Australian Government
Department of Health

Initial Submission to the Productivity Commission Inquiry into Mental Health

2019

Department of Health

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Introduction

The Department of Health (the department) welcomes the Productivity Commission's Inquiry into the role of improving mental health to support economic participation and enhancing productivity and economic growth (the Inquiry).

Following the National Mental Health Commission's report of the *Review of Mental Health Programmes and Services* (2014) and the development and ongoing implementation of *The Fifth National Mental Health and Suicide Prevention Plan* (2017) (the Fifth Plan), it is timely to reflect on the positive achievements of the programs, policies and initiatives administered by the department and our partners,[1] and to actively consider the opportunities for further mental health reform. The department supports the Inquiry's broad Terms of Reference, particularly its recognition that health outcomes have a real and practical effect well beyond the healthcare sector.

Australia's healthcare system is world-class, impacting every Australian throughout every stage of their life. It is a system that supports the care of families and children, that invests billions of dollars into medical research including mental health, that funds near half a million General Practitioner visits each day and that supports the growing life expectancy of Australians.[2] There are, however, ongoing health challenges that many Australians continue to face on a daily basis. The prevalence of mental ill-health within our communities is one such challenge.

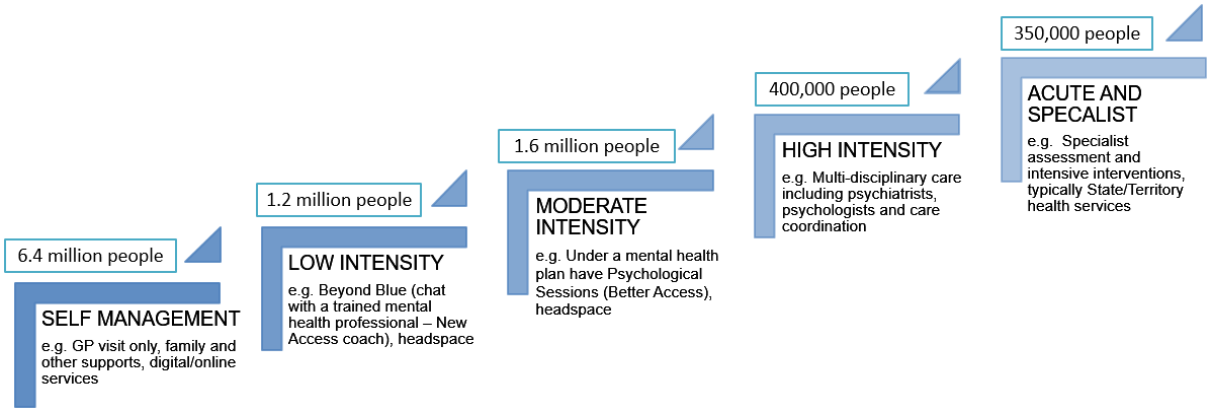
It is recognised that almost half of Australians aged over sixteen years of age will experience mental ill-health at some stage in their lives. Of those, one in five will experience mental ill-health each year.[3] Aboriginal and Torres Strait Islander people are particularly vulnerable to mental ill-health, with suicide rates twice as high compared to non-Indigenous Australians.[4] Mental ill-health can have a devastating effect on individuals, families and communities. International research suggests that individuals, including their families and informal carers, may suffer from psychological distress, social isolation, lower social participation and discrimination.[5] Those with mental ill-health also have poorer educational and work outcomes.[6] Australia is not alone in facing these challenges. There is growing recognition by governments worldwide that mental disorders account for one of the largest and fastest growing categories of the burden of disease.[7]

[1] Partners refers to the state and territory governments, and those organisations, groups and stakeholders that we work directly with in the development and delivery of our programs, policies and initiatives.
[2] See generally Department of Health 2017-18 annual report.
[3] See Australian Bureau of Statistics (ABS), *National Survey of Mental Health and Wellbeing*, Australia, 2007.
[4] See ABS, Causes of Death, Australia, 2012.
[5] See Knapp, M., McDaid, D. and Curran, C, *Identifying and Tackling the Economic Impacts of Mental Health Problems*, 2003, presented at Mental Health in Europe New Challenges, New Opportunities.
[6] See Organization for Economic Cooperation and Development (OECD), Mental Health, available at: www.oecd.org/els/health-systems/mental-health.htm.
[7] See OECD, *Mental Health*, available at: www.oecd.org/els/health-systems/mental-health.htm.

The economic costs of mental illness extend well beyond direct spending on health related services.[8] Within the OECD, the economic burden of mental ill-health has been estimated to be up to 4 per cent of gross domestic product.[9]

The government has an ongoing commitment to support the mental health of all Australians, with the largest ever investment in mental health of $5.3 billion projected to be spent on mental health in the 2019-20 financial year. This funding goes to supporting and strengthening a range of national initiatives to improve access to mental health and suicide prevention services to support frontline service delivery, improve access to services and building a better mental health system for all Australians. The government has also appointed a National Suicide Prevention Adviser to the Prime Minister to ensure a whole-of-government approach to addressing the priority area of suicide prevention.

Central to the government's current reform agenda is a stepped care approach to the provision of care. Stepped care is an evidence-based, staged system comprising of a hierarchy of interventions from the least to the most intensive, which can be matched to an individual's needs. It recognises that consumers have a spectrum of needs and that invariably there needs to be a spectrum of services to meet those needs, rather than a one size fits all approach to care. In contrast to 'step up/step down' services, the levels of care within the stepped care approach do not operate in silos or as one directional steps, but rather offer a continuum of service interventions, matched to the spectrum of mental illness. A stepped care approach makes the best use of workforce and technology, and supports early intervention – providing the right service at the right time, and having lower intensity steps available to support individuals before illness manifests. A visual representation of the stepped care approach is reproduced below:



As those with mild to moderate mental health conditions represent a significant proportion of people with mental illnesses,[10] the department acknowledges that investment in primary care is likely to result in the highest economic returns. It is estimated that one in two individuals with mental illness remain untreated, with those with mild to moderate mental ill-health costing approximately $11 billion in lost

[8] See OECD, *Making Mental Health Count: The Social and Economic Costs of Neglecting Mental Health Care*, 2014. Available at: www.oecd.org/els/health-systems/mental-health.htm.

[9] Ibid.

[10] See National Mental Health Commission (NMHC), *National Review of Mental Health Programmes and Services, Summary and Recommendations*, 2014.

productivity annually.[11] In treating mild to moderate mental illness, effective activities within the primary care setting such as improved integration and coordination, early intervention and self-directed low intensive therapies (such as e-mental health therapies) are likely to support improved treatment. It has been observed that e-mental health services can be up to 50 times more cost-effective than face-to-face treatment by a clinician.[12] E-health treatments can also reduce demands on the mental health workforce by supporting clinicians in directing their time and skills toward individuals with more complex needs.[13]

In addressing the ongoing challenges associated with mental ill-health, the government is committed to providing ongoing national leadership in population mental health and suicide prevention. The government also recognises the importance of maintaining certainty and continuity within the mental healthcare system, including through the funding of services and support through the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS), relevant programs and initiatives, and Primary Health Networks (PHNs).

At this stage in the ongoing reform, the Fifth Plan commits all Australian governments to collaborate in actioning activities in eight priority areas. For the first time, all governments have committed to integrate planning and service delivery at a regional level; specifically agreed to address social and emotional wellbeing amongst Indigenous Australians; and highlight the importance of reducing the stigma and discrimination that accompanies mental illness. Consumers and carers are also recognised as being a central part in designing, delivering and evaluating mental health services. The government is committed to building upon the momentum gained in actioning these matters in recent years through a new partnership with the states and territories for an integrated mental health system, supporting improved connectedness across prevention, treatment and recovery activities.[14]

It is through integrating mental healthcare with mainstream healthcare and other systems such as the education, social employment, social services, and housing and justice systems that a truly person-centred approach to mental health and wellbeing, across the lifespan, can be achieved. Over time, promotion and prevention should allow a shifting away from costly acute treatment and recovery, thereby improving the efficiency of the healthcare system and the wellbeing of the patient.

Furthermore, in ensuring our policies, programs and initiatives are evidenced-based and fit for purpose, the department strongly consults with consumers, carers, lived-experienced representatives, clinicians, academics, policy experts and industry representatives throughout their development and implementation. The government is also committed to ensuring that the available data used to inform the development of policy, program design and delivery is up to date and comprehensive, and able to

[11] See PriceWaterhouseCoopers, *Creating a mentally healthy workplace Return on investment analysis*, 2014, pp. vi, 1 and 10. Available at: www.headsup.org.au/docs/default-source/resources/beyondblue_workplaceroi_finalreport_may-2014.pdf?sfvrsn=90e47a4d_6.

[12] See Beyondblue, *Information Paper: Improved access - e-mental health programs*, 2013; Medical Journal of Australia, *E-mental health: a new era in delivery of mental health services,* 2010; and Australian and New Zealand Journal of Psychiatry, *Effectiveness randomized controlled trial of face to face versus internet cognitive behaviour therapy for social phobia*, 2011.

[13] See Australian Family Physician, *Anxiety and depression online resources and management tools*, 2011.

[14] See Minister for Health, the Hon. Greg Hunt MP, National Press Club (14 August 2019). Available at: www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/national-press-club-address-long-term-national-health-plan.

provide decision-makers with a deeper understanding of mental health challenges and conditions. To this end, the government is investing in an intergenerational health and mental health survey to update data on the health and mental health of Australians. The survey is discussed in more detail in *Part 3 – The road ahead*.[15]

This submission has been structured into three main parts to reflect the discussion and matters in the Productivity Commission's Inquiry into Mental Health Issues Paper.

Part 1 discusses the challenges faced in addressing the prevalence of mental illness within our communities. The discussion is focussed on the following four main challenges: access to high quality services and care; stigma and discrimination; the social and emotional wellbeing of Indigenous Australians; and the need for greater connectedness between systems of care to address mental ill-health. The policy opportunities that the government considers to be central to effectively and efficiently addressing mental ill-health are also discussed in this Part.

Part 2 considers the work currently underway, both domestically and internationally, in addressing mental health issues within our communities. The policies, programs and initiatives that we administer are discussed under four broad categories: mental health prevention, treatment and recovery; suicide prevention; comorbidities; and health workforce.

Part 3 looks ahead to the next reform agenda. As the activities under the current reform continue to be implemented and mature, we discuss a number of opportunities that may form the basis of future activity. As an enabler to overall improvements to population mental health and wellbeing, the government considers connectedness – including improved integration and coordination between levels of government and across portfolios – will continue to form a fundamental part of the ongoing reform. Also discussed here are the adoption of a co-commissioning approach to commissioning mental health services, the viability of care navigation, and the importance of effective data collection and use.

Commonwealth Funding

The Productivity Commission's Inquiry into Mental Health Issues Paper discussed the Commonwealth's mental health funding and expenditure. The commission noted that in 2016-17, the Australian Government contributed at least $12.1 billion to mental health-related services and payments, an amount that has growth significantly over time. [16] A significant proportion of this amount funded income support payments (approximately $7.3 billion), MBS-subsidised services (approximately $1.2 billion) and national programs and initiatives (approximately $1.1 billion). It was also noted that at the full rollout of the National Disability Insurance Scheme, it is anticipated that governments will fund services to people with psychosocial disability to an amount of approximately $3.3 billion per annum.

During the recent additional estimates 2018-19 (the department appeared on 20 February 2019), the department tabled to the Community Affairs Legislation Committee a funding schedule outlining the

[15] See Minister for Health, the Hon. Greg Hunt MP, National Press Club (14 August 2019). Available at: www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/national-press-club-address-long-term-national-health-plan.

[16] See Figures 9 and 10 on pages 33-34.

department's estimated mental health expenditure as at January 2019.[17] The department's internal estimates indicate the department of Health spent $4.117 billion in 2016-17 on mental health services. These figures do not include mental health expenditure through other portfolios (e.g. DSS-managed programs), which are included in the Report on Government Services (ROGS), however they do include the Commonwealth's contribution to public hospital funding for mental health services, which is not included in the ROGS.

Department of Health Estimated Mental Health Expenditure (as at April 2019)

Department of Health Estimated Direct and Indirect Spending on Mental Health Services	2017-18 Estimated Actual ($m)	2018-19 Estimated Actual ($m)	2019-20 Estimated Expenditure ($m)
Department of Health mental health programs (1)*	759.7	929.3	893.1
MBS mental health related services (2)	1,241.4	1,336.4	1,455.7
PBS prescriptions for mental-health related illnesses (3)	542.0	563.5	598.9
Australian Government's share of public hospital funding for mental health services (4)	1,770.0	1,790.9	2,036.0
Mental Health share of Private Health Insurance Premium rebates (5)	164.4	174.2	184.7
Estimated Total	**4,477.5**	**4,794.3**	**5,168.4**
Portfolio Agencies Estimated Direct and Indirect Spending on Mental Health Services	**2017-18 Estimated Actual ($m)**	**2018-19 Estimated Actual ($m)**	**2019-20 Estimated Expenditure ($m)**
NHMRC mental health research (6)	69.4	73.1	73.2
National Mental Health Commission (7)	7.4	10.1	12.4
Estimated Total	**76.8**	**83.2**	**85.6**
Total Health Portfolio Estimated Direct and Indirect Spending on Mental Health Services	**2017-18 Estimated Actual ($m)**	**2018-19 Estimated Expenditure ($m)**	**2019-20 Estimated Expenditure ($m)**
Estimated Total	**4,554.3**	**4,877.5**	**5,254.0**

Figures correct as at Budget 2019-20

[17] See also Australian Parliament House, *2018-19 Additional Estimates, Health portfolio, Tabled documents*. Available at: www.aph.gov.au/Parliamentary_Business/Senate_Estimates/ca/2018-19_Additional_estimates/health.

Part 1 – Current challenges

(a) The challenges we face

Mental illness accounts for a significant burden of disease worldwide. Within the Organization for Economic Cooperation and Development (OECD) countries, one in two people will experience a mental health problem at some point in their lifetime and one in five will be suffering from a mental illness at any given moment.[18]

The prevalence of mental illness within Australia is largely reflective of those among OECD countries.[19] After taking into account the associated disability, the prevalence of mental illness results in a substantial personal burden of disease. The Australian Institute of Health and Welfare has estimated that mental and substance use disorders represent over 12 per cent of the total disease burden in Australia, making it the third largest contributor of disease burden, following cancer and cardiovascular diseases.[20] Mental illness is experienced across a wide spectrum, with mild to moderate disorders including depression, anxiety and substance misuse disorders being the most commonly experienced mental illnesses. Depression and anxiety account for over half of the disease burden of mental illness, with depression being the leading single cause of disability among all disorders.[21] Severe mental illnesses including severe depression, schizophrenia, bipolar disorder and eating disorders are significantly less prevalent, with around three per cent of Australians experiencing an illness of this kind.[22]

In addition to the significant burden of disease placed on individuals, mental illness has far reaching impacts on socio-economic outcomes. The National Mental Health Commission has estimated that: close to 40 per cent of individuals with a mental illness are unemployed or not in the labour force; 20 per cent are in households in the lowest income bracket; and over 25 per cent receive government pensions and allowances as their main income source.[23] Those with mental ill-health are also overrepresented within the justice system with nearly 40 per cent of individuals in Australian prisons having a history of mental illness – almost twice that seen in the general population.[24]

As the cornerstone to improving population mental health outcomes, the ongoing challenges and opportunities in improving access to mental healthcare services continue to be a key focus for the government. In 2007, the National Survey of Mental Health and Wellbeing estimated that less than half of Australians who experience a mental health illness will access treatment.[25] Just prior to the survey, the Better Access Initiative was introduced to encourage more general practitioners to

[18] See OECD, *Making Mental Health Count: The Social and Economic Costs of Neglecting Mental Health Care*, 2014.
[19] For example, see the Australian Institute of Health and Welfare (AIHW); the ABS; and the National Mental Health and Suicide Prevention Plans.
[20] See AIHW, *Australian Burden of Disease Study: Impact and causes of illness and death in Australia*, 2011.
[21] World Health Organisation (WHO), *Depression,* 2018, available at: www.who.int/news-room/fact-sheets/detail/depression.
[22] National Mental Health Commission (NMHC), *National Review of Mental Health Programmes and Services*, Vol 1, p.20, 2014.
[23] See NMHC, *National Review of Mental Health Programmes and Services*, Vol 1, 2014.
[24] Ibid.
[25] See ABS, *National Survey of Mental Health and Wellbeing*, 2007.

participate in the provision of mental health services, improve access to psychiatrists and enhance the availability and affordability of psychological services.[26] An evaluation of the initiative suggested that it has improved access to mental healthcare for people with common mental disorders.[27] The uptake of relevant services was also found to be high, including among young and old people, people in rural and remote areas, and people in areas of high socio-economic disadvantage.[28]

The prevalence of stigma – that is, those views or attitudes that exclude, reject, shame or devalue someone – against individuals with mental illnesses continues to be a challenge, with three out of four individuals with a mental illness experiencing stigma.[29] Unfortunately, mental illnesses continue to often be associated with violence, unpredictability, criminal activity, incompetence or weakness in character.[30] The World Health Organisation (WHO) has classified stigma as a major cause of discrimination and exclusion, which affects an individual's self-esteem, disrupts their family relationships and limits their ability to socialise and obtain housing and employment.[31] It also discourages affected individuals to access treatment, complicates recovery, promotes discrimination and causes isolation,[32] issues that are compounded for groups who are already marginalised and experience discrimination.[33] Consequently, stigma has an adverse impact on the prevention of mental illness, the promotion of mental wellbeing and the provision of effective treatment and care.[34] In response to this, stigma and discrimination was elevated as a priority within the Fifth Plan, with actions over three core action areas continuing to be actioned by governments.[35]

Finally, the social and emotional wellbeing of Aboriginal and Torres Strait Islander people continues to be an ongoing challenge in addressing population mental health.[36] The burden of mental illness is significantly higher for Indigenous Australians with mental and substance use disorders accounting for 19 per cent of their total burden of disease.[37] Indigenous adults are three times more likely to

[26] See Department of Health, *The Better Access initiative*, 2010. Available at: www.health.gov.au/internet/publications/publishing.nsf/Content/mental-ba-eval-dexec-toc~mental-ba-eval-dexec-bet.

[27] See University of Melbourne, Centre for Health Policy, Programs and Economics, *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative*, Final Report, 2011.

[28] Ibid.

[29] See the Fifth Plan, p. 39; and Sane Research, Research Bulletin 4.

[30] See the Fifth Plan, p. 39.

[31] See the WHO, *Stigma and Discrimination*. Available at: www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/priority-areas/stigma-and-discrimination.

[32] See Sane Australia, *Reducing Stigma*. Available at: www.sane.org/mental-health-and-illness/facts-and-guides/reducing-stigma.

[33] See SANE Australia, *A life without stigma: A SANE report*, 2013; Beyondblue, Information paper: *Stigma and discrimination associated with depression and anxiety*, 2015; Victorian Government, Better Health, *Stigma, discrimination and mental illness*, 2015; and the NMHC, *National Review of Mental Health Programmes and Services*, 2014.

[34] See the WHO, *Stigma and Discrimination*. Available at: www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/priority-areas/stigma-and-discrimination.

[35] See the Fifth Plan, Priority Area 6: *Reducing stigma and discrimination*, pp. 39-41.

[36] See the Fifth Plan, Priority Area 4: *Improving Aboriginal and Torres Strait Islander mental health and suicide prevention*, pp. 30-35.

[37] See AIHW, *Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islanders*, 2016.

experience high to very high psychological distress[38] and have significantly higher rates of mental distress, trauma, intentional self-harm, and exposure to risk factors such as stressful life events, family breakdown, discrimination, imprisonment, crime victimisation and alcohol and substance misuse.[39] Indigenous Australians are also twice as likely to die by suicide as the general population.[40] In response to these challenges, the Fifth Plan has specifically outlined an agreed set of actions to address the social and emotional wellbeing of Indigenous Australians as a priority. These actions are strengthened by an acknowledgement that more needs to be done to better coordinate efforts and focus on achieving improved integration of culturally appropriate social and emotional wellbeing, mental health, suicide prevention, and alcohol and other drug services.

(b) The challenge of integration

A mental health system that is not sufficiently connected exposes affected individuals, their families and carers, and their communities to increased risks of adverse health and social outcomes. For individuals living with anxiety or depression, a lack of integration and coordination between mental health services may frustrate their efforts in finding appropriate care and, over time, impact on their ability to remain gainfully employed.[41] For individuals living with severe or chronic mental disorders, it may limit their ability to break the cycle of prolonged illness and dependency, ongoing discrimination and psychosocial disability.[42] This increases their risk of poverty, isolation, marginalisation and homelessness.[43]

The Commonwealth and the states and territories have a long history of coordinating efforts in addressing many of the mental health challenges facing our communities. In 1992, all governments endorsed the National Mental Health Strategy as the strategic framework to guide mental health reform. As the mental healthcare system continued to develop and mature, the strategy was updated in 2008 in recognition that a new approach was needed to address the prevalence of mental ill-health, maximise mental wellbeing and deliver health equality across all population groups.[44] In this context, it was recognised that sectors beyond health, including housing, education, employment, welfare, justice and Indigenous affairs, all have an important role to play in promoting the mental health and wellbeing of the general population and in contributing to the prevention and early intervention, and the recovery of mental ill-health.[45]

The Fourth National Mental Health Plan (2009-14) adopted and operationalised a population health framework, through which it was also acknowledged that a holistic response to mental health challenges was required. The approach highlighted the importance of integration by acknowledging that the determinants of mental ill-health are influenced by factors outside the health system, and

[38] See AIHW, *Mental Health Services in Australia: Psyhciatric disability support services*, 2014.
[39] See NMHC, *National Review of Mental Health Programmes and Services*, Vol 1, 2014.
[40] See ABS, Cause of Death, Australia, 2012.
[41] See NMHC, *National Review of Mental Health Programmes and Services*, Vol 2, 2014.
[42] Ibid.
[43] Ibid.
[44] See the National Mental Health Policy (2008), Chapter 1.3.
[45] Ibid.

therefore a whole-of-government approach across Commonwealth and state and territory levels of responsibility – extending beyond the mental health sector – was needed to achieve change.[46]

In 2014, the National Mental Health Commission found that the mental health system was not appropriately integrated,[47] with evidence of fragmentation and siloing of services and programs.[48] Consumers were unable to consistently access the appropriate level of support resulting negatively on their wellbeing and level of participation in the community. In response to this, the Commission recommended that the role of PHNs extend to be the regional architecture for equitable planning and commissioning of mental health and suicide prevention programs, services and integrated care.[49] It also highlighted the need for strategic direction to implement a national stepped care approach to mental health service delivery.[50]

Unfortunately, a lack of integration and coordination continues to exist within – and between – our systems of care. Individuals often journey between silos of intervention, including hospital wards, systems in housing, education and employment, and community and non-government services.[51] And many of these supports only cater to discrete aspects of an individual's needs, overlooking whole-of-life considerations across the spectrum of need, potentially leading to no overall improvement to their quality of life.[52]

As we learn more about the factors contributing to mental ill-health, particularly the social determinants of health,[53] the more fundamental it becomes that we have an integrated, coordinated and connected system of care, one that sees the whole person and reflects the reality that mental illness does not develop in isolation.

Therefore, it is only through connecting mental healthcare services with mainstream healthcare and other systems – such as those within the education, justice, and social services systems – that many of the challenges faced by those suffering from mental ill-health and their carers can be effectively and efficiently addressed.

The concept of a person-centred approach to care, through an integrated primary and mental healthcare system, has been raised as one of the principal means to improve integration,[54] a view strongly reflected in the Government's response to the National Mental Health Commission's 2014 report which emphasised the importance of partnerships.[55] While the concept of integration has been incorporated into each National Mental Health Plan, each have adopted differing focuses and actions.

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[46] See the Fourth National Mental Health Plan, p. 10, 2009.
[47] See NMHC, *National Review of Mental Health Programmes and Services,* p. 29, Vol 1. 2014.
[48] Ibid, p. 32.
[49] See NMHC, *National Review of Mental Health Programmes and Services,* 2014, Recommendation 8.
[50] Ibid, Strategic Direction 4.
[51] Ibid, Vol 2.
[52] Ibid.
[53] The WHO describes social determinants as *'the circumstances in which people grow, live, work and age, and the systems put in place to deal with illness.'* Social determinants can therefore be considered as including a range of factors including socioeconomic position, early life experiences, social exclusion through social disadvantage and lack of resources, employment and work, housing and homelessness. See WHO. Available at: www.who.int/social_determinants/en/.
[54] Ibid, Vol 1.
[55] See *Government Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services*, 2015.

Under the Fifth Plan, integration is placed as the flagship and theme that underpins the remaining priority areas. Under the Plan, integration is concerned with building relationships between organisations that have similar aims and that are seeking to improve the outcomes and experiences of consumers and carers.[56] In actioning the Government's response to the National Mental Health Commission's report, and more recently through the Fifth Plan, the Commonwealth has taken action by extending the scope of PHNs to be the key regional architecture for equitable planning and purchasing of mental health programs, services and integrated care pathways. This is a key example of the work currently being undertaken to improve integrated care for individuals.

The Fifth Plan does, however, acknowledge that integration, as a means to achieving cooperation between multiple levels of government and across portfolios, remains to be officially adopted and achieved.[57] It will be through adopting this broader view of integration that the healthcare and other social systems will be able to effectively address the mental health challenges facing our communities across the spectrum of care: prevention, treatment and recovery.

Prevention (including promotion and early intervention) must also be a major focus as, for most individuals, the mental illness experienced by many in adulthood has its onset in childhood or adolescence.[58] Two-thirds of those who experience an anxiety or affective disorder would have had their first episode before they reached 21 years of age,[59] with those aged between 18 and 24 years of age having the highest prevalence of mental illness than any other age group.[60] As such, the early onset of mental illness at an early age can have profound and long-term implications for individuals, particularly on their ability to effectively participate in social, family, educational and vocational roles.[61] Over time, the benefits of effective prevention activities are likely to improve the overall efficiency of the mental healthcare system and have significant flow-on effects on other systems such as social services, justice and education, as well as on workplaces.

Connectedness will help to introduce coherent and uniform systems across jurisdictions. For instance, better integration and coordination between services would support the development of a consistent approach to the level of care provided throughout the patient journey, minimising risk to the consumer. It would also provide the opportunity to develop a consistent reporting and accountability structure, through which all governments and mental health and health service providers will be held to account for their contribution to the improvement of population mental health outcomes. This would facilitate improved data collection and better monitoring and evaluation of the impact of policies and programs across the mental health system. It would also improve the efficiency of the healthcare system and reduce unnecessary costs associated with a less efficient system.

[56] See the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan), p. 18.
[57] Ibid.
[58] See the Fourth National Mental Health Plan, *The Magnitude of the Problem*, 2009 (the Fourth Plan).
[59] Ibid.
[60] See Black Dog Institute, *Facts & Figures about Mental Health*, 2018.
[61] See the Fourth Plan.

Part 2 – Addressing the challenges

(a) Our contribution to improving mental health and wellbeing

The Commonwealth's main role within the mental healthcare system is to fund mental healthcare services, primarily through the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS), the Repatriation Pharmaceutical Benefits Scheme (RPBS), and the National Healthcare Agreement.[62] The Commonwealth also leads the development of national policies such as supporting the improved integration of mental healthcare within the primary health context through regional planning and commissioning.[63]

The state and territory governments have primary responsibility for the direct provision of public health services and the regulation of healthcare providers including private hospitals, private practitioners, not-for-profit organisations and voluntary agencies.[64] They fund and deliver public specialised mental healthcare services, including specialised public psychiatric hospital services, residential services and community services.[65] These services are provided by a range of healthcare professionals including, but not limited to, general practitioners (GPs), psychiatrists, psychologists, nurses, occupational therapists, social workers and peer workers.[66]

The MBS underpins the provision of mental healthcare services at the population level. It is a universal, population-based system that provides Commonwealth subsidised treatment for selected mental health services provided by GPs, psychiatrists, psychologists and eligible social workers and occupational therapists. In 2006, the Commonwealth introduced the Better Access Initiative, substantially expanding the role of the MBS in the provision of mental health services to increase access for individuals with clinically diagnosable mental disorders to evidence-based treatment. Better Access has been the single biggest driver of advances in treatment rates, increasing treatment rates from one in three to more than 50 per cent of those with mental illness.[67] In 2017-18, 2.5 million individuals received subsidised mental health services using mental health specific MBS item numbers, with the vast majority (2.1 million people) consulting their GP, and 1.2 million individuals seeing a psychologist or other allied health provider. A total of 400,000 people consulted a psychiatrist.

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[62] See AIHW, *Mental Health Services – in brief*, pp. 4-5, 2018; and Senate Standing Committees on Community Affairs, *The cancer journey: informing choice*, Chapter 2, 2005.

[63] See Department of Health, *Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services*, 2015.

[64] Royal Australian and New Zealand College of Psychiatrists, *Understanding the Australian Mental Health-Care System*. Available at: www.ranzcp.org/RANZCP/media/elearning/SIMG_Module1_Understanding_the_Australian_mental_health-care_system/shell.html.

[65] See AIHW, *Mental Health Services – in brief,* pp. 4-5 2018.

[66] Ibid.

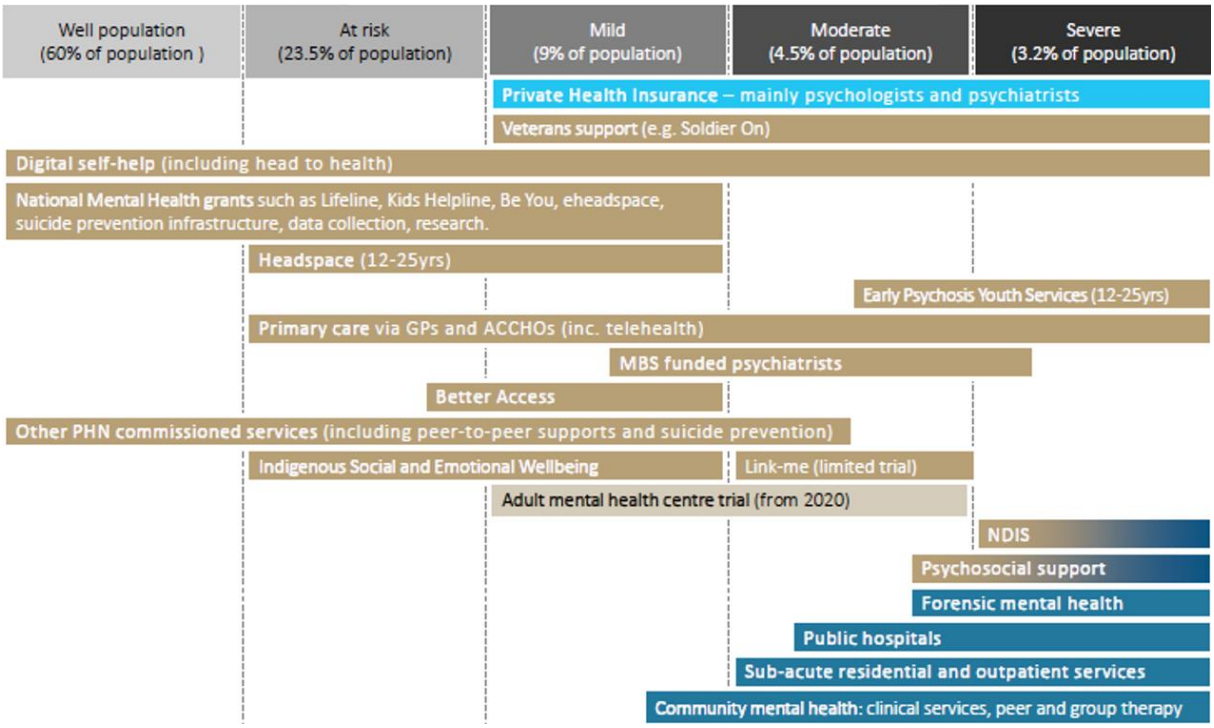
[67] See Department of Health, *Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services*, p. 14.

MBS-based services through Better Access has provided an efficient means of providing access to primary mental health service delivery.[68] Funding is also provided for other support programs and services, such as those managed by PHNs, as well as income support, social and community support, disability services, workforce participation programs and housing assistance.[69]

An example of a program that has adopted a non-traditional funding model is the Health Care Home (HCH) program. HCHs are general practices or Aboriginal Community Controlled Health Services (ACCHSs) that coordinate care for eligible patients with chronic and complex conditions. They aim to facilitate a partnership between the consumer, their families and carers, their treating GP and the extended health care team, allowing for better-targeted and effective coordination of clinical resources to meet the patient's needs and better manage their health. The program's funding model moves away from the traditional fee-for-service model, toward a bundled-payment approach. A Risk Stratification Tool is used to identify eligible patients and place them into one of three tiers based on their level of complexity and need for enrolment into a HCH. General practices or ACCHSs are then paid according to these tiers, with all general practice health care associated with consumers' chronic conditions (previously funded through the MBS) funded through the bundled payment.[70] The HCH program is being evaluated with interim reports due to the department in September 2019, June 2020 and a final report in December 2021. The lessons learnt from the program will then inform future primary care reform activities.

The figure overleaf summarises how the healthcare system is currently responding to community demand across the spectrum of need for mental health services, including how activities are shared between the Commonwealth, states and territories, and non-government organisations. Gold represents Commonwealth activity, dark blue represents state and territory activity, while light blue represents non-government activity.

[68] See Department of Health, *Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services*, p. 14.
[69] See AIHW, *Mental Health Services – in brief*, pp. 4-5, 2018.
[70] For further information, see Department of Health, *Health Care Homes*. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/health-care-homes.



Source: Australian Government (2019)

In late 2017, the Council of Australian Governments (COAG) Health Council endorsed the Fifth Plan (2017-22), which sustains the importance and momentum for improved integration of services and care through articulating eight nationally agreed priority areas and 38 actions for collaborative government action. Under the oversight of the Mental Health Principal Committee (MHPC),[71] numerous governance structures to support the implementation of the plan have been established, including the Mental Health Expert Reference Panel, the Suicide Prevention Project Reference Group, and the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group. These Groups are progressing their respective work plans.

Through the Fifth Plan, all Australian governments have committed to strengthening regional integration in planning and service delivery for mental health and suicide prevention services to support a more effective, person-centred mental healthcare system.[72] On this platform, the Commonwealth and the states and territories have taken strong action to improve integration through devolving identified service delivery responsibilities to PHNs and Local Hospital Networks (LHNs, or equivalent) as the key model to support joint integration at the regional service level, aligning efforts between both levels of government. PHNs and LHNs have been directed to develop joint integrated mental health and suicide prevention plans by June 2020, focussing on key areas including treatment and supports for people with severe and complex mental illness, supporting the health of people with mental illness, suicide prevention, and Indigenous mental health and suicide prevention. The adoption

[71] The Mental Health Principal Committee (MHCP) is one of four principal committees which directly report to the Australian Health Ministers' Advisory Council. MHCP is comprised of jurisdictional directors of mental health and related Commonwealth mental health policy senior officials. Its role is to develop and implement a shared National Mental Health and Suicide Plan in addition to advising AHMAC on mental health and drug service issues of national significance. More information is available at: www.coaghealthcouncil.gov.au/ahmac/principal-committees.

[72] See the Fifth Plan, 2017, Priority Area 1.

of a holistic approach to care for Indigenous people is a particular focus in developing these plans, reflecting the interconnection between spiritual needs, social and emotional wellbeing, and physical and mental health. The Integrated Regional Planning Working Group has developed a suite of guidance,[73] endorsed by MHPC, to support PHNs and LHNs in their joint regional planning activities. The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group, a Ministerially appointed advisory group also provides advice on strategic and practical actions to prevent suicide and improve mental health and social and emotional wellbeing of Aboriginal and Torres Strait Islander people. This includes providing advice on building and strengthening partnerships between PHNs and ACCHSs including through strengthening integrated planning.

Following the review of Medicare Locals in 2014, the Commonwealth established PHNs in 2015[74] to increase the efficiency and effectiveness of medical services and improve coordination of care.[75] This placed PHNs in a central position to support joint planning, collaborative commissioning and health service integration between Commonwealth and state and territory funded health services.[76] In actioning the Fifth Plan, PHNs and LHNs continue to progress the development of joint regional mental health and suicide prevention plans to support their commissioning of services. The development of these plans enable and support future service delivery pathways which are integrated, targeted to need across the spectrum of stepped care and which address local priorities.[77] The plans also offer the opportunity to embed partnerships needed to make optimal use of resources and ultimately deliver improved outcomes and experiences of care for consumers and carers as they journey through the system.[78]

Through the PHN Aboriginal and Torres Strait Islander Mental Health program, PHNs complement their approach to integrating mental health services and care through commissioning culturally appropriate services for Indigenous Australians. Under the program, PHNs commission mental health services that are connected, holistic and safe, and that complement and link with other activities such as social and emotional wellbeing services, headspace services, suicide prevention approaches and alcohol and other drug services. PHNs provide further integrated support for Indigenous people with chronic diseases through the Integrated Team Care (ITC) program, which coordinates care and assists clients enrolled on the program to navigate the health system and to access the care they need in clinically appropriate timeframes.

A number of PHNs have also been appointed as mental health reform leaders through the Mental Health Reform Lead Site Project (Lead Site Project). Ten PHNs have been appointed as 'Lead Sites' to provide enhanced services in nominated key focus areas, for example, by fast-tracking relevant activities, establishing different partnerships and funding arrangements for services, and/or trialling approaches that are innovative in terms of types and models of commissioned services. The five key

[73] See Department of Health, *Achieving integrated regional planning and service delivery*, 2018. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/mental-health-intergrated-reg-planning.
[74] Primary Health Networks (PHNs) replaced the former Medicare Local system. More information is available at: www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley036.htm.
[75] See Department of Health, *PHNs*. Available here: www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Home.
[76] See Department of Health, *PHN Program Performance and Quality Framework*, 2018.
[77] See Department of Health, *Regional Planning for Mental Health and Suicide Prevention – a Guide for PHNs*, 2017, p. 5.
[78] Ibid.

focus areas are: regional planning and service integration; stepped care; low intensity services; services for youth with or at risk of severe mental illness; and clinical care coordination for adults with severe and complex mental illness services. Each Lead Site has a selection of these focus areas they are responsible for. Through this project, information will be collected on the approaches taken by Lead Sites to the planning, integration and delivery of mental health services to inform future government policy and the activities of PHNs more generally.

The department is currently evaluating the PHN Lead Site Project, assessing the first four focus areas (regional planning and service integration; stepped care; low intensity services; and youth-severe services). The interim report suggests that the Lead Sites have made significant progress in leading the primary mental health care reforms through bringing a diverse range of stakeholders on board and commissioning a full suite of services. Their efforts appear to be improving access to care and leading to positive outcomes for significant numbers of consumers.[79]

In addition to funding various activities, the government has significantly increased its focus on research. It is through research that key insights into matters that inform policy are gained, and innovative approaches to treatment are developed. In recognition of this, and in supporting improved mental health outcomes, the government has committed to investing into the following three key research initiatives: the Million Minds Mental Health Research Mission (the Mission); the National Mental Health Research Strategy; and the National Health and Medical Research Special Initiative in Mental Health Research. These initiatives represent long-term investments and capacity building within mental health, enhancing our ability effectively tackle mental ill-health into the future, and adding to the collective body of knowledge.

The Mission was announced in May 2018 to invest $125 million over ten years in mental health research through the Medical Research Future Fund. The Mission takes a whole-of-life approach in supporting innovative, ground-breaking and translatable mental health and suicide prevention research. It aims to assist up to one million individuals who might not otherwise benefit from mental health research and trials to be part of new approaches to prevention, treatment and recovery developed from the Mission's work. The Mission is guided by an Advisory Panel which assists in identifying research priorities, and informing the design of the Mission's grant programs, and prioritises proposals for funding based on peer-review. The Panel comprises eminent researchers, practitioners and persons with lived experience of mental illness.

The first grant opportunity under the Mission closed in February 2019, targeting three initial research priorities: the mental health of children and young people; the mental health of Aboriginal and Torres Strait Islander peoples; and the prevention, identification and treatment of eating disorders. Research targeting the mental health of Aboriginal and Torres Strait Islander peoples will be promoted throughout the Mission and across its priorities. Critical and emerging priorities for research investment will be identified by the Mission's Advisory Panel for future grant opportunities. Over time, the outcomes of the Mission are expected to support improved economic and social participation of those with mental illnesses, and increased capacity in the mental health research sector.

[79] The interim report is expected to published on the Department of Health website later this year.

A number of programs, policies and initiatives administered by the department are discussed below under the following categories: Prevention, treatment and recovery; Suicide prevention, Comorbidities, and Health workforce. A full list of programs and initiatives administered by the department relating to each of these areas is at Appendices A, B, C, D and E.

Mental health prevention, treatment and recovery

In its 2014 report, the National Mental Health Commission discussed that prevention, early intervention and support for recovery were strong focuses in a person-centred, population-based model of care.[80] In response, the Commonwealth committed to continue promotion and prevention activities through its role in the ongoing reform.[81] Notably, the responsibilities for promoting mental wellbeing rests with many sectors beyond health, including aged and community care, housing, education, employment, welfare, justice and Indigenous affairs.[82] Together, these sectors have an important role to play in promoting the mental health and wellbeing of the general population, and contributing to prevention and early intervention, and the recovery of those experiencing mental ill-health.[83]

Youth

Approximately 560,000 Australian children and adolescents are estimated to a have mental illness,[84] with over one in four people aged 16-24 years experiencing mental ill-health in any given year.[85] In considering the mental health of the population, it is understood that three quarters of all mental illnesses begin to manifest in people under the age of 25. Effective interventions, both early in life and at an early stage of illness, is understood to be a necessary part of addressing mental illness, and reducing the impact it has on our communities.[86] In further supporting our work and the work of our partners in promoting the mental health and wellbeing of young people, and preventing the onset of mental ill-health, the government has announced a national Child Mental Health Strategy.[87] The Strategy will complement the range of programs and initiatives being delivered to support the mental wellbeing of children and adolescence, and underpin the development of policy and programs into the future. A number of programs and initiatives currently administered by the department are discussed below.

Through the Mental Health in Education initiative (Be You), the government supports promotion and prevention activities, including resilience building skills among children and young people. The initiative was developed in response to the issues raised by the National Mental Health Commission's

[80] See NMHC, *National Review of Mental Health Programmes and Services,* p. 45-48, Vol 1. 2014.
[81] See Department of Health, *Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services*, p. 3, 2015.
[82] See NMHC, *National Review of Mental Health Programmes and Services,* p. 42-43, Vol 1. 2014.
[83] See the National Mental Health Policy, 2008, p. 8.
[84] See AIHW, *Australia's Health*, 2016. Available at: www.aihw.gov.au/getmedia/fcd738e4-def0-4068-bdb4-546a316a9ad5/ah16-3-11-mental-health.pdf.aspx.
[85] See ABS, *National Survey of Mental Health and Wellbeing*, 2007. Available at: www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4326.0Main+Features32007?OpenDocument.
[86] See Victorian Auditor-General's Office, *Child and Youth Mental Health*, 2019. Available at: www.audit.vic.gov.au/report/child-and-youth-mental-health?section=33205--audit-overview.
[87] See Minister for Health, the Hon. Greg Hunt MP. Available at: www.greghunt.com.au.

2014 report concerning the delivery of child mental health programs, including duplication and siloed implementation, and the need for better targeting and integration of services.

Be You is designed to connect support for child mental health, commencing with the early years through to adolescence. This includes a single, integrated end-to-end school based mental health initiative to:

- increase the capacity of early learning services and primary and secondary schools to implement an approach to evidence-based mental health promotion, prevention and early intervention;
- increase the inclusion and coverage of mental health and suicide prevention in pre-service education through the tertiary and Vocational Education Training sectors for teachers and early learning staff; and
- deliver suicide postvention to respond, and assist, secondary schools in supporting students in the event of a suicide of a student.

In 2017, beyondblue was engaged to design, develop and deliver Be You, and in 2018 launched its website providing:

- a toolkit for early learning services (ELS) and schools to develop and implement their own mental health strategies;
- an online platform hosting a range of resources;
- a communication strategy targeted at students, parents, ELS and schools;
- a blended model of e-learning facilitated by a national network of support officers;
- personalised records for educators to track their continuing professional development; and
- a suicide response service to actively support schools following a suicide and to review and improve mental health strategies and plans to minimise risk into the future.

In complementing Be You, the government also directly supports the identification, support and referral of children at risk of mental ill-health through the National Workforce Support in Child Mental Health initiative (the Workforce Support initiative). This initiative is designed to assist clinical and non-clinical professionals and services who work with children to identify, support and refer children at risk of mental health difficulties, and to promote resilience building within children. This would particularly support providers working with children who would benefit from early intervention, including those who have experienced trauma, and support professionals in working with parents and families of these children. In 2017, Emerging Minds was engaged to design, develop and deliver the initiative. Later that year, Emerging Minds launched the National Workforce Centre for Child Mental Health (the Centre) to provide a:

- national online workforce hub for professionals with access to training and resources;
- network of child mental health consultants to connect national, state and regional service providers; and
- communication and shared knowledge strategies to embed effective early intervention in services.

As at 31 August 2018, there has been an average of 5,558 people visit the hub each month and 5,465 new e-learning registrations. Looking forward, Emerging Minds plans to build upon and extend the work of the Centre by:

- designing and promoting education and training for clinicians and non-clinicians who work with children and their families;
- collating and disseminating evidence for early intervention and prevention; and
- identifying gaps in the evidence base for early intervention and prevention.

Through the headspace program, the government also provides additional early intervention services targeted at young people between the ages of 12 and 25 with, or at risk of developing, a mental illness. Funded since 2006, headspace provides access to youth friendly primary health services with a single entry point to holistic care in four key areas: mental health; related physical health; substance misuse; and social and vocational support. The model provides a service platform for, and entry point to, existing services by engaging a range of youth workers and mental health professionals, as well as by referring young people to other appropriate services. As at 30 June 2019, there are 110 headspace services operating nationally. The government has committed to expanding this to 145 headspace services by 2021.[88] The headspace program also includes services provided through eheadspace, a free, confidential and anonymous telephone and web-based support service providing young people with an alternative approach to access support and help. eheadspace uses online communications tools that many young people have indicated is a preferred way of communication and accessing support services.

Following the recommendations of the National Mental Health Commission's 2014 report, the responsibility for commissioning headspace services has transitioned from the headspace National Youth Mental Health Foundation to PHNs, who now have flexibility to use headspace funding for headspace activities that best meet the needs of young people in their regions and improve integration with other services on a regional level.[89] eheadspace National Youth Mental Health Foundation continues to have responsibility in a number of areas and works to improve the headspace program and network, and the maintenance of the headspace model and licencing of services.

Through the headspace centre network, the government funds the Early Psychosis Youth Services (EPYS) program to support the prevention of, and early intervention for, young people who are at 'ultra-high risk' of experiencing their first episode of psychosis. The EPYS program aims to reduce the incidence and severity of psychosis within the community through adopting a holistic approach to care, supporting individuals in every aspect of their lives, including education, employment and relationships. Once registered in the program, young people are matched with a specialist case manager who develops an individual treatment plan and provides ongoing support throughout the treatment. Case managers monitor the impact of treatment plans closely, and consider whether those plans require changes to be made over time. As part of the program, consumers and their families can access a range of other holistic services, including functional recovery groups and family therapy.

[88] See the Youth Mental Health and Suicide Prevention Plan. Available at: https://parlinfo.aph.gov.au/parlInfo/download/media/pressrel/6622412/upload_binary/6622412.pdf;fileType=application%2Fpdf#search=%22media/pressrel/6622412%22.

[89] For more information see the Department of Health, *Mental Health PHN Circular 1 - 12 January 2016*. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Circular1.

Family and carers are also educated on psychosis treatment, self-care and how to implement interventions at home.

Case study – headspace

Since 2006, 446,645 young people have accessed support through centres, online and phone services and 2.5 million services have been delivered to young people. Awareness of the headspace brand has grown and is a trusted model of care that is recognised by young people, their families and communities for providing youth friendly mental health support. The number of young people accessing headspace services at a centre has increased from 59,047 in 2014-15 to 88,557 in 2017-18. The occasions of service provided through headspace centres has increased from 260,768 in 2014-15 to 382,116 in 2017-18. The number of young people accessing eheadspace services has also increased, from 15,709 in 2014-15 to 33,793 in 2017-18. As a result, the number of eheadspace services has also significantly increased from 48,779 occasions of headspace services in 2014-15 to 80,434 occasions of service in 2017-18.

There has been expansion to the number of headspace services operating within the national network, increasing from 68 in November 2014 to 110 in June 2019. The scope of the program has also broadened and undergone diversification with the introduction of new models of service delivery to better meet local needs. This includes the establishment of satellite services, outreach services, outpost services and a regional trial. The Pilbara trial in Western Australia is the first location to trial a flexible model of service delivery that brings headspace services to young people through outreach and community engagement, instead of young people travelling to a centre. headspace Pilbara staff and youth wellbeing workers collaborate with schools, youth centres, Aboriginal Medical Services and community centres across the region. In developing the trial, an extensive co-design process with local communities was undertaken to incorporate feedback from young people, service providers, community members and local Elders. Given the large geographical area of the Pilbara regional, the trial aims to provide access to headspace services for young people who m ay have otherwise had access to mental health services.

In relation to other severe mental illnesses, the government provides flexible funding to PHNs to plan and commission early intervention services for young people in their region. Through this flexible funding, PHNs are able to commission a range of innovative approaches to address the needs of their regions including psychological interventions, assertive outreach, care coordination, case management, and family and group counselling.

Additional funding and activities under the Youth Mental Health and Suicide Prevention Plan is discussed under the Suicide Prevention section.

Youth Mental Health Funding	2017-18 ($m)	2018-19 ($m)	2019-20 ($m)	2020-21 ($m)
headspace National Youth Mental Health Foundation - core funding	5.0	15.3	15.3	15.1
headspace National - Young ambassadors	0.0	0.0	0.6	0.6
Orygen, The National Centre of Excellence in Youth Mental Health - core funding	5.0	4.8	4.4	4.4
headspace Centres	94.1	105.5	116.3	121.6
headspace Capital	0.0	0.0	2.0	2.0
headspace Waiting Lists	0.0	13.0	0.0	16.0
eheadspace	6.4	6.4	6.4	6.4
Early Psychosis Youth Services program	47.8	47.0	47.0	47
Youth Severe - PHN funding	38.7	49.7	50.5	51.3
Mental Health in Education Initiative (Be You) – BeyondBlue	14.2	23.0	23.0	23.0
National Workforce Centre for Child Mental Health - Emerging Minds	8.0	8.0	8.0	8.0
Totals	**219.2**	**272.7**	**273.5**	**295.4**

Digital

The government also funds the provision of digital mental health services and supports for the broader population. Digital mental health services are particularly beneficial for people with, or at risk of, mild to moderate mental illness and may also be an important resource for some people with severe mental illness. They provide an opportunity to significantly increase access to care by transcending geographic, stigma, privacy and financial barriers. They can be used either as a complement or alternative to face-to-face therapies, and allow people to seek support in times of need or when it is most convenient for them. Digital mental health services and products can be delivered online via desktops, mobile devices and apps. The term also extends to telephone and online crisis and counselling services. Digital mental health services are delivered in real time through multiple settings, including the home, the workplace, schools and through clinicians' workplaces. Some services offer fully automated self-help programs, while others involve guidance from clinicians, volunteer crisis supporters, teachers, administrators or peers.

The broad range of digital mental health treatment options span health promotion, treatment and recovery. The suite of digital mental health services funded by the government are also free or low cost and cover a range of counselling, treatment and crisis support services, including suicide prevention and peer support. Services include, for example, Lifeline Australia's 13 11 14 telephone line, Kids Helpline, ReachOut, Mindspot (an online clinic), and SANE Australia's online community forums.

Head to Health, a digital mental health gateway, was developed following the National Mental Health Commission's 2014 report which highlighted that clinically effective digital mental health services offer

one of the greatest invest-to-save opportunities for government and the community.[90] The website itself was co-designed with consumers, carers, service providers, health professionals and other stakeholders, and contains professionally curated evidence-based information and advice, a decision support tool, an interactive service finder, and underpinning service catalogue. Head to Health is an indispensable enabler of the stepped-care approach, supporting improved access to digital resources and tools for all individuals at all stages of their mental health journey, and thereby supporting their overall social and emotional wellbeing. A telephone channel, as an alternative to the website, is expected to be implemented later this year.

Case study – Head to Health

Central to the government's mental health reform process is making optimal use of digital mental health services, including through the development of a consumer-friendly digital mental health gateway – Head to Health. Head to Health was launched in October 2017 to assist individuals in accessing relevant information, advice and free and low cost phone and online mental health services and supports. It also assists individuals in accessing non-digital information, advice and services where appropriate.[91]

The strong governance, advisory and co-design process has ensured Head to Health has been strongly informed and designed by end-users, including people with a lived experience of mental illness as well as the general community across diverse population groups, health professionals, and service providers. Head to Health continues to be informed by user feedback and has been received positively by the community, winning four national and international digital industry awards.[92]

As an indication of the impact that Head to Health has had, statistics indicate:[93]

- 625,774 sessions (averaging approximately 1,227 per day);
- a low bounce rate of 25.64% (where a bounce is when a user views only one page before leaving the site);
- 1,079,147 page views (1 million page views were reached on 6 February 2019);
- an average session time of 2 minutes 39 seconds;
- an average pages viewed of 1.72 per session; and
- a total of 73,169 conversions – including search completions, decision support tool completions (Sam the Chatbot), email resources and print resources.

[90] See NMHC, *National Review of Mental Health Programmes and Services,* p. 127, Vol 1. 2014.

[91] The Head to Health website is accessible at www.headtohealth.gov.au.

[92] Head to Health has won two Gold awards in the AMY Awards in the Collaboration and Healthy Living – Product; won the Sitecore Experience Award for Best Web Content Experience in the Australia and New Zealand region; and won the IMA Best in Class 2018 Award in the Healthcare category with a score of 495/500.

[93] The latest statistics are for the period 6 October 2017 – 28 February 2019.

Perinatal

Each year, 100,000 Australians are estimated to be affected by perinatal depression and anxiety, with up to one in ten women experiencing depression whilst pregnant and one in seven in the year following birth. Men can also experience perinatal mental illness, with about one in ten expectant and new fathers experiencing depression, anxiety or other forms of emotional distress in the perinatal period. Miscarriage, stillbirth and infant death can also have significant effects on mental health and wellbeing. The government currently provides funding to a range of organisations that deliver telephone and online peer support services for women and families with, or at risk of, perinatal depression and anxiety, or experiencing grief due to miscarriage, stillbirth or infant death. From 1 July 2020, the government will implement a new Perinatal Mental Health and Wellbeing Program[94] through which organisations will be able to apply for grants focusing on perinatal mental health support, perinatal loss and bereavement peer support, and perinatal mental health promotion and training. It is anticipated that the first open and competitive grant round for funding under the Perinatal Mental Health and Wellbeing Program will be released in early 2020, with a focus on funding priority gaps in national service provision.

Older Australians

In supporting older Australians, the government has committed to invest over $102.5 million through two measures designed to improve the mental health of Australians over the age of 75 whose mental and physical health are at risk due to social isolation and loneliness, and to support those who live in residential aged care and have been diagnosed with a mental disorder.[95]

The Mental Health Nursing Support measure is being implemented in a two staged approach, commencing with a two year pilot of social connectedness interventions. The pilot will target Australians aged over 75 living in the community who are, or may become, at high risk of mental health conditions due to social isolation and/or loneliness. The Australian College of Mental Health Nurses has been contracted to lead the initial two year pilot and two PHNs (Nepean Blue Mountains PHN and Perth South PHN) will participate in the pilot. The regions of Hawkesbury in NSW and Mandurah in WA have been selected as the project pilot sites. The University of Wollongong will undertake an independent evaluation of the pilot program to inform the broader interventions from 2020-21.

Eating disorders

The Fifth Plan acknowledges that eating disorders are complex mental disorders that result in significant physical impairment and have high rates of mortality.[96] Individuals with eating disorders experience higher rates of comorbid mental health problems than the general population, including depression and anxiety disorders, substance misuse and personality disorders.[97] People with eating

[94] Budget.gov.au, *Budget Measures: Budget Paper No. 2: 2019-20*, 2019, p. 104
[95] See Department of Health, *Better Ageing – mental health support for older Australians*. Budget 2018-19. Available at: www.health.gov.au/internet/budget/publishing.nsf/Content/budget2018-factsheet87.htm.
[96] See Fifth Plan, p. 6.
[97] See the National Eating Disorders Collaboration, *Eating disorders: The way forward: An Australian national framework*, 2010.

disorders can also experience significant physical comorbidities, such as higher levels of cardiovascular disease and neurological symptoms,[98] and are likely to experience stigma and discrimination as a result of their disorder.[99] Treatment for an eating disorder requires not only responses to the underlying pathology but also integrated responses to relevant mental and physical health comorbidities.

The government is investing in a range of initiatives to support people with eating disorders. In providing immediate, holistic support and specialist case, six new residential treatment centres will be established across six states and territories to support people with eating disorders.[100] In implementing this initiative, the department will be working closely with the Butterfly Foundation, the National Mental Health Commission and other relevant stakeholders in the establishment of these centres. This will be supplemented by a number of new MBS items dedicated to subsidise Medicare services for patients with eating disorders. These items will enable patients with anorexia nervosa, and other eating disorders with complex needs, to access up to 40 psychological and 20 dietetic services per year, depending on their needs. The government is also supporting research into eating disorders through the Million Minds Research Fund. This funding will support the development of a health system research centre and academic research into prevention and early intervention for eating disorders.

The government also provides funding to the Butterfly Foundation to support the National Eating Disorder Collaboration (NEDC). The NEDC brings together eating disorder stakeholders and experts across a broad range of fields to develop a nationally consistent approach to the prevention and management of eating disorders. The NEDC has also conducted workforce capability activities to build the capacity of the health and allied health workforce to identify and respond to eating disorders. In addition, the government also funds the Eating Disorders Access Project, a trial to assess the viability of delivering evidence-based eating disorders treatment through primary and allied care within regional PHNs. The Butterfly Foundation has been funded to develop, implement and manage the pilot, deliver training and facilitate access to tertiary supervision for health professionals. A few PHNs[101] have also been funded to commission pilot activities, facilitate engagement with health professionals, disseminate information to health professionals and manage their financial reimbursement for participating. The outcomes of the project will assist in reforming government policy on care pathways for people with eating disorders. Additional initiatives relating to eating disorders are listed at Appendix A.

In relation to nutrition more generally, studies have shown that better quality diets are associated with reduced risk of depression, while unhealthy dietary patterns are associated with increased depression and often anxiety.[102]

In supporting good nutrition within the population, the government leads a number of initiatives, such as the:

[98] See the National Eating Disorders Collaboration*, An integrated response to complexity—national eating disorders framework*, 2012.

[99] See Fifth Plan, p. 6.

[100] The six new residential treatment centres will be located in New South Wales, Tasmania, Victoria, the Australian Capital Territory and Western Australia.

[101] Central QLD, Wide Bay and Sunshine Coast PHN.

[102] See *Psychosom Med*, The association between habitual diet quality and the common mental disorders in commumity-dwelling adults: the Hordaland Health study, 2014.

- Australian Dietary Guidelines: As part of the government's Eat for Health program, the guidelines provide evidence-based advice on the types and amounts of foods to eat for good health, a healthy body weight and the prevention of chronic conditions such as obesity;
- Health Star Rating system: A voluntary labelling scheme developed to rate the nutritional profile of packaged food through the assignment of a rating system from ½ a star to 5 stars. It provides a quick, easy and standard way to compare similar packaged foods. The more stars, the healthier the choice; and
- Australian National Breastfeeding Strategy: Based on well-established evidence that breastfeeding has a range of long-term health and other benefits for infants and mothers, the strategy aims to encourage support and promote breastfeeding. There is some evidence that adults who were breastfed have reduced risk of depression.[103] The Western Australia Pregnancy Cohort (Raine) Study concluded that a shorter duration of breastfeeding may be a predictor of adverse mental health outcomes throughout the developmental trajectory of childhood and early adolescence.[104] The Strategy has recently been finalised and will be made publicly available on the COAG Health Council's website in July 2019.[105]

Physical activity

It is recognised that regular exercise can reduce stress levels and symptoms of mental health conditions including depression and anxiety, and may also assist with recovering from mental ill-health.[106] Studies have also shown that for treating mild-moderate depression, exercise can be as effective as talking therapy and medication.[107]

In supporting increased physical activity, the government has committed to a vision for sport in Australia – Sport 2030 – to, among other things, ensure Australia is the most active and healthy nation worldwide. One of the five outcomes of Sport 2030 is the improvement of the mental health of Australians through recognising the mental health benefits of sport and physical activity, including the improved management of mental illness and greater social connectedness.[108]

For Aboriginal and Torres Strait Islander people, evidence suggests that participation in sport, including participation in sports carnivals and festivals, is linked to improvements in mental health.[109] Locally

[103] See Journal of Affective Disorders, *Breastfeeding and mental health in adulthood: A birth cohort study in Brazil*. *J Affect Disord*. 2016. Available at: www.ac.els-cdn.com/S0165032716302361/1-s2.0-S0165032716302361-main.pdf?_tid=22fb3677-3e6f-4ea1-a0b8-2888ff821e17&acdnat=1552019183_74ab59a7645cb18d3ffcf5a9b6cad8df.

[104] See t*he Journal of Pediatrics, The long-term effects of breastfeeding on child and adolescent mental health: A* pregnancy *cohort study followed for 14 years*, 2010. Available at: www.jpeds.com/article/S0022-3476(09)01036-1/abstract.

[105] Available at: www.coaghealthcouncil.gov.au/.

[106] See HealthDirect, *Exercise and mental health*. Available at: www.healthdirect.gov.au/exercise-and-mental-health.

[107] See Beyondblue, *Exercise your way to good mental health*. Available at: www.beyondblue.org.au/personal-best/pillar/supporting-yourself/exercise-your-way-to-good-mental-health.

[108] See Sport 2030. Available at: www.sportaus.gov.au/nationalsportplan/home/featured/download/Sport_2030_-_National_Sport_Plan_-_2018.pdf.

[109] See Bankwest Curtin Economics Centre, *After the Siren: The community benefits of Indigenous participation in Australian Rules Football*, Research Report 5/17, 2017. Available at: www.bcec.edu.au/assets/BCEC-After-

relevant Indigenous sports and recreation programs can support mental health by helping to build a sense of purpose, hope and belonging in remote communities, and, in regional and urban areas, by providing opportunities for improved social inclusion in the broader community. There is evidence that community sports and recreation programs are linked to increased self-esteem, dignity, confidence and empowerment, and to reductions in harmful behaviours, self-harm and reduced suicide and depression amongst adolescents.[110]

Through the Indigenous Australians Health Programme (IAHP), the government contributes funding to a number of programs that directly support the mental wellbeing of Indigenous people through participation in sport. For example, through providing funding to the National Rugby League's Indigenous All Stars State of Mind program,[111] the government supports the delivery of mental health and resilience workshops to over 500 Indigenous people including Indigenous All Stars players, youth summit participants and 15 grassroots clubs with a high proportion of First Nations players. Online mental health information, tools and resources are also provided through the program.

Additional prevention, treatment and recovery programs and initiatives administered by the government are listed at Appendix A.

Suicide prevention

Intentional self-harm and suicide are inherently complex and multifaceted health and social policy issues which have profound impacts on families and communities. It is important to distinguish between intentional self-harm and suicide, including suicide attempts. While there is no universally accepted definition of intentional self-harm,[112] it is generally characterised by deliberate activity that causes pain or injury to oneself, although without the intention of taking one's life. Despite this distinction, there appear to be similar risk factors associated with both intentional self-harm and suicide, including genetic vulnerability, psychological, familial, social, cultural factors,[113] and the likelihood of the person having a diagnosable depression or anxiety disorder.[114] However, it is important to note that not every individual who dies by suicide will have a mental illness.[115] The WHO identifies a wide spectrum of risk factors associated with suicide, reflecting the social determinants of health, such as societal, community, and relationship factors.[116] Feelings of helplessness or being

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the-Siren-Report-Web.pdf; and Sport Management Review, *Australian Indigenous youth's participation in sport and associated health outcomes: empirical analysis and* implications, 2015. Available at: www.sciencedirect.com/science/article/abs/pii/S1441352314000333.

[110] See Closing the Gap Clearinghouse Resource Sheet no. 26, *Supporting healthy communities through sports and recreation programs*, 2013. Available At: www.aihw.gov.au/getmedia/61c83f53-3d74-40e4-8c99-554b5bce71cf/ctgc-rs26.pdf.aspx?inline=true.

[111] The NRL developed the State of Mind program in partnership with Lifeline, Kids Helpline, headspace and the Black Dog Institute.

[112] See Royal Australian and New Zealand College of Psychiatrists, *Psychiatrists clinical practice guideline for the management of deliberate self-harm*. Available at: www.ranzcp.org/files/resources/college_statements/clinician/cpg/deliberate-self-harm-cpg.aspx.

[113] See the Lancet, *Self-harm and suicide in adolescents*, Volume 379, Issue 9834, 23–29 June 2012, Pages 2373-2382. Available at: www.sciencedirect.com/science/article/pii/S0140673612603225?via%3Dihub.

[114] See ScienceDirect, *Differences in risk factors for self-harm with and without suicidal intent: Findings from the ALSPAC cohort*, Journal of Affective Disorders, Volume 168, 15 October 2014, Pages 407-414.

[115] See Fifth Plan, *Priority Area 2: Suicide Prevention*.

[116] See WHO, *Preventing Suicide: a global imperative*, 2014.

overwhelmed by a situation may also be associated with suicide attempts. Comorbidities were also observed to be co-occurring factors contributing to suicide, with 80 per cent of suicides in 2017 reported to have a comorbidity as a contributing causes of death. Mood disorders were the most common co-morbidity being present in 43 per cent of deaths. Almost a third (29.5 per cent) had a mental and behavioural disorder due to psychoactive substance use, and drug and alcohol disorders were also commonly noted (29.5 per cent).[117]

It is estimated that one per cent of Australians have self-harmed within the last month, while eight per cent have intentionally harmed themselves in their lifetime.[118] Those who intentionally harm themselves are estimated to be 70 per cent more likely to complete suicide.[119] The ABS has estimated that over 65,000 Australians attempt to end their lives each year,[120] with 3,128 dying by suicide in 2017. This equates to an age-standardised suicide death rate of 12.7 per 100,000.[121] From 2013-17, the aged-standardised suicide death rate has increased by an average of 3.2 per cent per annum.

There is significant disparity between men and women when considering deliberate self-harm and suicide. In considering suicide, men account for approximately three-quarters of those who commit suicide, while women are much more likely to plan or attempt suicide.[122] In contrast, the adjusted rates for hospitalisations due to deliberate self-harm were at least 40 per cent higher for women than males over 1999 to 2011-12.[123] In addition to this, some population groups, such as Aboriginal and Torres Strait Islander people, have a significantly higher risk of death by suicide than others. Suicide is the leading cause of death for people aged 15-44 and remains the leading cause of premature mortality in Australia.[124] National coordination across portfolios, sectors, services and all levels of government is needed to address this challenge. The National Mental Health Commission's 2014 report highlighted a lack of coordination in suicide prevention programs and duplication between Commonwealth and state and territory efforts. The report encouraged overall system redesign in this area, focussed on a whole of community approach with regional service integration and better targeting of investment. In 2017, all Australian governments committed to address suicide as a priority under the Fifth Plan. In this context, the fundamental objective is to align and integrate the individual activities being undertaken by governments, peak bodies, commissioning agencies and service providers into a consolidated national suicide prevention implementation strategy.[125]

On 8 July 2019, the Prime Minister appointed the National Suicide Prevention Adviser for a period of 18 months, with a possible extension if required. The newly created Adviser position will report directly to the Prime Minister and have a dedicated taskforce within the Department of Health. The Adviser will work across portfolios and with relevant Ministers to develop options to improve the design, coordination and delivery of suicide prevention activities. Key areas are:

[117] See ABS, *Causes of Death*, *Australia*. 2017.
[118] See Martin et al (2010), *Self-injury in Australia: A community survey*. Medical Journal of Australia.
[119] See Chan et al (2016), *Predicting suicide following self-harm: systematic review of risk factors and risk scales*. The British Journal of Psychiatry.
[120] See ABS, *National Survey of Mental Health and Wellbeing*, 2007.
[121] See ABS, *Causes of Death, Australia*, 2017.
[122] See AIHW, *Suicide and hospitalised self-harm in Australia: trends and analysis*, 2014.
[123] See AIHW, Suicide and hospitalised self-harm in Australia: trends and analysis, 2014.
[124] See ABS, *Alcohol-induced deaths decreasing over time*, 2018.
[125] See Fifth Plan, *Priority Area 2: Suicide Prevention*.

- Better connected communities through enhancing the capacity of frontline services, community-based organisations and families to identify and support those at risk or in crisis;
- Better connected journeys through improved pathways and system navigation for individuals and families; and
- Better connected data and evidence by mapping needs and services to ensure people receive the care they need, when they need it.

In actioning the Fifth Plan, the government established the National Suicide Prevention Leadership and Support Program to provide national leadership and support for whole of population suicide prevention activity. Under the program, funding is provided under five activity streams for a range of national activities that contribute to reducing deaths by suicide and suicidal behaviour (ideation, planning, self-harm and suicide attempts):

- National Leadership Role in Suicide Prevention;
- National Leadership in Suicide Prevention Research;
- Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention;
- National Media and Communication Strategies; and
- National Support Services for Individuals at Risk of Suicide.

The government currently funds 15 organisations to deliver 18 activities in areas including research, anti-stigma and awareness campaigns, face-to-face support for individuals in need, and training for frontline services. Work is currently underway to extend funding to organisations through to June 2021.

The government also provides funding to PHNs for the National Suicide Prevention Trial program, a systems-based approach to suicide prevention which aims to gather evidence on how to better prevent suicide in regional areas of Australia and in high-risk populations, including among Aboriginal and Torres Strait Islander people, young and middle-aged men, young people and veterans. There are currently 12 suicide prevention trial sites,[126] led by 11 PHNs, which are being guided by a range of suicide prevention models, such as the Black Dog Institute's Lifespan model, the Alliance Against Depression framework and the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project report recommendations. Through the program, PHNs have commissioned a range of trial activities, such as professional training, community education campaigns and school programs, to build community capacity to respond to the risk of suicide. Frontline services have also been commissioned in some areas to respond to local needs, including follow up services for people who have attempted suicide.

The government also provides funding to Lifeline Australia through the Suicide Hotspots Project to increase the capacity and reach of Lifeline's 24-hour Suicide Hotspot Crisis Line Service, and increase its capacity to promote help-seeking messages at hotspot locations. Funding is also provided to state

[126] The 12 sites are North Coast NSW; Western NSW; North Western Melbourne; Townsville; Brisbane North; Central Queensland, Wide Bay, Sunshine Coast; Perth South; the Kimberley; Mid-West, Western Australia; Country South Australia; Tasmania; and Darwin.

and territory governments to deliver infrastructure projects to deter people from attempting suicide at identified high-risk locations.

Additional funding is provided through a range of initiatives to support the mental health of individuals in drought affected areas. Through the Empowering our Communities initiative, funding is provided to nine PHNs to support them to plan and commission community-led mental health and suicide prevention services to address the immediate support needs of rural and regional communities, and foster longer term recovery and resilience. These services are aimed to support farmers and communities deal with the anxiety, stress and uncertainty of drought conditions. The government also funds ReachOut, the primary youth e-mental health service providing practical support, tools and tips to youth and children nationally through their counselling services group. Through ReachOut, an education campaign has been delivered to raise awareness of digital mental health services for youth and their families in drought affected communities in New South Wales and Queensland. The MBS has also recently been expanded through the Better Access initiative to include telehealth consultations via video conferencing to improve access to mental health services for people in regional, rural and remote Australia.[127]

In addition to these programs, the government has announced the Youth Mental Health and Suicide Prevention Plan for the investment of over $500 million in new funding to support the mental health and wellbeing of young Australians. Under the Plan, funding is proposed to strengthen the headspace network, support Indigenous suicide prevention, and enhance early childhood and parenting support.[128]

In addition to frontline activities, the government is continuing to build the evidence base for what works in suicide prevention through the Suicide Prevention Research Fund (Research Hub) and a best practice Suicide Prevention Hub. The Research Fund disburses funding through targeted research grants that address identified national priorities in suicide prevention research, with a focus on prevention models and strategies including for at risk groups. The Best Practice Hub will support and inform PHNs and other commissioning organisations to identify and select evidence-based suicide prevention programs and services.

Funding was also allocated through the 2019-20 Budget to establish a new national system for collection and communication of information on suicide and self-harm. The development of this system will be led by the AIHW in collaboration with the National Mental Health Commission and the Department of Health. The National Suicide Information Initiative will facilitate linkages between existing data collections to bring suicide and self-harm data together in a single location at a national level.

Additional suicide prevention programs and initiatives administered by the department on behalf of government are listed at Appendix B.

[127] See Department of Health, *Better Access Telehealth Services for people in rural and remote areas*. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba-telehealth.

[128] Further information on the Youth Mental Health and Suicide Prevention Plan is available at: https://parlinfo.aph.gov.au/parlInfo/download/media/pressrel/6622412/upload_binary/6622412.pdf;fileType=application%2Fpdf#search=%22media/pressrel/6622412%22.

Comorbidities

Comorbidity, or multimorbidity, is the occurrence of more than one condition or disorder in an individual,[129] and may refer to co-occurring mental disorders or co-occurring mental disorders and physical conditions.[130] The National Survey of Mental Health and Wellbeing found that an individual with co-occurring diseases or disorders is likely to experience more severe and chronic medical, social and emotional problems than if they had a single disease or disorder.[131] The survey also found that individuals with comorbid conditions are more vulnerable to alcohol and drug relapses, and relapses of mental health problems.[132]

It is estimated that approximately 12 per cent of the Australian adult population has both a mental disorder and a physical condition, with the most common comorbidity being the combination of anxiety disorders and physical conditions.[133] Women are more likely to have a comorbidity.[134]

When looking at drug abuse disorders, there is a strong reciprocal relationship with mental ill-health. It is estimated that half of individuals with a severe mental illness are affected by substance abuse, while nearly 40 per cent of those who abuse alcohol and other drugs have at least one serious mental illness. Individuals with mental illnesses are more likely to abuse alcohol or drugs to help ease their symptoms, while abusing alcohol or drugs may potentially trigger the first symptoms of a mental illness.[135] In the long term, however, abuse exacerbates the symptoms that were initially relieved by drugs or alcohol, and causes long-term side effects such as liver or heart conditions.[136] There are many mental health effects of commonly used drugs, such as anxiety, depression or sleeping problems, while the use of methamphetamines can trigger delirium or psychosis. Existing mental health problems can be exacerbated by the use of cannabis, with the use of this drug making a person more likely to develop a mental health problem (in particular psychosis) later in life. The use of cocaine can lead to panic attacks, paranoia, psychosis, depression and anxiety, while ecstasy use can cause hallucinations, paranoia, memory loss, anxiety and depression. Heroin can limit the efficacy of any treatments for mental health problems, as well as making symptoms worse.[137]

In relation to tobacco use, there is growing evidence that comprehensive and effective tobacco control measures promote improved mental health and wellbeing, prevent mental ill-health and support early intervention.[138] There is also evidence suggesting a possible causal relationship between tobacco smoking and schizophrenia spectrum disorders, potentially caused by nicotine.[139] Findings from

[129] See National Survey of Mental Health and Wellbeing, 2007.
[130] See *Report on the 2007 National Survey of Mental Health and Wellbeing*, 2009.
[131] See ABS, *National Survey of Mental Health and Wellbeing: Summary of Results, Comorbidity,* 2007.
[132] See *National Survey of Mental Health and Wellbeing*, 2007.
[133] See *National Survey of Mental Health and Wellbeing*, 2007.
[134] See AIHW, *Comorbidity of mental disorders and physical conditions*, ch 2, 2007.
[135] See HealthDirect, *Drugs, alcohol and mental health*. Available at: www.healthdirect.gov.au/drugs-alcohol-and-mental-health.
[136] See Australian College of Mental Health Nurses, *Addiction and Mental Health Fact Sheet*. Available at: www.acmhn.org/images/stories/Resources/AddictionandMentalHealth.pdf.
[137] See Australian College of Mental Health Nurses, *Addiction and Mental Health Fact Sheet*. Available at: www.acmhn.org/images/stories/Resources/AddictionandMentalHealth.pdf.
[138] See Tobacco in Australia*, Other conditions with possible links to smoking.* Available at: www.tobaccoinaustralia.org.au/3-18-other-conditions-with-possible-links-to-smoking
[139] See Front. Psychiarty, *Evidence of a Causal Relationship Between Smoking Tobacco and Schizophrenia Spectrum Disorders*. Available at:

multiple countries suggest that smoking increases the risk of anxiety, depression and suicidality, particularly in heavy smokers.[140] A recent review concluded that quitting smoking is associated with reduced depression, anxiety and stress and improved positive mood and quality of life compared when with continuing to smoke.[141]

The government is committed to addressing alcohol and drug misuse through the National Drug Strategy (NDS), an overarching framework seeking to build safe, healthy and resilient Australian communities through preventing and minimising alcohol, tobacco and other drug-related harms.[142] The NDS acknowledges that given the strong relationship between mental health and alcohol, tobacco and other drugs, it is imperative to improve the collaboration and coordination between services to ensure that the most appropriate treatments and supports are being made available to individuals.[143]

Under the NDS, a number of sub-strategies have been developed to provide direction and context for specific issues, including the National Tobacco Strategy 2012-18 (NTS). Through the NTS, the government, together with the states and territories, is committed to reducing the prevalence of smoking and its associated health, social and economic costs, and the inequalities it causes.[144] Reducing smoking among populations with a high prevalence of smoking, such as people living with a mental illness, is a priority area under the current NTS. Subject to endorsement with states and territories, the development of a new NTS is currently underway and is anticipated to commence later this year. A review of the department's tobacco control legislation[145] has also commenced to ensure that the legislative framework is suitable to address current and future challenges, and continues to achieve the government's objectives to reduce smoking prevalence and the use of tobacco products. This may provide an opportunity to further tobacco control as a means to assist in the prevention of mental ill-health and support general mental wellbeing.

In addressing alcohol abuse, the government is currently developing the latest iteration of the National Alcohol Strategy 2018-26 (NAS), another sub-strategy of the NDS. The NAS was released in 2017 for consultation, closing for comment in early 2018. It is intended that the NAS will provide a guide for governments, communities, organisations and industry for reducing the harm of alcohol on the Australian community and promote mental health and wellbeing, and support early interventions. As alcohol abuse can extend beyond mental health issues and impact on social connection, a lack of income, employment, housing and education, effective interventions require an integrated and

www.frontiersin.org/articles/10.3389/fpsyt.2018.00607/full?utm_source=F-NTF&utm_medium=EMLX&utm_campaign=PRD_FEOPS_20170000_ARTICLE.

[140] See American Journal of Preventive Medicine, *Nicotine Dependence and Pre-Enlistment Suicidal Behavior Among U.S. Army Soldiers*, 2019. Available at: www.sciencedirect.com/science/article/pii/S0749379718322840?via%3Dihub.

[141] See BMJ, *Change in mental health after smoking cessation: Systematic review and meta-analysis. British Medical* Journal, 2014. Available at: www.ncbi.nlm.nih.gov/pubmed/24524926.

[142] See Department of Health, the *National Drug Strategy 2017-2026*.

[143] See Department of Health, the *National Drug Strategy 2017-2026*, p. 27.

[144] See the NTS 2012-2018. Available at: www.nationaldrugstrategy.gov.au.

[145] The review covers the *Tobacco Advertising Prohibition Act 1992*, the Tobacco Advertising Prohibition Regulation, the *Tobacco Plain Packaging Act 2011* and the Tobacco Plain Packaging Regulations. More information is available at: www.consultations.health.gov.au/population-health-and-sport-division/review-of-tobacco-control-legislation/.

cross-agency response, including between health care, education, social services, liquor regulators, law enforcement, the justice system and local government.

Within our Aboriginal and Torres Strait Islander population, mental health and substance abuse disorders represented the largest burden of disease (accounting for 19 per cent of the total burden) followed by injuries, including suicide and self-inflicted injuries (accounting for 15 per cent).[146] Research suggests that people suffering from mental ill-health have very high rates of smoking compared to general populations, but that smoking cessation is associated with reduced depression, anxiety, and stress and improved positive mood and quality of life when compared with continuing to smoke.[147] The prevalence of tobacco use is significantly higher among Aboriginal and Torres Strait Islander people – 39 per cent identify as daily smokers, accounting for 12 per cent of their total burden of disease.[148]

To address the prevalence of smoking among Aboriginal and Torres Strait Islander people, the government established the Tackling Indigenous Smoking program, a targeted multi-faceted initiative which supports tobacco control approaches that are culturally tailored for, and targeted to, Aboriginal and Torres Strait Islander people. The National Tobacco Campaign *Don't Make Smokes Your Story* also targeted Aboriginal and Torres Strait Islander people in three phases in 2016, 2017, and 2018.

It is encouraging to note that the current smoking rate (daily and non-daily smoking) among Aboriginal and Torres Strait Islander people has declined significantly from 51 per cent to 42 per cent between 2002 and 204–15 for those aged 15 years and over.[149] The decline in smoking rates over 2008 to 2014-15 was associated with government investment in tobacco control initiatives targeted to Aboriginal and Torres Strait Islander people.[150]

Additional alcohol and other drugs-related programs and initiatives administered by the department on behalf of government are listed at Appendix C.

When considering older Australians, the prevalence of dementia and the presence of comorbidities are challenges our communities continue to face. Today, an estimated 436,000 Australians live with dementia, with estimates suggesting this could grow to over one million people by 2058.[151] Dementia is the second leading cause of death in Australia and for women is the leading cause of death.[152]

[146] See AIHW, *Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011*, 2016.

[147] Taylor G, McNeill A, Girling A, Farley A, et al, Change in mental health after smoking cessation: systematic review and meta-analysis. *The British Medical Journal* 2014; 348.

[148] See AIHW, *Alcohol, tobacco & other drugs in Australia*, 2018.

[149] See Department of the Prime Minister and Cabinet, *Aboriginal and Torres Strait Islander Health Performance Framework*, 2017.

[150] See ABS, *Aboriginal and Torres Strait Islander Peoples: Smoking Trends, Australia, 1994 to 2014-15*, 2017. Available at: abs.gov.au/ausstats/abs@.nsf/mf/4737.0.

[151] Institute for Governance and Policy Analysis, University of Canberra (for Dementia Australia), *Dementia Prevalence Estimates 2018-2058*, 2018. Available at: www.dementia.org.au/files/documents/2018-2058%20Prevalence%20CED_AUSTRALIA_alpha.pdf.

[152] See ABS, *Causes of Death*, Cat. 3303.0, 2018.

Dementia is not a mental disorder, it is a terminal condition that impacts on the brain's functions and affects an individual's normal social or working life.[153]

Depression is very common among people with dementia, with approximately 20 to 30 per cent of those diagnosed with dementia experiencing depressive symptoms. Individuals in long-term residential care appear to be particularly at risk of depression.[154] It can be difficult to distinguish symptoms of depression from those of dementia as many symptoms are common to both diseases, such as impaired ability to think and concentrate and problems with memory, which can lead to an incorrect diagnosis in an older person.[155]

All 31 PHNs have been contracted to commission in-reach mental health services for people living in residential aged care facilities with mild to moderate mental illness. The measure is being incrementally rolled out with initial services commencing from late January 2019 in most PHNs, and will build up to full implementation in 2021-22. At least 205 residential aged care facilities are involved in these initial services. In seeking to improve the health outcomes of those living with dementia, their families and carers, the department has developed and administers the following national programs and initiatives to meet the government's policy objectives:

- National Dementia Support Program: Delivers a range of consumer supports including a website, helpline, counselling and awareness-raising activities. The NDSP aims to increase awareness and understanding of dementia and provide supports for people living with dementia and their carers;
- Dementia Behaviour Management Advisory Service (DBMAS): Provides support and advice to service providers and individuals caring for people living with dementia where behavioural and psychological symptoms of dementia are affecting a person's care, either in residential aged care or home care settings. DBMAS offers access to 24-hour phone advice and face to face support to family carers, primary and acute care staff and aged care providers to improve the quality of life of a person living with dementia. Where a person is experiencing severe and extreme behavioural and psychological symptoms of dementia in a residential aged care setting, DBMAS can refer them to the Severe Behaviour Response Teams for additional support; and
- Severe Behaviour Response Teams (SBRTs): A mobile workforce of clinical experts who provide timely and expert advice to residential aged care providers who request assistance in caring for people with the most experiencing severe behavioural and psychological symptoms of dementia. SBRTs assess the causes of the behaviours, assist care staff until the immediate crisis is resolved, develop a care plan to address and deal with behaviours, then provide follow up assistance as needed. This can include the training and up skilling of staff to enable them to appropriately manage residents with severe behaviours. SBRT staff work face to face, over the phone and via video conferencing. All referrals to the SBRTs must be made through the DBMAS.

[153] See Dementia Australia, *About Dementia*. Available at: www.dementia.org.au/files/helpsheets/Helpsheet-AboutDementia01-WhatIsDementia_english.pdf.

[154] See Dementia Australia, *Depression and dementia*. Available at: www.dementia.org.au/national/support-and-services/carers/behaviour-changes/depression-and-dementia.

[155] See Beyondblue, *Dementia, anxiety and depression*. Available at: https://resources.beyondblue.org.au/prism/file?token=BL/0158.

In addition to dementia-specific activities, in 2017, the government launched the Aged Care Diversity Framework[156] to support action to address barriers to older people with diverse characteristics and life experiences accessing safe, equitable and quality aged care. The Framework recognises that older people with diverse characteristics and life experiences may have experienced exclusion, discrimination and stigma during their lives that affects their ability to access safe, equitable and quality aged care. It is premised on the basis that people will feel happier and better connected when they are receiving services which are culturally safe and respect their culture and identity. 'People with mental health problems and mental illness' is one of 12 diverse groups identified within the Framework. Earlier this year, Action Plans under the Framework were launched for the following groups:

- older Aboriginal and Torres Strait Islander people;
- older Culturally and Linguistically Diverse people;
- older Lesbian, Gay, Bisexual, Trans and gender diverse, and Intersex elders; and
- all diverse older people in the form of a 'Shared action plan'.

Examples of actions within these plans with a mental health focus include:

- developing policies and processes for identifying and reporting racism and discrimination;
- ensuring staff in aged care services are trained to provide trauma-informed care for vulnerable consumers, such as: refugees and asylum seekers, older migrants who have experienced war; older gay people who lost friends, family and partners due to the AIDS epidemic; members of the Stolen Generation; and Care Leavers more broadly;
- ensuring staff in aged care services receive cultural competency training and can provide culturally safe care; and
- engaging additional psychological/psychiatric services as required for consumers who have experienced trauma.

Health workforce

The mental health workforce must be appropriately structured and skilled to support any reforms to the mental healthcare system. It is only through ensuring that the workforce is fit for purpose can the full benefits of reforms be realised.

In December 2018, the government committed to develop a new National Mental Health Workforce Strategy to attract, train and retain the workforce needed to meet the demands of the mental health system in the future. The new national Mental Health Workforce Strategy, to be developed in collaboration with state and territory governments, will address current workforce challenges impacting on the effective provision of mental health services across Australia, including a focus on and access to, and quality of, mental health services in regional and remote areas. The strategy will be informed by an independent taskforce and a national consultation process, which will consider Australia's mental health workforce quality, supply, distribution and structure.

[156] See Department of Health, *Aged Care Diversity Framework*, 2018. Available at: www.agedcare.health.gov.au/support-services/people-from-diverse-backgrounds/aged-care-diversity-framework.

In supporting older Australians, the government recently developed the Aged Care Workforce Strategy to modernise the aged care workforce and position it to better meet the care needs of older Australians. The strategy highlights the need to improve workforce competencies, particularly amongst personal care workers (PCWs), across a range of areas including mental health care.[157]

In considering health workforce matters, the department has developed responses to a number of discrete questions contained within the Productivity Commission Inquiry into Mental Health Issues Paper below.

Configuration and capabilities

Providing a more equitable distribution of mental health professionals is a key workforce configuration challenge. A more equitably distributed workforce of psychiatrists, GPs with mental health training, psychologists and other mental health workers would directly address the current maldistribution of access to mental health services, and improve health outcomes for consumers in rural and remote areas.

The department is in the process of implementing key workforce planning measures that will inform long-term responses to questions of workforce configuration and capabilities. These are high-level activities to support workforce planning at various levels to determine the structure, composition and geographic distribution of the health and medical workforces that is required to meet emerging needs for services. The key measures are the:

- National Medical Workforce Strategy: To guide long-term medical workforce planning across Australia. The strategy will identify strategic priority actions to improve the long-term coverage of primary and specialist medical care by matching doctors to predicted needs; and
- Health Workforce Planning Framework: Announced as part of the Stronger Rural Health Strategy, the framework will function as an operational blueprint to support the long-term education, training, supply and distribution of Australia's health and medical professionals. The Framework will be the basis for collaborative planning and continuous monitoring at various levels to ensure Australia's health workforce is structured to meet emerging service needs.

Additionally, through the Workforce Incentive Program (to commence on 1 January 2020), the government will provide targeted financial incentives to encourage medical practitioners to deliver eligible primary health care services in regional, rural or remote areas. The program also provides financial incentives to support eligible general practices to engage multidisciplinary teams, including in rural, remote and regional settings. The program will replace the current Practice Nurse Incentive Program and the General Practice Rural Incentives Program. Eligible health professionals include psychologists and social workers.

[157] See Department of Health, Aged Care Workforce Strategy Resources, 2019. Available at: www.agedcare.health.gov.au/aged-care-workforce-strategy-resources.

Workforce shortages in regional and remote areas

There are several factors that influence the comparative lack of health and medical service provision in rural and remote communities relative to the major cities. In some cases, relevant factors apply to specific geographic regions. There are also several broader, system-level factors, that influence the geographic distribution of service access, with key factors being:

- the career aspirations of health professionals and medical practitioners not being aligned to working outside of the major cities – this can include a perception that rural careers are somehow limited in their scope and opportunity;
- access to education and training opportunities outside of the major cities;
- the need for program and funding arrangements that support a potential multitude of service delivery models, as a means of catering to the service needs of rural and remote communities of variable composition and size;
- reliable access to the technology that is required to support emerging models of care delivery; and
- consumer health literacy, which is influenced by access to health and medical professionals.

Government measures continue to invest significant effort in improving the geographic distribution of services by:

- developing and updating remoteness area classification systems to ensure its workforce distribution programs apply accurate and consistent definitions of remoteness that are linked to the latest evidence of the distribution of Australia's residential population;
- identifying geographic areas that have the most significant workforce shortages (a key example of this work is the district of workforce shortage classification system);
- creating programs that link financial incentives (including access to the MBS) to working in a rural or remote area or, to a lesser extent, an underserviced community in an outer metropolitan area; and
- expanding the geographic distribution of education and training opportunities.

In some rural and remote areas, it is not possible to support a sustainable and ongoing workforce. In these areas, the department funds outreach and locum support to provide services where there are no other viable options. The government funds the Royal Flying Doctor Service (RFDS) to provide services beyond the normal medical infrastructure, where there are no other viable options.

Since January 2019, the government has provided funding for the RFDS to deliver mental health outreach services. The aim is to support people living, working and traveling in rural and remote areas of Australia by ensuring access to mental health outreach services where there are few or no other services.

The Rural Health Outreach Fund (RHOF), has been established to improve access to medical specialists, GPs, allied and other health professionals for people living in regional, rural and remote Australia. There are four health priorities under the RHOF including mental health services.

The RHOF is administered by jurisdictional fundholders, who are responsible for needs assessment, planning, and delivery of outreach health services, including mental health services. Services include psychiatry, psychology, social work and mental health nursing.

Additional activities that would fall outside of the workforce programs could focus on addressing the perception, particularly amongst Australian graduates, that rural and remote careers are limited. In addition, work to develop and consider evidence of effective service delivery models being employed in rural and remote areas. This would provide an evidence base for identifying the features of these models that could be effectively adopted within other locations as a means of potentially improving service access in some of the most vulnerable communities in Australia.

Restrictions on scope of practice

While psychologists (clinical and other) are recognised as having a different scope of practice to other health and medical professionals, it is important to recognise that there are training and development opportunities available that allow individual health professionals to expand their scope of practice. Some of these allow health and medical professionals to expand their scope of practice to offer psychological services. An example is the mental health training that enables GPs and other doctors working in primary care settings to develop mental health care plans and offer psychological strategies under the MBS. This has allowed many doctors working in primary care settings to fill immediate service gaps and work with other mental health professionals under the MBS to offer focused mental health care.

Stress and turnover within the mental health workforce

Noting that the emotionally demanding nature of mental health work is in itself a significant risk factor, key opportunities to reduce stress and turnover include:

- health literacy activities, with a specific emphasis on activities that seek to reduce the stigma associated with mental health work;
- providing the basis for supporting multidisciplinary care and interactions between mental health workers and other health professionals (the mental health MBS items are an example of this approach);
- improving the work environment; and
- a postvention approach that places a specific emphasis on health and mental health professionals (an approach that addresses patient suicide scenarios to support the long-term mental health of this workforce).

In addition to workforce distribution activities, there are programs that support health professionals working in rural areas. CRANAplus offers support, training and professional services to health professionals working in remote or isolated areas. This includes operating the Bush Services Support Line, a free confidential telephone service (available 24 hours a day, seven days a week) to provide emotional support to remote health professionals and their families.

In the nursing profession, including mental health nurses, there is generally a lack of support and leadership in rural and remote areas, both in mentoring and teaching, particularly in primary health care and community settings. Improved support and leadership has the potential to reduce stress and high turnover.

Training and Continuing Professional Development

Access to rural training opportunities for health students, including those in disciplines related to mental health, are provided through the Rural Health Multidisciplinary Training Program. The program funds a university presence in rural communities through a network of rural clinical schools and university departments of rural health.

In 2018, the program supported placements for 194 psychology and social work students, comprising 2,831 placement weeks. The program has also supported the employment of mental health academics who undertake a range of activities including direct community engagement to raise mental health awareness and working with local health professionals to better recognise mental health issues.

The training standards for vocational General Practice training in Australia are set by the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine and includes training on mental healthcare as per the RACGP's Clinical Guidelines and the ACRRM's Primary Curriculum.

The Australian General Practice Training (AGPT) Program is a fully government funded post-graduate vocational education and training program, for doctors interested in pursuing a career in general practice. A minimum of 50 per cent of registrar training on the AGPT program occurs in rural and remote Australia resulting in greater access to mental healthcare for rural and remote communities. Additionally doctors training on the AGPT can access advanced training in mental healthcare.

The Rural Procedural Grants Program provides grants to encourage rural General Practitioners to maintain and enhance their procedural and emergency medicine skills. From 1 Jan 2020 rural GPs will be able access grants under this program to maintain their skills in the provision of emergency mental health services thereby enabling greater provision of emergency mental healthcare in rural and regional Australia.

From 2020, the National Rural Generalist Pathway will aim to improve access to medical practitioners for rural and remote communities, providing doctors with the right skills, in the right place, at the right time. This will enable doctors to develop key skills in general practice and other specialist skills, including mental health services, in rural and remote hospitals and communities.

The Specialist Training Program (STP) has been established to support psychiatry and other non-general practice vocational medical training, in regional, rural and remote areas. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has been funded to deliver 160 full time equivalent (FTE) psychiatry training positions in expanded settings with 50 FTE to be located in rural

areas to improve access to specialist services for people in rural communities.

The RANZCP has also been funded to deliver 34 rurally focussed STP training posts under the Integrated Rural Training Pipeline (IRTP) Initiative. The IRTP Initiative has built on the success of the STP will provide greater opportunities for trainees interested in rural careers to maintain connections to rural communities by supporting rural and regional fellowship training models across twenty non general practice medical specialties including psychiatry. Psychiatry trainees in these posts will spend the majority of their fellowship training, at least 66% of that time, in rural, regional and remote areas delivering psychiatry services to their local community.

The government's Mental Health Nurse Workforce program has developed a suite of online learning modules for primary health care nurses working in general practice. Improving the mental health literacy and clinical skills of general practice nurses working in primary health care settings is essential to sustain and build capacity and capability in the workforce. People experiencing a mental illness or distress will often present to a general practice.

The government also supports the physical and mental health of Aboriginal and Torres Strait Islander people through the Chronic Disease Support Project. The project is a training program that supports Aboriginal Health Workers and other health professionals to assist people living with chronic disease to achieve better health outcomes. In 2017-18, a new Obesity and Mental Health Specialist module was added to the training program, providing additional training specifically for the social and emotional wellbeing workforce.

Peer support workforce

The involvement of the peer workforce, including through volunteering arrangements, across the spectrum of care is central to the person-centred approach to mental healthcare. From the design of mental healthcare policies and services through to their delivery, the peer workforce has the ability to provide invaluable input to ensure services are fit for purpose. They are also invaluable to shaping the ongoing mental health reform. The importance of the peer workforce is acknowledged in the Fifth Plan, particularly in building recovery-oriented approaches to care, providing meaningful support to people and modelling positive outcomes from service experiences.[158] However, the National Mental Health Commission has observed the peer workforce is inconsistently utilised and poorly supported.

In response to this, all Australian governments have agreed to the development of Peer Workforce Development Guidelines, implementing the recommendation made in the National Mental Health Commission's 2014 report.[159] The development of the Guidelines will provide guidance to governments and employers in supporting the growth of a national, professional peer workforce, supporting a consistent approach to the engagement of peer workers across each jurisdiction. The department strongly supports the National Mental Health Commission in the development of the

[158] See the Fifth Plan, *Priority Area 8: Ensuring that the enablers of effective system performance and system improvement are in place*.

[159] See the Fifth Plan, *Priority Area 6: Reducing Stigma and Discrimination* (Action 20) and *Priority Area 8: Ensuring that the enablers of effective system performance and system improvement are in place* (Action 29); NMHC, *National Review of Mental Health Programmes and Services*, Recommendation 21.

Guidelines, which are expected to be finalised by 2021.[160] The government considers that greater engagement of peer workers in the provision of mental health services is likely to contribute to improved productivity gains, particularly by improving the efficiency of the mental health system through reducing demand on clinicians where appropriate.

However, in considering the level of involvement of the peer workforce across the spectrum of care, particularly services within acute settings, the government acknowledges that a balance must be struck between the clinical judgement and decisions made by qualified clinicians, and the involvement and views of peer workers. The government understands that while many services operate through multidisciplinary teams and that clinical decisions are informed by input from peer workers, the decisions made by clinicians take precedence.

(b) Measurement and reporting of outcomes

In addition to supporting the delivery of mental health services and programs, the department administers a number of data-related activities that assist in the provision and improvement of those services and programs.

Primary Mental Health Care Minimum Data Set

The department administers the Primary Mental Health Care Minimum Data Set (the MDS) which provides the basis for PHNs and the department to monitor and report on the quantity and quality of service delivery, and to inform future improvements in the planning and funding of Commonwealth-funded primary mental health care services. The MDS builds on the foundation established by previous data collection and reporting arrangements through the Access to Allied Psychological Services and the Mental Health Services in Rural and Remote Areas programs.

The data reported by PHNs through the MDS form the basis for production of key performance indicators used to monitor services delivered across PHN regions and to meet the requirements of funding schedules.

The first full year of data was collected in 2017-18, with PHNs being required to ensure all service data was entered into the MDS. PHNs use the MDS to monitor the services they commission, support evaluations and report to the department. The department is currently analysing 2017-18 information to determine whether mental health services are being delivered where they are needed. The performance indicators for assessing PHN mental health services include measures of access, efficiency, appropriateness and effectiveness.

As the MDS matures, the government will continue to work with PHNs to support them to make use of the data available to support performance monitoring and evaluation to inform what services to commission in their regions. The data will also be analysed to understand national trends, performance of PHNs and their providers, and the extent to which mental health services are achieving outcomes.

[160] See the NMHC website for further information. Available at: https://www.mentalhealthcommission.gov.au/our-work/mental-health-peer-work-development-and-promotion.aspx.

More information can be found on the department's website.[161]

National Outcomes and Casemix Collection

The National Outcomes and Casemix Collection (NOCC) collects information about mental health outcomes for consumers, and allows for the measurement of whether mental health care leads to improvement in mental health outcomes for consumers. It was implemented by the Australian Mental Health Outcomes and Classification Network (AMHOCN).

AMHOCN was established by the government in December 2003 to provide leadership to the mental health sector to support the sustainable implementation of the NOCC as part of routine clinical practice, and currently manages the NOCC on behalf of the Commonwealth.

AMHOCN works collaboratively with the states and territories, and others in the mental health sector to implement routine outcome measurement in public mental health services. It consists of three components:

- a data bureau responsible for receiving and processing information;
- an analysis and reporting component providing analysis and reports of submitted data; and
- a training and service development component supporting training in the measures and their use for clinical practice, service management and development purposes.

AMHOCN continues to provide critical support to the jurisdictions in the establishment and maintenance of NOCC. These outcome measures are available for benchmarking purposes at an aggregate jurisdiction level, providing the mental health sector with an increased knowledge of benchmarking.

National Mental Health Service Planning Framework

The National Mental Health Service Planning Framework (NMHSPF) is a tool designed to help plan, coordinate and resource mental health services to meet population needs. It is an internationally unprecedented, evidence-based framework providing national average benchmarks for optimal service delivery across the full spectrum of mental health services in Australia. It is the first nationally consistent tool for planning mental health services in Australia.

The Commonwealth and the states and territories have demonstrated a commitment to the refinement and application of the NMHSPF through the Fifth Plan. The department encourages PHNs and LHNs to use the NMHSPF in their regional planning.

Over 200 users from PHNs, LHNs and state and territory government health agencies have been trained and given access to use the NMHSPF. In 2019, NMHSPF licence arrangements will be expanded to allow access for a broader range of users with a legitimate government role in planning and resourcing of mental health services. The NMHSPF is also being transferred to the Tableau web platform for easier use and improved stability, and will require less training for users. This will support LHNs and PHNs to continue to use the tool in their planning activities. An NMHSPF Super User Network

[161] See Department of Health, *About the PMHC-MDS*. Available at: www.pmhc-mds.com/.

of experienced licenced users has been established to promote a community-of-practice to share knowledge and promote the use of the NMHSPF.

The further development of the NMHSPF is jointly funded by the Commonwealth and the states and territories. Over the next two years:

- further development will include improving estimates for Aboriginal and Torres Strait Islander populations and regional and remote communities; and
- the University of Queensland will work with epidemiological and mental health care experts to further develop the NMHSPF.

(c) Our international engagement

In addition to efforts in addressing mental health challenges within Australia, the government actively participates and contributes to activities at a global level that responds to the challenges associated with mental illness worldwide. Key contributions are outlined in this section.

Sustainable Development Goals

The 2030 Agenda for Sustainable Development was adopted by the United Nations (UN) in 2015. At the core of the 2030 Agenda are 17 Sustainable Development Goals (SDGs). Australia has endorsed the 2030 Agenda and actively participated in international discussions to shape the design of its Workplan.

The department provides leadership on SDG 3 'Good Health and Wellbeing', supporting the adoption of the 2030 Agenda through engagement in global and regional forums, and providing health data to Australia's knowledge platform162.

- Target 3.4: By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.
- Target 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.
- Australia delivered its first report on the SDGs (Voluntary National Review) to the UN High Level Political Forum on Sustainable Development on 17 July 2018.

Overall, Australia is tracking well against the health related SDGs.

[162] See Sustainable Development Goals, Australian Government's Reporting Platform on the SDG Indicators. Available at: www.sdgdata.gov.au.

2018 Political Declaration on non communicable diseases (NCDs)

In September 2018, the United Nations General Assembly (UNGA) held the third High-Level Meeting on the Prevention and Control of NCDs, where heads of state and governments committed to tackle NCDs, including by promoting mental health and wellbeing.

The meeting's Political Declaration linked the need to address NCDs with achieving the SDGs, and included commitments to promote mental health and well-being. This is the first time mental health issues have been elevated to the highest level of political commitment by the UN.

World Health Organization's (WHO) Comprehensive Mental Health Action Plan 2013–2020

The WHO Comprehensive Mental Health Action Plan 2013-2020 commits the WHO, Member States and international partners to: promote mental wellbeing, prevent mental disorders, provide care, enhance recovery, promote human rights; and reduce the mortality, morbidity and disability of persons with mental disorders. Australia reported against the Action Plan's indicators in 2014 and 2017, and it is anticipated that Australia will report again in 2020. Australia's 2017 country profile can be accessed via the WHO website.[163]

Australia provides funding to the WHO through annual assessed contributions. These payments are relative to each Member State's wealth and population, and enable participation in the WHO. Member states assessed contributions are a key source of financing for the WHO's Programme Budget. The contribution is split into US dollars and Swiss Francs, and is subject to exchange rates.

Global Action Plan for Healthy Lives and Wellbeing for All

The WHO, in collaboration with 10 other multilateral health organisations, is developing a *Global Action Plan for Healthy Lives and Wellbeing for All* to advance collective action and accelerate progress towards the SDGs.

The Plan will include assessment of gaps in the global health response and focus on emerging priorities including mental health. The department and the Department of Foreign Affairs and Trade are reviewing the first draft of the Plan and will contribute to further development through WHO Member State consultations.

WHO Mental Health GAP Action Programme (mhGAP)

The WHO mhGAP aims to expand services for mental, neurological and substance use disorders, including for depression, psychoses, suicide, epilepsy and dementia. The mhGAP provides evidence-based technical guidance, tools and training packages to expand countries' health services, particularly in low-resourced countries.

Australia actively participates in mhGAP forums. In October 2018, Australia delivered a National Statement that reiterated our commitment to mental health domestically, the importance of the Fifth

[163] See WHO, *Mental Health ATLAS 2017 Member State Profile*, 2017. Available at: www.who.int/mental_health/evidence/atlas/profiles-2017/AUS.pdf.

Plan, digital mental health initiatives and our promotion of mental health globally through the Alliance of Champions of Mental Health and Wellbeing.

The Alliance of Champions of Mental Health and Wellbeing

In 2018, Australia, the United Kingdom and Canada co-founded the establishment of the Alliance of Champions of Mental Health and Wellbeing. The Alliance aims to address a gap in the existence of a high-profile international forum for health leaders to share information on mental health initiatives and a forum for potential future cooperation.

Membership comprises Ministers from the three co-founding countries and 15 other countries: Argentina, Belize, Brazil, Chile, Jamaica, Peru, United States, Uruguay, Armenia, Belgium, France, Netherlands, Norway, Bangladesh, and New Zealand.

Organisation for Economic Co-operation and Development (OECD)

Addressing mental health is a priority for the OECD. Australia, through its membership of the OECD Health Committee, is active in the work of the OECD. The OECD Health Committee's work on mental health informs Australia's domestic health priorities including the development of indicators under the Fifth Plan. The OECD's key activities on mental health include:

- A Mental Health Performance Benchmark project: To better understand mental health performance across OECD countries. The OECD plans to publish the benchmarks in 2020, together with an analytical policy report highlighting best practices in 2019 and interactive ways to access this information; and
- The OECD Patient Reported Indicators Surveys (PaRIS) initiative: Aims to develop international benchmarks of health system performance as reported by patients. A new set of measures will be developed to help policy makers assess to what extent their policies are on track to make health systems more people-centred.

Australia benefits from the OECD health work by accessing a strong evidence base for policy development, comparative performance measurement and a forum to share best practice insights.

Global Mental Health Summit

In October 2018, Ms Lucy Brogden, the Chair of the National Mental Health Commission Advisory Board, represented Australia at the inaugural Global Mental Health Ministerial Summit in London. Australia's attendance at the Summit reinforced Australia's leadership in addressing mental ill-health and demonstrated our commitment to the global mental health agenda.

The Summit provided a platform for the Lancet Commission to launch its landmark report *Global Mental Health and Sustainable Development*. The Report aims to promote the prioritisation of mental health and ensure physical and mental health are valued equally by the global health and development

communities. The Report notes Australia's headspace Program as an example of best practice on improving access, quality, and continuity of youth mental health care.[164]

[164] See also OECD, *Children and Young People's Mental Health in the Digital Age – Shaping the Future*, 2018. Available at: www.oecd.org/els/health-systems/Children-and-Young-People-Mental-Health-in-the-Digital-Age.pdf; and Lancet at: www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31612-X/fulltext.

Part 3 – The road ahead

The Productivity Commission's Inquiry into Mental Health coincides with the timing of the development of the next tranche of mental health reforms. The commission's final report will provide timely and invaluable insights into key challenges and priorities that may inform future strategic activities, particularly those that form part of the Sixth National Mental Health and Suicide Prevention Plan (the Sixth Plan). The Victorian Royal Commission into Victoria's Mental Health System, the response to the Western Australian Coroners Report into the recent suicides in the Kimberley region, the development of the Medical Benefits Schedule review recommendations, and the Inquiry into Veterans transitioning from the Australian Defence Force will provide additional insights into policy challenges and opportunities. To further develop insights, the department, in collaboration with the National Mental Health Commission and the Department of the Prime Minister and Cabinet, will be coordinating the Youth Mental Health and Suicide Prevention Implementation Forum. These reviews, inquiries and fora will inform the development of a 10-year action plan which will span across all government portfolios as integrated and coordinated services are essential for providing timely and effective responses to support Australians' mental health. The department encourages the Productivity Commission to positively inform and engage on their various matters.

In this Part, we discuss a number of matters that we consider may form an important part of future reforms. While the economic impact of actioning these matters are largely unknown, the government is confident that including them as part of future reforms would support improved economic participation and enhance productivity and economic growth, particularly through the positive outcomes that would be experienced by individuals with mild to moderate mental ill-health.

Suicide prevention

In addressing the critical priorities, the government has committed to investing in new mental health services and programs for all Australians. The government recently announced funding of over $775.5 million in 2018-19 to be invested in a range of mental health initiatives to address youth ($500 million) and adult mental health and suicide prevention ($275.5 million) within the community.

On 8 July 2019, the Prime Minister appointed a National Suicide Prevention Adviser. The new Adviser role will be promoting a whole-of-government approach to suicide prevention. The Adviser will be instrumental in developing and implementing a national suicide prevention plan.

As we and our partners continue in our efforts to address intentional self-harm and suicide within our communities, there is a significant opportunity to close service gaps by improving the level of connectedness across governments, portfolios, sectors and services to support a unified and effective action against suicide.

There also continue to be opportunities to increase frontline outreach activities, including those that de-stigmatise and normalise mental illness, and improve resilience within individuals and communities. There is also an opportunity to expand research into suicide and self-harm, and the services being provided to those individuals. The importance of evidence and data in informing and supporting government and community-led activities cannot be understated.

The Adviser's Terms of Reference task them to work with relevant Ministers and agencies to develop options to improve the design, coordination and delivery of suicide prevention activities. Key priorities are:

- Better connected communities: enhancing the capacity of frontline services and community-based organisations to identify and support those at risk or in crisis;
- Better connected journeys: improved pathways and system navigation for individuals and families; and
- Better connected data and evidence: mapping needs and services to ensure people receive the care they need, when they need it.

The government is also committed to implementing the National Suicide Prevention Implementation Strategy, which will provide guidance to health ministers on how to work together to prevent suicide. The development of this strategy is Action 4 of the Fifth Plan and is due to be submitted to the COAG Health Council for consideration in November 2019.

Achieving greater connectedness

As discussed in Part 1(b) of this submission, a lack of sufficient integration within – and between – our systems of care has a profound impact on individuals and their families and carers, exposing them to increased risks of adverse health and social outcomes. Achieving an integrated mental healthcare system, one which facilitates access to the right care, at the right time, in the right place continues to be fundamental to the current reform agenda. As we learn more about the factors contributing to deaths by suicide and mental ill-health, particularly the impact of the social determinants of mental wellbeing, the importance of an integrated healthcare system that joins-up effectively with other front line government social policy systems becomes fundamentally important. The department is confident that the outcomes of integration, firstly at the regional level, then between governments and across portfolios, will strongly support improved economic participation and productivity. It is therefore essential that improving integration and the interface between services remains a central feature of any future reform.

The Fifth Plan and its Implementation Plan articulate eight nationally agreed priority areas and 38 actions for collaborative government action with a view to achieving an integrated mental health system. The Fifth Plan seeks to establish a national approach for collaborative government effort from 2017 to 2022 across eight targeted priority areas:

- Achieving integrated regional planning and service delivery;
- Effective suicide prevention;
- Coordinated treatment and supports for people with severe and complex mental illness;
- Improving Aboriginal and Torres Strait Islander mental health and suicide prevention;
- Improving the physical health of people living with mental illness and reducing early mortality;
- Reducing stigma and discrimination;
- Making safety and quality central to mental health service delivery; and
- Ensuring that the enablers of effective system performance and system improvement are in place.

These include a commitment to support joint regional planning for integrated mental health and suicide prevention services as the first action from the Fifth Plan. Governments require LHNs and PHNs to jointly develop and publicly release regional mental health and suicide prevention plans by mid-2020. These joint plans will address issues faced by people seeking support for their mental health, such as the fragmentation of services and pathways, gaps, duplication and inefficiencies in service provision, and a lack of person-centred care.

Joint regional mental health and suicide prevention plans will inform the coordinated commissioning of services across the stepped care spectrum of need for services and across the lifespan. They will also support opportunity for coordinated regional implementation of national priority areas of the Fifth Plan.

While the Productivity Commission's current inquiry provides an opportunity for consideration of integration efforts within the context of the Fifth Plan, there is also an opportunity to consider broader integration-related matters within the context of future reform agendas. The department acknowledges that integration remains to be in its early stages of development, and consideration of future progression is important to ensure a full range of activities are considered, measured and informed. The Department would welcome the Commission's views on how to improve cooperation between levels of government and across portfolios in order to improve the mental health and wellbeing of Australians.

The department acknowledges that effective governance structures and reporting, as well as the necessary mandate, would be fundamental in supporting improved integration and coordination across portfolios. [165] This will be a key focus in considering next steps here. The Productivity Commission's views on appropriate and effective governance structures that could oversee this work, including existing structures such as the Secretaries Board, at the portfolio department level would be invaluable.

Care navigation and support

Effective navigation within the mental healthcare system, as well as other systems of care, is fundamental to supporting improved integration. As a means of trialing innovative approaches to supporting navigation, the department has commissioned the Link-Me Trial as part of the Primary Health Network Mental Health Lead Site Evaluation Project currently being undertaken (total project funding $5.7 million over three years).The Link-Me Trial involves the use of an assessment Decision-Support Tool deployed within participating general practices for use by individuals. Following the assessment, individuals are advised of the recommended course(s) of action, ranging from low to moderate intensity activities, to the referral to a care navigator for assistance in navigating severe or complex needs in conjunction with their general practitioner. The department expects to receive the final results of the trial by the evaluator in late 2020. The department will then consider the results in determining future activities relating to the Decision-Support Tool and/or a care navigator. At this early stage, the Link-Me Trial is being positively received.

In further supporting innovation within the mental healthcare sector, and leading the application of the stepped care approach internationally, the department is developing a suite of guidance and a Decision-Support Tool to support PHNs in developing systems for the initial assessment and referral of

[165] For further information, see CoAG Health Council. Available at: www.coaghealthcouncil.gov.au/.

people who present with mental health conditions in primary healthcare settings. This work will support the application of a nationally consistent application of the stepped care model across all PHNs and their catchments, while maintaining the flexibility of assessors and referrers to tailor the level of coordination across service providers. The department will soon be undertaking a trial of the guidance and the Decision-Support Tool with a number of PHNs before their implementation nationally.

On 12 December 2018, the Prime Minister announced through, the Community Health and Hospitals Program (CHHP), that the government is investing $1.25 billion to fund projects and services in every state and territory, and supporting patient care while reducing pressure on community and hospital services. Mental Health is one of the four key priority areas of CHHP, with $112.4 million being directly towards strengthening mental health in Australia.

Discussed earlier in the submission, the Health Care Homes program is a positive example of a program currently being administered by the department that applies a coordinated approach to the provision of care for patients with chronic and complex health conditions. The program requires partnerships to be developed between consumers, families and carers, treating general practitioners and the extended healthcare team in designing flexible care models tailored to the needs of patients. The program also supports improved coordination and communication between various parts of the healthcare system to reduce the risk to patient safety and the cost on the healthcare system more broadly.[166]

As part of their practice support and system improvement role, the majority of PHNs have also developed HealthPathways in consultation with stakeholders to improve care coordination and integration of care in their regions. Rather than being traditional guidelines, each pathway is an agreement between primary and specialist services on how patients with particular conditions will be managed in the local context.

Data, research and reporting

Under the auspices of various strategic policies and activities, Australian governments have committed to develop and collect national mental health information.[167] Among the achievements of these activities are: the establishment and continued development of national data collections on state and territory specialised mental health services; the establishment and continued development of the *National Outcomes and Casemix Collection* (NOCC); the development of national consumer and carer experience surveys; and the development of a mental health interventions classification. Within the mental health system context, key information such as admitted patient and emergency department data collections, MBS and PBS payments data, and wider health workforce data have been collected. The Australian Bureau of Statistics data collection activities, particularly in collecting mental health data as part of the National Health Survey, have also added to this body of data, providing invaluable insights into the mental and behavioural conditions of Australian households. Improving the collection and use of data directly supports the reporting of information to inform the effectiveness of current

[166] For further information, see Department of Health, *Health Care Homes*. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/health-care-homes.

[167] See the National Mental Health Strategy (2008), Second National Mental Health Plan (1999-2003), *Mental health information development: national information priorities and strategies*; and the National Mental Health Information Priorities (2nd Edition).

and future policies and initiatives, including their possible impacts on economic participation, productivity and growth.

In considering future reforms in the collection and use of mental health data, the department will be strongly guided by the priorities in the *National Mental Health and Suicide Prevention Information Priorities*, with the 3rd edition released for consultation in March 2018. The department also acknowledges that any reforms to data collection and use would be made through our existing relationships and data governance structures with the states and territories. Reforms should also capitalise on the data sources contained within existing data sets, including the *NOCC,* the *National Minimum Datasets* managed by the Australian Institute of Health and Welfare, the *Primary Mental Health Care Minimum Data Set*, the *Private Psychiatric Hospitals Data Reporting and Analysis Service*, and the *National Mental Health Service Planning Framework*.

Looking forward, a key focus for the department is improving the availability of information across the full range of government funded mental health services. The challenge is to create a complete picture of where services are delivered and how these services are shaping consumer outcomes and experiences. For example, a clear data gap currently exists in the activity of non-government organisations in providing mental health services, which are not included in national data collections. Data gaps also continue to exist in the extent to which the mental health system is meeting the needs of communities, for example Indigenous Australians, rural, remote and very remote communities, people from culturally and linguistically diverse backgrounds, and people who identify as lesbian, gay, bisexual, transgender or intersex. Addressing these gaps to develop a complete picture of mental healthcare would significantly support the work of PHNs and LHNs in integrated service planning. It would also improve the evaluation of service delivery, our understanding of care pathways, the targeting of services, and integrated planning, which would support the adoption of an outcomes-based approach to the commissioning of mental health services. More broadly, a clearer picture of mental health is critical to informing policy, service planning, clinical service delivery, and support.

Another key focus for the department is to maximise the use and value of *existing* outcome and experience data sets to create greater insights. For example, there is an opportunity for data integration[168] to provide new datasets for statistical or research purposes, and for further investment in data capability by PHNs. In considering potential future activities, such as outcome-based commissioning, PHNs must be able to access, and understand and use available data in undertaking their functions. A core part of this involves building the necessary infrastructure in systems and methods, as well as developing data analysis capabilities. Over time, PHNs will be well-positioned to engage in data-driven policy, planning and service delivery in achieving improved outcomes within their regions.

The government is also investing in an intergenerational health and mental health survey to be undertaken by the Australian Bureau of Statistics to update official data on the health of Australians, including their mental health. The survey will allow a comprehensive, up-to-date picture to be drawn of the health of Australians, canvassing broad-ranging health issues, including mental health, physical

[168] Data integration involves bringing together multiple datasets, generally at the unit record level (i.e. for a person or organisation) or micro level (e.g. information for a small geographic area), to provide new datasets for statistical or research purposes. Data integration refers to the full range of management and governance practices around the process, including project approval, data transfer, linking and merging the data and dissemination.

health and preventative health matters. The mental health component of the survey will provide an updated view of the mental health of Australians, enabling an analysis of any changes over the past two decades, particularly through comparisons with the results of the two previous national mental health surveys undertaken in 1997 and 2007. This will provide timely insights into the ongoing challenge of mental ill-health within our communities, its burden on those communities and its co-occurrence with other health conditions. In moving forward, the data will provide a robust evidence-base upon which to inform policy development, program design and delivery over the next decade.

The commissioning of mental health services

As the practice of PHNs and LHNs in commissioning mental health services continue to mature, there is an opportunity to consider the appropriateness of outcomes-based commissioning as a means of informing future activity. While there are challenges inherently involved in adopting this approach such as the need to define, agree and measure outcomes, attribute impact, and counteract the risk of perverse incentives,[169] outcomes-based commissioning may represent a better practice approach to the commissioning of mental health services.

The department acknowledges that any decision to transition towards an outcomes-oriented funding framework would be an iterative process undertaken over time, and would also require all mental healthcare system participants to collaborate to implement the framework.[170] The data collected under the Primary Mental Health Care Minimum Data Set is intended to provide PHNs and the department with a robust dataset on the quantity and quality of commissioned services, particularly their access, efficiency, appropriateness and effectiveness. While full service data collection and reporting only commenced in 2017-18, there is an opportunity for PHNs to begin investing in their data analysis capabilities to, over time, support improved analysis of their service data. This dataset and analysis capability would also support PHNs in transitioning to an outcomes-based approach to the commissioning of mental health services.

In addition to outcomes-based commissioning, the department considers that the principles of co-design[171] and co-commissioning may form the basis of a future commissioning approach. As commissioning practices mature over time, consumers and carers are expected to have greater access to high quality care throughout their care journey. This will place PHNs and other funders into an ideal position to co-commissioning mental health services or complement community services to support mental health outcomes beyond the health portfolio.[172] The department believes there is a strong case for the adoption of co-commissioning as part of future reforms. It would improve consumer experiences and outcomes, and provide additional support for the integration of services across the spectrum of needs and domains such as alcohol and other drugs, the National Disability

[169] See Department of Health, *Reform and System Transformation: A Five Year Horizon for PHNs*, p. 21. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/mental-health-advisory-panel.

[170] Ibid, p. 22.

[171] The principle of co-design already forms part of the current approach to commissioning services, with PHNs encouraged to develop mental health services in partnership with stakeholders including consumers, carers, service providers and clinicians. See Department of Health, above n 169, p. 21.

[172] See related discussion in Part 2(a), p. 15.

Insurance Scheme and aged care.[173] Notably, in considering any refinements to PHN commissioning principles, the department will closely engage with all stakeholders, including PHNs.

Case study – Link-Me Trial

The client is a 61 year old male whose responses to the Link-me iPad survey indicated difficulties with general health, appetite, energy, personal finances, and anxiety. His survey responses also suggested that chronic health conditions affected the client's ability to complete daily activities. Using the iPad, the client indicated that his priority was to work on his anxiety and ability to manage on his available income, and reported a strong desire to improve things in these areas, but little confidence in doing so. He was recommended to work with a care navigator to develop and implement a tailored plan to address his selected priority areas and improve his mental health.

At their first meeting, the client's care navigator conducted a structured assessment to understand more about him and his treatment goals. The client was separated from his wife 18 years ago but boards in her house and has adult children who he is not in contact with. He suffers multiple chronic health conditions (e.g. arthritis), many of which are the result of a serious car accident several years ago, and he had recent surgery which was affecting his mobility. The client reported that he was on a disability pension and lives fortnight to fortnight in terms of money. He told his care navigator he feels hopeless because he has no job, no money for food, no car, and no home. The client also mentioned significant daily alcohol intake, and that his GP is aware of this. The client identified that his alcohol use was a barrier to improving his previously selected priority areas.

Over the course of several weeks, the client, his care navigator, and his GP worked together to put a tailored management plan into place. Given the client's concerns about being unable to afford food, his care navigator organised food hamper delivery through a local charity. She also facilitated assessment at the local alcohol and drug service which resulted in a referral to inpatient unit. The client's GP was surprised that the client not only accepted the referral but completed the inpatient program, as he has been suggesting this to the client for years. The client was interested in increasing his physical activity to help manage anxiety and general health, but was unsure how to go about this given his limited mobility and funds. His care navigator arranged care package funding for hydrotherapy class at local swimming pool, which also provided the client with the opportunity for social contact. At the end of his time in care navigation, the client felt more hopeful about life. At the client's last contact with the care navigator he provided a list of things he wanted to achieve like cooking and joining a local men's support group.

Depending on the evaluation of the trial, there may be opportunities to collaborate closely across portfolios in supporting improved integration through care navigation.

[173] See Department of Health, above n 169, p. 25.

Appendix A – Additional prevention, treatment and recovery activities administered by the Department

Eating Disorder Initiatives

Residential eating disorder treatment centres

$63 million will be provided to support the establishment of six new residential treatment centres for people with eating disorders (NSW, Tas, Vic, SA, ACT, and WA), and to provide additional support of $4.5 million for the build, establishment and operation of a centre to be built on the Sunshine Coast in Queensland, Butterfly endED House.

The centres will provide wrap-around support and specialist care through delivery of evidence-based treatment programs. Establishment of the centres will be informed by advice from the Butterfly Foundation, the National Mental Health Commission, and other relevant stakeholders.

New MBS Items for people with eating disorders

From 1 November 2019, $110.7 million (GST excl.) will be allocated to fund the first dedicated Medicare services for patients with eating disorders. This will enable patients with anorexia nervosa and patients with other eating disorders with complex needs to access up to 40 psychological and 20 dietetic services per year, depending on their needs.

National Eating Disorders Collaboration (NEDC)

$2.7 million (GST excl. from 2016-17 to 2018-19) for the Butterfly Foundation to support the NEDC to bring together stakeholders and experts across a broad range of fields to develop a nationally consistent approach to the prevention and management of eating disorders.

The NEDC has also conducted workforce capability activities to build the capacity of the health and allied health workforce to identify and respond to eating disorders. An additional $3.6 million will be provided over three years from 2019-20 to support the work of the NEDC.

Eating disorders pilot on the Sunshine Coast

A $3.2 million trial (over four years from 2017-18 to 2020-21) to assess the viability of delivering evidence-based eating disorders treatment through primary and allied care within regional PHNs has commenced. The Butterfly Foundation has been funded to develop, implement and manage the pilot, deliver training and facilitate access to tertiary supervision for health professionals.

Central QLD, Wide Bay and Sunshine Coast PHN have also been funded to commission pilot activities, facilitate engagement with health professionals, disseminate information to health professionals and manage their financial reimbursement for participating. The outcomes of the project may inform government policy on care pathways for people with eating disorders.

ED Hope

Butterfly Foundation's national online counselling service receives $1.5 million (GST excl.) each year to 2020-2021. In addition, $100,000 (in 2017-18 and 2018-19) was provided for the integration of ED Hope services into local services on the Sunshine Coast.

InsideOut Institute

$4 million (GST excl. from 2018-19 to 2021-22) for the InsideOut Institute to translate evidence into clinical practice for people with eating disorders.

Million Minds Research Fund

$5 million (GST excl.) for two research projects into eating disorders:

- $3.67 million (GST excl.) for the InsideOut Institute to develop a health system research centre; and
- $1.34 million (GST excl.) for Deakin University to lead research into prevention and early intervention for eating disorders.

Alcohol and Other Drugs treatment services provided through Primary Health Networks

PHNs have been established with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.

The government has provided funding over four years for PHNs to commission additional alcohol and other drugs treatment services to meet local need, including funding for Indigenous specific services. Funding to PHNs to commission additional drug and alcohol treatment services commenced on 1 July 2016.

Support for Day to Day Living in the Community (D2DL)

The Support for Day to Day Living in the Community (D2DL) program commenced in 2011-12 to assist people living with severe and persistent mental illness who experience social isolation. The program aims to improve social and health outcomes for participants by assisting them to live successfully at an optimal level of independence in the community. The program is delivered through both informal/drop-in and structured socially-based group activities that aim to assist participants to develop social networks and new skills and build confidence and independence. Activities may include cooking or art classes, bushwalking groups, yoga classes, social outings, skill-development groups such as computer classes and excursions to local organisations to explore support and service options.

D2DL is one of three government funded community mental health programs that have been progressively phased out with the roll-out of the National Disability Insurance Scheme (NDIS), and block funding ceased for this program on 30 June 2019. Existing clients will be provided with support under the National Psychosocial Support measure through to 30 June 2020 as they are assisted to test eligibility for the NDIS and transition to appropriate ongoing supports under the NDIS, or the Continuity of Support measure. For further information, see department's website.[174]

The government allocated $18.3 million to D2DL in 2018-19

Drug and Alcohol Program

The government provides funding to a range of drug and alcohol related activities through the Drug and Alcohol Program. This includes funding drug and alcohol treatment services, a range of prevention activities, as well as supporting National leadership activities to guide Australian drug and alcohol policy.

Work activities under this program include: Drug and Alcohol Treatment Services; Drug and Alcohol Prevention; and Drug and Alcohol National Leadership.

The objectives of the Program are to support:

- drug and alcohol treatment services across Australia to reduce the impact of substance misuse on individuals, families, carers and communities;
- prevention and early intervention activities and promote evidence-based information about drug and alcohol through education;
- the development of drug and alcohol data to support evidence-based treatment national policy and service delivery; and
- service linkages between drug and alcohol treatment services and mental health services, as well as with social, educational and vocational long-term support services.

Disaster Recovery

Immediate support was provided to Northern Queensland and Western Queensland PHNs to provide surge mental health services and other mental health services to people in those regions who are in need. This funding enabled the PHNs to facilitate activities, including:

- increasing the capacity of current online counselling services, referral services and mental health support services to ensure that those requiring assistance can access timely support;
- commissioning service providers where necessary to meet increased demand for mental health treatment and support services; and

[174] See Department of Health, Psychosocial support for people with severe mental illness. Available at: www1.health.gov.au/internet/main/publishing.nsf/Content/psychosocial-support-mental-illness.

- supporting general practices to provide mental health treatment and associated services to their patients who have been affected by the floods.

Integrated Team Care (ITC) program

The Integrated Team Care (ITC) program is funded through PHNs. It aims to improve timely access to coordinated and multidisciplinary care for eligible Aboriginal and Torres Strait Islander people with chronic disease, which can include mental health problems. Elements of ITC include: care coordination to support patients to navigate the health system so that they receive access to the care they need in clinically appropriate timeframes; and support for mainstream health services to provide culturally competent care to the Aboriginal and Torres Strait Islander people who attend these services.

ITC Program Funding profile	**2018-19 ($m)**	**2019-20 ($m)**	**2020-21 ($m)**
	68.5	69.5	70.4

World Mental Health Day project

The government has provided funding to Mental Health Australia (MHA) since 2006 to organise and coordinate national activities for World Mental Health Day, held annually on 10 October in a number of participating countries. The aim of this project is to increase community awareness and understanding of mental health issues, and help to reduce the stigma associated with mental illness.

This project involves the organisation and coordination of national activities to promote World Mental Health Day (WMHD) annually, including:

- liaising with member organisations to coordinate community activities around the annual WMHD theme;
- liaising with states and territories to encourage national support and participation in WMHD activities;
- partnering with organisations to utilise their distribution hubs for communication;
- building relationships with politicians and celebrities to endorse the campaign;
- developing, publishing and disseminating promotional materials;
- ongoing maintenance of the 10/10 website, ensuring clear links to national mental health services are available; and
- social media networking and advertising.

Medicare Benefits Schedule (MBS) Better Access to Psychiatrists, Psychologists and General Practitioners (Better Access initiative)

The Better Access initiative was introduced to the Medicare Benefits Schedule (MBS) in 2006 to address low treatment rates for common mental disorders such as depression and anxiety, particularly presentations of mild to moderate severity, where short-term evidence-based interventions are most likely to be useful. The number of treatment sessions required for mental disorders depends on the diagnosis, duration and severity of the particular disorder.

Under this initiative, patients can access Medicare rebates available for up to ten individual and/or ten group allied mental health services per calendar year to patients with an assessed mental disorder who are referred by a:

- GP managing the patient under a GP Mental Health Treatment Plan; or
- medical practitioner under a referred psychiatrist assessment and management plan; or
- psychiatrist or paediatrician.

Medicare rebates are available to patients for allied mental health services under this initiative and include psychological therapy services provided by clinical psychologists, focussed psychological strategies services provided by appropriately qualified GPs and eligible psychologists, social workers and occupational therapists.

As part of the government's Healthier Medicare initiative, the MBS Review Taskforce is undertaking a review of the entire MBS. As part of the Review, a Mental Health Reference Group (MHRG) was formed in June 2018 to review the mental health MBS items. The MHRG recently concluded its review of mental health MBS items and consultation on its draft report, and will submit its final report to the MBS Review Taskforce later in 2019. Further policy development in regard to the Better Access initiative will be required in response to the MHRG report.

Mental Health in Multicultural Australia (MHiMA)

The government has funded a national transcultural mental health program since 1995. Mental Health in Multicultural Australia (MHiMA) is an important program first funded by the government in 2011 to provide a national focus across Australia on matters relevant to CALD communities in relation to mental health and suicide prevention. The program helps ensure the mental health system reflects and responds well to Australia's diverse population, and that quality and culturally-responsive care is available when needed most.

Mental Health Australia are currently funded to provide the Mental Health in Multicultural Australia Program (MHiMA). Stakeholder and consumer and carer consultation is an essential element of the MHiMA program. Mental Health Australia will work with the Federation of Ethnic Communities' Councils of Australia, the National Ethnic Disability Alliance and consumer and carer representatives from culturally and linguistically diverse (CALD) backgrounds.

Activities under the program include:

- construct and support an inclusive governing structure.
- build on the previous project's strengths in capacity building using learnings
- further develop and implement the Framework for Mental Health in Multicultural Australia.
- engage CALD consumers and carers to participate at all levels of mental health service planning, delivery and evaluation
- improve outcomes in access, coordination across the continuum of care, quality and safety for CALD mental health consumers, carers and their families.
- increase mental health awareness, knowledge and capacity in CALD communities via culturally inclusive promotion, prevention and early intervention initiatives; and
- support a culturally responsive and diverse mental health workforce which is supported to deliver culturally and linguistically inclusive practice.

National Depression and Anxiety Initiative

The National Depression and Anxiety Initiative provides core funding for Beyondblue's work to address the health burden of depression, anxiety and suicide in Australia.

The National Depression Initiative (the Initiative) was agreed as part of the Second National Mental Health Plan, endorsed by all Australian Health Ministers in July 1998 to address the health burden of depression in Australia. It was launched in October 2000 and Beyondblue Limited was established as a public company limited by guarantee to deliver the Initiative.

The Mid-Term Review of the Second National Mental Health Plan for Australia (2002) recommended that all governments commit to the implementation of Beyondblue. Today, Beyondblue is a collaborative initiative funded by all governments, together with own-source revenue, which aims to raise community awareness and reduce stigma related to depression, anxiety and associated disorders in Australia.

The objectives Beyondblue is funded to achieve include:

- increase the capability of the Australian community to respond to issues associated with depression, anxiety (and related) conditions and suicide;
- reduce the impact of depression, anxiety (and related conditions) and suicide in the Australian community through providing communications, education tools and resources, research and evaluation, policy advice, community engagement activities, programs and services, aligned to mental health reform activities, which support people to protect their mental health and to recover when they are unwell; and
- reduce people's experiences of stigma and discrimination associated with depression, anxiety (and related conditions) and suicide, including through leveraging and collaborating with State and Territory governments, the business and community sectors, and media.

National Depression and Anxiety initiative funding	**2017-18 ($m)**	**2018-19 ($m)**	**2019-20 ($m)**	**2020-21 ($m)**
	17.1	16.9	16.9	16.9

The Initiative continues to be supported by the Commonwealth and all State and Territory governments and has evolved to align with priorities of subsequent Mental Health Plans and Australian Government mental health reform priorities. This will be achieved through activities such as:

- providing an appropriate early intervention and prevention focus for mental health for all Australians and for its diverse elements especially vulnerable population groups, including men, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse (CALD) people, and gay, lesbian, bisexual transgender or intersex (GLBTI) communities;
- improving mental health literacy and stigma reduction in relation to depression and anxiety conditions through collaborative and language specific publications, teleweb services and campaigns;
- providing support to PHNs, in respect of their own promotion, prevention and early intervention initiatives, including the introduction of self-management, peer-to-peer and low intensity services as part of a regional stepped care approach;
- promoting partnerships across the health, business, and community sectors and the media to enhance responsiveness and support to all Australians who may experience or be at risk of experiencing depression, anxiety (and related conditions) or suicide;
- trialling new and innovative prevention, early detection, treatment and management activities for depression, anxiety conditions and suicide, and disseminating information about best practice models of care as appropriate;
- supporting and commissioning research to enhance knowledge into the promotion of mental health and wellbeing and the prevention and management of depression, anxiety and suicide and incorporate new knowledge as appropriate into practice;
- contributing to enhancing professional training, development and support for general practitioners, allied health and welfare professionals and others providing services to people experiencing depression, anxiety and suicide risk, through collaborations with relevant professional associations and utilising jurisdictional collaborations and PHNs; and
- commissioning an independent evaluation, including economic evaluation, of Commonwealth funded activities conducted by Beyondblue and implement agreed recommendations.

Partners in Recovery (PIR)

Partners in Recovery (PIR) commenced in 2012-13 to assist people with severe and persistent mental illness with complex multi-agency needs, and their carers and families, by coordinating and integrating support services to promote collaboration, ease of access, and holistic flexible support provision.

As part of this program, each eligible individual has access to a Support Facilitator who assists them to assess their needs then access and coordinate required services across sectors including clinical and specialist mental health, drug and alcohol, housing, employment, education, hospital emergency departments, mental health and the broader non-government service sector.

PIR is one of three government funded community mental health programs that has been progressively phased out with the roll-out of the National Disability Insurance Scheme (NDIS), and block funding ceased for this program on 30 June 2019. Existing clients will be provided with support under the National Psychosocial Support measure through to 30 June 2020 as they are assisted to test eligibility for the NDIS and transition to appropriate ongoing supports under the NDIS, or the Continuity of Support measure. For further information, see department's website.

The government allocated $146.6 million to PIR in 2018-19

Programme of Assistance for Survivors of Torture and Trauma (PASTT)

The Program of Assistance for Survivors of Torture and Trauma (PASTT) has been funded since 1995, to provide counselling and related support services to survivors of pre-migration torture and trauma who have settled in Australia. Eligibility to receive PASTT services is open to Humanitarian Settlement Program entrants permanently resettled in Australia and people on Temporary Substantive Visas. PASTT agencies also provide education, training and resources for mainstream health and community organisations to increase understanding of the refugee experience and improve access to these services.

PASTT aims to promote the physical health and psychosocial recovery of people living in Australia who have pre-migration experiences of conflict and human rights abuses, which make them vulnerable to developing mental health problems. The PASTT program model allows for providers to deliver services tailored to the needs of clients, whether this involves short, medium or long-term support.

PASTT is delivered by member agencies of the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT). The FASSTT consortium comprises eight members, one in each state and territory. Activities include the:

- provision of direct counselling and related support services, including advocacy and referrals to mainstream health and related services to individuals, families and groups who are survivors of torture and trauma;

- provision of education and training to mainstream health and related service providers to assist them to understand and respond to the needs of survivors of torture and trauma;
- delivery of community development and capacity building activities to build refugee communities confidence in accessing mainstream health and related services;
- delivery of rural, regional and remote outreach services to enable survivors of torture and trauma to access comparable services outside metropolitan areas. These services include a focus on capacity building and educational activities which support and up-skill mainstream health and related service providers to provide effective services to survivors of torture and trauma, and may include face-to-face services as well as telephone and email support. These activities focus on creative and flexible cost effective models to facilitate the availability of support for survivors of torture and trauma in their state/territory of Australia;
- provision of resources to support and enhance the capacity of the specialist counselling and related support services to deliver effective services to survivors of torture and trauma and to respond to emerging client needs;
- delivery of community education and systematic advocacy to achieve long term positive change in relation to any barriers to access and equity for the client group; and
- provision of activities that promote the psychological health and wellbeing of survivors of torture and trauma.

$93.5 million (GST excl.) funding from 2018-19 to 2020-21, which includes $8.3 million SACS funding.

Response to the Review of Mental Health Programmes and Services – Primary Mental Health Services

The Digital Mental Health Program provides grant funds to 18 organisations for a range of services including online mental health treatment, telephone support and counselling and online counselling and peer support. Some of these organisations are delivering digital mental health projects not services to the public. The 18 organisations do not include digital mental health projects funded under separate digital mental health Budget measures (these are listed separately). eheadspace, beyondblue, services under the Maternity Peer Support program and perinatal anxiety and depression projects are not included here.

Ensuring an ongoing funding source for national telephone and web-based mental health services was recognised in the 2006 COAG Teleweb funding measure. Ensuring people have access to support via phone or web when they need it is regarded as a core health promotion/early intervention approach The 2012 Teleweb funding round sought to address gaps in service by funding other services, particularly for specific population groups. From 2012-13, digital mental health services such as QLife, Blue Knot, Butterfly Foundation and CanTeen have been funded.

Digital mental health services generally focus on high prevalence mental health conditions such as anxiety and depression, and are delivered online and via apps, on desktops and mobile devices. Funded digital mental health services include telephone and online crisis and counselling services.

There is an ongoing funding source for digital mental health services and it is intended to approach the market in 2019-20 for 2020-21 multi-year funding agreements. The program will be redesigned for this open approach to market.

Strengthening Mental Health Care - New investment in Digital Technologies

MYEFO 2016-17 provided $32.5 million for Synergy trials across several populations, including young people, veterans and those at risk of suicide and a Lifeline trial for a new crisis text service:

- $30 million was allocated to Synergy over three years from 2016-17 to improve access to mental health services; and
- $2.5 million was allocated to the Lifeline over two years from 2016-17 for the trial of a text crisis service.

Synergy trial outcomes are due by 30 June 2020. The Lifeline trial is also not yet complete but results have shown this service channel (known as Text4Good) can be successfully added to Lifeline's support service. Lifeline is currently assessing service funding options.

University of Sydney-Comorbidity Guidelines Project

In 2007, the government funded the University of Sydney to develop 'Guidelines on the management of the co-occurring alcohol and other drug mental conditions in alcohol and other drug treatment settings' (the Guidelines). The government approved further funding to maintain and expand the Guidelines across 2017-18 to 2019-20.

The Guidelines and evidenced-based training to assist with managing co-occurring alcohol, drug and mental health conditions can be accessed through a webpage.

Reclink Australia - Reclink National Program

The government currently funds the Reclink National Program which is a social inclusion initiative implemented by Reclink Australia, a not-for-profit organisation, which provides opportunities for people experiencing disadvantage, alcohol and drug addiction, homelessness, and mental health problems to participate in sport and recreation programs.

The Reclink National Program provides a diverse range of structured team based and individual sport and recreation participation opportunities for people aged 16 – 65 years experiencing high socio-economic disadvantage; high levels of youth unemployment; high levels of domestic and community violence; and low sport and recreation participation rates.

The intended outcomes of the Program are to:

- achieve demonstrated social inclusion among the target groups; and

- improve health benefits and outcomes for client participants.

This is achieved through activities such as:

- delivering targeted individualised and team based sport and recreation programs to engaging people at risk and people experiencing disadvantage;
- coordinating support with existing wrap-around case management and support services to participants;
- promoting social inclusion, improved health and wellbeing; and
- supporting each individual to engage with local secondary colleges, TAFE providers, accredited Registered Training Organisations delivering training and local employment service providers.

Community Street Soccer Program – The Big Issue

The government funds The Big Issue Community Street Soccer Program (CSSP) which aims to provide disadvantaged and marginalised Australians with the opportunity to improve their health and positively change their lives through participation in an organised community-based sporting activity.

The CSSP:

- is a national community program that uses sport (street soccer) to create an effective environment to deliver valuable health outcomes for those in disadvantaged circumstances;
- is outcome focussed, providing a stable, safe, welcoming and transformational programme for males and females; and
- involves weekly training sessions for disadvantaged and marginalised people in communities around Australia.

The Big Issue is an independent, not-for-profit social enterprise, which provides ways to assist Australians to participate in society as independently as possible and to make positive changes to their health and wellbeing.

National Psychosocial Support (NPS)

The National Psychosocial Support (NPS) measure commenced in January 2019 and provides psychosocial support to clients with severe mental illness resulting in psychosocial disability who are not supported through the National Disability Insurance Scheme (NDIS).

Services under the NPS measure have been commissioned through PHNs and aim to support participants to increase their ability to complete everyday activities. Supports are provided individually or in a group and focus on areas such as relationship building, skill development, budgeting and maintaining a home, physical and emotional wellbeing, education and workforce training, and facilitating access to appropriate support services.

In the 2017-18 Budget, the government committed $80 million over four years for the NPS measure. States and territories have matched funding and bilateral agreements between the Commonwealth and each jurisdiction have been in place since June 2018.

In addition, on 21 March 2019, the government announced purpose specific funding of $121.29 million over 12 months for extended transitional arrangements to provide additional time for clients of Commonwealth community mental health programs Partners in Recovery (PIR), Support for Day to Day Living in the Community (D2DL) and Personal Helpers and Mentors (PHaMs) to transition to the NDIS or Continuity of Support (CoS). This funding is in addition to the $80 million provided by the Commonwealth and matched by States and Territories over four years and is being provided to PHNs to be implemented under the NPS measure.

The focus of this funding is to ensure clients from ceasing government community mental health programs PIR, D2DL and PHaMs receive appropriate levels of support as they test eligibility for supports under the NDIS and transition to ongoing arrangements either under the NDIS or CoS. PHNs will fund, engage and commission supports for remaining clients of these programs from 1 July 2019 to 30 June 2020.

Continuity of Support (CoS)

The Continuity of Support (CoS) measure will provide ongoing support to clients of Commonwealth funded community mental health programs Partners in Recovery (PIR), Day to Day Living (D2DL) and the Department of Social Services administered Personal Helpers and Mentors (PHaMs) who have been found ineligible for support under the National Disability Insurance Scheme. CoS clients will be supported to achieve similar outcomes to those in PIR, D2DL and PHaMs through psychosocial support services commissioned through PHNs. Services delivered under the CoS measure commenced on 1 July 2019 as funding for PIR, D2DL and PHaMs ceased on 30 June 2019. PHNs will commission integrated and coordinated psychosocial services providing support activities that aim to increase personal capacity, confidence, self-reliance, and social participation, and streamline access to appropriate services. These supports will be delivered through both group, and individual activities.

In the 2018-19 Federal Budget, the Government announced $109.8 million from 1 July 2019 for the CoS measure. Support for this measure is ongoing, ensuring eligible participants have access to long-term, responsive support

Appendix B – Additional suicide prevention and related activities administered by the Department

Prioritising Mental Health - Aftercare after a suicide attempt (rollout of The Way Back Support Service)

In the 2018-19 Budget, the government announced $37.6 million over four years (2018-19 to 2021-22) to expand Beyondblue's The Way Back Support Service across Australia. In January 2019, the department entered into a Funding Agreement with Beyondblue to provide national support and oversee the implementation of The Way Back Support Service in selected PHN regions.

Given the joint responsibility for suicide prevention, state and territory governments contribute for the service delivery component

Funding includes $27.1 million for PHNs to commission services, and $10.5 million for Beyondblue to provide national support and oversee implementation:

PHN Service Commission funding	**2018-19 ($m)**	**2019-20 ($m)**	**2020-21 ($m)**	**2021-22 ($m)**
	1.3	7.3	9.0	9.5

Beyondblue funding	**2018-19 ($m)**	**2019-20 ($m)**	**2020-21 ($m)**	**2021-22 ($m)**
	5.2	1.2	1.5	2.5

Prioritising Mental Health - Suicide Prevention campaign (Better off with you)

In the 2018-19 Budget the government announced $1.2 million over 2018-19 for SANE Australia to develop and test a suicide prevention campaign – the Better Off With You campaign.

The Better Off With You campaign is being piloted in Western Victoria, Northern QLD and Northern Sydney PHNs, and is targeting people who are contemplating suicide to challenge the perception that they are a burden on their family, friends and other people in their lives. The campaign's final report is due in November 2019.

Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG)

In partnership with the Department of the Prime Minister and Cabinet

The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG) is a Ministerially appointed advisory body reporting to Ministers Wyatt and Hunt on issues relating to Aboriginal and Torres Strait Islander Mental Health, Social and Emotional Wellbeing and Suicide Prevention.

Key areas of focus for the ATSIMHSPAG include providing advice on:

- the implementation of the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing 2017-23;
- the implementation of the 5th National Mental Health and Suicide Prevention Plan, specifically relating to Aboriginal and Torres Strait Islander peoples; and
- improving outcomes Aboriginal and Torres Strait Islander mental health and suicide prevention outcomes through effective partnerships with PHNs and ACCHs and mainstream providers.

ATSIMHSPAG is co-funded with PM&C. An Assistant Secretary from the department sits as an ex-officio member of the Group.

Support to PHNs (suicide prevention activity as part of the mental health flexible funding schedule)

As part of the PHN Mental Health Schedule, PHNs are required to commission suicide prevention activities appropriate for their region.

This can include commissioning of community based suicide prevention services, including for Aboriginal and Torres Strait Islander people, education and training, and improving care pathways.

Funding is allocated to PHNs as part of the broader Mental Health Schedule funding.

Appendix C – Additional alcohol and other drugs-related activities administered by the Department

National Fetal Alcohol Spectrum Strategy 2018-2028

The National Fetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018-2028 (Strategic ActionPlan) has been developed to provide a clear pathway of priorities and opportunities to improve the prevention, diagnosis, support and management of FASD in Australia.

The Strategic Action Plan aims to reduce the prevalence of FASD and the impact it has on individuals, families, carers and communities. It identifies a series of priorities and opportunities to inform future approaches by governments, service providers and communities over the next decade.[175]

Future work activities will align with the following identified national priorities:

- Prevention
- Screening and diagnosis
- Support and management
- Priority groups and populations at increased risk

Future initiatives and activities will be delivered in accordance with the Grant Opportunity Guidelines currently under development.

[175] See Department of Health, *National Fetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018–2028*, 2018. Available at: https://beta.health.gov.au/resources/publications/national-fetal-alcohol-spectrum-disorder-fasd-strategic-action-plan-2018-2028.

Appendix D – Additional workforce activities administered by the Department

Stronger Mental Health Consumer and Carer Representation Project

The Australian Government has provided funding to Mental Health Australia (MHA) for administrative support for the National Mental Health Consumer and Carer Forum since 2002. Funding to administer the National Register of Mental Health Consumer and Carer Representatives was added to this agreement in 2007.

The aim of the Stronger Mental Health Consumer and Carer Representation project is to support the involvement of consumer and carer groups in policy development and the implementation of mental health reforms.

Through this activity, MHA provides:

- policy and advocacy support to the National Mental Health Consumer and Carer Forum; and
- administrative support for the National Register of Mental Health Consumer and Carer Representatives.

2018-19 funding: $0.45m (GST excl.).

Mental Health Professional Network

The Mental Health Professional Network (MHPN) has been funded by the Australian Government since 2008 to develop profession-specific materials and activities to support the provision of quality mental health care and, from 2011, to facilitate multidisciplinary, inter-professional networks to support the delivery of primary mental health care at the local level. The MHPN maintains and supports 380 interdisciplinary mental health networks (including 152 special interest networks), of which 41 per cent are located in regional, rural or remote locations; and the MHPN has enabled practitioners to engage in over 280,000 hours of professional development, with participation rates increasing over successive years.

The MHPN has been funded since 2008.The MHPN is currently funded $5.2 million (GST excl.) over three years from 2017/18:

MHPN funding	**2017-18 ($m)**	**2018-19 ($m)**	**2019-20 ($m)**
	1.7	0.170	1.8

General Practitioner Mental Health Standards Collaboration (GPMHSC)

The General Practitioner Mental Health Standards Collaboration (GPMHSC) supports General Practitioners (GP) to deliver quality primary mental health care through setting standards and accrediting training in mental health for GPs, providing mental health training and education and developing clinical resources.

The GPMHSC membership includes representatives from: Royal Australian College of General Practitioners (RACGP) (Chair and members); Australian College of Rural and Remote Medicine (ACRRM); Royal Australian and New Zealand College of Psychiatrists (RANZCP); Mental Health Australia (MHA); Australian Psychological Society (APS); and Consumer and carer representatives.

Core activities are accreditation of training providers, mental health education and training standards setting, Quality Assurance Review program, strengthening collaboration with the mental health sector, and promotion and marketing of the collaborative, and consumer and carer involvements.

The GPMHSC also work to support mental health reform implementation with appropriate GP training and education that reflects the system and service delivery requirements, including the PHN environment, promotion of e-mental health in clinical settings, uptake of MBS Better Access telehealth items in eligible rural and remote regions, and development of a range of clinical resources to support mental health care in general practice. GPMHSC is currently funded $2.1 million (GST excl.) over 3 years:

GPMHSC funding	**2017-18 ($)**	**2018-19 ($)**	**2019-20 ($)**
	685,292	705,851	727,026

Mental Health Professional Online Development

Mental Health Professional Online Development (MHPOD) is an established, national web-based professional education tool for mental health professionals and the curriculum is based on the National Practice Standards for the Mental Health Workforce 2013 ('National Practice Standards').[176]

The curriculum aims to align with the National Practice Standards which reflect the knowledge, skills and attitudes required for staff working in Australian mental health services. The National Practice Standards are available at:

A full redevelopment of MHPOD is currently underway to update the content and accessibility of MHPOD resources. Funding supports administration, hosting and maintenance of the MHPOD website and learning platform. There are over 100 hours of material across 68 topics, written and produced in Australia. The topics range from recovery, to legislation and dual disability. Each topic includes an overview, activity, in-practice section, and resources such as checklists, templates, or links to further information. The content of MHPOD is linked to the National Practice Standards for the Mental Health Workforce.

MHPOD is currently funded $1.5 million over 4 years:

MHPOD funding	**2017-18 ($)**	**2018-19 ($)**	**2019-20 ($)**	**2020-21 ($)**
	977,800*	191,760	191,760	191,691

***** Includes the government's contribution to MHPOD redevelopment

Phoenix Australia Projects

Phoenix Australia's mission is to build the capability of individuals, communities and organisations to prevent, recognise and reduce the adverse mental health effects of PTSD and other posttraumatic mental health problems across the Australian community.

Project 1 – Post Traumatic Stress Disorder Guidelines

- Establish a Practitioner Support Service to provide mental health advice and guidance to support practitioners supporting communities affected by the 2019 Queensland floods, and;
- Develop Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder.

[176] For further information visit: www.mhpod.gov.au/.

Funding of $850,000 (GST excl.) over three years 2018-19 to 2020-21 has been allocated for Project 1.

Project 2 - Australian Digital Training Platform in Disaster Mental Health

Develop and implement the Australian Digital Training Platform in Disaster Mental Health – this will enable future and longer-term support through education and training and free resources for practitioners who will be called on to support community members affected by disasters

Funding of $1,300,000 (GST excl.) over three years from 2018-19 to 2021-22 has been allocated for Project 2.

Appendix E – Additional measurement and outcome activities administered by the Department

Strengthening Mental Health Care - Digital Mental Health Gateway

Funding has been provided to the Australian Commission on Safety and Quality in Health Care (ACSQHC) to develop National Standards for Digital Mental Health Services (DMHS) and options for a Certification Framework for DMHS. The project aims to ensure quality of Australian digital mental health services by providing standards and a framework to assess digital mental health services against the standards.[177]

The project is currently in the consultation phase. Consultations will include face-to-face workshops, online sessions and an online written survey.

Funding of $2,209,802 over two years from 2017-18 to 2018-19 has been provided for this project.

[177] For further information visit: www.safetyandquality.gov.au/wp-content/uploads/2018/10/D18-24027-Project-fact-sheet-Certification-Framework-for-Digital-Mental-Health-Services-Oct-2018.pdf.