NSW Government Submission to the Productivity Commission's Draft Report on Mental Health

April 2020

The NSW Government welcomes the release of the Productivity Commission's draft report on mental health. We commend the breadth and depth of recommendations in the draft report. Improvements to mental health outcomes require a mix of reforms and coordinated action by governments. Reforms and actions need to build mental health resilience and reduce stigma, address social determinants and alleviate the impact of adverse circumstances, facilitate early intervention and improve access to care. Transparent funding, institutional and governance structures that provide the right incentives, flexibility and support are critical to success.

The reform areas identified in the draft report are broadly aligned with the direction of NSW mental health policy. This includes:

- An **outcomes-based whole-of-government approach** not limited to the health sector that invests in prevention and early intervention, integrates mental healthcare with other services, and ensures equity in access to mental health services.
- Delivering **the right service at the right time**, including through investments into community mental health services to provide alternatives to emergency departments and in-patient hospital services.
- **Evidence-based decision-making** supported by strong monitoring, evaluation and reporting frameworks.
- A system supported by an **adequate and fit-for-purpose mental health workforce.**

New South Wales welcomes the opportunity to explore bold reforms to funding and governance arrangements for mental health. This submission focusses commentary on the two proposed options for institutional reform. The proposed 'Rebuild' and 'Renovate' models have potential to address some fragmentation issues. **However, neither reform option seeks to address the challenging interface between Medicare-funded primary care and allied health services and the rest of the mental health system. Improving this interface is critical to support delivery of the right care at the right time**.

System reform should achieve genuine service integration across portfolios and governments. Regional commissioning of services – underpinned by an outcomes-based commissioning model – has the potential to facilitate more integrated service delivery. However, the proposed regional commissioning authorities under the 'Rebuild' model risk creating barriers between mental health services and physical health services.

We look forward to the final report's vision for a system that implements the stepped care model for mental health and achieves integration between services across portfolios, governments and sectors. A roadmap for reform, and impact assessments to inform prioritisation of the most effective package of reforms, will be of great assistance to all governments. It will be also helpful if the final report sets out a view on the transition arrangements needed to expand system capacity and capability, acknowledging the scale of reform and competing government priorities.

Proposed reforms to mental health funding arrangements

In response to:

Draft Recommendation 23.3 — structural reform is necessary

The Australian Government and State and Territory Governments should work together to reform the architecture of Australia's mental health system to clarify federal roles and responsibilities and incentivise governments to invest in those services that best meet the needs of people with mental illness and their carers. There should be greater regional control and responsibility for mental health funding.

Information Request 23.1 — architecture of the future mental health system

The Productivity Commission has proposed two distinct models for the architecture of the future mental health system:

- *The Renovate model, which embraces current efforts at cooperation between Primary Health Networks (PHNs) and Local Hospital Networks (LHNs).*
- *The Rebuild model, under which State and Territory Governments would establish 'Regional Commissioning Authorities' that pool funds from all tiers of government and commission nearly all mental healthcare (Regional Commissioning Authorities would take over PHNs' mental health commissioning responsibilities and also commission more acute mental healthcare) and psychosocial and carer supports (outside the NDIS) for people living within their catchment areas.*

At this stage, the Rebuild model is the Commission's preferred approach.

How could the Rebuild model be improved on? Are the proposed governance arrangements appropriate? Should RCAs also hold funding for, and commissioning of, alcohol and other drug services?

If you consider the Renovate model or another alternate approach is preferable, please describe why, and outline any variations you consider would be an improvement.

Draft Recommendation 24.1 — Flexible and pooled funding arrangements

MBS-rebated and regionally commissioned allied mental healthcare should be funded from a single pool, and commissioning agencies should be able to co fund MBS-rebated allied mental health professionals. State and Territory Government agencies should be permitted to co fund MBS-rebated out-of-hours GP services where this will reduce mental health related emergency department presentations.

In the short-term (in the next 2 years)

The Australian Government Minister for Health should issue a direction in relation to section 19.2 of the Health Insurance Act 1973 (Cth) that allows State and Territory Government agencies to provide additional funding to MBS-rebated out-of-hours GP services, with the agreement of PHNs. The Australian Government should direct PHNs to approve these requests if there is a reasonable prospect that additional out-of-hours GP services would yield reductions in mental health related emergency department presentations.

In the medium-term (over 2 – 5 years)

MBS rebates for allied mental healthcare should be explicitly linked to commissioning agencies' (PHNs or RCAs) mental health funding pools, so as to create a single budget from which all primary allied mental healthcare would be funded.

Once this linkage has been established, the Minister for Health should issue a direction in relation to section 19.2 of the Health Insurance Act 1973 (Cth) that:

- Allows commissioning agencies (PHNs or RCAs) to provide additional funding to allied mental health professionals whose services receive MBS rebates.
- Allows other Australian, State and Territory Government agencies to provide additional funding to MBS-rebated allied mental health professionals with the agreement of commissioning agencies (PHNs or RCAs).

NSW response:

Genuine service integration, supported by whole-of-government and cross-government cooperation, is key to delivering better outcomes at a system level.

Any reform model needs to incentivise new ways of collaborating and coordinating services, including through a commissioning for outcomes model. A significant cultural shift driven by strong leadership is necessary to achieve genuine service integration.

Structural reform must be achieved in collaboration with states and territories to support a system-wide shift. Structural reform must build on and align with similar reform to the broader health system. The long-term reforms within the National Health Reform Agreement 2020-25 (NHRA) include activity to address structural reform such as joint planning and funding at a local level to determine, address and fund local priorities.

Funding reform is supported where it enables enhanced service integration. Pooling mental health funding can improve funding efficacy, if it incentivises prevention, early intervention and community-based models. A pooled funding model should be tested and evaluated before it is scaled. A blended payment model with clear incentives for integrated models of care could be piloted for a comparative evaluation.

System reform cannot deliver significant improvements in mental health outcomes unless it encompasses the Medicare-funded primary care and allied health services.

Inadequate coordination and integration between services across portfolios, governments and sectors are the central institutional and governance issues to be addressed. Currently these issues create mis-matched incentives – resulting in inadequate investment across prevention and early intervention and the various components of the stepped care model. For system reform to tackle these issues, it must encompass the spectrum of healthcare delivery including the primary healthcare system delivered by General Practitioners (GPs) and allied health practitioners. These practitioners serve a central role both as a gateway to the mental health system and as providers of care.

As currently proposed, the scope of Regional Commissioning Authorities (RCAs) is mostly limited to current state and territory services with the addition of Primary Health Network (PHN) funding of around $0.4 billion. **Excluding the bulk of Medicare-funded mental health services from RCA's remit limits its potential to address the interface and comorbidity issues with the physical health system and non-health systems.** The latter

include the social services sector that is critical to mental health, including social housing and homelessness.

New South Wales welcomes consideration of reforms to the primary mental healthcare system, to improve its role in prevention and early detection/intervention and in reducing avoidable hospitalisations. The primary care system lacks a system manager. The current fee-for-service model creates significant disincentives for GPs to detect, diagnose and treat complex mental health conditions – challenges that exists more broadly in preventive health services and management of chronic conditions. Challenges also remain around access to quality GP services, which are often dependent on geographical location, time and socioeconomic status.

The proposal for States and Territories to assume responsibility for mental health must be met with adequate additional funding from the Commonwealth Government. State and Territory Governments already bear the majority of the costs of a poorly managed primary care system, through high acute care costs. Under the proposed model, state and territory governments will hold the majority of the risk to meet unmet service needs when demand exceeds contracted services. Clear governance roles, responsibilities and structures will also be needed to minimise duplication and gaps in services.

The 'Rebuild' model risks creating silos in mental and physical health

The proposed RCAs risk addressing one interface issue but creating another – between mental health services and physical health services. There have been significant efforts to date to integrate physical and mental healthcare into a whole-of-system approach that is patient-centred. Further consideration is required on how a separately funded and commissioned mental health body would avoid creating silos in mental health care for a vulnerable population group and losing gains made in mainstreaming mental health.

Implementation considerations

For the 'Rebuild' model

RCA funding should not be linked to Medicare rebates

The Commission proposes that RCA funding for each region be determined by deducting Medicare Benefits Schedule (MBS) rebates for allied mental health services for an overall funding envelope determined through a weighting scheme. The rationale for the linkage is unclear and results in RCAs being unfairly penalised and faced with funding uncertainty for factors beyond their control. Demand for allied health services is activity-driven and strongly linked to GP referral behaviour. This linkage will put at risk their ability to deliver continuity in services – to a cohort of people where service continuity is key. This methodology also assumes that services provided under MBS and by RCAs are complete substitutes. The Commission should consider and provide clarity over when allied mental health services and community mental health services are appropriate, as part of the stepped care model.

Draft Recommendation 24.1 proposes that funding be allocated between RCAs on a needs-basis, based on factors such as demography and cost of providing services. Consultation should be undertaken to consider other relevant factors (for example, adequacy of services to date and current levels of diagnosed and undiagnosed mental health conditions) and on the methodology.

Flexibility to co-fund MBS services could be beneficial but can result in cost-shifting

Flexibility for States and Territories to co-fund MBS-based allied mental health professionals can be beneficial. However, this reduces the accountability of and incentives for the Commonwealth Government to appropriately manage and adequately fund a fit-for-purpose primary care and allied health care system. Measures to address cost-shifting will need to be put in place.

Consideration should also be given to services that are not geographically based.

There are three Specialty Networks in New South Wales – Justice Health and Forensic Mental Health Network, St Vincent's Health Network, and the Sydney Children's Hospital Network. These networks would not fit a regional commissioning model based on population boundaries, leaving them at risk of isolation and underfunding.

The Commission should consider transition arrangements to protect consumers, using lessons from the rollout of the National Disability Insurance Scheme (NDIS)

Learnings from the roll-out of the NDIS should be considered and transitional arrangements implemented to avoid consumers falling through the gaps of a new system. These should include clear problem definition, consumer consultation and co-design and pilots. Adequate time should be allowed for the planning, trial and evaluation of reforms, and evaluations should result in redesign where necessary.

For the 'Renovate' model

There is merit in continuing to support models of Primary Health Network and Local Health Network coordination that are working well

The New South Wales Government supports efforts to build and strengthen relationships between Primary Health Networks (PHNs) and Local Health Networks (LHNs), referred to in New South Wales as Local Health Districts (LHDs) and Speciality Networks. Given that PHNs are still relatively new and may need more time to reach their potential, there is merit in further examining improvements to PHN and LHD coordination through the 'Renovate' model, rather than simply removing PHNs from the mental health system.

The Fifth National Mental Health and Suicide Prevention Plan recognises that PHNs and LHNs provide the core architecture to support integration at the regional level and that they are positioned to work with stakeholders to identify what needs to change and when.

There are examples of PHNs and LHDs being encouraged to work together and progressively moving towards more integrated commissioning of regionally appropriate services. In New South Wales, the North Coast LHD and the North Coast PHN are developing a model to support Regional Commissioning. Joint commissioning of services and fund pooling for packages of care and support can improve efficiencies, remove duplication and improve outcomes.

The role of PHNs in mental health can be strengthened through formal agreements

Specific tripartite agreements between each PHN, the Commonwealth and the respective State or Territory could strengthen the PHN role. Such an agreement could establish a

protocol for integrated planning with LHDs, specify the investments from the Commonwealth and the State or Territory, and set targets – with all three parties held accountable for progress. These agreements should facilitate the potential for co-commissioning and joint accountability.

Additional comments and information

Part I the case for major reform

Information request 3.1 — Education activities that support mental health and wellbeing

We are seeking information or methodologies that would help us to estimate the cost of activities undertaken by educational institutions in supporting mental health and wellbeing of students.

- NSW Health and NSW Department of Education have a strong working relationship around the mental health and wellbeing of children and young people. Collaborative programs such as NSW School-Link, Project Air for Schools and Got It! provide evidence-based early intervention programs in schools, and early access to specialist mental health services.
- School-Link is a statewide function of specialist NSW Child and Adolescent Mental Health Services (CAMHS) and provides specialist mental health services through consultation liaison, clinical care planning for recovery and the delivery of specialist mental health individual and group interventions in schools.
- Mental health reform funding has provided $1 million for additional School-Link Coordinator positions to strengthen links between the schools and mental health services. This brings the number of School-Link positions across NSW in 2019-20 to 21.
- An evaluation of the NSW School-Link Strategy and Action Plan (2014-2017) was completed in 2018 and will inform development of a refreshed School-Link strategic framework due for completion in early 2020.
- Getting on Track in Time – Got It! is a specialist school-based early intervention service delivered by NSW Health teams in partnership with NSW Department of Education. Got It! aims to reduce the frequency and severity of conduct problems in young children through clinicians engaging teachers and parents in a school-based universal and targeted clinical program to help young children develop practical skills in emotional self-regulation.
- In 2019-20, the New South Wales Government is investing over $11 million in Got It! for 15 teams across the 15 local health districts to deliver Got It! in partnership with Department of Education staff.
- In addition, under the New South Wales Government Mental Health Reform, two new Got It! initiatives are being developed:
    - South Western Sydney Local Health District have been funded to develop, trial and evaluate an Aboriginal Got It! Model with $2.7m over a four year period from 2017-18. This culturally safe version of Got It! will inform the work of existing Got It! teams to better engage Aboriginal families and help reduce the risk of behavioural issues amongst Aboriginal children and youth. In addition, five Got It! teams have been funded through Aboriginal Got It! enhancement funding to develop projects to improve engagement with aboriginal children, families and communities.
    - Justice Health Getting on Track in Time – Teen Got It! is an innovative prevention program aimed at young people aged 11-16 with disruptive behaviour disorder presenting for the first time in the NSW Children's Court.

- Project Air for Schools is a training program that aims to increase the confidence and capacity of high school staff to effectively work with young people experiencing complex mental health issues, (particularly personality disorder traits). It helps to manage challenging behaviours common in this population, including self-harm. A clinical intervention manual for Project Air has been developed with a complimentary training package to support school counsellors, school psychologists and child and adolescent mental health service clinicians to work effectively and safely with young people who present with self-harm and complex mental health concerns.

Part II Reorienting health services to consumers

Draft recommendation 5.2 — assessment and referral practices in line with consumer treatment needs

In the short-term (in the next 2 years)

Commissioning agencies (PHNs or RCAs) should promote best practice in initial assessment and referral for mental healthcare, to help GPs and other referrers match consumers with the level of care that most suits their treatment needs (as described in the stepped care model).

In the medium-term (over 2 – 5 years)

Commissioning agencies (PHNs or RCAs) should establish mechanisms for monitoring the use of services that they fund to ensure that consumers are receiving the right level of care. If service use is not consistent with estimated service demand, commissioning agencies may need to make changes to initial assessment and referral systems (or work with providers to do so).

- Educational and training opportunities should be provided for referrers to enable skills-based assessment and referral, particularly for consumers with complex needs.
- Appropriate referral pathways to correct levels of care need to be informed by engagement with mental health consumers, local health districts, private mental health clinicians (psychologists, nurses, occupational therapists, social workers, psychiatrists) and other service providers.

Draft Recommendation 5.3 — Ensuring Headspace centres are matching consumers with the right level of care

Headspace centre funding should be conditional on centres following the stepped care model.

In the medium-term (over 2 – 5 years)

Headspace grant funding for individual centres should be made conditional on centres meeting targets for the proportion of young people referred to low intensity services. The targets set by commissioning agencies (PHNs or RCAs) for each centre should depend on the full range of relevant characteristics of the young people they see. The targets should start low and increase over time.

- The stepped care model is an evidence-based approach for regional mental health planning.
- Commissioning authorities should clarify what evidence-base they would use to set targets for low intensity interventions.

Draft Recommendation 5.4 — MBS-rebated psychological therapy

MBS rebated psychological therapy should be evaluated, and additional sessions trialled.

In the short-term (in the next 2 years)

- The Australian Government should commission an evaluation of the effectiveness of MBS-rebated psychological therapy. As part of this evaluation, the Australian Government should undertake trials allowing up to 20 sessions of individual or group therapy in total over a year for consumers whose clinical condition requires more than the current 10 sessions. The trials should allow a GP to re-refer a consumer after the first 10 sessions rather than the present 6 sessions.
- The Australian Government should change the MBS so that the maximum number of sessions of MBS-rebated psychological therapy (Psychological Therapy Services and Focused Psychological Strategies) is per 12-month period, as opposed to per calendar year.

In the medium-term (over 2 – 5 years)

Based on the results of these trials and evaluation, the Australian Government should determine whether to:

- Roll out the trialled changes above.
- Continue funding psychological therapy through the MBS, or whether some other mechanism is more appropriate.
- Make any other changes to increase the effectiveness of MBS-rebated psychological therapy.

- The current ten sessions of MBS-rebated psychological therapy per year is not adequate for people experiencing moderate to severe mental illness, including people with complex trauma conditions, those experiencing psychosis and people with bipolar disorder.
- The evaluation should also include exploration of groups who have low rates of access to MBS-rebated psychological therapies (e.g. older people).

Draft recommendation 5.7 — Psychology consultations by videoconference

Widening access to psychology consultations by videoconference

In the short-term (in the next 2 years)

- The Australian Government should change MBS rules so that videoconference can be used for MBS rebated Psychological Therapy Services and Focused Psychological Strategies by consumers residing in metropolitan areas, regional centres and large rural towns (Monash Modified Model areas 1–3) in addition to those residing in small and medium rural towns, remote and very remote communities (Monash Modified Model areas 4–7).
- For consumers in areas 1–3, at least 3 out of each 10 sessions must be face-to-face (including at least one out of the first four), and there should be no restriction that the consumer and clinician must be at least 15 kilometres away from each other.

- The recommendation should also apply to other allied health practitioners, including social workers, occupational therapists and specialist mental health nurses.

Draft Recommendation 5.9 - Ensure access to the right level of care

The Australian, State and Territory Governments should reconfigure the mental health system to give all Australians access to mental healthcare, at a level of care that most suits their treatment needs (in line with the stepped care model), and that is timely and culturally appropriate.

- The Inquiry's final report should reflect the importance of culturally safe and trauma-informed care for Aboriginal and Torres Strait Islander people. It is essential that supports for Aboriginal mental health and social and emotional wellbeing are:
    - Culturally appropriate, people-centred holistic services that take account of the historic experiences and social issues faced by Aboriginal people. Effective services acknowledge the impact of intergenerational trauma, racism and discrimination, disadvantage and social exclusion on Aboriginal people's mental health.
    - Designed and provided in consultation with the National Aboriginal Community Controlled Health Organisation (NACCHO), Aboriginal Health and Medical Research Council (AH&MRC) of New South Wales, the NSW Coalition of Aboriginal Regional Alliances (NCARA) and local Aboriginal medical services.
    - Grounded in respect for Aboriginal self-determination. Programs and services should be co-designed, implemented and managed in partnership with Aboriginal people and communities.

- The Commission should also consider how different access pathways and models of care may be more effective for different age groups. For example, the use of mobile technology for access crisis helplines in addition to existing telephone services.

Draft Recommendation 6.1 — supported online treatment options should be integrated and expanded

The Australian Government should facilitate greater integration and use of supported online treatment, into the stepped care model as a low intensity service, for people living with mental ill-health with mild to moderate symptoms.

In the short-term (in the next 2 years)

- Funding should be expanded for services to accommodate up to 150,000 clients per year in supported online treatment.
- Supported online treatment programs offered should each have a strong evidence-base for their efficacy and be offered to children, youth and adults.
- To aid integration of healthcare services, supported online treatment should have the option for outcomes data to be forwarded to a nominated GP or other treating health professional. Online service providers should annually publish summary output on use of their services, treatment provided, and other measurable outcomes.

In the long-term (over 5 – 10 years)

A review of supported online treatment services as a low intensity option should be undertaken. This review should assess whether there are any barriers to take up, the effectiveness of the services contracted and future funding options.

- Supported online programs should be tailored to the needs of specific populations, for example older people with mental ill-health and people in a custodial environment, provided the necessary safeguards are put in place.

Draft recommendation 7.1 — Planning regional hospital and community mental health services

In the short-term (in the next 2 years)

State and Territory Governments should determine, through regional service planning, the numbers of public acute mental health beds in hospitals, specialist mental health community treatment services and subacute/non acute mental health bed-based services that would meet the specific needs of each region and undertake to provide these on an ongoing basis.

- Consumer and carer stakeholder groups consistently advise that people should be able to retain their connectedness to the community and access care where they live.
- Under agreements relating to the Fifth National Mental Health and Suicide Prevention Plan, Primary Health Networks and Local Health Districts are required to produce, by 2020, local regional plans utilising the National Mental Health Services Planning Framework (NMHSPF) that will identify the "gap" between actual and population estimated mental health beds. NSW Health's capacity to meet the "gap" would require substantial increases to capital and community resources.

Draft recommendation 8.2 — Child and adolescent mental health beds

In the short-term (in the next 2 years)

State and Territory Governments should provide child and adolescent mental health beds that are separate to adult mental health wards. If it is not possible to provide these beds in public hospitals, State and Territory Governments should contract with private facilities, or provide care as hospital in the home.

- Mental health services for children and young people are most appropriately provided in the community. Increases to child and adolescent assertive response teams would enable more care in the home, potentially prevent presentations to emergency departments and increase effective utilisation of acute services.

Part III Reorienting surrounding services to people

Draft recommendation 10.2 — Online navigation platforms to support referral pathways

Commissioning agencies should ensure service providers have access to online navigation platforms offering information on pathways in the mental health system.

In the short-term (in the next 2 years)

- All commissioning agencies (PHNs or RCAs) should, either individually or collaboratively, develop or maintain an online navigation platform, including detailed mental health referral pathways. The HealthPathways portal model, which is already used by most PHNs, can be used to contain this information.
- Access to these platforms should be expanded beyond health, in particular to schools and psychosocial service providers. Each commissioning agency should also, either individually or collaboratively, fund a small dedicated team supporting the users of the online platform.

In the medium-term (over 2 – 5 years)

All online navigation platforms should incorporate the ability to book consultations with service providers directly from the platform.

- New South Wales notes evidence suggesting people who are already experiencing high cognitive load have reduced capacity to make informed choices. Consideration should be given to the way information and choices are presented on online portals so not to overwhelm people. One way to do this is to couple the provision of information with tools to help people set their own goals and plan their own care.

Draft Recommendation 10.3 — Single care plans for some consumers

Governments should support the development of single care plans for consumers with moderate to severe mental illness who are receiving services across multiple clinical providers.

In the medium-term (over 2 – 5 years)

The Department of Health should:

- Develop and promote protocols for sharing consumer information between service providers, and allocating responsibility for plan development, follow-through and updating the consumer's primary treating clinician (unless otherwise agreed by their treating team).
- Amend the MBS to include a specific item to compensate a clinician overseeing a single care plan for their time.

- New South Wales suggests, in addition, that consideration is given to expanding MBS items for allied health clinicians to include case conferencing with GPs as a way to improve multidisciplinary care.

Draft recommendation 11.3 – More specialist mental health nurses

In the short-term (in the next 2 years)

Accreditation standards should be developed for a three-year direct-entry (undergraduate) degree in mental health nursing, similar to the option already available to midwives. The new standards should be developed by the Australian Nursing and Midwifery Accreditation Council in consultation with stakeholders, including the Australian College of Mental Health Nurses and the Nursing and Midwifery Board of Australia. Nurses who complete the three-year direct-entry degree would be registered as having an undergraduate qualification in mental health and (if the above recommendation results in a specialist registration system for nurses with advanced training in mental health) be distinguished from registered nurses with a post graduate degree in mental health.

In the medium-term (over 2 – 5 years)

The merits of introducing a specialist registration system for nurses with advanced qualifications in mental health should be assessed. The assessment should be independent and be commissioned by the Australian, State and Territory Governments through the COAG Health Council. If specialist registration is found to have merit, the COAG Health Council should direct the Nursing and Midwifery Board of Australia to provide it with a formal proposal to amend the registration arrangements for nursing to recognise nurses who have specialist qualifications in mental health.

- New South Wales will be looking to investigate this recommendation further with stakeholders.

Draft recommendation 11.6 — Mental health specialisation as a career option

Governments and specialist medical colleges should take further steps to reduce the negative perception of, and to promote, mental health as a career option.

In the short-term (in the next 2 years)

The Australian, State and Territory Governments should, in collaboration with specialist medical colleges, act to reduce the negative perception of, and to promote, mental health as a career option by:

- Exposing health students and practising health professionals to people with a mental illness (and their carers) outside a clinical environment to help break down negative perceptions.
- Rebalancing where trainees undertake clinical placements and internships to a more representative mix of settings, including in the private sector and settings other than inpatient units.

- New South Wales considers that this recommendation could be expanded to include allied health disciplines.
- New graduates often describe a lack of mental health related content in their undergraduate programs. There is value in targeting medical students who show interest in mental health to take up the training and of exposing students to people with mental illness across a range of mental health settings. Recovery Camp is an example of a program run by Wollongong University which puts health students and those with a lived experience together for a shared learning experience.

Draft recommendation 11.7 — Attracting a rural health workforce

In the short-term (in the next 2 years)

The Australian, State and Territory Governments should make working in rural and remote areas a more attractive option for health professionals by reducing professional isolation, increasing opportunities for professional development, and improving the scope to take leave. This should include:

- Greater use of videoconferencing, subject to the availability of communications infrastructure, for health workers to remotely participate in professional development activities and meetings and conferences with peers.
- Expanding initiatives such as the Rural Locum Assistance Program to fund visiting health professionals to temporarily stand in for rural and remote health workers, including psychiatrists, while they attend professional development activities, meetings and conferences with peers, and take leave.

- In addition, investment in mentors and/or coaches for regional and remote mental health staff would be beneficial.

Draft recommendation 12.1 — extend the contract length for psychosocial supports

In the short-term (in the next 2 years):

The Australian, State and Territory Governments should extend the funding cycle length for psychosocial supports from a one-year term to a minimum of five years.

- A robust and reliable performance and monitoring framework should be established for all psychosocial support across programs.

Draft recommendation 12.2 — Guarantee continuity of psychosocial supports

Requirements for continued access to psychosocial support should be changed so that anyone who requires it is able to access it, including former participants of Australian Government-funded psychosocial supports.

In the short-term (in the next 2 years)

- Should someone choose to apply for the National Disability Insurance Scheme (NDIS), they should continue to be supported during the application process.
- Should someone choose not to apply for the NDIS, they should be allowed to continue to access support through the National Psychosocial Support Measure, should they require it, until it has been phased out.

In the medium-term (over 2 – 5 years)

- For those who did not apply for the NDIS, the psychosocial support commissioning agencies should conduct an evaluation of barriers and remove them as necessary.
- When the National Psychosocial Support Measure is phased out, participants should either be shifted onto the NDIS, if appropriate, or access the replacement psychosocial support.

- It is important that people requiring psychosocial supports can access Commonwealth funded programs, as the public mental health system is not currently equipped to fill the gap. Given the high number of people from these programs who have not tested their

eligibility for the NDIS, as well as those who have withdrawn from the NDIS, it would be beneficial to conduct an evaluation to understand why individuals have chosen either not to test or to withdraw. This information could be used to improve the NDIS overall for people with psychosocial disability. NSW Health also supports the recommendation that once the National Psychosocial Support Measure is phased out, people should be offered the option to transition to the NDIS or another program.

- There is a significant gap for older people (over 65 years) with a psychosocial disability. The National Psychosocial Support Measure provides some opportunity for this population group in the short-term. While there are some opportunities for this type of support to be provided through the aged care system, advice from key stakeholders suggests access to tailored psychosocial support through this system is limited.

Draft recommendation 12.3 — NDIS support for people with psychosocial disability

The National Disability Insurance Agency (NDIA) should continue to improve its approach to people with psychosocial disability.

In the short-term (in the next 2 years)

- The NDIA should complete the evaluations of the psychosocial disability stream trial sites in Tasmania and South Australia, and incorporate improvements into the stream, as soon as possible.
- The psychosocial disability stream should be fully rolled out across all National Disability Insurance Scheme sites by end 2020.
- Incorporate the lessons learnt from the Independent Assessment Pilot into the National Disability Insurance Scheme access and planning processes by end-2020.

- There are significant issues for people with psychosocial disability accessing supports under the NDIS and resolving these should be priority for national and state governments.

Draft Recommendation 13.3 — Family-focused and carer-inclusive practice

Family-focused and carer-inclusive care requires mental health services to consider family members' and carers' needs and their role in contributing to the mental health of consumers.

In the short-term (in the next 2 years)

- Where this is not already occurring, State and Territory Government mental health services should routinely collect responses to the Carer Experience Survey. The data collected should be sufficient for each Local Hospital Network to compare and assess the level of carer-inclusive practice across its services.
- The Australian Institute of Health and Welfare should use the data to report publicly on survey take-up rates and survey results at the state and territory level.

In the medium-term (over 2 – 5 years)

To improve outcomes for children of parents with mental illness, the National Mental Health Commission should commission a trial and evaluation of the efficacy of employing dedicated staff to facilitate family-focused practice in State and Territory Government mental health services.

The Australian Government should amend the MBS so that psychologists and other allied health professionals are subsidised:

- To provide family and couple therapy, where one or more members of the family/couple is experiencing mental illness. These sessions should count towards session limits for psychological therapy.
- For consultations with carers and family members without the care recipient present. Consistent with existing items that are available to psychiatrists, there should be a limit of four subsidised consultations with carers and family members per 12-month period.

- The recommendation for amendments to the MBS should be expanded to include an item for allied health professionals to conduct case conferencing in consultation with GPs and psychiatrists, including through telemedicine.

Information Request 14.1 — Individual placement and support expansion options

The Productivity Commission is seeking further information about the pros and cons of the two distinct options for expanding the Individual Placement and Support (IPS) model of employment support. The options are:

- *Direct employment of IPS employment specialists by State and Territory Government community mental health services. This could be supported by additional Australian Government funding a new Australian Government-administered contract for IPS providers, based on fee-for-service compensation and subject to strict adherence to the IPS model (including that a partnership is in place with a State and Territory Government community mental health service).*

What are the pros and cons of each option? Which is your preferred option and why? If the direct employment option is pursued, how should State and Territory Local Hospital Networks be funded to deliver the service?

- Cost-effectiveness of Individual Placement and Support (IPS) in Disability Employment Services in regional areas in Australia have been evaluated and proven to be cost-effective, particularly with people with severe mental illness. Waghorn, G. and Parletta, V. (2016) concluded that "IPS enhanced employment services were most financially

beneficial when applied to participants with more severe psychiatric disabilities. Providers assisting people with psychological or psychiatric disabilities could benefit from developing a capability to deliver more intensive evidence-based practices such as IPS. The financial advantage of IPS enhancements increases with both the extent of clients assistance needs and with the funding system s emphasis on results-based funding."

- Successful implementation of IPS requires education to both mental health and IPS employment support services staff. National models exist in the UK (Centre for Mental Health) and US (IPS Employment Centre), and technical support on a fee-for-service basis from IPSWORKS, a department of the Western Australian Association for Mental Health (WAAMH).

Draft Recommendation 14.3 — Staged rollout of individual placement and support model

The Individual Placement and Support (IPS) model of employment support should be extended beyond its current limited application through a staged rollout to (potentially) all State and Territory Government community mental health services, involving co-location of IPS employment support services.

The Commission is seeking further feedback on whether this should occur through partnerships between dedicated IPS providers and community mental health services, or direct employment of IPS specialists by community mental health services.

In the short-term (in the next 2 years)

- Governments should thoroughly trial and evaluate the IPS program to better establish the factors that influence its cost-effectiveness (for example, the impacts of local labour market conditions and participant characteristics).
- The program should initially be open to all non-employed consumers of community mental health services who express a desire to participate and meet the other requirements of the IPS model. Participation in the program should fulfil mutual obligation requirements for income support recipients.

In the medium-term (over 2 – 5 years)

Subject to these trials, the IPS program should be rolled out gradually with data shared across jurisdictions and a mechanism for diffusion of best practice. If the net benefits of the program apparent in the small-scale trials are not replicated as the program is scaled up, its design (and if necessary, its desirability) should be re-appraised.

- If the IPS Model is implemented without adequate vocational staff resources, there will be pressure on current mental health staff to increase caseloads.
- A model of co-location of IPS employment support services in mental health services will require dedicated resources from the lead agency to provide oversight, governance, monitoring and evaluation of programs.

Draft recommendation 15.1 — Housing security for people with mental illness

Housing services should increase their capacity to prevent people with mental illness from experiencing housing issues or losing their home.

In the medium-term (over 2 – 5 years)

- Each State and Territory Government should offer and encourage the use of mental health training and resources for social housing workers. Training should incorporate awareness about how to identify early warning signs of mental illness and the benefits of early intervention. It should also provide advice on appropriate interventions to stabilise existing tenancies for people with poor mental health, such as connecting tenants to mental health services or care coordinators.
- State and Territory social housing authorities should review their policies relating to anti-social behaviour, temporary absences and information sharing to provide consideration for people with mental illness, so as to reduce the risk of eviction.
- Each State and Territory Government, with support from the Australian Government, should ensure that tenants with mental illness who live in the private housing market have the same ready access to tenancy support services as those in social housing by meeting the unmet demand for these services.

In the long-term (over 5 – 10 years)

- State and Territory Governments should monitor the impacts of forthcoming reforms to residential tenancy legislation, including no grounds evictions, and assess the potential impacts for people with mental illness who rent in the private market.

- Commonwealth and States and Territories should collaborate to address priority pathways to secure accommodation with public and social housing authorities, including novel approaches to maximising the efficient use of existing housing stock and building of new stock.
- Supporting Tenancies in Social Housing is being piloted in two sites in New South Wales and will be expanding in another three sites in 2020. The focus is on preventing negative exits from social housing due to rental arrears, property damage and anti-social behaviour. The approach includes case management and assisting tenants with mental health issues to access support services.
- People with mental illness and psychosocial disability experience access issues to NDIS Supported Independent Living and Specialist Disability Accommodation.
- The NSW Health-led National Hospital Discharge Delay Action Plan, endorsed by the Disability Reform Council on 28 June 2019, requires a range of actions, largely by the Commonwealth, to improve access to housing to facilitate transition of participants from hospital into the community.

Draft Recommendation 16.1 — Support for police

A systematic approach should be implemented to support the police response to mental health crisis situations.

In the short-term (in the next 2 years)

All State and Territory Governments should implement initiatives that enable police, health and ambulance services to collectively respond to mental health crisis situations. The approach undertaken in Queensland should be considered.

The initiatives should ensure that:

- Mental health professionals are embedded in police communication centres to provide real-time information on the individual to whom police are responding, to advise on responses and referral pathways, and to prioritise deployment of co-responder resources.
- Police, mental health professionals and/or ambulance services (draft recommendation 8.1) are able to co-respond to mental health crisis situations if necessary.
- Roles and responsibilities of all service providers are clearly defined.
- Approaches are tailored to meet the needs of particular groups, such as Aboriginal and Torres Strait Islander people.

- The proposal that mental health professionals be embedded in police communication centres would need to be examined and possibly trialled to assess cost and effectiveness. This option would also need to be considered in relation to the current Police, Ambulance and Clinical Early Response PACER pilot underway in NSW (referenced on p308 and p606 of the draft PC report).
- While less comprehensive than PACER, placing mental health professionals in police communication centres may be more straightforward than securing staff in each Police Area Command/Police District (of which there are 58) or each LHD in NSW.

Information Request 16.1 — Transition support for those with mental illness released from correctional facilities.

We are seeking further information on transition support for individuals with mental illness released from correctional facilities (on parole or not) that link them to relevant community services. This includes information on the benefits of transition support and the extent of transition support that should be provided.

- NSW is exploring opportunities for increased collaboration between agencies for recently released prisoners with mental health issues (at risk of homelessness). This has been highlighted following a 2019 review of the 2011 Housing and Mental Health Agreement between NSW Health and the NSW Department of Communities and Justice.

General transition information and services

- It is recognised that short-term prisoners and those held on remand are in need of assistance when returning to the community. There is much evidence of high rates of reoffending among released inmates, including the large subgroup who serve short-terms of 12 months or less. Even when incarcerated for short periods, individuals can suffer

damage to workplace and family relations which contributes to the likelihood of future offending.

- Principles of effective correctional programming require that treatment occur for a long enough period to effect a change in offenders. However, offenders may be under the responsibility of corrective services for only brief periods. Given the high number of inmates who spend a relatively short time in a correctional centre, support services during the pre and post-release stages are critical.
- If an inmate is to be released to supervision by NSW Community Corrections, a Community Corrections officer located within the inmate's correctional centre will work with the offender for the 6-9 months leading up to their release. While under supervision in the community, Community Corrections officers will work closely with services such as NDIS for assessment of the offender's needs and the services available. They will also refer the offender to local mental health services for ongoing treatment.
- Corrective Services NSW (CSNSW) also operates the Extended Reintegration Service (ERS) which provides accommodation and support to parolees under supervision of CSNSW in the community. The service supports parolees assessed as medium/high or high risk of reoffending and who have significant complex needs such as mental health and/or cognitive impairment and alcohol or other drugs dependency. Support is provided for 12 months, including up to nine months post-release. ERS complements Community Corrections case management which is focussed on the delivery of offender-focused programs and interventions. The service is provided through the collaboration of Community Corrections, the service provider and partner agencies including Housing NSW and NSW Health.
- Transitional services provided by CSNSW are evidenced-based and support the transition from custody to community based on the risk, need and responsibility principles.
- The Kirby Institute (UNSW) in partnership with NSW Health and CSNSW has undertaken a data linkage that establishes the benefits of ongoing clinical contact. A recent data linkage study showed that for people with a lifetime diagnosis of psychosis, reoffending decreases where there is an increased number of mental health service clinical contacts. Those with no mental health contacts were five times more likely to reoffend compared to those with the highest number of contacts.
- Those with a psychosis were 5 times more likely to have a criminal conviction and are responsible for 10% of offences committed in NSW (2001 – 2015).
- There are also increased odds of this group committing a violent offence so we are working to prioritise this group.
- 2000 people with serious mental illness leave prison each year.

Youth Justice-specific transition information

- NSW Youth Justice caseworkers in custody work closely with case managers in community to provide continuous delivery of service and support for young people from their time in custody until they are released, and until the expiration of their order. Discharge and exit planning commences from the time that the young person enters custody, including relapse and prevention planning, and referral to community services and programs. There are also a range of Youth Justice funded services which can provide casework support, accommodation support, post-custody release support and mentoring to support young people.

- The NSW Justice Health and Forensic Mental Health Network (JH&FMHN) collaborates with Youth Justice in case conferences to plan continuity of care for young people exiting custody. Their Community Integration Teams coordinate care for young people who have mental health problems and/or problematic drug use commencing when they are in custody and extending three months after their release. Further information on this program is publicly available here: https://www.aci.health.nsw.gov.au/ie/projects/community-integration-team

Information Request 16.2 — Appropriate treatment for forensic patients

The Productivity Commission is seeking further information about those held in correctional facilities who are eligible for forensic mental healthcare but are unable to access it due to capacity constraints. In particular, we are seeking information about the likely indirect costs and benefits to the wider community from increasing access to forensic mental healthcare.

- The number of inmates who are currently unable to access a forensic mental healthcare bed is not so great as to result in a significant cost offset against increased healthcare cost. Doing so would most likely come as a result of dispersing these inmates across several locations/facilities, increasing the cost of healthcare disproportionately to the savings made in the correctional system.
- The following three research articles address access to forensic mental health care:
    - Cusack, KJ, Morissey, JP, Cuddeback, GS, Prins, A & Williams, DM (2010). Criminal justice involvement, behavioural health service use, and costs of forensic assertive community treatment. Community Mental Health Journal, 46, 4, pp 356-363.
    - Cusack and colleagues (2010) conducted a randomised control trial in California and found that where forensic community mental health teams were able to provide treatment to patients in the community that addressed their problem behaviours, there was significant benefits to the community and reduced costs for managing patients in the community. At 12 months forensic patients who were able to utilise forensic assertive treatment teams had fewer prison bookings, greater outpatient contacts, and fewer hospital days than those who did not. Patients who received treatment from forensic community mental health teams had a higher probability of avoiding prison, although once imprisoned, the number of imprisoned days did not differ between groups. Increased outpatient costs resulting from Forensic Community Mental Health Teams outpatient services were partially offset by decreased inpatient and prison costs. The findings for the 24-month period followed the same pattern. These findings provide additional support for the idea that providing appropriate behavioural health services can reduce criminal justice involvement.
    - Adams, J, Thomas, S, Mackinnon, T & Eggleton D (2018), 'The risks, needs and stages of recovery of a complete forensic patient cohort in an Australian state', BMC Psychiatry, 18, 35. DOI: 10.1186/s12888-017-1584-8
    - Adams, J & Wells, S (2014) Focussing on Forensic Rehabilitation in the Community: A needs analysis of forensic and high-risk civil patients. Internal Report, Justice Health and Forensic Mental Health Network, NSW.

- Adams and colleagues identified a number of clinical needs that remain unmet as forensic patients transfer to the community. Over 30% of forensic patients displayed poor understanding of their condition and had unmet treatment needs; 20% displayed active symptoms of psychosis and had unmet substance needs; and almost half of all community patients had unmet social and relationship needs. Accommodation, lack of meaningful activity and psychological distress were also present. This suggests that forensic rehabilitation is necessary as patients transfer into the community and rehabilitation pathways across all levels of security need to be better coordinated.

Draft Recommendation 16.3 — Mental healthcare in correctional facilities and on release

Mental health screening and assessment of individuals in correctional facilities should be undertaken to inform resourcing, care and planning for release.

In the medium term (over 2 – 5 years)

- All State and Territory Governments should undertake mental health screening and assessment of all individuals (sentenced or unsentenced) on admission to correctional facilities, and on an ongoing basis where mental ill-health is identified.
- The mental health information obtained from the screening and assessment needs to be comprehensive enough to inform resourcing of mental health services in correctional facilities. Where appropriate, authorities should share this information with community-based mental health services to enable individuals with mental illness to receive continuity of care on release.

- In New South Wales, Corrective Services undertakes an initial on-boarding process known as Reception, Screening, Induction and Orientation (RSIO). As part of this process, every inmate undergoes screening within 36 hours of coming into a correctional centre. The assessment utilised in screening is the Intake Screening Questionnaire v6 (ISQ). The ISQ solicits information from the inmate relating to disability, disability pension, mental health issues, risk of self-harm, and suicide. This information is informs the services and care provided to inmates.
- For young people, a psychological assessment (either a brief or comprehensive) is completed by a centre-based Youth Justice psychologist within three working days of their admission. If there is an identified mental health or self-harm concern, this initial assessment is completed within 24 hours. A comprehensive psychological assessment is completed within seven days. This informs referrals to relevant mental health services.

Part IV Early intervention and prevention

Draft recommendation 17.1 — perinatal mental health

Governments should take coordinated action to achieve universal screening for perinatal mental illness.

In the short-term (in the next 2 years)

- The Australian Institute of Health and Welfare should expand the Perinatal National Minimum Data Set, to include indicators of mental health screening, outcomes and referrals. This data should be reported by State and Territory Governments.
- State and Territory Governments should use the data to evaluate the effectiveness of health checks for infants and new parents and adjust practice guidelines in accordance with outcomes.

In the long-term (over 5 – 10 years)

- The National Mental Health Commission should monitor and report on progress towards universal screening.
- State and Territory Governments should put in place strategies to reach universal levels of screening for perinatal mental illness for new parents. Such strategies should be implemented primarily through existing maternal and child health services, and make use of a range of screening channels, including online screening and outreach services.

- NSW Health collects prenatal and postnatal routine mental health and psychosocial data, for public Maternity/Obstetrics Hospital services, however there is a gap with private specialists and private hospitals who do not do this routinely. Additionally, there is no state-wide or national reporting mechanism to analyse and report on the screening rates, results or referrals.
- The Perinatal Minimum Data Set (PMDC) includes information on the mother and baby up to the point of discharge from hospital after birth. A different approach to obtain this 'longitudinal' information for mothers and babies will be needed. The existing recommendation could be modified as follows:

  "The Australian Institute of Health and Welfare should establish a longitudinal dataset on mental health during pregnancy and up to one year after birth."

  "The Australian Institute of Health and Welfare can utilise the dataset developed through the proposed new Maternity to Home and Wellbeing Program, a Commonwealth investment (2019 Federal election commitment 2020/21-22/23) to support routine and universal screening for perinatal depression amongst expectant and new mothers (and fathers)".

Draft Recommendation 17.2 — Social and emotional development in preschool children

Services for preschool children and their families should have the capacity to support and enhance social and emotional development.

In the short-term (in the next 2 years)

- State and Territory governments should use existing guidelines to expand early childhood health checks, such that they assess children's social and emotional development before they enter preschool.
- State and Territory departments of education should ensure that all early childhood education and care services have ready access to support and advice from qualified mental health professionals.
- The Australian Children's Education and Care Quality Authority should review the pre service training programs for early childhood educators and teachers to ensure qualifications include specific learning on children's social and emotional development.

In the medium-term (over 2 – 5 years)

- State and Territory departments of education, as the regulators responsible for early childhood education and care, should review the quality improvement plans of all services to ensure they include professional learning for staff on child social and emotional development.
- Where this is not already occurring, funding for backfilling should be made available to enable early childhood education and care staff to attend accredited professional development, to support their knowledge of child social and emotional development and mental health.
- State and Territory Governments should expand the provision of parent education programs through child and family health centres.

Early childhood checks and the role of child and family health centres

- There is merit in considering how the components of this recommendation directed at child and family health services may also apply to general practice. NSW Health estimates that by 18 months of age approximately 10 per cent of families remain engaged with community child and family health services.
- The build of the child My Health Record provides an excellent opportunity for national consistency through the inclusion of a consistent developmental screening tool.

Early Childhood Education and Care services

- The NSW Department of Education regulates the early childhood education and care sector. This comprises not only preschool but also long day care, outside of hours care and family day care among others. The age cohorts of this sector ranges from 0 to 12.
- The context surrounding screening and access to help in early childhood education and care services is very different to that facing school systems. Except for state-funded services like community preschools, state and territory governments are primarily the regulatory bodies for early childhood education (ECE) services, aiming to improve quality. The Commonwealth primarily provides funds to address affordability and workforce participation. Aside from a small number of Department preschools the NSW Department of Education does not play any role in the administration of education and care services.

- The Commission recommends that State education departments should guarantee that thousands of ECE services have 'ready access' to professional help from mental health professionals, usually child psychologists. It suggests the best way to achieve this is by extending existing school mental health and wellbeing programs to early childhood education services. The content of existing school-based programs is unlikely to be fit-for-purpose for ECE services. The ECE sector presents dynamic and varied types of care (including 24-hour and weekend care), hence training needs to be tailored to meet this variety of needs.
- New South Wales Government currently provides many different types of professional development on a variety of topics for the thousands of educators that operate in New South Wales. It would be costly to fund the backfilling of positions when staff attend professional development programs.

Draft recommendation 17.3 — Social and emotional learning programs in the education system

Governments should develop a comprehensive set of policy responses to strengthen the ability of schools to assist students and deliver an effective social and emotional learning curriculum.

In the short-term (in the next 2 years)

The COAG Education Council should develop a national strategic policy on social and emotional learning in the Australian education system. This policy should include:

- A clear statement on the role of the education system in supporting mental health and wellbeing, and the role of schools in interacting with the mental health system.
- A commitment to cooperate with the COAG Health Council in the implementation of mental illness prevention policy, and a clear delineation of responsibility, to prevent overlap and confusion in policy development.
- Guidelines for the accreditation of initial teacher education and professional development courses for teachers, which will include social and emotional learning. These guidelines should be developed by the Australian Institute of Teaching and School Leadership.
- Guidelines for the accreditation of external social and emotional learning programs offered to schools. These guidelines could be developed by an expert advisory panel.

In the medium-term (over 2 – 5 years)

- State and Territory departments of education should use the national guidelines to accredit social and emotional learning programs delivered in schools.
- State and Territory teacher regulatory authorities should use the national guidelines to accredit initial teacher education programs and professional development programs for teachers. Ongoing learning on child social and emotional development and wellbeing should form part of professional development requirements for all teachers. This should include the social and emotional wellbeing of Aboriginal and Torres Strait Islander children.

- The NSW Education Standards Authority (NESA) is responsible for the development of curriculum for New South Wales schools. It is not within NESA's remit to endorse external programs.
- NESA has a regulated system of professional development (PD) for teachers maintaining accreditation in New South Wales. All courses delivered by endorsed providers must be

aligned to the Australian Professional Standards for Teachers (APST) and fulfil other criteria relevant to the context of New South Wales teachers. While supporting AITSL's development of a set of guidelines in the area of social and emotional learning, these should not replace or override NESA's existing processes for the endorsement of NESA Registered Professional Development.

Draft Recommendation 17.4 — Educational support for children with mental illness

The education system should review the support offered to children with mental illness and make necessary improvements.

In the short-term (in the next 2 years)

The Disability Standards for Education are due to be reviewed in 2020. The upcoming review should:

- Include specific consideration of the way the standards affect students with mental illness and their educational outcomes.
- Examine application processes for adjustments and consider any necessary improvements.
- MBS-rebated health professionals treating children should be required to include recommendations for parents/carers and teachers in their report to the referring medical practitioner.

In the medium-term (over 2 – 5 years)

- The Australian Government should use data collected by schools as part of the National Consistent Collection of Data on School Students with Disability to evaluate the effectiveness of its disability funding structures for children with social-emotional disability.
- State and Territory departments of education should review the funding for outreach services supporting students who have disengaged from education due to mental illness to return to school. Services should be expanded such that they are able to support all students who are at risk of disengagement or have disengaged from their schooling. Departments should put in place clear policies for outreach services to proactively engage with students and families referred to them, once the student's attendance declines below a determined level, and monitor their implementation.

- In relation to the short-term recommendations, it is critical that health professionals understand the context of school and education when writing the recommendations to/for schools. Guidelines will be required to assist MBS-rebated professionals to write meaningful and constructive advice for school staff.
- In relation to the medium-term recommendations, it is not possible to use the National Consistent Collection of Data on School Students with Disability (NCCD) in the way proposed. The NCCD is based on the professional judgement of staff and is not therefore a precise indication of disability type. A student with mental illness may be counted in the category of "social-emotional" disability and or they may be counted under a different NCCD category. The teacher/school determine the primary disability for NCCD purposes. Therefore, the category of disability recorded in the NCCD cannot be taken as a sure indicator of either the presence or absence of a mental health issue. Moreover, the level of adjustment recorded is part of that teacher judgement and does not quantify the cost

associated with the adjustment or reflect any additional funding associated with individual students.

Draft Recommendation 17.5 — Wellbeing leaders in schools

All schools should employ a dedicated school wellbeing leader, who will oversee school wellbeing policies, coordinate with other service providers and assist teachers and students to access support.

In the short-term (in the next 2 years)

- State and Territory Governments should review existing programs that support school wellbeing initiatives and establish which funding could be redirected towards the employment of school wellbeing leaders in government schools.

In the medium-term (over 2 – 5 years)

- All schools should have a dedicated wellbeing leader. In larger schools, this should be a full-time position.
- Where government schools can demonstrate that they already employ a staff member in an equivalent position, and are delivering effective mental health and wellbeing programs, they should be able to access the equivalent funding to be used for additional investment in social and emotional wellbeing.

- All New South Wales public schools utilise a range of welfare and wellbeing positions including Head Teacher Welfare/Wellbeing, School Counsellors, School Psychologists, Deputy Principals and year advisors. Flexible equity funding allows those schools with the greatest need to vary their staffing mix to directly address these student and community needs. The Department of Education is continuing to innovate in the space of support for student wellbeing in its schools, including through the New South Wales Government's recent investment of over $88 million to give every public high school a full-time counselling allocation and student support officer.
- Further evidence is needed for wellbeing staff to have a teaching background, and for a new position on top of (or in place of) current, locally adapted arrangements. New South Wales is concerned that mandating a specific position (that must also be funded from existing budgets) could reduce schools' flexibility to address the need profiles of their students and ensure the best outcomes.

Draft Recommendation 17.6 — Data on Child Social and Emotional Wellbeing

Governments should expand the collection of data on child social and emotional wellbeing, and ensure data is used (and used consistently) in policy development and evaluation.

In the short-term (in the next 2 years)

- The Australian Government should fund the AIHW's work to finalise the development and implementation of an indicator of child social and emotional wellbeing. Where jurisdictions do not collect the required data, the AIHW should work with Departments of Health to implement data collection. Data should be collected and reported annually.
- State and Territory departments of education should use existing school surveys to monitor the outcomes of wellbeing programs implemented in schools. These should be used to identify schools that require additional support to implement effective wellbeing programs.

In the long-term (over 5 – 10 years)

- The Australian Government should fund the creation of an education evidence-base, including an evidence-base on mental health and wellbeing. This should include funding networks of schools to trial and evaluate innovative approaches.
- The Australian Government should fund the Australian Institute of Family Studies to establish new cohorts of the Longitudinal Study of Australian Children at regular intervals.

- Regarding the short-term recommendation to use existing school surveys to monitor wellbeing programs, New South Wales notes that the definition of wellbeing is broader than mental health, capturing a range of social, emotional and academic outcomes.
- In New South Wales, the 'Tell Them From Me' (TTFM) surveys capture the views of students, parents and teachers in public schools, on topics including student wellbeing. While the TTFM survey includes important indicators of broad student wellbeing at school, the survey does not involve the collection of mental health data and is unlikely to provide the required detailed evidence on the effectiveness of mental health programs implemented in schools. The survey scope does not cover the student populations identified by the Commission as most at risk from mental illness: young children and children with social and emotional disabilities. The NSW Department of Education has a plan of work to enhance the accessibility of the TFFM surveys but may not be able to provide the data in the timeframe envisaged by the Commission.

Part V Pulling together the reforms

Draft Recommendation 22.1 — a national mental health and suicide prevention agreement

All stakeholder groups, including government, should know which tier of government is responsible for funding particular services and is accountable for mental health outcomes that are attributable to the provision of those services.

In the short-term (in the next 2 years)

COAG should develop a National Mental Health and Suicide Prevention Agreement between the Australian, State and Territory Governments that:

- Sets out the shared intention of the Australian, State and Territory Governments to work in partnership to improve mental health and suicide prevention outcomes for all Australians.
- Recognises the importance of separating funding and governance arrangements of mental health from those of physical health to strengthen the accountability of individual jurisdictions for mental health outcomes.
- Specifies the responsibility of each tier of government to fund and deliver particular mental health services and supports, and suicide prevention activities to ensure maximum separation in responsibilities and maximum coverage of consumer and carer needs.
- Introduces new funding and governance arrangements between both tiers of government for mental health services and supports, including the mechanism for establishing funding allocations.
- Includes consumers and carers as key partners in developing the agreement.
- Recognises the role of non-health supports in meeting consumer and carer needs, particularly psychosocial supports.
- Sets out clear and transparent performance reporting requirements.
- Sets out the governance arrangements for the proposed Regional Commissioning Authorities, if recommended and accepted by all governments.

The COAG Health Council should be responsible for developing and implementing the proposed National Mental Health and Suicide Prevention Agreement.

- A new intergovernmental agreement on mental health could be beneficial if it presents a fair agreement and has a sufficiently long time period, that delivers a genuine partnership between all jurisdictions. The agreement should provide a non-prescriptive approach where States and Territories can have flexibility to allocate resources as required to best meet outcomes (rather than input-based requirements). There should also be consideration of the ongoing nature of the agreement – so that the burden of negotiation of an appropriate funding mechanism to maintain or improve outcomes does not fall entirely onto States and Territories.
- A new mental health and suicide prevention agreement must consider the broader context of health system reform and existing agreements across governments, such as National Health Reform Agreement (NHRA) commitments and the Fifth National Mental Health and Suicide Prevention Plan endorsed by the Council of Australian Governments (COAG) Health Council in 2017. Current negotiations on the 2020-25 NHRA recognise

the shared responsibility across all levels of government in improving mental health outcomes and preventing suicide.

- In addition to the components recommended in the report, any new National Mental Health and Suicide Prevention Agreement should also outline:
    - clear data collection and reporting obligations and sharing arrangements between Commonwealth, States and Territories
    - mechanisms to ensure Commonwealth funding reflects demand growth
    - how integration with the rest of the health system will be maintained
    - how unmet demand and additional funding requirements will be identified, and that this should occur before contributions and growth caps are locked into a National Agreement.
- Any mental health agreement should also be specific about New South Wales retaining its psychosocial case management programs – such as Housing Accommodation Support Initiative and Community Living Supports – as is the current arrangement for psychosocial disability support programs between New South Wales and the National Disability Insurance Agency (NDIA).
- The Commission has proposed that the National Mental Health Commission be responsible for national oversight and coordination. This can be beneficial given the devolvement of responsibilities to regionally based service delivery. Consistent action and policies across Australia should be balanced with regional autonomy.
- Areas where national coordination and oversight can be beneficial are:
    - ensuring consistency, baseline service delivery and to ensure some level of continuity of care for people moving between regions
    - evaluating and disseminating of information around best practice, learnings, and opportunities to scale up successful pilots
    - monitoring and advocating for redistributions of funds across portfolios where there are opportunities to improve the investment mix
    - monitoring integration of mental health services with other services
    - promoting evidence-based decision-making.

Draft Recommendation 22.2 — A new whole-of-government mental health strategy

A national strategy that integrates services and supports delivered in health and non health sectors should guide the efficient allocation of government funds and other resources to improve mental health outcomes over the long-term.

In the short-term (in the next 2 years)

The Council of Australian Governments (COAG) should amend the terms of reference of the COAG Health Council to enable it to include other COAG Councils in policy discussions and decisions, or ministers responsible for portfolios that do not have a relevant COAG council, where this is necessary to cement cross-portfolio commitment to reforms directed at the social determinants of mental health and suicide prevention.

The Australian Government should expedite the development of an implementation plan for the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023.

The COAG Health Council should develop a new whole-of-government National Mental Health Strategy to improve population mental health over a generational time frame. In developing the new strategy, the COAG Health Council should:

- Collaborate with relevant health and non-health portfolios of Australian, State and Territory Governments, consumers and carers, and the private sector.
- Redraft its mental health vision statement to better balance the outcomes desired by consumers and carers with the level of ambition it has for mental health reforms.
- Ensure that it is a single document that has the demonstrable support of consumers and carers, for whom it exists.

The National Mental Health Commission should be responsible for monitoring and reporting on the strategy's implementation annually.

The COAG Health Council should ensure that progress in implementing the strategy is independently reviewed and improvements recommended every five years.

The COAG councils should ensure that all national, and State and Territory agreements and strategies that affect mental health outcomes explicitly articulate how they contribute to meeting the aims of the National Mental Health Strategy and how they will demonstrate progress in meeting these aims. Similarly, the new National Mental Health Strategy should include corresponding links to other strategies that support it.

- The development of a new whole-of-government mental health strategy requires a collaborative approach with states and territories and must build on and align with long-term reforms within the 2020-25 NHRA. This includes activity to improve delivery of coordinated care, improve health outcomes and drive health system improvements.
- New South Wales supports closer cooperation and collaboration between COAG councils and the integration of performance measures and monitoring where there is an interface between health and other systems. Review cycles may need to be more frequent than five years.
- New South Wales notes COAG already has a number of sub-committees, including the Mental Health Subcommittee. The Subcommittee's role is to develop and implement a shared national mental health and suicide prevention framework, in addition to advising the Australian Health Ministers' Advisory Council on mental health and drug service issues of national importance.

Draft Recommendation 22.3 — Enhancing consumer and carer participation

Consumers and carers should have the opportunity to participate in the design of government policies and programs that affect their lives.

In the short-term (in the next 2 years)

- The Australian, State and Territory Governments should ensure that they collaborate with consumers and carers in all aspects of mental healthcare system planning, design, monitoring and evaluation.
- COAG should instruct the National Mental Health Commission to monitor and report on total expenditure by individual jurisdictions on systemic advocacy in mental health that is provided by peak representative bodies.

In the medium-term (over 2–5 years)

The Australian, State and Territory Governments should strengthen systemic advocacy by:

- Extending the funding cycle length for peak bodies to a minimum five years to improve business planning and capability development.
- Concluding contract renewals at least one year before expiry.
- Reporting their total funding to peak bodies that represent mental health consumers and carers through the annual Report on Government Services.

- There should be nationally consistent guidelines for appropriate consumer and carer remuneration in the development of policy or programs.

Draft Recommendation 24.2 — regional autonomy over service provider funding

In the short-term (in the next 2 years)

The Department of Health should cease directing PHNs to fund Headspace centres, including the Headspace Youth Early Psychosis Program, and other specific service providers. PHNs should be able to continue funding Headspace services or redirect this funding to better meet the needs of their local areas as they see fit.

In the medium-term (over 2 – 5 years)

There should be no requirements that commissioning agencies (RCAs or PHNs) have to fund particular service providers.

- There needs to be due consideration given to the brand power and buy-in that Headspace has built with young people over many years. Headspace is seen as a trusted and credible source of mental health information and care for young people. Changes to hypothecated funding of Headspace centres risks losing these gains and diluting the Headspace brand.

Draft Recommendation 24.5 — Private health insurance and funding of community-based healthcare

In the short-term (in the next 2 years)

The Australian Government should review the regulations that prevent private health insurers from funding community-based mental healthcare with a view to increasing the scope for private health insurers to fund programs that would prevent avoidable mental health-related hospital admissions.

- Any amendment to regulations needs to ensure that those people without insurance are not disadvantaged.
- The Commonwealth's private health insurance reforms announced the establishment of an Expert Committee to provide advice on options to eliminate or replace admitted mental health and rehabilitation services which deliver low value or inefficient care. The Improved Models of Care Working Group (set up under the Private Health Ministerial Advisory Committee) was funded for three years to 2019-20 to provide advice to inform consideration of future care. Any outcomes of this Working Group should inform this draft recommendation, should it proceed.

Corrections to report content

Confidentially of student counselling files

- A submission to the inquiry, reproduced in the draft report (page 683) states that "Students are also aware their files are not confidential; principals and other teaching staff can access files and, in some schools, counsellors must share files and cases with teaching staff who have no training in mental health". This is not the case in New South Wales public schools. Principals and teaching staff do not have access to student counselling files.
- Given the importance of confidentiality for young people and the potential impact on help-seeking behaviours, it is important that young people know their records are confidential, in line with privacy legislation.

Use of stigmatising language

- Draft Recommendation 11.6 (Mental health specialisation as a career option) recommends '**exposing** health students and practising health professionals to people with a mental illness'. This stigmatising language should be replaced e.g. 'increasing interactions between health students and practising health professionals and people with a mental illness'.