



Joint submission to the Productivity Commission: Draft report into mental health

January 2020

1. About MHV and VHA

Mental Health Victoria (MHV) is the peak body for organisations that work within or intersect with the mental health system in Victoria. Our members include consumer and carer groups, community health and mental health services, hospitals, medical associations and colleges, police and emergency services associations, unions, local governments, and other bodies across the health, housing and justice sectors.

Our aim is to ensure that people living with mental illness can access the care they need, when and where they need it. Our view is that all Australians should have access to a core suite of services that they can choose from – be they delivered in the home, the community, or in the hospital.

The **Victorian Healthcare Association (VHA)** is the peak body supporting Victoria's health services to deliver high quality care. Established in 1938, the VHA represents the Victorian \$20 billion public healthcare sector including public hospitals and community health services.

The VHA supports Victoria's healthcare providers to respond to system reform, shape policy and advocate on key issues, delivering vision, value and voice for the Victorian health sector. In addition, the VHA assists its members with the implementation of major system reform.

Our collective vision is for a mental health system that:

- involves people with lived experience, families and carers in decisions which affect their lives
- provides tailored, high-quality supports to people with different care needs and at different life stages
- wraps around a person, ensuring all of their needs can be met
- is easily navigable, providing continuity of care
- is outcomes-focused
- is adequately and sustainably resourced to meet current and future needs including demand.

2. This submission

This submission has been jointly written by MHV and the VHA, with close input from both organisations' members, and from the Victorian Mental Health Policy Network (VMHPN). The VMHPN represents the experiences and perspectives of dozens of organisations across the mental health and related sectors, including consumer, carer and professional peak bodies, public hospitals and community health services, and advocacy groups.

3. Introduction

We congratulate the Productivity Commission (PC) on its Draft Report (the Report), which represents a major milestone in Australia's mental health reform journey.

We welcome the opportunity to provide feedback on the Report and its recommendations for reform, and look forward to the publication of the final report in May 2020.

We note that there is broad support for the majority of recommendations proposed by the PC; however, we are concerned by a number of gaps in the Report that we believe should be addressed before the final report is presented to Government.

This submission is structured as follows:

- **Part 4** identifies several broad areas where the report can be strengthened, covering an overarching vision for mental health, the role of mental healthcare in the community, and key population gaps.
- **Part 5** responds to each section of the Report and provides further commentary and recommendations where relevant.

Given our broad support for the majority of the PC's recommendations, our considered feedback is largely focused on the sections relating to Workforce, Governance, and Federal Roles and Responsibilities.

4. Opportunities to strengthen the final report

The Report offers a succinct identification of the challenges facing consumers as they navigate the mental health system. Its focus is appropriately broad; however, there are specific gaps that we believe should be addressed in the PC's final report.

i. Provide an overarching vision for mental health and wellbeing

The case for change has been well articulated in the Report. Significant attention has been focused on outlining in detail the current state of the mental health system and its various gaps and failings. The recommendations are, for the main part, linked to identified areas of need and offer a coherent response to the identified gaps.

Despite this, the Report does not provide a clear articulation of the 'end state' of the reform journey. It does not sufficiently outline the PC's overarching vision for system reform, beyond responding to individual gaps that have been identified.

We recommend that the final report articulate a vision or blueprint for its proposed reforms, outlining clearly what its vision for Australia's mental health system is at key points into the future including how these will relate to and intersect with other important review and reform processes, such as the Victorian Government's Royal Commission into Mental Health.

ii. Mental healthcare in the community

We recommend that the final report include a clearer articulation of the critical role of recovery-orientated mental healthcare in the community. Unless community-based, recovery-oriented care is the priority for the mental health system of the future, there exists the risk of perpetuating the current system gaps and failings that the PC has identified in the Report.

To complement the recommendation above, we suggest that the PC articulate a process for developing a list of mental healthcare services which should be universally available to all Australians in the community, regardless of where they live. In its expanded role, the National Mental Health Commission would be ideally placed to conduct this work. This will complement the discussion in the report concerning the 'missing middle'.

In keeping with this, we recommend that Recommendation DR 7.1 be clarified to ensure that appropriate targets are developed for the broad range of clinical and non-clinical support services required.

iii. Address key population gaps

Mental health responses must be individualised to meet people's needs, as there is no one-size-fits-all approach to managing mental ill health. While the PC has acknowledged the needs of some key population groups, specific consideration must be given to the needs of all population groups to ensure equity across all demographics including age, gender, location, race, ethnicity, sexuality, gender identity, health status and life experiences.

In particular, we urge the PC to consider the mental health issues affecting older Australians and the LGBTIQ+ community. There are also other population groups who have high rates of mental ill health, individuated care needs and/or difficulties accessing appropriate services. Not all of these population groups have been addressed and we urge the PC to work with individuals and organisations with relevant expertise and lived experience to ensure that appropriate recommendations are provided for all population groups, including Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse (CALD) communities, including refugees and asylum seekers, women and girls, unpaid family and friend carers, and people with dual disability.

Older Australians

We recommend that the PC respond to the needs of older Australians in the final report.

Those aged 65 years and over – an arbitrary bureaucratic dividing line between being an ‘adult’ and an ‘older person’ – face significant disadvantages in accessing medical, allied health and other support services.

While stigma and stereotypes may tell us otherwise, mental ill health is not a normal part of ageing. Despite this, the mental health needs of older Australians are often overlooked or dismissed. With Australia’s rapidly ageing population, addressing the mental health needs of older people should be an urgent priority.

The following comments outline the significant challenges faced by older Australians, both in terms of the prevalence of mental ill health, and in accessing support and care:

- Navigating the service system is very difficult for individuals, unpaid family and friend carers and health professionals.
- Older people have very high PBS mental health medication rates but very low MBS service rates relative to the rest of the population.
- Men aged 85 and over have the highest age-specific suicide death rate in Australia.
- People living in residential aged care facilities (RACFs) generally rely on aged care staff and unpaid family and friend carers to identify their needs for mental healthcare.
- Providing long-term care can have a significant impact on an unpaid family and friend carer’s own health and wellbeing as well as their financial, vocational and educational security.
- Generally speaking, staff in RACFs have not been equipped to respond to the mental health needs of residents.
- Many incidences of depression and anxiety are not recognised or treated in RACFs due to the common misunderstanding that these conditions are corollaries of ageing.
- Training in identifying mental ill health in older people must be improved, particularly for those employed in RACFs, along with a broader focus on ensuring RACF residents have equitable access to allied health services, including mental healthcare, on a level comparable with community settings.

We understand that the PC has not considered in detail residential aged care and the broader mental health issues affecting older Australians due to the concurrent Royal Commission into Aged Care Quality and Safety.

We are concerned that, to date, the Royal Commission into Aged Care Quality and Safety has not dealt with mental health specifically and for this reason our recent submission –

which we have already provided to the PC – has an overarching recommendation that there be a special hearing that focuses on mental health services in the aged care sector.

Regardless of the response of the Royal Commission to our suggested special hearing, it is essential that the PC's final report address the mental health needs of older Australians. The two Commissions are running concurrently and must, where possible, work together to leverage the findings and recommendations of each to ensure that the consequent reform agenda is coherent and efficient.

People from LGBTIQ+ communities

Notwithstanding the acknowledgment of the mental health needs of people from LGBTIQ+ communities, the Report does not include sufficient findings or specific recommendations that are targeted to the lived experience and needs of Australians in LGBTIQ+ communities. The PC's final report should address the needs of LGBTIQ+ Australians, with recommendations that are clear, specific and targeted to their needs.

The needs of LGBTIQ+ community are unique and are often best served by a combination of community-controlled mental health services and action to ensure that mainstream health services are accessible, safe and inclusive for people from LGBTIQ+ communities. Recommendations should therefore aim to achieve, at a minimum, ongoing, sustainable funding for community-controlled LGBTIQ+ mental health services and LGBTIQ+ training for mainstream mental health services.

Beyond additional funding and support for community-controlled mental health services, it is important that broader peer-led programs are considered a core element of mental health care, supported by a robust evidence base that outlines the extent of mental ill health in this community, and guided by a specific LGBTIQ+ mental health prevention strategy that aims to end structural inequality, stigma and discrimination that continues to drive poor mental health and increased risk of suicide.

5. Feedback by Draft Report Section

i. SECTION 5: Primary mental healthcare

We welcome the PC's recommendations relating to primary mental healthcare. While we support accountability for performance, we are concerned at the choice of output in DR5.3 which dictates the behaviour of the service provider. In this case, tying funding to raw referrals may introduce an incentive to refer on, rather than address the need to improve the outcome and quality of care provided. A more holistic funding model may be more appropriate.

DR 5.9: The Australian, State and Territory Governments should reconfigure the mental health system to give all Australians access to mental healthcare, at a level of care that most suits their treatment needs (in line with the stepped care model), and that is timely and culturally appropriate.

DR 5.1: The Australian Government should introduce an MBS item for psychiatrists to provide advice to a GP over the phone on diagnosis and management issues for a patient who is being managed by the GP. The effectiveness of the new item should be evaluated after several years. The PC's final report should address the needs of LGBTIQ+ Australians, with recommendations that are clear, specific and targeted to their needs.

DR 5.2: Commissioning agencies (PHNs or RCAs) should promote best practice in initial assessment and referral for mental healthcare, to help GPs and other referrers match consumers with the level of care that most suits their treatment needs (as described in the stepped care model).

DR 5.3: headspace grant funding for individual centres should be made conditional on centres meeting targets for the proportion of young people referred to low intensity services. The targets set by commissioning agencies (PHNs or RCAs) for each centre should depend on the full range of relevant characteristics of the young people they see. The targets should start low and increase over time.

DR 5.4: MBS rebated psychological therapy should be evaluated, and additional sessions trialled.

DR 5.5: The Australian Government should change MBS rules so that group therapy is allowed with a minimum of 4 people (instead of 6 people), and with less than 4 people, as long as the course of group therapy began with at least 4 in the group.

DR 5.6: Commissioning agencies could learn from the success of Practitioner Online Referral Treatment Service (PORTS) in Western Australia in improving accessibility and effectiveness of online mental healthcare treatment options.

DR 5.7: The Australian Government should change MBS rules so that videoconference can be used for MBS rebated Psychological Therapy Services and Focused Psychological Strategies by consumers residing in metropolitan areas, regional centres and large rural towns (Monash Modified Model areas 1–3) in addition to those residing in small and medium rural towns, remote and very remote communities (Monash Modified Model areas 4–7).

DR 5.8: The Australian Government should amend the MBS regulations for referrals to require that general practitioners and other referrers advise people that they can use an alternative to any provider mentioned in a referral to a specialist or allied health professional that all referrals to specialists and allied health professionals include a prominent and easy to understand statement advising people that they can use an alternative to any provider mentioned in the referral.

We also note that the PC's focus is understandably centred on the role of the Medicare system. This is fair, given the essential role of the *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS Initiative*; however, we suggest that there are a range of non-MBS services, typically provided by community health services, that offer mental health supports, interventions and other essential wrap-around services for consumers and carers.

In relation to DR5.3, we recommend further consideration be given to the funding model which is most appropriate.

We further suggest that the PC consider introducing bulk-billing incentives as a means of improving access to psychiatrists and/or psychologists, including via consideration of higher rebates under the *Better Access Scheme* for people living in low socioeconomic households.

ii. SECTION 6: Supported online treatment

We welcome the PC's recommendations relating to supported online treatment. However, we note that digital consultations cannot be seen as the panacea for filling gaps in a stretched system, particularly in rural areas. We welcome the PC's requirement in DR6.1 that online treatment programs have a strong evidence base, and suggest that online treatment programs should be available for consumers only as an alternative to direct consultations with a practitioner or counsellor, rather than as a substitute.

DR 6.1: The Australian Government should facilitate greater integration and use of supported online treatment, into the stepped care model as a low intensity service, for people living with mental ill health with mild to moderate symptoms.

- Funding should be expanded for services to accommodate up to 150 000 clients per year in supported online treatment.
- Supported online treatment programs offered should each have a strong evidence base for their efficacy and be offered to children, youth and adults.
- To aid integration of healthcare services, supported online treatment should have the option for outcomes data to be forwarded to a nominated GP or other treating health professional. Online service providers should annually publish summary output on use of their services, treatment provided, and other measurable outcomes.
- A review of supported online treatment services as a low intensity option should be undertaken. This review should assess whether there are any barriers to take up, the effectiveness of the services contracted and future funding options.

DR 6.2: The Australian Government should instigate an information campaign to increase awareness of the effectiveness, quality and safety of government funded clinician supported online therapy for treatment of mental ill-health for consumers and health professionals.

iii. SECTION 7: Specialist community mental health services

While we support recommendations DR7.1 and 7.2, we recommend that there be a much more detailed focus of the importance of community-based mental healthcare in the final report. Unless there is a significant focus on ensuring access to community-based, recovery-oriented care is the priority for the mental health system of the future, we risk perpetuating the system gaps and failings that the PC has identified in the Report.

DR 7.1: State and Territory Governments should determine, through regional service planning, the numbers of public acute mental health beds in hospitals, specialist mental health community treatment services and subacute/non acute mental health bed-based services that would meet the specific needs of each region and undertake to provide these on an ongoing basis.

DR 7.2: The Australian Government should introduce a new suite of time tiered items for videoconference consultations to regional and remote areas (RA2–5), as recommended by the MBS Review Psychiatry Clinical Committee, removing item 288 from the MBS. In addition, the Australian Government should add new items for videoconference consultations mirroring existing items for psychiatric assessments (item 291) and reviews (item 293), that are available in major cities (RA1) as well as in regional and remote areas (RA2–5), and that are paid at the same rate as items 291 and 293.

We suggest that the PC articulate a process for developing a list specifying which mental healthcare services should be universally available to all Australians in the community, regardless of where they live. This will prevent gaps between broad regional service planning and regionalised commissioning decisions from arising. In its expanded role, the National Mental Health Commission will be ideally placed to conduct this work. This will complement the discussion in the report concerning the 'missing middle'.

In addition, the final report requires a clearer articulation of the critical role of recovery-orientated mental healthcare in the community.

We further recommend that Recommendation DR7.1 be clarified to ensure that appropriate targets are developed for the broad range of clinical and non-clinical support services required, including targets for high dependency beds and secure extended care beds.

iv. SECTION 8: Emergency and acute inpatient services

We welcome the PC's recommendations in relation to improving emergency mental health service experiences; however, we believe that there are further opportunities which may be capitalised upon with regard to both sectors.

DR 8.1: State and Territory Governments should provide more and improved alternatives to hospital emergency departments for people with acute mental illness, including peer and clinician led after-hours services and mobile crisis services.

- State and Territory Governments should consider best practice approaches to providing paramedics with access to mental health resources when undertaking medical assessments in the field.
- Public and private hospitals should take steps to improve the emergency department experience they provide for people with a mental illness. This could include providing separate spaces for people with mental illness, or otherwise creating an environment more suitable to their needs.
- State and Territory Governments should, when building or renovating emergency departments, design them to take account of the needs of people with mental illness.

DR 8.2: State and Territory Governments should provide child and adolescent mental health beds that are separate to adult mental health wards. If it is not possible to provide these beds in public hospitals, State and Territory Governments should contract with private facilities, or provide care as hospital in the home.

In relation to DR 8.1, we recommend a more holistic approach to improving crisis care including consideration of alternative assessment models, such as PROMPT, and opportunities to improve capacity among rural and remote areas services.

In relation to DR 8.2, we recommend that states and territories be required to provide gender-specific separate wards to improve safety, and suggest that the PC investigate the option of co-locating future child and adolescent mental health wards in facilities that also offer general paediatric services, to facilitate access to shared expertise and improve access to age-appropriate environments, with a focus on regional availability of these beds.

Emergency services

Public hospital emergency departments, particularly those in metropolitan and large regional centres, are significantly strained given current population levels and demand across all urgency categories. While we support recommendations for infrastructure redevelopments, other models and programs may be expanded upon which can help to provide alternative solutions which may be quicker to implement, more cost effective and

more preferable to the consumer. Accordingly, we urge the PC to consider addressing the emergency department experience holistically, rather than limiting its focus to improving the physical environments of acute hospitals, with a focus on identification of approaches that see the number of presentations to emergency departments drop.

There exist examples in Victorian hospitals where individuals in need of an assessment can be seen by specialists and triaged prior to, or in place of, attending an emergency department. Barwon Health and Ambulance Victoria's Prehospital Response of Mental Health and Paramedic Team (PROMPT) model is an award-winning approach that partners specialist mental health clinicians with paramedic teams when attending call-outs where mental ill health may be a factor. In appropriate instances, patients are assessed and triaged sooner, reducing the need for people to wait in an emergency department. Such models, while not the panacea for improving system efficiency and the patient experience, may be a superior alternative to expensive and relatively slow-moving redevelopments of physical infrastructure as they can be deployed at relatively short notice and within existing resources.

Where patients need to present to an emergency department for assessment, Psychiatric assessment and planning units (PAPU) provide specialist psychiatric assessment and short-term treatment to enable rapid transfer of patients who present at emergency departments, reducing or eliminating long stays in emergency departments and providing the option for discharge to community-based care rather than transfer to an inpatient unit. This is a proven model that has been successfully implemented at a number of Victorian health services. Ideally every major emergency department in public hospitals would have access to a nearby PAPU.

We suggest that the PC's final report include recommendations relating to emergency care that encompass the need for redevelopment of physical infrastructure alongside alternate programs and models such as those described above.

Acute inpatient services

With regard to acute inpatient care, Victorian hospitals have been working to develop hospital-in-the-home (HITH) models of care that allow patients to receive access to inpatient-equivalent care in their homes, rather than in specialist inpatient wards. Such models can help to improve the capacity of inpatient units by improving patient flow and facilitating alternative care settings. There is scope for existing models to be adapted for use in caring for people experiencing mental ill health, and subject to an evaluation of the model's efficacy, the PC should focus its attention on determining how it can support the expansion of HITH as an equitable alternative to inpatient care.

Regional capacity to manage increasing demand for inpatient beds needs to be viewed as an important part of the solution. Currently, regional responsibility for acute inpatient care is delegated to a regional health service, with a network of smaller scale rural hospitals working to support care by referring and transferring eligible patients as required. This system is under significant pressure, with limited bed capacity in regional health services meaning patients who have presented at a neighbouring hospitals' emergency department forced to wait for significant amounts of time before a full assessment and transfer can take place. Considering the role of rural hospitals and their capacity to work with consumers locally should be a significant part of the PC's deliberations.

v. SECTION 9: Physical and substance use comorbidities

We welcome the PC's commentary on physical and substance use comorbidities, however we note that there are no recommendations for reform contained in this section of the Report.

In particular, we note that the dual diagnosis of mental ill health and substance use comorbidities is a significant challenge for service providers. Traditional 'mental health' and 'alcohol and other drugs' (AOD) services are often poorly equipped to manage the complex needs of consumers with these comorbidities, with a lack of available places and funding for specific dual diagnosis clinics and providers. As a result, many consumers end up caught between mental health and AOD services without access to dual diagnosis services targeted to their needs.

We recommend clarification regarding the reforms required to address physical and substance use comorbidities, including with regard to the need for:

- increased availability of dual diagnosis services
- health promotion mechanisms and screening and lifestyle interventions (relating to smoking cessation, healthy exercise and diet, substance use, etc.) in all specialist mental health services providing care to people with complex mental health **issues**.

vi. SECTION 10: Care integration and coordination

We welcome the PC's recommendations for improving care integration and coordination.

DR 10.1: Assistance phone lines offering support for people with mental ill-health and their carers should facilitate better exchanges of information between service providers.

DR 10.2: Commissioning agencies should ensure service providers have access to online navigation platforms offering information on pathways in the mental health system.

DR 10.3: Governments should support the development of single care plans for consumers with moderate to severe mental illness who are receiving services across multiple clinical providers.

DR 10.4: All people with severe and persistent mental illness who require care coordination services due to their complex health and social needs should be receiving them. Governments should set a national benchmark for all commissioning authorities, to ensure such services are available and any gaps are addressed.

In relation to DR 10.4, we suggest the PC give consideration to how this may cohere with other reviews to ensure that adequate care coordination services can be provided for NDIS participants.

We further suggest that efforts be considered to ensure care coordination services are properly inclusive and cognisant of the role of family and friend carers.

vii. SECTION 11: Workforce

We recommend that the PC expand the scope of the Workforce section in the final report to include the very significant community component of the mental healthcare workforce.

DR 11.1: Better workforce planning by governments to align service provider skills, availability and location with demand.

DR 11.2: Training more psychiatrists in Australia by raising the number of training placements and availability of supervisors for trainees.

DR 11.3: Increasing the number of locally-trained mental health nurses by introducing an undergraduate degree in mental health nursing, and recognising specialist mental health qualifications as part of nurse registration.

DR 11.4: Strengthening the peer workforce through a more comprehensive system of training, work standards, an organisation to represent this workforce, and a program to build support for the value of peer workers among other health professions.

DR 11.5: Encouraging more GPs in rural and remote areas to undertake advanced specialist training in mental health.

DR 11.6: Reducing negative perceptions of mental health as a career option, such as by offering students in health disciplines more internships in settings other than inpatient units.

DR 11.7: Making rural and remote locations more attractive for health professionals, including expanding the availability of locums for workers when they are on leave or undertaking professional development.

We welcome and support the PC's specific recommendations for the psychiatrist/medical, nursing, peer and rural health workforces. Notwithstanding the acknowledgment of other professions in the report, there remains a need for a more holistic approach to ensure all relevant reforms and opportunities are considered for all relevant workforces, including integrated approaches. For example, further consideration is required for career progression and supervision arrangements for peer workers, and for training opportunities and retention efforts vis-a-vis volunteers.

Particular attention should be paid to the peer workforce, including differentiation between workers with lived experience as a consumer or as a carer. The two roles have very distinct needs and expectations, and should be defined separately for this reason. The value of both segments should be recognised intrinsically. Consumer and carer lived experience work are both highly skilled and specialised disciplines which require opportunities for career progression that do not involve changing specialisation, ongoing training and supervision from experienced lived experience workers, not other mental health professionals, and adequate and sustainable funding to grow over time.¹

Recommendation DR 11.1 regarding a new National Mental Health Workforce Strategy provides a good starting point for how to address these complex issues. Provision of further details in the PC's final report would be useful to ensure that the Strategy reflects the complex composition of the workforce. A list of relevant professions, including those not directly addressed in the Report, should be made explicit, with relevant options for attraction, retention and training/professional development considered for each.

It is also important that the Strategy explicitly maintain a long-term vision of reform, combined with relatively short review periods to ensure that it adequately reflects the new landscape after reforms have been implemented, and as the sector continues to grow. A robust consultation process should also be required to provide ample opportunity to identify and address gaps.

¹ For more information, see submissions from VMIAC and Tandem Inc.

Finally, greater coordination is required to ensure the Strategy coheres with other workforce planning initiatives from Commonwealth and state/territory governments, and across different disciplines and locations. Currently there are active workforce strategies, or strong calls to increase and deepen the workforce, in a variety of mental health-related areas such as aged care, alcohol and other drugs, family violence and clinical disciplines in rural areas. While not detracting from the need for strategic growth in the mental health workforce, it is important that efforts to address workforce shortages leverage off existing and complementary strategies across the health and human services portfolio.

In the interim, particular attention should be given to the community/psychosocial workforce which is collapsing under the transition to the NDIS. Interim supports are required to stem flow of workers into other sectors, with particular attention paid to remuneration and scopes of practice. For example, the reduced scope of practice for care coordinators under the NDIS is quickly eroding the availability of those who have the requisite skills and experience to provide care coordination services to people with mental health issues. While the PC's recommendation for an audit in DR 10.4 is welcome, this will likely only be finalised after further damage to the workforce has been done.

A new National Mental Health Workforce Strategy should address:

- the full range of professions associated with mental health service delivery including:
 - specialist mental health workers (e.g. consumer and carer/family peer workers, psychosocial support workers, psychiatrists, psychologists, mental health nurses)
 - primary health workers (e.g. GPs, allied health workers, generalist nurses)
 - specialist health workers (e.g. geriatricians, obstetricians)
 - alcohol and other drug (AOD) workers
 - recovery and social support workers (e.g. social workers, occupational therapists)
 - related workforces (e.g. community services, education, disability, housing, aged care, justice, first responders, youth services, creative therapies)
 - community streams across all workforces (e.g. volunteers, workers from Aboriginal and Torres Strait Islander, CALD and LGBTIQ+ communities)
- optimising deployment utilisation of roles within a multidisciplinary team to ensure teams function cohesively and cost-effectively
- training and development of all relevant professions including:
 - upskilling in mental health and mandatory skillsets in generalist undergraduate programs
 - pathways into postgraduate specialisations
 - consistency and appropriateness of training models and curricula
 - opportunities for integration (e.g. joint training, rotations between mental health and AOD sectors)
 - the meaningful inclusion of cultural competencies and LGBTIQ+ inclusion and safety in workforce development strategies, including community-led training of mainstream mental health services.
- attraction and retention of all relevant professions including:
 - remuneration for work and other financial supports
 - coaching/supervision and mentoring/apprenticeship programs
 - career progression opportunities
 - self-care programs and supports
- measures to address workforce shortages in rural, regional and remote areas, including:

- incentives to attract trained and candidate workers to relocate to country areas
- incentives for service providers to operate in areas with high demand/low availability of mental health services, across all disciplines.

viii. SECTION 12: Psychosocial Support

We support the PC's recommendations in relation to psychosocial support.

DR 12.1: The Australian, State and Territory Governments should extend the funding cycle length for psychosocial supports from a one year term to a minimum of five years.

DR 12.2: Requirements for continued access to psychosocial support should be changed so that anyone who requires it is able to access it, including former participants of Australian Government-funded psychosocial supports.

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

When the National Psychosocial Support Measure is phased out, participants should either be shifted onto the NDIS, if appropriate, or access the replacement psychosocial support.

DR 12.3: The NDIA should continue to improve its approach to people with psychosocial disability.

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

We recommend that the PC explicitly state that funding should be provided to satisfy the full demand for psychosocial support services – and not just the current level which is heavily rationed, leaving many people unsupported.

We further recommend that the PC consider ways of improving oversight of the level and quality of care provided by NDIS service providers to participants experiencing mental health issues.

ix. SECTION 13: Carers and Families

We support the PC's recommendations in relation to Carers and Families as set out below.

DR 13.1: Reduce barriers that affect mental health carers' access to Carer Payment and Carer Allowance.

DR 13.2: Employment support for mental health carers.

DR 13.3: Mental health professionals are skilled and supported to provide family-focused and carer-inclusive care.

We recommend that the PC further consider the need for state-based guidelines on care- and family-inclusive practices to be implemented in all states and territories, and the further reduction of barriers to carers' access to income payment support by calculating work restrictions on the basis of a 13-week period.²

² See submission from Carers Victoria.

x. SECTION 14: Income and Employment

We support the PC's recommendations for Income and Employment as set out below.

DR 14.1: Assessment tools for jobactive and Disability Employment Services participants should be more relevant to job seekers with mental illness

DR 14.2: Ongoing development of the New Employment Services should consider the needs of participants with mental illness.

DR 14.3: Extending the IPS model of employment support beyond its current limited application through a staged rollout involving placing IPS employment support specialists in community mental health services — either through direct employment or through partnerships with Disability Employment Services.

DR 14.4: The Departments of Human Services; Social Services; and Employment, Skills, Small and Family Business should provide greater flexibility in the application of the Targeted Compliance Framework for jobseekers experiencing mental illness.

We recommend that the PC consider the adequacy of income support as a preventable contributing factor to mental illness.

xi. SECTION 15: Housing

We support the PC's recommendations in relation to housing as set out below.

DR 15.1-15.2] State and Territory Governments should commit to a formal policy of no exits into homelessness for people discharged from institutional care, comprehensive mental health discharge plans, and services available in the community to meet the needs identified in the plans.

- working towards meeting the gap in supported housing places (that integrate housing, tenancy support and mental health services) for people who need regular mental healthcare and would otherwise be at risk of housing instability.
- working towards meeting the gap in homelessness services, with a focus on long term housing for people with mental illness
- services and housing places should first target people with severe and complex mental illness, who are persistently homeless.

Initiatives that can prevent people with mental illness from losing their home, such as expanding tenancy support services, should be developed

Australian, State and Territory Governments should work towards increasing ongoing funding for the additional housing places outlined as a priority above.

The National Disability Insurance Agency should encourage development of long-term supported accommodation for people with severe and chronic mental illness who require 24/7 support.

Mental health training should be provided for frontline housing workers to identify, monitor and respond appropriately to tenants with mental illness.

We note the critical importance of housing in preventing mental ill health, particularly in light of the complex relationship between housing security, social isolation and mental health. However, places in residential community rehabilitation facilities continue to be over-subscribed, largely due to a lack of secure and safe housing for consumers to live in after discharge from care facilities. Improving access to housing will reduce the length of stay in residential community facilities (community rehabilitation facilities), enabling better flow through the stepped care mental health service system.

We recommend that the PC consider:

- the role of housing insecurity as a preventable contributor to mental illness, and a major influence on the ability of mental health service providers to offer meaningful access to stepped care mental health services.
- the utility of ambitious and clear targets for the development of accessible housing that is intended for people experiencing, or at risk of developing, mental ill health.

xii. SECTION 16: Justice

We support the PC's recommendations in relation to justice as set out below.

DR 16.1: Police should be supported with access to mental health resources when responding to mental health related incidents.

DR 16.2 National mental health service standards should apply to mental healthcare service provision in correctional facilities.

DR 16.3: Improving the rigour of mental health screening and assessment processes in correctional facilities to inform resourcing, and planning for continuity of care post-release.

DR 16.4: Culturally capable mental healthcare should be available in correctional facilities for Aboriginal and Torres Strait Islander people.

DR 16.5: Developing disability justice strategies to ensure the rights of people with mental illness are protected in their interactions with the justice system.

DR 16.6 -16.7: Ensuring legal representation and non-legal advocacy services for those subject to involuntary treatment.

We recommend that the PC further consider:

- the need for improved access to mental health assessments and treatments in appropriate settings for people in prisons and justice facilities
- opportunities to work towards the elimination of restrictive practices with deleterious effects on mental health (e.g. solitary confinement)
- immigration detention settings, which have particularly deleterious effects on mental health
- Health–Justice Partnerships (e.g. First Step) which are an essential part of the mental health system service architecture.

We recommend that the PC consider mental health and suicide prevention support for police and other first responders who experience higher level of distress than the general population, including the need for:

- a unique and tailored mental health strategy for this cohort
- a treatment model that facilitates early intervention and access to appropriate levels of care across the full spectrum of care needs
- continuing care for workers who have left their roles.

xiii. SECTION 17: Interventions in Early Childhood and Schools

We support the PC's recommendations in relation to interventions in early childhood and schools.

DR 17.1: Governments should take coordinated action to achieve universal screening for perinatal mental illness.

DR 17.2: Services for preschool children and their families should have the capacity to support and enhance social and emotional development.

DR 17.3: Governments should develop a comprehensive set of policy responses to strengthen the ability of schools to assist students and deliver an effective social and emotional learning curriculum.

DR 17.4: The education system should review the support offered to children with mental illness and make necessary improvements.

DR 17.5: All schools should employ a dedicated school wellbeing leader, who will oversee school wellbeing policies, coordinate with other service providers and assist teachers and students to access support.

DR 17.6: Governments should expand the collection of data on child social and emotional wellbeing, and ensure data is used (and used consistently) in policy development and evaluation.

Beyond the six recommendations included in the Report, we suggest the PC consider including the following:

- Invest in positive infant mental health across a range of early parenting and early childhood settings, by including infant mental health as a central component in the development of all new relevant government strategies.
- Create a Perinatal Mental Health Plan, with a focus on enhanced and ongoing funding for Perinatal Emotional Health Programs.
- Introduce systematic antenatal mental health screening for all women throughout pregnancy.
- Actively promote the research on the first thousand days to a broad audience to increase understanding of the risk and protective factors for infants during this period that can influence their future mental health, development and wellbeing.
- Invest in a range of evidence-informed, self-determined perinatal and early years interventions that have proven successful in supporting the social and emotional wellbeing of Aboriginal and Torres Strait Islander children and their families.
- Explore options for increasing the availability and reach of infant mental health training and skills focused on the first thousand days for the early childhood workforce.
- Expand the links between community health services and the education system in order to provide enhanced access to mental health clinical support in education settings. Ensuring mental health is offered by a clinician employed by a health provider will facilitate access to broader health and social services, should they be needed. The Doctors in Secondary School program is a useful case study of how the two systems can operate effectively in tandem.

xiv. SECTION 18: Youth Economic Participation

We support the PC's recommendations in relation to youth economic participation.

DR 18.1: The Australian Government should amend the Higher Education Standards Framework (Threshold Standards) 2015 and the Standards for Registered Training Organisations (RTOs) 2015 to require:

- all teaching staff to undertake training on student mental health and wellbeing
- all tertiary education providers to make available guidance for teaching staff on what they should do if a student approaches them with a mental health concern and how they can support student mental health.

DR 18.2: The Australian Government should amend the Higher Education Standards Framework (Threshold Standards) 2015 and the Standards for Registered Training Organisations (RTOs) 2015 to require all tertiary education institutions to have a student mental health and wellbeing strategy. This strategy would be a requirement for registration and would be assessed by the Tertiary Education Quality and Standards Agency or Australian Skills Quality Authority as part of the registration process.

DR 18.3: To supplement guidance being developed for universities to address student mental health, the Australian Government should develop or commission guidance for non-university higher education providers and Vocational Education and Training providers on how they can best meet students' mental health needs. This should include best-practice interventions that institutions could adopt to build students' resilience and support their mental health.

We recommend that mental health first aid training be made more widely available, including to:

- young people so that they can provide peer support
- community members that have contact with young people (eg football coaches)
- workers in all education settings, including teaching and administrative staff.

xv. SECTION 19: Mentally Healthy Workplaces

We support the PC's recommendations in relation to mentally health workplaces.

DR 19.1: Psychological health and safety should be given the same importance as physical health and safety in workplace health and safety (WHS) laws.

DR 19.2: Codes of practice should be developed by Workplace Health and Safety authorities in conjunction with Safe Work Australia to assist employers meet their duty of care in identifying, eliminating and managing risks to psychological health in the workplace. Codes of practices should be developed to reflect the different risk profiles of different industries and occupations.

DR 19.3: Workers compensation schemes should provide lower premiums for employers who implement workplace initiatives and programs that have been considered by the relevant Workplace Health and Safety authority to be highly likely to reduce the risks of workplace related psychological injury and mental illness for that specific workplace.

DR 19.4: Workers compensation schemes should be amended to provide clinical treatment for all mental health related workers compensation claims, regardless of liability, until the injured worker returns to work or up to a period of six months following lodgement of the claim. Similar provisions should be required of self-insurers.

DR 19.5: WHS agencies should monitor and collect evidence from employer initiated interventions to create mentally healthy workplaces and improve and protect the mental health of their employees. They should then advise employers of effective interventions that would be appropriate for their workplace.

In keeping with DR 19.1 which seeks to create parity between physical and psychological safety, we recommend that the PC consider the mandating of mental health first aiders in workplaces and mental health training for management and leadership positions.

xvi. SECTION 20: Social Participation and Inclusion

We support the PC's recommendation in relation to social participation and inclusion.

DR 20.1: The National Mental Health Commission should develop and drive the implementation of a national stigma reduction strategy that focuses on the experiences of people with mental illness that is poorly understood in the community

DR 20.2: The Financial Services Council should update the mental health training requirements for insurers in Life Insurance Industry Standard 21, in consultation with a national consumer and carer organisation to reflect contemporary thinking about mental illness. The Financial Services Council should also:

- expand the coverage of Life Industry Standard 21 to include all employees of covered insurers so as to ensure the industry as a whole has a better understanding of mental illness
- publish data they receive on industry compliance with the Standard
- rollout the Standard to superannuation funds and financial advisory group members.

The Australian Securities and Investments Commission should evaluate the operation and effectiveness of the insurance industry Codes of Practice and industry standards that relate to the provision of services to people with mental illness.

DR 20.3: The Australian Government should evaluate best practices for partnerships between traditional healers and mainstream mental health services for Aboriginal and Torres Strait Islander people.

This evaluation should incorporate the knowledge and views of Aboriginal and Torres Strait Islander people and seek to improve the evidence about how a partnership between traditional healers and mainstream mental healthcare can most effectively support Aboriginal and Torres Strait Islander people with mental illness and facilitate their recovery in their community.

xvii. SECTION 21: Suicide Prevention

We support the PC's recommendation in relation to suicide prevention.

DR 21.1: Australian, State and Territory Governments should offer effective aftercare to anyone who presents to a hospital, GP or other government service following a suicide attempt. Aftercare should be directly provided or referred, and include support prior to discharge or leaving the service, as well as proactive follow up support within the first day, week and three months of discharge, when the individual is most vulnerable.

DR 21.2: The Council of Australian Governments Health Council should develop a renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and associated Implementation Plan to guide suicide prevention activities in Indigenous communities. Indigenous organisations should be the preferred providers of local suicide prevention activities for Aboriginal and Torres Strait Islander people. For all organisations providing programs or activities into Indigenous communities, the requirements of performance monitoring, reporting and evaluation should be adapted to ensure they are appropriate and reflective of the cultural context.

DR 21.3: The proposed National Mental Health and Suicide Prevention Agreement (DR 22.1) should identify responsibilities for suicide prevention activities across different levels of government and across portfolios to create a truly whole of government approach to suicide prevention. Responsibilities should be informed by, and consistent with, the National Suicide Prevention Implementation Strategy under development.

The National Suicide Prevention Implementation Strategy should be extended to include strategic direction for non-health government portfolios that have influence over suicide prevention activities.

The National Mental Health Commission should assess evaluations of current trials that follow a systems approach to suicide prevention. It should consider whether the evidence shows if these approaches are likely to be successful at reducing suicide rates and behaviours in Australia. If so, this approach should be implemented across all Australian regions.

We recommend that the PC include recommendations to target at-risk groups, including LGBTIQ+ people, current and former service personnel, and first responders.

We further recommend improvements in the availability of bereavement supports for people affected by suicide.

xviii. SECTION 22: Governance

Our mental health systems cannot meet the current and future needs of Australians. This is due to many interconnected and reinforcing factors, including:

- ineffective governance – compounded by Commonwealth, state and territory service silos, a multitude of commissioning bodies, in effective planning, and a lack of real targets and outcome measures
- a history of under-resourcing across all systems, resulting in rationing of services, ageing infrastructure and failure to meet growing demand
- insufficient focus on prevention, early intervention and recovery in the community.

We agree that major reforms are needed to the governance arrangements that underpin Australia's mental health system to ensure that consumers, families and carers participate fully in the design of policies and programs that affect their lives, that there is genuine accountability for system outcomes, and to clarify responsibilities for program funding and delivery.

We also agree with the broad priority governance reforms proposed by the PC, although we would like the NMHC to have a broader role, as discussed below.

DR 22.1: The Council of Australian Governments (COAG) should set clear divisions of responsibilities in a new National Mental Health and Suicide Prevention Agreement.

DR 22.2: COAG should develop a new whole-of-governments National Mental Health Strategy that aligns the collective efforts of health and non-health sectors to improve mental health outcomes.

DR 22.2: The Australian Government should expedite the development of an implementation plan for the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023.

DR 22.3: The Australian, State and Territory Governments should collaborate with consumers and carers in all aspects of mental healthcare system planning, design, monitoring and evaluation.

DR 22.4: The COAG Health Council should agree on a set of targets and specify key mental health and suicide prevention outcomes that Australia should achieve over a defined period of time.

DR 22.5: The National Mental Health Commission should have statutory authority and lead the evaluation of mental health and suicide prevention programs.

In relation to DR 22.5, beyond the expanded role proposed by the PC, we recommend that the NMHC have oversight of mental health, addiction, and wellbeing.

We believe that there is a need for a strong and independent national body to lead the evaluation of mental health, addiction and suicide prevention programs funded by the Australian Government, state and territory governments, and other programs that have strong links with mental health outcomes, including those in non-health sectors.

We consider that the fundamental purpose of the expanded NMHC should relate to:

- *Leadership:* Act as a system leader of mental health, addiction and wellbeing, encouraging a universal wellbeing approach with a focus on protective factors identified in resilience literature, such as social connection, belonging, value and meaning in life.
- *Oversight:* Help Australians hold commissioning bodies and successive governments to account, including by monitoring how well strategies and reforms relevant to mental health, addiction and wellbeing are being implemented by responsible agencies and by publicly reporting on progress.

- *Expertise*: Provide independent expert advice to commissioning bodies and governments, on its own initiative or as requested, on any matters relevant to mental health, addiction and wellbeing.
- *Advocacy*: Advocate for the collective interests of people with mental health and addiction challenges and their families.
- *Innovation*: Drive change while bringing others along on the need for innovation and best practice.
- *Integration*: Promote cross-sectoral collaboration, communication and understanding about mental health and wellbeing across mental health, justice, housing and other relevant sectors.

Specific responsibilities of a national leadership body should relate to:

- *Monitoring* how well the system is functioning, including with regard to access, service delivery and health outcomes, as well as how strategies and reforms relevant to mental health and wellbeing are being implemented by responsible agencies.
- *Reporting* publicly on the state of the system, the health of the nation, and the progress of strategies and reforms.
- *Data oversight* to ensuring suitable data collection and monitoring processes are undertaken at all levels, with data disaggregated according to key demographics.
- *Data analysis* to bring together national and state/territory-based data and provide comprehensive commentary and analysis.
- *Evaluation* of mental health, addiction, suicide prevention and wellbeing-related programs.³
- *Provision of evidence-based advice* to support governments, commissioning bodies and services, including with regard to:
 - minimum service needs, including a core suite of services, access pathways and infrastructural and workforce requirements
 - best-practice models of care coordination and options for service delivery across the care spectrum, including a model for community mental healthcare⁴
 - co-design approaches to research, service delivery and evaluation
 - appropriate funding models and their implementation for different types of services.

We recommend that the PC examine New Zealand’s Mental Health and Wellbeing Commission as a potentially useful model upon which to base the proposed expansion of the NMHC in Australia.

We also recommend that the PC consider its proposed changes to the NHMC in relation to new Victorian Collaborative Centre for Mental Health and Wellbeing (VMHRC Interim Report Recommendation 1) which will be established in 2020.

³ As per recommendation 22.5

⁴ For more details on a community mental healthcare model, see MHV RC submission.

xix. SECTION 23: Federal Roles & Responsibilities

We support the PC's recommendations for greater clarification of federal and state/territory responsibilities and have provided further feedback below on DR 23.2 and Information Request 23.1 regarding the architecture of the future mental health system.

DR 23.1: The Independent Hospital Pricing Authority should review the Australian Mental Health Care Classification to determine:

- whether the structure of the Australian Mental Health Care Classification and the variables within it should be refined or changed (especially the 'phase of care' variable)
- if the 'phase of care' variable is retained, how the variable can be refined to improve inter-rater reliability
- if a new costing study is required
- a revised timeframe for implementing the classification.

As an interim measure, the Independent Hospital Pricing Authority should consider developing a classification system for community ambulatory mental healthcare services based on hours of care provided.

DR 23.2: State and Territory Governments should take on sole responsibility for commissioning psychosocial and mental health carer support services outside of the National Disability Insurance Scheme. The Australian Government should provide funding to support the new and expanded roles that State and Territory Governments are taking on, and continue to administer the Carer Gateway's service navigation and information services for all carers.

DR 23.3: The Australian Government and State and Territory Governments should work together to reform the architecture of Australia's mental health system to clarify federal roles and responsibilities and incentivise governments to invest in those services that best meet the needs of people with mental illness and their carers. There should be greater regional control and responsibility for mental health funding.

Psychosocial and carer support services

As recommended by the PC, we agree that state and territory governments should take on sole responsibility for commissioning psychosocial and mental health carer support services outside of the NDIS and that the Australian Government should provide funding to support the new and expanded roles that state and territory governments will thereby take on.

We recommend that the PC explicitly state that the funding to be provided should be sufficient to satisfy demand for these services – and not just the current supply which is heavily rationed, leaving many people unsupported.

Architecture of the future mental health system

We strongly support the PC's efforts to probe options for reforming the architecture of the mental health system. Clearly, consumers, carers and families are not well-served by the fragmented planning and commissioning structures in place across Commonwealth and state/territory jurisdictions. We believe this should be a long-term iterative process, with the expanded NMHC playing a key role.

While the remit of the PC is to address gaps and necessary improvements to the mental health system, it is essential that fundamental reforms are contemplated in the context of what can best support the delivery of suitable services to consumers. In this regard, neither the Renovate nor the Rebuild model is entirely appropriate. There are components of each that, if implemented, would improve the responsiveness and efficiency of the mental health system, and improve remove many of the gaps between service providers and levels of

government. However, there are also components of each option that would lead to fragmentation within and between agencies.

It may be preferable to reform the system architecture in an ongoing fashion. This would allow important incremental changes to begin the process, while further consultation and collaboration can illuminate the most appropriate next steps as other elements of the system change. Getting governance of the system right is important and this would likely be achieved best with a measured and iterative approach.

With this in mind, we provide some further comments on specific aspects of the models suggested for the PC's consideration:

- *Regional Commissioning Authorities:* Creating an additional layer of bureaucracy carries significant risks associated with increased costs and administrative requirements for service providers. While single-stream providers (i.e. those who provide only mental health services) may not be as affected, 'generalist' providers (i.e. those who provide mental health services along with other services such as physical health and community services) will face considerable increases in compliance, cost and administrative burdens, having to contend with yet another commissioning body in addition to existing structures. In an overly complex system, a costly additional administrative burden will have the effect of placing a considerable brake on productivity. Furthermore, if the intent of the PC's focus on the consumer experience and streamlining their care is to be maintained, it is important that scarce funding is allocated effectively and in ways that support the provision of care. A new commissioning body, applied nationally, is an expensive and duplicative approach that will redirect funding from service provision to support its administration. As such, we do not support the proposal to introduce Regional Commissioning Authorities, or a new layer of bureaucracy responsible for commissioning services. Rather, we support efforts to improve the current commissioning system with the expanded NMHC playing a key role.
- *Decentralised decision-making:* While regional autonomy is desirable, a decentralised approach to decision-making presents the very real risk of further fragmentation and gaps in service provision. This is true regardless of the obligation to report back to the Australian Government for monitoring purposes. Taking the PHNs as an example, each is required to prepare a Mental Health and Suicide Prevention Plan for their respective regions subject to very broad guidance. The sum of these plans will not be a whole-of-population plan for a given state or territory. Nor can we pull out plans for at-risk cohorts, e.g. Aboriginal and Torres Strait Islander, LGBTIQ+, and CALD people. Inevitably, there will be gaps in service provision between regions without a more centralised approach. The expanded NMHC may be able to play an important role in this regard.
- *Pooled funding:* In principle, pooled funding of mental health services may provide significant benefits; however, caution must be exercised to ensure that it does not result in a reduction of service delivery funding available to service providers. Shifting services which are currently funded by state/territory governments into a commissioning model can have implications when the administration costs of running these commissioning bodies is taken into account.
- *Activity-based funding:* The suggestion for community mental health services to be activity-funded is a step backwards for consumers. While the PC argues that there are financial efficiency gains to be made under activity-based funding, we are concerned that if implemented, an activity-based model would come at the expense of flexibility in

meeting the individual needs of each consumer, the ability to develop a holistic models of care, and would undermine any meaningful progress at measuring and incentivising service providers to improve their quality of care. We urge the PC to consider this recommendation very carefully, and consider the implications of adding a fundamentally different funding model to community mental health services, many of which are situated in community health services, whose broader funding models are largely block allocations that support mental health promotion and other essential activities that are not easily represented within an activity-based funding classification. The potential benefits in matching the activity-based model used in acute inpatient hospitals with those in community settings do not outweigh the international and local moves away from purely activity-based models, to alternatives that incentivise outcomes such as value-based healthcare. As such, we do not support the proposal to introduce an activity-based funding model to community mental health services.

xx. SECTION 24 Funding Arrangements

We are broadly supportive of the following recommendations, and would make the following comment to clarify our position on DR 24.2: *Headspace*

DR 24.1: The Australian Government should tie the funding that commissioning agencies (PHNs or the Productivity Commission's proposed Regional Commissioning Authorities, as the case may be) receive to the volume of MBS rebates for allied mental health services paid in their regions. It should relax restrictions that prevent commissioning agencies from co-funding MBS-subsidised providers.

DR 24.2: The Australian Government should relax requirements for PHNs to direct funds to headspace centres.

DR 24.3: As part of the next renegotiation of the National Housing and Homelessness Agreement, the Australian Government should consider additional funding to State and Territory Governments for delivery of housing and homelessness services for people with mental illness.

DR 24.5: The Australian Government should review the regulations that prevent private health insurers from funding community-based mental healthcare.

DR 24.6: The Australian Government should permit life insurers to fund mental health treatments for their income protection insurance clients on a discretionary basis.

We support the autonomy of PHNs to fund the most appropriate organisations in their region to deliver services. We also consider the suite of services available under the headspace brand to be an important part of the national service architecture which should be available in all regions, and tailored to local conditions.

Headspace centres act as a one-stop shop for young people who need help with mental health, physical health (including sexual health), alcohol and other drugs or work and study support. The centres are recognised by the public as the 'go-to' place for youth mental health services.

Headspace is more than just a service model delivered under tender by a multitude of service providers. The brand itself plays a crucial role in stigma reduction and normalising help-seeking in the community.

Relaxing requirements for PHNs to direct funds to headspace centres will result in further fragmentation of the service system, with access to headspace available in some regions and not others. We fear that this will provide a confusing message to the public and will be counter to efforts to encourage help-seeking.

xxi. SECTION 25 Monitoring, Reporting & Evaluation

We support the PC's recommendations in relation to monitoring, reporting and evaluation.

DR 25.1: The Australian, State and Territory Governments should task the Mental Health Information Strategy Steering Committee with developing a strategy to improve data linkage.

DR 25.2: The Australian Government should support the ABS to conduct a National Survey of Mental Health and Wellbeing no less frequently than every 10 years.

DR 25.3: High quality and fit for purpose data should be collected to drive improved outcomes for consumers and carers.

DR 25.4: Monitoring and reporting should be more focused on outcomes for consumers and carers and broadened beyond health portfolios.

DR 25.5: The Australian, State and Territory Governments should authorise the Australian Institute of Health and Welfare (AIHW) to report all data relating to the performance of mental health and suicide prevention services at a regional level, as defined by commissioning agencies (PHNs or RCAs), as well as at a State and Territory, and national level.

DR 25.6: The Australian, State and Territory Governments should provide commissioning agencies (PHNs or RCAs) with guidance and support to enable them to implement standardised monitoring and reporting requirements for commissioned services, with minimal undue regulatory burden.

DR 25.7: The COAG Health Council should agree to a set of principles by which the National Mental Health Commission would undertake its evaluation function, as set out in DR 22.5. These principles should be set in consultation with relevant stakeholders.

DR 25.8: The Australian Government should consider the expected cost-effectiveness of all mental health programs or interventions before funding is provided. Allocation of funding should only be considered for programs or interventions that are expected, on the basis of evidence provided in the funding request, to be cost-effective.

DR 25.9: The Australian Government should fund the establishment of a national clinical trial network in mental health and suicide prevention. In developing this network, the Australian Government should consult with bodies that work in this area including the National Medical and Health Research Centre and the Australian Clinical Trials Alliance.

We note the important role of translational research in identifying opportunities to put evidence into practice, then testing and refining models of care before scaling up across states and nationally. While the Report canvasses the concept of embedded evaluation to ensure that programs achieve their goals and contribute to improved health and wellbeing outcomes, we encourage the PC to also consider fostering translational research, ideally embedded in centres of excellence within the specialist mental health service system. Further, we support approaches that enable the scaling up and sharing of proven models.

In addition to recommendation DR 25.9, we suggest the PC expand its recommendation to include the establishment of clinical trial networks that are specific to children, adolescents, young people, adults and older people, in separate cohorts.



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