of the MHNIP means that simply sharing the existing funding equitably across Australia will result in many areas which currently receive services facing substantial reductions in access to nurses.
- Payment of a proportion of the MHNIP as a loading on the PNIP will enable some of that inequity to be addressed.
- The Commission considers that, under the current funding model, payments into the MHNIP need to be at least maintained at its existing level of about $40 million a year. It would need to be increased to about $72 million a year to enable equitable access to mental health nurses in the private sector for those with severe and persistent mental illness.
- Until such time as there is a more equitable distribution of funding and services across Australia, and a mechanism for bringing together MHNIP payments (which are specific to mental health) with PNIP payments (which apply more broadly to general practice), MHNIP should not be included in the regional bundling of funds to PMHNs. However, PMHNs should be involved in decisions on eligibility for combined MHNIP/PNIP payments to general practices as an important factor in planning and setting regional priorities.
- To better equip areas of need, particularly in rural and remote Australia, to deliver mental health services, we need to look at innovative ways of ensuring they still have access to a fit-for-purpose workforce.
- Peer support workers are a key component of recovery-oriented mental health services as they illustrate to others the possibility of recovery and participation in social and employment activities, and provide support for their own recovery. Increasing the number of peer workers in mental health services nationally is an immediate priority that will be sustained over the Commission's 10-year implementation strategy.

Recommendation 22:

Improve education and training of the mental health and associated workforce to deploy evidence-based treatment.

How this will be achieved

1. Include in core curricula for those who will come into contact with people with a mental health problem education on how to better identify and understand mental health and trauma informed care: adopt person and family-inclusive practice and manage all the person's health needs—mental health, physical health and coexisting disorders or conditions including drug and alcohol difficulties, or intellectual and developmental disability.
2. Improve the capacity and competency of the health, social services, justice and workplace health and safety workforces, through embedding modules such as mental health first aid in curricula, to understand the needs of people with mental illness and their families and other support people. Inclusion of the person in treatment decision-making, and their families and other support people, is key to recovery-based approaches in mental health services.
3. Improve knowledge and capability of the primary health sector in identification, management and referral of people with mental illness, as well as mental health literacy and cultural competency. This should target all GPs, practice nurses, allied health professionals, Aboriginal health workers, nurse practitioners, peer support workers, paramedics and personal carers.

Issues:

- As part of our consultation process, we received hundreds of accounts from people with lived experience, their families and supporters which reflected the importance of the attitudes and behaviours of professionals they encounter when they seek help. In fact, these attitudes and behaviours very often seem to be the difference between a healing and a damaging experience of services. People with lived experience told us that a consistent relationship with a trusted professional is central to their recovery.
- While we heard many examples of such therapeutic relationships, we also heard a concerning number of stories from all over Australia in which poor professional attitudes had exacerbated a person's mental distress or had discouraged them from trying to seek help again. More than anything else, a poor experience of services for people with lived experience was associated with encountering dismissive or unkind attitudes which made them feel they were not being taken seriously. Being sent home without help or without promised follow-up, being told they were 'too complex' or 'not sick enough', and being fobbed off and shunted around between professionals were all too common experiences.
- The high levels of physical health problems experienced by people with a mental illness, as seen in the reduced life expectancy for people with psychosis by between 14 and 23 years,[6] requires that the treatment of mental health and physical health is routine and regular.

Recommendation 23:

Require evidence-based approaches on mental health and wellbeing to be adopted in early childhood worker and teacher training and continuing professional development.

How this will be achieved

1. Adopt measures of mental fitness in early childhood services, preschools, primary and secondary schools and education institutions to support healthy development and wellbeing of children and resilient and mental health-literate adults.
2. Engage with new parents, preschools and primary schools to fill the service gap for young children (aged birth–12 years) with mental health difficulties (social, emotional and behavioural) and ensure parents are supported to maximise their child's development and wellbeing.
3. Integrate and coordinate existing programmes with school communities to better target school aged children and families on a regional basis, and to get better outcomes from existing programme investments (such as KidsMatter and MindMatters) across communities. This includes with Aboriginal and Torres Strait Islander children.
4. Further, include in the national education curricula and pedagogical frameworks, strategies that address both resilience (universal programmes) and targeted interventions for children, families and communities with identified and emerging mental health difficulties.

Issues

- Half of all lifetime cases of psychiatric disorders start before 14 years.[83] The median age of onset is much earlier for anxiety (11 years) and impulse-control disorders (11 years).
- The impact of trauma on Aboriginal and Torres Strait Islander children and their families is a major determinant of mental health conditions in the Aboriginal and Torres Strait Islander adult population. However, services often fail to detect this trauma.[84]
- Evidence-based programmes and initiatives focusing on children in their earliest years and their families improve educational outcomes, can reduce the need for mental health treatment in later and adult years and limit intergenerational cycles of poor mental health.
- Early childhood settings can be an effective point of intervention, both for building resilience and for support with identified early difficulties in young children.
- In the school setting, points of transition from pre-school to school and from primary to secondary school are critical turning points in a young person's life. The evidence shows that it is possible to prevent or ameliorate social and emotional problems, which in turn directly impact on educational outcomes using school-based interventions.
- There is a range of preventive and early intervention programmes (Commonwealth, state and local community) across the education sectors addressing the mental wellbeing of young children and students. These focus more on those promoting

resilience among school children rather than supporting those with emerging or established difficulties.

- The problem lies in the plethora of initiatives, lack of consistent messaging and poor uptake across the country. There also are concerns about lack of comprehensive longitudinal evaluation of the impact of many initiatives, partly because they are not sustained over time.

9. Improve access to services and support through innovative technologies

What success looks like

- A population-based health information and health access (i.e. self-help and clinical care) model is in place within five years. This model recognises the need to grow access to modern technologies in relevant ways to connect effectively and at scale to the diverse needs of the Australian community.
- Significantly increased access to care by groups which now are low users of face-to-face services (young people, young and middle-aged men, older persons, geographically isolated groups, socio-economically constrained groups).
- Significantly increased access and cost-efficiency of technology-based crisis and emergency services, including those for persons with suicidal ideation.
- Effective integration of offline and online resources so that people can access a seamless experience of care, independent of the first point of contact.
- Much increased quality of self-care, self-monitoring systems (including linkage to novel biometric systems) and systematic monitoring of outcomes of care for those using self-care and those engaged with local systems of care.
- Information sharing across all technology platforms facilitated by the development of appropriate technical solutions and mandated for government-supported services.
- Continuing co-investment by relevant technically based business, government (notably the National Broadband Network) and community-based organisations such that the most cost-effective solutions are provided to the Australian population.
- Australian-based solutions lead the world in new solutions, new community and business models and new thought leadership through novel partnerships nationally and internationally, with Australian innovations linked to worldwide technical and information-based developments.
- Universal access to evidence-based self-help and self-monitoring strategies through widespread and affordable connections to mobile and online applications.
- E-mental health is an integral component of the Australian mental health service clinical model, typically providing easy initial access to care and then continuing to support local service providers as well as ongoing clinical or self-care through appropriate monitoring and online interventions.
- Duplication of services between current Australian Government-supported platforms and providers is minimised to enable maximum investment in this emerging sector.
- Key large-scale providers in Australia are recognised widely and supported to provide technical solutions across five key domains:
  - promotion
  - prevention and early intervention
  - crisis intervention and suicide prevention
  - treatment
  - recovery and support

Key recommendations

Recommendation 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.

How this will be achieved

1. While maintaining support for traditional person-to-person community-based telephony services, substantially increase capacity for crisis support through uptakes of new online and voice-activated technologies.
2. All telephony and new online services must link people directly to effective interventions (including self-help, community or professionally based) and local service systems.
3. Declining investments in outmoded models of traditional clinical practice (e.g. long-form psychology or psychiatry assessments or clinical interventions) being transferred to online environments.
4. Within existing funds, direct government co-investment in the substantial national community-based and government supported online initiatives to operate according to nationally agreed standards so that people experience a seamless transition from crisis to ongoing care.
5. Task the Project Synergy team with working with stakeholders to develop a model of integrated and shared approaches to enable seamless access for people with lived experience, their families and supporters to a system which prioritises crisis support, and links with self-help, information/education and treatment services.

Issues:

- The use of helplines across Australia is substantial. As examples, Lifeline provides telephone support to 820,000 callers per annum, in addition to online counselling to 40,000 clients. eheadspace provides telephone support to 40,000 young people each year, as well as online counselling via web-enabled chat.
- While direct call systems currently play a vital role, increasing investments in person-to-person counselling systems, particularly those based on conventional volunteer or detailed professional assessment and intervention services, will not result in very large increases in coverage or availability that are cost-effective or sustainable.
- From a user perspective, the current system of multiple call-lines and disconnected online services is confusing. This problem has been exacerbated by increased Commonwealth investments (directly or indirectly) in new and alternative services (e.g. those provided by beyondblue and eheadspace).
- Telephone helplines and other online services are not integrated, do not have common standards and are linked to few clinical pathways. Typically they experience major delays, confusing or conflicting notions of duty of care and/or subcontracting or referral to other agencies with technical, personnel or clinical capacity. Consequently, there are high levels of duplication across client groups (notably in the emergency/crisis calls and youth areas) and considerable potential to access the "wrong door" by users.

- There is limited availability of warm transfers, meaning that users generally need to re-tell their story when they are referred to another service. There is further potential for callers to be caught in a loop of being referred back and forth between services.
- A streamlined approach will reduce duplication and increase efficiency and effectiveness of the mental health helpline sector. This will reduce confusion about the service offerings available and create a clear line of sight for individuals about what is available for them. By retaining the expertise of existing large and nationally recognised helplines and community-based brands and organisation, a limited number of first points of contact can be established, with simpler warm transfers to the most appropriate service.
- 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 healthcare 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.
- In Australia, the investment in Project Synergy offers the potential for national linkage of online environments. Other major brands such as Lifeline stand out in the traditional telephony-based sector.

Recommendation 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.

How this will be achieved

1. Use new technologies to extend access to services, particularly in those populations which prefer to use technologies, do not wish to use face-to-face services or are limited by geography or socio-demographic constraints from accessing assessment, emergency or other ongoing services.
2. Build on the current Commonwealth Government investment in Project Synergy to develop common standards and linkage platforms for all major government-supported e-mental health delivery systems.
3. Decrease investments in first generation e-mental health type systems—essentially where traditional professional or counselling-type practices have been transferred online without leveraging the real benefits of co-investments or new technologies (e.g. eheadspace).
4. Invest in policy and evidence development by relevant community, industry, academic and service providers through establishment of a relevant national policy development and technical solutions advisory body.

5. New e-mental health contracts from June 2015 should be competitively tendered, with focus on provision of large-scale services by those community-based organisations with established technical capacity, external business links, substantial capacity to coinvest in development and service delivery and clear evidence of penetration in key population groups (e.g. child and family groups, young people, older persons, people with disabilities, perinatal groups, Aboriginal and Torres Strait Islander people, people in rural and remote areas) or with key illness targets (e.g. early intervention in young people, comorbid alcohol and drug misuse, common anxiety and depressive disorders, perinatal disorders, eating disorders, childhood attention and learning difficulties).
6. New contracts should be based on fostering intrasectoral cooperation, with leadership of each domain having the capacity to set up a working relationship with and shared data with the relevant NGOs or health providers to provide integrated care. Any person entering the e-mental health domain will have the opportunity to receive integrated care via relevant face-to-face health or NGO providers, or to other e-mental health providers as appropriate. This sets up a network of connections between agencies.
7. New contracts need to require the use of shared health records, responsiveness (online case management to guide people through the system and keep them online across systems, not just part of an internal programme), and commitment to systematic and intrinsic research and development, with particular emphasis on monitoring functional outcomes.
8. New contracts need to specify linking arrangements between *national* e-mental health services and *local* face-to-face mental health services, including primary health care, emergency departments, NGOs, headspace centres and multi-purpose services (MPSs) to provide continuity of care.

Issues:

- 'Bricks and mortar' solutions will never meet growing demand for accessible, affordable, responsive and personally controlled mental health services. The only feasible, cost-effective solution that can meet population need is to deploy e-mental health to move beyond a treatment-focused medical model to one that directly supports empowered and informed self-management. To achieve this, a national collaborative approach, supported by the public and private sectors, should be developed and guide Commonwealth investment priorities to align, consolidate and integrate the mental health system around the use of e-mental health technologies.
- Second and third generation e-mental health solutions have the capacity to meet the triple aims of health care[85]—population coverage (within an integrated population health model that combines public health initiatives with effective health services delivery), low cost per capita and enhanced and empowering experiences of care.
- Integration represents the greatest challenge to achieving the possibilities that e-mental health offers. Current Commonwealth-based investments have supported divergence, small-scale operators and first generation (largely clinically based) service systems.
- E-mental health offers one of the greatest invest-to-save opportunities for government and the community in mental health. E-mental health is clinically effective and huge cost savings can be gained by integrating it into a fully functional mental health system of stepped care.

- Next-generation e-mental health services will enable greater consolidation and integration between services operating within and across various domains (promotion; prevention and early intervention; crisis intervention and suicide prevention; treatment; recovery and support) and face-to-face services—but achieving this will require support as outlined below.
- Currently, the e-mental health sector is disaggregated. It needs intra-domain, inter-sectorial rationalisation, mechanisms for integration with other mental health services and expansion. New investments (starting with new tendering arrangements in 2015) need to promote collaboration across the sector, partnerships with business and technology departments and common technical solutions.
- New tendering arrangements in 2015 need to move from investments in systems developed in the late 1990s (i.e. simple closed information systems, simple transfers of existing counselling services online) to those relevant to the current decade and beyond.
- This work could build on that already funded by the Federal Government through Project Synergy. Project Synergy aims to develop a digital ecosystem enabling interoperability between existing and developed apps, tools and youth mental health services through common standards, protocols and analytics. It will enable technologies and data to interact across multiple services to be used by young people to manage their wellbeing and mental health.
- The aim is to ensure common technical standards, facilitate shared data warehousing, enable fast-tracking of the capacity for rapid research and development, reduce duplication and build a national e-mental health ecosystem that uses substantive business and nongovernment investments and keeps pace with worldwide technology trends.
- In this rapidly changing area, building on major international business and health system investments, there is a need to ensure that increased government investments do not undermine public and private partnerships.
- This is an area of investment where governments should seek to leverage existing public funds and explore the viability of alternative methods for cooperative financing.
- It is an area of mental health reform where Australia has the capacity for international thought leadership. Such leadership is more than a capacity to conduct research but rather to utilise the combined efforts of the university, community, government and industry partnerships. In this arena there is considerable potential for product licensing to assist with ongoing sustainability.
- The objective is for e-mental health to be integrated into the Australian mental health service model, as a mandated first step of service delivery (as appropriate), in a stepped care model. E-mental health should be offered nationally across five domains:
  - promotion
  - prevention and early intervention
  - crisis intervention and suicide prevention
  - treatment
  - recovery and support.

- To achieve this, e-mental health services need to be integrated, share data and communicate with each other.

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