Chapter 6

Issues—service delivery

The whole Australian mental health community, through both its lived experience and its technical experts, has combined to say to our respective governments that there is a fundamental need to move away from a programmatic funding approach in response to each crisis and towards locally led and organised services that work in regional Australia.[1]

Professor Ian Hickie
Commissioner, National Mental Health Commission

Introduction

6.1 The previous chapter outlined the issues of governance and funding in mental health service and programme delivery. This chapter draws again on the evidence from witnesses and submitters, but focuses instead on issues relating to service delivery, including services and programmes for specific groups. These issues include:

- stigma;
- Primary Health Networks (PHNs) and mental health;
- access to early intervention;
- linking housing and employment to mental health;
- workforce;
- suicide prevention;
- rural and remote communities;
- Aboriginal and Torres Strait Islander peoples;
- LGBTI (Lesbian, Gay, Bisexual, Transgender, Intersex);
- Culturally and Linguistically Diverse (CALD) communities; and
- e-mental health.

6.2 In considering each issue, the committee examines the findings of the Commission, the evidence received from witnesses, and where it exists, government reaction to the Commission's findings.

Stigma

6.3 A theme that runs throughout the Commission's review is that the aim of any action on increasing the effectiveness and efficiency of mental health services and programmes should be the de-stigmatisation of mental health. In describing the

1 Professor Ian Hickie, Commissioner, National Mental Health Commission, *Committee Hansard*, 26 August 2015, p. 6.

current state of mental health services and programmes in Australia, the Commission first statement was 'Stigma persists'. [2]

6.4 A relevant Commission recommendation states:

> Promote easy access to self-help options to help people, their families and communities to support themselves and each other, and improve ease of navigation for stepping through the mental health system.[3]

6.5 Stigma was an issue which the Commission identified as needing to be addressed by this recommendation:

> Stigma is associated with poorer physical and emotional health, as well as poorer employment outcomes. It can discourage individuals from disclosing their illness and from seeking help, both of which are important steps to gaining assistance in managing symptoms and preventing the development of a more serious experience of mental illness. In this way, stigma presents barriers to service access, creates additional distress and mental ill-health and ultimately drives up system costs.[4]

6.6 SANE Australia describe the impacts of stigma as:

> People with mental illness put up with a lot more than their illness. Stigma contributes another major stress they can well do without. Many say that stigma and prejudice is as distressing as the symptoms themselves.
>
> Most often stigma against people with a mental illness involves inaccurate and hurtful representations of them as violent, comical or incompetent – dehumanising and making people an object of fear or ridicule.[5]

6.7 Organisations like SANE Australia, ReachOut, RUOK? and Beyondblue try to reduce stigma by raising awareness of mental ill-health and encouraging public discussion of mental health issues. ReachOut for instance works to encourage access to information and assistance for mental ill-health. It has previously run a campaign to normalise the discussion of mental ill-health by making a comparison between the way physical health issues are publicly discussed and the way mental ill-health issues are often hidden or dismissed. ReachOut publishes graphics which ask 'what if we treated all health issues like we treat mental health?' Some example answers to this hypothetical question included:

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2 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 40.

3 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 87.

4 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 89.

5 SANE Australia, website, 'Changing attitudes, changing lives – We can all play a part in combating stigma', www.sane.org/stigmawatch/what-is-stigma (accessed 7 October 2015).

- 'I'm so sick of you and your constant heart disease.'
- 'We all feel like we have diabetes sometimes! Snap out of it.'
- 'I'm getting very tired of this "cancer" of yours.'
- 'Yeah, you just think you need your Asthma puffa because you can't deal with reality.'[6]

6.8 Ms Christine Morgan, the Chief Executive Officer of the Butterfly Foundation supported the need to fight the stigma around mental illness and facilitate better access to services for sufferers. The Butterfly Foundation has a particular focus on the treatment of eating disorders. Ms Morgan told the committee that in the case of eating disorders, the suicide rate is the highest of any psychiatric disorder. Early intervention in eating disorders is vital, but a major barrier to early intervention is the stigma associated with mental ill-health:

> At the moment, we know that less than 23 per cent of people with an eating disorder are seeking treatment. They are highly stigmatised. If you have anorexia nervosa, thankfully it is relatively accepted as a very serious illness. It also physically manifests itself and you must receive treatment. If you suffer from bulimia nervosa, a binge eating disorder or atypical presentations the average nondisclosure time is 10 years. That is 10 years when somebody is too ashamed to go for help. We must reduce stigma. I used to think that if you raised awareness, if you raised an understanding of the genetic vulnerability of somebody with an eating disorder, if you raised the impact of nutritional deprivation triggering something that actually changed their neural pathways, if you helped people understand that, they would not be stigmatised. But they are. Too many people still see it as people who do not know how to eat properly, who eat too much or too little, and they say 'Get on with it and fix it up.'[7]

6.9 Ms Morgan argued that reducing stigma was more complex than awareness raising campaigns. What is needed is a multi-faceted approach which targets all parts of the pathway to accessing mental health services and programmes:

> We must reduce stigma, and that is much more complex than just raising awareness. Sitting behind that, we also need workforce capacity and workforce development. I share the views of my colleague that GPs must not only be recognised as an incredibly important first portal but they have to be resourced. And sitting behind them they need pathways to care that are appropriately funded whether through…better access to Medicare rebates or through private health insurance—which to this day remains discretionary for anybody with an eating disorder, other than for the short time they spend in a private hospital. Anything as [an] outpatient is

6 ReachOut graphics sourced from the ReachOut Facebook page, see http://au.reachout.com/ (accessed 7 October 2015).

7 Ms Christine Morgan, Chief Executive Officer, Butterfly Foundation, *Committee Hansard*, 28 August 2015, p. 15.

> discretionary cover by private health fund. So we must make sure that they have access to those things.[8]

6.10 Mr Jack Heath, the Chief Executive Officer of SANE Australia observed that in terms of fighting the stigma around depression, much work had been done. However, more work was required so that the treatment of mental ill-health was seen as equal to the treatment of physical ill-health:

> In terms of stigma, we have done reasonably well around depression in the past five to 10 years. We have made no progress in the very severe end of the spectrum. SANE Australia earlier this year called for a five-year national stigma reduction campaign. We must have lived experience involved in all aspects of mental health policy formulation, research, system design, promotion, implementation and also evaluation. The life expectancy rates for people with severe mental illness are simply unacceptable, 25 years less than the general public. We need to do much better in terms of combining the work that we do around physical health issues alongside mental health issues. In the past there was an approach which said: let's get your head sorted first and then we will get to your body, and what happened was people never got to the body.[9]

Committee view

6.11 From the evidence the committee has heard, it is clear that one of the major barriers to people with mental ill-health accessing appropriate help is stigma. Many times the committee heard that stigma prevented those with mental illnesses from seeking help, or prevented conversations about the impact of mental ill-health on a person's social, working, and family life.

6.12 Thanks to campaigns like those run by RUOK?, Beyondblue, and ReachOut, mental health literacy is increasing in Australia. But the stigma around mental ill-health persists. The committee considers that there is an urgent need for a national conversation about how to counter it.

Recommendation 2

6.13 The committee recommends that the government response to the National Mental Health Commission's report should include a national stigma reduction strategy.

Primary Health Networks and mental health

6.14 Established in July 2015, the Primary Health Networks (PHNs) replaced the Medicare Locals as a means of organising and facilitating primary health care services

8 Ms Christine Morgan, Chief Executive Officer, Butterfly Foundation, *Committee Hansard*, 28 August 2015, p. 15.

9 Mr Jack Heath, Chief Executive Officer, SANE Australia, *Committee Hansard*, 26 August 2015, p. 39.

at a regional level.[10] There are 31 PHNs located around Australia. According to the information on the Department of Health website, the PHNs have 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.[11]

6.15 In its review, the Commission recommended that PHNs be used to help shift mental health funding priorities from hospitals and income support to community and primary health care services:

> Recommendation 8: Extend the scope of Primary Health Networks (renamed Primary and Mental Health Networks—PMHNs) as the key regional architecture for equitable planning and purchasing of mental health programmes, services and integrated care pathways.[12]

6.16 Professor Allan Fels, Chair of the National Mental Health Commission expanded on recommendation 8 in his evidence to the committee. Professor Fels argued that PHNs could be a way of 'bringing about greater regional parity in the treatment of mental health' at a primary care level, with PHNs being the facilitators of primary care in regional areas.[13]

6.17 Underpinning much of the Commission's work is the view that a regional approach to service delivery is an essential in order to be responsive to the diverse local needs of the different communities across Australia.[14] The Commission's first recommendation articulated the Commonwealth's role in mental health 'is through national leadership and *regional integration*, including integrated primary and mental health care.'[15]

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10 The committee examined the change from Medicare Locals to Primary Health Networks in Senate Select Committee on Health, First Interim Report, 2 December 2014, www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/First_Interim_Report (accessed 7 October 2015)

11 Department of Health, website, 'Primary Health Networks (PHNs)', www.health.gov.au/internet/main/publishing.nsf/Content/primary_Health_Networks (accessed 7 October 2015)

12 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 10.

13 Professor Allan Fels, Chair, National Mental Health Commission, *Committee Hansard*, 26 August 2015, pp 4–5.

14 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 15.

15 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 10, emphasis added.

6.18 In its report, the Commission argued that PHNs are an ideal mechanism to plan and distribute services on a regional basis, putting mental health care alongside primary care:

> The current development of 30 Primary Health Networks across Australia provides the ideal opportunity to build on that infrastructure and better target mental health resources to meet population needs on a regional basis. These new entities will be the meso-level organisations responsible for planning and purchasing services on a regional basis.[16]

6.19 Further, the Commission saw PHNs as being able to work in partnership with NGOs and others service providers to apply 'targeted, value-for-money interventions across the whole continuum of mental wellbeing and ill-health to meet the needs of their communities'.[17]

6.20 With their focus on primary health care, Professor Fels observed that the PHNs are best placed to promote the role of primary care in treating mental ill-health, and giving mental health a higher priority. Professor Fels explained why the Commission felt that the PHNs should be renamed Primary and Mental Health Networks:

> There are a couple of reasons for that. It would be a really important sign from the government and the parliament that mental health is taken seriously. It remains a rather low priority, I am sorry to say, all over Australia—at a federal and state level and in the community.[18]

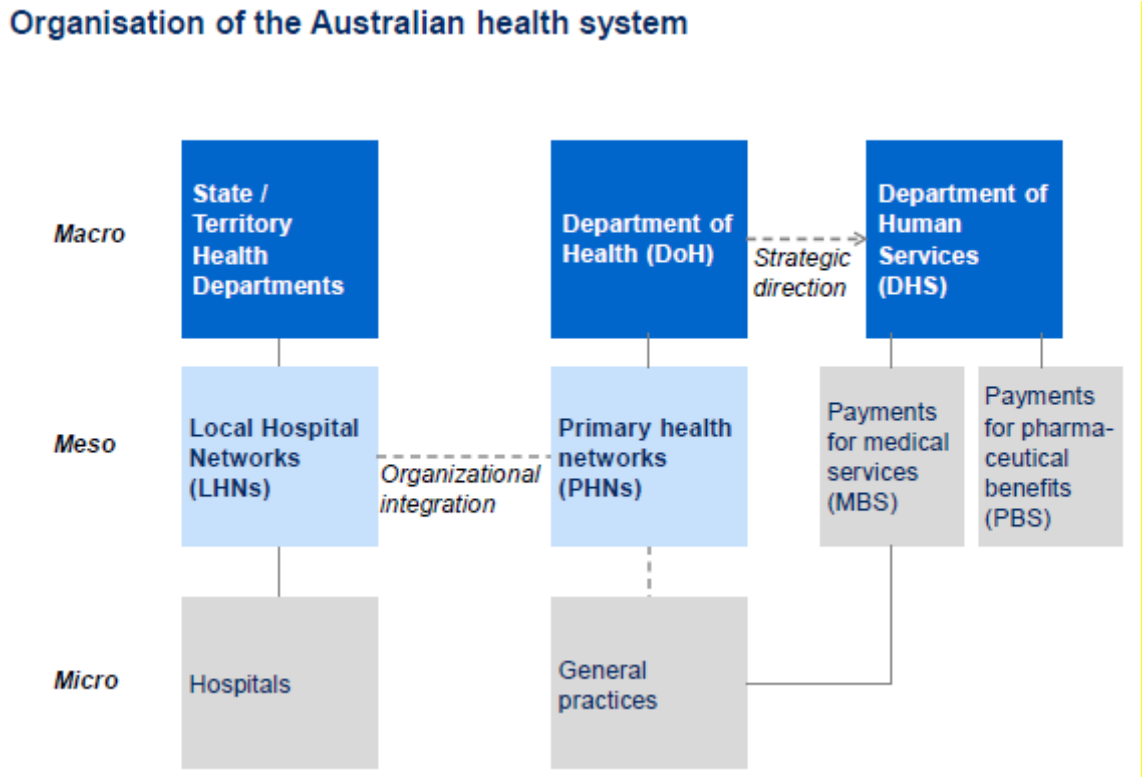
6.21 The grouping of meso-level organisations for regionalisation of planning and purchasing services has been trialled in both Australia and overseas. Figure 6 shows the various levels within the Australian health care system and how meso-level groups could integrate the provision of mental health services.

16 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 48.

17 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 48.

18 Professor Allan Fels, Chair, National Mental Health Commission, *Committee Hansard*, 26 August 2015, pp 4–5.

Figure 6—Australian health care system[19]



6.22 The background paper published by the Primary Health Care Advisory Group (PHCAG), *How can Australia improve its primary health care system to better deal with chronic disease?*, provided examples of where meso-level integration of organisations with combined funding pools have been used. The paper noted that while examples, including the United Kingdom, New Zealand, and Australia (SA Health Plus), 'demonstrate the promise of meso-level integration with combined funding pools, national rollout of the approach could be inefficient if it is not well coordinated.'[20]

6.23 Dr Steven Hambleton, Chair of the PHCAG, told the committee that as part of the PHCAG's public consultation on its discussion paper on chronic conditions 'many of our submissions support a meso-level organisation to assist the GP to deliver an outcome.'[21]

19 McKinsey & Company, written for the Primary Health Care Advisory Group, *How can Australia improve its primary health care system to better deal with chronic disease? Background Paper*, September 2015. p. 33.

20 McKinsey & Company, written for the Primary Health Care Advisory Group, *How can Australia improve its primary health care system to better deal with chronic disease? Background Paper*, September 2015. p. 33.

21 Dr Steven Hambleton, Chair, Primary Health Care Advisory Group, *Committee Hansard*, 18 September 2015, p. 13.

6.24 Professor Ian Hickie, a Commissioner of the National Mental Health Commission explained that regionalisation of care, as advocated in the Commission's report was a significant shift:

> That is the challenge that I think governments face in responding to this particular report. It fundamentally says there is a need to redesign the system architecture, to develop regionalisation of care. So I think both the Australian government and state governments face a challenge: can they actually back local leadership? Can they provide the resources to the 60-plus regions in Australia to bring together the relevant health and social services in a way that is relevant to those particular communities to provide the range of health and social supports that are necessary for people to live a contributing life? That is a fundamental shift in the way we have understood Commonwealth-state relationships and in particular the way that we have organised that set of funding and service priorities.[22]

6.25 Just as Dr Hambleton reported, Professor Hickie explained that despite the challenges associated with regionalisation, there was general consensus amongst organisations and state governments:

> I think it is important to say that it appears that there is consensus not only among providers but also among a number of the states—and, notably, from the Premier of New South Wales. In New South Wales, Queensland and WA in particular, there is a real appetite for implementation of this regionally focused approach that is backed by the resources of both the federal government and the state government. What we want to see is the implementation of locally led programs that are nationally significant, evidence based and accountable at the local level. That runs across the key areas of health and social services and suicide prevention and with a shift to a fundamental focus on resourcing the community, not necessarily the hospitals, the institutions or the traditional providers.[23]

6.26 However, witnesses told the committee that they had some reservations about the Commission's recommendation on PHNs. Mr Quinlan of Mental Health Australia told the committee that during a meeting with the Department of Health regarding the ERG process, PHNs were 'one of the topics of some heated and considered discussion'.[24] Mr Quinlan noted that while there was broad agreement at the meeting about the need for a focus on mental health and a means of delivering that focus at a regional level, the main concern about the PHNs being the vehicle for that delivery

22 Professor Ian Hickie, Commissioner, National Mental Health Commission, *Committee Hansard*, 26 August 2015, p. 5.

23 Professor Ian Hickie, Commissioner, National Mental Health Commission, *Committee Hansard*, 26 August 2015, pp. 5-6.

24 Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia, *Committee Hansard*, 26 August 2015, p. 28.

was that as organisations they are very new.[25] Further, Mr Quinlan said the meeting had raised questions about the structure of the PHNs:

> The concern I would summarise as this: if Primary Health Networks are dominated by GP interests and a GP-centric approach in the local community—and this is not to suggest that they are—then that will achieve certain goals but it will not achieve the breadth of engagement that many of our members are keen to see.[26]

6.27 Mr Quinlan argued that if PHNs were to be the delivery mechanisms for regionalisation, the governance of PHNs would be important and it would be essential to have consumers and those with lived experience of mental illness involved:

> If we are going to achieve the breadth of agreement and planning that we need, then we would have to go somewhere to what the commission recommends, which is primary and mental health networks. What would that mean? That would mean that community organisations, consumers and people with a lived experience of mental illness themselves and others were all engaged in those governance structures, on the boards of Primary Health Networks.[27]

6.28 The Royal Australian and New Zealand College of Psychiatrists (RANZP) argued that PHNs have the 'potential to greatly enhance the responsiveness and level of holistic care delivered to consumers', provided the PHN design had an adequate governance structure.[28] RANZP recommended that the PHNs should have:

> …strong mental health representation at all levels of the PHN governance structure, including Board, Clinical Council and Community Advisory Committee.[29]

6.29 In particular, the Community Advisory Committees should:

> …draw on the insight and experiences of mental health consumers and carers. The approach to shared decision making, consumer-focused care and incorporating consumers, carers and family into the treatment team can look very different in the mental health sector compared with other instances where physical health is the focus. For example, the process of developing informed consent, a recovery plan and a meaningful definition of wellbeing may be very different for a consumer with a severe mental illness, compared with a physical health issue. It is therefore essential that

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25 Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia, *Committee Hansard*, 26 August 2015, p. 28.

26 Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia, *Committee Hansard*, 26 August 2015, p. 28.

27 Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia, *Committee Hansard*, 26 August 2015, p. 28.

28 Royal Australian and New Zealand College of Psychiatrists, Answer to Question on Notice, p. 4.

29 Royal Australian and New Zealand College of Psychiatrists, Answer to Question on Notice, p. 4.

> the insight, priorities and experiences of mental health consumers and carers is adequately and consistently incorporated onto the Community Advisory Committees.[30]

6.30 Mr Quinlan also raised concerns about the 'localness' of PHNs and consequently their ability to deliver mental health services to a local and regional level:

> …Primary Health Networks would also look at their localisation and many of them, I suspect, would say: 'Actually, we're not that local. If there's only one Primary Health Network in this vast area, perhaps we need to have some structures by which we can have sublocalisation, if you like.' So I think there is a lot of anxiety about us investing too much too early in structures that are just emerging, notwithstanding, I think, the broad agreement that we need local structures to steer and govern investment.[31]

6.31 Conversely, Mr Meldrum of Mental Illness Fellowship of Australia reasoned that ultimately the PHNs are 'the only game in town for a regional structure and…we are going to have to work out a way…' to use the PHNs for mental health service delivery.[32] However, Mr Meldrum thought that some time would be needed for the PHNs to find their 'mission' and become established.[33] Without this, Mr Meldrum argued, little could be achieved:

> I also feel they need a personality transplant in a lot of cases before they can do it, because they are focused specifically on the role of the GP, who has an important role but not all the roles. The key issue is that they do not have a mission… Why suddenly chuck a whole amount of money at an organisation yet again without specifying what we want it to achieve? And while we have a national mental health plan that has not been finished, while any implementation strategy is yet to be dreamt up, while the NDIS arrangement is so unclear et cetera and while we do not have any of those key outcome objectives, there is no mission to give them. I would suggest that we are at least a year away from being able to describe to a Primary Health Network, 'The mission we need to achieve in mental health with this money is this.' That would be the very first step before they get given the job [of equitable planning and purchasing of mental health programmes, services and integrated care pathways], from my perspective.[34]

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30 Royal Australian and New Zealand College of Psychiatrists, Answer to Question on Notice, p. 5.

31 Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia, *Committee Hansard*, 26 August 2015, p. 28.

32 Mr David Meldrum, Executive Director, Mental Illness Fellowship of Australia, *Committee Hansard*, 26 August 2015, p. 29.

33 Mr David Meldrum, Executive Director, Mental Illness Fellowship of Australia, *Committee Hansard*, 26 August 2015, p. 29.

34 Mr David Meldrum, Executive Director, Mental Illness Fellowship of Australia, *Committee Hansard*, 26 August 2015, p. 29.

Committee view

6.32 The committee supports the Commission's findings in regards to regionalisation of service and programme delivery, and commends the Commission for identifying this area as a means of mitigating inequity of access.

6.33 The committee thanks the witnesses at its public hearings for their insightful comments regarding the suitability of PHNs for regionalisation, and their support of the need for regionalisation of service delivery.

6.34 In its First Interim Report, the committee examined the change from Medicare Locals to PHNs, and in its Second Interim Report the committee looked at the progress towards the commencement of the PHNs. The committee agrees with witnesses who argued that the PHNs need time to become established. For some PHNs, the process has been easier as they have changed from being Medicare Locals to being PHNs. For others the process requires more time as they are new organisations, or Medicare Locals with new regions to establish.

6.35 The committee considers that while the PHNs will have an important role in the regionalisation of service and programme delivery, including them in this process needs to recognise the challenges the PHNs face being relatively new organisations.

Recommendation 3

6.36 The committee recommends that the government response to the National Mental Health Commission's report should examine the possible role for Primary Health Networks in regionalisation of service and programme delivery.

6.37 However, the government should have regard to the evidence given to the committee in relation to the time needed for the PHNs to adequately establish themselves in their regions.

6.38 PHNs also need time to ensure that they have a governance structure in place which includes mental health at each level. The committee considers the suggestions provided by the RANZP about Community Advisory Councils and the inclusion of those with lived experience of mental illness to be particularly important.

6.39 The committee therefore recommends that the government response should emphasise the need for mental health, particularly the experience of mental health consumers and carers, to be imbedded in the governance structure of the Primary Health Networks.

Access to early intervention

6.40 Another central tenet of the Commission's findings was that access to early intervention not only resulted in a significant benefit to the individual sufferer, but also produced a major economic benefit as it reduced the need for acute and crisis

care.[35] However, the Commission found that the current system did not promote access to early intervention:

> For example, sometimes people need to inflict serious physical harm to gain access to support; even then, sometimes that care and support is not made available.
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> The idea of late intervention in physical health conditions (such as cancer, heart disease, COPD [Chronic Obstructive Pulmonary Disease]) is plainly unacceptable, with obvious costs and unnecessary harm to individuals. However, in mental illness, late intervention is too often the norm. This is due to two factors:
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> - low rates of help-seeking and treatment for mental illness, including delaying or avoiding treatment due to stigma, stress and other related factors, as well as anosognosia or lack of awareness of illness
> - low prioritisation of mental illness within the system as compared to physical illness.
>
> These are symptoms of a crisis-driven system. Critically, this system is trapped in a vicious cycle of underinvestment in effective services, leading to higher demands on more expensive and reactive modes of care and demand-driven safety net programmes.[36]

6.41 Witnesses agreed with the Commission's findings. For example Mr Ivan Frkovic, the Deputy Chief Executive Officer of Aftercare compared the situation in Australia with that in New Zealand, where a redirection of funding to community-based interventions meant a significant saving in spending on acute care, and a major benefit to individuals with a mental illness:

> What we do not have right in this country, and the Mental Health Commission report picked this up, is that we do not have the right balance of investment.
>
> I might not have the latest data, but New Zealand got to the stage where they had an investment in the community sector…at such a level that they started to feel the pressure come off their ED departments and their inpatient beds. That was with about 35 per cent of the mental health budget going into the community sector; that was the point where they started to feel it. That could be different for Australia and other jurisdictions, but you get to a point where, if you have supports for people in the community, you will see that translate into [reduced] pressure on inpatient beds and ED

35 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 28.

36 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 28.

> departments. I cannot tell you what that percentage is, but I think it is a bit like New Zealand: we need to keep investing until we see the benefits.[37]

6.42 Mr Quinlan, the CEO of Mental Health Australia argued that what was needed to embed early intervention into mental health pathways was certainty about what resources exist and the outcomes that need to be achieved:

> What we continue to fail to do is to set any overarching targets. So we ask those organisations that you listed—we ask Centacare to look at some family services, we ask Anglicare to do some youth counselling and we ask the Salvos to help out with financial support. Nobody ever sets a goal for your area and says, 'Okay, in the area of Inverell, here is what we want to achieve with our families: greater stability, higher employment rates and so forth.' We do not go to that local community of Inverell and say, 'Okay, what are the local assets and resources in terms of the abattoir and the agencies that are working there? Overall, how do we actually target this problem? We will put all of the money into one pool.' At the moment, I can guarantee you that all of those agencies working in your electorate are drawing a pittance of funding from 20 different funding sources each to try to put together a comprehensive program. What I think the commission has done is say, 'We don't want to support a system anymore, we want to look at some outcomes.' They have listed some very solid outcomes that could be agreed in the mental health space, which is to say that we want people to be in more secure and stable housing, we want people to be in employment, we want people to be less engaged with the criminal justice system…[38]

6.43 Ms Morgan of the Butterfly Foundation agreed that access to early intervention in mental health could make a significant difference to an individual's recovery. She advised the committee that the Butterfly Foundation had commissioned research which demonstrated that early intervention could reduce the impact of mental illness and increase benefits to the individual and to society as a whole:

> One thing that I would emphasise from an eating disorder perspective…is the importance of early intervention. The Butterfly Foundation has commissioned two socioeconomic reports from Deloitte Access Economics to try and put some figures on it and to take that business approach that we have heard around it. We know that the illness is very prevalent. It has a very high socioeconomic cost because the delay in the effect of treatment means that the productivity costs and the burden of disease cost are highly inflated, much higher than they need to be. The second report the Butterfly Foundation commissioned, *Investing in Need*, put a figure around the benefit of early intervention and fully integrated care for anybody with an eating disorder as akin to the sort of care you would get if you suffered from cancer in this country. Although the cost of rolling out that care was $2.8 billion the net savings or the benefit to cost was 5.38 to one—because

37 Mr Ivan Frkovic, Deputy Chief Executive Officer, National Operations, Aftercare, *Committee Hansard*, 26 August 2015, p. 21.

38 Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia, *Committee Hansard*, 26 August 2015, p. 22.

> if you intervene early you reduce the impact of the illness, you increase the survival rate and you increase productivity.[39]

6.44 Mr Jonathan Harms, the CEO of Mental Health Carers, ARAFMI NSW, compared the mental health funding and treatment model with that for physical health, and observed that in mental health, there was little funding dedicated to early intervention. Mr Harms told the committee that the result was that mental health treatment was so often focused on crisis. He argued that this would be unacceptable in the treatment of physical ill-health:

> There was an article in the *Medical Journal of Australia*, 'Where to mental health reform in Australia: is anyone listening to our independent auditors?' where one of the authors who was a former commissioner of mental health made the point that because we are spending so little on mental health compared to the need it is almost always focused on crisis and when people have become as sick as possible. It is something we would not accept in any other area of medicine. We would not say to someone with a broken leg, 'Come back when it's gangrenous.' We would actually start treating it straight away. What passes for early intervention in mental health is what would pass for simply ordinary treatment in any other area of health care. So we are squandering almost all of the money we are spending in many respects when you look at the results we could achieve compared to the results we do achieve because we are sticking a bandaid on. We are putting the ambulance at the bottom of the cliff. We are not comprehensively addressing the needs across sectors and across life span et cetera.[40]

Committee view

6.45 The committee strongly supports the findings of the Commission in relation to access to early intervention. The evidence the committee received clearly demonstrates that early intervention and prevention allows for better treatment of mental ill-health and facilitates the individual being active socially, economically, and in their community.

6.46 The benefit for Australia as a whole is also clear, as a reduction in individuals requiring acute care will result in a saving in the health system. Similarly the committee notes that one of the greatest economic costs of mental ill-health is through lost productivity. If a person can be treated effectively at an early stage, they can continue to be productive in both their work and family life.

Recommendation 4

6.47 The committee recommends that the government response to the National Mental Health Commission's report include evidence-based modes of care that promote early intervention.

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39 Ms Christine Morgan, Chief Executive Officer, Butterfly Foundation, *Committee Hansard*, 28 August 2015, p. 15.

40 Mr Jonathan Harms, Chief Executive Officer, Mental Health Carers ARAFMI NSW, *Committee Hansard*, 28 August 2015, p. 36.

Linking housing and employment to mental health

6.48 Closely related to the Commission's findings on access to early intervention is the connection between the treatment of mental ill-health, access to housing, and workforce participation.

6.49 A major part of the economic cost of mental ill-health (as discussed in Chapter 2) is the loss of productivity. In its report, the Commission noted that estimates of the cost of mental ill-health to the Australian economy from lost productivity and job turnover cost some $12 billion per annum.[41] The OECD figures, quoted in the Commission's report note:

> The costs of mental ill-health for the individuals concerned, employers and society at large are enormous… Most of these costs do not occur within the health sector. Mental illness is responsible for a very significant loss of potential labour supply, high rates of unemployment, and a high incidence of sickness absence and reduced productivity at work. In particular, mental illness causes too many young people to leave the labour market, or never really enter it, through early moves onto disability benefit. Today, between one-third and one-half of all new disability benefit claims are for reasons of mental ill-health, and among young adults that proportion goes up to over 70 per cent. [42]

6.50 As part of its findings the Commission argued that treatments for mental health conditions should centre on the whole person, and that this approach needed to include the person's community and economic participation. Professor Fels, the Chair of the National Mental Health Commission explained:

> If you can get labour force participation up, that is almost the best way of improving productivity and I am sure at this reform summit today [event on 16 August 2015 sponsored by *The Australian Financial Review* and *The Australian*] we will hear a lot about measures, tinkering here and there, that will get participation up. People with mental health problems have a 38 per cent non-participation rate versus 22 per cent in the general population. Our participation rate is low by the standards of good OECD countries. We are at the bottom of the top good 10, 12, 13 OECD countries. Most people with mental illness are at the mild to moderate end. The scope for their better participation in the workforce is very large. The World Economic Forum estimates the cost of lost output and income at about 1.75 per cent of GDP. Most people with mental illness want to work but find it difficult to get a job and then to hold it.[43]

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41 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 24.

42 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 24.

43 Professor Allan Fels, Chair, National Mental Health Commission, *Committee Hansard*, 26 August 2015, p. 2.

6.51 Professor Ian Hickie, a National Mental Health Commissioner told the committee that Australia already had a vast amount of evidence that the approach advocated by the Commission could be beneficial:

> There is a lot of evidence from specific trials. We love to trial things here in Australia. We have done trials of all of these things. We never move from the trials to the systematic implementation. So you not only have a reduction in cost; if you have somewhere to live, you do not come back into hospital. In Sydney a hospital bed is $800 to $1,000 a day. You could be at a very nice hotel for $800 to $1,000 a day. Currently we are using hospital beds for that. Not only will you offset the cost, you will be well. You will stay well if you have a home, and you will be less likely to have a relapse in your clinical problems. If you have a job, you do better. We use this expression all the time: 'You don't get well to go to work; you go to work to get well'. We all thrive in environments where we have a home and we have a job and we have social connections. Those things are not simply cost offsets; they deliver better outcomes.[44]

6.52 Professor Fels advised the committee that the connection between mental ill-health, housing and workforce participation was also recognised internationally:

> If I could just add to that: there is a movement in the US called Housing First. It really subscribes to the view that, if you fix housing for people with mental illness as the top priority, a lot of improvements will flow simply from that. It does not mean that they do not need other help. There is now a fair bit of data about the effectiveness of Housing First. Also in Canada the government gave $100 million to Housing First experiments, if you like—although that is a fairly big experiment—and there is now reporting and data showing there has been quite a significant improvement in mental health. I mentioned a project like that I am part of in Melbourne. It was independently evaluated by Monash University. Using a number of measures it concluded what everyone who goes there knows, which is that there has been an enormous improvement in the lives of people who are at the severe end.[45]

Committee view

6.53 The committee supports the Commission's finding in relation to the linkages between housing, employment, and mental health.

6.54 The committee notes Professor Hickie's comments regarding the need for action in this area.[46] The committee agrees that numerous past trials have proven beyond doubt the benefits to a coordinated approach to supporting those with mental illness. And the committee therefore reiterates its disappointment that the government,

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44 Professor Ian Hickie, Commissioner, National Mental Health Commission, *Committee Hansard*, 26 August 2015, pp 8–9.

45 Professor Allan Fels, Chair, National Mental Health Commission, *Committee Hansard*, 26 August 2015, p. 9.

46 Professor Ian Hickie, Commissioner, National Mental Health Commission, *Committee Hansard*, 26 August 2015, pp 8–9.

rather than responding quickly to the Commission's findings, chose to review the Commission's review resulting in a delay of at least ten months.

6.55 Further, the committee considers that this linkage demonstrates that mental health is not solely the preserve of the health portfolio. The effective treatment of mental health crosses into the portfolios of housing, employment, and others. The segregation of policy into separate portfolios has produced a situation in which programmes and services are not connected, or are duplicated, and people do not receive the help they need. It is clear that a mechanism which links programmes and services across portfolios is required.

Recommendation 5

6.56 The committee recommends that the government's response to the National Mental Health Commission's report recognise the linkages between housing, employment, and mental health. The government's response should include ways for services and programmes to be appropriately connected so that individuals can access holistic care.

Workforce

6.57 The Commission wrote in its report that the inefficiencies it had identified in the delivery of mental health services and programmes were exacerbated by issues related to the mental health workforce:

> These challenges [inefficiency, incorrect distribution of funding, the system not being cost-effective] are compounded by a mental health workforce under pressure, with services experiencing shortages, high rates of turnover and challenges in recruiting appropriately skilled and experienced staff. Too frequently, the voices of people with lived experience, their families and support people are ignored, misheard and undervalued.[47]

6.58 Further, the Commission noted that the efficiency of service delivery to rural and remote areas was greatly affected by the poor distribution of workforce, amongst other issues.[48]

6.59 Workforce issues appear in many of the Commission's recommendations, but particularly in recommendations 21 and 22 which related to the Commission's finding around the need to build workforce and research capacity to support systems change. Recommendations 21 and 22 are:

> Recommendation 21. Improve supply, productivity and access for mental health nurses and the mental health peer workforce.

47 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 13.

48 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 29.

> Recommendation 22. Improve education and training of the mental health and associated workforce to deploy evidence-based treatment.[49]

6.60 A particular example of the types of workforce issues the Commission identified is the Mental Health Nurse Incentive Programme (MHNIP). The Commission commented that the effectiveness of the MHNIP is limited by regulatory barriers, and programme requirements are 'often rigid and inflexible, potentially stymying innovation and integrated multi-disciplinary support by limiting fundholding arrangements.'[50] For example:

> …headspace cannot access the MHNIP to employ mental health nurses. Similarly, Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services) cannot hold Access to Allied Psychological Services (ATAPS) funding even though one of the target populations under the programme is Aboriginal and Torres Strait Islander people. These types of access barriers decrease timely and appropriate support, including through community-based services.[51]

6.61 Witnesses at the committee's public hearings agreed with the Commission's findings in relation to the MHNIP and the mental health workforce generally. For instance Mr Sebastian Rosenberg, a Senior Lecturer at the Brain and Mind Centre of the University of Sydney told the committee:

> With respect to mental health community outreach nurses, the Mental Health Nurse Incentive Program is a proven program that adds so much to the armaments of GP practices so that they can follow people into the community and provide care. The cost is only $40 million, which would be less than three weeks' worth of the Better Access program [government program which aims to provide better access to mental health practitioners through Medicare]. It is a tiny program with massive effectiveness. So, again, Australia has a program which it could scale but has not... and, again, the amount of money that is set aside for workforce development is tiny. Some of our colleagues in the College of Mental Health Nurses have been struggling to build that workforce.[52]

6.62 Mr Quinlan of Mental Health Australia told the committee that the MHNIP is one of the programmes which has been subject to short-term funding extensions and that this issue is further negatively impacting on the effectiveness of the programme:

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49 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 11.

50 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 31.

51 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 31.

52 Mr Sebastian Rosenberg, Senior Lecturer, Brain and Mind Centre, University of Sydney, *Committee Hansard*, 26 August 2015, p. 29.

> **Mr Quinlan:** The Mental Health Nurse Incentive Program is one of those programs on the list that has been extended on a 12-month-by-12-month basis for quite a number of years. It is not unique to this area, but it is one of those areas where clearly if you are a nurse in the community who is thinking, 'Where will I build my career in nursing?' this notion of 12-month-by-12-month funding does not create…a platform for people to say, 'That's where I'm going to invest my future', because you never know—
>
> **Mr Peters:** The uncertainty of mental health funding is probably causing as much stress as anything else...[53]

6.63 Mr Quinlan also explained that the uncertainty of funding was having an impact on the wider mental health workforce. He gave the committee an example from one of the members of Mental Health Australia in relation to the Partners in Recovery programme:

> As at today, if one of our agencies loses a staff member in, say, the Partners in Recovery Program, it can only offer a replacement staff member an eight-month contract with an uncertain future beyond that. That means that, as at today, the sorts of programs and services that we are delivering to people on the ground are starting to deteriorate again, because of the uncertainty of the arrangements beyond June next year. That is something that I think we need to be doing much more work on, and we stand ready to assist government and other interested parties to develop that work. I am happy to take further questions as we go on.[54]

6.64 Mr Frkovic of Aftercare agreed that uncertainty of funding was causing significant impacts on the mental health workforce. Mr Frkovic also acknowledged the consequent flow on effect on the provision of support to those with a mental illness and their families:

> …we have staff who are really struggling in terms of what happens to them. When you think about it, we have 450 staff, and a lot of people are wondering what happens beyond June next year. That whole system that is currently working is being unravelled from a whole range of perspectives, which I think is causing us some major challenges in terms of ongoing support for people with mental illness, and their families.[55]

6.65 Ms Jaelea Skehan, the Director of the Hunter Institute of Mental Health told the committee that a further impediment on the effectiveness of funding for mental health was the current government funding being provided on a year-by-year basis, creating a stressful situation for staff and putting pressure on organisations:

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53 Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia, and Mr Andrew Peters, Chief Executive Officer, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, 26 August 2015, p. 29.

54 Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia, *Committee Hansard*, 26 August 2015, p. 15.

55 Mr Ivan Frkovic, Deputy Chief Executive Officer, National Operations, Aftercare, *Committee Hansard*, 26 August 2015 p. 19.

> Single year funding is inefficient for any service, and it is completely inefficient when you are trying to work in a prevention framework, where you are really looking at five-year planning. Like many organisations, for the past two years we have been given notification of funding extensions in June for funding starting on 1 July. That is stressful for staff; it is very hard for staff turnover. My organisation, as well as many others at this table and in our sector, has staff on contracts. You can imagine that is a very challenging environment to work in. It is also not very good for those sectors that we are working with, particularly for front-line services that are providing services to individuals and families, to have that lack of certainty around continued funding.[56]

Committee view

6.66 The committee strongly supports the Commission's finding that a robust workforce is a key to the successful delivery of mental health services and programmes. The committee was disappointed that the government abolished the Health Workforce Australia agency in the name of efficiency. The committee considers that the government's action was a false economy, particularly in light of the Commission's findings that workforce development and distribution are critical in effective mental health service delivery.

6.67 The committee hopes that a government response to the Commission's findings will recognise the need for an overall health workforce strategy.

Recommendation 6

6.68 The committee recommends that the government's response to the National Mental Health Commission's report recognise need for a clear and comprehensive mental health workforce strategy.

Suicide prevention

6.69 The Commission's report identified suicide as a major issue in mental health:

> In 2012 more than 2,500 people died by suicide, while in 2007 an estimated 65,000 Australians attempted to end their own life. Suicide is the leading cause of death among people aged between 15 and 44 years old, and is more likely among men, Aboriginal and Torres Strait Islander people and people living outside of major cities.[57]

6.70 Reflecting the importance of including suicide prevention in any national mental health approach, the Commission made three recommendations and one finding relating specifically to suicide prevention:

> Recommendation 2. Develop, agree and implement a *National Mental Health and Suicide Prevention Plan* with states and territories, in

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56 Ms Jaelea Skehan, Director, Hunter Institute of Mental Health, *Committee Hansard*, 28 August 2015, p. 30.

57 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 19.

> collaboration with people with lived experience, their families and support people.[58]
>
> Recommendation 4. Adopt a small number of important, ambitious and achievable national targets to guide policy decisions and directions in mental health and suicide prevention.[59]
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> Finding 7. Reduce suicides and suicide attempts by 50 per cent over the next decade.[60]
>
> Recommendation 19. Establish 12 regions across Australia as the first wave for nationwide introduction of sustainable, comprehensive, whole-of-community approaches to suicide prevention.[61]

6.71 Witnesses supported the Commission's emphasis on suicide prevention with many telling the committee that there is a clear and urgent need for action in this area in Australia. For example Associate Professor Judith Proudfoot, the Head of eHealth at the Black Dog Institute observed that:

> Suicide prevention is cost-effective and Australia was one of the first countries to develop a national suicide prevention strategy, in 1995. Suicide rates have not declined significantly, in Australia, in the last decade. In fact, in the last 12 months the numbers have increased, particularly in young girls and Aboriginal and Torres Strait Islander men. Progress in this area has been hampered by the lack of integration and poor coordination of suicide-prevention activities and strategies. There has been activity there and a lot of good activity but it has not been integrated or coordinated… The economic cost, apart from the very traumatic personal cost, is $17.5 billion, annually, to the Australian community. So it is really timely that we do something about suicide and suicide prevention.[62]

6.72 Associate Professor Proudfoot explained that there was substantial evidence supporting a multi-faceted, cross-government approach to suicide prevention of the kind advocated by the Commission's report:

> Evidence from overseas shows, very clearly, that successful suicide prevention requires a simultaneous systems based approach that involves

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58 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 10.

59 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 10.

60 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 11.

61 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 11.

62 Associate Professor Judith Proudfoot, Head of eHealth, Black Dog Institute, *Committee Hansard*, 26 August 2015, p.40.

> multisectoral involvement by all government, non-government, health, business, people with lived experience, and education, research and community agencies and organisations. That is, it needs multiple points of intervention. Within a localised area, having done an audit of what services are available in the localised area, it means implementing evidence based strategies, at the same time, that are effective and demonstrating sustainability and long-term commitment… The research shows there are nine strategies that are evidence based and effective. The most promising of those is restricting means to suicide, GP education and gatekeeper training but, of course, they need to be fine tuned and tailored to the particular local area.[63]

6.73 One point of disagreement with the Commission's finding and recommendations on suicide prevention related to funding. The Commission had, in accordance with the government's direction, made its recommendations with the assumption of no additional funding to what was already being spent by government. Mr Matthew Tukaki, a Board Member of Suicide Prevention Australia; and Chairman of the National Coalition for Suicide Prevention argued that additional funding was essential if the recommendations the Commission had made were to be achieved:

> The stark reality is that many of our front-line service providers are already facing funding challenges and living from short-term contract to short-term contract. Imagine as we go deeper into the rabbit hole that the number of Australians seeking help will increase, thereby overwhelming services already under pressure. This comes back to the perennial question of whether or not the quantum of funding required is enough and how it is distributed is adequate. This means we need to look past just providing short and medium-term contract certainty, if indeed the current model of tendering or contracting out services is to continue, and focus more on the long-term certainty required by the many front-line service providers.[64]

6.74 Mr Tukaki told the committee that to make an impact on the economic costs of mental ill-health and suicide, additional funding was vital:

> Just as we have outlined our desire to see suicide reduced by half over the decade, we cannot get to that point unless we have an honest discussion about the investment required to reach that goal and the return on investment to the taxpayer. Saving lives saves money. But, as I know in business, to make money, you need to spend it. You need to make the long-term investments to make the return, the return obviously being the increased economic productivity of those who have been taken from us too early who otherwise would have made a substantive contribution to the national productivity question.[65]

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63 Associate Professor Judith Proudfoot, Head of eHealth, Black Dog Institute, *Committee Hansard*, 26 August 2015, p.40.

64 Mr Matthew Tukaki, Board Member, Suicide Prevention Australia; Chairman, National Coalition for Suicide Prevention, *Committee Hansard*, 28 August 2015, p. 14.

65 Mr Matthew Tukaki, Board Member, Suicide Prevention Australia; Chairman, National Coalition for Suicide Prevention, *Committee Hansard*, 28 August 2015, p. 14.

Committee view

6.75 The committee supports the priority the Commission has given to suicide prevention in its review, and commends the Commission's findings to the government.

6.76 The committee notes the comments from witnesses, particular Suicide Prevention Australia, that additional funding is needed if the suicide prevention targets recommended by the Commission are to be achieved.

Recommendation 7

6.77 The committee recommends that the government's response to the National Mental Health Commission's report include tangible and measurable actions to achieve the suicide prevention targets recommended by the Commission.

Rural and remote communities

6.78 The Commission gave particular emphasis to the mental health challenges facing those in rural and remote areas:

> On almost any indicator, people living outside of metropolitan areas experience inequity both in terms of their health and in getting access to the right services: lower life expectancy, lower access to Medicare-funded services which diminishes with increasing remoteness, reduced health workforce distribution, and lower rates of mental health service access, with access to psychological services significantly less than in major cities. The impact of these inequities is particularly significant for Aboriginal and Torres Strait Islander people living in these areas.[66]

6.79 Added to the factors facing those in rural and remote areas, the Commission also identified access to services, particularly the limited availability of non-medical services, as a significant barrier to those in rural and remote areas accessing assistance:

> In rural and remote areas, issues in mental health are compounded by reduced access to infrastructure, communications and costs to access services. The Commission has learned from submissions to the Review that discrimination due to mental illness is a factor which affects whether a person seeks services in their town. For some, anonymity is important and they will travel to the next town or regional centre to get the support they need. This presents another barrier to them getting timely access to the type of supports they need. The impacts of drought, bushfires and hard economic times also add to the distress of families and communities in these areas.[67]

66 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 36.

67 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 36.

6.80 The Commission found in relation to mental health in rural and remote areas that:

- Mental health services are often transient, impacted by workforce shortages, and are decreasing despite increased demand;
- Programmes are inadequately funded for the increased cost of delivering services across the distances in rural and remote areas; and
- Access to services could be improved by wider use of technology and by increasing community capacity.[68]

6.81 As a result of its findings, the Commission recommended that service equity for rural and remote communities should be improved through place-based models of care.[69]

6.82 Professor David Perkins, who is a Director and Professor for Rural Health Research at the Centre for Rural and Remote Mental Health (CRRMH) agreed with the Commission's findings in relation to rural and remote communities. He noted that needs and expectations of those in rural and remote communities is exactly the same as those in metropolitan areas:

> If we start with community members and people who live in rural and remote areas and ask what they want and need, I think we find the answers have been articulated well by the National Mental Health Commission and by my state's [NSW] mental health commission. People want a contributing life. They want to live well. They want a secure home, reliable income, education or employment, and to be able to take part in their communities, and they want their symptoms addressed—it might even be in that order. Sometimes we do not see it that way. Obviously, Aboriginal colleagues and friends refer to this as social and emotional wellbeing. I think the professions are beginning to talk about recovery.[70]

6.83 Professor Perkins told the committee that the term 'rural and remote' does not accurately reflect the great variety of communities that exist in regional areas. This variety is, as was identified in the Commission's findings, a key part of the difficulty in service delivery in regional Australia:

> The first [issue] is just how variable rural and remote communities are. A lot of our data says 'metropolitan and rural'. It does not distinguish adequately between the needs and the character of such communities, whether it is farming, mining, tourism or gastronomic rural, such as where I

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68 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 37.

69 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, Recommendation 10, p. 10.

70 Professor David Perkins, Director and Professor, Rural Health Research, Centre for Rural and Remote Mental Health, *Committee Hansard*, 28 August 2015, p. 44.

> live in Orange. There are also the needs of the local population—Indigenous and non-Indigenous. There are socioeconomic differences. There is also location and distance from service centres... I find myself defining 'rural' by saying the usual challenge is that there is a shortage of experts and specialists in every area. Those experts and specialists include medical experts and specialists, but across the board you begin to lose people with that level of expertise living locally.[71]

6.84 Despite the challenges of ensuring equity of access to services in rural and remote areas, Professor Perkins argued that community-based services were the best means of programme delivery. Further, Professor Perkins advocated for the need for health promotion and preventative health to be part of any community-based service delivery:

> Often, the poor health outcomes in rural and remote areas are attributed just to poor access. It is a bit like saying at an interview, 'It is the chemistry.' People have a simple explanation, which often does not seem to go far enough. We think that a broader, patient- and community-centred approach is needed that includes the traditional health services—the GPs and the mental health services—but also employers, community organisations, local government and other interested parties. We need rural and remote communities with health systems that will promote mental health and wellbeing, respond to mental illness and work collaboratively on those suicide rates. We need to develop mental health promotion, mental illness care and suicide prevention that are different for different sorts of communities, and they need to be fairly and equitably funded. But they will need to be designed to meet local needs—perhaps backed up by e-health and telehealth solutions where appropriate. In terms of that mental health promotion, one of the things we are trying to do is to set off 'mentally healthy Orange'. We are using the phrase 'mentally healthy' to be different to 'mental illness', and to say what are the things that an individual can do—at the personal, family, practical and non-institutional level—and then building in employers and others to improve one's mental health.[72]

Committee view

6.85 The committee commends the Commission for including in its review the difficulties of mental health service delivery in rural and remote communities, and the particular challenges facing those communities.

6.86 The committee agrees with the Commission's recommendations in relation to mental health service and programme delivery in rural and remote communities.

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71 Professor David Perkins, Director and Professor, Rural Health Research, Centre for Rural and Remote Mental Health, *Committee Hansard*, 28 August 2015, p. 44.

72 Professor David Perkins, Director and Professor, Rural Health Research, Centre for Rural and Remote Mental Health, *Committee Hansard*, 28 August 2015, p. 45.

Recommendation 8

6.87 The committee recommends that the government's response to the National Mental Health Commission's report address the challenges of mental health service delivery in rural and remote communities.

Aboriginal and Torres Strait Islander peoples and mental health

6.88 The *Close the Gap Progress and Priorities Report 2015* (Close the Gap Report), which was published in February 2015, shows the stark reality of the number of Indigenous Australians who suffer from mental health issues:

> There is an entrenched mental health crisis among Aboriginal and Torres Strait Islander peoples that must be addressed. Mental health problems, including self-harm and suicide, have been reported at double the rate of that of non-Indigenous people for at least a decade. Recent data suggests the situation is getting worse…
>
> The Aboriginal and Torres Strait Islander mental health gap:
>
> **Psychological Distress:** In 2012-13, 30 percent of respondents to the AATSIHS [Australian Aboriginal and Torres Strait Islander Health Survey] over 18 years of age reported high or very high psychological distress levels in the four weeks before the survey interview. That is nearly three times the non-Indigenous rate. In 2004-05, high and very high psychological distress levels were reported by 27 percent of respondents suggesting an increase in Aboriginal and Torres Strait Islander psychological distress rates over the past decade.
>
> **Mental Health Conditions:** Over the period July 2008 to June 2010, Aboriginal and Torres Strait Islander males were hospitalised for mental health-related conditions at 2.2 times the rate of non-Indigenous males; and Aboriginal and Torres Strait Islander females at 1.5 times the rate of non-Indigenous females. Rates of psychiatric disability (including conditions like schizophrenia) are double that of non-Indigenous people.
>
> **Suicide:** The overall Aboriginal and Torres Strait Islander suicide rate was twice the non-Indigenous rate over 2001-10. Around 100 Aboriginal and Torres Strait Islander deaths by suicide per year took place over that decade. In 2012, 117 suicides were reported. The OID [Overcoming Indigenous Disadvantage report] 2014 Report shows that hospitalisations for intentional self-harm increased by 48 percent since 2004-2005.[73]

6.89 The Closing the Gap Campaign Steering Committee therefore recommended that:

> The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing* provides the basis for a dedicated Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing plan. This is developed and implemented with the Health Plan, the *National Aboriginal and Torres*

73 Closing the Gap Campaign Steering Committee, *Close the Gap Progress and Priorities Report 2015*, p. 38.

> *Strait Islander Suicide Prevention Strategy 2013* and the *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy* implementation processes in order to avoid duplication, be more efficient, and maximise opportunities in this critical field.[74]

6.90 The Commission's findings agreed with the findings of the Close the Gap Report:

> Of critical concern is the dire status of the mental health and wellbeing of Aboriginal and Torres Strait Islander people. Indigenous people have significantly higher rates of mental distress, trauma, suicide and intentional self-harm, as well as exposure to risk factors such as stressful life events, family breakdown, discrimination, imprisonment, crime victimisation and alcohol and substance misuse. Service and system responses to these poor outcomes are inadequate, and have generally not been designed with the particular needs of Aboriginal and Torres Strait Islander people in mind.[75]

6.91 Similarly to the Close the Gap Report, the Commission found that rates of mental illness amongst Indigenous Australians are significantly higher than the non-Indigenous population:

> The mental health needs of Aboriginal and Torres Strait Islander people are significantly higher than those of other Australians. In 2011-12 nearly one-third (30 per cent) of Aboriginal and Torres Strait Islander adults (aged 18 years and older) had *high* or *very high* levels of psychological distress, almost three times (2.7) the rate for other Australians. Nationally, there were 22.4 suicides per 100,000 Aboriginal and Torres Strait Islander people during 2012, more than double the rate of 11.0 for other Australians. Aboriginal and Torres Strait Islander people aged 15 years and older report stressful events at 1.4 times the rate of non-Indigenous people.[76]

6.92 Further, the Commission noted that the concept of 'mental health' for Aboriginal and Torres Strait Islander peoples is 'tied inextricably to the concept of social and emotional wellbeing', thus placing wellbeing within the context of a person's experience of family, community, culture, and history:

> The concept of mental health comes more from an illness or clinical perspective and its focus is more on the individual and their level of functioning in their environment. The social and emotional wellbeing concept is broader than this and recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual. Social and emotional wellbeing problems cover a

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74 Closing the Gap Campaign Steering Committee, *Close the Gap Progress and Priorities Report 2015*, Recommendation 7, p. 40.

75 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 14.

76 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 19.

> broad range of problems that can result from unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination and social disadvantage.[77]

6.93 The Commission's finding in relation to Aboriginal and Torres Strait Islander mental health was that there is an urgent need to 'expand dedicated mental health and social and emotional wellbeing teams for Aboriginal and Torres Strait Islander people'.[78] As a result, the Commission recommended:

> Establish mental health and social and emotional wellbeing teams in Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services), linked to Aboriginal and Torres Strait Islander specialist mental health services.[79]

6.94 Witnesses at the committee's public hearings echoed the findings of the Commission and the Closing the Gap Report. Mr Quinlan of Mental Health Australia told the committee that a key part of delivering services in Indigenous communities was community ownership. He used the example of the Aboriginal Community Controlled Health Organisations to illustrate his point:

> I think supporting the sort of community controlled organisations that are genuinely taking control of their own destiny and delivering programs is important. As part of my trip north I visited the Miwatj health service, where there is a genuine ownership of the local strategies and services that are being delivered in that community. I think those sorts of programs provide an excellent model for what we could be doing in other places too.[80]

6.95 Mr Rosenberg of the Brain and Mind Centre agreed with Mr Quinlan, and gave the committee an example of the effectiveness of the Partners in Recovery (PIR) programme when coupled with community ownership and Indigenous workforce:

> I used to do some work in the Cairns area with their local Aboriginal mental health service, and that was one of the first times where I came across PIR in a very effective way. There was an Aboriginal workforce that was working within that program, and I was blown away. But one of the things that they found very difficult was that the rules preclude PIR from working with kids under 16. It is a classic example of a well-intentioned program

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77 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 19.

78 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 11.

79 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, Recommendation 18, p. 11.

80 Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia, *Committee Hansard*, 26 August 2015, p. 33.

> that is applied to mainstream health services with rules and so on, but its application to the Aboriginal community was so completely wrong and counter to their whole view about family and about the social and emotional wellbeing of the whole family. I think it was an example of the fact that we have got some things in place, but they need to be tailored appropriately to make the most of those opportunities.[81]

Committee view

6.96 The committee strongly supports the findings of the Commission in relation Indigenous mental health. From the evidence the committee has heard, it is clear that the Commission's findings are widely accepted, and that they align closely with those of the Closing the Gap Report.

6.97 The committee notes that the Closing the Gap Report identified health as a major area of need for Indigenous Australians and argued that without first addressing health, including mental health, little could be done to close the gap in other policy areas.

6.98 The committee agrees with this argument and strongly urges the government to have regard to the alignment between the Closing the Gap Report and the Commission's review findings and make Indigenous mental health a priority in the government response.

6.99 In this regard the committee notes that the ERG process was informed by an Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group. Ultimately, the government response in this area will be judged by the level of input, support, and ownership it has from Indigenous communities.

Recommendation 9

6.100 The committee recommends that the Government's response to the Mental Health Commission's report sets out a future policy direction to address Indigenous mental health and suicide prevention challenges.

LGBTI

6.101 The Commission identified LGBTI individuals as a vulnerable group, at risk in terms of mental ill-health and its attendant economic and social costs.[82] The Commission noted that there are gaps in the provision of specialised supports and programmes for LGBTI individuals, and that their situation is made more difficult as a result of discrimination and stigmatisation.[83]

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81 Mr Sebastian Rosenberg, Senior Lecturer, Brain and Mind Centre, University of Sydney, *Committee Hansard*, 26 August 2015, p. 33.

82 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 107.

83 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 34.

6.102 Ms Rebecca Reynolds, the Executive Director of the National LGBTI Health Alliance told the committee that her organisation agreed with the findings of the Commission regarding the risk of mental ill-health for LGBTI individuals:

> The prevalence of mental health problems in LGBTI Australians is disproportionately high and carries significant human, social and economic consequences… LGBTI people are part of all population groups, including Australians living in rural and remote areas, in Indigenous communities and in culturally and linguistically diverse populations. LGBTI people have demonstrated considerable resilience in looking after themselves in their communities despite adversity, and they lead healthy and fulfilling lives, contributing to their families, local communities, workplaces and society as a whole in most cases. Nevertheless, the experience of dealing with marginalisation and stigma often impacts on LGBTI people's mental health. These social determinants of mental health are reflected in higher rates of suicide, self harm and depression in LGBTI communities.[84]

6.103 Ms Reynolds told the committee that in comparison to the general population, LGBTI communities risk of suffering mental ill-health was in some instances double:

> …suicide rates for lesbian, gay and bisexual people are 14 times higher than for the general population. The rates for gender diverse Australians are alarmingly high at 35 per cent. Suicide Prevention Australia estimates that 28 per cent of lesbians have self harmed, compared with 8.3 per cent of heterosexual women. Self harm is also higher among gay men at 20.8 per cent, compared to 5.4 per cent for heterosexual men. Of young bisexual men and young bisexual women, 29.4 per cent and 34.9 per cent, respectively, commit self harm. The rate of depression in LGBTI communities is much higher than for the general population, sitting at three times higher for LGB Australians and 6.5 times higher for gender diverse Australians. *Private Lives 2*, a report on the health and wellbeing of LGBTI Australians, reported that 49 per cent of men and 45 per cent of women had experienced a major depressive episode and that 16 per cent of all respondents to that online survey had had suicidal ideation in the two weeks prior to the survey—this was conducted late last year.[85]

6.104 Recommendation 20 of the Commission's review stated the need to:

> Improve research capacity and impact by doubling the share of existing and future allocations of research funding for mental health over the next five years, with a priority on supporting strategic research that responds to policy directions and community needs.[86]

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84 Ms Rebecca Reynolds, Executive Director, National LGBTI Health Alliance, *Committee Hansard*, 28 August 2015, p. 31.

85 Ms Rebecca Reynolds, Executive Director, National LGBTI Health Alliance, *Committee Hansard*, 28 August 2015, p. 31.

86 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 116.

6.105 In outlining how this recommendation could be achieved, the Commission argued that there is a need to:

> Develop evidence about what works in areas which have the potential to realise greatest public value; for example:
>
> - infant trauma
> - child and adolescent health
> - mental health and aged care
> - stigma and discrimination
> - medications use, including metabolic syndrome
> - mental health for vulnerable groups e.g. people from culturally and linguistically diverse backgrounds, Lesbian Gay Bisexual Transsexual and Intersex (LGBTI) people
> - suicide and suicide prevention.[87]

6.106 Further, the Commission emphasised the need to direct research on successful programmes and services into interventions:

> Include consideration of interventions across the domains of:
>
> - promotion
> - prevention and early intervention
> - crisis intervention and suicide prevention
> - treatment
> - recovery and support[88]

6.107 Ms Reynolds explained that the lack of adequate data on LGBTI populations was one major reason for the services targeted at LGBTI communities not receiving attention and funding:

> Data collection is, however, one of the major issues I wanted to raise with you today—gaps in identifying key strategies for addressing negative mental health and suicidal behaviours in LGBTI populations and communities. Those statistics that we do have largely come from service attached consumers, not general population surveys. The 2007 national survey was one of the first national Australian surveys to include a question on sexual orientation. While this was a major step forward in gathering data on the lives of the same-sex attracted and bisexual people, the survey did not include questions on gender identity and intersex status. The continued

87 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 116.

88 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 117.

> absence of these questions on sexuality or sexual orientation, gender identity or intersex status means that our populations remain invisible in the programming of strategies and data. In the absence of any questions on gender identity and intersex status, there is no representative national data on the mental health of trans and intersex Australians and no way of comparing the rates of mental ill health and suicidal behaviours of trans and intersex Australians to the mainstream population and general community.[89]

6.108 Ms Reynolds also pointed out that in comparison to other vulnerable groups, LGBTI communities are often left out of national strategies and plans on mental health, and thus miss out on much-needed research and resourcing:

> The National Mental Health Strategy is made up of three documents: the National Mental Health Policy, released in 2008; the Fourth National Mental Health Plan, from 2009 to 2014; and the Mental Health Statement of Rights and Responsibilities, released in 2012. The first two documents have no mention of LGBTI people in them at all. The Mental Health Statement of Rights and Responsibilities states that in many cases people deserve to have their sexual orientation, gender and gender identity taken into consideration across multiple areas. However, there is no inclusion of intersex people in that at all—an invisible group. Finally, there are many other examples, but the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy has no inclusion of LGBTI, sistergirl or brotherboy people at all.[90]

6.109 Ms Reynolds argued that LGBTI mental health issues and support programmes and services must be included in any response to the Commission's review, or other national mental health plan:

> Given such a glaring lack of consistency across the national level, we strongly advocate for the adoption of an LGBTI mental health promotion and suicide prevention strategy, as is being successfully implemented in the ageing and aged-care sector by other government departments. A mental health and suicide prevention strategy must address these social determinants of reduced mental health amongst LGBTI people, including deeply embedded heterosexist beliefs and practices. It must also build on the capacity of LGBTI people and organisations to develop social relationships and networks with LGBTI populations and between LGBTI populations and the mainstream. Such individual and collective relationships are a source of resilience and social capital that act as protective factors against the increased risk of mental ill health and suicidal behaviours for LGBTI people.[91]

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89 Ms Rebecca Reynolds, Executive Director, National LGBTI Health Alliance, *Committee Hansard*, 28 August 2015, p. 31.

90 Ms Rebecca Reynolds, Executive Director, National LGBTI Health Alliance, *Committee Hansard*, 28 August 2015, p. 31.

91 Ms Rebecca Reynolds, Executive Director, National LGBTI Health Alliance, *Committee Hansard*, 28 August 2015, p. 31.

Committee view

6.110 The committee commends the Commission on its coverage of LGBTI issues in its review. The committee supports the Commissions assessment of the LGBTI community as an extremely at-risk segment of Australian society.

6.111 The committee acknowledges the work of the National LGBTI Health Alliance and similar groups in advocating for those vulnerable members of the LGBTI community.

6.112 The committee notes that the issue of data collection on 'what works' in mental health services and programmes is not restricted only to the LGBTI community. In fact the Commission identified that research across the entire range of Australian communities and mental health issues is badly needed. Targeted research funding must form part of the government's response to the Commission's review, as noted in Chapter 5.

6.113 The committee considers that the government response to the Commission's review must include specific actions in relation to services and programmes for the LGBTI community.

Recommendation 10

6.114 The committee recommends that the government's response to the National Mental Health Commission's report include adequate recognition of the need for data collection to inform services and programmes for LGBTI communities.

6.115 The committee also recommends that the government's response include specific actions and measurable targets in relation to the delivery of services and programmes for the LGBTI community.

Culturally and Linguistically Diverse communities

6.116 One of the Commission's findings was the need to 'promote the wellbeing and mental health of the Australian community, beginning with a healthy start to life'.[92] As part of this finding the Commission recommended:

> Use evidence, evaluation and incentives to reduce stigma, build capacity and respond to the diversity of needs of different population groups.[93]

6.117 This recommendation specifically included the need for cultural responsiveness and culturally appropriate programmes for Culturally and Linguistically Diverse (CALD) communities. In explaining how this recommendation could be achieved, the Commission listed requirements such as:

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92 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 11.

93 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 11.

> 3. Improve cultural responsiveness by supporting the widespread adoption of the *Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery* as a tool to help organisations identify what they can do to enhance their cultural responsiveness…
>
> 5. Adopt clear and explicit equity-oriented targets for people from Culturally and Linguistically Diverse (CALD) backgrounds from multicultural communities to include in government funding agreements.[94]

6.118 Mr Hamza Vayani, the National Project Manager of the Mental Health in Multicultural Australia (MHiMA) told the committee that in fact the first and most urgent task in providing targeted services to CALD communities was research and measurement of mental ill-health in CALD populations:

> If you then try to disaggregate [overall Australian mental-ill health population data] by population groups, it is simply not possible. If we were then to talk about investing prevention money and getting people in earlier, absolutely we would support that. But if we have not actually got an understanding or fix on the cultural and linguistic population groups, whilst you may be wanting to go down that trajectory, if you have not got any measurement around how that population group is going, the risk is that innovation in new practice can occur but you do not have quantified information vis-a-vis this population group and they are left further and further behind as the system progresses. That is the first kind of key challenge that I would really encourage us to think about.[95]

6.119 Ms Sharon Orapeleng, a Senior Project Officer at MHiMA told the committee that often language was a barrier to CALD individuals accessing mental health care. Ms Orapeleng argued the need for workforce training and cultural communication skills:

> Every single service in this country needs to be thinking, 'If I have somebody coming through my door who does not speak English, has a very different understanding of what mental health is because of their cultural background, and has a family who do not even have a word for it—because there are cultures who do not even have a word for mental health—what am I going to be doing to provide the support?' Either it is in the early intervention or prevention space or it is in acute. The whole spectrum of mental health care is where we really need to start thinking about what we are doing for whoever comes through that door. I would really like to see this conversation happening as a mainstream conversation rather than a conversation on the side. Almost 50 per cent of the population is born overseas or has one parent born overseas. It is our reality.[96]

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94 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, pp 105–6.

95 Mr Hamza Vayani, National Project Manager, Mental Health in Multicultural Australia (MHiMA), *Committee Hansard*, 18 September 2015, p. 42.

96 Ms Sharon Orapeleng, Senior Project Officer, MHiMA, *Committee Hansard*, 18 September 2015, p. 44.

6.120 Ms Orapeleng also noted that language was a barrier in collecting data about mental ill-health in CALD populations:

> If somebody comes to me and says, 'You work with multicultural communities; what is the prevalence of depression in the multicultural communities?' I would not be able to say what it is, because we know that, even in the national mental health and wellbeing survey, people who did not speak English were excluded. If you were able to speak English then you were able to answer the questions that were provided, but if you were not able to speak English then you were excluded… Unfortunately, we can say anecdotally that these things happen, but the data that is out there is not supporting what is going on.[97]

6.121 Mr Vayani told the committee that MHiMA's *Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery* online tool would be a great benefit for organisations to assess their multicultural work:

> …the Framework for Mental Health in Multicultural Australia, which is I believe world-leading work in that it is online and allows services to really assess what they are doing in terms of being culturally responsive and sets for the first time some metrics around services being able to plot what they are doing and also to measure that impact against national standards for quality and safety in health care as well as the national standards for mental health services.[98]

6.122 In fact, Mr Vayani advised that the Sydney Local Health District had been using the framework with good results, because it demonstrated a gap in service provision and allowed action to be taken:

> For instance, we know that in the Sydney Local Health District, when they started using this framework and mapping what they were doing, they realised that interpreters were not being called in, potentially two or three days into somebody's length of stay. That person does not have language and may not define mental health as we know it. Imagine: they are really unwell, and three days of very little or no communication or understanding of what is happening to them is difficult.[99]

Committee view

6.123 The committee supports the Commission's findings and recommendations in relation to targeting services and programme delivery to CALD communities. In particular, the committee commends the Commission for its support of the MHiMA *Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery*.

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97 Ms Sharon Orapeleng, Senior Project Officer, MHiMA, *Committee Hansard*, 18 September 2015, pp 43–44.

98 Mr Hamza Vayani, National Project Manager, MHiMA, *Committee Hansard*, 18 September 2015, p. 37.

99 Mr Hamza Vayani, National Project Manager, MHiMA, *Committee Hansard*, 18 September 2015, p. 44.

Recommendation 11

6.124 The committee recommends that the government response to the National Mental Health Commission's report should include support for the use of the Mental Health in Multicultural Australia *Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery*.

e-mental health

6.125 The Commission included e-mental health and information technology as part of its person-centred approach to care, noting that technology can be used 'to link people and services and promote self-care and wellbeing'.[100]

6.126 In its 'stepped care' approach to the provision of mental health services, the Commission saw a place for e-mental health and technology to assist individuals to manage their own care, as well as being a more flexible service delivery mode:

> A stepped care approach supports Australians to take greater responsibility for their own mental and physical wellbeing. A new service paradigm is needed to support that choice and responsibility. Significant advances occurring in e-mental health provide the opportunity to encourage a society where self-help is more fully integrated in the system, and that people know where to go and how to get access to the specific information and support they need. It does not obviate the need for face-to-face care when necessary, but it does reduce the need for expensive services for those things which people can do for themselves, or with their families or other support people. That creates efficiencies but also enables cost-effective use of the time and skills of clinical and other professionals—and frees up the valuable personal time of individuals.[101]

6.127 The Commission saw e-mental health as a means of implementing its recommendation in relation to improving 'service equity for rural and remote communities through place-based models of care'.[102] The recommendation reads:

> Include services that are mental health-specific, delivered through health and other non-health portfolios, e-mental health and other phone and online services, as well as broader services which contribute to the physical health of those with a mental illness.[103]

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100 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 44.

101 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 47.

102 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 84.

103 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 84.

6.128 The Commission also envisaged a role for e-mental health in its recommendation regarding the promotion of self-help options to assist people, their families and communities to support themselves and each other, and improve ease of navigation for stepping through the mental health system.'[104]

6.129 In regards to this recommendation, the Commission suggested that e-mental health could be one of the ways in which the promotion of resources and support mechanisms could be achieved:

> Drawing on the expertise of the mental health and community sectors—including e-mental health providers—to develop, disseminate and promote a suite of resources and supports for self-help and online services, and evidence of effectiveness of these supports.
>
> - This could include a 'Mental Fitness Ready Reckoner' for people, their families and other support people to explain psychological distress and mental health.
> - Distribution should be through various channels including social media, eHealth and telehealth, as well as through general practices, pharmacies, community centres, Centrelink offices, schools and workplaces.[105]

6.130 Mr Heath of SANE Australia agreed with the Commission's view that e-mental health should be part of the community-based, or 'upstream' services:

> It is critical that the spending on mental health should align with the burden of disease. At the moment, it is tracking at about seven per cent in terms of spending, 14 per cent in terms of burden. We need to have greater investment upstream, especially in the online and digital services. We are still not connecting with around half the people that have mental illnesses and we cannot do that in the ways that we have done in the past. The online world provides an excellent opportunity to do that. Within that environment, there is a huge untapped resource of peer-to-peer support that is available.[106]

6.131 Associate Professor Proudfoot of the Black Dog Institute told the committee that her organisation had done research which demonstrated the effectiveness of e-mental health in providing support for individuals suffering mental ill-health:

> I would like to say that, apart from it being available 24/7 to enable those in need of support and to assess risk factors in real time, there is a strong body of evidence worldwide demonstrating the clinical and the cost effectiveness

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104 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 87.

105 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 87.

106 Mr Jack Heath, Chief Executive Officer, SANE Australia, *Committee Hansard*, 26 August 2015, p. 39.

> of e-mental health programs for mild to moderate depression and anxiety, insomnia, alcohol and drugs, as well as suicide prevention. Controversially, there have been trials which show for these mild to moderate conditions that e-mental health programs are as effective as face-to-face therapy. The other great advantage is that they translate to real world conditions, and research, both ours and international, has shown that they do improve work and social functioning. They do not just reduce symptoms; they improve work and social functioning. This means that fewer people need to be referred to secondary and tertiary services.
>
> We have done some cost effectiveness analyses as well. We considered a fully-automated program—that is, without clinician support—but tailored to individuals, and it was about half the cost of antidepressant medication and about a sixth of the cost of face-to-face CBT [Cognitive Behaviour Therapy]. They are available; they are effective, but to date they have not been integrated into a stepped care model or into primary care. That was one of the recommendations from the National Mental Health Commission.[107]

6.132 Mr Woodward, the Executive Director Lifeline Research Foundation, Lifeline Australia, also supported the use of e-mental health, alongside telephone helpline services and web-based services. Mr Woodward explained that there needed to be clear priorities in the use and management of e-mental health and telephone helplines:

> In relation to the mental health system, we have made three points. The first is that there should be more recognition for teleweb and helpline services as components of the wider mental health system—not as projects or innovation trials or as short-term funded services, but as part of the overall system—and that they should be provided with programmed and continued funding on that basis. The second point is that improvements are possible in the makeup and operation of helplines and teleweb services in Australia through improved coordination and the operation of those services in an overall model of service drawing on public health principles to delineate the roles and specialities across the existing services and making the services more responsive, more accessible and less confusing to those who wish to contact and use the services. The third point is that we have recommended that there be work done with the helplines and teleweb sector to identify how that model of service and care should operate and the roles to be performed—rather than government making ad hoc or isolated decisions about one service's role or funding without reference to the impacts on others.[108]

Committee view

6.133 The committee supports the Commission's recommendations regarding e-mental health.

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107 Associate Professor Judith Proudfoot, Head of eHealth, Black Dog Institute, *Committee Hansard*, 26 August 2015, p. 41.

108 Mr Alan Woodward, Executive Director, Lifeline Research Foundation, Lifeline Australia, *Committee Hansard*, 28 August 2015, p. 16.

6.134 The committee agrees that e-mental health should be seen as an important element of the overall solution for improving equity in delivery of mental health services to rural and remote communities. It must be effectively integrated with community-based mental health services, support, and deliver ownership by the local community.

Recommendation 12

6.135 The committee recommends that the government's response to the National Mental Health Commission's report supports the Commission's findings and recommendations in relation to e-mental health.