Contributing lives, thriving communities

Report of the National Review of Mental Health Programmes and Services

Summary

30 November 2014
I just want to emphasise that people with mental health issues are a part of the community and that our lives matter. Not only that, but by denying people like me the chance to have a stable life, with stable housing and a reduction in poverty-related stress, you are also denying our kids and loved ones relief from those stresses.”

Person with lived experience, Victoria
Contents

Executive Summary 3

Background 4

This Review 4

Setting the scene 4

System reform 4

Overview of mental illness in our community 5

Economic and social costs to Australia 6

Commonwealth expenditure 6

Financial risk 7

Where we are now 8

Where we want to be 9

Future approaches and funding priorities 10

A person-centred approach 10

System architecture 12

Shifting funding to rebalance the system 12

Strategic directions and recommendations 15

1. Set clear roles and accountabilities to shape a person-centred mental health system 16

2. Agree and implement national targets and local organisational performance measures 16

3. Shift funding priorities from hospitals and income support to community and primary health care services 16

4. Empower and support self-care and implement a new model of stepped care across Australia 16

5. Promote the wellbeing and mental health of the Australian community, beginning with a healthy start to life 17

6. Expand dedicated mental health and social and emotional wellbeing teams for Aboriginal and Torres Strait Islander people 17

7. Reduce suicides and suicide attempts by 50 per cent over the next decade 17

8. Build workforce and research capacity to support systems change 17

9. Improve access to services and support through innovative technologies 17

Conclusion 18

Where can I get further information? 18

References 19
I think having two bureaucracies (federal and state) isn’t working. The money needs to go into one very efficient and competently run system—not be fragmented across NGOs, GP-referred groups and a lot of semi-trained/unregistered service providers. It should be a one-stop-shop where people tell their story once and an appropriate referral for follow-up is made.”

Member of the public, New South Wales
Executive Summary

This summary document presents an overview of the findings of the National Review of Mental Health Programmes and Services. The Review responds to the Terms of Reference provided to the National Mental Health Commission by the Commonwealth Government early in 2014.

On the basis of our findings, it is clear the mental health system has fundamental structural shortcomings. This same conclusion has been reached by numerous other independent and governmental reviews.

The overall impact of a poorly planned and badly integrated system is a massive drain on peoples’ wellbeing and participation in the community—on jobs, on families, and on Australia’s productivity and economic growth.

Despite almost $10 billion in Commonwealth spending on mental health every year, there are no agreed or consistent national measures of whether this is leading to effective outcomes or whether people’s lives are being improved as a result.

This Review is framed on the basis of making change within existing resources. We consider that Australia has a once-in-a-generation opportunity to improve the lives of millions of Australians without additional funding.

For example, the Review identifies measures to help the Commonwealth maximise value for taxpayers’ dollars by using its resources as incentives to leverage desirable and measurable results, and funding outcomes rather than activity. It also proposes reallocating funding from downstream to upstream services, including prevention and early intervention.

The ultimate goal of this Review is to make a set of recommendations for Government to consider, that will create a system to support the mental health and wellbeing of individuals in a way that enables them to live contributing lives and participate as fully as possible as members of thriving communities.

All of our recommendations and actions are designed to collectively lead us to that destination.

To achieve the required system reform, the Commission recommends 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.

These principles underpin the Commission’s 25 recommendations across nine strategic directions. They guide a more detailed implementation framework of activity over the next decade, which provides a comprehensive plan for action in mental health reform. The planned, coordinated implementation strategy outlined in the Review report will give strength to the recommendations by establishing a transparent and collaborative governance structure to work with communities, people, experts and those with lived experience to hone the recommendations for national adoption.

Taken together, they form a strong, achievable plan to take advantage of this unique opportunity to reform Australia’s mental health system for the wellbeing of Australia and Australians.
Background

This Review
In conducting this Review, the Commission’s primary areas of focus have been the efficiency and effectiveness of Commonwealth services and programmes and overall investment and spending patterns. We considered programme evaluations where available. We 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 Commission’s 2012 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 and support system as a whole. The public call for submissions was a significant input to these considerations.

Setting the scene
There have been considerable changes in mental health and suicide prevention policy, systems and services in the past three decades, featuring:

- the commencement in the 1990s of a National Mental Health Strategy and four subsequent National Mental Health Plans
- the initiation of a National Suicide Prevention Strategy and release of a National Recovery Framework in 2013
- increasing recognition of the rights of individuals and the need for least restrictive treatments, and involvement of people and their families and other support people in planning and making decisions about their care and support
- the development of the community mental health movement, supporting people in their community, with a growing role of the non-government, not-for-profit and private sectors
- the closure or downsizing of many large-scale dedicated psychiatric institutions (the policy of deinstitutionalisation)
- greater mainstreaming of services and attempts to fully integrate them across health, housing, employment, education, justice and welfare and around people’s needs
- a growing recognition of the different social and emotional needs of Aboriginal and Torres Strait Islander people, and the need for community-based and controlled services
- greater community understanding of mental health, mental illness and suicide, and a greater willingness to talk about issues and seek help.

System reform
The need for mental health reform enjoys long-standing bipartisan support. Yet as a country we lack a clear destination in mental health and suicide prevention. Our “mental health system”—which implies a planned, unitary whole—is instead a collection of often uncoordinated services introduced on an often ad hoc basis, with no clarity of roles and responsibilities or strategic approach that is reflected in practice.

We need system reform to:

- redesign the system to focus on the needs of users rather than providers
- redirect Commonwealth dollars as incentives to purchase value-for-money, measurable results and outcomes, rather than simply funding activity
- rebalance expenditure away from services which indicate system failure and invest in evidence-based services like prevention and early intervention, recovery-based community support, stable housing and participation in employment, education and training
- repackage funds spent on the small percentage of people with the most severe and persistent mental health problems who are the highest users of the mental health dollar to 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.
Overview of mental illness in our community

Each year, it is estimated that more than 3.6 million people (aged 16 to 85 years) experience mental ill-health—representing about 20 per cent of adults. In addition, almost 600,000 children and youth between the ages of four and 17 are affected by a clinically significant mental health problem. 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. Less than half will access treatment.

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

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

Our work has identified that many people with mental health difficulties 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. 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. Aboriginal and Torres Strait Islander people aged 15 years and older report stressful events at 1.4 times the rate of non-Indigenous people.

Many people with experience of mental illness do not seek support for their condition. The rates of help-seeking and treatment are much lower than prevalence in the community.

The experience of mental ill-health ranges across a wide spectrum, as illustrated in Figure 1.
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, with lost productivity and job turnover costing a further $12 billion a year—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). In Australia, this would equate to more than $60 billion or about $4,000 a year for each person who lodges a tax return.

Commonwealth expenditure

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

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 Mental 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 (DPMC) 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.
   - DPMC 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).

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 need in the public hospital system, including an estimated $280 million for patients in standalone psychiatric institutions.
Commonwealth expenditure on mental health 2012-13

- $9.6 billion expended
- 87.5% spent on the five largest programmes
- 12.5% spent on all other programmes

Disability Support Pension (DSP)
$4,676.3 million
▲ 35.6% since 2008–09

National Agreements – NHCA/NHRA
(est MH share of Commonwealth hospital funding)
$1,024.9 million
▲ 13.1% since 2008–09

Carer Payment and Allowance
$999.1 million
▲ 52.5% since 2008–09

Medicare Benefits Schedule
$907.9 million
▲ 21.3% since 2008–09

Pharmaceutical Benefits Scheme
$768.1 million
▼ 7.6% decrease since 2008–09

Other (11 programmes)
$1.2 billion

Figure 2: Commonwealth expenditure on mental health

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.

Financial risk

The Commonwealth’s major funding 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 achieve the best outcomes for individuals and communities and minimise costs to taxpayers.

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 are largely 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 focus must be on these programmes.
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 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, 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

A person-centred approach

This Review considers a person-centred approach to be the fundamental principle guiding its recommendations. In a person-centred mental health system, services are organised around the needs of people, rather than people having to organise themselves around the system.

Figure 3 illustrates an example of the design of a person-centred approach.

A person-centred approach means that, as a person’s acuity and functional impairment increase, the care team will expand to include different support providers. As acuity diminishes and functional capacity is improved, the team will contract as the person can take on more self-care. People are not transferred from one team to another but remain connected throughout, to a general practice or community mental health service, and with an ongoing core relationship with their family and other support people.

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

The first priority of a person-centred system is to enable individuals and their families to look after themselves. For most people, self-care and support from those closest to them are the most important resources they have to build and sustain good mental health and overall wellbeing, from birth until death. Conversely, relationships that are unhealthy or traumatic have an adverse effect, especially for children. Resilience and wellbeing can also come from life within a local community through social contacts and participation in employment, education, clubs and other activities.
Figure 4: Population-based architecture

**Very High Level of Need**
- Personal and flexible packages of comprehensive health and social care (including housing, income, and employment support)
- Specialist mental health and physical health treatments
- Coordinated care: One system, one care plan, one e-health record
- Maintain connections with families, friends, culture and community

**High Level of Need**
- Targeted and integrated clinical and social support
- Housing, income, psychosocial supports
- Self-directed low intensity therapies
- Early intervention
- Maintain connections with families, friends, culture and community

**Moderate Level of Need**
- Targeted and integrated clinical and social support
- Housing, income, psychosocial supports
- Self-directed low intensity therapies
- Early intervention
- Maintain connections with families, friends, culture and community

**Low Level of Need**
- Targeted and integrated clinical and social support
- Housing, income, psychosocial supports
- Self-directed low intensity therapies
- Early intervention
- Maintain connections with families, friends, culture and community

**Need for Wellbeing and Resilience Promotion**

---

### Principles for a person-centred system

- **Focus on early intervention at any age or stage of life**
- **Address social and economic determinants of mental health**
- **Ensure a stepped care service model: support is appropriate to need over time**
- **Whatever the level of need, ensure continuing connection with family of choice, social network, job, or education**

---

**Population affected at any one time**
- **Very high level of need**
  - Severe and persistent illness with complex multiagency needs – 65,000 people. Require significant clinical care and day-to-day support
  - 0.45%

- **High level of need**
  - Severe persistent – 210,000 people. Chronic with major limitations on functioning (i.e., very disabling) and without remission over long period
  - 1%

- **Moderate level of need**
  - Severe episodic – 415,000 people. Severely episodic with periods of remission
  - 2%

- **Low level of need**
  - Moderate – 1 million people
  - 5.5%

- **Need for wellbeing and resilience promotion**
  - Mild – 2 million people
  - 11%

- **Majority**
  - of adults will experience a mental disorder sometime in their lifetime – 7.3 million people
  - 45%

- **With need for wellbeing and resilience promotion – all 22.68 million people**

---

**For the Population**
- Investment in prevention and early intervention
- Foster healthy communities and encourage self help
- Foster mental resilience (families, schools)
**System architecture**

Alongside the guiding principle of a person-centred mental health system, the main objectives underpinning the proposed changes to the system are that it must be:

- **effective**: scarce resources used cost-effectively to achieve identified objectives
- **efficient**: programmes and services maximise net benefits to the community
- **evidence-based**: decisions based on meaningful data.

The person-centred approach described above fits within a population-based model that aims to match available resources to identified need, placing particular emphasis on population groups which are at higher risk or have special needs. It is supported 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.

As Figure 4 shows, the main features of such an approach are to differently target the population as a whole, the segment of the population with low-moderate needs and the segment of the population with high-very high needs.

The realignment of system architecture as recommended in this report also involves two other important features:

- A stepped care framework that provides a range of help options of varying intensity to match people’s level of need.
- Integrated Care Pathways (ICPs) for mental health, to provide for a seamless journey through the mental health system.

**Shifting funding to rebalance the system**

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, avoidable readmissions and income support payments).

A stepped care approach can also support people to take greater responsibility for their own mental and physical wellbeing, when accompanied by the appropriate services and supports.

This includes innovative service delivery models such as e-mental health which provide the opportunity to better integrate self-help, where people know where to go and how to access the specific information and support they need.

This does not obviate the need for face-to-face services. But empowering people, their families and other support people to support themselves where appropriate enables more cost-effective use of the time and skills of clinical and other professionals—and frees up the valuable personal time of individuals.

The Commission believes one of the most fundamental elements of the stepped care approach lies in prioritising delivery of care through general practice and the primary health care sector.

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 those countries that focus on specialist and acute care.

Indeed, the World Health Organization (WHO) has endorsed this approach: Integration of mental health into primary health care “not only gives better care; it cuts wastage resulting from unnecessary investigations and inappropriate and non-specific treatments.”

The development of 30 Primary Health Networks (or Primary and Mental Health Networks—PMHNs) across Australia provides the ideal opportunity to harness this 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. They can 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, enabling 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, with the aim that all can 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, priority should be given to pathways relevant to mental health conditions with the highest contribution to service use.

Based on modelling commissioned from KPMG, the outcome of implementing this change would be to slow the rate of increase in Disability Support Pension (DSP) and Carer Payment costs and 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 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 6).

For people who are high users of the mental health system, a system of voluntary enrolment and bundled payment models should be available. Voluntary enrolments through general practice 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: Reinvesting to save through regional integrators
Strategic directions and recommendations

As a result of the work of the Review, consultation and analysis of data and expert advice, the Commission has identified nine strategic directions to guide reform and proposed 25 recommendations. Together these support a detailed framework of activity over the next decade to take advantage of this once-in-a-generation opportunity to reform our mental health system for the wellbeing of Australia and Australians.

The strategic directions and recommendations take a whole-of-life, whole-of-government approach. Some are targeted at reform of individual programmes and services; others are focused on leveraging change at the system level to ensure that system and funds are best spent to enable people with mental health difficulties and their families and carers to enjoy contributing lives and progress their recovery journey.

Through the more than 1800 submissions made to the Review, the voices of people with lived experience of mental illness, their families and support people, as well as the views of professionals, advocates and peak bodies were clear. The most prominent theme to emerge from this wide range of submissions was that the way the mental health ‘system’ is designed and funded across Australia means that meaningful help often is not available until a person has deteriorated to crisis point. This is either because no mental health supports are accessible to them, they do not exist in their area, or they are inappropriate to their needs. Along the way they may have lost their job, their family or their home. Countless submissions pointed out that this makes neither economic nor humanitarian sense.

This unmet need was highlighted particularly strongly in relation to people living in regional, rural and remote areas of Australia, including farmers and fly-in-fly-out workers. Submissions conveyed that programmes and services currently did not meet the needs of communities with particular mental health challenges; if services are available, they often feel inappropriate and irrelevant to the people they are designed for. Programmes for Aboriginal and Torres Strait Islander communities and people who have migrated to Australia were given as examples. People with interrelated and complex difficulties which include a mental health problem (including those with substance misuse, history of trauma and abuse or intellectual disability) also are poorly served by a lack of collaboration across agency or disciplinary boundaries—each of their intertwined problems is viewed and treated in isolation.

The findings and recommendations of our report to the Government were informed by these voices, which revealed considerable consensus about which elements of our mental health system are working, and which elements need fixing.

Jennifer Westacott, Chair, Mental Health Australia

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
The nine strategic directions and associated recommendations are as follows:

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

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

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

Recommendations:
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.
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.
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.
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

Recommendations:
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.
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.
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.
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

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

**Recommendations:**
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

**Recommendation:**
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

**Recommendations:**
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.
21. Improve supply, productivity and access for mental health nurses and the mental health peer workforce.
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

**Recommendations:**
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.
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.
Conclusion

It is clear that our current mental health system suffers fundamental structural shortcomings that contribute to poor social and economic outcomes for individuals, communities and the nation as a whole. The only way to address this is through whole-of-system reform to build a better integrated, person-centred system that achieves desired outcomes through the effective use of existing resources, and a flexible approach that recognises diversity of people, culture, circumstance and location. Our consultation and submissions received from the community have confirmed this direction.

We believe that significant change is possible and affordable.

We have provided an implementation strategy for a clear and collaborative governance structure to advance the directions recommended in the Review. These structures establish a framework for the engagement with the community, people with lived experience of mental health difficulties and their families and other support people; government, non-government and private sector, and clinical and non-clinical experts.

The Commission looks forward to the Government’s consideration of the findings of the Review, and in working with Government to support implementation of the mental health reform agenda set by Government.

Where can I get further information?

This is a summary of a report to Government in response to the Terms of Reference which was 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.

Access to these volumes can be found on the National Mental Health Commission website.
References


This page has been left blank intentionally
Services need to be more family oriented to support the family unit as a whole. It is the carers/families/support people who are the one constant... family needs to be included, listened to and informed and educated... and not be looked on as part of the problem. The family is very important in supporting consumers to lead better quality of lives. We need more understanding, less stigmatisation, more education, and support.”

Support person, Australian Capital Territory
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
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.

ISSN 2201-3032
ISBN 978-0-9874449-6-7

Suggested citation:


Published by: National Mental Health Commission, Sydney.

© National Mental Health Commission 2014

This product, excluding the Commission logo, Commonwealth Coat of Arms and material owned by a third party or protected by a trademark, has been released under a Creative Commons BY 3.0 (CC BY 3.0) licence. The excluded material owned by a third party includes data, images, accounts of personal experiences and artwork sourced from third parties, including private individuals. With the exception of the excluded material (but see note below with respect to data provided by the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW)), you may distribute, remix and build upon this work. However, you must attribute the National Mental Health Commission as the copyright holder of the work in compliance with our attribution policy. The full terms and conditions of this licence are available at http://creativecommons.org/licenses/by/3.0/au/. Requests and enquiries concerning reproduction and copyrights should be directed to:

enquiries@mentalhealthcommission.gov.au

Note: Material provided by:

1. The Australian Bureau of Statistics is covered under a Creative Commons Attribution 2.5 Australia licence and must be attributed in accordance with their requirements for attributing ABS material as outlined at www.abs.gov.au.
2. The Australian Institute of Health and Welfare is covered by Creative Commons BY 3.0 (CC BY 3.0) and must be attributed to the AIHW in accordance with their attribution policy at www.aihw.gov.au/copyright/
Acknowledgements

We acknowledge those people with a lived experience of mental health issues, their families, friends and supporters who provided input into the Review process through our public call for submission process. Many professional organisations and nongovernment organisations which work in the mental health sector also responded to the call for submission process. Several organisations provided detailed advice to the Commission, as well as responding to requests for additional information used as case studies. We value the generosity of their time.

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
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
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terms of Reference</td>
<td>9</td>
</tr>
<tr>
<td>Executive summary</td>
<td>13</td>
</tr>
<tr>
<td>About this Review</td>
<td>17</td>
</tr>
<tr>
<td>Overview of mental illness in our community</td>
<td>19</td>
</tr>
<tr>
<td>Overview of findings</td>
<td>27</td>
</tr>
<tr>
<td>Future approaches and funding priorities</td>
<td>42</td>
</tr>
<tr>
<td>Our strategic intent</td>
<td>51</td>
</tr>
<tr>
<td>Strategic directions and recommendations</td>
<td>54</td>
</tr>
<tr>
<td>1. Set clear roles and accountabilities to shape a person-centred mental health system</td>
<td>54</td>
</tr>
<tr>
<td>2. Agree and implement national targets and local organisational performance measures</td>
<td>64</td>
</tr>
<tr>
<td>3. Shift funding priorities from hospitals and income support to community and primary health care services</td>
<td>72</td>
</tr>
<tr>
<td>4. Empower and support self-care and implement a new model of stepped care across Australia</td>
<td>87</td>
</tr>
<tr>
<td>5. Promote the wellbeing and mental health of the Australian community, beginning with a healthy start to life</td>
<td>100</td>
</tr>
<tr>
<td>6. Expand dedicated mental health and social and emotional wellbeing teams for Aboriginal and Torres Strait Islander people</td>
<td>109</td>
</tr>
<tr>
<td>7. Reduce suicides and suicide attempts by 50 per cent over the next decade</td>
<td>112</td>
</tr>
<tr>
<td>8. Build workforce and research capacity to support systems change</td>
<td>116</td>
</tr>
<tr>
<td>9. Improve access to services and support through innovative technologies</td>
<td>124</td>
</tr>
<tr>
<td>References</td>
<td>130</td>
</tr>
</tbody>
</table>
**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 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\(^2\), 2013\(^3\)). 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 pursuing 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—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. 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. Less than half will access treatment.

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

In 2012 more than 2,500 people died by suicide, while in 2007 an estimated 65,000 Australians attempted to end their own life. Suicide is the leading cause of death among people aged between 15 and 44 years old, and is more likely among men, Aboriginal and Torres Strait Islander people and people living outside of major cities (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. 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. Aboriginal and Torres Strait Islander people aged 15 years and older report stressful events at 1.4 times the rate of non-Indigenous people.

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.’
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 multi-agency 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.\textsuperscript{12}
- Of people experiencing mental illness, 20 per cent use alcohol excessively or have a drug addiction.\textsuperscript{13}

For social and economic outcomes for people with mental illness:\textsuperscript{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\textsuperscript{15}
- have suicide rates twice as high as non-Indigenous people.\textsuperscript{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\textsuperscript{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,\textsuperscript{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.\textsuperscript{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.\textsuperscript{18}

Across the nation there were:

- 1,514 state and territory specialised mental health care facilities in 2011–12\textsuperscript{19}
- 31.1 million prescriptions for mental health-related medications dispensed, of which 23.7 million were PBS-subsidised prescriptions in 2012–13\textsuperscript{20}
- 1.96 million Australians (9.2 per cent of the population) who received public and private mental health services in 2011–12.\textsuperscript{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.
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. This expenditure is predominantly in hospitals and specialised community mental health services. It includes around $300 million for NGOs.

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, with lost productivity and job turnover costing a further $12 billion a year—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). 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.”
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). 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.”

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.

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. Up to two per cent of people will develop bipolar disorder at some time in their lives. 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).

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.\footnote{32}

In addition, in 2011 Australia ranked second-highest in an OECD comparison of antidepressants consumption, behind only Iceland\footnote{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.\footnote{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.
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.

Source: [OECD Health Statistics 2013](https://www.oecd.org/health/)

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).
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 throughput 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
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.\(^\text{36}\) Of this group around 60,000 people are severely disabled because of their illness\(^1\)

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

---

\(^1\) 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. The World Health Organization (WHO) has called for mental health to be integrated into primary health care. “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.”
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.
Strategic directions and recommendations

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.”

• 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,
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 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. 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.
### 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.


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. 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, 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.”

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

<table>
<thead>
<tr>
<th>Year</th>
<th>$m</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017–18</td>
<td>100</td>
</tr>
<tr>
<td>2018–19</td>
<td>150</td>
</tr>
<tr>
<td>2019–20</td>
<td>200</td>
</tr>
<tr>
<td>2020–21</td>
<td>250</td>
</tr>
<tr>
<td>2021–22</td>
<td>300</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1000</strong></td>
</tr>
</tbody>
</table>

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. 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, 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 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
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 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, 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. 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.

- People with schizophrenia also tend to seek treatment late and access fewer services than the general population. 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.

- 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.” 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.
- More people with mental ill-health problems are encouraged to seek appropriate care.

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 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 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 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. They also have proven to be highly popular with the public.

- 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.\(^6^3\) 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.\(^6^4\) 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.

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. 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.


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.  

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. Families are pivotal to the wellbeing of Aboriginal and Torres Strait Islander children. Aboriginal and Torres Strait Islander families can be structured differently to non-Indigenous families, with child rearing managed more collectively. 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, 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. 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.

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 multidisciplinary 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, 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.

• 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, 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. In contrast, Australia’s suicide rate has not changed dramatically over the past 10 years.
- There were 2,535 suicide deaths in 2012—seven a day, approximately double the road toll (Figure 11).

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

- 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. 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.

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.

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
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. 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. 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.\(^1\)

• 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.\(^2\)

• 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, 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. 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.

- 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—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.
References


Attachment A: Current Commonwealth investment in mental health

This attachment provides detail about patterns of investment in mental health supports by the Commonwealth Government, including the types of support the Commonwealth funds, and how much money it dedicates to each at present.
A taxonomy of Commonwealth mental health investment

Sixteen Commonwealth Government departments and agencies fund 140 individual programmes which target mental health issues. The majority of these programmes are administered by:

- the Department of Health – 46 programmes ($3.29 billion in 2012–13)
- the Department of Defence – 26 programmes ($26.9 million in 2012–13)
- the Department of Social Services – 25 programmes ($5.86 billion in 2012–13)
- the Department of Veterans’ Affairs – nine programmes ($166.8 million in 2012–13).

To assist in the analysis of mental health programmes administered by the Commonwealth, the Commission grouped programmes under seven *mental health taxonomy* streams:

1. Direct Mental Health Programmes and Services for the population.
2. Direct Primary Mental Health Programmes and Services for individuals.
3. Direct Specialised Clinical Mental Health Programmes and Services for individuals.
5. Mental Health System Capacity, Quality and Support Programmes and Services.
6. Indirect Mental Health Support Programmes and Services.
7. Uncategorised mental health programmes.

1. Direct Mental Health Programmes and Services for the Population

Commonwealth-funded population-level mental health services are numerous and diverse. They include national programs delivered to the entire population, targeted programmes for high-risk groups, such as the National Perinatal Depression Initiative, and community development services designed for very specific geographic areas and/or groups.

Mental Health promotion/community development

There are three departments or agencies (Health, Veterans’ Affairs and the Australian National Preventive Health Agency) which delivered nine *Mental Health Promotion/Community Development* programmes at a cost of $62.8 million in 2012–13. The major programmes funded in this group include *beyondblue*, KidsMatter and an element of the National Suicide Prevention Programme:

- *beyondblue* is a collaborative initiative funded by the Australian, state and territory governments that aims to raise community awareness and reduce stigma related to depression, anxiety and associated disorders in Australia.
- KidsMatter is funded under the COAG Mental Health New Early Intervention Services for Parents, Children and Young People measure. This allocation provides for early intervention services for parents, children and young people, and aims to support early intervention for children and young people who were at risk of developing mental health problems, or who were showing early signs or symptoms of mental health problems.
- The National Suicide Prevention Programme (NSPP) funds suicide prevention activities across the Australian population and for specific at-risk groups including men, Indigenous people, people in rural and remote Australia, people bereaved by suicide, people with a mental illness and young people. The NSPP also provides funding to
other Commonwealth-funded mental health programs, including Access to Allied Psychological Services (ATAPS) and MindMatters, for the inclusion of suicide prevention specific activities under these initiatives.

**Mental Illness prevention**

The Department of Health delivers five *Mental Illness Prevention* programmes which totalled $22.4 million in 2012–13. Elements of *beyondblue* are funded under this taxonomy; however, the National Perinatal Depression Initiative is the major programme funded in this group ($9.9 million in 2012–13). The National Perinatal Depression Initiative (NPDI) aims to improve prevention and early detection of antenatal and postnatal depression and provide better support and treatment for expectant and new mothers experiencing depression. The initiative is cost shared between the Commonwealth and the states. Funding is also provided to *beyondblue* to support the NPDI and via the ATAPS program.

**Web-based self-help programmes**

The Department of Health delivers two *Web-based Self-help* programmes which totalled $5.4 million in 2012–13:

- The virtual clinic (MindSpot) provides free real-time, online and telephone-based cognitive behavioural therapy for high prevalence disorders with a trained therapist. Treatment is for those aged 18 years and over.
- The Teleweb measure is an ongoing Council of Australian Governments (COAG) initiative, the COAG Mental Health – Telephone Counselling, Self Help and Web-Based Support Programmes measure, with funding commencing in 2006. The Teleweb measure supports the provision of evidence-based telephone and online mental health programs to supplement or substitute for existing face-to-face services for people with common mental health disorders or those in psychosocial crisis.

2. **Primary mental health services**

Commonwealth-funded primary mental health care services target a range of populations with problems of varying severity and type. For example, mental health-specific Medicare Benefits Schedule (MBS) services are generally intended for people with any mental disorder. Some services target specific sub-groups—for example, the National Perinatal Depression Initiative provides treatment for women with perinatal depression, and the Mental Health Nurse Incentive Programme targets people suffering from severe and persistent disorders. Other services (e.g. Kids Helpline) are delivered to people who are experiencing mental health problems but may not have a formally diagnosed mental disorder.

The Commonwealth funds primary mental health care services through a range of mechanisms, including the Medicare Benefits Schedule, the Pharmaceutical Benefits Scheme/Repatriation Pharmaceutical Benefits Scheme and financial contributions to nongovernment organisations.

**Primary Care – General Practitioner**

The Department of Health and the Department of Veterans’ Affairs fund two programmes that fit within this category. The MBS, administered by the Department of Health, is the major programme of this category attracting $195.5 million in funding in 2012–13. Services are provided to individuals by general practitioners for the assessment and treatment of mental health problems. The majority of general practitioner mental health care activities are funded through the MBS, but this category may also be funded by third parties, including the
Department of Veterans’ Affairs, the Department of Defence, injury compensation (such as workers’ compensation or compulsory third party insurance) and other insurance funds.

The Department of Veterans’ Affairs also directly funds general practitioners, which totalled $21.8 million in 2012–13.

**Primary Care – Private Allied Health**

The Department of Health (10) and the Department of Veterans’ Affairs (1) deliver eleven *Primary Care – Private Allied Health* programmes, totalling $510.9 million in 2012–13. The major programmes within this category include: Better Access to Psychiatrists, Psychologists and GPs through the MBS (Better Access programme); ATAPS (Access to Allied Psychological Services); and general access to the MBS.

The purpose of the Better Access initiative is to improve early detection, treatment and management of common mental disorders such as anxiety and depression in the community through access to short-term psychological interventions in the primary care setting through MBS. It also funds access to psychiatrists.

The ATAPS programme provides short-term focused psychological strategies services in the primary care setting, currently through Medicare Locals, for people with a diagnosed mental disorder of mild to moderate severity. ATAPS targets hard-to-reach groups which continue to miss out on Medicare-subsidised services, including people from low socio-economic areas. In addition, funding is provided to several organisations to support Medicare Locals in the delivery of services in areas such as training, resource development and clinical support.

MBS payments for mental health-specific items are delivered by three provider groups:

- **Consultant Psychiatrists**: Expenditure reported refers to benefits paid for all services by consultant psychiatrists. The amounts reported exclude payments by the Department of Veterans’ Affairs under the Repatriation Medical Benefits Schedule.
- **General Practitioners**: Expenditure on GP mental health care is based solely on estimated benefits paid against the MBS mental health-specific GP items, which are predominantly the Better Access GP mental health items plus a small number of other items that were created in years preceding the introduction of the Better Access initiative.
- **Psychologists/Allied Health**: Expenditure refers to MBS benefits paid for clinical psychologists, psychologists, social workers and occupational therapists under items introduced through the Better Access to Mental Health Care initiative on 1 November 2006.

The Australian National Audit Office (ANAO) conducted an audit of ATAPS in 2012. The focus of the audit was on the then Department of Health and Ageing’s administration of the ATAPS program, including systems and processes the department employs to: guide its administrative efforts; manage day-to-day delivery of the programme through a large number of third party providers; plan and administer programme initiatives; monitor compliance with programme requirements; and report on the extent to which the programme is achieving the objectives set by government. Overall the ANAO audit was favourable.

**Primary Care – Web and Telephone-based**

The Department of Health funds one e-Mental Health programme which sits within this category, totalling $7.6 million of funding in 2012–13. Web-based programs provide interventions designed for both educational and therapeutic purposes. Interventions are
structured and similar to web-based self-help programmes, but direct support, guidance and feedback is provided by health/mental health workers on a one-to-one basis (e.g. via email, instant messaging, webcams, Skype). The total amount of human support and feedback provided to the user can vary from a few minutes to several hours.

Telephone-based programs include clinical mental health services and counselling provided by trained mental health professionals. These are designed to deal with a broad range of health problems for someone who may or may not be experiencing a mental illness, and hence are considered to be a primary mental health care intervention.

**Primary Care – Private Mental Health Nurses**

The Department of Health and Department of Veterans’ Affairs fund two Private Mental health Nurse programmes, totalling $61.5 million in 2012–13. The larger of the two programmes, the Mental Health Nurse Incentive (MHNI) programme, is administered by the Department of Health.

The MHNI programme provides incentive payments to community based general practices, private psychiatrist practices and other organisations that engage mental health nurses to assist in the providing of coordinated clinical care for people with severe mental disorders. Session caps to the MHNI programme were applied in May 2012.

The Department of Veterans’ Affairs purchases its mental health services from the mainstream public and private health sector, with the exception of Veterans and Veterans Families Counselling Service (VVCS), which provides free and confidential 24-hour counselling and support to members of the veteran and ex-service community, including veterans' partners and immediate family.

The VVCS provides counselling and group programs to Australian veterans, peacekeepers and their families. It is a specialised, free and confidential Australia-wide service.

VVCS staff are qualified psychologists or social workers with experience in working with veterans, peacekeepers and their families. They can provide a wide range of treatments and programs for war and service-related mental health conditions, including post-traumatic stress disorder (PTSD).

**Primary Care – Indigenous**

The Department of the Prime Minister and Cabinet funds one Primary Care – Indigenous programme, the Social and Emotional Wellbeing Programme, which totalled $47 million in 2012–13.

The objective of the Social and Emotional Wellbeing Programme is to enhance existing service delivery to Aboriginal and Torres Strait Islander communities, prioritising members of the Stolen Generations, through flexible models of service delivery and national coordination and support.

The funding is being provided for:

- counselling, family tracing and reunion services to members of the Stolen Generations through a network of eight Link Up services
- social and emotional wellbeing support and counselling services to Indigenous Australians, prioritising members of the Stolen Generations largely through more than 90 Aboriginal Community Controlled Health Organisations
- workforce, training, and development through nine Workforce Support Units and 11 Indigenous Registered Training Organisations
• Stolen Generations national organisations
• national coordination support to services and staff.

Primary Care – General Practitioner – Medicine Prescribing

The Department of Health is responsible for the Pharmaceutical Benefits Scheme (PBS) and administers the Repatriation Pharmaceutical Benefits Scheme (RPBS). The PBS and RPBS accounted for $646.6 million funding in 2012–13. Under the PBS, the government subsidises the cost of medicine for most medical conditions. Most of the listed medicines are dispensed by pharmacists, and used by patients at home.

The RPBS provides a wide range of pharmaceuticals and dressings at a concession rate for the treatment of eligible veterans, war widows/widowers and their dependents.

There were 23.74 million PBS and RPBS-subsidised prescriptions for mental health-related medications in 2012–13, accounting for 11.4 per cent of all subsidised prescriptions:

• 85.7 per cent of the mental health-related subsidised prescriptions were provided by GPs, with another 8.1 per cent being prescribed by psychiatrists and 6.1 per cent by non-psychiatrist specialists
• subsidised prescriptions comprised 76.4 per cent of the estimated 31.1 million community dispensed mental health-related prescriptions
• there was an average annual increase of 2.9 per cent in the rate of community dispensed prescriptions for mental health-related medications from 2008–09 to 2012–13.2

3. Direct Specialised Clinical Mental Health Programmes and Services for Individuals

Specialised Clinical Care – Acute inpatient

There are three departments (Health, Veterans’ Affairs and Treasury) delivering four Specialised Clinical Care – Acute inpatient programmes totalling $740.7 million in 2012–13. Inpatient services provide assessment, treatment and specialist psychiatric care to individuals with acute episodes of a mental disorder requiring short-term admission (average stay of 13.7 days) to a hospital-based psychiatric unit3. The major programme within this category is in the National Health Care Agreement administered by the Department of Health, and the mental health care component of the agreement comprises $574.0 million in 2012–13.

Specialised Clinical Care – Subacute inpatient

Subacute mental health care, as defined for the 2010 National Partnership Agreement on Improving Public Hospital Services, is “care in which the primary clinical purpose or treatment goal is improvement in function, behaviour and/or quality of life for a patient with a mental illness”. The Department of Health administers the National Partnership Agreement on Improving Public Hospital Services (NPA IPHS): Schedule E (New Subacute Beds Guarantee Funding), totalling $71.4 million in 2012–13. The NPA-IPHS Funding provided to states and territories to deliver and operate 1316 new subacute care beds nationally in hospital and community settings. These reforms will improve patient health outcomes, functional capacity and quality of life by increasing access to subacute services including rehabilitation, palliative care, subacute mental health, geriatric evaluation and management and psycho-geriatric services.
Specialised Clinical Care – Ambulatory

Three departments (Health, Immigration and Border Protection and Veterans’ Affairs) deliver ten Specialised Clinical Care – Ambulatory programmes, totalling $820.8 million in 2012–13. Ambulatory services are distinguished from bed-based services because they are delivered in community outpatient settings. Specialised assessment, treatment and ongoing management/rehabilitation services for mental disorders are often delivered in ambulatory settings. Elements of the National Health Care Agreement and National Partnership on Mental Health, both administered by the Department of Health, are included under this category.

Specialised Clinical Care – Psychiatrist/other specialist – Medicine Prescribing

The Department of Health delivers one Specialised Clinical Care – Psychiatrist/other specialist – Medicine Prescribing programme, through the PBS, which totalled $153.6 million in 2012–13. Mental health-related medications are prescribed by psychiatrists or other medical specialists (such as psychiatric registrars or other medical officers). These medications generally include antipsychotics, anxiolytics, hypnotics and sedatives, antidepressants, psychostimulants and nootropics.

4. Direct Specialised Non-Clinical Mental Health Programme and Support Services for Individuals

The Commonwealth funds a range of programmes targeting populations whose lives are severely affected by mental illness. Examples include Partners in Recovery, Personal Helpers and Mentors (PHaMs), and the Support for Day-to-Day Living in the Community Program. It also funds services that primarily deliver crisis support (e.g. Lifeline), but whose clients may or may not have a mental disorder. The majority of these services are funded via financial contributions to nongovernment organisations.

Specialised Community Support – Family and Carer Support

The Department of Social Services delivers two Specialised Community Support – Family and Carer Support programmes, totalling $80.4 million in 2012–13. Two programmes within the Targeted Community Care (Mental Health) Programme fit within this category: Family Mental Health Support Services (FMHSS) and Mental Health Respite: Carer Support (MHR:CS). The Targeted Community Care (TCC) Program commenced in 2006 following a Council of Australian Governments (COAG) agreement to a whole-of-government approach to mental health. The TCC programme aims to assist people with mental illness and their families and carers.

The Family Mental Health Support Services (FMHSS) provide flexible and responsive services for children and young people who are affected by, or at risk of mental illness, and their families. Services identify risk factors or issues which may lead to poor mental health outcomes for children and young people.

The aim of the Mental Health Respite: Carer Support (MHR:CS) programme is to assist carers of people with mental illness to sustain their caring roles and maintain connection with their communities, by increasing access to flexible, innovative carer support services. MHR:CS services are in scope to transition to the National Disability Insurance Scheme.

Specialised Community Support – Personalised Support

Two departments (Health and Social Services) deliver four Specialised Community Support – Personalised Support programmes totalling $139.5 million in 2012–13. The Personal Helpers and Mentors (PHaMs) initiative of the Targeted Community Care (Mental Health) programme...
is the major programme within this category. PHaMs provides one-to-one practical support for people over 16 years of age whose lives are impacted by mental illness. PHaMs has more than 220 sites nationally. PHaMs services are in scope to transition to the National Disability Insurance Scheme.

The PHaMs Employment initiative is a new stream of PHaMs, implemented as part of the 2011–12 mental health budget measures. Services have progressively become operational since June 2013. Services provide support for people with a mental illness receiving the Disability Support Pension or other government income support payments. They provide specialist support and work with employment services, such as Disability Employment Services, Job Services Australia, state-funded services and social enterprises, to assist PHaMs participants to address non-vocational issues that are barriers to finding and maintaining employment, training or education.

**Specialised Community Support – Mutual Support and self-help groups**

Elements of the National Suicide Prevention Programme delivered by the Department of Health are funded within this category, totalling $0.4 million in 2012–13.

**Specialised Community Support – Group Support Services**

The Department of Health delivers four Specialised Community Support - Group Support Services programmes totalling $25 million in 2012–13. The Day to Day Living Programme is the majority share funded within this category and it supports the Commonwealth Government’s contribution to the achievement of outcomes under the National Mental Health Strategy.

**Specialised Community Support – Employment / Education / Training**

Three departments (Health, Health Workforce Australia and Australian Federal Police) deliver seven Specialised Community Support – Employment/Education/Training programmes totalling $7.6 million in 2012–13. The majority of funding within this category funds headspace, administered by the Department of Health. The headspace National Office is funded to provide national management of the headspace network and to subcontract lead agencies for the delivery of services. Within centres treatment is delivered through GPs and allied health professionals. Eheadspace services are delivered by allied health professionals.

**Specialised Community Support – Care Co-ordination**

The Department of Health delivers one Specialised Community Support – Care Co-ordination programme totalling $62.5 million in 2012–13, which funds Partners in Recovery (PIR). PIR targets 24,000 people, out of an estimated 60,000, with severe and persistent mental illness with complex needs. The programme is delivered by PIR Organisations in each Medicare Local region - 48 regions are currently in contract. The PIR Organisation comprises a lead agency (35 Medicare Locals and 13 nongovernment organisations) and formal consortium member organisations which are listed in the funding agreement and collectively responsible for implementing PIR across the relevant region (210 in total). A comprehensive evaluation undertaken by an independent contractor commenced at the start of the initiative and will conclude in 2016. It is estimated that 70 per cent of PIR activities are in scope to transition to the National Disability Insurance Scheme.

**Specialised Community Support – Information / Referral / Counselling**

The Department of Health delivers five Specialised Community Support – Information/Referral/Counselling programmes totaling $61.8 million in 2012–13. The majority of funding within
this category funds headspace. The headspace programme commenced in 2006 and has been in a continual state of expansion since; current commitments total 100 sites across Australia by 2017. The funding model for the headspace programme was last revised in 2011–12. Centre funding is based on an average of $842,000 per annum per site and indexation has not been applied to this average. A future review of this average will be required for long-term sustainability.

The management of centres by locally based organisations (lead agencies) and their engagement of local health and social service organisations through consortium partnerships has been a critical factor in the success of the headspace model.

5. Mental Health System Capacity, Quality and Support Programmes and Services

Under several national agreements, the Commonwealth funds a range of specialised services delivered in private and public sector hospitals and ambulatory care settings. These services are generally intended for those with mental disorders of high severity. For example, the planned Early Psychosis Prevention and Early Intervention Centres will deliver specialised care to young Australians aged 15–24 years with emerging psychotic disorders. Services provided by private consultant psychiatrists subsidised through the MBS also fall into this category.

System Level – Population Research

Three agencies (Health, National Health and Medical Research Council (NHMRC), and Veterans’ Affairs) deliver four System Level – Population Research programmes, totalling $70.7 million in 2012–13. The majority of this funding is delivered by the NHMRC for research from NHMRC Medical Research Endowment Account (MREA) that includes mental health research.

System Level – Population Sector Capacity Building and Peaks

The Department of Health delivers six System Level – Population Sector Capacity Building and Peaks programmes, totalling $10.3 million in 2012–13. The majority of funding within this category funds the National Mental Health Commission.

Population Information Management and National Surveys

Two departments (Health and Prime Minister and Cabinet) fund six System Level – Population Information Management and National Surveys programmes totalling $16.5 million in 2012–13. The majority of funding within this category funds mental health reform.

Population Quality and Standards

Three departments (Health, Comcare and the Australian Commission on Safety and Quality in Health Care) deliver nine System Level – Population Quality and Standards programmes totalling $12.7 million in 2012–13. The majority of funding within this category funds departmental work within the Department of Health.

System Level – Individual Workforce Development Education and Training

Two departments (Health and Human Services) deliver seven System Level – Individual Workforce Development Education and Training programmes, totaling $15 million in 2012–13. The majority of funding under this category belongs to Additional Education Places Scholarships and Training in Mental Health and Better Access.
6. Indirect Mental Health Support Programmes and Services

The Department of Social Services administers Carer Payment, Carer Allowance and the Disability Support Pension. The Carer Payment and Carer Allowance are paid to carers of both adults and children. The annual $600 Carer Supplement may also be available to recipients of Carer Allowance for each person being cared for, and an additional $600 to those in receipt of Carer Payment or other eligible income support payment.

**Individual Carer Payment**

This payment provides financial assistance to carers whose caring responsibilities for people with disability, frailty because of age, or a severe medical condition severely restrict their ability to undertake paid employment. The carer must personally provide constant care in the home of the care receiver, and meet an income and assets test. A person cannot receive Carer Payment and another income support payment at the same time. Care receivers are subject to a separate income and assets test. In 2012–13 Carer Payment totalled $793.7 million in funding.

**Individual Carer Allowance**

In 2012–13 Carer Allowance totalled $205.4 million in funding.

*Carer Allowance (Adult)*

Carer Allowance (Adult) assists in making payments to financially assist carers who provide daily care and attention in a private home to a person with a disability or severe medical condition.

*Carer Allowance (Child)*

Carer Allowance (Child) assist in making payments to financially assist carers who provide daily care and attention in a private home to a child under age 16 with disability or a severe medical condition.

Carer Allowance is not taxable or income and assets tested, and it can be paid in addition to a social security income support payment. A carer who qualifies for Carer Payment (Child) automatically qualifies for Carer Allowance (Child).

**Disability Support Pension**

The Disability Support Pension (DSP) is an income support payment for people who are unable to support themselves adequately through work due to a permanent physical, intellectual or psychiatric impairment.

As at June 2012, to be eligible for Disability Support Pension a person must be permanently blind or have a permanent physical, intellectual or psychiatric impairment of at least 20 points under the impairment tables. If at least 20 points are not allocated under a single impairment table, a person must have also actively participated in a programme of support.

An ‘impairment’ is defined as permanent under the Social Security Act 1991 if it is fully diagnosed, treated and stabilised and likely to last for at least two years without significant functional improvement. The person must be unable to work for at least 15 hours per week at or above the relevant minimum wage for the next two years or be unable to be retrained for such work within the next two years because of that impairment.
As June 2013, there were 821,738 individuals receiving the DSP. At September 2013, there were 256,380 individuals receiving the DSP with a primary medical condition listed as ‘psychological/psychiatric’. This represented $4.67 billion in 2012–13.

7. Uncategorised

Uncategorised Mental Health Specific Programmes (non-Defence)

Five departments (Australian Human Rights Commission, Australian National Preventive Health Agency, the Department of Health, the Department of Human Services and the Department of Social Services) administer 29 programmes, totalling $12.8 million in 2012–13, which deliver outcomes for populations and/or individuals with mental health issues; however, they are not specific mental health care programmes.

Uncategorised Mental Health Specific Programmes (Defence)

The Department of Defence (Defence) administers 26 individual mental health programmes. Since 2009 Defence has spent almost $95 million on mental health services and support. Internally Defence administers mental health care through counselling and cognitive behaviour therapies undertaken by registered allied health professionals (e.g. clinical psychologists) to the Australian Defence Force. Australian Defence Force members also have access to services provided under the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme.
### 2012–13 Commonwealth investment in mental health

<table>
<thead>
<tr>
<th>Major Stream/sub-stream</th>
<th>Agency</th>
<th>Programme</th>
<th>2012-13 (Sm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All streams/programmes – Grand Total</td>
<td></td>
<td></td>
<td>9,577.5</td>
</tr>
<tr>
<td>1. Prevention, health promotion, self-help and education services and programmes</td>
<td></td>
<td></td>
<td>90.6</td>
</tr>
<tr>
<td>Mental Health promotion/community development</td>
<td></td>
<td></td>
<td>628</td>
</tr>
<tr>
<td><strong>Australian National Preventive Health Agency</strong></td>
<td></td>
<td></td>
<td>0.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Young Australians Alcohol Reporting System</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Department of Veterans’ Affairs</strong></td>
<td></td>
<td></td>
<td>3.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental health budget measures (aggregated)</td>
<td>3.3</td>
</tr>
<tr>
<td><strong>Department of Health</strong></td>
<td></td>
<td></td>
<td>59.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>beyondblue</td>
<td>12.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>e-mental health</td>
<td>2.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>KidsMatter</td>
<td>16.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Mental Health Programme</td>
<td>4.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Perinatal Depression Initiative</td>
<td>1.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Suicide Prevention Programmes</td>
<td>18.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Programme of Assistance for Survivors of Torture and Trauma</td>
<td>5.3</td>
</tr>
<tr>
<td><strong>Mental illness prevention</strong></td>
<td></td>
<td></td>
<td>22.4</td>
</tr>
<tr>
<td><strong>Department of Health</strong></td>
<td></td>
<td></td>
<td>22.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>beyondblue</td>
<td>3.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health and Wellbeing Checks for 3 year olds</td>
<td>0.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Mental Health Programme</td>
<td>4.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Perinatal Depression Initiative</td>
<td>9.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Suicide Prevention Programmes</td>
<td>4.6</td>
</tr>
<tr>
<td><strong>Web-based self-help programmes</strong></td>
<td></td>
<td></td>
<td>5.4</td>
</tr>
<tr>
<td><strong>Department of Health</strong></td>
<td></td>
<td></td>
<td>5.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>e-mental health</td>
<td>5.4</td>
</tr>
<tr>
<td>Major Stream/sub-stream</td>
<td>Agency</td>
<td>Programme</td>
<td>2012-13 ($m)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------</td>
<td>-----------</td>
<td>---------------</td>
</tr>
<tr>
<td>2. Primary mental health services</td>
<td>National Suicide Prevention Programmes</td>
<td>n.r.</td>
<td></td>
</tr>
<tr>
<td>GP-provided mental health services funded by MBS/third party funders</td>
<td>Department of Veterans’ Affairs</td>
<td>217.4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>General Practitioners (GPs)</td>
<td>21.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Department of Health</td>
<td>195.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicare Benefits Schedule (MBS) - GPs</td>
<td>195.5</td>
<td></td>
</tr>
<tr>
<td>Private allied health provided mental health services funded by MBS/third party funders</td>
<td>Department of Veterans’ Affairs</td>
<td>510.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Allied mental health provider services</td>
<td>2.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Department of Health</td>
<td>508.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Access to Allied Psychological Services</td>
<td>74.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Autism - Addition of Specific MBS Item</td>
<td>n.a.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maternity Peer Support</td>
<td>1.4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicare Benefits Scheme – Psychologists/Allied health</td>
<td>411.4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental Health Services in Rural and Remote Areas Programme</td>
<td>15.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental Health Support for Drought Affected Communities</td>
<td>n.r.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>National Advisory Council on Mental Health</td>
<td>n.r.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>National Suicide Prevention Programmes</td>
<td>5.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sisters of Charity Outreach</td>
<td>n.r.</td>
<td></td>
</tr>
<tr>
<td>Web/telephone-based mental health services provided by health professionals</td>
<td>Department of Health</td>
<td>7.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>e-mental health</td>
<td>7.6</td>
<td></td>
</tr>
<tr>
<td>Allied mental health delivered through state/territory community health centres</td>
<td>Department of Health</td>
<td>7.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n.a</td>
<td>n.a</td>
<td></td>
</tr>
<tr>
<td>Private mental health nurses in MBS-funded GP practices/third party funders</td>
<td>Department of Veterans’ Affairs</td>
<td>61.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Veterans and Veterans Families Counselling Service (VVCS)</td>
<td>26.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Department of Health</td>
<td>35.4</td>
<td></td>
</tr>
</tbody>
</table>

Notes: Nil : No expenditure incurred. n.r. : No reported expenditure information. n.a. : Not applicable. * : Unable to report at programme level. As at 13 November 2014. Based upon information provided by agencies to the NMHC February 2014.
<table>
<thead>
<tr>
<th>Major Stream/sub-stream</th>
<th>Agency</th>
<th>Programme</th>
<th>2012-13 (Sm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health services delivered through Aboriginal controlled mental health services</td>
<td>Department of Health</td>
<td>Mental Health Nurse Incentive Programme</td>
<td>35.4</td>
</tr>
<tr>
<td></td>
<td>Department of Health /Department of the Prime Minister and Cabinet (PMC)</td>
<td>Improving the Capacity of Health Workers in Indigenous Communities</td>
<td>n.r.</td>
</tr>
<tr>
<td>GP prescribed drug therapies</td>
<td>Department of Veterans’ Affairs</td>
<td>Repatriation Pharmaceutical Benefits Scheme</td>
<td>32.2</td>
</tr>
<tr>
<td></td>
<td>Department of Health</td>
<td>Pharmaceutical Benefits Scheme</td>
<td>614.5</td>
</tr>
<tr>
<td>3. Specialised clinical mental health services (delivered in healthcare settings)</td>
<td>Department of Veterans’ Affairs</td>
<td>Acute inpatient services</td>
<td>740.7</td>
</tr>
<tr>
<td></td>
<td>Department of Health</td>
<td>Private hospitals</td>
<td>32.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Public hospitals</td>
<td>29.2</td>
</tr>
<tr>
<td></td>
<td>Department of Veterans’ Affairs</td>
<td>National Agreements - NHCA/ NHRA (estimated mental health share of Commonwealth hospital funding)</td>
<td>574.0</td>
</tr>
<tr>
<td></td>
<td>Treasury</td>
<td>Private Health Insurance Premium Rebates</td>
<td>105.0</td>
</tr>
<tr>
<td>Subacute inpatient services</td>
<td>Department of Health</td>
<td>National Agreements - NPA Improving Public Hospital Services – Subacute beds</td>
<td>71.4</td>
</tr>
<tr>
<td>Nonacute inpatient services</td>
<td></td>
<td>No Commonwealth programmes identified</td>
<td>n.a</td>
</tr>
<tr>
<td>Residential services (with clinical staff)</td>
<td></td>
<td>No Commonwealth programmes identified</td>
<td>n.a</td>
</tr>
<tr>
<td>Major Stream/sub-stream</td>
<td>Agency</td>
<td>Programme</td>
<td>2012-13 (Sm)</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Emergency department services</td>
<td></td>
<td></td>
<td>n.a</td>
</tr>
<tr>
<td>Consultation liaison services</td>
<td></td>
<td>No Commonwealth programmes identified</td>
<td>n.a</td>
</tr>
<tr>
<td>Specialised ambulatory mental health services</td>
<td></td>
<td></td>
<td>n.a</td>
</tr>
<tr>
<td>Department of Immigration and Border Protection</td>
<td></td>
<td>Department of Immigration and Border Protection</td>
<td>820.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Department of Immigration and Border Protection</td>
<td>21.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Onshore Detention Health Services Contract</td>
<td>n.r.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Onshore Torture and Trauma Counselling Contracts</td>
<td>21.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psychological Support Program</td>
<td>n.r.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Regional Processing Countries Health Services Contract</td>
<td>n.r.</td>
</tr>
<tr>
<td>Department of Veterans’ Affairs</td>
<td></td>
<td>Department of Veterans’ Affairs</td>
<td>18.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psychiatrist services</td>
<td>18.0</td>
</tr>
<tr>
<td>Department of Health</td>
<td></td>
<td>Department of Health</td>
<td>781.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Early Psychosis Prevention and Intervention Centre (EPPIC)</td>
<td>9.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicare Benefits Schedule - Consultant Psychiatrist services</td>
<td>301.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Agreements - NHCA/ NHRA (estimated mental health share of</td>
<td>451.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Commonwealth hospital funding)</td>
<td>7.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Program of Assistance for Survivors of Torture and Trauma</td>
<td>12.3</td>
</tr>
<tr>
<td>Psychiatrist/other specialist prescribed drug therapies</td>
<td></td>
<td>Department of Health</td>
<td>153.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pharmaceutical Benefits Scheme</td>
<td>153.6</td>
</tr>
<tr>
<td>4. Specialised non-clinical mental health support services (delivered in the community)</td>
<td></td>
<td>Department of Social Services</td>
<td>377.2</td>
</tr>
<tr>
<td>Family &amp; Carer Support</td>
<td></td>
<td>Department of Social Services</td>
<td>80.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Targeted Community Care (Mental Health) Programme (TCC Programme) - Family</td>
<td>23.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental Health Support Services (FMHSS)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Targeted Community Care (Mental Health) Programme (TCC Programme) - Mental</td>
<td>57.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health Respite: Carer Support (MHR:CS)</td>
<td></td>
</tr>
<tr>
<td>Residential services (with non-clinical staff)</td>
<td></td>
<td>No Commonwealth programmes identified</td>
<td>n.a</td>
</tr>
</tbody>
</table>

Notes: Nil : No expenditure incurred. n.r. : No reported expenditure information. n.a. : Not applicable. * : Unable to report at programme level.
As at 13 November 2014.
Based upon information provided by agencies to the NMHC February 2014.
<table>
<thead>
<tr>
<th>Major Stream/sub-stream</th>
<th>Agency</th>
<th>Programme</th>
<th>2012-13 (Sm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personalised Support</td>
<td></td>
<td></td>
<td>139.5</td>
</tr>
<tr>
<td></td>
<td>Department of Social Services</td>
<td>Targeted Community Care (Mental Health) Programme (TCC Programme) - Personal Helpers and Mentors (PHaMs)</td>
<td>100.4</td>
</tr>
<tr>
<td></td>
<td>Department of Health</td>
<td>National Partnership on Mental Health</td>
<td>39.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Suicide Prevention Programmes</td>
<td>35.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tasmanian Health Assistance package - State SPP payments</td>
<td>2.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1.1</td>
</tr>
<tr>
<td>Mutual Support and self-help groups</td>
<td></td>
<td></td>
<td>0.4</td>
</tr>
<tr>
<td></td>
<td>Department of Health</td>
<td>National Suicide Prevention Programmes</td>
<td>0.4</td>
</tr>
<tr>
<td>Group Support Services</td>
<td></td>
<td></td>
<td>25.0</td>
</tr>
<tr>
<td></td>
<td>Department of Health</td>
<td>Day to Day Living Programme</td>
<td>25.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>EPPIC</td>
<td>13.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>headspace</td>
<td>1.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Suicide Prevention Programmes</td>
<td>9.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0.4</td>
</tr>
<tr>
<td>Employment, education and training</td>
<td></td>
<td></td>
<td>7.6</td>
</tr>
<tr>
<td></td>
<td>Australian Federal Police</td>
<td>ACT Policing - Mental Health Community Policing Initiative</td>
<td>n.r.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AFP Wellbeing Services</td>
<td>n.r.</td>
</tr>
<tr>
<td></td>
<td>Department of Health</td>
<td>EPPIC</td>
<td>7.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>headspace</td>
<td>1.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6.4</td>
</tr>
<tr>
<td></td>
<td>Health Workforce Australia</td>
<td>Mental Health Peer Workforce Study</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Mental Health Core Capabilities (NMHCC)</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Mental Health Workforce Reform Programme</td>
<td>n.r</td>
</tr>
<tr>
<td>Major Stream/sub-stream</td>
<td>Agency</td>
<td>Programme</td>
<td>2012-13 (Sm)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------</td>
<td>-----------</td>
<td>--------------</td>
</tr>
<tr>
<td>Care Co-ordination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Department of Health</td>
<td>Partners In Recovery</td>
<td>62.5</td>
</tr>
<tr>
<td>Information, referral and counselling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Department of Health</td>
<td>beyondblue</td>
<td>61.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>e-mental health</td>
<td>0.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>headspace</td>
<td>6.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lifeline - Assistance</td>
<td>47.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Suicide Prevention Programmes</td>
<td>n.r</td>
</tr>
<tr>
<td>S. Mental health system and staff capacity building, development and research</td>
<td></td>
<td></td>
<td>125.1</td>
</tr>
<tr>
<td>Research</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Department of Veterans’ Affairs</td>
<td>Australian Centre for Posttraumatic Mental Health (ACPMH)</td>
<td>70.7</td>
</tr>
<tr>
<td></td>
<td>Department of Health</td>
<td>Health Care (Appropriation) Act 1998 - Australian Health Care Agreements - Mental Health</td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Leadership in Mental Health Reform</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td>National Health and Medical Research Council (NHMRC)</td>
<td>NHMRC Research</td>
<td>67.1</td>
</tr>
<tr>
<td>Sector capacity building &amp; national peak bodies</td>
<td></td>
<td></td>
<td>10.3</td>
</tr>
<tr>
<td></td>
<td>Department of Health</td>
<td>Health Care (Appropriation) Act 1998 - Australian Health Care Agreements - Mental Health</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Leadership in Mental Health Reform</td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Mental Health Commission</td>
<td>6.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Suicide Prevention Programmes</td>
<td>1.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Taking Action to Tackle Suicide (TATS) Nationally consistent reporting measure</td>
<td>n.r</td>
</tr>
<tr>
<td>Information management &amp; national surveys</td>
<td></td>
<td></td>
<td>16.5</td>
</tr>
<tr>
<td></td>
<td>Department of Health</td>
<td></td>
<td>12.2</td>
</tr>
</tbody>
</table>

Notes: Nil: No expenditure incurred. n.r.: No reported expenditure information. n.a.: Not applicable. * : Unable to report at programme level.
As at 13 November 2014.
Based upon information provided by agencies to the NMHC February 2014
<table>
<thead>
<tr>
<th>Major Stream/sub-stream</th>
<th>Agency</th>
<th>Programme</th>
<th>2012-13 (Sm)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health Care (Appropriation) Act 1998 - Australian Health Care Agreements - Mental Health</td>
<td>n.r</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health Leaders in Mental Health Reform</td>
<td>6.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>National Agreements - National Health Care Agreement (MH reform payments)</td>
<td>n.r</td>
<td></td>
</tr>
<tr>
<td></td>
<td>National Suicide Prevention Programmes</td>
<td>2.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Partners in Recovery</td>
<td>3.3</td>
<td></td>
</tr>
<tr>
<td>Department of Health /Department of the Prime Minister and Cabinet (PMC)</td>
<td>Social and Emotional Wellbeing Programme</td>
<td>4.3</td>
<td></td>
</tr>
<tr>
<td>Quality and standards</td>
<td>Australian Commission on Safety and Quality in Health Care (ACSQHC)</td>
<td>n.r</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accreditation Workbook for Mental Health Services</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medication safety programme</td>
<td>n.r</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Scoping Review: Recognising and Responding to Deterioration in Mental State</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Scoping Study on the Implementation of National Standards by Mental Health Services</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td>Comcare</td>
<td>Centre of Excellence in Mental Health and Wellbeing at Work</td>
<td>n.r</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical Panel</td>
<td>n.r</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Development of a national accredited training program for all work health and safety inspectors that equips them to identify and address instances of workplace bullying for preventing and responding to workplace bullying matters</td>
<td>n.r</td>
<td></td>
</tr>
<tr>
<td>Department of Health</td>
<td>Department of Health: Departmental Admin Costs</td>
<td>24.7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Core support for Lifeline Australia National Secretariat Activities under the Health System Capacity Development Fund (HSCDF)</td>
<td>12.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Core support for Mental Health Council of Australia - National Secretariat Activities under the HSCDF</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health and Hospitals Fund</td>
<td>11.6</td>
<td></td>
</tr>
<tr>
<td>Workforce development, education &amp; training</td>
<td>DHS</td>
<td>n.r</td>
<td></td>
</tr>
<tr>
<td>Major Stream/sub-stream</td>
<td>Agency</td>
<td>Programme</td>
<td>2012-13 ($m)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MBS Primary Care Items eLearning program - EDUCATIONAL RESOURCE</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Department of Health</td>
<td>15.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Additional Education Places Scholarships and Clinical Training in Mental Health</td>
<td>8.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Better Access - education and training</td>
<td>6.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Leadership in Mental Health Reform</td>
<td>n.r</td>
</tr>
<tr>
<td>6. Income support for people and their families</td>
<td></td>
<td>Carer Payment</td>
<td>5,675.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DSS</td>
<td>793.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Carer Payment</td>
<td>793.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Carer Allowance</td>
<td>205.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DSS</td>
<td>205.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Carer Allowance</td>
<td>205.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disability Support Pension</td>
<td>4,676.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DSS</td>
<td>4,676.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disability Support Pension (DSP)</td>
<td>4,676.3</td>
</tr>
<tr>
<td>7. Uncategorised</td>
<td></td>
<td>Uncategorised mental health specific programs (non-defence)</td>
<td>39.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Australian Human Rights Commission (AHRC)</td>
<td>12.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Australian Human Rights Commission (AHRC)</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Access to justice for people with disability in the criminal justice system</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Close the Gap: Indigenous health campaign</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventing crime and promoting rights for Indigenous young people with cognitive disabilities and mental health issues</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Publication &quot;Workers with mental illness: A practical guide for managers&quot;</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ANPHA</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ANPHA</td>
<td>n.a.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Smoking and Disadvantage Network</td>
<td>n.a.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Department of Human Services (DHS)</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Better Start for Children with Disability Initiative - FAQ</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Better Start for Children with Disability Initiative - flowchart - EDUCATIONAL RESOURCE</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chronic disease management - EDUCATIONAL RESOURCE</td>
<td>n.r</td>
</tr>
</tbody>
</table>

Notes: Nil: No expenditure incurred. n.r.: No reported expenditure information. n.a.: Not applicable. *: Unable to report at programme level. As at 13 November 2014. Based upon information provided by agencies to the NMHC February 2014.
<table>
<thead>
<tr>
<th>Major Stream/sub-stream</th>
<th>Agency</th>
<th>Programme</th>
<th>2012-13 ($m)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Diagnostic Audiology Services - EDUCATIONAL RESOURCE</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicare requirements for Better Access to mental health care - EDUCATIONAL RESOURCE</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ministerial Referral Service for people presenting at risk of suicide or self-harm</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social Work Services</td>
<td>n.r</td>
</tr>
<tr>
<td><strong>DSS</strong></td>
<td></td>
<td>National Disability Strategy 2010-2020</td>
<td>0.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consumer Voices</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disability Employment Assistance</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disability Employment Services (DES) programme</td>
<td>0.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family and Relationship Services, including MensLine</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Find and Connect</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gambling Help Online</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MyTime Peer Support Groups for Parents and Carers of Children with Disability or Chronic Medical Condition</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Affordable Housing Agreement (NAHA)</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Disability Agreement (NDA)</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Disability Conference Initiative (NDCI)</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Disability Insurance Scheme (NDIS)</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Partnership Agreement on Homelessness (2013-14)</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Partnership Agreement on Mental Health</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>National policy approach to help problem gamblers</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reconnect</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Respite Support for Carers of Young People with Severe or Profound Disability Programme (RSCYP)</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Royal Commission Community-based support services</td>
<td>n.r</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Young Carers Respite and Information Services Programme</td>
<td>n.r</td>
</tr>
<tr>
<td><strong>Uncategorised mental health specific programs (Defence)</strong></td>
<td></td>
<td></td>
<td>26.9</td>
</tr>
<tr>
<td><strong>Defence</strong></td>
<td></td>
<td></td>
<td>26.9</td>
</tr>
<tr>
<td>Major Stream/sub-stream</td>
<td>Agency</td>
<td>Programme</td>
<td>2012-13 ($m)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------</td>
<td>-----------</td>
<td>--------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acute Mental Health on Operations (AMHOO)</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ADF Centre for Mental Health</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ADF Mental Health Day</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Annual Alcohol, Tobacco and Other Drugs Awareness</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Annual Suicide Awareness Course</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ASIST T4T</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ASIST, provided by Living Works (not a Defence owned training product)</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assessment and Case Formulation</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CIMHS T4T</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinician Administered PTSD Scale (CAPS)</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cognitive Processing Therapy</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coming Home Resettlement Program (CHRP)</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Critical Incident Mental Health Support (CIMHS)</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Defence Mental Health</td>
<td>26.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deployment Health Surveillance Programme</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Keep Your Mates Safe - Peer Support (KYMS-PS)</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental Health Portal</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental Health Prevalence and Wellbeing Study</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental Health Screening Continuum (MHSC)</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Operational Mental Health Screening</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outpatient Alcohol Treatment Program</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Recognising Early Signs of Emerging Traumatic Stress (RESET) Delivery</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self Management and Resilience Training (SMART Program)</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(BattleSMART, FamilySMART, LifeSMART</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suicide Risk Assessment Training (SRAT)</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Longitudinal ADF Study Evaluating Resilience (LASER-Resilience)</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Transition and Wellbeing Research Programme</td>
<td>*</td>
</tr>
</tbody>
</table>

Notes: Nil : No expenditure incurred. n.r. : No reported expenditure information. n.a. : Not applicable. * : Unable to report at programme level.
As at 13 November 2014.
Based upon information provided by agencies to the NMHC February 2014.
References


Attachment B: Programme Overview

What we found
Commonwealth programmes – the Commission’s overview

Our Approach

In January 2014 the Commission wrote to every Commonwealth and state government department requesting information on the programmes they funded or led over the past five years that had a mental health focus.

We identified four main Commonwealth departments which fund mental health programmes – Health, Social Services, Prime Minister and Cabinet and Veterans’ Affairs.

In 2012–13 the combined expenditure of mental health-related payments and programme funding was $9.6 billion. We found 140 different types of programmes, payments, grants and mental health partnerships, which were reported by 16 Commonwealth agencies over the past five years.

The landscape of Commonwealth funding is confusing.

A number of projects are funded under some items in our taxonomy, such as within the umbrella of the National Suicide Prevention Programme, while other funding was for a discrete programme (for example, headspace).

The Teleweb measures give grants to a range of agencies to manage a number of helplines to various groups of people, including Adults Surviving Child Abuse and Kids Helpline.

Other grants are for the delivery of a particular programme, such as Partners in Recovery, or services to a particular population.

This was problematic for our analysis. The Department of Defence, for example, reported programme expenditure of $26.9 million in 2012–13; however, this was not broken down into separate projects or programmes.

In Table 9.2, the Commission has focused its analysis on specific mental health support programmes delivered to people and their families.

Overall the Commission was underwhelmed at the level and currency of programme evaluations, despite, in some circumstances, a significant amount of Commonwealth investment. As a principle, a culture of evaluation of Commonwealth funding needs to be embedded in programme design and funded as a specific element of administration.

Of the top 20 items of Commonwealth expenditure reported in 2012–13, some are not specific mental health programmes delivered to people and families, and could not be assessed in a comparable way.

- Two items were payments to people and families (the mental health proportion of the Disability Support Pension and the Carer Payment and Allowance).
- The Pharmaceutical Benefits Scheme accounted for more than $750 million of expenditure in 2012–13.
- Two items were payments under the National Agreements to hospitals (share of Commonwealth funding and funding for subacute beds).
- Payments for private health insurance rebates for mental health-related costs were estimated at $105 million.
These items, along with National Health and Medical Research Council grants, accounted for almost $8 billion (or 82 per cent) of Commonwealth expenditure in 2012–13.

The remaining programmes which were in the ‘Top 20’ items of expenditure were MBS items claimed under the Better Access initiative, the Targeted Community Care Programme (PHaMs and Mental Health Respite Carer Support), ATAPS, headspace, the Mental Health Nurse Incentive Programme and the Social and Emotional Wellbeing Programme. Also included in the top 20 were Partners in Recovery, the National Partnership on Mental Health and the National Suicide Prevention Programme.

Commonwealth grants to these programmes accounted for approximately 12 per cent or $1.2 billion of expenditure.

The Commission has had to rely on existing evaluations and any other related evidence to inform its views on programmes and services. It is acknowledged that some programme streams have a specific focus and target population about which the respective department has expertise, such as the Department of Defence and the Department of Veterans’ Affairs.

Should the Government support the recommendations of this Review, it is envisaged that closer consultation with these and other departments will be undertaken in 2015. It is noted that the Department of Veterans’ Affairs has recently established a mental health review committee, and the Commission awaits that committee’s findings. The Commission supports the continuation of the mental health programmes of these two agencies.

The Department of Health funds a number of small national programmes for discrete services and the Commission confirms its support for these programmes. An example of a small national programme is the service for survivors of torture and trauma.

Other programme elements are provided to support mental health system advancement, such as funding national decision-making, quality and standards, data to inform system outcomes and performance and a national consumer and carer organisation. These programmes should remain in place and be included in any forward considerations of implementing the reform agenda as identified in this Review report.
Table 1 Commonwealth Programmes – The National Mental Health Commission’s View

<table>
<thead>
<tr>
<th>Programme</th>
<th>Description</th>
<th>Continue</th>
<th>Change</th>
<th>The Commission’s view is .....</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Allied Psychological Services (ATAPS)</td>
<td>This programme enables GPs to refer patients to mental health professionals for low-cost, evidence-based mental health care delivered in up to 12–18 sessions. Funds are currently held by Medicare Locals. ATAPS mental health professionals include psychologists, social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers with specific mental health qualifications. 2012–13 allocation: $74.1 M Evaluation? Yes</td>
<td>Y</td>
<td>Y</td>
<td>With the introduction of Primary Health Networks the ATAPS programme will need to be reformed to fit within the new remit of the networks. Given the number of programmes that target psychological and personal supports to people with mental health difficulties, it is appropriate that these population-driven programmes should be rolled up together as pooled funds to meet the needs of local communities. The Commission considers that ATAPS funding should form part of this pooled funding approach.</td>
</tr>
<tr>
<td>Better Access</td>
<td>Under this initiative Medicare rebates are available to patients for selected mental health services provided by GPs, psychiatrists, psychologists and eligible social workers and occupational therapists. 2012–13 allocation: $635 M in benefits paid Evaluation? Yes</td>
<td>Y</td>
<td>Y</td>
<td>Better Access has improved access to psychological treatment in the community and has been a positive initiative. More work needs to be done to ensure it is targeted to those most in need and rolled up into regional models to address community needs in an integrated way. Concern has been raised about the number of sessions available and the efficacy of the GP MH Care Plan. The Commission proposes amending Better Access to enable a simple referral and additional sessions for people with higher or more complex disorders.</td>
</tr>
<tr>
<td>Programme</td>
<td>Description</td>
<td>Continue?</td>
<td>Change?</td>
<td>The Commission’s view is .....</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
<td>-----------</td>
<td>---------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>headspace Youth Early Psychosis Programme (hYEPP—formerly EPPIC) Department of Health</td>
<td>The headspace Youth Early Psychosis Programme (hYEPP—formerly Early Psychosis Prevention and Intervention Centres (EPPIC)) offers an integrated and comprehensive mental health service to meet the needs of people aged 15-24 with a first episode of psychosis. 2012–13 allocation: $11.9 M Evaluation? No. The Department of Health in the process of commissioning an evaluation to be completed by 2016</td>
<td>Y</td>
<td>Y</td>
<td>This Review reconfirms the priority for early intervention for young people, especially when mental health problems first appear and when serious mental illness is developing. hYEPP should continue and be reviewed in the light of the findings of the 2016 evaluation and progress of other reforms arising from this Review regarding regional planning and delivery of services, especially for young people. Introduction of pooled funding within a regional framework should consider the inclusion of hYEPP funding.</td>
</tr>
<tr>
<td>headspace Department of Health</td>
<td>Funded under the Youth Mental Health Initiative Programme, and managed by the National Youth Mental Health Foundation, headspace offers specific services for people aged 12–25 who need help across some of the areas of mental health, employment, drug and alcohol, relationships and school. Allied health, GP and psychiatry services in this setting are funded through the Better Access Initiative. 2012–13 allocation: $63.7 M Evaluation? Yes (2009); new evaluation currently under way</td>
<td>Y</td>
<td>Y</td>
<td>headspace has rapidly expanded and an evaluation is currently being undertaken by the Social Policy Research Centre (UNSW) and is due in 2015. Changes to this programme should take into account the evaluation. Submissions to the Review highlighted a lack of local planning and duplication of current services in some headspace locations. There is concern that a one-size-fits-all approach does not meet the needs of people from diverse groups. The Commission recommends that this programme continues but local headspace services are transitioned into a regional model to better integrate and complement other services also targeting the same population group and to better meet the needs of local communities.</td>
</tr>
</tbody>
</table>
### Mental Health Nurse Incentive Programme (MHNIP)

**Department of Health**  
*(funding allocation)*

**Department of Social Services**  
*(grant waiting list management)*

This programme provides a non-MBS incentive payment to community-based general practice, private psychiatrists and Aboriginal and Torres Strait Islander Primary Health Care Services to engage mental health nurses to provide clinical care for people with severe and complex mental disorders in their practice or service.

**2012–13 allocation: $35.4 M**

**Evaluation? Yes**

Y Y

The Mental Health Nurse Incentive Programme has shown positive outcomes for participants, who also increased their social participation. Concerns have been raised about the programme’s design – including being capped at current funding levels rather than service levels, the transparency of the waiting list for grant allocations (especially the reallocation of funding where an approved grant holder may be underspending their grant and not providing the level of service for that community and equity of access for marginalised groups.)

The Commission considers redesign options for this programme under Recommendation 21.

### Mental Health Services in Rural and Remote Australia (MHSRRA)

**Department of Health**

MHSRRA provides funding to nongovernment health organisations such as Medicare Locals, Aboriginal Medical Services and the Royal Flying Doctor Service to deliver mental health services by social workers, psychologists, occupational therapists, mental health nurses, Aboriginal health workers and Aboriginal mental health workers.

MHSRRA funds the provision of mental health services in rural and remote communities that would otherwise have little or no access to mental health services, including in areas where access to Medicare-subsidised mental health services is low.

**2012–13 allocation: $15.9 M**

**Evaluation? Yes**

Y Y

With the introduction of Primary Health Networks to replace Medicare Locals, this programme will need to be reformed to fit within the new remit of the networks.

The well documented lack of mental health professionals in rural and remote Australia, the undersupply of Aboriginal and Torres Strait Islander trained mental health workers and the comparatively lower access to Medicare-subsidised services (especially GPs and specialist clinicians) provides a strong case for continuation of MHSRRA. This is supported by the evaluation of the programme, where local communities responded that the level of MHSRRA services could be expanded. Organisations reported that they would like to do more community development and health promotion work to target harder to reach groups; for example, Aboriginal and Torres Strait Islander communities, probation and parole groups and farmers. The variation across rural and remote communities was intrinsic to the local design and delivery of the programme.

To ensure that local community needs and context are reflected in the design and delivery of MHSRRA, the Commission considers that transferring MHSRRA funds into a regional pool will enable funds to be more efficiently allocated and programmes more tailored to local circumstance and community characteristics.
<table>
<thead>
<tr>
<th>Programme</th>
<th>Description</th>
<th>Continue?</th>
<th>Change?</th>
<th>The Commission’s view is .....</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National Depression Initiative</strong></td>
<td>beyondblue is the national initiative to raise awareness of anxiety and depression, providing resources for recovery, management and resilience.</td>
<td>Y</td>
<td>N</td>
<td>National mental health promotion and awareness should remain the responsibility of the Commonwealth. The Commission supports the continuation of beyondblue as a national initiative.</td>
</tr>
<tr>
<td>(beyondblue)</td>
<td></td>
<td></td>
<td></td>
<td>2012–13 allocation $16 M</td>
</tr>
<tr>
<td></td>
<td>Evaluation? Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>National Perinatal Depression Initiative</strong> (ATAPS and beyondblue)</td>
<td>The National Perinatal Depression Initiative aims to improve prevention and early detection of antenatal and postnatal depression and provide better support and treatment for expectant and new mothers experiencing depression.</td>
<td>Y</td>
<td>Y</td>
<td>The lack of a comprehensive evaluation limits an objective and detailed view of this programme.</td>
</tr>
<tr>
<td>Department of Health</td>
<td>Australian Government funding under this initiative is being distributed to states and territories as well as ATAPS to build the capacity of divisions of general practice to better support women with perinatal depression and beyondblue to support implementation, including raising community awareness about perinatal depression, and developing information and training materials for health professionals who screen and treat new and expectant mothers for perinatal depression.</td>
<td></td>
<td></td>
<td>This programme has two components:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• a community programme supporting women with perinatal depression</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• a national component to raise awareness of perinatal depression in the community and to develop information and training materials for health professionals.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>It is proposed that the community component be transferred to a regional funding entity such as the new Primary Health Networks, to better integrate and roll out perinatal initiatives along with other ATAPS and local health services for new parents and infants.</td>
</tr>
<tr>
<td>Programme</td>
<td>Description</td>
<td>Continue?</td>
<td>Change?</td>
<td>The Commission’s view is .....</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>---------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>National Suicide Prevention Programme (NSPP)</td>
<td>Funding for suicide prevention activities across the Australian population and for specific at-risk groups including men, Indigenous people, people in rural and remote Australia, people bereaved by suicide, people with a mental illness, and young people. The NSPP also provides funding to other Commonwealth-funded mental health programmes, including Access to Allied Psychological Services (ATAPS) and MindMatters, for the inclusion of suicide prevention specific activities under these initiatives. 2012–13 allocation: $23.0 M Evaluation? Yes</td>
<td>Y</td>
<td>Y</td>
<td>Funding of a range of suicide prevention programmes is a cluster of separate programmes under the Health Department (National Suicide Prevention Programme and Taking Action to Tackle Suicide, as well as Access to Allied Psychological Services) and the Department of Prime Minister and Cabinet in regard to Aboriginal and Torres Strait Islander interventions under the SEWB programme. Additionally, the Commonwealth also funds a number of helplines for people who are in distress (Lifeline, MensLine, Kids Helpline). Helplines need to be seen as part of the larger suicide prevention efforts, to also provide evidence-based approaches and streamlined access. The Commission considers that helplines need to be streamlined to ensure people in distress and crisis get one-on-one support when they call, and can be linked in to local services for additional in-person support. It is evident from available data that suicide rates are no longer decreasing. We need to accelerate efforts in a coordinated and targeted way, and to reconsider how to best to roll out evidence-based interventions. It is agreed by stakeholders that we also need a more robust and timely collection of attempted suicide and completed suicide figures, so funds are better used and better outcomes are achieved – more lives are saved. The Commission considers that clear targets are required to set a system goal and recommends a 50 per cent reduction in suicide attempts and suicides over the next ten years. Given the different programme streams that fund suicide prevention and postvention supports, and the imperative that approaches need to be better designed and targeted to the specific needs and vulnerabilities of communities, it is recommended that these programmes be rolled up into a regional model.</td>
</tr>
<tr>
<td>Department of Health</td>
<td></td>
<td>-----------</td>
<td>---------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Partners In Recovery (PIR)</td>
<td>Coordinated support and flexible funding for people with severe and persistent mental illness with complex needs. 2012–13 allocation: $65.8 M Evaluation? Currently under way</td>
<td>Y</td>
<td>Y</td>
<td>PIR has shown promise in some areas where it has been rolled out and submissions to the Review highlighted the value and positive impact of the programme. It is currently being formally evaluated, and the Commission understands that early findings have identified variability in quality across sites. The issue of the transfer of PIR to the NDIS is considered to erode the existing benefits to individuals in receipt of quality services. The Commission is concerned that new inefficiencies will arise when current eligible clients will not be covered by the NDIS and so will lose their supports and the advances they have made will be compromised. A more efficient approach for the person and the system would be to re-engineer the programme so that funding is integrated into a regional pool, with improved coordination and service delivery efficiencies and better targeting of local population and individual needs.</td>
</tr>
<tr>
<td>Programme</td>
<td>Description</td>
<td>Continue?</td>
<td>Change?</td>
<td>The Commission’s view is .....</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>---------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td><strong>Social and Emotional Wellbeing Programmes</strong>&lt;br&gt;Department of the Prime Minister and Cabinet</td>
<td>The objective of the Social and Emotional Wellbeing Programme is to enhance existing service delivery to Aboriginal and Torres Strait Islander communities, prioritising members of the Stolen Generations, through flexible models of service delivery and national coordination and support. 2012–13 allocation: $47.78 M Evaluation? Yes</td>
<td>Y</td>
<td>Y</td>
<td>There is no longer a discrete mental health/social and emotional wellbeing programme. All funding has been rolled into the new flexible outcome-based structure. This includes a safety and wellbeing stream. The grant round for 2014–15 is currently under way with applications closed but decisions yet to be made. The Commission’s view is that an additional target should be added to the COAG Closing the Gap programme to reduce early deaths and improve wellbeing.</td>
</tr>
<tr>
<td><strong>Support for Day to Day Living in the Community</strong>&lt;br&gt;Department of Health</td>
<td>A structured activity programme providing funding to improve the quality of life of individuals with severe and persistent mental illness by offering structured and socially based activities. This initiative recognises that meaningful activity and social connectedness are important factors that can contribute to recovery. 2012–13 allocation: $13.9 M Evaluation? Yes</td>
<td>Y</td>
<td>Y</td>
<td>This programme has been found to be highly effective for those interviewed in the evaluation as it provides a wide range of activities which improved the quality of life of participants. This was also reflected in the small number of submissions to the Review that the Commission received on this programme. The Commission considers that this programme should stay at its current funding levels and be transferred to be administered by a regional body, where pooled funding for programmes can be planned and allocated on local needs in an integrated delivery service framework.</td>
</tr>
<tr>
<td><strong>Taking Action to Tackle Suicide (TaTs)</strong>&lt;br&gt;Department of Health</td>
<td>The TaTs package provides further support for suicide prevention through universal and population-wide approaches and through community-led responses, including infrastructure for suicide hotspots and prevention activities and helplines. 2012–13 allocation: $19.2 M Evaluation? Partial (as part of NSPP)</td>
<td>Y</td>
<td>Y</td>
<td>Programmes need to continue under this initiative for target groups and special populations. All programmes run under this initiative should be evaluated rigorously and there is a need for a central point of planning with the NSPP. Funding for hotspots needs to be flexible and allocated to communities for local-specific solutions, administered by a regional model.</td>
</tr>
<tr>
<td>Programme</td>
<td>Description</td>
<td>Continue?</td>
<td>Change?</td>
<td>The Commission’s view is .....</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
<td>-----------</td>
<td>---------</td>
<td>-------------------------------</td>
</tr>
</tbody>
</table>
| **Targeted Community Care Programme – Personal Helpers and Mentors (PHaMs), Mental Health Respite: Carer Support (MHRCs) & Family Mental Health Support Services (FMHSS)** | Three separate programmes are funded under the umbrella of the TCC programme, to assist people and their families in the community by providing day-to-day support to manage the impact of living with a mental illness through PHaMs, Mental Health Respite and Family Mental Health Support Services. | Y | Y | The evaluation of this programme identified positive outcomes for people, their families and carers by improving access to daily support, increasing options for respite for carers and families.  
The Commission is concerned at the proposal to roll these programmes up into the NDIS, as this will leave some people without the services they are currently entitled to and affect the sustainability of some smaller organisations. As the largest single programme of supports for people with a mental illness and their families (other than income support), changing access will have the greatest impact upon current recipients. As such, given that components of the NDIS as they apply to people living with a mental health-related disability have not been clarified, now is the time to reconsider the rolling up of this programme into the NDIS. We should identify ways to ameliorate the episodic and longer-term impacts of disability arising from mental illness. |
| **Department of Social Services** | | | | |
| **Department of Veterans’ Affairs Mental Health Programmes** | These programmes provide education, advice and assistance for veterans and their families to recognise the signs of mental health problems and to act to improve and maintain mental health. | Y | Y | In recent years there has been a shift in the types of people being supported by DVA to an emerging cohort of younger members of the ADF and ex-service personnel from recent conflicts. The Commission recognises that serving and former members of the ADF and their families and supporters should have access to timely and efficient mental health care, and that access is not prevented by levels of red tape and bureaucratic processes.  
The Commission looks forward to the findings and advice from the Prime Ministerial Advisory Council on Veterans' Mental Health to support real change in this area. |
| **Department of Veterans’ Affairs** | | | | |
| **2012–13 allocation: $180.8 M** | | | | |
| **Evaluation? Yes** | | | | |
Attachment C:
Strategic Plan Years 1 and 2
Immediate Priorities
## National Review of Mental Health Programmes and Services

### Implementation Strategic Plan – Years 1 to 2 Immediate Priorities

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Steps Establish Accountability and Governance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government accept and endorse recommendations</td>
<td>Government</td>
<td>March 2015</td>
<td>Other Government agencies</td>
<td>Agreed reform agenda</td>
</tr>
<tr>
<td>Produce a 2015–16 budget proposal with an indicative 10-year outlook</td>
<td>Health Department and agencies</td>
<td>May 2015</td>
<td>Treasury</td>
<td>Agreed budget proposal and 10-year financial indicative outlook</td>
</tr>
<tr>
<td>Agree plan, KPIs, monitoring and evaluation process</td>
<td>Government</td>
<td>April 2015</td>
<td>COAG</td>
<td>Agreed reform plan</td>
</tr>
<tr>
<td>Develop governance structures to include people with lived experience, their families and other support people, Aboriginal and Torres Strait Islander peoples, expert or area specialist advisers, mental health sector, professional associations/colleges, providers (NGO, private, not-for-profit) and government representatives (Commonwealth/states/territories). [Note: where governance committees are included under ‘linkages’ it is always to be the case that people with lived experience and their supporters form part of all committees]</td>
<td>Health Department with National Mental Health Commission</td>
<td>April 2015</td>
<td>Other government agencies, Governance committees, Consumer and carer organisations, ATSIMHSPAG, MH sector peaks, National Mental Health Commission</td>
<td>Agreed governance structure, Establish governance committees, Establish community consultation process</td>
</tr>
<tr>
<td>Develop detailed implementation plan for 10-year horizon in consultation with project governance to test and verify recommended directions.</td>
<td>Government agencies with National Mental Health Commission</td>
<td>June 2015</td>
<td>Cross-government agencies and National Mental Health Commission</td>
<td>Agreed implementation plan</td>
</tr>
</tbody>
</table>
### 1: Set clear roles and accountabilities to shape a person-centred mental health system

#### Recommendation 1

**Agree the Commonwealth’s role in mental health is through national leadership and regional integration, including integrated Primary and Mental Health Care.**

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Commonwealth to confirm the principles which will guide its future policy and funding decisions regarding mental health.</td>
<td>Government</td>
<td>March 2015</td>
<td>COAG</td>
<td>Confirmed Commonwealth principles for mental health to guide future policy and funding decisions.</td>
</tr>
<tr>
<td>The Commonwealth to confirm its primary role in mental health as national leadership and enabling regional integration around the needs of people, their families and communities.</td>
<td>Government</td>
<td>March 2015</td>
<td>COAG</td>
<td>Confirmed Commonwealth role in national leadership of mental health and promotion of regional integration.</td>
</tr>
</tbody>
</table>

#### 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.**

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
</table>
| The Commonwealth, supported by the National Mental Health Commission, to lead development of the National Mental Health and Suicide Prevention Agreement, based on the directions identified in this report. | Government | December 2015 | Commonwealth agencies, National Mental Health Commission, COAG, Governance Committees | The development of a National Plan with states and territories Agreement to a set of:  
- overarching principles and objectives  
- clear reporting requirements and accountabilities  
- preconditions for hospital funding related to mental health supports  
Agency programme agreements amended to incorporate these principles.  
National Framework on roles and responsibilities in promotion of mental health and wellbeing and prevention of mental ill-health to be developed as part of agreement to clarify roles and responsibilities. |
### Recommendation 3
Urgently clarify the eligibility criteria for access to NDIS for people with disability arising from mental illness and ensure the provision of funding allows for a significant Tier 2 system of community supports.

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish a clear process and mechanism for the Government to determine NDIS response to: mental health programme versus personal funding transfer; clarity around Tier 2 supports and eligibility; undertake a mental health-specific NDIS trial and modelling exercise; incorporate mental health consumer and carer consultation in NDIS processes; include carer respite and supports in NDIS packages; reflect reforms flowing from the McClure review.</td>
<td>Department of Social Services</td>
<td>June 2015</td>
<td>Health Department National Mental Health Commission Governance committees</td>
<td>A defined and agreed approach for people with a mental health difficulty and their carers which clarifies the NDIS in regard to accommodating and supporting the needs of that group, as they move in and out of the NDIS system with supports following the person.</td>
</tr>
</tbody>
</table>

### 2: Agree and implement national targets and local organisational performance measures

### 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

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Commonwealth and COAG to endorse eight mental health and suicide prevention targets in consultation with governance committees, including data and outcomes measurement experts.</td>
<td>National Mental Health Commission</td>
<td>June 2015</td>
<td>COAG Governance committees Data/outcomes measurement experts</td>
<td>The Commonwealth and COAG agree to a set of mental health targets and indicators to apply nationally.</td>
</tr>
<tr>
<td>The Australian Bureau of Statistics (ABS) should incorporate the endorsed indicators into the 2017 national survey of mental health and wellbeing to provide baseline and contextual information.</td>
<td>Government</td>
<td>June 2015</td>
<td>ABS survey development committees</td>
<td>Commonwealth agreement to undertaking the 2017 national survey</td>
</tr>
<tr>
<td></td>
<td>ABS</td>
<td>December 2016</td>
<td>Governance committees</td>
<td>ABS to have an agreed framework for the inclusion of indicators in the 2017 survey.</td>
</tr>
<tr>
<td>Action</td>
<td>Responsibility</td>
<td>Estimated Completion Date</td>
<td>Linkages</td>
<td>Goal</td>
</tr>
<tr>
<td>--------</td>
<td>----------------</td>
<td>---------------------------</td>
<td>----------</td>
<td>------</td>
</tr>
<tr>
<td><strong>The Commonwealth to establish and maintain additional collection processes that support ongoing monitoring of progress against the targets at a national and programme level.</strong></td>
<td>Health</td>
<td>December 2015</td>
<td>Commonwealth agencies, National Mental Health Commission, COAG, MH Governance Committees</td>
<td>Established mechanisms for monitoring and reporting of progress under the National Plan. Established agreed processes for inclusion of formal evaluation mechanisms into all existing and future programmes. Established independent review process of targets after first 24 months of implementation.</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Government 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.</strong></td>
<td>Government</td>
<td>June 2015</td>
<td>COAG</td>
<td>Formal agreement and Closing the Gap priority is extended to include mental health. A mental health specific target for Closing the Gap is developed and agreed. The mental health gap forms an underpinning element of the Indigenous Advancement Strategy.</td>
</tr>
<tr>
<td></td>
<td>Government</td>
<td>June 2016</td>
<td>COAG</td>
<td>A national Aboriginal and Torres Strait Islander mental health plan is completed; developed through a coordinated and consultative process.</td>
</tr>
<tr>
<td><strong>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 (the basis of this should be the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group)</strong></td>
<td>Government</td>
<td>June 2015</td>
<td>COAG, Health, ATSIMHSPAG</td>
<td>Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention leadership and partnership mechanism (e.g. committee) established. The role of this group is to lead, oversee and participate in the development of Government targets, strategies and plans for Aboriginal and Torres Strait Islander mental health, and the implementation of recommendations of this Review.</td>
</tr>
<tr>
<td>Action</td>
<td>Responsibility</td>
<td>Estimated Completion Date</td>
<td>Linkages</td>
<td>Goal</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------------------------</td>
<td>---------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Undertake financial modelling on closing the mental health gap (i.e.</td>
<td>Government</td>
<td>June 2016</td>
<td>Proposed Aboriginal and Torres Strait Islander leadership and partnership</td>
<td>Agreed reinvestment plan and 10-year</td>
</tr>
<tr>
<td>from lower imprisonment rates, better physical health, increasing</td>
<td></td>
<td></td>
<td>mechanism, Government agencies, COAG</td>
<td>financial outlook.</td>
</tr>
<tr>
<td>employment and reducing unnecessary hospitalisation for mental</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>health conditions) to identify opportunities for medium and long-term</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>savings, so as to inform the development of and reinvestment to be</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>made a reinvestment-based funding strategy for closing the mental</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>health gap over the next decade.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendation 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tie receipt of ongoing Commonwealth funding for government, NGO and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>privately provided services to demonstrated performance, and use of</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a single care plan and e-health record for those with complex needs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Design and agree elements and specifications of a single care plan.</td>
<td>Government Health</td>
<td>June 2015</td>
<td>Health Department, Department of Social Services, Governance committees,</td>
<td>Agreement by people with lived experience</td>
</tr>
<tr>
<td></td>
<td>Department</td>
<td></td>
<td>Sector mental health providers</td>
<td>and their families and supporters to</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>the design of use of a single care plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(based upon an opt-out approach).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Agreed strategy, developed through</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>consultation, to implement a single care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>plan.</td>
</tr>
<tr>
<td>Action</td>
<td>Responsibility</td>
<td>Estimated Completion Date</td>
<td>Linkages</td>
<td>Goal</td>
</tr>
<tr>
<td>--------</td>
<td>----------------</td>
<td>--------------------------</td>
<td>----------</td>
<td>------</td>
</tr>
<tr>
<td>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.</td>
<td>Government Health Department</td>
<td>June 2015</td>
<td>Health Department, Department of Social Services, Governance committees, Sector mental health providers</td>
<td>Revised Commonwealth contracts available for 2015–16 year, including: performance reporting on an indicator of progress in moving to a single care plan throughout 2015–16; data/information sharing requirements for service providers to enable optimal care of the person, irrespective of whether that involves workers from a state-funded service, an NGO or a housing provider; with privacy and confidentiality aspects clarified and agreed to by the person; supported by information technology (a confidential central portal) for interagency sharing to support the single care plan</td>
</tr>
</tbody>
</table>

**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.

<p>| Develop Government 10-year funding strategy for mental health reform. | Government Health Department | December 2016 | Health Department, Treasury, COAG | Agreed Government strategy to inform the forward budget cycle, based upon consultation and negotiation process. |</p>
<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduce new national funding agreement.</td>
<td>Government Health Department</td>
<td>July 2017</td>
<td>Health Department Treasury COAG</td>
<td>✓</td>
</tr>
<tr>
<td>Agreed Commonwealth mental health budget strategy approved by Government, and to include:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Incentives to move investment away from acute services, to reflect a more balanced approach in line with the directions of this Review</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Principles for person centred systems and pathways.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-year financial plan, agreed to under a new National Plan, to:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● introduce pooled funding arrangements between the Commonwealth and states and territories for people with severe and complex needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● confirm efficiency targets for reinvestment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● redirect and reinvest $100 million in 2017–18— and increased by $50 million a year over each of the following four years to $300 million by 2021–22—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. This means:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017–18</td>
<td>$100m</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018–19</td>
<td>$150m</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019–20</td>
<td>$200m</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2020–21</td>
<td>$250m</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021–22</td>
<td>$300m</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$1000m</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop monitoring and performance mechanisms for implementation for the new 10-year financial plan.</td>
<td>Government Health Department</td>
<td>July 2017</td>
<td>Health Department Treasury COAG</td>
<td>✓</td>
</tr>
<tr>
<td>Monitoring, performance and evaluation mechanisms established for the 10-year financial plan, to include:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Placing future hospital funding agreement at risk dependent on state demonstration of achievement of a number of requirements</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reconsider scope and name of PHNs.</td>
<td>Government Health Department</td>
<td>March 2015</td>
<td>COAG</td>
<td>Renamed Primary and Mental Health Networks</td>
</tr>
<tr>
<td>Establish operating principles and remit of the Primary and Mental Health Networks (PMHN).</td>
<td>Health Department</td>
<td>June 2015</td>
<td>COAG</td>
<td>Established PMHN roles and responsibilities agreement:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Governance committees National Mental Health Commission</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>with requirements for formal consultation and advisory arrangements for PMHNs to be established:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- through Clinical Councils and Community Advisory Committees involving representation from people with lived experience of mental health difficulties, families and carers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- with service providers, including nongovernment organisations, private sector, not-for-profit etc.</td>
</tr>
<tr>
<td>Develop and implement new funding models for Primary and Mental Health Networks</td>
<td>Health Department</td>
<td>July 2016</td>
<td>PMHNs</td>
<td>Established financial and funding model that provides for:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>existing programmes to be rolled over in 2015–16</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>establishing locally appropriate funding options for programmes and flexible funding, to support integrated care pathways and a smaller number of broader, more flexible programmes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>exploring opportunities for flexible mental health funding through existing Multipurpose Services (MPSs) and ensuring that mental health is built in as an essential priority for future MPSs.</td>
</tr>
<tr>
<td>Action</td>
<td>Responsibility</td>
<td>Estimated Completion Date</td>
<td>Linkages</td>
<td>Goal</td>
</tr>
<tr>
<td>--------</td>
<td>----------------</td>
<td>--------------------------</td>
<td>----------</td>
<td>------</td>
</tr>
<tr>
<td><strong>Recommendation 9</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bundle programmes and boost the role and capacity of NGOs and other service providers to provide more comprehensive, integrated and higher-level mental health services and support for people, their families and supporters.</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>
| Develop a comprehensive and coordinated service and funding strategy to assist PMHNs to identify opportunities for delivering person-centred mental health supports and programmes, though a more flexible nongovernment sector. | Health Department | June 2016 | Department of Social Service Governance committees PMHNs | Agreed programme reform parameters for regional management by Primary and Mental Health Networks:  
- establish a smaller number of larger regional programmes  
- on a staged basis, move to contestability for these fewer but larger programmes  
- extend contract periods to up to five years, subject to risk rating and demonstration of performance  
- establish planning and management of new programme structures and related existing contracts at the regional level  
- provide for opportunities for industry assistance funding to improve business performance and potential merging/joint ventures of NGOs, via a business case process. |
<p>| This process to include a transparent consultation mechanism with the sector and people with lived experience, their families and carers, together with a clear communication strategy for all stakeholders on the new funding strategy and its implications and implementation timeframe. | | | | |
| <strong>Recommendation 10</strong> | | | | |
| Improve service equity for rural and remote communities through place-based models of care | | | | |
| Establish a process to consider rural and remote needs in PMHN funding agreements. | Health Department | June 2015 | Cross-government agencies Governance committees COAG | National funding agreements with PMHNs to specify the development of integrated mental health plans |</p>
<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>Health Department</td>
<td>December 2015</td>
<td>PMHNs, LHDs, Governance committees, Aboriginal and Torres Strait Islander mental health group, COAG</td>
<td>Established national planning parameters, with specific provision for the circumstances of regional, rural and remote areas: ● map the provision of services/identify gaps ● establish community consultation processes ● include services that are mental health-specific, delivered through health and other non-health portfolios, e-mental health and other phone and online services, including physical health ● address programmes delivered through governments and local governments, private and not-for-profit sectors, and the range of programmes across government, not just health and mental health ● local responsibility to apply the national planning parameters into local processes, with consultation and needs based planning ● identify local responsibility to coordinate activities and develop local initiatives for supporting integrated, multidisciplinary approaches in a rural, regional or remote context, identifying the needs specific to the local population ● consider opportunities to build upon the Multipurpose Service Programme.</td>
</tr>
<tr>
<td>Recommendation 11</td>
<td>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.</td>
<td>Define and agree the components and necessary supports to deliver a system of stepped and integrated care as a fundamental building block for the mental health system.</td>
<td>Health Department</td>
<td>December 2015</td>
</tr>
<tr>
<td>Action</td>
<td>Responsibility</td>
<td>Estimated Completion Date</td>
<td>Linkages</td>
<td>Goal</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------</td>
<td>----------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Establish and promote self-help supports with people with lived experience and their families and supporters</td>
<td>Health Department</td>
<td>December 2015</td>
<td>PMHNs, LHDs, Governance committees, Aboriginal and Torres Strait Islander groups</td>
<td>✓</td>
</tr>
<tr>
<td>Establish cooperative projects at both the national and local level to:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- promote self-help and building resilience as a first-line response to achieving wellbeing and reducing mental distress</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- develop, disseminate and promote a suite of resources and supports for self-help and online services, and evidence of effectiveness of these supports</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 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.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task the Mentally Healthy Workplace Alliance with mental health safety and wellbeing, self-help, and to reduce stigma and discrimination in the workplace.</td>
<td>National Mental Health Commission</td>
<td>December 2015</td>
<td>National Mental Health Commission, Mentally Healthy Workplace Alliance, Governance committees</td>
<td>✓</td>
</tr>
<tr>
<td>Establish cooperative projects at both the national and local level to:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- promote mental health first aid training and other evidence-based programmes for workers who are likely to come frequently into contact with people with mental illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- promote mental health wellbeing in the workplace</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- promote understanding and reduce discrimination at work by employers, managers and co-workers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- work with workplaces and employee groups where mental health issues often arise, such as human services agencies (including Centrelink and employment services agencies), justice, health, education systems, and human resources, as well as in early childhood and across education systems.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 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 a Medical Home for Mental Health

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
</table>
| Strengthen the central role of GPs in mental health care through incentives for use of evidence-based practice guidelines, changes to the Medicare Benefits Schedule, and staged implementation of a Medical Home for Mental Health | Health Department | June 2016 | Governance committees, GP associations, college and representatives | Development of an agreed coordinated incentive package through consultation and negotiation, to include:  
- The promotion of the use of evidence-based guidelines which support a stepped care approach  
- Changes to the Practice Incentives Programme (PIP) to promote quality mental health services in general practice  
- Inclusion of a mental health assessment in Medicare Benefits Schedule (MBS) Health Assessment Items  
- Establishment of a Medical Home for Mental Health | ✓ |
**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.

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
</table>
| Develop an enhanced Better Access programme through consultation and negotiation. | Health Department | June 2016 | Governance committees, GP associations, Allied Health | An approved enhanced Better Access package, using MBS and MHNIP payments to:  
- Realign the access to mental health allied health specialists and actively support GPs to extend access to evidence-based interventions, especially for people with more severe or complex mental health needs. Based upon considerations recommended in this Review.  
- From January 2016, limit access to Better Access for newly registered psychologists who are not endorsed to communities outside the Major Cities classification as identified under the Modified Monash Model, as recently adopted by the Commonwealth Government.  
- 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 rural and remote areas.  
- Use future indexation of Better Access benefits to introduce a Better Access rural loading. |

**Recommendation 14**
Introduce incentives to include pharmacists as key members of the mental health care team

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
</table>
| Introduce incentives to include pharmacists as key members of the mental health care team | Health Department | June 2015 | Governance committees, Pharmacist associations | Agreed incentive programme for pharmacists, including:  
- a substantial percentage of the new Sixth Community Pharmacy Agreement as reward payments to pharmacists who work as partners in the primary mental health team  
- Include pharmacists under the existing Practice Nurse Incentive Payment arrangements. |
5: Promote the wellbeing and mental health of the Australian community, beginning with a healthy start to life

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.

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify as a national priority for Primary and Mental Health Networks the mental health and wellbeing of children, adolescents and young adults.</td>
<td>Health Department</td>
<td>June 2015</td>
<td>Governance committees PMHNs</td>
<td></td>
</tr>
<tr>
<td>Establish principles, mechanisms and systems to support the priority to build resilience and target interventions for this group, developed through a national consultative process involving key and expert stakeholders.</td>
<td>Health Department</td>
<td>December 2015</td>
<td>Governance committees PMHNs</td>
<td>A child, adolescent and young adult wellbeing framework developed, including:</td>
</tr>
</tbody>
</table>
- funding mechanisms 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
- programme redesign and prioritisation recast as appropriate to reflect regional integration and evaluation within this new model
- ensuring links with maternal and child health are fundamental to an integrated approach
- including a coordinated response to eating disorders as a priority within the existing headspace model. |
<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undertake a consultation and development process to enable regional level co-design and co-creation of a system-wide framework for child and adolescent mental health, with integrated models of care and care pathways. These should be developed with PMHNs, Local Health Networks (LHNs) or their equivalent, local councils, NGOs, the private sector, early childhood services, schools, workplaces, clubs and community organisations.</td>
<td>Health Department</td>
<td>December 2015</td>
<td>Governance committees, PMHNs, PMHNs local consultation councils, States and territories</td>
<td>✓</td>
</tr>
<tr>
<td>Local PMHNs frameworks developed, including aims to:</td>
<td></td>
<td></td>
<td>• providing information locally and through online services on evidence-based programmes such as Positive Parenting Partnership (Triple P) and Every Parent&lt;br&gt; • working 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&lt;br&gt; • preventing or delaying the onset of mental ill-health through school based programmes&lt;br&gt; • supporting the roll-out of KidsMatter and Mindmatters through primary and secondary schools as part of a broader mental fitness and wellbeing agenda within schools.</td>
<td></td>
</tr>
<tr>
<td>Establish national measures and evaluation processes to monitor performance.</td>
<td>Health Department</td>
<td>December 2015</td>
<td>Governance committees, Cross-government agencies, PMHNs, States and territories</td>
<td>A child, adolescent and young adult wellbeing evolution framework established, comprising:&lt;br&gt; • conduct a national study into the scaling up of Triple P, including workforce implications and the potential to role the programme out by using the workforces of other organisations under contract to PMHNs&lt;br&gt; • the measurement of child development vulnerability with the Australian Early Childhood Development Index&lt;br&gt; • establishing 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</td>
</tr>
<tr>
<td>Action</td>
<td>Responsibility</td>
<td>Estimated Completion Date</td>
<td>Linkages</td>
<td>Goal</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------------------</td>
<td>---------------------------</td>
<td>----------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Establish a national commitment to the prevention of trauma from maltreatment during infancy and early childhood, and to support those impacted by childhood trauma.</td>
<td>Health Department</td>
<td>December 2015</td>
<td>COAG</td>
<td></td>
</tr>
<tr>
<td>Develop the evidence base; apply this to education curricula; raise public awareness and measure change over time.</td>
<td>Health Department</td>
<td>December 2015</td>
<td>Cross-government (Departments of Social Services, Education, Immigration)</td>
<td></td>
</tr>
</tbody>
</table>

National commitment defined and agreed, with:
- establishment of collaborative structures to design and develop the framework
- agreement on responsibilities at federal, state and regional levels.

National project on research, practical implementation and use in communities, to:
- develop options for a study into the cost to society of childhood trauma and of best investments to reduce the impact of childhood trauma
- implement an evidence-based approach on why respecting children matters, the lifelong impact of abuse, and actions to be done
- increase community awareness of current research about what occurs to children before they are born and how their early years can affect their health, mental health and wellbeing and opportunities later in life.
- 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
- adopt in the proposed National Research Strategy (see relevant recommendation) a long-range national infant and child wellbeing agenda for ongoing research to build evidence about what works and why, and to assist communities in linking research to practice.
<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendation 17</strong>&lt;br&gt;Use evidence, evaluation and incentives to reduce stigma, build capacity and respond to the diversity of needs of different population groups.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Develop a framework for recognising the needs of people with lived experience of mental health difficulties, their families and support people, from Culturally and Linguistically Diverse (CALD) backgrounds, at the national level for local application.</strong></td>
<td>Health Department</td>
<td>December 2015</td>
<td>Governance committees&lt;br&gt;PMHNs&lt;br&gt;LHNs</td>
<td>National framework developed, and available for local use, identifying the need to:&lt;br&gt;• adopt clear and explicit equity orientated targets for people from CALD backgrounds from multicultural communities to include in government funding agreements&lt;br&gt;• 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 assist to develop) alternative mechanisms.</td>
</tr>
<tr>
<td><strong>Develop a framework for the local response to population specific issues, to ensure integrated care pathways, recognition of the inadequacy of existing pathways and a person-centred response.</strong></td>
<td>Health Department</td>
<td>December 2015</td>
<td>Governance committees&lt;br&gt;PMHNs and LHNs</td>
<td>National agreements with PMHNs and LHNs to reinforce their responsibility to:&lt;br&gt;• work together to identify local clinicians to champion a multidisciplinary team approach to coexisting intellectual disability and mental health&lt;br&gt;• 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 and physical health services.</td>
</tr>
<tr>
<td>Action</td>
<td>Responsibility</td>
<td>Estimated Completion Date</td>
<td>Linkages</td>
<td>Goal</td>
</tr>
<tr>
<td>--------</td>
<td>----------------</td>
<td>--------------------------</td>
<td>----------</td>
<td>------</td>
</tr>
<tr>
<td>Undertake a series of individual strategic projects, each to identify the issues, best evidence, current service and policy responses and formulate a strategic plan for service improvement and outcomes for people, in line with the optics within each strategy, to be agreed nationally and implemented locally.</td>
<td>Health Department</td>
<td>December 2016</td>
<td>COAG</td>
<td>✓</td>
</tr>
</tbody>
</table>

- Governance committees
- Cross-government departments
- Area experts (academic, legal, medical)

A suite of strategic plans for:

- the reduction of stigma and discrimination through evidence-based approaches, and low cost options on how to permeate those approaches throughout the community, including engagement with employers, schools, community organisations and workplaces
- improving cultural responsiveness of services, programmes and providers through supporting the widespread adoption of the **Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery**
- the needs and options for transgender and intersex people, developed through tasking an organisation to facilitate a process with the professional colleges for obstetricians, paediatricians, psychiatrists and GPs, and the Australian Psychological Society, and other stakeholders, on education and communication with health professionals
- 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, based upon a review undertaken by an independent group of experts tasked with the project.
<table>
<thead>
<tr>
<th><strong>Action</strong></th>
<th><strong>Responsibility</strong></th>
<th><strong>Estimated Completion Date</strong></th>
<th><strong>Linkages</strong></th>
<th><strong>Goal</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>6: Expand dedicated mental health and social and emotional wellbeing teams for Aboriginal and Torres Strait Islander peoples</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Recommendation 18**

*Within 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.*

**Establish Mental Health and Social and Emotional Wellbeing Teams in Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Services)**

<p>| <strong>Set up a process to develop an agreed approach and framework for rolling out of Mental Health and Social and Emotional Wellbeing Teams in Indigenous Primary Health Care Organisations</strong> | <strong>Health Department</strong> | <strong>December 2015</strong> | <strong>Governance committees</strong> | <strong>ATSIMHSPAG</strong>&lt;br&gt;New Aboriginal and Torres Strait Islander mental health leadership group on mental health | <strong>A national model for Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing, where:</strong>&lt;br&gt;• Mental health services should be fully integrated within IPHCOs and ACCHS as a part of their existing comprehensive primary health care service package&lt;br&gt;• Each IPHCO/ACCHO 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&lt;br&gt;• The integrated teams would implement models of care / clinical pathways for: community mental health—screening, treatment, support; alcohol and other drugs; chronic illness support; and SEWB promotion / community strengthening&lt;br&gt;• The workforce requirements for the team models should be informed by planning work undertaken by the Aboriginal Medical Services Alliance Northern Territory (AMSANT). |</p>
<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a consistent best practice national approach for Aboriginal and Torres Strait Islander people when using specialist mental health services.</td>
<td>Department of Health</td>
<td>December 2015</td>
<td>Governance Committees ATSIMHSPAG New Aboriginal and Torres Strait Islander mental health leadership group on mental health States and territories</td>
<td>✔</td>
</tr>
<tr>
<td>Finalised national service guidelines for meeting the needs of Aboriginal and Torres Strait Islander people when they access specialist mental health services, that recognise the variance between jurisdictions in their mental health services systems, and to include:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Service supports 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</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- A set of care standards, including:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- ensuring each referred/admitted patient is linked from IPHCOS/ACCHS to the mainstream service and back again on discharge</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- cultural support during admission</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- access to traditional healers and healing services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- maintain link to family</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- facilitation of patient access to community support on return to community</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- An inclusive approach where all Aboriginal and Torres Strait Islander people admitted to a specialist (mainstream) mental health service are to be considered as within the target group for this service and have services that adhere to the above standards</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- General population mental health services are accountable for better Aboriginal and Torres Strait Islander mental health outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action</td>
<td>Responsibility</td>
<td>Estimated Completion Date</td>
<td>Linkages</td>
<td>Goal</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>---------------------------------------</td>
<td>---------------------------</td>
<td>-----------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Establish mechanisms and infrastructure to support the implementation, monitoring and capability of the model.</td>
<td>Department of Health</td>
<td>December 2015</td>
<td>Governance committees, ATSIMHSPAG, New Aboriginal and Torres Strait Islander mental health leadership group on mental health, States and territories</td>
<td>✓</td>
</tr>
</tbody>
</table>
| An operational framework to support the roll-out of the new team model, that: | | | • ensures professional development programmes are delivered to support mainstream staff develop cultural competencies  
• includes a commitment from all levels of government (Commonwealth, states/territories and local) to publish annual information on the proportion of resources they allocate to supporting Aboriginal and Torres Strait Islander people’s mental health needs. The report card should encompass both specialist and mainstream services and include funding and activity data  
• train and employ the Aboriginal and Torres Strait Islander workforce needed to close the Aboriginal and Torres Strait Islander mental health gap | |

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

Recommendation 19
Establish 12 regions across Australia as the first wave for nationwide introduction of comprehensive, whole-of-community approaches to suicide prevention.

<p>| Establish 12 regions across Australia as the first wave for nationwide introduction of comprehensive, whole-of-community approaches to suicide prevention. | Health Department | June 2015 | Governance committees, COAG, Cross-government agencies | A Suicide Prevention Framework developed though consultation with state and territory governments and other key groups which is based on Australian and international evidence, to guide implementation of the new model |</p>
<table>
<thead>
<tr>
<th><strong>Action</strong></th>
<th><strong>Responsibility</strong></th>
<th><strong>Estimated Completion Date</strong></th>
<th><strong>Linkages</strong></th>
<th><strong>Goal</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a costed strategy to support the initial roll-out of the first 12 regional <em>preventing suicides in communities</em></td>
<td>Health Department</td>
<td>December 2015</td>
<td>Governance committees, COAG, Cross-government agencies</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>An approved <em>preventing suicides in communities</em> strategy, with the following components:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• A programme budget, funded from within the National Suicide Prevention Programme the Taking Action to Tackle Suicide (TaTs) programme for starting up the 12 regional initiatives</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• A business case application process for proposals that are consistent with the Framework from regional partnerships on co-created models of suicide prevention.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• A prioritisation and assessment schema for models to demonstrate buy-in from local communities through inclusion of contributions (either in dollars or in kind) from partners, including local business, clubs and community organisations</td>
<td></td>
</tr>
<tr>
<td>Establish implementation prerequisites.</td>
<td>Health Department</td>
<td>December 2015</td>
<td>Governance committees, COAG, Cross-government agencies</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Formulate, through consultation, a set of monitoring and evaluation mechanisms, including:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• nationally consistent routine data collections for suicides and suicide attempts and related support service use</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• a national protocol for when hospitals discharge a patient from an inpatient service or after a suicide attempt</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• a parallel programme for mandatory training on suicide identification and prevention for all frontline staff likely to come into contact with potentially suicidal people – for example, in health, welfare, police, ambulance, justice and education</td>
<td></td>
</tr>
</tbody>
</table>
**Action** | **Responsibility** | **Estimated Completion Date** | **Linkages** | **Goal**
--- | --- | --- | --- | ---
| 8: Build workforce and research capacity to support systems change | National Mental Health Commission | June 2015 | | 

**Recommendation 20**

Improve research capacity and impact by doubling the share of research funding for mental health over the next five years, with a priority on supporting strategic research that responds to policy directions and community needs.

**From 2015–16, tie research funding to a National Mental Health Research Strategy to be facilitated by the Commission in consultation with stakeholders, and with research linked to strategic priorities in mental health, rather than being largely investigator-driven.**

- An agreed National Mental Health Research Strategy, which:
  - requires the participation of people with lived experience of mental health difficulties and their families and carers in all Commonwealth-funded mental health research planning, design and action
  - includes applied research in the area of Aboriginal and Torres Strait Islander peoples’ mental health and social and emotional wellbeing to better understand what interventions work as a research priority
  - canvasses both experimental and applied research that has the potential to generate innovative interventions and service models that are both efficient and cost-effective
  - develops evidence about what works in areas which have the potential to realise the greatest public value
  - includes consideration of interventions across the domains of:
    - Promotion
    - Prevention and Early Intervention
    - Crisis Intervention and Suicide Prevention
    - Treatment
    - Recovery and Support
<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
</table>
| Consider and develop a funding and grant allocation strategy to resource the new research directions. | Health Department               | June 2015                 | National Mental Health Commission | A strategy for identifying priorities and funding of mental health research to consider:  
- a mechanism for developing annual mental health research priorities  
- establishing a new specific Mental Health Research Committee, or establish one from existing structures  
- a funding plan for a staged and planned national mental health research agenda, including options such as:  
  - redirecting a proportion of NHMRC funding into a pool which is distributed on the advice of the proposed Mental Health Research Committee  
  - the National Mental Health 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 | ✓    |
| 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 | National Mental Health Commission | December 2015             | Health Department  
Governance committees  
Mental health research centres  
ARC  
NHMRC  
Business and philanthropic sector | A scoping study report identifying:  
- options for data linkage platforms for complex, cross sectoral aspects of delivery and design of services and supports for people with mental illness | ✓    |
**Recommendation 21**

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

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a revised strategy for Commonwealth programmes including, Better Access, MHNP for better workforces and workforce approaches and capacity</td>
<td>Health Department</td>
<td>June 2015</td>
<td>Department of Social Services, Nursing workforce associations/groups, Governance committees, LHNs, GPs</td>
<td>✓</td>
</tr>
</tbody>
</table>

Finalised programme redesign, to:

- Examine the cost effectiveness of including extension of Better Access to nurses with postgraduate qualifications in mental health
- Pay a proportion of the Mental Health Nurse Incentive Programme (MHNP) funding as a loading on top of the Practice Nurse Incentive Programme (PNIP) to attract more Mental Health Nurses into General Practice
- Remove the requirement for GPs to write a mental health care plan for referral to Mental Health Nurses under MHNP
- Extend MHNP eligibility to include residential aged care facilities and Multipurpose Services
- End the freeze on the MHNP as an identified priority for more equitable access to mental health services
- Commit to at least maintaining the existing level of funding for the programme: when funding permits, it should grow from its current allocation of $40 million to $72 million a year to enable an equitable distribution of funds for the target population
<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a practical training and workforce development strategy</td>
<td>Health Department</td>
<td>December 2015</td>
<td>Nursing workforce associations/groups, Governance committees, LHNs, GPs</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Establish a refreshed national workforce training approach specific to</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>supporting new models of care and workforce supply</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Retrain registered general Nurses as mental health nurses</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Train practice nurses to develop their mental health skills and provide</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>scholarship which enable them to train to become mental health nurses</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Develop the mental health competence of GPs and collaborative teams to</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>better meet the mental health needs of their patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Include a mandated amount of mental health curricula content and</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>assessed mental health competencies for undergraduate nurse preparation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Develop a more generalist workforce to provide services in areas of</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>greatest need,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Continue promotion, implementation and evaluation of recruitment,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>retention and incentive mechanisms, in both generalist and specialist</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>mental health career pathways.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Expand rural health education initiatives</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Promote National Mental Health Peer Workforce Development Guidelines</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Develop a national mental health peer workforce dataset, to measure</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>progress and support evaluation.</td>
<td></td>
</tr>
</tbody>
</table>

| Develop and initiate payment incentive strategies, to encourage        | Health Department       | December 2016              | Governance committees, Workforce groups/associations                    |      |
| integrated primary care models                                        |                         |                            | Agreed incentive strategy to:                                            |      |
|                                                                      |                         |                            | • Enable PMHNs to contract directly with mental health nurses instead of  |      |
|                                                                      |                         |                            | through an “eligible organisation” to provide greater flexibility across |      |
|                                                                      |                         |                            | multiple settings                                                        |      |
|                                                                      |                         |                            | • Encourage PMHNs and LHNs to 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.               |      |
### Recommendation 22

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

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit existing education and training curricula, to assess where teaching materials and approaches require updating with contemporary evidence-based treatment</td>
<td>Department of Education</td>
<td>December 2016</td>
<td>Standing Councils (COAG)</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Department of Education</td>
<td></td>
<td>Department of Education</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Governance committees</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Completed training and curricula audit and update to:
  - Include in core curricula education 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
  - Improve the capacity and competency of the broader health and social services workforce, justice, corrections and police, and workplace health and safety workforces
  - Improve knowledge and capability of the primary health sector in identification, management and referral of people with mental illness
<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
</table>
| Recommend 23 | Require evidence-based approaches on mental health and wellbeing to be adopted in early childhood worker and teacher training and continuing professional development. | Department of Education | June 2016 | Standing Councils (COAG) Governance committees Departments - Social Services and Education. | Completed update of training and curricula for teaching and education professionals, including a focus on evidence based approaches for resilience building and interventions, including:  
  - Measures for mental fitness in early childhood services, primary and secondary schools and education institutions, and to support healthy development and wellbeing of children and resilient and mental health-literate adults  
  - A family and parent engagement strategy for how to 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  
  - A school community engagement strategy to 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. | ✓ |
<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>9: Improve access to services and support through innovative technologies</td>
<td>Health Department</td>
<td>December 2015</td>
<td>Governance committees, Existing service providers</td>
<td>✓</td>
</tr>
</tbody>
</table>

**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.

Develop and cost a 10-year mental health technology and information support strategy.

Completed 10-year mental health technology and support strategy, including –

- maintaining support for traditional person-to-person community-based telephony services
- substantially increasing capacity for crisis support through uptakes of new online and voice-activated technologies
- requiring all telephony and new online services to link people directly to effective interventions (including self-help, community or professionally-based) and local service systems
- transferring declining investments in out-moded models of traditional clinical practice to online environments
- within existing funds, directing 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
- tasking the Project Synergy team with working with stakeholders to develop a model of integrated and shared approaches to enable seamless access for consumers to a system which prioritises crisis support, and links with self-help, information/education and treatment services.
<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a coordinated approach to investment in e-mental health across the Federal Government.</td>
<td>Health Department</td>
<td>June 2015</td>
<td>Governance committees</td>
<td></td>
</tr>
</tbody>
</table>

Completed investment strategy, including:

- using new technologies to markedly 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
- building 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
- decreasing investments in first generation e-mental health type systems – essentially where traditional professional or counseling-type practices have been transferred online without leveraging the real benefits of co-investments or new technologies (e.g. eheadspace)
- Investing 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 group (which can form part of the reform governance committee structure).
<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Estimated Completion Date</th>
<th>Linkages</th>
<th>Goal</th>
</tr>
</thead>
</table>
| Establish a new contract base for future e-mental health programme investment | Health Department | June 2015                 | Governance committees, e-mental health sector, Existing contract holders | New contractual framework in place, to allow new e-mental health contracts to be competitively tendered, with clear service delivery requirements included:  
  - 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 co-invest 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).  
  - new contracts should be based on fostering intrasectoral co-operation, 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 so that any person entering the e-mental health domain has the opportunity to receive integrated care via relevant face-to-face health or NGO providers, or to other e-mental health providers as appropriate.  
  - new contracts 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.  
  - new contracts 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 Multipurpose Services (MPSs) to provide continuity of care. | ✓ |
Contributing lives, thriving communities

Report of the National Review of Mental Health Programmes and Services

Volume 2

Every service is a gateway
Response to Terms of Reference

30 November 2014
About this Review
This document is Volume 2 of the four-volume report of the National Review of Mental Health Programmes and Services. All volumes can be downloaded from www.mentalhealthcommission.gov.au. A complete list of the Commission’s publications is available from our website.

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

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

ISSN 2201-3032

Suggested citation:
Published by: National Mental Health Commission, Sydney.

© National Mental Health Commission 2014

This product, excluding the Commission logo, Commonwealth Coat of Arms and material owned by a third party or protected by a trademark, has been released under a Creative Commons BY 3.0 (CC BY 3.0) licence. The excluded material owned by a third party includes data, images, accounts of personal experiences and artwork sourced from third parties, including private individuals. With the exception of the excluded material (but see note below with respect to data provided by the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW)), you may distribute, remix and build upon this work. However, you must attribute the National Mental Health Commission as the copyright holder of the work in compliance with our attribution policy. The full terms and conditions of this licence are available at http://creativecommons.org/licenses/by/3.0/au/. Requests and enquiries concerning reproduction and copyrights should be directed to:

enquiries@mentalhealthcommission.gov.au

Note: Material provided by:

1. The Australian Bureau of Statistics is covered under a Creative Commons Attribution 2.5 Australia licence and must be attributed in accordance with their requirements for attributing ABS material as outlined at www.abs.gov.au.
2. The Australian Institute of Health and Welfare is covered by Creative Commons BY 3.0 (CC BY 3.0) and must be attributed to the AIHW in accordance with their attribution policy at www.aihw.gov.au/copyright/
Acknowledgements

We acknowledge those people with a lived experience of mental health issues, their families, friends and supporters who provided input into the Review process through our public Call for Submission process. Many professional organisations and nongovernment organisations which work in the mental health sector also responded to the Call for Submission process. Several organisations provided detailed advice to the Commission, as well as responding to requests for additional information used as case studies. We value the generosity of their time.

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.
Contents

Introduction .......................................................................................................................... 5
Overview of Volume 2............................................................................................................ 7

Chapter 1: The case for change ......................................................................................... 9
The case for change ............................................................................................................ 10
Fundamental problems with the status quo ........................................................................ 14
The way forward ................................................................................................................... 21
References............................................................................................................................ 27

Chapter 2: Methodology ................................................................................................. 29
Collection of evidence ........................................................................................................ 30
Sources and types of evidence ............................................................................................ 30
Analysis of evidence ........................................................................................................... 32
Challenges in collecting evidence ....................................................................................... 33
References............................................................................................................................ 36

Chapter 3: Achieving a contributing life .......................................................................... 37
Listening to the evidence from people ............................................................................... 38
Creating equal opportunities and investing to save ........................................................... 39
Tailoring support to each person’s life circumstances and needs ....................................... 49
Where to from here – implications for reform ................................................................... 62
Actions ................................................................................................................................. 63
References............................................................................................................................ 66

Chapter 4: Aboriginal and Torres Strait Islander peoples’ mental health ...................... 69
What is happening now .................................................................................................... 71
Key findings ....................................................................................................................... 74
Where to from here – implications for reform ................................................................... 84
Actions ................................................................................................................................. 88
References............................................................................................................................ 92

Chapter 5: Regional, rural and remote Australia ............................................................... 95
What is happening now .................................................................................................... 97
Key findings ....................................................................................................................... 102
Where to from here – implications for reform ................................................................... 104
Actions ................................................................................................................................. 107
References............................................................................................................................ 109

Chapter 6: Suicide prevention ......................................................................................... 111
What is happening now .................................................................................................... 113
Key findings ....................................................................................................................... 114
Where to from here – implications for reform ................................................................... 116
Actions ................................................................................................................................. 118
References............................................................................................................................ 120

Chapter 7: Workforce development and training ............................................................. 121
What is happening now .................................................................................................... 123
Key findings ....................................................................................................................... 127
Where to from here – implications for reform ................................................................... 130
Actions ................................................................................................................................. 131
References............................................................................................................................ 133
<table>
<thead>
<tr>
<th>Chapter 8: Mental health research</th>
<th>135</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is happening now</td>
<td>136</td>
</tr>
<tr>
<td>Key findings</td>
<td>138</td>
</tr>
<tr>
<td>Where to from here – implications for reform</td>
<td>139</td>
</tr>
<tr>
<td>Actions</td>
<td>140</td>
</tr>
<tr>
<td>References</td>
<td>143</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter 9: Governance and accountability</th>
<th>145</th>
</tr>
</thead>
<tbody>
<tr>
<td>System governance</td>
<td>146</td>
</tr>
<tr>
<td>The efficacy and cost-effectiveness of programmes, services and treatments</td>
<td>146</td>
</tr>
<tr>
<td>Duplication in current programmes and services</td>
<td>155</td>
</tr>
<tr>
<td>Reporting requirements and regulation of programmes and services</td>
<td>160</td>
</tr>
<tr>
<td>Transparency and accountability for investment outcomes</td>
<td>162</td>
</tr>
<tr>
<td>References</td>
<td>169</td>
</tr>
<tr>
<td>Commonwealth programmes - the Commission’s overview</td>
<td>170</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter 10: Alternative approaches</th>
<th>179</th>
</tr>
</thead>
<tbody>
<tr>
<td>A new model of care delivery: integrated stepped care</td>
<td>180</td>
</tr>
<tr>
<td>Opportunities to use technology for better mental health</td>
<td>185</td>
</tr>
<tr>
<td>Where to from here – implications for reform</td>
<td>193</td>
</tr>
<tr>
<td>Investing for social change</td>
<td>195</td>
</tr>
<tr>
<td>Investing through regional funding models</td>
<td>198</td>
</tr>
<tr>
<td>References</td>
<td>202</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter 11: Implementation of a better mental health system</th>
<th>203</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic intent</td>
<td>204</td>
</tr>
<tr>
<td>Principles to underpin change</td>
<td>207</td>
</tr>
<tr>
<td>Accountability mechanisms and governance</td>
<td>207</td>
</tr>
<tr>
<td>Immediate priorities years 1 to 2</td>
<td>208</td>
</tr>
<tr>
<td>Establishing longer-term goals and targets</td>
<td>210</td>
</tr>
<tr>
<td>Data development needs of the sector</td>
<td>211</td>
</tr>
<tr>
<td>Directions over the longer term</td>
<td>212</td>
</tr>
<tr>
<td>A role for the National Mental Health Commission</td>
<td>220</td>
</tr>
<tr>
<td>References</td>
<td>223</td>
</tr>
</tbody>
</table>

| Glossary and Abbreviations | 225 |
Introduction

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

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

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

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

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

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

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

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

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

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

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

The recommendations of this Review are framed on the understanding that any implementation must be achieved within existing resources. The Commission considers that there is currently substantial investment in the mental health of Australians, but that this investment is not necessarily being spent on the right things — those services which prevent illness, keep people well, support recovery and enable people to live contributing lives.
Overview of Volume 2

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

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

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

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

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

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

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

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

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

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

**Mapping Terms of Reference to Volume 2 Chapters**

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

NOTE: Analysis of specific Commonwealth programmes is throughout the chapters, as is relevant to each Term of Reference.
Chapter 1: The case for change
The case for change

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

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

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

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

Why another review?

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

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

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

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

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

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

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

Review of Australia’s welfare system (McClure)

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

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

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

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

Flexibility is needed to respond to these changing circumstances.

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

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

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

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

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

The introduction of Primary Health Networks

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

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

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

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

The rollout of the National Disability Insurance Scheme (NDIS)

The NDIS is still in its formative years. The 2014 annual report of the National Disability Insurance Agency reports on the extent of the trialling of the scheme to date. In the past 12 months, trials have taken place for people in regions in New South Wales, Victoria and South Australia and across Tasmania. Launches are planned for parts of Western Australia, the Australian Capital Territory and the Northern Territory. There were 6,434 participants eligible for the scheme, with 5,414 having an approved plan by the end of March 2014.

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

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

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

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

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

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

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

Missed opportunities

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

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

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

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

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

The status quo means neglecting Australians in need

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

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

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

We cannot know with any accuracy the degree to which people who may need to access mental health supports actually receive them. The most up-to-date estimate of the treatment rate for mental disorders in Australia indicates that in 2009–10, 46 per cent of people with a 12-month mental disorder received an intervention for that illness. This means that over half of those who have experienced mental illness in the past year are not accessing treatment. Others may receive inappropriate or ineffective care. This is despite extensive Commonwealth expenditure across the mental health sector of $9.6 billion, of which $5.7 billion is in income support. It includes a deemed estimated $1 billion a year to the states and territories for mental health activity in hospitals under the National Health Reform Agreement (2011).

The public and private mental health systems are not providing the levels of support needed or paid for. At June 2014, 47.2 per cent of the population had some form of private health insurance, and for the 12 months to June 2014, $22.3 million was paid for psychiatric/psychological ancillary services to private health insurance members. However, we were told by individuals and industry that even people with private health insurance are finding it increasingly difficult to get the care they need and that private care is often highly disjointed, with poor continuity and lack of linkage back into the community. Private health insurers promote mental health as an ‘opt out’ saving to young people. Yet young people are more likely to have a mental health episode than any other health problem, for which they often do not opt out (for example, heart disease or cancer). This is a good example of private health insurers passing the risk off to the Commonwealth, states and territories and to individuals and families. Private health insurers should not be able to exclude mental health treatment from their insurance packages.
Information on the mental health of Aboriginal and Torres Strait Islander peoples is confronting, with significantly worse outcomes than other Australians across key indicators, as outlined in Chapter 4. We refer to this in shorthand as the ‘mental health gap’ and it is perhaps the clearest evidence we have that the mental health system is not meeting the needs of this group.

**The status quo provides a poor return on investment**

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

Source: concept designed by The National Mental Health Commission with expenditure information from Commonwealth agencies 2014
Table 1.1 shows a breakdown of the main programme streams making up the Commonwealth’s mental health expenditure. The Commonwealth spent $9.6 billion on mental health programmes in 2012–13, which included:

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

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health programmes and services: clinical and non-clinical (1)</td>
<td>3,116.3</td>
<td>3,235.1</td>
<td>3,358.5</td>
<td>3,533.2</td>
<td>3,737.4</td>
<td>19.9</td>
<td></td>
</tr>
<tr>
<td>Mental health support programmes (2)</td>
<td>4,106.0</td>
<td>4,330.7</td>
<td>4,772.1</td>
<td>5,345.9</td>
<td>5,675.4</td>
<td>38.2</td>
<td></td>
</tr>
<tr>
<td>Mental health system improvement (3)</td>
<td>188.8</td>
<td>104.9</td>
<td>106.8</td>
<td>111.7</td>
<td>125.1</td>
<td>-33.7</td>
<td></td>
</tr>
<tr>
<td><strong>GRAND TOTAL</strong></td>
<td>7,411.2</td>
<td>7,686.7</td>
<td>8,259.1</td>
<td>9,026.5</td>
<td>9,577.5</td>
<td>29.2</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

- Mental health programmes and services: clinical and non-clinical which comprises Medicare-subsidised mental health services; Pharmaceutical Benefits Scheme mental health-related medications; Commonwealth funding to public hospital mental health services; Commonwealth-funded community mental health programmes; and supported housing, care and coordination
- Mental health support programmes: indirect expenditure on Carer Payment and Allowance, and Disability Support Pension
- Mental health system improvement: direct expenditure on mental health research, workforce development, education and training.
The top five programmes by expenditure account for 87.5 per cent ($8.376 billion) of all expenditure in 2012–13 (see Table 1.2) — $7 of every $8 spent. Overall expenditure has grown at an average of 6.6 per cent a year between 2008–09 and 2012–13 and is forecast to continue its strong growth.

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

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability Support Pension (DSP)</td>
<td>3,449.7</td>
<td>3,664.0</td>
<td>4,031.5</td>
<td>4,471.6</td>
<td>4,676.3</td>
<td>35.6</td>
</tr>
<tr>
<td>National Health Reform Agreement (est. mental health share of C’wealth hospital funding)</td>
<td>906.3</td>
<td>952.8</td>
<td>967.6</td>
<td>1,003.4</td>
<td>1,024.9</td>
<td>13.1</td>
</tr>
<tr>
<td>Carer Payment and Allowance</td>
<td>656.3</td>
<td>666.7</td>
<td>740.7</td>
<td>874.3</td>
<td>999.1</td>
<td>52.2</td>
</tr>
<tr>
<td>Medicare Benefits Schedule</td>
<td>748.4</td>
<td>814.8</td>
<td>871.7</td>
<td>862.6</td>
<td>907.9</td>
<td>21.3</td>
</tr>
<tr>
<td>Pharmaceutical Benefits Scheme</td>
<td>831.6</td>
<td>830.4</td>
<td>827.5</td>
<td>842.0</td>
<td>768.1</td>
<td>-7.6</td>
</tr>
</tbody>
</table>


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

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

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

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

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

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

The status quo is inequitable

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

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

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

To maintain the status quo is to maintain the current inequity. We know that many groups are not getting fair access to services and programmes.
Aboriginal and Torres Strait Islander communities do not enjoy the same access to mental health services as other Australians. In part, this is because of a lack of dedicated Aboriginal and Torres Strait Islander mental health services, or otherwise culturally competent services. These work with cultural differences, including being guided by the holistic concept of health that includes the health of family, community and culture as well as mental and physical health. Further, a lack of focus on primary mental health care, including promotion, prevention, early detection and treatment in primary health care settings, leads to significantly higher per capita levels of expenditure on acute inpatient care—the most expensive part of mental health treatment.

For people in remote and very remote areas, there is poor access to specialist psychiatric care in hospitals, due to a concentration of facilities in larger population centres. The hospitalisation rate for people receiving specialist psychiatric care in major cities is almost twice as high as the rate for people who live in remote and very remote areas. Furthermore, people living in remote and very remote areas have high rates of hospitalisation without specialist care. This suggests you have less access to specialist care if you live in a remote or very remote area, which has implications for service choice, treatment and service outcomes.

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

People living in socio-economically disadvantaged areas are more than twice as likely to experience high levels of psychological distress as those living in the least disadvantaged areas, as depicted in the map below (Figure 1.2). Some areas have both higher disadvantage and higher psychological distress; some areas have lower disadvantage and lower psychological distress; and other areas have a combination of higher/lower disadvantage and psychological distress. Yet the proportions of people who access Department of Veterans’ Affairs (DVA) or Medicare Benefits Schedule (MBS) mental health items are roughly the same across all levels of disadvantage.

Higher rates of chronic physical illness and metabolic syndrome are experienced by people with severe and complex mental illnesses. For example, the life expectancy of people with schizophrenia can be up to 23 years less than the Australian average. Education access and outcomes are poorer for people with severe and complex mental illness. People who experience psychosis have a greater chance of not completing Year 12, with 32 per cent completion, compared to 53 per cent for the general community.
The way forward

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

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

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

That requires a realignment of mental health systems and services—of directions, roles and responsibilities—and a realignment of Commonwealth funding incentives to drive the right outcomes, based on evidence of what works.
The crucial role of people with a mental illness, families and support people

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

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

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

Leadership role for the Commonwealth Government

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

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

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

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

An emphasis on early intervention

Young people today who are first being diagnosed with a mental illness want a life where they can manage their illness and continue on their life journey. We know that mental illnesses typically develop in a person’s life from mid to late adolescence. Great opportunity lies at this point in a young person’s life. Keeping them mentally well and supported with the right interventions can keep them in school, allow them to complete their education and remain connected with family, their community and in employment. Evidence shows that keeping families healthy and resilient can reduce the future risk of mental health problems.
We know from evidence and expert advice that there are proven interventions to support young people living a contributing life (see Chapter 3).

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

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

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

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

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

A dedicated focus on Aboriginal and Torres Strait Islander mental health

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

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

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

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

A principles-based approach

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

Principles

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

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

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

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

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

### For the population:

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

### For service providers:

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

### For the system:

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

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

For Australia:

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

Source: concept designed by The National Mental Health Commission 2014
References


Chapter 2: Methodology

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

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

The collection of evidence proceeded in four phases.

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

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

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

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

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

Sources and types of evidence

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

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

Public consultation

To bring the voice of people with a lived experience of mental illness to the Review, the Commission held a public Call for Submissions over March and April 2014. A very enthusiastic response was received from across Australia, with more than 1,800 individuals, professionals and organisations submitting their views on the mental health system. The response represents good coverage of all geographical areas of the country, including rural and remote areas, and a balance of consumer/supporter and professional responses (621 and 861 respectively). These responses were read and then systematically analysed by Term of Reference theme. A paper outlining the methods and high level findings is included in Volume 3 of this report.

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

Information on expenditure and activity

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

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

Information on state and territory mental health funding and service provision

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

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

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

These projects were broadly divided into two streams.

**Stream 1:** Projects to provide advice on particular elements of the mental health service system.
- Economic analysis and cost of mental health investment scenarios
- Future workforce capability requirements of the mental health system
- Innovative technologies in e-mental health
- Prioritisation of mental health research
- Factors influencing primary mental health care integration with physical health care, social supports and specialist mental health services.

**Stream 2:** Projects to explore particular target or priority communities and issues.
- Challenges for rural, regional and remote Australia
- Gaps and challenges for Aboriginal and Torres Strait Islander wellbeing
- A study of people’s experiences of support following a suicide attempt (already commissioned at the time of the Review’s commencement).

Challenges in collecting evidence

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

**Gaps in data on Commonwealth investments**

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

**Limited cooperation from states and territories**

Despite repeated efforts over the course of the year, we were unable to obtain timely information from the jurisdictions about what they fund and deliver. We were referred to existing publicly available information, but received permission from states and territories to access AIHW-held Mental Health Establishments data very late in the Review process.
This gap in evidence meant we largely were unable to gauge levels of unmet need or to compare service access and provision across regions. We do not know whether an apparent gap in Commonwealth programmes is in fact met elsewhere by state or territory funded programmes. However, we were able to use information from 65 nongovernment organisations which responded to the Commission’s request for information on mental health programmes and services funding to provide a more complete picture of how funding arrangements are working on the ground.

**Lack of whole-of-life outcomes data**

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

**Challenges with Aboriginal and Torres Strait Islander data**

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

**Lack of access to National Mental Health Services Planning Framework**

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

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

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

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

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

Chapter 3: Achieving a contributing life

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

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

Term of Reference

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

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

Dealing with mental health symptoms in isolation is inefficient and ineffective, because other parts of a person’s life may exacerbate the symptoms or, conversely, may be a source of support for good mental health.

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

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

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

Listening to the evidence from people

What is happening now

There was a startling level of consensus among people and organisations which formally submitted evidence to the Review that people with a lived experience and their supporters’ expectations and needs are often not being met by services and programmes. Evidence from personal testimonials by people with lived experience of mental illness and their supporters, as well as from professionals and organisations, highlighted experiences of mental health supports which were, in their terms, often disturbing and sometimes tragic.
The characteristics of services and programmes which people have told us contribute to a poor experience or unsatisfactory outcome (or both) for people that use them and their supporters are wide-ranging. The focus here is on the themes which emerged most frequently from these responses.

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

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

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

Key findings

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

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

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

Creating equal opportunities and investing to save

The National Mental Health Commission developed the concept of ‘a contributing life’ in 2012 to emphasise that people with an experience of mental illness want the same thing as everyone else — to have an opportunity to fulfil their potential and to pursue their hopes and goals. It also reflects the fact that, just because a person experiences mental illness, it does not mean they are unable or unwilling to contribute to the social and economic wellbeing of the communities in which they live.
The Commission’s experience during the past three years of consultation with people with a lived experience of a mental illness, their families and supporters has confirmed the relevance of the contributing life idea as a guiding principle for the delivery of mental health services and programmes. People living with mental health problems do not want to be thought of as victims or passive recipients of ‘care’.

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

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

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

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

What is happening now

We know that many people living with a mental illness have fewer opportunities than the general population to participate socially and economically in the community. The proportion of people with a mental health condition in Australia who are not in the labour force is more than one-and-a-half times that of the general population (32 per cent compared to 21 per cent). This is partly because our inflexible welfare support system can trap people permanently on benefits even though their functioning is only impaired episodically. We have seen access to the Disability Support Pension for psychosocial disability rise by 76 per cent over the past ten years. At June 2013 only 14.6 per cent of DSP recipients from the previous year (June 2012) exited to be non-recipients of other Commonwealth allowances. The remaining 85.4 per cent of people exited the DSP due to death (21.6 per cent) or moved onto another Commonwealth allowance (63.9 per cent).
The interim McClure Report into Australia’s welfare system proposed changes to benefits to allow flexibility in the system, where people who want and are able to work can do so without jeopardising their chances of receiving a benefit should they fall ill in the future.\textsuperscript{4}

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

Lower levels of educational attainment have a significant effect on overall life chances and future employment.

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

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

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

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

Note: “Partially engaged” refers to people engaged in part-time work or study.

Such unequal opportunities are reflected in high rates of mental illness among people who are homeless or in contact with the justice system. During 2012–13 there were 46,037 specialist homelessness clients across Australia with a current mental health problem.\textsuperscript{7} During the five years to 2010, the number of occasions of service provided to people who were homeless or at risk of homelessness because of a mental health problem grew by five per cent each year.\textsuperscript{7}
In 2012, almost two in five people entering prison reported they had a history of mental illness. In one Queensland study, at least one mental health condition was detected in 72.8 per cent of male and 86.1 per cent of female Aboriginal and Torres Strait Islander prisoners.

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

**Harmonisation of legislation and practice in mental health**

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

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

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

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

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

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

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

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

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

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

*Submission from a person with lived experience*
Key findings

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

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

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

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

Accommodation and community support

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

Stable, safe and secure accommodation is the foundation from which people can build a contributing life and recover from mental illness. The relationship between housing and mental health is reciprocal. Poor housing can have a negative impact on mental health and wellbeing. Lack of support and care in the community can lead to people living with mental illnesses losing their accommodation. Additionally, the symptoms of mental illness can lead to financial insecurity, relationship and employment breakdown and in turn onto initial and continued homelessness.

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

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

Importantly, the provision of housing is not the same as the provision of accommodation. People can be given a house—but they may need help to fully engage with their local community.
Barriers also occur where claims of privacy interfere with the ability of mental health support workers to discuss client issues with housing providers. These barriers need to be broken down. Housing providers need to be included as part of the team and understand when there are mental health issues impacting on a person’s functional capability. Adelaide’s Common Ground provides a good example of an integrated accommodation and care provider and is described in the following case study.

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

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

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

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th></th>
<th>Before HASI ($)</th>
<th>During HASI ($)</th>
<th>Cost avoided ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average cost per person per year (n=197)</strong></td>
<td>47,425</td>
<td>19,508</td>
<td>27,917</td>
</tr>
<tr>
<td><strong>Average cost per admission</strong></td>
<td>5,462</td>
<td>1,821</td>
<td>3,641</td>
</tr>
<tr>
<td><strong>Total cost per year for all HASI consumers (n=1,076)</strong></td>
<td>51,029,192</td>
<td>20,990,070</td>
<td>30,039,122</td>
</tr>
</tbody>
</table>


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

**Justice reinvestment and court diversion**

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

A recent cost benefit analysis by the National Indigenous Drug and Alcohol Committee has shown long-term savings for court diversion programmes prison costs can be as high as $111,458 per offender.\textsuperscript{12}
Flexible pathways through education and training

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

This role is vital because young people experiencing mental ill-health are disproportionately represented among those who have disrupted educations or drop out of school early, and who subsequently fall into ‘NEET’ (not in education, employment or training) status. There is clear evidence of the link between level of educational attainment and quality of life indicators such as level of income.

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

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

Employment

Creating flexible opportunities for participation and employment

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

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

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

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

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

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

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

‘Brian’, Participant in Epic Employment Service

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

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

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

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

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

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

**Encouraging employers to create mentally healthy workplaces**

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

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

However, it is estimated that one in six Australian workers is affected by a mental health condition each year, and that Australian businesses lose six million working days per year due to depression.\(^4\)

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

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

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

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

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

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

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

Case Study: Mentally Healthy Workplace Alliance

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

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

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

Tailoring support to each person’s life circumstances and needs

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

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

- We know that a person’s age, family situation, cultural background, gender and sexuality can affect their experience of mental wellbeing and mental illness, as well as the types of support they may find helpful and appropriate
We also know that particular life experiences have considerable impact on—and can be impacted by—a person’s mental health, and therefore need to be considered at the same time. These include intellectual disability, substance misuse and chronic physical illness or disability.

We know that for Aboriginal and Torres Strait Islander people, specific issues such as sense of self, connection to land and belonging have a huge intergenerational impact.

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

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

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

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

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

Specific life circumstances

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

Families and caregivers

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

Several Commonwealth programmes have attempted to consider the needs of families and carers of people with severe mental illness, and to acknowledge the lost income a caring role might entail. The Carer Allowance and Carer Payment accounted for almost $1 billion of Commonwealth spending in 2012–13, while the Targeted Community Care (Mental Health) Programme dedicated $57.2 million to respite services for carers.
These programmes are welcomed by many carers and uptake has greatly increased in recent years, with combined spending on the three carer programmes increasing from $723.4 million in 2008–09 to $1 billion in 2012–13. The growth in carer payments should not be an area of criticism. Many people have contributed for a long time as unpaid carers. The fact that more of them are entitled to support payments to fulfil this role should be celebrated as an example of justice being achieved. The pressures of a caring/supporting role are evident. The Department of Social Services estimated that at June 2013, of the 256,380 Disability Support Pension customers who had a primary medical condition, 11,256 (4.4 per cent) had a previously recorded episode of Carer Payment.

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

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

**Infants, children and young people**

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

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

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

A case study describing a promising approach to collecting national data on the wellbeing of young people (the Middle Years Development Index (MDI)) is described on the following page. The Commission proposes the systemic introduction of the MDI as an action to help achieve one of our recommendations in Volume 1.
Case Study: Using data to drive effective change – at school, region and national level

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

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

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

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

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

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

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

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

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

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

Respondents to our Call for Submissions told us that mental health care for older people—let alone early intervention—is a big gap in systems of support in many areas of Australia. Nearly 35 per cent of all aged care home residents experience depression or anxiety at any one time. Older people with depression and anxiety are poorly served, as they currently have low access to non-medical MBS items for mental health interventions. The Mental Health Services-Census Data Integration Project shows that in 2011, 0.2 per cent of people aged over 75 accessed MBS items provided by clinical psychologists, compared to 1.5 per cent of people aged between 15 and 64.

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

**Women**

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

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

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

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

**Men**

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

**Lesbian, gay, bisexual, transgender and intersex people**

Violence and discrimination are the key risk factors for the relatively poorer health of lesbian, gay, bisexual, transgender and intersex (LGBTI) people. Discrimination and abuse lead to higher drug and alcohol use, mental health issues and other risky behaviour. Research suggests that LGBTI people are at increased risk of a range of mental health problems, including depression, anxiety disorders, self-harm and suicide. Despite this risk, same-sex attracted people, intersex and transgendered people still are not routinely identified in national minimum datasets nor in census statistics. This makes their need less visible and the impact of initiatives tailored to their particular mental health challenges difficult to determine. We understand that the National LGBTI Health Alliance is currently consulting on the inclusion of LGBTI-related data in health research and national data sets. This is a first step to providing sexuality and gender sensitive mental health supports.

**Aboriginal and Torres Strait Islander peoples**

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

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

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

**Culturally and linguistically diverse communities**

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

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

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

**People with interrelated needs**

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

**Physical health and medications management**

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

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

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

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

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

Figure 3.3 Antipsychotic use, 1990–2013


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

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

![Graph showing age-standardised rates of initiation of atypical antipsychotics, 2011](image)


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

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

**Figure 3.5 Antidepressant use, 1990–2013**


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).

In 2011 Australia ranked second-highest in an OECD comparison of antidepressants consumption, behind only Iceland (see Figure 3.6). However, it should be noted that this comparison does not include the United States, which saw the rate of antidepressant treatment nearly double between 1996 and 2005.

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

This particularly is the case for people with mental ill-health where there often are multiple co-morbidities and therefore multiple medications. This is complicated further by the fact that mental and physical health records can be kept in separate records so that knowledge of the complete history of medications is not always available to the treating practitioner.
Figure 3.6 International comparison of antidepressants consumption

Source: OECD Health Statistics 2013

Note: “[…] DDD [Defined Daily Dose] is a unit of measurement and does not necessarily correspond to the recommended or prescribed daily dose (PDD) […]. Sales or prescription data presented in DDDs per 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).

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

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

More broadly, the Commission considers that the high levels of use of pharmaceuticals within the mental health system warrant system wide evaluation. A review of cost effectiveness and efficacy should be undertaken, with results being used to determine the best approach to the
use of pharmaceuticals as part of a total package of care for people in the mental health system.

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

**Childhood trauma and later adult mental health**

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

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

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

AIHW statistics on notifications of suspected child abuse and neglect made to state and territory authorities are another source of information on the potential level of childhood trauma in Australia. In 2012–13 there were nearly 273,000 notifications of suspected abuse or neglect involving more than 184,000 children—a rate of 35.5 per 1,000 children in Australia. (Not all of these children will have been maltreated, as state and territory authorities are required to act when children also are at risk of being harmed.)

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

Nationally, at a policy level, the public health model for children and maltreatment is the dominant model of child protection, as seen in the National Framework for Protecting Australia’s Children 2009–2020 (COAG, 2009). This document does address the increased risk of poor health and wellbeing, both in childhood and later life.
During the past decade there has been rapid progress in the understanding of the effects of exposure to traumatic life experiences on subsequent psychopathology in children. Changing adult and primary caregiver behaviour can increase mental health and wellbeing development in children. In order to meet this challenge, we need to think in more integrated and innovative ways to ensure infants and children have improved chances of good mental health and wellbeing in later life.

**Intellectual disability and mental health**

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

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

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

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

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

**Substance misuse and mental health**

The service silo approach is repeated when responding to the needs of people who experience both substance misuse and mental illness. In the case of co-occurring substance use, the existence of one problem often excludes a person from help for the other problem, a practice related to separate funding streams and policy development.
Drugs and alcohol can exacerbate or induce mental illness, while self-medication to escape the effects of mental illness can lead to drug or alcohol addiction. The combination creates up to a 20 year reduction in life expectancy compared to the general population, and is associated with homelessness and prison experience as well as poor outcomes on a range of physical health indicators (including being twice as likely to become a smoker).

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

**Where to from here – implications for reform**

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

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

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

- **Employment:** develop partnerships between governments and businesses to ensure that meaningful employment is equally accessible, whether someone has a mental health difficulty or not. Bring Australia up to the standard of the OECD countries which have high rates of employment for people with disabilities. Support carers into employment at the same time as the people they are caring for are being supported into employment.

- **Education:** ensure that schools, universities and colleges are supported to build a mentally healthy and open culture which discourages discrimination and supports help seeking, and to recognise when a student is struggling with their mental health. Flexible pathways through education which ensure that mental illness is no barrier to achieving academic, sporting or vocational potential require further development. Integrate existing programmes within education to better target outcomes in this sector to ensure that the current service gap for children with emerging or established difficulties is closed.

- **Children:** support the resilience and wellbeing of children through engagement with new parents, preschools and primary schools to maximise development. Support adults to increase mental health literacy and resilience.

- **Housing:** build on the success of initiatives such as Housing First and Adelaide’s Common Ground, recognising that initial expenditure will be more than offset by savings in use of crisis and inpatient services.

- **Justice system:** scale-up court diversion and justice reinvestment schemes to ensure that people whose criminal behaviour is prompted by a struggle with mental illness and/or addiction are diverted to therapeutic rather than custodial interventions.

- **Personal supports:** ensure that consumer-identified family or other informal caregivers are given the information and support they need to fulfil their role and stay healthy themselves. Opportunities to prevent intergenerational effects of mental illness also be recognised.

- **Interrelated needs:** explore opportunities for joint care planning between mental health and intellectual disability services, and between mental health and substance use services, to provide a truly ‘no wrong door’ holistic response to people with concurrent needs.

- **Interrelated needs:** increase community awareness of and action on evidence about what occurs to children before they are born and how their early years can affect their health, mental health and wellbeing and opportunities later in life, to support a focus on prevention.

- **Aboriginal and Torres Strait Islander peoples:** Dedicated, national Aboriginal and Torres Strait Islander mental health planning and service and programme design is needed because mainstream mental health policy, service and programme design is, in general, not appropriate for Aboriginal and Torres Strait Islander peoples and does not support an effective patient transition through the system.

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

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

Source: concept designed by The National Mental Health Commission 2014
References


18. Clare M, Black-Blundell B, Clare J. Examination of the extent of elder abuse in Western Australia: A qualitative and quantitative investigation of existing agency policy, service responses and recorded data. Perth: Crime Research Centre: The University of Western Australia, 2011.


43. Lawrence D, Hancock K, Kisely S. The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. *BMJ* 2013; 346: f2539.


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

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

**Term of Reference**

Specific challenges for Aboriginal and Torres Strait Islander people.
Aboriginal and Torres Strait Islander Health and Wellbeing

- **10 years**
  The **life expectancy** for Aboriginal and Torres Strait Islander people is still around 10 years lower than for other Australians.

- **2.7 times**
  Aboriginal and Torres Strait Islander adults are 2.7 times more likely to have high/very high distress levels, compared with their non-Indigenous counterparts.

- **38 per cent**
  Of all Aboriginal and Torres Strait Islander people aged 15 years and over, **38.1% had experienced at least three ‘life’ stressors** in the previous 12 months. For example, death of a family member, serious illness, or inability to get to work.

- **27 per cent**
  In 2012, **27 per cent of the adult prison population** were Indigenous.

- **Twice as high**
  From 2001–2010, **suicide rates** amongst the Aboriginal and Torres Strait Islander population were around **twice as high** as they were amongst the non-Indigenous population.

---

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

- Too busy (for reasons such as work or family responsibilities) **34.0%**
- Decided not to seek care **31.7%**
- Dislikes the service or professional (or feeling afraid or embarrassed) **26.6%**
- Felt it would be inadequate **18.0%**
- Too long to wait—or the service was not available at the time **12.2%**
- Does not trust the counsellor **11.8%**
- Problems with transport or distance **10.4%**
- Other **17.2%**

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

What is happening now

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

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

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

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

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

On some indicators, such as life expectancy and child mortality, there has been progress in Closing the Gap. Educational attainment and employment indicators have improved, but remain well behind those of non-Indigenous people.
The Review commissioned research and consultation and sought advice on the needs of Aboriginal and Torres Strait Islander peoples and the current state of play in the system. The consultants worked closely with the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory group to the Commonwealth and with the National Aboriginal and Torres Strait Islander Leadership in Mental Health group that advises the mental health commissions of Australia. They also consulted subject matter experts and key stakeholders, conducted a literature review, stakeholder interviews and a review of Aboriginal and Torres Strait Islander-related submissions.

Highlights of that report showed:

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

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

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

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

A lack of focus on primary mental health care, including promotion, prevention, early detection and treatment in primary health care settings, leads to significantly higher per capita levels of expenditure on acute inpatient care; the most expensive part of mental health treatment.
Aboriginal and Torres Strait Islander people are proportionally over-represented in mental health-related hospitalisations, with specialised psychiatric care accounting for 4.9 per cent of these hospitalisations in 2012–13. They had a hospitalisation rate that was over double that of non-Indigenous people (12.7 and 6.3 per 1,000 population respectively).6

**Current national approaches to addressing these gaps and poor outcomes**

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

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

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

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

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

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

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

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

These top five issues were articulated as follows:

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

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

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

**Key findings**

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

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

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

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

Compounding the above problems, the Review identified significant limitations with policy implementation and monitoring. Dedicated, national Aboriginal and Torres Strait Islander mental health planning and service and programme design is needed because mainstream mental health policy, service and programme design is, in general, not appropriate for Aboriginal and Torres Strait Islander people. The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2014–2019 provides the basis for such planning and service and programme development.
The Review findings are presented below in five areas, reflecting where action is required:

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

**Social and emotional wellbeing**

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

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

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

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

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

**Underlying disadvantage and co-morbidities influencing mental health status**

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

**Chronic disease**

Much of the current national focus around Aboriginal and Torres Strait Islander disadvantage is drawn to the impacts of chronic disease.
Research over the past decade suggests a chain of causation may be present between mental health conditions (in particular, serious psychological distress) and chronic disease. The 2014 ‘Reeve Study’ correlated data from the 2004–05 ABS National Aboriginal and Torres Strait Islander Health Survey and the 2004–05 ABS National Health Survey\(^\text{12}\) to make some significant findings as to what was required to close the diabetes gap.

Among other findings, it found an association between people who self-reported diabetes and those who reported the forced removal of relatives. It described the finding as ‘consistent with emerging evidence that serious psychological stress contributes to a range of health problems and may be involved in the development of risk factors for metabolic syndrome, including raised blood glucose’\(^\text{12}\). Regardless of the causal link, mental health conditions must be considered as significant co-morbidities with chronic disease that can prevent the effective treatment of chronic disease and are associated with increased exposure to risk factors for chronic disease\(^\text{13}\).

**Employment**

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

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

**Alcohol and other drugs**

High alcohol consumption and at-risk drinking can have harmful short and long-term effects on a person’s physical, social and mental health and safety\(^\text{16}\). Conversely, alcohol and other drug use can lead to mental health problems and mental illness.

Of great concern is what could be referred to as ‘daily binge drinking’. The COAG Reform Council 2012 report on Closing theGap targets reported that approximately 14 per cent of Aboriginal and Torres Strait Islander men and 12.7 per cent of non-Indigenous men aged 15 and over were drinking an average of more than five standard drinks per day in 2011–12\(^\text{17}\). A significantly larger proportion of Aboriginal and Torres Strait Islander men (8.1 per cent) than non-Indigenous men (6.1 per cent) were drinking more than seven standard drinks per day\(^\text{17}\).

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

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

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

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

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

Submission from the Central Australian Aboriginal Congress

High rates of imprisonment

Twenty seven per cent of the adult prison population is Indigenous—drawn from just three per cent of the overall population. Of particular concern is the significant over representation of Aboriginal and Torres Strait Islander youth within juvenile detention centres, where they represent 54.7 per cent of juvenile detainees (approximately 460 people). Further, Aboriginal and Torres Strait Islander young people aged ten to 17 years were 28 times more likely to be in detention than non-Indigenous people that age, and 16 times more likely to be under community-based supervision in 2012–13.

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

In a recent Senate Legal and Constitutional Affairs References Committee report, Value of a justice reinvestment approach to criminal justice in Australia, released in June 2013, the economic costs of imprisonment were estimated at:

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

Further attention is required by mainstream services to the mental health needs of Aboriginal and Torres Strait Islander people in custodial care. A justice reinvestment programme for these detainees should be introduced to reduce the risk of reoffending and minimise future custodial
care outlays. Such a programme is an excellent example of an “invest to save” approach. Reducing recidivism is good for people and for taxpayers. It could also be extended to more youth mental health services in Aboriginal and Torres Strait Islander communities.

**Mainstream services capability and accountability**

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

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

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

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

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

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

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

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

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

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

Yarn Safe

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

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

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

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

- identity
- culture
- relationships
- responsibility
- stress and pressure
- alcohol and other drugs
- family
- racism
- community
Aboriginal and Torres Strait Islander people will have an ongoing need to access specialist mental health services funded and operated by state and territory public health services. As such, the application of the ‘one-size-fits-all’ approach should be avoided as it is wasteful use of resources and unable to meet the needs of Aboriginal and Torres Strait Islander people.

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

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

**Effectiveness of dedicated services and programmes**

In contrast to mainstream mental health services, the Review was able to identify Commonwealth mental health and related grants that were specifically targeted to Aboriginal and Torres Strait Islander people to a value of $123.1 million in 2012–13. In addition to some smaller programmes, the main recipients of these funds are as follows:

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

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

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

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

- **Link Up Services** – These provide family tracing, reunions and counselling for members of the Stolen Generations ($12.7 million in 2012–13 for 20 grants). Link Up services aim to work closely with SEWB counselling services and other organisations to assist clients to reunite with their families, culture and community, and restore their social and emotional wellbeing wherever possible. Link Up services are either stand-alone organisations or are positioned within a larger organisation such as ACCHOs.
- **SEWB Counselling Services** – These were previously funded as Link Up counsellors, Bringing Them Home counsellors and mental health workers ($18.6 million in 2012–13 for 116 grants). These services provide counselling support for Aboriginal and Torres Strait Islander peoples, prioritising members of the Stolen Generations. Priority is given in the following order:
people from the first generation who were directly impacted
- members of families and communities from which children were removed
- second, third, fourth and subsequent generations. These services are under stress because of the limited availability of other services to respond to the SEWB and mental health needs of Aboriginal and Torres Strait Islander people. Thus, in 2012–13, the programme provided support to 17,700 clients. But of these, almost half (47 per cent) were other than first, second, third, fourth or subsequent members of the Stolen Generations.

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

Funding provided for SEWB stolen generations counselling in 2012–13 is summarised in Table 4.1.

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

<table>
<thead>
<tr>
<th>Programme Component</th>
<th>Number of Services</th>
<th>Realised Demand</th>
<th>Recurrent Funding 2012–13 (($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEWB Counselling</td>
<td>116 grant recipients</td>
<td>17,725 clients (2012–13)</td>
<td>18.539</td>
</tr>
<tr>
<td>Workforce Support Units</td>
<td>11 grant recipients</td>
<td>Not applicable</td>
<td>5.218</td>
</tr>
<tr>
<td>Link up services</td>
<td>20 grant recipients</td>
<td>Not available</td>
<td>12.672</td>
</tr>
</tbody>
</table>

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

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

### Access to Allied Psychological Services (ATAPS) programme

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

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

Between July 2003 and June 2010 the ATAPS programme was not targeted to meet the needs of Aboriginal and Torres Strait Islander peoples. In this period, 115 General Practice Networks delivering ATAPS programmes generated 6,745 GP Mental Health Treatment Plans for Aboriginal and Torres Strait Islander people. This is an average of 863 GP Mental Health Care Plans generated for Aboriginal and Torres Strait Islander people each year over the life of the ATAPS programme.

While welcome, the first ATAPS was not functioning at a level to meet the needs of Aboriginal and Torres Strait Islander peoples. The 2012–13 AATSIHS reported that up to 30 per cent of
respondents had high to very high psychological distress.5 The number of places falls far short of the potential number of Aboriginal and Torres Strait Islander people requiring assistance.

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

- **Culturally competent mental health services.** This is designed to deliver culturally appropriate mental health services to Aboriginal and Torres Strait Islander people. Cultural competence training is provided by the Australian Indigenous Psychologists Association as a part of this component of the programme.

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

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

- The approach was developed in partnership by the Department of Health and Ageing and its (then) Aboriginal and Torres Strait Islander Mental Health Advisory Group.

- There are dedicated funds for services for Aboriginal and Torres Strait Islander people within the overall programme which reflect both population size and relative need.

- It built on partnerships, captured in formal agreements, between what were Medicare Locals (now moving to Primary Health Networks) and ACCHS. In particular, these agreements address the vital issue of service accessibility and standards. Further, they recognise the greater accessibility and better health outcomes associated with ACCHS.

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

A recent analysis by the University of Melbourne found low service uptake by Aboriginal and Torres Strait Islander people (2,097 clients in 2012–13) and suggested an average session cost of an ATAPS Tier 2 Aboriginal and Torres Strait Islander service of $483, compared to the average Tier 1 (overall population) cost of $170.25

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

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

- **Suicide prevention services.** Commonwealth initiatives for suicide prevention totalled $68.8 million in 2012–13. Around 12.7 per cent of this allocation ($8.7 million) targeted the needs of Aboriginal and Torres Strait Islander peoples in addition to the mental health funds discussed previously.\(^\text{25}\)

- **Mental Health Services in Rural and Remote Areas (MHSRRA) programme.** This provides funding for mental health professionals in more than 200 rural and remote communities across Australia that would otherwise have little or no access to MBS-subsidised mental health services. Two ACCHSs are funded under the MHSRRA programme: Wuchopperen Health Service, located in Cairns, and Nganampa Health Council, located in far northeast South Australia. In 2012–13, Wuchopperen received approximately $640,000 and Nganampa received approximately $375,000 (both GST exclusive).\(^\text{28}\)

- **The Mental Health Nurse Incentive Programme (MHNIP).** This was introduced in 2007 to provide support to people with severe mental disorders during periods of significant disability. The programme provides non-MBS incentive payments to eligible organisations such as community-based general practices and private psychiatrist practices, which engage mental health nurses to assist in the provision of coordinated clinical care for people with severe mental disorders. Three IPHCOs currently participate in MHNIP.

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

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

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

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

**Limitations with policy implementation and monitoring**

Mainstream mental health policy, service and programmes in general have not been designed with sufficient consideration of the needs of Aboriginal and Torres Strait Islander people in mind. This is due partly to the greater burden of mental health problems and mental illness among them, and also to the cultural and experiential differences that underpin the ‘mental
health gap’. The need for tailored services that work within the SEWB context and take into account cultural differences is well established.

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

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

Where to from here – implications for reform

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

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

Leadership and good governance

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

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

**Promoting productivity and participation**

Promoting Aboriginal and Torres Strait Islander workforce participation is guided by the new *Indigenous Advancement Strategy* (IAS). The 2011 Census results show that health services (including, but not limited to, mental health services) currently employ 14.6 per cent of employed Aboriginal and Torres Strait Islander people. Health services are thus the single biggest ‘industry’ source of employment, which has expanded by almost 4,000 places since 2006.29

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

**Developing a strong market**

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

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

**Infrastructure support**

There is a strong consensus among Aboriginal and Torres Strait Islander mental health experts consulted through the Review that IPHCOs/ACCHS provide value for money and a foundation for good practice for developing primary mental health services.
**Case Study: Statewide Specialist Aboriginal Mental Health Service**

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

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

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

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

**Smart use of technology**

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

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

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

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

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

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

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

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

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

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

Workforce development plans should include the following strategies.

- Identify current capacity and identify future workforce needs. We understand little has been done to date in this area, although under the NSW Mental Health and Wellbeing Policy, NSW Health required at least one Aboriginal mental health worker to be employed per 1,000 Indigenous people in the catchment area.
- Strengthen opportunities for Aboriginal and Torres Strait Islander health workers to attain advanced qualifications by strengthening educational pathways from the Vocational Education Training sector to the university sector.
- Strengthen Aboriginal and Torres Strait Islander participation rates in tertiary courses and in the mental health workforce. This will involve health professional associations and education providers taking greater responsibility for increasing the level of Aboriginal and Torres Strait Islander students undertaking their courses and entering the profession. The medical profession is demonstrating good practice in supporting the training and mentoring of Aboriginal and Torres Strait Islander medical students. The Djirruwang Program through Charles Sturt University is considered a programme of merit supporting increased participation of Aboriginal and Torres Strait Islander people as mental health practitioners in mainstream mental health services.

Research

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

While the knowledge and experience of clinicians has an important role to play in strengthening services, greater effort is required to undertake applied research projects and facilitate partnerships between service delivery organisations and research institutions.
Support was expressed in submissions to the Review for strength-focused research aimed at identifying effective approaches for:

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

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

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

**Actions**

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

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

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

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

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

- Establish mental health as a priority within the COAG Closing the Gap framework and within the Indigenous Advancement Strategy.
- Additional costs could be offset by the significant reductions in the costs associated with addressing chronic disease, unemployment, family breakdown, alcohol and other drugs abuse, smoking, and high rates of imprisonment in Aboriginal and Torres Strait Islander peoples. In part this could occur through a justice reinvestment programme.
Achievement of this will require activation of existing frameworks for national Aboriginal and Torres Strait Islander mental health planning and service and programme design over the next 12 to 18 months through the implementation of:

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

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

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

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

- Suicide prevention expenditure should be quarantined.
  - Funding allocated to implement the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and the National Strategic Framework for Aboriginal and Torres Strait Islander People’s Mental Health and Social and Emotional Wellbeing 2014–2019.
  - Wherever possible, existing expenditure should contribute to supporting IPHCOs/ACCHS Mental Health and SEWB Teams and also specialist Aboriginal and Torres Strait Islander mental health services.

- Further attention is required by mainstream services to the mental health needs of Aboriginal and Torres Strait Islander people in custodial care. A justice reinvestment programme for detainees should be introduced as a cost-effective way to reduce the risk of reoffending and minimise future custodial care outlays. It also could be extended to more youth mental health services in Aboriginal and Torres Strait Islander communities.

2. Integrated Mental Health and SEWB Teams

- Require mental health and SEWB teams to be established in all government-funded IPHCOs and ACCHS, as part of renewed service agreements.

- Mental health services to be fully integrated within these services as a part of their existing comprehensive primary health care service package. This will enable the early detection and expanded treatment of mental health problems and some mental illness in relatively inexpensive community and primary health care settings. Such mental health and SEWB teams also could help support recovery in community settings.

- The integrated teams will provide access to:
  - medical care, including pharmacotherapies and preventive health care and health checks to promote, maintain and treat physical health
  - structured interventions using evidence-based therapy
  - social and cultural support, including access to housing, support with issues of cultural identity and support from local Aboriginal people via Aboriginal health workers and Aboriginal mental health workers.
• With links to:
  - community mental health
  - alcohol and other drugs services
  - primary health care
  - access to a psychiatrist
  - mainstream services.

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

The integrated teams would implement models of care/clinical pathways for:
  - community mental health—screening, treatment, support
  - alcohol and other drugs
  - chronic illness support
  - SEWB promotion/community strengthening.

3. Invigorate culturally responsive and accountable mainstream mental health services

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

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

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

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

Each state and territory has a different infrastructure and mix of services, so the most appropriate responses will vary. Some jurisdictions could choose to establish specialist Aboriginal and Torres Strait Islander mental health services along the lines of the Western Australia Statewide Specialist Aboriginal Mental Health Service (SSAMHS) model.
Irrespective of the precise approach, all Aboriginal and Torres Strait Islander people admitted to a specialist (mainstream) mental health service should be in the target group for this service and the following features/capabilities should be standard:

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

5. Aboriginal and Torres Strait Islander mental health workforce development

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

Key components of the strategy should include:

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

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


Chapter 5: Regional, rural and remote Australia

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

Term of Reference
Specific challenges for regional, rural and remote Australia.
Rural, regional and remote Australia

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

### Majors Cities

For every 1000 people, there were **6.5** hospitalisations for mental health reasons with specialised psychiatric care, but **3.5** without specialised care.

For every 100 people, **8** received MBS-subsidised mental health services. Each of these people received **5.2** consultations.

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

- Psychiatrists: **$15.51**
- Other allied health providers: **$0.87**
- Other psychologists: **$8.66**
- Clinical psychologists: **$3.78**
- General practitioners: **$8.62**

### Remote/Very Remote

For every 1000 people, there were **3.5** hospitalisations for mental health reasons with specialised psychiatric care, but **8.2** without specialised care.

For every 100 people, **3** received MBS-subsidised mental health services. Each of these people received **3.0** consultations.

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

- Psychiatrists: **$1.96**
- Other allied health providers: **$0.13**
- Other psychologists: **$1.40**
- Clinical psychologists: **$1.38**
- General practitioners: **$2.59**

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

What is happening now

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

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

Local differences need to be recognised

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

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

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

This means that ‘one-size-fits-all’ solutions for these areas will not work. These factors must be considered in local responses to improve mental health of communities and individuals. Although greater external resourcing is required, we also need to leverage the strengths of communities and the technologies and resources already present.
In the absence of local data to pinpoint demand for services in particular communities, the following general trends give an impression of important distinctions between geographically defined categories. Evidence submitted to the Review and COAG Reform Council reporting shows that, in general, people in regional, rural and remote areas face higher levels of socio-economic, environmental, behavioural and physical health risks associated with mental ill-health than those who live in major cities. While there is no clear evidence that the prevalence or severity of mental illness is any greater in regional, rural and remote areas, or that geography alone affects perceived need for specific types of mental health services by people with a lifetime mental health disorder, this data may be unreliable.

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

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

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

Service provision declines with distance

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

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

‘My view is that funding should be reprioritised toward remote communities, and a distinction made between “rural” and “regional” locations. Some “regional” locations are in fact within 60 kilometres of a major city or town of over 250,000 people. Truly remote or regional locations are often 1,000 kilometres from a city or town. The difference in resource provision between these locations is profound, leading to undetected mental health problems in remote communities, without access to highly qualified treatment services.’

Submission from a clinical psychologist
The data shows reliance on public mental health services increases by remoteness (see Figure 5.1)\textsuperscript{14}

**Figure 5.1 Rate per 100 of population using clinical mental health services, by service type and remoteness, 2010–11**

<table>
<thead>
<tr>
<th>Rate per 100 population</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>1.4</td>
<td>1.9</td>
<td>2.1</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Private</td>
<td>0.1</td>
<td>0.1</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>MBS and DVA</td>
<td>7.3</td>
<td>7.4</td>
<td>5.4</td>
<td>3.0</td>
<td>1.8</td>
</tr>
</tbody>
</table>


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

**Figure 5.2 Rate per 100 of population receiving Medicare-subsidised mental health services, by provider type and remoteness area, 2012–13**

<table>
<thead>
<tr>
<th>Rate per 100 population</th>
<th>Psychiatrist</th>
<th>General practitioner</th>
<th>Clinical psychologist</th>
<th>Other psychologist</th>
<th>Other allied health</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major cities</td>
<td>1.6</td>
<td>1.1</td>
<td>1.3</td>
<td>1.6</td>
<td>0.7</td>
<td>8.0</td>
</tr>
<tr>
<td>Inner regional</td>
<td>0.7</td>
<td>0.3</td>
<td>0.3</td>
<td>0.2</td>
<td>0.2</td>
<td>2.3</td>
</tr>
<tr>
<td>Outer regional</td>
<td>0.3</td>
<td>0.2</td>
<td>0.1</td>
<td>0.3</td>
<td>0.0</td>
<td>1.7</td>
</tr>
<tr>
<td>Remote</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Very remote</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

Proportion of the population accessing a MBS subsidised mental health-related service in 2011 (SA3)
- 8.5 to 15%
- 6.8 to 8.5%
- 4.2 to 6.8%
- >0 to 4.2%
- Not enough data

Proportion of the population accessing a PBS subsidised mental health-related medication in 2011 (SA3)
- 14.5 to 19%
- 10.5 to 14.5%
- 7.1 to 10.5%
- >0 to 7.1%
- Not enough data

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

**Key findings**

**Losing local services**

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

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

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

The move to new Primary and Mental Health Networks (PMHNs) also needs to ensure the smooth transition of care-based models developed by Medicare Locals to suit particular geographical areas. The successful Mental Health Services in Rural and Remote Areas (MHSRRA) programme is one such example. This programme needs to be integrated with the new PMHNs and its focus on the implementation and management of services provided via local organisations retained, as well as its flexibility to be able to tailor services to local needs.
Workforce supply issues also need to be urgently addressed. Over the years, rural incentive programmes for professionals have had limited success. Regional, rural and remote areas remain unattractive for people to move to (for numerous reasons) and expansion of the current workforce mix for mental health care will require ongoing efforts.

**Potential solutions through developing technology and community capacity**

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

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

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

**Case Study: Farm-link**

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

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

*Adapted from Perceval, Fuller & Holley (2011)*

---

103
Where to from here – implications for reform

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

Addressing workforce concerns while finding alternatives

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

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

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

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

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

The Australasian Centre for Rural and Remote Mental Health's Wellbeing and Lifestyle Survey (currently 1,000+ workers) runs across several remote sites in Western Australia. It continues to identify all the significant risk factors directly related to work, split lifestyle and separation from family and friends. Risk factors include, but are not limited to:

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

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

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

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

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

Minds in Mines includes, but is not limited to:

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

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

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

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

Submission from the Australasian Centre for Rural and Remote Mental Health
Developing a coordinated regional approach, within a national framework

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

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

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

Understanding and addressing the broader factors affecting mental health

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

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

Ultimately, addressing these concerns requires answering the question posed by one stakeholder: “How do we create a sense of hope and opportunity in these places?”\(^{2021}\)
**Actions**

- Develop a regional model of service delivery based around the proposed Primary and Mental Health Networks (PMHN).
  - PMHNs to be tasked with working on behalf of, and in consultation with, local communities on the integration and coordination of place-based mental health and suicide prevention plans, including purchasing services and monitoring performance.
  - Models developed by Medicare Locals to suit particular geographical areas and existing programmes (including MHSRRA and ATAPS programmes) should be smoothly transitioned to PMHNs to enable services to be delivered to areas of need.
  - The National Mental Health Services Planning Framework to be used to support PMHNs to take such an approach. Location-specific gap analysis and needs assessments will be fundamental to ensuring that PMHNs invest in what each community needs, including specific needs of Aboriginal and Torres Strait Islander communities. The Commission-led data linkage project can provide population-level information on the use of MBS and PBS services.
  - Require PMHNs to be responsible and accountable within their jurisdictions for improved Aboriginal and Torres Strait Islander mental health outcomes. This includes developing partnership and other innovative funding and service delivery relationships with Indigenous Primary Health Care Organisations (including Aboriginal Community-Controlled Health Services) in their jurisdictions to support the mental health and social and emotional wellbeing teams and specialist mental health services proposed in this Review.

- Implement a range of changes to the Commonwealth’s Better Access programme to address workforce shortages impacting on service access.
  - Limit access to benefit payments for new registered psychologists (not clinical psychologists) to more remote areas of the geographical classification.
  - Examine cashing out Better Access benefits for registered psychologists from fee-for-service arrangements and distribute funds on a weighted population basis to regional purchasers to purchase psychological services on a salaried or sessional basis.
  - Examine the introduction of provisions requiring access to benefits payments under Better Access being dependent on all new allied health professionals providing a significant proportion of their services (i.e. 50 per cent in the first five years) to more remote areas of the geographical classification.
  - Examine the provision of incentives for allied health professionals to more remote areas through targeted scholarships for postgraduate study, support of professional development and mentoring, and financial and relocation inducements.

- Further develop pathways for stepped and integrated care, incorporating:
  - adoption of technology enablers; for example, support for face-to-face consultations with specialists through expansion of telehealth MBS items beyond telepsychiatry
  - the use of e-mental health interventions
  - using remote or online flexible delivery for the education and training of professionals
  - promotion of e-mental health services to regional, rural and remote communities.
• Invest in improving the capacity of community members, especially those with a personal experience of mental illness, to provide peer and/or mental health first aid services and supports to augment the existing workforce.
• Add a rural loading to the Better Access programme weighted similarly to those for the Practice Nurse Incentive Programme.
• Conduct further research on the determinants of mental health in regional, rural and remote Australia and effective service delivery models.
References


Chapter 6: Suicide prevention

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

Term of Reference

The prevention of suicide.
Suicidal behaviour in Australia

Geographical disparities in suicide rates

Age-standardised suicide deaths per 100,000 population, 2008–2012
- 20 to 27
- 15 to 20
- 10 to 15
- 5 to 10
- 0 to 5

Source: ABS, Causes of Death, 2012
Note: Numbers on map refer to age-standardised rate of suicide deaths, 2012

Slight upward trend in suicide rate

Source: ABS, Causes of Death, 2012

Age and sex disparities in suicide rates

Source: ABS, Causes of Death, 2012

Thousands affected by suicidal thoughts and behaviour each year

Source: ABS, Survey of Mental Health and Wellbeing, 2007
What is happening now

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

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

Trends in Australian suicide statistics paint a sad and frustrating picture. In 2012 more than 2,500 people died by suicide,² while in 2007 an estimated 65,000 Australians attempted to end their own life.³ The absolute number of deaths has increased each year since 2006, while rates have remained almost static at close to 11 deaths per 100,000 population.² Remarkably, in terms of total years of life lost each year due to premature deaths across the Australian population, suicide ranks third after cardiovascular disease and cancer, diseases which cause far greater numbers of deaths.⁴

Suicide is the leading cause of death among the most economically productive age group (between 15 and 44 years), and males die by suicide three times more frequently than females.⁵

People from Aboriginal and Torres Strait Islander communities, as well as people living outside of major cities, are more likely to die by suicide, compounding existing disadvantage.⁵ For the former, the overall suicide rate was twice the non-Indigenous rate between 2001 and 2010.⁶ Around 100 Aboriginal and Torres Strait Islander deaths by suicide per year took place over that decade.² In 2012, 117 suicides were reported. Rates of reported hospitalisations of Aboriginal and Torres Strait Islander people for self-harm rose by 48 per cent between 2004–05 and 2012–13.⁷ The compounding disadvantage experienced by Aboriginal and Torres Strait Islander peoples is discussed in Chapter 4.

The human suffering associated with the lead-up to a suicide or a suicide attempt for the person concerned, and in the aftermath for bereaved families and friends, has been called the ‘hidden toll’ and is not easily quantified.⁸ The direct and indirect costs to Australia’s economy from suicide, including lost productivity and tax revenue, have been estimated to be $1.7 billion each year.⁴ This estimate only includes deaths by suicide. Other estimates have put the figure at close to ten times that when non-fatal suicidal behaviours are taken into account.⁹

Continuing with the status quo, where numbers of suicides continue to rise year on year, clearly is acceptable. More people die by suicide than die on our roads or from skin cancer.¹

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

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

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

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

**Key findings**

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

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

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

*Submission from a person with lived experience*

The suicide-related stories submitted to the Review—by people with lived experience, caregivers, and professionals alike—exhibited a clear pattern of negative experiences. Three stand out features of these stories were as follows.
First, there was a common belief that services and supports would only be offered to people who had already made an attempt on their life, to the extent that multiple respondents reported deliberately attempting suicide out of desperation for professional support. This was related to a perception that there is no ‘middle ground’, in terms of help for acute suicidality, between inpatient hospital care and no support.

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

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

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

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

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

Adapted from McPhedran & De Leo (2013)  

Suicide prevention programmes

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

While these programmes have been found to be largely effective, they have tended to be conducted as separate initiatives rather than as a coordinated whole, and future efforts need
to be better coordinated and targeted, particularly to vulnerable groups and hot spots, and with collective action within communities.

These programmes need to accelerate their efforts in a coordinated way and build the evidence base for further development. It is now time for a new strategy to be rolled out on a regional basis so that programmes reflect the needs of local communities instead of a one-size-fits-all approach to preventing suicide.

**Where to from here – implications for reform**

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

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

Second, people told the Commission that if a crisis cannot be averted, empathic understanding from health professionals and first responders, which acknowledges emotional as well as physical distress, is crucial. Even simple kindnesses from health professionals can make a huge difference to a person’s recovery.²⁰

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

*Submission from a person with lived experience*

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

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

There is promising evidence that systemic approaches to prevention which encompass coordinated, multi-sectoral initiatives within specific communities have had success in bringing rates of suicidal behaviour down. These include programmes run by the US Air Force, the European Depression Initiative and communities in Norway and Denmark which employ a ‘chain of care’ model. These all emphasise an integrated system of support activities ranging from general awareness-raising and ‘gatekeeper’ training to crisis follow-up and continuity of care.²⁰
Recent evidence from England also infers that a coordinated multi-component approach to suicide prevention is an effective way to bring suicide rates down, this time among a specific population of people who access specialist mental health services. Figure 6.1 illustrates the types of practice and policy changes associated with the biggest differential reduction in suicide rates among people using mental health services which implemented the changes, compared to those for people using services which did not. It is interesting to note that most of these changes involve promoting joint work across sectors and between hospital and community services.

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

![Figure 6.1: Five practice changes associated with the greatest differential falls in suicide rates between implementing and non-implementing mental health organisations in England, 2004–2011](image)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8. Senate Community Affairs Committee Secretariat. The Hidden Toll: Suicide in Australia, 2010.
Chapter 7: Workforce development and training

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

Term of Reference
Mental health research, workforce development and training.
Australian mental health workforce

- **Psychiatrists**: 2,913 (1% are employed in remote and very remote areas, 1 in 6 are 65 years and older, less than 1% are employed in remote and very remote areas)
- **Psychologists working in mental health**: 14,753 (3/4 are female, 1% are employed in remote and very remote areas)
- **Registered nurses working in mental health**: 16,157 (69% are female, 29% are over 55 years of age)
- **Total mental health nurses (enrolled and registered)**: 19,048

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

- Other allied health providers: 3.0%
- Psychiatrists: 25.0%
- Other psychologists: 25.5%
- Clinical psychologists: 18.3%
- General practitioners: 28.2%
- **8.5 million MBS-subsidised mental health-related services**

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

- Non-psychiatrist specialists: 6.1%
- Psychiatrists: 8.1%
- General practitioners: 85.7%
- **31.1 million dispensed mental health-related prescriptions (both subsidised and under co-payment)**

Australian Government expenditure in 2012–13: **$874 million**
Australian Government expenditure in 2012–13: **$788 million**

**Sources:** 2014 Mental Health Services in Brief, AHW 2014, AHW National Health Workforce Data Set 2012
What is happening now

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

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

- Employment for counsellors has increased strongly over the past five years and rose moderately in the past decade. Employment for counsellors to November 2018 is expected to grow moderately, from an estimated 21,700 in 2013 to 22,900 in 2018.¹
- Employment for health and welfare service managers rose very strongly in the past five years and over the past decade. Employment for health and welfare services managers to November 2018 is expected to grow very strongly, from an estimated 19,200 in 2013 to 23,800 in 2018.²
- Employment for carers in the aged and disability sector rose very strongly in the past five years and over the past decade. Employment for carers in the aged and disability sector to November 2018 is expected to grow very strongly, from an estimated 127,000 in 2013 to 167,900 in 2018.³
- Employment for nursing support and personal care workers rose very strongly in the past five years and over the past decade. For this group, employment growth is expected to be very strong to November 2018, from an estimated 97,400 in 2013 to 110,900 in 2018.⁴

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

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

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

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

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

Source: AIHW National Health Workforce Data Set 2012

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

Source: AIHW National Health Workforce Data Set 2012

Professional workforce groups

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

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

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

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

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

We know that, per capita, major cities have almost four times as many psychiatrists, double the number of mental health nurses and three times as many psychologists as remote areas. The workforce characteristics of these three groups are presented in Table 7.1.
Table 7.1 Registered psychiatrists, mental health nurses and psychologists, 2012

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


Notes:
1 In 2012 there were 22,404 registered psychologists. Not all registered psychologists work in mental health services as defined by HWA. This figure is an estimate calculated using the distribution of psychologists by work setting (Health Workforce Australia [2014]: Australia’s Health Workforce Series – Psychologists in Focus).
2 The National Health Workforce Data Set 2012 collects information on the characteristics of registered and enrolled nurses combined. There is no separate characteristic data available for registered nurses only.

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

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

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

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

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

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

Submission from a person with lived experience

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

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

Action to reduce discrimination demonstrated by health workers also is needed, as it has been found to be a factor in people not seeking help, or poor interactions that result in people not returning to a service.¹¹ The Review has identified the need for professional groups who come into frequent contact with people with a mental health difficulty to improve their understanding of mental illness, and in doing so contribute to a better outcome for the person. This is especially important in particular workforce groups such as nursing, as well as groups in non-health workplaces such as the education sector. Half of all lifetime cases of psychiatric disorders start before 14 years of age.¹² Evidence suggests it is possible to prevent or ameliorate social and emotional problems that impact on educational outcomes using school-based interventions.¹³ These approaches rely upon health professionals working collaboratively in these environments. We know that in 2007 more than 2,000 psychologists worked across Australian school systems.¹⁴

Key findings

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

Reform in early childhood and teacher training, which is needed to support the focus on improving mental wellbeing in infants and children, is also covered in Volume 1, with a number of key actions to be completed by 2017.
The workforce comparison supply and demand projections undertaken by HWA demonstrate that without change in graduate supply and service delivery, demand for mental health nurses will substantially exceed supply by 2025. Workforce shortages also are apparent in the nongovernment mental health sector, albeit without the focus on nurses and psychiatrists. High staff turnover rates, staff supply shortages and challenges in recruiting staff with adequate experience remain concerns.

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

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

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

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

If services continue to be provided under current structures and the mental health workforce continues to be developed along current lines, mental health services will never meet the needs of the Australian population. Stakeholders have argued that more of the same will not work, and despite efforts and resources being applied to recruitment and retention of the mental health workforce, these will be insufficient to meet ongoing workforce requirements.

Particularly in small towns or across the community-managed sector, mental health training of existing workers could expand their scope of practice, or reform their current practice, to reflect more contemporary approaches for improved outcomes.

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

**Considerable potential for new workforce groups and work practices**

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

- There is a need for an expanded role at the frontline for mental health identification, management and referral to personal supports or specialist services. The Primary Health Care (PHC) workforce includes GPs, practice nurses, allied health professionals,
Aboriginal health workers, nurse practitioners and peer support workers. The PHC sector will need to develop and enhance its competence in mental health promotion, prevention, early intervention, medication management and referral to specialist services.

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

### Developing the Aboriginal and Torres Strait Islander mental health workforce

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

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

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

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

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

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

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

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

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

The primary health care sector needs to be more involved as the locus of care changes from inpatient (centralised) treatment settings to being provided in community collaborative settings. This means increasing the capacity of GPs, practice nurses, practice managers and others to work with people with a lived experience of mental health. The role of the general practice workforce, in particular, will need to be a focal point to assist in improved access to services, reduction of stigma, identification of mental health issues and management of mental health and physical health comorbidity.
Mental health peer workers are needed, particularly for those people with severe and complex mental illness. This group is a key component of recovery-oriented mental health services and also can play an important role in suicide prevention. In addition, other mental health support people will need to have mental health literacy competence to support individuals with a mental health issue to adopt a recovery-based pathway.

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

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

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

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

**Actions**

- Increase the number of mental health nurses by 1,000 by retraining general registered nurses as mental health nurses (using incentives such as recognition of prior learning and service, low-cost qualification pathways and scholarships).
- Improve productivity of the current workforce by training psychiatrists, psychologists and mental health nurses to make best use of e-mental health, tele-mental health and self-management technologies.
- Increase the supply of the skilled specialist workforce by exploring opportunities to use four-year trained psychologists, through provisional registration and associated limits on scope of clinical practice, such as the use of psychology assistants.
- Develop a more flexible workforce, driven by consumer demand and trained and distributed on the basis of competencies rather than professional categories; and encompass whole-of-life approaches, including mental health and social supports across health, human services and social services sectors.
- Increase the reach of the professional workforce expertise by using groups as consultants across services in the community, both through technology solutions and by providing direct assistance to primary health care teams.
- Embed the primary health care sector as the locus of care in community collaborative settings, particularly the role of general practitioners in improving access to services, reducing stigma, identification of mental health issues and management of mental health and physical health comorbidity.
- Embed the role of peer workers within the mental health team, particularly for those with severe and complex mental illness, as a key component of recovery-oriented mental health services.
• Reorient workforce development and planning from discipline-based teaching processes to broader capability-based learning experiences. Incorporate mental health training, including suicide prevention training, into the training and professional development of first contact staff such as hospital emergency department staff, ambulance officers, police, welfare officers, and in education.

• Include in continuing professional development training on recognition of clinical deterioration—both mental deterioration of people with a physical illness and physical deterioration of people with a mental illness.
References


Chapter 8: Mental health research

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

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

What is happening now

Context

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

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

The findings in this section are presented in the context of two recent developments for health research in Australia—the McKeon Review\(^1\) and the Australian Government’s announcement early in 2014 of a Future Fund for medical research.\(^2\) The Commission understands that as at the end of November 2014, the Government has not yet determined how funds under the Future Fund will be disbursed. We are concerned that mental health receives its ‘fair share’ of research funding, especially given that $73.8 million of mental health savings in the 2013–14 budget will be directed to the fund from the deferred establishment of Partners in Recovery organisations and non-indexation of mental health programme grants.\(^3\)

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

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

The status quo

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

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

**Funding priorities**

Detailed breakdowns of recent trends in mental health research spending by topic have been difficult for the Commission to determine using the information provided by the two research councils. The available NHMRC funding data shows that despite the growth in total mental health expenditure, funding dedicated to mental health research presently comprises 8.6 per cent of its total funding of health and medical research in 2013—less than might be expected from the burden of disease (BoD) attributable to mental health (the 2010 Global Burden of Disease study found mental disorders contributed 12.9 per cent of the total BoD and 22.3 per cent of the non-fatal BoD). Approximately 40 per cent and 35 per cent of NHMRC mental health funding is allocated to clinical and public health research respectively, 15 per cent to basic science and ten per cent to health services research, as shown in Figure 8.1. Beyond this, it is difficult to determine more detailed funding information due to opaque categorisation of research.
To supplement this data, evidence supplied to the Review by those working within and alongside the mental health research sector indicates that certain types of research appear to be under-prioritised. Basic science research and clinical research into single interventions under laboratory conditions are considered to be comparatively well funded.

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

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

Key findings

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

- There is a major disconnect between the research sector and the mental health services and supports sector. Researchers need to give greater consideration to the needs of practitioners, consumers and carers, while planners and providers of services do not always take account of available research and evaluation findings.
There is no national mechanism for prioritisation and oversight of mental health research to ensure it is aligned with policy priorities and the challenges faced by frontline practitioners.

Career progression for researchers is driven by peer regard and does not encourage increasing the impact of their research on services and programmes.

The lack of nationally consistent tools and infrastructure for collecting data about efficacy and cost-effectiveness significantly hampers research into which mental health and associated interventions work, and for whom.

There is a need to strengthen the evidence base for Aboriginal and Torres Strait Islander mental health, suicide prevention, and related services and programmes. The ongoing Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project provides a model for the development of this evidence base under Aboriginal and Torres Strait Islander leadership.

There is no mechanism to involve consumers, frontline practitioners and informal supporters systematically in prioritisation and conduct of evaluations and research.

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

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

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

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

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

Where to from here – implications for reform

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

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

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

**Partnership:** a wide range of stakeholders, including people with a lived experience of mental illness and their supporters, are involved in setting research priorities.
**Relevance:** improving the whole-of-life experience of consumers and supporters, including the experience of programmes and services, underpins research.

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

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

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

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

**Figure 8.2 Current and desired focus of mental health research**

![Figure 8.2](image-url)

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

**Actions**

- Establish a sense of urgency for change in mental health research priorities from mostly investigator led to mostly driven by the needs of policy makers, services, clinical professionals, consumers and carers. This might be achieved through a consultation document developed by a core group of key stakeholders.
- Establish a tangible national mechanism for consensus building about future strategic prioritisation of mental health research, such as a National Mental Health Research Strategy.
- Generate quick wins to demonstrate the value of greater connection between research and service sectors. For example:
  - introduce a ‘researcher in residence’ model as a way of embedding evaluation within the core business of service provision
- create an Australian mechanism for involvement of consumers and caregivers in the design and conduct of research, along the lines of UK models
- conduct an audit of current mental health data collection across Australia, including a gap analysis of data requirements
- investigate current data linkage platforms and how to improve these/scale them up—focusing on using them to assess the impact of complex, cross-sectoral supports on social and economic engagement
- establish a body under Aboriginal and Torres Strait Islander leadership to establish best practice in Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention and alcohol and other drug use prevention.

- Develop a single national data set which serves the needs of researchers, policy makers and service providers for quality improvement, accountability and evaluation purposes. This should be developed in consultation with consumers and caregivers and piloted extensively with services.
- Make it easier for policy makers and people working in frontline services to access and use research evidence and evidence of good or promising practice.
- Establish a ‘what works’ and ‘best buys’ internet portal, including Australian and international evidence about the efficacy, effectiveness and cost-effectiveness of mental health models of care and interventions.
- Create ‘hard’ incentive structures to encourage research focused on service and consumer priorities:
  - filter research grant applications through a panel of frontline professionals, consumers and supporters (once scientific and ethical validity have been established)
  - establish funds to encourage ‘new’ researchers with innovative ideas rather than funding research based exclusively on track record and publications
  - build research activity into continuing professional development requirements for frontline practitioners and ensure this time is funded

- Ensure strategic prioritisation of research activity is embedded in the everyday operating principles of research funding bodies, universities and service providers:
  - success for researchers to be measured in terms of policy and practice impact rather than exclusively peer-regard and numbers of publications
  - all government-funded projects incorporate time and funding for evaluation.
Case Study: the Cancer Australia model of research prioritisation

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

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

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

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

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

Submission from Research Australia
References


Chapter 9: Governance and accountability

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

Terms of Reference

- The efficacy and cost-effectiveness of programmes, services and treatments
- Duplication in current services and programmes
- The appropriateness, effectiveness and efficiency of existing reporting requirements and regulation of programmes and services
- Transparency and accountability for the outcomes of investment
System governance

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

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

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

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

How we have interpreted this Term of Reference

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

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

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

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

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

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

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

headspace: the National Youth Mental Health Foundation

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

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

The 2009 evaluation reported that:

- it took an average of seven months for new services to open and longer to provide a full complement of services
- the implementation approach for headspace does not significantly vary in terms of geographic location
- regular reviews of effectiveness are needed to ensure that headspace is reaching out to marginalised groups, including economically disadvantaged people, refugees and Aboriginal and Torres Strait Islander communities.
To date there is little systematic data available from headspace directly (or through independent evaluations) on a range of important issues: the impact of the establishment of headspace services on local service pathways; whether the services have increased access for young people in the regions served (or simply diverted young people from other pathways); provided greater access for those with limited access to standard care (by geographical, diagnostic or socio-demographic characteristics); improved the quality of clinical assessment of young people with emerging mental disorders (e.g. through earlier and better access to skilled general practitioners, clinical psychiatrists or specialist psychiatrists); or linked effectively with functional recovery services in education or employment participation. Currently, only service participation data has been reported at the national aggregated level.

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

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

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

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

**Partners in Recovery**

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

In the meantime, the Commission notes the Government’s stated intention to divert PIR monies into the NDIS. It is considered that any decision on the future of PIR needs to be informed by the formal evaluation and earlier advice in this report which recommended a re-consideration of rolling up all of the programme into the NDIS. It has been suggested that transferring PIR-funded services that are attached to individuals currently in receipt of those services when they are eligible under the NDIS should be considered. Evidence submitted to the Review emphasised that these decisions also should be informed by the following considerations.
• There is a clear need for integration mechanisms which help people who use mental health services and their carers navigate a complex and often opaque system of supports, and which encourage greater collaboration to provide a wraparound combination of supports tailored to each person. Whether this comes in the form of PIR support workers (who help guide people through the system) or another integration approach, consumers and professionals alike heavily emphasised the need for a more joined-up system of supports.

• There is some concern that existing (state and territory-funded) care coordination services are being duplicated by PIR in some areas. As is the case with headspace, this points to the need for any service of this type to be introduced only after local needs and service provision analysis has been undertaken.

• Many consumers and carers receiving PIR support are positive about the difference it has made to their lives. Some carers report that some of the burden of trying to navigate the system has been lifted from them. Providers also report they have found PIR helps them to link with other service providers so that a more holistic service can be provided.

**Targeted Community Care including PHaMs**

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

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

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

**Mental Health Nurse Incentive Programme**

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

A number of concerns were raised in submissions to the Review about the current freeze on this programme and the apparent red tape for providers in accessing further sessions. Some MHNIP services have ceased as a result. The Commission is concerned that if sessions are capped at current levels, without options for redesign that include regional planning in line with access to projects such as ATAPS and Better Access, the momentum and headway made throughout the first few years of this programme will be lost.
Another key risk to this programme is the potential shortage of mental health nurses. Workforce projections discussed earlier in this report indicate a shortage of approximately 1,000 nurses nationally, which could be reduced with scholarship incentives and wider adoption of double major nursing degrees, with mental health as one of the majors. Continuation and enhancement of the programme should take this into consideration, as well as opportunities to use the programme to continue to create incentives to improve recruitment and retention of mental health nurses and grow the workforce.

**Better Access to GPs, Psychiatrists and Psychologists under the MBS**

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

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

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

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

- **Unequal distribution of service provision:** the number of sessions does not match well with the clinical presentations, when a more differentiated, individualised approach would enable a better match of services and individual needs. There is a need to improve access by Aboriginal and Torres Strait Islander peoples, including by providing culturally competent professional services and monitoring their use of the programme.

- **Professional entitlements:** for no clear reason, some allied health professions are excluded from the MBS subsidy entitlement under Better Access. Professional groups which can usefully form part of a multi-disciplinary mental health team include neuropsychologists, counselling psychologists and speech pathologists.

- **Session entitlements:** a large number of negative comments were received relating to the 2012 reduction of the maximum number of MBS-subsidised sessions in a calendar year from 18 to ten. This new maximum entitlement is considered by providers and consumers to be too low for people with anything more than mild depression or anxiety. For people with greater need the reduction is counter-productive, as incomplete treatment can result in deterioration. KPMG modelling for the Review supports this. The modelling identified that provision of optimal care through Better Access can lead to better client and investment outcomes and less treatment required later on. This is especially the case for high prevalence conditions, such as anxiety and depression.
• clinical advisers consulted for the modelling project suggested that optimal care requires more than the current cap of ten services. For someone with severe and complex mental illness, this ranges from 18 sessions for the clinical scenario related to schizophrenia to 50 sessions for the case study related to adolescent anorexia (25 services for the young person and 25 services for the family).²

The growth in Better Access has been quite dramatic.

Figure 9.1 shows:

• For psychiatrists there has been little change.
• GP use of Better Access has increased dramatically, although most GP consultations in relation to mental health occur within standard consultation items: the growth seen here relates to specific GP items such as GP Mental Health Treatment Plans.
• Use of psychological therapies and focused psychological strategies has skyrocketed. This reflects the fact that services provided by psychologists, social workers and occupational therapists were not included on the Medicare Benefits Schedule prior to 2005–06.

A range of options for reform of Better Access is proposed at Recommendation 13 in Volume 1 of this report. This includes a number of actions. Action 9 proposes that current disparities in benefits payment between registered psychologists, social workers and occupational therapists be removed. Better Access currently has fees and payments for allied health professionals set at three levels.

The highest is for clinical psychologists, which reflects their higher level of training and the role they play in providing individual psychological therapies.

The clinical psychologist benefit is about 40 per cent higher than that for registered psychologists and 60 per cent higher than for social workers and occupational therapists—registered psychologists, social workers and occupational therapists all provide Focused Psychological Strategies.
There also is a 13 per cent differential between the benefit for a registered psychologist ($70.65) and that for social workers and occupational therapists ($62.25).

The Commission can find no obvious reason to justify this differential. Moreover, this appears to be a peculiar quirk of Better Access, because no such differential exists within ATAPS or DVA.

The Commission also considers there is a simple solution to resolve this issue.

Table 9.1 shows that in 2012–13, registered psychologists provided 2.179 million services, occupational therapists 0.048 million services and social workers 0.202 million services—a total of 2.434 million services.

The benefits paid for this group were $205 million.

<table>
<thead>
<tr>
<th>Provider type</th>
<th>Services</th>
<th>Benefits paid ($'000)</th>
<th>Fees charged ($'000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>2,136,042</td>
<td>290,211</td>
<td>363,720</td>
</tr>
<tr>
<td>General practitioners</td>
<td>2,408,612</td>
<td>187,557</td>
<td>198,960</td>
</tr>
<tr>
<td>Clinical psychologists</td>
<td>1,558,063</td>
<td>191,114</td>
<td>226,946</td>
</tr>
<tr>
<td>Other psychologists</td>
<td>2,179,161</td>
<td>185,775</td>
<td>232,170</td>
</tr>
<tr>
<td>Other allied health providers (total)³</td>
<td>255,129</td>
<td>19,698</td>
<td>24,113</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>48,123</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Social workers</td>
<td>202,280</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Other mental health workers</td>
<td>4,726</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>All providers</td>
<td>8,537,007</td>
<td>874,355</td>
<td>1,045,909</td>
</tr>
</tbody>
</table>

Source: Mental health services in Australia, AIHW

Note:
1. Other allied health providers (total) includes occupational therapists, social workers and other mental health workers.

This means that registered psychologists provided about 90 per cent of all services provided, and accounted for 93 per cent of the benefits paid.

If social workers and occupational therapists attracted benefit payments at the same level as registered psychologists, the cost would have been an additional $1.8 million.

A one per cent increase in fees and benefits under Better Access for these three groups (leaving aside clinical psychologists) would cost $2.05 million, hence the $1.8 million differential equates to about 0.9 per cent of an across-the-board increase.

The Commission proposes that, on the next indexation of Better Access items, the first 0.9 per cent for registered psychologists, occupational therapists and social workers should be applied to align MBS benefits for social workers and occupational therapists with those for registered psychologists.

Any indexation remaining above that 0.9 per cent then should be applied equitably to the Better Access items.
The Commission also considers that the number of sessions offered under Better Access should be based on clinical need and outcomes, rather than a pre-designated number of sessions.

**Better Outcomes in Mental Health: Access to Allied Psychological Services**

The continuing and detailed evaluations of the Access to Allied Psychological Services (ATAPS) programme have shown that it results in improved overall outcomes for participants.

However, concerns were raised in stakeholder submissions to the Review that the administration and structure of the programme is creating unnecessary access barriers. Given the administration of the ATAPS programme is to be transitioned to the new Primary and Mental Health Networks, there is an opportunity to consider its effectiveness in reaching marginalised groups, in particular:

- people from low socio-economic backgrounds (the average copayment for the programme is $18.15)
- Aboriginal and Torres Strait Islander people (only 3500 of the more than 350 000 referrals made to the programme were for Indigenous people, despite the programme’s specific priority to reach this community).

Submission from a person with lived experience

‘I think there are some fantastic online resources that young people can access for support with mental health problems. Sites like ReachOut.com, eHeadspace, Kids Helpline Online, beyondblue and the Butterfly Foundation, who provide information, referrals and services such as online counselling. I have used all of these services when I didn’t feel able to speak to anyone in person. They were a great help to me, and meant I didn’t need to disclose my mental health condition to friends and family until I was ready.’

Submissions to the Review also cited professional credentialing requirements and stringent eligibility criteria as creating inflexibility in the scheme, where money may be allocated but no appropriate professionals are available to fill vacant provider positions. This is particularly the case in disadvantaged communities.

Consideration also should be given to whether the programme would work more effectively if delivered through a less fragmented administrative structure, rather than through two tiers specifically and separately targeting a wide range of groups, including bushfire affected communities, children, people who are homeless, women with perinatal depression, suicide prevention and Aboriginal and Torres Strait Islander people. Broadbanding of ATAPS funding, instead of having any tiers or target groups, may be a good place to start. A further option would be to transfer Indigenous-specific spending associated with ATAPS to existing primary health care models that work within social and emotional wellbeing frameworks and are already in place in Indigenous communities.

**Teleweb programme**

Services funded under the Teleweb initiative (Telephone Counselling, Self Help and Web-based Support Programmes) are a vital national service to increase access to mental health information, counselling and suicide prevention.
People with lived experience of mental health difficulties and their families and carers reported to the Review that they found seeking help online and on the phone less confronting than approaching a service provider in person.

There is concern that these projects are funded in a “scattergun” way and that the myriad of support services available online and on the phone can be confusing for people to access and navigate. This is discussed in more detail in Chapter 10. It is an important area where access to help for people in remote areas can be increased in a cost-effective way. This type of assistance also helps to overcome barriers to seeking help, such as stigma or lack of privacy in small communities.

The promise of these approaches cannot be fully realised without streamlining them. As things stand there is a risk of duplication and inefficiency in this area. It has been difficult for the Commission to get a sense of outcomes for investment for grants under these projects due to the limited information available on this funding stream’s efficacy as a whole.

**Efficacy and cost-effectiveness in the nongovernment sector**

During 2012–13 three Commonwealth agencies allocated mental health funds to 542 nongovernment organisations (NGOs) under 64 programmes. Specifically:

- the Department of Health funded 55 programmes, with grants to 213 organisations
- the Department of Social Services funded six programmes, with grants to 196 organisations
- the Department of the Prime Minister and Cabinet funded three programmes, with grants to 133 organisations.

The Commission invited 310 nongovernment organisations to share information for the Review about their most recent Commonwealth programme funding arrangements. Responses were received and analysed from 65 organisations.

Although this is a small sample, the analysis demonstrated that the NGO sector is diverse and that most often, such organisations cannot be classified as exclusively providing ‘mental health’ services or supports. Commonly, organisations cater to a wide range of interrelated needs and their activity within mental health cannot be assumed from the amount received specifically as a grant.

**Fragmentation of funding**

A large number of NGOs receiving funding for mental health programmes and services also offer many other avenues of assistance, such as aged care services, domestic violence and family support. This was particularly the case for rural NGOs which offered a range of support services in their local area. Forty-eight of the 65 agencies (74 per cent) that responded to our request for information about their functions and programmes advised us that they provided a range of services in addition to offering specific mental health support.

Of the 65 organisations we reviewed in detail:

- 32 (approximately half) received less than $2 million in 2013–14 for mental health-related programmes and services
- 20 received funding of less than $1 million in 2013–14 for mental health-related services and programmes
- Six reported that they received funding of between $5 million and $10 million per annum.
Because of the small size of many of the grants they receive, and the wide variety of sources and potential sources of funding, NGOs are vulnerable to burdensome administrative requirements associated with each funding stream. For small organisations, this can significantly impact on the time made available for direct service delivery. Problems experienced in this sector with duplicated reporting requirements and accountability as identified through both programme evaluations (where they exist) and submissions to the Review are outlined below.

**Duplication in current programmes and services**

The Review has identified that in regard to Commonwealth-funded mental health-related programmes and services, the greatest potential for duplication lies between those psychosocial services and supports provided by the Departments of Health and Social Services. Duplication between Commonwealth, state and territory services could not be assessed (other than illustrated through the case studies cited below), as no state or territory government provided data that identified mental health programmes and services to a level that enabled any comparison to be undertaken.

The Commission examined whether there are programmes which either have similar or identical objectives, which target similar communities or population groups, or which in practice are achieving the same outcomes for consumers.

The example of suicide prevention activities is provided to illustrate how and why such duplication can occur.

**Suicide Prevention Programmes**

In 2012–13, $42.2 million was invested through the National Suicide Prevention Programme (NSPP) by the Department of Health. In addition, the Department of Social Services (DSS) has contributed funding to local communities at high risk of suicide and to those areas where there are suicide clusters. At the same time, states and territories have suicide prevention plans that are funded. Joint planning, co-design and co-commissioning (at both Commonwealth and Commonwealth-state levels) appear to be limited. Some initiatives are showing local results, but fragmentation of funding and delivery undermines efficiency (and effectiveness) of the investment and the economic benefit to individuals, their families and the broader community. Suicide prevention should be promoted as a whole-of-government and whole-of-community endeavour that stretches beyond the domain of mental health. It needs to be supported by robust data to assist local and regional planning and help better understand the nature of suicides—for example, whether they are from Aboriginal and Torres Strait Islander communities, farming communities, culturally and linguistically diverse communities, fly-in-fly-out workers, or people who identify as lesbian, gay, bisexual, transgender or intersex (LGBTI).

A nationally consistent and coordinated approach to suicide prevention activities would be promoted by taking the following steps.

- **Consolidation of effort:** planning and administration of the NSPP and other Commonwealth suicide prevention funding could be streamlined. We note that current NSPP contracts end in late 2014. This provides an opportunity for consolidation of suicide prevention efforts nationally.
- **Clear roles and responsibilities:** separation of roles between the Commonwealth (for national strategic direction and priorities) and regional or local areas (for service
delivery, coordination and integration) can provide a platform for more effective, co-designed service delivery, integrated governance and reduction in duplication of roles.

- **Accountability**: contracts should require that specific outcomes be reached and should include incentives for providers to prove their efficiency and effectiveness. Performance reporting should be streamlined and aligned to national priorities and targets. Where goals and targets are not achieved, the Commonwealth should be prepared to reduce funding or defund organisations and initiatives.

- **Longer funding terms**: longer-term contracts for suicide prevention activities would assist projects with recruitment, expansion and sustainability where programmes demonstrate high performance.

- **Time and care**: it is worth spending time and care to reach agreement with and between the states and territories on a nationally driven and coordinated approach. This is essential to fulfilling community expectations about reductions in suicide rates, especially given that rates have slightly increased in recent years.

### Inefficient programme development

The Commonwealth does not have a clear strategic framework across the range of its investments. Expenditure is not guided by a clear relationship to system outcomes and coordination and balance of investment across sectors is limited. This is compounded by siloed governance and eligibility and reporting structures that perpetuate separate service systems and reduce the capacity for whole-of-system planning. Those seeking information or assistance are often left to navigate a complex and fragmented service system on their own.

As things stand, opportunities for rationalisation or alignment of smaller programmes into a cohesive approach are lost, as are opportunities to prioritise achievement of whole-of-life outcomes rather than duplicated reporting of activity. Duplication is not only a measure of waste, but of opportunity foregone to drive improvements and productivity across the system.

Commonwealth mental health programmes are poorly linked to each other and to state mental health service systems. In particular, the increase in programme funding resulting from the COAG National Action Plan on Mental Health of 2006 has failed to drive practical solutions which would link effective recovery-based community support with clinical treatment to produce a wraparound and tailored range of supports for people who need them. The new funding has not created incentives or pathways to support people to access the coordinated care they need. It has provided focused support and interventions that generally have been found to be efficacious (where evaluations exist).

For example, headspace is seen as a worthy initiative, but it is nevertheless an example of the Commonwealth entering into areas of direct service provision which were previously the domain of the states and territories. Although headspace has been a “game changer” in terms of adolescent mental health, the need for each headspace centre to integrate and coordinate with state services has been under emphasised and under achieved. This was a common theme in submissions to the Review. With the development of the Youth Early Psychosis Programme (YEPP), which includes an acute service component, this is even more essential; to ensure a continuum of care, these centres need to be closely designed and implemented in association with state community and hospital-based services.

Mechanisms to achieve a “joined-up” system, which promotes a continuum of care and support, and makes best use of evidence-based pathways, need to be introduced. The quote below illustrates the impact of no overarching framework to guide investment in Commonwealth programmes.
'There is no clear relationship between Commonwealth-funded programs. There is no publicly available simple schema that shows the target population and the program to support this group.

It was suggested … that a mapping exercise should occur, so we are able to better target need, services and funding. To our knowledge this has not occurred.

As such, we continue to run the risk of duplication and patchwork services.'

Submission from the Australian College of Mental Health Nurses

Reducing duplication while retaining NGO expertise

Commonwealth funding of NGOs to deliver programmes presents another opportunity for improved coordination and strategic planning. There would be obvious administrative cost savings from rationalising NGO funding to reduce transaction costs and duplication of reporting. However, care needs to be taken in smaller communities, where local NGOs are often intimately acquainted with the needs of the communities they serve.

The proposal for a regional financing and governance model, recommended in Volume 1, promises to support both increased efficiency and improved tailoring of NGO services to meet local need. It involves considering the effectiveness and level of development of a local NGO “market” to support choice and retain regional expertise in programmes. This approach includes agencies such as the Red Cross and the Royal Flying Doctor Service, which fly into remote communities and develop local expertise, though they would not be regarded as being local on-the-ground organisations.

The introduction of a local NGO ‘market’ also needs to be sensitive to the impacts upon sustainability of that local market. For example, Share and Care Community Services, an NGO operating in Western Australia, reported to the Review that it received only a small proportion of funds in 2013–14 which were explicitly assigned to mental health, yet on investigation it provides a range of other services such as housing support, children’s services, community relief, domestic violence, men’s lodge, meals on wheels and home and community care. Rationalisation of mental health-specific grants into a larger organisation can risk the loss of the holistic model of community-wide support (which includes services not specifically labelled ‘mental health’). Opportunities for local organisations to form consortia or other approaches to build networks of sustainable NGO markets is regarded as one solution.

Diversity of provision is also found in large national organisations. For example, Anglicare Victoria provides a spectrum of services to support families and children, while Anglicare NSW is more targeted towards supporting older people and community care.

The Commission also recognises that some NGOs have expertise in working with a particular group of people and this cannot be determined by looking at funding. Such specific focus organisations include Oz Help Foundation (providing services to workers in regional and remote communities), the Butterfly Foundation (eating disorders) and Peer Support Australia (support for young people). The issue of clustering of NGOs in a community, where outcomes for people, services and funding are not always transparent, is illustrated in the following case study submitted to the Review.
“We know that in some regions there are too many visiting services with overlapping and sometimes competing roles that do not collaborate or work closely with either the primary health care service or each other. This leads to inefficiencies, miscommunications and a lack of a patient and family-centred approach. It also takes up a huge amount of Primary Health Care (PHC) time and does not employ or involve local Aboriginal people who know the community and can provide sustainable, culturally appropriate care.

In Central Australia there are a number of mental health services:

- Frontier Services
- The Mental Health Association of Central Australia (MHACA)
- Royal Flying Doctor Service (RFDS)
- Central Australian Mental Health Service (CAMHS)
- TEAMhealth
- MOSplus

And some communities have their own resident counsellor or Social and Emotional Well Being (SEWB) service.

There are a few problems with this model of service delivery.

Some communities get most or all of these services. Some get little or none. There is serious inequity in service delivery.

In communities where a number of services visit, services often see the same clients, but do not share information amongst themselves, creating duplication of effort.

Services rarely (if ever) use PHC medical records.

Most of these services are a visiting service. Hence if primary health staff are not aware of which service is seeing their patients, let alone what the care plan may be, it is almost impossible for them to provide ongoing support, let alone respond appropriately in a crisis.

This lack of communication also results in ‘body part’ medicine where the whole of a person’s health is not addressed. For example Wurli-Wurlinjang Health Service comments that “Clients who are under the care of mental health services are often lost to medical care and follow-up. People with psychoses, for example, might be getting their medications from mental health care services and not attending medical services for follow-up of the medical conditions that may exist along with their mental health problem and also reviewing the possible medical implications of taking their medications.

Having multiple providers results in a fractured mental health service. It would be better to have one inter-connected system.”

Submission from Aboriginal Medical Services Alliance Northern Territory
Rationalising funding streams or streamlining reporting requirements would assist with the ‘mental health’ money received for Commonwealth programmes. A sector-wide approach is needed. In addition, grant money also may be received from states and territories or other sources for aged care services and the like, so streamlined reporting and funding arrangements would have to be considered across traditional (state versus Commonwealth) boundaries if they were to meaningfully reduce reporting duplication and red tape burdens on the NGO sector. Bundling of programme funds on a regional basis could be one avenue to refocus resources to reflect local needs and drive performance and outcomes across the range of programmes delivered in that community. In turn, this approach would support better coordination, integration and easier pathways for people to negotiate to get the services they need.

**Gaps in programmes and services**

While duplication was identified in the evidence submitted to the Review, gaps in service provision were more commonly cited.

As the Commission was unable to obtain a clear view of the types and level of services provided by states and territories in particular geographic areas, it is difficult to determine whether apparent gaps in Commonwealth-funded provision are, in fact, filled by other services.

The most obvious gaps and inequalities— which were confirmed by our linkage of Medicare and Census data as well as substantial research evidence—have been identified elsewhere in this report, especially in relation to restricted service provision for people living in regional, rural and remote communities.

In identifying other types of unmet mental health needs in Australia, assessment of submissions to the Review made by people with lived experience of mental health difficulties, their families and carers, professionals and stakeholder organisations has been undertaken. Although it is acknowledged that claims about insufficient services are likely to be influenced by the vested interests of any individual or organisation, a number of patterns to responses infer that gaps exist beyond vested interests. Gaps were either a lack of supports targeted at particular difficulties, or a lack of supports which people find relevant and appropriate. The major ones are a lack of:

- services which recognise intergenerational trauma and the continued impact of colonisation on people of Aboriginal or Torres Strait Islander background.
- service provision which effectively addresses interrelated health needs concurrently. (Particular examples commonly cited were intellectual disability with mental health problems, and substance misuse with mental health problems.)
- provision of services which effectively address interrelated health, social and economic needs concurrently. Particular examples were gaps in services for prisoners and ex-prisoners and people from an economically disadvantaged background.
- affordable specialist support for severe and complex mental illness. Borderline Personality Disorder and eating disorders often were mentioned.
- culturally appropriate services, with interpreters, for people of culturally and linguistically diverse backgrounds, including recent immigrants and refugees.
- services informed about the impact of trauma, abuse and neglect in the origin and continuation of mental health difficulties, and the potential role of services in exacerbating this impact.
Reporting requirements and regulation of programmes and services

Service providers and professionals recognise reporting as an essential aspect of system regulation and service and programme accountability. Evidence provided to the Review showed that reporting is considered appropriate when reported information:

- does not just go one way (or is submitted and never heard of again)—it actually is used and becomes part of a system of feedback
- can be used to assist in planning and for quality improvement efforts, both by the reporters and the authorities requesting the information.

However, there are many circumstances in which reporting currently is not considered a productive activity, including where:

- reported information is not used by the authority requesting it
- multiple funders and agencies request similar information, resulting in duplication of effort by organisations and professionals
- reporting requirements can be subject to manipulation, have perverse consequences or have a detrimental effect on the quality of care delivered to consumers.

Suggested steps to improve the effectiveness and efficiency of reporting for regulation and accountability purposes include: focusing data collection on clinical and whole-of-life outcomes as well as activity, streamlining reporting requirements by rationalising funding sources and assessment/referral pathways and developing consistent, user-friendly data collection tools which can be standardised nationally. The necessity of reform in this area is nowhere more eloquently presented than in the following case study provided by Neami National.
‘Neami National is a specialist psychiatric rehabilitation and recovery support provider with service delivery sites across five states. The organisation receives funding through 33 funding streams: three federal departments, sixteen through state government bodies and fourteen through PIR consortia. Like most non-government organisations we struggle with the wide range of accountabilities, reporting requirements and quality standards which are largely uncoordinated and idiosyncratic to each funding stream. Acquittals can be monthly, quarterly or annually with different reporting frameworks, certification requirements and templates. In 2014 we were required to provide 28 separate audited acquittals in addition to 17 requiring management certification only.

Program reporting is another area where there can be huge discrepancies in data and interpretation of terms. For example, each funding program has different definitions of what is considered direct and indirect hours. For example some programs include travel to a client’s home as a component of the direct service delivery, others define this as indirect and some do not accept this as a legitimate cost. Quality accreditation is another area of complexity. Neami is required to report to at least ten quality frameworks, all running on their own timelines with distinctive requirements and costs associated.

There are many opportunities available to streamline these arrangements at program design stage but unfortunately there is rarely sufficient liaison between the funding body and the field, or across jurisdictions to secure arrangements which could promote efficiency and support evidence based decision-making or analysis.

Partners in Recovery is a useful example. It has been left to each consortium to choose the database it will use. This means that there is no capacity for our organisation to bring this data together as an organisation as some of the databases in use do not have interfacing capacity with other systems. What this means for us is needing to set up duplicate data capture arrangements.

In the case of the NDIS, Neami is active in two of the pilot sites and is funded to provide Disability services in another state. We have to register for the NDIS and as a disability provider in three states. We are also then required to meet the range of accountability and quality standards in the three states including three separate quality audit processes against the same standards, on different time cycles. Coordination of the auditing process and agreement at a national level to fully recognise a national approach to disability standards accreditation would be far more efficient.

These obligations result in high transaction costs and the need to dedicate precious funds to back of house administration functions at the expense of more direct care workers.’

Neami National
Transparency and accountability for investment outcomes

True accountability for investment was interpreted by those submitting evidence to the Review as being wider than just accountability to funding bodies; accountability to people with a lived experience of mental illness and to the community also is considered vital.

However, at present, true accountability for the outcomes of investment is hampered by a number of factors, including:

- lack of agreement on mandatory outcome indicators
- lack of data infrastructure and tools for collecting outcome information
- current focus on activity and activity based funding.

Mechanisms which respondents view as promoting proper accountability for outcomes include:

- allowing time and funds for proper evaluation
- involvement of consumers and supporters in service planning and evaluation
- being conscious of accountability, to both stakeholders and the community
- collecting longitudinal and experiential outcome information
- scaling up existing tools for effective evaluation.

Accountability to funding agencies, and hence the public, requires a commitment to regular programme evaluation. This Review has uncovered an inconsistent approach to evaluation and the subsequent public reporting of findings.

The need for nationally consistent outcome data collection

The first step in ensuring accountability for outcomes is the development of a tool which is consistently used to show what outcomes a service or programme is achieving. This does not exist at present. We know a lot about how much of each activity is being done across the country. However, this does not provide information on whether the activity is having a beneficial impact on people experiencing mental health difficulties.

This failure to focus on outcomes also means that at a population level we do not know, for example, how many people attempt suicide each year, because we do not collect this information at the point of service—whether that is an ambulance, hospital emergency department or police. Initiatives are under way in some parts of the country to undertake real-time monitoring of suicides and suicide attempts by using standardised ambulance and police reporting forms. These innovative practical and tested approaches need to be scaled up and implemented across the country. Further discussion on this is found in Chapter 6.

A nationally consistent outcomes collection would require joint development by the Commonwealth, states and territories. Rather than adding to the existing reporting burden, this would replace existing forms of reporting. In the regionalised approach to planning and delivering mental health supports proposed in this Review, all the providers in a region would be responsible for delivering on outcomes specified in a nationally consistent indicator set. These outcomes would apply regardless of funding stream, so that reporting would focus on what is important to people and national goals, rather than be structured around compliance with imposed administration standards. Not only would this encourage collaboration to achieve jointly the best overall impact on mental health, but it would free up regional authorities to tailor the means of achieving this impact to the local context.
Such a collection (based on outcomes) would include a small number of performance targets for regions to achieve. Particular targets and indicators which the Commission believes would support monitoring of whole-of-life consumer and carer outcomes are described in detail in this report. As such, consumer and carer involvement in designing outcome measures and reporting will ensure that these are meaningful to both individuals and programme evaluation.

In conducting this Review, the Commission has tried to remediate the lack of person-centred outcome collection by taking a consumer pathways approach to assessing efficacy and cost-effectiveness (described earlier in this chapter). We also have secured new person-centred data by sponsoring a project to link, for the first time, mental health-subsidised services under the MBS and PBS with the Census. This new and unique data set, the ‘Mental Health Services-Census Data Integration Project’, enables assessment of the socio-demographic characteristics of people using mental health services at a population level across geographical locations. Some initial findings are discussed in Chapter 3.

**Linking NGO performance to national goals**

A key factor limiting our analysis of the effectiveness and efficiency of the NGO sector, as well as duplication within the sector and with government programmes, has been the lack of a consistent approach to reporting on outcomes of investment. Government investors in the NGO sector generally do not apply a considered approach to monitoring the outcomes of investment that have a view beyond their own portfolios.

NGO reporting needs to be reconsidered to inform a nationally agreed framework for outcomes across NGO sector investment to ensure that:

- NGOs are achieving evidence-based outcomes
- NGOs are made responsible for better mental health outcomes for vulnerable groups, including Aboriginal and Torres Strait Islander peoples. Developing partnerships between NGOs and Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services) is one way to build capacity for dedicated culturally competent services.
- outcomes can be qualitatively and quantitatively measured
- outcomes tie in with nationally agreed goals about what mental health programmes and services should be achieving. Volume 1 recommends a suite of targets and indicators, including a reduction in suicide and suicide attempts, improved experiences of care and outcomes, a healthy start to life, having access to a stable home and participating in education and employment.

Opportunities to streamline NGO funding exist, but this should occur within the context of a regional and location-specific planning approach that takes into account local needs and existing service infrastructure and frameworks.
Where to from here – implications for reform

The Review has gathered evidence which shows that current arrangements are not working for people living with a mental illness, their families and supporters, and are also inefficient and ineffective from the perspective of governments.

‘Australia’s mental health system is trapped in multiple inefficiencies of cost and efficacy, in large part because of the sheer complexity of funding, levels of government, departments, delivery points and pathways. Successive well-intentioned governments have responded to this by new initiatives which only serve to create new levels of complexity onto those which already exist. [...] Further, funding must focus on the person’s recovery ahead of existing organisational, professional or governmental preferences.’

Submission from SANE Australia

It is not enough simply to report on what is wrong with the status quo. We need to restructure our siloed, separate data collections that are oriented around agencies, professions and services, to be more effectively grouped and clustered around individuals to identify and implement high-value investment opportunities. For example, in New Zealand the social services sector has implemented a linked and proactive approach to using reporting to give real time data for programmes and services to use and respond to. This has meant that ‘early warning’ signals (such as multiple notifications to child protection agencies) indicating a high likelihood of later use of and engagement with social services, welfare and justice systems are identified. People showing patterns of high service use are then offered assistance at a stage when interventions can be more meaningful, successful and cost-effective.

The work undertaken by the social services sector in New Zealand has empowered system decision-makers with the evidence to implement more effective responses. This has involved the use of ‘big data’ or cross-portfolio, person-focused data collection to track outcomes and more effectively predict the likely return on investment for particular interventions. This return on investment reflects not just savings for government, but better outcomes for individuals through earlier, more effective and evidence-based interventions.

The Commission has considered submissions to the Review and suggestions presented during consultations. We propose three key strategies for changing the way funding priorities of mental health programmes and supports are identified and the way they are structured and governed. These strategies are:

- assessing efficacy and cost-effectiveness using a person-centred consumer pathways approach
- implementing a regionally controlled funding and governance model
- establishing a holistic stepped care model of service delivery within a highly integrated system of supports.

Together, these strategies form solutions to the difficulties currently faced which result in skewed investment, fragmented systems of support, suboptimal consumer and carer experiences and outcomes, unnecessary red tape and opaque accountability.
Increasing cost-effectiveness using a consumer pathways approach

To keep deliberations focused on the aspects of system design which translate into optimal consumer and carer experience and outcomes, the Review commissioned a cost-modelling simulation of a series of theoretical optimal consumer pathways. Based on common clinical scenarios, the modelling encompassed consideration of life-course costs across health and non-health domains of the person’s life, and assessed the cost and implications of different interventions and supports along the way. The difference between the current situation and optimal care pathways also was determined. The scenarios are outlined in the table below and cover a broad range of diagnoses, functional impairments and age groups. They are not meant to be representative, but rather illustrative of how service and clinical pathways could be altered to achieve better outcomes, and how much this would cost.

<table>
<thead>
<tr>
<th>SET OF CLINICAL SCENARIOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 year-old male with mild anxiety experiencing poor interaction with peers, and whose mother is suffering moderate depression and is recently divorced (mother’s scenario was also modelled).</td>
</tr>
<tr>
<td>14 year-old female with severe anorexia nervosa, and a body mass index (BMI) of 15 for the past two years.</td>
</tr>
<tr>
<td>28 year-old female experiencing post-natal depression (PND) after birth of first child. She has experienced episodes of suicidality, and is at high risk of hospitalisation.</td>
</tr>
<tr>
<td>32 year-old female suffering post-traumatic stress disorder (PTSD) as a result of her son being involved in a motor vehicle accident, which left him with severe injuries. She is experiencing flashbacks and is unable to adequately care for her son.</td>
</tr>
<tr>
<td>36 year-old female with bipolar disorder who is obese and suffering Type II diabetes. She has experienced four episodes of mania in the past two years, all resulting in hospitalisation.</td>
</tr>
<tr>
<td>45 year-old male, homeless for past five years; chronic schizophrenia.</td>
</tr>
<tr>
<td>55 year-old female suffering from acute anxiety (panic attacks) brought on by a restructure at work. It is impacting her ability to work.</td>
</tr>
</tbody>
</table>


This cost modelling, undertaken by KPMG, identified options to improve outcomes and save system costs in two key ways:

- by improving current service provision, or investment in ‘optimal’ care pathways
- by investing differently to emphasise care and support options that reduce the likelihood that a person’s mental illness will increase in severity or simply not improve.

Investment in optimal care also should be accompanied by investment to promote mental health and prevent mental illness. This could target specific groups defined by age or other criteria or involve greater investment in targeting specific settings, such as mental wellness in the workplace.

Four strategies for optimising cost-effective pathways and maximising outcomes based upon the set of scenarios were:

- treating people early
- increased emphasis on primary and community care
- improving coordination of and access to psychosocial supports
- better subacute care.
**Key findings**

The implications of each of these strategies, if they were to be adopted, are outlined below.

**Treating people early**

Modelling of optimal care confirms that treating people early improves health outcomes. KPMG modelling found, for example, that annual improvements in health for a person living with bipolar disorder accessing optimal care can be up to 34 per cent. Alongside this finding was that treating people with bipolar disorder early led to an estimated saving of $653,000 over nine years. Under the same scenario, early treatment realised an estimated saving of $316,000 over nine years for a person living with schizophrenia. These savings are primarily generated by the avoidance of expensive treatments and indirect costs associated with more severe and complex mental illness.

This work provides positive directions for how, at a population level, such service reinvestment could yield health and social benefits for the person and their support network, and economic benefits to the community and government.

The modelling undertaken for the Review identified some other implications of a generalised early intervention approach: that increasing access to GPs, psychologists and psychiatrists can lead to improvement in health and reduce future costs; that the effectiveness of optimal care is affected by the ease of access and treatment pathways, and that optimal care includes access to supports other than health alone. The provision of housing with support is also identified as key for people with severe and complex mental illness. In the modelling of the pathway for a person with schizophrenia, stable housing was identified as crucial to enabling access to other services.

The role of housing in supporting good mental health has been demonstrated in programme evaluations of some state-supported housing programmes. This is detailed in Chapter 3.

**Increased emphasis on primary and community care**

Based upon the information provided by clinical consultants to support KPMG’s modelling, optimal care consists of providing more primary and community care services to people, regardless of the severity of their illness. This included more GP and psychologist visits, but also additional community care services that could substitute acute care directly.

Since the first National Mental Health Plan, the percentage of state and territory mental health spending allocated to community-based clinical services has grown nationally from 23 per cent of mental health spending in 1992–93 to 40 per cent in 2011–12. However, without access to the National Mental Health Service Planning Framework, the Commission has no benchmark to assess whether this level of investment is adequate.

The evidence suggests that the substitution of inpatient care with community-based care is both clinically appropriate and cost-effective. For example, modelling optimal care for a person with severe post-natal depression suggests that the number of days in a mother-baby unit within a hospital could be reduced by more than half, if it were substituted for a combination of increased GP, psychologist and psychiatrist visits, visits from community mental health teams (CMHT), group therapy and day-patient services.
Improving coordination of and access to psychosocial supports

The level of complexity associated with mental illness requires a multifaceted response to improving health outcomes, including health and community care, informal care, housing, substance misuse treatment, job training and education.

These services are delivered across a range of government portfolios and therefore investment in optimal care must be developed within a strategy that coordinates a broad range of programmes, planners and funders at a regional level. Working in regions allows services to be responsive to local needs.

Planning mental health care locally also requires commitment to all services, and not ‘cherry picking’ services, which is likely to reduce the potential improvements significantly in health and therefore lead to a waste in resources if complementary services are not accessible.

Maximising the benefits of psychosocial supports also requires taking an approach that looks at their role across the spectrum of severity of mental illness, and does not pin service categories to particular diagnoses. KPMG modelling undertaken on clinical pathways for schizophrenia suggests that stable housing is a crucial element for enabling improved access to other services (such as receiving visits from an acute care team at home), adherence to health care and improved health outcomes.²

Better subacute care

While primary and community care is important to prevent or avert the progression of mental illness, there always will be the need for services for people experiencing acute mental illness. This includes step up/step down and subacute options. This is identified in the KPMG study, where clinical advisers suggested that improvements in mental health require access to subacute services not currently available. For example, modelling clinical scenarios on anorexia and schizophrenia identified the reduced need for acute inpatient service by increasing subacute care services.²

In 2009 the National Health and Hospitals Reform Commission (NHHRC) noted that many parts of Australia have limited or poorly developed subacute care services, which created problems for the acute care sector and resulted in reduced patient outcomes. Subsequently, the Commonwealth injected $2.1 billion to increase subacute services under two National Partnership Agreements with the state governments. Under these agreements a component of subacute funding was directed to subacute mental health and specialist mental health services for older people. The impact of these investments cannot be commented upon due to the lack of data provided to the Review at state and territory level, specific to the mental health component. However, subacute services need to be available to the community as identified above, to provide access to optimal clinical pathways.

Other social and economic benefits of optimal care

The KPMG study found that benefits from optimal care also impact on a number of government portfolios. Modelling has shown that improved mental health has wide social and economic benefits, including the following:²

- increased productivity, which is expected to reduce the dependence on income support, increase taxation revenue for the Federal Government and increase payroll taxation for state governments.
- decreased need for social housing, which is expected to reduce the expenditure of departments which provide social services at a state and Commonwealth level.
• reduced contact (from people with a mental illness) with the judicial system. This will in turn reduce the costs of policing and the justice and prison systems.
• reduced need for informal care. This has a flow-on effect to carer income support payments and increased taxation revenue through higher participation rates.

Given that governments will receive the benefits from optimal care, there is an incentive to contribute to the cost of providing it.

This is one of the important turning points in any serious reform of mental health.

**Where to from here**

A cross-portfolio response to improve how programmes are delivered is necessary to ensure funds are directed well and activity is reported once, then used for evaluation and programme improvement. People and their supporters who are reliant upon programmes to meet their needs in a clinical and cost-effective way deserve this, as does the community.

This will require the development of a governance framework that can account for the competing demands for funds across portfolios, while ensuring the system is consumer-driven. This is a recommendation of the Review in regard to the implementation strategy of its directions. A governance structure is required that both reflects agency representation and participation of people with lived experience of mental illness and their carers, and is essential to drive change that acknowledges the risk of harmful unintended consequences at a portfolio and personal level.
References


Commonwealth programmes - the Commission’s overview

Our Approach

In January 2014 the Commission wrote to every Commonwealth and state government department requesting information on the programmes they funded or led over the past five years that had a mental health focus.

We identified four main Commonwealth departments which fund mental health programmes — Health, Social Services, Prime Minister and Cabinet and Veterans’ Affairs.

In 2012–13 the combined expenditure of mental health-related payments and programme funding was $9.6 billion. We found 140 different types of programmes, payments, grants and mental health partnerships, which were reported by 16 Commonwealth agencies over the past five years.

The landscape of Commonwealth funding is confusing.

A number of projects are funded under some items in our taxonomy, such as within the umbrella of the National Suicide Prevention Programme, while other funding was for a discrete programme (for example, headspace).

The Teleweb measures give grants to a range of agencies to manage a number of helplines to various groups of people, including Adults Surviving Child Abuse and Kids Helpline.

Other grants are for the delivery of a particular programme, such as Partners in Recovery, or services to a particular population.

This was problematic for our analysis. The Department of Defence, for example, reported programme expenditure of $26.9 million in 2012–13; however, this was not broken down into separate projects or programmes.

In Table 9.2, the Commission has focused its analysis on specific mental health support programmes delivered to people and their families.

Overall the Commission was underwhelmed at the level and currency of programme evaluations, despite, in some circumstances, a significant amount of Commonwealth investment. As a principle, a culture of evaluation of Commonwealth funding needs to be embedded in programme design and funded as a specific element of administration.

Of the top 20 items of Commonwealth expenditure reported in 2012–13, some are not specific mental health programmes delivered to people and families, and could not be assessed in a comparable way.

- Two items were payments to people and families (the mental health proportion of the Disability Support Pension and the Carer Payment and Allowance).
- The Pharmaceutical Benefits Scheme accounted for more than $750 million of expenditure in 2012–13.
- Two items were payments under the National Agreements to hospitals (share of Commonwealth funding and funding for subacute beds).
- Payments for private health insurance rebates for mental health-related costs were estimated at $105 million.
These items, along with National Health and Medical Research Council grants, accounted for almost $8 billion (or 82 per cent) of Commonwealth expenditure in 2012–13.

The remaining programmes which were in the ‘Top 20’ items of expenditure were MBS items claimed under the Better Access initiative, the Targeted Community Care Programme (PHaMs and Mental Health Respite Carer Support), ATAPS, headspace, the Mental Health Nurse Incentive Programme and the Social and Emotional Wellbeing Programme. Also included in the top 20 were Partners in Recovery, the National Partnership on Mental Health and the National Suicide Prevention Programme.

Commonwealth grants to these programmes accounted for approximately 12 per cent or $1.2 billion of expenditure.

The Commission has had to rely on existing evaluations and any other related evidence to inform its views on programmes and services. It is acknowledged that some programme streams have a specific focus and target population about which the respective department has expertise, such as the Department of Defence and the Department of Veterans’ Affairs.

Should the Government support the recommendations of this Review, it is envisaged that closer consultation with these and other departments will be undertaken in 2015. It is noted that the Department of Veterans’ Affairs has recently established a mental health review committee, and the Commission awaits that committee’s findings. The Commission supports the continuation of the mental health programmes of these two agencies.

The Department of Health funds a number of small national programmes for discrete services and the Commission confirms its support for these programmes. An example of a small national programme is the service for survivors of torture and trauma.

Other programme elements are provided to support mental health system advancement, such as funding national decision-making, quality and standards, data to inform system outcomes and performance and a national consumer and carer organisation. These programmes should remain in place and be included in any forward considerations of implementing the reform agenda as identified in this Review report.
<table>
<thead>
<tr>
<th>Programme</th>
<th>Description</th>
<th>Continue?</th>
<th>Change?</th>
<th>The Commission’s view</th>
</tr>
</thead>
</table>
| Access to Allied Psychological Services (ATAPS) | This programme enables GPs to refer patients to mental health professionals for low-cost, evidence-based mental health care delivered in up to 12–18 sessions. Funds are currently held by Medicare Locals. ATAPS mental health professionals include psychologists, social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers with specific mental health qualifications.  
2012–13 allocation: $74.1 M  
Evaluation? Yes | Y   | Y   | With the introduction of Primary Health Networks the ATAPS programme will need to be reformed to fit within the new remit of the networks. Given the number of programmes that target psychological and personal supports to people with mental health difficulties, it is appropriate that these population-driven programmes should be rolled up together as pooled funds to meet the needs of local communities. The Commission considers that ATAPS funding should form part of this pooled funding approach. |
| Better Access                                  | Under this initiative Medicare rebates are available to patients for selected mental health services provided by GPs, psychiatrists, psychologists and eligible social workers and occupational therapists.  
2012–13 allocation: $635 M in benefits paid  
Evaluation? Yes | Y   | Y   | Better Access has improved access to psychological treatment in the community and has been a positive initiative. More work needs to be done to ensure it is targeted to those most in need and rolled up into regional models to address community needs in an integrated way.  
Concern has been raised about the number of sessions available and the efficacy of the GP MH Care Plan. The Commission proposes amending Better Access to enable a simple referral and additional sessions for people with higher or more complex disorders. |
<table>
<thead>
<tr>
<th>Programme</th>
<th>Description</th>
<th>Continue?</th>
<th>Change?</th>
<th>The Commission’s view .....</th>
</tr>
</thead>
</table>
| **headspace Youth Early Psychosis Programme (hYEPP—formerly EPPIC)**<br>Department of Health | The headspace Youth Early Psychosis Programme (hYEPP—formerly Early Psychosis Prevention and Intervention Centres (EPPIC)) offers an integrated and comprehensive mental health service to meet the needs of people aged 15-24 with a first episode of psychosis. 2012–13 allocation: $11.9 M Evaluation? No. The Department of Health in the process of commissioning an evaluation to be completed by 2016 | Y | Y | *This Review reconfirms the priority for early intervention for young people, especially when mental health problems first appear and when serious mental illness is developing.*  
*hYEPP should continue and be reviewed in the light of the findings of the 2016 evaluation and progress of other reforms arising from this Review regarding regional planning and delivery of services, especially for young people. Introduction of pooled funding within a regional framework should consider the inclusion of hYEPP funding.* |
| **headspace**<br>Department of Health | Funded under the Youth Mental Health Initiative Programme, and managed by the National Youth Mental Health Foundation, headspace offers specific services for people aged 12–25 who need help across some of the areas of mental health, employment, drug and alcohol, relationships and school. Allied health, GP and psychiatry services in this setting are funded through the Better Access Initiative. 2012–13 allocation: $63.7 M Evaluation? Yes (2009); new evaluation currently under way | Y | Y | *headspace has rapidly expanded and an evaluation is currently being undertaken by the Social Policy Research Centre (UNSW) and is due in 2015. Changes to this programme should take into account the evaluation.*  
*Submissions to the Review highlighted a lack of local planning and duplication of current services in some headspace locations. There is concern that a one-size-fits-all approach does not meet the needs of people from diverse groups. The Commission recommends that this programme continues but local headspace services are transitioned into a regional model to better integrate and complement other services also targeting the same population group and to better meet the needs of local communities.* |
| Programme | Description | Continue? | Change? | The Commission’s view is ......
|------------|-------------|-----------|---------|-----------------------------------------------
| Mental Health Nurse Incentive Programme (MHNIP) | This programme provides a non-MBS incentive payment to community-based general practice, private psychiatrists and Aboriginal and Torres Strait Islander Primary Health Care Services to engage mental health nurses to provide clinical care for people with severe and complex mental disorders in their practice or service. 2012–13 allocation: $35.4 M | Y | Y | The Mental Health Nurse Incentive Programme has shown positive outcomes for participants, who also increased their social participation. Concerns have been raised about the programme’s design – including being capped at current funding levels rather than service levels, the transparency of the waiting list for grant allocations (especially the reallocation of funding where an approved grant holder may be underspending their grant and not providing the level of service for that community and equity of access for marginalised groups.) The Commission considers redesign options for this programme under Recommendation 21.
| Mental Health Services in Rural and Remote Australia (MHSRRA) | MHSRRA provides funding to nongovernment health organisations such as Medicare Locals, Aboriginal Medical Services and the Royal Flying Doctor Service to deliver mental health services by social workers, psychologists, occupational therapists, mental health nurses, Aboriginal health workers and Aboriginal mental health workers. MHSRRA funds the provision of mental health services in rural and remote communities that would otherwise have little or no access to mental health services, including in areas where access to Medicare-subsidised mental health services is low. 2012–13 allocation: $15.9 M | Y | Y | With the introduction of Primary Health Networks to replace Medicare Locals, this programme will need to be reformed to fit within the new remit of the networks. The well documented lack of mental health professionals in rural and remote Australia, the undersupply of Aboriginal and Torres Strait Islander trained mental health workers and the comparatively lower access to Medicare-subsidised services (especially GPs and specialist clinicians) provides a strong case for continuation of MHSRRA. This is supported by the evaluation of the programme, where local communities responded that the level of MHSRRA services could be expanded. Organisations reported that they would like to do more community development and health promotion work to target harder to reach groups; for example, Aboriginal and Torres Strait Islander communities, probation and parole groups and farmers. The variation across rural and remote communities was intrinsic to the local design and delivery of the programme. To ensure that local community needs and context are reflected in the design and delivery of MHSRRA, the Commission considers that transferring MHSRRA funds into a regional pool will enable funds to be more efficiently allocated and programmes more tailored to local circumstance and community characteristics. |
### Programme

<table>
<thead>
<tr>
<th>National Depression Initiative (beyondblue)</th>
<th>Description</th>
<th>Continue?</th>
<th>Change?</th>
<th>The Commission’s view is .....</th>
</tr>
</thead>
<tbody>
<tr>
<td>beyondblue is the national initiative to raise awareness of anxiety and depression, providing resources for recovery, management and resilience.</td>
<td>Y</td>
<td>N</td>
<td>National mental health promotion and awareness should remain the responsibility of the Commonwealth. The Commission supports the continuation of beyondblue as a national initiative.</td>
<td></td>
</tr>
<tr>
<td>2012–13 allocation $16 M</td>
<td>Evaluation? Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### National Perinatal Depression Initiative (ATAPS and beyondblue) Department of Health

<table>
<thead>
<tr>
<th>Description</th>
<th>Y</th>
<th>Y</th>
<th>The lack of a comprehensive evaluation limits an objective and detailed view of this programme.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The National Perinatal Depression Initiative aims to improve prevention and early detection of antenatal and postnatal depression and provide better support and treatment for expectant and new mothers experiencing depression.</td>
<td></td>
<td></td>
<td>This programme has two components:</td>
</tr>
<tr>
<td>Australian Government funding under this initiative is being distributed to states and territories as well as ATAPS to build the capacity of divisions of general practice to better support women with perinatal depression and beyondblue to support implementation, including raising community awareness about perinatal depression, and developing information and training materials for health professionals who screen and treat new and expectant mothers for perinatal depression.</td>
<td></td>
<td></td>
<td>- a community programme supporting women with perinatal depression</td>
</tr>
<tr>
<td>2012–13 allocation: $11.1 M</td>
<td></td>
<td></td>
<td>- a national component to raise awareness of perinatal depression in the community and to develop information and training materials for health professionals.</td>
</tr>
<tr>
<td>Evaluation? Partial</td>
<td></td>
<td></td>
<td>It is proposed that the community component be transferred to a regional funding entity such as the new Primary Health Networks, to better integrate and roll out perinatal initiatives along with other ATAPS and local health services for new parents and infants.</td>
</tr>
<tr>
<td>Programme</td>
<td>Description</td>
<td>Continue?</td>
<td>Change?</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>---------</td>
</tr>
<tr>
<td><strong>National Suicide Prevention Programme (NSPP)</strong></td>
<td>Funding for suicide prevention activities across the Australian population and for specific at-risk groups including men, Indigenous people, people in rural and remote Australia, people bereaved by suicide, people with a mental illness, and young people. The NSPP also provides funding to other Commonwealth-funded mental health programmes, including Access to Allied Psychological Services (ATAPS) and MindMatters, for the inclusion of suicide prevention specific activities under these initiatives. <strong>2012–13 allocation: $23.0 M</strong></td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Partners In Recovery (PIR)</strong></td>
<td>Coordinated support and flexible funding for people with severe and persistent mental illness with complex needs. <strong>2012–13 allocation: $65.8 M</strong></td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Programme</td>
<td>Description</td>
<td>Continue?</td>
<td>Change?</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
<td>-----------</td>
<td>---------</td>
</tr>
<tr>
<td><strong>Social and Emotional Wellbeing Programmes</strong>&lt;br&gt;Department of the Prime Minister and Cabinet</td>
<td>The objective of the Social and Emotional Wellbeing Programme is to enhance existing service delivery to Aboriginal and Torres Strait Islander communities, prioritising members of the Stolen Generations, through flexible models of service delivery and national coordination and support.</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Support for Day to Day Living in the Community</strong>&lt;br&gt;Department of Health</td>
<td>A structured activity programme providing funding to improve the quality of life of individuals with severe and persistent mental illness by offering structured and socially based activities. This initiative recognises that meaningful activity and social connectedness are important factors that can contribute to recovery.</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Taking Action to Tackle Suicide (TaTs)</strong>&lt;br&gt;Department of Health</td>
<td>The TaTs package provides further support for suicide prevention through universal and population-wide approaches and through community-led responses, including infrastructure for suicide hotspots and prevention activities and helplines.</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>
| Programme                                                                 | Description                                                                                                                                                                                                 | Continue? | Change? | The Commission’s view is ...
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|---------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------
| **Targeted Community Care Programme—Personal Helpers and Mentors**      | Three separate programmes are funded under the umbrella of the TCC programme, to assist people and their families in the community by providing day-to-day support to manage the impact of living with a mental illness through PHaMs, Mental Health Respite and Family Mental Health Support Services. |
| (PHaMs), Mental Health Respite: Carer Support                           | 2012–13 allocation: $180.8 M                                                                                                                                                                                      | Y         | Y       | The evaluation of this programme identified positive outcomes for people, their families and carers by improving access to daily support, increasing options for respite for carers and families. The Commission is concerned at the proposal to roll these programmes up into the NDIS, as this will leave some people without the services they are currently entitled to and affect the sustainability of some smaller organisations. As the largest single programme of supports for people with a mental illness and their families (other than income support), changing access will have the greatest impact upon current recipients. As such, given that components of the NDIS as they apply to people living with a mental health-related disability have not been clarified, now is the time to reconsider the rolling up of this programme into the NDIS. We should identify ways to ameliorate the episodic and longer-term impacts of disability arising from mental illness. |
| **Department of Social Services**                                        | Evaluation? Yes                                                                                                                                                                                                |-----------|---------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------
| **Department of Veterans’ Affairs Mental Health Programmes**            | These programmes provide education, advice and assistance for veterans and their families to recognise the signs of mental health problems and to act to improve and maintain mental health.                             | Y         | Y       | In recent years there has been a shift in the types of people being supported by DVA to an emerging cohort of younger members of the ADF and ex-service personnel from recent conflicts. The Commission recognises that serving and former members of the ADF and their families and supporters should have access to timely and efficient mental health care, and that access is not prevented by levels of red tape and bureaucratic processes. The Commission looks forward to the findings and advice from the Prime Ministerial Advisory Council on Veterans’ Mental Health to support real change in this area. |
| **Department of Veterans’ Affairs**                                     | 2012–13 allocation: $167 M                                                                                                                                                                                     | Evaluation? Yes |   |                                                                                                                                                                                                                                                                  |
Chapter 10: Alternative approaches

This chapter considers alternative approaches to optimise service collaboration and develop person-centred pathways. It outlines how mental health care and supports could be organised, how technology could be optimised and how funding could be allocated, to deliver population and person-centred mental health programmes and supports.

**Term of Reference**

Existing and alternative approaches to supporting and funding mental health care.
Supporting and funding mental health care involves collaborative efforts across the domains of service and support sectors, optimising new service platforms and effective funding allocation mechanisms for achieving improved mental health and reduced psychosocial disability. These issues are addressed in this chapter in the context of existing and alternative approaches to supporting and funding mental health care.

**A new model of care delivery: integrated stepped care**

We have received substantial evidence from all over the country that Australia’s mental health supports are fragmented across services and programmes, which each have their own remit and eligibility criteria. This has negative implications not just for the experiences of consumers and their supporters, but also for professional practice and for the overall efficiency of spending on mental health.

‘As family members we are worn out trying to be Sherlock Holmes trying to find out anything about anybody in the professional mental health field and what they are like (that are already few and far between) when we start out. Since we have next to no information on how good someone is ... in my case my family member had already seen someone they felt didn’t really care and couldn’t wait to wrap up exactly at the 40min bell. How does that make any young adult feel or a distraught exhausted family member who is disgusted that there is no decent 'system' to assist with help and guidance on any of this.’

*Submission from a support person*

Services and programmes are fragmented because of a diversity of funding sources as well as siloed operations within a sector or specialty. There are no incentives for organisations or professionals to work together in the interest of the person with multiple needs, meaning that both duplication and service gaps remain unchecked. People who use services have trouble navigating the disjointed array of supports available, fall through the gaps between services, and are not followed up after being turned away or discharged from a particular service.

All of this means that services respond not only to the needs and preferences of the people they are supposed to serve, but to the needs and preferences of funding and governing bodies. The person has to fit to the rigid service structure, rather than a combination of supports flexibly fitting around the needs of the person.

Our proposal for a regional primary and mental health network service delivery model, whereby services are commissioned for a defined population according to the assessed needs of that population, is one step towards ensuring that the focus is on improving outcomes overall, however that is achieved.

The way services could operate under such a regional network model would encourage collaboration and communication across service boundaries, provided that each organisation was judged on the performance—in terms of mental health outcomes—of the whole integrated system of services in that geographical area, rather than solely on their own levels of activity.
The following sections outline options for a model of care which is oriented around primary care-level mental health supports. These are linked closely with other supports in an integrated stepped care approach—stepping through care services as required by your mental health needs, rather than automatically being referred to a specialist as the first step (unless clinically warranted).

**Matching support to need**

Primary care, and especially the general practitioner, is most often the first port of call for someone who has decided to seek help for a mental health difficulty.

Currently, GPs usually refer on to specialist public or private mental health services if they consider their practice cannot provide the necessary expertise to manage a person’s difficulties. This means that many people who could usefully be helped by non-GP interventions at community or primary care level end up in expensive specialist services.

Where a service is not tailored to level of need, less complex options of GP care or specialist mental health professional intervention may help some people. This approach, however, will be an unsuitable choice for others. It is also an inefficient way to organise services.

A more responsive way to structure mental health supports is to use a stepped care model which assesses the current level of functional impairment and need of the person seeking help, and matches this to a suitable combination and intensity of support(s). The system allows them to ‘step up’ or ‘step down’ easily. So, for example, for people with mild, reactive or discrete mental health issues, the first line of support could be referral for exercise classes and computerised Cognitive Behavioural Therapy (CBT), which is supervised online. If this first-line support does not achieve the desired outcome for the person, consideration could be given to ‘stepping up’ to psychological therapy.

On the other hand, if a person is living in fraught circumstances where they are experiencing psychotic symptoms, are recently unemployed and have nowhere to live, under a stepped care approach they would be more appropriately referred for a holistic assessment of mental health, social and economic support requirements. This does not mean that they will always require similar levels of support long-term. When their needs for support diminish, they could ‘step down’ to be seen by a multi-disciplinary team in primary care, assisted by specialist input from a psychiatrist consulting to the primary care team.

‘The employment of locally respected, community-based, non-clinical Support Facilitators (e.g. Partners in Recovery) or Case Managers has already demonstrated that the case load of mental health clinicians/practitioners can be alleviated by preventing clients entering or re-entering the system by assisting them to manage their daily issues such as housing, finances, work-related issues, physical health and medication, etc. This ensures that there is a continuum of service and a targeted, appropriate level of support that fills the existing gap between an early intervention and intensive, acute or crisis clinical care.’

*Australasian Centre for Rural and Remote Mental Health*
Options for service integration

Integration of supports and services brings together people and organisations that represent different sectors or specialties, to align relevant practice and policy, and to improve access to and quality of support for consumers. Integration goes further than opening channels of communication and promoting collaborative or inter-professional practice. It means coherence across policies and legislation, developing cross-sectoral partnerships and agreements, as well as joint administrative, planning and funding arrangements.

Integration therefore occurs at different levels. The Review considers that using the proposed Primary and Mental Health Networks will provide the regional architecture to support integrated care and achieve the benefits for its communities from more efficient and tailored care and support. At the regional level, integration can occur between mental health and physical health supports, between mental health services that provide support at different levels of intensity or specialty and between primary health services and community supports across sectors.

Integration of mental health supports and physical health supports at the primary care level makes sense, given what we know about the interrelated nature of mental and physical wellbeing. Specifically, it would benefit people whose mental illness has arisen in tandem with a severe or chronic physical illness or disability, as well as people who are at risk of developing poor physical health as a side effect of their lifestyle or mental health medication.

Such integration would not simply mean individual GPs continuing to attend to both physical and mental health needs (although this is essential), but would extend to referral to a multi-disciplinary team of nutritionists and dieticians, pharmacists, gyms or personalised exercise programmes, many of which could be collocated in primary health centres.

Vertical integration between services delivering different intensities of mental health support—encompassing primary, secondary and tertiary health care professionals and organisations—provides a clear pathway for a person as their clinical support requirements change over time. In such a model, specialist mental health teams could provide consultation and supervision to primary care-based teams.

At present, the Mental Health Nurse Incentive Programme provides a mechanism for embedding specialist mental health professionals in the primary care context. ‘Mental Health Hospital @ Home’ in South Australia is another example of integrating community and hospital level services to keep people at a lower level of stepped care (and out of hospital). Acute level care is offered to people in their own home.

Integration between primary health services and community-based supports across the many different sectors is designed around a person’s needs, such as where a person experiencing mental illness may need to access housing or personal support, in addition to their mental health treatment support. This type of integration allows the whole-of-life, holistic support of a person and their family. Meaningful integration of this type could provide for individual support facilitators, such as currently employed under Partners in Recovery, to help the person navigate the system. A greater level of integration could also involve pooled funding, regular joint meeting, and joint care planning between multiple agencies involved in a person’s support.

Another avenue for cross-sectoral integration would be through collocation of different agencies under one roof. Young consumers have told us that they value the range of services available in the ‘one stop shop’ set up at headspace centres (including physical and mental health care, vocational and employment advice and substance use services).
The Faculty of Health, Queensland University of Technology, provides a multi-disciplinary health clinic which is described in the case study below. This illustrates how primary care-level clinics can reduce fragmentation of services by catering for physical health, mental health and lifestyle needs, as well as providing a range of levels of support from basic outreach and screening to partnership with specialist eating disorder services and support for family members.

‘The Faculty of Health operates a multi-disciplinary health clinic, which provides outreach health check services to vulnerable, high-risk groups such as the homeless and Indigenous people. These outreach services are low-stigma because they offer health checks across the spectrum - including optometry and podiatry, for example. The School of Psychology and Counselling, through its postgraduate student programs, provides a mental health screen as part of the health check and is able to assist with referral or brief consultation when this is indicated.

The School of Public Health and Social Work has developed and established the Interdisciplinary Family Based Treatment Clinic at the QUT Health Clinic, which engages with Psychology and Counselling, Nutrition and Dietetics, Nursing and Sports Exercise and a General Practitioner who specialises in Eating Disorders to deliver services for sufferers of eating disorders and their families. We have partnered with the Eating Disorders Outreach Service, Queensland Health, to provide training to our students and wider health services community in Self-Guided Cognitive Behavioral Therapy for Bulimia Nervosa and Binge Eating Disorder, and Skills-Based Learning Group for Carers and Families Affected by Eating Disorders.’

**Submission from Faculty of Health, Queensland University of Technology**

**Steps towards integrated supports**

Rolling out integrated mental health models is essential to leverage efficiencies from separate service providers or sectors, or even different providers within the one service. It is essential to achieving the mental health and wellbeing outcomes for people living with a mental health difficulty, their families and support people.

The practical steps to implement integration need to be based upon a clear set of principles. The World Health Organization (WHO) considers that a well-integrated mental health system emphasises the importance of life-course approaches, public mental health and whole-of-government approaches to planning, funding and delivering services. In practical terms, the literature suggests the following as necessary to underpin primary care-based integrated mental health.

**Supporting people**

- A ‘no wrong door’ approach to people seeking help for mental health difficulties, where they can access a tailored combination of supports wherever they first ask for assistance.
- A requirement for involvement of people with lived experience in the planning and implementation of integrated primary mental health care, reflecting practices in Aboriginal Community Controlled Health Services.
- A greater knowledge of the cross-sectoral multiple health needs of a person, and the mental health ramifications of different life experiences and events, to support further integration.

**Workforce**
- Increased levels of interprofessional training and education to improve awareness about potential for collaboration and about what each profession can offer.

**Using technology**
- Integration requires appropriate technology to enable effective referral pathways and shared electronic care records

**Financial incentives**
- A system of financial incentives for stepped care practices and structures, such as the recommended pooling of funding streams for commissioning at regional level by Primary Mental Health Networks in Volume 1.
- Incentives for collocation of multiple agencies as one-stop-shops for wraparound mental, physical, social and lifestyle supports to encourage integration.

The next two sections address the issues of technology and financial incentives.

---

**Seeing change through personal experience**

**Today**
- Every new person I see asks me the same questions all over again
- I never get to see the same people even though I’m having the same things done again and again
- I’m confused about what options are open to me and how I’ll deal with my conditions over the next few years
- No-one takes overall responsibility for helping me
- Different staff don’t seem to talk to each other

**Future**
- I only have to give my name and address once, and everyone I interact with knows what I’ve covered with other staff
- I have a plan to look after myself, which I really feel in control of
- The nurse at my practice just called to remind me that my early check is due next month, and I know to call my care coordinator if I find things are getting worse
- My pharmacist checks that I’m taking my medication because she notices if I haven’t picked up my regular prescription
- If I need something my care coordinator can organise it straight away—I don’t have to wait for another assessment

Source: concept designed by The National Mental Health Commission 2014
Opportunities to use technology for better mental health

Australia is a world leader in using information and communications technology, particularly e-mental health interventions, to improve mental health. This area presents one of the greatest opportunities to improve the efficiency and outcomes of mental health programmes and services. Using these technology-based approaches to their full potential would be a cross-cutting change.

‘Online services work well in terms of mental health because they are anonymous for the user. ReachOut.com for example, I find its online forums can be great fun and a great help. They offer fun games and such, helpful tools and advice when needed. And multiple people can help you with your issues without you needing to repeat yourself over and over again. KidsHelpLine is also helpful, it provides professional support and is also free, which is a good thing as younger kids who need it can use it without needing money.’

Submission from a person with lived experience

In this chapter the term e-mental health is considered to include a range of elements, and as such is an overarching concept defined as:

“...that form of e-health concerned with mental health... e-mental health services provide treatment and support to people with mental health disorders through telephone, mobile phone, computer and online applications, and can range from the provision of information, peer support services, virtual applications and games, through to real-time interaction with trained clinicians.”

The discussion also touches upon telehealth, e-health records and other technology-based approaches (such as telephone helplines and online support services).

Investing in the use of technology, and not in bricks-and-mortar services alone, aligns well with the overarching principles we have articulated in this report. Smart use of technology has the capacity, if planned and implemented well, to:

- put the individual at the centre of the response to mental health concerns, enabling choice and delivering a customised pathway for each person’s needs
- enable self-management of care as well as personal control of who sees each individual’s data, to enable a ‘tell it once’ experience
- better meet demand for mental health information and contact, freeing up highly valuable clinical resources by reallocating demand to the most cost-effective and appropriate modality for the need
- make use of proven, evidence-based resources to help reduce the progression to mental ill-health
- reduce the severity of conditions through the introduction of self-managed care in between face-to-face sessions
- increase availability of mental health services for people when they need it, especially segments of demand (e.g. rural and remote, or vulnerable populations) currently underserviced by clinics.

For Aboriginal and Torres Strait Islander peoples, the use of the single care plan and e-health record by dedicated specialist support services to help connect patient transitions needs to be culturally appropriate.
What is happening now

The benefits of e-mental health

E-mental health provides access to services at low cost and in flexible, non-stigmatising and private ways for people with mental health difficulties. This is particularly important for people with high-prevalence, low-severity disorders, who are over-represented in the group not currently receiving treatment.4

E-mental health can assist in improving the mental health of those population groups that have limited access to services. Planning and service delivery may improve as a result of online data collection and information management.4

E-mental health services also reduce demands on the workforce, ensuring that clinicians use their skills for more complex care, and provide access to information, clinical practice guidelines and professional education and support resources.4

Current status of Australian services and programmes

The possibilities presented through innovative technologies are enormous, and the knowledge and use of these possibilities is expanding quickly. Australia’s e-mental health services have grown up rapidly. First generation e-mental health services were funded under the Teleweb measure, and were often standalone e-mental health solutions providing web services directly to the community (e.g. Kids Helpline, MoodGYM, This Way Up and MyCompass).2 From one perspective, these represent the building blocks of the e-mental health system, given their strong evidence base.2

We are now at the second generation of e-mental health. E-mental health services are beginning to be linked to primary care and face-to-face services. Some are already established on IT platforms and provide specialist programmes for adults and youth (such as virtual clinics). Others leverage existing connections within organisations; for example, integrating e-mental health services with general practice referrals.2 Project Synergy, which is currently in development through a $5 million three-year government grant, will provide links for young people to virtual clinics for university students and virtual psychiatric clinics for young people and further links with face-to-face services.2,4

More traditional support services such as helplines still play a significant role in Australia, and are increasingly integrated with online support services. These support services provide anonymous and accessible options that people can access without having to leave the privacy of their homes. As examples, Lifeline provides telephone support to 820,000 callers per annum in addition to online counselling to 40,000 clients, while eheadspace provides telephone support to 40,000 young people each year, as well as online counselling via web-enabled chat.4 Telehealth plays a more limited role in mental health service delivery, with MBS-subsidised telehealth consultations in mental health limited to psychiatrists. Major Commonwealth Government involvement in mental health-related technology includes the initiatives outlined in Table 10.1. However, this is not a solely government-funded sector.
### Table 10.1 Major Commonwealth programme involvement in mental-health related technology, 2012–13

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Description</th>
<th>Funding details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Teleweb programme</strong></td>
<td>Provides evidence-based telephone and online mental health programmes for individuals with common mental health disorders and those in psychosocial crisis; both generalist lines (e.g. Lifeline) and specialist lines (e.g. QLife for the LGBTI community)</td>
<td>Department of Health grants to telephone counselling, self-help and web-based support programmes. $11.4 million 2012–13</td>
</tr>
<tr>
<td><strong>Personally Controlled Electronic Health Record (PCEHR)</strong></td>
<td>A secure online summary of an individual’s health information. The individual controls what goes into it and who is allowed to access it.</td>
<td>Department of Health $81.3 million 2012–13</td>
</tr>
<tr>
<td><strong>Project Synergy</strong></td>
<td>A technological solution currently being developed which allows data to be captured and stored across multiple services. The project will enable young people to experience a seamless user journey through mental health services.</td>
<td>Department of Health Project commenced 2013–14. Total project costs $5 million over three years. $2.5 million 2013–14</td>
</tr>
<tr>
<td><strong>mindhealthconnect</strong></td>
<td>An information aggregation website which provides content from leading health-focused organisations in Australia.</td>
<td>Operated by Health Direct Australia. No specific allocation with operational costs of $3.6 million p.a.</td>
</tr>
<tr>
<td><strong>Telehealth MBS item (telepsychiatry)</strong></td>
<td>Provides access to specialist video consultations under Medicare to eligible rural and remote areas in Australia so patients do not need to travel to major cities for care.</td>
<td>Department of Health Benefits payments. $3.5 million 2012–13</td>
</tr>
<tr>
<td><strong>E-mental health strategy for Australia</strong></td>
<td>A strategy that sets out a long-term vision for developing a respected, evidence-based, accessible, professionally recognised and integrated e-mental health service environment, building on the current funding for a small number of proven and successful online mental health and telephone crisis support services.</td>
<td>Department of Health strategy to coordinate e-mental health service and improve access. No specific funding allocation.</td>
</tr>
</tbody>
</table>


Different forms of e-mental health solutions have the potential to address needs across the spectrum of mental health care and support.

- Mobile applications and information websites can support the whole population to self-manage their own wellbeing.
- Self-directed online interventions and web-enabled chat can support individuals with moderate needs and augment face-to-face care for people with complex needs.
In this manner, e-mental health increases reach and frees up time to use clinical treatment for those people with very complex needs, such as eating disorders, major depression and anxiety, drug and alcohol addictions and psychoses. This stepped care approach via e-mental health is illustrated in Figure 10.1.

In submissions to the Review, people and organisations recognised a number of benefits of using technology in mental health services, including:

- Increased reach and accessibility of services, overcoming access issues related to stigma, privacy, geography and other circumstances.
- Offering social and peer support for consumers and caregivers.
- Disseminating information and sharing knowledge.
- Aiding professional networking, training and continuing professional development.
- Increased efficiency and effectiveness in provider roles.

They also saw a number of challenges, including:

- A lack of integration and coordination with existing services.
- Some ethical issues and lack of accountability in services delivery.

Some populations still find these resources difficult to access (e.g. in remote areas without reliable internet).
Figure 10.1 Stepped care, with e-mental health service matched to individual need and integrated with other services

Sources: Adapted from The Case For Mental Health Reform in Australia: a Review of Expenditure and System Design, Medibank Private and Nous Group, 2013
Figure 10.2 Illustrative examples of the current e-mental health landscape in Australia

From a consumer perspective, the system can be confusing. Figure 10.2, above, maps e-mental health services in Australia, showing the range of providers and services they offer.

Pathways through this map can be difficult. Currently telephone helplines are not integrated, they do not have common standards and there are limited referral pathways. There are various levels of duplication of target client groups and potential to be accessing the ‘wrong door’ by users. Figure 10.3 shows where duplication and gaps occur. There is duplication in information websites, portals/gateway websites, crisis and telephone support, and gaps in peer and family support and therapist guided care.

Figure 10.3 Areas of duplication and gaps in the Australian e-mental health landscape


Key findings

There are three key priorities requiring attention to realise the potential benefits of technology in mental health:

- integration of e-mental health with other services
- reorganisation of the e-mental health sector
- continuing use of other technologies and enablers.

Integration of e-mental health with other services

E-mental health is linked closely with primary mental health care services and should eventually be seen as a part of a wider integrated care model that enables people to access support at a level, time, and place that suits their needs.

Commissioned research for the Review from the Young and Well Cooperative Research Centre (YAW CRC) concluded that integration was the most important short-term priority for the use of new and emerging technologies in mental health. Their work proposed that e-mental health should be the lead modality for frontline response and early stage self-management.

E-mental health services integrated with primary care can be used as an adjunct to face-to-face treatment or as a guide for treatment sessions, ensuring high-fidelity, evidence-based care and building the capacity of practitioners. For example, better integration between general practice and e-mental health could include:

- feedback to GPs on progress of e-mental health referrals, and avenues to contact the consumer periodically to check progress
- screening in GP practices with direct transfer to e-mental health service provider for treatment or recovery services
• crisis and emergency support to those who have severe and complex mental health problems or urgent needs
• a relay connection activated by the technology back to the GP (nominated by the consumer), for individuals who have not responded to ‘stepped care’ at various points.  

‘Online cognitive behavioural therapy for adult anxiety disorders and depression has been an invaluable adjunctive tool in my work as a clinical psychologist in private practice. These courses provide a means for patients to access relevant, complementary information to that which we cover in session. It also allows excellent ongoing monitoring of patient symptoms via automated online questionnaires. Adjunctive use of these online programmes enables me to deliver more specialised and personalised instruction when meeting with private patients.’

Submission from a clinical psychologist

Integrating e-mental health into a fully functional mental health system of stepped care offers one of the greatest invest-to-save opportunities for government in mental health. A 2014 report prepared by the e-mental health Alliance concludes that delivery of e-mental health is both cost-effective and cheaper to provide than care as usual, particularly for depressive and anxiety disorders. There is significant return on investment from e-mental health services, which leads to improvements in both cost-benefit ratios and sustainability of care. For example, a social return on investment study of Lifeline Online Crisis Support Chat service estimated a return of $8.40 for every dollar invested in this service. A cost-utility analysis of clinical trial data from the myCompass programme for depression and anxiety shows that the programme can be delivered in a cost-effective manner, with a cost per quality-adjusted life year (QALY) gain of $3,508. This is approximately one-fifth the cost of treatment with antidepressants and a tenth the cost of recommended treatment with a psychologist to achieve the same QALY gain.

Reorganisation of the e-mental health sector

Despite Australia’s global leadership in e-mental health technology and research, the e-mental health sector is not a unified one. It needs intra-domain, inter-sectorial rationalisation and mechanisms for integration with other mental health services and expansion.

For this Review, it was difficult to identify any overarching design, guidance or role specification for current services, allowing organisations to build what services they want, based on perceived need, often with government funding. There is no public register of what has been publicly funded or how effective it is, or widely available quality or accreditation standards to ensure consumers are getting evidence-based online help. Finally, there is no overarching technical framework to guide interoperability between products, so data is rarely shared and used in aggregate to help individuals.
Continuing use of other technologies and enablers

Tele-health continues to offer a potential solution to gaps in services. Research suggests that tele-mental health can be an effective mode of delivery, and is no less effective than in-person care. Randomised clinical trials have found comparable treatment outcomes for patients who received treatment via videoconference compared to in-person delivery, with favourable results even for challenging mental health problems, such as PTSD.\(^4\) Submissions to the Review frequently mentioned extending the use of telephone counselling and internet sessions to increase access to service providers as another important element of incorporating technology into the integrated care system.\(^7\) Multiple professionals, organisations and consumers perceived the provision of psychological services through telephone or online services to be an effective use of resources, and recommended to the Review that Medicare rebates for consultations that occur via this method be expanded to professionals other than psychiatrists.

Many Australians also reported in their submissions to the Review that telephone helplines act as a valuable support for them to address mental health concerns. However, technology usage patterns have changed significantly, and the use of telephone helplines is complemented by the increased uptake of online counselling via web-enabled chat and a clear need for peer and family support online.\(^4\) The operation of hotlines and online help could be enhanced by providing direct triage to consumers to steer them towards providers of expertise and advice in the particular subject area, to reduce confusion about the services on offer to them.

Internationally, governments are increasingly considering some form of coordination and integration to ensure easy access and consistent quality across helplines and their websites. In the UK, a coordinated and integrated approach is being driven by a central agency which has seen improvement to services through the development of guidelines for operation. In New Zealand, the Ministry of Health has commenced a procurement process to develop and purchase an integrated national telehealth service to provide advice, support, assessment of symptoms, triage, treatment, preventive (educational) and curative aspects of health care services. It will be free of charge to users and available 24 hours a day, seven days a week either by telephone, text messaging or online.\(^4\)

Where to from here – implications for reform

The next generation of e-mental health services is now required. The sector, including both providers and funders, needs to collaborate on how to:

- consolidate services in the main services domains (such as health promotion, prevention and early intervention, crisis support lines, treatment and recovery)
- promote cross-connection across these domains
- introduce screening and continuity of care solutions
- integrate with face-to-face services
- promote integrated treatment services.

This next generation will move on from the current system of stand-alone services with some areas of integration, to one that integrates across services and sectors, taking up the opportunities that e-health can provide. The decisions for the sector are not only about the capacity of the technology, but the evolution of clinical models and the simplification of consumer pathways. This will enhance coverage of services to people, assist GPs in their primary care role and connect people to face-to-face services when they need them.
An integrated system will require functionally appropriate e-health records to enable genuinely integrated care to become a reality. There are concerns about the current Personally Controlled Electronic Health Record (PCEHR), including its low uptake, the limited additional functional benefit beyond digitising the paper system, and slow improvement timeframes. Our research advice forecasts that emerging technologies will progress to individuals’ data from multiple sources “talking to each other” through interoperability. This would contain real-time data and history, which individuals can use to gain a holistic perspective of their mental health and wellbeing, and which they can choose to share with professionals if they so wish to support their face-to-face care.4

Other mechanisms will include requirements around responsiveness (online case management to guide people through the system and keep them online across systems, not just as part of an internal programme), registration, a standardised adaptive screening tool to be used across all e-mental health domains,2 standards and interfaces for interaction between system components, and accreditation mechanism that gives users and clinicians confidence in using e-mental health interventions as part of an integrated care system.4

The rapid growth and the complexity of this sector require appropriate leadership to develop a consolidated transformative plan for integration between e-mental health and face-to-face services.

Continuing use of other technologies and enablers

Apart from an integration strategy for the sector, specific reforms to the MBS could support more effective use of technology and more quickly address access barriers.

New MBS items for telehealth services, beyond the current item for telepsychiatry, would provide an opportunity to address shortfall in face-to-face services in areas outside major cities.4 This could be extended so more professional groups are able to provide MBS-subsidised services under Better Access.

For telephone and online support services, the strategic direction is in creating a ‘joined-up’ model of crisis support helplines, with each helpline playing its part according to its expertise. This would reduce duplication, increase efficiency and enable collaborative work.

Aboriginal and Torres Strait Islander peoples

For Aboriginal and Torres Strait Islander peoples, culturally appropriate helplines and websites should be developed with Aboriginal and Torres Strait Islander mental health and suicide prevention leaders and stakeholders—such as the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG). Given that Aboriginal and Torres Strait Islander peoples have the highest suicide rates, it is important that crisis support be able to work in a culturally competent manner with Aboriginal and Torres Strait Islander people and other clients from vulnerable groups, and particularly those presenting with suicide ideation. For such crisis support, Aboriginal and Torres Strait Islander counsellors and counsellors from other vulnerable groups should be available at all times if required.

Actions

- A new Commonwealth agenda for developing a consolidated, integrated approach within the e-mental health sector is needed.
- Commonwealth and state and territory governments and private sector to work collaboratively on a financing model for the inclusion of e-mental health technologies in the overall mental health system.
- A reform blueprint be developed that builds on the current e-mental health strategy, for the digital transformation of the sector and its participants.
- In parallel, implement a sector-led framework for research, design, development and roll-out of new interventions, which must integrate with other systems and close system gaps.
- Transform how the e-mental health sector is funded through innovative business and funding models for sustainability.
- Within the e-mental health sector, establish a number of consolidated domains, each under the leadership of a current e-mental health provider with proven expertise. Retender all associated national e-mental health functions.
- Adopt an ‘ecosystem’ approach to the development and integration of e-mental health services, including systems to collect data for usage in service planning and research.
- Support innovative research in e-mental health through greater partnering with the private sector. The establishment of an E-mental Health Research Centre think tank that builds on the investment of the NHMRC, its Centres of Excellence and programme funding would be a vehicle for research coordination and priority setting and serve a clearing house function.
- In light of the above, assess the place of mindhealthconnect in supporting further development of the preferred model of integration.
- Prioritise training for general practitioners and other primary care professionals on e-mental health interventions to enable greater integration.
- Ensure the applicability of the PCEHR for mental health, especially e-mental health, incorporating user perspectives and an examination of interactivity with the most-used e-mental health interventions.
- Examine cost-effectiveness, including cost offsets through reductions in the use of other system areas, for MBS-subsidised mental health-related telehealth items to include allied health professionals, such as psychologists, social workers and occupational therapists.
- Create a coordinated, better integrated model of telephone and online support services, including crisis support and seamless pathways to online and offline information, education, biometric monitoring and clinical intervention.

**Investing for social change**

**What is happening now**

Social investment is a relatively recent development through which loans from businesses (usually to the nongovernment and not-for-profit sectors) can be used to achieve a combination of economic and social objectives. It has been popularised by philanthropists in the UK and USA. These schemes are on the rise in a number of countries but their application in Australia has been limited.

It is recognised that there are a number of initiatives in this area and there are companies operating to achieve a social purpose as well as financial gain in Australia. Similarly, the private sector is moving towards investing more strategically in social causes that align with its business objectives and can demonstrate social and financial outcomes.
Social investment in mental health is an avenue where real social outcomes can be achieved. As an emerging financial model for the sector, it has great relevance to emerging organisations. For example, young leaders in mental health starting up new peer services could be linked in with the social investment sector. Together with other business and corporate expertise, this collaboration would leverage the lived experience, enthusiasm and expertise of young people to work in mental health, thereby improving meaningful engagement with their peers on issues of mental health and wellbeing.

Social Ventures Australia (SVA) and Impact Investing Australia are two organisations that are leading national developments in this area.

SVA estimates that it has generated $45 million of investment from philanthropists within its first 12 years of operation.\(^8\) It has supported a number of innovative partnerships with nongovernment organisations and has been able to leverage private investment to match government funding for some initiatives.

The Queensland Social Enterprise Project (QSEP) started in 2006 as a $90,000 per annum project with joint funding from Brisbane City Council, PricewaterhouseCoopers (PwC) and Social Ventures Australia. By the end of 2012 the project had worked with 57 social enterprises, created almost 500 jobs and 110 employment pathways for people who were seriously disadvantaged in the labour market.\(^8\)

NSW is currently conducting its first trial of Social Benefit Bonds, which is a financial investment that pays a return based on outcomes rather than outputs. The aim of the programme is to intervene early with families who are expecting a child or have one child at least under six years old who is at risk of harm, as determined by the NSW Department of Family and Community Services. The structure of the programme is illustrated in Figure 10.4.

**Figure 10.4 NSW Social Benefits Bonds project structure**

![Diagram of NSW Social Benefits Bonds project structure](source: The Benevolent Society – Social Benefit Bonds)

**Key findings**

Evidence of which models work and do not work and the ability to measure outcomes remains a challenge and is in its infancy in Australia. Many companies which invest in social enterprises prefer to provide capital where there is less risk than investing in the outcomes for programmes; for example, by funding a building or a simple project.
The Commission notes that social enterprise schemes can be complex and can take considerable time to develop and negotiate, particularly when it comes to looking at independent outcome measurement.

However, these schemes do not replace government expenditure — government remains the ultimate funder, but the incentive for the programme to succeed is transferred onto providers.

Development in this area has a real potential to increase cross-sectoral collaboration to lead to more opportunities for people with a mental illness and their families.

**Actions**

- Seed fund a small demonstration project to explore models of social enterprise involvement in the mental health sector. This would require these steps:
  - identify priority areas where there potentially are clear, measurable outcomes
  - identify potential partners, social enterprise companies and financial institutions
  - facilitate linkages with NGOs and other service providers which may be interested in entering into consortia arrangements of some type
  - go to market with a clear set of objectives and seek innovative and creative responses on how to achieve those objectives.

**Case study: Ngaimpe Aboriginal Corporation—The Glen**

The Glen in Chittaway (Central Coast, NSW) is a residential rehabilitation centre set up in 1995 for men suffering from drug and alcohol addiction. It is one of only six specialised Indigenous drug and alcohol rehabilitation centres in NSW and provides a safe place to get a chance at breaking the cycle of moving in and out of jail. In September 2014 The Glen was awarded the NSW 2014 Mental Health Matters Award for Aboriginal Social and Emotional Wellbeing. In a 2013 study by the University of Wollongong, 70 per cent of clients were found to be free of addiction one month after leaving The Glen.

As a small non-government organisation, it has had to supplement its government funding with alternative sources. In 2013–14 The Glen received $1.04 million of funding from the Commonwealth and State Government bodies. It receives little to no private funding.

The largest barrier to success of The Glen is funding pressures. To mitigate this barrier The Glen is partnering with other rehabilitation centres on the Central Coast to create a consortium and eliminate some shared services to provide efficient and effective use of government funding. Since 2011, The Glen has also partnered with Bunnings on a work experience programme to assist clients. Additionally, it has recently published a funding prospectus to seek philanthropic funding from private sources.
Investing through regional funding models

What is happening now

Regional funding models can be used to shift the model of care in Australia from one focused on supply to one focused on the needs of individuals and local communities.

Instead of an often remote funder of service providers for local-level services—in isolation of each other—a regional funding model aims to pool funds at a regional level. This would enable regional planning and purchasing of services (including commissioning new services where none exist) and local services to be wrapped around the needs of people, families and communities. Such an approach is therefore highly applicable to the mental health sector.

A regional funding model involves three levels:

1. **Macro** – Commonwealth and state governments set high-level policy directions and outcomes, agree performance measures and accountabilities and provide funding on a weighted population basis.

2. **Meso** – regional entities (in this case, Primary and Mental Health Networks and Local Hospital Networks) receive pooled funding, undertake needs assessments for their local communities (including identification of local priorities and gaps in services), and plan and purchase/commission services to be delivered to meet those needs as determined by local priorities, with accountabilities and performance requirements tied to purchasing agreements.

3. **Micro** – service providers deliver the services purchased to achieve performance requirements (e.g. accessibility, continuity of care, effectiveness, efficiency and sustainability, responsiveness, safety).

Regional funding models are designed to support integrated primary and mental health services, and integrated care pathways between primary and secondary level services.

Source: Commonwealth Department of Health, July 2014
Key findings

The provision of integrated primary (and mental health) care, as compared to models of episodic treatment, has not kept pace with the need for integration associated with the rise in chronic disease and comorbidities. Chronic diseases account for 54 per cent of preventable hospitalisations. Importantly, patients with chronic diseases become increasingly expensive to care for once their health becomes more complex and irreversible complications develop, but those complications often can be delayed, reduced or avoided. These are predictable risks. The health system needs to be geared and oriented to prevent and minimise them rather than simply to respond when incidents occur.

Around the world, governments are responding to the increase in non-communicable diseases (NCDs) by developing stronger, more integrated general practice and primary health care systems which focus on early actions designed to protect and promote the health of their populations. This includes a focus on primary prevention (for those at risk), secondary prevention (for those who have developed chronic conditions), chronic disease management within the community, and initiatives to reduce avoidable hospitalisations.

There is considerable evidence from both developed and developing countries that countries with primary care-oriented health systems achieve better health outcomes, at lower cost and with greater equity in health, than do countries with a higher focus on specialist and acute care. However, reorienting the Australian systems towards strong, integrated community-based care will require redesign of systems, structures and incentives.

Integration and reorientation of primary health care will enable better management of predictable risks, to reduce the impact of avoidable morbidity and mortality and thus reduce future growth in health costs.

Aboriginal and Torres Strait Islander mental health – reinvestment for change

For Aboriginal and Torres Strait Islander peoples, this whole-of-government preventative emphasis requires a consideration of employment, access to education and community safety —the current priorities of the Indigenous Advancement Strategy (IAS). A broader approach to social and emotional wellbeing (SEWB) is required, based on empowerment and addressing identity, physical health, family, culture and community.

The systemic change proposed in this Review will require a rebalancing of funding towards SEWB promotion, prevention and primary health care and away from hospitalisation for preventable mental health conditions and from reinvestment from other areas—for example, reinvesting at least some of costs of imprisonment of Aboriginal and Torres Strait Islander people into mental health services over time. We know that the cost of delivering some specific services for Aboriginal and Torres Strait Islander peoples is higher on a per capita basis when compared to other Australians, and savings from improved efficiencies could also be reinvested. For example, hospital admissions for ‘mental health and behavioural disorders’ cost $336 per capita for Aboriginal and Torres Strait Islander people compared to $125 per capita for non-Indigenous people. The level to which these costs may reflect the greater overall poor physical health of Aboriginal and Torres Strait Islander peoples is unknown, and would need to be considered in any cost review.

A redirection of funds is also required to support the systemic changes to Aboriginal and Torres Strait Islander mental health services and programmes proposed in this Review. In particular, such savings could help fund the mental health and social and emotional wellbeing teams and dedicated specialist services proposed in the recommendations. Such redirection
should be managed in such a way as not to have a disproportionate or unequal impact on Aboriginal and Torres Strait Islander people already experiencing mental illness—recognising that in the short term, they will continue to rely more heavily on hospital services for the treatment of mental health conditions than other Australians. That is, until increased levels of primary health care have been in place long enough to take effect.

Change may also require assessment of what funding from mainstream programmes could be diverted into the new approach to offset costs. This must be subject to the outcome of individual programme reviews. All such planning is to occur in partnership with Aboriginal and Torres Strait Islander peoples—preferably under the guidance of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG) or some other credible Aboriginal and Torres Strait Islander-led mental health body. Within a reconsideration of programme funding and programmes in general, given the scale of issues and the size of the mental health gap, support for programmes that target the specific needs of Aboriginal and Torres Strait Islander people should continue. Further, there should be an assumption that—until evidence and evaluation is in place to say otherwise—having any programme or service in place is better than having none.

**Where to from here – implications for reform**

Future primary and mental health models require:

1. Access to comprehensive primary health care involving multi-disciplinary teams (nursing, allied health, pharmacists, Aboriginal Health Workers, personal carers, etc.).
2. Strong focus on prevention, tailored according to level of risk of hospitalisation or readmission, including services to improve patient self-management.
3. Partnership between the primary and acute sectors, including co-design of programmes: target avoidable hospitalisations and reductions in readmission and emergency department attendance rates, and measure success, including dollar savings to the acute sector.
4. Effective care coordination, both in periods of chronic illness and in crises/acute episodes.
5. Seamless transfer between the primary, acute and community and aged care settings, with agreed clinician-driven care pathways and handovers involving GPs, specialists, nurses, allied health professionals and other carers.

**Actions**

New funding models are required, especially to support those with complex needs. This could involve more of a blended payment model, involving a mix of fee-for-service (particularly for those with episodic needs), population-based payments and payments for performance, particularly for those with complex needs. For those at high risk of acute care, and those at risk of becoming higher risk, bundled payments which can be used to purchase services to support them to stay in the community, in housing, in employment and education—to live a contributing life—also should be available.

New integrated service delivery models are needed. Primary and mental health teams can provide frontline support by wrapping services and support around people, their families and support people. When functions and responsibilities go beyond the capacity of their services (for example, complex care coordination, wider public health and regional/population level services) they in turn require the support of the meso-level organisation to wrap support around them.
Agreement to roles is necessary. There are six key roles which regional primary health organisations can play to support frontline services.

1. Plan for the needs of populations and organise the myriad of services around them. Represent population (including regional) needs in dealing with traditionally more powerful interests in the acute health system.
2. Use data-driven processes to drive benchmarking, performance measurement and improvement.
3. Promote value for money interventions based on translation of evidence into practice.
4. Align financial incentives between the primary health care system and acute, subacute and aged care services, including strategic investment of capital.
5. Support widespread use of a single care plan and an electronic health record with care team and patient access and interaction.
6. Workforce planning, training and retention of team members who are supported to work together at the top of their scope of practice as defined for their separate disciplines, with agreed handover arrangements.
References


Chapter 11: Implementation of a better mental health system

This chapter outlines the steps for implementation to set the foundation for long-term change to improve outcomes for people and productivity of the system. A new National Mental Health Agreement is proposed between the Commonwealth and the states and territories, to give effect to new funding packages supported by defined roles and responsibilities in a cross-portfolio, inter-governmental model, embedding a person and carer-centred approach.
Strategic intent

This Review has identified a programme for redesign, realignment and rebalancing of funding of mental health programmes. It requires national leadership to redistribute funding across portfolios, from hospital-based services to primary and community care, and to adopt a set of national targets and indicators to measure and report upon progress.

The strategic intent of the recommendations is to realign the programme delivery mechanisms of government to better align with evidence-based treatment pathways. We want to adopt person, family, and carer-centred programme design, reinvest mental health funds saved through earlier treatment and mental wellbeing promotion, and integrate effort and investment for local communities.

This will be achieved by pursuing the following strategic directions:

1. Set clear roles and accountabilities to shape a person-centred mental health system.
2. Agree and implement national targets and local organisational performance measures.
3. Shift funding priorities from hospitals and income support to community and primary health care services.
4. Empower and support self-care and implement a new model of stepped care across Australia.
5. Promote the wellbeing and mental health of the Australian community, beginning with a healthy start to life.
6. Expand dedicated mental health and social and emotional wellbeing teams for Aboriginal and Torres Strait Islander people.
7. Reduce suicides and suicide attempts by 50 per cent over the next decade.
8. Build workforce and research capacity to support systems change.
9. Improve access to services and support through innovative technologies.

The Commission acknowledges that structural change is required to harness the dollars invested in mental health to drive performance and outcomes for people who are living with a mental health difficulty and the people who support them. Structural change is also required for governments to meet community needs within resources, and to manage risk over the forward budget period. Implementation over 10 years will enable the structures of reform to be discussed and agreed, and immediate priorities and longer-term actions to be scoped and implemented.

The recommendations require national leadership, to deliver person and carer-centred programmes and achieve strengthened communities with good mental health and wellbeing:

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

   Rec 1. Agree the Commonwealth’s role in mental health is through national leadership and regional integration, including integrated primary and mental health care.

   Rec 2. Develop, agree and implement a National Mental Health and Suicide Prevention Agreement with states and territories, in collaboration with people with lived experience, their families and support people.

   Rec 3. Urgently clarify the eligibility criteria for access to the National Disability Insurance Scheme (NDIS) for people with disability arising from mental illness and ensure the provision of current funding into the NDIS allows for a significant Tier 2 system of community supports.
2. **Agree and implement national targets and local organisational performance measures**
   - Rec 4. Adopt a small number of important, ambitious and achievable national targets to guide policy decisions and directions in mental health and suicide prevention.
   - Rec 5. Make Aboriginal and Torres Strait Islander mental health a national priority and agree an additional COAG Closing the Gap target specifically for mental health.
   - Rec 6. Tie receipt of ongoing Commonwealth funding for government, NGO and privately provided services to demonstrated performance, and use of a single care plan and e-health record for those with complex needs.

3. **Shift funding priorities from hospitals and income support to community and primary health care services**
   - Rec 7. Reallocate a minimum of $1 billion in Commonwealth acute hospital funding in the forward estimates over the five years from 2017–18 into more community-based psychosocial, primary and community mental health services.
   - Rec 8. Extend the scope of Primary Health Networks (renamed Primary and Mental Health Networks) as the key regional architecture for equitable planning and purchasing of mental health programmes, services and integrated care pathways.
   - Rec 9. Bundle programmes and boost the role and capacity of NGOs and other service providers to provide more comprehensive, integrated and higher-level mental health services and support for people, their families and supporters.
   - Rec 10. Improve service equity for rural and remote communities through place-based models of care.

4. **Empower and support self-care and implement a new model of stepped care across Australia**
   - Rec 11. Promote easy access to self-help options to help people, their families and communities to support themselves and each other, and improve ease of navigation for stepping through the mental health system.
   - Rec 12. Strengthen the central role of GPs in mental health care through incentives for use of evidence-based practice guidelines, changes to the Medicare Benefits Schedule and staged implementation of a Medical Home for Mental Health.
   - Rec 13. Enhance access to the Better Access programme for those who need it most through changed eligibility and payment arrangements and a more equitable geographical distribution of psychological services.
   - Rec 14. Introduce incentives to include pharmacists as key members of the mental health care team.

5. **Promote the wellbeing and mental health of the Australian community, beginning with a healthy start to life**
   - Rec 15. Build resilience and targeted interventions for families with children, both collectively and with those with emerging behavioural issues, distress and mental health difficulties.
   - Rec 16. Identify, develop and implement a national framework to support families and communities in the prevention of trauma from maltreatment during infancy and early childhood, and to support those impacted by childhood trauma.
   - Rec 17. Use evidence, evaluation and incentives to reduce stigma, build capacity and respond to the diversity of needs of different population groups.
6. **Expand dedicated mental health and social and emotional wellbeing teams for Aboriginal and Torres Strait Islander people**
   Rec 18. Establish mental health and social and emotional wellbeing teams in Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled 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 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 23. Require evidence-based approaches on mental health and wellbeing to be adopted in early childhood worker and teacher training and continuing professional development.

9. **Improve access to services and support through innovative technologies**
   Rec 24. Improve emergency access to the right telephone and internet-based forms of crisis support and link crisis support services to ongoing online and offline forms of information/education, monitoring and clinical intervention.
   Rec 25. Implement cost-effective second and third generation e-mental health solutions that build sustained self-help, link to biometric monitoring and provide direct clinical support strategies or enhance the effectiveness of local services.

**A logic model to guide implementation**

This Review is the first step in restructuring mental health programmes and services. With government support, the next step is taking the recommended directions and engaging in a national conversation. This should be inclusive of people living with mental health difficulties (and their carers and families), state and territory governments, mental health experts, professionals and the sector more broadly.

This consultation and development phase provides an opportunity for testing of the recommendations against a wider set of information (as the Review was limited by lack of access to state and territory programme data, for example) and input from those impacted by the new directions. Together with government agencies across the health and human services portfolios, this initial phase will develop a cross-portfolio programme strategy to inform the 2015–16 budget cycle. In support of this, the Review has identified initial priorities or action for the next two years as outlined in Volume 1.

These initial steps are to be taken within an overall programme logic of three stages. What is needed is a planning model to give effect to the changes at various levels, and to plan these over the course of ten years, so that priorities and targets can be agreed, system performance
driven and monitored, and outcomes measured and reviewed to ensure effort is sustained. The following logic model could guide implementation.

Source: concept designed by The National Mental Health Commission 2014.

**Principles to underpin change**

A high-performing quality mental health system needs to be built around a shared vision for change, which is developed by people with a lived experience, their families and carers.

What is important is the guiding principles to underpin implementation:

- strong, decisive leadership and good governance
- productive populations and communities and contributing individuals
- a strong market which promotes choice, availability of treatment and supports that are effective
- an infrastructure that supports good practice and drives value for money decisions and results
- world-leading smart use of technology
- team-led work practices
- world-leading research that translates into practice

**Accountability mechanisms and governance**

Redesign at the national level requires four things:

1. Agreed national targets and indicators for reform.
2. Monitoring and evaluation mechanisms, with public reporting.
3. Collaborative and inclusive consultation structures.
4. Agreed roles and responsibilities, and strong governance to manage risk and performance.

The initial step, after Government endorsement of the Review, is to establish accountability and governance mechanisms. Given the cross-portfolio, person and family/carer-centred approach and stakeholder engagement required for this national redesign of mental health, the first six months will:

- develop and agree programme KPIs, monitoring and evaluation processes for success
- establish governance structures including people with lived experience, their family and supporters, expert advisers, government and sector representatives
- develop a detailed, staged implementation strategy across governments and across sectors, with evaluation points for strategy recalibration
- prepare a costed 2015–16 budget proposal, with an indicative 10-year outlook.

**What success looks like**

The Key Performance Indicators for implementation are:

- Agreement between Commonwealth and state and territory governments on roles and responsibilities in mental health.
- A compact with stakeholders including consumer and carer groups, and NGO and private providers, on directions for change.
- Commitment by all governments on targets for achieving better outcomes in mental health and reducing numbers of suicides.
- New national accountability and transparency arrangements to improve accountability of policy makers, planners, purchasers and providers to consumers and carers.

**Immediate priorities years 1 to 2**

The Review’s recommendations set directions to commence in the first two years of the strategy, as outlined in Volume 1.

This is a strategy for people of all ages, where we use the word ‘people’ to encompass infants, children, young people, working age adults and older people as well as Aboriginal and Torres Strait Islander peoples and those from Culturally and Linguistically Diverse (CALD) backgrounds.

The programme for the first two years of reform (attached) sets out a staged implementation. It commences with Government endorsement of the Review and establishing accountability and governance.

This initial stage needs to be paralleled by a process to establish an agreed picture of success, interim governance structures for regional programmes, a parallel evaluation process for those major mental health programmes which have none, an evaluation of the administrative barriers of and between programmes, and a strategy for optimising existing technology and platforms for mental health online help and supports.

**Regional models of delivery and governance**

The reform framework is built on a regional model with integrated service delivery at the level of the individual. Future Commonwealth funding models will be supporting integration, avoiding duplication and allowing collaboration between programmes and services.
This will require major changes to the governance model at the delivery level, which will need to be negotiated with providers. It is envisaged this will be a major role for the proposed Primary and Mental Health Networks (PMHNs). It may also require contract incentives for local planning and collaboration.

The need for evaluation to guide programme directions

A number of key national programmes involving significant expenditure of approximately $250 million have not been comprehensively evaluated or evaluated recently (including these allocations in 2012–13: National Perinatal Depression Initiative - $11.0 million, the National Suicide Prevention Programme - $23.2 million, Taking Action to Tackle Suicide - $87.6 million), as well as headspace with an allocation of $63.8 million and PIR with an allocation of $62.5 million (both of which are currently being evaluated).

Comprehensive evaluation should accompany significant national investment. Evaluations should consider outcomes for people and whether both needs and service accessibility requirements are met; as well as cost effectiveness. Evaluations should consider whether programmes are providing a return on investment, are relevant to local needs and groups and are avoiding duplication with other programmes and services.

Access barriers to programmes and services

The Review has identified a range of access barriers to programmes and services, including caps on service delivery independent of need, and eligibility requirements that may hinder recovery. Although these can be addressed in any major restructuring, it is important that change does not disadvantage groups or individuals.

Maximising use of technology

Seeking help online and on the phone has been endorsed by consumers as an accessible point of service. The evidence backs the effectiveness of these programmes. However, the range of support services available online and on the phone can be confusing for people to access and navigate.

An e-mental health agenda is building among providers that sees its future as being integrated into the Australian mental health service model as the first step of service delivery (as appropriate) in a stepped care model.

Streamlining these services, with particular emphasis on crisis support, will need to take into account emerging technologies and best practice in communications, as well as the sector’s work in developing capacity, and the cost impacts upon users for download and internet connection. It is a medium-term project requiring dedicated planning resources.

One area of potential expansion for e-mental health tools is in improving access to care for, (and to support clinicians to work in culturally appropriate ways with), Aboriginal and Torres Strait Islander people. Clinicians need workforce development programs to equip them in the smart use of new technology. In particular, opportunities exist to promote better transitions across the health system for Aboriginal and Torres Strait Islander peoples through the use of e-health records. Communication technologies can also help people maintain connections with family and community when travelling from a remote or very remote area to receive treatment.
Establishing longer-term goals and targets

What is happening now

Public accountability and reporting against commitments made by governments is an important lever in the federal arrangements where accountability for outcomes is shared between levels of government.

The model under national agreements and partnerships has been for governments to agree on a small number of high-level national targets to drive change. One of the most successful reform areas for this approach has been in the area of Indigenous disadvantage. Six targets were set by COAG in 2008 for Closing the Gap in Indigenous Disadvantage which have been consistently pursued over time, reported on annually and have driven systems change through government policy and investment decisions.\(^1\)

While there has been agreement for many years (and across successive Mental Health Plans) on the need for a similar approach in mental health, there has not been agreement on what those targets should be. The most recent substantial work in this area was the report of the COAG Expert Reference Group (ERG) on National Targets and Indicators for mental health reform. The ERG was set up to advise on a set of ambitious and achievable national, whole-of-life, outcome-based indicators and targets for mental health that would be understood by the community and drive systemic change. The ERG proposed a set of 14 targets; the Commission considers that, while all are important, a subset of the 14 will provide for a better focus on systemic change and performance. The Commission therefore proposes eight targets to address the key themes of this Review report.

Proposed eight targets

1. Healthier start to life: Increase the proportion of young children and new parents receiving support for mental health development and wellbeing, mental fitness training and resilience, at home, in the community and through the education and care system.
2. Improve life expectancy of adults with a mental illness to achieve parity with adults without a mental illness. This means better physical health, with measures that focus on smoking and screening for physical and dental health issues.
3. Increase the proportion of the population of people with a lived experience of a mental illness and their families and carers in safe, affordable, appropriate and stable accommodation to meet their mental health support needs.
4. Increase participation: reduce the rate of 16–25 year olds not in Education, Employment or Training (NEET).
5. Timely access, care and treatment: Increase the proportion of people with mental health difficulty, families and carers who report timely access to the supports and services they need by 10 per cent each year.
7. Increase the proportion of people with a lived experience of mental illness, families and carers who report an improved and positive experience of mental health-related services and supports.
8. Reduce suicides and suicide attempts by 10 per cent in four years and 50 per cent in 10 years—supplementary target to Closing the Gap on suicide rates of Aboriginal and Torres Strait Islander people.
Data development needs of the sector

Throughout the Review, the Commission has been hampered in its analysis by the lack of a coherent framework for the collection, analysis and use of data. There are significant and well used data collections to support operational activity and population planning. Notwithstanding this investment, there are significant gaps and overlaps in the data needed at various levels of the system. Many collections do not ‘talk to each other’.

This means that for vulnerable populations in particular it is not possible to say whether resources are being efficiently and effectively targeted. For many Aboriginal and Torres Strait Islander people, for example, the mental health system requires them to rely on general population (‘mainstream’) services and programmes. However, we do not know the degree to which they are accessing these services, nor whether they lead to improved outcomes.

Data to support accountability and outcomes reporting

The proposed high-level goals and national targets for mental health reform will require timely access and robust data to report both on population status (high-level outcomes) and on service performance goals. This includes outcomes ratings provided by people with mental illness and carers.

Accountability frameworks at national, state and territory and provider-funder level will need to have coherent outcomes reporting and timely data to support them. Reduction of duplication and red tape in this accountability is essential.

Transparency and public accountability by way of reporting on outcomes is also an area where a coherent framework is not obvious to the public, the media or stakeholders. Important work and partnerships have been developed by the Commission with the two leading national statistics bodies—the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS)—which will be foundational in achieving improvement in this area.

The next National Survey of Mental Health and Wellbeing is due in 2017. This will be the third iteration of the survey (following previous surveys in 1997 and 2007) and is important as a key source of information to inform progress on the performance target agenda in relation to mental health conditions in Australians aged 16-85 years on a longitudinal basis.

Better understanding of data about people using mental health services

A very important project being conducted by the ABS in conjunction with the Department of Health, initiated and financed by the Commission, is the Mental Health Services Census Data Integration project. The project for the first time integrates data items from the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS) and the 2011 Census.

Unlike previous separate data sets, this provides information about the people accessing the Medicare-subsidised elements of the service system through a process of data linkage. It will enable improved planning at population, service and individual levels when more is known about the relationship between the circumstances and characteristics of people experiencing mental health issues and how they interact with the health system.
Directions over the longer term

The Review has identified system and structural changes required to reshape how programmes are delivered and funding allocated to improve outcomes for people and their families and carers. These are essential to redesigning the overall architecture of a mental health system, and are identified for planning and implementation in the first two years of the reform programme.

For the medium and long term—three to ten years—this chapter outlines programme priorities for consideration. These include proposed actions for change for specific priority groups and service needs, as identified under the Terms of Reference:

- challenges for Aboriginal and Torres Strait Islander peoples’ mental health
- supporting suicide prevention
- addressing regional, rural and remote mental health
- issues for workforce training and development
- directions for research

The following table outlines areas for action from the mid-to-long-term policy directions. These priorities were informed through the Review’s consultation process and by commissioned advice.
### Aboriginal and Torres Strait Islander Peoples’ Mental Health

#### Years 3–5: Set the foundation for long-term change

**Policy priority:** Evaluate progress with establishing mental health and social and emotional wellbeing teams.

**Implementation steps:**

*Working with the National Aboriginal Community Controlled Health Organisation and other stakeholders:*

- After a year’s operation, establish the optimal service model for mental health and social and emotional wellbeing teams.
- Audit existing delivery by teams and identify gaps.
- Identify workforce needs (both supply and training needs).

**Policy priority:** Dedicated Aboriginal and Torres Strait Islander services support Aboriginal and Torres Strait Islander individuals’ journeys across the mental health system.

**Implementation steps:**

*Working with leaders and stakeholders in Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention:*

- Support state and territory governments to facilitate the journey of Aboriginal and Torres Strait Islander people into and through the specialist mental health service system, and in particular from primary mental health care settings into mainstream specialist mental health services and programmes.
- State and territory governments assess the evaluation of the Western Australian Statewide Specialist Aboriginal Mental Health Service model for potential adaptation to their jurisdictions.

#### Years 5–10: A vision for change

**Policy priority:** General population mental health, suicide prevention, and alcohol and other drug use prevention professionals (including general practitioners) are culturally competent and services are culturally safe. Such professionals and services are accountable for better Aboriginal and Torres Strait Islander mental health, suicide prevention, and alcohol and other drug use prevention outcomes and closing the mental health gap.

**Implementation steps:**

*Working with leaders and stakeholders in Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention:*

- All relevant professional associations agree pathways to ensure their membership has undertaken cultural competence training within five to 10 years.
Years 5–10: A vision for change

- Relevant professional associations and education providers ensure that all graduates have undertaken cultural competence training within five to 10 years.
- Australian governments, through collaborative COAG processes, develop Aboriginal and Torres Strait Islander cultural safety standards for all general population mental health services and programmes, including those provided by NGOs.
- Progress in the above is benchmarked against standards developed by professional associations and education providers.
- Australian governments, through collaborative COAG processes, develop service and programme accountability mechanisms to ensure they play their part in closing the mental health gap. These could include area targets and assessments of equitable resource allocation against agreed levels.

Policy priority: Train and employ the Aboriginal and Torres Strait Islander workforce needed to close the Aboriginal and Torres Strait Islander mental health gap.

Implementation steps:

*Working with leaders and stakeholders in Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention:*

- Australian governments, through collaborative COAG processes, identify minimum mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention personnel requirements per population catchment area.
- Australian governments, through collaborative COAG processes, strengthen opportunities for Aboriginal and Torres Strait Islander health workers to attain advanced qualifications by strengthening educational pathways from the Vocational Education Training sector to the university sector.
- Relevant professional associations and education providers increase the numbers of Aboriginal and Torres Strait Islander students undertaking mental health and related training and entering the mental health professions and workforce. Progress is benchmarked against standards developed by professional associations and education providers.

Policy priority: A sound evidence base for Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention services and programmes.

Implementation steps:

*Working with leaders and stakeholders in Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention:*

- Australian governments, through collaborative COAG processes, designate a national body, with Aboriginal and Torres Strait Islander leadership, to establish best practice in Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention services and programmes.
### Supporting Suicide Prevention

#### Years 3–5: Set the foundation for long term change

**Policy priority**: Evaluate and implement whole-of-community approaches to suicide prevention.

**Implementation steps:**

- Evaluate the first wave (12 regions) across Australia of whole-of-community approaches to suicide prevention and begin to roll out nationally.
- Integrate e-mental health supports into clinical services, so hospital staff and GPs are able to refer people to appropriate sources of formal and informal online support.
- Establish a case worker system for people who have made a suicide attempt, such that workers are routinely assigned to everyone who presents to the ED after an attempt. This person would help the consumer navigate available supports and ensure they do not fall between gaps in services. This should be supported by a mandatory assertive follow-up system which is planned with the person.

**Policy priority**: Roll out suicide prevention training nationally for all frontline staff who are likely to come into contact with people experiencing a mental illness or a substance use disorder.

**Implementation steps:**

- Ensure that training for all health and welfare professionals includes principles of therapeutic communication and recognition of emotional distress when encountering people experiencing suicidal thoughts or behaviours.
- Ensure that health and welfare services adhere to a ‘no wrong door’ approach to people who are reaching out for help. No-one should be turned away without follow-up or referral, and no-one should feel dismissed or that their distress is trivialised.
- Routinely survey the experiences of people and their caregivers who have sought help for suicidal thinking or behaviour—particularly in relation to the attitudes they encounter—and link financial or other incentives for organisations to the result.

#### Years 5–10: A vision for change

**Policy priority**: Review outcomes and design of the first wave (12 regions) of whole-of-community approaches to suicide prevention.

**Implementation steps:**

- Fund and evaluate the systemic prevention initiatives in communities in order to build an evidence base for effective suicide prevention in the Australian context, and to inform the next wave of investment.
- Adhere to a nationally consistent data collection for suicide and suicide attempts.
- Roll out proven approaches nationally.
Addressing Rural, Regional and Remote Mental Health

### Years 3–5: Set the foundation for long term change

**Policy priority:** Build workforce and community capacity to respond to mental health concerns in regional, rural and remote Australia.

**Implementation steps:**

- Ongoing promotion, implementation and evaluation of recruitment, retention and incentive mechanisms to engage people in both generalist and specialist mental health career pathways in regional, rural and remote Australia, targeting in particular:
  - areas and communities that need it most, such as socio-economically disadvantaged areas or areas recovering from natural disasters that are underserviced by the current system
  - areas where there is evidence to suggest the efficacy and sustainability of recruitment and retention strategies
- Up-skill local community members (e.g. who complete a Mental Health First Aid-type course) to further extend effective workforce coverage, including in vulnerable industries or communities.
- Targeted community capacity building via funded projects within a regional framework using existing NGOs and networks.
- Support and promote mental health champions through a regional, rural and remote mental health leadership initiative.

**Policy priority:** Renewed focus on research, data collection and analysis of suicidal behaviour and mental health determinants, needs and services in regional, rural and remote Australia.

**Implementation steps:**

- Conduct further research and evaluation on how other related workforces (including allied health workers, non-mental health nurses, social workers, occupational therapists, and peer workers) may assist in augmenting traditional mental health workforce categories in regional, rural and remote areas.
- Conduct research and data analysis to develop a more precise understanding of the mental health needs and outcomes in regional, rural and remote populations in Australia.
- Conduct targeted research to better understand how rural and remote cultural paradigms affect help seeking and suicidal behaviours, particularly during heightened times of personal, social, and/or economic adversity.
- Pilot new evidence-based funding and administrative approaches in a number of regional, rural and remote communities to enable integrated service delivery for people experiencing mental illness.
Years 5–10: A vision for change

Policy priority: A cross-sectoral approach to creating and maintaining mentally healthy communities in rural, regional and remote areas is embedded in service planning and delivery principles.

Implementation steps:

- Develop regional governance models that harness the full resource capacity of government and community-based services in an integrated way.
- Governments to engage more proactively with the private sector to ensure that key investors in rural, regional and remote economies are also investing in the mental health of their workers and communities.
## Issues for Workforce Training and Development

### Years 3–5: Set the foundation for long term change

**Policy priority:** Maximise workforce potential by using the specialist mental health workforce more effectively.

**Implementation steps:**
- Improve links between general practice and psychiatrists to provide greater reach of specialist services, through development of mental health services and consultancy-type arrangements between the two groups.
- Increase the use of self-help and online (e-mental health) services for people with lower levels of mental ill-health by providing a platform that provides advice on effective, evaluated e-mental health services.

**Policy priority:** Increase the effective use of the psychologist workforce in mental health services.

**Implementation steps:**
- Undertake a study of the psychology workforce to estimate current and future supply, and improve rates of registration and retention within mental health services.

**Priority policy:** Increase the number of peer workers in mental health services nationally.

**Implementation steps:**
- Promote the accredited vocational training for peer work to persons with a lived experience of mental ill health and consider entire workplace-based options to encourage take up of training.

### Years 5–10: A vision for change

**Priority policy:** Improve broader workforce mental health assessment capabilities across sectors, including education, justice and housing.

**Implementation steps:**
- Develop and provide training to all non-mental health workforce groups which have significant contact with persons with mental illness.
- Include population health training (e.g. Mental Health First Aid) in mental health for all frontline workforces as a mandatory requirement.
- Implement changes in courses based on revised curricula.
## Directions for Research

### Years 3–5: Set the foundation for long term change

**Policy priority:** Establish a mental health outcomes National Minimum Data Set.

**Implementation steps:**
- Develop a single national data set which serves the needs of researchers, policy makers and service providers for quality improvement, accountability and evaluation purposes. This should be developed in consultation with consumers and caregivers and piloted extensively with services.

**Policy priority:** Make it easier for policy makers and people working in frontline services to access and use research evidence and evidence of good or promising practice.

**Implementation steps:**
- Establish a ‘what works’ and ‘best buys’ internet portal, including Australian and international evidence about the efficacy, effectiveness and cost-effectiveness of mental health models of care and interventions.

**Policy priority:** Create ‘hard’ incentive structures to encourage research focused on service and consumer priorities.

**Implementation steps:**
- Establish a panel of frontline professionals, people with a lived experience and supporters to provide advice on grant applications (once scientific and ethical validity have been established).
- Establish funds to encourage ‘new’ researchers with innovative ideas rather than funding research based exclusively on track record and publications.
- Build research activity into continuing professional development requirements for frontline practitioners and ensure this time is funded.

### Years 5–10: A vision for change

**Policy priority:** Strategic prioritisation of research activity is embedded in the everyday operating principles of research funding bodies, universities and service providers.

**Implementation steps:**
- Success for researchers to be measured in terms of policy and practice impact rather than exclusively peer regard and numbers of publications.
- All government-funded projects incorporate time and funding for continuous cycles of summative and formative evaluations.
A role for the National Mental Health Commission

Track record as a catalyst for change and improvement

The Commission considers that governments, taxpayers and people with a lived experience of mental health difficulties and their families and carers all benefit from having an independent Commission which is able to stand at arm’s length and provide a window into how the system is performing.

The National Mental Health Commission has established a high level of support and respect for its role in providing independent advice and performance reporting on the Australian mental health system.

The Commission views itself as a catalyst for improving the mental health system and establishing a collective for change in attitudes and behaviours of Australians about mental health issues. Through its unique mandate as an independent agent for change, the Commission brings together leaders and organisations from across the country to accelerate improvements which result in better health outcomes for the community.

The Commission walks with, but at arm’s length from, stakeholders—governments, service providers and people and their supporters. It has a particular focus on adopting an inclusive approach—that people with lived experience and families and carers are essential in any discussions that affects them—that they are heard, listened to and have their needs and preferences reflected at all levels of the mental health system.

The Commission was established to increase accountability and transparency in mental health through public reporting and to provide independent advice to Government.

Engagement with people remains at the heart of the Commission’s operations.

To date the Commission has released two Report Cards under the title *A Contributing Life*—in November of 2012 and 2013—containing 18 recommendations, and has led a number of projects arising from those recommendations.

This includes projects on:

- what enables a contributing life
- how to work towards elimination of seclusion and restraint
- establishment of the Mentally Healthy Workplace Alliance to support employers to recruit and retain people with mental health problems, and to recognise the value of good mental health in the workplace
- development of competencies and materials for a Certificate IV in Peer Work
- care and prevention after a suicide attempt.

The Commission also has produced Spotlight Reports to shine a light on areas of importance.

- Mental health research and evaluation in multicultural Australia
- Can we talk...about mental illness and suicide?
- Mental Health Report Card supporting paper on Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing
- Engaging young people in the development of a National Report Card on Mental Health and Suicide Prevention
- International Benchmarking of Australia’s Mental Health Performance.
Going forward

To be of ongoing value to government, people and the sector, the Government can direct the Commission to lead, collaborate, advise and report on directions and changes required in mental health, with the capability to identify and monitor progress made over time.

This includes clarity about the aspirations for mental health and suicide prevention, including what will be different, backed by evidence to demonstrate what improvements can be observed.

To achieve this, the Commission recommends that, just as occurred with mental health commissions created as catalysts of change in Canada and New Zealand, Australia’s National Mental Health Commission should be given a finite period to fulfil its objectives, with the ongoing need for the Commission to be subject to external evaluation.

Elsewhere in this report, the Commission has advised that this is a 10-year reform journey, with changes implemented on a stepped approach—where short-term priorities need to be achieved to establish a platform upon which medium-term priorities can be built, and which in turn enables longer-term priorities to be achieved.

In particular, while strategy directions and priorities have been identified in this report, there remains considerable work to be undertaken in a range of areas to build the platform for ongoing reform, and which can be facilitated by the Commission as an independent catalyst. Inclusive consultations on the Review’s directions are required prior to advancing.

It therefore is proposed that the Commission is given a 10-year time horizon (2015–2025) to match the proposed reform journey, with an initial five-year timeframe (2015–2020) and with the ongoing role of the Commission subject to Government consideration of an external review of its performance in Year 4 (2018–19).

As a priority, the Commission will develop a new Strategy and Action Plan for approval by Government, inclusive of a set of Key Performance Indicators (KPIs) to be used in the proposed external evaluation to measure the Commission’s achievements against its agreed objectives.

The Commission’s initiatives and projects will be led by experts who bring a variety of perspectives and experience to the table.

The Commission recognises the valuable specialised and expert contributions to its work made by people who have a first-hand experience of a mental health issue or are a family member or support person. Where the Commission forms advisory groups or committees to assist its work priorities, provide advice or inquire into particular matters, these sub-groups will be jointly chaired by a Commissioner or other expert, and a person with lived experience of mental health issues, either personally or as a family member or support person.

There will need to be a high level of engagement between the Commission and the states and territories, and with state mental health commissions, particularly on data and information to assist in the Commission’s reporting and advising role. Consultations will seek to identify opportunities for joint initiatives that align with the Strategies and Actions Plan and with state plans and priorities.

The Commission also will have strong formal and informal relationships with nongovernment organisations (NGOs) and various peak groups impacting on mental health and wellbeing.
Accountability and governance

As is highlighted throughout this report, many of those things which prevent mental ill-health and enable a contributing life lie outside the formal health system, in areas such as housing, education, employment, welfare and justice.

Hence it is important that the Commission is seen to transcend the formal health system and to take a whole-of-government, whole-of-community, whole-of-life, whole-of-system approach.

Accordingly, the National Mental Health Commission should be given an initial five-year mandate (2015–2020) as a catalyst for change, with extension of that mandate subject to government consideration of the outcome of an external review of effectiveness in the fourth year (2018–19).
References

Glossary and Abbreviations
## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal and Torres Strait Islander person</td>
<td>A person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander.</td>
</tr>
<tr>
<td>Activity Based Funding</td>
<td>Activity Based Funding (ABF) is a system for funding public hospital services where the health service providers (hospitals) are funded based on the activity they undertake: with that activity being treating patients. Australian Governments agreed to implement ABF under the National Health and Hospitals Reform Agreement 2012.</td>
</tr>
<tr>
<td>Affective disorder</td>
<td>Affective disorders are a set of mental illnesses, also called mood disorders, which are characterised by dramatic or extreme changes to a person’s mood. The main types of affective disorders are depression, bipolar disorder and anxiety disorder.</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>An anxiety disorder is characterised by persistent and excessive worry, where the feeling is so distressing it can make it hard for a person to cope with daily life or take pleasure in activities. A person with an anxiety disorder will feel distressed a lot of the time for no apparent reason.</td>
</tr>
<tr>
<td>Access to Allied Psychological Services (ATAPS)</td>
<td>This programme enables predominantly general practitioners (GPs) to refer patients with high prevalence disorders (e.g., depression and anxiety) to mental health professionals for low-cost evidence-based mental health care (most commonly cognitive behavioural therapy, or CBT). This care is typically delivered in up to 12 (or 18 in exceptional circumstances) individual and/or 12 group sessions. ATAPS is rolled out in two tiers, with Tier 1 targeting the broader population and common interventions and Tier 2 targeting harder to reach or more complex groups such as Aboriginal and Torres Strait Islanders, people in remote communities and people who are homeless.</td>
</tr>
<tr>
<td>Better Access Programme</td>
<td>The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative (Better Access) commenced in November 2006. Under Better Access, psychiatrists, GPs and psychologists (and appropriately trained social workers and occupational therapists) provide mental health services on a fee-for-service basis subsidised through Medicare. These services offer access to short-term psychological therapies through private providers.</td>
</tr>
<tr>
<td>Disorder</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>Bipolar Disorder is an illness that results from an imbalance of chemicals in the brain, which can cause extreme fluctuations of mood from the heights of mania (elevated mood which may be out of character for the person), to the depths of depression (persistent low mood). The disorder is characterised by people experiencing repeated episodes of changes in mood and activity levels.</td>
</tr>
<tr>
<td>Borderline personality disorder</td>
<td>People with Borderline Personality Disorder (BPD) frequently experience distressing emotional states, difficulty in relating to other people, and self-harming behaviour. Symptoms can include deep feelings of insecurity, persistent impulsiveness and confused and contradictory feelings.</td>
</tr>
<tr>
<td>Burden of disease</td>
<td>Burden of disease is a measure used to assess and compare the relative impact of different diseases and injuries on populations. It quantifies health loss due to disease and injury that remains after treatment, rehabilitation or prevention efforts of the health system and society generally.</td>
</tr>
<tr>
<td></td>
<td>One measure of burden of disease is disability-adjusted life years (‘DALYs’), which estimate years of life lost due to premature death, as well as years of healthy life lost due to disability from disease and injury.</td>
</tr>
<tr>
<td>Carer or supporter</td>
<td>A person who has a support role for someone living with a mental health difficulty. They may be a family member, friend or have another close relationship with the person. Also referred to as a ‘support person’.</td>
</tr>
<tr>
<td>Chronic disease</td>
<td>A diverse group of diseases, such as heart disease, cancer and arthritis, which tend to be long-lasting and persistent in their symptoms or development. Although these features also apply to some communicable diseases (infections), the term is usually confined to non-communicable diseases.</td>
</tr>
<tr>
<td>Contributing life</td>
<td>A term first used in the Commission’s 2012 National Report Card on Mental Health and Suicide Prevention, which means - A fulfilling life where people living with a mental health difficulty can expect the same rights, opportunities and health as the wider community. It is a life enriched with close connections to family and friends, supported by good health, wellbeing and health care. It means having a safe, stable and secure home and having something to do each day that provides meaning and purpose, whether this is a job, supporting others or volunteering.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Cognitive impairment</td>
<td>Any characteristic a person has that acts as barrier to the cognitive (or thinking) process. Can be used to describe poor mental function, confusion, forgetfulness and other mental impairments.</td>
</tr>
<tr>
<td>Comorbidity</td>
<td>The presence of one or more disorders (or diseases) in addition to a primary disease or disorder.</td>
</tr>
<tr>
<td>Day to Day Living in the Community (D2DL)</td>
<td>An Australian Government-funded structured activity programme aimed at improving the quality of life for individuals with severe and persistent mental illnesses by offering structured and socially based activities. The initiative recognises that meaningful activity and social connectedness contribute to people’s recovery.</td>
</tr>
<tr>
<td>Depression</td>
<td>A mood disorder where people can experience prolonged feelings of being sad, hopeless, low and inadequate, with a loss of interest or pleasure in activities and often with suicidal thoughts or self-blame.</td>
</tr>
<tr>
<td>Discrimination</td>
<td>Prejudicial action or distinguishing treatment of a person based on their actual or perceived membership in a certain group or category of people. This may take overt (intentional and obvious) or subtle (unintentional or embedded in social structure or process) forms. Discrimination can also include acts that are unlawful under the Australian Disability Discrimination Act 1992.</td>
</tr>
<tr>
<td>Diversion schemes</td>
<td>Programmes which seek to rehabilitate people who have committed a crime by focusing on the causes of a person’s offending rather than punitive action. This can take many forms, such as the person receiving a police caution, participating in group conferencing or a court-approved programme.</td>
</tr>
<tr>
<td>Dual diagnosis</td>
<td>Term used to describe experiencing co-existing mental illness and substance use problems.</td>
</tr>
<tr>
<td>Early intervention</td>
<td>Term used to describe intervening early. In the context of mental health it is used to describe a coordinated approach to assisting a child, young person or adult through the early identification of risk factors and the provision of timely treatment for problems which can alleviate potential harms caused. It is a term widely used in both mental health and childhood development.</td>
</tr>
<tr>
<td>Early Psychosis Youth Programme (EPPIC)</td>
<td>Programme to identify and treat the early symptoms of psychosis in young people.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Epidemiology</td>
<td>The population-level study of the distribution and determinants of health-related states or events (including disease), and the application of this study to the control of diseases and other population and public health problems.</td>
</tr>
<tr>
<td>Family and support people/supporters</td>
<td>“Family and support include family members, partners, friends or anyone whose primary relationship with the person concerned is a personal, supportive and caring one.” A national framework for recovery-oriented mental health services: Policy and theory (2013)</td>
</tr>
<tr>
<td>First responders</td>
<td>Term used to describe those who first intervene or respond to a crisis; for example, paramedics, police and fire-fighters.</td>
</tr>
<tr>
<td>Forensic services</td>
<td>Mental health services that work with people who are mentally unwell and who have been in contact with the criminal justice system. Facilities can include prisons, education courses, therapy, prison hospitals and forensic hospitals and services.</td>
</tr>
<tr>
<td>headspace</td>
<td>Established by the National Youth Mental Health Foundation, headspace offers specific services for people aged 12-25 who need help across the areas of mental health, employment, drug and alcohol, relationships and school.</td>
</tr>
<tr>
<td>Incarceration</td>
<td>Putting a person in jail, imprisonment.</td>
</tr>
<tr>
<td>Juvenile justice</td>
<td>The corrective system for young offenders aged 10–17 years.</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>The geographical area over which an authority extends. In the Review report this is used to refer to states, territories and the Commonwealth.</td>
</tr>
<tr>
<td>Justice system</td>
<td>Term describes the whole law enforcement system. This can include policy, law reform, policing, courts, tribunals, penalties, fines, prison, corrections and parole, legal assistance and victim support.</td>
</tr>
<tr>
<td>Involuntary treatment</td>
<td>Refers to a person being treated for their illness without their consent, either in hospital or in the community. This may occur when mental health problems or disorders result in symptoms and behaviours that lead to a person’s rights being taken away or restricted for a period of time.</td>
</tr>
<tr>
<td>Medicare Locals</td>
<td>Medicare Locals are primary health care organisations established under the Australian Government’s National Health Reforms to coordinate primary health care delivery and manage local health care needs and service gaps.</td>
</tr>
<tr>
<td>Medications</td>
<td>Mental health-related medications typically refers to five selected medications groups as classified under the Anatomical Therapeutic Chemical Classification System (World Health Organization), namely anti-psychotics, anxiolytics, hypnotics and sedatives, anti-depressants and psycho-stimulants and nootropics.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>Disturbances of mood or thought that can affect behaviour and distress the person or those around them, so the person has trouble functioning normally. They include anxiety disorders, depression and schizophrenia.</td>
</tr>
<tr>
<td>Mental health literacy</td>
<td>Knowledge and beliefs about mental illness which can impact problem recognition, mental illness management and prevention.</td>
</tr>
<tr>
<td>Mental health issue</td>
<td>Broader term used to describe mental health problems, which may or may not be in the context of life circumstances. If these issues are not addressed this may result in disadvantage or continued dependence on mental health treatment.</td>
</tr>
<tr>
<td>Mental Health First Aid (MHFA)</td>
<td>Mental Health First Aid (MHFA) is the help provided to a person who is developing a mental health problem, or who is in a mental health crisis, until appropriate professional treatment is received or the crisis resolves. MHFA courses teach mental health first aid strategies in evidence based training programmes.</td>
</tr>
<tr>
<td>Mental Health Nurse Incentive Programme (MHNIP)</td>
<td>This programme provides a non-MBS incentive payment to community-based general practices, private psychiatrist services, Divisions of General Practice, Medicare Locals and Aboriginal and Torres Strait Islander Primary Health Care Services which engage mental health nurses to assist in the provision of coordinated clinical care for people with severe mental disorders.</td>
</tr>
<tr>
<td>Mentally Healthy Workplace Alliance</td>
<td>A national collaboration between the National Mental Health Commission, business, government and the mental health sector. The Alliance aims to create mentally healthy workplaces across Australia, in small and large business across all sectors.</td>
</tr>
<tr>
<td>Model of care</td>
<td>A model of care defines the way health services are delivered. It outlines the group or series of services which are required for the optimum treatment of a person or population group for a specific injury or illness, those required across the stages of treatment and across the stages of care (from acute through to nonacute and rehabilitation) whether that be provided in the community or hospital/ facility or by different services.</td>
</tr>
<tr>
<td>Term</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>National Disability Insurance Scheme</td>
<td>Newly introduced national disability insurance scheme which provides individualised support for eligible people with permanent and significant disability, their families and carers.</td>
</tr>
<tr>
<td>NEET</td>
<td>Acronym used to describe a young person who is ‘not in education, employment or training’.</td>
</tr>
<tr>
<td>OECD (The Organization for Economic Co-operation and Development)</td>
<td>The Organization for Economic Co-Operation and Development is a global organisation with membership from 34 countries which works to promote policies that aim to improve the economic and social well-being of people around the world.</td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
<td>A form of anxiety disorder where repeated and unwanted thoughts and impulses disturb and dominate a person. Often involves rituals such as excessive hand washing, checking and counting, which in turn cause anxiety if such actions are prevented or out of control.</td>
</tr>
<tr>
<td>Participation</td>
<td>The act of taking part or sharing in something.</td>
</tr>
<tr>
<td>Partners In Recovery (PIR)</td>
<td>Partners in recovery or PIR is an Australian Government programme which aims to better support people with severe and persistent mental illness with complex needs and their carers and families, by improving collaboration and coordination. Initial funding was to support 24,000 people through this programme.</td>
</tr>
<tr>
<td>Person with lived experience of a mental health difficulty</td>
<td>To ensure that our language in the Review report is clear both to people who recognise the term ‘consumer’ and those who do not identify with an established mental health consumer movement, the Commission prefers to use the term ‘people with a lived experience’ to describe people experiencing mental health difficulties, their families and support people.</td>
</tr>
<tr>
<td>PHaMs (The Personal Helpers and Mentors Programme)</td>
<td>An Australian Government-funded programme which aims to provide increased opportunities for recovery for people whose lives are severely affected by mental illness. The programme takes a strengths-based recovery approach and assists people 16 years and over whose ability to manage their daily activities is impacted because of a severe mental illness.</td>
</tr>
<tr>
<td>Prevalence</td>
<td>The proportion of people in a population found to have a condition at a certain point in time. It is arrived at by comparing the number of people found with a condition to the number of people studied. Prevalence is usually expressed as a fraction or percentage.</td>
</tr>
</tbody>
</table>
| Psychiatric disability | Psychiatric disability is the consequence and impact of a mental illness on the affected person’s ability to function and is a term used in the Australian *Disability Discrimination Act 1992*. Psychiatric disability may be intermittent and associated with symptoms of schizophrenia, affective disorders, anxiety disorders, addictive behaviours, personality disorders, stress, psychosis, depression and adjustment disorders.

The Commission, however, prefers the term ‘psychosocial disability’ to describe the type of disability as it affects the daily functioning of a person and to recognise the broader social disadvantage and effects of mental illness on people. |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosis</td>
</tr>
<tr>
<td>Qualitative research</td>
</tr>
<tr>
<td>Recovery</td>
</tr>
<tr>
<td>Recidivism</td>
</tr>
<tr>
<td><strong>Remoteness area (Regional, Rural, Remote)</strong></td>
</tr>
<tr>
<td><strong>Restraint</strong></td>
</tr>
<tr>
<td><strong>Schizophrenia</strong></td>
</tr>
<tr>
<td><strong>Seclusion</strong></td>
</tr>
<tr>
<td><strong>Sentinel events</strong></td>
</tr>
<tr>
<td><strong>Sexual orientation</strong></td>
</tr>
<tr>
<td><strong>Specialist mental health service</strong></td>
</tr>
<tr>
<td>Term</td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Stigma</td>
</tr>
<tr>
<td>Structural discrimination</td>
</tr>
<tr>
<td>Substance misuse</td>
</tr>
<tr>
<td>Substance use disorder</td>
</tr>
<tr>
<td>Suicide</td>
</tr>
<tr>
<td>Suicide attempt</td>
</tr>
<tr>
<td>Suicidal behaviour</td>
</tr>
<tr>
<td>Suicidal ideation</td>
</tr>
<tr>
<td>Support person</td>
</tr>
<tr>
<td>Targeted Community Care (Mental Health) Programme (TCC)</td>
</tr>
<tr>
<td>Term</td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Twelve-month disorder</td>
</tr>
<tr>
<td>Twelve-month prevalence</td>
</tr>
<tr>
<td>Underemployment</td>
</tr>
</tbody>
</table>
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AATSIHS</td>
<td>Australian Aboriginal and Torres Strait Islander Health Survey</td>
</tr>
<tr>
<td>ABF</td>
<td>Activity Based Funding</td>
</tr>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ACCHS</td>
<td>Aboriginal Community Controlled Health Services</td>
</tr>
<tr>
<td>ACRRMH</td>
<td>Australasian Centre for Rural and Remote Mental Health</td>
</tr>
<tr>
<td>ACSQHC</td>
<td>Australian Commission on Quality and Safety in Health Care</td>
</tr>
<tr>
<td>ACT</td>
<td>Australian Capital Territory</td>
</tr>
<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
</tr>
<tr>
<td>AEDI</td>
<td>Australian Early Development Index</td>
</tr>
<tr>
<td>AHMAC</td>
<td>Australian Health Ministers’ Advisory Council</td>
</tr>
<tr>
<td>AMS</td>
<td>Aboriginal Medical Service</td>
</tr>
<tr>
<td>AMSANT</td>
<td>Aboriginal Medical Services Alliance Northern Territory</td>
</tr>
<tr>
<td>ASGS</td>
<td>Australian Statistical Geography Standard</td>
</tr>
<tr>
<td>ATAPS</td>
<td>Access to Allied Psychological Services</td>
</tr>
<tr>
<td>ATSIMHSPAG</td>
<td>Aboriginal and Torres Strait Islander Mental Health Suicide Prevention Advisory Group</td>
</tr>
<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse</td>
</tr>
<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
</tr>
<tr>
<td>COPMI</td>
<td>Children of Parents with a Mental Illness</td>
</tr>
<tr>
<td>D2DL</td>
<td>Day to Day Living in the Community</td>
</tr>
<tr>
<td>DoH</td>
<td>Commonwealth Department of Health</td>
</tr>
<tr>
<td>DSP</td>
<td>Disability Support Pension</td>
</tr>
<tr>
<td>DSS</td>
<td>Department of Social Services</td>
</tr>
<tr>
<td>DVA</td>
<td>Department of Veterans Affairs</td>
</tr>
<tr>
<td>FASTT</td>
<td>Forum of Australian Services for Survivors of Torture and Trauma</td>
</tr>
<tr>
<td>FTE</td>
<td>Full time equivalent</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioners</td>
</tr>
<tr>
<td>HASI</td>
<td>Housing and Accommodation Support Initiative programme</td>
</tr>
<tr>
<td>IAS</td>
<td>Indigenous Advancement Strategy</td>
</tr>
<tr>
<td>IPHCO</td>
<td>Indigenous Primary Health Care Organisation</td>
</tr>
<tr>
<td>IPS</td>
<td>Individual placement and support</td>
</tr>
<tr>
<td>LGBTI</td>
<td>Lesbian, Gay, Bisexual, Transgender and Intersex</td>
</tr>
<tr>
<td>MBS</td>
<td>Medicare Benefits Schedule (also known as Medicare)</td>
</tr>
</tbody>
</table>
MDI – Middle Years Development Index
MHDAPC – Mental Health, Drug and Alcohol Principal Committee
MHE-NMDS – Mental Health Establishments National Minimum Data Set
MHiMA – Mental Health in Multicultural Australia
MHNIP – Mental Health Nurse Incentive Programme
MHSRRA – Mental Health Services in Rural and Remote Areas programme.
NATSIISS – National Aboriginal and Torres Strait Islander Social Survey
NEET – Not in Education, Employment or Training
NDIS – National Disability Insurance Scheme
NGO – Non Government Organisation
NMHC – National Mental Health Commission
NMHSPF – National Mental Health Services Planning Framework
NHS – National Health Survey
NSPS – National Suicide Prevention Strategy
NSW – New South Wales
NT – Northern Territory
OID – Overcoming Indigenous Disadvantage
OECD – The Organization for Economic Cooperation and Development
PBAC – Pharmaceutical Benefits Advisory Committee
PBR – Payment by results
PBS – Pharmaceutical Benefits Scheme
PHaMS – Personal Helpers and Mentors
PIR – Partners in Recovery programme
PMC – Department of Prime Minister and Cabinet
PMHN – Primary and Mental Health Network
PND – Post Natal Depression
PTSD – Post Traumatic Stress Disorder
QLD – Queensland
SA – South Australia
SEWB – Social and Emotional Wellbeing programme
TAS – Tasmania
VET – Vocational Education Training
VIC – Victoria
WA – Western Australia
Contributing lives, thriving communities

Report of the National Review of Mental Health Programmes and Services

Volume 3

What people told us – analysis of submissions to the Review

30 November 2014
About this Review

This document is Volume 3 of a four-volume report of the National Review of Mental Health Programmes and Services. All volumes can be downloaded from www.mentalhealthcommission.gov.au. A complete list of the Commission’s publications is available from our website.

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

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

ISSN 2201-3032
ISBN 978-0-9874449-4-3

Suggested citation:


Published by: National Mental Health Commission, Sydney.

© National Mental Health Commission 2014

This product, excluding the Commission logo, Commonwealth Coat of Arms and material owned by a third party or protected by a trademark, has been released under a Creative Commons BY 3.0 (CC BY 3.0) licence. The excluded material owned by a third party includes data, images, accounts of personal experiences and artwork sourced from third parties, including private individuals. With the exception of the excluded material (but see note below with respect to data provided by the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW)), you may distribute, remix and build upon this work. However, you must attribute the National Mental Health Commission as the copyright holder of the work in compliance with our attribution policy. The full terms and conditions of this licence are available at http://creativecommons.org/licenses/by/3.0/au/. Requests and enquiries concerning reproduction and copyrights should be directed to: enquiries@mentalhealthcommission.gov.au

Note: Material provided by:

1. The Australian Bureau of Statistics is covered under a Creative Commons Attribution 2.5 Australia licence and must be attributed in accordance with their requirements for attributing ABS material as outlined at www.abs.gov.au.
2. The Australian Institute of Health and Welfare is covered by Creative Commons BY 3.0 (CC BY 3.0) and must be attributed to the AIHW in accordance with their attribution policy at www.aihw.gov.au/copyright/
Acknowledgements

The National Mental Health Commission would like to formally thank all those who spent their time and effort writing submissions to the Review of Mental Health Programmes and Services. We thank you for your generosity, your dedication to mental health reform and, importantly, your ideas on how to achieve that goal. The depth, breadth and quality of submissions informed the Review on a diverse range of topics, with perspectives from a whole range of sectors.

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.

The volume of information provided was substantial, and the Commission is optimistic that this unique resource can be drawn upon in the future.

All submissions received were considered by the Commission in preparing its final report to Government, and informed the development of the Review’s recommendations and analysis.
## Contents

*Executive summary* ................................................................................................. 5

1. **Overview of submissions received** ................................................................. 7
   1.1 Collection of the submissions ....................................................................... 7
   1.2 Analysis of the submissions ....................................................................... 7
   1.3 Respondents and their interests .................................................................. 8
   1.4 People with lived experience and support person responses overview (Survey 1) ........... 9
   1.5 Professionals’ responses (Survey 2) ........................................................... 12
   1.6 Organisational responses (Survey 3) .......................................................... 14

2. **Cost-effectiveness of existing services and programmes** .............................. 19
   2.1 Key findings ................................................................................................. 19
   2.2 Overview ...................................................................................................... 19
   2.3 Thematic findings ........................................................................................ 20
   2.4 Promising practice demonstrating cost-effectiveness ..................................... 31

3. **Duplication in current services and programmes** ........................................ 35
   3.1 Key findings ................................................................................................. 35
   3.2 Overview ...................................................................................................... 35
   3.3 Thematic findings ........................................................................................ 36
   3.4 Promising practice examples in avoiding duplication .................................... 41

4. **Efficacy of programmes and services in supporting aspects of a contributing life** .... 43
   4.1 Key findings ................................................................................................. 43
   4.2 Perspectives of people with lived experience ................................................ 44
   4.3 Overview ...................................................................................................... 45
   4.4 Thematic findings ........................................................................................ 46
   4.5 Positive programme examples contributing to positive “whole-of-life” outcomes .... 56

5. **Regulation, reporting and red tape** ............................................................... 58
   5.1 Key findings ................................................................................................. 58
   5.2 Overview ...................................................................................................... 58
   5.3 Thematic findings ........................................................................................ 59
   5.4 Promising practice examples ....................................................................... 71

6. **Gaps in services and programmes** ................................................................. 73
   6.1 Key findings ................................................................................................. 73
   6.2 Overview ...................................................................................................... 74
   6.3 Thematic findings ........................................................................................ 75
7. Emerging approaches: technologies and e-mental health ........................................ 84
   7.1 Key findings .............................................................................................................. 84
   7.2 Overview ................................................................................................................ 85
   7.3 Thematic findings .................................................................................................... 86
   7.4 Promising practice examples in using technology ................................................. 93
8. Emerging approaches: integrated care ................................................................. 95
   8.1 Key findings .............................................................................................................. 95
   8.2 Overview ................................................................................................................ 95
   8.3 Thematic findings .................................................................................................... 96
   8.4 Promising practice example of collaborative working and integrated services .... 103
9. Mental health research .......................................................................................... 104
   9.1 Key findings ............................................................................................................ 104
   9.2 Overview ................................................................................................................ 104
   9.3 Thematic findings .................................................................................................... 105
   9.4 Promising examples of research in practice ......................................................... 110
10. Mental health workforce planning, development and training ............................. 111
    10.1 Key findings .......................................................................................................... 111
    10.2 Overview .............................................................................................................. 112
    10.3 Thematic Findings ............................................................................................... 113
    10.4 Promising examples of effective workforce interventions ................................... 123
11. Specific challenges for regional, rural and remote Australia ............................ 125
    11.1 Key findings .......................................................................................................... 125
    11.2 Overview .............................................................................................................. 126
    11.3 Thematic findings ............................................................................................... 127
    11.4 Promising practice for regional, rural and remote areas ...................................... 134
12. Specific challenges for Aboriginal and Torres Strait Islander peoples .......... 135
    12.1 Key findings .......................................................................................................... 135
    12.2 Overview .............................................................................................................. 136
    12.3 Thematic findings ............................................................................................... 137
    12.4 Promising practice examples of effective Aboriginal and Torres Strait Islander peoples’ supports ................................................................. 143
13. Accountability for the outcomes of investment ............................................. 145
    13.1 Key findings .......................................................................................................... 145
    13.2 Overview .............................................................................................................. 146
    13.3 Thematic findings ............................................................................................... 146
    13.4 Promising practice examples of transparency and accountability for outcomes .... 153
Executive summary

This report provides an overview of key findings from the National Mental Health Commission’s public call for written submissions to the 2014 Review of Mental Health Programmes and Services. This public call, held over March and April 2014, was the main mechanism for people using and working in these programmes and services to contribute their views, and more than 1,800 written and online submissions were made by organisations and individuals.

The formal call for submissions was conducted as an online survey, with questions seeking views as to what was working, what was not and what should change in regard to the areas specific to the terms of reference. The collective effort put into these submissions was substantial, and the depth and breadth of information provided was clear. Through their submissions, the voices of people with lived experience of mental illness, their families and support people, as well as the views of professionals, advocates and peak bodies were loud and clear.

It is evident that there is considerable nationwide concern about the future direction of mental health reform in Australia. Respondents identified problems, opportunities and priorities. These ‘grassroots’ perspectives were an invaluable resource for the Commission in conducting its analysis and developing its recommendations to Government.

Interestingly, despite the diversity of their origins, these voices reveal considerable consensus about which elements of our mental health system are working, and which elements need fixing. None of these points of consensus is particularly surprising, and they have been repeated globally for decades. Perhaps the most prominent theme to emerge from this exercise was that the way the mental health ‘system’ is designed and funded across Australia means that meaningful help often is not available until a person has deteriorated to crisis point. This is either because mental health supports are not accessible to them, do not exist in their area, or are inappropriate to their needs. Along the way, they may have lost their job, their family or their home. Countless submissions pointed out that this makes neither economic nor humanitarian sense.

Another prominent area of consensus was the idea that services and programmes should be designed in consultation with the communities they aim to serve, and that they should be based on formal analyses of need. There were many examples provided in the submissions which show this is not happening, resulting in high levels of unmet mental health need. A picture emerges of a hit-and-miss arrangement of services and programmes across the country, seemingly based on no discernible strategy, creating duplication in some areas and leaving considerable unmet need in others.

This unmet need was highlighted particularly strongly in relation to people living in regional, rural and remote areas of Australia. It was also reported that programmes and services currently do not meet the needs of communities with particular mental health challenges; if services are available, they often feel inappropriate and irrelevant to the people they are designed for. Examples of inappropriate provision were those for Aboriginal and Torres Strait Islander communities and people who have migrated to Australia. People with interrelated and complex difficulties which include a mental health problem (including those with substance misuse, history of trauma and abuse, or intellectual disability) are also poorly served by a lack of collaboration across agency or disciplinary boundaries—each of their intertwined problems is viewed and treated in isolation.
Many and detailed suggestions were made about how the mental health system might be improved to support positive whole-of-life outcomes for people experiencing mental illness. Innovative and flexible use of existing funding, technology and human resources was reported to be a key mechanism to better meet the needs of diverse populations. Nationally consistent but locally relevant mechanisms to systematically measure outcomes—for accountability, quality improvement, and evaluation purposes—was widely considered to be the missing foundation stone for improving the experiences and outcomes of people living with mental illness in Australia.

This report presents the findings of a thematic analysis of submissions against each of the Review’s terms of reference. For ease of navigation, each section is prefaced by a ‘Key Findings’ summary (boxed) for that particular term of reference. The language within this report refers to ‘people with lived experience of mental illness’ or ‘people with lived experience’ when presenting the survey findings. Likewise, the term ‘support people’ includes families and carers, but ‘families and support people’ is also used.
1. Overview of submissions received

A very enthusiastic response was received from all over Australia—more than 1,800 individuals and organisations submitted their views on the mental health system. The response represents good coverage of all geographical areas of the country, including rural and remote areas, and a good balance of people with lived experience/their support people (including family members) and professional responses (621 and 861 respectively).

A diverse range of interests and communities were represented. While there was over-representation of some groups and an under-representation of others, our focus during analysis was on drawing out common themes across all submissions, rather than giving more weight to points that were made more frequently.

1.1 Collection of the submissions

In March 2014 the Commission hosted an online call for submissions survey on its website. To promote the survey, the Commission wrote to more than 500 stakeholder organisations inviting them to participate in the survey and encouraging them to inform their networks. The Commission and Commissioners also actively promoted the survey and submission process.

The online survey was intended to elicit specific examples of:

- what is working in the mental health system
- what is not working in the mental health system
- recommendations for change.

The call for submissions was designed with three different online surveys appropriate to the respondent’s role.

- Survey 1: for people with lived experience of mental illness, support people, family members and members of the public
- Survey 2: for professionals and other workers in the mental health support system
- Survey 3: for organisations

While Survey 1 asked in very general terms about peoples’ experiences of what was working or not working for them, Surveys 2 and 3 required respondents to provide examples of good and poor practice for each of the Review’s terms of reference. The design of the surveys considered the length and time for completion, the opportunity for respondents to provide their input in free text, consistency across surveys for analysis and relevance to the terms of reference.

1.2 Analysis of the submissions

As the majority of survey questions asked for free-text answers, standard analysis techniques for analysing qualitative (narrative) information was used. The same techniques were used to analyse submissions received in forms other than the online survey (for example, in letters and emails).

As the volume of responses was so high, a small team in the Department of Health, trained by the National Mental Health Commission team, undertook the first stage of analysis (coding of information). The Commission team then interpreted this coded information in terms of themes, against each term of reference. Coding was aided by the use of NVivo, a software programme which allows the user to categorise and group textual information for later interpretation. The phases of analysis are given in the table below.
Table 1: Phases of qualitative data analysis

<table>
<thead>
<tr>
<th>Phase</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Preparation</td>
<td>Collection of survey responses via online survey</td>
</tr>
<tr>
<td></td>
<td>Export of survey data to Excel, cleaning, organisation, de-identification</td>
</tr>
<tr>
<td></td>
<td>Development of initial Term of Reference (ToR)—based coding scheme in NVivo</td>
</tr>
<tr>
<td></td>
<td>Export of data to three NVivo master files (one for each survey)</td>
</tr>
<tr>
<td>2: Coding</td>
<td>Training of coders in NVivo and coding scheme</td>
</tr>
<tr>
<td></td>
<td>Descriptive coding of all responses applying and modifying coding scheme as appropriate</td>
</tr>
<tr>
<td>3: Thematic analysis</td>
<td>Interpreting patterns or themes in the coded content against each ToR. This involved reading a selection of content which already has been coded with the ToR category, and using finely grained sub-coding to detect prominent themes. Sub-coding continues within each group of responses until saturation point is reached (no new themes are emerging).</td>
</tr>
<tr>
<td>4: Case study identification</td>
<td>Identifying stories of good or poor experiences from people with a mental illness/support person/professional against each ToR</td>
</tr>
<tr>
<td></td>
<td>Identifying case studies of services/programmes commonly cited as displaying promising practice against each ToR</td>
</tr>
<tr>
<td>5: Write up</td>
<td>Staged write-up of thematic findings against ToRs to feed into the writing of final Review report</td>
</tr>
<tr>
<td></td>
<td>Supplementary report describing all thematic findings as Volume 3 (this work) to support the final report.</td>
</tr>
</tbody>
</table>

1.3 Respondents and their interests

1.3.1 Who responded?

The Commission received 1,834 separate submissions:

- In total, 1,750 submissions were made using the online survey. Thirty-two of these were found to be duplicated submissions, making a revised total of 1,718 online submissions.
- A further 116 submissions were received as direct submissions; that is, outside the online survey format.

The numbers of responses to each of the three online surveys are shown in the following table.
Table 2: Numbers of online responses, by type of respondent

<table>
<thead>
<tr>
<th>Online survey respondents</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionals and workers in the system</td>
<td>861</td>
</tr>
<tr>
<td>People with lived experience, families, support people, general public</td>
<td>621</td>
</tr>
<tr>
<td>Organisations</td>
<td>236</td>
</tr>
<tr>
<td><strong>TOTAL ONLINE SUBMISSIONS</strong></td>
<td><strong>1,718</strong></td>
</tr>
</tbody>
</table>

The additional 11 responses were received by email, post or phone. They were analysed using the same methods as used for the online submissions. A breakdown of these responses is shown in the following table.

Table 3: Numbers of non-online responses, by type of respondent

<table>
<thead>
<tr>
<th>Non-online respondents</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisations</td>
<td>71</td>
</tr>
<tr>
<td>Professionals and workers in the system</td>
<td>26</td>
</tr>
<tr>
<td>People with lived experience, families, support people, general public</td>
<td>19</td>
</tr>
<tr>
<td><strong>TOTAL NON-ONLINE SUBMISSIONS</strong></td>
<td><strong>116</strong></td>
</tr>
</tbody>
</table>

1.4 People with lived experience and support person responses overview (Survey 1)

1.4.1 Key points

- 621 online submissions were received from people who identified as having experienced a mental illness or as a family/support person.
- There was good geographical distribution of responses, but there was an over-representation of people with lived experience/support person responses from Victoria and an under-representation from New South Wales.
- Interest was roughly even between people identifying as having lived experience and those identifying as families and support people; one-third of respondents to this survey said they both were a person with lived experience and a family member or support person of someone else.
- While experience of services such as hospital admission and general practitioner (GP) consultation for a mental health problem was about even between people living in capital cities and those living elsewhere, use of the Disability Support Pension (DSP) was substantially higher among respondents living in regional, rural and remote areas.

1.4.2 Respondent place of residence

- **Two-thirds of respondents lived in a state or territory capital city,** with the remaining one-third reporting that they lived in a regional town or a rural/remote area of Australia.
  - This means that the population distribution of respondents to Survey 1 by area of residence was representative of Australia’s population distribution. \(^7\)
The biggest response to Survey 1 was received from Victoria (34.3 per cent of responses), followed by NSW (26.4 per cent), Queensland (14.0 per cent), South Australia (10.5 per cent), Western Australia (9.3 per cent), the Australian Capital Territory (2.6 per cent), Tasmania (1.9 per cent) and Northern Territory (1 per cent).

- This means there was an over-representation of people from Victoria (who make up 24.9 per cent of Australia’s population), from the Australian Capital Territory (1.6 per cent) and from South Australia (7.3 per cent of the population) responding to Survey 1, with an under-representation of people from NSW (32.2 per cent of Australia’s population), Queensland (20.2 per cent) and a slight under-representation of Western Australia (11.2 per cent), Tasmania (2.1 per cent) and the Northern Territory (1 per cent).²

1.4.3 Respondent lived experience

- 210 people (33.8 per cent) had lived experience as both a service user and family member or support person
- 173 (27.9 per cent) were service users and not family members or support people
- 154 (24.8 per cent) were family members or support people and not service users
- 16 (2.6 per cent) were interested members of the public
- The remaining 68 (11.0 per cent) were professionals who answered this survey rather than survey 2 [A note for the survey design and legibility].

1.4.4 Respondents’ interaction with support systems

537 people with lived experience and family members or support people answered questions about how they had interacted with mental health supports over the past five years.

- As well as their lived experience, 24.7 per cent of people primarily identifying themselves as service users or support people considered themselves to also have a job within the mental health system. Those living in capital cities were slightly more likely than those living outside of capital cities to fall into this group.
- 59.4 per cent of people with lived experience and family members or support people reported that they or the person they support has attended a GP for mental health reasons. Those living in capital cities were slightly more likely to attend a GP for mental health reasons.
- 27 per cent of people with lived experience and family members or support people reported that they or the person they support has been admitted to a hospital bed for mental health reasons. Those living in capital cities were slightly more likely to be admitted to hospital.
- 20.5 per cent of people with lived experience and family members or support people reported that they or the person they support has received the Disability Support Pension for mental health reasons. Those living in regional, rural or remote areas (24.7 per cent) were more likely than those living in capital cities (18.4 per cent) to have received the DSP.

1.4.5 What works for people with lived experience, family members and support people?

Illustrative examples of common responses given by people with lived experience/family members/support people about what works for them in terms of mental health supports included the following.

- Services and professionals demonstrating genuinely caring attitudes.
• Supports and pursuits other than formal healthcare—such as support from friends and family, support to attend education, stay in employment, empowering self-help such as exercise and creative activities.
• Sufficient time being allowed for more formal interventions, such as therapies, according to a person’s need. Building trust in the relationship between clinician and client is important to success of intervention.
• Being aware of what help is available through adequate information and signposting.
• Continuity of care over time and communication between professionals and services so a story does not have to be repeated.
• Peer support from those with similar experiences—whether online or in groups.

Q: What, in your experience, works in terms of mental health supports?
A: ‘Support in terms of encouragement and friendly social support to feel you are once again part of the community. Goal setting, talking about the future, motivation. Lack of patronising and a certain amount of expectation of improvement in the situation.’

1.4.6 What is not working for people with lived experience, family members and support people?
Illustrative examples of common responses given by people with lived experience/family members/support people are given below.

• Insufficient appropriate services available to meet need, meaning that issues can escalate—and only being considered eligible for services when ‘at risk’.
• Affordability determining access to treatment.
• Poor experiences of inpatient and crisis care, especially judgmental or dismissive staff.
• Low expectations by services and professionals of what is possible.

Q: What, in your experience, does not work in terms of mental health supports?
A: ‘Not being able to afford private help, and the extremely limited subsidised services means problems are left to destruction, or an extended stay in a psychiatric facility.’

1.4.7 What are the main changes people with lived experience, family members and support people would like to see?
Illustrative examples of common responses given by people with lived experience/family members/support people are given below.

• Greater involvement of people with lived experience, carers, family members and support people in design of, and decisions about, support and care.
• Greater support for carers and families who often feel excluded when their relative is ill.
• Increases in availability of longer-term Medicare Benefits Schedule-subsidised services (especially increased number of sessions under Better Access).
• More emphasis on early intervention, including school-based programmes.
More emphasis on public understanding of mental illness.

Q: What improvements do you believe need to be made in terms of mental health support?
A: ‘I think having two bureaucracies (federal and state) isn’t working. The money needs to go into one very efficient and competently run system—not be fragmented across NGOs, GP-referred groups, and a lot of semi-trained/unregistered service providers. It should be a one-stop-shop where people tell their story once and an appropriate referral for follow-up is made.’

Member of the public, New South Wales

1.5 Professionals’ responses (Survey 2)

1.5.1 Key points from Survey 2:
- 861 responses were received from people with a mental health-related job.
- Once again, Victorians were more enthusiastic respondents than those in other states and territories and were over-represented among professional respondents.
- Psychologists, and particularly clinical psychologists, were over-represented among professional respondents, while doctors and nurses were under-represented.
- One-fifth of professionals reported having personal experience of mental illness.
- Seven in ten responses were received from professionals working at least some of their time in the private sector, far outnumbering not-for-profit and public sector employees.

1.5.2 Respondents’ professional background
- Clinical psychologists (n=370) accounted for 43 per cent of people responding to the professionals’ survey.
- All types of psychologists accounted for 63.5 per cent of professional respondents. ‘Other’ psychologists identified themselves primarily as registered psychologists, but counselling, education, occupational, specialist, research and neuropsychologists were also represented.
- The remainder of responses were made up of counsellors and psychotherapists (11 per cent of total responses); other allied health (5.2 per cent); nurses (3.6 per cent); managers (3.0 per cent); peer workers (2.7 per cent); doctors (1.8 per cent); researchers (1.4 per cent) and miscellaneous professions (2.8 per cent). People with lived experience (not working in mental health) who answered the wrong survey made up the remaining 5 per cent. [A note for the survey design and legibility]
  - When compared to the overall mental health workforce, the responses to Survey 2 show an over-representation of psychologists and an under-representation of nurses and doctors. Within the Australian mental health workforce, there are an estimated 6.4 times as many nurses as psychiatrists, and an estimated 7.6 times as many psychologists with full registration as psychiatrists. Psychiatrists as a group therefore are heavily under-represented when compared to psychologists in this survey, and nurses are also heavily under-represented.
- 21.5 per cent of all professional respondents reported having had personal lived experience of a mental illness.
1.5.3 Respondents’ place of residence

- Two-thirds of professionals lived in a state or territory capital city, with the remaining one-third reporting that they lived in a regional town or in a rural/remote area of Australia.
- This means that the population distribution of professionals by area of residence was representative of Australia’s population distribution—but not distribution of mental health professionals generally, which is concentrated in capital cities.¹
- The biggest professional response was received from Victoria (27.74 per cent), followed by NSW (25.8 per cent), Queensland (19.4 per cent), South Australia (10.6 per cent), Western Australia (11.8 per cent), Tasmania (2.5 per cent), the Australian Capital Territory (1.3 per cent), and Northern Territory (0.6 per cent).
- This means there was an over-representation of professionals from Victoria (which makes up 24.9 per cent of Australia’s population) and from South Australia (7.3 per cent of the population), with an under-representation of people from NSW (32.2 per cent of Australia’s population), and a slight under-representation from Queensland (20.2 per cent), from the Australian Capital Territory (1.6 per cent) and the Northern Territory (1 per cent).²

1.5.4 Respondents’ place of professional practice

Of the 820 professional respondents (excluding people with lived experience who accidentally answered this survey):

- 33.1 per cent reported working for public sector mental health or community health services
- 17.7 per cent reported working for a nongovernment sector organisation
- 70.5 per cent reported providing services through the private sector or private practice.

Some respondents reported working part-time for different sectors, which means the above percentages total more than 100 per cent.

1.5.5 What is working for professionals?

Illustrative examples of common responses about what works for them as given by professionals are as follows.

- Leveraging multi-disciplinary collaboration, often on an ad-hoc basis, and often with non-health agencies such as schools, to provide a more holistic set of interventions to a client. Liaison between GPs and psychologists via Better Access also is frequently mentioned as facilitating improved care.
- Technology is used to improve the efficiency and effectiveness of a professional’s practice—from administrative matters such as use of EFTPOS machines and text message appointment reminders, to clinical uses such as online therapies and telehealth interventions in remote areas, to training and professional development activities.

The constant accessibility of programs and apps also allows the delivery of support and reminders (e.g. via SMSs or emails) at times and places where the challenges to coping are being faced, rather than having therapy being confined to sessions.

Clinical psychologist, Queensland
1.5.6 What is not working for professionals?

- By far the biggest complaint in this survey was connected to the reduction in Better Access sessions to ten per calendar year per client. Reinstating the previous 18-session maximum, or addressing the inequity between the numbers of sessions subsidised for psychologists and for psychiatrists, were both commonly suggested solutions.
- Psychologists who have a specialist registration equivalent to that of a clinical psychologist believe they are treated inequitably in terms of Medicare subsidies.

1.5.7 What are the main changes professionals would like to see?

Illustrative examples of common responses given by professionals are given below.

- Increase subsidised services: as well as increasing the number of sessions rebateable under Better Access, mention is made of the need to subsidise according to case complexity, for non-client-facing activity, and for particular allied health services such as telehealth and family therapy.
- Create incentives for professionals to work in rural and remote areas.
- Changes to workforce training/development: university-based training should be relevant to practice challenges and updated to reflect changes in practice, including multidisciplinary working; ensure that the work clinicians are allowed to do matches their level of training, expertise and specialisation (especially differentiation of those with basic and specialist APS registration).

1.6 Organisational responses (Survey 3)

1.6.1 Key points

- 236 organisations completed our online survey. They ranged from small private providers to national peak bodies representing hundreds of organisations, and from professional representative organisations to university departments.
- The range of organisations responding ensures that the views of the whole mental health sector (and beyond) are heard in our analysis; this compensates for any over or under-representation of certain professions or interests in the individual submissions.

1.6.2 Types of organisation

In total, 236 responses were received via the online survey from organisations. These were divided into four categories as follows, according to the organisation’s self-defined main purpose.
Table 4: Organisational responses by type of organisation

<table>
<thead>
<tr>
<th>Type of organisation</th>
<th>No. respondents</th>
<th>Percentage of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider of mental health related support</td>
<td>138</td>
<td>58.5</td>
</tr>
<tr>
<td>Advocacy or representative organisation</td>
<td>49</td>
<td>20.8</td>
</tr>
<tr>
<td>Professional peak body</td>
<td>28</td>
<td>11.9</td>
</tr>
<tr>
<td>Research body</td>
<td>21</td>
<td>8.8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>236</td>
<td>100</td>
</tr>
</tbody>
</table>

Of the 138 providers of mental health-related support:
- 42 per cent (n=58) were not-for-profit organisations
- 26 per cent (n=36) were operating in the private sector
- 21 per cent (n=29) were Medicare Locals
- 11 per cent (n=15) were operating in the public sector

Of the 49 advocacy and representative organisations:
- 46.9 per cent (n=23) were advocacy or lobbying organisations, of which eight also provide support to people with lived experience or carers
- 24.5 per cent (n=12) represent a number of similar organisations
- 20.4 per cent (n=10) were national interest peaks for a particular diagnosis or mental health
- 8 per cent (n=4) were public legal or policy organisations

Of the 28 professional peak bodies:
- 6 represented psychologists
- 6 represented counsellors or psychotherapists/psychoanalysts
- 5 represented other allied health disciplines
- 4 represented doctors
- 4 represented all professional disciplines
- 3 represented nurses

Of the 21 research bodies:
- 38.1 per cent (n=8) were research departments specifically for rural and remote health

1.6.3 Jurisdiction of operation

Organisations reported operating in jurisdictions as described in the following table (many organisations operate in multiple jurisdictions). The number of organisations operating in the smaller states and territories (in terms of population size) is greater than might be expected.
Table 5: Organisations’ jurisdiction(s) of operation

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Number of respondents</th>
<th>Percentage of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>All—National</td>
<td>31</td>
<td>13.1</td>
</tr>
<tr>
<td>New South Wales</td>
<td>116</td>
<td>49.1</td>
</tr>
<tr>
<td>Victoria</td>
<td>102</td>
<td>43.2</td>
</tr>
<tr>
<td>Queensland</td>
<td>84</td>
<td>35.6</td>
</tr>
<tr>
<td>South Australia</td>
<td>74</td>
<td>31.4</td>
</tr>
<tr>
<td>Western Australia</td>
<td>71</td>
<td>30.0</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>53</td>
<td>22.5</td>
</tr>
<tr>
<td>Tasmania</td>
<td>53</td>
<td>22.5</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>52</td>
<td>22.0</td>
</tr>
</tbody>
</table>

1.6.4 Organisations’ mental health-related interests

We asked organisations to nominate the principal issues with which their organisation is engaged in relation to mental health. They could nominate more than one from a list. It is noteworthy that a sizeable minority of organisations did not identify as being involved in clinical community-based or hospital health care. The list below also illustrates that there was a wide variety of whole-of-life issues which were perceived by respondents to be directly related to their overall support of people’s mental health. This shows that the philosophy of a ‘contributing life’ is one which resonates across the mental health sector and beyond.

- 59 per cent (n=140) were engaged in health care (community or hospital-based)
- 35 per cent (n=82) were engaged in education
- 27 per cent (n=64) were engaged in carer/family support
- 23 per cent (n=54) were engaged in peer support
- 16 per cent (n=37) were engaged with substance use issues
- 14 per cent (n=34) were engaged with cultural issues
- 14 per cent (n=32) were engaged with housing/homelessness issues
- 12 per cent (n=28) were engaged in online support
- 12 per cent (n=28) were engaged in employment (for people with mental health difficulties)
- 11 per cent (n=25) were engaged with justice system issues
- 5 per cent (n=11) were engaged with sport, leisure or creative pursuits

1.6.5 Interest in Commonwealth programmes

The table below reflects how many times organisations mentioned particular Commonwealth mental health programmes in their responses.
Table 6: Commonwealth programme mentions in the text of organisations’ survey responses

<table>
<thead>
<tr>
<th>Programme</th>
<th>Mentions in Survey 3 responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATAPS</td>
<td>1,114</td>
</tr>
<tr>
<td>Better Access</td>
<td>749</td>
</tr>
<tr>
<td>headspace</td>
<td>644</td>
</tr>
<tr>
<td>Partners in Recovery</td>
<td>580</td>
</tr>
<tr>
<td>Mental Health Nurse Incentive Programme</td>
<td>350</td>
</tr>
<tr>
<td>Personal Helpers and Mentors</td>
<td>263</td>
</tr>
<tr>
<td>National Disability Insurance Scheme</td>
<td>156</td>
</tr>
</tbody>
</table>

1.6.6 What works well in the mental health system?

- Effective collaboration and integration between agencies and services was the most frequently mentioned example of things working well in the organisations’ experiences.

Good integration requires trust and genuine partnerships... the health gains that have been provided by Aboriginal Controlled Community Health Services is due to the model ... initiated by the local Aboriginal community, governed by the local Aboriginal community, and implemented by the local Aboriginal community...

National Aboriginal Community Controlled Health Organisation

1.6.7 What is not working in the mental health system?

Illustrative examples of common responses given by organisations are given below.

- Inefficient use of funding was attributed to clumsy or duplicative administration processes, to inappropriate distribution of the workforce, and to an overall imbalance of funding within the mental health system. However, inefficiency was most commonly associated with the provision of ineffective or inappropriate support to people with lived experience.

- The most commonly cited sources of a poor experience of mental health support were access difficulties, lack of a person-centred approach, lack of consideration of interrelated needs, and falling through gaps between services.

- Workforce concerns emerge from these responses principally in terms of training curricula and professional development not keeping up with developments in population needs and new ways of working; gaps in expertise for particular difficulties and among particular professionals; and a perceived inflexibility in the deployment of the workforce at present.

Transition periods lead to individuals not effectively having their needs met in a holistic manner. Examples of transition periods are from primary school to secondary school, and also from youth to adulthood. There appears to be a lack of attention paid and services available ... which leads to consumers and carers falling through the cracks and not obtaining the type of support they may require.

Batyr Australia Ltd.
1.6.8 What are the main changes that organisations would like to see?

The most common desired changes were as follows:

- **Changes to funding**
  - e.g. more investment ‘upstream’ in early intervention
  - e.g. longer funding cycles
- **Changes to policy or strategy**
  - e.g. ‘National strategy’ for particular special interest
  - e.g. Strategic planning of services (e.g. intellectual disability)
- **Changes to how or where support is provided**
  - e.g. addressing more than one need at once
  - e.g. alternatives to inpatient care for acute crisis

One practical step to improve the mental health system would be to facilitate timely and efficient transfer and clinical handover for consumers transferring between acute, sub-acute and primary care settings including:

- timely access to secure and high-level care settings when this is needed
- streamlined transfer and clinical handover between public and private sectors when this is clinically necessary and/or requested by the consumer
- effective coordination of care for consumers requiring care for multiple conditions (psychiatric and non-psychiatric).

*Australian Private Hospitals Association*
2. Cost-effectiveness of existing services and programmes

2.1 Key findings

1. The most prominent characteristics of cost-effective mental health services and programmes are that they:
   a. Respond to identified needs of people with lived experience in a timely, accessible way.
   b. Address interrelated needs and enable rapid re-engagement in life.
   c. Are evidence-based and well evaluated.
   d. Demonstrate resourcefulness and creativity, including leveraging collaboration.

2. The most frequently cited sources of inefficiencies in programmes and services are:
   a. Failure to consult communities about what they need.
   b. Administrative inefficiency and inflexibility.
   c. Failure to match professional skills to tasks.

3. Common recommendations for improving the cost-effectiveness of programmes and services are:
   a. Greater flexibility in how funding is used to enable it to be tailored to local needs.
   b. Greater emphasis on equity of support for different populations.
   c. Investing in more sustained interventions which prevent the revolving door effect.

2.2 Overview

Term of reference 1 asked the National Mental Health Commission to assess:

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

The present chapter deals with cost-effectiveness, while the efficacy aspect is considered in chapter 4.

2.2.1 Survey questions

The analysis below is primarily based on answers to the following survey questions.

Professional and organisational respondents were asked to provide an example from their own experience (or that of their organisation) of a service, programme, policy or initiative:
   a. demonstrating value for money (cost-effectiveness)
   b. demonstrating or encouraging inefficiency in the organisation or delivery of services

While people with lived experience, family members and support people were not asked specifically about cost-effectiveness, we have included in our analysis references made by those respondents to this issue.

2.2.2 Survey responses

For question (a), 82.2 per cent of organisations (n=194) and 87 per cent of professionals (n=749) provided a response.

For question (b), 66.1 per cent of organisations (n=156) and 66.4 per cent of professionals (n=572) provided a response.

Analysis for this chapter considered three sources of evidence—responses to these particular survey questions, plus material from unsolicited submissions, and answers to other survey questions which addressed issues relevant to the chapter.
2.2.3 Note on interpretation

High response rates could be a result of these questions being presented first in their respective sections. The analysis presented below focused on finding patterns in what respondents believe to be a cost-effective or inefficient service or programme, and this information should be interpreted in conjunction with other thematic findings.

2.3 Thematic findings

2.3.1 Overall

Responses to questions about cost-effectiveness of services and programmes show that for people using and working in the mental health system, this is not a simple calculation to make. Cost-effectiveness for many of these stakeholders does not just mean maximising outcomes per dollar spent. Their submissions show that an assessment is complicated by four factors:

- Mental health problems can be chronic or episodic over a lifetime, and so cost-effectiveness needs to take into account the future impacts of the present intervention.
- Mental health problems also can affect and be affected by many aspects of a person’s life, including family circumstances, employment and education, housing, physical health—and these ramifications also must form part of cost-effectiveness considerations.
- Individual responses to different types of mental health supports and interventions often are highly particular to that individual and therefore effectiveness often is hard to generalise.
- An effective response to a person experiencing mental illness often does not consist of a discrete intervention (such as a single drug or surgical procedure) but requires a combination of interconnected supports.

Overall, the key characteristic of a cost-effective mental health programme is that people actually find it accessible, appropriate and relevant to their needs. Large numbers of respondents thought that services and programmes which are forward-thinking and are able to forestall the need to access other services—either because multiple needs are not recognised, or when things deteriorate later on—demonstrated cost-effectiveness. An example is the higher cost of delivering the same programme in a rural or remote area; sometimes greater relative spend is needed in some areas to ensure equity across the country.

The key argument here is that what is cost-effective for people with lived experience (because it meets their needs and prevents deterioration) also can be cost-effective for governments and taxpayers.

2.3.2 What makes a mental health service or programme cost-effective?

This section describes the most prominent characteristics of a cost-effective mental health service or programme.

The service or programme enables early intervention

The most important feature of a cost-effective programme or service, according to our submissions, is that it aims to intervene early in the course of a person’s mental illness. This is seen to be cost-effective because enabling people to access appropriate help early, before symptoms significantly impair daily functioning, will a) avert the need for use of more intensive (and expensive) services such as inpatient admission, and b) prevent cycles of disadvantage which occur when a problem becomes entrenched and jobs or housing are lost as a result.
When asked specifically about examples of a cost-effective service, many respondents cited services which seek to support children and young adults’ mental health.

... evidence-based early childhood programs [...] are the key to the primary prevention of both mental and physical illness and will save the community a lot of funding in the future in terms of jail, supported accommodation, employment etc.

Central Australian Aboriginal Congress

Early intervention was seen as a key principle of cost-effectiveness across all age groups, not just the young. For example, for someone who has been living with a severe mental illness for some time, early intervention means keeping them out of hospital—whether through preventing crises occurring or through alternative crisis support.

Community mental health working in an assertive case manager model where clients are remaining on the books if they have a serious and persistent mental health problem so that they are followed up regularly to ensure they stay well. This model maintains people in the community and allows them to remain there whilst having an exacerbation of their illness as a crisis service can accommodate their needs for daily or more often, contact with a mental health professional thus avoiding hospitalisation. Well utilised, this model needs less beds in the hospital but more staff working in the community over a 24 hour period to provide the support necessary. Research into this model showed it was more efficient and less costly than hospital based care.

Allied health professional, New South Wales

The prevention of knock-on impacts in other parts of a person’s life, expense to other parts of the health and welfare system, and the cost of lost productivity also were recognised through individual stories such as the following.

A man who had formerly been a successful entrepreneur, a valued family man and a significant contributor to community activities, developed severe depression which, despite medication, had him sitting staring at the wall for seven years, when he was referred for clinical psychology services. He began treatment feeling little expectation of change. After 16 sessions he was so well that a business colleague offered him a franchise opportunity and he soon developed a new thriving business … This occurred during the few years when Medicare rebates could be paid for up to 18 sessions in a calendar year. The total treatment cost (at today's rates including a gap fee of $42.00 per session) was $4,400.00 or $3,392.00 to the taxpayer through Medicare rebates. Compare that to seven years of Centrelink payments, not to mention the people who were not employed by him over those years!

Clinical psychologist, New South Wales

The service or programme meets users’ needs

Many responses to questions about cost-effectiveness followed the argument that if you build something (a service or programme) and people cannot access it or find it does not meet their needs, it is bad value for money. Good value for money therefore relies on the service or programme being accessible (financially and physically), as well as being relevant and
appropriate to a person’s needs and world view (such as their cultural or age-specific needs). In addition, services or programmes which are set up in ways which recognise that people presenting with a mental health difficulty may have other inter-related needs also were frequently mentioned as offering good value for money.

**Affordability**

Making services affordable to the end-user was seen as an important aspect of cost-effectiveness, because of the preventive gains made when services are accessed in a timely manner. Being unable to access services because they are unaffordable was frequently mentioned in relation to the limit of ten sessions accessible under Medicare rebates for Better Access; a few psychologists reported working pro bono or for a nominal fee for some clients after the Medicare sessions ran out. People with lived experience reported feeling that they were left without support because of the lack of availability of any other appropriate service once their psychology sessions were exhausted.

**Location**

Services located close to home were thought to be cost-effective, partly because they aided timely access, and partly because, for people living in regional or rural areas, transport costs to the individual or to the health service could be averted.

---

**Country Health SA Mental Health Service**

Country Health SA Mental Health Service provides a community-based sub-acute level of care (known as intermediate care service) in five regional communities, Whyalla/Port Augusta, Mt Gambier, Pt. Lincoln and Kangaroo Island. The nurse-led service enables consumers to stay in their own community, and generally in their own home with their family, avoiding transfers to the metropolitan service and mental health inpatient admissions. The team works closely with the local hospital and is well integrated with the community mental health team, and local NGO providers.

**National Alliance for Rural and Remote Health**

The service or programme enables rapid re-engagement in life

Services or programmes which enable people to quickly re-engage in the normal activities of daily living—such as work, education, family duties and community participation—are thought to offer good value for money. This is because productivity losses associated with prolonged illness can be minimised, and because factors such as having a meaningful occupation and strong social networks in turn are protective of mental health.

---

**Eating disorders (anorexia nervosa, bulimia nervosa, binge eating disorder and atypical presentations of each) impair physical, psychological and social health and untreated/unsupported have very high productivity and burden of disease costs ($15.1B and $52.6B respectively in 2012 as calculated by Deloitte), due to their early onset, duration when not properly treated, and high fatality rate. Deloitte estimated that 4 per cent of the population (+913,000) Australians had eating disorders in 2012 with less than 25 per cent in treatment. [...] A focus on ability rather than disability is key to reducing negative impact. Someone with an eating disorder is able to participate but needs support and flexibility, during their treatment and through recovery. This is particularly important during school years. Ironically, those with a genetic disposition to an eating disorder such as anorexia nervosa are typically highly intelligent and high achievers—those able to contribute significantly to
Australia’s productivity if they receive encouragement to stay engaged in education and employment.  

Butterfly Foundation

Community-based activities and drop-in centres that cater for people with complex needs, including mental health needs, are low-cost initiatives that provide significant, and at times, life-saving benefits to mental health consumers. Some of these centres are part of a neighbourhood centre and some are part of a mental health NGO. An example is the Day to Day Living program which is commonly run in drop-in centres. Consumers said these are safe spaces that help reduce social isolation. The activities and social interactions also serve as important stepping stones into more active community participation.  

NSW Consumer Advisory Group - Mental Health Inc. (now trading as BEING)

The service or programme is evidence-based

Many respondents associated cost-effectiveness with implementing services and programmes which are ‘evidence-based’. The evidence cited by respondents to justify claims of cost-effectiveness ranged from formal research such as randomised controlled trials which ‘proved’ the positive impact of a particular intervention, to in-house evaluations of services which had been assessed positively by service users or which showed good clinical outcomes.

When evaluated in 2010, the RichmondPRA Young People’s Outreach (YPOP) Program cost $278,000 per year to operate. (The cost has gone up in intervening years to now being around $330,000 per year.)

Data about hospitalisation rates for 44 of the 45 young people for the two years prior to entry to YPOP was obtained. The total number of hospital days for this period was 1,321 days. The total number of hospital days for the same group after entry to YPOP was 265. This is a reduction of about 80 per cent in the amount of time spent in hospital by the young people.

This also represents a cost saving of $915,522 for acute admissions or $691,680 for non-acute admissions (based on Mental Health Drug and Alcohol Office, NSW Ministry of Health average costs for adult inpatient hospital admissions and average length of stay, December 2011).

RichmondPRA

The service or programme leverages joint working and economies of scale

A surprisingly prominent aspect of respondents’ understandings of cost-effectiveness was the value of cooperative working. Commonly cited examples of cooperation that contribute to the cost-effectiveness of services and programmes were:

- deliberate coordination between different services to offer greater continuity of care to people with lived experience and therefore reduced duplication of information
- pooling of expertise to make funding and staffing go further, especially in rural and remote areas
- coordination of multiple programme funding streams to gain administrative economies of scale
• centralised referral processes and triage
• collocation of multiple services, offering benefits in terms of reduced overheads for providers and also convenience for people with lived experience
• capacity-building through partnerships between mental health professionals and volunteers and peer workers.

Using a train-the-trainer approach and building the capacity of teaching staff to implement the Peer Support Program and the capacity of students to run the program provides a very effective and highly successful method of increasing penetration, and impacting on school communities throughout Australia. To use the program schools pay a small fee for service and an annual membership. Based on school enrolments for schools using the program, at March 2014 almost 517,000 students were actively involved. The cost to run the organisation is approximately $1m p.a. This equates to less than $2 per student. Approximately 50 per cent of this ($1 per student) is met by government funding (state and federal). The balance is covered by philanthropic support and fee for service.

Peer Support Australia

The Adelaide Hills ‘SHARE-Doing Life Together’ program ... is a partnership between the Adelaide Hills Community Mental Health team [state funded] and a network of churches in the region, which combines a 0.20FTE community mental health nurse role with training and mentoring for volunteers to reduce social isolation. The return on investment from this minimally funded program is magnificent.

Northern Adelaide Medicare Local

An example combining several of these cooperation strategies is provided by a Medicare Local which operates across regional, rural and remote areas of its state, and reports that it achieves cost-effectiveness by integrating funding streams and staffing across Commonwealth programme delivery.

Our mental health service is delivered in an integrated model—so the funding streams across ATAPS, headspace, MHNIP, Better Access and RPHS [Rural Primary Health Services] match the needs of the individual and the community. These services have a one-stop-shop approach [which] cuts down on other overhead costs, improves access for clients, and attracts a multidisciplinary workforce rather than isolated practice. This model supports growing a workforce especially vital for regional and rural communities as we are able to support interns and new graduates. This is cost-effective over time as it reduces the burden on FIFO/DIDO workforce while being more acceptable to communities.

Townsville-Mackay Medicare Local

The service or programme is cheap to run

Small NGOs as well as some professionals and people with lived experience reported the value of services which are cheap to run and which are resourceful in gaining funding from philanthropic, industry and other fundraising. Cheap-to-run services often were those which provided activities offering social connection and support, especially to people living with severe or chronic mental illness.
Scalable interventions include those which require little further investment after initial development to reach additional users, such as online information portals and unsupervised e-therapies. For example, young people responding to the survey reported that online forums hosted by sites such as reachout.com gave them a safe, anonymous place to feel less alone and to offer mutual support as part of the website’s forums. The use of e-therapies as part of an integrated support system as a first line approach for mild difficulties also could be cost-effective:

E-health platforms reach large numbers of people and are scalable. Standard therapies such as cognitive behaviour therapy (CBT) can be effectively delivered online to large numbers of individuals for a fraction of the cost of face-to-face therapies. The per-person cost of providing this level of treatment has become very low. Likewise, preventive services that promote mental wellbeing can be targeted to people with few symptoms who would not meet the clinical criteria for a mental disorder.

2.3.3 Aspects of Commonwealth programmes offering good value for money

By substantially increasing the numbers of people accessing mental health treatment, Better Access is seen as filling a large gap in provision for people with mild to moderate mental health difficulties who previously would not have had any access to affordable mental health care unless they deteriorated to crisis point. Making such a service available on demand to the wider community is thought to increase the timeliness of access to appropriate help.

The Better Access to Mental Health has allowed many of our clients in a regional area to access mental health services that were previously inaccessible to them. Our clients who would previously only be seen once they have reached severe crises are now able to be proactive and seek support before it overwhelms them and can then contribute to society rather than withdraw or need expensive inpatient assistance.

The collocation model adopted by many headspace services—whereby GPs, psychiatrists, psychologists and other allied health and vocational advisory staff are located in the same youth-friendly environment—is reported by some people with lived experience as being convenient and approachable, and by some providers as providing economies of scale.

headspace has an innovative funding model which comprises a core grant of slightly less than $1 million annually, together with an establishment grant of $400,000, supplemented by local contributions from a lead agency (grant holder) and other local agencies in a consortium partnership. These services are also supported by a range of Medicare Benefit Scheme (MBS)-funded service providers co-located on the headspace site, meaning that a comprehensive range of services are available to young people to improve their mental health.
2.3.4 What makes a mental health service or programme inefficient?

**Failure to consult communities**

The failure to develop, design and plan services and programmes in consultation with the communities to which they are targeted is seen by many as a key cause of inefficiency. This was particularly true with regard to the particular challenges, needs and preferences of people whose first language is not English or whose cultural background may mean they understand mental illness and its appropriate treatment in different ways. Without consultation, money spent on services and programmes may be wasted because they are not felt to be relevant or appropriate for the communities concerned. As the following example illustrates, when there is a further failure to acknowledge the specific requirements of these communities during the everyday operation of clinical care, experiences of people with a mental health difficulty and outcomes can suffer.

Failure by general mental health services to consult specialist state-wide transcultural mental health services in a timely fashion often leads to delayed diagnosis as well as poor consumer and family engagement. It also has the added risk of health care services prematurely terminating treatment, which can result in multiple complications and readmissions. Unpublished state and territory data demonstrates that people born overseas from non-English speaking backgrounds tend to experience increased risk of hospitalisation compared to Australian-born and/or people from English-speaking backgrounds. Once admitted, this population group tends to experience longer lengths of stay and severity of mental illness.

*Mental Health in Multicultural Australia (MHiMA)*

**Location**

People with lived experience in many regional, rural and remote areas find logistical challenges to accessing services because of low per capita numbers of psychologists and psychiatrists outside of capital cities. Long drives for each appointment are not uncommon. For those in remote areas, fly-in/fly-out clinicians often are different each time, preventing continuity of care which is important in the therapeutic process.

**Common examples of inefficiencies in Commonwealth programmes**

Although Better Access is generally seen as providing good value for money, there were two aspects of the programme’s design which were seen by many respondents as inefficient.

The first was a widespread questioning of the requirement for GP referral and later review; GP Mental Health Care Plans generally were not seen as a good use of resources because assessments of problems usually are made again by psychologists or other clinicians during the initial Better Access appointment.

Removing the essential requirement of an initial GP plan would remove unnecessary administrative costs. If psychologists could give people even an initial appointment without a GP referral to assess what is needed and then send people back to GPs with a tentative diagnosis to have a plan constructed, that would be more efficient, accurate and cost-efficient. Psychologists are well trained and placed to make such a judgement.

*JumpStart Psychology*
From the GP’s perspective, the process is burdensome for some, to the extent that some people with lived experience are blocked from Better Access because their GP is unwilling to complete the paperwork.

One GP said "oh that's too much paperwork" when a friend who was suffering depression wanted a referral to a psychologist. When people are depressed they also feel disempowered and will not press for a referral.

Support person, Victoria

I had a feeling of guilt that the GP and psychologist seemed to have to fill in so much paperwork. Both the GP and psychologist mentioned this and I felt like a burden, even though they were very nice about it.

Person with lived experience, New South Wales

The second and most common complaint—made by hundreds of psychologists and people with lived experience—about Better Access was related to the reduction in numbers of sessions eligible for Medicare rebates, from the original 18 to ten in 2012–13. Respondents commented that this reduction often makes the difference between offering a complete treatment and offering only part of what is needed. If a person has more complex difficulties than mild depression or anxiety, ten sessions appears to not be enough, leaving the person without services or to try to access (more expensive) specialist mental health services. Ultimately, the reduction was felt to be inefficient, especially because building a therapeutic relationship takes time and having to access a different service only duplicates that effort.

The Australian Psychological Society (APS) undertook a survey of psychologists to investigate the impact on consumers of the reduction in sessions. Data was collected on 900 consumers who, at the end of the allowable 10 sessions, were judged by their psychologist to need further treatment. Treating psychologists managed these consumers in a variety of ways but nearly a quarter were required to wait until the new calendar year to obtain further treatment due to lack of alternative arrangements. Only 16 per cent were able to obtain treatment from another mental health service.

Australian Psychological Society

I think 10 sessions is not enough support. Mental health is not like a physical illness where it just 'heals'. It can linger and remain present; the symptoms may become less severe but they do resurface and although I have weeks where I feel fine, there are also weeks where I can barely survive. Having the ability to see a psychologist when I need to would be really beneficial. Mental health does not operate on a 10-week time frame, therefore neither should treatment.

Person with lived experience, Victoria
The previous 18 sessions granted under the Better Access scheme meant that an adolescent client was able to stay at school and still complete relatively intensive mental health treatment. Under the current system, that same girl has had to leave school to participate in a more expensive day patient program.

Clinical psychologist, Victoria

At 93 years of age, the man who created cognitive therapy, Dr Aaron T Beck, has written to our Minister for Health, Peter Dutton MP, suggesting that 24 visits of psychological care would be more optimal for most cases of depression (http://bit.ly/1gph8Vy). We think this is a powerful expression of the need for a change in Medicare policy. Our suggestion is that the allowance of 50 visits of psychiatric care per annum could be more equitably shared with psychological treatment. For the vast majority of Australians needing psychological care, an allowance of a maximum of 25 visits would be more than adequate and far more cost-effective in the long term.

Alliance for Better Access

The National Suicide Prevention Programme is criticised by some for funding too many small, uncoordinated initiatives which are not integrated with other mental health supports.

There is widespread frustration in the mental health sector that suicide prevention monies are being spent using a scattergun approach, not informed by the evidence, and in small bundles with no alignment between the states. Additional dissatisfactions include: (a) poor targeting of funding to specific risk groups (young men, indigenous youth, displaced and separated men, those with mental health disorders, particularly depression); (b) many suicide prevention organisations do not deliver treatments or early interventions that research evidence suggests “works”; (c) there has been no attempt to reform the mental health services that provide help so that services are accessible to those at risk; and (d) there is a divide between population-based approaches and mental health treatment (almost parallel universes). The outcome is that our response to suicide prevention is not integrated, cohesive or effective. Many suicidal people remain “under the radar”.

Black Dog Institute

2.3.5 Options for improving the cost-effectiveness of services and programmes

‘Invest to save’ in early intervention, prevention and promotion

Increasing investment in services and programmes which offer early intervention and prevention approaches was suggested by many respondents as helping to rebalance the system away from expensive acute services and preventing secondary impacts on a person’s social and economic circumstances and welfare service use.

There are significant gains to be made in improving the quantity and quality of mental health promotion, early intervention, community development and service integration. These gains can be made in the reduction in suicide, improved educational and employment retention,
reduced costs to the criminal justice system, families sustained and fewer lives dissolved. The meaningful contributions of people who might otherwise be isolated and excluded can make up meaningful components of families and communities. The value from these investments is not just in the money saved but in the quality of life for individuals and their families and in the lives saved.

*Victorian Aboriginal Community Controlled Health Organisations (VACCHO)*

There is a great burden of mental illness among tertiary students. These illnesses affect individuals at an emergent stage of life, and the cost in terms of productivity lost is immense. These students are also all readily accessible on campuses. Universities must develop strategies that include the provision of mental health services on campus, strategies to detect at-risk individuals and follow-through with their care, and connections between on-campus services and community services. This would be a cost-effective way to reach a significant proportion of the population affected by mental illness.

*Australian Medical Students’ Association*

**Greater flexibility in use of funding**

Inflexibility in the use of funding, particularly funding for Commonwealth programmes, can sometimes mean that the programmes can come across as siloed and not addressing the needs of the whole person. Efforts to increase flexibility are demonstrated by an innovative group of volunteers described in the extract below.

headspace has been conducting counselling for youth and until recently the main emphasis was on the youth. As the program was evaluated it was recommended that a whole family approach was needed. However, the headspace charter has no real provision for the inclusion of partners or parents in the process. There was a perceived need and with the assistance of volunteers a program was instigated to address this need. This program has great potential to be an entry point to assist all parents or partners of those with mental health issues.

*Allied health professional, South Australia*

Reforming the Better Access initiative in order to take into account the complexities associated with the management of mental health in the community. The demand for psychological services will continue to rise. Therefore, it is important the program not only evolves to improve access issues, but also ensures that the quality and quantity of mental health services provided is proportional to need. This involves implementing a flexible funding model to enable complex mental health cases to access more than 10 consultations, when deemed necessary. This funding model should also be flexible to provide additional support and resources to clients with diverse and special need.

*General Practice Mental Health Standards Collaboration (RACGP)*
Greater emphasis on equity of support for different populations

Inequities in the availability of appropriate support for Aboriginal and Torres Strait Islander peoples and for regional, rural and remote communities were commonly cited by respondents and will be dealt with in detail in dedicated sections of this report. As an example, the arguments for greater equity between metropolitan and rural areas include the following.

More equitable distribution of existing resources for rural and remote areas from existing budgetary allocations. Improved equity is essential due to:

- the higher comorbidity and greater number of suicides in rural and remote Australians (Kolves, et al, 2012)
- the disproportionate contribution by rural and remote workers to Australia’s economic prosperity through agriculture and mining, which account for 67 per cent of the value of Australia’s exports
- the prediction that the population outside capital cities will grow by 26 per cent by 2026.

De-identified research organisation

Other inequities were identified in the availability of appropriate mental health support for people given certain diagnoses (especially eating disorders and personality disorders), communities with particular mental health challenges (including diverse sexualities, veterans, prisoners and ex-prisoners), and culturally and linguistically diverse communities, including refugees.

Lack of specialist provision for these different groups is perceived by many to lead to increased use of crisis services when needs cannot be met.

The criminal justice system contains many people with various levels of mental illness. They generally go untreated and unsupported while incarcerated, contrary to the duty of care of the prison, prior to their release back into the general community. The government’s fiscal situation could be greatly assisted by justice reinvestment programs across the mental health, drug and alcohol and community development systems.

VACCHO

Previous funding of $22.4m for the Mental Health: Taking Action to Tackle Suicide package, to be allocated across all at-risk groups, is insufficient to adequately address consumer needs across all high-risk groups including LGBTI people. Additional funding will allow for currently targeted suicide prevention activities to reach a greater audience across high-risk groups. Funding should also be increased for support and crisis services that have the ability to offer specialised support to LGBTI people.

NSW Gay and Lesbian Rights Lobby

Options for increasing cost-effectiveness through equity of support provision include:

- not assuming that mental health service models designed for one community can be transplanted without adaptation to a different community—one size does not fit all
• a strong grasp of how different communities understand the origin and nature of mental illness
• involvement of community members in the design, implementation and delivery of a service or programme.

**Investing in more sustained interventions to prevent the revolving door effect**

There is a sense that the lack of flexibility with Better Access and ATAPS in terms of number of sessions does a disservice to people with more complex difficulties and therefore is ultimately inefficient. More sustained interventions, particularly in terms of talking therapies, are recommended by many respondents. An example is longer-term psychotherapy for people living with personality disorders:

Intensive psychodynamic psychotherapy is a specialised intensive form of psychotherapy that helps severely traumatised and disadvantaged mentally ill patients, and those with personality disorders who are resistant to other forms of mental health care; it is usually offered after simpler methods have failed, and more thorough treatment is required; it undertakes deep change of the personality, and is different to supportive measures; it is required for patients whose lives are often stuck in severely self-destructive cycles, and it reduces high costs in other parts of the health care system and wider society.

*Australian Psychoanalytical Society*

**2.4 Promising practice demonstrating cost-effectiveness**

NACCHO represents 150 Aboriginal Community Controlled Health Organisations (ACCHSs) who are located in urban, regional, remote and very remote Australia. The model of service provided by ACCHS’s is comprehensive primary health care which is inclusive of Mental Health and Social Emotional Wellbeing. NACCHO’s ACCHS’s Report Card and *Economic Value of ACCHSs Report 2014* demonstrated that 80 per cent of ACCHS’s saw 311,000 Aboriginal and Torres Strait Islander people and other Australians, perform 2 million episodes of care annually, as an industry employs over 5,500 health professionals and receives 1/4 of the Indigenous Health Expenditure compared with mainstream providers who receive 3/4 of this expenditure without demonstrating health outcome or gains. Both of these current NACCHO reports demonstrated cost effectiveness and efficiency however investment into ACCHS’s to deliver appropriate Mental Health and SEWB services has been lacking over a 10 year period with majority of the mental health funding being distributed to mainstream providers.

*National Aboriginal Community Controlled Health Organisation*
2.4.1 Lifeline social return on investment (SROI) evaluation

Lifeline’s online Crisis Support Chat service: translating the Lifeline 13 11 14 telephone crisis line to an online chat environment, utilising Australian Government funding for initial development plus operational funding from a private corporate donor. A Social Return on Investment study, also funded by the corporate donor to demonstrate the impact of the service on help seekers, found an $8.40 return for every dollar invested in the chat service, providing a case for other parties, including government, to invest in funding the service.

Lifeline Australia

2.4.2 Housing and Accommodation Support Initiative (HASI)

The NSW Housing Accommodation Support Initiative (HASI) provides intensive home-based service delivery for people with serious mental illness. It relies on a strong partnership and collaboration between housing agencies, public clinical health services and non-government service providers. The aim of the program is to provide stable housing, coordinated clinical care and social/rehabilitation support based on social inclusion principles. Although cost per package is considerable, HASI is both cost-effective in absolute terms and comparable, as it targets people who would otherwise be at risk of repeated re-admission to acute inpatient care or homelessness. HASI improves participants’ mental health by keeping people in accommodation, clinically well and socially engaged.

Australian Association of Social Workers

Within HASI, consumers are successfully maintaining their tenancies and using relevant mental and physical health services; have improved mental health outcomes, decreased hospitalisations, improved social contact with family and friends, and increased participation in community activities, including engagement in work, education and training for some consumers. Furthermore, results indicate that there has been a 59 per cent decrease in the average number of days spent in hospital per year, a 68 per cent decrease in the average number of days hospitalised per admission, and a 24 per cent drop in the number of admissions to hospital (Social Policy Research Centre, 2012).

Murrumbidgee Medicare Local

2.4.3 Individual Placement and Support (IPS)

The WA Mental Health Commission [MHC] has provided two project funding grants of $150,000 (2013–14) and $165,000 (2014–15) to the Western Australian Association for Mental Health (WAAMH), from which WAAMH has provided development and technical assistance to establish 12 formal Individual Placement and Support (IPS) partnerships between mental health services and disability employment services in metropolitan and rural WA. WAAMH’s approach is based on the State Trainer model developed at Dartmouth Medical School in the USA and implemented by the National Health Service in the UK.
Through these partnerships mental health services receive direct access for their clients to specialist employment services, have an employment specialist co-located within their service, and receive expert development support and technical assistance from an independent specialist IPS development unit.

IPS has been evaluated in 19 randomised controlled trials in North America, Europe, Asia and Australia. 60 per cent or more of IPS clients obtain competitive jobs, compared to about 24.3 per cent of those achieved by the DES service in Australia in 2012 (Australian Government, Department of Education, Employment and Workplace Relations, Evaluation of Disability Employment Services Interim Report Re-issue March 2012.)

**Western Australian Association for Mental Health**

### 2.4.4 Alcohol supply reduction in Alice Springs

Alcohol supply reduction measures in Alice Springs, based on increasing the minimum price of alcohol, are incredibly cost-effective in the primary and secondary prevention of mental illness. An increase in the price of 25 cents per standard drink, which cost nothing, has reduced population alcohol consumption by 10 per cent and prevented a large number of hospital admissions, including admissions for assault. As a result, children in their early years are less exposed to the type of violence and trauma which the Californian Adverse Early Childhood Study has demonstrated lead to the development of mental illness, especially depression, in later life. In addition, as adults get less drunk less often they are less likely themselves to suffer from alcohol-caused mental illnesses and more able to respond to the needs of their own children. Further reduction of alcohol supply is one of the most cost effective initiatives that could be undertaken in the primary and secondary prevention of mental illness. This is also true for the impact of the former system of photo licensing at the point of sale and the Banned Drinkers Register which effectively targeted the heaviest drinkers and led to a major reduction in hospital admissions (see the paper from the NDRI on Alcohol Control Measures in Alice Springs for further details).

**Central Australian Aboriginal Congress**

### 2.4.5 Return on Investment for StandBy Suicide Response service

StandBy Response is a national suicide postvention initiative to support people and communities bereaved by suicide. The argument below is an example of cost-effectiveness calculations made by the organisation delivering this initiative, which demonstrate an attempt to quantify the benefits of their service in economic as well as human terms.
If the StandBy Response Service was providing coverage of the Australian continent, it would mean even further economies of scale, greater service cohesion and reduced gaps for those experiencing the devastating effects of the loss of a loved one to suicide. Currently the Department of Health has invested $4.5M annually across 16 StandBy Response Service sites in Australia. United Synergies has recently completed modelling that has estimated a further $9.2M would complete the coverage of Australia. Thus a total of a $13.7M annual investment would provide national coverage and support by the StandBy Response Service. Expanding the StandBy Response Service coverage to the entire Australian population would mean the following further investments and sites (using the combinations of Medicare Local Boundaries) would be made in each state and territory. In completing this we have made some further economies to bring together some sites under more efficient coordination and natural boundaries.

Return on investment (Model 1):

- Over the next three-year period (the financial years 2015 to 2018), calculating 2 per cent CPI the total investment would be $42 million.
- Using the findings of the economic evaluation into the StandBy Response Service for this investment the ‘net economic benefit’ over the three-year period would be between $19 and $43 million (calculated on a 50–70 per cent uptake of the service)
- It should also be remembered that the benefits of the StandBy Response Service intervention has lasting benefits so the benefit can only assume to have larger economic returns/impacts than calculated here.

*United Synergies Ltd*
3. Duplication in current services and programmes

3.1 Key findings

- Many respondents denied that any duplication in provision of services or programmes existed, instead emphasising lack of services and unmet need.
- Most examples of duplicated service provision were linked to overlapping remits of, and lack of coordinated planning between, Commonwealth and state/territory-funded mental health supports and services.
- Some duplication of remit was perceived between Commonwealth programmes, especially Better Access and ATAPS.
- Respondents argued that reducing duplication should be seen as an exercise in increasing equity of access to mental health supports across Australia, rather than as an excuse for cutting services.
- Respondents also thought that reducing duplication should not be at the cost of restricting choice available to people with lived experience.
- A commonly suggested strategy for reducing duplication is a geographically based collaborative mental health needs analysis process and mapping of current service provision to ensure that the introduction of new programmes or services fills geographical or needs-based gaps.

3.2 Overview

Term of reference 2 asked the National Mental Health Commission to assess:

Duplicate in current services and programmes

This chapter addresses duplicated provision or remit of services and programmes. Duplication in reporting and administrative activity is addressed separately in Chapter 5 of this document.

3.2.1 Survey question

Organisations and professionals were asked the question:

a. Please give a specific example of an area where there is duplicated provision of services or programmes.

While people with lived experience, family members and support people were not asked specifically about duplication, we have included in our analysis references made by those respondents to duplicated provision of services or programmes.

3.2.2 Survey responses

For question (a), 37.7 per cent of organisations (n=89) and 22.1 per cent of professionals (n=190) provided a response.

Analysis for this chapter considered three sources of evidence—responses to this particular survey question, plus material from unsolicited submissions, and answers to other survey questions which addressed issues relevant to the chapter.

3.2.3 Note on interpretation of the responses

It is not clear whether the low response rates to this question were because respondents could not think of any examples of duplication or whether they simply chose not to answer the
question. The analysis presented here focuses on examples of duplication which were provided, but this information should be interpreted in conjunction with other thematic findings (particularly those about gaps in provision under term of reference 5).

3.3 Thematic findings

3.3.1 Prevalence of duplicated services and programmes

Duplication as a foreign concept

Of the 75 organisations providing a valid response to the question, a total of 24 (32 per cent) stated explicitly that they knew of no duplication and that, on the contrary, there are not enough services to meet need. Some greeted the idea of duplication with derision or comments such as ‘I wish’. The same response was seen in 20 per cent of valid professional responses.

The Australian Psychological Society (APS) is not aware of any instances of duplication of mental health services or programs across Australia. Anecdotal feedback from members of the society is that the demand for mental health services continues to exceed supply.

Australian Psychological Society

Duplication vs. choice

Some respondents argued that duplication is not always a bad thing. They cautioned against removing perceived duplication, which is actually empowering choice among people with lived experience. Others noted that knowing whether one service is duplicating another or not requires a detailed investigation of how, where and with what purpose each is delivered, and whether services which appear to be very similar are in fact catering to different client preferences and need.

Duplication should not be confused with genuine consumer choice around their own individual needs, and services should have flexibility to deliver individually tailored options rather than providing a ‘menu’ or programmatic response.

De-identified national provider organisation

There is a danger in significantly reducing the 'choice' clients/consumers have as it creates an unequal power balance and reduces clients' opportunity when there is only one provider and this provider only provides a limited number of services in a defined manner.

Merri Community Health Services, Victoria

3.3.2 Types of duplicated services and programmes

Duplication between Commonwealth and state/territory-funded services

Duplication was most commonly perceived to occur as a result of confusion between the responsibilities of different levels of government to directly deliver services.
Australia’s mental health system is trapped in multiple inefficiencies of cost and efficacy, in large part because of the sheer complexity of funding, levels of government, departments, delivery points and pathways. Successive well-intentioned governments have responded to this by new initiatives which only serve to create new levels of complexity onto those which already exist. [...] Further, funding must focus on the person’s recovery ahead of existing organisational, professional or governmental preferences.

*SANE Australia*

Examples of Commonwealth/state duplication of service delivery usually were framed in terms of Commonwealth-funded services being ‘dropped’ into an area without adequate consultation about local need or existing provision. This can result in a confusing multiplicity of uncoordinated services in particular geographical areas, as illustrated by this nurse’s experience working in Victoria.

Histologically the service planning and program implementation catchments of Commonwealth programs do not align with state-funded catchments. This leads to a swathe of services operating within areas that are poorly understood by professionals, let alone the general community. This has also been exacerbated historically through the process of tendering for services, which has also led to a multiplicity of providers operating within geographical catchment areas.

*Nurse, Victoria*

Examples mentioned multiple times:

- Existing arrangements for care coordination in an area being duplicated by the introduction of Partners in Recovery.

**PIR - Central West and Western NSW** . There already exists, in [regional towns in this area], Care Coordination Committees whose role is almost identical to Partners in Recovery. Why did someone not do a needs analysis and find this out?

*Psychologist, New South Wales*

- Duplication of public community mental health services in some areas by Commonwealth-funded services which are perceived to do the same job. An example cited several times was the introduction of headspace centres to towns where public child and youth mental health services and youth support NGOs were already operating.

There seems to be overlap in our region between the services provided by Jigsaw and headspace. As a local psychologist I cannot confidently say that I am aware of the difference between these services and what would constitute an appropriate referral to one and not the other.

*Clinical psychologist, Victoria*
Duplication between Commonwealth programmes

The most commonly cited case of duplication between Commonwealth-funded programmes was between Better Access and ATAPS. While respondents acknowledged that the purpose of these two initiatives was different, many argued that they did not work in practice as intended.

- Many private psychologists saw ATAPS as an expensive, over-administered version of Better Access. Some told of their experiences of trying to get registered as an ATAPS psychologist, reporting that they had given up because of the amount of paperwork and re-education required even for very experienced clinicians.
- In many areas there is a perverse situation where the least qualified professionals are seeing the most complex clients. This is because of the comparative pay structures of the two programmes. While registered psychologists can earn more under ATAPS payments than under Better Access rebates, for clinical psychologists the situation is reversed and they gravitate towards Better Access.
- Although the idea of targeting funds for certain disadvantaged communities through ATAPS is thought to be a good one in principle, many respondents felt that the same goal of addressing disadvantage could be achieved using the less onerous administrative and governance arrangements of Better Access through bulk-billing arrangements.

Remit duplication

Examples were given of services which seemed to be catering to the same need. These included:

- Many government-funded organisations running similar initiatives such as mental health helplines and online resources, including in the suicide prevention space and the youth mental health space.

Australia has a large number of mental health telephone helplines and online services, which operate independently and cause confusion and difficulty for people seeking help. There is an opportunity to improve the efficiency and effectiveness of telephone support lines in particular. Australians should have a single national number to call as a starting point. National helpline workers could ask and assess what people need and then connect them to the most appropriate service or support, which could range from online therapies to other, highly specialised lines, crisis services or simply information. Technology could link up information and show where and how people are travelling through ‘the system’. This would avoid duplication, minimise the risk of people ‘falling through the cracks’, and measure outcomes. It would also provide savings to government by minimising the management costs inherent in managing multiple contracts.

Beyondblue
Local NGOs with ‘psychosocial support’ remits not being clearly differentiated from each other or from government services.

A number of government and non-government services in WA are funded for psychosocial support and/or clinical rehabilitation. However, there is a lack of guidance about which agencies should target which needs, resulting in duplication and under-utilisation of excellent services.

**Allied health professional, Western Australia**

### 3.3.3 Reported consequences of duplication

**Inequitable provision between metropolitan and other areas**

Respondents pointed out that it often is the wealthiest areas of the country which also have the best mental health provision and the greatest choice of public and private providers. Eastern Sydney and metropolitan Perth and Brisbane were all cited by multiple respondents as being over-supplied with services.

The RANZCP has concerns that the ongoing lack of Commonwealth-state coordination in funding and service provision creates significant regional disparities in service provision, from very high in inner city areas to very variable outside these. The RANZCP would like to highlight the lack of data exploring the apparent poor access to services in outer metropolitan areas that are often very socio-economically disadvantaged and in high need of mental health support.

**Royal Australian and New Zealand College of Psychiatrists (RANZCP)**

**Inequitable provision between different rural and remote communities**

Numerous examples were provided of communities in regional, rural and remote Australia which have been descended upon by multiple providers, creating duplication of services in some communities while their neighbours go without. However, the chaos produced by the number of (often visiting) providers means that community needs still are not met.

We know that in some regions there are too many visiting services with overlapping and sometimes competing roles that do not collaborate or work closely with either the primary health care service or each other. This leads to inefficiencies, miscommunications and a lack of a patient and family-centred approach. It also takes up a huge amount of primary health care time and does not employ or involve local Aboriginal people who know the community and can provide sustainable, culturally appropriate care.

**Aboriginal Medical Services Alliance Northern Territory**

**Impact on people with lived experience**

Many services which appear to do the same thing can make it more difficult for people with lived experience, family members and their support people to navigate their way to appropriate services. This also can result in people with multiple needs receiving a fragmented
service, where providers deal with a narrow problem and do not talk to each other. We also received reports of mental health clients having multiple case managers.

There are a number of programs in western Sydney that provide services to a range of people with mental illness. These include federal and state-funded services which are distributed to a number of NGOs, private and state organisations, many of which essentially deliver services to the same or similar population group. Many of these programs are offered by more than one provider (organisation), adding complexity for the patient to navigate the system.

**WentWest**

**Impact on providers**

Where many small providers compete for funding in a small community, service provision and care coordination can become less important than survival.

In one community within our region with a population of 15,000 persons, as many as 17 organisations are in some way involved in service delivery or service support. While options and choice for the consumer are ideal and should be promoted, it becomes impossible to better coordinate services when the organisations have to focus on service delivery but also continuity of their organisation.

**Country North South Australia Medicare Local**

2.3.4 **Suggestions to reduce duplication**

- Use systematic geographically based needs and gap analysis, as well as meaningful community involvement, to form the basis of coordinated service planning.
- Prioritise filling gaps in areas where needs are not being met by existing services, rather than aiming for universal coverage of a particular programme.

Scoping rural and remote community needs is required to identify local issues prior to programme development. Such scoping would provide a deeper understanding of rural and remote mental health care needs to which health care provision can then be tailored for greater efficiency and effectiveness.

**Mental Health Academics of the Australian Rural Health Education Network**
• Examine opportunities for pooling Commonwealth funding to particular geographical areas to enable local decision-making about mental health priorities and needs.

To avoid duplication of services and ensure local needs were met it would seem appropriate to pool all primary mental health funding (i.e.: Commonwealth and state, including for example MH Nurse Incentive scheme, ATAPs, PHAMS etc.) and allocate these to Medicare Locals on a flexible basis—allowing them to commission a fully integrated primary health care service system based upon the identified and agreed needs of their local communities: thereby cutting out duplication and waste and targeting those most in need.

De-identified Medicare Local

• Examine opportunities for leveraging collaboration in particular localities between programmes or organisations which have similar remits and a shared vision.

I had a maternal health nurse call me up this week to work out how she could best refer a struggling father to me for psychological therapy. She had initially referred to me via ATAPS, but then realised that I was not registered for ATAPS. She subsequently sent this father to his GP to get a Mental Health Care Plan so he could see me under Better Access, but the GP refused to do a referral … A cost-effective and non-stigmatising system would allow people to be referred to a clinical psychologist by a variety of health professionals, schools or even self-refer.

Clinical psychologist, Victoria

3.4 Promising practice examples in avoiding duplication

3.4.1 Mates in Construction

Mates in Construction [a suicide prevention and mental health case management scheme for construction workers] is provided in Queensland, New South Wales, South Australia and Western Australia. Similar programs are provided in Victoria through Incolink, the Australian Capital Territory and Northern Territory through Oz Help Australia and in Tasmania by OzHelp Tasmania. Each of these organisations has formed a collaborative working party that ensures service provision is not duplicated and that a joint message of mental health and wellbeing is delivered to the industry. OzHelp and Mates in Construction have jointly created the Life Skills Tool Box Pty Ltd initiative aimed at pooling our resources in development of a program targeting young workers.

Mates in Construction
3.4.2 Federal and state-funded services collaborating

The [Medicare Local] is, in partnership with the [Local Health District] developing an integrated care model which will be built upon an established base of longstanding strategic relationships and local joint services including government, non-government and private sector service providers. Through increased integration, the [area] will have a responsive, flexible network of service providers and improved capability of the primary health care sector to increase their capacity to provide local services that add value and reduce duplication. [...] Local commissioning of services will ensure that services meet the needs of the community, improve access, provide better outcomes and are efficient and sustainable at a regional level. Integrated service delivery will reduce duplication and span service gaps through new models of care, new or improved workforce roles/capability and improved operational efficiencies.

Central Coast NSW Medicare Local
4. Efficacy of programmes and services in supporting aspects of a contributing life

4.1 Key findings

Respondents identified a number of key characteristics of an effective journey for people with lived experience, their family and support people. These include:

- Easily and readily accessible mental health services.
- Effective and ongoing collaboration and communication between mental health care providers.
- Effective therapeutic relationships with mental health providers.
- Holistic and individualised approach to recovery, meeting the needs of the “whole person”.
- Peer support, community and family support.

Effective support for a contributing life included four main characteristics. These were:

- Coordinated approach to provide integrated mental health support.
- Ongoing and community-based mental health service delivery.
- Supportive community environment.
- Inclusion of community, family members and friends in recovery.

Primary barriers to supporting a contributing life included:

- Inaccessible, unaffordable professional services and support.
- Over-emphasis of medical model approach to mental health therapy and recovery.
- Ineffective utilisation and integration of services and agencies.
- Social exclusion and stigma for those experiencing mental illness.

Strategies to produce “whole-of-life” outcomes included:

- Increased opportunities and support for those experiencing mental illness outside mental health services.
- Integration of opportunities for social participation, engagement and inclusion.
- Use of a whole-of-community approach to mental health support and integration.
- Family-oriented service delivery.
4.2 Perspectives of people with lived experience

Mental health is something that affects so many Australians during their lifetimes, whether it’s through them experiencing issues with mental health themselves or watching someone close to them experiencing issues. Therefore, I believe that it should be held as a top priority at a government level to make sure that our system of delivering mental health services is a supportive, efficient and as well formed as we can possibly make it.

*Person with lived experience, WA*

Living with mental health conditions is difficult because stigma makes it hard to speak up about your issues. At the same time, you don’t have a physical sign that makes the community aware that you need a little bit of extra support. A person with a broken leg carries crutches and will receive the kind help of strangers. A person going through depression may be brushed aside. While the government does not have a huge role in this particular aspect of living with mental illness, it’s important to remember that these attitudes are pervasive. We will fund cancer research because the effects of cancer are obvious—and devastating. We forget that the DALYs [Disability Adjusted Life Years] of mental illness are often greater. The costs to our economy, society, and services as a result of mental illness are well worth re-looking at funding models.

*Person with lived experience, New South Wales*
4.3  Overview

This chapter assesses submission responses which address experiences and outcomes for people with lived experience, family members and support people. It responds to two terms of reference, as follows.

**Term of reference 3** asked the National Mental Health Commission to assess:

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

**Term of reference 1** asked the National Mental Health Commission to assess:

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

The ‘cost-effectiveness’ aspect was the subject of a separate analysis (Chapter 2 of this document). The current chapter deals with the ‘efficacy’ aspect of ToR 1 in terms of improving the lived experience of people living with mental illness and their family members and support people.

4.3.1  Survey questions

Organisations and professionals were asked to give an example of a service or initiative which:

a. supports multiple aspects of a contributing life (e.g. physical health, housing, education and training)

b. has proven to be efficient and effective and has resulted in good outcomes for people experiencing mental health problems and/or their families

c. does not effectively address or meet needs of the whole person (e.g. physical health, housing, education and training)

d. results in people living with mental health problems and/or their supporters having a poor experience

e. has proven to be inefficient or ineffective and has not resulted in good outcomes for people experiencing mental health problems.

Although these were the questions directly related to supporting a contributing life, references to improving the lived experience of people with mental illness and their family members and support people also were found throughout responses to other questions in the survey and were coded appropriately. Material from unsolicited submissions was also considered.

People with lived experience and support people were not asked to provide any specific examples regarding aspects of a contributing life, but relevant references to this issue were found throughout their responses and coded accordingly.

4.3.2  Survey responses

For question (a), 67.4 per cent of organisations (n=159) and 51.8 per cent of professionals (n=446) provided a response.

For question (b), 51.3 per cent of organisations (n=121) and 38.7 per cent of professionals (n=333) provided a response.

For question (c), 56.4 per cent of organisations (n=133) and 42.5 per cent of professionals (n=366) provided a response.
For question (d), 66.1 per cent of organisations (n=156) and 56.3 per cent of professionals (n=485) provided a response.

For question (e), 36.0 per cent of organisations (n=85) and 29.5 per cent of professionals (n=254) provided a response.

4.4 Thematic findings

4.4.1 Aspects of an effective journey for people with lived experience, family members and support people

The Commission received many stories from people with lived experience and support people of positive encounters with health and other support services. Most often, these related to the support of one individual professional who went out of their way to ensure a person was well cared for. However, there were also examples of journeys of people with lived experience through multiple services which worked together to achieve both a positive experience and a good outcome.

Friends who sounded the alarm, the family GP who contacted a terrific psychiatrist and a really wonderful clinic in the next suburb. All of these contributed to a speedy diagnosis of depression. A fast turnaround with drugs and two weeks of psychologist-directed group sessions inside the clinic, allowed the young person to learn from others in the same boat, how to recognise the signs of stress and to reach out for help if things start to overwhelm. The system really worked for us because the groundwork had been laid by heaps of media coverage of mental health issues and a lifting of the stigma attached.

Support person, New South Wales

Key characteristics of a positive journey for people with lived experience, a family member and support person include:

- easily and readily accessible mental health services
- effective and ongoing collaboration and communication between mental health care providers
- effective therapeutic relationships with mental health providers
- holistic and individualised approach to recovery, meeting the needs of the ‘whole person’
- peer support, community and family support.

4.4.2 Characteristics of effective support for a contributing life

Coordinated approach to provide integrated mental health support

Examples were frequently provided of effective collaboration and coordination with various service providers and other disciplines to provide a person-centred approach to recovery involving various aspects of an individual’s life. An individual approach to recovery that incorporated various life aspects and multiple disciplines often was perceived to be effective.
Building up a team of health professionals to support different aspects of a mentally ill person's life, such as a GP, psychologist, psychiatrist, art therapist, school liaison, social worker, etc. Good case management of this team is essential; there is often no clear person to fill this role and the patient or carer often lacks experience to fill this role well.

Person with lived experience, Victoria

Positive examples also were commonly mentioned where educational institutions were engaged in mental health support.

I work in the public education sector in policy, planning and management of psychology services for preschool (kindergarten) and school age students. Managing mental health issues for children and youth works well when a psychosocial perspective is taken and a team is wrapped around the young person, coordinated by a delegated lead professional. Engaging the education support services and school staff is critical to support the young person.

Psychologist, South Australia

Other successful examples often mentioned included the inclusion of services that offered support for drug and alcohol use, as well as housing and employment assistance.

After the problems listed below, I finally started seeing a clinical psychologist who bulk-billed me in mid-2013, after my doctor did a referral to him under Better Access to psychologists. They finally did a proper assessment of my life and drug and alcohol and mental health. They got me doing homework tasks and taught me relaxation to use instead of drugs and alcohol. Since I have been seeing this person I have done very well. I am on a disability pension due to my mental health but am now starting to look for work. I have cut back my drinking and stopped using drugs.

Person with lived experience, New South Wales

Ongoing and community based mental health service delivery

People’s mental health needs extend beyond the walls of an acute mental health ward.

Support person, South Australia

Mental health is a lifelong battle for many people in our community. Long-term support and ongoing access to psychologists can mean the difference between a precarious existence spent in and out of hospital and surviving day-to-day, and living a fairly stable, almost normal life as a productive member of society.

Person with lived experience, Victoria

Respondents often provided examples where ongoing support delivered in the community allowed recovery to occur outside the acute care or ‘traditional’ mental health setting.
Commonly, respondents provided examples of how positive life outcomes were received by integrating mental health services into peoples’ daily lives.

An important aspect of community-based supports appears to be that these are provided for as long as a person needs them in order to attain meaningful personal and clinical recovery and to return to full engagement in life.

The use of trainee (Master of Psychology - Clinical) students at [name removed] University to provide an extended (now over 2 years) community-based treatment program for a [young] male. He had been housebound for [many] years (could not even walk to the house letterbox) suffering severe social anxiety, panic disorder, depression, and agoraphobia. Suicidal risk was extremely high at the time of referral which came via his mother seeking help from a private clinical psychologist for her own anxiety and depression. Notably, the standard public health (CAMHS) service and private psychiatry since age nine could not meet his clinical needs. The client is now catching public transport, going into shops and purchasing goods, studying online, obtained a learner’s driver’s license, etc. While there is still work to go, the client’s sense of future is now hopeful and positive.

Clinical psychologist, Victoria

I make reference specifically to the Mental Health Nurse Incentive Program. This program has demonstrated that it stops hospital admissions, allows people to remain at home and in their own environment and to remain employed. It supports both client and carer and is cost-effective. As there is no session limit in this program, I may respond to client’s needs as and when necessary. I have many concrete examples, should you wish to hear of them, where clients have been free to live lives without fear of hospitalisations and concomitant loss of job, self-esteem and even family.

Mental health nurse, New South Wales

**Supportive community environment**

A supportive environment in the community setting was mentioned as significant to aid recovery, experience of a contributing life and positive mental health outcomes. Mental health support, awareness and understanding from employers and educators were examples of vital non-clinical supports for recovery.

An employer who you can feel comfortable talking with about mental health issues and any ways it might affect your work. Understanding and a little bit of flexibility on occasion is something I am very grateful for. I am more loyal to my employer because of this.

Person with lived experience, New South Wales
The option in schools or universities to talk to a counsellor or a trained professional in such areas about any problems regarding school, family, friends or mental health. In my personal experience during both high school and university they have made sure we are aware that these types of services are provided for us. I think that has worked well and the fact that they are making us more aware that mental health problems are real problems.

_person with lived experience, New South Wales_

**Inclusion of community, family members and friends in recovery**

Support from family members, friends and peers from the community can make an important contribution to positive mental health outcomes. The need for support services to proactively involve informal support networks in the care ‘team’ is encouraged by both support people and people with lived experience. This helps individuals feel less isolated and alone in their recovery, and enables family members and support people to receive the valuable advice and support they themselves need.

_I think that having an integrated approach where the mental health professionals involve family and friends in a care plan can work very well. In my experience as a carer, it is really helpful to understand what services are available, and what the community team is planning._

_support person, Victoria_

Such inclusive services include family-centred services and specific support for families and other support people. Services which come to meet people in their home context also were highly praised by people with experience of mental illness.

_I personally have found that having a mental health nurse regularly visit me in my home has not only been beneficial for me but also for my children and my husband; she supports all of us, not just me. She has been extraordinary really in her support: you hear of so many cases of family breakdowns due to mental illness and I know that would have applied to us if it wasn’t for the support of my mental health nurse._

_person with lived experience, Victoria_

Formal and informal support groups often are mentioned as aiding in recovery and providing meaningful opportunities to connect with others in the community.

_Group programs give meaningful experiences, opportunities for sharing experiences, give a voice, socialising, stimulation and an opportunity to be considered for who they are, and recognise the skills they do have._

_support person, Victoria_
Groups! Meeting people with the same or similar issues. Or even people who are totally different, who can help each other. Buddy systems. Social things. Obviously it would be harder for people with social anxiety and things like that, but for other issues and mental health problems it can be really awesome to meet people who can identify personally.

*Person with lived experience, New South Wales*

Peer Support Groups and our 24/7 Peer Grief Telephone Support Line has proved efficient and effective, resulting in good outcomes to bereaved parents and siblings. Frequently we receive written expressions of the fact that the connections with these services ‘saves’ people’s lives and sanity and ability to rebuild their lives. The words of the parents who use the services best articulate this message:

“When I lost my daughter to suicide I was put in touch with The Compassionate Friends quite quickly. The support that they gave me in those early dark days was immeasurable. Without the ongoing contact with other bereaved parents, people who actually understand what I am going through, I think I would have lost my sanity. At every meeting I attend I find a comfort in knowing I can speak about my feelings and my lost daughter and not be judged or misunderstood.”

*The Compassionate Friends Victoria Inc.*

4.4.3 Primary barriers to supporting a contributing life

**Inaccessible, unaffordable professional services and support**

The existence of multiple barriers to accessing appropriate mental health supports was one of the main concerns highlighted by all groups of participants. Access difficulties often were attributed to the cost of services, stigma and inflexible working practices. Inflexible eligibility criteria for a service were criticised by many—where it was felt to be obvious that a certain service would help a person but, because of their age or diagnosis, they were prevented from using supports that would have helped their recovery. Organisations quoted many instances of people being told that they are either ‘too complex’ or ‘not ill enough’ and then being turned away completely or being ‘fobbed off’ to one agency after another. In rural and remote areas, the requirement to see a GP to access other MBS mental health services often was felt to be a barrier due to lack of GPs in some areas.

This inflexibility is related to a common perception that services and professionals are organised for their own convenience, rather than around the needs or preferences of people using them. A ‘one-size-fits-all’ approach is seen to predominate over a person-centred, needs-based approach. The tendency of services to work in silos also results in a failure to recognise peoples’ interrelated needs. This was especially frequently mentioned in relation to physical health needs being allowed to deteriorate by services which only can ‘see’ a person’s mental health diagnosis. For people with complex needs, only having one element of their problem addressed while other elements are neglected can reduce the impact of any help that is provided. There appears to be a widespread failure to take a whole-of-life approach to support.
Common examples provided by respondents indicated the inability to access ongoing professional support with the current number of Medicare-subsidised appointments.

I think 10 sessions is not enough support. Mental health is not like a physical illness where it just 'heals'. It can linger and remain present; the symptoms may become less severe but they do resurface and although I have weeks where I feel fine, there are also weeks where I can barely survive. Having the ability to see a psychologist when I need to would be really beneficial. Mental health does not operate on a 10-week time frame, therefore neither should treatment.

*Person with lived experience, Victoria*

Mental health issues are not solved in such a short space of time and people need ongoing help to achieve better outcomes. For someone to miss out on seeing a psychologist because they have run out of sessions and can’t afford the ongoing costs is unacceptable.

*Person with lived experience, Victoria*

**Over-emphasis on medical model**

Respondents often mentioned that an over-emphasis on medical treatments and psychological interventions was a barrier to achieving a positive mental health outcome and long-term recovery. Examples often were provided of the need to consider the ‘whole person’ and all aspects of an individual’s life in order to produce positive mental health outcomes.

Medical-centric service delivery that emphasises medical symptoms over social, personal, financial, environmental issues. People’s lives are very complex and to treat perceived symptoms conveniently ignores the many other barriers and issues that a person may be experiencing.

*Person with lived experience, South Australia*
I feel that there is an over-medicalisation of mental health which leads many treating doctors to ignore the broader context of patients' lives and the broader contributing factors which lead to people being unwell. There is a tendency to treat the symptoms of mental illness rather than to undertake the more time-consuming and relation based work of helping patients to build their own self-awareness, identify triggering events and patterns for poor mental health episodes or to find strategies for coping with long-term mental health problems. A person with mental health issues is a whole person and they come with lived experiences, challenges, family relationships and so on. They are not merely a patient with symptoms.

The attitude of some medical staff (not all) is that they are the experts and that family members are a nuisance that need to be 'handled' or managed. This is a shame, as concerned family members and friends can often have knowledge of the broader context behind a patient’s mental illness, as well as knowledge about symptoms, behaviour and patterns which it might be difficult to gain from discussions with a mentally ill person.

Support person, Australian Capital Territory

Lack of collaboration between services and agencies

The complexity of coordinating and navigating the wide range of agencies and services involved in supporting a contributing life was felt by many to be a barrier to effective whole-of-life approaches to people’s needs.

Provision of care and support for people with mental health issues lacks effective coordination across healthcare, community services and support payment systems. The nature of mental illness increases the likelihood that consumers will interact frequently with multiple parts of the healthcare system, relevant community services (including employment services) and support payment systems. However, there is a lack of coordination between these systems. [There are a] large number and variety of service providers that contribute to the complexity of the mental health system. In this context the coordination of an individual’s care and support across the different systems is a challenging task.

Community Services and Health Industry Skills Council

Fragmentation and siloed working negatively affects people when they fall through the cracks between organisations and as a consequence do not have any of their needs met. This contrasts with the continuity of care and trusting relationships with professionals which many view as essential components of a person’s recovery. Damaging and traumatising experiences, some ending in the suicide of the person concerned, were reported to be the result of being pushed around between services. In some circumstances, informal carers can become the only consistent source of support.
Communication between and within departments in the health system, mental health system, community mental health system, private health system, NGOs, housing and other departments involved in the consumers’ lives is very poor. We, the carers, have had to become the co-ordinators. We have many examples of the miscommunication and inappropriate actions. You have only asked for one example but one example does not demonstrate how bad it is or how much it impacts on the person and their family.

Support person, Australian Capital Territory

Failure to collaborate was especially often mentioned in relation to the interface between the public sector and private sector, the interface between mental health and substance misuse services, and between disability or physical health services and mental health supports. This results in a general failure to support complex or interrelated needs in a holistic way.

For example, if a client goes to a drug and alcohol service to deal with their drug addiction issues, they are not being supported for other issues such as trauma, medication management and housing support. These services all tend to run separately and can become disjointed in their approaches to managing clients.

Counselling psychologist, Western Australia

Examples also were provided by people with lived experience, family members and support people of being unaware of or unable to access various services.

In the four years since our child has been diagnosed we are still finding out about services that would have been immediately available to us and very helpful but because we did not know about them have not accessed. e.g. health care card, disability support at school, special programs at the [name removed] school. These services would have made a huge difference to our child and family.

Person with lived experience and support person, Victoria

Social exclusion and stigma

People with lived experience commonly reported encountering stigmatising attitudes from employers and other members of the community, which had the effect of excluding them from opportunities to achieve a contributing life.

I had to leave my last job because of a combination of bullying from a co-worker and a boss who didn’t understand depression; she suggested that, although my standard of work was not an issue, I should stay home when I am depressed because I dragged the whole team down.

Person with lived experience, Victoria
Schools and all workforces need to realise that mental health is very real; just because it’s not a physically visible disorder does not mean it’s not real. We aren’t lazy or irresponsible; we’re incapable of getting out of bed for the most part, and our brains lack a specific chemical. It’s not because we’re trying to get out of work/school because of laziness.

Person with lived experience, Western Australia

4.4.4 Suggested strategies to support positive “whole-of-life” outcomes

Increased opportunities and support outside of health services

Increased opportunities for gaining secure housing and employment often were mentioned as necessary to facilitate mental health recovery and result in positive outcomes. The provision of stable accommodation was seen by many as a prerequisite for starting on the road to recovery.

The Doorway project, by Mental Illness Fellowship in Victoria, has ... [helped] 50 people with a mental illness and their families who are homeless or at risk of homelessness to secure housing in the private rental market. Early evaluation of The Doorway in 2013 has found that those who have participated in the program have improved their day-to-day living skills in areas such as financial planning and maintaining their housing and have experienced greater connection to their community.

Psychiatric Disability Services of Victoria (VICSERV)

In terms of employment, some respondents felt they needed to access a specific programme to support them into employment, recognising their experience with mental illness. Others felt that the onus should be on employers to create flexible working practices and support to enable them to fulfil their potential.

Applying for jobs and going to interviews is stressful for anyone, but when you have anxiety it feels almost impossible. I know that if someone would just give me a chance that I am as capable as anyone else. I think that’s why more emphasis should be placed on creating opportunities for job seekers with mental health problems, rather than throwing them in the pool with everyone else out there who is also looking for a job. I also think that specific support needs to be provided to jobseekers with a university degree. DESPs [Disability Employment Service Providers] seem to be more geared towards helping unqualified jobseekers look for work.

Person with lived experience, Queensland

Engagement with the community through social and recreational activities is important to many people with lived experience to maintain and improve their mental health. Opportunities for physical activity and other creative or recreational activities frequently were acknowledged as positive in contributing to recovery and developing a sense of social inclusion, meaning and life purpose. Supporting children to remain in school despite difficulties also is cited as an important way to promote and enhance their mental health.
In Aurukun there exists a range of primary school children who had not been engaged with the schooling system and who have very low/poor social supports and traumatic histories leading to emotional difficulties. The RFDS (Queensland) Wellbeing Centre initiated a program to target these children and be involved across a full spectrum of needs. The program involves collecting children from home where necessary, providing a nutritional breakfast, walking to school, remaining in class with the children and intervening when emotional difficulties arise. After school the children are involved with a range of sporting, art and craft and music activities along with assisting their support workers with a range of ancillary duties such as tidying and gardening Wellbeing Centre grounds.

**Royal Flying Doctor Service**

**Whole-of-community approach to mental health support and integration**

Examples commonly mentioned the need for a “whole-of-community” approach to help those experiencing mental illness, their family members and their support people achieve positive whole-of-life outcomes. Examples were commonly provided of the need to increase mental health awareness within the community and provide all individuals with the tools needed to help and support those who are experiencing mental illness.

The prevalence and burden of mental health problems in the community is so great that we need a whole-of-community approach where every citizen has some skills in how to support their own and other people’s mental health, including prevention and mental health first aid skills. Carers and consumers also need to be trained, because they are the real frontline of care.

**Researcher, Victoria**

**Family-oriented service delivery**

People with lived experience, family members and support people commonly mentioned examples of how mental illness is a family experience, and that to ensure adequate outcomes, mental health support also is required for carers and the ‘whole family’. Examples often were provided of carers and support persons themselves experiencing mental illness which was perceived as an added barrier to achieving recovery and positive outcomes.

Services need to be more family-oriented to support the family unit as a whole. It is the carers/families/support people who are the one constant in their lives and when all else fails they are the treating team. The family needs to be included, listened to and informed and educated on equal terms and not be looked on as part of the problem. The family is very important in supporting consumers to lead better quality of lives. We need more understanding, less stigmatisation, more education and support.

**Support person, Australian Capital Territory**
4.5 Positive programme examples contributing to positive “whole-of-life” outcomes

4.5.1 Partners in Recovery Programme:

My ... son has suffered from schizophrenia for nearly 13 years. He has had four occasions of acute care in mental health units. The effect on his family has been devastating, financially, emotionally, physically. When my son is in psychosis he is a danger to me, his mother, and has violently assaulted me on a number of occasions. Acute care has worked to making him psychologically well, but as soon as that care stops, he goes off medication and becomes acutely unwell again.

In recent months he has connected with Partners in Recovery. For the first time in 13 years he is supported, has stable supported housing, is getting physical and psychological support, is being assisted to gain employment, training, social engagement. For the first time in 13 years, I feel safe from attack; I can become a parent again, can see a time when my son reconnects with family and community, gains employment, gets off Disability Pension, pays taxes. He can have a life again and so can I. PIR has been fantastic wrap-around support for consumers, but most of all, it has been of enormous benefit for CARERS. I plead that PIR remains, is given time to be established and measured—there is nothing else for people like my son who is living with severe and persistent mental illness.

Support person

Example of an effective “whole person” approach to recovery:

The philosophy of the Harte Felt Centre provides evidence-based services from a person-centred perspective. We don't work from the medical model which categorises people into diagnoses but formulates people's problems and mental health issues from an evolutionary and developmental perspective. "What has happened to this person that has led to their behaviour being this way?" From this perspective we ascertain what has contributed to this person’s problems and look at how to respond in respectful and collaborative ways. We aim to understand and support people using evidence-based interventions but from a non-pathologising perspective. We see people as fellow human beings who haven't been given the same opportunities as others or who have had trauma as part of their background history. We understand mental health as at times circumstantial, a "cry for help" and not just a malfunctioning of people's brain chemistry. Our clients respond really well to this evidence-based philosophical and theoretical approach. The outcome is seeing people who have journeyed into despair and dysfunction come through to living full and empowered lives.

Registered psychologist, Victoria
Example of a successful supported employment service for mental health recovery:

Cleanforce—a subsidiary of Wise employment services—Amazing and inspiring example in Melbourne of a successful social enterprise that has soul and meaning and is making a difference to vulnerable people’s lives via work. 80 per cent of the workforce starts working at this organisation with a severe mental illness and are nurtured to get well through work and support and patience but also boundaries where the commercial reality is gently but firmly addressed. Many success stories—the workforce is ready for the open market in about 5 years. All are paid on an award rate; this is not a working shelter but a real workplace. One person who started had severe schizophrenia, after 5 years he was able to go to university and graduated as a doctor!

*Consumer advocate, Victoria*
5. Regulation, reporting and red tape

5.1 Key findings

Service providers and professionals recognise reporting as an essential aspect of system regulation and service and programme accountability. Respondents tell us that reporting is appropriate when:

- reported information does not just go one way—that it is used and becomes part of a whole system of feedback
- reported information can be used to assist in planning and for quality improvement efforts both by the reporters and by the authorities requesting the information.

However, there are many circumstances in which reporting currently is not considered a productive activity, including where:

- reported information is ‘sat on’ by the authority requesting it, without being used
- multiple funders and agencies request similar information, resulting in duplication of effort by organisations and professionals
- reporting requirements are subject to gaming, have perverse consequences or have a detrimental effect on the quality of care delivered to people with lived experience.

Suggested steps to improve the effectiveness and efficiency of reporting for regulation and accountability purposes included:

- Focusing data collection on clinical and whole-of-life outcomes as well as activity.
- Streamlining reporting requirements by rationalising funding sources and assessment/referral pathways, and by developing consistent, user-friendly data collection tools which can be standardised nationally, harnessing the power of ICT.

5.2 Overview

Term of reference 4 asked the National Mental Health Commission to assess:

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

5.2.1 Survey question

Organisations and professionals were asked to give an example of a service, programme, policy or initiative which:

a. demonstrates effective and efficient use of reporting
b. is subject to excessive red tape
c. is not subject to excessive red tape

While people with lived experience, family members and support people were not asked specifically about reporting and red tape, we have included in our analysis references made by those respondents to this issue.

5.2.2 Survey responses

For question (a), 52.1 per cent of organisations (n=123) and 43.3 per cent of professionals (n=373) provided a response.
For question (b), 50.4 per cent of organisations (n=119) and 46.7 per cent of professionals (n=402) provided a response.

For question (c), 56.8 per cent of organisations (n=156) and 49.9 per cent of professionals (n=430) provided a response.

Analysis for this chapter considered three sources of evidence—responses to these particular survey questions, plus material from unsolicited submissions, and answers to other survey questions which addressed issues relevant to the chapter.

5.2.3 Note on interpretation of the responses

In our analysis, we interpreted ‘reporting requirements’ to mean regular submission of any information about the provision of mental health-related supports to a funding or oversight organisation. The reporting may be done either by organisations or by individual professionals.

Many individual professionals, especially those providing services under Better Access, regard the reporting of a client’s progress to the referring GP to be their primary reporting activity.

‘Regulation’ has been interpreted here as ensuring compliance with policies, laws, rules and guidelines. Reporting is the principal mechanism through which regulation is achieved.

5.3 Thematic findings

5.3.1 Overall

The importance of reporting and regulation

Respondents to our surveys emphasised the real everyday impacts that reporting and regulation activity had on their practice or on their experience of services. What stands out in the respondents’ commentary about reporting is that this activity should not just be for the benefit of regulating authorities. They gave us many examples of where reported information is used in multiple (and creative) ways by the reporters themselves, to improve the quality and safety of their services, to assess gaps, to assess trends over time, to assist in service planning, and to inform and improve the care they offer to an individual client in real time. In turn, reporting by third parties to the providers (such as client satisfaction surveys) was thought to be useful to improve the responsiveness of services.

There was a tension evident in some responses regarding the right balance between convenience and accountability. For example, levels of reporting required of private providers under Medicare Benefits Schedule services generally is praised by providers as being manageable. However, some argued that convenience for providers needed to be balanced with governments’ need to know if they are getting good value for money.

5.3.2 Characteristics of effective and efficient regulation and reporting

Reporting should be useful to all stakeholders

Figure 1 represents a summary of what respondents want from a reporting and regulation system. From the perspective of those working in and receiving services ‘on the ground’, reporting should not be a one-way process (from provider to funder or regulator) which ultimately becomes a chore. Reporting to funding or regulating authorities should instead be part of a purposeful, whole-of-system feedback loop which drives improvement.
Respondents want reporting to be useful to people with lived experience and carers, service providers, regulators and funders alike. They want information to be available in a form which can be easily interpreted and used. They want streamlined collection and reporting mechanisms, where information can be submitted once and used many times. They recognise that all stakeholders in the mental health system have a role to play in sustaining the feedback loop, and it needs to be as easy as possible for each stakeholder to play their part.

**Effective reporting between people with lived experience and service providers**

For organisations, effective service provision means using reports about quality, outcomes and satisfaction directly received from people with lived experience and their support people to improve the responsiveness of the service to local need. Collecting this information requires establishing accessible mechanisms for submission of feedback by people with lived experience and their families and supporters; more than this, it requires their meaningful involvement in determining what this feedback means for quality improvement.

ReachOut.com employs a suite of measures designed to obtain continuous feedback on our service and thus implement ongoing improvements, including regular monitoring of Google analytics, the ability for visitors to rate and comment on individual pieces of content or tools, regular rounds of user experience testing as well as an annual cross-sectional survey. The findings from each of these are then used to continuously implement improvements to the service, ensuring that it remains relevant and of a high quality.

*ReachOut Australia*

For professionals, obtaining client and family/support person outcome information (whether informally or through standardised scales and tools) is a useful indicator of progress and an essential component of ‘real time’ care planning.
For people with lived experience and families and support people, the most important thing is that reporting activity by providers does not interfere with the availability or quality of the support service they are receiving. This will be further elaborated upon in a later section. In terms of how people with lived experience and carers want to use information reported by service providers and governments, navigability of the system is paramount. It often is difficult for people to be aware of the choices they have for a certain type of support in their local area, even if they go actively looking for information.

I believe a process whereby you could have a better chance of accessing a mental health professional who is most suitable for your needs would be valuable. This could be in the form of a database where the therapist answers as many of a set of questions they feel comfortable with and may include their specialties or a bit about themselves. That way, a patient or their family or support people can access some information to make an informed choice about who to see. Also, an outline for anyone who needs to see a psychologist or psychiatrist that states what individuals are able to access, including Medicare, ATAPS, private health coverage and the costs involved, bulk billed vs. out of pocket costs; or a service (telephone or web based) that explains how to go about finding the best way to receive good mental health care.

**Person with lived experience and support person, Victoria**

There are some examples of efforts by organisations to present their public reports in an accessible format, as below—using the opportunity to spread healthy living messages as well.

Over the last few years, Dental Health Services Victoria (DHSV) has presented its report in a magazine format with a celebrity ambassador gracing the cover. The reporting requirements have been included in a series of stories that use simple and accessible language. The magazine includes patient stories, staff profiles, information on how to look after your teeth and general health as well as information on how to access treatment in the public system. It also includes recipes for healthy eating and a competition that offers free movie tickets to people who provide us with feedback on the magazine. This is an innovative way of hitting two birds with one stone—fulfilling reporting requirements and providing the community with a fun, informative and accessible publication.

**Dental Health Services Victoria**

**Effective reporting between providers and funders/regulators**

Reporting is considered efficient and effective when reported information is actively used as part of a feedback loop to inform policy and planning at both local and national or state/regional level. In the example below, the organisation feels that reporting has led to positive change.
Monitoring of quality and safety indicators particularly on high risk indicators such as seclusion, readmission rates, post discharge contacts. The monitoring through this reporting has driven change in the area. The review of inpatient deaths by the Office of the Chief Psychiatrist in 2009 provides a benchmark for deaths in inpatients settings. Utilisation of this data enabled Monash Health to benchmark death rates in the community and inpatient settings.

**Victorian Healthcare Association**

In order to inform policy and planning at a state, national or programme level, many respondents felt that standardisation of information format was important. The housing of all submitted information in a centralised repository was thought to be helpful, especially if the information could be accessed and used by providers themselves to assist in benchmarking and quality improvement activities.

An effective use of reporting is the ATAPS program that captures qualitative and quantitative local data and the collection of a minimum data set (MDS) at a national level, enabling local evaluation, quality improvement practices and national reviews to take place.

**South Eastern Sydney Medicare Local**

[Our organisation] has been conducting routine outcome measurement since 2001 (BASIS-32 & Camberwell Assessment of Need) and now has a very large database that enables us to analyse change over time for consumers against service use and needs in different cohorts. We use this data for program planning and to drive initiatives that target identified unmet need.

**De-identified national provider organisation**

Many service providers emphasised the value of having collated information about their local population and about service use to enable them to do needs analyses and gap analyses to inform service design and planning.

By having access to reports pertaining to the health of the population within our catchment, it has informed our decision-making processes and assisted with understanding where the greatest areas of need are and hence assist with planning and service redevelopment. It is important that there are agencies with responsibility to collect and provide population health data, such as: local government, so as to inform effective local planning.

**De-identified mental health planning organisation**
Reported information can be used by services for benchmarking and in safety and quality improvement efforts

Responses indicate that reported information should be actively used by service providers for quality improvement purposes. The detailed example below shows how one NGO used reported information on outcomes to re-orient its services towards a recovery approach.

Our new Management Team reviewed all aspects of service delivery to ensure it was supportive of recovery processes. Reviewed data showed that our organisation did not work towards people moving on and programs that were delivered resulted in long-term dependence built up, through messages about how “Safe” it was to come to us. Three years later our statistics show a reduction in support for all individuals on packages, with some no longer needing this support and all on block funding averaging a three to four month period of support before being exited from programs. We also now conduct monthly Outcomes reviews to identify a range of outcomes—these include:

- per cent participants have an individual plan
- per cent increase/decrease in support
- per cent participation in paid/unpaid work
- Hospitalisation rates
- per cent maintenance of sustainable housing
- per cent reduction/cessation of substance use
- per cent level of ability to self-manage daily activities
- per cent achievement of defined goals
- per cent engagement in community/recreational activities/hobbies
- per cent engagement in educational opportunities
- per cent engagement with family and/or developed family/social/spiritual connections
- per cent improvement in their self-care

Feedback from workshops, support groups and annual surveys are used to drive service improvement so long as they align with evidence based practice

De-identified provider organisation

Reporting that encourages collaboration

For many individual professionals, the main benefit of requirements to report on individual client progress is the collaboration it forces between different professionals looking after the same client with lived experience. This seems particularly true for private practitioners, many of whom value the collaborative approach facilitated by reporting back to referring GPs on a regular basis.

Some professionals also mentioned the value of a shared care record to their ability to provide collaborative continuity of care. In some states (such as Queensland and Victoria) this is a state-wide electronic repository.
Consumer Integrated Mental Health Application (CIMHA) is a consumer-centred electronic information system used across Queensland. It ensures a consumer’s information, including medical, social, current issues and where treatment has occurred, is accessible to all health professionals between hospitals and health services. It allows for integrated and collaborative care for the patient; reduces the potential for missing information that could inform treatment plans, evaluate service delivery and assist with service planning.

*Future Health Leaders (FHL)*

**5.3.3 Characteristics of inappropriate and unproductive reporting**

Ineffective reporting was described both in terms of inefficiencies in how data is collected and how that data is used (or not used).

With a few notable exceptions, the use of data and reporting tools in Australia is not done particularly well, resulting in burden for clients, clinicians and inaccessible and poor quality data.

*De-identified research organisation*

The RANZCP notes that there is extensive reporting related to the expenditure and activity of public money at the Commonwealth level (such as the Report on Government Services, National Mental Health Reports, Mental Health in Australia, AMHOCN Web Decision Support Tool (wDST), but has concerns about its effectiveness.

*Royal Australian and New Zealand College of Psychiatrists (RANZCP)*

Most of the deficiencies of the ‘system’ have been recognised for long, and it may be burdensome to report them again.

*Australian Centre for Psychoanalysis*

**Reporting processes are bound up in red tape**

The most common complaint about reporting mechanisms was that they are bound up in unnecessary red tape, such as each funding body having separate reporting requirements (which duplicate one another); as well as cumbersome manual reporting mechanisms.

The WAAMH Mapping Report of the Community Mental Health Sector in WA identified that for many organisations there is a high level of administrative complexity in reporting and managing programs with similar target groups, sometimes in the same locations, from both state and federal funding sources. This arises as a result of the lack of a coordinated state and federal funding framework.

*Western Australian Association for Mental Health*
Reporting requirement of the EMML MHNIP clinical sessions to Medicare Australia remains a manual process of delivery, evaluation, resubmission and sessional receipting. Delivery of clinical sessional data to Medicare requires 1FTE admin staff. The procurement, evaluation, submission, re-submission and receipting process of the EMML MHNIP sessional data is a clear and accurate Government reporting requirement of unnecessary red tape.

*Eastern Melbourne Medicare Local*

**Gaming the system**

Some respondents complained that where funding is dependent on activity reported, there can be a perverse incentive to game the system in ways which detract from offering the best clinical care.

Activity-based funding/recording occasions of service wastes clinical time on administration and promotes inefficiency via organisations trying to maximise activity/occasions of service to maximise funding.

*Clinical psychologist, New South Wales*

**Information is not used**

The importance of information being used for some purpose—preferably by being fed back to the people who have provided it in the first place to enable them to improve their service—was repeatedly emphasised in professional and organisational responses. However, many respondents said that at present, their reporting efforts did not have any recognisable benefit for them or their service.

I provided weekly client data over 15 years of working in the public service and never saw any summarising information reported back to me on the data that I and others had collected.

*Clinical psychologist, Victoria*

The Victorian Dept. of Health’s Quarterly Data Collection functions well in that it has easy reporting functions. A report can be created from an agency’s database and sent electronically. Unfortunately the department lacks analytical capabilities to use the data for more detailed monitoring, feedback and evaluation of projects.

*De-identified national provider organisation*

**Information requests are duplicative or inconsistent**

Everything being picked up by both the ATAPS and PIR reporting frameworks are then required to be re-entered into online minimum data sets. Essentially we need to report on the information twice to two separate bodies. There is no new information that hasn’t already
been provided. The MDS cannot be accessed, as a database, by Medicare Locals, which means it is of no value from an evaluation perspective to individual organisations. MDS money could be going directly into service delivery.

Central Coast NSW Medicare Local

The [ATAPS] paperwork duplicates information. The doctor and the psychologist both fill out demographic information. When a client has two consecutive tranches of sessions the psychologist has to fill out very similar paperwork after session and then again after session—this is nonsensical and a waste of time. The required forms are badly designed i.e. the session report to the GP is a new form rather than an addition to the report sent after session one so new information has to be re-input [...] why not just have one form that populates two parts with the same data?

Clinical psychologist, New South Wales

**Perverse consequences of regulation for people with lived experience**

Many people with lived experience reported that their experience of services often is made more stressful by administrative processes. They reported that this extra stress comes in the form of:

- the expectation that they can easily ask and advocate for what they need, when in fact this may be very difficult

Red tape & making it so hard (impossible now) to even get the DSP is unacceptable. Most people with mental health issues are ashamed of their illness & humiliated by their inability to cope with the simplest of things, so more often than not they won’t be 100 per cent forthcoming about their problems when applying for the DSP. Giving more financial support for medications. I’m on five different medications that need to be refilled every three weeks—that adds up fast, especially if you don’t have a concession card.

Person with lived experience and support person, New South Wales

- overly complex referral pathways which require them to tell their story to multiple professionals; many mentioned the GP Mental Health Care Plan here

Obtaining a MHTP through GPs for ATAPS and Better Access restricts accessibility to a large population. Also prevents referrals from other sources, such as other health professionals, teachers. It creates a gap in service delivery to a population who may not be able to pay for a GP appointment or access a GP.

Southern NSW Medicare Local
• form filling and assessments which feel like having their individuality dismissed or having to justify that they are ‘really’ ill

Seeing a GP who I don’t know that well in order to talk to my psychologist who I do trust makes it really hard. I wish it was easier; if I need help, I’m feeling vulnerable. I don’t always have it in me to jump hoops. Just turning up to see someone is really hard.

*Person with lived experience and support person, Queensland*

I have received support from three different Disability Employment Service Providers. There is too much focus on ticking the boxes for the government and not actually assisting people to find work. With one of the DESPs I visited, all my appointment time was spent updating my Employment Pathway Plan and no time was ever spent actually supporting me in getting a job. [...] Over a period of at least a few months I was told at every appointment how busy they were completing their tender application for the next round of government funding. It made me feel like they didn’t really have the capacity to help me find a job.

*Person with lived experience, Queensland*

Professionals and people with lived experience gave examples of regulatory and reporting requirements obscuring the purpose of services and programmes and getting in the way of face-to-face therapeutic interaction.

There is so much paperwork to complete within mental health services that over half the time each day is spent on this compared to 1:1 work with clients. A lot of this is repetitive e.g., needing to re-do risk assessments every 24hrs for highly risky clients despite their level of risk remaining this high throughout the commencement of treatment.

*Clinical psychologist, Australian Capital Territory*

The increase in daily reporting has been incredible. We now input our daily activities into the computer service (this is an inefficient program that takes up to 30 mins a day to account for your activities); fill forms including: treatment plans - recovery plans - family care plans - care review summary - relapse prevention plans - crisis intervention plans, and outcome. This is on top of the very important reports: Clinical Assessments documents; letters to GPs; risk reviews; ITO reports, and in my case psychological and cognitive specific reports. Service managers judge us by our computer input rather than our clinical work—this skews the way services operate. Solid documentation and communication is very important, but at some stage the relentless introduction of new paperwork and computer-based reporting needs to stop or we will have little time for clients. My biggest concern is that no-one even looks at half of this stuff once it’s done—it’s done to meet service requirements rather than to assist clients. I am aware of some services whose stats and service levels are amazing—but they see far less clients—this is crazy stuff.

*Clinical psychologist, Queensland*
Referral pathways in Commonwealth programmes can delay access to helpful interventions, create clinically harmful pauses in treatment, or cause people to give up seeking treatment altogether.

There is too much paperwork once the initial sessions have been used. My psychologist asked me to get my psychiatrist to complete paperwork; can’t, has to be GP, wait 4 days for doctor appointment, he doesn’t have psychologist report, go back to psychologist, he can’t get on to doctor. I’m left with no support for weeks and gave up. Request for additional sessions needs to be simpler.

*Person with lived experience and support person, Victoria*

A core aspect of clinical psychology practice is a succinct précis to the referrer once assessment, case formulation and diagnosis have been conducted. Then at the conclusion of treatment. Informal case consultations are the norm. This has always been a part of practice. However, recent mental health programs (ATAPS, Better Access etc.) have increased reporting to the point where regulation increases the costs of mental health care and creates high risk pauses to treatments (e.g. reporting after six then four sessions; GP reviews; GP mental health care plans).

*APS College of Clinical Psychologists*

5.3.4 **Suggestions for increasing the utility and efficiency of reporting**

*Enable the reporting of experiences and outcomes—not just activity*

Although it may be useful to funding and regulatory authorities, the reporting of activity information (such as ‘occasions of service’ reported by professionals in public mental health services) is not seen as useful to the improvement of the quality and safety of services. Many respondents suggested that there is a need to develop an outcomes-focused reporting system which has the experiences of people, their family members and supporters at its core.

*PHaMs reporting is very user-friendly and allows for client stories to be heard through the medium of case studies.*

*Merri Community Health Services*

Such demands for experience-based reporting are reflected in respondents’ comments that present reporting systems do not account for the complexity of mental health interventions and their impacts on a person’s life.

*How do you report on the complexity of peoples’ lives and situations with numbers and by ticking boxes? It is hugely inadequate and presents a very simplistic view of an incredibly complex picture.*

*Allied health professional, Queensland*
If reporting is to be useful to the organisation required to undertake it, there needs to be sufficient flexibility in the reporting system to accommodate what a ‘good’ or meaningful outcome entails for the people receiving the service or support.

What you report and the way you report it reflects your paradigm and your world view. We would think that Minimum Data Set is only the answer if you already subscribe to a world view predicated upon western European individual clinical therapeutic case management and individualised service delivery model.

*Kimberley Aboriginal Law and Cultural Centre (KALACC)*

Long-term follow-up and longitudinal evaluations of the outcomes of interventions and programmes also is seen as a desirable aspect of meaningful reporting by many respondents.

A much bigger problem for all mental health care programs is long-term follow-up. To properly evaluate all of our programs we would require follow-up data about people who exit systems of care, at the 3 month, 6 month, 12-month and 3 year interval. From a psychological standpoint, it would be worthwhile to have long-term symptom severity data for most of our treatment programs.

*Alliance for Better Access*

**Remove Better Access Mental Health Care Plan requirements**

Two suggestions were made to decrease red tape associated with Better Access: either removing the Mental Health Care Plan requirement (and associated MBS item) altogether, allowing GPs to refer with a letter in the way they refer to other professionals, or to only remove the review requirement after the initial six sessions.

Many respondents doubted the usefulness of Mental Health Care Plan requirements, regarding them as documentation which the GP does not have the time to complete, which impose extra expense on people and on Medicare, and which are duplicative of work done as part of Better Access providers’ normal practice.

A red-tape problem is the need for a patient to return to a doctor to get a re-referral to continue treatment with the psychologist. In a number of cases this is an unnecessary waste of time and expense to all concerned. Some patients, often busy farmers, have had to travel over 100 or more kilometres simply to get this re-referral.

*Administrator, Western Australia*

**Streamline reporting requirements**

According to providers of services, reporting currently happens in two main ways for two main purposes. First, providers often create their own localised reporting mechanisms (e.g. bespoke software for client records) which they use to inform in-house monitoring and improvements. Second, they use multiple systems of reporting required of them by funders, in which they must enter similar information multiple times, in order to demonstrate compliance and accountability. While many respondents valued the ability to report against a national minimum data set (e.g. for ATAPS reporting online) and to access that data to benchmark their
own performance, there evidently also is a widespread need for data collection and reporting systems which are tailored to local circumstances.

Our own Client Information System allows us to gather a wide range of data not only that is required by Departments but also our own data, such as screening and risk assessments that inform our practice and policies.

De-identified service provider

One way to simplify this situation might be to develop, using online technology, a reporting system which has mandatory modules (i.e. a national minimum data set) for reporting performance to funding bodies, with a variety of (linked) optional modules which can be used by organisations and practitioners for their own purposes. The mandatory reporting modules would satisfy the requirements of multiple funders (i.e. Commonwealth and states) and the information would only need to be entered once by providers but could be accessed by multiple funding and regulatory authorities. Mandatory reporting would be focused on client and experiences—because these would be of interest to all funders, whatever the particular supports or interventions they are funding.

Reporting in Mental Health could be made more efficient if minimum data sets, and reporting portals or lodgement mechanisms, were unified and systemised across Commonwealth-funded contracts, and with state-funded contracts, if possible.

The Richmond Fellowship of WA

State and federal governments working more closely together—aligning their capacity and resources to enable nationally used systems and outcomes and tools to get a clear idea of where we’ve been, where we are and where we should be going.

Grow

Examples of such streamlined reporting do exist; these would merit further study to determine whether such approaches could be scaled up.

In 2012 RFDS Queensland signed an agreement with the (then) Department of Health and Ageing to combine funding streams into a single set of comprehensive reports across four program areas. This has been implemented and is widely regarded as a highly successful example of efficiency in reporting. The process has highlighted and rectified deficiencies in data reporting that were previously unrecognised by the RFDS and the funding body alike. IT has generated a range of system improvements leading to better work flows for clinicians and better data production for use in managing the service operation and direction.

Royal Flying Doctor Service
Reporting requirements are burdensome; however, they are also necessary. Using electronic systems similar to that of the National Health Service (UK) would cut down enormous amounts of time. Unfortunately, until then, this means long unpaid hours for committed health professionals.

_Clinical psychologist, South Australia_

Allowing individual professionals more self-regulation opportunities was another option to streamline reporting burden on providers:

Clinical audits violate client confidentiality and place clinicians in professional and ethical dilemmas. Expensive audits of the clinical notes in files do not ensure or relate to quality of treatment. Supervision, Peer review and Professional Development are better means of promoting treatment quality and have been traditionally used to ensure clinical standards by professional bodies such as the APS.

_Clinical psychologist, Western Australia_

5.4 Promising practice examples

5.4.1 Promising examples of appropriate and effective reporting mechanisms

The Private Mental Health Alliance ... provides private psychiatric hospitals with the opportunity to contribute to the Centralised Data Management Service (CDMS). This service provides a national data collection which meets the needs of hospitals and health funds for annual reporting and benchmarking purposes. This data collection also provides a valuable resource for government agencies and other stakeholders. It has been designed with the specific needs of the private hospital sector in mind.

_Australian Private Hospitals Association_
The following example we received is sensitive to the needs and preferences of recently arrived culturally and linguistically diverse (CALD) communities from overseas and settled generations of multicultural communities as well. It is aligned to relevant policies, legislation and accreditation requirements in Australia.

MHIMA has launched an online self-assessment and annual reporting tool entitled the ‘Framework for Mental Health in Multicultural Australia’ with support from the Commonwealth. A number of state government and non-government mental health services have taken up and used the framework across Australia.

Development of the framework has received positive feedback from a number of public mental health services in some of the most culturally and linguistically diverse communities in Australia, such as Western Sydney, Dandenong, Perth, Gold Coast and the Metro South Hospital & Health Service in Brisbane. Based on initial feedback there is merit in exploring whether the framework could be formally integrated into accreditation requirements as set out in the ‘National Safety and Quality Health Service (NSQHS) Standards’, thereby enabling uptake and utilisation across all states and territories in Australia. Utilisation of the framework to drive quality improvement could also form the basis for effective, efficient and transparent allocation and better targeted commissioning of resources to meet the needs of CALD populations.

Mental Health in Multicultural Australia (MHIMA)
6. Gaps in services and programmes

6.1 Key findings

There was a high level of consensus across all groups of respondents about the gaps in the mental health system at present. Respondents (particularly individuals) are limited in their ability to assess system-wide gaps as they can only speak from personal or professional experience, and therefore could be prone to suggesting that their own area of residence or expertise is underserved. However, the regularity with which particular gaps were mentioned across the groups of respondents gives confidence in the findings presented below.

The major gaps mentioned in submissions can be categorised as either an overall lack of certain supports, or gaps between services, sectors, or professionals.

Gaps were cited in relation to:

- gaps between services, sectors or professionals
- lack of service provision in particular geographical areas, especially in regional, rural and remote areas
- availability of specific types or modalities of support
- availability of appropriate treatments for specific diagnoses
- lack of services catering to needs of particular life stages, life experiences and backgrounds.

The existence of these gaps commonly was attributed to:

- a mental health system set up to react to crisis rather than prevent crisis
- a focus on time-limited rather than ongoing support
- a mental health system where access to appropriate support is often based on ability to pay
- uneven rollout and inflexible implementation of Commonwealth programmes
- a failure to structure services around a recognition of the intertwined nature of mental health and social and economic circumstances
- workforce shortages or gaps in expertise.

Some of the problematic consequences of these gaps include the following:

- Lack of consistent, ongoing support which is flexibly tailored to a person’s needs makes it more likely that a person will continue in a vicious cycle of deteriorating to crisis point, being admitted to an inpatient unit, and then discharged without follow-up
- There is a lack of continuity of care for people experiencing a mental illness.
6.2 Overview

Term of reference 5 asked the National Mental Health Commission to assess:

*Funding priorities and gaps in mental health services and programmes, given the current fiscal circumstances*

In this chapter, we focus on the gaps in mental health services and programmes which were mentioned most frequently by respondents. The issues of balance of funding and funding priorities have been incorporated with ToR 1 in chapter 2 of this document, especially in section 2.3.5.

Many respondents emphasised that addressing gaps in services and programmes would not necessarily equate to funding new services, but would likely entail encouraging existing services to work in a more collaborative way, or to work differently (for example, harnessing technologies to deliver support in rural and remote areas). This issue of improving service delivery through collaborative or innovative ways of working is addressed in chapters 7 and 8 under ToR 6.

6.2.1 Survey question

Organisations and professionals were asked to give examples of:

a. an area, state or territory where there are gaps in services and programmes

People with lived experience, family members and support people were not asked specifically about gaps, but elements of their responses to other questions which identified gaps were included in analysis for this ToR.

6.2.2 Survey responses

For question (a), 58.5 per cent of organisations (n=138) and 38.6 per cent of professionals (n=332) provided a response.

Analysis for this chapter considered three sources of evidence—responses to this particular survey question, plus material from unsolicited submissions, and answers to other survey questions which addressed issues relevant to the chapter.
6.3 Thematic findings

6.3.1 Overall
Respondents interpreted gaps in services and programmes in two ways:
- a total absence of a particular service or programme for a certain population or nationwide
- a gap between two services, professionals or sectors caused by lack of collaborative working and communication between them and resulting in poor experiences or outcomes of support for people with lived experience.

6.3.2 Types of gaps in programmes and services

Gaps between services or sectors
All stakeholders reflected an overall perception that Australia’s mental health systems and services are fragmented, not only at a national level (in terms of gaps between jurisdictions) but also at the level of the individual client’s experience. Organisational respondents were more likely to indicate higher level gaps—such as between private and public sectors—while individual professionals and people with lived experience provided more localised examples of multiple services operating in isolation from one another.

Gap between public hospital and private psychology services
The most concerning gap identified by many respondents was a perceived absence of support for people living with moderate to severe mental illness between clinical services in the form of hospital treatment on the one hand, and private psychology services on the other. For many, there appears to be no service or programme between these two which can provide ongoing clinical and non-clinical support in the community to prevent return to hospital.

For people, especially teenagers, identified as high risk or having emerging serious mental health services their only resource is often CAMHS [public child and adolescent mental health services]. However, the waiting list can be three months or longer and in the meantime real and lasting harm can be done to the family dynamic and make meaningful recovery even more difficult. There’s nothing in between 10 Medicare rebateable sessions with a psychologist and complete hospitalisation or removal from the home.

Clinical psychologist, Victoria

In many cases, this ‘stop-start’ availability of support, which is accessible only at points of crisis or for a limited number of sessions, leaves people for long periods vulnerable to deterioration. For those who cannot afford the gap payment for private psychology and psychiatry consultation, and cannot find a bulk-billing practitioner, there appears to be little community-based ongoing support across many areas of the country.
Policies directed towards the outsourcing of rehabilitation and community support services to NGOs demonstrate a gap in service delivery. NGOs are funded on a time-limited basis, but are often dealing with lifelong or chronic problems. Community teams tend to fade by attrition in current funding conditions and financial constraints lead to a lack of cover for active staff, a lack of replacements for staff on leave, and indefinite delays in replacement of staff that have resigned or retired.

Royal Australian and New Zealand College of Psychiatrists

I am currently undergoing intense sessions with a Psychologist due to the acute nature of my condition, and I have quickly reached the limit of my 6 sessions. I am now left alone to fend for myself for a month until I can see my GP again and get my remaining 4 sessions underway.

Person with lived experience and support person, Victoria

Characteristic of comments both about inpatient treatment and private psychology (in the form of Better Access) was the feeling of being ‘dropped’ and left to cope with problems alone after a short period of support is provided. In the case of inpatient hospital care, we received many stories of people with lived experience who were discharged from hospital before they felt ready or without any form of follow-up support. Many others reported that they could not access public hospital inpatient care, being told that they were not considered sufficiently at risk to need such intervention.

The access in public hospitals to their mental health wards is terrible. If you are in a really bad state mentally and need to be hospitalised you pretty much have to have attempted to harm yourself as they will try to turn you away and suggest that you are better off at home.

Person with lived experience, Queensland

The gap in continuity of care presented to the many people who complete their ten session allocation under Better Access frequently was mentioned as contributing to adverse experiences for people with a mental illness. This gap is dealt with in detail in Chapter 4 of this document (against ToR 3)—but the point to emphasise is that for many, the end of Better Access appears to mean the end of any support at all until the new calendar year comes around. This can create perverse consequences, as the following quotes show.

... there were constant references to the countdown of my six sessions, and this created much pressure on me, and prevented me from actually getting anywhere, because I was too scared to open up to my issues of trauma, and then potentially be left without support. I am frustrated because my inability to get adequate treatment for my PTSD means that I am unable to hold down a job or study, when I know I do have the potential.

Person with lived experience, Victoria
[What doesn’t work for consumers is] after the completion of the 10 sessions, and seeing their improvement over this period, then all of a sudden either being left out in the cold, forced to see a psychiatrist (or GP) and start all over again (i.e. developing rapport, explaining their story), and then having to wait until January to be able to return to the ONLY person who seems to make a difference to their mental health!

Support person, Victoria

The absence of ongoing community-based support means that Better Access becomes the only option for many people with severe illness (if they can afford it), with professionals reporting that they are trying to deal with complex and entrenched difficulties, including personality disorders and often tied up with histories of abuse and trauma, under a programme which was designed for less severe problems.

Better Access was for mild/moderate (as I understand it) and state/territory to manage moderate/severe. This is not borne out in reality now, as except for acute/crisis presentation and consumers with psychosis dx, the severe depression, anxiety, trauma, personality disorders are being turned away. These people are often impaired environmentally, socially, developmentally and financially (loss of productivity etc.). The flow-on effect is a waste to public resources (e.g. management in ED, short-stays in hospital to manage a crisis, multigenerational effect on children) and does not provide adequate treatment, according to evidence base.

Clinical psychologist, Australian Capital Territory

**Gap between clinical and non-clinical services**

Failure to recognise a person’s interrelated needs—where mental, physical, social and economic health are recognised as interdependent—is reflected in a scenario commonly mentioned in submissions. This scenario involves a person being discharged from an inpatient unit, only to encounter difficulties to do with housing, family, or finances which then impact negatively on their mental health. Such difficulties might range from returning to an empty house where there is no food to being discharged to unstable accommodation or a harmful family or social situation characterised by violence or drug-taking.

I live alone and have no real family support. Therefore the three visits I have had to hospital have left me without food and supports when I go home. A lot could be done in this space to speed up recovery and to avoid readmissions.

Person with lived experience, New South Wales

Clinical services in these scenarios have failed to liaise with available non-clinical supports such as housing services, which in turn leads to a greater likelihood of readmission to hospital. The quote below shows that even if clinical services are available, if they are not backed up by and linked with non-clinical supports such as employment services, a person may find it hard to sustain any mental health gains made.
Despite significant focus in the areas of men, youth, mums with children under two years, elderly, there is insufficient support specific to mums/females with depression and other mental illness in the form of support groups and therapies.

It is recommended as part of recovery for mental illness that you should undergo paid work or volunteer work; however, there are no strategies, support mechanisms that can support someone with mental illness to manage both their illness and their employment.

*Person with lived experience, Victoria*

The fragmented nature of the mental health system at present means that it is difficult for services and programmes to holistically assess and address a person’s family context and to use whole-of-family therapeutic interventions. This is especially important when a parent is experiencing a mental illness which in turn may affect their children, or when a child is experiencing a mental health difficulty which affects (or is affected by) their siblings and parents.

In most areas of Australia, there is significant disconnect between adult mental health and child and family services. The interdependence of outcomes of adults experiencing mental illness and outcomes for children have been well demonstrated, yet services for adults and children are rarely integrated and do not routinely address the parenting needs of adults with mental illness, the needs of the whole family, or the individual needs of their children. Improved integration, collaboration and pathways of support and information sharing needs to occur across the range of adult, child and family services.

*Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA)*

**No services in a geographical area**

**Regional, rural and remote areas of Australia**

By far the most common gap identified by respondents was the lack of particular (or in some cases, any) mental health supports in outer-metropolitan, regional, rural and remote areas of Australia. Long waiting lists, requirements to travel long distances, or simply a complete lack of access to support, were all identified as problems in these parts of the country. These gaps have been addressed in detail under ToR 8 in Chapter 11 of this document.

The first quote below illustrates the shortage of services even where a person is able to pay for private treatment, while the second lists the multiple gaps in mental health related supports in a particular geographical area. Some areas lack whole systems of support, while others lack appropriate support for particular difficulties.
My daughter was unable to access the headspace service on return to her university studies in [a regional town] after having taken a year leave due to her hospitalisation and ongoing treatment because she had already used the 10 psychology appointments covered under her mental health plan. She was unable to gain any support apart from regular monitoring from the GP and had to travel [many] hours home to Sydney every few weeks to visit a private psychologist. The ability to access support in [the regional town] is very difficult with only 1 psychiatrist with expertise in [my daughter’s problem] who I was told had a 4 month waiting list.

Support person, New South Wales

[A regional area in Queensland] has more gaps than services:
- No high care service.
- No crisis accommodation for Men.
- No rehab services.
- No child psychologist
- No LGBTI services
- No family and carer support groups.
- No MH support group run by people with MH issues.
- No dementia diagnostician or services for mod / high care.
- No bulk billing
- No MH beds
- No effective access to psychiatrist (QHealth—good luck; Private—every six weeks if funding renewed).
- No ASD [autistic spectrum disorders] trained clinician
- Limited DV [domestic violence victim support]

Psychologist, Queensland

The significant gaps in provision of mental health supports in regional, rural and remote Australia could be said to result from decisions about prioritisation of funding, as argued in the following extract:

The distribution of mental health funding in South Australia between Rural and Metropolitan service is inappropriately balanced [...] A prime example is the funding allocation for mental health services for older persons, Rural SA has approximately 10 to 12 clinicians to provide this service across a population of 395,000 people and a geographical spread of approximately 1,000 sq. km in comparison to Adelaide with well over 120 Clinicians.

Researcher, South Australia
Programmes unevenly distributed

Geographical disparities often were cited in relation to uneven distribution or rollout of Commonwealth mental health programmes, especially Partners in Recovery and the Mental Health Nurse Incentive Programme.

While the evaluation of the MHNIP has reported significant client outcomes it also identifies the limited uptake in some jurisdictions such as WA and SA and no uptake in the NT. There are a range of factors for this; however, a significant factor has been a lack of investment in the program. The investment in supporting the uptake and implementation of general practice nurses has been significant compared to the MHNIP. From the DoH (DoHA) there has been little promotion of the program, or support for organisations and services that want to use the program.

Australian College of Mental Health Nurses

Eleven Medicare Local regions [have] yet to be provided Partners in Recovery funding. This has left [them] lacking a service which would provide consumers and their family and carers with a personalised approach to identifying their health, mental health, vocational and recreational goals and would ensure access to relevant services and supports is streamlined and coordinated. PIR would enable consumers to receive wrap-around supports and coordinated access to services to prioritise their needs. [...] The absence of Partners in Recovery has also resulted in a lack of resources to support the development of systemic partnership enhancement across the region which would facilitate service system integration, coordination and care pathway improvements.

De-identified Medicare Local

Gaps due to service closures

Many individual respondents cited concerns about services which had closed recently or which potentially faced imminent closure. Concerns were raised that they were not being replaced by an equivalent service and that therefore gaps in support would result in that town or community.

The Newcastle and Hunter area has recently been informed that our community health counselling service will close. They stopped taking clients on 3rd March, and already the impact of this terrible decision has been felt. The community health counselling service employed some of the most highly skilled psychologists in the area, treating some of the most complex and vulnerable community members. Its closure leaves a tremendous gap. Already most private practices are full, and even if clients could get in, 10 sessions is not adequate for the complexity of these presentations.

Clinical psychologist, New South Wales
Lack of appropriate services for particular types of mental health problems

Two diagnoses frequently mentioned as receiving inadequate specialist care were personality disorders (especially borderline personality disorder) and eating disorders.

In terms of personality disorders, it was widely felt that there is insufficient attention paid to making therapies available which are considered particularly effective for such difficulties, including dialectical behaviour therapy for borderline personality disorder. People experiencing a personality disorder frequently have complex histories, often including experience of trauma and abuse, and many professionals feel that the existing limit of ten subsidised psychology sessions under Better Access is insufficient to effect meaningful change. Establishing trust can be an issue with people with such complex needs, and of itself can take considerable time. Insufficient therapeutic intervention can lead to a revolving door effect where crisis after crisis is dealt with reactively by inpatient services—ultimately an inefficient situation.

[There are] too many examples to list of overloaded emergency care services leaving distressed and injured people with BPD [borderline personality disorder] waiting hours for treatment or being sent home without being seen. In one case a young woman who had self-harmed was treated with band aids, a tranquiliser tablet and sent home alone on a bus. The young woman later died at another hospital following further similar injuries.

*Former psychiatric nurse, South Australia*

People with experience of an eating disorder and those who support them find that, in most areas of Australia, expertise and service capacity are lacking. A common complaint is that even where specialist eating disorder services do exist, they focus on physical parameters including weight gain as evidence of recovery, without supporting someone to achieve broader quality of life outcomes or psychological recovery.

[A woman with anorexia nervosa] deteriorated to the point where her psychiatrist required her to present to emergency at a large public teaching hospital in a major city. She spent two days in emergency before being admitted to a ward. A dietician not experienced in eating disorders was assigned to her—she ate no food. Her weight continued to fall but it took a number of days before her treating team agreed to a nasogastric tube. No one on her team had any experience in treating eating disorders, nor were they inclined to consult with those with experience (at another hospital). No psychological services were provided ... The family did not feel safe leaving her without someone by her bedside to insist on care. There was no multi-disciplinary approach and a lack of willingness to understand and treat the illness.

*Butterfly Foundation*

Many respondents referred to gaps in mental health expertise among staff in primary healthcare and emergency departments (EDs). Because these services are usually the first place people turn for help when experiencing mental health problems for the first time, this is concerning. Respondents told us that stigmatising and dismissive attitudes are a common problem for people seeking help. One emergency department nurse attributed this to a failure to consider emergency service workers as part of mainstream mental health services, leading to a failure to train them in how to deal appropriately with someone experiencing a mental health crisis.
There exists in EDs a tension due to conflicting cultures of practice where recovery-orientated practice is not (rarely) understood in EDs and as such clients may experience care that reinforces stigma and undermines the person-centred nature of contemporary mental health care ... I believe that the general trained nurses who assess and initially manage clients with a mental illness [in the ED] are in fact part of the mental health workforce—their needs are poorly considered and rarely met.

*Nurse, Queensland*

**Lack of appropriate services for particular life stages and population groups**

Respondents from different parts of Australia reported gaps in services catering to the particular mental health challenges of young people, of pregnant women and new mothers, and of older people. Although the gaps vary from place to place, there was a common perception of being cut off from services because of reaching a life milestone.

For example, young people who had been supported through headspace find that when they turn 25 they may not be able to receive the same level of support from adult services. Parents report that they have found it difficult to find appropriate support for their child who is going through difficulties. The quote below illustrates how age-appropriate support or treatment is particularly hard to find when a child is going through phases of transition.

There are minimal psychiatric inpatient services available for children under 12. I was told the only option for my child was the [name removed] child psychiatric unit, but the unit wouldn’t admit her due to the mix of patients there at the time (oppositional defiant boys). I was told once she turned 13 there would be more options as there are several adolescent psych units; however, I also had mental health professionals tell me it was not a good environment for a 13-year-old girl as there were often patients in there with substance abuse issues and a culture encouraging self-harm.

*Support person, Victoria*

Appropriately tailored support for older people with mental health difficulties who are not experiencing dementia appears to be scarce.

In NSW, there is a lack of appropriate mental health care for older people. Aged care services typically do not actively identify or respond to the needs of older people with mental illness, and there is a poor understanding of mental health issues in the aged care sector. While there are specialist mental health services for older people in NSW, their availability is limited to people with the more severe symptoms.

*NSW Consumer Advisory Group - Mental Health Inc. (now trading as BEING)*
Lack of appropriate services for interrelated needs

Many submissions referred to the seeming inadequacy of current support arrangements in addressing interrelated needs in a way that ensures the needs of the whole person are met. Respondents told us that this is especially the case where mental illness occurs at the same time as other social, health and economic problems, or in the context of particular life experiences. For example, people who experience a substance abuse issue or a physical or intellectual disability as well as their mental health problem may find that the mutually influencing nature of these difficulties is not recognised and that different problems are either not addressed or are addressed in piecemeal fashion. There is also the risk that the person will be considered as another agency’s business and fall through the gaps between services.

In a similar way, people whose mental health can be affected by their life experiences, background, or circumstances can have their clinical symptoms treated without consideration of how such contextual factors can either support or adversely affect their mental health. For example, we heard stories of young people discovering their sexuality and not being able to find support services where they felt comfortable discussing this—especially in rural areas.

These deficiencies in support for interrelated needs are discussed more extensively in Chapter 8 of this document in relation to integrated care.
7. Emerging approaches: technologies and e-mental health

7.1 Key findings

Respondents identified four key aspects of using technology effectively in mental health service delivery. These were:

- service accessibility for people with lived experience
- social support for people with lived experience, family members and support people
- dissemination of information and knowledge sharing
- aids to professional networking, training and continuing professional development
- increased efficiency and effectiveness in provider roles.

Challenges of using technology in delivery of mental health services included:

- integration and coordination with existing services
- ethical issues and accountability in service delivery
- universal accessibility and availability.

Suggestions to improve the use of technologies in mental health services were:

- incorporate alternative service delivery technologies
- increase access to service providers through telephone and internet sessions
- improve existing technological infrastructure.

Promising practice examples include the innovative use of technology within existing services and mental health programmes. The Australian Government’s Teleweb initiative also was identified as contributing to positive outcomes and innovative mental health service delivery online.
7.2 Overview

Term of reference 6 asked the National Mental Health Commission to assess:

Existing and alternative approaches to supporting and funding mental health care

We selected two issues to highlight as alternative approaches to service organisation and delivery in response to this ToR. These two stood out as prominent themes across responses from all respondent groups. While Chapter 8 will deal with the role of innovative models of collaborative working and integrated care delivery in improving mental health support, the current chapter explores the potential of technologies to improve the delivery of existing models of mental health support and to be the basis of new models of care delivery in the future.

7.2.1 Survey questions

Analysis for use of technology was based on two surveys—one completed by people with lived experience and the other by organisations and professionals.

Professionals and organisations were asked to provide:

a. an example of the use of technology to improve the experience or effectiveness of services

Although this was the only question directly related to the use of technology, references to technology were also found throughout responses to other questions in the survey and were coded appropriately.

People with lived experience and support people were not specifically asked to provide examples regarding use of technology, but references to technology were found and coded accordingly for use in this analysis.

7.2.2 Survey responses

For question (a), 57.2 per cent of organisations (n=135) and 39.5 per cent of professionals (n=340) provided a response.

7.2.3 Note on interpretation

It should be noted that the only question directly related to technology asked professionals and organisations to provide an example of effective use. Therefore, as might be expected, there were a greater number of comments about technology being effectively used in comparison to where technology was thought to be ineffective. Although some responses identified examples of ineffective use of technologies, these responses were comparatively limited.

In our analysis, we found that respondents defined ‘technology’ primarily in terms of information and communication technologies—including electronic patient records, remote professional consultations via videoconference, and online peer support.
### 7.3 Thematic findings

#### 7.3.1 Aspects of effective use of technology in mental health services

Respondents from all groups provided numerous examples of how the effective use of technology has contributed to improved delivery of mental health services. Responses from people with lived experience identified that online technology was useful for them to access mental health information, services and support. Professionals also reported that technology can improve their knowledge, efficiency and effectiveness in performing their roles and supporting positive people with lived experience outcomes.

**Service accessibility for people with lived experience**

A key benefit of communication technologies identified by respondents is the increased reach and accessibility of services to people with lived experience. Where barriers to accessing traditional mental health services might exist, online or phone-based alternatives were viewed positively.

For example, the anonymity of online and telephone services encouraged those who would otherwise feel uncomfortable (especially because of stigma issues) to gain access to services and support. It was often mentioned that the availability of online and telephone services increased access for youth in particular.

> Having an anonymous outlet can be very helpful, especially for first point of contact. Also, for me, when I felt embarrassed and ashamed about something I was going through, an anonymous outlet was the only means which I felt comfortable using. I chose to use the eHeadspace service.

*Person with lived experience, Victoria*

Internet and telephone support services were also frequently mentioned as an effective means to deliver professional services to those who ordinarily experience barriers to accessing face-to-face sessions. Telemedicine, telepsychiatry, telehealth, e-health and online support were perceived to offer increased convenience and access to people, most notably in regional, rural or remote areas.

> The use of telehealth is a prominent example of an innovation and government investment that has enabled rural and remote patients to access care. The government incentive, which has provided up-front payments for practices to be involved in telehealth, offered patients in outer metro, rural and remote regions of Australia the opportunity to visit their GP in order to conduct a consultation with a specialist via video-link, rather than having the patient travel long distances to a large city for the appointment.

*Royal Australian College of General Practitioners (RACGP)*
Social support for people with lived experience, family members and support people

Online mechanisms such as discussion forums were commonly cited as an effective way to increase informal social and peer support for people with lived experience and also for their families and supporters. This was frequently mentioned as one of the benefits of using technology to connect with others and receive support that may not be available from traditional mental health services.

I think there are some fantastic online resources that young people can access for support with mental health problems. Sites like ReachOut, eHeadspace, Kids Helpline Online, beyondblue and the Butterfly Foundation, which provide information, referrals and services such as online counselling. I have used all of these services when I didn’t feel able to speak to anyone in person. They were a great help to me, and meant I didn’t need to disclose my mental health condition to friends and family until I was ready.

Person with lived experience, Victoria

Websites such as Reachout.com and beyondblue are invaluable in their ability to provide this sort of affirmation and validation in circumstances where individuals are unable to access such support. This support enables them to reduce the sense of shame and self-blame associated with mental health problems, and focus on constructively approaching solutions.

Person with lived experience, New South Wales

Examples were also provided of increased support for care providers and other support people.

The Support After Suicide website, online community and Facebook presence have enabled people to access information and support at any time, and from any location. Importantly, they facilitate access to information and support in a non-judgmental and non-stigmatising way, and can preserve anonymity. This may be particularly helpful for some people who are suicide bereaved.

Jesuit Social Services

Peer Support Groups and our 24/7 Peer Grief Telephone Support Line have proved efficient and effective resulting in good outcomes to bereaved parents and siblings. Frequently we receive written expressions of the fact that the connections with these services ‘saves’ people’s lives and sanity, and ability to rebuild their lives.

De-identified provider organisation
Dissemination of information, knowledge sharing

The capacity of information technology to disseminate mental health information widely to people with lived experience, professionals and the public is felt to be of benefit to mental health coping and outcomes, as the information is readily available and easily accessible.

Online information, like what is provided on ReachOut.com, is really helpful. Fact sheets on how I am feeling, tips and advice on a range of issues, forums to talk to other young people about mental health is so valuable. I never really wanted to see a counsellor all the time, sometimes I feel awful, and I just turn to the internet to cheer me up or to get more information.

Person with lived experience, New South Wales

Online resources that increase the connectivity between providers and clients were often mentioned as contributing increased knowledge sharing and dissemination of mental health information. Many examples were provided of successful online platforms.

[Name removed] is a single digital social media and information platform for all things health [in our geographical area]. It includes a web-based information repository, Facebook, Twitter and You Tube channel. The platform is designed to provide two-way information for the community and clinicians. The site provides a professional networking platform for a variety of professional groups, including mental health professionals.

North Coast NSW Medicare Local

Aids to professional networking, training and continuing professional development

From the perspective of both professionals and organisations, examples were provided of the use of technology to aid in professional networking, training and continuing professional development. Online virtual training courses and video seminars were commonly mentioned as examples of where technology had been used to enhance professional development.

I recently completed a webinar for ATAPS providers that was organised by the Australian Psychological Society. This seems like a really good way to make this information accessible to a large number of people.

Clinical psychologist, Victoria

Common examples included the use of these technologies in regional, rural and remote areas where added benefits were perceived for enhancing workforce development.

APAS [Australian Psychoanalytical Society] runs Skype training for clinicians in rural areas. A recent programme run by the Sydney branch taught a wide range of mental health workers in rural and remote Australia the fundamentals of understanding and treatment of autism and related disorders.

Australian Psychoanalytical Society (APAS)
Increased efficiency and effectiveness in provider roles

The integration of technology into mental health service delivery has in several ways increased the efficiency and effectiveness of services provided. For example, professionals identified how the supplementation of traditional face-to-face therapies with alternative methods and tools helped to improve client outcomes. The use of e-therapies (such as computerised cognitive behavioural therapy) and mobile phone applications were some of the specific tools that professionals reported integrating into their practice.

Online cognitive behavioural therapy for adult anxiety disorders and depression has been an invaluable adjunctive tool in my work as a clinical psychologist in private practice. These courses provide a means for patients to access relevant, complementary information to that which we cover in session. It also allows excellent ongoing monitoring of patient symptoms via automated online questionnaires. Adjunctive use of these online programmes enables me to deliver more specialised and personalised instruction when meeting with private patients.

Clinical psychologist, New South Wales

Professionals also report that they use simple communication technologies to improve the service they provide to clients. For example, email and text messaging was perceived to improve compliance (such as appointment attendance) and to assist with building the therapeutic relationship.

I have also found that between-session contact with clients (e.g. in the form of a quick email or text message) is well received by clients, aids in the therapeutic relationship and helps to keep clients motivated in therapy.

Clinical psychologist, South Australia

7.3.2 Challenges of using technologies for mental health support

Integration and coordination with existing services

A number of challenges were identified by respondents in the integration of new technologies into existing service models. Examples were provided of difficulties in ensuring consistency and continuity in care with the variety of technologies being introduced and used by people with a mental illness and service providers. Some mentioned that the continual use of emerging technologies caused services to become “fragmented” and resulted in confusion and lack of coordination among service providers.

The current offering online has evolved in parallel with the offline service offering and there is little or no integration across or between services. This is a missed opportunity and one that should be addressed immediately.

Young and Well Cooperative Research Centre

One example of this is the use of online services and self-guided web based therapies by people with lived experience. Many respondents identified the challenges of incorporating these services into mainstream service provision. There remains considerable uncertainty about how these services could be most usefully employed to connect people with existing service providers and to ensure continuity of care.
There have been rapid developments in online platforms for the identification, prevention and treatment of mental health problems, with e-mental health services shown to be highly effective, efficient and cost-effective. However, e-mental health services largely exist independently of traditional service settings. Health care providers rarely utilise e-mental health systems in their practice.

Black Dog Institute

Ethical issues and accountability in service delivery

A number of ethical issues and lack of service accountability in the use of certain technologies were also mentioned by respondents. In the delivery of mental health services outside of traditional settings, an inability to discern whether services have been effective, and a lack of accountability for service providers, were concerning to some.

It’s hard when a young person logs on and shares their story and people respond with great advice and the young person is involved in that moment but when they don’t come back to share the rest of their story it’s hard to not worry about that one person.

Moderator, mental health website

Universal accessibility and availability of services

Respondents identified a lack of universality in the availability and accessibility of some technologies for mental health support. Examples illustrated limited access to online services and similar technologies for disadvantaged populations and those living in rural, remote and regional areas.

Internet-based health initiatives are only as useful as their accessibility and a lack of reliable internet available to Aboriginal and Torres Strait Islander and rural communities is a significant disadvantage to these groups.

Doctor, Victoria

7.3.3 Suggestions to improve use of technologies in mental health services

Incorporate alternative service delivery technologies

The need to incorporate technologies and alternative mental health therapies into existing and “traditional” models of mental health service delivery was expressed by many respondents. Although many identified the challenges that this can produce, respondents frequently recommended that these services be incorporated as an adjunct to complement and work alongside existing models.
Mental health is definitely not a 'one-size-fits-all' model, so it is essential we ensure the support available for those suffering with mental health problems remains diverse. This includes maintaining a balance of face-to-face and alternative services. I think online services are an excellent resource for both people who are not ready/comfortable to seek help and rural Australians. E-health can also provide care and support outside office hours, which I know, from personal experience, is quite often when young people need help the most.

Person with lived experience, Tasmania

Many respondents provided examples of how online services by themselves are ineffective, and vice versa. Recommendations highlighted the need to have an effective balance of services accessible through various avenues.

Technologies simply cannot replace therapy, particularly for young people with complex, severe and enduring mental health problems such as major depression, drug and alcohol addictions, eating disorders, psychosis and personality disorders. That said, used effectively and as a part of a comprehensive and integrated mental health system, technologies have the potential to reach a large number of people at lower cost to treat high prevalence disorders like anxiety and depression, thereby freeing up professionals and services to focus on those with more complex needs.

Young and Well Cooperative Research Centre

Increase access to service providers through telephone and internet sessions

The use of telephone counselling and internet sessions to increase access to service providers was mentioned frequently as an effective use of technology that should be prioritised and expanded to improve accessibility of mental health services.

If I could request anything I would ask for more serious online and hotline services, not just crisis hotlines, but 6–10 sessions of phone counselling. I have looked for these services before (both for my own mental health and for the young people I work with as a youth worker) and haven’t found any other than crisis lines. I want a personal counselling session over the phone with a trained professional, who I can speak to for several sessions, or a one-off.

Person with lived experience, Western Australia

Multiple respondents perceived the provision of psychological services through telephone or online services to be an effective use of resources. However, the need to address existing constraints in availability and affordability of these services for people with lived experience was frequently cited.

Phone consultations with a trusted psychologist who has been successful in the past for treating me and who knows my entire mental health history were more beneficial than face-to-face consults with another professional. I had to cease my phone consultations due to financial reasons which has set my recovery back considerably and even though I have found another care provider, I do not feel as comfortable and feel this is jeopardising my recovery.

Person with lived experience, Australian Capital Territory
Multiple professionals, organisations and people with lived experience recommended the expansion of Medicare rebates for consultations that occur via this method to professionals other than psychiatrists.

People in rural areas often want to receive my services but are not covered by Medicare for phone consultations. I have worked in EAP programmes in the private sector providing clinical psychology treatment via telephone and it was as effective as my face-to-face work. It would make the world of difference if Medicare could provide phone treatment to people in rural settings as they would have a far wider choice of service providers.

Clinical psychologist, South Australia

Improve existing technological infrastructure

Respondents provided a number of examples of how the existing technological infrastructure could be strengthened to improve the efficiency and effectiveness of mental health services. Many professionals indicated a number of areas where technology could be better integrated into the everyday provision of services with clients. Examples were provided in the existing systems to access Medicare rebates, perform referrals and record, collect and share client information.

The need to expand use of shared electronic patient records, and the potential benefits including time saving, improved continuity of care and patient safety, were commonly mentioned.

A key enabler for coordinated care is e-health, including an e-health record. The personally controlled e-health record might be a solution but the roll out has been slow and there has been few “drivers” for state-funded organisations to get involved. The e-health record has the capacity to work well and improve informed, available and cohesive care and improve the effectiveness of services for consumers. More work should be done to support uptake amongst mental health clinicians and with states to push uptake in hospitals, community health services and not for profit organisations.

De-identified mental health planning organisation

Better integration of mental health care with physical health care also was indicated as a potential benefit.

Integration of electronic patient files across services would clearly offer greater opportunities for care that bridges current mental and physical health divides, and integration of selected e-mental health programmes and services with electronic patient files would offer even greater efficiencies, effectiveness and safety.

Clinical psychologist, Queensland
7.4 Promising practice examples in using technology

7.4.1 Innovative uses of technology in existing programmes

Multiple examples were provided of the innovative use of technologies in mental health services and programmes.

Technology has been used to improve data collection in existing programmes.

The use of technology at headspace, as an example, has improved the effectiveness of gathering minimum data from young people attending the service. Headspace Lismore uses iPads which electronically collect the data and are linked to online scoring and interpretation. The iPad also collects information on the client experience of services at headspace, which provides valuable data for the service improvement and timeliness of service provision. The use of iPads and electronic data collection has enabled staff to access data, reports, trends in client outcomes and service information more easily.

North Coast NSW Medicare Local

Innovative use of social media also has been indicated to successfully link people with lived experience with mental health services and improve outcomes especially with youth.

The PSY [Preventing Suicide in Youth] Facebook Group has now approximately, 20,000 members from both Australia and New Zealand (gated community), and is governed strictly by ‘duty of care’ and ethical guidelines and policies for dealing with crisis management and response situations. A difficult and challenging medium for provision of such support, this PSY Facebook Group is also balanced by a positive, resilience-based approach to increasing help-seeking behaviour in youth and young adults, providing mentoring and education for members via well-trained and supervised volunteers.

An average of 400 requests for support are made each month and an average of 2 emergency services call-outs are made each week to the PSY Facebook Group. This data points clearly to a need within the youth and young adult community for help-seeking responses and support in the arena of suicidality and mental health. With the future prospect of rigorous evaluation of the website already in the planning stages, I have no doubt that this invaluable service will become even more critical and essential for meeting the future needs of our young people at risk.

Researcher, Queensland
7.4.2 Teleweb initiative programmes and services

The Australian Government’s Teleweb initiative was mentioned as contributing to a number of successful online interventions and the use of innovative and effective mental health services.

The SANE Online Forums (a Teleweb project funded by the Australian Government) will come online in mid-2014, for the first time providing mutual support via online forums for carers as well as adult consumers, for people affected by any mental health condition, and concerned about any related issue—anywhere in Australia, 24/7.

The volume of users will ensure a rich and empathetic resource for people concerned about their own mental health or that of a person they care for—promoting guided self-care, mutual support and referral to local support services as needed. In addition to utilising a sophisticated technology platform, The SANE Online Forums will use an innovative distributed service model, in partnership with local consumer and carer support organisations all around Australia. Instead of solely expecting users to come to the SANE website to access the service, the service will go to them—embedded in the websites of their local mental health support organisations. This unparalleled level of support using peer-to-peer mutual support would be impossible without the use of technology and our syndicated service model, to provide a safe and effective environment for promoting recovery.

*SANE Australia*
8. Emerging approaches: integrated care

8.1 Key findings
Integrated care is not just about making sure that professionals communicate with each other about a person they are supporting (although this is an important aspect). In order to deliver a system of supports which recognises the needs of the whole person, meets interrelated needs and ensures that people do not fall into gaps between siloed services, multiple levels of integration are required.

These include:

- integrated governance and planning
- models of care recognising the person as an integrated whole
- infrastructure to support integration such as buildings and technology
- collaborative ways of working.

This chapter examines examples of each of these levels of integrated practice cited by respondents, and shows the consequences of the current failure to address these complementary aspects of integration. The key message is that integration is not just about structural change—it is about cultural change too. Providing and accessing an integrated system of supports was such a central concern of respondents to our call for submissions that it appears to be a prerequisite for improving outcomes for people experiencing mental illness.

8.2 Overview
Term of reference 6 asked the National Mental Health Commission to assess:

**Existing and alternative approaches to supporting and funding mental health care**

We selected two issues to highlight as alternative approaches to service delivery in response to this ToR. These stood out as prominent themes across responses from all respondent groups. Chapter 7 dealt with the potential of technologies to improve the delivery of existing models of mental health support and to be the basis of new models of care delivery in the future. This chapter discusses the role of innovative models of collaborative working and integrated care delivery in improving the outcomes and experiences of people with lived experience, family members and support people.

8.2.1 Survey questions
Professionals and organisations were asked to provide an example of different services, policies, programmes or initiatives which:

a. demonstrate good integration, joint working, or collaboration with other services, programmes or initiatives
b. are not well integrated or don’t communicate with each other.

Although these were the only specific references to integration in the survey questions, responses relevant to this issue also were found throughout responses to other questions in the survey and were coded and used in this analysis.

People with lived experience, family members and support people were not asked to provide specific examples of integration, but references to integration, collaboration and communication were coded appropriately and used as the basis of analysis for this chapter.
8.2.2 Survey responses

For question (a), 79.2 per cent of organisations (n=187) and 69.0 per cent of professionals (n=594) provided a response.

For question (b), 63.8 per cent of organisations (n=150) and 47.7 per cent of professionals (n=411) provided a response.

8.2.3 Note on interpretation

The term ‘integrated care’ is commonly used in health and welfare policy. However, what it actually means is seldom properly defined. For the analysis underpinning this chapter, we have elected to be inclusive, and have adopted Konrad’s continuum of integration which incorporates a range of types of integration according to formality of the joint working arrangements.

Figure 2 Konrad’s continuum of integration


The definitions along this spectrum are diverse, but all share the implication that some agent (a person, organisation, group) is engaged in a sustained way in a joint endeavour with another agent across some divide (such as a boundary between professional disciplines, organisations or sectors). In the case of mental health supports, agents may be working towards a shared goal to improve the life experiences or health outcomes of an individual or of a defined group of people.

8.3 Thematic findings

8.3.1 Overall

Improving the way professionals, people with lived experience, family members and support people, organisations, sectors and jurisdictions work together across traditional boundaries was one of all groups of respondents’ most commonly mentioned concerns about mental health services and programmes.

This is perhaps because improving the integration of services and programmes at multiple levels of the mental health system is seen as a basic mechanism to effect mental health reform. Many of the problems with the quality, effectiveness and efficiency of mental health support cited by respondents are attributed to the ‘system’ being fragmented. This fragmentation extends from the highest levels of governance (such as confusion about state and federal responsibilities) to the poor experiences of people with lived experience whose support professionals do not talk to one another.

This chapter examines what people told us about evidence of insufficient integration, collaboration and communication within and between programmes and services, and the consequences of this for people with lived experience, family members, support people, professionals and taxpayers. We also received many examples of pockets of effective
collaboration and integration, and from these examples we have developed a picture of the
types of integration that are possible and the benefits which can accrue.

While not proposing that increased collaboration and integration is a panacea, our analysis
shows that these are considered by many stakeholders to be both structural and cultural
prerequisites for reform.

8.3.2 Consequences of failure to achieve joint working and integration

Evidence of lack of collaboration and integration appears in many other parts of this
document, and this lack is frequently perceived as contributing to poor experiences and
outcomes for people with lived experience, family members and support people, as well as
inefficiencies in the system. In particular, the analysis of gaps in programmes and services
presented in Chapter 6 of this document (ToR 5) is a catalogue of evidence for such a lack.

Many of these failures reflect a system that is not set up to see the whole person or to tackle
interrelated needs in a coordinated way. In responses from people with lived experience,
family members and support people it became clear that where people do receive effective
support for complex or multiple needs, this is the result of an ad-hoc process whereby the
initiative and energy of individual clinicians and other professionals is the glue holding the
system of support together. It also was common for people with lived experience, family
members and support people to report that they themselves had become default care
coordinators in the absence of any other mechanism to achieve this.

For many, this task proves difficult or impossible because they have no way of knowing what
support was available or what different support organisations are supposed to do. Therefore,
where a person did have a good experience of multiple supports working together, this
seemed often to be despite the ‘system’ rather than because of it.

There was a common thread to many of the stories we received about poor experiences of
mental health services and programmes. This was a failure of continuity and consistency of
support resulting from the failure of different sectors (such as health, education, or housing),
different organisations and individual professionals to communicate with each other about the
individual person’s support. People with lived experiences reported having to repeat their
story multiple times to multiple providers, and sometimes to the same provider.

Educate peripheral service providers, e.g. housing, education, rehabilitation, Centrelink to
become involved in and communicate with psychological and medical providers, to facilitate
holistic interventions and treatments that address every aspect of a mentally ill person’s
needs. Otherwise everyone’s efforts are often wasted, don’t last, or result in a situation where
one problem is addressed only to have another arise, which causes deterioration in the first
etc. etc.

As we noted in relation to ToR 5 (gaps in services and programmes), people with lived
experience report commonly being left without ongoing support after a short episode of care
(such as an inpatient admission or a series of Better Access sessions), or after a visit to an
emergency department.

My friend recently attempted suicide twice. [In] both cases she was admitted to [the
emergency department] but in the second case they had no idea about the first time she had
been admitted which was only [a few] weeks prior. So she was very traumatised about speaking about her experience over and over again to the many different health professionals ... There was no communication between them internally or across the incidents.

*Person with lived experience, Victoria*

The absence of a well-integrated system of supports, whether at a national or local level or around an individual person, means that people experiencing mental illness receive a suboptimal level of care unless they are able to self-advocate or have tireless personal or professional advocacy to find and receive the combinations of supports they need.

There is a wider implication of this absence, however, which is overall inefficiency of investment in mental health services and programmes. Wherever a person has one difficulty addressed but another is ignored, wherever they have to repeat their story, wherever a professional does not know a person’s history, quality of support is compromised and a cycle of deterioration, crisis and inpatient treatment is more likely. The burnout of personal support people and secondary social and economic impacts also are more likely to happen with repeated experiences of this type.

I had a team of doctors for several different injuries after a car accident. A neurologist diagnosed my migraines as being caused by depression/anxiety, then prescribed me medication—without consulting with my psychiatrist to see if these meds would clash with what I was prescribed by the psychiatrist. The end result was an increase of my psychological issues, leading to my last suicide attempt.

*Person with lived experience, New South Wales*

The consequences of the current failure to adopt integrated service models, sustained interprofessional communication, collaborative ways of working or the governance and infrastructure to support these, are perceived to be damaging for people and governments alike.

### 8.3.3 Levels of integration and collaboration

It is difficult to talk about ‘integrated care’ (as in service delivery) in isolation. Respondents reflected the interdependence of different levels of integrated working, from high-level governance to how individual professionals work together. It seems from the responses we received that so-called ‘integrated care’ is not just achieved at the ‘coalface’ of support and treatment, but that it must be supported by infrastructure which encourages boundary-crossing, and by a culture of collaborative working which infuses the whole mental health system.

Findings for the remainder of this chapter are presented according to the different aspects of integration and collaboration identified in submissions. The levels of integration mentioned by respondents were:

- Integrated governance and planning
- Integrated philosophy and model of care
- Infrastructure to support integration (finance, technology, buildings)
- Collaborative ways of working.
For each type, the following are identified:

- Rationale and proposed benefits of this type of integration
- Proposed mechanisms to achieve this type of integration
- Barriers to this type of integration
- Examples of this aspect of integration at work.

**Integrated governance and planning**

Joint governance and planning of mental health supports was thought by many respondents to be a necessary foundation to underpin the delivery of integrated services and programmes. The following excerpt summarises the case for integrated governance.

In our experience, mental health clients require an array of physical, social and psychological services. The biggest challenge is lack of coordination of this care. This coordination does not require an additional layer of services, but greater integration of services. For the majority of clients, this can be achieved through the ‘Medical Home’ or ‘Wrapped-Around’ model of care. … What is required is a reconceptualisation of funding and service design guidelines to achieve this care coordination.

*North Coast NSW Medicare Local*

Different forms of joint governance were mentioned by respondents. Shared structures may be set up, such as a centralised triage or intake point which acts as a hub for referral to a range of agencies, programmes or services. Agreements may be made between agencies sharing similar goals to tackle those goals in a collaborative rather than competitive way.

*WentWest*

Another form of this type of governance entails setting up formal structures for sustained and regular involvement of people with lived experience, family members, support people and communities in the design, operation and evaluation of particular mental health supports.

The key to mental health service reform is true collaborative partnerships based on trust and mutual respect. These partnerships need to occur on many levels, between and among services and service providers, but most importantly with consumers. They should be seen as the real leaders of mental health service reform and health care professionals should adopt a ‘leadership of service’ to mental health consumers.

*Faculty of Health, University of Technology Sydney*

A concrete example of this philosophy in practice can be seen in the following quote.
The Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA) administers the COPMI initiative. The association’s aim is to actively promote the mental health and wellbeing of infants, children, adolescents and their families and/or carers in Australia. The meaningful involvement of people living with mental health problems and their families/supporters is a key philosophy and practice of the organisation and is evident at all levels. COPMI’s consultation group, the COPMI National Lived Experience Forum, meets on a quarterly basis and is involved in the development of all the initiative’s materials and resources as well as recruitment of staff.

Integrated governance also may involve a collaboration of multiple agencies jointly conducting a needs assessment and setting out a plan for how they will cooperate to meet the needs of their local population. This may then be followed by a long-term commitment to a joint approach to service delivery. Multiple agencies may come from the same sector (e.g. health agencies funded by state and Commonwealth source, or health agencies at primary and secondary care level) or may originate in traditionally separate sectors.

Integrated or collaborative governance is seen in a variety of contexts, not just service delivery. Often, a project or initiative to improve mental health support—such as guideline development or investigation of new technologies—is developed in partnership between different types of stakeholders including service providers and universities. The idea of leveraging combined expertise and integrating theory and practice is important here.

The National Centre for Farmer Health (NCFH) [is] one of the most exciting initiatives in agricultural healthcare in more than a generation. It is a new university research, service delivery and education centre that provides national leadership to improve the health and wellbeing of farmers, farm workers and their families across Australia. It is a partnership between Deakin University and Western District Health Service.

Barriers to integrated governance and joint planning primarily appear to stem from disparate funding streams (for Commonwealth programmes, philanthropic sources, state government funding and so on) and competition for funding at local or regional level. These can act as disincentives for collaboration between agencies, sectors and organisations.

The process of tendering to multiple NGOs encourages competition among participants and reduces inter-agency cooperation. Often those agencies are not locally managed and this impacts on service provision, costs of service and their ability to coordinate with other local services.

**Integrated philosophy and model of care**

The benefits of joint governance and planning which cross organisational or sector boundaries include the increased ability to implement a ‘no wrong door’ policy. If a combination of services and programmes are designed on a regional level to work together to meet the needs of that region, it should not matter which programme or service a person goes to first. The
idea is that a person accessing any service will have their whole-of-life needs jointly assessed by the relevant agencies, which, together with the person, decide which of their service offerings will, in combination, meet these needs. This is more user-friendly for people with lived experience, family members and support people, who do not need to act as their own care coordinators across a fragmented system.

The idea of integrated governance, therefore, is that it will make it easier for local services and programmes to be implemented in a way which recognises and attempts to meet the needs of the whole person, in their family and community context, rather than as a collection of isolated symptoms and needs. In other words, ‘integrated care’ presumes that the person with lived experience is seen as an integrated whole with interdependent needs, strengths and preferences.

Respondents gave us many isolated examples of services and programmes which they felt were guided by such an integrated view of the person. Commonly, these demonstrate a ‘client pathway’ approach to delivering support, where the goal is that the person experiences a seamless continuity of care, however many service or programme boundaries they may cross.

One mechanism for achieving this cited by respondents is to orientate mental health supports around primary healthcare. Increasingly, for example, psychologists are working within primary healthcare practices alongside GPs. Other examples of primary healthcare-oriented integrated service models are seen in some rural and remote primary health care services which, out of necessity, pool expertise and limited workforce to deliver a wide range of services. 

Primary care psychology involving the co-location of appropriately trained psychologists in the primary care setting with GPs enables optimal (effective and efficient) reporting and team-based integration of knowledge about the patient. Use of "Medical Director" or "Best Practice" software systems in the general practice setting enable both the doctor and psychologist to share (from session to session) approved but confidential information in a way that serves patient best interest and outcomes. Given delays in the e-health initiative, this integrated note-taking is not available between professionals working in their own separate "silos"—such as psychiatrists and psychologists who work autonomously in their private practice settings. Shared notes, co-location enabling effective and timely (often informal) verbal interchanges (again in confidence) enhances patient care. Research evidence also indicates that such multi-disciplinary team-based care and communication results in better treatment outcomes.

*Clinical and health psychologist, New South Wales*

**Infrastructure to support integration**

The above example shows that an important aspect of providing an integrated service model is that it requires the participating agencies or professionals to share information, to ensure continuity of care and to reduce duplication of effort. Respondents mentioned that a shared care record, hosted on an IT platform which is accessible by all agencies and professionals, can significantly aid this process.

Infrastructure may come in the form of introducing new workforce roles to actively coordinate services around a person. This is an alternative to top-down mechanisms of integrated governance where organisations routinely work together. Instead, active coordination requires that particular professionals or organisations work together on an ad-hoc basis where the needs of a particular person demand it. These already exist in many places in the form of care...
Coordination professionals and most recently in the form of Partners in Recovery support facilitators, but it appears that the availability of such supports is confined to people with the most complex needs and even then only in certain places.

A third type of infrastructure to support integrated care is the provision of buildings where collocation can occur. This is where multiple agencies, organisations and professionals house their services in the same or nearby buildings, theoretically increasing their ability to work together to meet interrelated needs, and increasing convenience for the client.

**Collaborative ways of working**

The idea of setting up joint governance, infrastructure and whole-person models of care is to make it easier for those working in support services to implement collaborative ways of working during their everyday practice. In theory, working collaboratively ‘at the coalface’ is increasingly being achieved through multi-disciplinary teams within health services, which sometimes have housing, vocational and drug and alcohol specialists embedded within the team. Better Access was mentioned by people with lived experience and professionals alike as facilitating communication between professionals who usually work in isolation. Having what feels like a network of informal and professional supports around them who communicate with one another can be important to some people with lived experience (while raising privacy concerns for others).

> Having a "safety net" of connected people that I can rely on in periods/moments of crisis to take action if required. This includes my wife, GP, counsellor, psychiatrist, close friends. During some episodes of depression and suicidality in the past months, it was important that they knew they had my prior permission to escalate concern over my wellbeing and, if required, intervene on my behalf.

*Person with lived experience and support person, Victoria*

However, collaborative whole-person integrated care is about more than crossing inter-disciplinary boundaries—it also is about crossing traditional organisational and sectoral boundaries. The following is an example of mental health supports in a rural area which worked collaboratively to improve whole-of-life outcomes for a person who had previously been in and out of hospital in a far distant metropolitan area. According to the excerpt below, a new intermediate care service (ICS) was able to intervene in this cycle by working with existing community professionals.

> The consumer was homeless, with a history of not being able to maintain their living environment, physical, financial and own wellbeing, not compliant with medication or keeping of appointments. A relationship was established with clinician and psychosocial support worker while in hospital. The local mental health clinician had an excellent relationship with the local hospital, enabling the consumer to stay in hospital for 30 days with escorted day leave to establish a sustainable community living environment. Result in consumer now living in rented accommodation, with ongoing psychosocial support, paying rent, cooking for self, maintaining daily living requirements etc. This outcome was possible due to the flexibility of the ICS program across the community, local general hospital and government and non-government organisations.

*National Alliance for Rural Mental Health*
People with lived experience, family members and support people often reported that it is important to feel they are a part of a collaborative arrangement where all parties are committed to working towards their goals.

[What is effective in terms of mental health supports?] Patients and doctors/therapists working together through setting and working to achieve the patient's goals. In addition, the therapist exercising patience with the patient. My psychiatrist is patient with me and together, we set ways for me to get better sooner.

*Person with lived experience and support person, Western Australia*

### 8.4 Promising practice example of collaborative working and integrated services

Integration of education and health and wellbeing supports were seen by many respondents as a desirable way to ensure that school achievement and attendance is not affected by mental health difficulties. This was one of the more common inter-sectoral integration opportunities identified.

The benefits of having mental health supports working as part of the school community, under partnership arrangements between health and education authorities, are thought to include: a reduced sense of stigma for young people and for parents if supports can be accessed in school settings; an opportunity for widespread early intervention in emerging mental health difficulties; and the ability to meet the young person in their own life context. The following example describes such a partnership which is underpinned not only by a shared vision and governance, but a whole-of-community, whole-of-family approach to children’s wellbeing in recognition of their interdependent needs.

Doveton College is a community focused school in the City of Casey in south-east Melbourne catering for families and children, prenatal to early adulthood by offering a fully integrated wrap-around service, including early learning, family support, and mental health support services. Doveton also provides a range of community development initiatives. The model is strongly supported by research recommending school and community services are needed to be woven together to overcome barriers for children’s learning and development. Within this initiative Family Life provides access to the Family Mental Health Support Services (SHINE), and has delivered our Creating Capable Leaders program in 2013, developing skills for local leadership and volunteering. The eight-week program achieved more than 20 parent graduates in 2013 alone, who are now actively leading local initiatives such as a food cooperative to improve child and community wellbeing.

The Family Mental Support staff work closely with other service providers at the college such as general practitioners, allied health, early childhood intervention services, family support services and teachers. All the services contribute and subscribe to a shared vision, use one family file, establish partnerships and create effective referral pathways between each participating agency. All participating agencies sign a Memorandum of Understanding (MoU) with Doveton College for the services they provide.

*Family Life (Southern Family Life Service Association Inc.)*
9. Mental health research

9.1 Key findings
Responses identified a number of perceived problems with the current mental health research agenda in Australia. The most prominent were:

- gaps in existing research activity in terms of both topic and methodology
- misaligned priorities in mental health research
- research evidence not translated into practice.

To address these problems, a number of improvements and changes to mental health research were suggested. Most commonly these were:

- increased funding for mental health research
- integration of service priorities and research activity
- partnerships between researchers and service providers
- research coordination and information sharing.

Promising practice examples of research initiatives in mental health include recent initiatives by the National Health and Medical Research Council (NHMRC) to improve translation of research evidence. The formation of groups such as the Alliance for the Prevention of Mental Disorders also is contributing to more informed mental health policy decision-making and a shift from treatment to prevention research.

9.2 Overview

Term of reference 7 asked the National Mental Health Commission to assess:

*Mental health research, workforce development and training*

The research aspect of ToR 7 is dealt with in this chapter. The ‘workforce development and training’ aspect is the subject of a separate analysis in Chapter 10.

9.2.1 Survey questions

Professionals and organisations were asked to provide an example of a service, policy, programme or initiative which demonstrated:

- a. regular and effective use of evaluation or research to inform evidence-based practice
- b. poorly prioritised, funded or organised research activities.

All respondents, including people with lived experience and support people, were asked:

- c. What is your view about the current funding, organisation and prioritisation of mental health research?
- d. What specific action or strategy do you think could improve this situation?

9.2.2 Survey responses

For question (a) 62.7 per cent of organisations (n=148) and 43.1 per cent of professionals (n=371) provided a response.

For question (b) 41.1 per cent of organisations (n=97) and 26.7 per cent of professionals (n=230) provided a response.
For question (c) 32.6 per cent of organisations (n=77), 18.9 per cent of professionals (n=163), and 16.4 per cent of people with lived experience and support people (n=102) provided a response.

For question (d) 30.5 per cent of organisations (n=72), 16.1 per cent of professionals (n=139) and 13.5 per cent of people with lived experience and support people (n=84) provided a response.

Analysis for this chapter considered three sources of evidence—responses to these particular survey questions, plus material from unsolicited submissions, and answers to other survey questions which addressed issues relevant to the chapter.

9.2.3 Note on interpretation

It should be noted that although service and programme evaluation are often seen as distinct activities from formal academic research, respondents to our survey commonly interpreted ‘research’ to include service evaluation as a sub-category. We have therefore included comment on service and programme evaluation in our analysis for this ToR, but have also considered the use of evaluation for accountability purposes as part of ToR 10 on transparency and accountability.

9.3 Thematic findings

9.3.1 Perceived problems with current research in mental health

Gaps in existing research activity

Respondents from all backgrounds listed a multitude of research gaps spanning a wide variety of mental health topics, conditions, interventions and services. Research regarding the effectiveness of existing services was more commonly identified as being of potential use but currently under-resourced in comparison to research into new treatments, interventions and practices. All categories of respondent provided examples of research gaps in assessing the effectiveness of mental health services and programmes currently being delivered across Australia.

There would be benefits to both clinicians and policy makers if the funding priorities for mental health research included studies on the effectiveness of mental health interventions and service delivery models, including programme evaluations. Efficacy and effectiveness studies serve different purposes, although funding for the latter is increasingly scarce in Australia.

Australian Psychological Society

A key research gap in such applied research was identified as being investigation of effective preventive approaches to mental health support. Within prevention research, the need to research approaches to improve mental health awareness among the general public, assist with suicide prevention and address environmental and other socio-economic risk factors for mental illness were specifically cited.

We need to fund research into evidence-based preventative approaches to reduce the reliance on 'medical model' approaches. There needs to be a lot more research into early intervention strategies. For example, empowering people in how to support themselves and what to do to alleviate a crisis; low-security support residential retreat services should be trialled to see
whether it significantly alleviates the course of illness and prevents in-patient unit care and emergency transport.

Researcher, New South Wales

The consensus from a large body of evidence supports the contention that interventions to prevent mental disorders across the lifespan can be both effective and cost-effective. However, funding for research in the area of prevention of common mental disorders is considerably lower than that for research in the areas of treatment, epidemiology and neurobiology. Thus, there is a clear imperative to direct funding towards prevention research to redress this imbalance.

The Benevolent Society

Research into addressing existing service gaps and mental health disparities among disadvantaged groups and populations also was felt to be under-prioritised. Research into the specific support needs and effective service responses for children and youth, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse groups, marginalised and at-risk populations, individuals living in rural and remote communities, LGBTI groups and ageing populations were all cited as being in need of attention.

The lack of translational CALD mental health research is an inhibitor for services which are interested in addressing service gaps through utilisation of contemporary evidence-based research practice. Better coordination and governance around evaluation and research would assist in supporting creativity and innovation in terms of CALD mental health service planning, allocation of resources and routine review of service delivery outcomes.

Mental Health in Multicultural Australia (MHiMA)

Misaligned priorities in mental health research

Existing priorities in mental health research appear to many respondents to be poorly aligned with the existing service needs, and with gaps in knowledge about what works within mental health services. Respondents often cited current funding arrangements and prioritisation of research as ineffective in ensuring the most beneficial mental health outcomes.

For example, over-prioritisation of clinically focused research was thought to lead to decreased funding availability for mental health research outside the realm of a medical model.

The funding, organisation and prioritisation of mental health research in Australia tends to have a focus on scientific research to facilitate an improvement in the outcomes of clinical intervention. By comparison, research in the psychosocial, including vocational, recovery field is relatively under-resourced and undeveloped in Australia, compared to what has been achieved in the rest of the developed world.

The Richmond Fellowship of WA

Such a clinical focus was perceived to be exemplified by the distribution of funding under grants given by the National Health and Medical Research Council (NHMRC).
There is a lack of interest in funding research which is to evaluate and implement mental health projects. NHMRC has a particular focus on the biomedical model of health and as such mental health lacks the intensity of research required to alleviate the burden of mental health on families, communities and peak service providers along with governments.

Centre for Rural and Remote Mental Health, University of Newcastle

A variation on this theme was a perceived prioritisation of basic or experimental research in preference to applied mental health research to solve existing problems. Examples were provided of funding being disproportionately awarded to studies that are conducted under controlled conditions and which therefore are seen to lack immediate ‘real world’ applications.

We have argued that mental health research funding is heavily biased in favour of RCTs, and against meaningful ‘real world’ research, which may often be much more cost-effective and immediate in its impact. We note that “major” funding bodies such as the NHMRC typically privilege efficacy and basic science research, usually conducted in city-based university settings. We draw attention to the dearth of translational and implementation research in mental health; we suggest that Australia is lagging behind some other countries in its approach to implementation research; and in terms of ‘real world impact,’ we question whether government and research funders have currently got the balance right.

University Centre for Rural Health North Coast (NSW)

Research evidence not translated into practice

People with lived experience, professionals and organisations provided a number of examples where it was perceived that mental health research findings had not been effectively integrated into existing mental health policies, services and programmes. Often, existing evidence regarding effective therapies, treatment models and methods of service delivery were seen as not being incorporated into policies, service models and programmes.

There was frustration that research regarding the effective number of therapy sessions with clinical psychologists appeared to have been overlooked—along with positive evaluations of the scheme—in the move to change Medicare-supported consultations for psychological services under Better Access. Many thought that policy makers were ignoring the evidence.

We wouldn’t dream of providing half a treatment for physical health problems, like a half dose of antibiotics, so why do we do this for mental health? Research evidence clearly shows some patients require longer-term psychological therapy, and that clinical psychologists are the most highly trained professionals and produce cost-effective outcomes.

Clinical psychologist, Victoria

9.3.2 Suggested improvements and changes to mental health research

Increased funding for mental health research

Respondents often mentioned the need for increased overall funding for mental health research. In addition to providing a number of examples where further funding in mental
research is needed, respondents often perceived that funding for mental health was not equally distributed in comparison to “physical” health research.

More globally, funding for research into mental health, which constitutes the third largest burden of disease, lags a long way behind funding for most physical disorders.

De-identified research organisation

Research activity is underfunded throughout Australia and the NHMRC or ARC do not prioritise it. Every year very small percentage (usually about 4–5 per cent) of the national medical research budget is spent on mental health.

Researcher, Victoria

Integration of service priorities and research activity

Many respondents identified that under existing funding arrangements, strategic prioritisation of mental health research is necessary to ensure the greatest potential benefit to the community. Many examples were provided which identified a need for organisations that fund and conduct research to ensure research activities address existing service gaps, improve delivery and access to services and contribute to positive mental health outcomes.

Research funding and prioritisation is seen to be removed from service needs and priorities.

The NHMRC uses a peer review process which seeks to ensure that the highest quality research proposals are funded. While this focus on excellence is, of course, important, it provides little opportunity to consider the strategic importance of particular areas of research or particular approaches.

While the NHMRC has the capacity to make a targeted call for research, it does so only rarely, relying instead on researchers to propose research topics. Better use of research funds could come from closer links between the research and mental healthcare sectors.

Research Australia

A promising example of how this has been achieved within cancer research also was provided by Research Australia.

Cancer Australia’s primary research funding program is the Priority driven Collaborative Cancer Research Scheme (PCCRS) to support research that reduces the impact of cancer on the community and improves outcomes for people affected by cancer. The scheme brings together the government funding administered by Cancer Australia with funding provided by other cancer research fundraising bodies in the philanthropic sector. It seeks to better coordinate the funding of cancer research across the whole sector, and seeks submissions for investigator-initiated research for specific research priorities in relation to cancer, covering the spectrum from primary to translational and public health research.

Research Australia
**Partnerships between researchers and service providers**

Strengthening the partnerships between researchers and service providers was another strategy for mental health research often mentioned by respondents. Examples were provided of how increased collaboration between researchers and service providers can contribute to a number of added benefits in providing evidence-based practice and ensuring effectiveness.

A more collaborative environment would be beneficial so all stakeholders are aware of research being conducted, and researchers improve their ‘on-the-ground’ knowledge of mental health treatment. This collaboration may operate to reduce research costs, by facilitating completion of programmes within services, which would increase sample sizes and reduce costs of payment to clinicians. Effectively this increases the likelihood of best practice being applied, and also had the potential to reduce funds required for research.

*Hunter Medicare Local*

A number of factors in the current approach to research, including funding arrangements, were also perceived to restrict collaboration. It was mentioned that an adjustment to how research is funded and incorporated is needed to increase collaboration.

Linkage and partnership research should encourage and support high-quality integration between services and researchers but often fails to do so. Project-based funding often results in episodic engagement rather than long-term collaboration. Services often have inadequate resources to make a genuine contribution and policy and funding settings are inadequate to promote strong commitment to research and evaluation. Benefits of participation in research and evaluation are often intangible. In the absence of a clear R&D culture framework, services understandably prioritise service delivery.

*Faculty of Health, Queensland University of Technology*

**Research coordination and information sharing**

In addition to building partnerships, respondents identified a need to improve research coordination and dissemination of findings in a ‘digestible’ format for practitioners. Examples were provided of how multiple research studies and service and programme evaluations fail to share findings of ‘best practice’ and to relay information in a systematic and useful way.

There are some fantastic innovations in rural mental health. However, due to lack of research infrastructure and coordinated knowledge translation, pockets of excellence remain virtually unknown and unrecognised. This is a tragic loss of valuable applied knowledge.

*Broken Hill University Department of Rural Health, University of Sydney*

Many respondents mentioned that there was a lack of information sharing between researchers and providers.

I just did a PhD. I received an OK scholarship. I finished my PhD and not one person in the university asked how my work could be applied in practice. This highlights my comment about the poor translation of research into practice. My PhD was on improving practice.
Respondents identified a need to increase information sharing between providers to ensure the most effective delivery of mental health services is achieved.

Currently funding is spread across multiple organisations running programmes and campaigns which have little evidence to support their use, and without built-in evaluation strategies to measure impact on the target audience. A large number of campaigns attempting to address stigma, suicide prevention and other areas of mental health promotion are often being run simultaneously with little coordination between agencies or sectors, resulting in the public receiving confusing and sometimes contradictory messaging.

9.4 Promising examples of research in practice

9.4.1 Initiatives from the National Health and Medical Research Council (NHMRC)

NHMRC Call for Action NHMRC has established a Research Translation Faculty to support expediting the translation of research evidence. The faculty, which comprises around 2,900 Chief Investigators and Fellows funded by NHMRC, has been asked to identify areas where research outcomes have not been taken up in policy and practice, and put together a written case proposing actions to address this. Mental health is one of 14 areas of focus for the faculty. These ‘Cases for Action’ will initially be considered by the Council of NHMRC. The mental health Case for Action is expected to be considered in the first half of 2015.

NHMRC’s Prevention and Community Health Committee (PCHC) provides evidence-based health advice to the Council of NHMRC on a range of matters in community and population health, prevention and environmental health. PCHC is examining effective parenting practices and their role in promoting resilience and mental wellbeing in children and later on as adults. PCHC is aiming to develop advice for parents, including those in high risk and disadvantaged groups.

9.4.2 Information and support to policy makers

The new Alliance for the Prevention of Mental Disorders (APMD.org.au), which represents many of the most senior mental health researchers in Australia, has been set up to provide information and support to policy makers. Our aim is to support the realignment of mental health research and services from a predominant emphasis on treatment to prevention and mental health promotion. This approach recognises the centrality of mental health to the physical and economic health of the population, and prevention and promotion as the most effective and cost-effective approaches to the considerable global burden of disease imposed by mental disorders.
10. Mental health workforce planning, development and training

10.1 Key findings

Respondents identified three key elements of effective use of the mental health workforce, incorporating planning, training and development. These were:

1. Strategic alignment of workforce planning and distribution priorities with changing policy and provision priorities including identified gaps and unmet need.
2. Using development and training to promote and enable collaborative working within multi-disciplinary teams and between different health and welfare agencies.
3. Ensuring adequate emotional support for staff in order to improve staff retention and prevent burnout.

Current workforce barriers to optimal outcomes for people with lived experience, family members and support people included:

1. Inequitable geographic distribution of professionals.
2. Inequitable recognition of disciplinary groups under Commonwealth programmes.
3. Imbalance between medical and allied health rebates under Better Access creating a skew towards a medical model of care.
4. Stigmatising, dismissive or judgemental attitudes among service providers.

Options for improving workforce planning, training and development include a 'back to basics' approach which:

1. Prioritises the person with lived experience, family member and support person experience of their interaction with services.
2. Addresses attitudes among professionals which are detrimental to the person with lived experience.
3. Acknowledges the basic importance of the professional-client relationship in the effective practice of mental health care.
10.2 Overview

Term of reference 7 asked the National Mental Health Commission to assess:

*Mental health research, workforce development and training*

This analysis deals only with the workforce aspect of ToR 7. The research aspect is the subject of a separate analysis in Chapter 9 of this document.

10.2.1 Survey questions

Professionals and organisations were asked to provide an example of a service, policy, programme or initiative which demonstrated:

a. effective workforce planning, development or training
b. poor use or planning of workforce/human resources.

All respondents, including people with lived experience and support people, were asked:

c. What is your view about the current way mental health workforce development and training is carried out in Australia; and

d. What specific action or strategy do you think could improve this situation?

10.2.2 Survey responses

For question (a) 58.5 per cent of organisations (n=138) and 34.6 per cent of professionals (n=298) provided a response.

For question (b) 44.1 per cent of organisations (n=104) and 27.1 per cent of professionals (n=233) provided a response.

For question (c) 45.3 per cent of organisations (n=107), 27.2 per cent of professionals (n=234), and 15.9 per cent of people with lived experience and support people (n=99) provided a response.

For question (d) 40.7 per cent of organisations (n=96), 23.6 per cent of professionals (n=203) and 13.7 per cent of people with lived experience and support people (n=85) provided a response.

Analysis for this chapter considered three sources of evidence—responses to these particular survey questions, plus material from unsolicited submissions, and answers to other survey questions which addressed issues relevant to the chapter.

10.2.3 Note on interpretation

It should be noted that responses from professionals are not representative of the entire mental health workforce. A high number of respondents identified as psychologists, while there was limited representation from nursing and medical fields, including psychiatry and general practice. It should also be noted that there is an uneven distribution of responses between states, rural and metropolitan areas, as well as between workers from acute care and community care settings. Respondents working in the private sector far outnumber not-for-profit and public sector employees.
10.3 Thematic Findings

10.3.1 Overall

Workforce issues identified by survey respondents highlighted the multiple layers and complexity of workforce development within mental health services. Respondents provided examples from an organisational level to an individual level, and identified challenges across education, ongoing professional development and training, regulation, supervision and management, recruitment and retention within a number of disciplines. Workforce planning issues also were raised regarding appropriate and optimal use of human resources and ensuring roles and responsibilities of professionals are well aligned to the needs of people. Respondents identified a number of areas across and between disciplines where improved workforce planning could be used to strengthen the delivery of mental health services.

10.3.2 Elements of effective planning and use of the workforce

Strategic alignment of workforce development priorities with identified service gaps

Respondents identified a wide range of examples of how effective workforce strategies are being used to address current service gaps within mental health services. There were two primary examples of successful workforce strategies proposed to address these needs—the delivery of targeted professional development, education and training of existing mental health professionals, and coordination and collaboration with educational institutions to increase workforce numbers in specialties where high needs exist.

We received evidence that professionals across disciplines are being provided with additional training and professional development to meet current or anticipated mental health needs within the community. As a result of the wide variety of mental health professionals and organisations represented, a range of successful professional development and training programmes being implemented at a number of levels was identified. These ranged from innovative and unique internal training programmes in a single organisation, to national workforce education programmes that have been implemented across a number of settings. In general, opportunities to participate in or deliver staff training were viewed favourably by organisations and professionals.

A commonly cited example of a successful national intervention involved the up-skilling of mental health professionals to address an existing service gap in the delivery of children’s mental health services. The provision of children’s mental health training through the Tier 2 ATAPS programme was mentioned frequently as contributing to positive service outcomes.

The use of workforce planning principles to identify a potential gap in training has enabled the anticipated workforce challenges to be addressed ‘upfront’ in a rapid, accessible and cost-effective manner. The recipients of the CMHS [Children’s Mental Health Service] now have access to clinicians with up-to-date training and able to deliver evidence-based practice suitable to the developmental age of the consumer.

Australian Psychological Society
Further mental health training for GPs and new accreditation standards set by the General Practice Mental Health Standards Collaboration (GPMHSC) were also mentioned as positive developments by some respondents. Such training was seen as particularly valuable in rural areas.

A GP from a rural Queensland town with a population of 4,500 explained how her advanced focused psychological skills in mental health were vital when her town became severely affected by drought. With waiting times of several weeks to access mental health services through headspace, the Divisions of General Practice and hospital-based mental health teams, this GP was able to provide timely and local treatment to individuals with chronic mental health issues. The town did not have a resident psychiatrist or psychologist, so the GP was able to address this service gap and play an integral part in mental health service delivery in her rural area.

*Royal Australian College of General Practitioners (RACGP)*

Another common example of where workforce training was used successfully to address service gaps was in the delivery of mental health services for ageing populations. Not only was this identified as a strategy to address current needs, but also as an example of how service planning can anticipate future workforce demands.

By having a 10-year plan, public mental health services for older people in NSW have been able to link service development priorities to workforce information and training. As community services were planned to expand significantly, a significant proportion of clinicians were expected to have limited experience. Therefore ‘beginner competencies’ for older persons mental health clinicians were developed, then cooperation with the NSW Institute of Psychiatry, both their older persons mental health training adapted to support this, and training developed to assist managers to use the competencies constructively.

*Psychiatrist, New South Wales*

The second most commonly identified workforce strategy for filling service gaps was through links with educational institutions and targeted training pathways to meet current needs. Numerous responses from both professionals and organisations identified how strategic planning and coordination between academic institutions and service providers can help leverage the existing workforce for better outcomes. This was achieved in a number of ways, including the provision of scholarships, and targeted recruitment and training within final placements. Numerous benefits were identified, including improved staffing ratios, cost-effective service delivery and higher staff retention.

Respondents mentioned successful programmes where students are recruited into high-needs areas. The most common examples highlighted the benefits of targeted training programmes in remote and rural areas.

*The Commonwealth Government-funded Specialist Training Programme provides funding for training positions to enable medical specialist trainees to rotate through an expanded range of settings beyond traditional public teaching hospitals is an example of effective planning in the field of both workforce and training.*
An example of such a successful programme is the Hunter New England Training in Psychiatry programme, which is a well-resourced rural specialist training programme that delivers care to a region of around 850,000. Models of specialist training such as this should be replicated in other regional centres if the Government is to ensure the supply of psychiatrists into the future.

*Royal Australian and New Zealand College of Psychiatrists*

Smaller organisations also find that training placements offered in high-needs areas can successfully address service delivery gaps.

*Workforce development opportunities are informed by regional needs, workforce capacity and demands. For example, a developing workforce shortage in geropsychology services is being addressed through a psychologist placement programme in line with the region's ageing population, ageing workforce and shortage of state health services.*

*North Sydney Medicare Local*

The provision of scholarships also was perceived to be a highly effective workforce strategy from both the professional and organisation perspective. Examples of numerous scholarship programmes and resulting benefits were provided.

*There is no strategic development of a rural and remote mental health workforce other than current University Departments of Rural Health (UDRH) support (0.5 FTE) for students and mental health workers. A concerted effort with scholarship programs that are targeted—through UDRH, for example—would greatly improve the rural and remote mental health workforce.*

*Mount Isa Centre for Rural & Remote Health, James Cook University*

**Developing a collaborative mental health workforce**

One of the most commonly identified examples of an effective mental health workforce was where a high level of collaboration existed within multi-disciplinary or multi-agency teams. Mental health professionals working closely with or alongside other service providers frequently was associated with positive service experiences and outcomes for those experiencing mental health issues. Respondents identified a number of benefits including improved communication, shared knowledge and expertise, increased understanding of clients’ needs and experiences and improved continuity of care.
For example:

- **Psychology services in primary care:**

  Primary care psychology (the provision of quality controlled psychological services in the general practice setting, involving collaborative care between GPs and psychologists) enables effective and timely feedback between clinical psychologists and the GPs they are working directly with—both via shared notes and formal and informal discussions and evaluations of patient outcomes together. This results in ongoing effective monitoring of shared patient outcomes, and ongoing solutions re: patient treatment. Effective communication between practitioners is the key and co-location definitely facilitates this—ensuring effective monitoring and motivation of service improvement.

  *Clinical and health psychologist, New South Wales*

- **Online collaboration:**

  The Mental Health Professionals Network Webinars provide an excellent resource and consultative forum for professionals across health and community sectors to work collaboratively and improve delivery and quality of services & outcomes for mental health clients and carers.

  *De-identified rural health research organisation*

- **Multi-agency collaboration; including education, housing and social services and drug and alcohol services among others:**

  As a Principal of a special school I am called to work with the GAP Clinic [mental health assessment service] and we find this a successful approach to a complex issue as when all aspects of the child's life are considered then a full picture emerges.

  *Teacher/educator, South Australia*

  Responses from people with lived experience, support people and family members identified positive experiences when various disciplines worked collaboratively to provide optimal mental health outcomes for both those with lived experience of mental illness and their families.

  Mental health issues are not resolved by medication alone or psychological assistance alone. A good outcome isn’t really reached without the collaboration of medical and allied health specialist supported by appropriate housing, employment or education. When we got more collaboration (through the involvement of the Department of Human Services) things started to come together for us. As a parent I was unable to make that collaboration happen.

  *Support person, Victoria*
[Partners in Recovery Programme] partnerships have given rise to an unprecedented level of inter-sectoral and inter-agency collaboration, spanning the health, housing, welfare, disability, education and employment sectors. The key advantages of this are that (a) people with complex mental health needs now have access to a single integrated package of mental health support; (b) consortium members are aligning their organisational goals and programmes to reduce service duplication and make system level improvements; and (c) long-standing service gaps in rural and remote Australia are being filled for the very first time.

De-identified organisation

Providing emotional support for mental health professionals

Both professional and organisation respondents identified the unique emotional needs and workplace stressors experienced by mental health professionals. Strategies to address these needs were regarded highly, and were perceived to contribute to positive workforce outcomes, including improved staff satisfaction and retention.

De-identified provider organisation

We recognise that mental health work is emotionally demanding and that mental health work presents problems for staff over and above those encountered in other organisations. Mental health workers have poorer job satisfaction and higher job burnout and turnover compared with established norms for other occupational groups.

Early intervention for staff mental health was mentioned by respondents as a successful strategy for emotional support.

The use of the Early Intervention Programme (EIP) which resulted in early identification of employees with mental health problems, direction to appropriate treatment options and also early resolution of problems in the workplace. This mitigated the risk of absenteeism, performance issues and potential workers compensation claims.

 Allied health professional, Queensland

ATAPS/Better Access training

Workforce training programmes funded through ATAPS and Better Access were mentioned multiple times as being successful initiatives. These included online suicide prevention training, child mental health training and Aboriginal mental health and perinatal streams of training for ATAPS providers. Mandatory training as required by ATAPS was viewed very positively and was often perceived to contribute to improved service outcomes, including mandatory training for ATAPS providers to conduct cognitive behavioural therapy.
10.3.3 Current barriers to effective use of the mental health workforce

Uneven workforce distribution and use of professional skills

Concerns were expressed by professionals, organisations and people with lived experience alike that current workforce distribution and professional services were unmatched to mental health service delivery needs. In terms of the current distribution of the mental health workforce, service providers were noted to be in high demand, especially in remote and rural areas. Accessibility and utilisation of the mental health workforce not only was influenced by physical location, but also by availability within the existing benefit scheme. Many respondents indicated that current Medicare benefits eligibility requirements prevent people with lived experience from accessing a number of alternative professional services, and results in negative service outcomes.

Limited availability of professionals in remote and rural areas

In terms of workforce distribution, many respondents provided examples of uneven service availability and high workforce needs across remote and rural areas.

Service coverage and quality are quite variable between areas, depending on service creativity and a relatively small number of professionals providing services, who are difficult to replace upon illness, retirement or relocation.

Clinical psychologist, Victoria

Multiple examples were provided by both professionals and organisations of the consequences of inadequate human resources on service delivery, including limited accessibility of services, staff burnout and poor staff retention. Some examples also highlighted the impacts of temporary workers and that long-term solutions are needed to address mental health workforce needs within individual communities.

Rural and remote communities are significantly disadvantaged by variable resourcing of mental health and other support services, and significant workforce supply issues. There is a lack of specialist mental health professionals in remote and rural communities across NSW. The reliance on 'fly-in and fly-out' service providers is ineffective. Many people in such communities are also sceptical of professionals coming from outside of the community.

NSW Consumer Advisory Group - Mental Health Inc. (now trading as BEING)

In practice, there is an endless succession of inexperienced people cycling through these important roles with no development of their practice. It probably has a “burn out” effect on the staff attempting to deliver such services, which have the odds stacked against them through the service delivery model. It also means investment in services is not targeted at the community, meaning no local capacity is developed.

De-identified service provider
Many people with lived experience also provided examples of limited access to mental health professionals in rural areas and how this may contribute to poorer service outcomes.

Having been admitted to hospital in a rural area is a nightmare. The psychiatrists have to fly in each day, which means, you see them once a week whilst in hospital and as they are the ones that have the final say in your treatment you are required to see them before being discharged. They are available for maybe a few hours a day (toggling between community and hospital whilst in town) … And in winter, if foggy, they may get delayed or not get to town at all, which delays everything and causes frustration! The system is so stretched in rural areas that sometimes you can be waiting to see the mental health services for weeks even if in crisis.  

*Person with lived experience, New South Wales*

**Inequitable recognition and treatment of professional groups under Better Access**

Many examples from mental health professionals, organisations and people with lived experience identified the negative aspects of having no more than ten sessions with a psychologist (or other approved allied health professional) under Better Access. Although psychiatric treatments can be funded for up to 50 sessions per year, many respondents across all groups felt that this provided a barrier to the effective use of non-psychiatric human resources.

**Counselling psychologist, Victoria**

There are some clients who would benefit from more than 10 sessions a year, and thus they fill up psychiatrists' waiting rooms. Whereas a counselling or clinical psychologist would be just as suitable, provide more practical therapies and be far less expensive.

Clients of mental health services provided many examples of how limited financial resources have prevented access to preferred mental health care providers, and resulted in poorer service outcomes and experiences.

*Person with lived experience, Victoria*

50 sessions with a psychiatrist per year is absolutely meaningless to me. In the regional city where I live, psychiatrists do not have the time or interest in helping someone like me. They do not offer or have the expertise to work with someone who has complex trauma-related mental health issues. The reason I have been caught in the mental health system for so long is that psychiatrists simply medicated me. That has never helped; in fact it made my life worse due to medication side-effects.
Some clinical psychologists described why they believe the current system of workforce planning is not cost-effective or conducive to positive client outcomes.

Clinical Psychologists have received the ideal training for working with mental illness: a single and comprehensive focus within an eight-year training in the evidence-based prevention, early identification, assessment, case formulation, diagnosis, treatment and evaluation of mental illness and cognitive problems across the entire lifespan and range of complexity and severity, particularly in the moderate to high range. It would seem more sensible, therefore, to allocate 50 sessions per year to clinical psychologists to work with high needs patients and who can work in partnership with psychiatrists when medication is required. This would provide a considerable saving to the Government and free up the small psychiatric workforce to more adequately deal with very severe cases.

Clinical psychologist, New South Wales

Under Better Access, it is also perceived that other qualified mental health professionals are being overlooked in terms of their capability and capacity to deliver mental health services. Numerous examples were provided by counselling psychologists, counsellors, psychotherapists and mental health nurse specialists.

We need a system of mental health care that provides due respect for the diverse skills each mental health professional brings to each patient and values each person’s right to seek care from a professional they trust. Our system also needs to encourage skilled mental health care practitioners from every discipline to help members of the public recover from mental health conditions.

Alliance for Better Access

Clients miss out on the professional services of a diversified group of Counsellors and psychotherapists who presently cannot get a Medicare rebate for their clients. Doctors also miss out on knowing of and referring to perhaps better qualified professionals who are not just a psychologist. Doctors would have a wider range for referral.

Counsellor/psychotherapist, New South Wales

The existing higher Medicare rebate for clinical psychologists is poor use of the workforce of psychologists and unjustifiably favours one group of specialists within the profession. It skews the financial incentives for students to choose clinical psychology in preference to other specialist streams such as counselling psychology and rewards clinical psychologists more than other psychology specialties such as counselling psychologists. In NGOs such as Medicare Locals, it provides an incentive to employ clinical psychologists with Medicare provider numbers because when clients are billed the ML receives a higher rebate per session than when other psychologists employed by the ML bill Medicare.

Psychologist, Western Australia
10.3.4 Options to improve workforce training, planning and development: back to basics

People with lived experience, professionals and organisations identified a number of areas where professional service delivery was not conducive to positive service outcomes. Through interactions with clients, multiple examples were provided where mental health professionals’ delivery of services and resulting client outcomes could be strengthened.

The improvements suggested by respondents often related to the most basic of workforce principles. The primary aspects of professional service delivery that commonly were mentioned as detrimental to clients were negative attitudes and behaviours from staff, a lack of knowledge and understanding of mental health issues, and utilisation of inappropriate or ineffective treatment pathways.

Need to improve staff attitudes

Numerous examples were provided by people with lived experience of negative attitudes and behaviours of professional staff. These attitudes and behaviours not only create negative perceptions of mental health services in general, but also have negative consequences on the development of a therapeutic relationship and result in poor individual outcomes.

My personal view is that many doctors still get away with treating people who present with mental health problems as dirt under their shoes. The amount of discourtesy, disrespect, ignorance and stupidity is egregiously bad.

Person with lived experience, Western Australia

The way that somebody with mental health problems is judged by staff at services (particularly public hospitals). My husband was treated badly. He was humiliated and made to feel insignificant.

Support person, New South Wales

Responses from people with lived experience also identified examples of how staff attitudes and behaviours can contribute to positive outcomes. Common examples included experiences where respondents felt they were listened to, respected and not judged for their condition. People identified caring, compassionate, patient and empathetic behaviours as most positive, and valued services that were individually focused.

Need to address gaps in professional knowledge

A further example of problems with staff training and development identified by people with lived experience was a lack of knowledge and understanding of mental health issues from professionals. Many examples were provided where respondents perceived that health care providers and, in particular, general practitioners, lacked understanding and adequate knowledge about mental health issues.
Even though they are the first port of call for families seeking help and diagnosis, it seems most GPs are not adequately trained in youth mental health, lack knowledge to confidently make decisions regarding appropriate medication, may have limited knowledge of local mental health services & private psychiatrists and psychologists to whom they can refer patients, and may not know how to discuss mental health issues appropriately with their young patients.

*Support person, Victoria*

Primary care clinicians are generally not fully trained to diagnose or treat mental health problems, yet people with these conditions typically are seen in primary care more than any other setting and referrals to community-based mental health providers are relatively low. Studies show that well over half of primary care docs are not successful in referring patients to mental health professionals in the community for a variety of reasons.

*Central Adelaide and Hills Medicare Local*

A number of positive examples also were provided where primary care providers contributed to service outcomes through improved knowledge and active involvement mental health outcomes.

Having a GP who was sensitive to mental health issues was great. I know some GPs focus more on physical symptoms but my GP assessed all of my symptoms, was sensitive and not dismissive of the psychological symptoms. She referred me to a psychologist and also pointed me in the direction of support groups and group therapy programmes.

*Person with lived experience, Victoria*

Seeing a GP who was happy to have long consults with me to just let me talk about what I was feeling when I was in a crisis, was incredibly helpful. GPs who care about the mentally ill as WELL as the physically ill, that have a proper amount of experience with disorders and won’t stigmatise you for 'looking' well when you very well might not be, are rare in my experience however. Only finding two who were able to help me and properly listen to me.

*Person with lived experience, Western Australia*

Respondents also provided a number of examples where providers’ underlying treatment philosophies and lack of focus on recovery were perceived to impact on outcomes for clients. Many examples were provided where an emphasis on medication management was perceived negatively.
While drugs have a role, the medical model under which we operate emphasises medication rather than psychotherapy for many mental disorders. The more severe the problem, the more reliance is placed on drugs. This needs to change. We need to spend more time and more care/love on those with more ‘severe’ mental disorder as that is what they lack.

*Person with lived experience, Victoria*

Professionals and organisations have also recognised the importance of engagement with people with lived experience and holistic recovery philosophies in delivering the most effective service outcomes.

Programmes don't provide support, people do. There is a need to get away from the 'treatment motif' and look more at the 'connection and engagement motif'. Practitioners want to treat rather than relate.

*NGO manager, Victoria*

The evidence increasingly shows that while accommodation, employment and social connection services are central to the mental health recovery journey, it’s also the recovery philosophy and relationship skills that mental health workers bring to their roles that help instil a sense of belonging, connection, empowerment and hope in those experiencing mental illness.

*Psychiatric Disability Services of Victoria (VICSERV)*

### 10.4 Promising examples of effective workforce interventions

The Mental Health First Aid Programme was identified multiple times as a successful programme for increasing mental health awareness to providers, not only within mental health but elsewhere.

The Mental Health Professionals Network also was identified as a successful initiative encouraging coordination and collaboration between mental health providers through multi-disciplinary/collaborative training.

Innovative internal training programmes are being delivered to professional service providers in an effort to improve therapeutic relationship development with people with lived experience.

A Local Health Network project called ‘Safety for All’ was identified as an excellent example of an innovative programme which looks to transform traditional mandatory aggression training to a course co-delivered by peer workers that focuses on building therapeutic relationships, trauma informed care and recovery oriented services.

Under the Better Access initiative, further training and improved mental health credentials are seen as having the potential to improve service delivery and mental health outcomes.
The RACGP is continuously committed to ensuring GPs are well equipped with the appropriate skills and knowledge to detect, diagnose and treat mental health issues. This is particularly evident through its management of the Commonwealth’s General Practice Mental Health Standards Collaboration (GPMHSC) project, which ensures that GPs are skilled to a certain standard of education before enabling them access to MBS item numbers under the Better Access initiative. Since its establishment, more than 22,000 GPs have completed a mental health training activity accredited by the standards set by the GPMHSC.

Royal Australian College of General Practitioners (RACGP)
11. Specific challenges for regional, rural and remote Australia

11.1 Key findings

Responses highlighted a number of significant challenges to provision of adequate and appropriate mental health programmes and services in regional, rural and remote (RRR) areas. The most prominent were:

- lack of accessible supports for mental health difficulties
- workforce shortages
- high prevalence of mental illness and suicide
- Stigma and lack of anonymity.

Characteristics of ineffective programme and service provision included:

- funding not reflecting the additional demands of service delivery in RRR areas
- failure to adapt service models for the particular needs of RRR areas
- transient services, initiatives, and workforce.

Characteristics of currently effective programmes and services in RRR areas included:

- small or no out of pocket expense
- flexible service delivery models.

Suggestions to improve the effectiveness of services and programmes in RRR areas were:

- capacity building and incentives for the mental health workforce
- greater use of innovative delivery mechanisms including e-health.
11.2 Overview

term of reference 8 asked the National Mental Health Commission to assess:

Specific mental health challenges for regional, rural and remote Australia

11.2.1 Survey questions

Analysis for this term of reference was primarily based on answers to two questions which appeared in all surveys.

a. What is your/your organisation’s view about the current provision of mental health support in remote and rural Australia?

b. What specific action or strategy do you think could improve this situation?

11.2.2 Survey responses

For question (a) 45.8 per cent of organisations (n=108), 21.7 per cent of professionals (n=187), and 14.5 per cent of people with lived experience and support people (n=90) provided a response.

For question (b) 42.8 per cent of organisations (n=101), 20.1 per cent of professionals (n=173) and 12.7 per cent of people with lived experience and support people (n=79) provided a response.

Analysis for this chapter considered three sources of evidence—responses to these particular survey questions, plus material from unsolicited submissions, and answers to other survey questions which addressed issues relevant to the chapter.

11.2.3 Note on interpretation

It should be noted that respondents living in a regional town or a rural/remote area represented one-third of the total responses from people with a lived experience, providing accurate representation of this group as per Australian population distribution. One-third of professionals also identified as living in a regional town or in a rural/remote area, allowing for a good representation of this workforce. There was a strong representation from organisations whose primary interest is in rural and remote health and mental health, perhaps indicating the strength of feeling about the need for change and improvement in these areas. Of the 65 regional, rural and remote related organisations which responded, 52 per cent (n=34) were advocacy/peak bodies and 18 per cent (n= 10) were research departments specifically for rural and remote health.
11.3 Thematic findings

11.3.1 Types of challenges in providing effective mental health support in regional, rural and remote Australia

**Mental health services unavailable and/or gaps in service provision**

Respondents from all groups expressed concern that mental health services often are unavailable across regional, remote and rural areas.

As a psychologist living and working in a rural community, it has been my experience that many service gaps exist. People who live in these communities are disadvantaged in many ways, including few (sometimes non-existent) specialist services which they can access; the need to travel very long distances to access such services and the enormous expense involved.

*Clinical psychologist, Queensland*

Common examples where service needs are greatest included a number of speciality services. Some respondents identified service needs for groups that may be at high risk of developing mental health problems, including Aboriginal and Torres Strait Islander populations and individuals working in agriculture. Services for culturally and linguistically diverse populations also were perceived to be needed in rural areas. Effective services for people with chronic mental health concerns and for people requiring support to recover from a crisis or acute episode of illness were both perceived to be lacking.

There are many gaps nationally in rural/remote areas, but one significant gap is in appropriate treatment for people with chronic and severe mental health problems. Due to the severity and type of illness this patient group experiences, they require longer-term psychological treatment (above typical 6/10/12 session or 4–6 month limits), and so present intermittently but repeatedly to short-term services, which provide a 'stop-gap' service but are not capable of fully meeting the needs of this group.

*Clinical psychologist, Victoria*
In some examples, limited service availability had resulted in devastating consequences for those with critical mental health needs.

It is also possible that due to my brother’s rural place of residence that he was denied this assessment that probably would have treated his acute symptoms and saved his life. He had a problem that was completely solvable—he was 19 and was struggling to come out as gay. This struggle is unsurprising given his lack of exposure to other gay men in the small farming community he lived in, and also given the fact that there are absolutely no support services for LGBT youth in this part of country Victoria. The closest headspace centre is 1hr 20mins away, and my brother did not have his driver’s license. Ultimately, there was no support for his specific issue anywhere near him, and there was no support for him when he faced crisis.

*Support person, Victoria*

**Qualified mental health professionals unavailable**

Another challenge frequently mentioned in the delivery of rural and remote mental health services, and a primary cause of lack of service availability, was the availability of qualified mental health professionals. Limited access to mental health professionals such as psychiatrists, psychologists and other allied health providers was often listed as a barrier to effective service delivery in rural areas. Frequent staff shortages and high turnover of staff were also mentioned as contributing to irregular and unreliable mental health service delivery.

Multiple examples were provided which identify the lack of mental health professionals as a cause of decreased access to mental health services.

**Access to quality healthcare providers is strongly linked with improved health outcomes.** Australians living in rural and remote areas have significantly reduced levels of access to mental health professionals such as psychiatrists and psychologists compared with those living in major cities. One of the most important ways to improve mental health outcomes for rural and remote Australians is to improve their access to quality mental health professionals.

*Rural Health Workforce Australia*

Mental health professionals provided many examples of how existing working conditions contribute to poor staff satisfaction and poor staff retention in remote areas.

I live in a remote area in Far North Queensland where support services and counselling are extremely limited. The services that are on offer to the public are utilised to the absolute fullest and maximum; because of this, staff exhaustion and the 'burnout' rate is high.

*Counsellor, Queensland*

**Poor mental health and high rates of mental illness in regional, rural and remote areas**

Respondents often mentioned high rates of mental illness and suicide in regional, rural and remote areas. A number of examples provided descriptions of the unique mental health needs in these areas, including many examples where livelihoods such as involvement in agriculture lead to high levels of stress and high risk of mental illness.
There are particular factors that contribute to poor mental health or mental illness in rural and remote areas. This includes those commonly recognised, such as the challenges and hardships associated with drought and other climatic conditions, but also broader challenges such as isolation, loneliness, and lack of engagement with other people due to low population numbers, the distances between residences and limitations in technology.

*Royal Flying Doctor Service*

**Issues with stigma, and a lack of anonymity in small communities**

In small and remote communities, an additional barrier to service access was the fear of stigma due to a lack of anonymity, as well as associated confidentiality issues.

*Women’s Mental Health Network Victoria Inc.*

**11.3.2 Characteristics of ineffective services and programmes in RRR areas**

**Funding**

Both professionals and organisations commented that existing funding arrangements fail to differentiate between the needs of urban and rural areas, as well as between different regional, rural and remote communities. Even though extra weighted funding for initiatives delivered in rural and remote areas was recognised, this was often perceived to be inadequate. Complaints were made by individual professionals that their travel time was not paid for under programmes such as Better Access, for example.

There are also additional costs for services providing mental health programs to rural and remote communities in relation to car leasing, car maintenance and travel and accommodation costs to have MHPs provide services on an outreach basis to towns where it is not feasible to have a MHP to be situated or where there are no MHP living locally. Such costs are not currently adequately factored in to the funding allocations for programs like ATAPS where funding is allocated on a per-session basis.

*Goldfields Midwest Medicare Local*
My view is that funding should be reprioritised toward Remote communities, and a distinction made between 'rural' and 'regional' locations. Some 'regional' locations are in fact within 60 km of a major city or town of over 250,000 people. Truly remote or regional locations are often 1,000 km from a city or town. The difference in resource provision between these locations is profound, leading to undetected mental health problems in remote communities, without access to highly qualified treatment services.

Clinical psychologist, South Australia

Service models

Respondents expressed concerns about the translation of programmes perceived to be suited to an urban environment into rural areas. Despite the programme’s explicit goal of targeting disadvantaged communities, existing services provided through ATAPS and/or Better Access sometimes were seen as ineffective in improving access to affordable services for those living in rural, remote and regional areas.

Providing mental health services to rural and remote Australia is also very different to implementing services in metropolitan areas as the fabric of rural communities is different to urban ones. However, specific rural and remote issues are seldom considered in funding agreements and are rarely, if ever, simple adaptations of an urban model to a rural area.

De-identified representative organisation

Reasons that were commonly listed by people with lived experience, professionals and organisations included a decreased number of providers and specifically general practitioners (who are required to gain access to the scheme in the first place), psychiatrists and other mental health professionals who bulk bill. High waiting times for access to referrals and inability to receive coverage for services delivered through alternate means such as on the telephone and online sessions.

I offer my services in one of these communities (an Indigenous community), for an extremely reduced rate so that the members of this community may receive much needed support. I am not in position to offer counselling for free, but I have recognised the catastrophic need and offer this much needed and utilised service.

Counsellor, Queensland

Transient services, programmes and workers

Although some respondents mentioned how drive-in or fly-in (DIDO and FIFO) mental health services helped to fill some needs within communities, many examples from professionals in particular indicated that high costs and inconsistencies of temporary programmes and workers were an ineffective (and expensive) solution to existing service needs.

Community engagement, relationship development and experience and knowledge of unique community context were mentioned frequently as lacking where temporary programmes and transient workers were utilised in rural areas.
Many of the drive in/drive out services have no long-term connection to the communities they are attempting to service, and [our organisation] has often seen such services disappear once the contract is lost, taking with them any corporate knowledge developed over time with government funding. This endless loss of experience means services never have the chance to develop over time. In practice, there is an endless succession of inexperienced people cycling through these important roles with no development of their practice. It probably has a “burn out” effect on the staff attempting to deliver such services, which have the odds stacked against them through the service delivery model. It also means investment in services is not targeted at the community, meaning no local capacity is developed.

De-identified service provider

While the principal problem in RRR areas was lack of services, we heard from several respondents about some communities where there was a perverse duplication of services from many different providers. In some small communities perceived as having high levels of need, we heard of cases where many providers arrive unannounced and with no consultation, while communities up the road receive nothing. This can result in a situation where providers leave the community when they discover they cannot survive there.

As a volunteer with Headspace [in a regional town], it was regularly noted that there are many diverse and varied groups in the community that in some instances duplicated their services. There were also many examples of times that each organisation was competing for funding from the same source at the detriment to another organisation. In a rural setting this type of duplication and competition is creating some animosities between organisations.

This lack of coordination has resulted in some programs only being conducted for a short period of time and not really being effective. Mental health clients need continuity and constant support, all too often the client gets a few months aid then is left to look elsewhere as the funding for the current program has ended.

Allied health professional, South Australia

Respondents often mentioned how temporary and impermanent solutions for mental health services were not cost-effective and did not lead to long-term solutions for service provision.

Although the lack of infrastructure in remote communities makes drive in/drive out servicing seem attractive, and such services seem to be proliferating, these do not represent good value for money and have a long-term negative effect on the region’s capacity.

De-identified service provider

11.3.3 Characteristics of effective services and programmes in RRR areas

Affordable services

Proving affordable services through existing programmes such as MHSRRA [Mental Health Services in Rural and Remote Australia] often was mentioned as an effective means of providing increased coverage and improved access to services in rural and remote communities. Both ATAPS and MHSRRA programmes were seen as useful in filling gaps where the availability of Medicare-subsidised services is lacking.
MHSRRA funding is flexible and less rigid in its operational guidelines than ATAPS and enables MLs to provide mental health services to areas not well serviced by general practice, specialists or state services. MLs rely on MHSRRA funding to deliver mental health services to rural/remote catchments which the inflexibility in ATAPS funding makes it difficult to do.

De-identified representative organisation

MHSRRA and ATAPS programmes both have their place in the Kimberley and represent effective programmes for people with high prevalence mental health issues from a psychological treatment perspective. Without these programmes in the Kimberley there would be no psychological treatment services that were affordable for the majority of the population. There are very few private providers and all charge gap fees that encourage only those with high incomes to be able to afford such initiatives as the Better Access incentives. The MHSRRA and ATAPS programmes allow access to some of the most socially and economically disadvantaged individuals in Western Australia.

Mental health nurse, Western Australia

Flexible service delivery models

People with lived experience, professionals and organisations perceived access to mental health services through alternative service models to be an effective means of service delivery in regional, rural and remote areas. Although many also identified that there are difficulties in ensuring reliable access to internet and phone services, when available they were perceived as making positive contributions to mental health services.

I am really surprised how effective Skype is to continue to see clients when they find it difficult to attend in person. Given that I have people referred to our practice from lengthy distances away and in this area adverse weather conditions often cut roads, this is a good option to continue with the therapy. I also have many clients who at times cannot afford the petrol to drive into the regional town I work from; they can call me and let me know and I can Skype them. It is also useful when clients relocate further away and we have agreed to continue the therapy.

Mental health nurse, New South Wales

Examples identified a number of benefits to these services including easy access, no cost and anonymity.

I believe online and hotline (phone call) services are the most accessible for young people, especially in remote areas. I believe these services work best as you can seek the support you need without having to face someone. Sometimes facing a real person is just too hard, and on the phone you can deal with the issue, then hang up and get on with life knowing you won't run into your counsellor at the local shops in a small town.

Person with lived experience, Western Australia
11.3.4 Strategies to improve mental health services in regional, rural and remote areas

**Strengthening the mental health workforce in regional, rural and remote areas**

A common recommendation for the improvement of mental health service delivery in regional, rural and remote areas was to strengthen the mental health workforce in these areas. Many examples of how this should be done included up-skilling existing generalist service providers to better meet mental health needs, and increasing recruitment and retention of mental health practitioners in regional, rural and remote areas.

Mental health services in rural Australia have long experienced difficulties staffing much-needed services in the absence of suitably qualified clinicians. Strategies used successfully in other health professions include one-off payments for professionals relocating from metropolitan to rural areas, annual incentives to remain in a rural area of need and new graduate HECS debt reduction incentives if they work in rural and remote areas post-graduation. These strategies need to be adopted and applied to address mental health workforce shortages in psychology, social work, occupational therapy and mental health nursing. Furthermore, GPs and other allied health professionals need incentives to participate in mental health CPD and postgraduate mental health qualifications.

*Murrumbidgee Medicare Local*

There should be a focus on providing additional support to the service providers who already provide mental health services in rural and remote areas, including those providing more general health services. It is unlikely that in the foreseeable future, every remote community will have regular access to specialist mental health services, and instead GPs and other primary health service providers should be supported to enhance their knowledge and expertise.

*Royal Flying Doctor Service*

**Greater use of technology and innovative ways to increase access to services**

Another strategy suggested for improving access to mental health support was to increase the use of technology and develop innovative solutions. People with lived experience provided many examples of how access to mental health services through online and telephone delivery models has contributed to positive mental health outcomes. Many professionals and organisations also identified a strong need to continue to develop these interventions and to prioritise research into how services can be more effectively delivered using technology.

For example, increasing the use of telemedicine and telepsychiatry was suggested.

The application of telemedicine to psychological services for individuals who are housebound or live in rural and remote areas would enable services to reach those people in need of treatment for mental health problems who would otherwise miss out.

*Clinical psychologist, South Australia*
Many responses also identified a need for increased funding and coverage of these services to enable increased delivery and access through these means.

The barriers presented by distance and limited health workforce can be ameliorated through improved access to telehealth options for doctors, patients and allied health professionals. This will require the establishment of necessary infrastructure and development of an MBS item for telehealth consultations directly with patients.

Australian Medical Association

With the development of evidence-based e-mental health interventions, funding support for these modalities to be used extensively by MLs in providing primary mental health care to the appropriate populations in these areas is extremely important.

Hunter Medicare Local

11.4 Promising practice for regional, rural and remote areas

Multiple online and telephone-based services were mentioned as valuable and effective in providing mental health services and support to those living in regional, rural and remote areas. ReachOut.com, eHeadspace, Lifeline and Kids Helpline online were mentioned often, in addition to other online information and counselling services.

I find ReachOut.com an excellent site for me, with advice given in everyday language for my problems I experience. The forums on the site are excellent for me in particular to give advice as someone who truly understands what the [other] person is going through from my own experience, and I can give advice from what has worked for me. Telephone numbers, in particular those that are 24/7 are vital services as problems and emergencies do not keep work hours only. For example Lifeline and Youth Lines as well. Another Organisation for all Mental illnesses that has been preventive for me and helped to keep me well and out of Hospital is the NSW Schizophrenia Fellowship. They have a telephone outreach service where someone rings up regularly to support so you can cope with what you have to deal with. It I have found very supportive and helpful in keeping me well.

Person with lived experience, New South Wales

Many examples of successful telepsychiatry programmes were also identified by respondents.

In South Australia, the SA Rural and Remote Mental Health Unit Tele-Psychiatry outreach programme has been running for more than 10 years, and provides effective ‘between visits’ support to people who live a distance from health services. Similarly, in NSW telephone, email, and Skype are all used between face-to-face appointments.

Royal Flying Doctor Service
12. Specific challenges for Aboriginal and Torres Strait Islander peoples

12.1 Key findings

Respondents identified three key challenges to mental health service delivery for Aboriginal and Torres Strait Islander people. These were:

1. Marginalisation and social and economic disadvantage resulting in poor mental health outcomes for Aboriginal and Torres Strait Islander peoples.
2. Disconnect between mainstream mental health services and Aboriginal and Torres Strait Islander communities.
3. Limited mental health services and support for Aboriginal and Torres Strait Islander peoples.

Some aspects of mental health service delivery that were perceived to be inappropriate or ineffective included:

1. Culturally inappropriate provision.
2. Funding restrictions and barriers.
3. Limited coordination, partnerships and consultation between service providers and with local Indigenous communities.

Some aspects of mental health services that were perceived to be most effective included:

1. Targeted financial investment in Aboriginal and Torres Strait Islander mental health.
2. Community-based programmes.

Some key strategies and recommendations for improving Aboriginal and Torres Strait mental health services were:

1. Strengthen the Aboriginal and Torres Strait Islander mental health workforce.
2. Improve delivery of primary and preventive mental health services.
12.2 Overview

Term of reference 9 asked the National Mental Health Commission to assess:

Specific challenges for Aboriginal and Torres Strait Islander people

12.2.1 Survey questions

Analysis for this term of reference was primarily based on answers to two questions which appeared in all surveys.

a. What is your/your organisation’s view about the current provision of support for Aboriginal and Torres Strait Islander people’s mental health?

b. What specific action or strategy do you think could improve this situation?

12.2.2 Survey responses

For question (a) 38.1 per cent of organisations (n=90), 13.8 per cent of professionals (n=119), and 6.9 per cent of people with lived experience and support people (n=43) provided a response.

For question (b) 34.3 per cent of organisations (n=81), 10.8 per cent of professionals (n=93) and 5.5 per cent of people with lived experience and support people (n=34) provided a response.

Analysis for this chapter considered three sources of evidence—responses to these particular survey questions, plus material from unsolicited submissions, and answers to other survey questions which addressed issues relevant to the chapter.

12.2.3 Note on interpretation

It should be noted that demographic data on Indigenous status was not collected from respondents, and that professional and people with lived experience/family member/support person representation from the Aboriginal and Torres Strait Islander population is unknown. However, nine Aboriginal and Torres Strait Islander organisations and interest groups provided comprehensive responses, which form the majority of the material used for this analysis.
12.3 Thematic findings

12.3.1 Barriers to appropriate mental health support for Aboriginal and Torres Strait Islander peoples

Respondents identified a number of unique and specific challenges in the delivery of mental health services to Aboriginal and Torres Strait Islander peoples. People with lived experience, professionals and organisations identified many examples of where poor social and economic circumstances are leading to negative mental health outcomes. Examples also pointed to stigma surrounding mental health within Aboriginal and Torres Strait Islander communities, and where traditional beliefs and practices are not well aligned to ‘mainstream’ mental health services. Many responses indicated that access to mental health services and support for Aboriginal and Torres Strait Islander people is lacking, and provided a number of examples where services are needed.

**Marginalisation and social and economic disadvantage result in poor mental health outcomes for Aboriginal and Torres Strait Islander people**

Responses from all groups identified the complex and unique challenges facing mental health providers when providing services to Aboriginal and Torres Strait Islander people. Many respondents highlight the underlying social and political issues, as well as historical legacies of trauma, which place Aboriginal and Torres Strait Islander peoples at higher risk of mental illness, and which mean that ‘Western’ models of mental health intervention may not be appropriate or effective.

The long history of marginalisation and under privilege for Indigenous people and communities and the complex, multi-generational history of trauma and the disrupted cultural context mean that mental health problems in these groups present unique challenges, and it is not surprising that many mental health initiatives do not produce the results hoped for.

*The Australasian Confederation of Psychoanalytic Psychotherapies*

Aboriginal peoples’ preference to referring not to ‘mental health’ but to ‘social and emotional wellbeing’ reflects my perspective that the large majority of mental health problems are caused by factors in the social, political and physical environment

*Researcher, Australian Capital Territory*

**Disconnect between mainstream mental health services and Aboriginal and Torres Strait Islander communities**

Respondents cited the fact that access to ‘mainstream’ mental health services is relatively poor among Indigenous communities. Some framed this in terms of stigma surrounding mental illness or distrust of services preventing people seeking formal help, while others acknowledged that access might be low because many services do not appear relevant or appropriate to Indigenous conceptualisations of mental distress.
There are very few services equipped to deal with Aboriginal and Torres Islander mental health issues and they generally do not feel trusting of the regular services available that are not specific to their culture. I have certainly had some patients from these cultures that have been happy to use the general services. However, the low numbers referred to the organisation I worked for leads me to suspect that there are many more who may not.

_Mental health services manager, South Australia_

Poor mental health often still carries the negative stigma for Aboriginal and Torres Strait Islander people. Within the pervasive ‘medical model’ of mental health service delivery and care there can be limited opportunity to work with an individual’s sense of reality; for example, their traditional beliefs about their mental health issue/illness and the western diagnosis.

_Indigenous Allied Health Australia_

**Limited mental health services and support for Aboriginal and Torres Strait Islander peoples**

Limited access to mental health services for Aboriginal and Torres Strait Islander people was commonly mentioned by respondents. In particular, communities in regional, remote and rural areas commonly were identified as lacking appropriate mental health services.

Aboriginal and Torres Strait Islander peoples, historically and today, enjoy significantly less access to mental health and related services and programmes than other Australians. By ‘accessible services’, we mean by location and cost; services that do not discriminate; and services that are culturally acceptable to Aboriginal and Torres Strait Islander peoples (or ‘culturally competent’).

_National Aboriginal and Torres Strait Islander Leaders in Mental Health_

A lack of resources also was commonly mentioned as contributing to limited mental health support and services for Aboriginal and Torres Strait Islander communities.

Whilst the Aboriginal community-controlled health sector has historically played a major role in responding to people displaying high levels of social and emotional distress and high levels of disturbance and self-destructive behaviour, it has lacked the resources and trained staff to adequately deal with these complex issues.

_Western Australian Association for Mental Health_

Respondents provided examples of the consequences of limited availability of appropriate mental health services. Common examples included frequent deterioration to crisis point resulting in hospitalisation and high rates of suicide.
We have so many deaths from suicide, mostly young people, we have a community in a constant state of grief. We cannot seem to attract funding for these services (there is no funding programme that we can identify) and yet the risks are so high.

South Coastal Women’s Health Services

Obviously Aboriginal and Torres Strait Islander people are not receiving effective mental health services. They continue to be over represented at MH services, usually at the point of crisis. There is tragedy happening amongst our Indigenous populations.

Allied health professional, Queensland

12.3.2 Aspects of services and programmes perceived as ineffective for Aboriginal and Torres Strait Islander peoples

In the provision of mental health services to Aboriginal and Torres Strait Islander people, a number of examples were provided of ineffective approaches to service delivery. The three main issues identified were:

- cultural inappropriateness
- funding restrictions and barriers
- limited coordination, partnerships and consultation between service providers and with local Indigenous communities.

The Aboriginal community of Victoria carries a significant burden of social and emotional wellbeing and mental health issues. Services for Aboriginal people with mental health challenges are often fragmented, uncoordinated, discontinuous, poorly integrated, culturally inappropriate and hard to sustain and access.

Victorian Aboriginal Community Controlled Health Organisation

Culturally inappropriate provision

Examples of how existing mental health service delivery models are poorly aligned with cultural beliefs and practices within the Aboriginal and Torres Strait Islander community were commonly mentioned by respondents.

Our mainstream mental health services struggle to provide culturally responsive care to our Aboriginal community as they do not understand the holistic concept of health that Aboriginal people have. Without understanding this model of health then the mainstream is unable to provide proper care and services.

Credentialed mental health nurse, Victoria
Aboriginal people are forced to conform to "white ways" of mental health support (i.e.: doctors, referrals, assessment forms, clinics, offices and waiting rooms, appointments etc...). Even when Aboriginal people specifically request to sit and talk, or go fishing to build rapport with workers, the workers are often confined by organisational/funding guidelines. Service delivery needs to be tailored to and centered around the client.

*Allied health professional, Western Australia*

**Funding restrictions and barriers**

Existing funding arrangements can prove challenging and restrictive in the delivery of appropriate mental health services to Aboriginal and Torres Strait Islander populations.

As an example of this, respondents cited an inability to provide appropriate, sustainable, long-term solutions with Aboriginal and Torres Strait Islander communities through short-term funding.

Short-term funding cycles create significant barriers to sustainable service provision, particularly in rural and remote regions and ATSI populations/communities where relationship development, community consultation, joint planning and cultural respect is essential. Short-term funding results in service provision that is unsustainable, not cost-effective, lacking consultation and often poorly planned.

*Northern Territory Medicare Local*

Respondents also identify a lack of flexibility in specific Commonwealth programme requirements and funding guidelines. This is perceived to be ill-suited to the needs of Aboriginal and Torres Strait Islander communities.

The prescriptive nature of the funding guidelines severely limits the ability of our service to respond with flexibility to the needs of Aboriginal and Torres Strait Islander peoples; for example, the requirement of a GP Mental Health Treatment Plan, the prescriptive 6+6 service delivery model and the restrictions placed on therapeutic approaches that may be used.

*New England Medicare Local*

The ATAPS ATSI and ATAPS ATSI Suicide Prevention programmes can deliver valuable services to the ATSI community; however, the requirements under the programmes for a GP referral and structure of the ATAPS programme often do not fit with the ATSI community’s needs. The requirement from a GP referral is often prohibitive for clients for several reasons, including that they are either not linked in with a GP, they are unable to afford to go to a GP or there is limited access to GPs in the local community.

*Goldfields Midwest Medicare Local*
Limited coordination, partnerships and consultation between service providers and local Indigenous communities

Another commonly identified aspect of ineffective service delivery was a lack of collaboration and partnerships between relevant Aboriginal and Torres Strait Islander organisations, mental health providers and Aboriginal and Torres Strait Islander communities. Many respondents referred to current mental health services as operating in “silos” and identified examples of where collaboration could be improved.

In remote locations it is common to hear of a duplication of services with no coordinating body or network to ensure efficiencies and cost-effectiveness. In some remote Aboriginal communities, for example, it is not unusual to have multiple organisations (including NGOs and government organisations) visiting these communities to provide mental health services. With different organisations visiting the same communities, however, it also means that other communities get no services at all.

Centre for Remote Health, Northern Territory

Strategies that target Aboriginal and Torres Strait Islander emotional and social wellbeing need to be collaborative in their approach and complement one another, rather than working in silos. For example, the Closing the Gap Program and Aboriginal and Torres Strait Islander ATAPS programs

De-identified representative organisation

12.3.3 Aspects of mental health services and programmes perceived to be effective for Aboriginal and Torres Strait Islander peoples

There were two main aspects of mental health services and programmes perceived to be effective for Aboriginal and Torres Strait Islander peoples.

Investment in Aboriginal and Torres Strait Islander mental health through existing funding arrangements

Increased and targeted investment for Aboriginal and Torres Strait Islander people through the ATAPS Tier 2 service was mentioned frequently as a step in the right direction in recognition of the mental health needs for this population. In particular, many responses from professionals identified existing ATAPS arrangements as contributing to improved access to mental health services for Aboriginal and Torres Strait Islander people that did not previously exist. Other common examples of benefits to the programme included employment of Aboriginal health workers and development of cultural competencies.

Funding under ATAPS Tier 2 has improved service delivery to Aboriginal community members. Additional benefits include the scope to employ Aboriginal health workers and utilise culturally appropriate therapies (e.g., narrative therapy). Furthermore, an investment by the Commonwealth in training ensured that all clinicians working with the target group received training in culturally competent practice.

Murrumbidgee Medicare Local
Mental Health Services for Rural and Remote Australia (MHSRRA) also was identified by organisations as an effective funding model which has enabled improved mental health service delivery to Aboriginal and Torres Strait Islander communities in regional, remote and rural areas.

Mental Health Services for Rural and Remote Australia (MHSRRA) provides funding to eligible NGOs such as MLs, Aboriginal Medical Services (AMSSs) and Rural Flying Doctor Services (RFDS) to deliver mental health services to rural and remote Australia. MHSRRA funding is flexible and less rigid in its operational guidelines than ATAPS and enables MLs to provide mental health services to areas not well serviced by general practice, specialists or state services. MLs rely on MHSRRA funding to deliver mental health services to rural/remote catchments which the inflexibility in ATAPS funding makes it difficult to do.

De-identified representative organisation

Community-based programmes

Multiple examples were provided by people with lived experience, professionals and organisations of successful local and community-based mental health outreach and engagement programmes directed towards Aboriginal and Torres Strait Islander people. These programmes were perceived to result in very positive mental health outcomes, and were viewed as highly effective in their ability to provide tailored, culturally appropriate services to address mental health issues. A ‘community-based’ approach to mental health issues was frequently identified as resulting in the most positive mental health outcomes for Aboriginal and Torres Strait Islander populations as opposed to individualised approaches.

The success of the health gains that have been provided by ACCHSs [Aboriginal Community-Controlled Health Organisations] is due to the model of service which is initiated by local Aboriginal community, governed by the local Aboriginal community and implemented by local Aboriginal community.

National Aboriginal Community Controlled Health Organisation

12.3.4 Suggested strategies to improve existing mental health services for Aboriginal and Torres Strait Islander community members

There were two main strategies identified to improve mental health services for Aboriginal and Torres Strait Islander peoples, namely capacity building in the Aboriginal and Torres Strait Islander professional workforce and orienting care delivery around primary care.

Strengthen the Aboriginal and Torres Strait Islander mental health workforce

The development of the Aboriginal and Torres Strait Islander workforce to address mental health needs was commonly mentioned as a successful and important strategy for improving mental health outcomes. Common responses identified the importance of workforce development to ensure sustainable and appropriate interventions.
The approach of engaging local Aboriginal mental health workers ensures a range of positive benefits and outcomes for individuals and communities including capacity building, continuity of care and sustainability. Aboriginal mental health workers have been critical enablers of effective, innovative, culturally appropriate delivering of mental health support that also supports community control, self-determination and empowerment.

Northern Territory Medicare Local

Aboriginal people benefit most from health care provided by Aboriginal people. This will particularly be the case in relation to their mental and social and emotional health. The AMA believes, and research shows, that Aboriginal community-controlled health services have a strong capacity to provide comprehensive care that can address drivers of poor mental health.

Australian Medical Association

Improve delivery of primary and preventive mental health services

Many respondents from all groups highlighted the need to prioritise preventive and primary mental health services for Aboriginal and Torres Strait Islander populations. The greater mental health needs within the Aboriginal and Torres Strait Islander community, added to current service inefficiencies, conveyed a sense of urgency to address these issues and prevent emergency service encounters once people reach a state of crisis.

Effective prevention initiatives are urgently needed to reduce the impact of both mental ill-health and suicide. It should remain a priority and investment made in partnerships and approaches that build sector and community capacity.

Hunter Institute of Mental Health

There needs to be more awareness, education, promotion and detection for mental illness and we need to keep on 'closing the gap' in terms of mental and physical states of illness for Aboriginal and Torres Strait Islander communities. It's shameful to know that for those of Aboriginal and Torres Strait Islander descent, the suicide rate is 2.5 times higher for males and 3.4 times higher for females (Lifeline)

Educator, Victoria

12.4 Promising practice examples of effective Aboriginal and Torres Strait Islander peoples’ supports

In addition to a number of innovative locally developed and delivered community mental health outreach programmes, Aboriginal Community-Controlled Health Services (ACCHS) were commonly mentioned as contributing to positive mental health outcomes.
AHCRA believes that good examples of cost-effective services can be found in many Aboriginal Community-Controlled Health Services (ACCHS), such as Wurli-Wurlinjang Health Service in Katherine. It is also evident in some Victorian community health services, e.g. Inner South Community Health. This latter service provides a wide range of mental health, alcohol and drug and primary health and support services in an integrated manner, avoiding the need for many clients of a disjointed system of care among multiple providers, ultimately a more expensive option for funders.

*Australian Healthcare Reform Alliance*

Another national awareness programme that was positively perceived was mental health first aid training which has been tailored to Aboriginal and Torres Strait Islander populations. It was perceived that the program was successful in delivering culturally appropriate mental health awareness and promoting the wellbeing of Indigenous Australians.

Mental Health First Aid Australia runs an Aboriginal and Torres Strait Islander Mental Health First Aid training program. There are over 160 Aboriginal instructors teaching the program and they have trained over 13,500 people. Evaluation of the program has found that it is culturally appropriate and acceptable to Aboriginal people. A recent review recognised Mental Health First Aid training as one of the most promising interventions for improving the social and emotional wellbeing of Indigenous Australians.

*Researcher, Victoria*
13. Accountability for the outcomes of investment

13.1 Key findings

True accountability for investment was interpreted by respondents as being wider than just accountability to funding bodies; accountability to people with lived experience and to the community also is vital.

However, true accountability for the outcomes of investment is hampered by a number of factors including:

- lack of agreement on mandatory outcome indicators
- lack of data infrastructure and tools for collecting outcome information
- current focus on activity and activity based funding.

Mechanisms which respondents view as promoting proper accountability for outcomes include:

- allowing time and funds for proper evaluation
- involvement of people with lived experience, family member and support people in service planning and evaluation
- being conscious of accountability to stakeholders and the community
- collecting longitudinal and experiential outcome information
- scale up existing tools for effective evaluation.

Promising practice examples of attempts to provide transparent accountability for outcomes include organisations receiving Commonwealth funding which organise their own independent evaluations from universities; whole-of-community commitment to monitor and improve outcomes; and public reporting of client outcomes.
13.2 Overview

Term of Reference 10 asked the National Mental Health Commission to assess:

*Transparency and accountability for the outcomes of investment*

13.2.1 Survey question

Organisations and professionals were asked the questions:

Please give an example of a service, programme, policy or initiative which:

a. demonstrates transparent accountability  
b. demonstrates effective monitoring of outcomes  
c. fails to demonstrate transparent accountability  
d. fails to demonstrate effective monitoring of outcomes

While people with lived experience, family members and support people were not asked specifically about accountability, we have included in our analysis references made by those respondents to this issue.

13.2.2 Survey responses

For question (a) 43.6 per cent of organisations (n=103) and 32.2 per cent of professionals (n=277) provided a response.

For question (b) 64.0 per cent of organisations (n=151) and 46.1 per cent of professionals (n=397) provided a response.

For question (c) 33.1 per cent of organisations (n=78) and 23.2 per cent of professionals (n=200) provided a response.

For question (d) 41.1 per cent of organisations (n=97) and 27.8 per cent of professionals (n=239) provided a response.

Analysis for this chapter considered three sources of evidence—responses to these particular survey questions, plus material from unsolicited submissions, and answers to other survey questions which addressed issues relevant to the chapter.

13.3 Thematic findings

13.3.1 Overall

Accountability for outcomes was strongly linked by respondents to the need for independent evaluation of services and programmes. Without such evaluation, it is difficult for providers to show accountability for their use of taxpayer dollars.

The evaluation of HASI (‘HASI One Evaluation’), which involved substantial qualitative and quantitative data analysis including significant consumer and carer input, is an example of public accountability for the outcomes of investment.

*Australian Association of Social Workers*

The issue of accountability is strongly linked to ToR 4 regarding regulation and reporting, because accountability is achieved through reporting to governments, stakeholders and to the public. Therefore, there is some overlap in our findings for ToR 4 and ToR 10.
However, our emphases in analysis were different. In this summary of thematic findings on ToR 10, we have focused specifically on whether the outcomes of investment in mental health services and programmes are transparent or not, and on the extent to which mechanisms for public accountability exist or are implemented. In contrast, ToR 4 carried more of an emphasis on the use and usefulness of all types of reported information for multiple purposes, including accountability.

13.3.2 Factors hampering transparent accountability for outcomes

Respondents highlighted a variety of barriers to the achievement of transparency and accountability for the outcomes of investment in the mental health system. The following excerpt shows the extent of the difficulties, which range from a failure to collect meaningful outcomes, to a lack of analysis capability and infrastructure to use outcome data, to a lack of routine public reporting.

The most significant gap in this space is the effectiveness of the outcome monitoring. Across both Commonwealth and state-provided and funded services, there is a failure to capture meaningful data and measures (including consumer feedback). Furthermore, there is minimal intelligence capability across agencies and few opportunities to benchmark. Finally, very few providers have practices in place that ensure transparent reporting to the community (e.g., scorecards, report cards, or publicly available independent evaluations/reports).

Murrumbidgee Medicare Local

Lack of consistent outcome measurement across services and programmes

A basic problem with demonstrating accountability for the outcomes of investment is perceived to be the fragmentation of responsibility for direct service funding between Commonwealth and states/territories. When service providers are accountable to multiple funders, each of which has their own outcome measures and funding terms, it is difficult for them to demonstrate the benefits of a service or programme to the population over the long term.

The monitoring of benefits and population health outcomes requires an ongoing commitment to a comprehensive mental health strategy with service development and funding sustained over the long term to be able to measure any discernible change in population health ... a joined-up approach to population needs assessment, joint and sustained strategic planning across a 5–10 year period, population heath outcome measures and monitoring is required. Due to the fragmentation across the current mental health service system (e.g.: funding, responsibilities, accountabilities, jurisdictions etc.) it is unclear how whole system and population health outcomes can be monitored and utilised to inform quality improvement in the short term.

De-identified Medicare Local

Lack of a national agreement on appropriate mandatory outcome indicators for mental health services is perceived as a barrier to accountability for the outcomes of government investments. Some respondents highlighted the difference in levels of accountability for outcomes between Commonwealth-funded programmes. For example, Better Access and the Mental Health Nurse Incentive Programme often are seen as demonstrating low levels of
public accountability because reporting is minimal and mostly occurs only between the private provider and Medicare. In contrast, Medicare Local-administered programmes such as ATAPS often are perceived as providing a more comprehensive set of outcome information via National Minimum Data Sets.

Some respondents highlighted the danger that with a focus on activity-based reporting (and activity-based funding), accountability for outcomes may become confused with accountability for outputs, meaning that accountability does not rest on whether a service or intervention actually helped a person with lived experience.

Statistics can be manipulated—e.g. number of clients versus number of sessions booked, versus number of sessions delivered (outputs vs. outcomes). Outcomes may not be known for some time after interventions, but it’s the small increments that can have a big difference on day-to-day life of individuals with mental illness/ill health.

Allied health professional, Victoria

Lack of adequate tools for meaningful outcome measurement

Many professional respondents argued that it is difficult to prove accountability for outcomes when the outcome measurement required by programmes and services is inappropriate or cursory.

Existing outcome measurement practices are thought to be deficient because:

- They are not designed for accountability to people with lived experience:

Everywhere, outcomes monitoring is for government purposes and rarely is used to respond to the emerging and ongoing needs of the clients of services. Embed this phrase in your minds 'I have no mouth and I want to scream'; that is pretty much how most people I know, including myself, feel about their experience with mental health services in South Australia.

Person with lived experience, South Australia

- They do not measure whole-of-life outcomes:

Eating disorder treatment only uses weight gain as an outcome measure. Weight has nothing to do with recovery.

Person with lived experience, New South Wales

The biggest indicator of success of a mental health program is not HONOS or DASS21 or K10. It’s when the individual tells you they have a job or a relationship, and when they have something more important in their life they no longer need mental health services. The biggest indicator of a successful mental health service is that when an individual experiences a crisis they have a secure therapeutic relationship to return to if they need it (GP and MHNIP).

Genesis Medical Centre, Victoria
They do not account for the unique nature of improvement and recovery from mental illness:

It is a complete furphy to think that clinical psychological treatment can be subjected to the same treatment outcome measures as other areas of medicine. It’s not the same as performing an operation or fixing a broken leg. Patients can find benefits up to five years after treatment, but may not recognise benefits immediately upon completion of treatment. Further, dealing with patients who suffer chronic and/or serious acute mental illness means gains can be small, particularly over a brief period of intervention.

Clinical psychologist, Western Australia

Self-reporting is sometimes difficult for people with lived experience:

It’s often very difficult for people who are experiencing significant mental health difficulties to complete questionnaires (pre and post treatment measures), or to return them.

Clinical psychologist, South Australia

Professionals do not complete measures:

Several different outcome measures were required to be reported at [public] mental health services. That a colleague of mine managed to get away with not doing these for her 30+ case-load for 12 months without it being noticed would suggest that the outcome measures were not being used in any meaningful way.

Clinical psychologist, Queensland

Outcomes measurement does not affect policy or practice

Like other types of reporting, outcomes monitoring was perceived by some professionals as not being useful to their everyday practice.

Outcomes monitoring so frequently fails to measure anything other than being 'seen' to do something. Little is actually reaching the ground.

Allied health professional, South Australia

The use of HONOS [Health of the Nation Outcome Scale]. All the data is collected nationally. No feedback is ever given back to health practitioners as to what this data indicates re practice. It therefore has become just red tape and its collection consumes massive resources.

Clinical psychologist, Victoria
SDQs [Strengths and Difficulties Questionnaires] are routinely completed, but the online form has some mistakes in it and most clinicians do not use them to feed back to clients or to monitor progress. In a previous service we chose our own outcome measures that were applicable to individuals and picked our review points. While this was not as rigorous, it was much more appropriate for our client group and also meant we were more likely to use outcome measures as useful therapeutic tools.

*Clinical psychologist, Australian Capital Territory*

Some professionals (particularly psychologists) were frustrated that policy decisions, particularly around the number of sessions under Better Access, seemed to be made without regard for outcomes-based research. Evidence was cited by these respondents supporting the argument that for many mental health problems, ten sessions of psychological therapy is insufficient to affect positive clinical outcomes for clients.

*Clinical psychologist, Queensland*

**Lack of time and funding dedicated to outcomes monitoring and evaluation**

Independent evaluation is considered a vital component of accountability because it allows services and professionals to demonstrate their worth to funders and the wider public. However, there is widespread concern that time and resources for evaluation are not built into funding agreements routinely.

*Clinical psychologist, Queensland*

MIC was funded under the TATS [Taking Action to Tackle Suicide] program and was specifically required not to include evaluation of the program in the funding. From MIC industry revenue MIC has engaged in several evaluation processes to ensure the programs are best practice.

*Mates in Construction*

A related difficulty in demonstrating accountability for outcomes is when evaluations are carried out before initiatives have had time to ‘bed in’—giving poor results when the benefits of an intervention may take a long time to accrue.

*AHCRA is concerned that the resources provided to carry out service provision in the mental health sector seldom have sufficient or allocated funds for evaluation, especially given that many of the outcomes can only be measured several years from initiation of a program. Often the tools to appropriately evaluate a specific program have not been developed when the program is implemented, often because of a lack of funds for the research required. This undermines accountability for mental health funding and makes it difficult to know whether or not funds are being used to achieve maximum outcomes.*

*Australian Health Care Reform Alliance*
Even where outcome monitoring tools do exist, some respondents report that there is insufficient infrastructure or user support to ensure the potential benefits of using the tools are realised.

... there is an increasing focus on outcomes rather than outputs, which our members rate as positive. However, there are still improvements that need to be made. For example, use of the Psychiatric Outcomes Measurement Tool has been highly variable, largely due to the absence of suitable and affordable software, lack of user support, and inconsistent use of the tool across the sector.

**St Vincent de Paul Society**

13.3.3 Factors facilitating transparent accountability for outcomes

**People with lived experience, family member and support person involvement as an accountability mechanism**

When asked about accountability for the outcomes of investment, many organisations reported that involving people with lived experience, family members and support people in the planning and scrutiny of their activity was a powerful mechanism to keep them ‘honest’.

The headspace Youth Reference Groups were mentioned multiple times as a method of ensuring accountability to the young people targeted by the service. The public and media attention often attracted by the opening of a headspace centre was felt by some to heighten the sense of accountability to the community.

The headspace Wagga centre is accountable not only to the funding body (via the reporting and evaluation framework) but to the public and young people. A consortium of stakeholders, consumer and parent representatives and the MML Board jointly govern the headspace Wagga centre ... the centre also facilitates a Youth Reference Group, which is a critical part of the service delivery model and aids accountability. The centre is transparent about its programs and activities and is frequently featured in the media—indicative of a sense of responsibility for being in the public eye and ensuring that the public have a positive perception of the service. We also understand the reputation of the centre is the most important asset; if young people lose trust in the brand or the service provided, they will stop seeking our help.

**Murrumbidgee Medicare Local**

St Vincent’s Health Sydney has established an “Urban Partnership for Health, Social Inclusion and Well-being” (UP). UP is a wider forum including service providers, consumers and carers for the community to be fed back the results of surveys, to workshop solutions to specific service issues and for the Inner City service provider network to jointly plan services around areas chosen by the UP for attention e.g. the upcoming Acute Services Symposium.

**St Vincent’s Health Australia**
A different mechanism for community involvement in ensuring accountability for outcomes is the District Health Advisory Council model run in Western Australia.

Whilst transparency with regard to informing the general public regarding spending and outcomes can seem to be lacking, there are some clear examples. Across Western Australia there are District Health Councils comprised of hospital, Aboriginal community health, private allied health practitioners, Medicare Local, GPs and community representatives. Matters of priority funding and resources put into implementation of policies & procedures (such as the four-hour rule in hospital ED) are reported upon and reviewed.

**De-identified rural health research provider**

*Being accountable to local stakeholders and the local community*

Direct communication with the public was mentioned by many organisations as being a way in which they tried to ensure they could be held accountable for the work they do and the outcomes they achieve. Mechanisms for such direct communication were regular newsletters, website news updates, and public meetings.

The Annual General Meeting, Report Back Meeting and Annual Report are the formal mechanisms used to report to our stakeholders, whilst ... a summarised annual report [is] sent to all clients, families, carers and stakeholders. These include information about our work throughout the year, financial and operational performance as well as client profile data. The ... website is a key communication tool and provides a platform for disseminating information about our governance structures, services, research and outcomes for clients. This is supported by a quarterly newsletter (distributed to 25,000 people) as well as a client newsletter.

**Mind Australia**

Improved transparency sometimes is achieved through governance mechanisms which ensure that an organisation’s work develops in consultation with, and under scrutiny of, local stakeholders.

Eastern Melbourne PIR is one of EMML’s programs governed by a consortium made up of service providers across the region. This group is afforded complete transparency to all data accumulated by the project including consumer and stakeholder satisfaction. The consortium will be the authorising group of any applications for the use of flexible funding above $5,000, with the Recovery Focused Advisory Committee (see above) being the authorising group for expenditure between $500 and $4,999. This is a clear indication that the accountability for the use of PIR Flexible Funding is not dominated by EMML as the lead agency of the project but instead shared with its major stakeholders.

**Eastern Melbourne Medicare Local**

Somewhat different models of accountability are considered effective by individual professionals, especially those in private practice. These professionals often cite the importance of choice for people with lived experience and the ‘vote with their feet’ model of accountability—if a practitioner is not known for achieving positive outcomes, no-one will refer to them.
The Medicare model of psychological care offers accountability through the patient reporting of outcomes to their GP at review appointments and at ongoing medical visits after psychological care has concluded. In most cases, those providers who are performing poorly simply do not get ongoing referrals, due to negative client feedback or a backlog of disappointing case reports. Conversely, GPs and psychiatrists tend to refer to trusted psychologists who they see a pattern of positive outcomes with prior referrals made.

Alliance for Better Access

Mechanisms for ensuring financial accountability and due diligence were mentioned frequently in relation to private practitioner audits by Medicare.

In providing Medicare-funded psychology services, psychologists are required to comply with Medicare Australia’s auditing arrangements. The focus of the Medicare Australia compliance audits is to determine that billing for services is legitimate. Compliance audits of retrospective services, for up to two years previous, are conducted with Medicare service providers either by telephone, letter or through a face-to-face interview. These audits work to detect and prevent fraudulent claims and other inappropriate practices by providers and are an example of clear public accountability.

Australian Psychological Society

13.4 Promising practice examples of transparency and accountability for outcomes

13.4.1 Transparent accountability to the whole community

The concept of partnership governance and joint accountability is extended in an example provided by SANE Australia of a US programme called StriveTogether. This is a framework for individual communities to use to commit to the improvement of developmental and educational outcomes among its youth population. It involves baseline measurement and then regular reporting on a series of key indicators. The programme is jointly governed and committed to by multiple community organisations (not limited to schools), to represent whole-of-community commitment to improved youth outcomes.

A good example of clear public accountability for the outcomes of an investment can be found by looking overseas to the StriveTogether ‘cradle to career’ vision for education in the US. This ‘collective impact model’ has a very strong framework, which underpins its work. The StriveTogether framework includes roadmaps with key benchmarks and understands the importance of ensuring the processes, mechanisms and relationships are in place to effectively assess and share the data to measure and report impact. Identification of key levers is critical, along with the development of a Community Report Card, which identifies the baselines and highlights changes against these annually.

SANE Australia
13.4.2 StandBy Response evaluation

We also have heard about many examples of organisations involved in delivering Commonwealth-funded programmes using evaluations to increase their public accountability for taxpayer dollars. Commonly, they partner with university-based evaluation teams. Cost-effectiveness evaluations are emerging piecemeal as a result of this. For example, the StandBy Response initiative is a national suicide bereavement support service funded under the National Suicide Prevention Programme; it has undergone an economic evaluation and had its outcomes published in the peer-reviewed literature (Comans, Visser & Scuffham, 2013).

13.4.3 Comprehensive accountability at RFDS

In 2012–13 RFDS Queensland took part in a trial of streamlined Commonwealth funding and reporting called the ‘Single Desk Report’. This was an attempt by the then Department of Health and Ageing to find a way to reduce red tape for NGOs which results from multiple funding streams. RFDS’ submission to us indicates that the trial has had a positive impact on its activities and on the public accountability it is able to provide.

In the experience of RFDS Queensland, the outcome measures and the Single Desk Report are clear examples of a service under public scrutiny like no other. The Single Desk reports deliver outcome measures statistically analysed to provide evidence of efficacy of service across a broad range of social reform areas. Outcome measures are broken down to analyse changes in behaviour, social cohesiveness, mental health and a range of substance use issues. The remainder of the reports reflect service activity including individual counselling, non-client contact activity that nonetheless relates to specific clients, group activities with a breakdown on type of activity, target group of activity, numbers of attendees and psycho-educational components (the nature of the message contained within an activity—e.g. parenting, cannabis use), community networking and planning and meeting activity.

Royal Flying Doctor Service

13.4.4 Feedback Informed Treatment

Individual professionals (particularly psychologists) frequently mention the usefulness of a tool called ‘Feedback Informed Treatment’ (FIT). This tool is a way for practitioners to collect information about clients and outcomes in order to monitor trends in their practice over time and to inform client care planning. Some psychology practices publish the de-identified results of this data collection on their websites—see for example JumpStart Psychology’s Feedback Informed Treatment Outcomes.
About this Review

This document is Volume 4 of a four-volume report of the National Review of Mental Health Programmes and Services. All volumes can be downloaded from www.mentalhealthcommission.gov.au. A complete list of the Commission’s publications is available from our website.

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

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

ISSN 2201-3032

ISBN 978-0-9874449-5-0

Suggested citation:


Published by: National Mental Health Commission, Sydney.

© National Mental Health Commission 2014

This product, excluding the Commission logo, Commonwealth Coat of Arms and material owned by a third party or protected by a trademark, has been released under a Creative Commons BY 3.0 (CC BY 3.0) licence. The excluded material owned by a third party includes data, images, accounts of personal experiences and artwork sourced from third parties, including private individuals. With the exception of the excluded material (but see note below with respect to data provided by the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW)), you may distribute, remix and build upon this work. However, you must attribute the National Mental Health Commission as the copyright holder of the work in compliance with our attribution policy. The full terms and conditions of this licence are available at http://creativecommons.org/licenses/by/3.0/au/. Requests and enquiries concerning reproduction and copyrights should be directed to:

enquiries@mentalhealthcommission.gov.au

Note: Material provided by:

1. The Australian Bureau of Statistics is covered under a Creative Commons Attribution 2.5 Australia licence and must be attributed in accordance with their requirements for attributing ABS material as outlined at www.abs.gov.au.
2. The Australian Institute of Health and Welfare is covered by Creative Commons BY 3.0 (CC BY 3.0) and must be attributed to the AIHW in accordance with their attribution policy at www.aihw.gov.au/copyright/
Acknowledgements

We acknowledge those people with a lived experience of mental health issues, their families, friends and supporters who provided input into the Review process through our public call for submission process. Many professional organisations and nongovernment organisations which work in the mental health sector also responded to the call for submission process. Several organisations provided detailed advice to the Commission, as well as responding to requests for additional information used as case studies. We value the generosity of their time.

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.
Overview of Volume 4

In arriving at the findings and recommendations of the final report of the National Review of Mental Health Programmes and Services, we took a series of steps in collecting evidence over the course of 2014. This Volume provides more detail about the phases of this stepped approach, and consolidates the data and themes that emerged.

This is not the first Review of a country’s mental health system, and it is important to learn from the work that has been completed before us. We examined and analysed a wide range of Australian and international review reports, and found a high level of commonality of themes among the recommendations of 34 reports.

These themes are briefly outlined in Paper 1, along with a short history of Australian mental health reform.

After looking to the past, the next phase of analysis involved looking out across the nation to gain a high level overview of current mental health need in the Australian population, and how we are currently responding to that need. This overview is provided in Paper 2, showing what we found in terms of demand for and supply of mental health supports, evidence of unmet need, and how governance of mental health support is currently organised.

We then examined patterns of investment in mental health supports by the Commonwealth Government, which are supplied in Volume 1 (Attachment A) of this report.

Paper 3 presents publicly available state and territory data on expenditure, workforce and occasions of service. The state and territory data (which has been prepared for us by the Australian Institute of Health and Welfare) presented in Paper 4 was only made available to us late in the Review process through the Mental Health Drug and Alcohol Principal Committee.

In Paper 5, the Australian Bureau of Statistics presents its initial findings from the Mental Health Services-Census Data Integration project. This project, which was sponsored by the Commission, offers unique insights into the characteristics of people accessing mental health services and medication in Australia, developed by linking Census data with Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) administrative information. This paper and data tables are available on the Australian Bureau of Statistics website.
Paper 1: Learning from history

Ours is not the first review of a country’s mental health system, and it is important to learn from the work that has gone before us. We therefore examined and analysed a wide range of Australian and international mental health review reports, and found a high level of commonality of themes among the recommendations of 34 reports. These themes are briefly outlined here, along with a short history of Australian mental health reform.
Mental health reform in Australia

Like most industrialised nations, the history of care for people experiencing mental health problems in Australia is characterised by a long phase of incarceration followed by (more recent) efforts to support the vast majority of people to live in the community. In the early 1960s, a process of deinstitutionalisation began which saw the number of psychiatric beds across Australia decrease rapidly from 30,000 in 1965 to approximately 8,000 in 1993. At the same time, there was only a limited development of the community services required to compensate for the closure of long-stay hospitals.\(^1\)

By the 1980s there was increasing concern that the situation was unacceptable, and that the mental health system (in particular the supports available to people living in the community) had been largely neglected in planning, policy and funding.

The impetus for the development of a national approach to mental health strategy and policy was the Burdekin Report in 1993. This was a national inquiry by the Australian Human Rights and Equal Opportunity Commission into the human rights of people with a mental illness.

The report took into account evidence from other inquiries and concluded that people affected by mental illness were among the most vulnerable and disadvantaged in our society. It also recommended providing Aboriginal and Torres Strait Islander peoples with the training, power and resources needed to determine and deliver mental health strategies within culturally based understandings of mental health.\(^1\)

The Burdekin report outlined that:

- the human rights of individuals affected by mental illness were being ignored or seriously violated
- ignorance and discrimination were widespread
- the problematic consequences of deinstitutionalisation were apparent, with a lack of available community-based supports including accommodation.\(^1\)

A national approach to mental health strategy

The National Mental Health Strategy has guided mental health reform in Australia since 1992 and is articulated through the following documents:

- the 2008 National Mental Health Policy (which provides an overarching framework for the Strategy)\(^2\)
- the National Mental Health Plans through which the National Mental Health Policy is put into action (the current plan, the fourth, runs from 2009 to 2014)\(^3\)
- the Mental Health Statement of Rights and Responsibilities.\(^4\)

While the first plan (1992–1997) emphasised structural changes in where and how mental health services were delivered, subsequent plans have broadened the approach to focus on partnerships between different sectors, the inclusion of promotion, prevention and early intervention, and a greater emphasis on the roles of consumers and carers.

However, these plans, as Federal Health Ministers’ documents, have difficulty in getting traction with non-health agencies and sectors, and state/territory governments. There are, however, two further mechanisms for helping to set a unified direction for mental health policy—the National Mental Health Commission and the Council of Australian Governments (COAG).
The National Mental Health Commission was established by the Government in 2012 as an independent executive agency. It reports to the Health Minister, to increase transparency and accountability in the mental health system and provide advice to the Government on achieving better whole-of-life outcomes for people experiencing mental illness and their supporters.

Figure 1 Timeline showing recent history of mental health reform in Australia

COAG is the principal forum for bringing Commonwealth and state/territory governments to the same table, and therefore plays a vital role in gaining meaningful nationwide agreement on policy directions.

In 2006 COAG responded to the growing recognition of the significance of mental health issues and the importance of housing, employment, justice, community and disability to maximise treatment outcomes and recovery from mental illness. Through the National Action Plan, across all jurisdictions, 145 measures or modifications to existing programmes were introduced.

COAG released The Roadmap for National Mental Health Reform 2012–2022 on 7 December 2012. This established five broad principles for reform: promote a person-centred approach; improve the mental health and social and emotional wellbeing of all Australians; prevent mental illness; focus on early detection and intervention; and improve access to high-quality services and supports.² ³

The Standing Council on Health (ScoH) reports to COAG and is responsible for the implementation of COAG decisions on mental health reform in recognition of the broad impact that mental health issues have on Australian society.⁵

Milestones of Aboriginal and Torres Strait Islander mental health policy include the 1989 National Aboriginal Health Strategy, which defined health for Aboriginal and Torres Strait Islander peoples as ‘not just the physical wellbeing of the individual but the social, emotional, and cultural wellbeing of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life’.⁶

Also important was the 1991 report of the Royal Commission into Aboriginal Deaths in Custody—which drew national attention to the growing problem of suicide and the removal of children from their families.⁷

Perhaps the most significant single advance was the 1995 Ways Forward report. This provided the first national analysis of Aboriginal and Torres Strait Islander mental health and emphasised the importance of social and emotional wellbeing.⁸ In 1996 the Australian
Government responded with the *Aboriginal and Torres Strait Islander Emotional and Social Well Being (Mental Health) Action Plan (1996–2000).*

In 2004 the first *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2004–2009* was released. It signaled the growing recognition and legitimacy of the social and emotional wellbeing concept for policy-makers. Action 7 of the *Fourth National Mental Health Plan* (2009–2014) calls for the renewal of the 2004 Framework, and this is currently under way.

**International and Australian mental health system reviews**

The Commission undertook a brief web-based search and analysis of mental health system reviews in the international and Australian grey literature. Documents included in the analysis were published by government departments, universities, nongovernment organisations, think-tanks and private consultancies. Based on our web search we selected 17 key Australian reports and 17 reports from other countries for further analysis. Themes commonly emerging in the recommendations of these documents are summarised in the following table.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Governance</strong></td>
<td>Collaborative governance mechanisms must be developed at all levels (from national policy making to local delivery level), to span traditional departmental silos and to incorporate the interests of public, private and NGO providers as well as people with lived experience and their supporters.</td>
</tr>
<tr>
<td></td>
<td>Leadership must be taken at the level above individual sector and departmental interests.</td>
</tr>
<tr>
<td></td>
<td>Local ownership of reform principles, especially by clinicians and community groups, is vital. (This means real thought about how these apply to local circumstances and could be monitored and benchmarked locally)</td>
</tr>
<tr>
<td></td>
<td>Clearer demarcation of responsibilities (delivery, funding) is required between state and federal levels of government</td>
</tr>
<tr>
<td><strong>Policy</strong></td>
<td>Alignment of policies across departmental and jurisdictional boundaries</td>
</tr>
<tr>
<td></td>
<td>Alignment of incentives to keep people out of hospital</td>
</tr>
<tr>
<td></td>
<td>A ‘mental health in all policies’ approach to be taken across all sectors and levels of government</td>
</tr>
<tr>
<td></td>
<td>Key policy choices which need to be made by governments include:</td>
</tr>
<tr>
<td></td>
<td>Balancing development of low intensity services for large numbers of people with anxiety/depression with the development of high intensity services for small numbers of people with severe and persistent problems</td>
</tr>
<tr>
<td></td>
<td>Balancing investment in youth (where there is greater potential for lifetime benefits) against older people (whose mental capital is substantially under-utilised)</td>
</tr>
<tr>
<td>Themes</td>
<td>Priorities</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Service delivery**        | Existing variability of service quality and availability must be tackled through improved access in primary care and other community-based settings  
                             | Co-ordination of care pathways means using a stepped care model across sectors  
                             | Integration of services is needed: between primary and secondary care; between physical and mental health care; between specialist community and crisis/inpatient services  
                             | Many people with chronic mental health difficulties could be successfully managed at a lower level of service intensity and using a greater variety of social interventions  
                             | Alternatives to inpatient admission must urgently be developed and evaluated, such as crisis resolution teams and crisis houses  
                             | Successful examples of service delivery are offered in many reports from different perspectives. For governments, successful initiatives are described as those that have good clinical outcomes, improved quality of life, cost outcomes, and perform against social outcomes such as reducing poverty and homelessness. For carers and people with lived experience, access to professional care, being treated with dignity and respect and responding to individual needs are important aspects of service provision. |
| **Consumer orientation and human rights** | Reduction in inequality of access to support, levels of disadvantage and health outcomes must be a central driver of all mental health initiatives and evaluations  
                             | Respect, dignity and human rights including reduced involuntary incarceration, unnecessary hospitalisation and use of seclusion and restraint  
                             | Specific anti-discrimination legislation for mental health problems needs to apply across sectors  
                             | Consumer needs and values-focused outcome measurement  
                             | Empowerment to be involved in decision-making, policy development, service delivery and design |
| **Tackling disadvantage**   | In Australia there is insufficient focus in programme evaluation on how successfully interventions are reaching (or appropriate to) disadvantaged groups  
<pre><code>                         | Disadvantage and its persistence needs to be longitudinally tracked nationally |
</code></pre>
<p>| <strong>Resources</strong>               | Pool funding for mental health support and wellbeing promotion to avoid difficulty of costs and benefits accruing to different sectors |</p>
<table>
<thead>
<tr>
<th>Themes</th>
<th>Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce</td>
<td>Up-skilling primary care and a generalist workforce for brief interventions</td>
</tr>
<tr>
<td></td>
<td>Sustainability will require much greater use of the peer and consumer workforce</td>
</tr>
<tr>
<td></td>
<td>Focusing on the wellbeing and morale of mental health professionals</td>
</tr>
<tr>
<td></td>
<td>Role redesign may be required if resources are redirected ‘upstream’—for example, specialist mental health professionals may have a dual role as</td>
</tr>
<tr>
<td></td>
<td>clinicians and as advisers to generalists within an integrated primary/secondary care system</td>
</tr>
<tr>
<td>Data/evidence</td>
<td>A crucial barrier to reform in all countries is the absence of routinely collected outcomes data—or any means of collecting it. Urgent</td>
</tr>
<tr>
<td></td>
<td>development is required globally, based both on clinical outcomes and on what people with lived experience and supporters find valuable and life-</td>
</tr>
<tr>
<td></td>
<td>enriching</td>
</tr>
<tr>
<td></td>
<td>Data infrastructure must be developed nationally around electronic care records</td>
</tr>
<tr>
<td></td>
<td>This should provide nationally consistent, fine-grained data on health determinants, prevalence and service utilisation by postcode</td>
</tr>
<tr>
<td></td>
<td>National prevalence studies should determine the extent of each problem and inform policy directions</td>
</tr>
<tr>
<td></td>
<td>There is a lot we don’t know about Australian service use and cost, including how much is spent on mental health services, how much is spent on each</td>
</tr>
<tr>
<td></td>
<td>condition overall and on severe mental illnesses. The true cost of mental illness cannot truly be known or estimated¹¹,¹²</td>
</tr>
<tr>
<td></td>
<td>There are limited studies into the cost-effectiveness of whole-of life programs or mental health-related programmes and treatments that are inclusive of areas such as housing, education, employment and justice</td>
</tr>
<tr>
<td></td>
<td>What works in terms of policy interventions and reform is not known on a wide scale, and there are few examples of successful whole-system reform</td>
</tr>
<tr>
<td>Research</td>
<td>Prioritisation of translational research in mental health</td>
</tr>
<tr>
<td></td>
<td>Increase funding levels commensurate with burden of disease</td>
</tr>
<tr>
<td></td>
<td>Randomised controlled trials urgently needed to assess effectiveness, especially of social interventions</td>
</tr>
</tbody>
</table>
Cross-sector collaboration needed on research
Develop evidence base for workplace mental health improvement

**Productivity**

Increasing the productivity of the population is the principal economic argument for investing in appropriate and timely support for mental health difficulties and promotion of resilience in the general population. The benefits far outweigh any costs of intervention—the costs of lost productivity amount to twice the costs of direct provision of health and social care.

Productivity refers both to the potential to improve the productivity (improved outcomes for reduced cost) of the mental health system and to getting people with mental illness back into work to support meaningful lives and reduce benefit costs, absenteeism, presenteeism and early retirement.

Educating employers and prioritising wellbeing in the workplace to tackle persistent labour market exclusion of people with mental illness.

The productivity of the mental health system itself can be enhanced through investment in early intervention at all stages of the life course.
References


Paper 2: Mental health need and Australia’s response

After looking to the past, the next phase of analysis involved looking out across the nation to gain a high-level overview of current mental health need in the Australian population, and how we are currently responding. This overview is provided below, showing what we found in terms of demand for and supply of mental health supports, evidence of unmet need, and how governance of mental health support is currently organised.
Australia’s mental health needs

Prevalence and burden of disease

It is estimated that 45 per cent of Australians aged 16–85—that is, 7.3 million people—will experience some form of mental disorder in their lifetime. In the past year alone, one in five Australians have experienced symptoms of a mental health problem.¹

The most common mental illnesses experienced in Australia among those aged 16–85 are anxiety disorders (experienced by 14.4 per cent during the past 12 months), mood disorders (6.2 per cent), and substance use disorders (5.1 per cent).¹ Less common illnesses involving psychosis tend to have greater impact on many aspects of a person’s life and an estimated 64,000 people are in contact with specialised mental health services for psychotic illness nationally each year.²

The most recent available estimates show that in 2010 mental illness accounted for about 12.9 per cent of Australia’s total burden of disease, which is a combination of premature mortality and years lived with disability.³ Mental and behavioural health problems are the second-highest cause of healthy years of life lost globally as well as in Australia, accounting for almost one quarter (22.3 per cent) of this total burden.³ It is estimated that about 327,000 years of healthy life are lost each year in Australia due to mental illness.⁴

The pattern of mental illness for people across their life course is highly variable when compared to many other types of health conditions. While many people recover from a single episode of illness (especially if it was connected to the stress of a particular life event), sometimes mental health problems follow a chronic or episodic course. This means that an individual will have different levels of need for formal and informal support during their lifetime. This also makes early intervention relevant and vital at any age or stage of life.

The statistics represent massive human suffering and a loss of opportunity for those who are unwell and for their families and supporters. The following sections look in more depth at how Australia’s response to its population’s mental health needs is organised and delivered, and at the evidence of unmet mental health need in the Australian population.

For Aboriginal and Torres Strait Islander peoples, the data suggests an entrenched, perhaps worsening mental health crisis and significantly greater mental health needs than other Australians. In 2012–13, 30 per cent of respondents to the Australian Aboriginal and Torres Strait Islander Health Survey over 18 years of age reported high or very high psychological distress levels in the four weeks before the survey interview.⁵ That is nearly three times the non-Indigenous rate.⁵ In 2004–05, high and very high psychological distress levels were reported by 27 per cent of respondents, suggesting an increase in Aboriginal and Torres Strait Islander psychological distress rates over the past decade.⁵
Current responses to Australia’s mental health needs

Roles, responsibilities and governance

Although Australian articulation of national mental health policy has been world-leading, the reality of high-quality implementation has not followed. This difficulty with implementation is partly attributed to the divided responsibilities for funding and provision between Commonwealth and state/territory governments as well as between public, private and not-for-profit entities.

States and territories are principally responsible for the provision of specialist mental health services, including inpatient hospital care, community mental health services, and community-based residential care to those with ‘low prevalence, high severity’ difficulties. Commonwealth funds are mainly dedicated to public mental health initiatives including prevention and promotion, welfare support such as the Disability Support Pension, and universally accessible benefits paid under the Pharmaceutical Benefits Scheme and Medicare Benefits Schedule.

The Commonwealth Government has historically been responsible for setting direction through policy, influencing workforce development and influencing system behaviour via pricing and incentives. In recent years the Commonwealth’s role has expanded into service provision to target perceived gaps in services, including for primary care level services (via the Mental Health Nurse Incentive Programme), young people’s mental health (via headspace), and for disadvantaged groups (via ATAPS Tier 2).

The result of these developments is a fragmented system of governance, complex funding streams and reporting requirements, and siloed provision which is difficult to navigate for those needing help.

Service provision

People with mental health issues have access to a variety of support services provided by a range of healthcare professionals in a number of settings. Someone with a mental health issue might receive care, for example, from a specialised public or private hospital service, residential mental health service, community mental health care service, private clinical practice and/or a non-government organisation.

Approximately 1.95 million people or 9.3 per cent of the population received clinical mental health services in 2011–12, compared with 1.38 million people or 6.6 per cent in 2007–08. Approximately 300,000 of the 1.95 million people received mental health treatment from a public provider in 2011–12 (Figure 1).
There is inherent variability between jurisdictions in the type of mental health services offered, mental health spending and activity. Although the services implemented by states and territories reflect national goals and approaches, their processes have been tailored to meet local requirements and differing models of care adopted by each jurisdiction. Similarly, methods used to count and identify activity also differ between jurisdictions.

The Commission estimates that the Commonwealth Government and the state and territory governments spent a combined total of $13.52 billion on specialised mental health services in 2011–12. While this is an underestimate of the total spending by governments on mental health-related services (it does not include services such as ambulance, police, justice and some housing support), it also includes an estimated $1 billion double count of National Healthcare Agreement/National Health Reform Agreement funds paid by the Commonwealth Government to the states and territories. Of the estimated $13.52 billion, the Australian Government spent $9.02 billion on mental health programmes and services in 2011–12; the remaining $4.5 billion was spent on state and territory specialised mental health services.

**Commonwealth funding and provision**

- The Commonwealth Government spent $9.02 billion on mental health programmes in 2011–12. Of this, spending was largest for the Disability Support Pension ($4.410 billion), National Healthcare Agreements ($989.6 million), Carer Payment and Allowance ($862.3 million), Medicare Benefits Schedule ($850.6 million), and the Pharmaceutical Benefits Scheme ($830.4 million).
- According to our analysis of direct and indirect mental health spending, Commonwealth funding of mental health services increased by about 29.2 per cent over the past five years.
- This increase was due in large part to investment in, and uptake of, brief psychological interventions through the Better Access initiative which resulted in an average annual increase in all Medicare subsidised mental health consultations of 8.2 per cent.9
• GP visits for mental health problems number roughly 15.8 million per year in Australia, which is about 12 per cent of visits. However, this is likely to be an underestimate because GPs may not code a mental health visit with a mental health-related MBS item.

• Psychiatric medications are responsible for direct Commonwealth health spending on mental illness, and absolute spending rose by 0.5 per cent annually in the five years to 2012–13. However, this represents a decreasing proportion of Commonwealth spending over that period. Approximately 24 million PBS and Repatriation Pharmaceutical Benefits Scheme (RPBS) subsidised prescriptions for mental health related medications were issued during that year, and about 31 million mental health-related medications in total (both subsidised and under co-payment), of which more than 60 per cent were antidepressants.

State and territory funding and provision

• The largest proportion of state and territory funds for specialised mental health services is spent on inpatient care ($1.9 billion in 2011–12) followed by community mental health care ($1.8 billion).

• The majority of publicly funded mental health beds are now located in psychiatric units or wards as part of public acute hospitals, rather than in standalone psychiatric hospitals. The number of hospital beds dedicated to mental health use has reduced from 45.5 per 100,000 people in 1992–93 to 29.8 per 100,000 in 2011–12. In 2011–12 there was a total of 8,781 mental health beds, of which 24 per cent were in the private sector.

NGO sector provision

• The contribution made by mental health non-government organisations (NGOs) in providing mental health-related services to people living with a mental illness, their families and carers has grown significantly over the past decade.

• NGOs are funded by both the Commonwealth and state and territory governments, with each state and territory commissioning a unique set of programmes and initiatives from NGOs to meet local requirements and service delivery models. This diversity in NGO service delivery, coupled with the absence of a systematic mental health NGO data collection, has resulted in a lack of definitive information regarding the number of NGOs receiving government funding, the amount of funding received and the activities funded.

• In 2009–10 it was estimated that there were 798 ‘mental health’ NGO service providers offering a range of services from face-to-face counselling through to telephone services operating in Australia. However, this investigation did not differentiate between those funded by state and territory and Australian Government funding.

• Analysis undertaken by the Commission found that in 2012–13 the Commonwealth Government Departments of Health, Social Services and The Prime Minister and Cabinet funded 542 NGOs, with a total expenditure of $606 million.

• In 2011–12, the latest data available, mental health NGO funding from state and territory health portfolios was $380 million. This figure is inclusive of all jurisdictional NGO grants for services provided to those with a mental illness dispersed across all areas of social and community care, health promotion, accommodation, vocational, policy and advocacy (not only mental health).
Private sector provision

- The private sector, funded by either insurance funds, personal funds or through MBS-subsidised items such as psychiatrist and psychologist consultations, plays a significant role in Australia’s mental health provision. Eight out of ten people who received mental health-specific health services received these from the private sector.  
- Data on private hospital-based psychiatric services are collected and reported from the Private Mental Health Alliance’s Centralised Data Management Service (PMHA-CDMS).
- Nationally, 31,846 patients received specialised psychiatric care from private hospitals which contributed data to the PMHA-CDMS in 2012–13. However, as data is only available for four states and the private hospital model differs between jurisdictions, adequate comparisons between state and territory private mental health services cannot be made.
- The PMHA-CDMS also captures the outcomes of people discharged from private hospital psychiatric units using the Health of the Nation Outcome Scales (HoNOS). Of all private hospital specialised psychiatric care separations, 79.5 per cent had completed HoNOS ratings at both admission and discharge. From these, 72.4 per cent reported a significant improvement following care.
- It is estimated recurrent expenditure by private psychiatric units in 2010–11 was $307 million, an increase of 142 per cent since 1992–93. This increase in expenditure outweighs the increases in beds, patient days and staffing.

More detail about mental health service investment and provision is given in Volume 1: Attachment A (Commonwealth) and Volume 4: Paper 3 (state and territory).

Evidence of unmet need

There are three principal pieces of evidence of unmet mental health need in Australia.

1. Low rates of access to timely and appropriate support.
2. High indirect costs of reduced productivity due to mental illness.
3. Compounding cycles of disadvantage for people experiencing mental illness.

Low rates of access to timely and appropriate support

There is evidence of low levels of access in the Australian population to timely, appropriate, evidence-based clinical services for mental health problems.

- It is estimated that fewer than half of people experiencing a common mental health problem access treatment for that problem.
- Emergency department (ED) attendances for mental illness have not declined over the past five years, with almost 250,000 attendances during 2011–12. Compared to non-mental health attendances, these were much more likely to be among young and middle-aged people (15–54 years). Such high levels of ED attendances are evidence of failure to provide timely community-based mental health support.
- There is inequitable opportunity to access appropriate clinical support in rural areas and in Indigenous communities. Help-seeking is low among certain populations including those who are homeless, and young men.
Economic costs of lost productivity

The impact of mental illness is not limited to individuals and families but also to communities and ultimately to Australia’s social fabric and economic productivity. Internationally, it has been found that the costs of lost productivity to the economy consistently dwarf the cost of direct service provision by a factor of two to one.\(^1\)

Those with mental health problems experience high levels of unemployment and underemployment; for those with psychotic illness, the unemployment rate is more than five times that of the general population at 27.4 per cent.\(^2\) Australia has one of the lowest employment participation rates for people with a disability anywhere in the developed world.\(^20\)

The costs of human suffering and lost quality of life have not been calculated in Australia but have been estimated in the UK as being roughly equivalent to lost productivity and direct health and social care costs added together.\(^21\)

Psychological illness and stress are now the leading causes of being absent from work – among Australian Public Service employees, for example, there was a 54 per cent increase in mental health-related claims accepted by Comcare between 2006–07 and 2010–11.\(^22\) An upward trend is also evident in the numbers of people claiming the Disability Support Pension (DSP) for a psychological or psychiatric condition, which currently account for 31.2 per cent of DSP grants and which have grown by 20 per cent in the five years to 2012–13 against an overall increase of eight per cent.\(^23\)

Compounding cycles of disadvantage

Mental illness is not just an economic problem; it also compounds existing social disadvantage and damages chances for social and community participation. Although it can affect any person at any time, at a population level mental illness disproportionately affects those who already experience some level of disadvantage and who are often those with the least access to mental health support.

Those living in rural, regional and remote communities have lower access to support for health problems compared with metropolitan areas. Aboriginal and Torres Strait Islander peoples and those living in socio-economically disadvantaged areas experience high levels of psychological distress. For Aboriginal and Torres Strait Islander peoples, the well-documented poverty and disadvantage in many communities are associated with an underlying burden of mental health problems. Studies indicate that mental health problems and suicide already make significant contributions to the overall health gap.\(^24\) Mental health issues also contribute to unemployment and lower community safety,\(^25\) as well as the high levels of imprisonment of Aboriginal and Torres Strait Islander peoples.

Young people (aged 16–24) and elderly people living in residential care also experience a greater burden of mental illness than working-age adults.\(^26, 27\)

Social disadvantage and mental illness compound and exacerbate each other, creating and accelerating a cycle of disadvantage (see Figure 2).

- Young people experiencing mental health problems are less likely to complete high school and are more likely to fall into NEET (not in employment, education or training) status than their peers.\(^28, 29\)
In turn this makes unemployment more likely later in life. Unemployment is a psychological stressor which can exacerbate mental health difficulties, but also increases risk of poverty and poor housing, and the cycle of disadvantage accelerates. Homelessness, substance abuse and involvement in the criminal justice system are all more likely to happen to those who have mental health problems, while at the same time worsening existing conditions. Those with a mental disorder are about 4.5 times as likely as their peers to have ever experienced homelessness, and 23.8 per cent of those accessing Supported Homelessness Services report a current mental health problem. Up to 70 per cent of those presenting to specialist mental health services also experience a substance use problem. Nearly 40 per cent of people entering prison in 2012 had been previously told by a health professional that they had a mental illness.

Figure 2 Compounding cycle of disadvantage and mental illness

- Worsening mental health problems
- Low educational attainment
- Potential involvement in criminal justice system
- Unemployment
- Poverty and poor housing
References


Paper 3: State and territory mental health activity

Gaining a comprehensive picture of what is funded and delivered at the state and territory level proved difficult. This paper presents a synopsis of the data about service provision and workforce which was initially made available to us by some states and territories.
Delivery of state and territory specialised mental health care

Specialised mental health care in Australia is delivered in a range of facilities including public and private psychiatric hospitals, psychiatric units or wards in public and private acute hospitals, community mental health care services and residential mental health services.

In 2011–12 there were 1,514 specialised mental health facilities nation-wide, the majority of which were public sector facilities (1,459 facilities). There were 6,709 public sector specialised mental health hospital beds available in Australia and 2,072 beds available in private psychiatric hospitals. There were 2,352 residential mental health service beds nationally (Figure 1). In all jurisdictions the majority of public sector specialised mental health facilities were community mental health care services, ranging from 88.1 per cent of services in New South Wales to 45.7 per cent of services in Tasmania.¹

Figure 1: Number of specialised mental health care facilities, available beds and activity in Australia, 2011–12

Source: Mental Health Establishments NMDS
Types of service delivery

Mental health-related services can be provided by states and territories in a variety of ways including hospitalisation, community-based treatment, residential care and NGO support services.

Admitted patient care

People with mental health problems may require treatment as an inpatient. This may mean receiving specialised psychiatric care in a psychiatric hospital or at a psychiatric unit within a hospital. People may also be admitted to a general ward where workers are not specifically trained to care for the mentally ill. Under these circumstances, the admissions are classified as without specialised psychiatric care.

In 2012–13 there were 241,389 mental health-related separations in Australian hospitals. Of these, 60.9 per cent received specialised psychiatric care. The rate of separations with specialised psychiatric care varied across jurisdictions from 7.4 separations per 1,000 population in Queensland to 5.7 in both Victoria and South Australia. For separations without specialised psychiatric care, South Australia had the highest rate and Queensland the lowest, with 5.3 and 3.4 per 1,000 population respectively (Figure 2).

Figure 2: Rate of mental health-related separations, with and without specialised care, 2012–13

<table>
<thead>
<tr>
<th></th>
<th>With specialised psychiatric care</th>
<th>Without specialised psychiatric care</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>6.6</td>
<td>4.0</td>
</tr>
<tr>
<td>VIC</td>
<td>5.7</td>
<td>4.0</td>
</tr>
<tr>
<td>QLD</td>
<td>7.4</td>
<td>3.4</td>
</tr>
<tr>
<td>WA</td>
<td>6.3</td>
<td>4.4</td>
</tr>
<tr>
<td>SA</td>
<td>5.7</td>
<td>5.3</td>
</tr>
<tr>
<td>TAS</td>
<td>6.4</td>
<td>4.0</td>
</tr>
<tr>
<td>ACT</td>
<td>4.0</td>
<td></td>
</tr>
<tr>
<td>NT</td>
<td>5.3</td>
<td></td>
</tr>
<tr>
<td>National</td>
<td>5.7</td>
<td>3.4</td>
</tr>
</tbody>
</table>

Source: National Hospital Morbidity Database

Note: Tasmania, Northern Territory and Australian Capital Territory hospital figures are not published due to confidentiality reasons. However, the figures are included in the national totals.
**Emergency departments**

Hospital emergency departments (EDs) also play a role in treating mental illness and can be the initial point of care for a range of reasons. It is estimated that there were 248,501 mental health-related public hospital ED occasions of service in 2011–12. There was substantial variation between jurisdictions in the rate of emergency department occasions, ranging from 198.0 per 10,000 population in the Northern Territory to 70.8 in New South Wales (Figure 3).

**Figure 3: Mental health-related emergency department occasions in public hospitals, 2011–12**

Source: State and Territory supplied National Non-Admitted Patient Emergency Department Care Database
Community mental health care

Mental illness is frequently treated in community and hospital-based ambulatory care settings. Collectively, these services are referred to as community mental health care. In 2012–13, approximately 301,000 patients accessed community mental health care services, resulting in over 6.2 million service contacts between these patients and community mental health care service providers. Between 2009–10 and 2012–13, the national rate of community mental health care service contacts has increased. However, this trend should be interpreted with caution as Victorian data is excluded from the national total in 2012–13.4

In 2012–13 the rate of community mental health care service contacts varied across jurisdictions, from 698.5 service contacts per 1,000 population in the Australian Capital Territory to 255.1 in the Northern Territory (Figure 4).

Figure 4: Rate of community mental health care service contacts, 2012–13

Source: Community Mental Health Care NMDS

Note: Data were not available for Victoria in 2012–13 due to service level collection gaps resulting from protected industrial action during this period. Industrial action in Tasmania in 2012–13 affected the quality and quantity of Tasmania’s community mental health care data and rates are not published for this jurisdiction.
Residential care

Residential mental health care services provide 24/7 specialised mental health care on an overnight basis in a domestic-like environment. Residential mental health services may include rehabilitation, treatment or extended care.

During 2012–13, Tasmania had the highest rate of episodes of care (20.9 per 10,000 population). This reflects the mental health service profile mix of Tasmania, which has a substantial residential care component. New South Wales had the lowest rate for episodes (0.4 per 10,000 population); again, reflecting the service profile mix for the state (Figure 5).\(^5\)

**Figure 5: Rate of residential mental health care episodes, states and territories, 2012–13**

![Figure 5: Rate of residential mental health care episodes, states and territories, 2012–13](image)

Source: Residential Mental Health Care NMDS

Note: Queensland does not report any residential mental health services.

**Who delivers these services?**

A range of different health care professionals, including psychiatrists, psychologists, nurses, general practitioners and social workers, provide the various mental health-related support services in Australia. However, workforce data is currently only available for psychiatrists, nurses and registered psychologists who work principally in mental health care and related areas.

In order to enable meaningful comparison, the rate (per 100,000 population) of full-time-equivalent (FTE) figures is used. The FTE measures the number of 38 hour-week workloads completed, regardless of full-time or part-time work.

In all jurisdictions psychiatrists had the lowest rate of employed FTE per 100,000 in 2012, ranging from 8.2 in the Northern Territory to 15.1 in South Australia. The rate of mental health nurses (per 100,000 population) ranged from 62.1 in the Australian Capital Territory, to 86.3 in Western Australia. The rate (per 100,000 population) for registered psychologists ranged from 59.3 in South Australia to 138.4 in the Australian Capital Territory (Figure 6).\(^6\)
Figure 6: Rate of employed FTE staff by profession type, states and territories, 2012

Source: National Health Workforce Data Set

Consumer and carer participation in mental health care

Peer workers are people who have lived experience of mental illness, often directly or within their family, and are employed specifically to share this experience and knowledge to help other people and families experiencing mental ill-health. Peer workers are employed around the country, but in a range of ways.

The number of specialised mental health service organisations employing consumer and carer workers has risen by 3.8 and 4.3 per cent respectively from 2007–08 to 2011–12.¹

In 2011–12 there were 47.5 full-time-equivalent (FTE) peer workers employed for every 10,000 FTE staff in the mental health workforce. Although an increase in employment of carer and consumer workers can be seen across the majority of jurisdictions, the greatest increase can be observed in Tasmania, increasing from 0.5 FTE peer workers per 10,000 FTE in 2007–08 to 32 workers per 10,000 FTE in 2011–12.¹

State and territory expenditure

Of state and territory expenditure in 2011–12, the largest proportion was spent on public hospital services for admitted patients ($1.9 billion), followed by community mental health care services ($1.8 billion) (see Figure 7). Across the jurisdictions, per capita expenditure on specialised mental health services ranged from $182 per person in Victoria to $243 per person in Western Australia, compared to a national average of $198 per person (Figure 8). Between 2009–10 and 2011–12 change in per person expenditure varied across jurisdictions, from an annual average decrease of 3.7 per cent in Tasmania to an annual average increase of 6.3 per cent in the Northern Territory; compared to the national average of 2.6 per cent average annual increase.⁷
Figure 7: Proportion of expenditure, by service type, state and territory specialised mental health services, constant prices, 2011–12

Source: Mental Health Establishments NMDS

Figure 8: Per capita expenditure, state and territory specialised mental health services, constant prices, 2009–10 to 2011–12

Source: Mental Health Establishments NMDS
How do we know if mental health service activity is making a difference?

Two outcome orientated national mental health indicator sets from the suite of Mental Health Indicators are typically used to monitor the activity of the Australian mental health sector. The Fourth National Mental Health Plan indicators monitor the mental health sector more generally, while the Mental Health Service KPIs specifically monitor the progress and outcomes of state and territory mental health services. However, not all indicators are able to be reported at this time.

Two example indicators are reported here: MHS KPI 2 - percentage of people readmitted to an acute psychiatric inpatient unit within 28 days of discharge, and MHS KPI 12 - percentage of patients leaving acute inpatient care that are followed up by a community mental health service contact within seven days of discharge.

In 2011–12, the percentage of admissions to state and territory acute psychiatric inpatient units that were followed by a readmission within 28 days was 14.4 per cent nationally (MHS KPI 2). This figure has been stable since 2005–06. Readmission rates are often used as an indicator of mental health system performance. High rates may point to deficiencies in hospital treatment or community follow-up care, or a combination of the two.8

Two states had readmission rates lower than ten per cent in 2011–12: the Northern Territory (9.8 per cent) and South Australia (9.3 per cent) (Figure 9).9

Figure 9: Proportion of separations with a readmission to an acute psychiatric inpatient unit within 28 days of discharge, 2011–12

![Figure 9: Proportion of separations with a readmission to an acute psychiatric inpatient unit within 28 days of discharge, 2011–12](image-url)
Discharge from hospital is a critical transition point in the delivery of mental health care. People leaving hospital after an admission for an episode of mental illness have a heightened level of vulnerability and, without adequate follow-up, may relapse or be readmitted. In 2011–12, 54.6 per cent of Australian admissions to state and territory acute psychiatric inpatient units were followed by an episode of community care (in the seven days after discharge). This percentage has been improving incrementally since 2005–06. There is substantial variation across jurisdictions, with 2011–12 one week post-discharge follow-up rates ranging from a low of 27.4 per cent in Tasmania to a high of 77.7 per cent in the Australian Capital Territory (Figure 10).

Figure 10: Proportion of separations from acute inpatient care units that are followed up by a community mental health service contact within 7 days, 2011–12

Source: MHS KPI 12

Note: Data are not available for Victoria in 2011–12 due to service level gaps resulting from protected industrial action.
Additional Summary Data

Expenditure constant prices

Figure 11: Recurrent expenditure per capita on state and territory specialised mental health services, constant prices, by service type 2011–12

![Graph showing recurrent expenditure per capita on state and territory specialised mental health services, constant prices, by service type 2011–12. The graph compares expenditure across different states and territories for various service types, including all mental health service types, community mental health services, and grants to non-government organisations.](image)

Source: Mental Health Establishments NMDS

Figure 12: Expenditure on MBS-subsidised mental health services, per capita, constant prices, by practitioner type, 2012–13

![Graph showing expenditure on MBS-subsidised mental health services, per capita, constant prices, by practitioner type. The graph compares expenditure across different states and territories for various practitioner types, including psychiatrists, general practitioners, clinical psychologists, other psychologists, and other allied health professionals.](image)

Source: Mental Health Establishments NMDS
Figure 13: Expenditure on MBS-subsidised mental health services, per capita, constant prices, by practitioner type and remoteness, 2012–13

![Expenditure on MBS-subsidised mental health services, per capita, constant prices, by practitioner type and remoteness, 2012–13](image)

Source: Medicare Benefits Schedule data

Figure 14: Expenditure on PBS-subsidised mental health medications, per capita, constant prices, 2010–11 to 2012–13

![Expenditure on PBS-subsidised mental health medications, per capita, constant prices, 2010–11 to 2012–13](image)

Source: Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme
Workforce

Figure 15: Employed general practitioners, psychiatrists, psychologists and mental health nurses, FTE per 100,000 population by remoteness, 2011

![Bar chart showing FTE per 100,000 population by remoteness for general practitioners, psychiatrists, mental health nurses, and psychologists in 2011.]

Source: National Health Workforce Data Set

Note: General practitioners data are 2012 figures; all other workforce categories are 2011 figures.

Figure 16: Employed general practitioners, psychiatrists, psychologists and mental health nurses, FTE per 100,000 population by remoteness, 2012

![Bar chart showing FTE per 100,000 population by remoteness for general practitioners, psychiatrists, mental health nurses, and psychologists in 2012.]

Source: National Health Workforce Data Set
Services

Figure 17: Public sector specialised mental health hospital beds per 100,000 population, by hospital type, 2011–12

![Figure 17: Public sector specialised mental health hospital beds per 100,000 population, by hospital type, 2011–12](image)

Source: Mental Health Establishments NMDS

Figure 18: Public sector specialised mental health hospital beds per 100,000 population, 2007–08 to 2011–12

![Figure 18: Public sector specialised mental health hospital beds per 100,000 population, 2007–08 to 2011–12](image)

Source: Mental Health Establishments NMDS
Table 1: Mental health-related services – 2011–12

<table>
<thead>
<tr>
<th>Hospital Services</th>
<th>NSW</th>
<th>VIC</th>
<th>QLD</th>
<th>WA</th>
<th>SA</th>
<th>Tas.</th>
<th>ACT</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total public sector specialised mental health hospital beds (per 100,000 pop)</td>
<td>36.5</td>
<td>22.2</td>
<td>31.0</td>
<td>29.7</td>
<td>29.2</td>
<td>25.6</td>
<td>17.5</td>
<td>13.8</td>
</tr>
<tr>
<td>Public acute hospital specialised mental health beds (per 100,000 pop)</td>
<td>24.1</td>
<td>19.6</td>
<td>23.4</td>
<td>19.4</td>
<td>15.2</td>
<td>25.6</td>
<td>17.5</td>
<td>13.8</td>
</tr>
<tr>
<td>Public psychiatric hospital specialised mental health beds (per 100,000 pop)</td>
<td>12.4</td>
<td>2.7</td>
<td>7.6</td>
<td>10.3</td>
<td>14.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Private sector specialised mental health hospital beds (per 100,000 pop)</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Residential mental health services</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Government-operated service beds (per 100,000 pop)</td>
<td>1.9</td>
<td>19.5</td>
<td>0.0</td>
<td>0.6</td>
<td>6.4</td>
<td>11.9</td>
<td>8.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Non-government-operated service beds (per 100,000 pop)</td>
<td>0.5</td>
<td>6.9</td>
<td>0.0</td>
<td>12.1</td>
<td>1.9</td>
<td>19.7</td>
<td>14.0</td>
<td>6.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental health-related supported housing</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Supported housing places (per 100,000 pop)</td>
<td>n.a.</td>
<td>20.8</td>
<td>6.3</td>
<td>59.1</td>
<td>18.2</td>
<td>4.5</td>
<td>12.9</td>
<td>23.6</td>
</tr>
</tbody>
</table>

Source: Specialised mental health care facilities section of Mental Health Services in Australia.

Note: n.a. = not applicable
References


Paper 4: National Mental Health Commission request for ad hoc analysis of the Mental Health Establishments National Minimum Data Set

This paper presents state and territory mental health data prepared by the Australian Institute of Health and Welfare in support of the Review’s work. This data was made available to the Commission late in the Review process through the Mental Health Drug and Alcohol Principal Committee of the Australian Health Ministers’ Advisory Council (AHMAC), and disaggregates state and territory information by remoteness category.
National Mental Health Commission request for ad hoc analysis of the Mental Health Establishments National Minimum Data Set

October 2014
# Table of Contents

National Mental Health Commission request for ad hoc analysis of the Mental Health Establishments National Minimum Data Set ............................................ 1

1. **Background** ................................................................................................................................. 4

2. **Current activity** ........................................................................................................................... 4

3. **Methodology and caveats** .......................................................................................................... 5
   Specialised mental health services ................................................................................................. 5

4. **Jurisdictional data** ..................................................................................................................... 8
   New South Wales ......................................................................................................................... 8
   Victoria ............................................................................................................................................. 13
   Queensland ....................................................................................................................................... 18
   Western Australia ......................................................................................................................... 23
   South Australia .............................................................................................................................. 29
   Tasmania ........................................................................................................................................... 35
   Northern Territory ......................................................................................................................... 42
1. **Background**

The Australian Government tasked the National Mental Health Commission (NMHC) to conduct a national Review of Mental Health Programmes and Services (The Review).

The Review examined existing mental health services and programmes across all levels of government, and the private and non-government sectors. The focus of the review has been to assess the efficiency and effectiveness of programmes and services in supporting individuals experiencing mental health issues and their families and other support people to lead a contributing life and to engage productively in the community.

In evaluating available mental health data on which to base the Review the NMHC has identified considerable published data on mental health expenditure, facilities and workforce at the jurisdictional level; but note that there is a paucity of data at the sub-jurisdictional level.

2. **Current activity**

In light of this identified data gap, the NMHC approached the Mental Health Drug and Alcohol Principal Committee (MHDAPC) to request approval for an ad hoc sub-jurisdictional analysis of the Mental Health Establishments NMDS (MHE NMDS), to be undertaken by the Australian Institute of Health and Welfare (AIHW).

In response to this request the MHDAPC established a time limited Data Protocol Working Group (DPWG) to assist the NMHC in formulating a data request for consideration, through MHDAPC, by the Australian Health Ministers’ Advisory Council (AHMAC).

An initial draft of the populated data request was circulated to the Mental Health Information Strategy Standing Committee (MHISSC) and the Mental Health, Drug and Alcohol Principal Committee (MHDAPC) for consideration and clearance prior to potential provision to the NMHC. Feedback from both MHISSC and MHDAPC have been incorporated.

Seven jurisdictions – New South Wales, Queensland, Victoria, Western Australia, South Australia, Tasmania and the Northern Territory – approved the provision of this analysis to the NMHC for the purpose of informing the Review. Data from these seven jurisdictions are included in the main body of this document. Publically available data for the Australian Capital Territory has been collated and included as Appendix 1.
3. Methodology and caveats

Specialised mental health services

Data has been sourced from the National Mental Health Establishments Database (NMHED). Jurisdictions supply these data in accordance with the definitions published in the Mental Health Establishments National Minimum Data Set (MHE NMDS) (see METeOR ID 424725 for the 2011–12 definitions). The scope of the MHE NMDS includes all specialised mental health services managed or funded, partially or fully, by state or territory health authorities. Specialised mental health services are those with the primary function of providing treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function.

Remoteness

The data presented in the following tables is a measure of the distribution of services and does not reflect the residential location of persons accessing the service. Service access data currently cannot be linked to MHE NMDS data. The remoteness allocation of a specialised mental health service is reported by jurisdictions based on the primary location of the service, defined by the data element Geographical Location of Establishment. More specifically, the ASGC 2010 classification (METeOR 413243) was used for the 2011–12 collection period and ASGC 2006 (METeOR 341798) for the 2007–08 collection period. Data for both years was analysed using concordance files mapped to the 2011 population.

The nature of the ASGC location data means that some location codes map to more than one remoteness category. Where this was the case, data was apportioned based on the ABS concordance proportions. For example, the code for the Blue Mountains maps to three remoteness categories as follows: Major cities (88.12%), Inner regional (11.83%) and Outer regional (0.05%). Therefore, all data for a service unit with a Blue Mountains ASGC code would be proportionally allocated to the three remoteness categories.

State-wide services and Rural/remote/regional services

Some jurisdictions have specialised mental health services, in particular those hospital services that are ‘state-wide services’, that is, they are intended for use by patients/consumers regardless of their usual residential location. Therefore, for some states, the absence of services in a particular remoteness category does not necessarily reflect that services are not available to residents of those remoteness categories. This issue has been highlighted in the caveats to some of the supplied jurisdictional data. This is also a common issue for rural and remote or regional services where one principal service outlet supplies services to a large geographical area.

The issue of state-wide services was examined closely and several options were considered to correct for these effects, including apportioning some specific services pro-rata based on (i) population distributions or (ii) a data request to states/territories on actual service utilisation. However, presenting apportioned data that had been adjusted by assumed or actual access for some service types and in some states only was considered to be more misleading than the data in its current form.
Aggregate activity data

Aggregate service type activity data are supplied by jurisdictions for a range of purposes in accord with the definitions of the MHE NMDS. Data are used to calculate a variety of measures, for example, average patient day cost. The aggregate patient level activity data included in the data tables are all sourced from the NMHED. The following technical information highlights the potential limitations of this data source.

- **Accrued mental health care days for Public hospital services** are limited to the number of care days provided by specialised mental health care services, that is, psychiatric hospitals and specialised psychiatric wards/units in public acute hospitals. The data will not equal figures reported from the *National hospital morbidity database* due to scope differences between the two collections.

- **Accrued mental health care days for Residential mental health services** comprises the number of care days provided by all services, including government and non-government operated services, and 24-hour and non-24-hour staffed services. Therefore, the figures presented will not equate to those reported from the *Residential mental health care database* due to differing collection scopes.

- **Community mental health care contacts** are the total number of contacts provided by specialised mental health care community (ambulatory) services, as defined by the MHE NMDS. Therefore, figures will not equate to those reported from the *Community mental health care database* due to differing scope.

The *number of separations* for public hospital services and *number of residential episodes* undergo limited scrutiny during the data validation process. Therefore, these data have not been included as part of this data supply as the quality of this data is unclear.

The NMHED does not permit an analysis of patient level activity based on the usual residence of the patient/consumer. Patient level activity data collections provide a more accurate insight into the normal area of residence of people accessing specialised mental health care services.

**Full-time-equivalent (FTE) staff figures**

FTE staff figures are not collected at the same level as the location data. Staff numbers are reported across the specialised mental health service organisation, which may have one or more hospitals and/or residential services and/or community mental health care services. Therefore, an apportioning methodology was used to approximate the number of staff working at each geographical location. FTE was apportioned across remoteness categories based on the proportion of the organisation that was assigned to each remoteness area.

**Aggregation of data**

The data presented for this ad hoc data request has not been aggregated or supressed with the exception where a state-wide result consisted of a remoteness category with less than one hospital bed. Where this occurred, the remoteness categories were combined to assist in interpretation of these data and tables for footnoted accordingly.

When reviewing these data jurisdictions may request additional aggregation or suppression due to data sensitivities.
**Constant prices**

Expenditure aggregates in this report are expressed in current prices and/or constant prices. The transformation of current prices to constant prices is termed ‘deflation’, using price indexes or ‘deflators’. There are a variety of deflators that can be used to translate current prices into constant prices. The deflators that were used by AIHW for the various expenditure items are outlined in the table below. For further information on the methodology used to calculate deflators, refer to the technical notes of Mental health services in Australia, or Health expenditure Australia 2010–11 (AIHW 2012).

Table 1: Area of health expenditure, by type of deflator applied.

<table>
<thead>
<tr>
<th>Area of expenditure</th>
<th>Deflator applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public psychiatric hospitals/acute hospitals with a specialised psychiatric unit or ward</td>
<td>Government final consumption expenditure (GFCE) hospitals and nursing homes&lt;sup&gt;a)&lt;/sup&gt;</td>
</tr>
<tr>
<td>Community mental health care services</td>
<td>Professional health workers wage rate index</td>
</tr>
<tr>
<td>Residential mental health services</td>
<td>Professional health workers wage rate index</td>
</tr>
<tr>
<td>Expenditure on specialised mental health services</td>
<td>Government final consumption expenditure (GFCE) hospitals and nursing homes&lt;sup&gt;a)&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a)</sup> Australian Bureau of Statistics (unpublished data).

The 2011–12 expenditure data is presented in current prices, that is, no deflator was applied to the data. The 2007–08 expenditure data has been deflated to the 2011–12 data to permit valid comparisons between the two time points.

**Reference**

4. Jurisdictional data

New South Wales

Table 2: NSW: Recurrent expenditure\(^{(a)(b)}\) ($'000) on state and territory specialised mental health services, by service type, 2007–08 (constant prices)\(^{(c)}\)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(^{(d)})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(e)(f)})</td>
<td>445,825</td>
<td>121,247</td>
<td>3,630</td>
<td>0</td>
<td>0</td>
<td>570,701</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>320,674</td>
<td>73,739</td>
<td>22,273</td>
<td>1,961</td>
<td>964</td>
<td>419,612</td>
</tr>
<tr>
<td>Residential mental health services(^{(g)})</td>
<td>10,250</td>
<td>6,587</td>
<td>176</td>
<td>0</td>
<td>0</td>
<td>17,012</td>
</tr>
<tr>
<td><strong>All mental health service types(^{(h)})</strong></td>
<td>776,749</td>
<td>201,573</td>
<td>26,079</td>
<td>1,961</td>
<td>964</td>
<td>1,007,326</td>
</tr>
</tbody>
</table>

(a) Expenditure excludes depreciation.
(b) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.
(c) Constants prices are referenced to 2011–12 and are adjusted for inflation.
(d) Totals may not add due to rounding to the nearest $'000.
(e) Includes public hospital services managed and operated by private and non-government entities.
(f) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.
(g) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

Table 3: NSW: Recurrent expenditure\(^{(a)(b)}\) ($ per capita\(^{(c)}\) on state and territory specialised mental health services, by service type, 2007–08 (constant prices)\(^{(d)}\)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(e)(f)})</td>
<td>88.92</td>
<td>90.24</td>
<td>8.30</td>
<td>0</td>
<td>0</td>
<td>83.51</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>63.96</td>
<td>54.88</td>
<td>50.95</td>
<td>63.41</td>
<td>113.65</td>
<td>61.40</td>
</tr>
<tr>
<td>Residential mental health services(^{(g)})</td>
<td>2.04</td>
<td>4.90</td>
<td>0.40</td>
<td>0</td>
<td>0</td>
<td>2.49</td>
</tr>
<tr>
<td><strong>All mental health service types(^{(h)})</strong></td>
<td>154.92</td>
<td>150.02</td>
<td>59.65</td>
<td>63.41</td>
<td>113.65</td>
<td>147.40</td>
</tr>
</tbody>
</table>

(a) Expenditure excludes depreciation.
(b) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.
(c) Crude rate is based on the state and territory estimated resident population by remoteness area as at 30 June 2007.
(d) Constants prices are referenced to 2011–12 and are adjusted for inflation.
(e) Includes public hospital services managed and operated by private and non-government entities.
(f) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.
(g) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.
(h) Totals may not add due to rounding.
### Table 4: NSW: Recurrent expenditure\(^{(a)(b)}\) ($'000) on state and territory specialised mental health services, by service type, 2011–12 (current prices)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(^{(c)})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(d)(e)})</td>
<td>578,831</td>
<td>158,019</td>
<td>7,940</td>
<td>0</td>
<td>0</td>
<td>744,790</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>375,845</td>
<td>96,079</td>
<td>23,801</td>
<td>1,296</td>
<td>1,312</td>
<td>498,333</td>
</tr>
<tr>
<td>Residential mental health services(^{(f)})</td>
<td>8,016</td>
<td>4,642</td>
<td>98</td>
<td>0</td>
<td>0</td>
<td>12,755</td>
</tr>
<tr>
<td>All mental health service types(^{(g)})</td>
<td>962,692</td>
<td>258,740</td>
<td>31,839</td>
<td>1,296</td>
<td>1,312</td>
<td>1,255,878</td>
</tr>
</tbody>
</table>

\(^{(a)}\) Expenditure excludes depreciation.

\(^{(b)}\) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.

\(^{(c)}\) Totals may not add due to rounding to the nearest $'000.

\(^{(d)}\) Includes public hospital services managed and operated by private and non-government entities.

\(^{(e)}\) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.

\(^{(f)}\) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

\(^{(g)}\) Totals may not add due to rounding.

### Table 5: NSW: Recurrent expenditure\(^{(a)(b)}\) ($ per capita\(^{(c)}\)) on state and territory specialised mental health services, by service type, 2011–12 (current prices)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(d)(e)})</td>
<td>108.54</td>
<td>112.61</td>
<td>17.92</td>
<td>0</td>
<td>0</td>
<td>103.18</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>70.47</td>
<td>68.47</td>
<td>53.71</td>
<td>42.45</td>
<td>155.11</td>
<td>69.04</td>
</tr>
<tr>
<td>Residential mental health services(^{(f)})</td>
<td>1.50</td>
<td>3.31</td>
<td>0.22</td>
<td>0</td>
<td>0</td>
<td>1.77</td>
</tr>
<tr>
<td>All mental health service types(^{(g)})</td>
<td>180.51</td>
<td>184.38</td>
<td>71.84</td>
<td>42.45</td>
<td>155.11</td>
<td>173.98</td>
</tr>
</tbody>
</table>

\(^{(a)}\) Expenditure excludes depreciation.

\(^{(b)}\) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.

\(^{(c)}\) Crude rate is based on the state and territory estimated resident population by remoteness area as at 30 June 2011.

\(^{(d)}\) Includes public hospital services managed and operated by private and non-government entities.

\(^{(e)}\) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.

\(^{(f)}\) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

\(^{(g)}\) Totals may not add due to rounding.
Table 6: NSW: Number of specialised mental health beds, by service type, 2007–08

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialised psychiatric units or wards in public acute hospitals</td>
<td>1,111</td>
<td>278</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>1,400</td>
</tr>
<tr>
<td>Public psychiatric hospital services</td>
<td>810</td>
<td>214</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,024</td>
</tr>
<tr>
<td>Residential mental health care services</td>
<td>157</td>
<td>91</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>251</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,078</strong></td>
<td><strong>583</strong></td>
<td><strong>14</strong></td>
<td>0</td>
<td>0</td>
<td><strong>2,675</strong></td>
</tr>
</tbody>
</table>

Notes:
1. Housing and Accommodation Support Initiative (HASI) services provided in New South Wales are considered out-of-scope as residential services according to the Mental Health Establishments NMDS.

Table 7: NSW: Number of specialised mental health beds, by service type, 2011–12

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialised psychiatric units or wards in public acute hospitals</td>
<td>1,245</td>
<td>483</td>
<td>19</td>
<td>0</td>
<td>0</td>
<td>1,747</td>
</tr>
<tr>
<td>Public psychiatric hospital services</td>
<td>844</td>
<td>59</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>902</td>
</tr>
<tr>
<td>Residential mental health care services</td>
<td>98</td>
<td>76</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>176</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,187</strong></td>
<td><strong>618</strong></td>
<td><strong>21</strong></td>
<td>0</td>
<td>0</td>
<td><strong>2,825</strong></td>
</tr>
</tbody>
</table>

Notes:
1. Housing and Accommodation Support Initiative (HASI) services provided in New South Wales are considered out-of-scope as residential services according to the Mental Health Establishments NMDS.

Table 8: NSW: Full-time-equivalent staff, state and territory specialised mental health care facilities, by staffing category, 2007–08

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total[a]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant psychiatrists and psychiatrists</td>
<td>310.6</td>
<td>60.4</td>
<td>11.6</td>
<td>1.1</td>
<td>0.3</td>
<td>384.0</td>
</tr>
<tr>
<td>Psychiatry registrars and trainees</td>
<td>329.3</td>
<td>38.2</td>
<td>4.3</td>
<td>0.2</td>
<td>0.0</td>
<td>372.0</td>
</tr>
<tr>
<td>Other medical officers</td>
<td>73.8</td>
<td>5.7</td>
<td>0.1</td>
<td>0.0</td>
<td>0.0</td>
<td>79.5</td>
</tr>
<tr>
<td>Psychologists</td>
<td>429.5</td>
<td>120.0</td>
<td>41.1</td>
<td>5.5</td>
<td>4.5</td>
<td>600.6</td>
</tr>
<tr>
<td>Diagnostic and health professionals[b]</td>
<td>776.0</td>
<td>132.7</td>
<td>27.5</td>
<td>0.5</td>
<td>0.0</td>
<td>936.7</td>
</tr>
<tr>
<td>Nurses[c]</td>
<td>3,227.5</td>
<td>914.4</td>
<td>138.4</td>
<td>14.3</td>
<td>5.0</td>
<td>4,299.6</td>
</tr>
<tr>
<td>Carer workers[d]</td>
<td>3.5</td>
<td>2.6</td>
<td>0.9</td>
<td>0.0</td>
<td>0.0</td>
<td>7.0</td>
</tr>
<tr>
<td>Consumer workers[e]</td>
<td>22.0</td>
<td>4.3</td>
<td>1.5</td>
<td>0.1</td>
<td>0.0</td>
<td>27.9</td>
</tr>
<tr>
<td>Other personal care[h]</td>
<td>33.6</td>
<td>29.5</td>
<td>6.0</td>
<td>0.9</td>
<td>0.1</td>
<td>70.1</td>
</tr>
<tr>
<td>Other staffing categories[i]</td>
<td>1,458.7</td>
<td>282.2</td>
<td>62.6</td>
<td>9.9</td>
<td>5.2</td>
<td>1,818.6</td>
</tr>
<tr>
<td><strong>Total[a]</strong></td>
<td><strong>6,664.4</strong></td>
<td><strong>1,589.9</strong></td>
<td><strong>294.0</strong></td>
<td><strong>32.5</strong></td>
<td><strong>15.1</strong></td>
<td><strong>8,595.9</strong></td>
</tr>
</tbody>
</table>

Notes:
[a] Totals may not add due to rounding.
[b] Diagnostic and health professionals includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature and covers all allied health professionals and laboratory technicians, including Social Workers, Occupational Therapists and others (METeOR identifier 287611).
[c] Includes registered and enrolled nurses.
[d] The definition of these categories was modified from 'consultants' to 'mental health workers' for the 2010–11 collection, in order to capture a variety of contemporary roles.
e) Other personal care staff includes staff engaged primarily in the provision of personal care to patients or residents, not formally qualified, for example attendants, assistants of home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants (METeOR 270171).

f) Other staff includes administrative and clerical and domestic and other staff categories.

Notes:
1. Includes consumer and carer workers and staff employed at a higher organisational level. Excludes staff employed at regional or state level in mental health policy units of the associated relevant health department or equivalent.

Table 9: NSW: Full-time-equivalent staff, state and territory specialised mental health care facilities, by staffing category, 2011–12

<table>
<thead>
<tr>
<th>Staffing Category</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant psychiatrists and psychiatrists</td>
<td>327.3</td>
<td>86.0</td>
<td>19.0</td>
<td>2.5</td>
<td>1.0</td>
<td>435.9</td>
</tr>
<tr>
<td>Psychiatry registrars and trainees</td>
<td>387.7</td>
<td>46.1</td>
<td>3.2</td>
<td>0.2</td>
<td>0.0</td>
<td>437.2</td>
</tr>
<tr>
<td>Other medical officers</td>
<td>60.0</td>
<td>25.5</td>
<td>6.9</td>
<td>0.3</td>
<td>0.1</td>
<td>92.7</td>
</tr>
<tr>
<td>Psychologists</td>
<td>511.1</td>
<td>98.2</td>
<td>19.0</td>
<td>1.9</td>
<td>0.6</td>
<td>630.8</td>
</tr>
<tr>
<td>Diagnostic and health professionals</td>
<td>838.3</td>
<td>216.2</td>
<td>55.8</td>
<td>5.8</td>
<td>2.5</td>
<td>1,118.6</td>
</tr>
<tr>
<td>Nurses</td>
<td>3,825.6</td>
<td>1,092.8</td>
<td>182.9</td>
<td>18.5</td>
<td>7.1</td>
<td>5,126.9</td>
</tr>
<tr>
<td>Carer workers</td>
<td>11.4</td>
<td>2.8</td>
<td>1.5</td>
<td>0.2</td>
<td>0.1</td>
<td>15.9</td>
</tr>
<tr>
<td>Consumer workers</td>
<td>17.0</td>
<td>5.4</td>
<td>1.4</td>
<td>0.1</td>
<td>0.0</td>
<td>23.9</td>
</tr>
<tr>
<td>Other personal care</td>
<td>18.2</td>
<td>35.1</td>
<td>4.7</td>
<td>0.1</td>
<td>0.0</td>
<td>58.1</td>
</tr>
<tr>
<td>Other staffing categories</td>
<td>1,620.6</td>
<td>396.0</td>
<td>78.8</td>
<td>8.3</td>
<td>3.0</td>
<td>2,106.8</td>
</tr>
<tr>
<td>Total</td>
<td>7,617.1</td>
<td>2,004.0</td>
<td>373.3</td>
<td>37.8</td>
<td>14.5</td>
<td>10,046.7</td>
</tr>
</tbody>
</table>

a) Totals may not add due to rounding.

b) Diagnostic and health professionals includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature and covers all allied health professionals and laboratory technicians, including Social Workers, Occupational Therapists and others (METeOR identifier 287611).

c) Includes registered and enrolled nurses.

d) The definition of these categories was modified from ‘consultants’ to ‘mental health workers’ for the 2010–11 collection, in order to capture a variety of contemporary roles.

e) Other personal care staff includes staff engaged primarily in the provision of personal care to patients or residents, not formally qualified, for example attendants, assistants of home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants (METeOR 270171).

f) Other staff includes administrative and clerical and domestic and other staff categories.

Notes:
1. Includes consumer and carer workers and staff employed at a higher organisational level. Excludes staff employed at regional or state level in mental health policy units of the associated relevant health department or equivalent.
Table 10: NSW: State and territory specialised mental health service activity, by service type, 2007–08

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days[^a^]</td>
<td>629,882</td>
<td>146,880</td>
<td>3,975</td>
<td>0</td>
<td>0</td>
<td>780,737</td>
</tr>
<tr>
<td>Community mental health care contacts[^b^]</td>
<td>1,954,524</td>
<td>242,223</td>
<td>43,763</td>
<td>1,470</td>
<td>755</td>
<td>2,242,735</td>
</tr>
<tr>
<td>Residential mental health care days[^c^]</td>
<td>49,753</td>
<td>23,976</td>
<td>437</td>
<td>0</td>
<td>0</td>
<td>74,166</td>
</tr>
</tbody>
</table>

a) Hospital days, also known as accrued mental health care days for public hospital services, will not equal figures reported from the National hospital morbidity database due to scope differences between the two collections.

b) Community mental health care contacts will not equate to those reported from the Community mental health care database due to differing scope.

c) Residential mental health care days comprises the number of care days provided by all services, including government and non-government operated services, and 24-hour and non-24-hour staffed services. Figures will not equate to those reported from the Residential mental health care database due to differing collection scopes.

Table 11: NSW: State and territory specialised mental health service activity, by service type, 2011–12

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days[^a^]</td>
<td>672,321</td>
<td>149,906</td>
<td>5,542</td>
<td>0</td>
<td>0</td>
<td>827,770</td>
</tr>
<tr>
<td>Community mental health care contacts[^b^]</td>
<td>1,771,581</td>
<td>484,012</td>
<td>107,487</td>
<td>6,637</td>
<td>1,746</td>
<td>2,371,462</td>
</tr>
<tr>
<td>Residential mental health care days[^c^]</td>
<td>34,584</td>
<td>19,441</td>
<td>559</td>
<td>0</td>
<td>0</td>
<td>54,583</td>
</tr>
</tbody>
</table>

a) Hospital days, also known as accrued mental health care days for public hospital services, will not equal figures reported from the National hospital morbidity database due to scope differences between the two collections.

b) Community mental health care contacts will not equate to those reported from the Community mental health care database due to differing scope.

c) Residential mental health care days comprises the number of care days provided by all services, including government and non-government operated services, and 24-hour and non-24-hour staffed services. Figures will not equate to those reported from the Residential mental health care database due to differing collection scopes.

1. IMPORTANT note for NSW – AIHW is investigating the increase in Outer regional community mental health care contacts (approx. increase of 63,000 contacts) and the associated change in expenditure (approx. $1.5 million). Based on the data presented in this paper, this means that the average cost per contact for Outer regional services has changed from around $508 in 2007–08 to around $221 in 2011–12. This compares with the state-wide average of $187 and $210 respectively. The AIHW will contact NSW Health with a view to undertaking additional analysis regarding these data, however, further review of the data by NSW is indicated in order to understand whether some data should be suppressed due to data quality issues. >
### Victoria

#### Table 12: VIC: Recurrent expenditure\(^{(a)(b)}\) ($'000) on state and territory specialised mental health services, by service type, 2007–08 (constant prices)\(^{(c)}\)

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(^{(d)})</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public hospital services</strong>(^{(e)})</td>
<td>235,941</td>
<td>46,084</td>
<td>4,737</td>
<td>0</td>
<td>n/a</td>
<td>286,762</td>
</tr>
<tr>
<td><strong>Community mental health services</strong></td>
<td>253,824</td>
<td>81,035</td>
<td>9,953</td>
<td>192</td>
<td>n/a</td>
<td>345,004</td>
</tr>
<tr>
<td><strong>Residential mental health services</strong>(^{(g)})</td>
<td>114,877</td>
<td>33,508</td>
<td>823</td>
<td>92</td>
<td>n/a</td>
<td>149,300</td>
</tr>
<tr>
<td><strong>All mental health service types</strong>(^{(h)})</td>
<td>604,642</td>
<td>160,627</td>
<td>15,513</td>
<td>284</td>
<td>n/a</td>
<td>781,065</td>
</tr>
</tbody>
</table>

n/a Not applicable.

- \(a\) Expenditure excludes depreciation.
- \(b\) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.
- \(c\) Constant prices are referenced to 2011–12 and are adjusted for inflation.
- \(d\) Totals may not add due to rounding to the nearest $'000.
- \(e\) Includes public hospital services managed and operated by private and non-government entities.
- \(f\) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.
- \(g\) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

#### Table 13: VIC: Recurrent expenditure\(^{(a)(b)}\) ($) per capita\(^{(c)}\) on state and territory specialised mental health services, by service type, 2007–08 (constant prices)\(^{(d)}\)

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public hospital services</strong>(^{(e)})</td>
<td>60.71</td>
<td>45.28</td>
<td>19.38</td>
<td>0</td>
<td>n/a</td>
<td>55.64</td>
</tr>
<tr>
<td><strong>Community mental health services</strong></td>
<td>65.31</td>
<td>79.62</td>
<td>40.72</td>
<td>38.90</td>
<td>n/a</td>
<td>66.95</td>
</tr>
<tr>
<td><strong>Residential mental health services</strong>(^{(g)})</td>
<td>29.56</td>
<td>32.92</td>
<td>3.37</td>
<td>18.50</td>
<td>n/a</td>
<td>28.97</td>
</tr>
<tr>
<td><strong>All mental health service types</strong>(^{(h)})</td>
<td>155.58</td>
<td>157.82</td>
<td>63.47</td>
<td>57.41</td>
<td>n/a</td>
<td>151.56</td>
</tr>
</tbody>
</table>

\(a\) Expenditure excludes depreciation.

- \(b\) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.
- \(c\) Crude rate is based on the state and territory estimated resident population by remoteness area as at 30 June 2007.
- \(d\) Constant prices are referenced to 2011–12 and are adjusted for inflation.
- \(e\) Includes public hospital services managed and operated by private and non-government entities.
- \(f\) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.
- \(g\) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.
- \(h\) Totals may not add due to rounding.
### Table 14: VIC: Recurrent expenditure(a)(b) ($’000) on state and territory specialised mental health services, by service type, 2011–12 (current prices)

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(a)(b)</td>
<td>258,536</td>
<td>53,482</td>
<td>3,372</td>
<td>0</td>
<td>n/a</td>
<td>315,390</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>293,170</td>
<td>86,027</td>
<td>14,931</td>
<td>233</td>
<td>n/a</td>
<td>394,360</td>
</tr>
<tr>
<td>Residential mental health services</td>
<td>127,658</td>
<td>35,583</td>
<td>814</td>
<td>90</td>
<td>n/a</td>
<td>164,144</td>
</tr>
<tr>
<td>All mental health service types(g)</td>
<td>679,363</td>
<td>175,092</td>
<td>19,177</td>
<td>323</td>
<td>n/a</td>
<td>873,894</td>
</tr>
</tbody>
</table>

n/a: Not applicable.

(a) Expenditure excludes depreciation.
(b) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.
(c) Totals may not add due to rounding to the nearest $’000.
(d) Includes public hospital services managed and operated by private and non-government entities.
(e) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.
(f) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

### Table 15: VIC: Recurrent expenditure(a)(b) ($) per capita(c) on state and territory specialised mental health services, by service type, 2011–12 (current prices)

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(a)(b)</td>
<td>61.34</td>
<td>49.85</td>
<td>13.76</td>
<td>0</td>
<td>n/a</td>
<td>56.95</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>69.55</td>
<td>80.18</td>
<td>60.91</td>
<td>48.82</td>
<td>n/a</td>
<td>71.21</td>
</tr>
<tr>
<td>Residential mental health services</td>
<td>30.29</td>
<td>33.16</td>
<td>3.32</td>
<td>18.86</td>
<td>n/a</td>
<td>29.64</td>
</tr>
<tr>
<td>All mental health service types(g)</td>
<td>161.18</td>
<td>163.19</td>
<td>77.99</td>
<td>67.68</td>
<td>n/a</td>
<td>157.80</td>
</tr>
</tbody>
</table>

(a) Expenditure excludes depreciation.
(b) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.
(c) Crude rate is based on the state and territory estimated resident population by remoteness area as at 30 June 2011.
(d) Includes public hospital services managed and operated by private and non-government entities.
(e) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.
(f) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.
(g) Totals may not add due to rounding.
Table 16: VIC: Number of specialised mental health beds, by service type, 2007–08

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialised psychiatric units or wards in public acute hospitals</td>
<td>863</td>
<td>187</td>
<td>12</td>
<td>0</td>
<td>n/a</td>
<td>1,062</td>
</tr>
<tr>
<td>Public psychiatric hospital services</td>
<td>154</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>n/a</td>
<td>154</td>
</tr>
<tr>
<td>Residential mental health care services</td>
<td>1,127</td>
<td>270</td>
<td>7</td>
<td>1</td>
<td>n/a</td>
<td>1,404</td>
</tr>
<tr>
<td>Total</td>
<td>2,144</td>
<td>457</td>
<td>19</td>
<td>1</td>
<td>n/a</td>
<td>2,620</td>
</tr>
</tbody>
</table>

n/a Not applicable.

Table 17: VIC: Number of specialised mental health beds, by service type, 2011–12

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialised psychiatric units or wards in public acute hospitals</td>
<td>887</td>
<td>192</td>
<td>12</td>
<td>0</td>
<td>n/a</td>
<td>1,091</td>
</tr>
<tr>
<td>Public psychiatric hospital services</td>
<td>150</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>n/a</td>
<td>150</td>
</tr>
<tr>
<td>Residential mental health care services</td>
<td>1,193</td>
<td>275</td>
<td>7</td>
<td>1</td>
<td>n/a</td>
<td>1,476</td>
</tr>
<tr>
<td>Total</td>
<td>2,230</td>
<td>467</td>
<td>19</td>
<td>1</td>
<td>n/a</td>
<td>2,717</td>
</tr>
</tbody>
</table>

n/a Not applicable.

Table 18: VIC: Full-time-equivalent staff, state and territory specialised mental health care facilities, by staffing category, 2007–08

<table>
<thead>
<tr>
<th>Staffing Category</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant psychiatrists and psychiatrists</td>
<td>169.4</td>
<td>47.8</td>
<td>7.2</td>
<td>0.2</td>
<td>0.0</td>
<td>224.6</td>
</tr>
<tr>
<td>Psychiatry registrars and trainees</td>
<td>235.4</td>
<td>13.7</td>
<td>1.5</td>
<td>0.0</td>
<td>0.0</td>
<td>250.6</td>
</tr>
<tr>
<td>Other medical officers</td>
<td>96.3</td>
<td>13.9</td>
<td>1.6</td>
<td>0.0</td>
<td>0.0</td>
<td>111.9</td>
</tr>
<tr>
<td>Psychologists</td>
<td>282.3</td>
<td>94.8</td>
<td>11.9</td>
<td>0.7</td>
<td>0.0</td>
<td>389.6</td>
</tr>
<tr>
<td>Diagnostic and health professionals</td>
<td>649.7</td>
<td>118.6</td>
<td>15.1</td>
<td>0.2</td>
<td>0.0</td>
<td>783.6</td>
</tr>
<tr>
<td>Nurses(^{(c)})</td>
<td>2,596.1</td>
<td>723.3</td>
<td>78.9</td>
<td>3.3</td>
<td>0.0</td>
<td>3,401.6</td>
</tr>
<tr>
<td>Carer workers(^{(d)})</td>
<td>10.8</td>
<td>3.9</td>
<td>0.8</td>
<td>0.0</td>
<td>0.0</td>
<td>15.5</td>
</tr>
<tr>
<td>Consumer workers(^{(d)})</td>
<td>11.1</td>
<td>5.1</td>
<td>3.7</td>
<td>0.0</td>
<td>0.0</td>
<td>20.0</td>
</tr>
<tr>
<td>Other personal care(^{(d)})</td>
<td>191.2</td>
<td>47.4</td>
<td>4.8</td>
<td>0.1</td>
<td>0.0</td>
<td>243.4</td>
</tr>
<tr>
<td>Other staffing categories(^{(d)})</td>
<td>456.2</td>
<td>158.1</td>
<td>32.0</td>
<td>0.2</td>
<td>0.0</td>
<td>646.5</td>
</tr>
<tr>
<td>Total(^{(d)})</td>
<td>4,698.5</td>
<td>1,226.6</td>
<td>157.4</td>
<td>4.7</td>
<td>0.0</td>
<td>6,087.3</td>
</tr>
</tbody>
</table>

(a) Totals may not add due to rounding.
(b) Diagnostic and health professionals includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature and covers all allied health professionals and laboratory technicians, including Social Workers, Occupational Therapists and others (METeOR identifier 287611).
(c) Includes registered and enrolled nurses.
(d) The definition of these categories was modified from ‘consultants’ to ‘mental health workers’ for the 2010–11 collection, in order to capture a variety of contemporary roles.
Other personal care staff includes staff engaged primarily in the provision of personal care to patients or residents, not formally qualified, for example attendants, assistants of home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants (METeOR 270171).

Other staff includes administrative and clerical and domestic and other staff categories.

Notes:
1) Includes consumer and carer workers and staff employed at a higher organisational level. Excludes staff employed at regional or state level in mental health policy units of the associated relevant health department or equivalent.

Table 19: VIC: Full-time-equivalent staff, state and territory specialised mental health care facilities, by staffing category, 2011–12

<table>
<thead>
<tr>
<th>Category</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant psychiatrists and psychiatrists</td>
<td>232.1</td>
<td>51.5</td>
<td>6.6</td>
<td>0.2</td>
<td>0.0</td>
<td>290.4</td>
</tr>
<tr>
<td>Psychiatry registrars and trainees</td>
<td>280.1</td>
<td>14.3</td>
<td>1.6</td>
<td>0.0</td>
<td>0.0</td>
<td>296.1</td>
</tr>
<tr>
<td>Other medical officers</td>
<td>83.7</td>
<td>12.5</td>
<td>1.0</td>
<td>0.0</td>
<td>0.0</td>
<td>97.2</td>
</tr>
<tr>
<td>Psychologists</td>
<td>297.0</td>
<td>106.8</td>
<td>17.5</td>
<td>0.6</td>
<td>0.0</td>
<td>422.0</td>
</tr>
<tr>
<td>Diagnostic and health professionals(b)</td>
<td>733.6</td>
<td>143.5</td>
<td>16.6</td>
<td>0.2</td>
<td>0.0</td>
<td>893.8</td>
</tr>
<tr>
<td>Nurses(c)</td>
<td>2,935.2</td>
<td>757.8</td>
<td>70.5</td>
<td>2.0</td>
<td>0.0</td>
<td>3,765.4</td>
</tr>
<tr>
<td>Carer workers(d)</td>
<td>12.1</td>
<td>5.0</td>
<td>1.4</td>
<td>0.0</td>
<td>0.0</td>
<td>18.5</td>
</tr>
<tr>
<td>Consumer workers(e)</td>
<td>12.1</td>
<td>5.8</td>
<td>1.1</td>
<td>0.0</td>
<td>0.0</td>
<td>19.1</td>
</tr>
<tr>
<td>Other personal care(e)</td>
<td>191.8</td>
<td>50.8</td>
<td>4.3</td>
<td>0.1</td>
<td>0.0</td>
<td>247.0</td>
</tr>
<tr>
<td>Other staffing categories(f)</td>
<td>520.4</td>
<td>142.9</td>
<td>32.5</td>
<td>0.2</td>
<td>0.0</td>
<td>696.0</td>
</tr>
<tr>
<td>Total(a)</td>
<td>5,298.2</td>
<td>1,290.9</td>
<td>153.1</td>
<td>3.3</td>
<td>0.0</td>
<td>6,745.4</td>
</tr>
</tbody>
</table>

Notes:
1. Includes consumer and carer workers and staff employed at a higher organisational level. Excludes staff employed at regional or state level in mental health policy units of the associated relevant health department or equivalent.
### Table 20: VIC: State and territory specialised mental health service activity, by service type, 2007–08

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days[^a^]</td>
<td>323,754</td>
<td>57,990</td>
<td>3,771</td>
<td>0</td>
<td>n/a</td>
<td>385,515</td>
</tr>
<tr>
<td>Community mental health care contacts[^b^]</td>
<td>1,553,678</td>
<td>522,233</td>
<td>57,518</td>
<td>1,229</td>
<td>n/a</td>
<td>2,134,658</td>
</tr>
<tr>
<td>Residential mental health care days[^c^]</td>
<td>376,774</td>
<td>87,030</td>
<td>2,380</td>
<td>260</td>
<td>n/a</td>
<td>466,445</td>
</tr>
</tbody>
</table>

n/a Not applicable.

a) Hospital days, also known as accrued mental health care days for public hospital services, will not equal figures reported from the National hospital morbidity database due to scope differences between the two collections.

b) Community mental health care contacts will not equate to those reported from the Community mental health care database due to differing scope.

c) Residential mental health care days comprises the number of care days provided by all services, including government and non-government operated services, and 24-hour and non-24-hour staffed services. Figures will not equate to those reported from the Residential mental health care database due to differing collection scopes.

### Table 21: VIC: State and territory specialised mental health service activity, by service type, 2011–12

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days[^a^]</td>
<td>332,545</td>
<td>58,453</td>
<td>3,843</td>
<td>0</td>
<td>n/a</td>
<td>394,841</td>
</tr>
<tr>
<td>Community mental health care contacts[^b^]</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>n/a</td>
<td>0</td>
</tr>
<tr>
<td>Residential mental health care days[^c^]</td>
<td>386,905</td>
<td>85,073</td>
<td>2,416</td>
<td>261</td>
<td>n/a</td>
<td>474,656</td>
</tr>
</tbody>
</table>

n/a Not applicable.

a) Hospital days, also known as accrued mental health care days for public hospital services, will not equal figures reported from the National hospital morbidity database due to scope differences between the two collections.

b) Community mental health care data are not available for Victoria in 2011–12 due to service level collection gaps resulting from protected industrial action during this period.

c) Residential mental health care days comprises the number of care days provided by all services, including government and non-government operated services, and 24-hour and non-24-hour staffed services. Figures will not equate to those reported from the Residential mental health care database due to differing collection scopes.
Queensland

Table 22: QLD: Recurrent expenditure\(^{(a)(b)}\) ($'000) on state and territory specialised mental health services, by service type, 2007–08 (constant prices)\(^{(c)}\)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(^{(d)})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(e)(f)})</td>
<td>228,002</td>
<td>70,744</td>
<td>41,155</td>
<td>1,042</td>
<td>215</td>
<td>341,159</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>187,533</td>
<td>45,857</td>
<td>54,943</td>
<td>3,523</td>
<td>3,169</td>
<td>295,025</td>
</tr>
<tr>
<td>Residential mental health services(^{(g)})</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All mental health service types(^{(h)})</td>
<td>415,535</td>
<td>116,601</td>
<td>96,099</td>
<td>4,565</td>
<td>3,384</td>
<td>636,184</td>
</tr>
</tbody>
</table>

\(^{(a)}\) Expenditure excludes depreciation.
\(^{(b)}\) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.
\(^{(c)}\) Constant prices are referenced to 2011–12 and are adjusted for inflation.
\(^{(d)}\) Totals may not add due to rounding to the nearest $'000.
\(^{(e)}\) Includes public hospital services managed and operated by private and non-government entities.
\(^{(f)}\) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.
\(^{(g)}\) Queensland does not fund community residential services, however, it funds a number of extended treatment services, both campus and non-campus based, which provide longer term inpatient treatment and rehabilitation services with a full clinical staffing 24 hours a day seven days a week.

Table 23: QLD: Recurrent expenditure\(^{(a)(b)}\) ($ per capita\(^{(c)}\) on state and territory specialised mental health services, by service type, 2007–08 (constant prices)\(^{(d)}\)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(e)(f)})</td>
<td>90.28</td>
<td>83.89</td>
<td>67.36</td>
<td>13.76</td>
<td>3.88</td>
<td>82.99</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>74.26</td>
<td>54.38</td>
<td>89.93</td>
<td>46.49</td>
<td>57.16</td>
<td>71.76</td>
</tr>
<tr>
<td>Residential mental health services(^{(g)})</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All mental health service types(^{(h)})</td>
<td>164.53</td>
<td>138.26</td>
<td>157.29</td>
<td>60.24</td>
<td>61.04</td>
<td>154.75</td>
</tr>
</tbody>
</table>

\(^{(a)}\) Expenditure excludes depreciation.
\(^{(b)}\) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.
\(^{(c)}\) Crude rate is based on the state and territory estimated resident population by remoteness area as at 30 June 2007.
\(^{(d)}\) Constant prices are referenced to 2011–12 and are adjusted for inflation.
\(^{(e)}\) Includes public hospital services managed and operated by private and non-government entities.
\(^{(f)}\) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.
\(^{(g)}\) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.
\(^{(h)}\) Totals may not add due to rounding.
Table 24: QLD: Recurrent expenditure\(^{(a)(b)}\) ($'000) on state and territory specialised mental health services, by service type, 2011–12 (current prices)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(^{(c)})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(d)(e)})</td>
<td>245,349</td>
<td>72,785</td>
<td>45,479</td>
<td>983</td>
<td>254</td>
<td>364,851</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>254,846</td>
<td>63,399</td>
<td>72,310</td>
<td>5,899</td>
<td>5,009</td>
<td>401,463</td>
</tr>
<tr>
<td>Residential mental health services(^{(f)})</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All mental health service types(^{(g)})</td>
<td>500,196</td>
<td>136,184</td>
<td>117,789</td>
<td>6,882</td>
<td>5,263</td>
<td>766,314</td>
</tr>
</tbody>
</table>

\(^{a}\) Expenditure excludes depreciation.

\(^{b}\) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.

\(^{c}\) Totals may not add due to rounding to the nearest $'000.

\(^{d}\) Includes public hospital services managed and operated by private and non-government entities.

\(^{e}\) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.

\(^{f}\) Queensland does not fund community residential services, however, it funds a number of extended treatment services, both campus and non-campus based, which provide longer term inpatient treatment and rehabilitation services with a full clinical staffing 24 hours a day seven days a week.

Table 25: QLD: Recurrent expenditure\(^{(a)(b)}\) ($ per capita\(^{(c)}\)) on state and territory specialised mental health services, by service type, 2011–12 (current prices)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(^{(h)})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(e)})</td>
<td>88.58</td>
<td>79.95</td>
<td>68.91</td>
<td>12.58</td>
<td>4.35</td>
<td>81.50</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>92.00</td>
<td>69.64</td>
<td>109.56</td>
<td>75.49</td>
<td>85.82</td>
<td>89.68</td>
</tr>
<tr>
<td>Residential mental health services(^{(g)})</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All mental health service types(^{(h)})</td>
<td>180.58</td>
<td>149.60</td>
<td>178.47</td>
<td>88.07</td>
<td>90.17</td>
<td>171.18</td>
</tr>
</tbody>
</table>

\(^{a}\) Expenditure excludes depreciation.

\(^{b}\) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.

\(^{c}\) Crude rate is based on the state and territory estimated resident population by remoteness area as at 30 June 2007.

\(^{d}\) Constant prices are referenced to 2011–12 and are adjusted for inflation.

\(^{e}\) Includes public hospital services managed and operated by private and non-government entities.

\(^{f}\) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.

\(^{g}\) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

\(^{h}\) Totals may not add due to rounding.
Table 26: QLD: Number of specialised mental health beds, by service type, 2007–08

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialised psychiatric units or wards in public acute hospitals</td>
<td>766</td>
<td>128</td>
<td>126</td>
<td>11</td>
<td>2</td>
<td>1,033</td>
</tr>
<tr>
<td>Public psychiatric hospital services</td>
<td>192</td>
<td>157</td>
<td>27</td>
<td>0</td>
<td>0</td>
<td>376</td>
</tr>
<tr>
<td>Residential mental health care services&lt;sup&gt;a)&lt;/sup&gt;</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>958</td>
<td>285</td>
<td>153</td>
<td>11</td>
<td>2</td>
<td>1,409</td>
</tr>
</tbody>
</table>

<sup>a)</sup> Queensland does not fund community-based residential services, but funds both campus and non-campus based extended treatment services.

Table 27: QLD: Number of specialised mental health beds, by service type, 2011–12

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialised psychiatric units or wards in public acute hospitals</td>
<td>785</td>
<td>132</td>
<td>131</td>
<td>7</td>
<td>2</td>
<td>1,057</td>
</tr>
<tr>
<td>Public psychiatric hospital services</td>
<td>162</td>
<td>156</td>
<td>27</td>
<td>0</td>
<td>0</td>
<td>345</td>
</tr>
<tr>
<td>Residential mental health care services&lt;sup&gt;a)&lt;/sup&gt;</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>947</td>
<td>288</td>
<td>158</td>
<td>7</td>
<td>2</td>
<td>1,402</td>
</tr>
</tbody>
</table>

<sup>a)</sup> Queensland does not fund community-based residential services, but funds both campus and non-campus based extended treatment services.

Table 28: QLD: Full-time-equivalent staff, state and territory specialised mental health care facilities, by staffing category, 2007–08

<table>
<thead>
<tr>
<th>Staffing Category</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total&lt;sup&gt;a)&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant psychiatrists and psychiatrists</td>
<td>165.4</td>
<td>27.8</td>
<td>38.3</td>
<td>2.5</td>
<td>1.2</td>
<td>235.2</td>
</tr>
<tr>
<td>Psychiatry registrars and trainees</td>
<td>182.4</td>
<td>23.5</td>
<td>24.7</td>
<td>1.1</td>
<td>0.2</td>
<td>231.9</td>
</tr>
<tr>
<td>Other medical officers</td>
<td>11.7</td>
<td>10.1</td>
<td>13.3</td>
<td>1.1</td>
<td>0.3</td>
<td>36.6</td>
</tr>
<tr>
<td>Psychologists</td>
<td>250.4</td>
<td>60.3</td>
<td>76.7</td>
<td>5.5</td>
<td>2.7</td>
<td>395.5</td>
</tr>
<tr>
<td>Diagnostic and health professionals&lt;sup&gt;b)&lt;/sup&gt;</td>
<td>405.3</td>
<td>79.0</td>
<td>108.0</td>
<td>9.0</td>
<td>8.4</td>
<td>609.7</td>
</tr>
<tr>
<td>Nurses&lt;sup&gt;c)&lt;/sup&gt;</td>
<td>1,567.6</td>
<td>434.7</td>
<td>464.3</td>
<td>30.4</td>
<td>17.1</td>
<td>2,514.1</td>
</tr>
<tr>
<td>Carer workers&lt;sup&gt;d)&lt;/sup&gt;</td>
<td>1.1</td>
<td>0.3</td>
<td>0.1</td>
<td>0.0</td>
<td>0.0</td>
<td>1.5</td>
</tr>
<tr>
<td>Consumer workers&lt;sup&gt;e)&lt;/sup&gt;</td>
<td>7.2</td>
<td>1.0</td>
<td>1.4</td>
<td>0.1</td>
<td>0.0</td>
<td>9.7</td>
</tr>
<tr>
<td>Other personal care&lt;sup&gt;f)&lt;/sup&gt;</td>
<td>97.0</td>
<td>26.5</td>
<td>64.1</td>
<td>6.0</td>
<td>5.5</td>
<td>199.1</td>
</tr>
<tr>
<td>Other staffing categories&lt;sup&gt;g)&lt;/sup&gt;</td>
<td>454.0</td>
<td>153.0</td>
<td>170.8</td>
<td>14.4</td>
<td>10.0</td>
<td>802.3</td>
</tr>
<tr>
<td>Total&lt;sup&gt;a)&lt;/sup&gt;</td>
<td>3,142.2</td>
<td>816.2</td>
<td>961.7</td>
<td>70.1</td>
<td>45.5</td>
<td>5,035.7</td>
</tr>
</tbody>
</table>

<sup>a)</sup> Totals may not add due to rounding.

<sup>b)</sup> Diagnostic and health professionals includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature and covers all allied health professionals and laboratory technicians, including Social Workers, Occupational Therapists and others (METeOR identifier 287611).
c) Includes registered and enrolled nurses.

d) The definition of these categories was modified from 'consultants' to 'mental health workers' for the 2010–11 collection, in order to capture a variety of contemporary roles.

e) Other personal care staff includes staff engaged primarily in the provision of personal care to patients or residents, not formally qualified, for example attendants, assistants of home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants (METeOR 270171).

f) Other staff includes administrative and clerical and domestic and other staff categories.

Notes:
1. Includes consumer and carer workers and staff employed at a higher organisational level. Excludes staff employed at regional or state level in mental health policy units of the associated relevant health department or equivalent.

2. Queensland implemented a new methodology to calculate FTE in 2009–10 therefore caution should be exercised when conducting time series analysis.

Table 29: QLD: Full-time-equivalent staff, state and territory specialised mental health care facilities, by staffing category, 2011–12

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant psychiatrists and psychiatrists</td>
<td>198.0</td>
<td>36.5</td>
<td>42.8</td>
<td>3.0</td>
<td>1.4</td>
<td>281.6</td>
</tr>
<tr>
<td>Psychiatry registrars and trainees</td>
<td>233.2</td>
<td>26.8</td>
<td>37.7</td>
<td>1.6</td>
<td>0.1</td>
<td>299.5</td>
</tr>
<tr>
<td>Other medical officers</td>
<td>14.7</td>
<td>6.9</td>
<td>10.9</td>
<td>1.2</td>
<td>0.2</td>
<td>33.8</td>
</tr>
<tr>
<td>Psychologists</td>
<td>264.1</td>
<td>65.8</td>
<td>96.2</td>
<td>7.0</td>
<td>6.3</td>
<td>439.4</td>
</tr>
<tr>
<td>Diagnostic and health professionals(b)</td>
<td>541.4</td>
<td>91.2</td>
<td>139.5</td>
<td>12.0</td>
<td>11.9</td>
<td>796.0</td>
</tr>
<tr>
<td>Nurses(c)</td>
<td>1,841.2</td>
<td>430.5</td>
<td>559.6</td>
<td>34.8</td>
<td>23.1</td>
<td>2,889.2</td>
</tr>
<tr>
<td>Carer workers(d)</td>
<td>5.1</td>
<td>0.8</td>
<td>0.4</td>
<td>0.0</td>
<td>0.0</td>
<td>6.4</td>
</tr>
<tr>
<td>Consumer workers(d)</td>
<td>11.8</td>
<td>3.2</td>
<td>3.7</td>
<td>0.5</td>
<td>0.4</td>
<td>19.5</td>
</tr>
<tr>
<td>Other personal care(e)</td>
<td>85.8</td>
<td>31.1</td>
<td>98.2</td>
<td>6.0</td>
<td>5.4</td>
<td>226.5</td>
</tr>
<tr>
<td>Other staffing categories(f)</td>
<td>501.6</td>
<td>140.8</td>
<td>199.5</td>
<td>14.8</td>
<td>14.2</td>
<td>870.9</td>
</tr>
<tr>
<td>Total(a)</td>
<td>3,696.9</td>
<td>833.5</td>
<td>1,188.5</td>
<td>80.7</td>
<td>63.1</td>
<td>5,862.8</td>
</tr>
</tbody>
</table>

a) Totals may not add due to rounding.

b) Diagnostic and health professionals includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature and covers all allied health professionals and laboratory technicians, including Social Workers, Occupational Therapists and others (METeOR identifier 287611).

c) Includes registered and enrolled nurses.

d) The definition of these categories was modified from 'consultants' to 'mental health workers' for the 2010–11 collection, in order to capture a variety of contemporary roles.

e) Other personal care staff includes staff engaged primarily in the provision of personal care to patients or residents, not formally qualified, for example attendants, assistants of home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants (METeOR 270171).

f) Other staff includes administrative and clerical and domestic and other staff categories.

Notes:
1. Includes consumer and carer workers and staff employed at a higher organisational level. Excludes staff employed at regional or state level in mental health policy units of the associated relevant health department or equivalent.

2. Queensland implemented a new methodology to calculate FTE in 2009–10 therefore caution should be exercised when conducting time series analysis.
Table 30: QLD: State and territory specialised mental health service activity, by service type, 2007–08

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days(^{(a)})</td>
<td>297,300</td>
<td>91,373</td>
<td>48,747</td>
<td>2,857</td>
<td>755</td>
<td>441,032</td>
</tr>
<tr>
<td>Community mental health care contacts(^{(b)})</td>
<td>759,765</td>
<td>220,029</td>
<td>146,347</td>
<td>7,865</td>
<td>6,839</td>
<td>1,140,845</td>
</tr>
<tr>
<td>Residential mental health care days(^{(c)})</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

a) Hospital days, also known as accrued mental health care days for public hospital services, will not equal figures reported from the National hospital morbidity database due to scope differences between the two collections.

b) Community mental health care contacts will not equate to those reported from the Community mental health care database due to differing scope.

c) Queensland does not fund community-based residential services, but funds both campus and non-campus based extended treatment services. Data from these services are included in Hospital days.

Table 31: QLD: State and territory specialised mental health service activity, by service type, 2011–12

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days(^{(a)})</td>
<td>291,741</td>
<td>95,363</td>
<td>49,841</td>
<td>2,582</td>
<td>741</td>
<td>440,267</td>
</tr>
<tr>
<td>Community mental health care contacts(^{(b)})</td>
<td>789,421</td>
<td>224,122</td>
<td>156,683</td>
<td>13,115</td>
<td>12,520</td>
<td>1,195,862</td>
</tr>
<tr>
<td>Residential mental health care days(^{(c)})</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

a) Hospital days, also known as accrued mental health care days for public hospital services, will not equal figures reported from the National hospital morbidity database due to scope differences between the two collections.

b) Community mental health care contacts will not equate to those reported from the Community mental health care database due to differing scope.

c) Queensland does not fund community-based residential services, but funds both campus and non-campus based extended treatment services. Data from these services are included in Hospital days.
Western Australia

- Caution should be used in interpreting Western Australia data for disaggregation by remoteness as service location does not necessarily reflect the catchment area for that service.

Table 32: WA: Recurrent expenditure\(^{(a)(b)}\) ($’000) on state and territory specialised mental health services, by service type, 2007–08 (constant prices)\(^{(c)}\)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(^{(d)})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(e)(f)})</td>
<td>194,027</td>
<td>6,948</td>
<td>4,106</td>
<td>0</td>
<td>0</td>
<td>205,080</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>173,267</td>
<td>14,243</td>
<td>12,835</td>
<td>6,316</td>
<td>851</td>
<td>207,512</td>
</tr>
<tr>
<td>Residential mental health services(^{(g)})</td>
<td>9,428</td>
<td>423</td>
<td>1,010</td>
<td>0</td>
<td>0</td>
<td>10,861</td>
</tr>
<tr>
<td>All mental health service types(^{(h)})</td>
<td>376,722</td>
<td>21,615</td>
<td>17,951</td>
<td>6,316</td>
<td>851</td>
<td>423,454</td>
</tr>
</tbody>
</table>

(a) Expenditure excludes depreciation.
(b) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.
(c) Constant prices are referenced to 2011–12 and are adjusted for inflation.
(d) Totals may not add due to rounding to the nearest $’000.
(e) Includes public hospital services managed and operated by private and non-government entities.
(f) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.
(g) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

Table 33: WA: Recurrent expenditure\(^{(a)(b)}\) ($) per capita\(^{(c)}\) on state and territory specialised mental health services, by service type, 2007–08 (constant prices)\(^{(d)}\)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(^{(d)})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(e)})</td>
<td>121.35</td>
<td>37.16</td>
<td>23.63</td>
<td>0</td>
<td>0</td>
<td>97.37</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>108.36</td>
<td>76.18</td>
<td>73.86</td>
<td>67.25</td>
<td>16.19</td>
<td>98.53</td>
</tr>
<tr>
<td>Residential mental health services(^{(f)})</td>
<td>5.90</td>
<td>2.26</td>
<td>5.81</td>
<td>0</td>
<td>0</td>
<td>5.16</td>
</tr>
<tr>
<td>All mental health service types(^{(g)})</td>
<td>235.61</td>
<td>115.60</td>
<td>103.30</td>
<td>67.25</td>
<td>16.19</td>
<td>201.06</td>
</tr>
</tbody>
</table>

(a) Expenditure excludes depreciation.
(b) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.
(c) Crude rate is based on the state and territory estimated resident population by remoteness area as at 30 June 2007.
(d) Constant prices are referenced to 2011–12 and are adjusted for inflation.
(e) Totals may not add due to rounding.
(f) Includes public hospital services managed and operated by private and non-government entities.
(g) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.
(h) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.
### Table 34: WA: Recurrent expenditure\(^{(a)(b)}\) ($'000) on state and territory specialised mental health services, by service type, 2011–12 (current prices)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(^{(c)})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(a)(c)})</td>
<td>240,685</td>
<td>10,064</td>
<td>5,250(^{(d)})</td>
<td>n/a</td>
<td>n/a</td>
<td>255,999</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>196,406</td>
<td>16,368</td>
<td>16,199</td>
<td>9,993</td>
<td>1,286</td>
<td>240,252</td>
</tr>
<tr>
<td>Residential mental health services(^{(g)})</td>
<td>17,807</td>
<td>1,905</td>
<td>1,844</td>
<td>0</td>
<td>0</td>
<td>21,556</td>
</tr>
<tr>
<td>All mental health service types(^{(h)})</td>
<td>454,898</td>
<td>28,337</td>
<td>23,293(^{(g)})</td>
<td>9,993</td>
<td>1,286</td>
<td>517,808</td>
</tr>
</tbody>
</table>

n/a: Not applicable

(a) Expenditure excludes depreciation.

(b) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.

(c) Totals may not add due to rounding to the nearest $’000.

(d) Includes expenditure for public hospital services in remote and very remote areas.

(e) Includes public hospital services managed and operated by private and non-government entities.

(f) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.

(g) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

### Table 35: WA: Recurrent expenditure\(^{(a)(b)}\) ($) per capita\(^{(h)}\) on state and territory specialised mental health services, by service type, 2011–12 (current prices)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(a)(c)})</td>
<td>133.81</td>
<td>47.71</td>
<td>26.87(^{(l)})</td>
<td>n/a</td>
<td>n/a</td>
<td>108.78</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>109.19</td>
<td>77.59</td>
<td>89.08</td>
<td>101.06</td>
<td>20.40</td>
<td>102.09</td>
</tr>
<tr>
<td>Residential mental health services(^{(g)})</td>
<td>9.90</td>
<td>9.03</td>
<td>10.14</td>
<td>0</td>
<td>0</td>
<td>9.16</td>
</tr>
<tr>
<td>All mental health service types(^{(h)})</td>
<td>252.91</td>
<td>134.33</td>
<td>128.09</td>
<td>101.6</td>
<td>20.40</td>
<td>220.02</td>
</tr>
</tbody>
</table>

n/a: Not applicable

(a) Expenditure excludes depreciation.

(b) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.

(c) Crude rate is based on the state and territory estimated resident population by remoteness area as at 30 June 2011.

(d) Includes public hospital services managed and operated by private and non-government entities.

(e) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.

(f) Includes expenditure for public hospital services in remote and very remote areas.

(g) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

(h) Totals may not add due to rounding.
Table 36: WA: Number of specialised mental health beds, by service type, 2007–08

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialised psychiatric units or wards in public acute hospitals</td>
<td>391</td>
<td>18</td>
<td>16</td>
<td>0</td>
<td>0</td>
<td>425</td>
</tr>
<tr>
<td>Public psychiatric hospital services</td>
<td>245</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>245</td>
</tr>
<tr>
<td>Residential mental health care services</td>
<td>90</td>
<td>11</td>
<td>29</td>
<td>0</td>
<td>0</td>
<td>130</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>726</strong></td>
<td><strong>29</strong></td>
<td><strong>45</strong></td>
<td>0</td>
<td>0</td>
<td><strong>800</strong></td>
</tr>
</tbody>
</table>

Notes:
1) Caution is required when interpreting Western Australian data. A review of services resulted in the reclassification of beds between the acute and non-acute categories for the 2010–11 collection, to more accurately reflect the function of these services. In addition, data prior to 2010–11 include a small number of emergency department observation beds in one hospital.

Table 37: WA: Number of specialised mental health beds, by service type, 2011–12

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialised psychiatric units or wards in public acute hospitals</td>
<td>415</td>
<td>31</td>
<td>17</td>
<td>n/a</td>
<td>n/a</td>
<td>463</td>
</tr>
<tr>
<td>Public psychiatric hospital services</td>
<td>246</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>246</td>
</tr>
<tr>
<td>Residential mental health care services</td>
<td>246</td>
<td>28</td>
<td>29</td>
<td>0</td>
<td>0</td>
<td>303</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>907</strong></td>
<td><strong>59</strong></td>
<td><strong>46</strong></td>
<td>n/a</td>
<td>n/a</td>
<td><strong>1,012</strong></td>
</tr>
</tbody>
</table>

Notes:
- n/a Not applicable
- a) Includes beds in remote and very remote areas

1. Caution is required when interpreting Western Australian data. A review of services resulted in the reclassification of beds between the acute and non-acute categories for the 2010–11 collection, to more accurately reflect the function of these services. In addition, data prior to 2010–11 include a small number of emergency department observation beds in one hospital.
### Table 38: WA: Full-time-equivalent staff, state and territory specialised mental health care facilities, by staffing category, 2007–08

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(^a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant psychiatrists and psychiatrists</td>
<td>90.2</td>
<td>5.7</td>
<td>3.9</td>
<td>2.5</td>
<td>0.3</td>
<td>102.6</td>
</tr>
<tr>
<td>Psychiatry registrars and trainees</td>
<td>98.2</td>
<td>1.4</td>
<td>1.0</td>
<td>0.8</td>
<td>0.2</td>
<td>101.6</td>
</tr>
<tr>
<td>Other medical officers</td>
<td>69.2</td>
<td>6.7</td>
<td>0.3</td>
<td>0.9</td>
<td>0.1</td>
<td>77.2</td>
</tr>
<tr>
<td>Psychologists</td>
<td>143.6</td>
<td>8.3</td>
<td>6.2</td>
<td>0.9</td>
<td>0.1</td>
<td>159.1</td>
</tr>
<tr>
<td>Diagnostic and health professionals(^b)</td>
<td>399.4</td>
<td>28.0</td>
<td>32.6</td>
<td>8.7</td>
<td>1.2</td>
<td>469.9</td>
</tr>
<tr>
<td>Nurses(^c)</td>
<td>1,360.5</td>
<td>69.5</td>
<td>51.9</td>
<td>10.7</td>
<td>1.3</td>
<td>1,493.8</td>
</tr>
<tr>
<td>Carer workers(^d)</td>
<td>0.5</td>
<td>0.1</td>
<td>0.2</td>
<td>0.0</td>
<td>0.0</td>
<td>0.8</td>
</tr>
<tr>
<td>Consumer workers(^d)</td>
<td>1.2</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>1.2</td>
</tr>
<tr>
<td>Other personal care(^d)</td>
<td>102.5</td>
<td>7.2</td>
<td>17.9</td>
<td>3.8</td>
<td>0.2</td>
<td>131.6</td>
</tr>
<tr>
<td>Other staffing categories(^d)</td>
<td>580.2</td>
<td>27.8</td>
<td>42.2</td>
<td>17.8</td>
<td>2.6</td>
<td>670.6</td>
</tr>
<tr>
<td><strong>Total(^d)</strong></td>
<td><strong>2,845.4</strong></td>
<td><strong>154.7</strong></td>
<td><strong>156.2</strong></td>
<td><strong>46.2</strong></td>
<td><strong>5.9</strong></td>
<td><strong>3,208.3</strong></td>
</tr>
</tbody>
</table>

\(^a\) Totals may not add due to rounding.

\(^b\) Diagnostic and health professionals includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature and covers all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff) (METeOR identifier 287611).

\(^c\) Includes registered and enrolled nurses

\(^d\) The definition of these categories was modified from ‘consultants’ to ‘mental health workers’ for the 2010–11 collection, in order to capture a variety of contemporary roles.

\(^e\) Other personal care staff includes staff engaged primarily in the provision of personal care to patients or residents, not formally qualified, for example attendants, assistants of home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants (METeOR 270171).

\(^f\) Other staff includes administrative and clerical and domestic and other staff categories.

**Notes:**

1. Includes consumer and carer workers and staff employed at a higher organisational level. Excludes staff employed at regional or state level in mental health policy units of the associated relevant health department or equivalent.
Table 39: WA: Full-time-equivalent staff, state and territory specialised mental health care facilities, by staffing category, 2011-12

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant psychiatrists and psychiatrists</td>
<td>128.7</td>
<td>9.1</td>
<td>5.5</td>
<td>3.5</td>
<td>0.5</td>
<td>147.3</td>
</tr>
<tr>
<td>Psychiatry registrars and trainees</td>
<td>108.0</td>
<td>2.7</td>
<td>3.3</td>
<td>1.0</td>
<td>0.2</td>
<td>115.2</td>
</tr>
<tr>
<td>Other medical officers</td>
<td>78.4</td>
<td>8.2</td>
<td>0.2</td>
<td>0.0</td>
<td>0.0</td>
<td>86.9</td>
</tr>
<tr>
<td>Psychologists</td>
<td>166.4</td>
<td>8.7</td>
<td>1.7</td>
<td>0.0</td>
<td>0.0</td>
<td>176.8</td>
</tr>
<tr>
<td>Diagnostic and health professionals(b)</td>
<td>431.6</td>
<td>40.7</td>
<td>36.9</td>
<td>18.7</td>
<td>2.2</td>
<td>530.1</td>
</tr>
<tr>
<td>Nurses(c)</td>
<td>1,506.1</td>
<td>96.8</td>
<td>59.0</td>
<td>19.2</td>
<td>2.7</td>
<td>1,683.8</td>
</tr>
<tr>
<td>Carer workers(d)</td>
<td>0.2</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.2</td>
</tr>
<tr>
<td>Consumer workers(e)</td>
<td>2.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Other personal care(e)</td>
<td>228.5</td>
<td>16.8</td>
<td>28.4</td>
<td>1.1</td>
<td>0.2</td>
<td>275.0</td>
</tr>
<tr>
<td>Other staffing categories(f)</td>
<td>635.8</td>
<td>27.8</td>
<td>38.0</td>
<td>12.9</td>
<td>1.7</td>
<td>716.2</td>
</tr>
<tr>
<td>Total(d)</td>
<td>3,285.6</td>
<td>210.9</td>
<td>172.9</td>
<td>56.6</td>
<td>7.5</td>
<td>3,733.5</td>
</tr>
</tbody>
</table>

a) Totals may not add due to rounding.

b) Diagnostic and health professionals includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature and covers all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff) (METeOR identifier 287611).

c) Includes registered and enrolled nurses

d) The definition of these categories was modified from ‘consultants’ to ‘mental health workers’ for the 2010–11 collection, in order to capture a variety of contemporary roles.

e) Other personal care staff includes staff engaged primarily in the provision of personal care to patients or residents, not formally qualified, for example attendants, assistants of home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants (METeOR 270171).

f) Other staff includes administrative and clerical and domestic and other staff categories.

Notes:
1. Includes consumer and carer workers and staff employed at a higher organisational level. Excludes staff employed at regional or state level in mental health policy units of the associated relevant health department or equivalent.
### Table 40: WA: State and territory specialised mental health service activity, by service type, 2007–08

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days&lt;sup&gt;a&lt;/sup&gt;</td>
<td>210,466</td>
<td>5,101</td>
<td>5,012</td>
<td>0</td>
<td>0</td>
<td>220,579</td>
</tr>
<tr>
<td>Community mental health care contacts&lt;sup&gt;b&lt;/sup&gt;</td>
<td>465,235</td>
<td>49,436</td>
<td>38,307</td>
<td>13,279</td>
<td>1,527</td>
<td>567,784</td>
</tr>
<tr>
<td>Residential mental health care days&lt;sup&gt;c&lt;/sup&gt;</td>
<td>26,996</td>
<td>656</td>
<td>2,702</td>
<td>0</td>
<td>0</td>
<td>30,354</td>
</tr>
</tbody>
</table>

<sup>a</sup> Hospital days, also known as accrued mental health care days for public hospital services, will not equal figures reported from the National hospital morbidity database due to scope differences between the two collections.

<sup>b</sup> Community mental health care contacts will not equate to those reported from the Community mental health care database due to differing scope.

<sup>c</sup> Residential mental health care days comprises the number of care days provided by all services, including government and non-government operated services, and 24-hour and non-24-hour staffed services. Figures will not equate to those reported from the Residential mental health care database due to differing collection scopes.

### Table 41: WA: State and territory specialised mental health service activity, by service type, 2011–12

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days&lt;sup&gt;a&lt;/sup&gt;</td>
<td>222,310</td>
<td>8,460</td>
<td>4,887&lt;sup&gt;b&lt;/sup&gt;</td>
<td>n/a</td>
<td>n/a</td>
<td>235,657</td>
</tr>
<tr>
<td>Community mental health care contacts&lt;sup&gt;b&lt;/sup&gt;</td>
<td>623,844</td>
<td>52,187</td>
<td>49,709</td>
<td>23,576</td>
<td>3,103</td>
<td>752,419</td>
</tr>
<tr>
<td>Residential mental health care days&lt;sup&gt;d&lt;/sup&gt;</td>
<td>81,583</td>
<td>10,176</td>
<td>9,387</td>
<td>6</td>
<td>0</td>
<td>101,152</td>
</tr>
</tbody>
</table>

<sup>n/a</sup> Not Applicable

<sup>a</sup> Hospital days, also known as accrued mental health care days for public hospital services, will not equal figures reported from the National hospital morbidity database due to scope differences between the two collections.

<sup>b</sup> Includes activity occurring in remote and very remote areas

<sup>c</sup> Community mental health care contacts will not equate to those reported from the Community mental health care database due to differing scope.

<sup>d</sup> Residential mental health care days comprises the number of care days provided by all services, including government and non-government operated services, and 24-hour and non-24-hour staffed services. Figures will not equate to those reported from the Residential mental health care database due to differing collection scopes.
South Australia

- Specialised mental health hospital services in South Australia are located in *major cities* only, however, for acute service access the Rural and Remote Distance Consultation and Emergency Triage and Liaison Service is available 24 hours a day, seven days a week. This service is staffed by mental health clinicians who triage admissions to an inpatient service and provide a comprehensive range of advice and support including access to psychiatrists. The Rural and Remote Service also incorporates a telepsychiatry service which uses video conferencing to enable a person to remain in or close to their own community while receiving psychiatric consultations for initial assessment, discharge planning and ongoing treatment. See *South Australian Health, Acute Mental Health Services* for more information.

- Locations of SA country-based Child and Adolescent services, historically split into “Northern” and “Southern”, have been reported under their respective administrative central office locations both of which are in metropolitan Adelaide.

- Data for community mental health care services in the very remote category reported in 2007–08 were no longer considered in-scope for the MHE NMDS collection in 2011–12 due to a change in the model of care of the service.
Table 42: SA: Recurrent expenditure\(^{(a)(b)}\) (\$'000) on state and territory specialised mental health services, by service type, 2007–08 (constant prices)\(^{(c)}\)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(^{(d)})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(e)(f)})</td>
<td>157,416</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>157,416</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>102,445</td>
<td>3,392</td>
<td>6,997</td>
<td>1,781</td>
<td>93</td>
<td>114,707</td>
</tr>
<tr>
<td>Residential mental health services(^{g})</td>
<td>7,365</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7,365</td>
</tr>
<tr>
<td>All mental health service types(^{h})</td>
<td>267,225</td>
<td>3,392</td>
<td>6,997</td>
<td>1,781</td>
<td>93</td>
<td>279,488</td>
</tr>
</tbody>
</table>

\(a\) Expenditure excludes depreciation.
\(b\) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.
\(c\) Constant prices are referenced to 2011–12 and are adjusted for inflation.
\(d\) Totals may not add due to rounding to the nearest \$'000.
\(e\) Includes public hospital services managed and operated by private and non-government entities.
\(f\) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.
\(g\) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

Table 43: SA: Recurrent expenditure\(^{(a)(b)}\) (\$) per capita\(^{(c)}\) on state and territory specialised mental health services, by service type, 2007–08 (constant prices)\(^{(d)}\)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(e)(f)})</td>
<td>137.52</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100.23</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>89.50</td>
<td>20.48</td>
<td>34.72</td>
<td>40.10</td>
<td>6.48</td>
<td>73.03</td>
</tr>
<tr>
<td>Residential mental health services(^{g})</td>
<td>6.43</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4.69</td>
</tr>
<tr>
<td>All mental health service types(^{h})</td>
<td>233.45</td>
<td>20.48</td>
<td>34.72</td>
<td>40.10</td>
<td>6.48</td>
<td>177.95</td>
</tr>
</tbody>
</table>

\(a\) Expenditure excludes depreciation.
\(b\) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.
\(c\) Crude rate is based on the state and territory estimated resident population by remoteness area as at 30 June 2007.
\(d\) Constant prices are referenced to 2011–12 and are adjusted for inflation.
\(e\) Includes public hospital services managed and operated by private and non-government entities.
\(f\) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.
\(g\) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.
\(h\) Totals may not add due to rounding.
Table 44: SA: Recurrent expenditure\(^{(a)(b)}\) ($'000) on state and territory specialised mental health services, by service type, 2011–12 (current prices)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(^{(c)})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(d)(e)})</td>
<td>137,463</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>137,463</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>130,943</td>
<td>3,121</td>
<td>8,931</td>
<td>1,512</td>
<td>0</td>
<td>144,506</td>
</tr>
<tr>
<td>Residential mental health services(^{(f)})</td>
<td>18,442</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>18,442</td>
</tr>
<tr>
<td>All mental health service types(^{(g)})</td>
<td>286,847</td>
<td>3,121</td>
<td>8,931</td>
<td>1,512</td>
<td>0</td>
<td>300,411</td>
</tr>
</tbody>
</table>

\(^{(a)}\) Expenditure excludes depreciation.

\(^{(b)}\) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.

\(^{(c)}\) Totals may not add due to rounding to the nearest $'000.

\(^{(d)}\) Includes public hospital services managed and operated by private and non-government entities.

\(^{(e)}\) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.

\(^{(f)}\) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

\(^{(g)}\) Totals may not add due to rounding.

Table 45: SA: Recurrent expenditure\(^{(a)(b)}\) ($) per capita\(^{(c)}\) on state and territory specialised mental health services, by service type, 2011–12 (current prices)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(d)(e)})</td>
<td>114.51</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>83.84</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>109.08</td>
<td>17.59</td>
<td>44.26</td>
<td>33.48</td>
<td>0</td>
<td>88.13</td>
</tr>
<tr>
<td>Residential mental health services(^{(f)})</td>
<td>15.36</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>11.25</td>
</tr>
<tr>
<td>All mental health service types(^{(g)})</td>
<td>238.94</td>
<td>17.59</td>
<td>44.26</td>
<td>33.48</td>
<td>0</td>
<td>183.22</td>
</tr>
</tbody>
</table>

\(^{(a)}\) Expenditure excludes depreciation.

\(^{(b)}\) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.

\(^{(c)}\) Crude rate is based on the state and territory estimated resident population by remoteness area as at 30 June 2011.

\(^{(d)}\) Includes public hospital services managed and operated by private and non-government entities.

\(^{(e)}\) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.

\(^{(f)}\) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

\(^{(g)}\) Totals may not add due to rounding.
Table 46: SA: Number of specialised mental health beds, by service type, 2007–08

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialised psychiatric units or wards in public acute hospitals</td>
<td>243</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>243</td>
</tr>
<tr>
<td>Public psychiatric hospital services</td>
<td>357</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>357</td>
</tr>
<tr>
<td>Residential mental health care services</td>
<td>71</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>71</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>671</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>671</strong></td>
</tr>
</tbody>
</table>

Table 47: SA: Number of specialised mental health beds, by service type, 2011–12

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialised psychiatric units or wards in public acute hospitals</td>
<td>250</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>250</td>
</tr>
<tr>
<td>Public psychiatric hospital services</td>
<td>230</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>230</td>
</tr>
<tr>
<td>Residential mental health care services</td>
<td>138</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>138</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>618</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>618</strong></td>
</tr>
</tbody>
</table>

Table 48: SA: Full-time-equivalent staff, state and territory specialised mental health care facilities, by staffing category, 2007–08

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant psychiatrists and psychiatrists</td>
<td>96.5</td>
<td>0.3</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>96.8</td>
</tr>
<tr>
<td>Psychiatry registrars and trainees</td>
<td>104.2</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>104.2</td>
</tr>
<tr>
<td>Other medical officers</td>
<td>16.8</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>16.8</td>
</tr>
<tr>
<td>Psychologists</td>
<td>105.7</td>
<td>1.0</td>
<td>1.0</td>
<td>2.0</td>
<td>0.0</td>
<td>109.7</td>
</tr>
<tr>
<td>Diagnostic and health professionals(b)</td>
<td>332.4</td>
<td>9.4</td>
<td>17.5</td>
<td>3.4</td>
<td>0.6</td>
<td>363.4</td>
</tr>
<tr>
<td>Nurses(c)</td>
<td>1,187.5</td>
<td>15.2</td>
<td>32.1</td>
<td>7.9</td>
<td>0.0</td>
<td>1,242.7</td>
</tr>
<tr>
<td>Carer workers(d)</td>
<td>1.8</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>1.8</td>
</tr>
<tr>
<td>Consumer workers(d)</td>
<td>4.7</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>4.7</td>
</tr>
<tr>
<td>Other personal care(d)</td>
<td>14.1</td>
<td>3.1</td>
<td>5.9</td>
<td>0.0</td>
<td>0.0</td>
<td>23.1</td>
</tr>
<tr>
<td>Other staffing categories(d)</td>
<td>469.5</td>
<td>5.6</td>
<td>5.5</td>
<td>3.0</td>
<td>0.0</td>
<td>483.6</td>
</tr>
<tr>
<td><strong>Total(d)</strong></td>
<td><strong>2,333.3</strong></td>
<td><strong>34.6</strong></td>
<td><strong>62.0</strong></td>
<td><strong>16.3</strong></td>
<td><strong>0.6</strong></td>
<td><strong>2,446.8</strong></td>
</tr>
</tbody>
</table>

a) Totals may not add due to rounding.

b) Diagnostic and health professionals includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature and covers all allied health professionals and laboratory technicians, including Social Workers, Occupational Therapists and others (METeOR identifier 287611).

c) Includes registered and enrolled nurses.

d) The definition of these categories was modified from ‘consultants’ to ‘mental health workers’ for the 2010–11 collection, in order to capture a variety of contemporary roles.
e) Other personal care staff includes staff engaged primarily in the provision of personal care to patients or residents, not formally qualified, for example attendants, assistants of home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants (METeOR 270171).

f) Other staff includes administrative and clerical and domestic and other staff categories.

Notes:
1) Includes consumer and carer workers and staff employed at a higher organisational level. Excludes staff employed at regional or state level in mental health policy units of the associated relevant health department or equivalent.

Table 49: SA: Full-time-equivalent staff, state and territory specialised mental health care facilities, by staffing category, 2011–12

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant psychiatrists and psychiatrists</td>
<td>116.9</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>116.9</td>
</tr>
<tr>
<td>Psychiatry registrars and trainees</td>
<td>101.9</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>101.9</td>
</tr>
<tr>
<td>Other medical officers</td>
<td>5.2</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>5.2</td>
</tr>
<tr>
<td>Psychologists</td>
<td>94.6</td>
<td>0.0</td>
<td>1.7</td>
<td>0.3</td>
<td>0.0</td>
<td>96.6</td>
</tr>
<tr>
<td>Diagnostic and health professionals(b)</td>
<td>296.5</td>
<td>8.7</td>
<td>20.4</td>
<td>6.3</td>
<td>0.0</td>
<td>331.8</td>
</tr>
<tr>
<td>Nurses(c)</td>
<td>1,183.4</td>
<td>16.2</td>
<td>45.3</td>
<td>13.5</td>
<td>0.0</td>
<td>1,258.3</td>
</tr>
<tr>
<td>Carer workers(d)</td>
<td>3.8</td>
<td>0.1</td>
<td>0.3</td>
<td>0.1</td>
<td>0.0</td>
<td>4.2</td>
</tr>
<tr>
<td>Consumer workers(d)</td>
<td>7.7</td>
<td>0.1</td>
<td>0.3</td>
<td>0.1</td>
<td>0.0</td>
<td>8.2</td>
</tr>
<tr>
<td>Other personal care(e)</td>
<td>110.7</td>
<td>1.7</td>
<td>8.1</td>
<td>2.0</td>
<td>0.0</td>
<td>122.5</td>
</tr>
<tr>
<td>Other staffing categories(f)</td>
<td>301.3</td>
<td>2.7</td>
<td>8.2</td>
<td>2.3</td>
<td>0.0</td>
<td>314.5</td>
</tr>
<tr>
<td>Total(a)</td>
<td>2,221.9</td>
<td>29.4</td>
<td>84.2</td>
<td>24.6</td>
<td>0.0</td>
<td>2,360.1</td>
</tr>
</tbody>
</table>

a) Totals may not add due to rounding.

b) Diagnostic and health professionals includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature and covers all allied health professionals and laboratory technicians, including Social Workers, Occupational Therapists and others (METeOR identifier 287611).

c) Includes registered and enrolled nurses.

d) The definition of these categories was modified from 'consultants' to 'mental health workers' for the 2010–11 collection, in order to capture a variety of contemporary roles.

e) Other personal care staff includes staff engaged primarily in the provision of personal care to patients or residents, not formally qualified, for example attendants, assistants of home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants (METeOR 270171).

f) Other staff includes administrative and clerical and domestic and other staff categories.

Notes:
1. Includes consumer and carer workers and staff employed at a higher organisational level. Excludes staff employed at regional or state level in mental health policy units of the associated relevant health department or equivalent.

Table 50: SA: State and territory specialised mental health service activity, by service type, 2007–08

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days(d)</td>
<td>197,644</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>197,644</td>
</tr>
<tr>
<td>Community mental health care contacts(b)</td>
<td>405,839</td>
<td>13,476</td>
<td>28,571</td>
<td>5,207</td>
<td>1,187</td>
<td>454,280</td>
</tr>
<tr>
<td>Residential mental health care days(c)</td>
<td>17,301</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>17,301</td>
</tr>
</tbody>
</table>

a) Hospital days, also known as accrued mental health care days for public hospital services, will not equal figures reported from the National hospital morbidity database due to scope differences between the two collections.
b) Community mental health care contacts will not equate to those reported from the Community mental health care database due to differing scope.

c) Residential mental health care days comprises the number of care days provided by all services, including government and non-government operated services, and 24-hour and non-24-hour staffed services. Figures will not equate to those reported from the Residential mental health care database due to differing collection scopes.

Table 51: SA: State and territory specialised mental health service activity, by service type, 2011–12

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days</td>
<td>161,797</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>161,797</td>
</tr>
<tr>
<td>Community mental health care contacts</td>
<td>558,838</td>
<td>13,562</td>
<td>30,298</td>
<td>8,683</td>
<td>0</td>
<td>611,381</td>
</tr>
<tr>
<td>Residential mental health care days</td>
<td>39,809</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>39,809</td>
</tr>
</tbody>
</table>

a) Hospital days, also known as accrued mental health care days for public hospital services, will not equal figures reported from the National hospital morbidity database due to scope differences between the two collections.

b) Community mental health care contacts will not equate to those reported from the Community mental health care database due to differing scope.

c) Residential mental health care days comprises the number of care days provided by all services, including government and non-government operated services, and 24-hour and non-24-hour staffed services. Figures will not equate to those reported from the Residential mental health care database due to differing collection scopes.
Tasmania

- Tasmanian hospital services are mostly located in *Inner regional* and *Outer regional* areas, however, several services, namely the Psychiatric Intensive Care Unit, Roy Fagan Centre and Millbrook Rise, employ a model of care that accepts state-wide admissions. See [Tasmanian Department of Health and Human services, Inpatient and Extended Treatment Mental Health Services](#) for more information.

- The remoteness methodology contained in the general ‘Methodology and caveats’ has been altered for Tasmania with the remote concordance re-mapped to outer or inner regional as appropriate. Inclusion of the remote category inappropriately allocated a small number of resources providing a misleading picture of resource allocation.
Table 52: TAS: Recurrent expenditure\(^{(a)(b)}\) ($'000) on state and territory specialised mental health services, by service type, 2007–08 (constant prices)\(^{(c)}\)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(^{(d)})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(e)(f)})</td>
<td>n/a</td>
<td>30,972</td>
<td>6,728</td>
<td>0</td>
<td>0</td>
<td>37,700</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>n/a</td>
<td>28,311</td>
<td>5,000</td>
<td>0</td>
<td>0</td>
<td>33,311</td>
</tr>
<tr>
<td>Residential mental health services</td>
<td>n/a</td>
<td>21,040</td>
<td>1,027</td>
<td>0</td>
<td>0</td>
<td>22,067</td>
</tr>
<tr>
<td>All mental health service types(^{(g)})</td>
<td>n/a</td>
<td>80,323</td>
<td>12,755</td>
<td>0</td>
<td>0</td>
<td>93,078</td>
</tr>
</tbody>
</table>

\(^{n/a}\) Not applicable.

\(^{a}\) Expenditure excludes depreciation.

\(^{b}\) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.

\(^{c}\) Constant prices are referenced to 2011–12 and are adjusted for inflation.

\(^{d}\) Totals may not add due to rounding to the nearest $'000.

\(^{e}\) Includes public hospital services managed and operated by private and non-government entities.

\(^{f}\) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.

\(^{g}\) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

Table 53: TAS: Recurrent expenditure\(^{(a)(b)}\) ($ per capita\(^{(c)}\) on state and territory specialised mental health services, by service type, 2007–08 (constant prices)\(^{(d)}\)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(e)(f)})</td>
<td>n/a</td>
<td>96.25</td>
<td>41.99</td>
<td>0</td>
<td>0</td>
<td>76.43</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>n/a</td>
<td>87.98</td>
<td>31.21</td>
<td>0</td>
<td>0</td>
<td>67.53</td>
</tr>
<tr>
<td>Residential mental health services</td>
<td>n/a</td>
<td>65.38</td>
<td>6.41</td>
<td>0</td>
<td>0</td>
<td>44.74</td>
</tr>
<tr>
<td>All mental health service types(^{(g)})</td>
<td>n/a</td>
<td>249.60</td>
<td>79.61</td>
<td>0</td>
<td>0</td>
<td>188.70</td>
</tr>
</tbody>
</table>

\(^{n/a}\) Not applicable.

\(^{a}\) Expenditure excludes depreciation.

\(^{b}\) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.

\(^{c}\) Crude rate is based on the state and territory estimated resident population by remoteness area as at 30 June 2007.

\(^{d}\) Constant prices are referenced to 2011–12 and are adjusted for inflation.

\(^{e}\) Includes public hospital services managed and operated by private and non-government entities.

\(^{f}\) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.

\(^{g}\) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

\(^{h}\) Totals may not add due to rounding.
Table 54: TAS: Recurrent expenditure\(^{(a)(b)}\) (\$’000) on state and territory specialised mental health services, by service type, 2011–12 (current prices)

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(^{(c)})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(d)(e)})</td>
<td>n/a</td>
<td>30,187</td>
<td>9,956</td>
<td>416</td>
<td>0</td>
<td>40,560</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>n/a</td>
<td>29,469</td>
<td>4,767</td>
<td>66</td>
<td>0</td>
<td>34,302</td>
</tr>
<tr>
<td>Residential mental health services(^{(f)})</td>
<td>n/a</td>
<td>19,038</td>
<td>799</td>
<td>0</td>
<td>0</td>
<td>19,837</td>
</tr>
<tr>
<td>All mental health service types(^{(g)})</td>
<td>n/a</td>
<td>78,695</td>
<td>15,522</td>
<td>482</td>
<td>0</td>
<td>94,699</td>
</tr>
</tbody>
</table>

n/a Not applicable.

(a) Expenditure excludes depreciation.

(b) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.

(c) Totals may not add due to rounding to the nearest \$’000.

(d) Includes public hospital services managed and operated by private and non-government entities.

(e) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.

(f) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

Table 55: TAS: Recurrent expenditure\(^{(a)(b)}\) (\$) per capita\(^{(c)}\) on state and territory specialised mental health services, by service type, 2011–12 (current prices)

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(d)(e)})</td>
<td>n/a</td>
<td>90.07</td>
<td>60.18</td>
<td>49.25</td>
<td>0</td>
<td>79.30</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>n/a</td>
<td>87.93</td>
<td>28.82</td>
<td>7.78</td>
<td>0</td>
<td>67.06</td>
</tr>
<tr>
<td>Residential mental health services(^{(f)})</td>
<td>n/a</td>
<td>56.81</td>
<td>4.83</td>
<td>0</td>
<td>0</td>
<td>38.78</td>
</tr>
<tr>
<td>All mental health service types(^{(g)})</td>
<td>n/a</td>
<td>234.81</td>
<td>93.82</td>
<td>57.03</td>
<td>0</td>
<td>185.15</td>
</tr>
</tbody>
</table>

n/a Not applicable.

(a) Expenditure excludes depreciation.

(b) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.

(c) Crude rate is based on the state and territory estimated resident population by remoteness area as at 30 June 2011.

(d) Includes public hospital services managed and operated by private and non-government entities.

(e) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.

(f) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

(g) Totals may not add due to rounding.
Table 56: TAS: Number of specialised mental health beds, by service type, 2007–08

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialised psychiatric units or wards in public acute hospitals</td>
<td>n/a</td>
<td>108</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>128</td>
</tr>
<tr>
<td>Public psychiatric hospital services</td>
<td>n/a</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Residential mental health care services</td>
<td>n/a</td>
<td>161</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>176</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>n/a</td>
<td>269</td>
<td>35</td>
<td>0</td>
<td>0</td>
<td>304</td>
</tr>
</tbody>
</table>

n/a  Not applicable.

Table 57: TAS: Number of specialised mental health beds, by service type, 2011–12

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialised psychiatric units or wards in public acute hospitals</td>
<td>n/a</td>
<td>95</td>
<td>34</td>
<td>2</td>
<td>0</td>
<td>131</td>
</tr>
<tr>
<td>Public psychiatric hospital services</td>
<td>n/a</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Residential mental health care services</td>
<td>n/a</td>
<td>147</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>162</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>n/a</td>
<td>242</td>
<td>49</td>
<td>2</td>
<td>0</td>
<td>293</td>
</tr>
</tbody>
</table>

n/a  Not applicable.
Table 58: TAS: Full-time-equivalent staff, state and territory specialised mental health care facilities, by staffing category, 2007–08

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant psychiatrists and psychiatrists</td>
<td>n/a</td>
<td>22.9</td>
<td>4.1</td>
<td>0.0</td>
<td>0.0</td>
<td>27.0</td>
</tr>
<tr>
<td>Psychiatry registrars and trainees</td>
<td>n/a</td>
<td>15.5</td>
<td>0.6</td>
<td>0.0</td>
<td>0.0</td>
<td>16.0</td>
</tr>
<tr>
<td>Other medical officers</td>
<td>n/a</td>
<td>0.9</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.9</td>
</tr>
<tr>
<td>Psychologists</td>
<td>n/a</td>
<td>20.3</td>
<td>4.5</td>
<td>0.0</td>
<td>0.0</td>
<td>24.8</td>
</tr>
<tr>
<td>Diagnostic and health professionals(b)</td>
<td>n/a</td>
<td>55.9</td>
<td>12.3</td>
<td>0.0</td>
<td>0.0</td>
<td>68.2</td>
</tr>
<tr>
<td>Nurses(c)</td>
<td>n/a</td>
<td>310.6</td>
<td>37.5</td>
<td>0.0</td>
<td>0.0</td>
<td>348.1</td>
</tr>
<tr>
<td>Carer workers(d)</td>
<td>n/a</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Consumer workers(d)</td>
<td>n/a</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Other personal care(e)</td>
<td>n/a</td>
<td>134.8</td>
<td>19.9</td>
<td>0.0</td>
<td>0.0</td>
<td>154.7</td>
</tr>
<tr>
<td>Other staffing categories(f)</td>
<td>n/a</td>
<td>105.7</td>
<td>12.3</td>
<td>0.0</td>
<td>0.0</td>
<td>118.0</td>
</tr>
<tr>
<td><strong>Total</strong>(d)</td>
<td>n/a</td>
<td>666.5</td>
<td>91.2</td>
<td>0.0</td>
<td>0.0</td>
<td>757.7</td>
</tr>
</tbody>
</table>

n/a  Not applicable.

a) Totals may not add due to rounding.
b) Diagnostic and health professionals includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature and covers all allied health professionals and laboratory technicians, including Social Workers, Occupational Therapists and others (METeOR identifier 287611).
c) Includes registered and enrolled nurses.
d) The definition of these categories was modified from ‘consultants’ to ‘mental health workers’ for the 2010–11 collection, in order to capture a variety of contemporary roles.
e) Other personal care staff includes staff engaged primarily in the provision of personal care to patients or residents, not formally qualified, for example attendants, assistants of home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants (METeOR 270171).
f) Other staff includes administrative and clerical and domestic and other staff categories.

Notes:
1. Includes consumer and carer workers and staff employed at a higher organisational level. Excludes staff employed at regional or state level in mental health policy units of the associated relevant health department or equivalent.
## Table 59: TAS: Full-time-equivalent staff, state and territory specialised mental health care facilities, by staffing category, 2011–12

<table>
<thead>
<tr>
<th>Category</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant psychiatrists and psychiatrists</td>
<td>n/a</td>
<td>25.1</td>
<td>4.6</td>
<td>0.1</td>
<td>0.0</td>
<td>29.8</td>
</tr>
<tr>
<td>Psychiatry registrars and trainees</td>
<td>n/a</td>
<td>13.2</td>
<td>2.2</td>
<td>0.1</td>
<td>0.0</td>
<td>15.5</td>
</tr>
<tr>
<td>Other medical officers</td>
<td>n/a</td>
<td>3.7</td>
<td>2.0</td>
<td>0.0</td>
<td>0.0</td>
<td>5.7</td>
</tr>
<tr>
<td>Psychologists</td>
<td>n/a</td>
<td>15.0</td>
<td>4.8</td>
<td>0.1</td>
<td>0.0</td>
<td>19.9</td>
</tr>
<tr>
<td>Diagnostic and health professionals(b)</td>
<td>n/a</td>
<td>59.7</td>
<td>14.8</td>
<td>0.3</td>
<td>0.0</td>
<td>74.8</td>
</tr>
<tr>
<td>Nurses(c)</td>
<td>n/a</td>
<td>283.0</td>
<td>53.2</td>
<td>1.2</td>
<td>0.0</td>
<td>337.5</td>
</tr>
<tr>
<td>Carer workers(d)</td>
<td>n/a</td>
<td>0.4</td>
<td>0.1</td>
<td>0.0</td>
<td>0.0</td>
<td>0.6</td>
</tr>
<tr>
<td>Consumer workers(e)</td>
<td>n/a</td>
<td>1.4</td>
<td>0.1</td>
<td>0.0</td>
<td>0.0</td>
<td>1.5</td>
</tr>
<tr>
<td>Other personal care(e)</td>
<td>n/a</td>
<td>142.9</td>
<td>18.4</td>
<td>0.3</td>
<td>0.0</td>
<td>161.5</td>
</tr>
<tr>
<td>Other staffing categories(f)</td>
<td>n/a</td>
<td>82.6</td>
<td>16.9</td>
<td>0.3</td>
<td>0.0</td>
<td>99.8</td>
</tr>
<tr>
<td>Total(f)</td>
<td>n/a</td>
<td>627.0</td>
<td>117.3</td>
<td>2.4</td>
<td>0.0</td>
<td>746.6</td>
</tr>
</tbody>
</table>

n/a Not applicable.

(a) Totals may not add due to rounding.

(b) Diagnostic and health professionals includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature and covers all allied health professionals and laboratory technicians, including Social Workers, Occupational Therapists and others (METeOR identifier 287611).

(c) Includes registered and enrolled nurses.

(d) The definition of these categories was modified from ‘consultants’ to ‘mental health workers’ for the 2010–11 collection, in order to capture a variety of contemporary roles.

(e) Other personal care staff includes staff engaged primarily in the provision of personal care to patients or residents, not formally qualified, for example attendants, assistants of home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants (METeOR 270171).

(f) Other staff includes administrative and clerical and domestic and other staff categories.

Notes:
1. Includes consumer and carer workers and staff employed at a higher organisational level. Excludes staff employed at regional or state level in mental health policy units of the associated relevant health department or equivalent.
Table 60: TAS: State and territory specialised mental health service activity, by service type, 2007–08

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days(a)</td>
<td>n/a</td>
<td>32,428</td>
<td>5,624</td>
<td>0</td>
<td>0</td>
<td>38,052</td>
</tr>
<tr>
<td>Community mental health care contacts(b)</td>
<td>n/a</td>
<td>79,143</td>
<td>15,306</td>
<td>0</td>
<td>0</td>
<td>94,449</td>
</tr>
<tr>
<td>Residential mental health care days(c)</td>
<td>n/a</td>
<td>43,560</td>
<td>4,526</td>
<td>0</td>
<td>0</td>
<td>48,086</td>
</tr>
</tbody>
</table>

n/a Not applicable.

a) Hospital days, also known as accrued mental health care days for public hospital services, will not equal figures reported from the National hospital morbidity database due to scope differences between the two collections.

b) Community mental health care contacts will not equate to those reported from the Community mental health care database due to differing scope.

c) Residential mental health care days comprises the number of care days provided by all services, including government and non-government operated services, and 24-hour and non-24-hour staffed services. Figures will not equate to those reported from the Residential mental health care database due to differing collection scopes.

Table 61: TAS: State and territory specialised mental health service activity, by service type, 2011–12

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days(a)</td>
<td>n/a</td>
<td>30,542</td>
<td>11,042</td>
<td>575</td>
<td>0</td>
<td>42,159</td>
</tr>
<tr>
<td>Community mental health care contacts(b)</td>
<td>n/a</td>
<td>82,037</td>
<td>15,875</td>
<td>198</td>
<td>0</td>
<td>98,109</td>
</tr>
<tr>
<td>Residential mental health care days(c)</td>
<td>n/a</td>
<td>45,520</td>
<td>3,891</td>
<td>0</td>
<td>0</td>
<td>49,411</td>
</tr>
</tbody>
</table>

n/a Not applicable.

a) Hospital days, also known as accrued mental health care days for public hospital services, will not equal figures reported from the National hospital morbidity database due to scope differences between the two collections.

b) Community mental health care contacts will not equate to those reported from the Community mental health care database due to differing scope. Industrial action in Tasmania in 2011–12 has affected the quality and quantity of Tasmania’s Community mental health care data.

c) Residential mental health care days comprises the number of care days provided by all services, including government and non-government operated services, and 24-hour and non-24-hour staffed services. Figures will not equate to those reported from the Residential mental health care database due to differing collection scopes.
Northern Territory

Table 62: NT: Recurrent expenditure(a)(b) ('$000) on state and territory specialised mental health services, by service type, 2007–08 (constant prices)(c)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(a)(d)</td>
<td>n/a</td>
<td>n/a</td>
<td>9,244</td>
<td>3,718</td>
<td>0</td>
<td>12,963</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>n/a</td>
<td>n/a</td>
<td>9,731</td>
<td>7,389</td>
<td>1,933</td>
<td>19,053</td>
</tr>
<tr>
<td>Residential mental health services</td>
<td>n/a</td>
<td>n/a</td>
<td>530</td>
<td>0</td>
<td>0</td>
<td>530</td>
</tr>
<tr>
<td>All mental health service types</td>
<td>n/a</td>
<td>n/a</td>
<td>19,505</td>
<td>11,107</td>
<td>1,933</td>
<td>32,545</td>
</tr>
</tbody>
</table>

n/a Not applicable.

(a) Expenditure excludes depreciation.
(b) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.
(c) Constant prices are referenced to 2011–12 and are adjusted for inflation.
(d) Totals may not add due to rounding to the nearest $'000.
(e) Includes public hospital services managed and operated by private and non-government entities.
(f) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.
(g) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

Note:
1) The Northern Territory do not have public psychiatric hospitals as defined in the MHE NMDS.

Table 63: NT: Recurrent expenditure(a)(b) ($) per capita(c) on state and territory specialised mental health services, by service type, 2007–08 (constant prices)(d)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(a)(d)(e)</td>
<td>n/a</td>
<td>n/a</td>
<td>79.06</td>
<td>81.31</td>
<td>0</td>
<td>60.64</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>n/a</td>
<td>n/a</td>
<td>83.22</td>
<td>161.59</td>
<td>37.84</td>
<td>89.14</td>
</tr>
<tr>
<td>Residential mental health services</td>
<td>n/a</td>
<td>n/a</td>
<td>4.53</td>
<td>0</td>
<td>0</td>
<td>2.48</td>
</tr>
<tr>
<td>All mental health service types</td>
<td>n/a</td>
<td>n/a</td>
<td>166.80</td>
<td>242.91</td>
<td>37.84</td>
<td>152.26</td>
</tr>
</tbody>
</table>

n/a Not applicable.

(a) Expenditure excludes depreciation.
(b) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.
(c) Crude rate is based on the state and territory estimated resident population by remoteness area as at 30 June 2007.
(d) Totals may not add due to rounding.

Note:
1) The Northern Territory do not have public psychiatric hospitals as defined in the MHE NMDS.
Table 64: NT: Recurrent expenditure\(^{(a)(b)}\) ($’000) on state and territory specialised mental health services, by service type, 2011–12 (current prices)

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(^{(c)})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(d)(e)})</td>
<td>n/a</td>
<td>n/a</td>
<td>10,539</td>
<td>5,365</td>
<td>0</td>
<td>16,004</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>n/a</td>
<td>n/a</td>
<td>12,797</td>
<td>8,184</td>
<td>2,306</td>
<td>23,287</td>
</tr>
<tr>
<td>Residential mental health services(^{(f)})</td>
<td>n/a</td>
<td>n/a</td>
<td>1,486</td>
<td>0</td>
<td>0</td>
<td>1,486</td>
</tr>
<tr>
<td><strong>All mental health service types(^{(g)})</strong></td>
<td>n/a</td>
<td>n/a</td>
<td>24,922</td>
<td>13,549</td>
<td>2,306</td>
<td>40,777</td>
</tr>
</tbody>
</table>

n/a: Not applicable.

(a) Expenditure excludes depreciation.

(b) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.

(c) Totals may not add due to rounding to the nearest $’000.

(d) Includes public hospital services managed and operated by private and non-government entities.

(e) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.

(f) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

(g) Totals may not add due to rounding.

Note:

1) The Northern Territory do not have public psychiatric hospitals as defined in the MHE NMDS.

Table 65: NT: Recurrent expenditure\(^{(a)(b)}\) ($ per capita\(^{(c)}\)) on state and territory specialised mental health services, by service type, 2011–12 (current prices)

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(d)(e)})</td>
<td>n/a</td>
<td>n/a</td>
<td>82.40</td>
<td>110.17</td>
<td>0</td>
<td>69.20</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>n/a</td>
<td>n/a</td>
<td>99.12</td>
<td>168.04</td>
<td>43.12</td>
<td>100.68</td>
</tr>
<tr>
<td>Residential mental health services(^{(f)})</td>
<td>n/a</td>
<td>n/a</td>
<td>11.51</td>
<td>0</td>
<td>0</td>
<td>6.43</td>
</tr>
<tr>
<td><strong>All mental health service types(^{(g)})</strong></td>
<td>n/a</td>
<td>n/a</td>
<td>193.03</td>
<td>278.22</td>
<td>43.12</td>
<td>176.30</td>
</tr>
</tbody>
</table>

n/a: Not applicable.

(a) Expenditure excludes depreciation.

(b) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.

(c) Crude rate is based on the state and territory estimated resident population by remoteness area as at 30 June 2011.

(d) Includes public hospital services managed and operated by private and non-government entities.

(e) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.

(f) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

(g) Totals may not add due to rounding.

Note:

1) The Northern Territory do not have public psychiatric hospitals as defined in the MHE NMDS.
### Table 66: NT: Number of specialised mental health beds, by service type, 2007–08

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialised psychiatric units or wards in public acute hospitals</td>
<td>n/a</td>
<td>n/a</td>
<td>26</td>
<td>8</td>
<td>0</td>
<td>34</td>
</tr>
<tr>
<td>Public psychiatric hospital services</td>
<td>n/a</td>
<td>n/a</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Residential mental health care services</td>
<td>n/a</td>
<td>n/a</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>n/a</td>
<td>n/a</td>
<td>31</td>
<td>8</td>
<td>0</td>
<td>39</td>
</tr>
</tbody>
</table>

**n/a** Not applicable.

### Table 67: NT: Number of specialised mental health beds, by service type, 2011–12

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialised psychiatric units or wards in public acute hospitals</td>
<td>n/a</td>
<td>n/a</td>
<td>26</td>
<td>6</td>
<td>0</td>
<td>32</td>
</tr>
<tr>
<td>Public psychiatric hospital services</td>
<td>n/a</td>
<td>n/a</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Residential mental health care services</td>
<td>n/a</td>
<td>n/a</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>n/a</td>
<td>n/a</td>
<td>41</td>
<td>6</td>
<td>0</td>
<td>47</td>
</tr>
</tbody>
</table>

**n/a** Not applicable.

### Table 68: NT: Full-time-equivalent staff, state and territory specialised mental health care facilities, by staffing category, 2007–08

<table>
<thead>
<tr>
<th>Staffing Category</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant psychiatrists and psychiatrists</td>
<td>n/a</td>
<td>n/a</td>
<td>5.2</td>
<td>2.4</td>
<td>1.1</td>
<td>8.7</td>
</tr>
<tr>
<td>Psychiatry registrars and trainees</td>
<td>n/a</td>
<td>n/a</td>
<td>6.4</td>
<td>1.4</td>
<td>1.0</td>
<td>8.8</td>
</tr>
<tr>
<td>Other medical officers</td>
<td>n/a</td>
<td>n/a</td>
<td>2.0</td>
<td>2.3</td>
<td>0.7</td>
<td>5.0</td>
</tr>
<tr>
<td>Psychologists</td>
<td>n/a</td>
<td>n/a</td>
<td>7.2</td>
<td>3.7</td>
<td>1.6</td>
<td>12.5</td>
</tr>
<tr>
<td>Diagnostic and health professionals(b)</td>
<td>n/a</td>
<td>n/a</td>
<td>11.4</td>
<td>8.7</td>
<td>3.0</td>
<td>23.2</td>
</tr>
<tr>
<td>Nurses(c)</td>
<td>n/a</td>
<td>n/a</td>
<td>60.4</td>
<td>28.5</td>
<td>12.6</td>
<td>101.6</td>
</tr>
<tr>
<td>Carer workers(d)</td>
<td>n/a</td>
<td>n/a</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Consumer workers(d)</td>
<td>n/a</td>
<td>n/a</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Other personal care(d)</td>
<td>n/a</td>
<td>n/a</td>
<td>6.3</td>
<td>1.0</td>
<td>0.5</td>
<td>7.8</td>
</tr>
<tr>
<td>Other staffing categories(e)</td>
<td>n/a</td>
<td>n/a</td>
<td>12.8</td>
<td>8.5</td>
<td>3.2</td>
<td>24.5</td>
</tr>
<tr>
<td><strong>Total</strong>(d)</td>
<td>n/a</td>
<td>n/a</td>
<td>111.7</td>
<td>56.6</td>
<td>23.7</td>
<td>192.0</td>
</tr>
</tbody>
</table>

**a)** Totals may not add due to rounding.

**b)** Diagnostic and health professionals includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature and covers all allied health professionals and laboratory technicians, including Social Workers, Occupational Therapists and others (METeOR identifier 287611).

**c)** Includes registered and enrolled nurses.

**d)** The definition of these categories was modified from ‘consultants’ to ‘mental health workers’ for the 2010–11 collection, in order to capture a variety of contemporary roles.
e) Other personal care staff includes staff engaged primarily in the provision of personal care to patients or residents, not formally qualified, for example attendants, assistants of home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants (METeOR 270171).

f) Other staff includes administrative and clerical and domestic and other staff categories.

Notes:
1. Includes consumer and carer workers and staff employed at a higher organisational level. Excludes staff employed at regional or state level in mental health policy units of the associated relevant health department or equivalent.
2. Domestic staff FTE figures are not available for the Northern Territory.

Table 69: NT: Full-time-equivalent staff, state and territory specialised mental health care facilities, by staffing category, 2011–12

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant psychiatrists and psychiatrists</td>
<td>n/a</td>
<td>n/a</td>
<td>5.9</td>
<td>7.4</td>
<td>2.2</td>
<td>15.5</td>
</tr>
<tr>
<td>Psychiatry registrars and trainees</td>
<td>n/a</td>
<td>n/a</td>
<td>9.0</td>
<td>3.9</td>
<td>1.8</td>
<td>14.7</td>
</tr>
<tr>
<td>Other medical officers</td>
<td>n/a</td>
<td>n/a</td>
<td>0.8</td>
<td>0.1</td>
<td>0.1</td>
<td>1.0</td>
</tr>
<tr>
<td>Psychologists</td>
<td>n/a</td>
<td>n/a</td>
<td>8.5</td>
<td>3.0</td>
<td>1.6</td>
<td>13.2</td>
</tr>
<tr>
<td>Diagnostic and health professionals(b)</td>
<td>n/a</td>
<td>n/a</td>
<td>16.2</td>
<td>10.2</td>
<td>3.9</td>
<td>30.3</td>
</tr>
<tr>
<td>Nurses(c)</td>
<td>n/a</td>
<td>n/a</td>
<td>68.2</td>
<td>36.0</td>
<td>15.0</td>
<td>119.3</td>
</tr>
<tr>
<td>Carer workers(d)</td>
<td>n/a</td>
<td>n/a</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Consumer workers(d)</td>
<td>n/a</td>
<td>n/a</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Other personal care(e)</td>
<td>n/a</td>
<td>n/a</td>
<td>18.7</td>
<td>2.6</td>
<td>0.9</td>
<td>22.1</td>
</tr>
<tr>
<td>Other staffing categories(f)</td>
<td>n/a</td>
<td>n/a</td>
<td>15.2</td>
<td>11.0</td>
<td>3.9</td>
<td>30.1</td>
</tr>
<tr>
<td>Total(g)</td>
<td>n/a</td>
<td>n/a</td>
<td>142.5</td>
<td>74.3</td>
<td>29.3</td>
<td>246.1</td>
</tr>
</tbody>
</table>

Notes:
1. Totals may not add due to rounding.
2. Diagnostic and health professionals includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature and covers all allied health professionals and laboratory technicians, including Social Workers, Occupational Therapists and others (METeOR identifier 287611).
3. Includes registered and enrolled nurses.
4. The definition of these categories was modified from ‘consultants’ to ‘mental health workers’ for the 2010–11 collection, in order to capture a variety of contemporary roles.
5. Other personal care staff includes staff engaged primarily in the provision of personal care to patients or residents, not formally qualified, for example attendants, assistants of home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants (METeOR 270171).
6. Other staff includes administrative and clerical and domestic and other staff categories.

Notes:
1. Includes consumer and carer workers and staff employed at a higher organisational level. Excludes staff employed at regional or state level in mental health policy units of the associated relevant health department or equivalent.
2. Domestic staff FTE figures are not available for the Northern Territory.

Table 70: NT: State and territory specialised mental health service activity, by service type, 2007–08

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days(h)</td>
<td>n/a</td>
<td>n/a</td>
<td>7,850</td>
<td>3,140</td>
<td>0</td>
<td>10,990</td>
</tr>
<tr>
<td>Community mental health care contacts(i)</td>
<td>n/a</td>
<td>n/a</td>
<td>25,484</td>
<td>9,929</td>
<td>1,428</td>
<td>36,841</td>
</tr>
<tr>
<td>Residential mental health care days(j)</td>
<td>n/a</td>
<td>n/a</td>
<td>1,737</td>
<td>0</td>
<td>0</td>
<td>1,737</td>
</tr>
</tbody>
</table>

n/a Not applicable.
a) Hospital days, also known as accrued mental health care days for public hospital services, will not equal figures reported from the National hospital morbidity database due to scope differences between the two collections.

b) Community mental health care contacts will not equate to those reported from the Community mental health care database due to differing scope.

c) Residential mental health care days comprises the number of care days provided by all services, including government and non-government operated services, and 24-hour and non-24-hour staffed services. Figures will not equate to those reported from the Residential mental health care database due to differing collection scopes.

Table 71: NT: State and territory specialised mental health service activity, by service type, 2011–12

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days&lt;sup&gt;a&lt;/sup&gt;</td>
<td>n/a</td>
<td>n/a</td>
<td>8,617</td>
<td>1,872</td>
<td>0</td>
<td>10,489</td>
</tr>
<tr>
<td>Community mental health care contacts&lt;sup&gt;b&lt;/sup&gt;</td>
<td>n/a</td>
<td>n/a</td>
<td>30,990</td>
<td>15,924</td>
<td>1,955</td>
<td>48,869</td>
</tr>
<tr>
<td>Residential mental health care days&lt;sup&gt;c&lt;/sup&gt;</td>
<td>n/a</td>
<td>n/a</td>
<td>4,828</td>
<td>0</td>
<td>0</td>
<td>4,828</td>
</tr>
</tbody>
</table>

n/a Not applicable.

a) Hospital days, also known as accrued mental health care days for public hospital services, will not equal figures reported from the National hospital morbidity database due to scope differences between the two collections.

b) Community mental health care contacts will not equate to those reported from the Community mental health care database due to differing scope.

c) Residential mental health care days comprises the number of care days provided by all services, including government and non-government operated services, and 24-hour and non-24-hour staffed services. Figures will not equate to those reported from the Residential mental health care database due to differing collection scopes.
Appendix 1

Australian Capital Territory

The ACT declined to provide data for this report. The data presented here has been sourced from the publically available data published on the Mental health services in Australia website: http://mhsa.aihw.gov.au/home/ as requested by the NMHC.

It should be noted that the data presented here were calculated using different methodology to the data presented for the other jurisdictions presented in this report and readers are advised to read associated footnotes and caveats.

Table 72: ACT: Recurrent expenditure\(^{(a)(b)}\) ($'000) on state and territory specialised mental health services, by service type, 2007–08 (constant prices)\(^{(c)}\)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(^{(d)})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital services(^{(e)(f)})</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>17,792</td>
</tr>
<tr>
<td>Residential mental health services(^{(g)})</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>8,477</td>
</tr>
<tr>
<td>All mental health service types(^{(h)})</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>67,911</td>
</tr>
</tbody>
</table>

\(n.p.\) Not published.

\((a)\) Expenditure excludes depreciation.

\((b)\) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.

\((c)\) Constant prices are referenced to 2011–12 and are adjusted for inflation.

\((d)\) Totals may not add due to rounding to the nearest $'000.

\((e)\) Includes public hospital services managed and operated by private and non-government entities.

\((f)\) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.

\((g)\) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

Source: National Mental Health Establishments Database.

Table 73: ACT: Recurrent expenditure\(^{(a)(b)}\) ($) per capita\(^{(c)}\) on state and territory specialised mental health services, by service type, 2007–08 (constant prices)\(^{(d)}\)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
</table>

\(n.p.\) Not published.

\((a)\) Expenditure excludes depreciation.
(b) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.

(c) Crude rate is based on the state and territory estimated resident population by remoteness area as at 31 December 2007.

(d) Constant prices are referenced to 2011–12 and are adjusted for inflation.

(e) Includes public hospital services managed and operated by private and non-government entities.

(f) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.

(g) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

(h) Totals may not add due to rounding.

Source: National Mental Health Establishments Database.

Table 74: ACT: Recurrent expenditure\(^{(a)(b)}\) (\(\$'000\)) on state and territory specialised mental health services, by service type, 2011–12 (current prices)

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(^{(c)})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential mental health services(^{(f)})</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>11,014</td>
</tr>
<tr>
<td>All mental health service types(^{(g)})</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>65,895</td>
</tr>
</tbody>
</table>


(a) Expenditure excludes depreciation.

(b) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.

(c) Totals may not add due to rounding to the nearest $'000.

(d) Includes public hospital services managed and operated by private and non-government entities.

(e) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.

(f) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

Source: National Mental Health Establishments Database.

Table 75: ACT: Recurrent expenditure\(^{(a)(b)}\) (\(\$\)) per capita\(^{(c)}\) on state and territory specialised mental health services, by service type, 2011–12 (current prices)

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community mental health services</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>95.54</td>
</tr>
<tr>
<td>Residential mental health services(^{(f)})</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>29.69</td>
</tr>
</tbody>
</table>


(a) Expenditure excludes depreciation.

(b) Expenditure excludes grants to non-government organisations and indirect expenditure at the state/territory, region and organisation levels not apportioned to service units.

(c) Crude rate is based on the state and territory estimated resident population by remoteness area as at 31 December June 2011.
(d) Includes public hospital services managed and operated by private and non-government entities.

(e) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospitals outpatient departments are included in community mental health care services.

(f) Residential mental health services include the total operating costs for partially or wholly government funded non-government-operated residential mental health services.

(g) Totals may not add due to rounding.

Source: National Mental Health Establishments Database.

Table 76: ACT: Number of specialised mental health beds, by service type, 2007–08

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialised psychiatric units or wards in public acute hospitals</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>70</td>
</tr>
<tr>
<td>Public psychiatric hospital services</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>0</td>
</tr>
</tbody>
</table>


Source: National Mental Health Establishments Database.

Table 77: ACT: Number of specialised mental health beds, by service type, 2011–12

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialised psychiatric units or wards in public acute hospitals</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>65</td>
</tr>
<tr>
<td>Public psychiatric hospital services</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>0</td>
</tr>
<tr>
<td>Residential mental health care services</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>82</td>
</tr>
</tbody>
</table>


Source: National Mental Health Establishments Database.
Table 78: ACT: Full-time-equivalent staff, state and territory specialised mental health care facilities, by staffing category, 2007–08

<table>
<thead>
<tr>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatry registrars and trainees</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>16.5</td>
</tr>
<tr>
<td>Other medical officers</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>1.4</td>
</tr>
<tr>
<td>Psychologists</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>48.9</td>
</tr>
<tr>
<td>Diagnostic and health professionals(b)</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>31.5</td>
</tr>
<tr>
<td>Nurses(c)</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>169.4</td>
</tr>
<tr>
<td>Carer workers(d)</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>0.0</td>
</tr>
<tr>
<td>Consumer workers(d)</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>0.0</td>
</tr>
<tr>
<td>Other personal care(e)</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>32.2</td>
</tr>
<tr>
<td>Other staffing categories(e)</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>62.3</td>
</tr>
<tr>
<td><strong>Total(f)</strong></td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>377.0</td>
</tr>
</tbody>
</table>


a) Totals may not add due to rounding.

b) Diagnostic and health professionals includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature and covers all allied health professionals and laboratory technicians, including Social Workers, Occupational Therapists and others (METeOR identifier 287611).

c) Includes registered and enrolled nurses.

d) The definition of these categories was modified from ‘consultants’ to ‘mental health workers’ for the 2010–11 collection, in order to capture a variety of contemporary roles.

e) Other personal care staff includes staff engaged primarily in the provision of personal care to patients or residents, not formally qualified, for example attendants, assistants of home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants (METeOR 270171).

f) Other staff includes administrative and clerical and domestic and other staff categories.

Notes:

1. Includes consumer and carer workers and staff employed at a higher organisational level. Excludes staff employed at regional or state level in mental health policy units of the associated relevant health department or equivalent.

Source: National Mental Health Establishments Database.
Table 79: ACT: Full-time-equivalent staff, state and territory specialised mental health care facilities, by staffing category, 2011–12

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total(a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatry registrars and trainees</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>17.2</td>
</tr>
<tr>
<td>Other medical officers</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>0.8</td>
</tr>
<tr>
<td>Diagnostic and health professionals(b)</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>39.1</td>
</tr>
<tr>
<td>Nurses(c)</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>171.9</td>
</tr>
<tr>
<td>Carer workers(d)</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>0.0</td>
</tr>
<tr>
<td>Consumer workers(d)</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>0.0</td>
</tr>
<tr>
<td>Other staffing categories(f)</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>67.6</td>
</tr>
<tr>
<td>Total(a)</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>412.6</td>
</tr>
</tbody>
</table>


a) Totals may not add due to rounding.

b) Diagnostic and health professionals includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature and covers all allied health professionals and laboratory technicians, including Social Workers, Occupational Therapists and others (METeOR identifier 287611).

c) Includes registered and enrolled nurses.

d) The definition of these categories was modified from ‘consultants’ to ‘mental health workers’ for the 2010–11 collection, in order to capture a variety of contemporary roles.

e) Other personal care staff includes staff engaged primarily in the provision of personal care to patients or residents, not formally qualified, for example attendants, assistants of home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants (METeOR 270171).

f) Other staff includes administrative and clerical and domestic and other staff categories.

Notes:
1. Includes consumer and carer workers and staff employed at a higher organisational level. Excludes staff employed at regional or state level in mental health policy units of the associated relevant health department or equivalent.

Sources: National Mental Health Establishments Database.

Table 80: ACT: State and territory specialised mental health service activity, by service type, 2007–08

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days[a]</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>n.p.</td>
<td>18,539</td>
</tr>
</tbody>
</table>


a) Hospital days, also known as accrued mental health care days for public hospital services, will not equal figures reported from the National hospital morbidity database due to scope differences between the two collections.
b) The Community mental health care contacts reported here are sourced from the National Community Mental Health Care Database and are not directly comparable with the results reported for other jurisdictions from the Mental Health Establishment database due to differing scope.

c) Residential mental health care days comprises the number of care days provided by all services, including government and non-government operated services, and 24-hour and non-24-hour staffed services. Figures will not equate to those reported from the Residential mental health care database due to differing collection scopes.

Sources: National Mental Health Establishments Database and National Community Mental Health Care Database.

Table 81: ACT: State and territory specialised mental health service activity, by service type, 2011–12

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
<th>Total</th>
</tr>
</thead>
</table>


a) Hospital days, also known as accrued mental health care days for public hospital services, will not equal figures reported from the National hospital morbidity database due to scope differences between the two collections.

b) The Community mental health care contacts reported here are sourced from the National Community Mental Health Care Database and are not directly comparable with the results reported for other jurisdictions from the Mental Health Establishment database due to differing scope.

c) Residential mental health care days comprises the number of care days provided by all services, including government and non-government operated services, and 24-hour and non-24-hour staffed services. Figures will not equate to those reported from the Residential mental health care database due to differing collection scopes.

Sources: National Mental Health Establishments Database and National Community Mental Health Care Database.
Paper 5: Characteristics of people using mental health services and prescription medication, 2011

The following paper presents the Australian Bureau of Statistics initial findings of the Mental Health Services-Census Data Integration project. This project was sponsored by the Commission to support the Review, and linked Census data with Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) administrative information. This provided the Commission with new insights on the characteristics of people using mental health services and prescription medication, and will inform the development and evaluation of mental health programmes and support services now and into the future. This paper and data tables are available on the Australian Bureau of Statistics website.
Characteristics of people using mental health services and prescription medication, 2011

4329.0

Released 28 October 2014
SUMMARY

Introduction

The Mental Health Services-Census Data Integration project brings together for the first time the breadth of the 2011 Census data with administrative information on people accessing subsidised mental health-related Medicare Benefits Schedule (MBS) services and Pharmaceutical Benefits Scheme (PBS) prescription medication.

This project was initiated on behalf of the National Mental Health Commission (NMHC) with the aim of informing the National Review of Mental Health Services and Programmes (the Review). The focus of the Review is 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’ (Endnote 1).

Integrating a selected subset of data items from the Medical Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS) and the 2011 Census of Population and Housing (Census) has greatly increased the power of the data to support analysis of the circumstances and characteristics of people experiencing mental ill-health as they interact with the health care system. The Mental Health Services-Census Integrated Dataset includes people who responded to the 2011 Census and those who accessed subsidised mental health-related items listed on the MBS or PBS in 2011. For more information on these datasets, see Explanatory notes.

This project will contribute significantly to the pool of mental health-related data available in Australia to assist in the development and evaluation of mental health programs and support services now and into the future. Questions can be answered about people accessing subsidised mental health-related services and medications with evidence that up until now has not been available. For example, analysis of the integrated data will answer questions about the relationship between mental health-related services, medication use, and key socio-economic information such as education, employment and housing.

The confidentiality of these data are protected by the Census and Statistics Act (1905) and the Privacy Act (1988). MBS and PBS information provided by the Department of Health and the Department of Human Services to the ABS is treated in the strictest confidence as is required by the National Health Act (1953), and the Health Insurance Act (1973).
Overview

Good mental health is a crucial aspect of good general health, and underpins a productive and inclusive society. Mental health and illness result from the complex interplay of biological, social, psychological, environmental and economic factors at all levels (Endnote 2).

The information in this publication relates to people who actually accessed either an MBS mental health-related service or a PBS subsidised medication in 2011. (For more information, please refer to the Explanatory Notes). As the following graph shows, the age structure of these two groups was quite different.

Graph 1 shows the proportion of the population in each age group that accessed a subsidised mental health-related service or medication in 2011.

Graph 1: Proportion of Australian population who accessed subsidised mental health-related MBS services and PBS medication -- 2011, by Age

The proportion of the population accessing PBS subsidised mental health-related prescription medications increased with age, with over one-third (34%) of all people aged 75 years and over accessing one or more of these drugs in 2011. By comparison, a higher proportion of people aged 15-64 years accessed MBS subsidised mental health-related services compared with people younger or older than this age group.
In 2011, there were over 1.5 million people who accessed MBS subsidised mental health-related services provided by psychiatrists, general practitioners (GPs), psychologists and other allied health professionals such as mental health nurses, occupational therapists, social workers and Aboriginal health workers.

**MBS Demographics**

**Age and Sex**

Graph 2 shows the proportion of each age group of males and females in Australia who accessed MBS subsidised mental health-related services in 2011.

Females were more likely to access MBS subsidised mental health-related services than males with around 9% of all Australian females accessing services in 2011 compared with 6% of all males. Overall, a higher proportion of people aged 15-64 years accessed these subsidised mental health-related services compared with people younger or older than this age group.

Graph 2: Proportion of Australian population accessing MBS subsidised mental health-related services -- 2011, by Age and Sex
Provider type

As Graph 3 shows, for both females and males, General Practitioners (GPs) were the most common service provider with over 1.2 million Australians attending a GP in 2011 for a subsidised mental health-related service. Around 7% of all females and 4% of all males attended the GP. Psychologists were the next most common service provider for both females and males (4% of all females and 2.4% of all males).

Graph 3: Proportion of Australian population accessing MBS subsidised mental health-related services -- 2011, by Provider Type and Sex

State and Regional Differences

In 2011, Victoria, NSW, South Australia and Queensland had similar rates of subsidised mental health-related services (around 7 to 8% of all people in each State). People in Major Cities and Inner Regional areas were more likely to access one of these services than people living outside of these areas. As with the national pattern, GPs were the most common service provider across all of the remoteness areas.

Socioeconomic Circumstances

The Index of Relative Socio-economic Disadvantage (IRSD) is a general socio-economic index that summarises a range of information about the economic and social conditions of people and households within an area. By using the IRSD from the Census and combining it with the MBS data it is possible to determine the socio-economic patterns amongst those who accessed subsidised mental health-related services.

In 2011, of all people living in the most disadvantaged areas, 6.2% accessed a subsidised mental health-related service from a GP, followed by 2.9% accessing a psychologist and 1.3% accessing a psychiatrist. Of all people living in areas of least disadvantage, 5.2% accessed a subsidised mental health-related service provided by a GP, followed by 3.6% accessing a psychologist and 1.7% accessing a psychiatrist.
MBS Work and Education

Education

Education and training are important means by which individuals can realise their full potential and make positive choices about their wellbeing. Education and training are often essential to gaining paid employment, and can provide the pathway to a rewarding career (Endnote 3).

Overall, there was little difference in the proportion of the population accessing a subsidised mental health-related service in 2011 by highest level of educational attainment. Of the 3 million Australians aged 15-64 years whose highest level of education was a Bachelor degree or higher, 9.5% accessed a subsidised mental health-related service in 2011, with a similar rate (9.8%) for those with Year 11 or below. However, people with a Bachelor degree or higher were more likely to see a clinical psychologist (2.1%) and psychiatrist (2.2%) than people with Year 11 or below (1.3% and 1.7% respectively).

Graph 4: Proportion of Australian population aged 15-64 years accessing MBS subsidised mental health-related services -- 2011, by Level of Highest Educational Attainment and Provider Type
Employment

Paid employment is a major source of economic resources and security for most individuals. It allows people to contribute to their community and it can enhance their skills, social networks and identity (Endnote 3).

Generally, participation in the labour force tends to be lower in the teenage years, before rising in the twenties as people complete their educational qualifications and begin a career. The rate for men tends to stay quite high until they reach their late fifties and into their sixties, when many men retire. For women, the labour force participation rate tends to dip during the peak child-bearing years (between 25 and 44 years) (Endnote 4).

In 2011, of all employed Australians aged 15-64 years, 8.2% accessed subsidised mental health-related services, compared with 12.6% of all people who were unemployed and 12.4% of all people who were not in the labour force.

Unemployed people aged 15-64 years were more likely to see a psychiatrist (2.3%) than were employed people (1.4%) within this age group.

Graph 5: Proportion of Australian population aged 15-64 years accessing MBS subsidised mental health-related services -- 2011, by Labour Force Status and Provider Type
In 2011, there were over 2.3 million people who accessed PBS subsidised mental health-related medications which included: Antipsychotics, Anxiolytics, Hypnotics and Sedatives, Antidepressants and Psychostimulants and Nootropics (please see Explanatory Notes for more details).

**PBS Demographics**

**Age and Sex**

In 2011, females were more likely to access PBS subsidised mental health-related medications than males with 13.3% of all Australian females accessing these drugs compared with 8.5% of all males. The proportion of the population accessing these medications increased with increasing age, with over one-third (34%) of all people aged 75 years and over accessing one or more of these drugs in 2011.

Graph 6: Proportion of Australian population accessing PBS subsidised mental health-related prescription medication - 2011, by Age and Sex
Prescription Medication Type

For females, Antidepressants were the most common drug type (around 10% of all females), followed by Anxiolytics (3.1%) and Hypnotics and Sedatives (2.9%). For males, Antidepressants were also the most common type of drug prescribed although the rate was lower than for females (5.6%).

Graph 7: Proportion of Australian population accessing PBS subsidised mental health-related prescription medication - 2011, by Drug Type and Sex

State and Regional Differences

Care must be taken when analysing the differences among states and regions as any differences may reflect the underlying age structure within the geographical area. In general, the populations outside Major Cities such as Inner Regional and Outer Regional areas have older age structures than the Major Cities and Remote/Very Remote areas. Also, the PBS data does not have complete coverage with some groups under-represented, particularly people in the Aboriginal Health Services program. Data for Remote, Very Remote and the Northern Territory are particularly affected (see Explanatory notes for further detail).

In 2011, Tasmania (14.5%) had the highest proportion of the population accessing a PBS subsidised mental health-related prescription medication, reflecting in part the underlying older age structure of the State. Similarly, people living in Inner and Outer regional areas also tend to be older and again these regions had higher proportions of people accessing mental health-related prescription medication (13.5% and 12% respectively) than Major Cities (10.3%) which have a younger age profile.
Socioeconomic Circumstances

The Index of Relative Socio-economic Disadvantage (IRSD) is a general socio-economic index that summarises a range of information about the economic and social conditions of people and households within an area. By using the IRSD from the Census and combining it with the PBS data it is possible to determine the socio-economic patterns amongst those who use subsidised mental health-related prescription medication.

In 2011, of all people living in the most disadvantaged areas, 15.4% accessed a PBS subsidised mental health-related medication, most commonly Antidepressants (10.8% of all people living in these areas). Of all people living in the least disadvantaged areas, 7.2% accessed a PBS subsidised mental health-related medication, again most commonly Antidepressants (5.2% of all people living in these areas).
PBS Work and Education

Education

Education and training are important means by which individuals can realise their full potential and make positive choices about their wellbeing. Education and training are often essential to gaining paid employment, and can provide the pathway to a rewarding career (Endnote 3).

Of the 3 million Australians aged 15-64 years whose highest level of education was a Bachelor degree or higher, 6.4% accessed a PBS subsidised mental health-related medication in 2011.

Of the 3.7 million Australians aged 15-64 years whose highest level of education was Year 11 or below, 14.5% accessed a PBS subsidised mental health-related medication in 2011.

Antidepressants were the most commonly used medication across all levels of educational attainment.

Graph 8: Proportion of Australian population aged 15-64 years accessing PBS subsidised mental health-related prescription medication -- 2011, by Level of Highest Educational Attainment and Drug Type
Employment

Paid employment is a major source of economic resources and security for most individuals. It allows people to contribute to their community and it can enhance their skills, social networks and identity (Endnote 3).

Generally, participation in the labour force tends to be lower in the teenage years, before rising in the twenties as people complete their educational qualifications and begin a career. The rate for men tends to stay quite high until they reach their late fifties and into their sixties, when many men retire. For women, the labour force participation rate tends to dip during the peak child-bearing years between ages 25 and 44 years (Endnote 4).

In 2011, of all employed Australians aged 15-64 years, 6.6% accessed subsidised mental health-related medications, compared with 13.3% of all people who were unemployed and 20% of all people who were not in the labour force.

In particular, people aged 35 years and over who were not in the labour force were more likely to access a subsidised PBS mental health-related medication than people who were employed or unemployed.

Graph 9: Proportion of Australian population aged 15-64 years accessing PBS subsidised mental health-related prescription medication - 2011, by Age and Labour Force Status
ENDNOTES


ABOUT THIS RELEASE

The Mental Health Services-Census Data Integration project used statistical techniques to link person-records from a selected subset of data items from the Medical Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) to the 2011 Census of Population and Housing to create the Mental Health Services-Census Dataset, 2011. This publication provides a cross-section of key results from the linked dataset. It provides an overview of selected social and economic characteristics of people using subsidised mental health-related services and subsidised prescription medication including the type of services or medication these people are accessing.
EXPLANATORY NOTES

INTRODUCTION

The Mental Health Services-Census Data Integration project combined data from 2011 Census of Population and Housing with a subset of data from the Medical Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS). De-identified transaction information from the MBS and PBS was transformed to person-level information. Probabilistic linkage techniques were used to combine this information with person-records from the Census to create the new dataset.

The Mental Health Services-Census Integrated Dataset, 2011 comprises persons who accessed subsidised mental health-related MBS services or subsidised PBS prescription medications and responded to the Census in 2011.

DATA

The data were produced using the following data sources:

a) 2011 Census of Population and Housing

The 2011 Census measured the number and key characteristics of people who were in Australia on Census night 9 August 2011. For information about the 2011 Census please refer to Census 2011 Reference and Information and Census Data Quality on the ABS website.

b) Medicare Benefits Schedule Data

The Department of Human Services collects data on the activity of all persons making claims through the Medicare Benefits Scheme and provides this information to the Department of Health. Information collected includes the type of service provided (MBS item number) and the benefit paid by Medicare for the service. The item numbers and benefits paid by Medicare are based on the Medicare Benefits Schedule (MBS) which is a listing of the Medicare services subsidised by the Australian Government. The Mental Health Services-Census Integrated Dataset includes MBS mental health-related services as defined in Appendix A.

c) Pharmaceutical Benefits Scheme Data

The Department of Human Services provides data on prescriptions funded through the Pharmaceutical Benefits Scheme (PBS) to the Department of Health. The PBS lists all of the medicines available to be dispensed to patients at a Government-subsidised price. The Government is advised by the Pharmaceutical Benefits Advisory Committee (PBAC) regarding which drugs should be listed on the PBS Scheme. The Mental Health Services-Census Integrated Dataset includes those PBS mental health-related medications as defined in Appendix B.

SCOPE

The scope of the data is restricted to persons who responded to the 2011 Census of Population and Housing AND accessed subsidised mental health-related items listed on the MBS or PBS datasets in 2011 (see Appendix A and B).
The data excludes:

- Persons whose Census record indicated that they were an overseas visitor;
- Persons who were out of the country on Census night; and
- Persons who did not return a Census form.

In addition the data excludes:

- Persons who received services provided by hospital doctors to public patients in public hospitals, or services that qualify for a benefit under the Department of Veterans’ Affairs National Treatment Account;
- The Repatriation Pharmaceutical Benefits Scheme which is subsidised by the Department of Veterans’ Affairs;
- Persons who were supplied medications or accessed services only through programs that do not use the Medicare processing system, for example Aboriginal and Torres Strait Islander Health Programmes;
- Persons accessing private prescription drugs, over the counter drugs, drugs that cost less than the co-payment.

These exclusions are discussed further in the Data Quality section.

**LINKAGE RESULTS**

At the completion of the linkage process:

- 1,072,284 person-records (69.6%) of the 1,540,836 person-records on the MBS dataset were linked to the 2011 Census; and
- 1,669,278 person-records (70.9%) of the 2,354,118 person-records on the PBS dataset were linked to the 2011 Census.

**METHODOLOGY**

**DATA INTEGRATION: OVERVIEW**

Statistical data integration involves combining information from different administrative and/or statistical sources to provide new datasets for statistical and research purposes (Endnote 5).

Data linking is a key part of statistical data integration and involves the technical process of combining records from different source datasets using variables that are shared between the sources. Data linkage is typically performed on records that represent individual persons, rather than aggregates. Two common methods used to link records are deterministic and probabilistic linkage. Deterministic linkage links person-records on exact matches using a unique identifier (such as a social security number or a created unique identifier such as a linkage key). Probabilistic linkage links person-records on close matches based on the relative likelihood that two records refer to the same person, using a number of linking variables (such as date of birth, sex, geographic area).

For further information on data integration see Glossary and the National Statistical Service website – Data Integration.

**DATA INTEGRATION METHOD**

The Department of Health provided the ABS with de-identified MBS and de-identified PBS data extracts, while the Department of Human Services extracted and provided the associated de-identified demographic data extract on behalf of the Department of Health. This data was de-identified in that it did not include name, address, Medicare Number or Pharmaceutical Benefits number. ABS then transformed this administrative data from transaction-level to person-level.
Data from the 2011 Census, and the transformed MBS and PBS data, were brought together using probabilistic linkage. The variables used to link the MBS and PBS data to the Census were Date of Birth, Sex and Mesh Block. The method involved linking without the use of name and address; this information was destroyed at the end of the 2011 Census processing cycle.

The process also placed importance on accuracy and uniqueness. Only records that matched exactly on the linkage variables and were unique matches were retained. In this linkage project, a unique match was defined as instances where a record on the MBS or PBS file had only one matching record on the Census, and that same Census record does not match to any other record on the MBS or PBS file.

Before records between datasets are compared, the contents of the linking variables of each dataset need to be as consistent as possible to facilitate comparison. This process is known as standardisation. The standardisation procedure for the Mental Health Services-Census Data Integration project included coding imputed and invalid values on the data to a common missing value. These variables included Date of birth, Age, Sex, Mesh Block, Statistical Area Level 1 (SA1) and Postcode.

Table 1 lists the variables used to link in each pass. Each record pair required exact matching of all variables used in the pass in order for a link to be created.

Table 1 Linking variables used for each pass

<table>
<thead>
<tr>
<th></th>
<th>PASS 1</th>
<th>PASS 2</th>
<th>PASS 3</th>
<th>PASS 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Mesh Block</td>
<td>Y</td>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>SA1</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Postcode</td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
</tr>
</tbody>
</table>

REPRESENTATIVENESS

The linkage rates that were achieved for the MBS and PBS datasets were in line with expected results, and were relatively consistent across most sub-populations – the exceptions were Northern Territory, Remote, Very Remote, and younger adults, which had lower linkage rates.

LINKAGE ACCURACY

False links can occur during the linkage process because, even when a record pair matches on all linking fields, the records may not actually belong to the same individual. While the methodology is designed to ensure that the majority of links are true some false links will be present within the dataset.
UNLINKED RECORDS

There are three main reasons why records from the MBS and PBS datasets were not linked to a 2011 Census record:

1. Records belonging to the same individual were present in the MBS or PBS dataset and the 2011 Census but these records failed to be linked because they contained missing or inconsistent information in one or more of the datasets.

2. There was no 2011 Census record corresponding to an MBS or PBS record because the person was not counted in the Census.

3. There were more than one Census records that agreed on the same linkage variables – only unique matches were retained.

WEIGHTING

Some groups of records were more likely to link, or conversely less likely to link, than other groups of records. This resulted in over representation of some groups and under representation of others. Records are more difficult to link when a person has poorly reported, poorly coded, missing or non-applicable values for linking variables. The non-random distribution of links has the potential to cause bias.

To compensate for differences in propensity to link, the data were weighted to represent the original MBS or PBS dataset.

Weighting is the process of adjusting a sample to infer results for the relevant population. To do this, a ‘weight’ is allocated to each sample unit - in this case, persons. The weight can be considered an indication of how many people in the relevant population are represented by each person in the sample.

For this project, estimates were created by weighting the linked records to represent the original MBS or PBS dataset, using: Age group, Sex, State/Territory, Remoteness Area, SEIFA, broad groups for services and medication. For a relatively small number of records some of these variables were imputed for weighting purposes.

DATA QUALITY

All data collections are subject to sampling and non-sampling error. Non-sampling error may occur in any data collection. Possible sources of non-sampling error include errors in reporting or recording of information, occasional errors in coding and processing data, and errors introduced by the linkage process (discussed above).

A small number of geographies (State and Remoteness Area) were imputed, and a very small number of unusual records were removed prior to linkage.

MBS DATA

The Department of Human Services collects data on the activity of all persons making claims through the Medicare Benefits Scheme and provides this information to the Department of Health. Information collected includes the type of service provided (MBS item number) and the benefit paid by Medicare for the service. The item numbers and benefits paid by Medicare are based on the Medicare Benefits Schedule (MBS) which is a listing of the Medicare services subsidised by the Australian Government.
MBS data includes Medicare-subsidised mental health-related services provided by psychiatrists, general practitioners (GPs), psychologists and other allied health professionals—including mental health nurses, occupational therapists, some social workers, and Aboriginal health workers. These services are defined in the Medicare Benefits Schedule (MBS) (See Appendix A).

Medicare data covers services that are provided out-of-hospital (e.g. in doctors’ consulting rooms) as well as in-hospital services provided to private patients whether they are treated in a private or public hospital. The figures do not include services provided to public patients in public hospitals or services that qualify for a benefit under the Department of Veterans Affairs National Treatment Account. The States and Territories are the custodians of public hospital data (Endnote 6).

For further information (Endnote 7).

PBS DATA

The Department of Human Services provides data on prescriptions funded through the Pharmaceutical Benefits Scheme (PBS) to the Department of Health. The PBS lists all of the medicines available to be dispensed to patients at a Government-subsidised price. The Government is advised by the Pharmaceutical Benefits Advisory Committee (PBAC) regarding which drugs should be listed on the PBS Scheme.

PBS data include subsidised prescription medication from the following groups: Antipsychotics, Anxiolytics, Hypnotics and Sedatives, Antidepressants, Psychostimulants, agents used for ADHD and Nootopics (See Appendix B).

The data refer only to prescriptions scripted by registered medical practitioners who are approved to work within the PBS and to paid services processed from claims presented by approved pharmacists who comply with certain conditions. They exclude adjustments made against pharmacists’ claims, any manually paid claims or any benefits paid as a result of retrospective entitlement or refund of patient contributions (Endnote 8).

The PBS data exclude non-subsidised medications, such as private and over-the-counter medications. Under co-payment prescriptions (where the patient co-payment covers the total costs of the prescribed medication) data are available from mid-2012; and therefore not available for 2011 (Endnote 8).

Data does not include the Repatriation Pharmaceutical Benefits Scheme (RPBS) which is subsidised by the Department of Veterans’ Affairs (Endnote 9).

For further information (Endnote 8).

CENSUS

The 2011 Census measured the number and key characteristics of people who were in Australia on Census night 9 August 2011. For information about the 2011 Census please refer to Census 2011 Reference and Information and Census Data Quality on the ABS website.
GEOGRAPHY

The mesh block information used in the linkage process may not be aligned between the MBS and PBS files, and the Census, for a range of reasons, including:

- Differences arising because MBS and PBS mesh block are based on postal address whereas the Census mesh block was based on the usual residential address;

- Persons may have changed their address but not updated their Medicare records.

Medicare claims data used in this dataset are based on the mesh block of the enrolment address of the patient. As clients may receive services in locations other than where they live, these data do not necessarily reflect the location in which services were received (Endnote 10). The data therefore reflects geographic information about the patient, rather than where they received each service – for example, the data does not show GP services by state, but rather the GP services provided to patients in each state.

REMOTE AREAS

People living in Remote and Very Remote areas of Australia are underrepresented in the data. This may be for a number of reasons including:

- GPs are less likely to charge Medicare in Remote areas (Endnote 11).

- Non-metropolitan hospitals are more likely to admit patients, and people in Remote areas are more likely to attend hospital accident and emergency (A&E) departments for primary care medical consultations than people from Major Cities (Endnote 11). People accessing these hospital services may be public inpatients and therefore not in scope. States and Territories are the custodians for this data and it is not included in the dataset.

- In 2010-11, despite there being more GPs in Remote areas, there were about half the GP services provided per person in Very Remote areas as in Major Cities (Endnote 12).

- The Aboriginal Health Services Program is funded by the PBS however person-level data is not in the PBS processing system. Data from Remote and Very Remote areas, and the data from the Northern Territory are most affected (Endnote 8).

The Census also undercounts the number of people living in some areas of Australia more than others. In 2011, the Northern Territory recorded the highest net undercount rate of all states and territories (6.9%) and showed the largest difference in the net undercount rate between its greater capital city and rest of state region (3.7% and 10.9% respectively) (Endnote 13).
ACKNOWLEDGEMENT

The ABS acknowledges the continuing support provided by the National Mental Health Commission and the Department of Health for this project. The provision of data by the Department of Health and the Department of Human Services, as well as the funding from the National Mental Health Commission was essential to enable this important work to be undertaken. The enhancement of mental health statistics through data linkage by the ABS would not be possible without their cooperation and support. The ABS also acknowledges the importance of the information provided freely by individuals in the course of the 2011 Census. Census information provided by individuals to the ABS is treated in the strictest confidence as is required by the Census and Statistics Act (1905). MBS and PBS information provided by the Department of Health and the Department of Human Services to the ABS is treated in the strictest confidence as is required by the National Health Act (1953), and the Health Insurance Act (1973).
GLOSSARY

Apart from the concepts relating to variables originating from the MBS and PBS and data integration, all other terms and definitions relate to Census variables. Explanations have been provided below, however, the Census Dictionary can be referred to if more detail is required. For more information on MBS and PBS definitions see

Administrative data

Information that is collected for purposes other than that of a statistical nature. This type of information is often obtained from records or transactional data from government agencies, businesses or non-profit organisations which use the information for the administration of programs, policies or services.

ATC Code

The code allocated by the WHO Collaborating Centre for Drug Statistics Methodology. ATC Name In the Anatomical Therapeutic Chemical (ATC) classification system, the drugs are divided into different groups according to the organ or system on which they act and their chemical, pharmacological and therapeutic properties. For more information see (www.whocc.no/atcddd/).

Data Integration

Statistical data integration involves combining information from different administrative and/or statistical sources to provide new datasets for statistical and research purposes. Further information on data integration is available on the National Statistical Service website – Data Integration.

Data Linkage

Data linking is a key part of statistical data integration and involves the technical process of combining records from different source datasets using variables that are shared between the sources. Data linkage is typically performed on records that represent individual persons, rather than aggregates. Two common methods used to link records are deterministic and probabilistic linkage. Deterministic linkage links person-records on exact matches using a unique identifier (such as a social security number or a created unique identifier such as a linkage key). Probabilistic linkage links person-records on close matches based on the relative likelihood that two records refer to the same person, using a number of linking variables (such as date of birth, sex, geographic area).

Date of service

The date on which the provider performed the service.

Date of supply

This is the date on which the PBS item was supplied.
De-identified data/records

Data that have had any identifiers removed. May also be referred to as unidentified data. The Census, MBS and PBS records used by the ABS for this project were de-identified and did not include person name, address or Medicare number.

Item Category

The Medicare Benefits Schedule (MBS) comprises a hierarchical structure of Categories, Groups, Subgroups and Items numbers, to group similar professional services together.

Medicare Benefits Schedule (MBS)

The Department of Human Services collects data on the activity of all persons making claims through the Medicare Benefits Scheme and provides this information to the Department of Health. Information collected includes the type of service provided (MBS item number) and the benefit paid by Medicare for the service. The item numbers and benefits paid by Medicare are based on the Medicare Benefits Schedule (MBS) which is a listing of the Medicare services subsidised by the Australian Government.

Medicare Item Number

A number that identifies the service provided by the provider as per the Medicare Benefits Schedule.

Mental health-related medications

Mental health-related medications included in this publication were from 5 selected medication groups as classified in the Anatomical Therapeutic Chemical (ATC) Classification System (WHO 2011), namely antipsychotics (code N05A), anxiolytics (code N05B), hypnotics and sedatives (code N05C), antidepressants (code N06A), and psychostimulants and nootropics (code N06B)—prescribed by all medical practitioners (that is, general practitioners (GPs), non-psychiatrist specialists and psychiatrists) (See Appendix B).

Mental health-related services

Mental health-related services include services provided by psychiatrists, general practitioners (GPs), psychologists and other allied health professionals—mental health nurses, occupational therapists, social workers and Aboriginal health workers. These services are defined in the Medicare Benefits Schedule (MBS) and are provided in a range of settings, for example in hospital, consulting rooms, home visits, and over the phone (See Appendix A).

Mesh block

Mesh Blocks are the smallest geographic region in the Australian Statistical Geography Standard (ASGS) and form the basis for the larger regions of the ASGS. There are approximately 347,000 Mesh Blocks covering the whole of Australia without gaps or overlaps. They broadly identify land use such as residential, commercial, agricultural and parks etc.

Mesh Blocks are the building blocks for all the larger regions of the ASGS. As Mesh Blocks are very small they can be combined together to accurately approximate a large range of other statistical regions.
Pharmaceutical Benefits Scheme (PBS)

The Department of Human Services provides data on prescriptions funded through the Pharmaceutical Benefits Scheme (PBS) to the Department of Health. The PBS lists all of the medicines available to be dispensed to patients at a Government-subsidised price. The Government is advised by the Pharmaceutical Benefits Advisory Committee (PBAC) regarding which drugs should be listed on the PBS Scheme.

PBS Item Code

Number which indicates item prescribed as per Schedule of Pharmaceutical Benefits.

Remoteness Area (RA)

Within the Australian Statistical Geography Standard (ASGS), the Remoteness structure comprises six categories, each of which identifies a non-contiguous region in Australia, being a grouping of Statistical Areas Level 1 (SA1s) sharing a particular degree of remoteness. The degrees of remoteness range from 'Major Cities' (highly accessible) to 'Very Remote'.

The degree of remoteness of each SA1 was determined using the Accessibility/Remoteness Index of Australia (ARIA). SA1s have then been grouped into the appropriate category of Remoteness to form non-contiguous areas within each state.

Socio-Economic Indexes for Areas (SEIFA)

Socio-Economic Indexes for Areas (SEIFA) is a product developed by the ABS that ranks areas in Australia according to relative socio-economic advantage and disadvantage. The indexes are based on information from the five-yearly Census. SEIFA 2011 is based on Census 2011 data, and consists of four indexes, each focusing on a different aspect of socio-economic advantage and disadvantage and being a summary of a different subset of Census variables. The Index used in this publication is the Index of Relative Socio-Economic Disadvantage (IRSD).

Statistical Area Level 1 (SA1)

The Statistical Area Level 1 (SA1) is the second smallest geographic area defined in the Australian Statistical Geography Standard (ASGS), the smallest being the Mesh Block. The SA1 has been designed for use in the Census of Population and Housing as the smallest unit for the processing and release of Census data.
## APPENDIX A – MBS ITEMS

### MBS subsidised mental health-related services

<table>
<thead>
<tr>
<th>Provider</th>
<th>Item group</th>
<th>MBS Group &amp; Subgroup</th>
<th>MBS item numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>Initial consultation new patient(a)</td>
<td>Group A8</td>
<td>206, 297, 299</td>
</tr>
<tr>
<td></td>
<td>Patient attendances—consulting room</td>
<td>Group A8</td>
<td>291(a), 293(a), 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319</td>
</tr>
<tr>
<td></td>
<td>Patient attendances—hospital</td>
<td>Group A8</td>
<td>320, 322, 324, 326, 328</td>
</tr>
<tr>
<td></td>
<td>Patient attendances—other locations</td>
<td>Group A8</td>
<td>330, 332, 334, 336, 338</td>
</tr>
<tr>
<td></td>
<td>Group psychotherapy</td>
<td>Group A8</td>
<td>342, 344, 346</td>
</tr>
<tr>
<td></td>
<td>Interview with non-patient</td>
<td>Group A8</td>
<td>348, 350, 352</td>
</tr>
<tr>
<td></td>
<td>Telepsychiatry</td>
<td>Group A8</td>
<td>353, 355, 356, 357, 358, 359(b), 361(b), 364, 366, 367, 369, 370</td>
</tr>
<tr>
<td></td>
<td>Case conferencing</td>
<td></td>
<td>855, 857, 858, 861, 864, 866</td>
</tr>
<tr>
<td></td>
<td>Electroconvulsive therapy(c)</td>
<td>Group T1, Subgroup 13</td>
<td>14224</td>
</tr>
<tr>
<td></td>
<td>Referred consultation for assessment, diagnosis and development of a treatment and management plan for autism or any other pervasive developmental disorder (PDD)(d)</td>
<td>Group A8</td>
<td>289</td>
</tr>
<tr>
<td>General practitioners</td>
<td>GP Mental Health Treatment Plan—accredited</td>
<td>Group A20, Subgroup 1</td>
<td>2710(a)(f), 2715(g), 2717(g)</td>
</tr>
<tr>
<td></td>
<td>GP Mental Health Treatment Plan—non-accredited(a)</td>
<td>Group A20, Subgroup 1</td>
<td>2700(g), 2701(g), 2702(g)</td>
</tr>
<tr>
<td></td>
<td>GP Mental Health Treatment Plan—other</td>
<td>Group A20, Subgroup 1</td>
<td>2712(a), 2713(a), 2719(g)(h)</td>
</tr>
<tr>
<td></td>
<td>Focussed Psychological Strategies</td>
<td>Group A20, Subgroup 2</td>
<td>2721, 2723, 2725, 2727</td>
</tr>
<tr>
<td></td>
<td>Family Group Therapy</td>
<td>Group A6</td>
<td>170, 171, 172</td>
</tr>
<tr>
<td></td>
<td>Electroconvulsive therapy(i)</td>
<td>Group T10</td>
<td>20104</td>
</tr>
<tr>
<td></td>
<td>3 Step Mental Health Process—GP(j)</td>
<td>Group A18, Subgroup 4</td>
<td>2574, 2575, 2577, 2578</td>
</tr>
<tr>
<td></td>
<td>3 Step Mental Health Process—other</td>
<td>Group A19, Subgroup 4</td>
<td>2704, 2705, 2707, 2708</td>
</tr>
</tbody>
</table>
### 4329.0 - CHARACTERISTICS OF PEOPLE USING MENTAL HEALTH SERVICES AND PRESCRIPTION MEDICATION, 2011

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Medical Professional</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical psychologists Psychological Therapy Services(a)</td>
<td>Group M6</td>
<td>80000, 80005, 80010, 80015, 80020</td>
</tr>
<tr>
<td>Other psychologists Enhanced Primary Care</td>
<td>Group M3</td>
<td>10968</td>
</tr>
<tr>
<td>Focused Psychological Strategies (Allied Mental Health)(a)</td>
<td>Group M7</td>
<td>80100, 80105, 80110, 80115, 80120</td>
</tr>
<tr>
<td>Assessment and treatment of PDD(c)</td>
<td>Group A10</td>
<td>82000, 82015</td>
</tr>
<tr>
<td>Follow-up allied health service for Indigenous Australians(k)</td>
<td>Group M11</td>
<td>81355</td>
</tr>
<tr>
<td>Other allied health providers Enhanced Primary Care—mental health worker</td>
<td>Group M3</td>
<td>10956</td>
</tr>
<tr>
<td>Focused Psychological Strategies (Allied Mental Health)—occupational therapist(a)</td>
<td>Group M7</td>
<td>80125, 80130, 80135, 80140, 80145</td>
</tr>
<tr>
<td>Focused Psychological Strategies (Allied Mental Health)—social worker(a)</td>
<td>Group M</td>
<td>80150, 80155, 80160, 80165, 80170</td>
</tr>
<tr>
<td>Follow-up allied health services for Indigenous Australians—mental health worker(k)</td>
<td>Group M11</td>
<td>81325</td>
</tr>
</tbody>
</table>

(a) Item introduced 1 November 2006.
(b) Item introduced 1 November 2007.
(c) Item may include services provided by medical practitioners other than psychiatrists.
(d) Item introduced 1 July 2008.
(e) Item introduced 1 January 2010.
(f) Item discontinued after 31 October 2011.
(g) Item introduced 1 November 2011.
(h) Item discontinued after 30 April 2012.
(i) Item is for the initiation of anaesthesia for electroconvulsive therapy and includes services provided by medical practitioners other than GPs.
(j) Item discontinued after 30 April 2007.
(k) Item introduced 1 November 2008.

### APPENDIX B – PBS ITEMS

**PBS subsidised mental health-related prescription medication**

<table>
<thead>
<tr>
<th>Code</th>
<th>Medication groups</th>
<th>Code</th>
<th>Medication subgroup</th>
</tr>
</thead>
<tbody>
<tr>
<td>N05</td>
<td>Psycholeptics</td>
<td>N05A</td>
<td>Antipsychotics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N05AA</td>
<td>Phenothiazines with aliphatic side-chain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N05AB</td>
<td>Phenothiazines with piperazine structure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N05AC</td>
<td>Phenothiazines with piperidine structure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N05AD</td>
<td>Butyrophenone derivatives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N05AE</td>
<td>Indole derivatives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N05AF</td>
<td>Thioxanthen derivatives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N05AH</td>
<td>Diazepines, oxazepines, thiazepines and oxepines</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N05AL</td>
<td>Benalamides</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N05AX</td>
<td>Other antipsychotics</td>
</tr>
<tr>
<td>N05B</td>
<td>Anxiolytics</td>
<td>N05BA</td>
<td>Benzodiazepine derivatives</td>
</tr>
<tr>
<td>N05C</td>
<td>Hypnotics and Sedatives</td>
<td>N05CD</td>
<td>Benzodiazepine derivatives</td>
</tr>
<tr>
<td>N06</td>
<td>Psychoanaleptics</td>
<td>N06A</td>
<td>Antidepressants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N06AA</td>
<td>Non-selective monoamine reuptake inhibitors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N06AB</td>
<td>Selective serotonin reuptake inhibitors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N06AF</td>
<td>Monoamine oxidase inhibitors, non-selective</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N06AG</td>
<td>Monoamine oxidase A inhibitors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N06AX</td>
<td>Other antidepressants</td>
</tr>
<tr>
<td>N06B</td>
<td>Psychostimulants, agents used for ADHD and Nootopics</td>
<td>N06BA</td>
<td>Centrally acting sympathomimetics</td>
</tr>
</tbody>
</table>
Descriptions of Medications

<table>
<thead>
<tr>
<th>N05 Psycholeptics</th>
<th>A group of drugs that tranquillises (central nervous system depressants)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipsychotics (N05A)</td>
<td>Drugs used to treat symptoms of psychosis (a severe mental disorder characterised by loss of contact with reality, delusions and hallucinations), common in conditions such as schizophrenia, mania and delusional disorder.</td>
</tr>
<tr>
<td>Anxiolytics (N05B)</td>
<td>Drugs prescribed to treat symptoms of anxiety.</td>
</tr>
<tr>
<td>Hypnotics and sedatives (N05C)</td>
<td>Hypnotic drugs are used to induce sleep and treat severe insomnia. Sedative drugs are prescribed to reduce excitability or anxiety.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>N06 Psychoanaleptics</th>
<th>A group of drugs that stimulates the mood (central nervous system stimulants)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressants (N06A)</td>
<td>Drugs used to treat the symptoms of clinical depression.</td>
</tr>
<tr>
<td>Psychostimulants and nootropics (N06B)</td>
<td>Agents used for attention-deficit hyperactivity disorder and to improve impaired cognitive abilities (nootropics).</td>
</tr>
</tbody>
</table>

FOR MORE INFORMATION . . .

www.abs.gov.au the ABS website is the best place for data from our publications and information about the ABS.

INFORMATION AND REFERRAL SERVICE

Our consultants can help you access the full range of information published by the ABS that is available free of charge from our website. Information tailored to your needs can also be requested as a ‘user pays’ service. Specialists are on hand to help you with analytical or methodological advice.

POST Client Services, ABS, GPO Box 796, Sydney NSW 2001
FAX 1300 135 211
EMAIL client.services@abs.gov.au
PHONE 1300 135 070

FREE ACCESS TO STATISTICS

All ABS statistics can be downloaded free of charge from the ABS web site.

WEB ADDRESS www.abs.gov.au